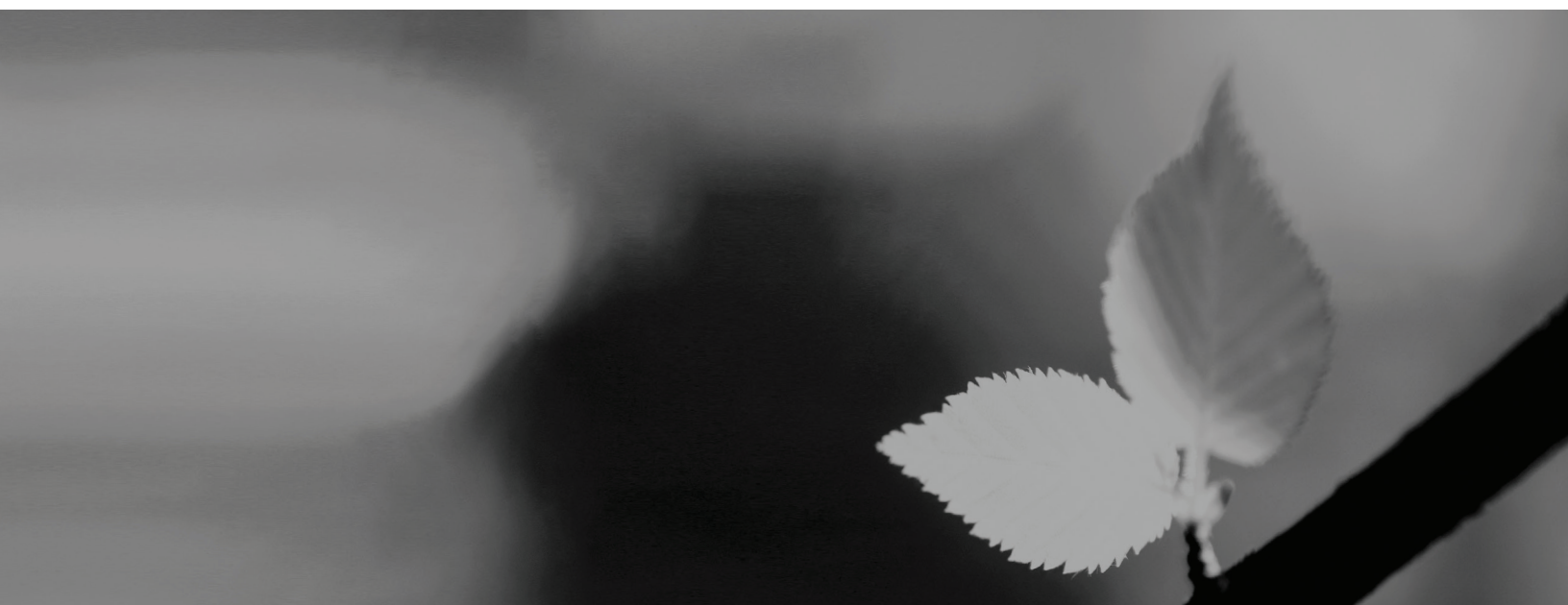


GUIDELINES FOR THE IMPLEMENTATION OF MOTHER-CHILD UNITS IN CANADIAN CORRECTIONAL FACILITIES

August 2015



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The University of British Columbia, 2206 East Mall,
Vancouver, BC V6T 1Z3

Tel: 604-827-4976, Toll free: 1-855-999-4976
www.ccphe.ubc.ca

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Graphic Design by David Ko: designgradient@gmail.com

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INTRODUCTION

These guidelines are predicated on the clear and compelling evidence that early mother-infant bonding supports positive future outcomes for the child, and that the child has a right to non-discrimination.

The best interests of the child must be of a primary concern, including her/his safety and security, and the physical, emotional and spiritual well-being of the child. It is in the best interests of the child to remain with her/his mother, to breastfeed and be allowed to develop a healthy attachment.(1) The wide range of psychological, physiologic and developmental harm caused by separation of a child from her/his mother is well documented.(2–4) Recent epigenetic evidence demonstrates that a newborn’s attachment to her/his mother is critical to her/his long-term healthy development.(5)

Women who are expected to give birth while in custody, or who are the primary caregivers of dependent children, should remain in the community where ever possible. The justice system should make all effort to seek supportive community alternatives to custody for these women.(6)

Throughout the world, incarcerated women tend to be young and of childbearing age, often lacking financial resources and poorly educated.(7) In addition, many incarcerated women have experienced physical and sexual abuse and traumatic childhoods, which in some cases has led to substance use and mental health issues.(7) In 2003, an estimated 20,000 Canadian children were separated from their mothers because of incarceration.(8)

Aboriginal people face extremely high rates of incarceration and involvement/interaction with the justice system. Aboriginal people - meaning First Nations, Inuit and Métis (FNIM) - in Canada face additional discrimination, because of the long-term multigenerational effects of colonization, intergenerational trauma, attempted cultural genocide and ongoing racism. In addition, the powerful impact of the social determinants of health for Indigenous peoples result in health inequities.(9, 10) The United Nations Declaration on the Rights of Indigenous Peoples recognizes the right of Indigenous families and communities to retain shared responsibility for the upbringing, training, education and well-being of their children.(11) This Declaration has been endorsed by Canada, but has yet to be implemented.

The World Health Organization (WHO) and the United Nations (UN) have established minimum standards regarding the rights of the child and the rights of the family.(12,13) The standards, which have been endorsed by Canada, were incorporated into the writing of these guiding principles.(10) In addition, the WHO recommends exclusive breastfeeding for the first six months, and breastfeeding up to two years of age.(14–16)

The Canadian landmark decision of the Supreme Court of British Columbia, December 2013, stated that the decision to cancel a provincial correctional facility mother-child unit infringed the constitutional rights of mothers and babies.(17) When community alternatives to custody are not possible, mother-child units are beneficial, and these benefits have been demonstrated internationally. For example, mother-child units in correctional facilities allow children to bond with their mothers in a safe and supportive environment and allow mothers to develop positive parenting and social skills.(18–20) Through this lens, incarceration can be viewed as a transformative period for mothers and their children. A collaborative interdisciplinary, inter-agency approach can achieve this by promoting stability and continuity for mother-child health and relationship in and beyond the correctional facility.

In this document, we describe guiding principles, and the practices that are required for optimal child and maternal health inside a correctional facility, including the correctional context, pregnancy, birth, education, correctional and medical care, discharge planning and community partner engagement. In

Canadian federal institutions, four years is the upper age for children in mother-child units; therefore, these guidelines cover children up to the age of four years.(21) For the purpose of these guidelines, we define infant as aged 0-1 years, and child as aged 1-4 years. In addition, we use the term 'correctional facility' to designate any institution that holds women in custody.

Guiding Principles

1. The *best interests and safety of the child* are a primary concern in addition to the rights of the mother.
2. *Protection of the family unit* is at the core of our societal value system and is entitled to protection by the state. The woman defines who are members of her family unit.(22)
3. Preserving the *integrity of the mother-child relationship* should be a priority at all times and is the responsibility of all service providers. Any practice that separates a child from her/his mother (for any reason other than the safety or well-being of the child or the well-being of the mother), and does not provide for the maintenance of the mother-child relationship, harms the family unit.
4. Canadian correctional *gender-based statements of philosophy* affirm that correctional practices should be responsive to the needs to women both inside a correctional facility and in the community. (23,24)
5. As explained in the introduction, all efforts should be made to seek out *supportive community alternatives to custody* for women giving birth during their sentence.(1)
6. *Child safety* is the shared responsibility between the child protection authorities and the ministries of health and justice (including correctional staff and hospital staff).
7. Women are incarcerated for many reasons, and only some reasons are associated with child protection concerns. Therefore, correctional mother-child care should be reviewed on a case by case basis, with child protection authorities' involvement in cases only where deemed appropriate
8. *Woman centered care* should be implemented in correctional facilities, using the *same standards as the community*, recognizing that incarcerated women are valued as key informants for all decisions for their care and their future, including defining their own family.(22) (See guiding principle 2)
9. Pregnant and parenting incarcerated women should be informed of their *choices and rights*.
10. Women's religious, cultural and spiritual *customs and beliefs* relating to pregnancy, giving birth and parenting should be respected without compromising safety and security.(25)
11. Respectful and *trauma informed care* that is sensitive to the needs of those recovering from past trauma and/or substance use challenges should be offered to all incarcerated women; correctional staff should be responsive to the impacts of physical, psychological and/or sexual violence in women's lives.(26, 27)
12. Pregnant or postpartum incarcerated women should receive appropriate individual holistic health care, in the form of an *individualized health care plan*, which is developed in collaboration with a qualified health practitioner. Within correctional facilities, pregnant and postpartum women, and their babies and children, should be offered adequate and timely nourishment, a healthy environment and regular exercise opportunities, similar to that offered in the community.(1)
13. It is important to identify and *build on strengths* and protective factors of incarcerated women, their families and their communities.(22) Focusing on protective factors, such as improving housing and nutrition, can improve outcomes for mothers and their children, thereby reducing harm.
14. When planning for release, a *continuum of help* should be accessible and offered to women and their families, in order to support and to respect women's goals for change. In addition, integrated case management, including continuity of medical care, should be actively supported on release to community, in order to nurture and stabilize mother-child relationships.
15. *Collaborations are fostered* between correctional facilities/ministries and community health organizations/ ministries in order to provide seamless care for mother-child unit participants.

BEST PRACTICES TO SUPPORT THE GUIDING PRINCIPLES

1. Best Practices for the Correctional Context

- a. Incarcerated mothers and their children up to the age of four years are eligible to participate in mother-child programs in correctional facilities.
- b. The child protection threshold for determining that the child can live with the mother should be the same as applied to situations in the community.
- c. If any mother is precluded from the mother-child program, an automatic expedited review process should be available for the decision to be reviewed. The mother should have access to an advocate, either designated or one of her choosing.⁽²⁸⁾
- d. When a mother and child are accommodated at a correctional facility, an interdisciplinary inter-ministry team will be involved in dialogue with the mother, which may include:
 - i. If child protection is involved in the case, representatives from the Child Protection Authority, including the primary social worker and the leader of the team responsible for the planning and decision making for the child.
 - ii. Representatives from the provincial or federal Correctional Services of Canada (CSC) and the Ministry of Justice, including the case coordinator, warden or her/his designate, and the health care manager in the correctional facility.
 - iii. Clinicians involved in her care including attending physician, or midwife, nurse or social worker, maternity unit manager or charge nurse.
 - iv. Mother and members of the immediate or extended family (as identified by the mother).
 - v. This team may also include as needed:
 1. Aboriginal (FNIM) advisor/Elder and/or band representatives with relevant cultural/language fluency;
 2. Addictions counselor from the community, facility or hospital;
 3. Community or public health nurse;
 4. Spiritual advisor.
- e. The decision process (to accommodate the mother and child) should be timely so that no interruption in bonding and attachment occurs following birth and so that stress is minimized. The stress caused by the possible separation of the mother with her infant may cause detrimental effects to the pregnancy and child.
- f. In order to preserve the confidentiality of women accessing community resources, it is beneficial for correctional officers to be non-uniformed when accompanying mother (and child) into the community. It is strongly recommended that restraints are not used.
- g. It is beneficial that the mother and the correctional facility sign an individualized parenting agreement that outlines the conditions under which the child will reside within the correctional facility.

2. Best Practices for Pregnancy

- a. All incarcerated women should have timely access to pregnancy testing. The correctional health care manager should alert the local hospital as soon as the incarcerated woman reaches her third trimester of pregnancy.
- b. Timely discharge planning should begin at the time of confirmation of pregnancy. See section 7 below for more details.
- c. Pregnant women should be provided access to, and encouraged to participate in, pre-natal classes and parenting programs, either in a correctional facility or in the community.

- d. Consideration should be given to providing pregnant women with suitable employment and recreation, which ensures a balance of rest, healthy activity/exercise and participation, and access to cultural support to promote emotional and spiritual health.
- e. Health care in a correctional facility should recommend products to address common discomforts of pregnancy. (e.g. extra pillows or blankets, ice pack or heating pads).
- f. Pregnant women's increased nutritional needs should be taken into account and provided for.
- g. Pregnant women should be given, where possible, the option of services in her pregnancy from the health region of the correctional facility, which might include the option of midwife and/or doula services, as well as trauma informed care and counseling.
- h. Pregnancy and birth during incarceration can be traumatic. All efforts should be made to provide clear and timely access to health care during this time.
- i. Women should be encouraged to identify a person to support her during labour and delivery; this could include a doula, a family member or friend.
- j. All pregnant women should be offered culturally safe and competent pre-natal, delivery and post-natal care. For example, Aboriginal practices should be accommodated upon request and where possible.

3. Best Practices for Birth

- a. The correctional health care manager should have alerted the local hospital about the date of confinement when the woman reaches her third trimester of pregnancy. (See 2b)
- b. The health care provider (physician or midwife), in collaboration with the woman, should create an individualized health care plan for the woman and her baby for the intra-partum and post-partum period, as well as for her return to the correctional facility.
- c. At the onset of regular contractions, the correctional facility should notify the hospital and/or health care provider (physician or midwife) as previously arranged, prior to moving the woman from the correctional facility.
- d. At the onset of regular contractions, the correctional facility should also at this time notify the woman's identified support person. (See 2h).
- e. The woman should be given the opportunity to speak directly with health care staff (either her health care provider at the correctional facility or hospital staff) prior to leaving the correctional facility.
- f. The woman giving birth should be escorted to hospital by at least one female correctional staff.
- g. Where security levels permit, the best practice would be for escorting correctional staff to be absent from the delivery room, during the birth and labour, unless requested by the woman. If the woman requests the correctional staff to remain in the delivery room, the woman should provide verbal consent with a health care provider as witness. It should be made clear that the woman can change this consent at any time.
- h. According to international standards, no mechanical restraint may be used at any time during labour and delivery, and immediately after birth, under any circumstances.⁽¹⁾

4. Best Practices for the Care of Woman/Child in Correctional Facilities

- a. It is important that correctional staff are empathetic and knowledgeable when dealing with women and their children in the correctional setting. Therefore, additional staff orientation and training should be provided for both community and institutional correctional staff. (See Education 6c)
- b. Staff roles may include: escorting women to activities outside of correctional facilities (community agencies), supporting mothers to provide relevant activities for their child/children, supporting the mother to participate in parenting programs.
- c. When escorting a child to medical or other community appointments, the mother is responsible for the care and safety of her child. Both the mother and the correctional officers should receive instruction on

- the correct use of safety equipment such as car seats. The mother should accompany the child to any community appointments and programs. In the event that the mother is unable to accompany her child, alternative pre-approved child escorts should be used.
- d. Placement of other incarcerated women into the mother-child unit should be on a case by case basis. A mix of mothers and selected non-mothers is recommended.(29,30)
 - e. The woman should be allowed access, where practicable, to a range of social outlets, work and life skills activities, consistent with that available to other women in the correctional facility. Access to ceremony, elders and culturally relevant activities should be facilitated. The woman's primary responsibility is to her child, and this should be taken into account when establishing her sentence plan.
 - f. If the woman is breastfeeding, she should have access to a private place for breastfeeding whenever the baby needs to breast feed.(31)
 - g. Only mothers, approved babysitters, and health care personnel should be allowed to care for the babies/ children. In the case of an emergency, where safety and security are deemed to be at risk, staff in the correctional facility may handle the child in order to mitigate the emergency situation. As for any infant in the community, no one should touch an infant unless the mother gives her prior approval.
 - h. Mothers should nominate other women as babysitters. Applicants for the babysitter positions should be screened. If approved, babysitters should receive orientation and training and should sign an agreement that contains applicable rules.
 - i. Each mother should have a crib beside her bed for her baby to sleep in, to promote holding and caring for their baby around the clock.
 - j. All efforts should be made to ensure a safe environment for the infants and children. Opportunities to access community programs for the mother and child should be facilitated, such as, parenting, recreational activities, first aid and early childhood development programs. If custodial status does not permit the mother access to the community, the community agencies should be encouraged to provide these opportunities within the correctional facility.
 - k. It is recommended that a two-way process is developed for communication and information between the mother and correctional staff. It was valuable to identify a consistent information source (i.e. a designated staff person) to aid in resolving communication issues.(30)
 - l. In cases where Child Protection Authority is involved, visits with the mother, child and/or extended family should be arranged with Child Protection Authority consultation.
 - m. The mother-child unit environment should be child age appropriate. This includes age-appropriate equipment, toys, books, play areas (indoors and outside) and child safety-proofed living areas.

5. Best Practices for Medical care

- a. Having an opiate dependent pregnant woman go through withdrawal may be harmful for the baby. If opiate using at the time of delivery the newborn may need to be assessed for medical and or opiate withdrawal. (32,33)
- b. The woman should have access to appropriate medical care and access to the routine pre-natal and post-partum checks as for any woman in the community. All pregnant women should be offered the community equivalent standard of prenatal care including assessment for health issues such as HIV and hepatitis C, and to obstetrical consultation as needed.
- c. The infant/child should have access to medical care and well-baby health developmental checks, in collaboration with community health services, as for any child in the community. For example, medical care and follow up may be performed by the physician and health care professionals at the correctional facility, and also by community public health nurses.
- d. Correctional facility health care staff who are assigned to female correctional facilities are encouraged to

participate in continuing medical education (CME), as required by their respective professional licensing organization, that is linked to maternal and child health care.

6. Best Practices for Education

- a. Education about providing non-judgmental and respectful care, for mother and child regardless of previous life experience and history, including exposure to substances, is recommended for all groups listed in 6.c. below.
- b. Education and training about cultural competency is recommended for all of the groups listed in 6.c. below. An example of cultural competency training is the on-line Indigenous Cultural Competency Course, Provincial Health Services Authority.[34]
- c. Specific education, is recommended for the following groups, as guided by the correctional facility's local health ministry or authority:
 - i. Correctional staff education should include: evidence regarding healthy long-term outcomes (e.g. breast feeding, maternal-infant bonding and epigenetic evidence); caring for infants and mothers; Fetal Alcohol Spectrum Disorder; Cardio-Pulmonary Resuscitation; basic child safety and safe utilization of equipment (i.e. car seats); maternal-child attachment; when to call medical/nursing; support and understanding of breastfeeding; trauma informed care; training and awareness in recognizing child protection concerns;
 - ii. Correctional health care staff (e.g. physicians and nursing staff) education should include CME about infant care, and pre- and post-natal care (See also 5d);
 - iii. Community hospital staff providing pre-, intra- and post-natal care for incarcerated women education should about their role in facilitating incarcerated women to become mothers and caregivers. Maximum provision should be made for mother-baby interaction (i.e. skin-to-skin at birth, rooming in, breastfeeding, cuddling/holding the baby) as for any woman in the community;
 - iv. Community agencies that provide services inside correctional facilities should receive education that orients them to the correctional context;
 - v. Incarcerated women should have access to individualized, life-skill education and training to build their competencies in caring for children inside the and in the community. This education should include: shopping and budgeting; food preparation and cooking; infant and child development/behaviour; infant and child nutrition; basic housekeeping skills; and, age-appropriate child-safety environments.

7. Best Practices for Discharge Planning

- a. According to international standards, a best interests assessment of the child should be followed:[1,35]
 - i. The child should be respected as a person and acknowledged as the most vulnerable party in the proceedings;
 - ii. Placement decisions should take central account of the child's important relationships of attachment;
 - iii. The child should be provided with a stable, long-term living situation as soon as possible;
 - iv. Whoever is caring for the child in the role of parent should be able to provide a suitable standard of care.
- b. In order to prepare for a successful community release that ensures continuity of care, the following discharge planning processes should occur:
 - i. The woman must be involved in all aspects of her discharge plan, so that she may articulate prior to her discharge, her concerns and her need for supports;
 - ii. Discharge planning should begin with the woman and the interdisciplinary/agency team when

- pregnancy is confirmed;
 - iii. Discharge planning meetings should continue throughout the duration of the woman's sentence;
 - iv. A process should be in place, articulated and documented, regarding the specific supports and follow-up for the woman and child in the community;
 - v. A Child Protection Authority representative or social worker may be assigned to individual cases, or to the correctional facility, in order to facilitate discharge planning.
 - c. The following discharge planning supports should be considered for mother and child:
 - i. Continuity of health care providers and medical care for mother and child, which includes the sharing of medical information between health care providers with woman's consent;
 - ii. Housing support;
 - iii. Relevant community support;
 - iv. Extended family involvement, and/or placement;
 - v. If relevant, community substance use treatment and support;
 - vi. If the woman is from a First Nations community, the woman's return to her community should be supported, with the necessary links to community based programs and services.

8. Best Practices for Evaluation

- a. All research evaluation projects must be governed by the Canadian Tri-Council Policy Statement Research Ethics Review Board Processes, which includes policies on confidentiality and participation.⁽³⁷⁾
- b. Future Mother-Child Program evaluations should be informed by the following UN recommendations:
 - i. Efforts shall be made to organize and promote comprehensive, result oriented research on the offences committed by women, the reasons that trigger women's confrontation with the criminal justice system, the impact of secondary criminalization and imprisonment on women, the characteristics of women offenders, as well as programs designed to reduce reoffending by women, as a basis for effective planning, program development and policy formulation to respond to the social reintegration needs of women offenders;
 - ii. Efforts shall be made to organize and promote research on the number of children affected by their mothers' confrontation with the criminal justice system, and imprisonment in particular, and the impact of this on the children, in order to contribute to policy formulation and program development, taking into account the best interests of the children;
 - iii. Efforts shall be made to review, evaluate and make public periodically the trends, problems and factors associated with offending behaviour in women and the effectiveness in responding to the social reintegration needs of women offenders, as well as their children, in order to reduce the stigmatization and negative impact of those women's confrontation with the criminal justice system on them.
- c. Correctional institutions routinely collect data to assess recidivism rates, in order to evaluate the effectiveness of programs in reducing recidivism rates. As such, the following question should routinely be addressed, "Are changes in women's incarceration rates associated with women's participation in correctional facility mother child programs?" (Small sample size and lack of appropriate comparison groups might preclude causal links.)
- d. When a correctional institution establishes a mother-child unit, a program evaluation framework should be developed to assess how effectively the program is being implemented. Thus, multi-method evaluation data might be collected for any or all of the 49 items mentioned above in practices to support the best practices to support the guiding principles: 1. Best practices for the correctional context (a-g); 2. Best practices for pregnancy (a-h); 3. Best practices for birth (a-h); 4. Best practices for the care of woman/child in correctional facilities (a-m); 5. Best practices for medical care (a-d); 6. Best practices for education (a-c); and, 7. Best practices for discharge (a-c).
- e. Longer-term outcome research is needed to establish the impact of mother-child units. Academic

institutions, and community health organizations, should be encouraged to foster research collaborations with correctional institutions to conduct multidisciplinary, mixed-method (qualitative and quantitative), long-term, prospective evaluations of the anticipated changes in maternal and child health that may result from the implementation of best practice maternal child programs in correctional facilities. Research factors to be considered might include:

- Infant/child: Do children demonstrate maternal attachment/bonding? What was the duration of breastfeeding? Were age-appropriate childhood developmental milestones achieved? Longer-term health and social indicators (e.g. future involvement with Child Protection Authority)? What impact does mother-child units have on factors relating to child mental, emotional, physical and spiritual health?
- Mother: In what ways did the mother complete her own goals? Did she learn what she hoped to learn? In what ways was this experience transformative? What impacts has this experience had on mother's long-term health? What impact does mother-child units have on factors relating to mother's mental, emotional, physical and spiritual health?
- Correctional impact: What is the impact of the mother-child unit on the health and social well-being of other incarcerated women and of correctional staff? On other aspects of correctional practices, programs and experiences?
- Cultural aspects: What is the impact of this experience on families' generational legacy of maternal-child separation (e.g. incarceration, foster homes and/or residential schools)? How are mother and child welcomed into her community/family following her release? How are mother's feelings of role security and identity?
- Community release: Is there supportive housing upon release? Is there on-going support (life-skills, parenting, financial, public health) for mother-child dyad following release? Is there family support following release?
- Economic factors: Is there a return on investment (i.e. investing in early childhood)?

APPENDIX 1 – GLOSSARY

Aboriginal is a term used in the guidelines to include three groups of people in Canada: First Nations, Inuit and Métis (FNIM).

Attachment is a concept applied to the infant/child relationship with the mother and other caregiving figures and is a neurobiological process in the child which takes place over the first years of life; is categorized as secure or insecure (with the latter characterized as avoidant, resistant or disorganized); becomes a system that is triggered to protect the child during situations of fear, illness, or harm; creates a pattern for establishing later relationships; and is predictive of the child's social and emotional development.

Bonding is a concept applied to the early mother-infant relationship, particularly during the neonatal period, which describes the mother's positive affect toward the infant and her comfort with proximity to the infant including gaze, vocalizations, affectionate touch, and skin-to-skin contact. (Bonding is a different concept than attachment and the two terms should not be used interchangeably).

Correctional Facility is the term used in the guidelines to designate any correctional institution that holds women in custody.

Cultural Safety refers to an encounter in which the client feels respected and empowered, and that their culture and knowledge has been acknowledged. Cultural safety refers to the client's feelings in the encounter, while cultural competence refers to the skills required by a professional to ensure that the client feels safe.

APPENDIX 2 – THE WRITING PROCESSES

The Collaborating Centre for Prison Health and Education (CCPHE) hosted a working meeting on March 14th and March 15th, 2014, at the University of British Columbia, Vancouver, to generate best practice evidence-based guidelines.

Experts were invited to present, during the working meeting, during four panel discussions entitled, 'the rights of the child', 'the correctional context', 'pathways and programs' and 'evaluation'.

Stakeholder organizations were invited to contribute to the writing of the guidelines by selecting delegate representative(s), who would participate in the working meeting and who would review/edit the draft guidelines.

All meeting delegates were invited to consent to video- and audio- recording during the meeting. Presentations and discussions were recorded (using typed field notes, hand-written notes, video- and audio- recording and PowerPoint slides) and selected audio-recordings were subsequently transcribed by volunteer assistants.

The CCPHE contracted Sarah Payne to write an initial guideline framework, based on her analysis of the meeting proceedings. The guideline framework was edited in an iterative manner as follows:

- Each transcriptionist compared and contrasted the codes and themes emerging in each transcription with the guideline framework, and highlighted any new major themes; new themes were incorporated into the guideline framework;
- All transcriptions and meeting data were reviewed a final time, seeking any 'new' major themes that were not already included in the guideline framework;
- Finally, we reviewed and cited the international resources and research publications, which had been presented by experts as evidence during the working meeting.

All members of the planning committee reviewed and approved the draft guidelines. The draft guidelines were circulated to all meeting delegates, inviting comment and edits. Each editing comment received was compared and contrasted with the 'data' that were generated during the working meeting, and was considered individually for inclusion into the guidelines.

In June 2014, all meeting delegates received the penultimate version of the guidelines, to be forwarded to the organizations that they represent inviting endorsement of the guidelines.

Appendix 7 includes a list of organizations that have endorsed the guidelines at the time of publication (August, 2015).

APPENDIX 3 – ACKNOWLEDGEMENTS

We gratefully acknowledge the following organizations for providing unrestricted financial support to CCPHE for the Mother-Child Prison Health Working Meeting:

- Interior Health Authority
- First Nations Health Authority
- Native Youth Sexual Health Network
- University of the Fraser Valley, Centre for Safe Schools and Communities
- Vancouver Island Health Authority
- Women’s Health Research Institute
- Provincial Health Services Authority

The following representative delegate(s) of stakeholder organizations participated in the working meeting and the editing process.

Aboriginal Mother Centre Society	Chelsea Bowers
Aboriginal Mother Centre Society	Lulla Sierra Johns
BC Civil Liberties Association	Grace Pastine
BC Corrections, Alouette Correctional Centre for Women	Ardith Watson
BC Corrections, Alouette Correctional Centre for Women	Bonnie Smith
BC Corrections, Alouette Correctional Centre for Women	Debbie Hawboldt
BC Corrections, Alouette Correctional Centre for Women	Barbara Collis
BC Corrections, Alouette Correctional Centre for Women and Justice Institute	Martina Cahill
BC Corrections, Research Evaluation and Planning	Carmen Gress
BC Government and Employee Services Union	Jan Wilson
BC Ministry of Children and Family Development	Yasmin Remtulla
BC Ministry of Children and Family Development, Child Welfare and Youth Services Policy, Policy and Provincial Services	James Wale
BC Ministry of Health, Healthy Development and Women’s Health Directorate	Carolyn Solomon
BC Women’s Hospital	Cheryl Davies
Bonding Through Bars	Samantha Sarra
Canadian Aboriginal AIDS Network	Jessica Danforth
Canadian Friends Service Committee	Sarah Chandler
Collaborating Centre for Prison Health and Education	Ben Fussell
Collaborating Centre for Prison Health and Education	Debra Hanberg

Collaborating Centre for Prison Health and Education	Ruth Elwood Martin
College of Family Physicians of Canada, Maternal and Newborn Care	William Ehman
Contracted Advisor for Incarcerated Mothers	Alison Granger-Brown
Correctional Service of Canada	Chantal Allen
Correctional Service of Canada, Fraser Valley Institution	Nellie Taylor
Correctional Service of Canada, Fraser Valley Institution	Marie Verbenkov
Correctional Service of Canada, Fraser Valley Institution	Elizabeth Watt
Elizabeth Fry Society of Greater Vancouver	Jodi Sturge
Family Help Trust, New Zealand	Libby Robins
Fir Square Program, BC Women's Hospital	Georgia Hunt
First Nations Health Authority	Naomi Dove
Fraser Health Authority	Sarah Kaufman
Fraser Health Authority	Pam Munro
Fraser Health Authority	Michelle Urbina-Beggs
Health and Early Learning Project (HELP), UBC	Michele Sam
Institute of Health Economics and Bonding with Babies Society	Amy Salmon
Native Youth Sexual Health Network	Krysta Williams
New Zealand Department of Corrections	Tracy Cherie Tyro
Nicola Valley Institute of Technology	Lara-Lisa Condello
Office of the Correctional Investigator of Canada	Ivan Zinger
Representative for Children and Youth Office	Melanie Mark
Retired health care manager, Fir Square Program, BC Women's Hospital	Sarah Payne
Retired Warden, BC Corrections	Brenda Tole
Retired Warden, Correctional Service of Canada	Nancy Wrenshall
Society of Obstetricians and Gynaecologists of Canada	Elizabeth Harrold
Surrey Women's Centre	Noreen Baker
University of British Columbia, Midwifery	Saraswathi Vedam
University of British Columbia, Midwifery	Allison Campbell

University of British Columbia, Department of Paediatrics	Andrew Macnab
University of British Columbia, Department of Psychiatry	Adele Diamond
University of the Fraser Valley, Criminology Faculty	Hayli Millar
Vanier Centre for Women/The Birthing Well Collective/The Barbra Schlifer Clinic	Lisa Marie Thibodeau
Westcoast Family Centres Society	Freeza Anand
Westcoast Family Centres Society	Wendy Fitzjohn
Winteringham MacKay Law Corporation	Janet Winteringham
Women in2 Healing	Amanda Edgar
Women in2 Healing	Christine Hemmingway
Women in2 Healing	Mo Korchinski
Women in2 Healing	Devon (and Dallas) MacDonald
Women in2 Healing	Pamela Young

Skype participation:

Center for Children and Families, Columbia University, New York	Mary Byrne
Retired warden, Bedford Hills Correctional Facility for Women, New York	Elaine Lord

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Members of the Planning Committee:

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- Jessica Danforth, Canadian Aboriginal AIDS Network
- Brenda Tole, BA, retired prison warden
- Amy Salmon, PhD, Institute of Health Economics
- Alison Granger-Brown, MA, PhD, contracted advisor for incarcerated mothers
- Debra Hanberg, Project Coordinator, Collaborating Centre for Prison Health and Education
- Ruth Elwood Martin, MD, FCFP, MPH, Collaborating Centre for Prison Health and Education

APPENDIX 4 – PANEL PRESENTATIONS DURING THE WORKING MEETING

Panel 1 – The Rights of the Child (facilitator Jessica Danforth)

- Michele Sam PhD (cand), Ktunaxa Nation, UBC HELP
- Ivan Zinger JD PhD, Executive Director and General Counsel, Office of the Correctional Investigator of Canada
- Melanie Mark, Associate Deputy Representative, Advocacy, Aboriginal and Community Relations, Representative for Children and Youth, Burnaby
- Janet Winteringham QC, Counsel for BC Civil Liberties Association
- William Ehman MD, Maternity and Newborn Care Program, College of Family Physicians of Canada

Panel 2 – The Correctional Context (facilitator Debbie Hawboldt)

- Tracy Tyro, Acting Prison Manager, Christchurch Women's Prison, Dept. of Corrections, New Zealand
- Chantal Allen, Senior Project Officer, Interventions and Policy, Women Offender Sector, Correctional Service of Canada
- Nancy Wrenshall, retired warden (Burnaby Correctional Centre for Women and Fraser Valley Institute)
- Brenda Tole, retired warden (Alouette Correctional Centre for Women)
- Mary W. Byrne PhD, Director, Center for Children and Families, Columbia University, NY (via Skype)
- Elaine Lord, Bedford Hills Correctional Facility for Women, New York (via Skype, over lunch)

Panel 3 – Pathways and Programs for Maternal Child Health (facilitator Alison Granger-Brown)

- Libby Robins, Director of Family Help Trust, New Zealand
- Lisa Marie Thibodeau, Vanier Centre for Women/The Birthing Well Collective/The Barbra Schlifer Clinic
- Devon, a woman who lived with her baby in a BC prison Mother Baby Unit
- Sarah Payne RN, former health care manager, Fir Square Program, BC Women's Hospital
- Naomi Dove MD, Health Promotion & Disease Prevention, First Nations Health Authority
- Yasmin Remtulla MSW, BC Ministry of Children and Family Development

Panel 4 – Evaluation (facilitator Mo Korchinski)

- Michele Sam PhD(cand), Ktunaxa Nation, UBC HELP
- Andrew Macnab MD, Professor, UBC Department of Pediatrics
- Amy Salmon PhD, Director of Institute of Health Economics
- Carmen Gress PhD, Director of Research and Planning, B.C. Corrections, Ministry of Justice
- Mary Byrne PhD, Director of Center for Children and Families, Columbia University, New York (via Skype)

APPENDIX 5 – RECOMMENDED EDUCATIONAL MATERIALS

1. Indigenous Cultural Competency Course. On-line education. Provincial Health Services Authority. Available at <http://www.culturalcompetency.ca/>
2. KidCareCanada website (www.kidcarecanada.org) Video materials to help mothers and staff to understand the everyday measures that are known to help maternal child interaction and promote health infant development.
3. Rourke Baby Record.(38) Available at <http://rourkebabyrecord.ca/national.asp> (38)
4. Children of Prisoners. University of Huddersfield (6)

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APPENDIX 7 – ENDORSEMENT OF THE GUIDELINES

Organizations that endorsed the guidelines at the time of publication (August 2015):

- Aboriginal Mother Centre Society, Board of Directors
- British Columbia Civil Liberties Association
- British Columbia Women’s Hospital
- Bonding Through Bars
- Canada FASD Research Network
- Canadian Friends Service Committee (Quakers)
- Center for Children and Families, Columbia University, New York
- College of Family Physicians of Canada
- College of Midwives of British Columbia
- Elizabeth Fry Society, Greater Vancouver
- Family Help Trust, New Zealand
- First Nations Health Authority
- Fraser Health Authority
- Native Youth Sexual Health Network
- New Zealand Department of Corrections
- Nicola Valley Institute of Technology
- Society of Obstetricians and Gynaecologists of Canada
- University of the Fraser Valley, College of Arts, Dean and Faculty
- University of the Fraser Valley, Centre for Public Safety and Criminal Justice Research
- University of the Fraser Valley, Centre for Safe Schools and Communities
- Vancouver Coastal Health Authority
- Westcoast Family Centres Society
- Women in2 Healing



