DISCUSSION AND DEBATE

Commentary: Access to Psychedelics for Psychological Suffering at the End of Life – Prioritizing Our Priorities

Commentaire : Accès aux thérapies psychédéliques pour soulager la souffrance psychologique en fin de vie – mettre de l'ordre dans nos priorités

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Abstract

We agree with Kratina et al. (2023) that the problem of psychological suffering at the end of life deserves attention from a policy standpoint and that psychedelic therapies show promise in this clinical context. However, we argue the following in this rejoinder: (1) disproportionate attention to psychedelics may overstate the current evidence base, potentially diverting resources away from existing evidence-based programs; (2) a more pressing policy priority related to this public health problem is to address population-level inequities in accessing high-quality, early and holistic palliative care, including psychosocial care; and (3) discussions about expanded access to psychedelics must also foreground equity issues.

Résumé

Nous convenons avec Kratina et al. (2023) que le problème de la souffrance psychologique en fin de vie mérite une attention politique et que les thérapies psychédéliques sont prometteuses dans ce contexte clinique. Cependant, nous soutenons ce qui suit dans la présente réplique : (1) une attention disproportionnée aux thérapies psychédéliques pourrait exagérer le fondement des données actuelles, en détournant les ressources des programmes existants qui sont fondés sur des données probantes; (2) une priorité politique plus urgente liée à ce problème de santé publique est de remédier aux inégalités des populations en matière d'accès à des soins palliatifs précoces et holistiques de haute qualité, notamment les soins psychosociaux et (3) les discussions sur l'élargissement de l'accès aux thérapies psychédéliques doivent aussi mettre de l'avant le question de l'équité.

Introduction

Psychedelic research is enjoying a re-medicalization renaissance. Early findings from trials on psychedelic therapies using compounds such as psilocybin and 3,4-methylenedioxymethamphetamine (MDMA) are promising for a range of conditions, including major depressive disorder and post-traumatic stress disorder. One area that has received considerable attention is palliative care, with recent trials suggesting that psychedelic-assisted therapies (PATs) may reduce psychological suffering common to people with advanced disease.

As an author team actively engaged in the field of PAT research, as well as its ethics, we welcome the policy conversation initiated by Kratina and colleagues (2023). Indeed, we welcome new, safe, effective and compassionate approaches that not only help to promote patient well-being but also help healthcare professionals achieve the *telos* of medicine – that is, the alleviation of pain and suffering. This is particularly important given the context of medical assistance in dying (MAID) in Canada, as the authors note, where the presence of intolerable suffering is a key criterion (Kratina et al. 2023). However, we do not believe that the lack of access[1] to psychedelic therapies at the end of life (EOL) – or as an alternative to MAID – is as urgent a health policy priority as the authors suggest. In our view, this line of argumentation distorts the policy landscape in two important ways. First, it may lead to the misperception that PAT is the best – or even the *only* – intervention available to alleviate psychological distress among dying patients, which may divert attention and resources away from existing evidence-based interventions and clinical programs. Second, it does not address what we believe should be a higher policy priority, which is to reduce existing population-level inequities in accessing high-quality, early and holistic palliative care, including psychosocial care. Furthermore, any potential PAT rollout must not reproduce similar inequities.

MAID and the Public Health Problem of Psychological Suffering at EOL

The authors state that Canadian MAID legislation in 2016 "marked the creation of a clinical condition called EIPS [enduring and intolerable psychological suffering] as an indication for MAID" (p. 136) and define this as an extreme form of demoralization/existential distress/

death anxiety. Attention to the clinical problem of psychological end-of-life distress (EOLD), and research focused on its treatment, has a long history that coincides with the rise of the palliative care field, although it has received less attention relative to physical distress (Kaasa et al. 2018). Most research on psychological EOLD has focused on depression and other common clinically recognized outcomes rather than assisted dying requests, and there are many evidence-based interventions available to treat those outcomes (Breitbart and Chochinov 2022).

The authors' framing of MAID as the "second line of treatment" (p. 136) for EIPS is not quite accurate. The push to legalize assisted dying came largely from outside traditional healthcare, spurred by advocacy groups and public pressure (Li et al. 2017), rather than from within healthcare as treatment for an identified clinical problem. The drivers of MAID requests and potential prevention strategies remain poorly understood, partly because MAID remains relatively uncommon; a small proportion of patients with advanced disease make these requests, and an even smaller proportion follow through with a MAID intervention (Li et al. 2021; Vehling and Kissane 2018). It remains an empirical question whether psychedelics may decrease MAID requests, with some evidence that ketamine treatment of depression may not consistently reverse these decisions (Berens and Kim 2022; Rosenblat and Li 2021). Given the demographic similarities between those receiving MAID and those receiving PAT (Michaels et al. 2018; Redelmeier et al. 2021; Sellers et al. 2018) – that is, they are more likely to be white, with higher education and of higher socio-economic status – it is possible that PAT and MAID may appeal to the same population on the basis of personality, class or commonly held western liberal values favouring individual autonomy and independence.

We agree that the broader clinical problem of psychological EOLD is an important one and argue that what is needed is more research focused on this problem, as well as improved knowledge of and consistent access to existing evidence-based interventions.

Psychedelics and EOLD: The Story So Far

Psychedelic therapies appear to be safe for some patients with life-threatening illnesses, both from physiological and psychological standpoints (Maia et al. 2022). To our knowledge, no serious adverse events attributable to the study drug have been reported in contemporary trials using psilocybin, MDMA and lysergic acid diethylamide–assisted therapies in this patient population. With respect to efficacy, both quantitative and qualitative data from recent early-phase studies of PAT suggest tremendous promise for the rapid and enduring alleviation of symptoms of depression and anxiety associated with life-threatening illness along with improvements in quality of life, spiritual well-being, death anxiety and existential distress.

However, these broad conclusions must be followed by strong caveats. Trials to date have had stringent inclusion and exclusion criteria, limiting the generalizability of the findings to community practice. The heterogeneity of study participants with respect to disease status also limits the conclusions drawn about safety in this patient population; some participants had curable cancers, and some participants were enrolled while their disease was in remission. We do not yet know how safe PAT is among people with more limited prognoses, people in hospice care or homecare settings, people with complex comorbidities, or in other specific cases (e.g., those with metastatic disease of the central nervous system).

Similarly, it is likely that participants in these early trials were highly motivated, and many had prior psychedelic experience(s). While the same may be true for some patients wanting access to PAT in the community, it is also likely that some patients, desperate for relief from their suffering, may seek these treatments because of the considerable hype surrounding psychedelics (Yaden et al. 2022), which often paints these substances as miracle pills that lead to instant cure through a "brain reset" (Watts 2022). The reality is that psychedelic therapies are complex and often intense interventions, of which the psychedelic substance is only one part. Trial therapy protocols have involved considerable support for participants (e.g., many hours of preparatory therapy, the presence of two therapists throughout the intervention and aftercare in the form of structured integration sessions), and study therapists have been highly trained.

Further research is needed to address important knowledge gaps that remain in this field (Beaussant et al. 2021). In the meantime, we are concerned that in the accelerated pace to grant widespread access to psychedelic therapies, patients may be at risk of harm because clinical best practices and standards regarding clinician competency are simply not yet in place.

Prioritizing Our Priorities: Inequitable Access to Palliative and EOL Care

Palliative care is critical for promoting quality of life for people with advanced disease and their families, including at EOL. While access to palliative care has improved in Canada, there continue to be population-level inequities in access to palliative and EOL care. Members of structurally disadvantaged groups, such as those experiencing poverty and homelessness, face the most barriers (Costante et al. 2019; Stajduhar 2020).

Depending on how PAT is regulated, policy makers must ensure that its implementation does not intensify existing inequities, particularly those that exist in the current context of lack of publicly funded psychotherapy and no universal pharmacare. For example, it would be problematic from a health equity perspective if decriminalized psychedelics are regulated solely in the private sector where access is determined based on the ability to pay – as is the case for many medications and psychotherapy available outside of hospital settings (Rea and Wallace 2021).

The focus on expanding access to PAT – provided that favourable evidence concerning its safety and efficacy profile continues to emerge – without due attention to reducing population-level inequities may provide great benefit to a small, privileged population with profound psychological suffering at EOL. This should not be discounted. However, prioritizing the expanded access goal in health policy discussions should not divert attention or scarce resources away from the complex socio-structural factors that make high-quality and holistic palliative and EOL care, including psychosocial care, out of reach for many individuals. Policy decisions should not entrench inequities.

Conclusion

Kratina et al. (2023) have provided the opportunity for an important conversation at the intersection of experimental interventions, health and drug policy and palliative and EOL care. While we remain excited about the possibilities for PAT, we have underscored the *tempered approach* surrounding the policy question of prioritizing expanded access to medicalized psychedelic therapies, given our concern that these efforts could divert the policy focus away from ensuring equitable access to high-quality, early and holistic palliative care. This is particularly so in the case of psychosocial palliative care, which has received less attention relative to interventions targeting physical symptoms. Calls for expedited access to psychedelic therapies for people with life-threatening illness must also come with a careful analysis of the safety and efficacy of these interventions, an acknowledgment of critical knowledge gaps and attention to equity concerns.

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Note

1. At the time of writing this article, eight Canadians with support from the psychedelic non-profit advocacy group TheraPsil had filed a Charter challenge, arguing that lack of access to psilocybin and PAT violated their Section 7 Charter rights to life, liberty and security of the person (TheraPsil n.d.).

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