I. Policy Developments Regarding the Treatment of Women Offenders in the U.S.: The Slow Process of Change

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A. Introduction

In 1971, President Richard Nixon convened the National Conference on Corrections to address the topic of prison reform in the United States.The conference was a response to the deadly 1971 Attica Prison riot, which had called attention to the neglected state of America's prisons. It brought together many experts on the topic.Among many speakers, Dr. Edith Flynn delivered the only address on women offenders. In "The Special Problems of Female Prisoners", Dr. Flynn called attention to the fact that female offenders had been blatantly ignored in policy developments and research. In her speech she also noted that prevailing theories of criminal behavior were inapplicable to women and that the resulting lack of information had adverse implications for managing and treating female offenders in America's correctional agencies. To support of her assertions, she referred to a recent President's Commission on Law Enforcement and Administration of Justice (1967),stating that"not a single paragraph or statistic on the female offender could be found in any of the material" (Flynn, 1971).

In the intervening years, research has put forward a clearer picture of how women become involved in the justice system and what their treatment needs are when they get there. However, there is clear reason to lament the arduously slow pace in which emerging evidence is impacting policies and services for women(Belknap, 2007; Belknap & Holsinger, 2006; Blanchette & Brown, 2006; Bloom, Owen & Covington, 2003; Chesney-Lind, 2000; Holtfreder, Reisig, & Morash, 2004; Messina, Grella, Cartier, & Torres, 2010; Reisig,

Holtfreter, & Morash, 2006; VanDieten, 2011;VanVoorhis, 2009).Over 40 years have passed since Dr. Flynn delivered her address and we in the U.S. are still struggling to bring about meaningful reform for women.

Early attempts to fill the knowledge gap observed by Dr. Flynn includedsurveys of correctional programs (Glick & Neto, 1977) and women offenders (U.S. GAO, 1979). A number of classic qualitative studies followed over the ensuing decades (Arnold, 1990; Bloom, 1996; Chesney-Lind & Rodriguez 1983; Chesney-Lind & Shelden, 1992; Daly, 1992, 1994; Gilfus, 1992; Holsinger, 2000, Owen, 1998; Richie, 1996; Smart, 1976). Over time, these studies portrayed very different pictures of women's and men's entry (pathways) to crime, one that,for women,called attention to abuse and trauma, poverty, unhealthy relationships, mental illness, substance abuse, and parental stress.

These few studies appeared to call attention to the need for psychological programs targeted to mental health, trauma, and substance abuse. The need for educational and employment programs to improve women's socio-economic status was another implication of the early studies. However, notwithstanding this research, very little attention was devoted to showing how the identification ofwomen's needs might impact correctional programs and services for women. At that point, infact, very few state and federal policies favored correctional rehabilitation for females *or males.* Until the 1990s correctional priorities favored policies of incapacitation and punishment….not attempts to change offender behavior or improve their circumstances (see Cullen, 2005).

This began to change in the 1990s with a more favorable political climate and emerging research that found that well-run rehabilitative psychological, educational, and social service programs could reduce the reoffending of 15 to 30% of convicted offender

populations (Andrews, Zinger, Hoge, Bonta, Gendreau & Cullen, 1990a; Lipsey, 1992).Even so, the research fueling the policy transition was largely conducted on boys and men. For example, two highly influential meta-analyses[1] of correctional programsconcluded with warnings that women and girls were under-represented in the research (Andrews et al., 1990a; Lipsey, 1992). Just the same, the meta-analysis conducted by Donald Andrews and his associates at Carlton University (Andrews et al., 1990a),generated a series of "Principles of Effective Intervention" (see also Gendreau, 1996; Andrews & Bonta, 2010) and the Principles of Effective Interventionfueled the development of the now predominant correctional treatment paradigm, variously referred to as "the Canadian Model," the Risk Needs Responsivity Model (RNR), and the "What Works" Model. Through the remainder of this essay, I will refer to this approach as the Principles of Effective Intervention or "the Principles."

The Principles of Effective Intervention offered some clear and important guidelines that have been well supported by subsequent research. These guidelines are fundamental to the way that effective correctional treatment programs are operated in the U.S. and Canada. There are several principles (see Smith, Gendreau, & Goggin, 2009). For purposes of this paper, we focus on the three most important principles, the risk principle, the needs principle, and the guideline to utilize cognitive behavioral treatment modalities:

i. *The Risk Principle* maintains that intensive correctional programs are appropriate for high risk but not low risk populations.In order to achieve meaningful reductions in recidivism, it is necessary to confine intensive services to medium and high risk offenders. Taking this a step further, the research typically finds that directing intensive services to low risk clients makes them worse, and does so for many reasons;

[1] A meta-analysis is an empirical study which synthesizes findings of numerous experimental studies (Glass, McGraw, and Smith, 1981). Meta analyses produce "effect sizes" for each of the modalities studied; the "effect size" statistic is noted to produce more stable findings than former methods of summarizing findings across studies.

ii. *The Needs Principle*states that in order to achieve success in changing offenders' behavior, it is essential to target the risk factors for future offending. As with medical treatments, it makes little sense to target a factor which is not relevant to a particular disease. The guidelines further give priority to the treatment of "the Big 4": criminal history, antisocial attitudes, antisocial personality, and antisocial associates. Alternatively, sources sometime recommend the "Central 8" consisting of the "the big 4" plus substance abuse, family/marital, education/employment, and use of leisure/recreation time (see Andrews & Bonta, 2010).

iii. The *cognitive behavioral therapeutic modality* is more likely to reduce offender recidivism than other psycho-therapeutic modalities such as psychodynamic therapy, person-centered therapy and other models. Cognitive-behavioral modalities target the criminal attitudes or thought processes that lead to and support antisocial behaviors.

Correctional research conducted over the past 25 years has also resulted in the development of dynamic risk/needs assessments to classify correctional offenders into low, medium, and high levels of risk on the basis of needs known to significantly predict future offending. Since the assessments identified an array of predictive needs, they also served as a valuable tool for triaging offenders into programs most likely to turn them away from lives of crime. The early construction validation studies for these assessments were also based largely on male offender samples (e.g., see Brennan, 1998; Blanchette & Brown, 2006; Holtfreder et al., 2004; Van Voorhis, Wright, Salisbury, & Bauman 2010) and validated on women much later than their initial construction (e.g., see Andrews, Dowden, & Rettinger, 2001; Lowenkamp, Holsinger,& Latessa, 2001; Manchak, Skeem, Douglas, & Siranosian, 2009; Smith, Cullen, & Latessa, 2009). For the most part, the revalidation studies found these assessments to be valid for women. For our purposes, it is important to note that the following needs are typical to most of these assessments:

Criminal history
Employment/education
Financial
Housing/neighborhood situation

Alcohol/drug use
Family marital
Emotional stability (mental health)
Use of leisure time
Antisocial friends
Antisocial thinking

The critics of the Principals of Effective Intervention and the risk/needs assessments, feminist scholars for the most part, do not so much fault their validity among women, but rather the fact that the Principles, the programs, and the assessments are not the correctional treatment paradigm that we would have *if we had started with women* at the time the models were developed. For example, by the time researchers finally addressed the problem of the external validity of the assessments, by conducting research on women, it was too late to include the needs that researchers found most relevant to women offenders. Thus, programs were not targeted to many of the problems that brought women into crime (Belknap & Holsinger, 2006; Bloom et al, 2003; Hannah-Moffat, 2009; Van Voorhis et al., 2010). With no assessments to identify these problems, women were less likely to be triaged to gender-specific services such as protection from abusive partners, childcare services, and access to reliable transportation, or programs targeted to low self-efficacy, trauma and abuse, parenting programs, healthy relationships, or realistic employment opportunities that allowed for self-support (Bloom et al., 2003).

This is the state of correctional treatment in the U.S. today. Generally, programs, strategies, policies, even prisons, are designed for men and applied to women with little thought or research. The U.S. federal government did much to try to change this situation, mostly through projects funded through the National Institute of Correction in the U.S.

Department of Justice.[2] Still the new assessments and programs presented on Monday and Tuesday of this week (Van Voorhis, 2013) have struggled for funding or broad-scale implementation. Although there are some very progressive U.S. states which are implementing the gender-responsive models, progress is slow. The gender-responsive work has been faulted for lacking evidence (Andrews & Bonta, 2010), not because the work has not passed empirical scrutiny, but because it will be decades before the volume of experimental studies of female programs approaches the number of male-based studies included in the large meta-analyses. Thus, it is not the "lack of evidence" per se, but rather the loss of a "numbers game." And the failure to win that numbers game is adversely impacting efforts to improve treatment programs for women offenders.

The intent of the paper is not to overly lament this situation but rather to take a studies look at how this happens. Why is it so difficult to advocate for women? The paper couldlament sexist, patriarchal policies, and male-dominated governments and funding policies but this paper will examine the role of science, instead.I was privileged to work on several of these projects along with teams of extremely talented and committed graduate students, government officials, scholars, administrators, practitioners, and activists. Beginning in the late 1990s, the University of Cincinnati secured a cooperative agreement with NIC to construct a public domain women's risk/needs assessment (WRNA). Along with the research, my staff and I operated in the role of *embedded researchers* (Petersilia, 2008), as

[2]Some maintain that even these advances would not have occurred without rather dramatic increases in the number of women incarcerated (Buell et al, 2011). Largely resulting from policies promoting mandatory sentencing for drug offenders and reductions in funding for mental health services (see Austin et al., 2001; Mauer, Potler & Wolf, 1999), growth in the size of women's prison populations far outpaced growth in the size of men's prison populations (Bureau of Justice Statistics, 1999). Most recent figures show a decline in state and prison populations (Guerino et al., 2011; Pew Center on the States, 2010), however, the national imprisonment rate declined for men and remained unchanged for women (Guerino et al., 2011).

research partners with the agencies participating in our research and adopting the assessments. This vantage point offered a discouraging view of the barriers that science posed to progress. Having spent most of my career studying male offenders, including a good deal of research on the Principles of Effective Intervention, I was not prepared for my first-hand introduction to the abysmal state of science as it accounts for, or more accurately, fails to account for, the lives of women. On reflection, how that science has unfolded in a culture where "male is norm" (Tavris, 1992) was discouraging to observe, and the costs of the "male is norm" scientific model are substantial. Thus, I was also embedded in the process of an emerging body of evidence that ran contrary to the prevailing evidence of the day. There is a story to that, and I believe that it is important to tell it.

As will be seen, a number of these scientific issues were not unique to corrections but rather reflected the scientific culture of our times. Other challenges emerged from the recent science of correctional treatment itself. In the pages that follow, I discuss the challenges impacting the gender-responsive movement in corrections. I will, however, conclude on a more optimistic note with an overview of emerging evidence, a body of research that, while still not as plentiful as that regarding male offenders, is nevertheless achieving consistency across studies and showing a rather promising path to improving approaches for women (VanDieten, 2011).

It is now almost 40 years since Professor Flynn reminded the National Conference on Corrections that the field had produced no research on women offenders, and that, as a consequence, women served by the male model of corrections were not receiving appropriate programs and services. The science needed to correct this situation emerged too slowly. Moreover, new evidence-based treatment models for women are even now mostly in a

dissemination stage, far from full implementation. True, some correctional and pretrial agencies adoptedevidence-based,gender responsive assessments and programs, but many of these efforts have experienced fit-fullstarts and stops. I continue to agree with Dr. Flynn. As an overview, science was a factor in the following key ways:

i. As far as women and minorities are concerned, many endeavors of science, including medicine, education, and mental health, to name a few, have fallenfar short of formulating scientifically representative samples. Many such studies then develop conclusions that inappropriately generalize findings to women and minorities. As far as women and minorities are concerned, scientific problems with external validity (a concept taught early in most research methods courses) are pervasive;

ii. The recent policy mandates for evidence-based practice and the commensurate elevation of meta-analysis as the "gold standard" have had the effect of blaming women for their invisibility. The perceived failure to produce the multitude of studies needed to support a meta-analysis of interventions for women offendersruns the strong risk of stifling innovation and causing some to downplay the emerging evidence on women that is available;

iii. An emerging body of evidence on women offenders is being ignored. This literature, while probably not sufficient in numbers to supportmeta-analytic study, is remarkably consistent across studies and linked to favorable outcomes for women. Taken as a whole the emerging science also forms a coherent model for women offenders which modifies some but not all of the above Principles of Effective Intervention.

But getting to the current stage of progress (number iii above), required that arguments "on behalf of women offenders" sustain several identifiable "scientific" challenges.

B. *First, the problem observed by Dr. Flynn four decades ago was not unique to corrections, but rather was embedded in the wider scientific culture, impacting women in the general population as well as those encountering the criminal justice system. Sadly, inattention to women was apparent in medical trials, validations of educational exams used to determine college entrance and receipt of scholarships, and research on mental health assessments, and practices.*

The historical exclusion of women from vital clinical trials ultimately led to the National Institute of Health Revitalization Act of 1993 (Public Law 103-43, 103rd Congress) which required the inclusion of women and members of minority groups in all NIH-supported biomedical and behavioral research except in instances where a clear and compelling reason

was established that to do so would be inappropriate (e.g., the study of a sex-specific illness).[3]The guidelines further stipulated that childbearing potential or the addedcost of including women and minorities were no longer acceptable justifications for not including women in equal numbers to men in clinical trials. Up until that point, exclusion of women from medical research was, according to some, an unintended consequence of protecting vulnerable populations, including pregnant women, and pre-menopausal women who were capable of becoming pregnant (Goldenberg, 2003; Killien et al.,2000). For others, the exclusion was the outcome of a naive assumption that findings observed from studies on male subjects could be generalized to women without modification, a startling "leap of faith: in an otherwise rigorous research enterprise" (NIH, 1999: 10, quoted in Bloom et al., 2003). So strong was the "male is norm" filter that it successfully trumped one of the core lessons in any graduate research methods class--external validity.

Notwithstanding the 1993 guidelines,which had no enforcement provisions, subsequent forums and publications demonstrated an ongoing failure torecruit sufficient numbers of women in clinical trials. Even fewer studies disaggregated findings by gender, where true gender-specific findings would be observed (NIH, 1999; Geller Goldstein, & Carnes, 2006: Ramasubbu, Gurm, & Litaker, 2001; Vidaver, Lafleur, Tong, Bradshaw & Marts, 2000).[4]Among the costsincurred by generalizing findings from male samples to females: a) a mistaken understanding of the role of aspirin in preventing women's strokes and

[3]By 1995 the National Institute of Health Revitalization Act of 1993 had been adopted by other federal agencies, including the Agency for Health Research and Quality (AHRQ) and the Center for Disease Control and Prevention (CDC).

[4]Evidence of this problem emerged in a study accounting for only those federally funded trials that could have been started after the NIH 1993 guidelines took effect. The authors found 30 percent of the later studies failed to assemble samples that were comprised of at least 30 percent or more women. This figure increased to 44 percent when drug trials were examined. Furthermore, 87 percent of the trials failed to disaggregate findings by sex or include sex as a covariate. None of these acknowledged concerns for generalizability (Geller et al., 2006).

heart attacks (Ridker, Cook, & Lee, 2005); b) a limited understanding of heart disease in women (Chen, Woods, & Puntillow, 2005; Dey, Flather, Devlin, Brieger, Gurfinkel, Steg, Fitzgerls, Jackson, & Eagle, 2007; Rathore, Wang & Krumholtz, 2002); and c) a host of issues with pharmaceutical dosages (Keiser, 2005; Vidaver et al., 2000).

Female college students also were not being adequately understood in early validations of U.S. college entrance examinations, including theScholastic Aptitude Test (SAT), the National Merit Examination, and the Graduate Record Examination (GRE). Later, higher education was resistant to replicated studies conducted during the 1980s and 1990swhich consistently found that educational tests used for vital college entrance decisions tended to under-predict the ultimate performance of women and over predict the performance of men, including on the National Merit Exam (NACAC, 2008), the SAT (Bridgeman & Wendler, 1991; Clark & Gandy, 1984; Leonard &Jiang, 1999; Silverstein, 2000; Wainer & Steinberg, 1992) and the GRE (House, Gupta, & Xiao, 1997; Sternberg & Williams, 1997). Therefore, in large competitive schools which placed primary reliance on the exam results, women applicants were observed to have lower entrance rates than men (Leonard & Jiang, 1999).

Use of the disparate tests in awarding scholarships and making college entrance decisions led to a number of lawsuits and changes to state policy [e.g., Sharif v New York State Education Department; 709 F. Supp. 345, 362 (S.D.N.Y. 1989)] and, in the case of the National Merit Exam, a fairly large out of court settlement. A writing sample was added to the SAT to correct the problem (NACAC,2008).Reportedly, the gender prediction gap on these exams was known to insiders for over a quarter of a century (Leonard & Jiang, 1999).

I first learned of the external validity problems associated with some cognitive, personality and mental health assessments from Carol Gilligan. I had the good fortune to be sent to Harvard University by my dissertation advisor, Marguerite Warren, to learn how to classify probationers according to Lawrence Kohlberg's Stages of Moral Judgment (Kohlberg, Colby, Gibbs, Speicher-Dubin, & Candee, 1979). Gilligan, a faculty member, addressed my fellow workshop participants and I after a long day of workshops on the Moral Development scoring protocol. She explained to us and a group of Harvard researchers and instructors, who clearly were less than happy with her, that the Stages of Moral Judgment had been formulated on the study of the lives of boys and men and then erroneously generalized to girls and women. After the fact, females were assessed on the protocol, only to find that many clustered around Stage 3 on the stage-based typology. Stage 3 is a stage reserved for humans who base moral decisions on a concern for reciprocity in close relationships. One could develop to higher stages of moral development, stages reserved for those who valued the importance of maintaining social systems or universal principles of moral action, but women seldom did. Gilligan later rectified the problem by studying samples of women and observing that "the Stage 3 problem" was a function of the "male is norm" assumption and the failure to account for the fact that women are relational and factor relationships into most decision-making regardless of "maturity" (Gilligan, 1982; Taylor, Gilligan, & Sullivan, 1995).

There arestrong professional guidelines recommending the use of mental health assessments only on populations "whose validity and reliability has been established for use with members of the population tested" (APA, 2010). However, one can now deviate from these in cases where the author expresses appropriate reservations. Concerns have been raised for the Mf (Masculinity-Femininity) scale of the Minnesota Multiphasic Personality

Inventroy-2 (MMPI-2) (Lewin & Wild, 1991), the Psychopathy Checklist-Revised (PCL-R) (Baker & Mason, 2010); tests of worker satisfaction (Hesse-Biber, Nagy, & Yaiser, 2004), and intelligence (Hyde, 1990). The absence of females from psychological research is similar tothat seen in medicine, education and criminal justice with concerns raised for psychotherapy in general (APA Divisions 17 and 35, 2004: Levrant & Silverstein, 2005) as well as specific specialty areas such as school psychology (Holverstott, Ehrhardt, Parish, Ervin, Jennings, & Poling, 2002), mental retardation (Porter, Christian & Poling, 2003), psychopharmacology (Poling, Durgin, Bradley, Porter, Van Wagner, Weeden & Panos, 2009), and organizational psychology (Jarema, Snycerski, Bagge, Austin, & Poling, 1999).

In sum, women's issues do not become the focus of policy and innovation, because the science that would foster such change devotes limited attention to them, and what is not seen is not attended to. This rather obvious knowledge gap underscores the poignant titles chosen for some recent scholarship, e.g., *The Mismeasure of Woman* (Tavris, 1992); 2) *The Invisible Woman* (Belknap, 2007); and 3) *Half the Human Experience* (Hyde, 2007).

C. *The second scientific challenge occurred within the past decade when public sector funding placed a premium onthose practices and policies which showedempirical evidence of achieving effective outcomes. The "evidence-based practice" mantra refers to the use of research and science, particularly experimental studies, to identify the best practices in a field. It has been voiced by policy makers ranging from agency heads to Presidents of the United States. However, the evidence-based mandate places women and minorities, who have been understudied,at a distinct disadvantage.*

The movement to evidence based practice began in medicine in the early 1990s and then moved to other fields such as psychotherapy (Task Force, 1995) and more slowly to corrections (Cullen & Gendreau, 2001; MacKenzie, 2000). It forms the foundation for many public, performance-based budgeting systems, holds a prominent place in the new U.S. health

care law (Obamacare), and factors heavily into funding of social policy and research.Many, myself included, believed that the evidence-based mandate was past due, especially in the field of U.S. corrections with its less than professional tradition ofeclectic and creative interventions which could not possibly have produced favorable outcomes, e.g., cake decorating, horseback riding, wagon trains, and plastic surgery (Van Voorhis, Cullen & Applegate, 1995).

Key to the "evidence-based" movement in corrections wereseveral influential meta-analyses,a methodologically rigorous strategy for synthesizing findings across numerous controlled studies (Glass et al., 1981). Such studies produce "effect sizes" for each of the modalities studied and the "effect size" statistic was noted to produce far more stable findings than former methods of synthesizing research (e.g. vote-counting).

A number of meta-analyses of correctional treatment programs were conducted during the 1990s, but two have been exemplified throughout this essay (Andrews et al., 1990a; Lipsey, 1992). One was a study of 154 evaluations of correctional programs (Andrews et al., 1990a) which generated the Principles of Effective Intervention (see also Andrews, Dowden & Gendreau, 1999; Gendreau, 1996). The second reviewed 443 delinquency prevention and intervention programs (Lipsey, 1992). Both showed policy makers that rehabilitation models substantially reduced future offending. Other meta-analyses established treatment-relevant predictors of recidivism (Andrews, Bonta, & Hoge, 1990b; Gendreau, Little, &Goggin, 1996). Meta-analyses also convincingly countered naïve assumptions that the crime problem could be solved by such approaches as boot camps (MacKenzie, Wilson, & Kider, 2001) or other punitive ideas (Andrews et al., 1990a; Gendreau et al, 1996; Gendreau, Goggin, & Cullen, 1999; Langen & Leven, 2002).

Even so, the power of evidence,especially evidence put forward by the meta-analyses, looped around full circle to fault the gender-responsive movement for the invisibility of women in key policy and programmatic research.Evidence came to drive policy, but for women, there was no evidence; as noted above, the invisibility of women in key research was pretty much a fact of science.Indeed, only 2.4 percent of the experimental studies examined in Mark Lipsey's meta analysis sampled only girls, and 5.9 percent sampled primarily girls (Lipsey, 1992). The meta analysis conducted by Andrews and his associates concluded with the admonition that gender effects required more detailed analysis. Even, Lipsey's larger, most recent analysis reported that only 4.0 percent of the studies sampled mostly female studies versus 87 percent accounting forall male or mostly male samples (Lipsey, 2009). The authors acknowledged their concerns for the limited research on women, but their findings nevertheless formed the foundations of today's approach to correctional treatment, treatment models that are offeredto both males and females.

The founders of the meta-analysis technique warned of such problems when they noted that findings are highly dependent upon the criteria for selecting studies from the total universe of available studies (i.e., selection bias)(Glass et al, 1981; Smith, 1980). Although the authors of the correctional meta analyses certainly did not appear to commit selection bias, their results had the same effect, becausethe requisite studies on women were not available. In areview of psychological, educational, and behavioral treatments, Lipsey and Wilson (1993) presented the problem in very thoughtful terms:

> Meta analysis is only possible for treatment approaches that have generated a corpus of research sufficient in quantity and comparability for systematic analysis within a statistical framework. Such a body of studies, in turn, is only likely to be produced for widely used and well-developed approaches growing out of established theory or practice, or for promising innovations. Thus the treatment approaches represented in meta analysis and reviewed in this article represent rather mature instances that are

> sufficiently well developed and credible to attract practitioners and sufficiently promising (or controversial) to attract a critical mass of research. (Lipsey & Wilson, 1993: 1200).

Simply put, meta-analysis and EBP is not the friend of under-represented groups attempting to secure knowledgeof optimal medical, therapeutic or other treatments (Sue & Zane, 2005) and it should not purport to be. For their part, the Canadian authors of the Principles of Effective Interventionsought to rectify the under-representation of women by conducting meta-analyses on necessarily smaller programmatic data bases of women offenders (e.g., Dowden & Andrews, 1999). Later, validations of the risk/needs assessment accompanying the Principles of Effective Intervention (Andrews & Bonta, 1995), were also conducted on samples of women offenders, and the sample sizes of these studies increased over time (e.g., Andrews & Bonta, 1995; Andrews, Bonta, & Wormith, 2004; Coulson, Ilacqua, Nutbrown, Giulekas, & Cudjoe,1996; Lowenkamp 2001; McConnell, 1996; Rettinger, 1998; Simourd & Andrews, 1994; Smith et al., 2009). However, evidence, in the case of these studies, conformed to a pattern of repeated tests of topics relevant to the Principles of Effective Interventionand proud assertions that the favorable findings refuted critics of the model and the assessments. These criticsincluding feminist scholars and other proponents of alternative gender-responsive approaches (see Andrews & Bonta, 2010).

Another scientific impediment was one that is typically overlooked in objections to the gender-responsive movement and its recommendations for women. The studies supporting the Principles of Effective Intervention for girls and women did not test the gender-responsive models. Instead their studies conformed to a pattern of repeated tests of the Principles of Effective Intervention programs and assessments and proud assertions that their favorable findings refuted their critics, including feminist scholars and other proponents of alternative,

gender-responsive approaches. As such, there was no basis for any conclusions that gender-responsive approaches were flawed.Only two of these authors (see Blanchette and Brown, 2006; Smith et al. 2009) acknowledged the logical error of refuting gender responsive proponents without directly testing thegender-responsive treatment targets and programs.

Not everyone would say there is anything wrong with this state of science. For example, in response to the well-established ethnic disparities in mental health research, the U.S. Surgeon General (2001) issued the guideline that minority mental health clients should be given treatments supported by the "best available evidence." Of course, "best available evidence" is a favorable alternative to using no evidence, or making medical and other decisions on the basis of guesswork alone. However, an over-reliance on best available evidence can minimizes the urgency to conduct more appropriate research and risks inattention to emerging research. For purposes of women offenders, it is likely the case that the "best available evidence" is not a picture of the assessment and treatment models we would have if we had started with girls and women. Therefore, critics of the Principles of Effective Intervention note that, while evidence-based, they were nevertheless formulated on the basis of research on male populations and only later found to be effective with women (Bloom et al., 2003). Several feminist critics faulted the over-reliance on meta-analysis to the dismissal of qualitative studies which comprised most of the evidence supporting gender-responsive approaches to corrections (see Chesney-Lind, 1997, 2000; Hannah-Moffit & Shaw, 2000: Kendall, 2004). Still more scholars faulted the assessments for neglecting to include gender-specific factors (Blanchette & Brown, 2006; Funk, 1999; Holtfreter &Morash, 2003; Reisig et al., 2006; Van Voorhis, et al., 2010). The consistent response of a least two of the Canadian authors underscores the point of this section(Andrews & Bonta, 2010):

> With all due respect, it is time for those who feel they are entitled to offer programs inconsistent with (Principles of Effective Intervention) perspectives to show some social responsibility. They must begin to program and evaluate in a "smarter" manner. To our knowledge, the evidence base in support of their approaches flirts with nil. (Andrews & Bonta, 2010:514).

In sum, the sequence of events was as follows, research on women offenders was an afterthought and unfunded. In the context of limited research,state and federal evidence-based policies mandated evidence in order to secure funding and implementation. The evidence for women, of course, was not available, and the "best available evidence," volumes of it, consisted of studies on male offenders. Then scholars and policy makers alike, continued to use the evidence-based argument to counter emerging evidence with simple comparisons of the huge volume of studies on males compared to females (i.e., the numbers game).

D. An emerging body of evidence on women offenders is being ignored. This literature, while probably not sufficient in numbers to support meta-analytic study, is remarkably consistent across studies and linked to favorable outcomes for women. Taken as a whole the emerging science also forms a coherent model for women offenders which modifies some but not all of the above Principles of Effective Intervention.

For this response, let us return to the Principles of Effective Intervention presented on page 3. Many gender-responsive scholars stop far short of recommending that they be ignored. The evidence on women appears to converge on a hybrid model which modifies the prevailing Principles of Effective Intervention for women. However, in the case of some of the Principles, such as the needs principle (defined above), extensive modification appears to be warranted. The Principles continue to form a meaningful organizational structure for presenting an evidence-based model for women, but that model differs in several key ways.

First, the evidence suggests that the *risk principle* should continue to apply to women but do so with important qualifications. The risk effect (an interaction between risk and

intensive treatment) has been found in evaluations of two intensive gender responsive programs (Gehring, Van Voorhis & Bell,, 2010; Orbis Partners, 2010) and one evaluation of gender-neutral halfway houses across the State of Ohio (Lovins, Lowenkamp, Latessa & Smith, 2009). That is, even with women, high risk offenders have better treatment outcomes in intensive programs than low risk offenders. Moreover, what too often gets ignored in policy formulations of the risk principle is the fate of low risk offenders who have worse outcomes even in state of the art, "evidence-based," programs than they might have had if we had not intervened or brought them further into the justice system. By definition, low risk offenders have many pro-social influences in their lives. These women may need less intensive interventions for fewer needs, but they also will benefit, where possible, from ongoing contact with the prosocial influences in their lives (Salisbury, Van Voorhis, Wright & Bauman, 2009).

Furthermore, the evidence does not support the argument that risk management and risk assessment is inappropriate for women offenders (Blanchette & Brown, 2006). Underlying this argument is the assertion that women are not dangerous and therefore should not be classified by levels of risk (Hannah-Moffitt. 2004.2009; Smart, 1982). In our research, however, 12-month recidivism in community samples ranged from 21 percent in a probation sample to 44 percent in a parole sample. Among high risk groups these rates are much higher. This is sufficient to support interventions for high risk women and accurate, assessment-based indications of who they are.

Just the same, an appropriate risk management policy for women should reconceptualize notions of maximum custody and high risk. The high risk/high custody woman is not the same as the high risk/ high custody male offender, and this is seldom

reflected in correctional policy. Most validations of risk and custody assessments find that even in high risk groups, women reoffend, commit serious misconducts,[5]and return to prison at considerably lower rates than high risk men (Hardyman & Van Voorhis, 2004; Wright, Van Voorhis, Salisbury, & Bauman, 2009). A simple comparison of high risk males and females on their rate of offense-related outcomes would, in most cases, reveal this distinction to policy makers and administrators. Women's rates are typically much lower than men's. These comparisons should perhaps be made before impractical investments are devoted to overly secure and austere prison structures located far from children and other supportive family members (Wright et al., 2009). Supervision policies for high risk females in the community also should reflect differences between males and female (Salisbury et al, 2009).

The scholarship specific to women offenders places the needs principle of the principles of effective intervention under greatest scrutiny (Blanchette & Brown, 2006) and finds it to be incomplete and in need of considerable modification (Buell et al., 2011; Blanchette, 2009; Salisbury & Van Voorhis, 2009; Van Voorhis et al., 2010; Wright et al, 2009) . The commonsense notion that in order to reduce criminal behavior, we must address the risk factors for criminal behavior still holds. However, scholars raise questions about *what* should be targeted (see Blanchette & Brown, 2006; Holsinger & Van Voorhis, 2005; Holtfreter & Morash, 2003; Reisig et al., 2006; Salisbury et al., 2009; Van Voorhis et al., 2010; Wright, Salisbury, & Van Voorhis, 2007). Recent research has identified a new set of

[5]In prison settings, this comparison should be not include minor infractions, such as insubordination. These actually tend to be higher for women than men, reflecting poor staff skills in managing women offenders and a tendency to revert to excessive issuance of misconducts in order to do so (Hardyman & Van Voorhis, 2004). A comparison of serious or aggressive misconducts, typically finds much lower rates for women than men.

gender-responsive risk/need factors. It also appears that the priority given to the "Big 4" (history, attitudes, personality, and associates) should be reconsidered for women.

In support, a number of studies compared the needs of male and female offenders. A lengthy review of these studies is beyond the scope of the present essay. However the studies generally noted higher rates of mental illness, abuse, and trauma among women than men (see Blanchette & Brown, 2006; Hubbard & Pratt, 2002; Langan & Pelissier, 2001; Messina, Grella, Burdon, & Prendergast, 2007; Salisbury & Van Voorhis, 2009). Another suggestion that the picture of women's risk factors might be qualitatively different than men's risk factors appeared on the gender-neutral risk needs assessments, themselves. For example, several authors have found the LSI-r predictive for males and females (Kroner & Mills, 2001; Gendreau, Goggin, & Smith, 2002; Manchek et al, 2009; Smith et al., 2009). However, a comparison of needs scores showed differences between males and females. For example, women scored significantly higher than men on the emotional personal (mental health) (Holsinger, Lowenkamp, & Latessa, 2003: Manchak et al., 2009; Mihailides, Jude, &Van den Bosshe, 2005; Palmer & Hollin, 2007; Raynor, 2007), family/ marital (Holsinger et al, 2003) and financial domains (Heilbrun, Dematteo, Fretx, Erickson, Yasuhara, & Anumba, 2008; Holsinger et al, 2003; Manchak et al., 2009; Mihailides et al., 2005; Raynor, 2007). Women scored significantly lower than men on criminal history (Heilbrun et al., 2008; Holsinger et al., 2003; Manchak et al., 2009; Mihailides et al, 2005; Raynor, 2007), use of leisure time, criminal thinking (Holsinger et al., 2003; Manchak et al., 2009), companions and substance abuse (Holsinger et al, 2003). Male female comparisons on other measures of the same gender-neutral risk/need factors as those noted on the LSI-r show a similar pattern of findings (e.g., see Bell, 2012; Gehring, 2011). Most of these studies did not compare the predictive

merits of each of the LSI-r (Andrews & Bonta, 1995) need domains. However, in one study financial issues were potent predictors for women while criminal history financial needs and substance abuse were predictive for men (Manchak et al., 2009).

In the U.S., research on the utility of a hybrid gender-responsive classification and risk/needs assessments began in 2000 with a cooperative agreement awarded to the University of Cincinnati by the National Institute of Corrections. The UC/NIC research took this inquiry a step further to determine whether gender-responsive needs noted in the qualitative, feminist literature were predictive of future offending and serious prison misconducts. The findings of associations between needs such as trauma, depression, abuse, low self-efficacy, unhealthy relationships and offense-related outcomes, would afford their placement within the needs principle, thereby suggesting new treatment priorities for women.

The research generally found the traditional gender neutral dynamic risk/need factors and assessments to be predictive of recidivism and prison misconducts, but the addition of the gender-responsive risk/need factors improved the overall predictive validity of the gender neutral risk/needs assessments for women offenders (Van Voorhis et al., 2010). In addition to the significant incremental validity of the additional block of gender-responsive factors, the predictive merits of specific gender-responsive factors identified several important treatment targets. These varied somewhat across types of correctional settings (probation, prerelease, and prison), but generally implicated mental health issues, financial problems, parental stress, unsafe housing, and self-efficacy in community settings. Abuse variables appeared to lead to mental health and substance abuse problems in a pathway that ultimately led to recidivism (Salisbury & Van Voorhis, 2009), a pathway that is also seen in other studies (e.g., McClellan et al., 1997; Messina et al., 2007). Risk factors predisposing women to more serious forms of

misconduct in prison settings included mental health problems, child abuse, and dysfunctional relationship dynamics. A revalidation study is currently underway with larger samples and will be completed in the months ahead, however, 11 of 12 samples have been analyzed (See Van Voorhis & Groot, 2010; Van Voorhis, Bauman, & Bruschette, 2012a; Van Voorhis, Bauman, & Brushette, 2012b; Van Voorhis, Brushette, & Bauman, 2012; Van Voorhis, Bauman, & Brushette, 2013) and the results are consistent with the earlier construction validation research.

Evidence that issues such as trauma, substance abuse, mental health, healthy relationships, and parental issues are important risk factors for women can also be gleaned from the fact that programs designed to address these problems actually reduces women's recidivism. They "work" in other words. For example, a key risk factor for women's recidivism, especially in community settings, is parental stress exhibited by women who have little financial and emotional support in raising their children and who also experience difficulties with child management (Van Voorhis et al., 2010). *The Visiting Nurses Program*, a fairly well know intervention for at risk mothers, provides support addressing child health and child management. Experimental research found favorable outcomes for both the children and their mothers who had lower post program offense rates than mothers in a comparison group (Olds, Robinson, Pettitt, Luckey, Holmberg, Ng, Isacks, Sheff, & Henderson, 2004). Behavioral child management programs have long showed favorable effects on at risk children, but we are beginning to learn that they have important outcomes for parents as well (Piquero, Farrington, Welsh, Tremblay, & Jennings, 2009). Another parenting program with promising outcomes is the *Female Offender Treatment and Employment Program (FOTEP)*, a residential re-entry program for women that offered

intensive case management to women and focused on employment and substance abuse. The parenting focus was on reunification with dependent children. Findings showed a reduction in recidivism for FOTEP participants (Grella, 2009).

One of the gender-responsive principles noted in *Gender Responsive Strategies: Research, Practice and Guiding Principles for Women Offenders* (Bloom et al., 2003) advocated for wrap around services. Multimodal services are recommended for most offender populations (see Lipsey, 2009), but two program models tailor the notion to women offenders. *Moving On* (Van Dieten & MacKenna, 2001) teaches women to access and mobilize varied community resources. Consistent with the emerging profiles of women offenders *Moving On* also works with women to enhance strengths, build healthy relationships, and target self-defeating thoughts. The program uses a cognitive behavioral treatment modality. A matched comparison group study was recently completed among probationers in Iowa and found significant reductions in recidivism (Gehring et al., 2010). A second program, *Women Offender Case Management Model* (VanDieten, 2008) works with correctional practitioners to develop comprehensive case management strategies for women. The development of a network of community services and partnerships is one of the requirements of WOCMM program sites. The program also trains case managers to address gender responsive risk/need factors and use strengths-based and relationship-focused approaches. This program was also evaluated and found to have favorable reductions in recidivism (Orbis Partners, Inc, 2010).

Advocating for an approach to substance abuse that recognizes its co-occurrence with mental health and trauma, Stephanie Covington developed a women's substance abuse program, *Helping Women Recover: A Program for Treating Addiction* (Covington, 2008). The program builds from four perspectives on women's addiction: these accommodate the

importance of women's pathways to crime, relationship issues, and addictions co-occurring with mental health issues and trauma. Attention is given to self efficacy and the impact of sexism and trauma upon perceptions of the self and the self in relationship with others. Program modules also discuss families of origin, healthy support systems, sexuality, body image, and spirituality. A second program *Beyond Trauma* (Covington, 2003) provides information on trauma and its effects and then moves to the development of coping skills. Both programs use cognitive-behavioral approaches and exercises, along with psychoeducation, guided imagery, and expressive art techniques. A recent randomized experimental study of both programs administered sequentially found significantly lower return to prison rates for women in the two gender-responsive programs than those in the standard therapeutic model (Messina et al., 2010). Effects on intermediate outcomes pertaining to psychological well-being have also been favorable (Covington, Burke, Keaton, & Norcott, 2008; Messina et al, 2010).

Two additional programs for addressing abuse and trauma, *Seeking Safey* (Najavits, 2002) and *Dialectical Behavioral Therapy* (Linehan, 1993), were not developed specifically for offender populations. As such there are numerous studies, but all speak to favorable intermediate outcomes, such as reductions in suicide attempts and drug use and improvements in treatment retention, mental health, and PTSD systems. *Seeking Safety* is a cognitive behavioral program for co-occurring disorders of trauma/PTSD and substance abuse. Evaluation research shows favorable intermediate outcomes, but it was not possible to locate any evaluations of the program's impact on offense-related outcomes (Najavits, Weiss, R., Shaw, & Muenz, 1998; Najavits, Gallop, & Weiss, 2006). DBT is also a cognitive-behavioral approach involving skills training, motivational enhancement and coping skills.

The impact of DBT has been tested in a number of treatment settings and found to have a number of positive intermediate outcomes (for a summary of evaluation findings, see Dimeff, Koerner, & Linehan, 2002).

Another substance abuse program for women, *Forever Free,* targeted gender-responsive risk factors, such as self efficacy, healthy relationships, abuse and trauma, and parenting. *Forever Free* included a voluntary aftercare program. Services were multimodal and evaluation results showed that the program significantly reduced drug use and recidivism (Prendergast et al, 2002; Hall, Prendergast, Wellish, Patten, & Cao, 2004).

Programs designed to address these gender-responsive needs appear to be working. Empirical observations of the influences of trauma, mental illness, parental stress, poverty and unhealthy relationships also suggest a merger of the criminogenic focus of correctional policy with a public health focus (Butler & Engle, 2011). There is evidence to support this shift and the shift advocates well for policies and approaches that bring other social service agencies (e.g., substance abuse, labor, education, mental health, child services, and welfare) to the table. In fact, partnerships among such agencies are seen in a number of prison re-entry programs and several pretrial, "pre-entry" programs (e.g., Buell et al.,2011).

E. Conclusion

In closing, most innovative approaches for women offenders have only been implemented within the past decade. Moreover, these changes have occurred on a very small scale. This is largely because the research needed to support such innovation was unavailable in corrections and other fields. More startling, scientific enterprises habitually generalized findings pertinent to men to women, and this practice resulted in substantial costs to women.

Additional costs were observed when evidence-based guidelines imposed “best available practices” and faulted the critics of “male is norm” practices for the fact that women are understudied.

It is not essential to refrain from issuing the frequent call for more research, but policy makers mustgive credence to the evidence currently supporting innovative programming for women. There is the ongoing risk that women’s invisibility to science could extend to a denial of the evidence that is beginning to amass. The evidence on behalf of women offenders is not nil, and policy makers should not be encouraged to ignore it.

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Notes.