2016

Communicating With Clients About Therapeutic Use Of Psychedelic Medicines

Bruce Tobin, Ph.D., RCC

Abstract

This paper examines some ethical and legal issues pertaining to a clinician's discussion with clients about therapeutic use of currently illicit psychedelic medicines. It examines conditions under which the conduct of psychedelic-assisted psychotherapy might be considered legally and ethically defensible, and advocates a way forward in in the accessibility of psychedelic medicine for Canadians in dire need.

Psychedelic (hallucinogenic)[1] medicines comprise a diverse group of substances that, despite having differing chemical structures and possibly involving different molecular mechanisms, produce similar, and often profound alterations in user perception, mood and cognition[2]. Examples include mescaline, psilocybin, LSD, MDMA and ayahuasca.

The past few years have seen a steady increase in research literature and stories in popular news media suggesting that psychedelic drugs, currently illegal[3] in Canada, may nonetheless have significant potential as psychotherapeutic agents. This increase in profile of these drugs as "medicinal" substances raises some important questions for counselling professionals, especially those who might be believers in the merits of psychedelic therapy:

- To what extent can clinicians legally and ethically tolerate, cooperate with, condone or promote client interest in or therapeutic use of psychedelics?
- What specific responses or messages should we be giving clients in situations involving their interest in or medicinal use of psychedelics?
- Are there circumstances under which psychedelic-assisted psychotherapy could be conducted in an ethically and legally defensible way?

It is well beyond the scope of this paper to make or evaluate the argument that psychedelics can be safe and effective psychotherapeutic medicines. (I do, however, make note below of several websites that aggregate the type of scientific and clinical research that should be used to make that argument, and I leave it to my reader to evaluate the strength of that evidence.) My purpose here, rather, is to examine four hypothetical clinical situations (I'll call them *scenes*) in which these questions might naturally arise for thoughtful therapists. In each situation I suggest some specific practical verbal messaging open to therapists, and I offer some legal and ethical comment in support of those messages. I intend my thinking throughout to be tentative and exploratory. But I do hope to encourage a conversation among my fellow clinicians that might lead to further clarity in assessing the ethical and legal aspects of therapist involvement in a client's "therapeutic" or "medicinal" psychedelic use.

Let's begin by looking at each of the two current faces of the psychedelics.

Psychedelics As Problem Substances

Most clinicians recognize that use of psychedelics sometimes leads to significant problems for personal wellbeing and functioning. DSM-5 (2013) specifies three mental disorders relating to use of psychedelics.

1) *Hallucinogen Use Disorder* describes a problematic pattern of hallucinogen (other than phencyclidine) use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period: 1) The hallucinogen is often taken in larger amounts or over a longer period than was intended. 2) There is a persistent desire or unsuccessful efforts to cut down or control hallucinogen use. 3) A great deal of time is spent in activities necessary to obtain the hallucinogen, use the hallucinogen, or recover from its effects. 4) Craving, or a strong desire or urge to use the hallucinogen. 5) Recurrent hallucinogen use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences from work or poor work performance related to hallucinogen use; hallucinogen-related absences, suspensions, or expulsions from school; neglect of children or household). 6) Continued hallucinogen use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the hallucinogen (e.g., arguments with a spouse about consequences of intoxication; physical fights). 7) Important social, occupational, or recreational activities are given up or reduced because of hallucinogen use. 8) Hallucinogens are used recurrently in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by the hallucinogen). 9) Hallucinogen use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the hallucinogen. 10) Tolerance, as defined by either of the following: a) A need for markedly increased amounts of the hallucinogen to achieve intoxication or desired effect; b) A markedly diminished effect with continued use of the same amount of the hallucinogen. (Notably, unlike cannabis, withdrawal symptoms and signs are not established for hallucinogens.)

2) *Hallucinogen Intoxication* involves clinically significant problematic behavioral or psychological changes such as marked anxiety or depression, ideas of reference, fear of "losing one's mind," paranoid ideation, and impaired judgment. These are accompanied by perceptual changes: subjective intensification of perceptions, depersonalization, derealization, illusions, hallucinations, and synesthesias.

3) *Hallucinogen Persisting Perceptual Disorder* describes clinically significant distress or impairment of functioning resulting from the post-use re-experiencing of one or more of the perceptual symptoms that were experienced while intoxicated with the hallucinogen (e.g., geometric hallucinations, false perceptions of movement in the peripheral visual fields, flashes of color, intensified colors, trails of images of moving objects, positive afterimages, halos around objects, etc.).

Therapists sometimes encounter clients presenting these disorders for treatment. Consider, for example, the following scene involving Hallucination Intoxication:

Scene W: An Emergency Mental Health Clinician Assists an Adult at a Local Hospital
Alice, age 27, has taken an unknown amount of LSD, and is suffering acute panic, paranoia and confusion. She has been brought to the emergency ward by a police officer after responding to a noise complaint about a loud house party. Alice arrives screaming and crying, insisting she is dying, and that "everything is melting". She reports visions of "being chased by evil beings". The clinician quickly finds her a quiet, private room, and lowers the lighting. She puts on some soothing music, and invites Alice to wrap up in a "nice cosy blanket" on a couch and close her eyes. She remains with Alice, encouraging her occasionally to pay attention to her breathing and just follow it wherever it wants to go. Alice undergoes several deep emotional experiences involving intense hostility toward a family member, and then grief involving deep sobbing. Later, as Alice calms, the therapist enters into a quiet therapeutic conversation with her about her experiences. Alice gradually settles into a peaceful state in which she reflects on herself, her current relationships, and what is most important to her in life. Hours later, she finally falls asleep.

How do clinicians ideally respond to clients like Alice, for whom psychedelics are a problem? Yes, some therapists sometimes do express serious concern or foreboding about a client's self-destructive drug behavior. But in almost all situations involving treatment of the psychedelic use-related disorders, wise clinicians respond by providing the client a sense of personal and emotional safely, comfort and support. They develop rapport and trust. They respond with warmth and empathy. *Tolerance* or *acquiescence* in relation to the behavior, *acceptance of the person,* and a *commitment to the client's wellbeing* are the primary responses. Our tolerance of the problem drug behavior here serves the client in that it assists in the development of a relationship with the client that ideally becomes a vehicle for the client's personal growth and healing.

How are we to assess Scene W ethically? Here, we typically refer to a *code*. The BCACC *Code of Ethical Conduct* (2014), for example, describes ethical practice, as that which serves the "client's best interests" (p.7, 11), is "for the client's benefit" (p.7), promotes "the well being of individuals" (p.7, 11), and will "maximize benefits and minimize potential harm to individuals" (p.8). There are no questions about the clinician's ethical probity in Scene W, as her conduct so obviously serves the client's best interests; it maximizes client benefit and minimizes harm.

Neither do we have any legal concerns here about the clinician's service to Alice. Yes, the client has ingested an illegal drug, but there is no Canadian law prohibiting clinical service to a person affected by an illegal drug in a mental health setting. Indeed, the mental health clinician, who has trained for just this sort of intervention, is working in concert with the police who have just referred the client for immediate treatment.

Psychedelics As Medicinal Substances

Psychedelic substances have, of course, been used in healing and spiritual contexts for millennia in aboriginal cultures. They were the subjects of considerable research in North America in the 50s and 60s, where they showed significant promise as psychotherapeutic agents. But the federal government abruptly terminated that research in the early 70s, when the substances were

proscribed and the “ psychedelics-as-problem” mindset took hold. Now, after a hiatus of some forty years, we are seeing a renaissance in clinical research into the psychiatric merits of psychedelics. There is now a growing literature[4] detailing the clinical efficacy and promise of these substances in the treatment of a variety of mental health issues (including depression, anxiety, PTSD, addictions and chronic pain), and increasing calls for their inclusion into the legitimate psychiatric pharmacopeia.

This revival of interest by researchers in psychedelics as therapeutic agents is now receiving increasing attention by mainstream North American print and TV media. This, coupled with word-of-mouth testimonials from current medicinal users, has led to an increase in interest and awareness among the Canadian public at large about the possible benefits that these substances might hold for them personally. Clinicians may thus expect that a growing number of clients over time will disclose that they are using, or considering using psychedelics in what they believe to be a medicinal, or therapeutic way. We can expect that these clients will seek from us some sort of response beyond simple acknowledgment of their use. They may well ask for our professional opinions as to whether psychedelics might be helpful in their own personal cases. They may desire that we in some way tolerate, accept, support, condone or become complicit in their use.

Just as part of our clinical competence lies in our having a good general understanding of current orthodox psychiatrist-prescribed pharmaceuticals, it is it also incumbent on us to be generally aware of emerging or experimental treatments that may look promising, even though they are not yet accepted as orthodox. Clinicians have a responsibility to their clients to be sufficiently acquainted with the emerging research literature on the potential risks, benefits and applications of psychedelics to be able to knowledgeably discuss them.

That research has now progressed to the point where, arguably, a conventionally trained psychotherapist who comprehensively reviews the literature may reasonably form the opinion that though these substances pose some demonstrable risks, and more research is certainly merited, there are good grounds for believing that many individuals do benefit from their medicinal use (especially within a context of clinical supervision and adjunct treatment), and it is likely that continued research with these substances will further confirm the promise of these medications rather than diminish it.

Accordingly, it becomes plausible that a well-read clinician with a clear understanding of the potential effects – including both risks and benefits - of psychedelics might come to believe that it is in a *particular* client’s best interests that they try a psychedelic medicine. This belief might become especially compelling when that particular client faces the following personal circumstances that collectively constitute what we shall call *dire need*:

- Client psychological distress is chronic;
- Client distress is serious and debilitating;
- The client has not responded well to current orthodox behavioral, cognitive, psychodynamic or other nonpharmacological treatment approaches;
- The range of conventional medicines has been tried and proven unhelpful or has intolerable side-effects;

- The client is facing end-of-life issues. Consideration of possible long-term risks is not relevant.

For caring, well-informed, and ethically sensitive practitioners familiar with the scientific literature on psychedelics this clinical situation may create some uncertainty: how could this counsellor *belief,* formed through following the research, translate ethically and legally into verbal or clinical *practice* with one's client? What forms of expression of tolerance, support, collaboration, advocacy or encouragement are open to us in our communication with clients about their use of these substances while still remaining within the bounds of legal and ethical professional conduct? What messages may we legitimately give our clients about psychedelic substances? At what points might we run afoul of ethical or legal practice limits?

Let's seek some clarity by examining three more hypothetical clinical situations in which these questions naturally present.

Scene X: An Adult Client Discloses that He is Using or Considering Using a Psychedelic Therapeutically, and Seeks his Therapist's Opinion

Notice first how this scene differs from situations involving medical cannabis. Unlike cannabis, there is currently no provision (outside of research studies) in Canada for the legal use of medicinal psychedelics, no equivalent of Health Canada's *Marihuana for Medical Purposes Regulations (MMPR)*, physician quasi-prescriptions, or cannabis dispensaries. Furthermore, psychedelics are far more intense in their effects than cannabis. The risks of use without proper supervision are greater; in fact, 'therapeutic use without clinical supervision' may well be an oxymoron. Much more so than with cannabis, the therapeutic value of the psychedelic consists not so much in merely ingesting it, but in the kind of therapeutic emotional "work" the client is able to do while under its influence. Unlike cannabis, the success of a psychedelic session will depend to a large measure on it being structured according to a clinical protocol and the therapist having some specialized training and skill.

A client's belief that a psychedelic is indeed therapeutic may not necessarily be shared by a counsellor. In some cases it will be abundantly clear to the clinician that the client's substance use really is dysfunctional, and the client's stated belief in the drug's therapeutic benefit is a form of denial, rationalization, or excuse for misuse. But clinicians who are educated in the research literature regarding psychedelics may well find themselves in other situations where they are inclined to believe that clients have correctly appraised the benefit of the medicine for their particular clinical conditions, and it may be tempting for the therapist to voice something more than the kind of tolerance expressed in situations involving problem use. How far *beyond* simple tolerance can we go?

As with cannabis, counselors will wisely begin *any* discussion of psychedelics with the client with two general declarations:

> **Message X1**. Psychedelic medicines are illegal to sell or possess. As your therapist I do not and cannot advise, encourage, or recommend that you engage in any illegal behavior.

231 **Message X2**. As a psychotherapist, I am not licensed to practice medicine. In
232 particular, I cannot *prescribe* any drug, legal or otherwise. Please understand that
233 I am not ever ethically or legally able to suggest, recommend, encourage or advise
234 you to take *any* drug, legal or not.
235
236 Failure to establish these two messages as parameters for subsequent discussion of psychedelic
237 use creates risk of both civil and criminal liability. Counselling clients to break a federal law
238 creates exposure to a civil malpractice suit, as does counselling them to take any particular drug,
239 since that can look like *prescribing* a medicine, which clearly falls outside a counsellor's Scope
240 of Practice[5].
241
242 The risk for a clinician of *criminal* liability arises from the fact that, though normally, culpability
243 for possession of a psychedelic falls upon the person who actually engages in the possession,
244 criminal culpability does not always end with the individual actor. A person can be convicted of
245 an offence, even though that person did not engage *directly* in the illegal conduct. Section 21(1)
246 of the *Criminal Code*[6] states that every one is a party to an offence who "actually commits it,
247 who does…anything for the purpose of *aiding* any person to commit it"; or who "*abets* any
248 person in committing it". Aiding and abetting is defined here as "doing (or, in some
249 circumstances, omitting to do) something that assists or encourages the perpetrator to commit the
250 offence. While it is common to speak of aiding and abetting together, the two concepts are
251 distinct, and liability can flow from either one. Broadly speaking, 'to aid under s. 21(1)(b) means
252 to assist or help the actor. To abet within the meaning of s. 2(1)(c) includes encouraging,
253 instigating, promoting or procuring the crime to be committed."[7]. The *Code* (s. 22(1)) further
254 states: "Where a person counsels another person to be a party to an offence and that other person
255 is afterwards a party to that offence, the person who counselled is a party to that offence…", and
256 that "Every one who counsels another person to be a party to an offence is a party to every
257 offence that the other commits in consequence of the counselling that the person who counselled
258 knew or ought to have known was likely to be committed in consequence of the counselling (s.
259 22(2)). For the purposes of this Act, "counsel" includes procure, solicit or incite (s. 22(3)).
260
261 Given these constraints imposed by the *Criminal Code* respecting aiding, abetting or counseling
262 a client to possess or use a psychedelic, the interesting question here becomes what the
263 counsellor may say *in addition* to Messages X1 and X2 above.
264
265 Let's begin by noting that our lack of entitlement to prescribe medications does not totally
266 preclude our freedom to express a positive attitude toward a medication, and to direct clients to
267 an appropriate authority – ideally a physician or psychiatrist - who might more fully inform them
268 about the medicine and perhaps prescribe it. In the case of antidepressants, for example, we
269 might rightfully say the following to a clinically depressed client who asks about their possible
270 benefit to him: "Joe, you and I agree that you're suffering from a serious clinical depression.
271 Research shows that many clinically depressed people do benefit from taking a prescription
272 antidepressant medication. Now, I cannot prescribe medicines, but I'm going to invite you to
273 read some relevant literature that I would like to give you on the benefits of antidepressants, as
274 well as their risks or downsides." Here, though we declare that we are not entitled to prescribe
275 drugs, we do feel that we can ethically share with our clients our general clinical understanding

of the research results on antidepressants, and steer them toward sound factual information. To what extent can this response be transposed into the situation involving psychedelics?

There may be some occasions in which therapists in Scene X believe they have reasonable evidence that a psychedelic is suitable for the client's condition, and confidence that the client appreciates the need for, and has the ability to follow, a structure during the session and a plan involving support when the session is over. In these cases therapists may rightly elect to take the clinical conversation in a direction closely analogous to that which might unfold in the discussion of cannabis. They may follow Messages X1 and X2 with a simple statement of a fact confirmable by a literature search:

> **Message X3**: In response to your questions about therapeutic psychedelic use, I acknowledge that, yes, there is a significant body of literature based on clinical anecdote and formal research that indicates that psychedelics could be helpful to persons suffering from your symptom profile.

A careful and responsible therapist will want to especially underscore the *risk factors* involved in psychedelic-assisted therapy with something like:

> **Message X4**: Psychedelics appear be very helpful in some situations, but also carry the risks of creating anxiety, disorientation or confusion, unless used in clinically appropriate circumstances and supervised by a trained therapist. They should *not* be used alone or without clinical supervision or proper aftercare.

Now, the therapist may continue the conversation in a manner very similar to a discussion involving cannabis.

> **Message X5**: Though I cannot recommend that you use the drug, I *do* encourage you also to educate yourself about both the merits and the risks of psychedelics use for your issues.

> **Message X6**: I'm willing to give you a well-balanced reading list that I believe will help you in your education about psychedelics.

> **Message X7**: When you have read this material I will be willing to discuss it with you, to assist you in understanding it, and to answer any questions you may have about it.

Messages X3-X7 clearly fall short of recommending psychedelic use; collectively they only provide clear, *evidence-based factual information*, and encourage clients to *educate themselves* more about psychedelics. A balanced approach would suggest that in addition to our responsibility to alert clients to the risks and dangers posed by psychedelics, we also have a responsibility to ensure that they are apprised of their possible benefits. The two supplemental Messages X6 and X7 support the client's ability to make a *maximally informed* decision, though their propriety is dependent on the clinician being sufficiently familiar with the relevant literature.

Counsellors will now want to supplement Messages X1- X7 with a somewhat philosophical, but nonetheless fundamentally important message:

> **Message X8**: The use of psychedelics for therapeutic purposes is still a contentious issue politically and medically. You will encounter disagreement among authors and among professionals. The bottom line is that *you* will make *your own mind up* about its possible benefits, and *you* will make *your* decisions respecting use accordingly.

This message flows directly from the current BCACC *Code of Ethical Conduct*. Principle 2-3 states: To practice the principle of Responsible Caring, Registered Clinical Counsellors will "respect the abilities of individuals to make decisions on their own behalf" (p.8) Message X8 affirms that the individual has the right – and the responsibility - to ultimately decide what is best for self. This empowering message supports self-efficacy and self-responsibility, and can be a profound expression of respect for our client. (Note, of course, that the propriety of Message X8 will depend on age, developmental level and cognitive abilities of clients; it assumes that they are adults having no known impediments to understanding the relevant information and forming rational decisions.)

We can also imagine a further point in the conversation (which may well range over several sessions) in which the client has responded positively to a counsellor's invitation to read the research and discuss it, and has come to a decision to try therapeutic use. The counselor finally says:

> **Message X9**: I understand and respect that *you* have come to *your* decision to use a psychedelic medicinally, even though it is not a decision I am able to recommend.

Message X9 demonstrates respect for the client's autonomy. But it stops one step short of *condoning* illegal behavior, one step short of going over the red line into contradicting X1 or X2 above. Collectively, however, Messages X1-X9 appear to go farther than the simple tolerance expressed in situations involving improper use; they demonstrate *acceptance* of and *respect* for the client's autonomy, decision and behavior without implying outright agreement with it.

It will be a counselor's responsibility, of course, to deliver Messages X3-X9 in such a way that they do not detract from Messages X1 and X2. Those skeptical of the propriety of Messages X3-X9 may suggest that despite the verbal clarity with which they are delivered, there could nonetheless still be a subtle and implicit complicity expressed "between the lines" (nudge, nudge, wink, wink) in their delivery. The counsellor's challenge here will thus be to ensure that all implicit, nonverbal or paralinguistic messages are indeed congruent with the verbal messages. But, congruently delivered, Messages X3-X9 may well serve the client's best interests; their delivery may thus be considered ethical. The therapist is here willing to encourage the client in crisis to explore something that there is reason to believe may be helpful. These messages assist the client's education in the relevant research. They assist the client in understanding difficult or complex information involving medicinal psychedelic use, and they show respect the client's

final decision. This question facing our client regarding psychedelic use is not different in kind from many other complex client questions whose successful solutions may involve moral and legal reasoning, as well as understanding empirical information: issues such as whether or not to have an abortion, whether or not to leave one's spouse of forty years, whether or not to confess a weekend affair to a partner. It is precisely to deal with these difficult questions that clients often seek out counsellors for assistance.

Scene Y: A Clinician Initiates a Discussion to the Effect that a Psychedelic May Be Beneficial For the Client

Note that in Scene X, it is the client, not the therapist, who introduces the subject of psychedelic use. But let's consider a variation for a moment. Suppose that, as in Scene X, the counsellor believes that a psychedelic may well benefit the client, but, unlike X, the client does not raise the subject of psychedelics. Is it permissible for the *therapist* to raise the subject? Well, let's return to consideration of the antidepressant situation. There are certainly some occasions when our client is either unaware of, or negatively disposed to antidepressants where it will be our ethical *duty* to strongly urge clients to explore and consider taking an antidepressant. As long as we have clearly articulated Messages X1 and X2, we may follow with Messages X3-X9, even though we, rather than the client, have initiated the discussion of psychedelics. If, as literature-savvy clinicians, we really believe a psychedelic indeed may benefit our client, it will be an ethical *duty* to raise the subject, to acquaint the client with an option to be considered along with others.

Scenes X and Y above involve *talking about* therapeutic psychedelic use. Let's now look at a perhaps more radical clinical situation, one that appears even closer to outright support of the client's psychedelic use – one in which a clinician actually *participates* as a therapist in a client's psychedelic session.

Scene Z: A Client Requests that the Clinician Provide Psychotherapy in a Session in which the Client has Ingested a Psychedelic

Jeanette, 75, has been a client in psychotherapy for several years. She is in declining physical health. She has suffered many major personal losses in the past few years, and is showing increasing depression and anxiety about growing old and dying. Conventional treatments and medications have proved ineffective. A family member has read about work in the United States using LSD for depression and anxiety relating to end-of-life issues[8]; she has talked about it to Jean, and Jean would very much like to undergo psychedelic-assisted psychotherapy. She approaches her therapist about it: "I would like you to attend a session in which I take LSD, and take care of me throughout according to your clinical wisdom."

Imagine an ongoing conversation with Jeanette in which the counsellor has conveyed Messages X1- X9, and finally says:

> **Message Z10**: Yes, I consent to attend your session and provide psychotherapy to you while and after you are under the influence of a psychedelic.

Here, the therapist would actually be providing *psychedelic-assisted psychotherapy*. Does this involve a problem level of complicity with the client? Would this lie outside the boundaries of ethical and legal practice?

Let's first consider the ethical aspect. A preliminary issue here will involve a therapist's *competence* to supervise a psychedelic session. Section 2-7 of the BCACC *Code of Ethical Conduct* states that a counsellor will "limit practice … to the areas of competence in which proficiency has been gained through education, training or experience". Counsellors *are,* however, able to gain competency in psychedelic therapy. Both a substantial training literature (Grof, 2001; Ruse et al, 2011) and training opportunities[9] for the conduct of psychedelic-assisted psychotherapy are available.

Given this acquired competence, a counselor whose literature-informed belief (coupled with an individualized assessment) that conducting a psychedelic session is in the client's best mental health interests, has a strong argument that Message Z10 and his or her supervision of a psychedelic session is ethical, whether or not it satisfies legal probity.

Now, how might Message Z10 and the supervision of the psychedelic session be assessed from a legal perspective? To what extent does the therapist's, actions risk legal exposure if he or she complies with the client's request? Well, the proponent of Message Z10 might begin by inviting us to compare Scene Z with Scene W, where the counsellor worked in the emergency room with the panicked client suffering a "bad trip". There, the counsellor promoted a drug-affected client's mental health interests as humanely and helpfully as possible. In that situation, it was legally permissible to work with the client because there is no Canadian law prohibiting a professional from assisting a drug-affected client. The proponent might argue here that this also holds true in Scene Z, that Scene Z is really no more radical than Scene W, and that both share the same legal status. Do we feel some hesitation to agree?

One reason why Scene W might appear more clearly legally permissible for the therapist than Scene Z is that in Scene W the therapist obviously had no role whatsoever in the client coming to take the drug; the drug's ingestion was a *fait accompli* before the therapist ever met the client. But this is not true for Scene Z. Psychedelic therapists may therefore seek to bolster the legitimacy of Message Z10 by further solidifying the parallel between Scene W and Scene Z: he or she may wish to supplement Response Z10 with the following caveats Z10a-c:

a) I cannot and will not supply a psychedelic to you, nor will I administer it to you;
b) I cannot and will not be present when you ingest it;
c) I require you to sign a statement (see Appendix A) just prior to the session that acknowledges that I have indeed clearly delivered Messages X1- X9, and that I have complied with (a) and (b) above.

With caveats Z10a-c, therapists attempts to build a firewall between attendance at the session and any complicity in the client's coming to use the psychedelic. These caveats are designed to ensure that therapists are not party to the procurement of the psychedelic or the decision to use it; they avoid therapist exposure to charges of trafficking, possession, or aiding/abetting possession. Then, they may argue, they have indeed brought Scene Z into direct alignment with Scene W: in

each case, a counselling professional with special clinical expertise assists a drug-affected client so as to maximize the client's interests and reduce harm by providing safety and competent clinical intervention on the basis of an appropriate assessment. Both, the proponent argues, now stand on the same ethical and legal footing.

Can this position be challenged in a court of law or an ethics committee of a professional association? If a legal or ethical complaint were ever actually laid against a psychedelic therapist, whether because of a negative outcome of a psychedelic session, or because a professional association protested against him or her making psychedelic therapy services public, we will want something more substantial than the above-stated contention of the parallel between Scenes W and Z. What legal precedents might be relevant to a defense of Scene Z?

Fortunately, a promising defense of the therapist's participation in Scene Z stems from the *Canadian Charter of Rights and Freedoms*. Section 7 guarantees that "everyone has the right to life, liberty and security of person". This has been interpreted by Canadian courts as implying that a citizen has the right to personal autonomy in making health care decisions and the right to be free from criminal prohibitions or unduly restrictive regulatory schemes interfering with that medical autonomy. In this regard, three court cases appear relevant to Scene Z. First, in *R. v. Parker*[10] (2000) the Ontario Court of Appeal affirmed the right of Canadians to access an illegal substance, cannabis, for the treatment of an illness in situations when there were no effective conventional treatment alternatives. This led the courts to order access to cannabis for certain patients through the *Marihuana for Medical Purposes Regulations* (MMPR). Second, *R. v. Smith*[11] (2015) affirmed the right of medical cannabis users to access non-smokable forms of cannabis (e.g. edibles, tinctures, salves, etc.) as well as the smokable form available through MMPR. The Supreme Court of Canada (SCC) ruled that the prohibition of nonsmokable forms of cannabis "limits the liberty of medical users by foreclosing reasonable medical choices through the threat of criminal prosecution. Similarly, by forcing a person to choose between a legal but inadequate treatment and an illegal but more effective one, the law also infringes security of the person". Most recently, in *Allard v. Canada* (2016), the same *Charter*-based reasoning led the Federal Court to rule that approved medical cannabis users could legally grow their own cannabis as an alternative to purchasing it from government-approved "licensed producers".

The parallels between *Parker/Smith/Allard* and Scene Z are striking. To the extent that a client's psychological condition is not amenable to current orthodox treatments, and to the extent that it can be shown that psychedelic-assisted psychotherapy is a "reasonable medical choice", we could use the reasoning underlying *Parker/Smith/Allard* to argue that the Scene Z client has a *Charter*-based entitlement to a constitutional exemption to the *Criminal Code* provisions respecting psychedelics, and that the federal court should order that the current law against possession of a psychedelic be modified to allow medical use. (Think *Psychedelics for Medical Purposes Regulations*.) Since, with such an exemption, the client could not be charged with possession of a psychedelic, the clinician would, ipso facto, be protected from a charge of aiding and abetting, of being a party to psychedelic possession. We might also argue, a la *Parker*, that justification for providing a Scene Z psychotherapeutic *service* stems from the same recognition of the client's right to make health care decisions that led MMPR to provide a *substance*.

Yet another recent SCC court decision may also be helpful to the defense of Message Z10 and the conduct of psychedelic therapy, as it explicitly legitimatizes the provision of a service rather than a substance. The right to health care autonomy flowing from section 7 of the *Charter* also served as the basis for the 2011 Supreme Court decision[12] to uphold Vancouver's safe-injection Insite[13] program. This decision allows health-care practitioners to supervise injections of dangerous drugs such as heroin, so as to minimize risk of medical complication. The Court ruled that Insite clients' *Charter* right to life, liberty and security of the person would be denied them if clinical supervision of their injections was denied.

The parallels between Insite and Scene Z appear compelling: just as medical supervision of an addict's injection of a street drug reduces the risk of infection, so supervision of a psychedelic experience reduces risk of a "bad trip" or counter-productive session. The services desired in each case by the client are health care services that contribute to harm reduction. Those services would be denied if the clinician refused the client's request for supervision. The clinician's supervision of a psychedelic session honors the client's right to health care autonomy. The therapist's supervision of a psychedelic session in Scene Z is therefore just as professionally defensible as the nurse's supervision of an Insite client's injection of a drug they have no role whatsoever in providing. And, if the Insite-Scene Z parallel holds, clients coming to their psychedelic session should have no need to fear arrest for possession of a psychedelic. The Insite argument would protect both psychotherapist and client.

But this *Insite*-based argument, though compelling, is not without weakness. Those skeptical of this defense may counter that Scene Z *is* different from Insite in one important respect. Insite clients are addicts: they don't have control over their drug use, and they will use their drugs whether or not there is professional health care present. The psychedelic-seeking client, on the other hand, will not likely use the drug without the therapist's supervision, especially after having been advised of the risks of psychedelic use without supervision in Message X4. In fact, the skeptic may contend, the client's decision to pursue psychedelic therapy may stem partly *from* the availability of clinical supervision. In such case, the therapist's availability actually *increases* the likelihood of a client acquiring the illegal drug in a way that is *not* the case with an Insite client. So, the skeptic continues, does not the therapist's very willingness to be available to conduct psychotherapy in a psychedelic-assisted session amount to *aiding and abetting* the client's contravention of the *Criminal Code*, as the client would not enter into possession of a restricted substance unless he knew he could use it under the supervision of the therapist? If true, the clinician would be party to a crime (possession) and may be criminally liable, *despite* what verbal messages were delivered.

But this skeptic's counter-argument may be challenged in at least three ways. One reply is to allow that the skeptic's objection will certainly hold true for *some* clients seeking a supervised psychedelic session. But it ignores the fact that many other clients, while not drug addicts, nevertheless do experience a degree of *desperation* comparable to that of addicts. They have lived with debilitating depression, anxiety or PTSD over time. They have tried a succession of therapists, treatment programs and prescription medications to little avail. These clients have become desperate to the point of intent to pursue outside-the-box options even under conditions that they recognize are less than optimal. This group of clients *does* mirror the status of the Insite clients, and thus avoids the objection based on abetting. Accordingly, the clinician will

550 wisely limit legal exposure by confining Message Z10 and subsequent service to only those
551 situations of dire need, as described above, where the need for relief is believed to be acute,
552 where all other treatment options have been exhausted and where the clinician has reason to
553 believe that the client is adamant to the point of willingness to go ahead with a psychedelic
554 session with or without the therapist.
555
556 A second response to the skeptic's argument above might be to concede that Scene Z and Insite
557 are not sufficiently parallel to obviously justify Message Z10 by appealing to the Insite ruling.
558 So let's, for argument, abandon Insite as a particular basis for an argument for providing service
559 to those clients who are not so desperate that they would take the drug even if we do not assist.
560 But in abandoning support from Insite, we do not loose the *Charter*-derived right to health care
561 autonomy as a justification to serve clients, desperate or not. Let's agree with the skeptic that,
562 yes, in a way, it is true that the therapist may aid and abet, but argue that it is trivial. We begin
563 by returning to our Scene W – Scene Z comparison, pointing out just how closely they are
564 parallel. We will argue, with Scene W in mind, that the decisions of individuals like Alice to
565 take drugs recreationally at a party, or to give them to their friends, are made within the context
566 of implicit knowledge that there is a mental health safety net in the background. They don't
567 think they'll need it, but they know that they can rely on if it turns out they *do* need it. So, for
568 recreational drug users, the knowledge that there are emergency rooms and mental health crisis
569 workers waiting in the wings if needed, contributes to their perception that it is safe to take the
570 drug, and hence to the taking of the drug itself. So the existence of the emergency room
571 counselors *implicitly* aids and abets the recreational drug taker's illegal behavior in the same way
572 that the skeptic argues that therapists abet clients' illegal behavior by being available to supervise
573 their psychedelic sessions. But, we might argue, we don't support eliminating the mental health
574 crisis counselors from the emergency rooms because they might inadvertently play an abetting
575 role. Why? Because it is in the *public interest* that they be retained: the good they can do in
576 minimizing the negative aspects of a psychedelic "bad trip" vastly outweighs the risk to the
577 public incurred by whatever role they might also play in abetting the illegal behavior. In like
578 manner, we might argue, the virtue of a therapist's availability for psychedelic-assisted
579 psychotherapy outweighs the risk posed by any abetting function implicit in that availability, and
580 nullifies abetment as grounds for professional censure.
581
582 Finally, the prospective medical psychedelic user may urge us to consider one more argument in
583 support of the ethical and legal legitimacy of Message Z10: Most Canadians agree that it is in the
584 public interest that crisis intervention counsellors are available at mental health facilities to deal
585 with Scene W individuals, who often make impulsive, reckless and irresponsible drug choices
586 about what they take and where they take it. They agree that even those foolish citizens are
587 entitled to the provision of Scene W emergency mental health services. But medical psychedelic
588 clients see themselves as eminently *responsible* users. Their intent is to use the psychedelic in
589 accordance with research-confirmed applications, to follow clinical protocols developed by
590 experts, and to seek the type of session supervision recommended by professionals. So, asks this
591 "medical" psychedelic user, is it not just as much in the public interest that the individual who
592 responsibly seeks a medical outcome receive access to the health care clinical supervision of
593 Scene Z as someone in Scene W who carelessly pursues a merely recreational outcome? Should
594 the responsible user be any less entitled to competent supervision than the careless user?
595

The foregoing arguments, based on the *Charter*, and on the parallels between Scene Z and *Parker/Smith/Allard* or *Insite*, indicate that conduct of psychedelic therapy could, under limited circumstances, be considered both ethically and legally defensible. Both the ethical and the legal cases would appear strongest when involving clients who are desperate and in dire need, who would clearly be using a psychedelic with or without the therapist; the case is less compelling when it involves less desperate clients who would be deterred from taking the psychedelic if they did not have clinical supervision. But even under the most favorable circumstances, legal defensibility does not present itself immediately.

The court case for medical psychedelic use could go forward in one of two ways. In the first, the Scene Z clinician would perform the psychedelic therapy service. He or she would then be arrested, charged with aiding and/or abetting client possession of a psychedelic, and found guilty. Exoneration would come only on appeal, likely at the Supreme Court level, in the event that the court saw fit to grant a constitutional exemption for the client and the therapist along the lines of the above-cited cases. In practice, the law is rarely entirely clear until push comes to shove. Though a *Charter* defense seems possible, counselors should not be encouraged to go down this road unless they have a clear-eyed willingness to face all possible consequences. The ideal legal clarity we desire as a basis for practice will come only from future court rulings that we cannot fully predict. As a result, clinicians will experience a tension between an ethically based desire to mitigate client suffering and a practical desire to protect themselves from legal risk. These situations will thus require careful personal reflection and sustained discussion not only with legal counsel, but with trusted supervisors, peers and mentors within the counsellor's professional community.

The importance of this *consultation*[14] relative to the ethical aspects of Scenes X-Z cannot be over-emphasized. Ethical reasoning is ultimately a personal process; we ourselves are ultimately responsible for the ethical decision-making that guides our practice. The best outcomes result from sound reasoning from fundamental ethical principles, not from following group consensus or authority for its own sake. Some ethical decisions will not require consultation because they are very clear and straightforward from the beginning. But scenes such as X-Z may involve more difficult and higher-risk decisions, and the risk of doing harm, especially in Scene Z, is higher. There may be room for genuine disagreement about what the client's interests really are, or how to best serve them; there may be more than one approach that can genuinely be considered ethical. Here, collegial collaboration in the ethical reasoning process becomes crucial for counselors, whether employed or in private practice. Two additional considerations support this view. First, solitary ethical reasoners may not know what they don't know, and hence not know when they're missing an important piece of the ethical picture under consideration, a piece that others, especially those familiar with similar situations, may readily see and point out. Second, solitary reasoners cannot easily know when they are falling into self-deception, when their interpretations of clinical facts or ethical principles, and hence their conclusions, are being swayed by factors – personal desires, needs, motivations or emotions – that they are not aware of, factors that others might clearly see and point out. So, though the decision is ours alone to make, it is ideally made within a *relational* context of clinical supervision or peer consultation: we want to do our best to know that we have not overlooked something in making our decision. It will be prudent to regard subjective reluctance or resistance to engaging in this relational aspect of the ethical reasoning process as an important hint that the conclusions of our

solitary reasoning process might not be sound.

A second course of legal action is, however, far more preferable to the therapist than becoming charged as a defendant in a criminal possession case. With this option the therapist avoids all risk of legal or ethical censure. Here, the therapist, not the Crown would initiate the legal action. Prior to providing any psychedelic therapy service, the therapist would begin by petitioning the federal government on behalf of a well-chosen specific client for a medical exemption to the criminal code provisions for possession of a psychedelic. If and when that petition is denied, the therapist would then sue the federal government in court on the grounds that the prohibition of possession for medical purposes contravenes the provisions of the Charter. This approach transforms the focus of the case from being about a criminal defense of a therapist to being about patients' human rights.

There is yet another possible legal outcome to seek using *Charter*-based arguments to pursue the availability of psychedelic medicine for those in dire need. Canadians now have a legally recognized "right to die"; approved patients in dire medical straits will have the right to take drugs that will kill them. Our initiative advocates for the "right to *try*" to live by obtaining legal access to experimental medicines, that, while not yet ready for prime time, offer reasonable hope of relief for a desperate client. Some two dozen American states have recently have passed "right-to-try" laws that allow the terminally ill to use drugs that show positive results in Phase I and 2 clinical safety trials, but have not yet completed the multiyear Phase 3 trials for dosing and efficacy that lead to adoption as an orthodox pharmaceutical. Canada has its own right-to-try provisions. Health Canada's *Special Access Program* (*SAP*) allows practitioners treating patients with serious or life- threatening conditions to request access to drugs unavailable in Canada when conventional treatments have failed, are unsuitable or unavailable. But that "special access" is limited. Certain "restricted" drugs, including the psychedelics, are *not* available through the *SAP*. It is now fairly clear how the Charter-based arguments outlined above could, in addition to compelling changes in the *Controlled Drugs and Substances Act* to allow for medical use, also be successful in compelling Health Canada to rewrite its *SAP* regulations to allow access to psychedelic medicines.

Summary

The recent increase in profile of psychedelic drugs as purported medicines poses some important questions for practicing mental health clinicians, especially those sympathetic to the idea of psychedelic therapy: How might we respond, ethically and legally, to clients who might choose to possess controlled drugs for use in therapy? To what extent can we tolerate, condone or cooperate with the medicinal use of these substances? Could we actually conduct psychedelic therapy in an ethically and legally defensible way?

We have examined three hypothetical clinical situations (Scenes X-Z) that pose these questions. In each situation, clinicians face some legal peril. Depending on the factual circumstances, the practitioner risks an argument being made that he or she either counselled – in the sense of

688 incited – the patient to commit the act of possession, or abetted that action – in the sense of
689 encouraged, promoted or instigated the act to occur. If so, culpability would attach and the
690 practitioner could be able to be convicted of possession.[15]
691
692 In Scenes X and Y the risk of falling into aiding/abetting involves what a clinician *says* to a
693 client. I have argued that our messaging there be circumscribed by two cardinal maxims, X1 and
694 X2: I can't advocate illegal behavior, and I can't recommend psychedelic medicines. Within
695 these limits, however, I have defined additional messages, X3-X9, that go beyond the simple
696 tolerance appropriate in situations involving problem use. These messages offer clients
697 assistance in gathering and understanding basic factual information about psychedelic therapy,
698 and clarification that a decision to use a psychedelic would be the client's own decision. They
699 also offer clinician acceptance and support of client's decision to use a psychedelic medicine. I
700 contend that Messages X1-X9 are both ethically and legally defensible for the clinician; although
701 they collectively may appear close to the legal red line, they stop short of aiding or abetting.
702
703 In Scene Z the risk of aiding or abetting stems not only from what counselors might say, but
704 from their very availability to conduct psychedelic psychotherapy. I contend, however, that
705 under certain defined circumstances involving desperation and dire need, a therapist in Scene Z
706 may be legally and ethically justified in providing psychedelic-assisted psychotherapy. I support
707 this with a Charter-based line of defense, which does not shield a clinician from initial
708 prosecution, but offers the likelihood of exoneration on appeal. A far more desirable alternative,
709 however, is that the therapist use the Charter-based arguments in a proactive court case *before*
710 rendering the psychedelic psychotherapy service rather than waiting until after he/she has
711 rendered the service and is charged as a criminal defendant for aiding and abetting possession of
712 a psychedelic.
713
714 I am sympathetic with those who believe there is sufficient substance in research literature to
715 validate optimism that currently illegal psychedelics have an important role to play in clinical
716 treatment strategies. I intend, however, that my tone be cautionary: even when we may have
717 sympathy with the "medical" merits of psychedelics, let's be clear and careful with our
718 messaging to clients or our participation in psychedelic-assisted psychotherapy. This view rests
719 in turn on my belief that the agenda for advancing the availability of psychedelic medicine in
720 Canada will best be realized when our professional conduct remains within ethical and legal
721 limits. But it also suggests a way forward: let's focus at this point on clinical cases involving
722 desperation and dire need. Choosing a theoretically ideal client, a therapist can take the initiative
723 in court to sue the federal government prior to providing the psychedelic service. Ideally, that
724 case will lead, analogous to *Parker/Smith/Allard* or *Insite,* to the High Court and to a ruling that
725 a constitutional exemption be made to the *CDSA* statute concerning possession of psychedelics,
726 one that permits use for medical purposes.

727 **References**

728

729 American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental*
730 *Disorders*, 5th Edition: DSM-5 Washington DC: American Psychiatric Association.
731
732 BC Association of Clinical Counsellors (2014). *Code of Ethical Conduct, Standards of Clinical*
733 *Practice & Guidelines for Registered Clinical Counsellors*. http://bc-
734 counsellors.org/wp-content/uploads/2014/07/BCACC-Code-of-Ethical-Conduct-
735 2014.pdf
736
737 Grof, S., LSD Psychotherapy. (2001) Sarasota, FL, US: Multidisciplinary Association for
738 Psychedelic Studies.
739
740 Health Canada (2014). *Marihuana for Medical Purposes Regulations (MMPR)* http://www.laws-
741 lois.justice.gc.ca/eng/regulations/SOR-2013-119/FullText.html
742
743 Ruse, J., Mithoefer, M., Jerome, L., Doblin, R. Gibson, E. (2011). MDMA-assisted
744 psychotherapy for the treatment of posttraumatic stress disorder: A revised teaching
745 manual draft. Multidisciplinary Association for Psychedelic Studies.
746 http://www.maps.org/research/manual_1.16.2011.pdf
747
748

Appendix A

CLIENT DECLARATION FORM

I, ________________________________ , being of sound mind, and under no influence of any psychoactive substance, do affirm the following:

1. I first approached Dr. ______________ on ________________________to request that he attend, as a veteran psychotherapist, at my psychedelic session. At that time I had already decided (i.e. formed a clear intention within myself) on the basis of my own research, to use a psychedelic drug in a psychotherapeutic way. Dr. __________ played no role whatsoever in my decision to use a psychedelic medicine. I approached him to attend my psychedelic session because I believed that his presence would enhance my sense of emotional safety and maximize the therapeutic benefit of the psychedelic session.

2. At no point in his professional contact with me did Dr. ___________ ever prescribe, encourage, recommend or otherwise render a professional opinion that taking a psychedelic would be helpful in the treatment of my personal issues.

3. Dr. ________ advised me in detail of the risks involved in psychedelic therapy pertaining to purity of substance, certainty of dosage, and the illegality of psychedelic substances. At no time did he ever recommend that I engage in unlawful behavior. I gave Dr. _________ a clear assurance that I myself undertake responsibility for any and all risk I incur from taking a psychedelic medicine.

4. I have provided my own psychedelic substance for my session. Its provision had nothing whatsoever to do with Dr. _____________.

Signed _______________________________________

Date ____

Footnotes

[1] Proponents of these substances as medicines usually prefer the terms *psychedelic* (meaning "mind manifesting" or "consciousness expanding"), or *entheogen* (meaning "promoting the experience of God within") to the somewhat pejorative term *hallucinogen* (used in DSM - 4 & 5) as being more accurately descriptive of their effects. See Wikipedia for an introductory discussion of these terms: http://en.wikipedia.org/wiki/Psychedelic_drug

[2] See DSM – 5, Other Hallucinogen Disorder, Diagnostic Features.

[3] Psychedelic drugs are illegal in Canada under the Controlled Drugs and Substances Act (1996). http://laws-lois.justice.gc.ca/eng/acts/C-38.8/

[4] As examples, click on the 'Research' and 'Resources' tabs on the homepage of the Multidisciplinary Association for Psychedelic Studies home page: http://www.maps.org/. See 'Psychedelic Research Papers' and 'Psychedelic Bibliography' under the 'Resources' tab for literature relating to the clinical efficacy and promise of in the treatment of a variety of mental health issues: http://www.maps.org/. See also http://www.mdmaptsd.org/ for information on treatment of PTSD with MDMA.

[5] See, for example, BCACC *Scope of Practice* statement: http://bc-counsellors.org/general/about-us/scope-of-practice

[6] *Criminal Code* (R.S.C., 1985, c. C-46)

[7] *R v. Vang*, (1999) 132 CCC (3d) 32 at para 24

[8] For example, see the following New York Times article that appeared in April 2012: http://www.nytimes.com/2012/04/22/magazine/how-psychedelic-drugs-can-help-patients-face-death.html?_r=2&pagewanted=all

[9] See training opportunities offered by the Multidisciplinary Association for Psychedelic Studies http://www.maps.org/participate/pep/

[10] *R. v. Parker*, (2000) CanLII 5762 (ON CA) http://www.canlii.org/en/on/onca/doc/2000/2000canlii5762/2000canlii5762.html

[11] *R. v. Smith*, (2015) SCC 34 http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/15403/index.do

[12] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44 http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/7960/index.do

[13] See Insite website http://supervisedinjection.vch.ca/

[14] I wish to thank my early readers of this paper, John Gawthrop, and Dr. Jean Pettifor, for encouraging me to develop my thinking in this paragraph on the relational aspects of ethical decision-making, as well as their valued feedback on the whole manuscript. My thanks also to Dr. Clive Perraton Mountford for his very helpful feedback on the whole manuscript.

[15] I wish to acknowledge Kirk Tousaw, barrister, for his substantial assistance in researching and interpreting the *Criminal Code* with respect to this paragraph.

Author Note: Bruce Tobin, Ph.D., Registered Clinical Counsellor, has maintained a private practice in Victoria, B.C. for thirty years, and taught Expressive Therapies at University of Victoria, where he is an Adjunct Assistant Professor. Please address correspondence to: bruce.a.tobin@gmail.com

April 15, 2016