Psychedelic therapies are returning to psychiatry

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Professor Erika Dyck, Canada Research Chair in History of Health & Social Justice at the University of Saskatchewan, looks to psychedelic therapies outside the pharmaceutical industry to aid mental illness

The number of people who suffer from mental illness has grown steadily, with the WHO now reporting that 1 in 5 people in the world lives with mental illness. Estimates of the burden of mental illness, due to lost employment opportunities, is over $1 trillion USD each year, yet government spending on mental health remains a small fraction of overall spending. Pundits and critics alike have levelled blame at governments who seem unwilling to invest in mental health, and at a multi-billion-dollar pharmaceutical industry accused of prioritizing profits over a search for genuinely restorative treatments.

Over the past decade, psychedelic therapies have emerged on this landscape as a potential treatment that may improve individual lives while also transforming the way we diagnose and treat mental illness around the world. Observers are calling this phenomenon a psychedelic renaissance.

Life-changing treatments that could revolutionise mental health

Psychedelic drugs, including substances like psilocybin mushrooms, 3,4-Methyl enedioxymethamphetamine (MDMA), and ketamine, are joining a list of psychedelic treatments that historically included d-lysergic acid diethylamide (LSD), mescaline, and N,N-Dimethyltryptamine (DMT) in psychiatry. Many of these substances also have Indigenous roots connected to plants and fungi-based ceremonies that included peyote, mushrooms, and ayahuasca among other mind-altering substances and practices.

Psychedelic therapies, whether conducted in ceremonial settings or clinical ones, are being touted as life-changing moments for their capacity to efficiently transform an individual's perspective on themselves.

In recent years the field of psychedelic studies has accelerated quickly. In 2017, the US Food and Drug Administration (FDA) designated MDMA-assisted psychotherapy for Post-Traumatic-Stress Disorder a "breakthrough therapy"; in 2018 and 2019, it designated the same status to psilocybin therapy for treatment-resistant depression and major depression, respectively. In the wake of the FDA declarations, North Americans began demanding greater access to psychedelic treatments.

The legal landscape on psychedelic therapies and drugs is changing quickly

In 2020, voters in Oregon made their state the first to decriminalize psilocybin for medical use. Other states, including Washington, Florida, Connecticut and Virginia have submitted decriminalization petitions, while American cities like Denver, Colorado and Oakland, California have changed municipal orders to allow for the medical use of psilocybin.

These relatively new initiatives to legalize, decriminalize, and/or regulate psychedelics have taken different legal forms and arguably build on examples from outside of the United States, including pre-existing laws that allow for varying access to psychedelics in the Netherlands, Brazil, Costa Rica, Mexico, Portugal, Peru, Jamaica, and Switzerland. In just the first 2 months of 2023, new jurisdictions joined this list, including Australia and parts of Canada. The legal landscape is changing quickly and differs depending on the jurisdiction as to whether psychedelics are available as medicines, ceremonial substances, restricted to certain groups (from psychiatrists to Indigenous shamans), or are limited for export rather than personal use.

What has happened to allow for these changes, and how are they affecting psychiatry and the global burden of mental illness?

Psychedelics have had other heydays. Besides their long history of use in non-medical settings and association with Indigenous traditions for millennia, psychedelic therapies also fluoresced in psychiatry in the 1950s and 1960s. Claiming unprecedented successes in treating alcoholism and trauma-based disorders (before the introduction of post-traumatic stress disorder as a category of illness), psychedelics combined with psychiatric therapies (typically psychotherapy, psychoanalysis, or group therapy) offered a therapeutic model that challenged existing paradigms.

As psychedelic therapies emerged in western psychiatry in the 1950s many jurisdictions were seeking alternatives to long-stay custodial care for people with mental illnesses. Psychopharmacological remedies were also on the horizon in this decade, promising to ameliorate symptoms, arguably allowing psychiatric patients the chance to live in communities in record numbers. The seismic shift in psychiatry that occurred with deinstitutionalization also redistributed budget lines in mental health services, at times splintering budgets across multiple departments and introducing new gaps and inequalities into an already underfunded segment of the health care system.

Psychedelic therapies appealed to reform-minded psychiatrists eager to secure improvements in patient populations without necessarily resorting to daily-use pharmaceuticals. Early clinical investigations with psychedelics like LSD and mescaline suggested that a single dose combined with psychotherapy could provide lasting benefits, perhaps even life-changing ones. Hundreds of clinical trials using case reports produced evidence that patients reported sustainable results, meaning they resumed work, restored relationships, or entered new ones, and described the results as personally meaningful. Despite inspiring results, psychedelics fell out of favour by the end of the 1960s, culminating in the 1971 United Nations Convention on Psychotropic Drugs that condemned the use of psychedelics.

Learning from transferrable science, like psychoanalytical therapy

Psychedelic researchers in this earlier era designed approaches to studying psychedelics that borrowed from techniques they had learned elsewhere, including psychoanalytical therapies, 12-step models like Alcoholics Anonymous, and even from some Indigenous ceremonies. Despite genuine attempts to design appropriate and systemic methodologies for assessing psychedelics, another problem emerged in this period.

Psychedelics did not perform well in randomized controlled trials. Although some psychedelic researchers designed trials with the intention of proving their therapeutic value, the methodology itself contradicted the psychedelic therapy ethos. Psychedelic therapists argued that to do therapy well, one must accumulate personal experience with psychedelics. Or at the very least, psychedelic researchers needed to appreciate the non-pharmacological influences of a psychedelic experience, namely the psychological and environmental features, or “set and setting” that mediated the experience itself.

This idea initially offended contemporary pharmacological researchers who argued instead that one needed to be objective about the results and measure the pharmacological effect, not the anticipation of a research subject or the quality of a musical playlist. Aspects like investigator empathy, environmental cues, and psychological or emotional expectations had the potential to confound results by muddying the data.

Psychedelics soon attracted consumers beyond a controlled clinical context

Non-medical psychedelic enthusiasts generated a rival form of social capital and psychedelic expertise in the latter part of the 1960s. Fully embracing a mantra of experience, cultural advocates of psychedelic drug use shed the rhetoric of objectivity altogether, instead aligning psychedelic drug use with a form of liberation, however problematic that message may have been. Historically this shift in psychedelic drug use, from the clinic to the street has been blamed for triggering a prohibition.

In today’s psychedelic renaissance, we continue to face the legacy of this split in how we evaluate psychedelics and what kind of evidence to trust when it comes to taking psychedelics and in what contexts. Today celebrities and philanthropists tout the benefits of psychedelics, without adhering to the rigours of institutional oversight, ethics boards, competitive funding schemes, or RCTs. Meanwhile, psychedelic scientists are amassing evidence evaluating psychedelics in RCTs, leading regulators to acknowledge their potential in a mental health care landscape that once again is desperate for new approaches that combine efficacy with equity for mental illness sufferers globally. But the desire to minimize bias continues to compete with the considerable influence that comes from popular endorsements, reminding us that whether approved as medications or not, people have and will continue to take psychedelics for other reasons, and will identify other sources of information to trust.

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