Australian Government
Department of Health, Disability and Ageing
Therapeutic Goods Administration

Notice of interim decisions to amend (or not amend) the current Poisons Standard

29 May 2026

Confidentiality

All submissions received will be placed on the TGA's Internet site, unless marked confidential. Any confidential material contained within your submission should be provided under a separate cover and clearly marked "IN CONFIDENCE". Reasons for a claim to confidentiality must be included in the space provided on the TGA submission form. For submission made by individuals, all personal details, other than your name, will be removed from your submission before it is published on the TGA's Internet site. In addition, a list of parties making submissions will be published. If you do not wish to be identified with your submission you must specifically request this in the space provided on the submission form.

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Notice of interim decision made under Regulation 42ZCZN of the Therapeutic Goods Regulations 1990

This publication constitutes a notice for the purposes of regulation 42ZCZP of the Therapeutic Goods Regulations 1990 (the Regulations). In accordance with regulation 42ZCZP, this notice sets out:

- the interim decisions made by a delegate of the Secretary of the Department of Health and Aged Care responsible for scheduling of medicines and chemicals (the Delegate)[1] under regulation 42ZCZN in relation to proposed amendments to the current Poisons Standard which were referred to an expert advisory committee[2] under subdivision 3D.2 of the Regulations in June 2025.
- the proposed date of effect of the proposed amendments (in circumstances where the interim decision proposes an amendment to the current Poisons Standard).

In accordance with regulation 42ZCZP, interested persons (including the applicant requesting the amendment) are invited to make submissions to the Secretary in relation to this interim decision on or before 3 July 2026.

Submissions should be provided through our consultation hub. Submissions will be considered by the Delegate in making the final decision.

Please note that in accordance with subregulation 42ZCZQ(4) of the Regulations, the Secretary must publish all relevant submissions received, unless the Secretary considers the information to be confidential information.

Defined terms

In this notice the following defined terms are used in addition to those above:

- the Therapeutic Goods Act 1989 (Cth) (the **Act**)
- the Scheduling Policy Framework 2018 (the **SPF**)
- the Scheduling handbook: Guidance for amending the Poisons Standard (the **Handbook**), and
- the Therapeutic Goods Administration (the **TGA**).

[1] For the purposes of s 52D of the *Therapeutic Goods Act 1989* (Cth)

[2] Established under sections 52B and 52C of the *Therapeutic Goods Act 1989* (Cth).

Interim decisions on proposed amendments referred to the Advisory Committee on Medicines Scheduling (ACMS #47, JUNE 2025)

Interim decision in relation to psilocybine

Proposal

The applicant proposed to amend the Controlled drugs (Schedule 8) entry of psilocybine (also referred to as psilocybin) to include a new indication to allow supply for existential distress towards end of life. Currently psilocybine can only be supplied as a Schedule 8 substance for treatment-resistant depression (TRD). The proposed changes would enable access for patients facing a terminal illness accompanied by severe existential or psychosocial suffering.

Schedule 8: proposal to amend entry

PSILOCYBINE in preparations for human therapeutic use for the treatment of:

a. treatment resistant depression

b. existential distress towards the end of life only when

i) used as part of psychotherapy in medically controlled environments; and

ii) the patient's diagnosis and the proposed treatment plan is confirmed by at least one independent reviewing specialist doctor.

Appendix D

Clause 5: (Poisons for which possession without authority is illegal)

PSILOCYBINE

Clause 9: Amend clause

PSILOCYBINE in preparations for human use may be supplied only for:

(i) the treatment of treatment-resistant depression:

(a) if psilocybine is prescribed, or its supply is authorised, by a medical practitioner:

(i) registered under State or Territory legislation that forms part of the Health Practitioner Regulation National Law as a specialist psychiatrist; and

(ii) for whom an authority under subsection 19(5) of the Act that covers psilocybine is in force; or

(b) for use in a clinical trial that is approved by, or notified to, the Secretary under the Act; or

(ii) the treatment of existential distress towards the end of life when:

(a) used as part of psychotherapy in medically controlled environments; and

(b) the patient's diagnosis and proposed treatment plan is confirmed by at least one independent reviewing specialist doctor; and

(c) if psilocybine is prescribed, or its supply is authorised, by a treating palliative care specialist:

(i) who has received specific training; and

(ii) for whom an authority under subsection 19(5) of the Act that covers psilocybine is in force.

Interim decision

Pursuant to regulation 42ZCZN of the Regulations, the Delegate has in relation to the proposed amendment, made an interim decision that the current scheduling of psilocybine remains appropriate.

Materials considered

In making this interim decision, the Delegate considered the following material:

- The application to amend the current Poisons Standard with respect to psilocybine (the **Application**)
- The 595 public submissions, with 321 including a written component, received in response to the pre-meeting consultation under regulation 42ZCZK of the Regulations (the **Submissions**)
- The advice received from the 47th meeting of the Advisory Committee on Medicines Scheduling (the **Committee**)
- Subsection 52E(1) of the Act, in particular (a) risks and benefits of the use of a substance; (b) the purposes for which a substance is to be used and the extent of use of a substance; (c) the toxicity of a substance; (d) the dosage, formulation, labelling, packaging and presentation of a substance; (e) the potential for abuse of a substance; and (f) any other matters that the Secretary considers necessary to protect public health
- The SPF, and
- The Handbook.

Summary of Committee advice to the Delegate

The Committee recommended that no change be made to the scheduling of psilocybine on the basis that there was insufficient evidence to support changes to the current scheduling.

The Committee members considered the proposal to contain limited evidence of therapeutic efficacy and safety of psilocybine assisted psychotherapy in the treatment of end-of-life distress. The Committee was of the view that the clinical trials provided in support of the proposal involved small numbers of participants and lacked the methodological rigor typically expected.

The Committee discussed that the application lacked clarity regarding the diagnostic criteria for existential distress at end of life, the accreditation process for specialist prescribers, and the mechanisms for controlling dispensing.

The condition proposed to be treated with psilocybine as a Controlled drug (Schedule 8) is not well defined; existential distress is absent as a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders Fifth Addition (DSM-5).[3] Its diagnosis is dependent on interpretation, the surrounding circumstances and cultural norms. Symptoms of existential distress relate to meaning, mortality, identity, dignity, and freedom; however, no validated, internationally accepted diagnostic tool exists for existential suffering or distress.[4] Tools such as the EDS (Existential Distress Scale) exist but measure severity and is not a diagnostic category.[5]

[3] https://www.ifeet.org/files/DSM-5-TR.pdf

[4] https://www.mypcnow.org/fast-fact/existential-suffering-part-1-definition-and-diagnosis/

[5] https://gippec.org/output/preliminary-psychometrics-of-the-existential-distress-scale-in-patients-with-advanced-cancer.html

The Committee discussed a recent Cochrane review which reported that psilocybine assisted therapy may reduce existential distress when measured on some scales, but not when measured on others, and ultimately the evidence has a high degree of uncertainty.[6]

The Committee considered the proposal to be ambiguous in its identification of prescribers and reviewing clinicians, and the role of the pharmacy compounding likewise warrants further elaboration. The regulatory impact of implementing the proposed scheduling by state and territory poisons and medicines regulators would also need to be considered in detail.

The Committee acknowledged that existential distress associated with end-of-life is a unique form of psychological distress. However, they disagreed with the applicant and stated that patient autonomy in end-of-life decisions is acknowledged through Voluntary Assisted Dying (VAD) (which is currently available in 7 jurisdictions) and is consistent with patients' rights in modern palliative care for choice over palliative treatments.

Members agreed that the relevant matters under subsection 52E(1) of the Act included: (a) risks and benefits of the use of a substance; (b) the purposes for which a substance is to be used and the extent of use of a substance; (c) the toxicity of a substance; (d) the dosage, formulation, labelling, packaging and presentation of a substance; (e) the potential for abuse of a substance; and (f) any other matters that the Secretary considers necessary to protect public health.

The reasons for the Committee's advice with respect to psilocybine included:

a) the risks and benefits of the use of a substance

Risks

- Population studies for adverse effects showed the most common being psychological adverse experiences – anxiety and negative mood and physical – cardiovascular (mild to moderate increases in blood pressure and heart rate), occasional nausea and headache.
- There is a limited number of robust, peer reviewed clinical trials (each with a small number of participants) demonstrating efficacy of treatment for relief of end-of-life distress although there is a growing body of promising research.
- The research base is emerging, demonstrating evidence for use in end-of-life distress. However, further research is needed to establish therapeutic value.
- The conclusions of the studies are mixed and the degree of uncertainty is high.
- Therapy risks can be linked to the context of care and the qualification and skills of the practitioner providing them.
- Training programs and credentialing of practitioners should be robust but are outside the remit of scheduling.
- There is no standardised clinical definition of existential distress, no standardised treatment protocol, product or dosage regimen for the use of the substance for the proposed indication.
- The use of 3 years as the benchmark for defining end-of-life is inconsistent with current frameworks.

Benefits

- One study of 28 individuals indicated some benefits (demoralisation reduction).[7]

[6] Schipper S, Nigam K, Schmid Y, Piechotta V, Ljuslin M, Beaussant Y, Schwarzer G, Boehlke C. Psychedelic-assisted therapy for treating anxiety, depression, and existential distress in people with life-threatening diseases. Cochrane Database of Systematic Reviews 2024, Issue 9. Art. No.: CD015383. DOI: 10.1002/14651858.CD015383.pub2

[7] Schipper S, Nigam K, Schmid Y, Piechotta V, Ljuslin M, Beaussant Y, Schwarzer G, Boehlke C. Psychedelic-assisted therapy for treating anxiety, depression, and existential distress in people with life-threatening diseases. Cochrane Database of Systematic Reviews 2024, Issue 9. Art. No.: CD015383. DOI: 10.1002/14651858.CD015383.pub2

- Claimed benefits of psilocybine include treating anxiety, depression, demoralisation and fear of death in terminally ill patients
- Submissions supported the opportunity for psilocybine to address unmet treatment needs of patients in palliative care and for compassionate/ethical and moral reasons. Safety was cited as a benefit noting that adverse effects are rare and typically mild when administered under the supervision of trained professionals under strict controls.

b) the purposes for which a substance is to be used and the extent of use of a substance

- Use of single dose therapy in conjunction with psychotherapy to treat existential distress towards end of life in patients with life-limiting illnesses.
- The target population is adults (18+ years) diagnosed with life-limiting illnesses, ideally with a prognosis of up to 1,000 days and at least 3–6 months remaining, allowing sufficient preparation, dosing, and integration sessions.

c) the toxicity of a substance

- No serious adverse events have been reported in clinical trials where psilocybine was administered under professional supervision and side effects are generally mild and transient e.g. elevated blood pressure, headache, or anxiety. These symptoms resolved without long-term complications.

d) the dosage, formulation, labelling, packaging and presentation of a substance

- Psilocybine is not listed as an ingredient in the TGA ingredient database and there are no approved products on the Australian Register of Therapeutic Goods (ARTG).

e) the potential for abuse of a substance

- Increasing harm is noted in US where psilocybine down-regulation has occurred. Rising psilocybine poisoning exposures reported to the US National Poisons Data System since regulatory changes in 2019 which may be related to people attempting self-treatment.[8]
- Participants in trials have higher rates of lifetime illicit psychedelic use.

f) any other matters that the Secretary considers necessary to protect public health

- The amendment to Schedule 8 to include this indication presents significant clinical and implementation issues.
- Scheduling alone is not sufficient to protect public health and whole of regulatory framework needs to be considered for applications of this nature.
- There is no clear pathway for implementation and key stakeholders, such as The Australasian Chapter of Palliative Medicine (AChPM) should provide input before this proposal is considered further.

[8] Rockhill KM, Black JC, Ladka MS, Sumbundu KB, Olsen HA, Jewell JS, Hunt J, Wolf RC, Nerurkar K, Dart RC, Monte AA. The Rise of Psilocybin Use in the United States: A Multisource Observational Study. Ann Intern Med. 2025 Apr 22. doi: 10.7326/ANNALS-24-03145

Reasons for the interim decision (including findings on material questions of fact)

I agree with the Committee's advice on the relevant provisions of section 52E of the Act and its recommendation that that the current scheduling of psilocybine remains appropriate.

Psychedelic-assisted therapy encompasses a range of therapeutic practices in which psychedelic substances such as psilocybine are administered under the supervision of trained healthcare professionals. It has been postulated that this therapeutic approach may alleviate symptoms of anxiety, depression, and existential distress in individuals confronting life-threatening illnesses, such as cancer. However, these substances remain prohibited in most jurisdictions and have been associated with potential clinical and ethical risks. In Australia, research involving prohibited psychedelic substances may nonetheless be lawfully undertaken where approval is granted through the TGA's clinical trials framework. This includes authorisation via a Human Research Ethics Committee (HREC) under the Clinical Trial Notification or Clinical Trial Approval schemes[9] in addition to state or territory health authority approval.

I have considered the 595 public submissions received during the pre-meeting consultation period. Of these, 590 submissions supported the proposal of which 316 provided written justification, 3 partially supported of which all 3 provided written justification and 2 submissions did not support the proposal of which both provided written justification.

The majority of submissions supported the proposal, citing individual opinions regarding psilocybin's ability to alleviate depression, anxiety, and existential suffering in terminally ill patients. Comparisons were made that unlike conventional treatments such as antidepressants or sedation, which may be slow-acting or superficial, psilocybine-assisted therapy can produce rapid, profound, and lasting psychological relief after just one or two sessions. Submissions speak to individual patient experiences that help them reframe their fears about death, rediscover meaning, and experience peace and acceptance. Submissions in support of the proposal outline this therapy as a "compassionate tool that restores dignity and agency at the end of life.''

Many of the submissions emphasised the safety and tolerability of psilocybine when administered in controlled clinical settings, with no evidence of toxicity, physical dependence, or withdrawal. Submissions expressed the sentiment that psychological risks are mitigated through structured therapeutic environments, and adverse effects are rare and mild. Many submissions advocate for tightly regulated access, with prescribing limited to trained professionals such as palliative care specialists and psychiatrists. Group therapy settings were also supported, as they are believed to enhance outcomes through shared emotional processing and integration.

The submissions called for expanded eligibility beyond the terminally ill, including patients with progressive, life-limiting conditions such as advanced cancer, Chronic Obstructive Pulmonary Disease (COPD), Multiple Sclerosis, Amyotrophic Lateral Sclerosis, heart failure, and atypical Parkinsonian disorders. Concern was expressed that restricting access to those within 6–12 months of life expectancy would exclude many who suffer prolonged psychological and spiritual distress. Submissions suggest that specialists managing these conditions, such as neurologists and cardiologists, should be involved in identifying suitable candidates.

In opposition to the proposal, Palliative Care Australia raised concerns that the research in the area remains experimental, and currently insufficient to support routine use. They raised concerns around the ambiguity of the qualifications and training required to deliver this proposed therapy. Palliative Care Australia interpreted the proposal as an expansion to the currently permitted use of psilocybine under Schedule 8 of the Poisons Standard, currently limited to treatment-resistant depression.

In assessing the factors under section 52E(1)(a) and (c) concerning the risks, benefits, and toxicity of psilocybine, I note that while there is emerging evidence suggesting potential therapeutic use in alleviating distress around end-of-life, the current research base remains limited and inconclusive. Clinical trials to date have involved small participant numbers and lack standardised treatment

[9] https://www.tga.gov.au/products/unapproved-therapeutic-goods/access-pathways/clinical-trials

protocols, dosage regimens, or definitions of existential distress, making validity and reproducibility challenging.

To date, clinical trial findings evaluating psychedelic-assisted therapies for the treatment of existential distress in individuals with life-threatening illnesses have yielded mixed and inconclusive results.

A systematic review conducted in 2024[10] examined psychedelic-assisted therapy for treating existential distress in people with life-threatening diseases. Six studies (randomised controlled trials (RCTs)) were included in the review, testing psychedelic-assisted therapy using psilocybine (3 studies), lysergic acid diethylamide (LSD) (2 studies), and 3,4-methylenedioxymethamphetamine (MDMA) (1 study). The studies involved 149 adults with anxiety, depression, or existential distress. The largest study tested psilocybine in 56 people and the two smallest studies tested either psilocybine or LSD in 12 people. The studies took place in the USA and Switzerland in outpatient settings. Most of the psychedelic-assisted therapy studies had a follow-up of 6 to 12 months.

The review authors concluded that existential distress (such as feeling that life has no meaning) and quality of life may be improved by classical psychedelics, but that the evidence is mixed and uncertain. No severe negative side effects of psychedelic-assisted therapy were reported in the studies.

The studies examined in the review had issues with certainty of evidence. Although all 6 studies had intended to blind participants, personnel, and assessors, blinding could not be achieved as this is very difficult in studies investigating psychedelics. Using GRADE criteria,[11] the study authors judged the certainty of evidence to be low to very low, mainly due to high risk of bias and imprecision (small sample size).

The implications of the systematic review are that psychedelic-assisted therapy with psychedelics such as psilocybine, may be effective for treating anxiety, depression, and possibly existential distress, in people facing a life-threatening disease. Psychedelic-assisted therapy seemed to be well tolerated, with no treatment-emergent serious adverse events reported in the studies included in this review. The substantial uncertainty associated with the evidence may change as additional research becomes available.

In contrast, a randomised, blinded, controlled crossover study examining the efficacy of a single psilocybine administration (0.3 mg/kg), compared with an active control condition (niacin 250 mg), delivered in conjunction with psychotherapy, yielded more compelling findings.[12] The study investigated treatment effects for clinically significant anxiety and depression among individuals with life-threatening cancer. Of the 29 participants, 90 per cent met DSM-IV criteria for cancer-related adjustment disorder with anxious and/or depressive features. A single moderate dose of psilocybine, administered alongside psychotherapeutic support, produced rapid and sustained anxiolytic and antidepressant effects, persisting for a minimum of 7 weeks and potentially extending up to 8 months. Treatment was also associated with reductions in cancer-related existential distress, enhancements in spiritual wellbeing and overall quality of life, and more adaptive attitudes toward death. Statistically significant between-group differences were observed across all 6 primary outcome measures prior to crossover at 7 weeks post-administration. Relative to the active control, participants in the psilocybine condition exhibited immediate, clinically meaningful, and sustained reductions in symptoms of anxiety and depression.

Collectively, these findings suggest that psilocybine may represent a promising novel pharmacological-psychosocial intervention for addressing psychological and existential distress associated with advanced cancer. Nevertheless, the investigators emphasised the need for further rigorous empirical research to establish its safety, efficacy, and generalisability within this population.

Building on these findings, a single-site study conducted at a tertiary hospital's palliative care department (St. Vincent's Hospital Melbourne affiliated with the University of Melbourne), similarly ran a double-blind, placebo-controlled, randomised phase 2b trial (RCT) with an open-label extension

[10] https://pmc.ncbi.nlm.nih.gov/articles/PMC11390284/#CD015383-sec-0008

[11] https://www.cdc.gov/acip-grade-handbook/hcp/chapter-7-grade-criteria-determining-certainty-of-evidence/index.html

[12] https://pmc.ncbi.nlm.nih.gov/articles/PMC5367551/#section30-0269881116675512 (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. *Journal of Psychopharmacology*. 2016;30(12):1165-1180).

design and 6-month follow-up.[13] The 35 participants were randomised to receive the blinded treatment (n = 17 psilocybine treatment; n = 18 niacin placebo). This study's findings broadly supported psilocybine's use in palliative populations (not solely cancer sufferers). Participants were randomised to receive 25 mg psilocybine or 100 mg niacin (active placebo), alongside 3 preparatory psychotherapy and 6 post-dose integration psychotherapy sessions. After 6–7 weeks post double-blind dose, all participants received 25 mg psilocybine in an open-label extension, enabling a 2-dose versus 1-dose group comparator. Participants were followed up to 26 weeks post open label dose.

The primary outcome was the mean change in Hospital Anxiety and Depression Scale (HADS)[14] depression and anxiety subscales from baseline to 6/7 weeks post-dose 1. The HADS, a 14-item scale, has subscales for anxiety and depression, each ranging from 0 to 21, with scores ≥8 indicating clinically significant symptoms. However, existential distress was not measured as a primary outcome. Secondary outcomes demonstrated significant reductions in DAPR Fear of Death scores in the psilocybine group compared with the control group from baseline to 6/7 weeks post double-blind dose, with a moderate effect size. The psilocybine group experienced a significant increase in Spiritual Wellbeing scores at 6/7 weeks post dose, compared to placebo with a large effect. However, only primary outcomes were subject to hypothesis testing. Treatment-emergent adverse events were more common in the psilocybine group (100 %) than in the niacin group (61.1 %). The most frequent were transient blood pressure elevation (88.2 %), nausea (47.1 %), chills (41.2 %), elevated heart rate (29.4 %) and headache (23.5 %) Psychiatric events included transient anxiety (23.5 %), transient paranoia (5.9 %), and passive suicidal ideation (5.9 %), all of which were short-lived and resolved within the therapy session.

The treatment's impact on spiritual well-being was supported by qualitative data and clinician reports. Given the prevalence of existential suffering in terminal illness, improvements in both spiritual and psychiatric symptoms suggest psilocybine-assisted therapy may be a valuable intervention. This aligns with the WHO's definition of palliative care, emphasising psychological and spiritual support at the end of life.

Despite these promising findings, several limitations warrant consideration. The small sample sizes and limited statistical power precluded subgroup analyses and may have inflated effect size estimates for some secondary measures. Generalisability was further constrained by limited demographic diversity and an uneven distribution of malignant and non-malignant diagnoses. Blinding can also pose challenges, as participant expectations may contribute to functional unblinding. Although treatment-emergent adverse events were more common in the psilocybine group, they were transient, manageable within the therapeutic setting, and consistent with known pharmacological effects.

Feedback across multiple studies suggest that future research should employ larger, more diverse samples, examine existential distress as a primary outcome, and refine trial methodologies to mitigate expectancy effects and better reflect the diversity of spiritual and existential concerns within palliative care populations.

I note that several clinical trials are currently recruiting to evaluate psilocybine-assisted interventions for psychological and existential distress in palliative care populations. The PSYCHED-PAL study (NCT04754061)[15] is a Phase 1 and 2 trial recruiting 20 participants across two sites in Ontario, Canada, examining psilocybine for psychological and existential distress in palliative care settings. Building on this work, the PSYCHED-PAL-RCT trial (NCT07063862)[16] is a larger Phase 3, multicentre randomised controlled trial recruiting 120 participants across seven sites in Ontario and Quebec, Canada, investigating the efficacy of psilocybine microdosing for psychological and existential distress in palliative care. In addition, the Psilocybine Therapy in Advanced Cancer trial (NCT05398484)[17] is a

[13] https://www.sciencedirect.com/science/article/pii/S0163834325001574?via%3Dihub (Williams M, Boughey C, O'Callaghan C, Hiscock R, Dwyer J. Psilocybin-assisted psychotherapy for depression and anxiety associated with life-threatening illness: a phase 2b randomized controlled trial. General Hospital Psychiatry. 2025;96:322-331).

[14] https://clinicaltoolslibrary.com/hospital-anxiety-and-depression-scale-hads/

[15] Study Details | NCT04754061 | PSilocybin for psYCHological and Existential Distress in PALliative Care (PSYCHED-PAL) | ClinicalTrials.gov

[16] Study Details | NCT07063862 | Psilocybin Microdose for Psychological and Existential Distress in Palliative Care (PSYCHED-PAL-RCT) | ClinicalTrials.gov

[17] Study Details | NCT05398484 | Psilocybin Therapy in Advanced Cancer | ClinicalTrials.gov

Phase 2 and 3 study recruiting approximately 200 participants across sites in Colorado and New York, United States, focusing on the therapeutic potential of psilocybine to alleviate distress in individuals with advanced cancer.

The completion of additional Phase 3 studies with larger participant cohorts will enable the collection of more robust evidence regarding treatment impact and clinical effectiveness of psilocybine in patients experiencing existential distress at the end of life. Phase 3 trials are designed to establish treatment efficacy, defined as the ability to deliver clinically meaningful benefits relative to placebo or standard care. Findings from Phase 3 trials are critical in building the weight of evidence required to inform decision making such as regulatory approval and for broader clinical implementation.

The submissions reported benefits including reductions in anxiety, depression, demoralisation, and fear of death in terminally ill patients, with one study of 28 participants indicating some positive outcomes. However, these findings are preliminary and require further validation through robust, large-scale trials. Adverse effects, while typically mild and transient under professional supervision, include elevated blood pressure, nausea, headache, and psychological discomfort such as anxiety or negative mood. I agree with the Committee which noted that peer reviewed evidence of therapeutic efficacy and safety of psilocybine is inconsistent.

Furthermore, the risk and efficacy of psychotherapies are intrinsically linked to the context of care and the qualifications and skills of the providing practitioner. Practitioner training, care setting, and patient vulnerability all play significant role in both efficacy and safety outcomes. This raised concerns around the credentials of approved practitioners and what bodies could offer a robust and independent means of credentialing. The Committee advised that the proposed amendment to authorise the prescribing and supply to a “treating palliative care specialist” is not clearly defined. The applicant seeks such authorisation to be broader than a specialist palliative medicine physician (under the Medical Board of Australia’s listed specialities) and to include oncologists and GPs with palliative care training. This would be a broader authorisation than currently permitted for treatment resistant depression, which is currently limited to specialist psychiatrists.

The submissions report that no serious adverse events have been reported in controlled clinical environments, but the lack of standardisation and the uncertain evidence base underscore the need for caution. While submissions highlight compassionate and ethical motivations for access, the risks, particularly in unregulated or poorly supervised settings must be carefully weighed against the currently unproven therapeutic claims. These risk considerations provide important context for evaluating the proposed therapeutic use and presentation of the substance.

Pursuant to sections 52E(1)(b) and (d), I considered that psilocybine is proposed for use as a single-dose therapy administered alongside psychotherapy to treat existential distress in adults with life-limiting illnesses. The target population includes individuals aged 18 years and over, ideally with a prognosis of up to 1,000 days (about 2 years 7 months) and at least 3–6 months remaining to allow for adequate preparation, administration, and integration sessions. However, the actual extent of therapy sessions, use in clinical or compassionate settings remains unknown.

Psilocybine is not currently listed as an ingredient in the TGA’s ingredient database and there are no psilocybine products included on the Australian Register of Therapeutic Goods (ARTG). There are no approved products, formulations, or standardised dosage regimens available in Australia. This absence of regulatory listing and product standardisation presents challenges for consistent clinical application, quality assurance, and oversight. While the therapeutic intent is focused and supported by emerging research, the lack of formal regulatory recognition and standardised presentation highlights the need for caution and further development of appropriate governance frameworks.

Finally, under sections 52E(1)(e) and (f), concerning the potential for abuse and other public health considerations, I note emerging concerns that warrant attention. In overseas jurisdictions such as the United States, where regulatory controls on psilocybine have been relaxed, there has been a documented increase in harm, including a rise in poisoning exposures reported to the National Poisons Data System (NPDS) since 2019. This trend has been linked to individuals attempting self-treatment outside of clinical settings, as highlighted by Rockhill (2025). Additionally, participants in clinical trials reported higher rates of lifetime psychedelic use, raising questions about bias in the study results, with these participants predisposed to having a positive view of the effects of psychedelic assisted therapy. The potential for misuse or dependency may also exist in certain populations.

While the proposed amendment to Schedule 8 seeks to enable controlled therapeutic use for another indication, it presents significant clinical and implementation challenges surrounding diagnosis. When the entry for use of psilocybine in treatment-resistant depression (TRD) was approved there was literature, studies and solid diagnostic criteria on which to base this decision. TRD is a clinical descriptor applied to major depressive disorder (MDD) following failure of adequate treatment trials. TRD is currently not a standalone Diagnostic and Statistical Manual of Mental Disorders (DSM 5) diagnosis but there is a high level of international agreement.[18,19,20] By contrast, "existential distress" or "existential suffering" is not recognised in DSM-5-TR as a diagnostic category, specifier, or modifier.[21] Its core concerns relate to meaning, mortality, identity, dignity, and loss of self-worth, reflecting broad palliative-care constructs rather than psychiatric pathology.[22,23]

Accordingly, suicidal ideation in TRD is understood within depressive psychopathology, whereas a wish to accelerate death in existential distress may arise from loss of meaning, perceived burden, or reduced dignity and may occur in the absence of MDD.[24,25]

Protocols for the treatment of TRD can be operationalised using defined criteria (e.g. number and adequacy of failed treatments assessed with validated rating scales), whereas currently existential distress cannot; its identification is inferential, contextual, and culturally mediated.[26] No validated internationally accepted diagnostic instrument exists for existential suffering; available tools, such as the Existential Distress Scale, measure severity domains rather than define a diagnosis.[27,28]

Scheduling alone is insufficient to safeguard public health; a comprehensive regulatory framework is required to ensure safe and ethical application of medicines. Notably, there is currently no clear pathway for implementation of the proposed indication based on the issues discussed above, and the relevant peak bodies who have not yet made comment should be formally approached before any decision is made. Given the complexity of the therapeutic context and the potential for unintended consequences, I am of the view that a cautious, whole-of-system approach is essential to protect public health.

Regarding patient vulnerability, the Committee raised concerns that end-of-life patients (especially in late stages) may be vulnerable to active promotion of these therapies. Concerns regarding the outcomes in these patients were exacerbated by the fact that individuals with less than 3 months life-expectancy were excluded from clinical trials.

While there is substantial public support for the proposal, the evidence is still emerging, and any use of psilocybine for patients with a terminal illness should currently continue within a clinical research framework. I acknowledge that the application addresses a range of important safeguards, including restricted prescribing and administration in controlled settings, defined training standards, and ethical and clinical protections such as patient autonomy, informed consent, and assessments of mental capacity. Under the safeguards in the proposal, psilocybine for end-of-life existential distress would be permitted only in a medically supervised setting and delivered as part of psychotherapy, with the

[18] Gaddey HL, Mason B, Naik A. Depression: Managing resistance and partial response to treatment. Am Fam Physician. 2024;109(5).

[19] Cleveland Clinic. Treatment-Resistant Depression: What It Is & Symptoms. Updated 16 May 2023.

[20] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR). Washington, DC: APA; 2022.

[21] American Psychiatric Association. DSM-5-TR Update Supplement. September 2025.

[22]Thomas C, Kulikowski JD, Breitbart W, et al. Existential suffering as an indication for palliative sedation: Identifying and addressing challenges. Palliat Support Care. 2024;22(4):633-636

[23] Boston P, Bruce A, Schreiber R. Existential suffering in the palliative care setting: An integrated literature review. J Pain Symptom Manage. 2011;41(3):604-618

[24] Bates AT. Addressing existential suffering. BC Med J. 2016;58(5):268-273.

[25] Kissane DW, Appleton J, Lennon J, et al. Psycho-existential Symptom Assessment Scale (PeSAS) screening in palliative care. J Pain Symptom Manage. 2022;64(5):429-437.

[26] Ferrell B, Borneman T. Existential distress at the end of life. In: Spiritual Care in Palliative Care. Springer; 2024.

[27] Lo C, Panday T, Zeppieri J, et al. Preliminary psychometrics of the Existential Distress Scale in patients with advanced cancer. Eur J Cancer Care. 2017;26(6):e12597.

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patient's diagnosis and proposed treatment confirmed by one or more independent specialist physicians. In addition, palliative care specialists who prescribe or authorise the supply of psilocybine would be required to complete specific training and meet the same approval requirements that apply to specialist psychiatrists participating in the TGA's Authorised Prescriber Scheme.

Whilst the proposal seeks to improve quality of life for patients at the end of life and alleviate severe psychological distress where existing interventions have been insufficient, major stakeholders, including Palliative Care Australia, have advised to await the outcomes of more advanced clinical trials before considering further amendments to the current regulatory settings.

On balance, I agree that the current evidence base is not sufficient to support the proposal. I agree with the Committee that the Schedule 9 entry for other uses of psilocybine is not a substantial regulatory impost for generating additional clinical data regarding the efficacy and safety of psilocybine as a psychotherapy. Along with the Committee, I acknowledge that existential distress is a unique form of psychological pain but currently there is no internationally recognised definition of existential distress in research literature. The Committee agreed that together with the limited evidence base for therapeutic efficacy and the lack of sufficient clarity regarding clinical diagnosis of the condition, prescribing practices, and dispensing regulation, it is impractical to implement the proposed scheduling. It should be noted that without a Schedule 8 entry for the indication of use in existential distress, clinical access remains available via the current Schedule 9 entry which can be utilised for clinical trials.

The Committee are of the opinion that should additional evidence become available, in accordance with the criteria that must be considered under the Act, scheduling may be revisited. This includes sufficient clarity around the training or qualifications of 'independent reviewing specialist doctors' and their authority to prescribe psilocybine. It also includes clearly defined and broadly accepted clinical diagnostic criteria for patients.

For the reasons listed above, I am satisfied that the current scheduling of psilocybine for the proposed indication remains appropriate and that the risks and uncertainties in implementation of a Schedule 8 entry for this indication outweigh the benefits with the current limited evidence. As per Committee recommendations, submissions will be sought from the relevant peak professional bodies who have not made submissions as part of the public consultation prior to making a final decision.

In considering the present proposal, I have had regard to the Delegate's final decision of February 2023 in relation to psilocybine for treatment-resistant depression (TRD). That decision accepted that the therapeutic value of psilocybine was not yet fully established but concluded that, in the context of TRD, the balance of benefits and risks favoured a limited expansion of access under Schedule 8, having regard to the existence of a well-characterised underlying psychiatric condition, a growing body of clinical evidence including later-phase clinical trials (including Phase 3), and the capacity to operationalise diagnostic criteria and treatment protocols under the Authorised Prescriber Scheme with oversight of the HREC.

While the current proposal similarly seeks to rely on controlled settings and specialist oversight to mitigate risk, it differs materially in the nature of the condition proposed to be treated and the maturity of the supporting evidence. Unlike TRD, existential distress at end of life is not a recognised diagnostic category within established psychiatric classification systems and lacks agreed diagnostic criteria or standardised treatment protocols that can be operationalised, creating additional risks if implementation.

Further, the clinical evidence base supporting this indication remains limited and heterogeneous, with small sample sizes, mixed findings, and low certainty of effect. In these circumstances, and notwithstanding the similarities in proposed safeguards, I am not satisfied that the factors which supported the 2023 amendment apply with equal force for the current proposal. Accordingly, I do not consider that deciding not to amend the current scheduling of psilocybine in this instance is inconsistent with the earlier decision but rather reflects a different balance of the matters required to be considered under section 52E of the Act in light of the specific indication, evidentiary base, and implementation risks presently before me.

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