A Public Health Rebuttal to *The Guardian*'s Coverage of Oregon's Psilocybin Program

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Introduction

On Dec. 12,2025, The Guardian published an article titled '*The attrition is setting in: how Oregon's magic mushroom experiment lost its way*' examining Oregon's regulated psilocybin program. For many readers, particularly those working inside the field, the piece could easily be read as disheartening and alarming, suggesting an industry that is buckling under economic pressure, regulatory weight, and limited access.

I want to offer a different perspective.

What is currently unfolding in Oregon's psilocybin ecosystem is not a sign of failure. It is, in fact, a highly predictable and well-documented phase of early adoption in a brand-new public health model that is unfolding under extraordinary social, legal, and historical constraints.

This article offers a public-health and systems-level rebuttal to several of the claims and implications raised in The Guardian piece. Rather than viewing the program through a narrow economic or snapshot-in-time lens, I expand the frame to include historical precedent, diffusion science, workforce realities, regulatory ethics, and most importantly, the lived outcomes reported by clients and practitioners.

Across the following sections, I address the article's core concerns point by point, offering multiple rebuttals for each claim. These rebuttals are grounded in peer-reviewed research, government data, and established public-health frameworks. The goal is not to dismiss criticism, but to contextualize it accurately, and to prevent a premature narrative of failure from doing real harm to a field that is, by every meaningful measure, still taking its first steps.

When we zoom out, a different picture emerges: one of profound healing, cautious normalization, ethical course-correction, and long-term growth. The feedback from clients consistently reflects deep, often life-changing benefits. The regulatory model, while imperfect, represents a serious attempt to bring a historically underground practice into safe,accountable, transparent, and

ethical care. What follows is an invitation to widen the lens, and to understand why what we are seeing now is just the beginning of this program.

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I. Market Dynamics: Distinguishing Attrition from Failure

The Guardian narrative that Oregon's psilocybin program is "buckling" because of service center closures is a surface-level observation that lacks historical, structural, and sociological context.

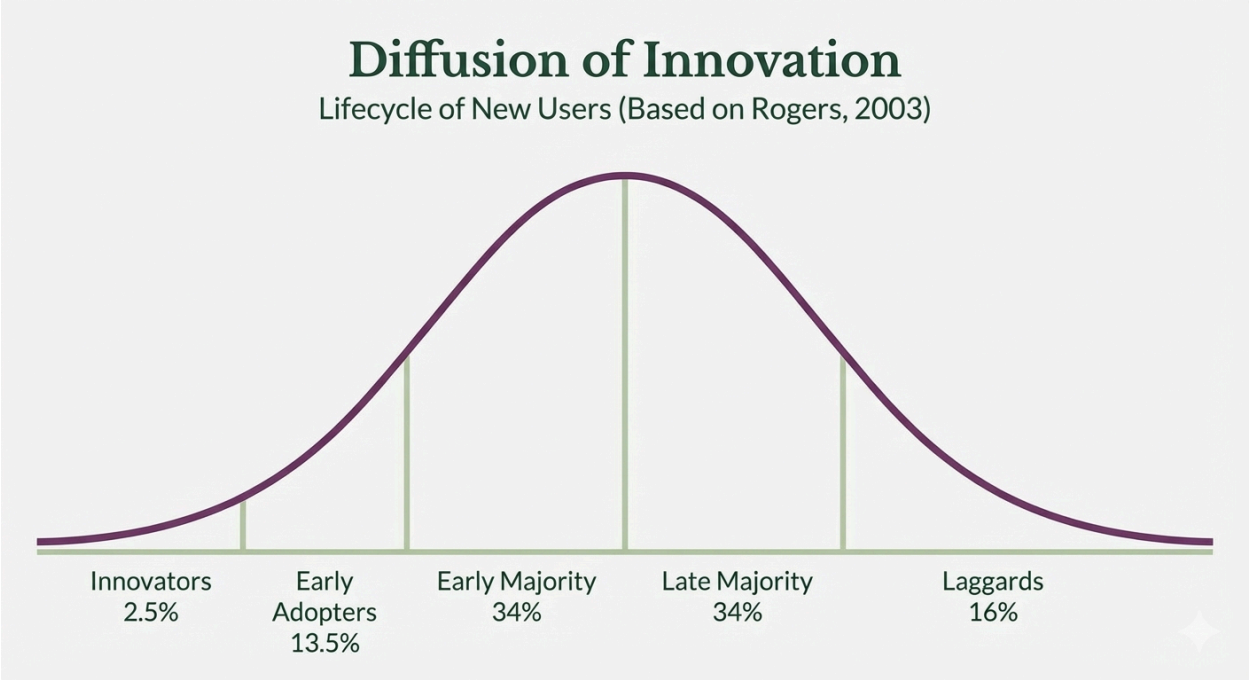
When we look at this through the lens of public health and emerging markets, what we see is a predictable normalization process.

1. The Diffusion of Innovation: Our Current Position

To understand the current state of psilocybin in Oregon, we must use the Diffusion of Innovation Model. From massage therapy to midwifery, every paradigm-shifting health intervention follows a specific curve: Innovators, Early Adopters, Early Majority, Late Majority, and Laggards (Rogers, 2003).

We are currently in the transition between "Innovators" and "Early Adopters." In this stage, attrition is a feature of market maturation. Unlike traditional startups, we are fighting 50 years of "War on Drugs" propaganda.

Another challenge is that the most powerful tool for Early Adopters, word of mouth, is suppressed because clients are often still afraid to share their transformative experiences due to lingering social stigma.



2. The Framework for Adoption: Designing for Diffusion

For a health innovation to succeed in a complex regulatory environment, it must navigate the Designing for Diffusion (D4D) framework. Recent global health research identifies critical factors for success, including the navigation of policy context and the reduction of social stigma. Successfully bridging the gap between a new therapeutic concept and the mainstream public requires "Linking Agents" who can translate clinical benefits into accessible community care. This

academic roadmap is essential for the psilocybin industry to move from early adoption into a sustainable public health reality (Shin et al., 2022).

3. Market Maturation at the Five-Year Milestone

Oregon's psilocybin services are currently reaching a standard five-year milestone of market maturation. The rate of business renewals remains consistent with regular economic cycles for any pioneering health sector. National statistics from the Bureau of Labor Statistics show that roughly 20 percent of new businesses across all sectors fail within their first year, and nearly 50 percent fail within five years (U.S. Bureau of Labor Statistics, 2024–2025). The handful of closures reported in the media represents a small fraction of the total licensed service centers and facilitators currently operating in the state. These closures are a predictable outcome of standard market forces within a brand-new, highly regulated industry.

4. A Growing National Movement

Oregon is the first domino in this public health revolution. Colorado and New Mexico have launched their own psilocybin programs. Arizona, New Jersey, Massachusetts, and Connecticut are moving rapidly toward similar frameworks. Market research projects that the psychedelic therapeutics industry was valued at roughly 3.1 billion dollars in 2025, and is expected to soar to over 12 billion dollars by 2035 (Roots Analysis, 2025). This represents a historic normalization process in real time. We are seeing the exit of the speculators and the rise of the true professionals.

II. The Affordability Paradox: Value-Based Pricing in Mental Health

The critique that Oregon's psilocybin services are cost-prohibitive often lacks the economic context of traditional mental healthcare. When evaluated through a "Time-for-Money" or "Value-Based" lens, psilocybin services emerge as one of the most cost-effective interventions currently available in the public health landscape.

1. The "Five Years of Therapy" Metric

A common sentiment among participants is that a single psilocybin experience can provide the emotional breakthrough equivalent to five years of traditional talk therapy. The financial implications of this comparison are significant:

- **Traditional Care:** A licensed psychologist in 2025 charged an average of $250 per hour. Over five years, a standard weekly session schedule totals 260 hours, resulting in a $65,000 investment.
- **The Psilocybin Investment:** Even at a price point of $3,000, psilocybin represents a 95 percent cost reduction compared to the traditional care it may replace. Recent research

supports this, showing that depressive remission from a single session can last for years (Davis et al., 2025).

2. The "Hour-for-Hour" Professional Reality

The public often perceives the fee as a price for the medicine itself, rather than the comprehensive therapeutic container provided by the practitioner. In reality, a facilitator provides 15 to 25 hours of undivided, high-level attention.

According to frameworks established by researchers like Janis Phelps, the "Core Competency" of this work is trust enhancement (Phelps, 2017) . Rushing the intake process to save on costs would compromise the safety of the experience. Whether a participant requires three weeks of trust-building preparation or ten hours of continuous presence during a session, the professional fee covers the labor-intensive reality of this deep work.

3. The Midwifery Model of Safety

License fees and administrative requirements serve the same purpose as the regulations found in midwifery. Midwifery is regulated under the Oregon Health Authority and the Department of Regulatory Agencies (DORA) in Colorado. Psilocybin is held to these same high standards for the protection of the client. The licensure fees and facility standards for service centers are remarkably similar to those for birth centers. These costs provide a framework for professional accountability (Oregon Health Authority, OAR 333-076-0000).

Operating within a state-sanctioned framework ensures a path for recourse and a professional code of ethics. This legitimacy creates a safe harbor for the public. We are establishing a professional standard that protects the client and ensures ethical oversight.

4. Value-Based Outcomes: Calculating the "Return on Life"

True affordability is measured by the long-term health expenditures a treatment removes from a person's budget. While individual results vary, many participants experience a return on investment that far exceeds the initial session fee.

The following cases represent typical outcomes reported by clients over a two-year period following their sessions:

- **Nervous System Regulation:** One participant previously spent $150 weekly on specialized bodywork to manage chronic cortisol levels, totaling $15,600 over two years. Following her psilocybin work and integration, she gained the ability to regulate her own nervous system independently, resulting in a net saving of over $13,000.
- **Alcohol Cessation:** A participant previously consuming wine every two to three days spent approximately $5,300 over two years. Following a single session, he reported a near-total cessation of alcohol use, saving over $3,300 after accounting for the cost of the session.

Beyond the financial metrics, the "Return on Life" represents the recovery of years lost to isolation or grief. For a dancer who found the courage to return to her community after years of self-isolation, or a widower who transitioned from a loop of loneliness to active social participation, the value is immeasurable. These are not just "trips"; they are biological and emotional resets that allow individuals to stop being "patients" and start being active participants in their lives.

5. The Pricing Spectrum and the Insurance Gap

The media often highlights outlier prices of $3,000, but this does not represent the industry standard. Most independent practitioners in Oregon set fees ranging from $800 to $2,500. Furthermore, the industry is not waiting for state intervention to solve the access problem. Most independent facilitators already operate Social Equity Plans, providing sliding scales and reduced rates out of their own pockets because they believe in the efficacy of the medicine (Oregon Psilocybin Services, 2024).

The primary barrier to access is not practitioner greed, but the current lack of insurance coverage. To blame facilitators for the cost of services is to ignore that they are providing a revolutionary public health service without the institutional support or reimbursement provided to every other form of healthcare. The Oregon model is currently operating a 21st-century health solution within a legacy insurance system that has yet to catch up to the science.

III. The Demographic Mirror: Navigating the Narrative of Gentrification

The observation that Oregon's current participant base is predominantly white, higher-earning, and over the age of 44 often fuels a narrative of psilocybin gentrification. This is a significant and sensitive critique. For many, the professionalized model mirrors the exclusions of the existing healthcare system. As a BIPOC-led organization, we approach this conversation with empathy. These statistics reflect the landscape we are working within and the historical trust gap between marginalized communities and medical institutions.

1. The Context of the Oregon Landscape

The current data mirrors the demographic reality of the state. Oregon's general population is over 72 percent White, and in many counties, that figure reaches 85 to 90 percent. Furthermore, the traditional mental health workforce in Oregon is 93 percent White (Oregon Health Authority, 2025). To understand why the early adopters of this program look the way they do, we must acknowledge that this initiative was built within a pre-existing demographic framework.

2. The Invisible Demographic

Public data often ignores a significant population of participants who use this medicine in silence. Due to the federal status of psilocybin, many individuals—including federal employees, military

veterans, and professionals in high-security fields—cannot publicly disclose their participation. These individuals seek a path out of long-term pharmaceutical loops. They require the discretion and legitimacy that only the Oregon model provides. The visible data represents only those who feel safe enough to be counted.

3. The Generation of Exhaustion

While the age of the average participant is often viewed through the lens of income, in practice, this group represents a generation of exhaustion. These participants have spent decades navigating the limitations of traditional pharmaceuticals and talk therapy. They have tried every other clinical option and are finally seeking a biological and emotional reset that works.

4. The Diffusion of Innovation

In the scientific model of Diffusion of Innovation, the first 2.5 percent of participants—the innovators—are almost always those with the highest financial security and risk tolerance (Rogers, 2003). This is a standard pattern in the rollout of any new health system. We view this as a starting point rather than a final destination.

5. Restoring Trust Through Representation

Communities of color have a well-earned distrust of new medical systems. As a BIPOC woman and school owner, I know that building a therapeutic alliance with my community takes time and a specific type of safety. We are doing the slow, deep work of restoring the trust that the traditional system eroded over decades (Phelps, 2017). We are stewards of a new way of being. The future of this medicine is found in the diversity of the leaders brave enough to hold the space today, ensuring that as this model matures, it moves toward a truly inclusive public health reality.

IV. The Resilient Middle: A New Path for Public Health

The suggestion that Oregon's non-medical framework creates risk overlooks the history of this medicine and the depth of specialized facilitator training. We are moving toward a structure that prioritizes community safety and cultural integrity.

1. The Somatic Approach and the History of Care

The pioneers of this work were Indigenous healers and community stewards. Their expertise was rooted in human connection. Maria Sabina, the Mazatec healer who introduced this medicine to the West, was a master of this practice without holding a formal medical degree. She remains the grandmother of our current work (Estrada, 1981).

In alignment with state standards and ancient wisdom, our training focuses on a trauma-informed, non-directive, and empathetic abiding presence (OHA Psilocybin Services, 2025). We safeguard a sacred experience. Effective facilitation requires a regulated nervous system and a deep

commitment to the participant. We provide a therapeutic alliance that focuses on the innate intelligence of the individual.

2. Defining the Resilient Middle

The Oregon model occupies the resilient middle of the psilocybin landscape. We exist between the unregulated underground and the cold, clinical medical model. While the underground offers accessibility, it lacks the oversight and accountability necessary for public safety. While the medical model offers clinical data, it often strips the medicine of its heart and human connection (Kaczmarczyk et al., 2023).

The resilient middle combines the best of both worlds. We maintain the high safety standards and ethical accountability of a regulated system while preserving the somatic, heart-centered approach of traditional care. This is a new category of public health.

3. The Future of the Model

We believe that the price of legitimacy is a necessary investment in the integrity of the work. We are doing the heart-centered work of restoring trust in a system that has historically failed the individual. We are building a safe harbor for everyone ready to step out of the shadows and into a supported, legal journey.

V. The Safe Harbor: Integrity Over Attrition

The regulatory framework in Oregon is often described as a stranglehold that threatens the industry's survival. From my perspective as a school owner and practitioner, these rules represent a necessary investment in accountability. We are establishing a system where this medicine is protected from the influence of ego and the lack of oversight that characterized the unregulated market.

1. The Professional Standard

The high cost of state licensure is a frequent point of criticism. However, these standards are the floor of a safe house. Just as midwifery moved from the fringes into a regulated framework to protect families, psilocybin is moving into a structure that protects the participant (Oregon Health Authority, OAR 333-076-0000). In the unregulated market, safety was often an illusion dependent on the individual facilitator. We pay for state legitimacy to ensure there is a professional code of ethics and a clear path for recourse.

2. Bridging the Federal Shadow

The program's costs are influenced by the federal status of the medicine, which creates unique operational hurdles (Oregon Revised Statutes 475A.290, 475A.305 & 475A.310). Many participants are professionals—including teachers, parents, and federal employees—who require a

state-sanctioned environment to feel safe. They are seeking an exit from decades of pharmaceutical dependence. By maintaining a legitimate, trauma-informed process, we ensure these individuals can access self-care without the stigma of criminalization.

3. The Resilience of the Middle Way

The current phase of the industry is a period of distillation. While some see attrition, I see a resilient community of practitioners who are committed to the long-term integrity of the work. We are the innovators who believe in the human connection at the heart of this medicine.

Conclusion: A Path Forward

The current critiques of Oregon's psilocybin program capture a snapshot of a beginning, not the conclusion of an experiment. Beyond the headlines of cost and demographics, there is a community of stewards holding the line for a new kind of healing. We are witnessing individuals find freedom from lifelong negative thought loops. We are training a new generation of facilitators in a somatic, non-directive presence. We lead with heart and social equity to prove that a human-centered public health model is possible (Oregon Psilocybin Services, 2024).

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