

## **Recherche sur les femmes soumises à une probation imposée par le tribunal ou à une ordonnance de probation**

**Jodi Hall et Lorie Donelle**

Le cadre de vie des délinquantes constitue un bon exemple des inégalités sanitaires que l'Organisation mondiale de la santé a cernées comme étant d'importants déterminants de la santé. Au cours de la dernière décennie, on a noté une hausse importante des condamnations menant à une détention correctionnelle chez les femmes, ce qui fait ressortir la nécessité pressante d'entreprendre des travaux de recherche dans ce domaine. Pour répondre à cette nécessité, une étude pilote a été menée au Canada, plus précisément en Ontario, en vue d'examiner les besoins des femmes qui ont des démêlés avec la justice en ce qui concerne la promotion et les notions en matière de santé. Les auteures font ressortir les aspects du processus de recherche employé auprès de délinquantes en énumérant les difficultés professionnelles et personnelles auxquelles peut se heurter l'équipe de recherche lors du déroulement d'une telle enquête. Dans leur conclusion, elles formulent des recommandations pour les futurs travaux de recherche entrepris auprès des délinquantes en se servant des leçons tirées de l'étude pilote.

Mots clés : délinquantes

# **Research With Women Serving Court-Mandated Probation or Parole Orders**

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The life context of women offenders exemplifies the health inequities that the World Health Organization highlights as important determinants of health. In the past decade the sentencing of women to correctional detention has increased dramatically, prompting an urgent call for research in this area. In response to this call, a pilot study was conducted in the Canadian province of Ontario to investigate the health promotion and health literacy needs of women in conflict with the law. The authors highlight aspects of the research process with female offenders by recounting the personal and professional challenges experienced by the research team in carrying out an investigation with this population. They conclude with recommendations for future research with women offenders using lessons learned over the course of the pilot study.

Keywords: health promotion, women offenders, prisoners, research methods

## **Introduction**

Over the past decade admissions to correctional detention centres have increased in Canada, with women representing 10% of admissions to provincial/territorial custody, 5% of admissions to federal custody, 11% of admissions to remand, and 17% of probation and conditional sentencing (Statistics Canada, 2006). The largest proportion of offences leading to incarceration relates to administration of justice (breach of probation conditions and failure to appear in court), theft and possession offences, and assault and related offences (K. Underhill, Statistics and Applied Research, Correctional Services Division, personal communication, October 1, 2008).

The lives of women in conflict with the law are characterized by poverty, abuse, homelessness, multiple health concerns, illiteracy, and lack of education (Cox, 2007; Simpson, Yahner, & Dugan, 2008). High-risk health behaviours (e.g., prostitution, substance abuse, sharing of IV drug paraphernalia) are characteristic of this population (Yasunaga, 2001). In fact, women in conflict with the law tend to have mental health concerns (e.g., schizophrenia, bipolar disorder, depression), high rates of communicable disease (e.g., HIV/AIDS), high mortality rates, substance use issues, and high incidence of chronic disease (Auditor General of Canada,

2003; Correctional Services Canada [CSC], 2004; Enders, Paterniti, & Meyers, 2005; Evans, 2006; Johnson, 2006; Robert, Frigon, & Belzile, 2007), all of which usually persist upon one's release into the community (CSC, 2004). Of women offenders, approximately two thirds are mothers with dependent children (Shaw, 1994) and over 90% serve sentences of less than 6 months (K. Underhill, personal communication, October 1, 2008). In fact, many women serving short sentences and probationary sentences (open custody arrangements) return to poor and/or unsafe housing, unemployment, unstable lifestyle, and extreme marginalization (Condon, Hek, & Harris, 2006; Evans, 2006), conditions that exacerbate their difficulty accessing appropriate health services in their communities (Whynot, 1998). Consequently, the promotion of health within this population has a reverberating effect as women return to their children, families, and communities (Condon et al., 2006; Freudenberg, 2004; Williams, 2007).

In this "health information age," inadequate health literacy constitutes a significant health-care hurdle. Health literacy is defined as the ability to access, understand, and use information in ways that promote and maintain good health (Nutbeam, 2000). Adequate health literacy skills are foundational to effective health promotion and are critical for the successful navigation of the health-care system (Health Canada, 2003; Institute of Medicine, 2004; Nutbeam, 2000). Health literacy also reflects one's ability to act on personal and community health by improving personal lifestyle and general living conditions. Because of its role in enhancing access to and ability to use health information, health literacy is critical to empowerment, which is in and of itself health promoting (Nutbeam, 2000).

It has been estimated that 70% of inmates in Canada read below the Grade 8 level (CSC, 2004). In practical terms, these individuals are challenged to read and comprehend information unless it is brief, simply laid out, and presented in a familiar context (Canadian Council on Learning, 2007; Human Resources Development Canada, 2003). Outcomes of health literacy (i.e., informed decision-making, self-efficacy, and personal empowerment), coupled with effective, accessible community services, are prerequisites for successful transition from custody to community (Evans, 2006; Nutbeam, 2000).

In effect, the life context of women offenders exemplifies the inequities highlighted by the World Health Organization ([WHO], 2008) as important determinants of health. In the past decade increasingly more women have been in conflict with the law (Statistics Canada, 2006), which has resulted in an urgent call for research in this area (Williams, 2007). In response to this call, we conducted a pilot study to investigate the health promotion and related health literacy needs of women offend-

ers in the province of Ontario. While it includes a summary of our findings, this article focuses on the personal and professional challenges we encountered in our research with women offenders. We conclude with research recommendations based on lessons learned during the course of the study. Finally, we highlight our research process with women offenders in the hope of generating further research with this population.

### **Literature Review**

We found a striking lack of research evidence regarding the health of Canadian women in conflict with the law. Of 786 possible publications of interest, 41 were related to the health of incarcerated women and women on probation/parole. While none of the publications addressed health literacy, health promotion, or health-seeking behaviour among women on probation/parole, five addressed the health of Canadian federal women offenders and one addressed the health-related concerns of provincially incarcerated women.

Researchers in the United States have focused on female offender assessment (Brunsman Lovins, Lowenkamp, Latessa, & Smith, 2007), substance use and mental health (Johnson, 2006), and re-integration challenges (Freudenberg, 2004; Hammett, Roberts, & Kennedy, 2001). Research conducted in the United States also reports on women's pathways to offending (see Simpson et al., 2008; Steffensmeier & Allan, 1996) and the impact of gender-neutral public policy on the lives of women offenders (Bloom, Owen, & Covington, 2004). Canadian research on female offenders addresses issues related primarily to federally incarcerated women and on the importance of defining, assessing, and managing a range of issues (e.g., recidivism, violence to oneself or others, escape) (Hannah-Moffat, 2004). After conducting interviews with 27 women incarcerated in a Canadian medium-security institution, Micucci and Monster (2004) conclude:

Numbers incarcerated, all-time high correctional expenditures, unpredictable and degrading conditions currently faced by women in provincial prisons, shorter sentences and less serious offending compared with their federal counterparts, and methodological gaps in the existing Canadian data base on female corrections also combine to produce a desperate need now for some carefully prepared case studies involving female offenders in provincial correctional facilities. This type of research would assess progress and identify deficiencies in need of correction. (p. 515)

Women who have entered the criminal justice system are confronted with significant health challenges that existed before their initial criminal charge and extend well beyond it (Condon et al., 2006; Evans, 2006).

While evidence suggests that women's experiences of incarceration and probation are significantly different from those of men, women do not enjoy equal access to resources in the community upon sentencing or release (Hannah-Moffat, 2004). Despite the increasing presence of women in the Canadian criminal justice system, there remains a dearth of literature on women's unique experiences within the system, barriers to women's access to health care within the system, and the ways in which women attempt to have their health-related needs met in the face of such adversity (Micucci & Monster, 2004; Yasunaga, 2001).

### **Theoretical Framework**

The project coordinator and principal investigator was a nurse educator-researcher with expertise in community health. One of the research assistants had worked as a counsellor with female survivors of abuse before embarking on doctoral studies in the health sciences. The other was an undergraduate health sciences student with experience in social health research and with marginalized communities. Consequently our philosophical underpinnings and research orientation were rooted in our collective personal, professional, and academic experiences.

Consistent with our pluralistic perspective, our research was situated primarily within the constructivist paradigm, according to which reality is socially co-constructed and the dynamic interaction between researcher and participant is central to capturing and describing lived experience (Weaver & Olsen, 2006). Our study was informed by a feminist theoretical perspective, which makes no single set of claims aside from some generalizations that constitute *feminist theory* (Harding, 1991); the research design is shaped by common themes such as the use of researcher reflexivity, an action orientation, a valuing of women's experiences from their own perspectives, and an acknowledgement that knowledge produced by the research process has the potential to facilitate change in the researcher and in the participants (Fonow & Cook, 1991; Harding, 1989). A feminist perspective also enabled us to remain mindful of the multiple and intersecting vulnerabilities of the research population and therefore to acknowledge the potential of women offenders to experience exploitation and re-victimization within a research context (Hlavka, Kruttschnitt, & Carborne-Lopez, 2007).

### **Method**

The research process began with a comprehensive review of the research literature, which was followed by an investigation of the health promotion and health literacy needs of women offenders using a mixed-method design.

### ***Literature Search***

A search of the CINAHL, PubMed, Scopus, MEDLINE, and Sage Full Text: Nursing and Health Sciences databases was conducted using the following search phrases: women + probation, women + incarceration, women + prison, women + parole, women + offenders, and women + prison + health. All searches were limited to English and to the years 1995 to 2008. Reference lists were consulted for relevant journal articles, conference proceedings, government reports, and media releases. The review focused on literature related to health services, barriers to health, health literacy, health promotion, and health-seeking behaviours of incarcerated women and women on probation or parole.

### ***Participant Recruitment***

Research Ethics Board approval was obtained for the conduct of a mixed-methods study. Purposive sampling was used to recruit women over the age of 18 who were serving court-mandated probation or had completed probation within the preceding 18 months. Women were excluded from the study if they had an active, unmanaged mental health issue that compromised their ability to provide informed consent. Participants were given a \$10 coffee shop gift card as a research stipend. Recruitment strategies were focused on community services and organizations, including probation and parole services, the Children's Aid Society, a group-counselling program for women charged with domestic violence, and a drop-in centre for homeless women. In addition, recruitment posters were placed in strategic locations throughout the downtown core, including a methadone clinic, a sexual assault centre, a women's shelter, a shelter and a coffee house for homeless persons, and a health clinic serving high-risk populations. In order to engage in further community service networking, the researchers attended local workshops for women offenders; at the beginning of several sessions, time was provided for the researchers to discuss and raise awareness about the study.

### ***Data Collection***

Participants were asked to complete (1) a general demographic survey; (2) a researcher-administered functional health literacy assessment whereby the respondent reviewed a food label provided to her and verbally responded to six standardized questions (Weiss et al., 2005); (3) an e-health literacy assessment — a 10-question paper-and-pencil tool assessing self-reported skill in finding, accessing, and assessing online health information (Norman & Skinner, 2006); and (4) a semi-structured interview centred on issues of health promotion and health literacy, during which the respondent was invited to share information regarding

her personal definition of health, her perceived health status, barriers to and facilitators of health care, her experiences with the health-care system, and perceived skills needed to engage in effecting change in her community.

### **Findings**

Data were collected from 12 women ranging in age from 25 to 45 years, of whom 11 identified as Caucasian and one as Aboriginal. One participant was married and 11 were single. One participant was employed. All unemployed participants received government assistance because of mental health issues or physical disabilities. Most of the women reported an annual income of less than \$15,000 ( $n = 8$ ; 66.7%) and limited education (high-school completion:  $n = 6$ ; 50%). Functional health literacy skill was limited (NVS mean = 2.25/6), yet most women ( $n = 9$ ; 75%) self-reported good to excellent reading ability and numerical comprehension ( $n = 9$ ; 75%).

Three themes emerged from the data: perception that participants' health was influenced by factors such as "people being judgemental"; participant access to health information ("community health clinic," or specialized health services for vulnerable populations); and recommended changes to the health-care system ("outreach... somebody from the ministry should... come out... and ask questions or see where we need our help... many times I've called on the phone, left my name, and gotten nothing back").

### ***Challenges to the Research Process***

During meetings of the research team, discussions tended to manifest around four themes: participant recruitment, data-collection methods, physical and emotional safety, and professional and personal tensions.

### ***Participant Recruitment: Shifting Strategies***

Members of the research team appreciated the importance of developing trusting and transparent relationships with study participants. Although women offenders are not a homogeneous group, we were aware of intersecting vulnerabilities (poverty, homelessness, substance use, mental illness, trauma) and the fact that mistrust of outsiders is sometimes bred through negative experiences with health and social service workers (Ensign & Panke, 2002; Hatton, Kleffel, Bennett, & Gaffrey, 2001; Zrinyi & Balogh, 2004). Consequently we solicited assistance from community workers who interacted directly and on a daily basis with this population. Although we had the support of most key persons and organizations working with women offenders, we did meet with some resistance. Influenced as we were by the tenets of feminism, we did not anticipate a

lack of support regarding participant recruitment. However, this is what we encountered on the part of a few select community health-care providers; for example, a women's health clinic refused to display our recruitment posters in its waiting area.

Initially we relied on the obligatory interaction between probation/parole officers and women offenders as our primary means of recruitment (placing a poster in the probation office waiting room and raising awareness of the study among probation officers). Even with the strong support of the district manager of the local probation and parole office, we failed to recruit research participants in this setting. We then revisited our recruitment strategy and broadened our community outreach. A referral from our network of community services linked the research team to the local police service, specifically to an officer who served as coordinator of a program for persons at risk of offending (e.g., female prostitutes). This police officer played a gatekeeper role in linking us with potential participants. In order to "meet the women where they are at," members of the research team accompanied the officer on her rounds of at-risk neighbourhoods. She acted as an intermediary, introducing the researchers to at-risk community members. As a result of this experience, we focused our subsequent recruitment activity on a drop-in day shelter for women. Staff members at the shelter supported the research by raising awareness of the project among their clients. Two members of the research team (on a rotating basis) spent two full mornings a week at this location for 6 weeks, in order to minimize our "outsider" status among the clients and also to minimize the inconvenience associated with research participation.

### ***Methods of Data Collection: Issues Related to Time, Space, and Place***

The transient nature of the study population (Condon et al., 2006) made recruitment and data collection a challenge. Women frequenting the drop-in day shelter appeared curious about the researchers and the project. However, they were extremely reluctant to commit to a set meeting time, and when a meeting was scheduled they often did not show up as arranged. This inability to commit to a set interview time was complicated by the multiple engagements competing for the women's time, such as court appointments, probation meetings, counselling sessions, group activities at the day shelter, and informal gatherings with their peers.

Although the interview is currently the most widely used method in health research (Nunkoosing, 2005), the competing issues faced by many of the women made this data-collection method less efficient and effective than expected. Many of the women appeared to accelerate the interview process by responding without elaboration or saying such things as



“next question.” Many of the participants fidgeted throughout the interview, and many had trouble making or keeping eye contact. Experienced day shelter staff suggested that shorter interviews, lasting no longer than 20 or 30 minutes, would be more appropriate. Such a short time span challenged our ability to build the trust and rapport necessary to elicit participants’ narratives and left us few opportunities to probe for explanation or clarification. Consequently the interviews took on the unanticipated tone of a question-and-answer session.

Because of participants’ reluctance to modify their daily routines and their preference for meeting in familiar surroundings, the interviews were held in shared space at the day shelter. However, the limited space and lack of privacy posed limitations to the data-collection process. While participants stated that they were comfortable being interviewed in a semi-private space, our audio-recorders had difficulty picking up nuances in the conversation and some participants may have been inhibited from sharing details they might have disclosed in more private circumstances. On the other hand, some women might not have participated at all in unfamiliar surroundings and without the presence of trusted staff and peers.

### ***Physical and Emotional Safety of the Research Team and the Participants***

Qualitative researchers build relationships with participants as a means of exploring questions “about the experiences and meaning people give to dimensions of their lives and social worlds” (Hewitt, 2007, p. 1149). Furthermore, the skill required to facilitate such exploration is strengthened by the researcher’s ability to empathize — recognizing, however, that this also renders the researcher/participant relationship more vulnerable (Hewitt, 2007). Our research team recognized the potential of the research context to trigger issues around their own personal or professional traumatic experiences. The team prepared for the study by exploring several questions: Are we equipped to deal with our own emotional responses to what the women might share? What would be the consequences for our participants if we became emotional during an interview? How can we learn to manage our own feelings and reactions so as to minimize any potentially unsupportive comments or body language during an interview? How can we best take care of ourselves and one another?

The team initially met on a weekly basis to discuss, de-brief, share successes, and support one another through some of the challenges of interviewing women offenders. We validated and supported one another’s feelings as they surfaced. We kept in contact on a regular basis via e-mail and orchestrated availability to one another on data-collection days. After completing an interview, each researcher checked in with at least one

other team member. Since the effect of a woman's story would not necessarily manifest until hours or even days after an interview, we decided that we would call team meetings as required in order to provide support and debriefing.

Meeting women offenders "where they were at" sometimes meant being in physically unsafe areas. Therefore as a team we discussed strategies for keeping ourselves and our participants safe during recruitment and data collection. To mitigate the hazards of the research process, we developed the following "rules of engagement" to maximize our emotional and physical safety and well-being: data collection would be conducted in a confidential space but in a public setting; each researcher would carry a cell phone; interview settings outside the day shelter were reviewed for safety and security; there would be no "home" visit interviews; and all researchers would be informed of when and where each interview was to take place.

Throughout recruitment and data collection, we were mindful of the vulnerability of the participants. Because of the social vulnerability of sex workers, women who have experienced violence, and women who are engaged in illegal or marginalized activities, we considered the potential for feelings of re-victimization through participation in the study (Liamputtong, 2007). Potential re-victimization was mitigated through respectful negotiation of interview locations, provision of access to appropriate and current information about community resources should a woman request further support, solicitation of feedback from day shelter staff with regard to the research process and potential challenges for participants, and reflexivity on the part of the research team throughout the study.

### ***Professional and Personal Tensions***

Throughout the research process we were aware of the potential for team members to witness activities or disclosures that could cause legal, ethical, or moral tensions. The team also grappled with personal feelings of guilt because of our position of relative privilege, as well as frustration or anger over the choices the women felt compelled to make given their life situation. The field notes of one of the research assistants included the following:

*What was so interesting (yet infuriating) about what she [the research participant] shared was how grateful she was to be going on to probation (for a mischief charge) because she would get quicker access to substance use treatment...and would have the assistance of the probation officer in keeping on the straight and narrow. She had to leave a partner because he was too substance involved and she wanted to get off of drugs (opiates).*

*She said numerous times that it was “a good thing for [her]”...and I thought how crazy that someone in this country should have to go to such lengths to get timely health care. Here she has a 2.5-year-old in [foster] care, and so of course you do what you need to do to get services. It made me think about all the ways in which people are resilient and yet demonized for being so, the ways that women cope with trauma (i.e., substance use), only to find themselves re-victimized by the very actions that they take to survive.*

One of the ways in which the team managed such feelings was to revisit the purpose and objectives of the study. Researchers reflected on the potential for the women to have positive experiences through their participation in the interview. Participation in research can give a voice to marginalized populations such as women offenders, as well as an opportunity to gain unanticipated benefits such as a sense of purpose and empowerment; by sharing their stories, the women might have a cathartic experience that serves to enhance their well-being and reduce their feelings of isolation and stigmatization (Hlavka et al., 2007; Hutchinson, Wilson, & Skodol Wilson, 1994).

### **Recommendations for Future Research With Female Offenders**

Lessons learned through this pilot investigation were invaluable to us in revising our approach to research with women offenders. The limited literature on health promotion and health literacy among women offenders may be a reflection of the inherent difficulties and challenges of conducting research with this population. Women offenders often feel compelled to make themselves invisible because of the stigma and shame attached to their life experiences (Martel, 2004). They tend to live within tight networks limited to those they trust (e.g., mental health and outreach workers).

Our recommendations for future research with female offenders include careful attention to the selection of research setting, the methods of data collection, and the establishment of community collaboration.

#### ***Selection of Research Setting***

We see several distinct advantages to conducting research with women offenders who are in closed custody (incarcerated) as opposed to open custody. Women in closed custody are less likely to engage in activities that may inhibit or preclude their participation in research (i.e., substance use). Correctional facilities have suitable space available for conducting confidential and safe data collection. Women in closed custody have periods of unstructured time and have greater time flexibility than those in open custody in terms of participating in research (Robert et al.,

2007). Daily routines in closed custody make for a structured, less chaotic environment than open custody living arrangements. Finally, research participants in closed custody are afforded the time, space, and a secure environment in which to engage in self-reflection (Robert et al., 2007).

There are also drawbacks to conducting research with women who are incarcerated. These include the permission process attached to accessing the target population, the amount of time needed to develop effective working relationships at multiple levels within government correctional services, and the potential for correctional processes to impede the research process (Martel, 2004). In addition, incarcerated women may fear reprisal from prison officials. Finally, data collected in an artificial living environment such as a prison may not reflect the strengths, deficits, and resiliencies of women's health as fully as the reality of open custody or living arrangements that are unencumbered by legal conflict.

### ***Methods of Data Collections***

Alternative methods of data collection with this particular population include body mapping and photovoice. Body mapping is an arts-based method of data collection that entails participant creation and use of the traced outlines of participants' bodies to gather and share health-related information. It has the ability to facilitate change through awareness-raising and critical dialogue (Cornwall, 1992; Devine, 2008; Weinand, 2006). Researchers encourage women to use their body maps to elicit explanations of their health concerns and their sources of resiliency and support. By using people's own representations of their bodies as a starting point from which to explore particular health issues, body mapping can facilitate a less scripted interviewing style, allowing exploration of issues that are difficult to access through verbal discussion alone (Cornwall, 1992).

Photovoice is a promising method of data collection with women offenders. It was developed by Wang and Burris (Wang, 1999) to enable Chinese village women to photograph their "everyday health and work realities" and has been expanded to include other populations (Frohmann, 2005; Moffitt & Vollman, 2004; Oliffe & Bottorff, 2007). Regardless of the research topic, photovoice has three main objectives: to give people an opportunity to document and reflect on their community's strengths and weaknesses (Wang & Burris, 1997); to facilitate critical dialogue and knowledge regarding one's community; and to reach people who are in a position to effect change, such as policy-makers, program administrators, and health-care providers (Wang, 1999; Wang & Burris, 1997). Research has demonstrated that photographs can access memories that may not be accessible through a narrative method alone (Oliffe & Bottorff, 2007).

### ***Community Collaboration***

Recruitment of the women offender population requires the budgeting of adequate time to network and develop relationships (with substance abuse counsellors, mental health outreach workers, and the staff of drop-in centres or coffee houses for the homeless) within the communities in which women offenders find themselves. We found the social service personnel linked with this population of women to be very protective of them, and gaining the trust of these personnel was an essential but time-consuming task. A community advisory committee, if formed, could have assisted tremendously with the recruitment of participants. It could have ensured that our recruitment strategies were appropriate to the target population and could have assisted with the dissemination of findings among the target population, health professionals, and other stakeholders.

These observations are consistent with those of Logan, Walker, Shannon, and Cole (2008), who report that building trust and community collaboration is integral to the recruitment of women living in a context of trauma. Participants in their study confirmed that community collaboration gives credibility to a research study, as they were inclined to check with their community supports about a study before agreeing to participate.

### **Discussion**

This pilot study of health promotion issues among female offenders was conducted with a small group of women serving time in open custody. The literature review indicated that there is limited interest in health promotion and health literacy among female offenders in Canada. The research team considered some of the relatively intangible but perhaps salient reasons for the lack of health promotion research with women offenders. Health promotion is defined as the “process of enabling people to increase control over, and to improve, their health” (WHO, 1986). The principles that have been established for the practice and promotion of health are founded on social justice and equity, such that differences in health status, opportunity, and access to resources are minimized through supportive environments, access to information, the development of effective life skills, and the opportunity to control choices.

Growing research evidence has begun to shift the health promotion dialogue from one of individual blame related to lifestyle choice to a consideration of the external influences underlying such circumstances as homelessness and poverty (Raphael, 2003). Yet the complex web of health determinants that characterize the lives of women offenders and the failure to acknowledge the circumstances that influence women’s “choices” reinforce the idea of individual blame. Blaming the individual,

rather than illuminating the complexity of factors that facilitate or impede “choice,” obscures the need for health promotion researchers to fully explore the “web of causation” that guides the choices of women offenders (Bloom et al., 2004; Evans, 2006; Johnson, 2006).

Researchers, clinicians, and policy-makers are beginning to acknowledge the complex influences of hyper-consumption and obesity, smoking and cancers, and languor and heart disease. We are therefore hopeful that they will become more inclined to examine the complex conditions of poverty, abuse, addiction, and threats to mental and physical health that women offenders must navigate in order to survive (Covington, 2002; Evans, 2006; Johnson, 2006). Investigators can confront their deeply entrenched beliefs only by examining a woman’s life from her own perspective, attending to the nuances that are not easily captured using traditional research designs.

### **Conclusion**

The findings of this study with women serving time in open custody highlight important issues related to participant recruitment, methods of data collection, physical and emotional safety, and professional and personal tensions. Women offenders face myriad complex issues related to their psychological, emotional, and physical health (Evans, 2006). For women who are incarcerated, in the process of integrating back into their communities after incarceration, or coming to terms with the reality of living life under probationary supervision (Covington, 2002), their involvement in the criminal justice system has lifelong effects on their health status, extending well beyond the initial criminal charge (Evans, 2006). Fully understanding and appreciating the health promotion and health literacy needs of women offenders should be a priority for health researchers concerned with social justice and equitable access to services and resources, for these women are among the most vulnerable by virtue of their life circumstances.

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