Psychedelic Medicine
Volume 0, Number 0, 2023

DOI: 10.1089/psymed.2022.0009

psychedelic medicine

Open camera or QR reader and scan code to access this article and other resources online.

Applying Key Lessons from the Hospice and Palliative Care Movement to Inform Psychedelic-Assisted Therapy

Megan Miller,[1,*] William E. Rosa,[2] Alden Doerner Rinaldi,[3,4] Katie Addicott,[5] Dingle Spence,[6,7] and Yvan Beaussant[4,8]

Abstract

Background: Psychedelic-assisted therapy (PAT) has re-emerged as a promising intervention for addressing mental health conditions and existential concerns. Despite growing enthusiasm, PAT may be difficult to integrate into mainstream health systems. The rich sacramental traditions of psychedelics, their centering of the human experience, proposed substrates of action, context-dependent outcomes, and highly relational method of therapy all challenge dominant reductionistic approaches of the biomedical model. Hospice and palliative care are well established as holistic evidence-based standards of care, yet they began as a radical grassroots movement. Hospice and palliative care models may offer unique insights to support the growing field of PAT.

Purpose: The intention of this commentary is to articulate the deep synergies between hospice and palliative care and PAT, with the intention of fostering interdisciplinary dialogue that may aid in implementation of human-centered high-quality PAT.

Conclusions: Various aspects of hospice and palliative care models were identified and explored, which may support the implementation of human-centered high-quality PAT at scale. These include a focus on truly interdisciplinary care, applying a holistic lens to health and illness, bearing witness to suffering and healing, customized care, centering human relationships, decentralized models of care, generalist/specialist competencies, fostering spirituality, organizing as a social moment around shared goals, and growth from grassroots community organizations to mature care systems. Although hospice and palliative care can offer practical lessons for scaling human-centered experiential therapies, PAT, with its radical centering of meaning-making and relationship in the healing process, may also mutually innovate the fields of hospice and palliative care.

Keywords: palliative care, supportive care, hospice; psychedelics; psilocybin; holistic; psychosocial; spiritual care; psychedelic-assisted therapy

[1]University of Wisconsin-Madison School of Nursing, Madison, Wisconsin, USA.
[2]Department of Psychiatry and Behavioral Sciences, Memorial Sloan Kettering Cancer Center, New York, New York, USA.
[3]Care Dimensions Hospice, Danvers, Massachusetts, USA.
[4]Harvard Medical School, Boston, Massachusetts, USA.
[5]Department of Palliative Medicine, Maine Medical Center, Portland, Maine, USA.
[6]Hope Institute Hospital, Kingston, Jamaica.
[7]Jamaica Cancer Care and Research Institute, Kingston, Jamaica.
[8]Department of Psychosocial Oncology and Palliative Care, Dana–Farber Cancer Institute, Boston, Massachusetts, USA.

*Address correspondence to: Megan Miller, PhD, RN, University of Wisconsin-Madison School of Nursing, Madison, 701 Highland Avenue, WI 53705, USA, E-mail: miller89@wisc.edu

Psychedelic-assisted therapy (PAT) has re-emerged as a promising intervention for increasingly prevalent mental health conditions, often unresponsive to standard care.[1,2] Within the context of sacred traditional Indigenous medicine practices came a Western interest in psychedelics, leading to a fertile period of research from the 1950s–1970s, then an abrupt ban on this research due to political and cultural upheavals.[3] Despite current resurgence of PAT research, urgent needs for supportive care interventions to address suffering, multi-stakeholder enthusiasm for the promise of PAT, and a growing evidence base (see Refs.[1,4–6] for a thorough review), the nascent field of modern PAT may be challenged to integrate into mainstream health systems and the Western biomedical model. It is our shared belief that the hospice and palliative care movement may provide unique insights to inform development of the field of PAT in a way that is holistic, interdisciplinary, equitable, and compassionate.

The rich sacramental traditions of psychedelics, their centering of human experience, proposed substrates of action, context-dependent outcomes, and highly relational method of therapy all challenge dominant reductionistic approaches to care. Case in point: Research has demonstrated that the strength of the so-called ''mystical-type experience'' mediates therapeutic benefit of psychedelics in clinical samples and catalyzes lasting change in nonclinical populations.[7,8]

Moreover, participants regularly rate psilocybin experiences as among the most meaningful and spiritually significant of their lives.[9] Whether these transcendent and deeply personal PAT encounters can be feasibly, meaningfully, and effectively amenable to rigid diagnostic categories, quantified in psychopharmacological and neurobiological terms, and commodified in clinical practice, service delivery, and health economics remains to be seen. Yet, prohibiting further research and clinical implementation despite their therapeutic potential raises fundamental ethical questions.

Although spirituality and related concepts have long been at the periphery of the health sciences, the modern-day hospice movement and the field of palliative care have recentered them.[10] It is our perspective, as clinicians trained in both palliative care and PAT, that the integration of psychedelics into clinical settings is an opportunity for a more thorough incorporation of spirituality and a whole person approach into clinical care itself.

In this brief commentary, we aim to begin articulating the deep synergies between hospice and palliative care and PAT, with the intention of fostering interdisciplinary dialogue that may aid implementation of human-centered high-quality PAT. To this aim, Table 1 offers an overview of core palliative care principles, linked with corollaries in PAT. This table was developed through a drafting, refining, and consensus process carried out by our authorship team, an interdisciplinary group of clinicians and researchers with expertise across PAT and palliative care. Key aspects of this collaborative effort are expanded upon throughout the rest of this commentary.

What Palliative Care Can Teach PAT

Palliative care ''is the active holistic care of individuals across all ages with serious health-related suffering due to severe illness and especially of those near the end of life. It aims to improve the quality of life of patients, their families, and their caregivers,'' aligning care holistically with a patient's wishes and values.[11,12] Hospice entails specialized palliative services for those with a medical prognosis of six months or less and who are opting to forego life-prolonging treatments.[13] Although now broadly regarded as an essential component of all serious illness care, provision of palliative care and hospice began as a radical movement that insisted on bringing the liminal spaces of mortality and spirituality into the mainstream of medical and popular culture. The ineffable sacred meaning-centered nature of both being with those who are dying and being with those who are in psychedelic states are especially salient. Death and dying are nonordinary states of consciousness, and the dying person's bedside is often a sacred space.[14]

To better contextualize connections between the palliative care and hospice movement and PAT, it may be helpful to detail a bit of history. The birth of hospice and palliative care as a recognized specialty in the post-War period of the 1950s and 1960s coincided with the first wave of psychedelic medicine in the West. This was a time when organized religion's monopoly over transcendent dimensions of human experience waned, and the health professions began to exert greater influence over this meaningful existential ground.[15]

Dame Cecily Saunders, founder of the modern hospice and palliative care movement, was trained as a social worker, nurse, and physician.[15] It is relevant to note that hospice and palliative care remain thoroughly interdisciplinary to this day, drawing on Saunders' embodiment of this principle. Saunders was a clinician scientist, engaging with patients as whole individuals with meaningful narratives, who integrated scientific knowledge with care and love. She articulated the construct of ''total pain'' to express the irreducible physical, psychological, social, and spiritual domains of human suffering,[16] which remains a central concept in hospice and palliative care today.

Saunders brought her values, sensibilities, and diverse training into her clinical care, boldly and unapologetically. This vision was manifest in the founding of St. Christopher's Hospice in London in 1967, the first medical rather than religious institution of its kind, dedicated to the care of the dying.[15] In so doing, she expanded the clinical gaze beyond treating disease, to addressing the needs of the person living with a terminal diagnosis.

Table 1. Core Palliative Care Principles and Corollaries in Psychedelic-Assisted Therapy

Palliative care principles	*Implications for PAT*
Holistic, person- and family-centered, value concordant care, and communication	PAT clinicians must maintain a focus on the human being at hand with attention to their personhood. PAT clinicians should address holistic considerations, including social support systems and symptoms beyond the psychological (e.g., physical and spiritual). PAT clinicians must function as compassionate interfaith spiritual care providers. PAT clinicians must ensure that preparatory, dosing, and integration sessions are guided by the client's values and goals. Empathic communication should guide the assessment of patient/family needs, exploration and clarification of goals, and expectations. Ensuring values concordant approaches will assist when working with uncertainty in PAT experience; allowing space for goals to evolve quickly and over time. PAT clinicians should have a clear understanding of family dynamics and the influence on a person's healing, processing, and decision-making.
Maintains a twofold aim to alleviate suffering and improve quality of life	While focused on mitigating the index symptom (e.g., depression), PAT clinicians should aim to improve the overall lived experience of the client. PAT clinicians should understand how the client defines and understands quality of life and suffering. PAT clinicians should determine therapeutic efficacy based on client-reported outcomes and could consider adding rating scales that look specifically at quality of life. PAT clinicians can ensure a salutogenic rather than pathogenic model of research and practice. PAT practices must cultivate ways of being with suffering to alleviate contributing factors and move toward healing.
Integrated care models are key	All clinicians should be familiar with the legalities and logistics regarding access to PAT for patients. Primary team involvement and partnership with PAT teams is critical for client well-being and transparency. Policy changes for PAT integration models should be informed by both empirical data and client narratives describing the art and science of the field. All clinicians should have a strong knowledge base of the heightened ethical concerns involved in PAT such as patient safety, confidentiality, resource allocation, power differentials, and potential barriers to access. PAT providers should be aware of cultural and historical contexts around psychedelics, holding respect for Indigenous practices and ways of knowing.
Requires both generalist and specialist clinicians	All clinicians where PAT is used should be equipped with generalist-level knowledge to provide understanding and emotional support to clients and their families. All clinicians where PAT is used should be trained with generalist-level competencies, including empathic communication (both verbal and nonverbal). PAT specialists should be consulted to provide generalist-level education and work with potential clients who meet medically indicated criteria based on local policies.
Inherently interdisciplinary	PAT as a field must leverage the expertise of interdisciplinary partners to optimize impact and approach (e.g., medicine, nursing, social work, chaplaincy, ethics, and cultural brokers) especially when considering social issues (impact on family, community, and cultural biases). The science of PAT should be driven by a range of experts to identify clinical implications across settings. PAT guidelines should be informed by interdisciplinary stakeholders to ensure safe and secure transitions throughout the care continuum and whenever PAT is used. The team is based in caring and mutual respect for each other's specialties and scopes of practice while dismantling confining and irrational hierarchies.
Attuned to loss, grief, and bereavement throughout continuum of suffering, and to transcendental experiences that may offer opportunities to make meaning in the face of suffering	Clinicians should understand the role of loss, grief, and bereavement that is fundamental to healing for many people who have experienced trauma, illness, and other psychosocial wounds that bring someone to PAT. PAT clinicians must attend to anticipatory losses experienced by patients as they move toward healing, surrendering old or outdated aspects of self and identity. Teams must offer transitional support between PAT dosing sessions and integration period as patients reacclimate to external social relationships and circumstances, some of which may no longer serve and will be brought to a close.

PAT, psychedelic-assisted therapy.

Saunders' writings offered first- and second-person accounts that were morally salient, speaking directly to the values embedded in the caring professions.[17] By elevating an ethos of nonabandonment, she promoted an accountability that extends beyond the purely technical competencies of diagnosis and treatment, to encompass stewardship and presence for dying individuals and their loved ones. It is our belief that the growing field of PAT could draw upon lessons embedded in this evolution of hospice and palliative care, and that the core values and ideals of hospice and palliative care may be a solid reference point for developing an interdisciplinary PAT structure.

Furthermore, modern hospice teams, along with managing care in patient's homes, freestanding hospices, and skilled nursing facilities, are ultimately offering and holding space for transformative experiences. As challenging as it can be sublime, hospice care focuses on ''thriving while dying'' and helping to facilitate a ''good death,'' free from avoidable suffering and aligned with the wishes of patients and their families, while also holding space and witnessing unavoidable suffering.[18] These wishes and preferences will be different for every patient and family, and the nature of hospice work is to empower those we serve to define and articulate them for themselves.

Similarly, palliative care clinicians, when triangulating between interdisciplinary clinical teams, patients, and families, engage in ''goals of care discussions,'' which articulate expectations while aligning with patient's values and priorities. These conversations support a standard of care tailored to individual needs and sensibilities, while acknowledging the limits of medical interventions to control and cure illness. Rather than applying the top-down prescriptive model sometimes dominant in medicine and psychiatry, this palliative care approach to customizing care and centering human relationship at scale could inform future PAT approaches as well.

St. Christopher's Hospice served as a demonstration project and an academic teaching facility, and its model was adapted at Connecticut Hospice in 1974, then replicated iteratively ever since, with >4,500 hospice organizations operating in the United States alone as of 2018.[19] Most of these organizations are small, serving <50 patients on any given day, and community-based, delivering care into homes as well as more traditional health care facilities. Without novel pharmaceuticals or medical technology to commodify, demonstrating the value of hospice care came about in a decentralized manner with community organizations adapting to address local needs with bottom-up innovation. Hospice and palliative care, similar to PAT today, are resource-intensive in terms of human time, attention, and caring. PAT can look to existing hospice and palliative care models to effectuate culture change and humanize care at a time of short supply and high demand.

Similar to the containment practiced to maintain psychological safety during PAT, palliative care teams create a supportive ''set and setting'' by coordinating care to reflect the needs of the human being at hand.[20] This strategy creates coherence that can stabilize amid turbulent and chaotic events. The collaborative nature of stewardship among hospice and palliative care teams who are longitudinally involved in care not only shapes clinical outcomes, but also extends efforts by engaging patient and family resources in the continued healing process. Furthermore, those in the palliative care field have posited that every clinician must become a palliative generalist, in addition to specialist providers, to ensure relief, interfaith spiritual support, and goal-concordant care are available at all stages of the serious illness trajectory.[21]

This may be true of PAT as well. In settings where PAT is delivered, all clinicians are encouraged to have a baseline understanding of what PAT entails, common experiences and adverse effects, and the full scope of the process (e.g., preparation, dosing, and integration sessions).[22] Such knowledge and preparation could avoid inadvertent stigmatizing of clients or invalidation of the client experience. Specialist PAT therapists and/or chaplains would then be available for both client consultation and generalist education purposes. Drawing on palliative care experience, such a model could help empower patients and providers across various PAT settings.

The transformation from small grassroots care delivery to the current field of palliative care has certainly not come without challenges. Notably, when legislation was proposed to expand palliative care access through the Affordable Care Act, partisan efforts targeted this meaningful health care reform with implications that palliative care access equated with ''death panels.'' In the face of these criticisms, palliative care, through organizations such as the Center to Advance Palliative Care, invested in branding as an exercise in self-definition to counter damaging public distortions.[23] It is probable that PAT will face criticisms and mischaracterizations of similar proportions, and that similar efforts may be needed to maintain clarity of purpose in the public eye.

Crisis has repeatedly been the impetus to reaffirm and exercise our values to strengthen the moral stance of the caring professions. Myriad global humanitarian crises, such as the HIV/AIDS and COVID-19 pandemics, have mobilized a sense of urgency and moral coherence that brought shared values and social commitments to the fore as a field. Galvanized by crisis, hospice formulated itself self-consciously as a *social movement*, or a loosely organized effort by a large group of people to achieve particular goals, typically social or political ones.[24] Rather than a ''renaissance'' suggesting the emergence of animating, almost transcendental ideas, a psychedelic ''movement'' will need to be mobilized, across ''socio-psychedelic imaginaries'' that are co-existing and evolving today.[25]

This movement can be strengthened by organizing broadly around shared goals of addressing our society's mental health and meaning crisis, repairing the trauma of war and pervasive violence, countering the pandemic of social isolation in the wake of COVID, as well as responding to oppressive systems (global capitalism, white supremacy, etc.) and structural injustices (racism, sexism, ableism, transphobia, etc.) propagating and amplifying trauma. This organizing can occur at local levels (such as within the numerous existing psychedelic societies), state levels (such as within universities and health sciences training programs), national and international levels (such as within large professional organizations).

Forty years after the 1982 congressional act first articulated hospice as a distinct Medicare benefit, hospice teams now serve >1.4 million Medicare beneficiaries annually.[19] Interdisciplinary palliative care teams are present in >80% of hospitals with 50 beds or more[21] and hospice is now providing services to the majority of Medicare decedents.[19] Professional organizations have been dedicated to developing robust models demonstrating value in terms of quality outcomes, as well as efficiency gains and cost saving on a population level, bringing investment in quality teams and community-based patient-centered services.[26] This growth from grass roots community hospice and palliative care organizations to distinct and mature health systems could serve as a roadmap for one relatively decapitalized approach to scaling PAT services.

PAT and Palliative Care in Dialogue

We envision PAT that artfully holds space for intense human emotion, meaning-making, and reverence for the human condition. In this model, we would seek not to ''fix'' suffering but rather to bear compassionate witness, deepening our relationship with and understanding of suffering and the human being before us. Rather than further pathologizing illness and suffering, we hope models of PAT may promote health and well-being by activating coping and resiliency behaviors and balancing inner resources with external solutions, whereas reducing inequities, empowering individuals, and honoring the systems and communities in which they are embedded. Practically and philosophically aligned, hospice and palliative care may serve as templates for the expansive project of establishing an authentic and mature interdisciplinary field of PAT at the interface of clinical care and spirituality.

Although hospice and palliative care offer practical lessons for scaling human-centered experiential therapies at the interface of clinical care and spirituality, PAT, with its radical centering on meaning-making and relationship in the healing process, could mutually innovate the fields of hospice and palliative care.[27]

Despite this useful framework, many questions remain, such as the following: How can current systems, built for profit and efficiency, integrate the PAT movement and its starkly contrasting ethos? What research infrastructures are needed to continue to monitor and explore PAT's safety and efficacy? Which PAT training models are needed to provide quality care, while simultaneously honoring Indigenous practice and various ways of knowing? Which policy changes are most needed to support careful widespread access to human-centered PAT? Which financial models are needed to center equity in access to PAT? How can ethical conduct be elevated among PAT providers, and how will breaches be handled, when needed? How can PAT care delivery systems be structured to address and prevent further clinician burnout?

Finally, and importantly, self-awareness in the clinical practice of PAT may provide insights into the lived experiences of attunement and countertransference, as well as provide practice for becoming more fully embodied with our patients, appreciating how much wisdom our bodies contain.[28] PAT also calls us to examine our roles as providers, often simply bearing witnesses to the wonderment of the healing process. This requires a strong emphasis on the clinician's personal process, self-reflection, and accounting of how we are relating with the patients we serve.

Although efforts have been made to highlight the psychological aspects of palliative care[29] and develop self-care and resiliency as a professional competency,[30,31] the introduction of PAT offers new opportunities for raising visibility of our own personal growth, vulnerabilities, and beliefs, necessitating greater transparency and accountability of providers engaged in such sensitive work. This is the work our team is actively continuing to explore, and we hope that this commentary serves as a next step within the emergent dialogue.

Acknowledgment

The authors thank Christopher Adrian, MD, MDiv, for his thoughtful review and comments on a late version of this piece.

Authors' Contributions

M.M. led the writing and editing process. All authors contributed to the conceptualization, drafting, and editing of this article, and approved the final version.

Author Disclosure Statement

Y.B. received philanthropic research funding from the Oppenheimer Family Psychosocial Oncology and Palliative Care Research Grants, Carey and Claudia Turnbull Family Foundation, Heffter Research Institute, George Sarlo Foundation, RiverStyx Foundation, Council on Spiritual Practices Fund at the San Francisco Foundation, Nikean Foundation and Jack Smith, as well research grants from Sunstone Therapies.

Funding Information

W.E.R. acknowledges the NCI/NIH Cancer Center Support Grant P30 CA008748. MM received research support from the University of Wisconsin-Madison, Office of the Vice Chancellor for Research and Graduate Education with funding from the Wisconsin Alumni Research Foundation.

References

1. Lehto R, Miller M, Sender J. The role of psilocybin-assisted psychotherapy to support patients with cancer: A critical scoping review of the research. J Holist Nurs 2022;40(3):265–280; doi: 10.1177/08980101211039086
2. Oliveria Maia L, Beaussant Y, Garcia AC. The therapeutic potential of psychedelic-assisted therapies for symptom control in patients diagnosed with serious illness: A systematic review. J Pain Symptom Manage 2022;63(6):e725–e738; doi: 10.1016/j.jpainsymman.2022.01.024
3. Byock I. Taking psychedelics seriously. J Palliat Med 2018;24(4):417–442.
4. Romeo B, Karila L, Martelli C, et al. Efficacy of psychedelic treatments on depressive symptoms: A meta-analysis. J Psychopharmacol 2020;34(10):1079–1085; doi: 10.1177/0269881120919957
5. Wheeler S, Dyer NL. A systematic review of psychedelic-assisted psychotherapy for mental health: An evaluation of the current wave of research and suggestions for the future. Psychol Conscious 2020;7(3):279–315.
6. Krediet E, Bostoen T, Breeksema J, et al. Reviewing the potential of psychedelics for the treatment of PTSD. Int J Neuropsychopharmacol 2020;23(6);385–400; doi: 10.1093/ijnp/pyaa018
7. Griffiths R, Johnson MW, Umbricht A, et al. Psilocybin produces substantial and sustained decreases in depression and anxiety in patients with life-threatening cancer: A randomized double-blind trial. J Psychopharmacol 2016;30(12):1181–1197; doi: 10.1177/0269881116675513.
8. Ross S, Bossis A, Guss J, et al. Rapid and sustained symptom reduction following psilocybin treatment for anxiety and depression in patients with life-threatening cancer: A randomized controlled trial. J Psychopharmacol 2016;30(12):1165–1180; doi: 10.1177/0269881116675512
9. Agin-Liebes G, Malone T, Yalch M, et al. Long-term follow-up of psilocybin-assisted psychotherapy for psychiatric and existential distress in patients with life-threatening cancer. J Psychopharmacol 2020;34(2):155–166; doi: 10.1177/0269881119897615
10. Steinhauser K, Fitchett G, Handzo G, et al. State of the science of spirituality and palliative care research part I: Definitions, measurement, and outcomes. J Pain Symptom Manage 2017;54(3):428–440; doi: 10.1016/j.jpainsymman.2017.07.028
11. International Association for Hospice and Palliative Care. Global Consensus Based Palliative Care Definition. Houston, TX; 2022. Available from: https://hospicecare.com/what-we-do/projects/consensus-based-definition-of-palliative-care/definition/ [Last accessed: April 12, 2023].
12. Radbruch L, De Lima L, Knaul F, et al. Redefining palliative care: A new consensus-based definition. J Pain Symptom Manage 2020;60(4):754–764; doi: 10.1016/j.jpainsymman.2020.04.027
13. National Institute on Aging. What Are Palliative Care and Hospice Care? 2021. Available from: https://www.nia.nih.gov/health/what-are-palliative-care-and-hospice-care [Last accessed: April 12, 2023].
14. Sallnow L, Smith R, Ahmedzai SH, et al. Report of the lancet commission on the value of death: Bringing death back into life. Lancet 2022;399(10327):837–884; doi: 10.1016/S0140-6736(21)02314-X
15. Saunders C. The evolution of palliative care. J R Soc Med 2001;94(9):430–432; doi: 10.1177/014107680109400904
16. Saunders C. The symptomatic treatment of incurable malignant disease. Prescribers J 1964;4:68–73.
17. Saunders C. Cicely Saunders: Selected Writings 1958–2004. Oxford University Press: Oxford, New York; 2006.
18. Institute of Medicine (US) Committee on Care at the End of Life. Approaching Death: Improving Care at the End of Life. National Academies Press (US): Washington, DC, USA; 1997.
19. National Hospice and Palliative Care Organization. NHPCO Facts and Figures: 2020 Edition. 2020. Available from: https://www.nhpco.org/wp-content/uploads/NHPCO-Facts-Figures-2020-edition.pdf [Last accessed: April 12, 2023].
20. Pfaff K, Markaki A. Compassionate collaborative care: An integrative review of quality indicators in end-of-life care. BMC Palliat Care. 2017;16(1):65; doi: 10.1186/s12904-017-0246-4
21. Beaussant Y, Nichipor A, Balboni T. Integration of Spiritual Care into Palliative Care Service Delivery Models. In: Oxford Textbook of Palliative Medicine (Cherny N, Fallon K, Portenoy R, et al. eds.) Oxford University Press: Oxford, UK; 2021; pp. 1072–1080.
22. Cosimano M. The Role of the Guide in Psychedeilc-Assisted Treatment. In: Handbook of Medical Hallucinogens. (Grob CS, Grigsby J. eds.) The Guilford Press: New York, NY, USA; 2021; pp. 377–394.
23. Center to Advance Palliative Care. About the Center to Advance Palliative Care. Available from: https://www.capc.org/about/capc/ [Last accessed: April 12, 2023].
24. Smelser N. Social Movement: Encyclopaedia Britannica; 2022. Available from: https://www.britannica.com/topic/social-movement [Last accessed: April 12, 2023].
25. Schwarz-Plaschg C. Socio-psychedelic imaginaries: Envisioning and building legal psychedelic worlds in the United States. Eur J Futures Res 2022;10(1):10; doi: 10.1186/s40309-022-00199-2
26. Center to Advance Palliative Care. Marketing and Messaging Palliative Care, 2022. Available from: https://www.capc.org/toolkits/marketing-and-messaging-palliative-care/ [Last accessed: April 12, 2023].
27. Beaussant Y, Tulsky J, Guérin B, et al. Mapping an agenda for psychedelic-assisted therapy research in patients with serious illness. J Palliat Med 2021;24(11):1657–1666; doi: 10.1089/jpm.2020.0764
28. Back AL. What psilocybin taught me, one year later. J Palliat Med 2020;23(8):1130–1131; doi: 10.1089/jpm.2020.0018
29. von Gunten C, Campbell M, Higginson I, et al. Special series: Psychological elements of palliative care. J Palliat Med 2021.
30. National Coalition for Hospice and Palliative Care. Clinical Practice Guidelines for Quality Palliative Care, 4th edition. Richmond, VA; 2018. Available from: https://www.nationalcoalitionhpc.org/wp-content/uploads/2018/10/NCHPC-NCPGuidelines_4thED_web_FINAL.pdf [Last accessed: April 12, 2023].
31. Huggard P, Huggard J. Self-Care and Palliative Care. In: Textbook of Palliative Care. (MacLeod R, Van den Block L. eds.) Springer, Cham: New York, NY, USA; 2010; pp. 617–632.