



Commentary

Policy pathways and historical insights: Canada's evolving approach to psychedelic access for end-of-life distress

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ABSTRACT

Canada's evolving attitudes toward psychedelic interventions in palliative and end-of-life care reflect a departure from historically prohibitionist policies and an emerging recognition of their therapeutic potential for individuals facing end-of-life distress. This shift parallels international regulatory developments in jurisdictions such as the United States, Australia and parts of Europe, where cautious policy liberalization has signaled growing acceptance of psychedelics within clinical contexts. Canada is also a relevant case because of its formative role in the development of modern palliative care, its contemporary frameworks emphasizing holistic approaches to suffering at the end of life, and its experience with medical assistance in dying, all of which have shaped national conversations about suffering, autonomy, and end-of-life care. Additionally, Canada's distinctive historical approach to drug regulation—marked by federal flexibility, mechanisms for compassionate access, and responsiveness to patient advocacy—combined with rising public demand and incremental provincial changes, may uniquely position the country along a transitional pathway toward clinical integration of psychedelics in palliative care. At the same time, Canadian drug policy remains heterogeneous across substances and provinces, underscoring the political contingency of reform. Within this dynamic landscape, Canada's psychedelic drug policy trajectory aligns with broader international trends toward cautious medicalization and regulated access to psychedelic therapies, while also offering an instructive case for how end-of-life frameworks and federal-provincial governance shape policy development.

Introduction

The national conversation in Canada surrounding end-of-life care has evolved considerably in recent years, reflecting broader societal concerns about what constitutes good quality of dying and death amidst an aging population and post-pandemic consciousness about mortality (Office of the Chief Science Advisor of Canada, 2022). Within this context, therapeutic psychedelic interventions (TPIs) have emerged as a topic of clinical and policy interest, driven in part by increasing public demand for options to alleviate refractory psychological suffering at the end of life (Nanos Research, 2021; Plourde et al., 2024). The term TPIs was selected because it captures the broader intervention context in which psychedelics may be used. This includes not only the psychedelic

substance itself, but also elements such as set and setting, music, and psychological support, while remaining broad enough to include models in which the psychedelic substance alone is the primary therapeutic component.

Psychedelics were subject to prohibitionist drug policies firmly established through regulatory frameworks of the 1970s and 1980s, propagating a fear-based approach to public health information, emphasizing the negative consequences of use with little attention to medicinal benefits (Barber, 2018; Dyck, 2011). Over the past two decades, there has been a resurgence of scientific inquiry, coupled with shifting professional and societal attitudes about the therapeutic potential of psychedelic interventions in palliative care (Grob et al., 2011; Jones, 2020; Nanos Research, 2021; Plourde et al., 2024). Clinical trials

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of TPIs in patients with cancer or life-threatening illnesses have reported reductions in anxiety, depression and existential distress (e.g., Griffiths et al., 2016; Ross et al., 2016; Grob et al., 2011). Reviews and meta-analyses similarly suggest clinically meaningful improvements in psychological distress among patients with serious or life-threatening illness, while emphasizing the need for larger controlled trials and more diverse samples (Sicignano et al., 2023; Vargas et al., 2020; Yu et al., 2021). The issue of access to TPIs at end of life has entered the public agenda, drawing government attention and prompting discussions of policy changes to better meet patient needs. Together, historical developments and policy contexts position Canada as a useful case for examining how TPI access for end-of-life distress has emerged through interaction of federal compassionate access mechanisms, patient advocacy, evolving drug policy, Medical Assistance in Dying (MAID) regulation, and palliative care developments.

Brief history of therapeutic psychedelic interventions in Canada

Psychedelic substances have long been used across various cultures for healing, ceremonial, and spiritual purposes (Muraresku, 2020). Many Indigenous communities and syncretic religions in the Americas have long incorporated psychedelic plants into their ritual practices (Labate & Cavnar, 2018). While these knowledge traditions exist outside Western biomedical paradigms, they have increasingly informed contemporary discussions regarding therapeutic applications (Dames et al., 2025; Hauskeller et al., 2023; Urrutia et al., 2023).

The early- to mid-20th century marked the discovery of synthetic psychedelics including lysergic-acid diethylamide (LSD), N,N-dipropyltryptamine (DPT), ketamine, and 3,4-methylenedioxymethamphetamine (MDMA, also known as ecstasy). These substances drew attention for their psychoactive effects and potential to treat mental health-related conditions, namely end-of-life distress, refractory depression, and substance use disorders. Canada played a formative role during this early scientific period. Beginning in the 1950s, investigators in British Columbia, Ontario, and Saskatchewan focused on mescaline and LSD therapy, contributing to therapeutic models and theoretical understandings (Dyck, 2008; Grinspoon & Bakalar, 1979; Oram, 2018).

Although early research on psychedelic substances generated considerable clinical and scientific interest, methodological limitations, rising sociopolitical concern, and the cultural diffusion of psychedelics beyond clinical settings (Hartogsohn, 2020; Wesson, 2011) precipitated a regulatory backlash within an increasingly evidence-oriented regulatory environment (Bonson, 2018; Tupper et al., 2015; Rucker et al., 2018). Together these factors contributed to increased regulatory scrutiny and a limitation on research, including in Canada (Dyck, 2008; Hartogsohn, 2020). By the late 1960's to the 1970s, research was curtailed by a confluence of medical, cultural and political factors that intensified societal fears of psychedelics as morally corruptible and socially destabilizing substances (Dyck, 2015). Following the UN Convention on Psychotropic Substances, which placed psychedelics under international control prohibiting their use, Canadian drug policy and regulatory frameworks increasingly restricted non-authorized use and research involving these substances (Dyck, 2008; Dyck, 2012; Dyck, 2015; Hall & Farrell, 2021). These developments contributed to a regulatory environment in Canada that limited psychedelic research for several decades and continue to influence research and contemporary regulatory debates.

A resurgence of psychedelic research began in the early 2000s, including studies conducted across Canadian cities such as Montreal, Calgary, Ottawa, Kingston and Toronto and in other places in the world (Hadar et al., 2023). At this stage, developments were confined to research settings, with pathways for therapeutic access confined to clinical trials. This renewed scientific agenda, largely focused on psilocybin- and MDMA-assisted therapies, has been accompanied by improving methodological rigour, discussions on ethical frameworks, and a growing recognition of the unmet needs of patients with

psychological suffering at end of life. This resurgence of research has developed within a Canadian policy environment increasingly attentive to federal compassionate access, thereby setting the stage for Canada's contemporary reconsideration of TPIs.

The evolving federal regulatory landscape of TPIs for end-of-life distress in Canada

The contemporary regulatory environment governing TPIs in Canada must be understood alongside the country's approach to palliative and end-of-life care. The term palliative care was introduced in Canada in 1975 (Williams et al., 2010) to describe a medical specialty and the services that were made available to patients at the end of life (Fowler & Hammer, 2013; Williams et al., 2010). During this period, there was increased attention from clinicians in the fields of oncology and psychiatry to the problem of psycho-spiritual distress at the end-of-life (Clark, 2007; Kübler-Ross, 1969; Spiegel & Yalom, 1978), contributing to the later development of manualized psychotherapies (Saracino et al., 2019). Notably, earlier psychedelic research conducted from the 1960s to the early 1980s also examine TPIs for end-of-life distress, often emphasizing mystical experiences, which were thought to be a key mechanism (Grof et al., 1973; Kurland et al., 1972; Richards et al., 1972; Richards, 1978; Saracino et al., 2019).

Decades later, a defining shift in Canadian policy concerning dying and death was the passage of Bill C-14 in 2016, which legalized MAID. MAID marked a significant change in Canadian health policy by formally recognizing enduring and intolerable psychological suffering, in the context of a grievous and irremediable medical condition, as a legitimate basis for requesting medically assisted death. Initially, eligibility was limited to individuals whose natural death was reasonably foreseeable. Subsequent legislative changes, introduced through Bill C-7, created a two-track structure: one for persons whose natural death is reasonably foreseeable and another for persons whose natural death is not reasonably foreseeable (Department of Justice Canada, 2021). The expansion of MAID to persons whose sole underlying condition is a mental illness has remained politically, clinically, and ethically contested (Angus Reid Institute, 2024; Bergen, 2024; Kirkup, 2026; Tasker, 2024), and its implementation has been delayed until March 17, 2027.

MAID is relevant to the policy history of TPIs not because the two interventions are clinically, ethically, or legally equivalent, but because the legalization of MAID shaped Canadian health policy by formally recognizing the relief of end-of-life distress as a legitimate objective of medical care. This comparison also highlights a current tension in Canadian end-of-life policy: patients may have access to a legally established and institutionally supported pathway to an irreversible intervention—MAID, while access to potentially distress-alleviating and quality-of-life improving TPIs remains comparatively limited, case-by-case and administratively burdensome.

The comparison between MAID and TPIs illustrates how different policy trajectories have shaped access to interventions that address suffering related to the end of life. The contrast between established access to MAID and the much more limited access to TPIs for end-of-life distress may partly reflect the two different regulatory ecosystems governing each intervention, namely, from a healthcare systems framework vs. a controlled substances framework. MAID emerged through constitutional and rights-based legal reform focused on autonomy, dignity, liberty and security of the person, and was embedded in federal legislation as a response to a specific problem. Although access to TPIs has drawn on similar rights-based arguments, they have not yet achieved the same level of recognition. Instead, psychedelic substances are governed through controlled-substance regulation, and some are accessible through a federal exceptional access pathway—the SAP. They also carry a historical association with drug prohibition and recreational use, which may contribute to greater regulatory caution.

As with MAID, which expanded beyond its initial end-of-life framing to include persons whose natural death is not reasonably foreseeable,

access to TPIs for end-of-life distress could prompt questions about whether their use might similarly expand beyond end-of-life contexts. This parallel is particularly relevant given ongoing debate about MAID eligibility for those persons whose sole underlying condition is mental illness. In the case of TPIs, similar questions could arise about access for other populations including major depressive disorder, generalized anxiety disorder, post-traumatic stress disorder (PTSD), adjustment disorder, and substance use disorders. Such expansion raises ethical questions about how psychological suffering is defined, compared, and prioritized, particularly when access is granted to some conditions but limited or excluded for others. These questions also intersect with broader debates about legalization and non-medical, recreational, or wellness uses.

Since the legalization of MAID, Canada's research, regulatory, and policy landscape concerning TPIs has evolved with a particular focus on the treatment of end-of-life distress (see Table 1). Contemporary federally authorized medicinal access to psilocybin first emerged in this context. In 2020, four terminally ill Canadians were granted a subsection 56(1) exemption under the *Controlled Drugs and Substances Act (CDSA)*, permitting them to possess psilocybin-containing mushrooms for the treatment of end-of-life distress (Jones, 2020). Shortly thereafter, exemptions were extended to 19 Canadian health professionals to allow experiential training intended to support competent clinical delivery (Dubinski, 2020). These decisions signaled an important, nonetheless cautious, federal willingness to accommodate compassionate access.

Reliance on case-by-case ministerial exemptions revealed its limitations. By the end of 2021, the Federal Minister of Health stopped granting subsection 56(1) exemptions under the *CDSA* to individual patients and therapists. This decision was likely influenced by the lack of regulatory oversight regarding the production, quality, and dose of psilocybin mushrooms. In practice, those with an exemption were required to cultivate the psilocybin mushrooms themselves or resort to the underground market.

Regulatory amendments introduced in January 2022 changed this landscape. Revisions to the *Food and Drug Regulations* enabled prescribers to access psilocybin for treatment resistant major depressive disorder and end-of-life distress and MDMA for PTSD through the Special Access Program (SAP), on a case-by-case basis. A single case of psilocybin for cluster headache has been authorized (Kirkey, 2024). By situating psychedelics within an established medical pathway, the SAP provided a more structured mechanism, balancing therapeutic use with federal oversight (Health Canada, 2023). Case-by-case approval of psilocybin for end-of-life distress via the SAP has since slowed in Canada since 2022 (Psychedelic Association of Canada, 2025). Emerging provincial initiatives, including reforms in Quebec and Alberta, further suggest an interest in exploring integration within healthcare systems.

Public demand for TPIs has continued to intensify, accompanied by increasing governmental recognition of a policy problem centred on how best to regulate access while safeguarding patient safety. Canadians are seeking broader and easier access to TPIs from the federal government (see Table 1) (Baig, 2022; Donnini, 2023; Fraser, 2023; Peesker, 2023; Psychedelics Canada, 2025; TheraPsil, 2024).

These calls for greater access have emerged within a broader Canadian drug policy landscape in which a general ethos of support for harm reduction principles has, at times, influenced policy development and regulatory experimentation, (Abidi et al., 2020; Hyshka et al., 2019; Smye et al., 2011), and somewhat progressive approaches to drug policy (Tunney, 2020). Notably, in 2023 British Columbia trialed a three-year pilot project to decriminalize possession of small amounts of non-prescribed opioids, cocaine/crack cocaine, methamphetamine and MDMA (ecstasy), providing a recent example of regulatory experimentation within this broader paradigm (British Columbia Public Service, 2024). However, in January 2026, the province announced it would not renew the federal exemption, thereby reinstating criminal penalties for personal possession (British Columbia Centre for Disease Control, 2026).

Table 1

Timeline of landmark events concerning psychedelics and end-of-life care.

Year	Canadian Developments
1950s	Research with psychedelics begins in Canada.
1956	The term "psychedelic" is coined by Humphrey Osmond and Aldous Huxley.
1975	The term "palliative care" is coined by Dr. Balfour Mount in Québec.
1985	Canada's first free-standing hospice is established.
1996	The <i>Controlled Drugs and Substances Act (CDSA)</i> is passed, implementing three United Nations treaties: Single Convention on Narcotic Drugs, Convention on Psychotropic Substances, and United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.
1999	Severely ill patients requested and received access to cannabis through subsection 56(1) of the <i>CDSA</i> .
2000	The Senate report on quality end-of-life care establishes that every Canadian is entitled to a death that is "as free as possible from physical, emotional, psychosocial, and spiritual distress," making quality end-of-life care a right for all Canadians.
2001	The Marihuana Medical Access Regulations (MMAR) allows authorized individuals to access medical cannabis by growing their own, designating a producer, or purchasing from Health Canada.
2013	The Marihuana for Medical Purposes Regulations (MMPR) allows individuals with medical needs to access quality-controlled dried marijuana produced by commercial industry.
2016	Bill C-14 is passed, enabling access to MAID for enduring and intolerable psychological and/or physical suffering associated with a foreseeable natural death.
2016	The Access to Cannabis for Medical Purposes Regulations (ACMPR) replace the MMPR allowing access for individuals to grow their own cannabis, through licensed producers, and increasing the type of cannabis products legally available.
2018	The <i>Cannabis Act</i> legalizes recreational cannabis.
2020	Access to psilocybin-containing mushrooms through a one-year subsection 56(1) under the <i>CDSA</i> is granted to four Canadians for the treatment of end-of-life distress.
2021	Bill C-7 receives Royal Assent, no longer requiring a person's death to be reasonably foreseeable to access MAID.
2021	19 Canadian health professionals are granted a subsection 56(1) of the <i>CDSA</i> to possess and use psilocybin as part of their psilocybin-assisted training.
2021	By the end of 2021 the Federal Minister of Health no longer grants subsection 56(1) of the <i>CDSA</i> to individual patients.
2022	Canadian health professionals' request for psilocybin through a subsection 56(1) of the <i>CDSA</i> is rejected by Health Canada.
2022	Case-by-case access to MDMA for PTSD and psilocybin for end-of-life distress and treatment-resistant depression is granted through the SAP with medical supervision.
2022	Eight Canadians file a challenge under the <i>Canadian Charter of Rights and Freedoms</i> against the Government of Canada and the Minister of Health to increase access to psilocybin therapy.
2022	A recommendation is given before the Special Joint Committee on MAID to improve access to psilocybin therapies for alleviating existential suffering for both research purposes and for individual use as part of palliative care supports.
2022	Québec's provincial health insurance, the Régie de l'assurance maladie du Québec, is the first in Canada to reimburse family physicians for the costs of their services in providing psilocybin-assisted therapy.
2023	The issue of access to MDMA and psilocybin-assisted therapy for those with a mental illness who may eventually qualify for MAID is brought up during a Debate of the Senate.
2023	The Federal Minister of Mental Health and Addictions announces a \$3 million investment through the Canadian Institutes of Health Research (CIHR) to fund three clinical trials on psilocybin-assisted psychotherapy in different populations.
2023	Alberta's government introduces an amendment to the <i>Mental Health Services Protection Regulation</i> creating requirements for the provision of psychedelic-assisted therapy, including ketamine.
2024	Alberta Blue Cross becomes the first third-party insurance provider to include psychedelic-assisted therapies as part of its coverage options.
2024	Bill C-62 comes into effect, temporarily postponing the MAID eligibility date for persons suffering solely from a mental illness until March 17, 2027.
2024	Health Canada approved psilocybin treatment for cluster headaches through the SAP and granted a subsection 56(1) exemption of the <i>CDSA</i> for individual possession without medical supervision.
2025	The Canadian Cancer Society funds the Canadian Network for Psychedelic-Assisted Cancer Therapy through their Breakthrough Team Grant competition to understand the efficacy of psychedelic-assisted cancer therapy.

At the same time, this broader policy landscape has been accompanied by provincial policy developments that emphasize involuntary treatment. Both Alberta and British Columbia are advancing measures that expand involuntary treatment for those with substance use disorders. *Alberta's 2025 Compassionate Intervention Act* legalized provisions for enforced addiction treatment (Alberta Medical Association, 2025; Hong, 2022), while British Columbia has introduced amendments to its *Mental Health Act* to strengthen involuntary care for those with substance use disorders (Eby, 2025). These developments echo earlier efforts, such as British Columbia's 1978 *Heroin Treatment Act*, which was ultimately declared unconstitutional (Fischer et al., 2025).

Harm-reduction measures have also faced retrenchment. Alberta has significantly constrained safer supply programs (Wilson et al., 2024), Ontario has limited their geographic expansion through zoning mechanisms (Government of Ontario, 2024), and federal support for safer supply initiatives concluded in March 2026 (McCarthy, 2023). Meanwhile, Ontario has broadened retail access to alcohol despite longstanding evidence linking increased availability to higher rates of alcohol-related morbidity and mortality (Centre for Addiction and Mental Health, 2023; Canadian Public Health Association, 2023). These developments illustrate the patchwork nature of Canadian drug policy, marked by the coexistence of harm-reduction and more restrictive or coercive approaches. Reform efforts vary by province, substance, and political context, reflecting a landscape characterized less by uniform progression than by iterative experimentation, politically driven policy-making, and divergence.

This broader context matters for TPIs because governments do not evaluate controlled substances solely on the basis of pharmacological risk. This point is especially relevant for psychedelics, which occupy an ambiguous policy position: they are being studied as therapeutic interventions yet remain shaped by a history of prohibition and patterns of recreational use. Policies related to substance use are relevant to TPIs not because psychedelics are equivalent to opioids or other higher-risk substances, but because their medical integration is shaped by controlled-substance governance.

Canada's experience with medical cannabis offers an additional policy reference. In 1999, severely ill patients requested and received access to medical cannabis through a subsection 56(1) exemption under the *CDSA* granted by the Federal Minister of Health (Government of Canada, 2016). This marked the beginning of regulatory changes enabling access to medical cannabis, which was eventually followed by the legalization of recreational cannabis (Cox, 2018). While differences distinguish cannabis from psychedelics such as psilocybin including their patterns of use and clinical risk profiles, both substances share a socio-cultural and political history as natural substances with emerging therapeutic value. Each has also been influenced by various Indigenous healing traditions, and their trajectories have been shaped by grassroots patient advocacy, evolving therapeutic narratives, and gradual movement from prohibition toward regulated medical access. Both substances faced restrictions through international and national controls in the early 20th century (International Narcotics Control Board, 2023) after increased recreational use in the 1960s and 70s. While cannabis has since experienced more widespread legalization and acceptance, psilocybin is still in the early stages of regulatory change and medical acceptance. Legal access for medicinal purposes was first granted to cannabis through a subsection 56(1) exemption under the *CDSA* (Government of Canada, 2016) and later to psilocybin (Jones, 2020) through the same exemption mechanism.

Although legal medicinal access to cannabis and psilocybin was initially facilitated through the same exemption pathway, their regulatory trajectories have since diverged in meaningful ways. Whereas access to medical cannabis expanded through the implementation of cannabis regulations beginning in 2001 (see Table 1) (Shim et al., 2023), psilocybin and MDMA remain accessible only through limited mechanisms, namely the SAP and clinical trials. Contemporary psychedelic policy is unfolding within a more cautious, tightly regulated climate.

Taken altogether, the differing regulatory approaches to psilocybin and cannabis, Canada's history of pioneering palliative care (Williams et al., 2010), early leadership in psychedelic research (Dyck, 2012), experience with MAID regulation, and a willingness to experiment with controlled drug regulation and access mechanisms suggests a policy landscape shaped by historical and structural conditions that may be conducive to advancing TPIs for end-of-life distress.

Situating Canada within an emerging, fragmented global policy landscape

Policy developments across North America, Oceania, Europe and parts of Latin America reflect a growing international shift toward more nuanced, evidence-based understandings of TPIs. However, these developments remain highly heterogeneous, with regulatory pathways shaped by jurisdiction-specific legal structures, health-system arrangements, political priorities, and cultural conditions. The global landscape is best understood as a set of distinct regulatory models rather than a convergent pathway, providing a comparative backdrop for situating Canada's emerging approach. Four broad models can be identified: decentralized subnational service and enforcement-reform models; nationally authorized medical prescribing models; exceptional or compassionate-access programs; and culturally or market-driven grey-zone governance (see Table 2).

In the U.S., reform has largely occurred through decentralized subnational initiatives. Oregon became the first state to authorize regulated adult psilocybin services for mental health concerns including end-of-life issues in 2020, followed by Colorado's authorization of regulated natural medicine centres (Psychedelic Alpha, 2023). These models differ from conventional medical prescribing because access is not necessarily diagnosis-specific or embedded within a prescriber-mediated healthcare pathway. Rather, the models allow adults to access facilitated TPIs under state-level rules. Early implementation has proven uneven, with approximately one-third of Oregon service centres reportedly closing (Jacobs, 2026). Other states have moved toward more explicitly therapeutic or medicalized models. Utah enacted a narrow health-system pilot framework authorizing certain healthcare systems to develop treatment programs involving psilocybin or MDMA under clinical supervision, although implementation appears limited or uncertain (UtahLegislature, 2024). New Mexico enacted a regulated medical psilocybin program for qualifying conditions including treatment-resistant depression, PTSD, substance use disorders, and end-of-life care, with the program scheduled for implementation by December 31, 2026 (New Mexico Department of Health, n.d.). Several states have moved toward deprioritizing enforcement of the possession and use of psychedelics (Psychedelic Alpha, n.d.). These developments reflect a decentralized model that has encouraged regulatory innovation but produced variable oversight and a largely commercial service landscape.

More recently, U.S. federal policy has signaled the beginning of a shift toward a growing openness toward TPIs. In April 2026, President Donald Trump signed an executive order directing the Food and Drug Administration (FDA) to accelerate research, review and approval pathways for TPIs for mental illness mainly focusing on psilocybin, methylone, and noribogaine/ibogaine-related compounds (Reddick, 2026; U.S. Food and Drug Administration, 2026). Unlike Canada's existing SAP pathway, this federal development remains oriented primarily toward research and drug approval rather than case-by-case clinical access.

A second model is nationally authorized medical prescribing. Australia is one of the clearest examples. In July 2023, the Therapeutic Goods Administration authorized specially trained psychiatrists to prescribe MDMA and psilocybin for treatment-resistant depression and PTSD (Therapeutic Goods Administration, 2024), under strict controls. Compared with Canada, Australia's model is more centralized, indication-specific, and specialist-gated, whereas Canada's SAP pathway

Table 2
International approaches to accessing therapeutic psychedelic interventions.

Regulatory/ Governance Model	Jurisdiction	Access Pathway	Type(s) of Psychedelic
Exceptional or compassionate- access program	Canada	Prescriber-mediated, case-by-case federal authorization through the SAP, with provincial implementation shaping delivery	Psilocybin and MDMA
Decentralized subnational service and enforcement- reform model	USA	State-level service centres, decriminalization initiatives, and emerging federal interest in research and drug development pathways	Psilocybin and MDMA
Nationally authorized medical prescribing	Australia	Centralized federal authorization, allowing psychiatrists to prescribe for specific clinical indications, delivered largely through private- pay specialist psychiatric care	Psilocybin and MDMA
Nationally authorized medical prescribing	New Zealand	Highly limited specialist prescriber access	Psilocybin
Nationally authorized medical prescribing	Czech Republic	Legislated medical model allowing psilocybin in specialized clinical settings involving psychiatrists and psychotherapy	Psilocybin
Exceptional or compassionate- access program	Switzerland	Physician application for exceptional authorization; decentralized but federally regulated	LSD, psilocybin, and MDMA
Exceptional or compassionate- access program	Germany	Case-by-case compassionate-use authorization for treatment-resistant depression in controlled settings	Psilocybin
Culturally or market-driven grey-zone governance	Netherlands	Commercial and non- medical access through permitted sclerotia/ truffle products	Psilocybin- containing truffles/ sclerotia
Culturally or market-driven grey-zone governance	Costa Rica	Retreat-based and market-driven access, often operating in a legal grey zone	Ayahuasca, San Pedro cactus (contains mescaline)
Culturally or market-driven grey-zone governance	Peru	Ceremonial, Indigenous, retreat and tourism- based access	Ayahuasca, San Pedro cactus (contains mescaline)
Culturally or market-driven grey-zone governance	Brazil	Ceremonial, Indigenous, retreat and tourism- based access	Ayahuasca

is broader in principle but is case-by-case and dependent on individual prescriber requests and bureaucrat approval. Australia's approach is largely private-pay, with substantial costs limiting uptake, and the number of patients treated remains limited. New Zealand has adopted a more limited version of specialist prescriber access. In 2025, Medsafe granted one psychiatrist approval to prescribe psilocybin for treatment-resistant depression (Ministry of Health [New Zealand], 2025), while psilocybin otherwise remains an unapproved medicine. The Czech Republic has moved further toward legislated medical use, with national reforms permitting psychiatrists to provide psilocybin with psychotherapy for PTSD, depression, including cancer-related depression, and substance use disorders (Madero et al., 2026).

Compared with Canada, the Czech model appears more explicitly oriented toward formal clinical prescribing for defined indications, whereas Canada remains in a more transitional phase, relying on SAP access, provincial policy experimentation (e.g., Alberta's psychedelic drug treatment regulations), and emerging clinical-research networks.

A third model involves exceptional-access or compassionate-use programs. Switzerland has operated a limited medical-use framework since 2014, allowing authorized physicians to treat selected patients with LSD, psilocybin, and MDMA, under Federal Office of Public Health authorization (Madero et al., 2026). Switzerland is perhaps the closest comparator to Canada because both jurisdictions rely on case-by-case authorization for otherwise prohibited psychedelics. However, Switzerland differs in having developed a limited medical-use framework, with more routinized clinical practices and specialized services. Canada's pathway remains more federally-provincially mediated whereby Health Canada authorizes access to the substance through the SAP while provincial regulations and individual clinicians shape delivery. Germany has adopted a narrower compassionate-use approach through a nationally approved psilocybin Compassionate Use Programme for adults with treatment-resistant depression who have not responded to standard therapies and are ineligible for clinical trials (Central Institute of Mental Health, 2025; Gründer et al., 2026). Eligibility is established by a psychiatrist, as one of the participating clinical centres. Treatment costs are largely covered by public health insurance (Gründer et al., 2026). Compared with Canada, Germany's model is more restricted by indication and setting, while Canada's SAP is potentially broader but not developed as a structured clinical service model.

Elsewhere, psychedelic governance occupies legal grey zones shaped by cultural recognition and market demand, rather than formal healthcare delivery. The Netherlands permits the sclerotia of psilocybe mushrooms while prohibiting ayahuasca (University of California, Berkeley, Center for the Science of Psychedelics, 2024). Costa Rica classifies DMT (the main psychoactive ingredient of ayahuasca) as a Schedule I drug but is home to numerous ayahuasca retreat centres in a country experiencing a booming psychedelic tourism industry (University of California, Berkeley, Center for the Science of Psychedelics, 2024). Both in Peru, the initial epicentre of ayahuasca tourism (BBC, 2026), and in Brazil ayahuasca is legalized due to its designation as a cultural heritage (Fotiou, 2016). These jurisdictions differ markedly from Canada because access is not primarily organized around clinical indication, prescription, professional oversight, or integration into healthcare systems.

Viewed comparatively, Canada aligns most closely with the exceptional-access (Health Canada, 2023) and medically governed models (Government of Alberta, 2026), particularly Switzerland's limited medical-use framework. However, Canada's pathway remains distinct. Unlike U.S. state-level service models or grey zone tourism markets, Canada's trajectory is placed within healthcare governance. Unlike Australia's nationally authorized prescribing model or the Czech Republic's legislated medical model, Canada has not yet created a routine indication-specific prescribing framework that includes a therapeutic model for TPIs. Instead, Canada's contemporary pathway began with federally authorized access to psilocybin mushrooms for end-of-life distress, when four terminally ill patients received subsection 56(1) exemptions under the CDSA (Jones, 2020). This origin point is significant: access to psilocybin in Canada first emerged not through psychiatric prescribing or commercial services models, but through compassionate access for people facing end-of-life suffering. Since then, access to TPIs has developed incrementally through a federal mechanism, specifically the SAP (Health Canada, 2022), alongside emerging provincial policy initiatives (Government of Alberta, 2026; Herrington, 2022; CNW Group, 2024) and growing clinical-research networks (ATMA Journey Centers Inc., 2026; Canadian Cancer Society, 2025).

Implications for Canadian health policy

The global landscape is best characterized by fragmentation spanning decentralized state-level service models, cautious medical authorization, exceptional-access pathways, and ceremony or tourism-based markets. Against this backdrop, Canada appears to be pursuing a medicalized pathway that situates psychedelic therapies within federally regulated mechanisms namely the SAP while emphasizing continued research investment. At present, however, the SAP remains a case-by-case access mechanism rather than a clinically based prescribing pathway. Prescribers cannot prescribe psilocybin or MDMA as approved therapies; they must apply to Health Canada, and access depends on federal authorization. As demand grows, the SAP may function less as a permanent solution than as a transitional policy instrument, raising questions about whether more durable regulatory structures will be required to support safe and scalable access.

Canada may be particularly well-positioned to navigate this policy challenge. Its publicly funded health system, historical leadership in palliative care, federal experience with exceptional or compassionate-access pathways, provincial regulatory initiatives, willingness to explore less punitive drug regulation, and a policy ethic that recognizes the clinical significance of psychological suffering at the end of life, collectively create conditions conducive to responsible integration. These features suggest that Canada has institutional and ethical resources that could allow TPIs to be incorporated within healthcare governance, rather than developing primarily through commercial or informal access models.

Several priorities will shape whether this integration can occur responsibly. Consistent with Canadian stakeholder concerns identified by Kratina et al. (2026), these include addressing a limited and evolving evidence base regarding safety, effectiveness, and the comparable effects of different models of treatment; clarifying eligibility criteria and evidentiary thresholds; reducing patient and prescriber burden with access pathways; ensuring equitable access across geographic and socioeconomic contexts; developing competency-based training standards in collaboration with professional bodies; sustaining research investment; and building sustainable system capacity, including determining the role of public and private insurance in financing access. Future policy development will also need to mitigate risks associated with underground access and commercial influence. Meaningful engagement with Indigenous communities whose healing traditions have long incorporated these medicines will be essential to support culturally informed, ethically grounded policy development.

The challenge for Canadian policymakers is no longer whether TPIs warrant consideration, but how to govern their integration in ways that balance innovation with clinical rigour, equity, and public and clinician trust. Canada's next policy steps will shape its domestic trajectory, and may offer important lessons for other jurisdictions seeking to integrate TPIs into end-of-life care.

CRedit authorship contribution statement

Sarah Kratina: Writing – review & editing, Writing – original draft, Visualization, Project administration, Methodology, Investigation, Formal analysis, Conceptualization. **Robert Schwartz:** Writing – review & editing, Validation. **Carol Strike:** Writing – review & editing, Validation. **Chris Lo:** Writing – review & editing, Validation, Supervision. **Brian Rush:** Writing – review & editing, Validation, Supervision.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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