Elite Learning Podcast

Psychedelic-Assisted Therapy and Psychiatric Nursing

From underground to operational—psychedelic therapy isn't theoretical anymore. It's time to prep for protocols, REMS, and real-world care. ✨

⏱️ **Listen time: ~65 minutes** • 👥 **Audience: Mental health professionals, pysch-curious clinicians, psychiatric nurses, RNs, APRNs** • 🎧 **Listen now:** elitelearning.com/ce-podcasts

Featured Voices

Host: Dr. Candace Pierce, DNP, RN, CNE, COI Faculty with Elite Learning by Colibri Healthcare, nurse educator, and advocate passionate about transforming nursing education	**Guest: Nicholas Goodwin, DNP,** Psychiatric NP specializing in esketamine treatment, ketamine-assisted psychotherapy, and psychedelic integration care

What You'll Learn

- The difference between ketamine (generic IV) and esketamine (brand-name nasal spray)
- Why REMS requirements exist and what nurses must document
- Baseline screenings: contraindications, DSM-5 gatekeeping, and insurance hurdles
- How to manage dissociation panic, blood pressure spikes, and nausea without escalating to 911
- Discharge criteria: when is a patient stable enough to leave with a ride?
- The medical vs. experiential debate—and why Oregon's non-medical clinics matter
- FDA approval pathways: fast-track, phase III trials, and why MDMA was denied
- Training needs for nurses entering psychedelic-assisted care

Key Takeaways

Psychedelic therapy is operational—not alternative: FDA has draft guidance, esketamine has REMS, and multi-site trials show efficacy in treatment-resistant depression.

Ketamine is not esketamine: Racemic ketamine (generic IV) vs. S-ketamine isomer (brand nasal spray). Think Celexa vs. Lexapro—similar, but insurance only covers esketamine.

REMS = Risk Evaluation & Mitigation Strategy: Mandatory for esketamine. Log patients, monitor dissociation/BP/diversion, report adverse events. Expect this for psilocybin and future approvals.

Insurance is the gatekeeper: Esketamine requires major depressive disorder (not bipolar), 2+ failed med trials, and stable blood pressure. Off-label use = patient pays out of pocket.

Medical vs. experiential pathways are both happening: Oregon allows non-medical psilocybin clinics for experience, while medical providers push for FDA approval and insurance coverage.

Dissociation panic is the #1 nursing skill gap: Patients think this will never end or I am dying. You cannot negotiate—just sit, reassure, play music, and wait 30-60 minutes. IV lorazepam optional.

Blood pressure rarely spikes: 1 in 3-5 patients see a transient increase. Recheck manually, let them chill 20 minutes, or give clonidine. If symptomatic at 180/110, send to ER.

Nausea is preventable: Ask screening: Do you get nauseous easily? Offer Zofran 4-8mg before dosing. Esketamine drips down throat and tastes gross—warn them or they will be shocked.

Discharge = 2 hours post-dose minimum: Dissociation wears off in 30-60 minutes. If they can walk, have a ride, and are not symptomatic, they are safe to go—even if a little sedated.

Absolute contraindications: Pregnancy/breastfeeding, severe hepatic impairment, uncontrolled hypertension, aneurysmal vascular disease, history of intracerebral hemorrhage. Active substance use = pause.

Bipolar exclusion is an FDA technicality, not a clinical one: Esketamine only approved for MDD. But ketamine works in bipolar depression if patient is on a mood stabilizer and not manic. Off-label = fair game.

Stigma delays treatment by years: I heard about Matthew Perry is a real barrier. Patients need time to research and feel ready—do not push if they are ambivalent.

Fast Facts That'll Make You Think

- Esketamine is FDA-approved with a mandatory REMS program: in-clinic dosing + 2-hour monitoring, no exceptions
- Ketamine (racemic) is generic and widely accessible—some clinics now ship it home (raising safety concerns)
- Psilocybin is legally available in Oregon for experiential use in non-medical clinics—no DSM-5 diagnosis required
- MDMA for PTSD was denied FDA approval in 2024, despite fast-track status and phase III trials
- Psychedelic research thrived from 1943-1970, then halted by the Controlled Substances Act—we lost 50+ years of science
- Only 1 of 3 esketamine phase III trials was positive, yet FDA approved it using a maintenance study as the second win
- Matthew Perry's ketamine-related death increased public stigma—patients now mention it in initial consults
- Washington state plans psilocybin rollout by 2027 for both medical and non-medical use

Do This Next

- [ ] Review your state's psychedelic legislation—search your state psilocybin bill 2025
- [ ] Bookmark the FDA's draft guidance on psychedelic drug development
- [ ] Complete training in de-escalation, motivational interviewing, and trauma-informed care
- [ ] Shadow an esketamine clinic or reach out to a Spravato provider to observe workflows
- [ ] Join Open Nurses Facebook group to stay updated on psychedelic nursing discussions
- [ ] Learn your facility's policy on ketamine—who can prescribe? Who can monitor?
- [ ] Practice your informed consent script: dissociation, bad taste, 2-hour commitment, no driving

Clinical Spotlight: Core Concepts

REMS (Risk Evaluation & Mitigation Strategy: FDA-mandated drug safety program. Providers log patients, monitors for adverse events, and report serious incidents. Required for high-risk meds like esketamine.

Dissociation: Out-of-body, dreamlike state. Not the same as PTSD dissociation. With ketamine, it is temporary (30-60 min), but can trigger panic if intense.

Treatment-Resistant Depression (TRD): Depression that has not improved after 2+ adequate medication trials. TRD is the disorder esketamine was invented for—but it is not in the DSM-5.

Fast-Track Designation: FDA status for drugs addressing unmet needs with promising data. Speeds up review process. Esketamine, psilocybin, and MDMA all got it—but approval is not guaranteed.

Phase III Trials: Large-scale studies proving safety and efficacy. FDA typically requires 2 positive phase III trials. Esketamine had 1 positive trial + 1 maintenance study.

Integration vs. Therapy: Integration = processing the psychedelic experience afterward (can be done by trained facilitators). Therapy = structured, evidence-based psychotherapy (requires licensed therapist). FDA does not approve therapy—just drugs.

K-Hole: Slang for deep ketamine dissociation—feeling stuck in a disorienting, anxious state. Rare with esketamine dosing, more common with IV ketamine at higher doses.

🚨 Red Flags: When to Pause or Refer

- Uncontrolled hypertension at baseline (treat first, dose later)
- Active substance use (screen with UDS—history is okay, active use is not)
- Pregnancy or breastfeeding (absolute contraindication)
- Severe hepatic impairment, aneurysmal vascular disease, history of intracerebral hemorrhage
- Patient is ambivalent or pressured into treatment (My therapist said I should try this)
- Only 1 failed med trial—insurance will deny, and patient may respond to another SSRI
- Bipolar disorder + manic symptoms currently (esketamine only approved for MDD, not bipolar)
- Patient expects cure or one-time miracle—set realistic expectations for gradual improvement
- No reliable ride home or unstable housing—post-dose safety requires support
- Dissociation panic lasting more than 90 minutes or requiring repeated IV lorazepam—escalate care

💼 Nursing Skills Checklist

What you need to be competent in psychedelic-assisted care:

- Baseline screening: contraindications, med history, substance use, pregnancy status
- Vital sign monitoring: manual BP checks, pulse ox, recognizing trends
- Dissociation management: calm presence, grounding techniques, music therapy, sitting with discomfort
- De-escalation for panic: non-negotiable reassurance, time-limited statements (This will pass in 20 minutes)
- Nausea/vomiting: prophylactic Zofran, scopolamine patches, lidocaine gargle for throat numbing
- Blood pressure spikes: clonidine administration, when to call AMR (symptomatic + 180/110)
- Discharge assessment: stability, coordination, safe ride home, post-visit instructions
- REMS documentation: logging treatments, reporting adverse events, tracking diversion risks
- Informed consent delivery: dissociation, taste, time commitment, driving restrictions, realistic expectations
- Trauma-informed communication: validating concerns, pacing education, avoiding coercion

💬 Conversation Starter

If psychedelic therapy had been continuously researched from the 1970s to now—instead of being halted—how might psychiatric care look different today?

For Psych Nurse Educators

Add psychedelic-assisted therapy to your pharmacology or mental health clinical courses. Cover REMS workflows, dissociation management, and informed consent scripts. Assign students to research their state's psychedelic legislation and present on implications for psychiatric nursing practice. This is the future—teach it now.

🔗 Resources & Links

FDA Draft Guidance on Psychedelic Drug Development: https://www.fda.gov

Esketamine (Spravato) REMS Program: https://www.spravatohcp.com

State-by-state psychedelic legislation tracker: https://recovered.org/hallucinogens/psilocybin/psilocybin-legal-status

Episode page: https://elitelearning.com/ce-podcasts

CE courses: https://EliteLearning.com

Colibri Healthcare

🎧 **Subscribe & Share**

Apple Podcasts • Spotify • YouTube • EliteLearning.com

Disclaimer: Educational content only. Not legal, financial, or medical advice. Views are the speakers' own.

📧 **Contact:** EliteLearning.com | Social: @ColibriHealthcare