AMAPP

Australian Multidisciplinary Association for Psychedelic Practitioners

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POSITION STATEMENT

Clarifying the Evidence Base: A Response to RANZCP Public Commentary on Cannabinoid Prescribing and the Wilson et al. (2026) Review

Prepared by: Australian Multisciplinary Association for Psychedelic Practitioners (AMAPP)
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Contact: chair@amapp.org.au
ACN 666 322 256 | ABN 61 666 322 256 | info@amapp.org.au

Executive Summary

AMAPP supports rigorous scientific evaluation of medicinal cannabis. While current randomised controlled trial (RCT) evidence in psychiatry is limited and heterogeneous, recent public commentary may risk overstating conclusions and underrepresenting clinical nuance.

This statement clarifies key distinctions in the evidence base, emphasising that absence of evidence is not evidence of absence, and that clinical decision-making requires integration of multiple forms of evidence, including real-world data and patient context.

About AMAPP

AMAPP is the peak professional body representing psychedelic-assisted therapy practitioners in Australia, advancing safe, ethical, and evidence-informed practice across emerging therapeutic domains.

AMAPP's mission is to create a trusted and ethical space for practitioners to thrive. Through peer support, advocacy, education, and resources, AMAPP strengthens a movement that honours healing, integrity, and the responsible role of emerging therapies in mental health care.

AMAPP is guided by three core pillars:

Peer Support
A connected, multidisciplinary community supporting professional development, ethical practice, and practitioner wellbeing.

Advocacy
Promoting safe, equitable, evidence-informed access, harm reduction, and client rights.

Trust
Integrating research into real-world practice with scientific rigour, openness, and a commitment to balancing potential and risk.

Core Position

The Australian Multidisciplinary Association for Psychedelic Practitioners (AMAPP) supports rigorous scientific evaluation of medicinal cannabis and agrees that current RCT evidence in psychiatry is limited and heterogeneous.

However, AMAPP is concerned that recent public communication by the Royal Australian and New Zealand College of Psychiatrists (RANZCP, 2026) may risk overstating conclusions and underrepresenting clinical nuance.

It is essential to distinguish between absent evidence, weak evidence, low-certainty evidence, and evidence of harm. These are not equivalent.

Scientific caution must not become scientific overreach.

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1. Scale and Context of Clinical Use

A significant driver of the limited RCT evidence base is structural rather than scientific. Cannabinoids are derived from a natural plant and are inherently more difficult to patent in their natural form, reducing the commercial incentive that typically drives large-scale pharmaceutical trials (Nutt et al., 2013).

Notwithstanding this limitation, the scale and duration of real-world clinical use is substantial. Canada implemented regulated medical cannabis access in 2001, representing over two decades of accumulated clinical experience (Health Canada, 2001; Hathaway et al., 2022).

In Australia, prescribing has grown rapidly since access pathways were introduced in 2016, with approval volumes exceeding 80,000 per month as of 2024 (Therapeutic Goods Administration [TGA], 2024).

Any meaningful evaluation of medicinal cannabis should consider this broader ecosystem of evidence, including real-world clinical experience alongside RCT data.

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2. Scope of Wilson et al. (2026) and the Limits of RCT-Only Analysis

Wilson et al. (2026) is a systematic review and meta-analysis restricted to peer-reviewed RCTs. While RCTs are considered the gold standard for determining efficacy, they do not represent the full scope of clinically relevant evidence.

Open-label trials, observational studies, case series, and accumulated clinical experience contribute meaningfully to understanding safety, tolerability, and potential benefit—particularly where structural barriers limit trial development (Sackett et al., 1996; Greenhalgh et al., 2014).

The broader evidence base does not support claims that there is “no evidence” of clinical utility.

The principle remains: absence of evidence is not evidence of absence (Altman & Bland, 1995).

Limited RCT evidence should therefore not be interpreted as conclusive evidence of no clinical utility.

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3. Heterogeneity and Interpretation of Findings

Wilson et al. (2026) analysed 54 RCTs involving 2,477 participants across a 45-year period, identifying significant heterogeneity across formulations, dosages, populations, durations, and outcome measures.

This heterogeneity limits interpretability and reduces the strength of pooled conclusions.

Where findings are described as showing “no significant effects,” a more precise interpretation is that there is insufficient evidence to determine whether cannabinoids have a significant effect. These positions are scientifically distinct (Altman & Bland, 1995).

Importantly, no eligible RCTs were identified for depression, despite it being a common prescribing indication. Absence of eligible trials cannot be interpreted as evidence of no efficacy.

4. Trial Formulations and Real-World Practice

Many included RCTs used formulations that do not reflect current prescribing practices in Australia, including nabiximols (Sativex®) and cannabidiol products (e.g., Epidyolex®).

Nabiximols delivers a relatively low and fixed dose per actuation (approximately 2.7 mg Δ9-THC and 2.5 mg CBD per spray), which differs from dosing ranges commonly used in broader clinical practice (GW Pharmaceuticals, 2022).

Similarly, Epidyolex® is a high-concentration cannabidiol formulation (100 mg/mL) developed primarily for treatment-resistant epilepsy, and its use in psychiatric contexts is not representative of most contemporary prescribing practices (Jazz Pharmaceuticals, 2022).

This discrepancy limits the external validity of pooled findings. The key issue is the alignment between trial conditions and real-world prescribing practices.

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5. Safety Requires Nuanced Interpretation

Adverse events associated with cannabinoids require careful monitoring. However, safety profiles vary significantly across formulations, doses, and cannabinoid compositions.

The Therapeutic Goods Administration (TGA) decision to down-schedule cannabidiol applies to oral preparations up to a maximum daily dose of 150 mg for adults, following a safety review indicating that adverse events were not serious (TGA, 2020).

While sometimes described as “low-dose” in regulatory terms, this threshold represents a clinically meaningful range and should be interpreted within the context of safety and accessibility rather than minimal pharmacological activity.

This highlights the importance of formulation- and dose-specific interpretation, rather than generalised conclusions.

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6. Clinical Decision-Making Beyond RCT Evidence

Public statements suggesting that prescribing is “rarely justified” risk conflating population-level uncertainty with individual clinical decision-making.

Clinical justification requires integration of:

- Evidence
- Patient context
- Safety and tolerability

- Available alternatives

(Sackett et al., 1996)

Many psychiatric treatments demonstrate modest or variable efficacy. Standards of evidence should be applied consistently (Cipriani et al., 2018; Leucht et al., 2012).

What AMAPP Calls For

AMAPP calls for:

- Greater precision in public communication of scientific findings
- Balanced consideration of RCT, observational, and real-world evidence
- Recognition of structural barriers to RCT development for natural products
- Acknowledgement that clinical decision-making extends beyond RCT data
- Investment in high-quality, longer-duration, formulation-specific research

This approach supports both scientific integrity and patient-centred care in emerging therapeutic domains.

AMAPP remains committed to safe, ethical, and evidence-informed practice.

Appendix: RANZCP LinkedIn Post

Royal Australian and New Zealand College of Psychiatrists (RANZCP)
LinkedIn post, 19 March 2026

“A landmark review has found there is no evidence to support medicinal cannabis treatment for mental illnesses including anxiety, depression and PTSD.”

“There is no evidence to support the use of cannabis in the majority of psychiatric illnesses.”

“Emergency departments in Queensland had seen a rise in teenagers who experienced psychosis after using medicinal cannabis that never should have been prescribed to them.”

“The vast majority of prescriptions for mental illness were from doctors who did not have specialised psychiatry training.”

AMAPP Response

Wilson et al. (2026) do not conclude “no evidence.” Rather, they identify limited, heterogeneous, and low-certainty evidence.

AMAPP's position is that:

- Limited evidence does not equal no evidence
- Absence of evidence is not evidence of absence
- Heterogeneity limits conclusions
- Clinical decisions require more than RCT data alone
- Trial formulations do not reflect real-world prescribing

Statements such as "no evidence" may risk:

- Misrepresenting the scientific literature
- Undermining patient trust
- Reducing clinician confidence
- Increasing unregulated use

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