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End-of-Life in Prison Symposium Report

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2017

End-of-Life in Prison Symposium Report

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DALHOUSIE UNIVERSITY
SCHULICH SCHOOL OF LAW

FONDATION TRUDEAU FOUNDATION

DALHOUSIE UNIVERSITY
HEALTH LAW INSTITUTE

MEDICAL ASSISTANCE IN DYING FOR CANADIAN PRISONERS

Implementing "An Act to amend the *Criminal Code* and to make related amendments to other Acts (medical assistance in dying)" in Canadian Prisons:

A Prison-Focused Satellite Meeting After the Second International Conference on End-of-Life Law, Ethics, Policy, and Practice

SUMMARY

In 2016, the Canadian Parliament passed "An Act to amend the *Criminal Code* and to make related amendments to other Acts (medical assistance in dying)" (S.C. 2016, c. 3). This statute decriminalized providing medical assistance to the dying in a defined set of circumstances. The *Corrections and Conditional Release Act (CCRA)* was also amended: section 19 now reads "(1.1) Subsection (1) does not apply to a death that results from an inmate receiving *medical assistance in dying*, as defined in section 241.1 that Act."

Pursuant to these amendments, this meeting focussed on issues that may arise in implementing MAiD in the carceral context, asking "How can MAiD be implemented for Canadian prisoners responsibly?" or, in other words, "What obligations does the new MAiD legislation place on the Correctional Service of Canada and how can these be fulfilled".

Participants to the meeting agreed that MAiD and palliative care are essential aspects of a broader discussion: the options of an individual approaching end-of-life. In the prison context, end-of-life care, including MAiD and palliative care, raise specific concerns regarding security considerations, availability of appropriate health care services, and voluntary consent to medical treatment. Discussions on specific concerns and potential solutions were divided into four categories: palliative care within prisons, MAiD in prisons, MAiD outside prisons and palliative care outside prisons. Issues surrounding release options and transfers to community for palliative care and MAiD were at the forefront of the discussions.

Our hope is that this summary will provide a taste of the conversations had at this event – the concerns and potential solutions generated. Our longer term goal is to catalyze action at all federal, provincial, and territorial levels of government and within both the correctional system and the health system such that we better care for prisoners at the end of life.

MEETING REPORT

OVERVIEW

Introduction

In 2016, as a result of *Carter v. Canada*, the Canadian Parliament passed "An Act to amend the *Criminal Code* and to make related amendments to other Acts (medical assistance in dying)" (S.C. 2016, c. 3). This statute amended the *Criminal Code*, and it decriminalized providing medical assistance to the dying in a defined set of circumstances. In particular, anyone over the age of 18 and capable of making decisions with respect to their health, and meeting the legislation's eligibility criteria and procedural safeguards, would be permitted to receive medical assistance in dying (MAiD). The *Corrections and Conditional Release Act (CCRA)* was also amended, and section 19 now stipulates that "(1.1) Subsection (1) does not apply to a death that results from an inmate receiving *medical assistance in dying*, as defined in section 241.1 that Act."

The meeting organizers recognized that the implementation of MAiD for Canadian prisoners was inevitable and fraught. They conceived an event to discuss how the MAiD legislation can and should be implemented responsibly in the context of end-of-life care for prisoners.

The event focussed on issues that may arise in implementing MAiD in the carceral context. The event did not address the question of whether MAiD *should* be available to prisoners. In light of the federal legislation and the principle of equivalence between community and prison health care, that is a settled issue. Rather, the event brought participants from a wide range of relevant backgrounds together to reflect on "How can MAiD be implemented for Canadian prisoners responsibly?" or, in other words, "What obligations does the new MAiD legislation place on the Correctional Service of Canada and how can these be fulfilled, with particular attention to potential barriers?" The present document is intended to summarize the discussions that took place at the event and provoke reflection, with the goal of contributing to the ongoing discourse of how to improve the care and quality of life of Canadian prisoners at their end of life. As the discussion was intended to capture a full range of perspectives and ideas, this document captures comments and suggestions made but does not reflect a consensus perspective of all participants.

Co-hosts

Dalhousie Health Law Institute and Schulich School of Law, Dalhousie University

DALHOUSIE UNIVERSITY SCHULICH SCHOOL OF LAW — FONDATION TRUDEAU FOUNDATION — DALHOUSIE UNIVERSITY HEALTH LAW INSTITUTE

Sponsor

Pierre Elliott Trudeau Foundation (through Fellowship of Jocelyn Downie)

Organizers/Facilitators

Crystal Dieleman, PhD, Assistant Professor, School of Occupational Therapy, Dalhousie University

Adelina Iftene, PhD, Assistant Professor, Schulich School of Law, Dalhousie University

Assistant/Secretary

Hanna Garson, Article Clerk

Participants[1]

David Byrne, University of St. Michael's College/Joint Centre for Bioethics (PhD Candidate), Executive Director, Peterborough Community Chaplaincy

Jennifer Chandler, Professor, Faculty of Law, University of Ottawa

Jocelyn Downie, University Research Professor, Schulich School of Law and Faculty of Medicine, Dalhousie University

Gubitz, Neurologist & MAiD provider, Nova Scotia

Emma Halpern, Barristers' Society Nova Scotia & East Coast Prison Justice Society

David Henderson, Palliative Care Physician, Nova Scotia

David Hooey, Director of Policy and Research, Office of the Correctional Investigator

Archie Kaiser, Professor, Schulich School of Law, Dalhousie University

Hugh Kierkegaard, Head of CSC Atlantic Chaplaincy

Mark Knox, President Canadian Association of Prison Lawyers & East Coast Prison Justice Society

Adrienne MacDonald, Regional Director, The John Howard Society of Nova Scotia

Darlene MacEachern, Executive Director, Elizabeth Fry Society of Nova Scotia

[1] The Parole Board of Canada was invited but declined to participate.

Diana Majury, Canadian Association of Elizabeth Fry Societies

Colleen Cash, Nova Scotia Hospice and Palliative Care Association

Jennifer Metcalfe, Executive Director, Prison Legal Services, West Coast Justice Society, British Columbia

Andrea Monteiro, Review Team Manager, Independent Review of Ontario Corrections

Paula Osmok, Executive Director, The John Howard Society of Ontario

Kim Pate, Senator for Ontario, Senate of Canada

John Peach, Executive Director, The John Howard Society of Nova Scotia

Henry de Souza, Director Health Care Sector, Correctional Service Canada

Scott Theriault, Forensic Psychiatrist, Associate Professor, Dept. of Psychiatry, Dalhousie University

Eric Wasylenko, Medical Director, Health System Ethics and Policy, Health Quality Council of Alberta, University of Alberta

Ellen Wiebe, Family physician and MAiD Provider, Clinical Professor, Dept. Of Family Practice, University of British Columbia

Sheila Wildeman, Associate Professor, Schulich School of Law, Dalhousie University

The Agenda [see attached]

Process

The event adhered to an adaptation of the Chatham House Rule[2], allowing the participants and their affiliations to be identified at the outset of this document, and allowing the information generated by the event to be used by participants, but without attributing particular perspectives or comments to any one or more participants. Explicitly stated conventions for the day included respect for each other and respect for different views.

Substance

Participants were provided with relevant materials to read in advance of the meeting: Bill C-14 "An Act to amend the Criminal Code and to make related amendments to other Acts (medical

[2] https://www.chathamhouse.org/

assistance in dying)"; Corrections and Conditional Release Act; World Health Organization: Prisons and Health (2014); CSC Palliative Guidelines [attached].

The foundation for the discussion was laid through four brief presentations: Jocelyn Downie on the legal status of MAiD in Canada; Henry De Souza on Correctional Services Canada's (CSC) plan for the implementation of MAiD; Eric Wasylenko on the current state of end of life care in the community in Canada; and David Hooey on the current state of end of life care in prisons in Canada.

The discussion was then divided into two sections. First, identification of the issues of concern with respect to the implementation of MAiD for Canadian prisoners. Second, identifying potential solutions to the challenges associated with providing Canadian prisoners with access to MAiD. The information generated by these discussions is presented below:

GENERAL COMMENTS

Consideration of the issue should proceed against the backdrop of the *Mandela Rules (United Nations Standard Minimum Rules for the Treatment of Prisoners (2013))* and the *World Health Organization: Prisons and Health (2014)*, with particular attention to cultural humility regarding the needs and preferences of indigenous peoples, as well as people from a wide range of ethnicities and cultures.

There is an underlying and pervasive tension between the security-focussed framework in which the Correctional Service operates and the focus of the MAiD system which is the promotion of autonomy and the alleviation of suffering.

Institutionalization can have significant impact on decision-making capacity. It can do this by reducing options (e.g., prisoners may no longer have family or friends to take them in for end of life care). It can do this by impairing the perception of options (e.g., prisoners may lose the ability to conceive of options beyond incarceration). And it can reduce cognitive capacity.

Those with lived experience should be consulted before any decisions or recommendations are made about MAiD for prisoners. Additionally, the Elizabeth Fry and John Howard Societies have a long history of working with those with lived experience, and these organizations should also be consulted before moving forward.

End of life care (including palliative care and MAiD) for prisoners (both within and outside prisons) could be included as part of the National Health Strategy. The government should consider creating a plan devoted to ensuring equitable access to end of life care for prisoners.

This plan could be grounded in the current legal obligations Canada has towards incarcerated people as they result from the *CCRA* (s. 86(2) & 4); *Mandela Rules* (e.g. rule 24), and WHO principles and guidelines.

SPECIFIC COMMENTS

Palliative care within prisons

Concerns

Despite the principle of equivalency, there is a lack of access to consistent quality palliative care in prisons.

There are institutional barriers to the provision of good palliative care in prisons.

There is a lack of support for enabling prisoners to complete advance directives to direct their end of life care.

Potential solutions

Additional resources could be provided to enable prisons to increase the human resources required to improve access to palliative care and advance directives in prison.

A "Panel of palliative care for education and change" could be created.

Collaborative care clinics might be established with prisons.

Palliative care outside prisons

Concerns

Prisoners in need of palliative care should be provided with this care out in the community.

The current system for compassionate release is inadequate to ensure that prisoners who need palliative care are able to receive it in the community. In particular, there is inadequate access to parole-by-exception (CCRA, s. 121), inadequate training of parole board members in relation to health issues, and excessive rigidity with respect to the consideration of health related criteria in regular parole hearings.

There are already not enough facilities for the provision of palliative care in Canada. More funding will be needed if hospices and halfway houses are to be able to provide palliative care for prisoners.

Some existing palliative care facilities do not have the cultural competence required to provide end of life care to prisoners.

Many participants were concerned about the issue of where gravely ill individuals will reside upon release. There was general agreement that residential decisions, especially for people in such critical situations, should be made on an individual basis, informed by where the person's social, family, and medical support can be maximized.

Most people are automatically sent to a halfway house when released on parole. While that may be the only option in some circumstances, some incarcerated people have strong community and family ties, and they could be released into their care for end of life care. Furthermore, indigenous prisoners could be allowed to spend their last months or years in their indigenous communities where support and care exist, regardless of the jurisdiction in which they would normally be required to reside on parole. Care also needs to be taken to ensure that individuals are not be required to reside, while on parole, in a jurisdiction in which there is significant difficulty in accessing mental health care and/or other type of medical care they may require.

Given the federal/provincial/territorial division of responsibilities, who will coordinate and pay for the end of life services for prisoners?

Potential solutions

A special board within the Parole Board of Canada could be established to deal with parole-by-exception applications for prisoners requiring end of life care. This board could be specialized and re-trained regularly on issues regarding end of life care and its incompatibility with incarceration.

Existing palliative care facilities could be provided with educational programs designed to counter myths and stereotypes compromising the care of prisoners.

A primary care person could be appointed to coordinate the transfer of prisoners from the health care system of prisons to community. This position could be created through an agreement between CSC and local medical authorities. In addition a ministerial funding commitment could be made to cover the costs. It is possible that investing in a program that diverts the care of very sick individuals from prison into community, is not only more effective and humane, but also more cost effective.

MAiD within prisons

Concerns

It may not be possible for prisoners to make truly free requests for MAiD while in prison.

It may be difficult to find the independent witnesses required for requests for MAiD.

It may be difficult for prisoners to access MAiD assessors and providers.

It may be difficult to find appropriate spaces within which to provide MAiD in prisons.

It may be disruptive to the prison community to know that MAiD is being provided within the prison.

Potential solutions

A volunteer witness roster could be created (the roster could draw from those who already volunteer in prison and thus have security clearance).

Video or telephone assessments may be used to improve access.

Personal Family Visit (PFV) space may be used as a congregation space so that family and friends can be present for the provision of MAiD.

Oversight might include an automatic post-MAiD inquest, as well as independent oversight for MAiD provision, perhaps from the OCI and perhaps also from an independent board.

MAiD outside prisons

Concerns

The legislation (*CCRA)* and the intent behind this legislation strongly support prison administrative decision makers more readily allowing access to the community for health purposes. However, the current correctional policies and correctional culture deter such liberal access being granted.

s.121(1) (allowing exceptional access to parole "at any time" where one is terminally ill) does not apply to persons serving a life sentence or indeterminate sentence

Incarcerated individuals are not guaranteed access to legal assistance when applying for exceptional parole and or escorted temporary absences.

The process between compassionate release application and decision can be egregiously long.

There may be legal barriers that would prevent enabling access to provincial health services by paroled prisoners.

How long should a prisoner be allowed to remain in the community (while assessing options and being assessed) having left the facility in anticipation of (potentially) receiving MAiD.

Should the assessments for eligibility for MAiD be allowed/required to take place in the prison or only after release?

Should a prisoner be returned to prison if they decide not to proceed with MAiD? If so, what is the impact of that consequence on the right to refuse to go through with the procedure?

How can a request for MAiD be made part of an overall care plan and relationship (it is important to harmonize MAiD decisions and conversation with palliative care and advance care planning).

Prisoners may face stigma from community and community health providers.

Policies and practices with respect to prisoners being transferred for palliative care or MAiD need to address current norms re: shackling prisoners on transfer to hospital.

The law limits who can give information about health care in prison (health professionals) and concerns were raised around the potential for coercion if CSC staff are acting as information sources with respect to MAiD and other end of life care.

Access may be unjustifiably limited through a pre-screening process (determining whether an incarcerated individual is given access to speak with a health care provider to ask for a MAiD assessment).

How can policies and practices ensure that friends of prisoners are able to accompany their friend for receipt of MAiD, if so desired by the MAiD recipient?

What should be the requirements of reporting and release of the body of the MAiD recipient?

How can the system ensure that the conditions of confinement are not the reason for requesting MAiD?

Concerns about post-parole residential decision-making mentioned above apply also to MAiD outside prisons.

Potential solutions

A variety of *CCRA* provisions could be amended to facilitate and ensure access to MAiD outside prisons: s.121(1) (allowing exceptional access to parole “at any time”; s.17 (Escorted Temporary

Absences); S.29 (b): permitting institutional heads to authorize transfer to hospital); as well as sections relating to Community Residential Facilities.

A specialized board or subset of the PBC could be created to allow timely and specialized consideration of applications from prisoners seeking the ability to access MAiD outside prison.

Establishing a cohort of dedicated professionals and perhaps a dedicated care facility with experience caring for prisoners could respond to the concerns about stigma and discrimination.

A right to access to counsel in all cases involving MAiD could be established.

Providers and assessors should have experience-based understanding of the prison context, aware of what to look for in terms of compromised voluntariness. Staff should be trained to seek responses to care needs, for example, situations where an individual's pain has been exacerbated by the institutional environment.

Prisoners could be given access to an outside independent central care coordinator (rather than allowing any institutional pre-screening).

It is unlikely that all people needing palliative care, when released, would be received by hospices. Some private halfway houses could be turned into hospices, with some medical changes being made since halfway houses are currently not fit to respond to the need of paroled people who are very sick. Hospices could be created for people on parole who have nowhere else to go. These could be jointly funded by CSC and provincial health authorities. It would likely be cheaper and more effective to do this than to continue to incarcerate people in need of end of life care.

NEXT STEPS

- The following individuals, committees, organizations, and/or departments were identified as essential participants in the ongoing discussions re: seeking and implementing solutions. This report will be forwarded to these institutions, as a next step
  - Public Safety Minister
  - Correctional Service Canada
  - provincial/territorial and federal Ministers of Health
  - provincial/territorial and federal Ministers of Justice
  - federal Minister of Indigenous Services
  - Senate Human Rights Committee
  - Parole Board of Canada
  - The Office of the Correctional Investigator

- Provincial/territorial Corrections Departments
- Provincial/territorial Parole Boards
- National Halfway House Associations
- Indigenous populations' halfway house associations
- Independent Review of Ontario Corrections Elizabeth Fry Regional Advocates
- Canadian Families in Prison Groups
- National Association of Agencies Involved in Criminal Justice
- Canadian Family and Corrections Network
- Provincial and federal law reform commissions
- National Judicial Institute
- medical practitioners and their professional organizations, nurse practitioners and their professional organizations
- provincial/territorial Colleges of Physicians and Surgeons and Colleges of Nurses
- The Coalition for Health Care in Ontario Disability rights organizations

CONCLUSIONS

The need for, and right to access, palliative care and MAiD are established in law and accepted by the CSC. It is now the time to determine how best to provide good end of life care to prisoners. This will require deep reflection on foundational assumptions as well as detailed attention to the multitude of logistical complications associated with providing healthcare within the umbrella of the corrections system. The event reported on in this document started a conversation across a group of individuals and organizations with a wide range of perspectives. Our hope is that this summary will provide a taste of the conversations had at that event – the concerns and potential solutions generated. Our longer term goal is to catalyze action at all federal, provincial, and territorial levels of government and within both the correctional system and the health system such that we better care for prisoners at the end of life.