Psilocybin

By Drug Science,
Mind Medicine Australia

With Support from
Norrsken Mind

Part I - History and Law

Drug Science was formed by a committee of scientists with a passionate belief that the pursuit of knowledge should remain free of all political and commercial interest.

Founded in 2010 by Professor David Nutt, following his removal from his post as Chair of the Advisory Council on the Misuse of Drugs, Drug Science is the only completely independent, science-led drugs charity, uniquely bringing together leading drugs experts from a wide range of specialisms to carry out ground-breaking research into drug harms and effects.

The Drug Science mission is to provide an evidence base free from political or commercial influence, creating the foundation for sensible and effective drug laws. Equipping the public, media and policy makers with the knowledge and resources to enact positive change.

Drug Science want to see a world where drug control is rational and evidence-based; where drug use is better informed and drug users are understood; where drugs are used to heal not harm.

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Mind Medicine Australia is a registered charity working to alleviate the suffering and suicides caused by mental illness by expanding treatment options through the safe, clinical use of psychedelic-assisted therapies to treat depression, trauma, addictions and other intractable conditions. MMA's wholly clinical focus includes building a national ecosystem encompassing professional development for health practitioners through the world-leading Certificate in Psychedelic-Assisted Therapies (CPAT)™, patient access pathways, medicine supplies, regulatory and research advancements, clinical rollouts and widespread awareness and education.

MMA made global history through their successful rescheduling applications for psilocybin and MDMA making Australia the first nation in the world to reschedule these medicines for clinical use in 2023. You can learn more about our key achievements on our website.

@MindMedicineAU **/MindMedicineAU**

Norrsken Mind is a non-profit foundation dedicated to advancing psychedelic science. The foundation funds high-quality, independent research into the therapeutic potential of psychedelics for mental health disorders, along with non-profit initiatives to lay the foundation for a future integration of these treatments into healthcare.

Beyond research funding, Norrsken Mind promotes public education, stakeholder engagement, and policy dialogue. By offering grants and facilitating partnerships, Norrsken Mind aims to create the necessary conditions for psychedelic treatments to be rigorously studied, responsibly implemented, and ultimately accessible to patients in need.

Norrsken Mind actively works to mobilize philanthropic capital for psychedelic science. The foundation is funded through donations from committed benefactors and its affiliation with Norrsken Foundation.

Drug Science has received grant support from Norrsken Mind, which supported the development of this educational material.

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What is Psilocybin?

Psilocybin is an indole alkaloid, chemically similar to the neurotransmitter serotonin (5-HT)

Psilocybin occurs naturally in up to 100 species of mushrooms belonging to the genus *Psilocybe*.

Psilocybe mushrooms occur widely in natural habitats, but some species are also amenable to cultivation.

Psilocybin can also be synthesised chemically, or via biochemical synthesis, both in vivo and in vitro.

Psilocybin is easily converted both chemically and biochemically to the simpler compound, Psilocin.

Pharmacologically, psilocybin is a prodrug of psilocin.

Psilocybin itself is not active.

Psilocin acts to stimulate (is an agonist of) the 5-HT2A receptor.

Psilocybin History

Listen to Drug Science Podcast featuring Dr Andy Letcher on the cultural history of magic mushrooms

The psychotropic effects of Psilocybe mushrooms were largely unknown in the West until the 1950s, despite evidence that they had a long history of indigenous use in Central and South America, and possibly other parts of the world.

Psilocybe mexicana mushrooms were introduced to the West by investment banker and amateur mycologist, **R. Gordon Wasson**, in 1957.

In 1958, a sample of Psilocybe mexicana provided by Wasson enabled **Dr Albert Hofmann** at Sandoz Laboratories to identify and characterise psilocin and psilocybin, after which he developed a method to chemically synthesise psilocybin.

The psychoactive effects were noted by Hofmann to be similar to those of LSD; he and his colleagues surmised that psilocybin could be useful as an adjunct to psychotherapy in certain applications. Consequently, Sandoz produced and commercialised the compound as **"Indocybin".**

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History of Psilocybin Use in the USA

1950-60s

Awareness of psilocybin spread in the West in the late 1950s and accelerated as the psychedelic era took hold in the 1960s

1960

The Harvard professor and later LSD proponent, Dr Timothy Leary, was introduced to Psilocybe mushrooms in Mexico

1960-63s

Leary and his research group, the Harvard Psilocybin Project, studied psilocybin - both formally and informally

1962

Pahnke's Good Friday Experiment demonstrated psilocybin could occasion mystical experiences in a double-blind setting.

Psilocybin saw relatively limited therapeutic use in the USA, as interest in the therapeutic applications of LSD was already established

1971

Psilocybin, along with many other psychedelic compounds, was scheduled through the UN Convention on Psychotropic Substances

Use of Psilocybe mushrooms went underground and continued largely recreationally, but possibly also therapeutically, to the present day

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History of Psilocybin Use in the UK and Australia

Awareness of psychedelics, including psilocybin, spread from the USA to Canada, the UK, Europe and Australasia during the 1960s.

Despite being illegal, wild psilocybe mushroom species were ingested in non-clinical contexts across the West.

To this day, mushroom truffles (the subterranean part of a mushroom), are legal in the Netherlands.

UK

Psilocybe semilanceata grows wildly in the UK and northern Europe

Australia

Psilocybe semilanceata is probably an introduced species in Australasia

Psilocybe subaeruginosa is native to Australasia

Psilocybe cubensis was probably introduced to Australia with the arrival of domestic cattle

Why was Psilocybin banned?

Psilocybin was banned globally primarily for political reasons.

Psilocybin is a "classical psychedelic", grouped with LSD and other psychedelic compounds in the 1960s and classified globally as a drug of abuse.

Ostensibly, psilocybin and other psychedelics were controlled on the basis of risks to physical and mental health. However, there was minimal evidence at the time to support such assertions, and in fact a significant amount of anecdotal evidence - some of which, such as the "strychnine myth", persists to this day - was fabricated by authorities and their affiliates in support of prohibition.

Psychedelics were associated in the 1960s with the counter-culture movement and were seen by the government and other authorities as representing a destabilising influence, hence a threat to the established cultural norms of the time.

The majority of clinical research into psychedelics between 1970 and 2000 was directed towards establishing or supporting the "pathological paradigm" that wanted to “prove” that psychedelics were harmful to justify their ban.

Social Impact of the War on Drugs

Effects on developing economies through economic exploitation & supply reduction efforts

Diversion of resources to law enforcement and prison-industrial complex

Increases in associated crime, social dislocation, mental illness & comorbidity

Increased incarceration rates, particularly in USA, UK, Europe and Australia

Establishment & sustenance of global illicit drug trade, cartels & paramilitary organisations

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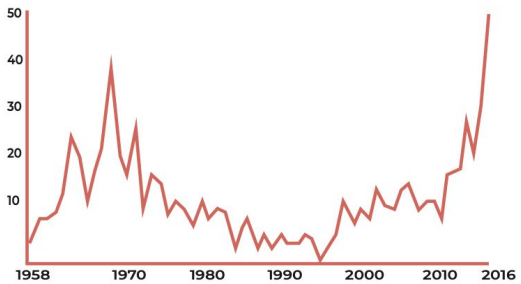
Scientific & Healthcare Impact of the War on Drugs

1. Stigma associated with psilocybin and psychedelic research
2. Limitations on fundamental neurobiology research
3. Limited/no funding for medical treatments
4. Bureaucracy associated with research approval
5. Funding restrictions on biomedical research

The Intervening Years

Number of scientific articles published per year about psilocybin (adopted from Beckley Foundation)



After psychedelics were made illegal in the late early 1970s, research almost stopped.

Little or no published human research into psilocybin was conducted between 1970 and 1990. The small number of published papers were primarily review and commentary articles, or reported on animal studies

In the 1990s, research began again slowly due to the work of some determined scientists.

In 1991, Dr Rick Strassman recommenced clinical research into classical psychedelics with his Phase 1 studies of N,N-dimethyltryptamine (DMT) and psilocybin in healthy volunteers.

The Heffter Institute was established by researchers David Nichols PhD, Charles Grob MD, Dennis McKenna PhD, and colleagues in 1993, to "promote research of the highest scientific quality with classic hallucinogens and related compounds (sometimes called psychedelics).

The Psilocybin Renaissance

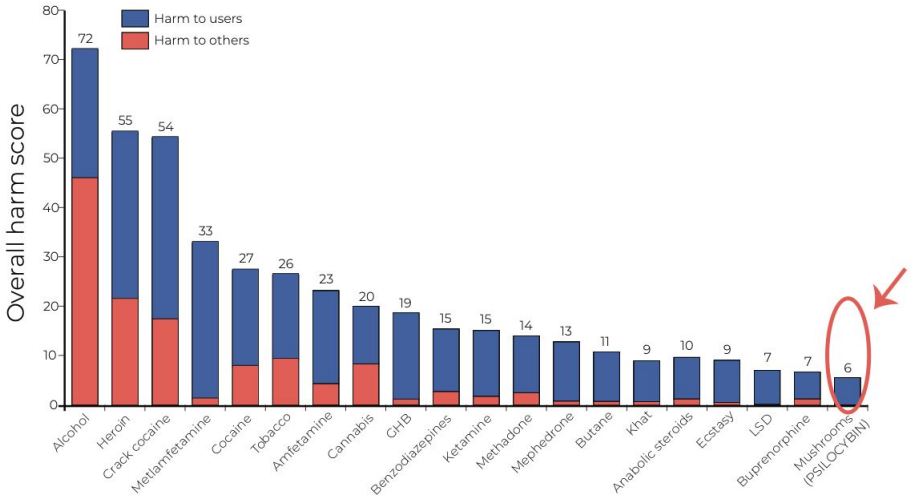
1993	The Heffter Research Institute is founded and begins funding modern human studies of psilocybin, including early safety and dose-finding work at Harbor–UCLA and Johns Hopkins.
2000 2010	Phase 1 trials in healthy volunteers and the first modern Phase 2 studies of psilocybin for anxiety and depression in people with life-threatening cancer restart clinical research after a decades-long pause.
2010s	First human brain-imaging studies of psilocybin at Imperial College (with Beckley Foundation) show decreased default-mode network (DMN) activity and altered brain connectivity, providing the first map of the neural correlates of the psychedelic state, especially the breakdown of the DMN. Open-label and pilot trials explore psilocybin-assisted therapy for treatment-resistant depression, obsessive–compulsive disorder, tobacco and alcohol dependence, and anorexia nervosa.
2018 2019	The US FDA grants Breakthrough Therapy designation to psilocybin-assisted therapy for treatment-resistant depression (COMPASS Pathways, 2018) and for major depressive disorder (Usona Institute, 2019), signalling regulatory recognition and supporting large multicentre phase-2 and phase-3 programmes.
2020s	Multiple phase-2 randomised controlled trials in major depressive disorder and treatment-resistant depression consistently show rapid antidepressant effects of psilocybin plus psychotherapy with generally acceptable short-term safety.
2025	Compass Pathways publishes results from the first Phase 3 trial of a classic psychedelic. Across 32 US clinics and 250+ patients, a single dose of COMP360 beat placebo on depression symptoms at 6 weeks, with no unexpected safety concerns (Compass Pathways, June 2025). Usona Institute finishes enrolling for their own Phase 3 trial of PSIL301 for depression. They're now tracking participants for a full year and preparing to apply to the FDA for approval (Usona Institute, 2025).
Ongoing	Trials are broadening. Compass has a second, larger trial in the US and Europe testing whether two doses work better than one, with results due late 2026. Both Compass and Usona are in active talks with the FDA. Researchers are increasingly asking longer-term questions: how durable are the effects, who responds best, and how does the therapy component interact with the drug itself.

Beyond Depression: Emerging Therapeutic Targets

Early signal-finding studies with psilocybin in conditions other than depression have led to a growing number of structured clinical trials exploring its broader therapeutic potential.

End-of-life distress	Double-blind RCTs in patients with life-threatening cancer show that one high-dose psilocybin session with psychotherapy can produce rapid and sustained reductions in depression and anxiety associated with existential distress (Griffiths et al., 2016; Ross et al., 2016). Newer Phase 2 studies are testing more scalable models e.g., group-therapy and palliative-care adaptations.
Substance use disorders	Building on promising pilot work in tobacco and alcohol dependence, more rigorous phase 2 trials are now underway for alcohol use disorder, nicotine dependence and other substance-related conditions, typically combining supervised psilocybin sessions with structured psychotherapeutic support (Meshkat et al., 2025; van der Meer et al., 2023). Published trials have already yielded encouraging results, including reductions in heavy drinking days (Bogenschutz et al., 2022) and greater smoking abstinence compared to nicotine replacement therapy (Henningfield et al., 2024).
Headache and pain disorders	Exploratory randomised and open-label studies in cluster headache and migraine suggest that psilocybin, given as single or repeated “pulse” doses, may reduce attack frequency and headache burden in some patients, although evidence remains preliminary and dosing regimens are still being optimized (Bhanot et al., 2023; Emmanuelle et al., 2023).
Post-traumatic stress disorder + trauma-related conditions	Phase 2 trials are testing psilocybin-assisted therapy and take-home psilocybin formulations as adjuncts to psychotherapy in PTSD and trauma-related conditions, targeting intrusive symptoms, avoidance and mood symptoms linked to trauma (McGowan et al., 2025).
Other psychiatric indications	Early-phase and proof-of-concept trials are investigating psilocybin-assisted therapy for obsessive-compulsive disorder (OCD), anorexia nervosa, generalised anxiety and related conditions, reflecting a broader shift toward transdiagnostic, mechanism-focused use of psychedelic-assisted psychotherapy (Graziosi et al., 2024; Bevione et al., 2025).

Physical Safety of Psilocybin



Nutt et al., 2010, *Lancet*

Psilocybin is considered physiologically safe at typical doses, with very low physical toxicity and no evidence of addictive potential.

However, it is psychologically powerful and can precipitate or worsen mental health problems (e.g. psychosis, severe mood disturbance) in vulnerable individuals, especially in non-clinical or poorly supported settings. Careful screening, preparation, skilled facilitation and post-session integration are therefore essential to reduce risks and support positive outcomes.

Potential Psychological Risks of Psilocybin

Clinical trials & Psilocybin-Assisted Psychotherapy	Naturalistic / unregulated settings
Common short-term effects: headache, nausea, dizziness, fatigue, and a brief ↑ in blood pressure.	
Many participants also experience periods of intense anxiety, confusion or “challenging" emotions during the dosing session. In clinical trials these usually resolve within 24-48 hours with proper preparation and support.	
• In patient populations, a small minority experience clinically significant worsening of depression, emergent suicidal ideation or behaviour, or brief psychotic / manic symptoms during or in the weeks after dosing; such events are very rare in healthy volunteers but have been reported in modern trials. • To reduce these risks, trials typically exclude people with psychotic or bipolar 1 disorder or first degree releatives with these conditions, plus unstable personality pathology or high suicide risk, and use structured monitoring, crisis plans and follow-up visits after dosing sessions.	• Many report lasting benefits, but ~1 in 10 prospective surveys report sustained negative impacts (e.g. lingering anxiety, low mood, derealisation, social or work difficulties), especially when support and integration are limited. • A minority report brief "flashbacks" persistent visual changes or drug-like re-experiences. Although very rare, these have been described in case reports. These are called hallucinogen persisting perceptual disorder (HPPD). • Powerful experiences can sometimes fuel grandiose or ego-inflated narratives; structured psychotherapy may help channel rigid self-idealisation toward more prosocial change.

Psychedelic Ethics

Participant vulnerability & informed consent	• Psychedelic states can strongly change perception, emotions, sense of self and values, which makes it harder to fully anticipate or evaluate risks in advance. • Ethics authors propose “enhanced consent”: clear discussion of possible personality/value shifts, difficult or traumatic material, mental and cardiovascular risks, approving the use of touch if requested, and the real possibility of non-response or symptom worsening, with consent revisited across preparation, dosing and integration sessions.
Power dynamics & exploitation	• Heightened suggestibility, regression-like states and any use of physical touch create strong power imbalances and increase the risk of boundary violations, including documented cases of serious misconduct. • Suggested safeguards include strict professional boundaries, explicit touch policies, specialised training, two-therapist or video-recorded sessions, and robust institutional oversight.
Risk–benefit with limited long-term data	• Recent reviews and expert groups stress cautious, stepwise clinical adoption: small trials are promising, but data on long-term effects, rare adverse events and outcomes in vulnerable groups are still limited.
Equity, access & therapeutic reliationships	• Ethical frameworks highlight the need to avoid reinforcing existing inequalities by ensuring fair access, transparent selection criteria, compassionate-use pathways, and diverse representation among therapists and patients, while prioritising trust, a safe therapeutic relationship and ongoing patient safety.

Psilocybin-Assisted Psychotherapy Model

Listen to Prof. Sara Tai on the best therapy models for psychedelics

Modern psylocybin trials use structured psychotherapy models rather than “drug only” approaches. A typical 3-stage clinical model includes:

1. Preparation (2–4 sessions)

Screening for medical, psychiatric and medication risks; clarifying indications and exclusions.

Building rapport and trust; exploring history, current difficulties and supports.

Providing psychoeducation about psilocybin, possible (including challenging) experiences and safety measures.

Using “enhanced consent” to discuss touch, boundaries, recording, and the possibility of non-response or symptom worsening.

Helping the patient set intentions and practise basic grounding/emotion-regulation skills.

2. Administration / dosing session(s)

Conducted in a quiet, comfortable room with two trained therapists present.

Standardised dosing with continuous monitoring of vitals and mental state, rescue medication available.

Use of eyeshades and music; therapists maintain a mainly non-directive, supportive stance (“stay with, trust and explore the experience”), offering reassurance and grounding without leading suggestions.

3. Integration (2–4+ sessions)

Reviewing the experience in detail and identifying key images, emotions and insights.

Linking themes to the person’s values, relationships and goals (e.g. “accept, connect, embody”).

Co-creating concrete behaviour changes and coping plans, coordinated with ongoing care.

Harm Reduction & Peer Support Principles

Read the MAPS Manual of Psychedelic Support

Psychedelic harm reduction is a non-clinical, peer-support approach used at festivals, events and other naturalistic settings to help people through difficult psychedelic experiences—mainly by optimising set & setting and offering calm, compassionate care. The goal is not to direct the trip, but to provide ethical, boundaried support.

Core Zendo principles of psychedelic harm reduction:

Safe space

Be a calm, grounded presence. Reduce noise and crowding, offer basics like water and blankets, ask before any touch, and keep what's shared confidential.

Talk through, not down

Help them stay with and name what they're feeling, inviting curiosity instead of distraction or suppression.

Sitting, not guiding

The "intervention" is steady, accepting companionship, not therapy. Let the person's own process unfold instead of pushing advice or an agenda.

Difficult ≠ bad

Normalise that challenging trips can be meaningful and growth-promoting; encourage a gentle, curious approach to fear and struggle.

Compassionate listening

Reflect back what you hear, ask gentle clarifying questions, and avoid minimising or judging their experience.

Expression & grounding

Make space for crying, laughing, drawing or moving, and offer simple grounding (breathing, walking, stretching) when someone is anxious or tense.

Current Legal Status of Psilocybin

UN Convention on Psychotropic Substances (1971)

- Psilocybin is explicitly scheduled under the Convention.
- **Plants are not scheduled:** the official Commentary clarifies that psychedelic plants (including mushrooms) and their preparations (e.g., “beverages”) are not themselves listed as controlled items under the Convention.
- Article 32(4) reservations: this clause exists so States could reserve an exemption for traditional/religious use if certain wild-growing psychotropic plants were ever added to Schedule I in the future.
- Currently, no plants or plant products are included in the Schedules of the 1971 Convention.

National schedules

- **US Schedule 1**
- **UK Schedule 1**
- **Australia Schedule 9** (with Schedule 8 use for treatment-resistant depression)

These schedules characterize psilocybin as a high-risk substance with high abuse potential and no recognised medical use (US Schedule I, UK Schedule 1, Australia Schedule 9), although Australia has now introduced tightly controlled Schedule 8 pathways for limited therapeutic use in treatment-resistant depression.

Control of psilocybin-containing mushrooms is therefore determined by national law, usually by treating them as material containing a scheduled substance rather than scheduling the plants themselves.

Research is permitted with appropriate ethics approval and the necessary state and national controlled-drug licenses.

Evolving Regulatory Guidance on Psilocybin

Regulators are increasingly focused not on whether psilocybin may be studied, but on how psilocybin-assisted therapies should be evaluated and, if effective, integrated into clinical care.

United States — FDA draft guidance

The US Food and Drug Administration has issued draft guidance for industry, **Psychedelic Drugs: Considerations for Clinical Investigations**, which sets out general expectations for study design, dosing sessions, integration of psychotherapy, monitoring of acute psychological effects, suicidality and cardiac risk, and assessment of abuse potential for compounds such as psilocybin.

Europe — EMA depression guideline

The European Medicines Agency has updated its **Guideline on the clinical investigation of medicinal products for the treatment of depression** (Revision 3), including a dedicated section on psychedelic treatments that sets expectations for study design, timing of primary endpoints in single-course treatments, durability of effect, and long-term safety follow-up, thereby formalising a European regulatory framework for psilocybin and related compounds in depression trials.

Commentary in leading journals (including **JAMA** and the **New England Journal of Medicine**) and stakeholder feedback to the EMA describe these FDA and EMA texts as early regulatory frameworks for psychedelic medicine, stressing the need to adapt trial design and endpoints to single-course psychedelic treatments, standardise the psychotherapy component, manage blinding to conspicuous drug effects, and generate robust data on durability and long-term safety.

State-Level Psilocybin Access in the US

Oregon
Regulated Psilocybin Services

Measure 109 (2020) created the first state-regulated psilocybin services programme for adults, framed as supervised "psilocybin services" rather than medical treatment. The Oregon Health Authority spent two years developing rules, licensing and training standards; licence applications opened in early 2023 and the first manufacturers, service centres and facilitators began operating later that year, offering non-medical, facilitated sessions for adults 21+.

Colorado
"Natural Medicine" Decriminalisation and Regulated Access

Colorado's Natural Medicine Health Act (Proposition 122, 2022) decriminalised adult possession, cultivation and sharing of specified "natural medicines" (including psilocybin and psilocin) and created a phased, statewide regulated access system for supervised use at licensed facilities, with possible later inclusion of DMT, ibogaine and mescaline, making Colorado a hybrid decriminalisation-plus-regulated-services model.

New Mexico
Medical Psilocybin Programme

New Mexico's Medical Psilocybin Act (SB 219, 2025) establishes a Department of Health-run medical psilocybin programme for conditions such as treatment-resistant depression, PTSD, substance use disorders and end-of-life distress. The programme is scheduled to start in June 2025 and be fully implemented by 2027, with psilocybin administered in licensed medical centres under clinician supervision and remaining illegal outside this framework.

National Medical Pathways

Switzerland — Limited Medical Use via Exceptional Authorisations

Since 2014, Switzerland's Federal Office of Public Health has granted exceptional licences allowing medical use of psilocybin, MDMA and LSD for severe, treatment-resistant conditions in specialist clinics under strict case-by-case authorisation.

Germany — Compassionate Use Programme for Psilocybin

In July 2025, the German Federal Institute for Drugs and Medical Devices approved a compassionate-use programme allowing psilocybin therapy for adults with treatment-resistant depression at selected centres.

Canada — Special Access Program (SAP)

Regulatory amendments in 2022 restored Health Canada's ability to authorise restricted drugs, including psilocybin and MDMA, via the Special Access Program when conventional treatments fail, with 2023 guidance clarifying requests for psychedelic-assisted psychotherapy.

Czech Republic — Legal Medical Use from 2026

Act No. 270/2025 will permit psilocybin-assisted therapy for defined mental disorders from 1 January 2026 in psychiatric hospitals and clinics under specialist supervision.

Australia — First National Down-Scheduling for Clinical Use

In 2023 the Therapeutic Goods Administration reclassified psilocybin and MDMA so that, from 1 July 2023, specified preparations may be prescribed as Schedule 8 medicines for treatment-resistant depression (psilocybin) and PTSD (MDMA), while remaining Schedule 9 otherwise, marking the first national down-scheduling for medical use.

New Zealand — First Psilocybin Prescriber Approved

In June 2025, Medsafe authorised the first psychiatrist to prescribe medicinal psilocybin for treatment-resistant depression outside trials, creating a narrow case-by-case access route while psilocybin remains a Class A, unapproved medicine.

Psychedelic Justice

Indigenous knowledge, biocultural justice & reciprocity

Contemporary psychedelic practice often draws, directly or indirectly, on medicines and ceremonies developed by Indigenous peoples. Ethical guidelines emphasise the need for respectful engagement, reciprocity and community benefit, and for protecting sacred practices from superficial adoption or commercial exploitation. Concerns include cultural appropriation of ceremonial forms and unacknowledged extraction of traditional knowledge.

Commercialisation, IP and conflicts of interest

A rapidly growing for-profit psychedelic sector has focused attention on how corporate investment, intellectual property strategies and market expectations may influence research priorities, trial design and public messaging. Commercial funding can accelerate drug development and scale access, but also raises questions about transparency, independence of evidence and the affordability of future treatments. Broad patents on psychedelic molecules, formulations or dosing and therapy protocols are viewed by some as necessary to attract investment, and by others as potentially limiting competition, constraining academic freedom and restricting equitable access if psilocybin-based medicines are approved.

What does this mean for doctors?

What is preventing doctors from considering psilocybin-assisted therapies?

- Many clinicians see the evidence as promising but still evolving, especially for long-term outcomes, comparative effectiveness and safety in routine practice.
- Regulatory status is complex: psilocybin remains a controlled substance in most places, with access confined to research, special programmes or tightly regulated pathways.
- Public health systems lack clear service models (who delivers therapy, how sessions run, how risks and costs are managed).
- Limited training providers in psychedelic-assisted psychotherapy, with uncertainty about scope of practice, professional boundaries and indemnity.
- Stigma, mixed media coverage and concern about hype or commercial interests make some clinicians cautious.

Why is the evidence base still viewed as incomplete?

- Historical restrictions and scheduling have slowed research and limited large, publicly funded trials.
- Many studies use small, highly selected samples, short follow-up and face methodological challenges (e.g. blinding, expectancy effects).
- There are few pragmatic trials in real-world settings and limited health-economic data for payers and policymakers.
- Real-world data and health-economic evidence remain scarce globally, but Australia's authorised prescriber pathway is now generating precisely this kind of evidence, with much data being reported to ANU's psychedelic-assisted psychotherapy registry
- Questions remain about optimal dosing, indications, therapist training and how to scale these interventions safely and ethically beyond specialist centres.

What does this mean for patients?

Current treatment landscape

- Many patients with mood and anxiety disorders, trauma-related conditions and substance use disorders do not achieve adequate relief from existing treatments or cannot tolerate side effects.
- Media coverage and early trial results have raised expectations around psilocybin-assisted therapy s a potential “breakthrough”, even though access and robust evidence remain limited.

Access to psilocybin-assisted therapy

- In most countries, psilocybin is still a controlled substance; access is largely confined to clinical trials, special access or compassionate-use programmes, or small pilot services.
- Even when patients are interested and clinicians are supportive, psilocybin-assisted therapy is often unavailable locally or only offered in a few specialised centres.

Where patients turn instead

- Some patients seek help in unregulated or underground settings (retreats, informal guides, online or black-market supply), sometimes overseas, where standards of screening, support and integration are highly variable.
- This can expose vulnerable people to clinical, psychological, financial and ethical risks, and may widen inequities if only those with resources can travel or pay out of pocket.

The Role of the Medical Student

Medical students need a clear, balanced understanding of psilocybin-assisted therapy—its evidence base, regulatory status, and ethical issues—along with a solid grasp of potential benefits and risks, so they can correct misinformation and help patients weigh options within a broader treatment plan.

They can also support progress by contributing to well-designed research, critical appraisal, and rigorous reporting of both benefits and harms, while advocating for safe settings, robust consent, and appropriate safeguards.

Over time, they can serve as informed communicators to colleagues, patients, and policymakers, and help shape future training standards, services, and policy if these therapies enter mainstream care.

Where can you find out more?

Drug Science Website

Drug Science Podcast

David Nutt's Book, *Drugs Without the Hot Air: Making Sense of Legal and Illegal Drugs* (2012)

David Nutt's Book, *Psychedelics: The revolutionary drugs that could change your life - a guide from the expert* (2024)

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