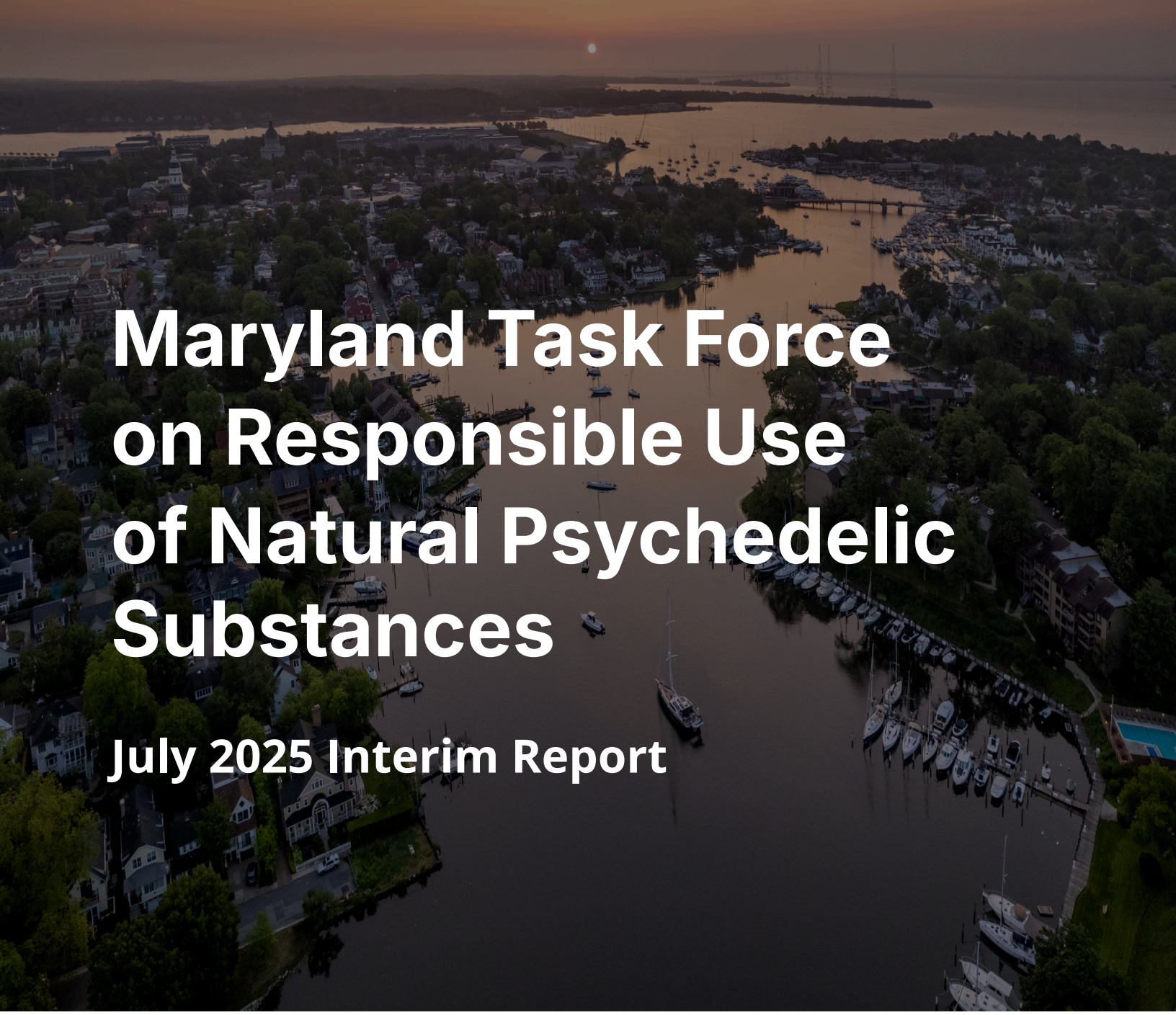

Maryland Task Force on Responsible Use of Natural Psychedelic Substances

July 2025 Interim Report

MCA
MARYLAND
CANNABIS
ADMINISTRATION

Chapters 792 and 793 of 2024 establish the Maryland Task Force on Responsible Use of Natural Psychedelic Substances, staffed by the Maryland Cannabis Administration. The Task Force is charged with studying existing laws, policies, practices, and data relating to the use of psilocybin/psilocin (from mushrooms), dimethyltryptamine (from plants), and mescaline (from cacti); and making legislative recommendations which may involve access to regulated treatment, public education, safe production, and transition from criminalization.

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Executive Summary

The Maryland Task Force on Responsible Use of Natural Psychedelic Substances was established by the General Assembly to evaluate and recommend policy frameworks for legal access to natural psychedelic substances. Since convening in late 2024, **the Task Force has held over 100 meetings, reflecting more than 500 hours of volunteer service by Task Force members above and beyond their professional responsibilities.** This extraordinary public commitment underscores the seriousness with which this body has approached its charge.

The findings presented in this interim report are grounded in **extensive stakeholder consultation, scientific literature review, public listening sessions, and a rigorous consensus-based process to form recommendations.** To analyze the merits and risks of various access frameworks, the Task Force employed a modified Delphi methodology and a structured Policy Impact Matrix. These tools have enabled members to evaluate 85 carefully crafted policy propositions across seven distinct policy models.

Our preliminary findings suggest a consensus supporting regulated frameworks such as medical and therapeutic use, supervised adult use, and/or commercial sales of natural psychedelic substances, with an initial focus on psilocybin. These models show promise in addressing unmet mental health needs, enabling safety oversight, and offering viable economic pathways for small businesses. **The Task Force does not support delaying state action pending future federal FDA approval.**

The Task Force will issue recommendations in October 2025, including further consideration of mescaline and DMT. The Task Force believes further work is needed before issuing a recommendation on religious use models and non-commercial peer sharing.

Maryland institutions have been leaders in psychedelic science since the 1950s. Maryland also leads in cannabis reform, with a widely respected medical program and the most extensive cannabis expungement effort in the country to date. The state is well-positioned to build on these precedents to craft responsible psychedelic policy that reflects Maryland values—centering safety, equity, scientific rigor, and public trust.

To that end, the **Task Force is partnering with economists from Johns Hopkins University to assess the potential economic and social impacts of different regulatory frameworks.** The Task Force is also **drawing on lessons from other states**—especially DC, Oregon, Colorado, and New Mexico—whose pioneering efforts have offered valuable insights into both successful innovations and early challenges.

The work of the Task Force continues, and **this interim report is shared with the public, lawmakers, and institutional stakeholders as an invitation to engage.** Between now and October 2025, the Task Force will continue its consultations, finalize its recommendations, and prepare a comprehensive report to guide thoughtful and evidence-based policy for Maryland. We hope this document makes clear the level of seriousness, care, and collaboration that have shaped our efforts, and that it will support continued dialogue as we move together toward final recommendations.

Guide to the Interim Report

These suggested reading paths highlight the most relevant sections for legislators, regulators, researchers, service providers, and members of the public. Each path is designed to support focused engagement with the material, whether the reader is developing legislation, preparing for regulatory implementation, contributing to public health strategy, or simply seeking to understand how psychedelic policy reform may affect their community.

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Preface: A Primer on Psychedelics

Providing essential context for policymakers and the public

What are "Natural Psychedelic Substances"?

Psychedelic substances are **a class of psychoactive substances** that induce non-ordinary states of consciousness, characterized by profound alterations in perception, mood, and cognitive processes. While some psychedelic substances are synthesized exclusively in laboratories (LSD, MDMA, Ketamine, etc.), others **naturally occur in plants and fungi**.

<table>
<tr><td colspan="9">Psychedelic Substances</td></tr>
<tr><td colspan="5">Natural</td><td colspan="4">Synthetic</td></tr>
<tr><td>Psilocybin / Psilocin</td><td>Mescaline</td><td>Dimethyltryptamine (DMT)</td><td>Ibogaine</td><td>And others</td><td>LSD</td><td>MDMA</td><td>Ketamine</td><td>And others</td></tr>
<tr><td colspan="3">Currently studied by this Task Force</td><td colspan="2">Out of scope, may be added later</td><td colspan="4">Out of scope, would require change in Legislative mandate to study</td></tr>
</table>

Figure 1. Psychedelic Substances Within and Beyond the Scope of this Task Force

Psilocybin / psilocin found in mushrooms	**Dimethyltryptamine (DMT)** found in plants	**Mescaline** found in cacti
		

Figure 2. Images of Psychedelic Substances Within the Scope of this Task Force

The substances studied by this Task Force are **physiologically safe** with low toxicity; low abuse potential; minimal risk of physical addiction, withdrawal, or dependence; and **no known fatal dose** in humans. Use by individuals with certain health conditions may be contraindicated. **Rare adverse psychiatric events can occur**, but these are usually short-lived and can be largely prevented by appropriate use of these substances.

In the brain, “classic psychedelics" activate the serotonin 5-HT2A receptor, increase connectivity between brain regions that typically communicate minimally, and promote neuroplasticity—**growth of new brain connections**.

Effects vary significantly depending on the substance, route of administration and dosage:

- At lower “microdoses”, users report **improved mood, cognition, and creativity**.
- At higher doses, users report **altered perception of time and space**, often mystical and transcendent experiences, such as being “one with the universe” or reliving memories.

Because they impact psychological states, experiences also vary based on “set” and “setting:”

- (mind)“Set” refers to the user’s internal psychological factors: mood, intentions, expectations, culture, worldview, physical health, mental preparation, etc.
- “Setting” refers to the user’s external environment: location, lighting, temperature, sensory input, social support, etc.

In many traditional and clinical settings, psychedelic use is framed not merely as a biochemical event, but as a socially and spiritually significant process. Whether in Indigenous ceremonies or structured therapeutic trials, practices often involve intentional preparation, supported sessions, and post-experience integration—highlighting the essential role of context in shaping outcomes.

Historical and Scientific Overview

Psychedelic plants **have been used for millennia** by global cultures in traditional healing and spiritual ceremony. Psychedelic research was popular in the mid 20th century until largely halted in the 1960s due to prohibition. There has been a significant resurgence of scientific research in recent decades, exploring therapeutic potential:

- The **Food and Drug Administration** designated psilocybin a **“breakthrough therapy.”**
- The **Department of Defense is funding psychedelic research** for military and veterans.
- **Maryland passed SB709 (2022)** funding research into psilocybin for PTSD.

A growing body of research shows promise in natural psychedelic substances for cost-effective mental health applications:

- Depression (including Treatment-Resistant depression)
- Anxiety (including End-of-Life anxiety)
- Post-Traumatic Stress Disorder (PTSD)
- Substance Use Disorders
- Chronic Headache and Pain
- Traumatic Brain Injury (TBI)
- Suicidality
- And more

Legal Overview

The natural psychedelic substances studied by this Task Force are classified Schedule I substances under the Controlled Substances Act (CSA): they are federally illegal and considered to have no accepted medical use and a high potential for abuse. **Despite federal prohibition, multiple states and cities have enacted reforms** to reduce penalties or establish regulatory frameworks for use. Regulatory models range **beyond traditional pharmaceutical models,** from licensed clinics to personal cultivation to community-based/spiritual-use models.

At this time, Marylanders interested in natural psychedelic access have few options:

- IRB-approved clinical trials
- Religious exemptions through the Religious Freedom Restoration Act (RFRA)
- Travel domestically to state-programs (e.g. Oregon) or deprioritized jurisdictions (e.g. D.C.)
- Travel abroad (e.g. Peru)

The current presidential administration has taken an assertive stance on advancing psychedelic research. In July 2025, President Trump signed the Halt All Lethal Trafficking (HALT) of Fentanyl Act, which includes provisions that expedite research on psychedelics and other Schedule I substances. That same month, Health Secretary Robert F. Kennedy Jr. stated, *"This line of therapeutics has tremendous advantage if given in a clinical setting, and we are working very hard to make sure that happens within 12 months."*

As federal policy evolves, states face a strategic choice: wait for further federal action and adopt future national frameworks, or move proactively to establish state-specific policies. There are risks both to forging ahead as well as to delaying action. While findings from clinical research are preliminary and state-led programs remain in early stages, **Maryland has a time-limited opportunity to tailor its approach to the needs of its residents**—potentially shaping national models rather than inheriting and reacting to them.

Introduction

To the Interim Report of the Maryland Task Force on Responsible Use of Natural Psychedelic Medicines

The Purpose of the Task Force and of the Interim Report

The Maryland General Assembly created the Task Force on Responsible Use of Natural Psychedelic Substances through HB548/SB1009 (Chapters 792 and 793 of the Acts of 2024) in response to growing scientific evidence, public interest, and evolving policy across the country regarding psychedelic-assisted care. Recognizing both the potential public benefits and risks, the legislature charged this Task Force with a comprehensive mandate: **to study, deliberate, and make recommendations for a safe, equitable, and evidence-informed statewide approach to natural psychedelic substances** such as psilocybin, dimethyltryptamine (DMT), and mescaline excluding peyote.

This work is timely. Around the country, jurisdictions are moving forward with psychedelic policies while in parallel developing frameworks for safety, training, public education, and regulatory oversight. Despite this uncertainty, early results are encouraging, and **Maryland is well positioned to be among the first states to expand access to psychedelic substances.** Our ultimate goal is to recommend whether to create a Maryland Natural Psychedelic Substance Access Program, and if yes, how to do so while ensuring it builds upon lessons in other jurisdictions, reflects our values, and meets the diverse needs of our residents.

This interim report marks a pivotal point in our process. **It is not the final set of recommendations.** Rather, it is a strategic tool to engage public agencies, professional boards, researchers, clinicians, advocates, and community members in constructive dialogue. By surfacing key questions and outlining initial policy directions under consideration, we aim to gather the critical input necessary to develop thoughtful, feasible, and impactful recommendations for consideration before the 2026 legislative session.

This is Maryland's chance to learn from the experiences of other states, to design systems that maximize benefits and avoid preventable harms, and to ensure that any future access to psychedelic substances is grounded in principles of **safety, equity, and accountability.**

Scope and Activities of the Task Force

From its inception, the Maryland Natural Psychedelic Substances Task Force has been guided by a clear intent: to provide a well-reasoned, evidence-informed foundation for future policy.

Since our first meeting in November 2024, we have structured our efforts through five committees:

- Substances
- Models of Access
- Public Education and Legislative Support
- Regulations and Governance
- Financial Impact

With administrative support from the Maryland Cannabis Administration, but without dedicated funding, our approach has emphasized collaboration, stakeholder engagement, and strategic use of limited resources. We initiated **public listening sessions** which will eventually reach every county in Maryland and are ongoing. These sessions are designed to gather community input, elevate diverse voices, and better understand concerns and priorities from across the state.

We engaged **subject matter experts** from Johns Hopkins University, national advocacy groups, and from psychedelic access programs in other states. We identified **seven access models** we deemed most promising for Maryland lawmakers to consider. We reviewed implementation lessons from Oregon, Colorado, and New Mexico, and participated in a **collaborative literature review process**. This review informed a **comparative matrix** examining each major psychedelic substance across the range of access models we identified.

Building on this foundation, we drafted **85 policy propositions** that identify the key decisions lawmakers may face—ranging from eligibility and safety protocols to taxation, equity provisions, and religious accommodations. To evaluate these propositions and move toward formal recommendations, we launched a **modified Delphi process**, a structured method for developing consensus among experts. That process is still in progress at the time of this report.

Recognizing that economic feasibility will be essential to any legislative proposal, we partnered with economists at the Johns Hopkins University Carey Business School. Their **independent economic analysis** will model the costs and benefits of various access models under consideration, with particular attention to scalability, public health outcomes, and fiscal impact.

Importantly, **the Task Force has not yet completed consultation with all relevant regulatory agencies or finalized our recommendations**. These areas remain part of our mandate and will

be addressed in our final report. Our approach is methodical because the stakes are high. This interim report is a critical waypoint in that journey.

Why the Task Force is Uniquely Positioned to Deliver this Interim Report

As a **nonpartisan, all-volunteer body supported by the Maryland Cannabis Administration**, we are not beholden to commercial interests or ideological agendas. We are grounded in public service and guided by a shared commitment to deliver clear, actionable recommendations that can inform responsible legislation in 2026 and beyond. **Our authorizing legislation passed unanimously in both chambers** of the Maryland General Assembly and was signed into law by Governor Wes Moore in 2024. This **bipartisan consensus** affirms a shared recognition: that natural psychedelic substances deserve thoughtful, proactive consideration rooted in science, public health, and equity.

Our composition reflects those same intentions. Each member of the Task Force was appointed by the Governor or other state official, as outlined in statute. All members underwent ethics review to identify potential conflicts of interest. Collectively, we bring interdisciplinary expertise, representing multiple interests in this new and emerging field: medicine, pharmacology, behavioral health, spirituality, law enforcement, drug policy, chronic pain, addiction treatment, and public health. **We leverage Maryland's leadership in groundbreaking psychedelic research**, including a representative from the University System of Maryland, a representative formerly from Sheppard Pratt and Johns Hopkins University's Center for Psychedelic and Consciousness Research, and a leader of the private clinical research facility Sunstone Therapies. Per our mandate from the General Assembly, **the Task Force reflects the socioeconomic, ethnic, and geographic diversity of the state**. Our team also includes individuals with lived experience as patients and representation from tribal, religious, and rural communities.

We are not working in isolation. Throughout our process, **we have actively consulted with stakeholders and experts from across the country**, including policymakers and authors of psychedelic legislation in other states. These conversations have helped us understand both the promises and pitfalls of early policy implementation and reinforced the value of Maryland's measured, inclusive process.

What This Report Adds

This report **builds on the foundation laid by earlier state efforts** in Oregon, Colorado, Minnesota, Nevada, Connecticut, Vermont, Washington state, and the District of Columbia. **We draw upon published reports and the insights of regulators, researchers, and advocates who have generously shared their lessons learned**. In addition to reviewing and comparing policy frameworks across jurisdictions, we are evaluating multiple access models simultaneously. To rigorously and efficiently formulate our recommendations, **we are employing the modified Delphi method**—a structured and transparent alternative to standard surveys or deliberations that requires a supermajority to reach consensus and results in graded and easily interpreted recommendations. We are **collaborating with an independent team of economists at Johns Hopkins University**, analyzing the economic impact of our recommendations, including both traditional and novel metrics that may better reflect the social implications of reform. Taking an important lesson from early experiences in Oregon and Colorado, **we will assist lawmakers and regulators to plan for long-term learning and improvement**: starting small with pilot programs or phased access, building in evaluation and accountability mechanisms from the outset, gathering real-world data, and committing to an iterative approach to policymaking.

The Maryland Context

Maryland stands at the intersection of historical precedent, scientific leadership, and policy innovation.

A Legacy of Religious Freedom

From its founding, Maryland has held a unique role in protecting religious freedom. The **Maryland Toleration Act of 1649** was the earliest law in colonial America granting religious liberty. Although it initially applied only to Christians and was repealed and reinstated multiple times, it modeled the separation of Church and State enshrined in the U.S. Constitution. Today, that legacy resonates as sincere religious groups face legal and bureaucratic barriers to the sacramental use of psychedelic substances—even under the federal **Religious Freedom Restoration Act (RFRA) of 1993**.

A Historic Role in Psychedelic Science

Maryland also has deep roots in the scientific study of psychedelics. **Spring Grove Hospital Center in Catonsville** was once the country's leading institution conducting psychedelic research. Beginning in the early 1950s and, after a brief hiatus, resuming from 1963 until 1976—when research was outlawed nationally—Spring Grove researchers explored therapeutic uses of LSD and psilocybin in psychiatric care. These early studies focused on schizophrenia, alcohol use disorder, depression, OCD, and end of life care for cancer. Researchers at Spring Grove established routines still used in clinical trials today, laying groundwork for exploring scientific questions that are now being revisited with modern tools and ethical standards.

That foundation was revitalized by the late Dr. Roland Griffiths, a pioneering neuroscientist at the **Johns Hopkins Center for Psychedelic and Consciousness Research**, which he founded. In 2001, Dr. Griffiths received the first federal grant for psychedelic treatment research in 50 years. His group soon published a landmark study showing that a single high dose of psilocybin could reliably induce profound, spiritually meaningful experiences in healthy volunteers. These findings helped restore scientific credibility to the field after decades of stigma and prohibition and paved the way for the return of federally funded research into psychedelics. His subsequent research demonstrated psilocybin's potential to treat depression, addiction, anxiety, and end-of-life distress. Until his death in 2023, Dr. Griffiths remained a leading voice in psychedelic science, committed to exploring not only therapeutic benefits but also the deeper human questions of meaning, mortality, and transcendence.

A Hub for Research and Clinical Innovation

Maryland is now home to multiple leading institutions in psychedelic science and therapy.

- **Johns Hopkins** Center for Psychedelic and Consciousness Research, backed by $55 million in funding, remains a global leader in clinical research on psychedelics for both illness and wellness.
- **Sheppard Pratt** Institute for Advanced Diagnostics and Therapeutics investigates uses for psychedelic medications across a wide range of psychiatric illnesses.
- **Sunstone Therapies**, based at the Aquilino Cancer Center in Rockville, conducts clinical trials on psychedelic-assisted therapy.
- **CBH Health**, a psychiatric clinical research site in Gaithersburg, features an inpatient observation unit and has conducted multiple psychedelic trials.
- **Walter Reed National Military Medical Center**, in Bethesda, in 2025 received one of two $4.9 million grants from the Department of Defense to fund a study of psychedelic therapy for active-duty service members.
- **National Institutes of Health**, a federal agency headquartered in Bethesda, administers extramural grants to outside researchers and sponsors pivotal intramural research on the use of ketamine for difficult-to-treat depression.
- **Food and Drug Administration**, a federal agency headquartered in White Oak, has designated 3 psychedelic medications — psilocybin, MDMA, and LSD — as breakthrough therapies. Approval of psychedelic therapy by the FDA would likely retrigger rescheduling of the approved substance under federal law, paving the way for legal access through the mainstream healthcare system.
- **BrainFutures**, a non-profit launched by the Mental Health Association of Maryland, dedicated to advancing access to evidence-based innovations in brain health and optimizing learning and performance across the lifespan. It produces white papers, evidence reviews, and policy guidance that help set the evolving standard of care for psychedelic assisted psychotherapy.

These organizations, together with Maryland's broader academic and clinical communities, provide a uniquely robust ecosystem for advancing safe, effective, and ethical access to psychedelic treatments.

Innovation in Health Care Financing

Maryland's leadership extends beyond research to health policy. As the only state with an all-payer rate-setting system for hospitals, Maryland has long prioritized innovation in health care financing. That tradition continues with the forthcoming implementation of the **AHEAD (Advancing Health Equity and Access to Care Transformation)** Model in 2026. AHEAD enables states to align payment models across Medicare, Medicaid, and commercial insurers—creating opportunities to integrate emerging treatments like psychedelic therapy into value-based care models where appropriate.

Psychedelic therapy could also help advance **Maryland's State Health Improvement Plan (SHIP)**, particularly in its **focus on behavioral health**. By addressing conditions such as PTSD, depression, and substance use disorders, psychedelic-assisted therapies may serve as important tools supporting SHIP's population-level strategies for mental health promotion and disease prevention.

Serving Those Who Served

Maryland is home to over 324,000 military Veterans, accounting for approximately 6.6% of the state's population. In Maryland, 25% of Veterans have a disability, compared with 13.2% of non-veterans. **Over 23% of Veterans live with post-traumatic stress disorder (PTSD), and many others live with depression and other mental health conditions that have not responded to traditional therapies.** Veterans are five times more likely to experience major depression than civilians, and 3 in 10 veterans with traumatic brain injury have depression.

Veterans are at 72% higher risk of suicide than those who haven't served. Among Veterans who died by suicide in 2022, the prevalence of depression was 38.6%, anxiety 26.1%, and PTSD 24.9%, according to data from the Veteran's Health Administration. In 2022, there were 6,407 suicides among Veterans and 41,484 among non-Veteran U.S. adults. Among all U.S. adults in 2022, there were, on average, 131.2 suicides per day, with 17.6 Veteran suicides per day.

In addition to military Veterans, there are over 16,000 sworn law enforcement officers in Maryland and on the order of 10,000 career firefighters and 24,000 volunteer firefighters and emergency medical responders, as well as thousands of retirees. While about 6% of U.S. adults are diagnosed with PTSD, this figure can increase to as high as 11% in the public safety community, which includes police officers, firefighters, EMS personnel, and public safety telecommunications workers. This significant rise may help explain the higher suicide rate among first responders compared to civilians. Many of these men and women who are also

exposed to trauma in their work lives have the potential to benefit from psychedelic-assisted therapy, which has shown promise in studies of Veterans and First Responders.

In recognition of the urgent need for new treatment options, the **Maryland General Assembly passed Senate Bill 709 in 2022, establishing a psychedelic treatment fund for Veterans with PTSD.** This bill passed unanimously in May 2022 and was enacted without Gov. Hogan's signature via "pocket approval." The law allocated state funding to support clinical research on psychedelic-assisted therapy and enabled qualified Veterans to access treatment under approved research protocols. The Maryland Department of Health (MDH), Behavioral Health Administration, issued a Request for Applications (RFA) which closed on August 9th, 2024. According to leading advocates of the bill and public record, **the funding was never allocated, and the mandated report was never submitted**. Despite this setback, this initiative positioned Maryland as one of the first states in the country to invest public funds specifically to explore psychedelic therapies for Veterans.

Psychedelic Law Enforcement Trends in Maryland

Psychedelic substances are not well tracked in national or state law enforcement data systems. According to a 2024 RAND Corporation report, "official national figures for the number of arrests involving psychedelics do not exist." Based on data from 13,293 law enforcement agencies contributing to the FBI's National Incident-Based Reporting System (NIBRS), RAND estimated that **psychedelic-related arrests in 2022 were likely "in the low double-digit thousands," accounting for no more than 2% of total drug arrests nationwide.** Similarly, the National Forensic Laboratory Information System (NFLIS) 2022 Annual Report found that psilocybin accounted for just 0.84% of drug reports submitted for laboratory analysis. Dimethyltryptamine (DMT) and mescaline were not listed in the available data set.

Maryland-specific data mirrors these national trends in underreporting. According to the Drug Enforcement Administration's 2022 list of the most frequently identified drugs in Maryland, psilocybin/psilocin ranked 16th with 149 detections—just ahead of caffeine (145). By comparison, cocaine (4,967), fentanyl (3,206), and cannabis/THC (1,368) were far more prevalent. DMT and mescaline were not identified in this dataset.

The Maryland Uniform Crime Report for 2022 also provides limited insight. **Psychedelics are not categorized separately in statewide arrest data.** One dataset groups drugs into "Opium/Cocaine," "Marijuana," "Synthetic," and "Other." It is presumed that substances such as psilocybin and DMT fall under "Other," which accounted for just 10 of 262 drug arrests (3.8%) for sale/manufacture and 175 of 1,855 arrests (9.4%) for possession. However, this category likely

also includes substances unrelated to this Task Force's mandate, such as PCP, prescription stimulants or sedatives, or inhalants.

A second dataset within the same report tracked demographic characteristics of hallucinogen-related seizures. County-level seizures ranged from 1 in Garrett County to 122 in Prince George's County (31.4% of the statewide total). Demographic breakdowns show that 67% of hallucinogen seizures involved Black individuals, compared to 30% involving White individuals. Most seizures involved people identified as Non-Hispanic (71%) and male (81%). Again, the "hallucinogens" category is undefined and may include LSD, ketamine, PCP, or other unrelated substances. Furthermore, these data highlight persistent inequities in how drug laws are applied across different communities.

Maryland's Phased Evolution of Cannabis Policy

Maryland's journey toward responsible **cannabis regulation has evolved through an incremental approach in parallel with public sentiment**. It began with Senate Bill 364 (2014), when Governor Martin O'Malley signed legislation decriminalizing possession of under 10 grams of cannabis—transforming it into a civil infraction enforcing modest fines and drug education rather than criminal punishment. That same year, House Bill 881 established the Natalie M. LaPrade Medical Cannabis Commission, which launched Maryland's regulated medical cannabis program in 2017.

Building on these foundations, voters approved Question 4 in November 2022, mandating adult-use legalization. Meanwhile, the legislature passed HB 837 (2022) to legalize possession of up to 1.5 ounces and home cultivation of two plants, while creating the Cannabis Public Health Advisory Council, a dedicated fund for public health initiatives, and social equity licensing provisions. HB 556/SB 516 (2023) laid out a phased licensing framework, a graduated excise tax structure, and measures to automatically expunge eligible criminal records.

These policy milestones illustrate Maryland's consistent approach: incremental reforms informed by scientific and fiscal analysis, paired with health safeguards such as youth prevention programs, potency limits, and funding for impacted communities. While **critical differences exist between natural psychedelic substances and cannabis** (see Table 11, p. 77), this adaptive strategy sets a precedent for how Maryland might expand access to psychedelics.

Cannabis Expungement and Clemency

Maryland's cannabis policy evolution has been accompanied by deliberate efforts to repair the harms of "the War on Drugs." In 2025, the General Assembly passed SB 432, **The Expungement Reform Act**, expanding eligibility for expungement and opening new paths to work, wages, and wealth for thousands of Marylanders who have served their time and fulfilled their rehabilitation requirements. Governor Wes Moore championed this legislation as part of a broader agenda to dismantle structural barriers created by prior criminal convictions. The law helps alleviate the long-lasting impacts of criminal records on access to employment, housing, education, and licensure.

The Expungement Reform Act builds on **Governor Moore's Executive Clemency Order**, which in June 2024 pardoned more than 175,000 cannabis possession convictions, which was then the largest pardon in the country for misdemeanor cannabis offenses. In June 2025, Governor Moore added nearly 7,000 pardons for cannabis convictions. Together, these actions signal a clear commitment that Maryland's approach to drug policy must not only reflect current science and social norms but also acknowledge and undo the enduring consequences of past laws.

Behavioral Health: A Statewide Priority

Maryland has identified behavioral health as one of its most urgent health priorities.

Findings from the Maryland State Health Assessment

Maryland residents have identified mental and behavioral health as urgent and unaddressed needs. In a statewide community survey conducted by the Maryland Department of Health released in 2024, **58% of Marylanders selected mental health as the most pressing health issue,** followed closely by access to care (56%). Respondents described the mental health crisis as multifactorial—driven by poverty, COVID-19, isolation, and physical health challenges—and made worse by limited access to timely, high-quality care.

An environmental scan of local health assessments across 22 of Maryland's 24 jurisdictions further underscores the scope of the challenge. **Among 92 community-identified priorities, behavioral health accounted for over 30%**, with key concerns including mental illness (57%), substance use (36%), and suicide (7%).

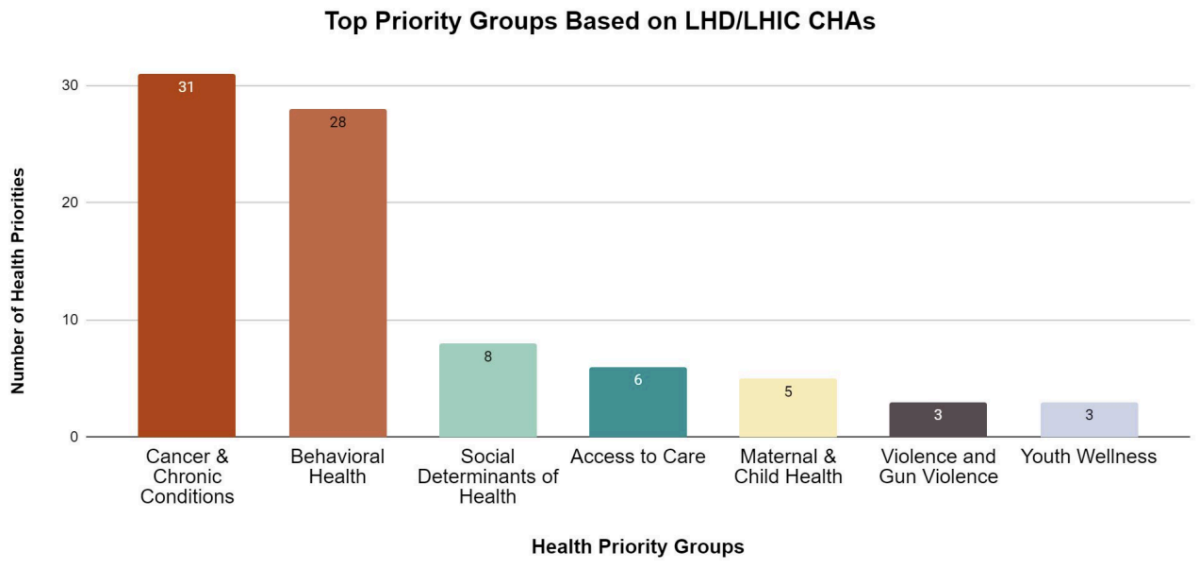

Figure 3. Health Priorities Identified in Environmental Scan of Local Health Department and Local Health Improvement Coalition Community Health Assessments, 2024. Source: Maryland State Health Assessment.

The impact of **Adverse Childhood Experiences (ACEs)** is particularly notable. Adverse Childhood Experiences (ACEs)—such as abuse, neglect, household dysfunction, or exposure to violence—are strongly associated with long-term impacts on both mental and physical health.

Adverse Childhood Experiences (ACEs)

Individuals with high ACE scores face significantly increased risks of depression, anxiety, substance use disorders, and post-traumatic stress disorder (PTSD), as well as chronic medical conditions like heart disease, diabetes, and cancer. ACEs can disrupt brain development, stress response systems, and health behaviors, contributing to poor health outcomes and reduced life expectancy if unaddressed. Early intervention and trauma-informed care are critical to breaking this cycle and promoting resilience.

- **37% of Maryland children** have experienced at least one ACE.
- **More than 60% of adults** report at least one ACE, with **22% reporting 3 or more.**
- Baltimore City and Cecil County carry the highest adult ACE burden, where nearly one-third report high ACE scores.

Maryland continues to experience high rates of drug and alcohol-related deaths, with a growing number of fatalities involving both alcohol and opioids. **Between 2010 and 2020, Maryland's drug-induced death rate quadrupled**, and in 2020 alone, more than 2,800 residents died from overdose—nearly 90% of them between ages 25 and 64. The vast majority of drug-related deaths are the result of opioids/fentanyl.

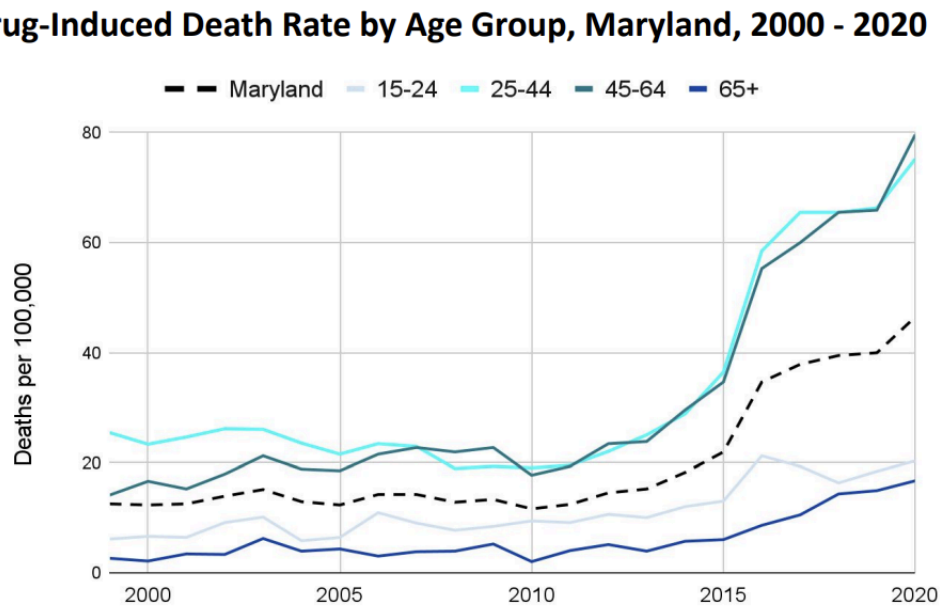

Figure 4. Death Rate Associated with Use of Non-Prescription Drugs, by Age Group, 2000-2020. Source: Maryland State Health Assessment.

Suicide also remains a critical concern:

- Male suicide rates are nearly four times higher than female rates in Maryland.
- The most common means of suicide is with a firearm.
- Among **high school students, 20.6% reported suicidal ideation** in 2021, with significantly higher rates among females (26.7%) than males (14%).

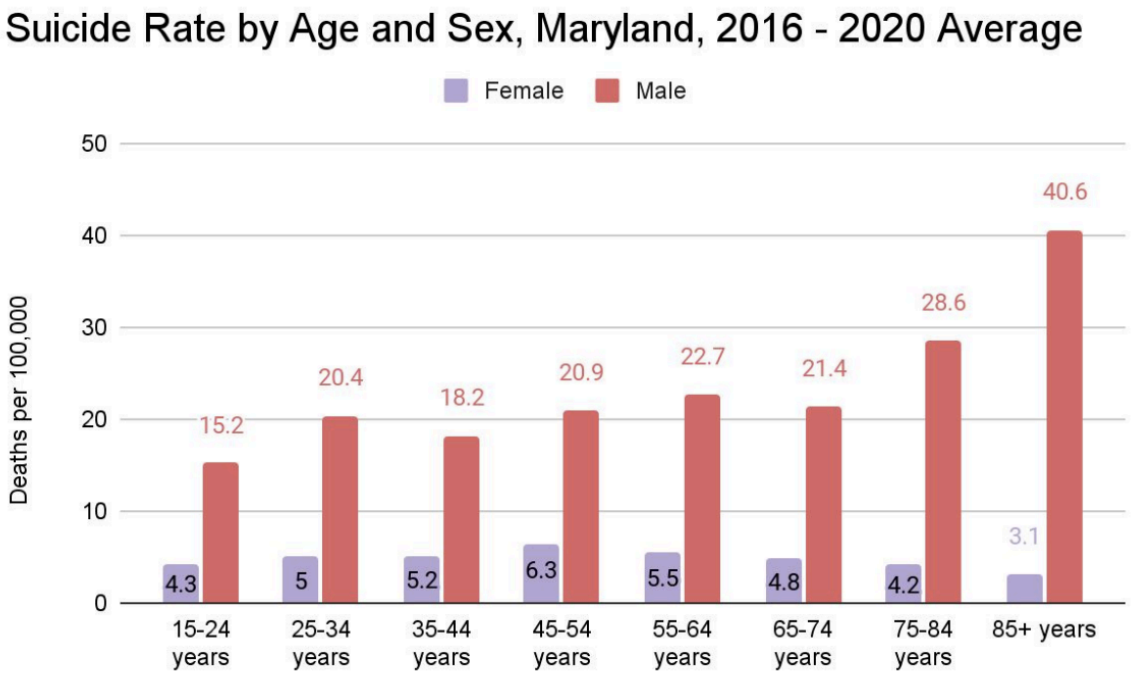

Figure 5. Suicide Rate in Maryland, by Age and Sex, 2016-2020. Source: Maryland State Health Assessment.

Together, these findings reflect a clear mandate. **Maryland's behavioral health burden is significant, widely acknowledged, and not fully addressed by existing systems.** Early research has shown that psychedelics hold promising potential for treating a range of behavioral health conditions, including suicidality, addiction, PTSD, anxiety, and depression. Psychedelic-assisted therapy, when implemented with appropriate safeguards, may offer a novel and urgently needed tool within a broader public health response.

Shifting Public Perceptions of Psychedelics

While support is rising for certain applications of psychedelics, it is not uniform, and significant reluctance remains.

Over the past decade, public perceptions of psychedelic substances have shifted considerably. Once synonymous with counterculture or recreational excess, **psychedelics are now increasingly viewed as potential sources of medical advances, mental health innovation, and cultural healing**. This shift, however, is neither uniform nor uncontested. Substantial skepticism and resistance remain, reflecting divergent beliefs about safety, efficacy, morality, and social risk. This section examines these evolving attitudes, highlighting both the data that reflect increasing public acceptance and the cultural, legal, and political forces that sustain opposition.

Use of Psychedelics is Increasing

Recent survey data suggest that the use of psychedelics is both more common than previously understood and increasingly mainstream. The 2023 RAND Psychedelic Survey found that 12.1% of U.S. adults—approximately **31.7 million people—reported lifetime use of psilocybin**, with 3.1% (8.1 million) having used it in the past year. Use has also accelerated in states with legal access models. From 2019–2020 to 2021–2023, past-year psychedelic drug use in Oregon and Colorado rose by 65.9%, compared with an 18.9% increase in the rest of the U.S. during the same period. Importantly, as this study did not include a control group, this increase cannot be fully attributed to decriminalization or regulated access alone. RAND authors caution that other factors—such as the COVID-19 pandemic and national media attention—likely contributed to the observed increase, suggesting broader shifts in public attitudes.

These findings are consistent with the Berkeley Psychedelics Survey, a representative sample of registered U.S. voters repeated in 2023 and 2025, with a margin of error of ± 2.5%. **In 2025, a majority of voters (55%) reported that they or someone close to them have used psychedelics at some point in their lives**. Between 2023 and 2025, proximity to psychedelic use among self-identified conservatives increased from 43% to 50%. Among liberals, proximity remained relatively stable, rising slightly from 64% to 65%. Proximity also rose among older age

groups. In those aged 65 to 74, it rose from 41% to 51%, and among those over 74, from 23% to 38%. The largest increase was reported by Black voters, whose proximity grew from 26% to 42% over the two-year period.

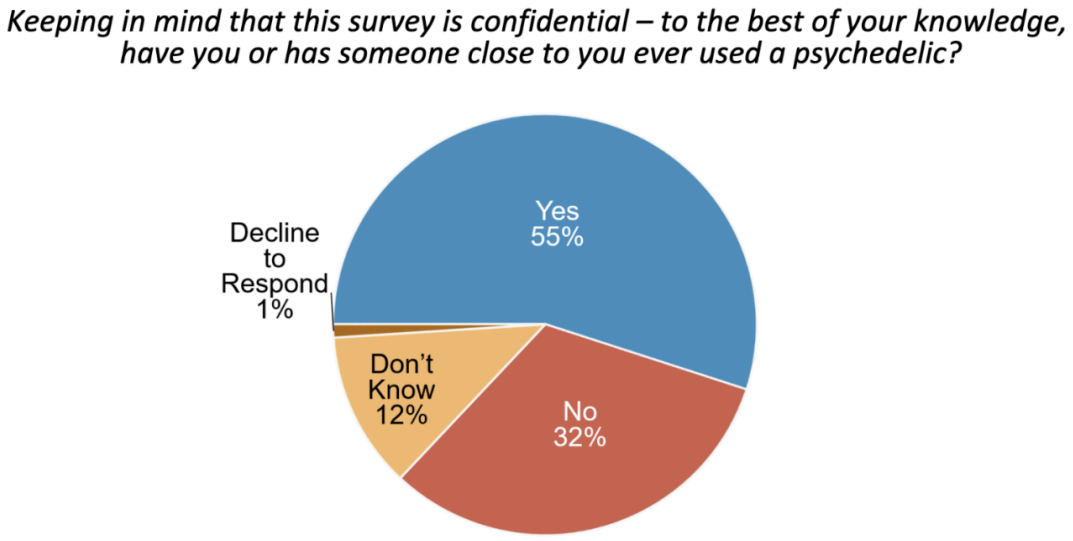

Figure 6. Lifetime History of Use of Psychedelics Among U.S. Registered Voters, 2025. Source: Second Berkeley Psychedelics Survey, UC Berkeley Center for the Science of Psychedelics.

Growing Public Interest and Support

There is broad public backing for specific legal uses of psychedelics, and this support grew between 2023 and 2025. **A large majority of respondents support easing access for scientific research (81%), legalizing therapeutic use (72%)**, gaining federal approval to permit prescription access (66%), and eliminating criminal penalties for personal possession (51%). Support is lower for personal spiritual use (48%) and for use within organized religion (43%).

Proposal	Total Support		
	2023	2025	Difference
Allowing therapeutic use of psychedelics to be legal	61%	72%	+11%
Obtaining FDA approval so that people can access them as prescription medicines	56%	66%	+10%
Allowing the personal use of psychedelics for spiritual purposes	44%	48%	+4%
Making it easier for scientists to study psychedelics	78%	81%	+3%
Removing criminal penalties for personal use possession of psychedelics	49%	51%	+2%
Allowing the use of psychedelics as part of an organized religious practice	44%	43%	-1%

Figure 7. Support For Specific Uses of Psychedelics Among U.S. Registered Voters, 2023 and 2025. Source: Second Berkeley Psychedelics Survey, UC Berkeley Center for the Science of Psychedelics.

More than half of registered U.S. voters support regulated therapeutic access to psychedelics for specific groups (light blue in Figure 8): people with depression (61%), military Veterans (56%), and individuals with addiction (55%). Fewer than half support psychedelic access for people in end-of-life care (48%) or for all adults aged 21 and over (38%). Support for removing criminal penalties is generally lower (dark blue in Figure 8). While 38% support removing criminal penalties for end-of-life care patients who use psychedelics, only 11% support doing so for individuals with addiction. Overall, respondents were most permissive toward those in end-of-life care, with 86% supporting decriminalization or regulated therapeutic access, compared with 78% for military Veterans and 77% for people with depression.

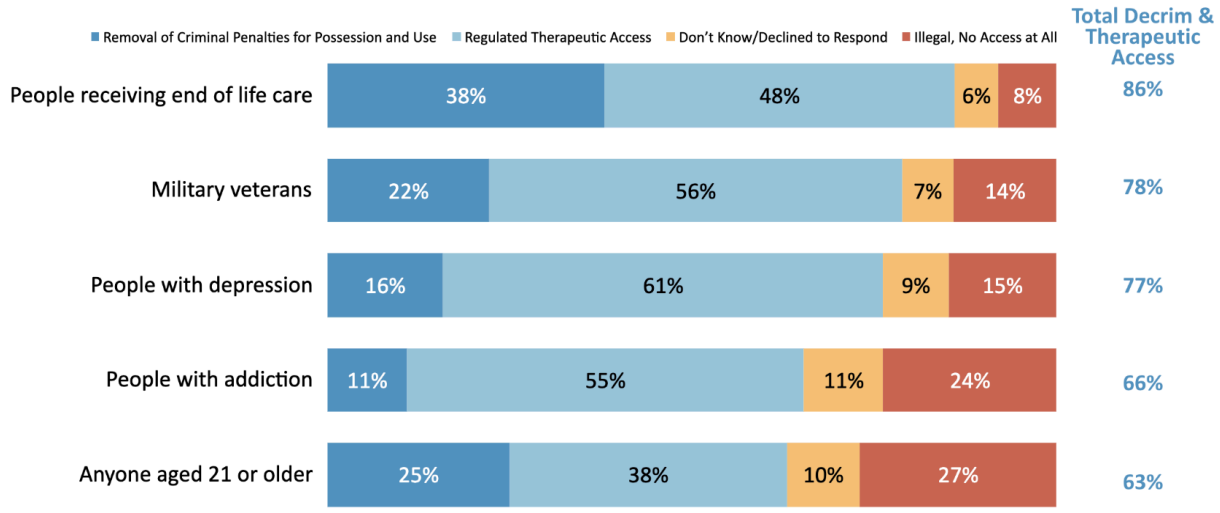

Figure 8. Support For Access to Psychedelics for Specific Groups Among U.S. Registered Voters, 2025. Source: Second Berkeley Psychedelics Survey, UC Berkeley Center for the Science of Psychedelics.

Perspectives of Healthcare Professionals

A 2023–2024 survey conducted by the University of Maryland School of Social Work explored the attitudes, practices, knowledge, and training needs of social workers and nurses related to psychedelic-assisted therapies. The findings show broad support for therapeutic use: **75% of respondents believe psychedelics hold promise for treating psychiatric disorders**, and 57% see potential for treating substance use disorders. Nearly two-thirds (64%) agree that psychedelic-assisted therapy is a reasonable treatment approach, and **76% support legalization for therapeutic purposes.**

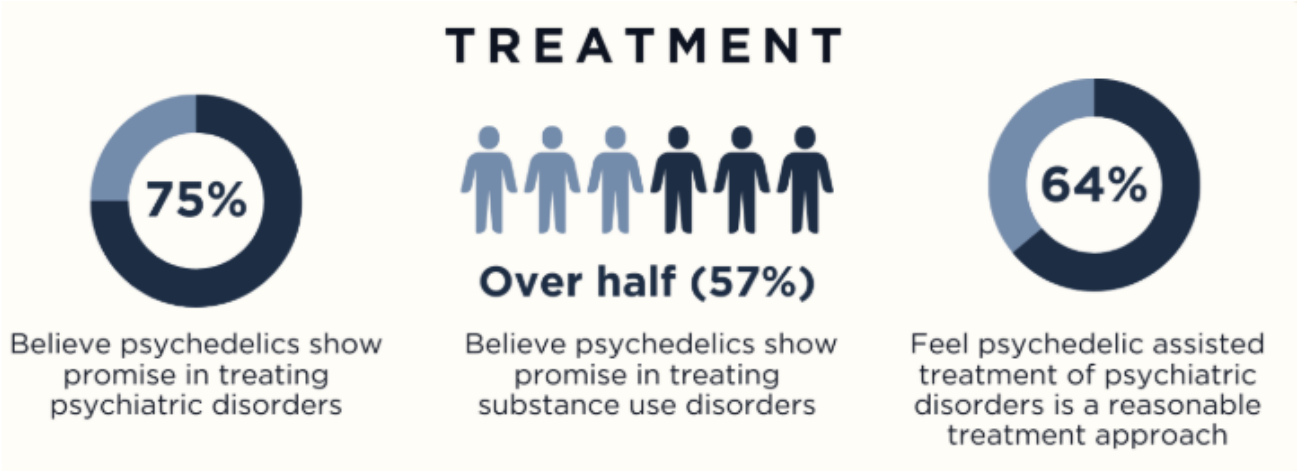

Figure 9. Perspectives of Social Workers and Nurses on Psychedelic Assisted Therapies, 2023-2024, University of Maryland, Baltimore School of Social Work.

Despite these positive perceptions of psychedelic therapy, **only 34% of nurses and social workers endorse legalization of psychedelics for recreational use**. A strong majority (**85%) believe that any future legal psychedelic treatments should be tightly regulated and delivered in controlled settings following standardized protocols**. Meanwhile, 61% reported discomfort discussing psychedelics with patients, and 46% expressed interest in learning more about psychedelic therapy. While based on a modest sample of 152 respondents, these findings suggest growing professional interest alongside caution and a desire for structured guidance.

A 2024 survey by Johns Hopkins researchers assessed knowledge, attitudes, and concerns about psilocybin and MDMA among U.S. healthcare professionals, based on responses from 879 professionals, including nurses and physicians. In this national survey, respondents demonstrated strong belief in the therapeutic potential of both psilocybin and MDMA. Specifically, **93% of respondents believed that psilocybin can be administered safely in clinical settings**, while 76% felt the same about MDMA. However, objective knowledge about

pharmacology, therapeutic use, and risks was notably lower, highlighting a clear gap between enthusiasm and understanding.

The **primary concerns among healthcare professionals included a lack of trained providers, the financial cost of treatment, and medical contraindications.** Factors associated with greater openness to clinical use included prior personal psychedelic use, higher self-rated knowledge, and younger age; in contrast, physicians reported lower openness than nurses and other providers. These findings point to the urgent need for formal education, professional training programs, and infrastructure development if psychedelic-assisted therapies are to be safely and equitably integrated into healthcare.

Negative Public Perceptions

Even many who support policy change hold negative perceptions. In the 2023 Berkeley Psychedelics Survey, nearly half of registered voters supporting policy change express concerns about psychedelics. Of the 61% of respondents who support regulated therapeutic use, 47% agree that psychedelics are not "good for society," 56% agree that psychedelics are not "something I am interested in learning more about," and 63% agree that psychedelics are not "something for people like me." These findings suggest that **public support reflects tolerance for psychedelic policy changes aimed at mental health benefits for certain groups, not broad cultural approval.**

Based on our review of media reports of failed psychedelic policy initiatives and consultations with experts, objections to legal psychedelic therapy fall into four primary categories: legal and regulatory, scientific and medical, moral and social, and practical and operational. From a legal standpoint, critics often cite federal illegality and the absence of FDA approval. In response, states may regulate substances under state law, as seen with cannabis, and can contribute meaningfully to evidence development through well-designed pilot programs. Issues around licensure and scope of practice can be addressed with provisional guidance, as already done with ketamine used for mental health conditions and chronic pain.

Table 1. Summary of Objections to Legalizing Psychedelic Therapy

	Objection	Counterpoint
Legal and Regulatory	Federally illegal	States can regulate under state law; cannabis sets precedent.
	No authority to override federal law	State public health policy is often a precursor to federal reform. States are responsible for regulating the health and safety of their citizens.
	Not FDA-approved	States can create pilot programs and contribute to data collection, which may inform Federal reforms
	Licensure conflicts	Boards can issue provisional guidance; precedent exists with ketamine.
Scientific and Medical	Insufficient long-term data	Ongoing trials show positive outcomes; pilot programs can manage risk.
	Risk to vulnerable populations	Evidence-based screening criteria and exclusion protocols reduce this risk.
	Risk of psychosis or trauma	Screening, preparation, supervision, and integration support minimize these outcomes.
Moral and Social	Sends wrong message	Clear public education distinguishes therapeutic from recreational use.
	Morally wrong	Ground policy in compassion, harm reduction, saving lives, not punishment.
	Politically unpopular	Polling shows support; aligns with mental health, chronic pain, and Veterans' needs.
Practical and Operational	No infrastructure	Build on Maryland's existing academic/clinical hubs; establish facilitation centers; scale with feedback.
	Unsafe providers	Train and certify facilitators; define scope of practice; review complaints.

Scientific and medical concerns center on the perceived lack of long-term safety data and the potential for adverse reactions in vulnerable individuals. However, the growing body of positive clinical trial outcomes and risk mitigation strategies—such as rigorous screening, preparation, and supervised use—help address these concerns.

Moral and social objections, including fears that psychedelic legalization sends the wrong message or is inherently immoral, are countered by grounding policy in compassion and public health rather than criminalization. Public education can also help people distinguish between therapeutic and recreational contexts, and public polling indicates substantial support when policies focus on mental health and Veteran populations. Conversely, it may be framed as morally wrong to prohibit Veterans and others with severe mental illness access to potentially life saving treatment.

Finally, operational challenges such as lack of infrastructure or unsafe practitioners can be addressed by starting with trusted clinical and academic institutions and building regulatory frameworks to ensure safe, competent facilitation, when appropriate. Through phased implementation and thoughtful regulation, these concerns can be responsibly managed.

Table 2. Summary of Objections to Decriminalization of Psychedelics

Category	Objection	Counterpoint
Legal and Regulatory	Conflict with federal law	States have leeway; decriminalization deprioritizes enforcement, not full legalization.
	No regulatory framework	Develop clear local or statewide guidelines and enforcement boundaries.
Scientific and Medical	Increased unsupervised use	Provide harm reduction tools and public education.
	Impaired driving risk	Include penalties and prevention programs modeled on cannabis and alcohol.
Moral and Social	Normalizes drug use	Reframe as a public health and liberty issue, not moral judgment.
	Appropriation of traditions	Protect ceremonial use through exemptions and Indigenous involvement.
Political and Institutional	Public confusion	Pair policy with outreach and community education.
Practical and Operational	No standards for dosing/packaging	Consider a regulated adult-use model with product labeling and safety protocols.
	Cannot control underground markets	Decriminalization plus legal access reduces illicit activity and improves transparency.

Opposition to decriminalization or legal adult use of psychedelics spans several key areas, including legal concerns, scientific and medical risks, moral objections, political messaging, and operational readiness. Legally, critics worry about conflict with federal drug laws and the absence of a regulatory framework. These concerns can be addressed by clarifying that decriminalization or deprioritization decrease enforcement without creating legal markets, and by implementing local or state-level guidelines to set clear boundaries for enforcement.

From a medical standpoint, increased unsupervised use and the potential for impaired driving are cited as risks. These can be mitigated by incorporating harm reduction messaging, making educational materials widely available, and establishing penalties and prevention programs based on cannabis and alcohol policy models.

Moral and cultural objections include fears that legalization will normalize drug use and disrespect sacred Indigenous practices. These issues can be addressed by emphasizing a public health and personal liberty framing, and by creating clear exemptions and protections for traditional ceremonial use, in collaboration with Indigenous leadership.

On the political and institutional front, public confusion is a real concern, but one that can be offset through robust community engagement and clear, transparent communication. Finally, practical challenges like lack of standards for packaging or dosing, and concerns about underground markets, point to the need for careful attention to the sequence in which access models are introduced. By combining decriminalization with thoughtfully designed legal access pathways, states might reduce illicit trade, enhance product safety, and support responsible adult use.

What the Task Force Has Accomplished So Far

Turning mandate into momentum through research, outreach, and consultation.

Since its first meeting in November 2024, the Maryland Task Force on Responsible Use of Natural Psychedelic Substances has made substantial progress toward fulfilling its legislative mandate. As of the publication of this interim report, **the full Task Force has convened 18 times and its five committees have met more than 100 times in total**. These meetings represent **more than 500 hours of volunteer time** contributed by Task Force members, not including the additional hours donated by external advisors, public participants, and national experts who continue to inform the work of the Task Force.

Structure of the Task Force

The Maryland Cannabis Administration (MCA) has played an essential role in the success of the Task Force, providing administrative staffing, scheduling, communications, and documentation support for all full Task Force meetings and most committee meetings. The dedication of MCA staff has made it possible to coordinate a large and complex volunteer-driven policy development process without the benefit of state appropriations.

To facilitate the efficient division of labor and to focus expertise where it was most needed, four committees were established early in the process by the Chair of the Task Force, based on input gathered from members during initial one-on-one consultations and early open meetings. These initial committees—**Substances, Models of Access, Public Education and Legislature Support, and Regulations and Governance**—allowed the Task Force to structure its inquiry around both topic areas defined in statute and critical issues identified through consultation. In April 2025, a fifth committee on **Economic Impact** was created to address specific questions around fiscal risk, economic opportunity, and long-term social costs and benefits.

Together, these committees have overseen the development of dozens of key outputs, including: technical monographs, issue matrices, stakeholder engagement processes, economic modeling frameworks, and an 85-item set of policy propositions which are now being evaluated through a modified Delphi consensus process. Each committee has also drawn on public testimony, stakeholder presentations, academic literature, regulatory documents from other states, and the lived experience of Task Force members themselves.

The following section provides a detailed summary of each committee's scope, leadership, membership, and accomplishments to date, including complete and ongoing deliverables, key activities, and next steps. A full list of Task Force members and our professional affiliations appears in Appendix 2.

Table 3. Summary of Task Force Committees

Committee	Chair	Scope	Members	Key Deliverables Completed	Ongoing Work
Executive	Dr. Andy Coop	Coordination of Committee Deliverables	Bregman, Oglesby-Adepoju, Hamilton, Lewis, Nichols, Selleh	Agenda planning, oversight of Delphi process	Final report synthesis, legislative briefings
Substances	Dr. Benjamin Bregman	Pharmacological study, literature review	Macri, Agrawal, Johnson, Nichols	Substances Template, Psilocybin/Psilocin Monograph	DMT & Mescaline Monographs, Data Matrix, Delphi Deliberation
Models of Access	Candace Oglesby-Adepoju	Policy frameworks in other jurisdictions	Bosak, White, Selleh, Norte	Equity Definition, Access Models Comparison Chart	Data Matrix, Delphi Deliberation
Public Education & Legislature Support	Timothy Hamilton	Stakeholder engagement, public education	Feldman, Martinez, Barrett, Coop	Task Force Website	Listening Sessions, Public Comments, Data Matrix, Delphi Deliberation
Regulations & Governance	Shanetha Lewis	Regulatory structures and impact issues	Augustine, Shah, Sterling	Impact Issues Catalog	Listening Sessions, Data Matrix, Delphi Deliberation
Economic Impact	Dr. Joey Nichols	Economic risks and benefits	White	Initial Economic Estimations, Delphi Survey Mechanisms	Data Matrix, Delphi Deliberation

Committee Highlights and Activities

Executive Committee: Led by Dr. Andy Coop, the Executive Committee ensures alignment and coordination across all committees. It has convened regularly to oversee progress, set agendas, and facilitate integration of committee outputs into Task Force-wide activities. It continues to lead preparation of the final report and supports legislative strategy.

Substances Committee: Chaired by Dr. Benjamin Bregman, this committee has led Maryland's review of the pharmacology and therapeutic potential of psilocybin, mescaline, and DMT. Completed deliverables include a detailed psilocybin/psilocin monograph and a general substance evaluation template. The committee continues work on additional monographs and the cross-committee impact data matrix.

Models of Access Committee: Chaired by Candace Oglesby-Adepoju, this committee has developed a structured framework for comparing different legal models of psychedelic access, including their equity impacts. It produced a widely referenced access model comparison chart and equity definition and remains instrumental in shaping policy propositions.

Public Education and Legislature Support Committee: Chaired by Timothy Hamilton, this committee has developed and maintained the Task Force's public-facing website, organized public listening sessions, and designed feedback mechanisms to collect public comment. These efforts ensure transparency and inclusivity across the process.

Regulations and Governance Committee: Chaired by Shanetha Lewis, this committee has focused on the regulatory mechanisms and governance frameworks needed to ensure public safety, transparency, and program integrity. It developed the initial impact issues framework and continues to collaborate on ongoing listening sessions and data analysis.

Economic Impact Committee: Chaired by Dr. Joey Nichols, this committee works with economists from Johns Hopkins University assisting them with independently assessing the broader societal impacts of various access models. Early deliverables include projected high-level analysis of the access models and design and implementation of the Delphi survey.

Table 4. Meeting Schedule and Frequency of Task Force Committees

	Meeting Recurrence	# of Meetings to Date
Full Task Force	Bi-Weekly	18
Executive Committee	Weekly	25
Substances Committee	As Needed	10
Models of Access Committee	Bi-Weekly	15
Public Education & Legislature Support Committee	Bi-Weekly	13
Regulations & Governance Committee	Bi-Weekly	13
Economic Impact Committee	As Needed	7

Open Meetings

Task Force meetings that achieve a quorum are subject to the Maryland Open Meetings Act and are live-streamed via GoToWebinar as hosted by the MCA. Written Agenda and Audio/Video Minutes (recordings) are also available on the MCA's Other Public Meetings webpage here: https://cannabis.maryland.gov/pages/other-public-meetings.aspx.

Weekly Executive Committee Meetings and Bi-Weekly Committee Meetings are not subject to the Maryland Open Meetings Act and are not live streamed, although extensive records are kept internally to ensure transparency and efficient use of Task Force resources.

Stakeholder Engagement

As authorized by the legislation establishing this Task Force, members were empowered to consult with experts and stakeholders to inform their deliberations. The Task Force has taken this responsibility seriously, investing significant time and effort into inclusive public engagement, outreach to industry experts, and consultations with Maryland constituents, organizations, and national leaders in psychedelic policy.

Public Listening Sessions

The Public Education and Legislature Support Committee organized four public listening sessions across various regions of the state. These sessions were designed to gather input from Maryland

residents who may be directly impacted by psychedelic policy reform. Each session included a brief educational overview followed by 1–2 hours of open testimony. Sessions were advertised through Task Force websites and media channels and allowed for anonymous participation to promote openness. Attendance ranged from 3 to 12 participants per session, and all input received was recorded and made available to Task Force members for review and analysis. Given limited resources, the Task Force opted strategically to begin with meetings in central Maryland, and will expand across all of Maryland between August to October 2025.

Table 5. Public Listening Sessions, March through June 2025

Date	Location	Time	City	County
March 27, 2025	Michael E. Busch Annapolis Library	5–6 PM	Annapolis	Anne Arundel
May 1, 2025	Rockville Memorial Library	6:30–7:30 PM	Rockville	Montgomery
May 12, 2025	Howard County Library Central Branch	6–7 PM	Columbia	Howard
May 19, 2025	Waldorf West Branch	6–7:30 PM	Waldorf	Charles
June 15, 2025	Arbutus Branch Library	6:30-7:30 PM	Baltimore	Baltimore
July 15, 2025	Severna Park Library	6:30-7:30 PM	Severna Park	Anne Arundel

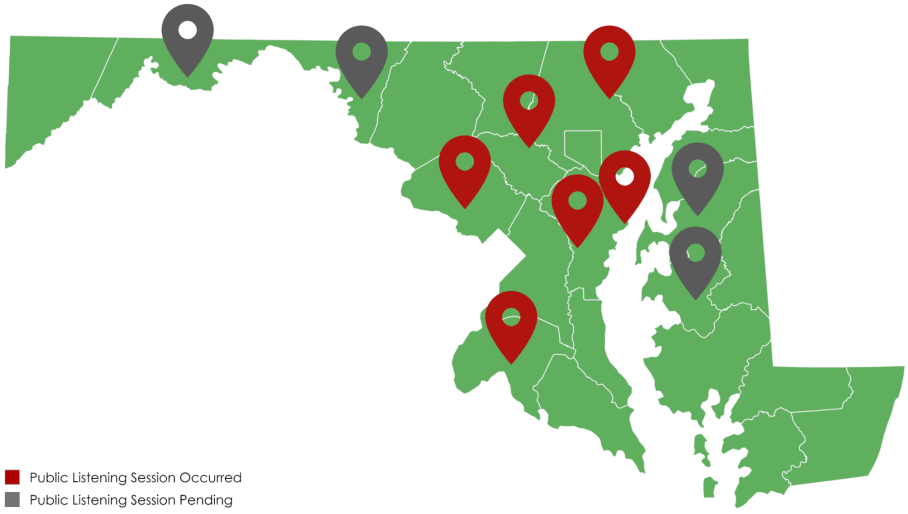

Figure 10. Public Listening Sessions Occurred and Pending as of July 2025

Written Public Comments

To increase accessibility, a Google Form was embedded on the Task Force website, allowing members of the public to submit structured feedback on issues such as perceived benefits, risks, policy suggestions, and personal or professional affiliations. This input will be analyzed as part of the ongoing policy development process.

Stakeholder Presentations

The Task Force has welcomed presentations from a wide range of stakeholders and subject matter experts, spanning public health, law enforcement, harm reduction, religious freedom, policy innovation, and social equity. These in-depth presentations have provided diverse, nuanced, and often thought-provoking insights, offering valuable context and expertise to inform the Task Force's ongoing discussions and recommendations. Collectively, they have deepened the Task Force's understanding of both the potential benefits and risks associated with natural psychedelic substances, while highlighting key considerations for responsible policy development.

Presenters included:

- Maj. Neill Franklin (Ret.), Law Enforcement Action Partnership – on police wellness and psychedelic therapy
- Erica Siegal, LCSW, NEST Harm Reduction & SHINE Collective – on public health risks and harms
- Allison Hoots, Esq. & Kevin Lenaburg – on New York's psilocybin permit bill
- Bob Wold & Kevin Lenaburg, Clusterbusters – on psychedelic policy gaps and psychedelics for chronic pain
- Dr. Megan Meyer, University of Maryland – on the role of social workers
- Kai River Blevins, GWU – on Washington, DC's gray market
- Jesse Gould, Heroic Hearts Project – on Veterans, governance, and equity
- Matt Zemon, MSc – on religious access and public safety
- Mario Macis, PhD, Johns Hopkins University – on economic modeling approaches

Several additional presentations are pending or awaiting scheduling, including stakeholders from indigenous communities, religious practitioners, patient advocacy groups, nonprofit organizations, and Maryland-based businesses.

- Kal Shah – Mission Maryland, LLC
- Johnny BlackHawk
- Taylor Martin – Maryland's Marvelous Mushrooms; Maryland's Cannabis Reserve

- Joanna Zeiger – Canna Research Foundation
- Mark Huslage, Sahffi Lynne, Josh Halbedel – Baltimore Psychedelic Society
- Nancy Alexander – Masters in Theological Studies
- Brad Stoddard, PhD – Luz Sagrada
- Deborah Servetnick – ServeMedicine (501c3 nonprofit)
- Dr. Sadanand Dhekney, PhD; Dr. Burton H. Bluhm, PhD; William Valois, CEO;
- Trish Hall, Compliance Officer – Grow West
- Daniel Peterson – Association of Entheogenic Practitioners Inc.
- Heather Kuiper, Chris Alley, Missi Wooldridge – The Center for Psychedelic Public Health
- Kristel Carrington, MD; Adam Foster, JD; David L. Nathan, MD – Doctors for Drug Policy Reform (D4DPR)

Expert Consultations and Written Feedback

The Task Force has received one-on-one consultations and written comments from additional thought leaders including Dr. Charissa Fotinos (Washington State), Eileen Brewer (Psychedelics and Pain Association), Larry Norris, Ph.D. (Decriminalize Nature), Taylor West (Healing Advocacy Fund) and representatives of the Association of Entheogenic Practitioners, among others. Outreach was also extended to professional societies such as MedChi, the Maryland Academy of Family Physicians, and the Maryland Society of Addiction Medicine.

National and Regional Outreach

Members of the Task Force proactively sought to learn from other jurisdictions. Five Task Force members attended the MAPS Psychedelic Science 2025 Conference in Denver at their own expense. While there, they engaged in numerous informal consultations with policy experts, clinicians, and psychedelic advocates from around the country, enhancing Maryland's comparative policy knowledge and expanding its national network.

Communications and Media

The Task Force maintains an official webpage hosted by the Maryland Cannabis Administration and a secondary informational site (https://tfnps.com) to facilitate timely updates. Media engagement has included appearances in *Marijuana Moment* and *Montgomery County Media*, and outreach via Reddit, Facebook, and other platforms to ensure the public stays informed and invited to participate.

The Federal Policy Landscape

Between 2015 and 2025, the federal policy landscape around psychedelics evolved from near-total prohibition toward greater institutional openness, driven largely by scientific research, advocacy for Veterans' mental health, and bipartisan legislative efforts. Some key federal milestones from the past decade are listed in Figure 11.

- **2017-2019:** FDA grants breakthrough therapy status to MDMA and psilocybin
- **2019:** First congressional psychedelic amendment introduced by Rep. Alexandria Ocasio-Cortez (D-NY) - failed but established precedent
- **2021:** Second psychedelic amendment introduced by Rep. Ocasio-Cortez shows growing support (+49 votes)
- **2022:** First dedicated psychedelic bill (Breakthrough Therapies Act) introduced
- **2022:** Congressional Psychedelics Caucus formed
- **2024:** First enacted federal psychedelic legislation (NDAA provisions)
- **2025:** Multiple bipartisan bills pending for expanded research and VA programs

Figure 11. Key Federal Milestones in Psychedelic Policy and Regulation, 2017 to 2025

A number of important psychedelic regulatory actions have advanced in recent years. The FDA granted Breakthrough Therapy designations to MDMA (in 2017) and psilocybin (in 2018 and 2019) for treatment-resistant mental health conditions including PTSD and major depressive disorder. These designations accelerated clinical trials and created a policy foothold for future regulatory change, even though they do not guarantee rescheduling. In December 2023, Lykos Therapeutics submitted the first-ever New Drug Application for a psychedelic-assisted therapy (MDMA for PTSD), which received Priority Review status in 2024. The FDA declined to approve Lykos's application in 2024, requesting an additional Phase 3 trial. The U.S. Department of Veterans Affairs has requested $1.5 million for further study into MDMA. Meanwhile, the DEA increased its manufacturing quotas for research purposes.

Table 6. Federal Psychedelics Regulatory Actions, 2015 to 2025

Year	Action	Agency/ Authority	Type	Status	Overview
2017	MDMA Breakthrough Therapy Designation	FDA	Regulatory designation	✅ Granted	FDA designated MDMA-assisted therapy as breakthrough therapy for PTSD treatment
2018	Psilocybin Breakthrough Therapy Designation	FDA	Regulatory designation	✅ Granted	FDA designated psilocybin-assisted therapy as breakthrough therapy for treatment-resistant depression
2019	Psilocybin Breakthrough Therapy Designation	FDA	Regulatory designation	✅ Granted	FDA designated psilocybin-assisted therapy as breakthrough therapy for major depressive disorder, not limited to treatment-resistant depression
2023	Increased Production Quotas for Psychedelics	DEA	Manufacturing quotas	✅ Implemented	DEA significantly increased 2023 aggregate production quotas for MDMA, psilocin, 5-MeO-DMT, MDA, LSD for research purposes
2024	Committee Report H. Rept. 118-647	House Appropriations Committee	Congressional guidance	✅ Adopted	Advises VA should include FDA-approved psychedelics in formulary for Veterans (PTSD, suicidal ideation); requests report to Congress

On the legislative front, several bills were introduced in Congress over this period. Most focused on creating protections for state-regulated psychedelic programs or improving access for terminally ill patients under Right to Try laws. Key bills included the VISIONS Act (to block federal interference in state-legal psilocybin programs), and the Breakthrough Therapies Act, which aimed to facilitate access to Schedule I drugs with FDA breakthrough designations. In 2024, the National Defense Authorization Act included funding for psychedelic research for Veterans and active-duty service members, marking a significant policy milestone. The growing visibility of

these issues led to the formation of congressional working groups and bipartisan support from lawmakers interested in Veterans' health and mental health innovation.

The Congressional Psychedelics Advancing Therapies (PATH) Caucus, relaunched in the 118th Congress (2023–2024), is a bipartisan group co-chaired by Representatives Lou Correa (D-CA) and Jack Bergman (R-MI). Its mission is to elevate and support rigorous clinical research into therapeutic uses of psychedelics such as psilocybin and MDMA, with a special focus on mental health conditions like PTSD, depression, anxiety, and substance use disorders. Since its relaunch, the caucus has held regular briefings on Capitol Hill and issued public requests for stakeholder and public input to inform federal policy on supervised psychedelic therapy programs.

Table 7. Federal Psychedelics Legislation, 2015 to 2025

Year	Bill/Act	Sponsors	Type	Status	Overview
2019	AOC Amendment #1	Rep. Alexandria Ocasio-Cortez (D-NY), Rep. Lou Correa (D-CA), Rep. Ro Khanna (D-CA), Rep. Matt Gaetz (R-FL)	Research barrier removal amendment	❌ Failed (91-331)	First federal amendment to remove 1996 rider prohibiting federal funds for Schedule I drug legalization advocacy; would have enabled psychedelic research
2021	AOC Amendment #2	Rep. Alexandria Ocasio-Cortez (D-NY), Rep. Lou Correa (D-CA), Rep. Ro Khanna (D-CA), Rep. Matt Gaetz (R-FL)	Research barrier removal amendment	❌ Failed (140-285)	Second attempt to remove research barriers; gained significant support (+49 votes from 2019)
2022	Breakthrough Therapies Act (Original)	Sen. Cory Booker (D-NJ), Sen. Rand Paul (R-KY)	Rescheduling legislation	❌ Referred to Senate Judiciary Committee	Original bill to reschedule FDA breakthrough therapies from Schedule I to Schedule II; would have streamlined research registration
2023	H.R. 3684 - Douglas Mike Day Psychedelic Therapy to Save Lives Act	Rep. Dan Crenshaw (R-TX)	DOD research grants	❌ Stalled in House Armed Services Committee	Directs Department of Defense to award grants for psychedelic therapy research for active-duty Armed Forces with PTSD/TBI

Year	Bill/Act	Sponsors	Type	Status	Overview
2023	Breakthrough Therapies Act (Revised)	Sen. Cory Booker (D-NJ), Sen. Rand Paul (R-KY), Rep. Madeleine Dean (D-PA), Rep. Nancy Mace (R-SC)	Rescheduling legislation	❌ Introduced	Updated version removing research registration sections; focuses on rescheduling breakthrough therapies and FDCA waiver drugs
2023	Validating Independence for State Initiatives on Organic Natural Substances (VISIONS) Act	Rep. Robert Garcia (D-CA)	Federal "safe harbor"	❌ Referred to the House Energy and Commerce Committee and the Judiciary Committee	Prohibits use of federal funds to interfere with state or local psilocybin laws, covering use, distribution, possession, cultivation, and research
2024	National Defense Authorization Act (NDAA) - Psychedelics Provisions	Rep. Dan Crenshaw (R-TX), Rep. Jack Bergman (R-MI), Rep. Morgan Luttrell (R-TX), Rep. Ro Khanna (D-CA)	Military research funding	✅ Passed & Enacted	Requires DOD to establish $10M clinical trial grant program for psychedelic-assisted PTSD and TBI research; 180-day implementation
2025	Innovative Therapies Centers of Excellence Act	Rep. Lou Correa (D-CA), Rep. Jack Bergman (R-MI), Rep. Morgan Luttrell (R-TX), Rep. Ro Khanna (D-CA), Rep. Dan Crenshaw (R-TX)	VA research centers	🟡 Pending	Directs VA to create at least 5 Centers of Excellence for psychedelic research (MDMA, psilocybin, ibogaine, ketamine) for PTSD, chronic pain, SUD, Parkinson's
2025	Breakthrough Therapies Act (Revised)	Sen. Rand Paul (R-KY), Sen. Cory Booker (D-NJ)	Automatic rescheduling	🟡 Pending	Would automatically reschedule any FDA-designated "Breakthrough Therapy" (MDMA, psilocybin) to Schedule II
2025	HALT Fentanyl Act (Halt All Lethal Trafficking of Fentanyl Act)	Sen. Bill Cassidy (R-LA), Sen. Martin Heinrich (D-NM), Rep. Morgan Griffith (R-VA), Rep. Bob Latta (R-OH)	Fentanyl criminalization + Schedule I research provisions	✅ Passed	Permanently criminalizes fentanyl analogues as Schedule I but includes provisions removing barriers to Schedule I research including marijuana, psychedelics; expedites research applications (30-45 day review), eliminates duplicative registrations for research teams

The State Policy Landscape

The state-level psychedelic policy landscape is expanding rapidly, with **38 states introducing over 220 bills of psychedelic-related legislation since 2020**. Most state efforts have followed one of three pathways: task forces or working groups to study policy options (e.g., 13 enacted, including Maryland, Georgia, Minnesota, Nevada, Vermont, Washington), clinical trial or pilot program bills (e.g., enacted in Arizona, Indiana, North Carolina, Maryland, Connecticut, Utah, and elsewhere), or decriminalization or legal adult use proposals, often via ballot initiatives (e.g., enacted in New Jersey). While 68 of these bills remained in progress as of April 2025, at least 29 have passed, signaling a shift in public and political attitudes, especially around the therapeutic potential of psychedelic substances.

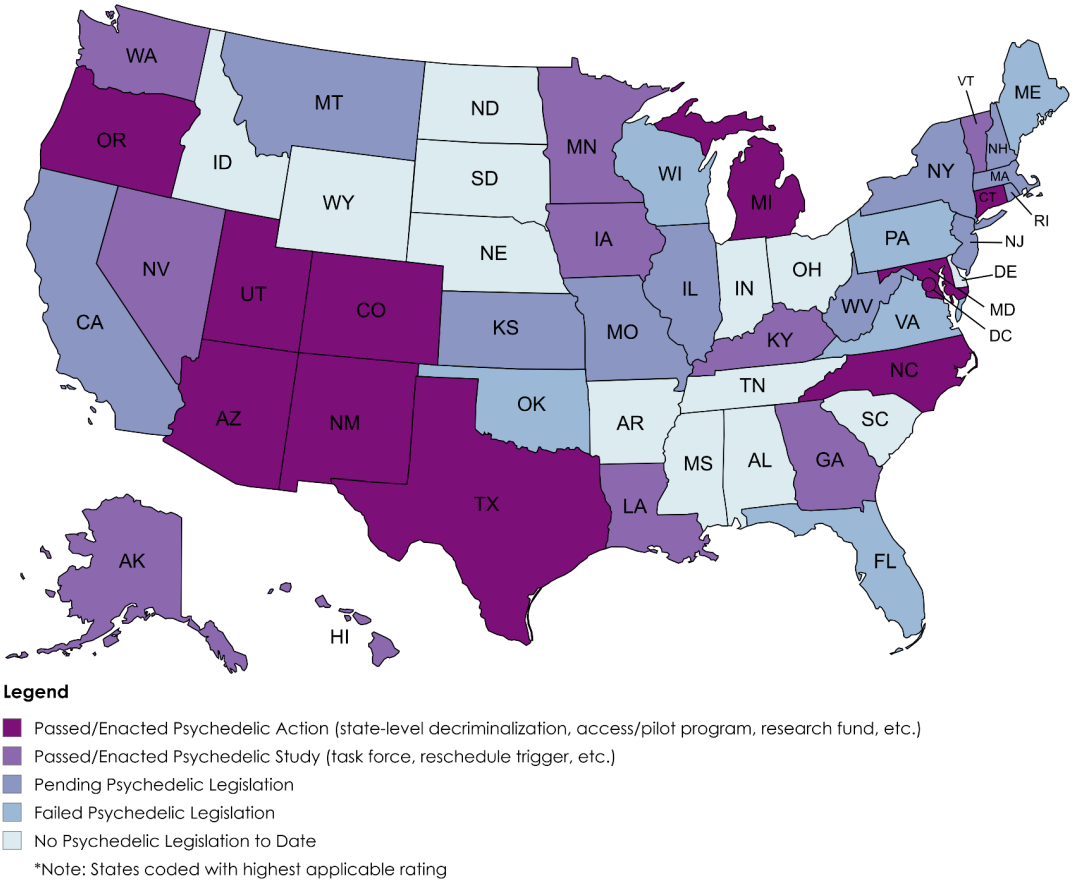

Figure 12. National Psychedelic Legislative Activity as of July 2025

Several states appear "ripe" for meaningful policy change in the next legislative cycle. **Nevada and Texas have established state-sanctioned psychedelic research programs** with bipartisan support and significant participation from Veterans' advocates. **Illinois, Missouri, and Indiana** are showing early signs of legislative interest, often through **Republican-sponsored bills aimed at medical access**, particularly for PTSD and difficult-to-treat depression. These states are **politically diverse, but share a common emphasis on incremental policy that centers Veterans, First Responders, and clinical settings** rather than broader adult-use frameworks.

In more progressive states like California, Massachusetts, and New York, the psychedelic movement has followed a **broader and more complex trajectory**. **California's statewide decriminalization bills have faced repeated setbacks**, despite the City of San Francisco and others adopting local deprioritization. Meanwhile, activists are moving forward with a 2026 ballot initiative that would legalize regulated adult use of psilocybin and establish a state agency to oversee access. **Massachusetts had both a well-supported task force process and a 2024 ballot initiative, narrowly defeated** at 57% to 43%, that would have legalized possession, cultivation, and licensed-facilitator administration of psilocybin and established a regulatory commission. **New York has introduced several bills to permit medical access or protect religious and ceremonial use**, with strong grassroots support and some bipartisan interest.

Connecticut and Arizona also stand out. **Connecticut passed legislation in 2021 to fund psilocybin therapy pilot programs for Veterans and First Responders**. The program is overseen by the state's Department of Mental Health and Addiction Services and aims to align with federal regulatory processes. **Arizona, meanwhile, has created a $5 million psychedelic research grant program**, reflecting rising interest in the therapeutic potential of psychedelics even in historically conservative states. Both states may serve as bellwethers for how early clinical research efforts can evolve into broader legal frameworks.

Overall, the outlook is one of cautious expansion. States are exploring different models that reflect their political cultures, healthcare infrastructure, and public opinion. **States adopting deliberate, data-informed strategies—like Oregon's regulatory adult-use system and Colorado's hybrid framework—are shaping the policy conversation nationally.** As more states move from research and task force stages into implementation, the next few years will be critical in defining safe, equitable, and scalable approaches to legal psychedelic access. We offer a summary of our lessons learned from our study of key states of interest below. **A detailed listing of state and local legislation from 2015 to 2025 appears in Appendix 3.** For a comprehensive review of the federal and state policy environment, we refer the reader to the

National Psychedelic Landscape Assessment presented by the Center for Psychedelic Policy (2025).

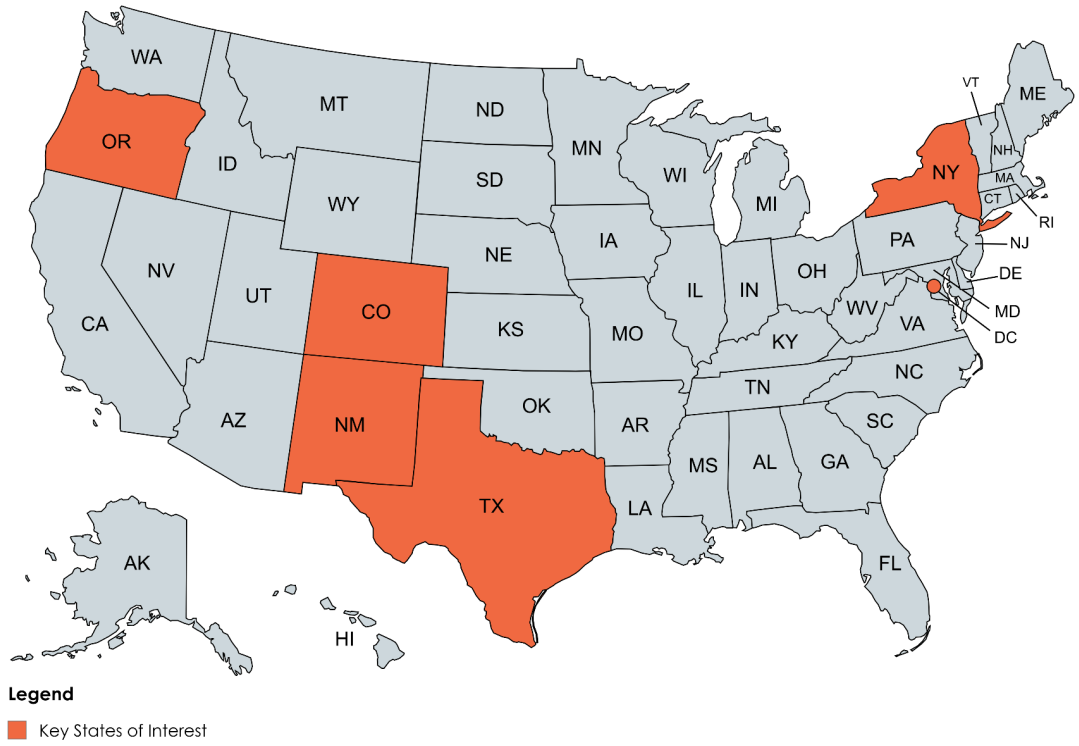

Figure 13. Key States of Interest for Psychedelic Policy Activity in 2025-2027

Oregon

Oregon stands as the pioneer of state-level psychedelic legalization, having implemented the **most comprehensive and mature regulatory framework** in the United States. **Measure 109 passed in 2020 with 56% support**, making Oregon the **first state to legalize supervised adult use of psilocybin at licensed service centers** with licensed facilitators since 2023. Measure 110, passed simultaneously, **decriminalized possession of small amounts of all drugs** including LSD and MDMA, redirecting cannabis tax revenue to treatment services, **although this was partially reversed in 2024**. Oregon's psilocybin program requires extensive facilitator training, state licensing, and operation at least 1,000 feet from schools, with all products cultivated and tested by licensed businesses. The state has faced implementation challenges, including **numerous local opt-outs by cities and counties that have blocked service centers**, and ongoing legislative refinements through bills like HB 2387 (2025) that enhance facilitator protections and update licensing requirements. **Affordability remains a central concern**, as costs per session in Oregon range from $400 to over $3,000, depending upon the dosage

consumed and whether clients are participating in individual or group sessions. Oregon rules **require licensees to submit a social equity plan** that identifies ways that licensees will support social equity. Many licensees are subsidizing psilocybin services with donations, offering reduced rates for certain individuals, or providing scholarships to clients. While **approximately 10,000 or more sessions have occurred under Oregon's framework in the first two years**, this number suggests that the majority of psychedelic use may still be happening outside legal access models. In summary, Oregon's real-world experience with regulated psychedelic services provides crucial data and lessons for other states.

Colorado

Colorado represents one of the most progressive psychedelic policy landscapes in the United States, building from grassroots efforts to comprehensive state regulation. Denver made history in 2019 as the first U.S. city to decriminalize psilocybin via Initiative 301, establishing the foundation for statewide reform. **Proposition 122 passed in 2022 with 54% voter support,** making Colorado the second state after Oregon to establish supervised adult use of psychedelics. Proposition 122 created a comprehensive "Natural Medicine Health Act" that immediately **decriminalized personal possession and use of psilocybin, mescaline (excluding peyote), DMT, and Ibogaine for adults 21 and older**, while establishing a phased rollout of **licensed healing centers, cultivation facilities, manufacturing facilities and testing laboratories which began serving clients in June 2025**. Like Oregon, Colorado's program requires training and licensing of facilitators; however **Colorado offers several facilitator licenses, depending on previous qualifications and licensure as well as lived experience**. Notably, the Clinical Facilitator license allows medical and mental health professionals to integrate psilocybin care into their pre-existing professional practices. Colorado's 2025 legislation included SB 25-297 which **required data collection from psilocybin programs starting July 2026 to monitor both positive and adverse outcomes**. Colorado also passed complementary psilocybin-centric legislation unrelated to the regulatory program, HB25-1063, which is a **"trigger law" allowing medical professionals to prescribe crystalline polymorph psilocybin (synthetic, vs. natural) statewide once federally rescheduled by the FDA.** There are key differences between Colorado's implementation and Oregon's earlier program. Colorado's regulations created a category of micro-licenses for manufacturing facilities and healing centers. **Micro-healing centers, added on to existing medical practices or wellness centers, make program participation more accessible for facilitators who will only conduct a few psilocybin sessions each month**. These micro-centers have less elaborate security requirements and lower costs of operation, in exchange for less natural medicine and natural medicine products kept on premise. Colorado's framework allows regulation of time, place and manner of healing center operations, but **unlike Oregon's county opt-out provisions, it prevents local jurisdictions from banning healing centers**, ensuring statewide

access to regulated psychedelic services. Additionally, pursuant to SB 23-290, Colorado regulators **commissioned a report from a working group of Federally Recognized American Tribes and Indigenous Communities** to inform its implementation of the Natural Medicine Health Act and an annual report from the Department of Revenue regarding the program.

New Mexico

New Mexico achieved a historic milestone as the **first state to pass comprehensive psychedelic legislation through the legislative process**, establishing a framework that prioritizes equity and medical access. After 11 years of advocacy and collaboration between lawmakers and state agencies, SB 219 became law in 2025, making New Mexico the first state where psychedelic legalization was accomplished through legislative action rather than citizen initiatives. The legislation establishes a medical psilocybin advisory board to oversee rulemaking and clinical program development, with **therapy access required to begin by the end of 2027**. New Mexico's model is **limited initially to people with qualifying diagnoses and to psilocybin therapy**, creating a more conservative regulatory framework compared to Colorado and Oregon’s broader adult-use models. The state's legislation represents a significant geographic expansion of psychedelic reform into the Southwest, potentially influencing neighboring states and demonstrating that legislative rather than ballot-driven reform is viable. New Mexico's success shows how **psychedelic policy can advance through traditional governmental processes, where experienced leadership and effective collaboration between state agencies exist**, offering a pathway for states such as Maryland where ballot initiatives are not possible or where lawmakers prefer to guide policy development and implementation timelines.

Texas

Texas has emerged as an unexpected leader in psychedelic research and Veteran-focused therapy, driven primarily by Republican lawmakers advocating for military mental health solutions. **HB 1802 in 2021 made Texas the first state to enact psychedelic research legislation,** requiring partnership with Baylor College of Medicine to study psilocybin for Veteran PTSD. The state's commitment escalated dramatically **in 2025 with HB 4561 and SB 2308, which authorized an unprecedented $50 million in state-backed matched funding for FDA-approved ibogaine clinical trials**. Texas's approach uniquely focuses on both psilocybin and ibogaine research, targeting opioid use disorder, PTSD, and TBI through **public-private partnerships that allow the state to retain intellectual property stakes and revenue sharing**. The legislation establishes consortiums including public universities, hospitals, and drug developers, with specific provisions for Veteran-focused funding. This Republican-led initiative demonstrates how psychedelic reform has become a genuinely bipartisan issue, particularly when framed around Veteran healthcare and addiction treatment.

New York

New York has positioned itself as a major East Coast hub for psychedelic policy innovation, with an unprecedented volume of legislative activity and research initiatives spanning Veteran care to comprehensive regulation. The state **currently has six distinct psychedelic bills pending in 2025,** including S 1801/A 3845 for **Veteran and first-responder psilocybin pilots**, A 3375 for **clinically supervised naturally grown psilocybin** with $5 million in grants, and A 2142/S 5303 establishing a **regulated permit system for adult non-commercial use**. New York's approach uniquely **emphasizes in-home psilocybin use under clinical supervision, distinguishing it from facility-based models in Oregon and Colorado.** The state's legislation includes comprehensive ibogaine research programs (S 1817/A 1522 and S 4664) specifically targeting addiction treatment and PTSD, reflecting the state's focus on evidence-based policy development. New York lawmakers have designed their framework to mirror successful structures from other states while adding innovative elements like **permit-based cultivation systems that would allow adults to grow psilocybin for personal use after completing health screenings and educational requirements**. The state's multiple legislative approaches suggest a comprehensive strategy to address both therapeutic access and broader decriminalization goals.

District of Columbia

The District of Columbia achieved one of the most decisive victories in psychedelic decriminalization history, establishing itself as a model for urban entheogenic plant and fungi policy reform. **Initiative 81 passed in November 2020 with an overwhelming 76% voter approval, making enforcement of laws against natural psychedelics (psilocybin, ayahuasca, ibogaine, DMT, mescaline) among the lowest police priorities**. The "Entheogenic Plant and Fungus Policy Act of 2020" covers a broad spectrum of naturally occurring psychedelics, specifically focusing on plant and fungal sources rather than synthetic compounds. D.C.'s policy represents one of the most comprehensive local deprioritization measures in the United States, going beyond psilocybin-only initiatives to include traditional medicines like ayahuasca and ibogaine. The initiative's success in the nation's capital carries significant symbolic weight, demonstrating urban acceptance of psychedelic policy reform and potentially influencing federal conversations about drug policy. Unlike state-level legalization efforts, D.C.'s approach focuses purely on enforcement deprioritization, avoiding the complex regulatory frameworks required for legal therapeutic markets while still providing meaningful protection for adult users of entheogenic plants and fungi.

Outlook, Trends and Key Drivers for 2026 and Beyond

Looking ahead to 2026 and beyond, several powerful forces are likely to accelerate psychedelic policy reform across the United States. **Veteran-led mental health advocacy continues to provide compelling bipartisan support**, especially for clinical access to MDMA, a synthetic psychedelic, and psilocybin, the naturally occurring psychedelic with the largest body of research to date. These efforts have helped destigmatize psychedelic research and created political momentum in both conservative and progressive jurisdictions. A major potential inflection point is the **anticipated FDA approval of MDMA-assisted therapy, possibly in 2027 or 2028**. Such approval could trigger a cascade of state-level rescheduling actions and catalyze broader access to one form of psychedelic therapy through traditional healthcare systems. Meanwhile, results from **early access models and pilot programs in Connecticut, Texas, Colorado, and Oregon are expected to shape policymaking by offering concrete, localized evidence on program design, safety, and efficacy.** Economic and biotech interests will also play a decisive role, as **states such as Texas and Indiana position themselves as hubs for biotech or psychedelic therapy innovation and job creation**. These converging trends suggest that the next wave of **psychedelic policy may be shaped by competition between states** within a growing field of medical and economic transformation, in addition to public health and criminal justice priorities.

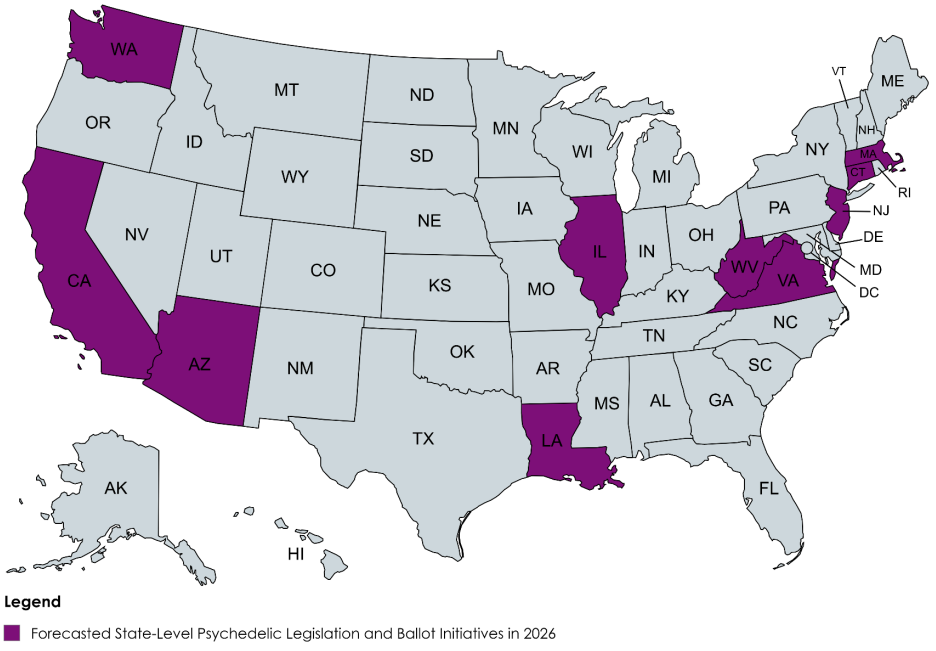

Figure 14. Forecasted State-Level Psychedelic Legislation and Ballot Initiatives in 2026

Table 8. Outlook for State-Level Psychedelic Legislation and Ballot Initiatives in 2026

State	Trend	Possible Outcome
Arizona	Local momentum for decriminalization	Could prompt legislative action
California	Significant public pressure, growing Veteran support, multiple cities passing decrim bills	Pilot programs for veterans/first responders; expanded psychedelic-assisted therapy licensing
Connecticut	Passed House already; Senate delay only obstacle	Possession decriminalization and study bill likely refiled and passed
Illinois	HB 1143 sponsors plan to refile; coalition support growing	Revised psilocybin therapy bill with new regulatory guardrails
Louisiana	Veterans task force report expected Feb 2026	Could prompt pilot or access bill in late 2026
Massachusetts	Narrowly failed ballot initiative in 2024 strong grassroots effort	Another ballot initiative (therapy and decriminalization) likely in 2026; new pilot bills in legislature
New Jersey	S 2283 already drafted and held; increasing legislative support	Psilocybin therapy and research legalization
Virginia	Bipartisan support for psychedelics research exists	Rescheduling and advisory board bill could pass with minor edits
Washington	Task force already studying access issues	Narrow access bills (clinical and tribal exemptions) may be refiled
West Virginia	Research bills got House support	Ibogaine/psilocybin studies could return with broader legislative backing

Comparison of State and Federal Pathways for Psychedelic Policy Reform

As Maryland considers a range of options for responsible access to natural psychedelic substances, a critical question emerges: **Should reform efforts align with federal timelines for FDA approval, or proceed through state-level legislative or regulatory initiatives?** Each path presents distinct advantages and trade-offs in terms of safety, speed, equity, innovation, and accessibility.

Federal Pathway: FDA Approval Route

Pursuing reform through **the FDA approval process ensures a high level of medical legitimacy and scientific rigor**. Treatments approved by the FDA undergo extensive clinical trials to establish safety, efficacy, dosage, and long-term effects, creating standardized protocols that are **broadly accepted across the healthcare system**. This route also **opens the door to eventual insurance coverage**, which is a reliable pathway to provide for widespread access to patients with qualifying health conditions. Clinicians and researchers may also benefit from reduced legal risk, as **FDA approval provides clearer protection under federal law**.

However, the federal route comes with considerable limitations. It is often slow—sometimes taking a decade or more to bring new treatments to market—**delaying access for individuals with urgent mental health needs**. The FDA's preference for highly standardized clinical models **may exclude community-based, ceremonial, or culturally rooted practices**. Additionally, existing disparities in clinical trial participation mean that **approved protocols may not be well-suited to people of color, LGBTQ+ individuals, those from low-income backgrounds, or persons who have been underrepresented in clinical research** in the U.S. and abroad. Even when treatments are covered by insurance, **high deductibles or limited networks can make access unaffordable**, particularly in the face of recent cuts to Medicaid and Medicare reimbursement.

State Pathway: Legislative or Regulatory Reform

State-level action—through legislation, ballot measures, or administrative rulemaking—offers a **more flexible and timely approach,** which could be implemented significantly sooner than a federally driven model. States like Oregon, Colorado, and New Mexico have already adopted access models that **allow broader experimentation with supervised adult use, peer support, and ceremonial access**. This creates opportunities for Maryland to center community-led models that are culturally responsive and accessible outside of clinical settings. **State policy can also be structured around reparative justice—incorporating expungement,**

equity-focused licensing, and reinvestment in communities impacted by criminalization. A state-level approach could serve as a **"laboratory of democracy," testing various approaches to access, training, and integration** outside of a top-down federal system that may leave less room for flexibility.

Yet, state-led reform also entails significant risks and limitations. Psychedelics such as psilocybin **remain classified as Schedule I substances under federal law, which places providers and patients in potential legal jeopardy despite state-level protections**. Without federal oversight, **states must develop their own safety standards, product testing protocols, and training requirements for facilitators**—an expensive and complex undertaking. Furthermore, **services offered outside the medical model are unlikely to be covered by health insurance**, placing a high initial financial burden on individuals seeking care and exacerbating existing inequities in access.

Conclusion

The choice between state and federal pathways is not binary. **Many advocates envision a complementary approach in which states take early steps to pilot culturally responsive and equitable access models, while continuing to monitor federal developments.** Maryland is uniquely positioned to do both: it has a legacy of innovation in psychedelic science and a strong track record in public health leadership. By learning from other states and contributing its own data, Maryland can shape national policy while also addressing local needs through thoughtful, phased, and inclusive reform.

Overview of Access Models

The Task Force identified a spectrum of policy options based on our review of scientific literature, expert consultation, and efforts in other states. **These definitions below are distinct and not mutually exclusive, such that multiple options may be implemented in a parallel or complementary fashion.** Each model has specific precedents and real-world examples, allowing for clear delineation and elaboration of their respective pros and cons. They also carry distinct economic implications.

Table 9. Comparison of Access Models for Natural Psychedelic Substances. Source: M. Macis, Johns Hopkins University

	Commercial Sales	**Supervised Adult Use**	**Medical / Therapeutic Use**	**Non-Commercial Peer Sharing**	**Deprioritization / Decriminalization**	**Religious Use**	**FDA-Approved Use**
Examples	Maryland cannabis dispensaries	Oregon (originally)	New Mexico	Colorado "Grow and Give"	Washington, D.C.	Native American Church	No state-level action; Esketamine
State involvement	High	High	Moderate/High	Moderate	Low/Moderate	Low	Lowest
State revenue potential	High	Moderate to High	Moderate	Low	Low	Low	Lowest
Policy lead time	Moderate	Slow (2+ years)	Slow (2+ years)	Fast	Fastest	Fast	Slowest (3+ years)
Regulated market and supply chain	Yes	Yes	Yes	No; “Gift economy”	No; “Gray market”	No; Church donations	Yes
Breadth of access	Broad	Broad	Moderate	Broad/Moderate	Broad/Moderate	Narrow	Narrow
Health screening	Maybe (via user permitting)	Yes	Yes	Maybe (via user permitting)	No	No	Yes
Required supervised use	No	Yes	Yes	No	No	Probably	Probably
Cost to Consumer	Moderate	Moderate/High	High	Low	Moderate	Lowest	High
Provider barriers to entry	Low/Moderate	High	Moderate	Low	Lowest	Low/Moderate	High

Above models are organized left-to-right from highest-to-lowest state involvement, based on the analysis and guidance of external economic advisors from Johns Hopkins University.

Commercial Sales

In the commercial sales model, licensed private businesses are authorized to cultivate, manufacture, and sell natural psychedelic substances through a regulated marketplace. This model most closely mirrors adult-use cannabis systems and includes oversight for safety testing, packaging, labeling, advertising, and taxation. Maryland's own cannabis dispensaries, along with proposals like New York's A2142 Personal Psilocybin Permit bill, serve as key examples. In one variation, consumers complete a screening process and an educational module to obtain a personal use permit, allowing them to purchase taxed psychedelic products from licensed providers and self-administer independently or with optional facilitation. This model could be limited to require sales only to those with medical authorization or who are working with a licensed professional.

State Involvement: High. This model requires a comprehensive regulatory structure encompassing licensing, quality control, zoning, tax collection, compliance monitoring, and enforcement.

State Revenue Potential: High. Revenues would stem from licensing fees, retail and excise taxes, and economic spillover effects such as tourism and job creation.

Costs:

- State: Investment in infrastructure for regulation, public education, and enforcement.
- Private Sector: High startup costs, compliance burdens, and reputational risk.
- Society: Potential for commercialization-driven inequities, normalization without sufficient guardrails, and risk of exploitative marketing.

Benefits:

- State: Predictable revenue streams, economic stimulation, job growth, potential for public health reinvestment.
- Private Sector: Large and scalable market opportunities with potential for innovation.
- Society: Expanded access, normalized discourse, and safe and tested product choice for diverse consumers.

Supervised Adult Use

Under the supervised adult use model, sometimes referred to as "regulated access," adults 21 and older may legally access psychedelics through trained, state-licensed facilitators in non-medical settings such as wellness centers or retreat environments. Unlike medical models, this approach does not require a clinical diagnosis or that a clinical practitioner administers the medicine—just professionals trained in facilitation as regulated by the state. Oregon was the first

state to implement this model, and Colorado has since adopted similar frameworks. Emphasis is placed on participant screening, session safety, facilitator training, and facility licensure to minimize risks and maintain public trust.

State Involvement: High. Requires robust infrastructure for licensing facilitators, certifying training programs, approving service centers, and ensuring quality and compliance.

State Revenue Potential: Moderate to High. Revenue derives from licensing fees for facilitators and facilities, as well as taxation on service provision.

Costs:

- State: Regulatory and compliance development, enforcement, and administrative oversight.
- Private Sector: High barriers to entry due to required training and infrastructure; limited scalability due to long session durations.
- Society: High out-of-pocket costs restrict access, particularly for low-income populations. These cost barriers have been well documented in both Oregon and Colorado.

Benefits:

- State: Generates licensing revenue while supporting public health objectives.
- Private Sector: Creates space for innovation in service delivery, retreat design, facilitator training, and supportive technologies.
- Society: Offers broad access without requiring a medical gatekeeper. Establishes strong safety, screening, and training standards that reduce harm and professionalize care delivery. Enables large-scale data collection for future research and policy refinement. Broad accessibility supports inclusion of historically marginalized communities and respects diverse motivations for use, if special care is taken to avoid structural and cultural barriers. Creates accountability for potentially bad actors.

Medical / Therapeutic Use

This model restricts access to psychedelics to patients with qualifying diagnoses under the care of licensed healthcare providers. Medical access programs are rooted in clinical trial protocols and aim to align with insurance and healthcare delivery systems. Examples include amended provisions in Oregon and Colorado, as well as New Mexico's Senate Bill 0219. Access is typically granted to individuals with PTSD, depression, anxiety, chronic pain, or substance use disorders. State-approved practitioners, such as psychiatrists, physicians, and licensed therapists, deliver services in regulated settings.

State Involvement: Moderate to High. Requires regulatory oversight for clinical protocols, facility standards, and professional licensure.

State Revenue Potential: Moderate. Derived from licensing, clinic permits, and limited taxation on services.

Costs:

- State: Requires alignment with insurance programs and oversight of clinical safety protocols. Potential need for public subsidies.
- Private Sector: High entry costs and unclear legal protections may discourage provider participation.
- Society: Access is limited to those with diagnoses or the means to pay out-of-pocket. Implementation is slowed by institutional resistance and high service costs.

Benefits:

- State: May reduce downstream healthcare costs, including hospitalizations and pharmaceuticals.
- Private Sector: Expands opportunities in clinical training and therapeutic service delivery.
- Society: Legitimizes use through integration into established healthcare systems. Offers relief for treatment-resistant conditions. Establishes a strong evidentiary base, builds public trust, and creates pathways for eventual insurance reimbursement.

Other Considerations: Establishing licensure and regulatory systems for psychedelic facilitators is complex and time-intensive. Legal uncertainties may deter clinician involvement unless explicit statutory protections are enacted. Without financial assistance or insurance alignment, participation is likely to remain limited. Sustainable program success will require dedicated funding, public education, limited sales for off-site use, and continuing adaptation.

Non-Commercial Peer Sharing

This model allows adults to grow psychedelic-containing plants or fungi and share them with others without compensation. The statutory framework for this approach—exemplified by Colorado's "Grow and Give" law (CO Rev. Stat. 18-18-434(5)(a))—permits cultivation and gifting of natural psychedelics while explicitly prohibiting sales or advertising. It promotes personal autonomy, mutual aid, and community-based healing outside of formal healthcare or commercial systems. In some proposed versions, individuals could apply for a personal psychedelic use permit following education or health screening, but this is not a requirement in

most peer sharing laws. Penalties for unauthorized possession are replaced by civil fines or warnings, reducing criminalization while still deterring misuse.

State Involvement: Moderate. Requires clear legal definitions, limitations on advertising or sales, and oversight of public safety concerns.

State Revenue Potential: Low. Minimal revenue may be generated through permit fees, or the testing of products through state-licensed testing facilities. No tax revenue is associated with non-commercial transactions.

Costs:

- State: Complex-to-enforce boundaries between gifting and illicit “disguised” sales, although this is similar to current criminalization schemes where a law enforcement agent has to examine each case to distinguish between possession, intent to distribute, and trafficking.
- Private Sector: Limited to voluntary testing for potency and purity.
- Society: Quality control is limited; safety risks may emerge from untested or improperly prepared substances. Need to invest in public education.

Benefits:

- State: Relatively low administrative burden and enforcement costs compared to commercial systems. State-provided testing of non-regulated products allows for monitoring trends in substance use, which may inform future regulation and policy discussions.
- Private Sector: May indirectly support ancillary markets, such as cultivation supplies, harm reduction education, or integration coaching.
- Society: Expands access with minimal financial barriers. Supports community care and decriminalization efforts while minimizing reliance on commercial or medical institutions. Avoids commercial influence on public health regulations. Avoids commercial pressure to expand use via advertising and promotion.

Deprioritization / Decriminalization

This model involves either the formal removal of criminal penalties or a shift in law enforcement priorities for personal use, possession, cultivation, or gifting of psychedelic substances. Examples include Washington, D.C.’s 2020 ballot initiative concerning "entheogenic plants and fungi," which made enforcement the lowest priority for local police. Under "deprioritization," psychedelic substances remain illegal but are rarely prosecuted, while "decriminalization" statutorily removes criminal penalties and often replaces them with civil fines or health assessments.

Decriminalization legislation may include language that provides for non-commercial peer sharing. Neither model establishes legal protections for facilitators or regulated access systems.

Table 10. Comparison of Deprioritization and Decriminalization

	Deprioritization	**Decriminalization**
Legal Status	Substance remains technically illegal	Removes criminal penalties and sometimes civil penalties as well
Law Change	A shift in enforcement policy/priority	Requires a change in law/statute
Consequences	Reduced likelihood of arrest/prosecution by police	Fines (which could lead to criminalization if unpaid), health assessments, no criminal record (although arrest and conviction records prior to decriminalization must be cleared)
Enforcement Risk	Still at risk from state or federal authorities	Lower risk from local authorities

State Involvement: Low to Moderate. Requires policy changes or legislative action but little in the way of regulatory infrastructure.

State Revenue Potential: Low. These models generate no tax revenue but may reduce costs associated with criminal enforcement.

Costs:

- State: No regulatory income; does not leverage healthcare or economic systems.
- Private Sector: No legitimate market or formal investment opportunities.
- Society: Underground use continues without product testing or facilitator standards. Unregulated storefront sales may increase, provoking local backlash.

Benefits:

- State: Cost savings on enforcement and incarceration. Politically easier to implement and generally avoids federal interference.
- Private Sector: Advocacy and education markets may expand. Decriminalization may signal policy momentum.
- Society: Reduces stigma and incarceration risks. Increases affordability and access through gray markets, even if informally. Encourages broader public discourse and may pave the way for future reforms. Provide victims of abuse a legal pathway to hold unscrupulous actors accountable through the criminal and civil courts.

Other Considerations: Lack of national public health data limits the ability to rebut concerns about safety. Ethical risks remain for seekers interacting with guides and individuals who may take advantage of novices or individuals who have not gained knowledge of psychedelics. Policymakers often worry about increased youth access, product contamination, and the potential for disorganized or unsafe use. Whereas, criminalization doesn't remove these concerns and may actually exacerbate safety issues (e.g., people reluctant to go take a friend to the hospital or call for an ambulance because the substances they've ingested are illegal).

Denver remains the only city to have published an official report on the effects of decriminalization (2019–2021). Briefly, Psilocybin-related criminal cases decreased by roughly two-thirds in the three years following deprioritization. While poison control reports increased up to three-fold among adults and more than seven-fold among children, hospital or emergency department admissions for psilocybin-related incidents remained minimal. There was no evidence of increased youth exposure, public disturbances, or destabilized social behavior tied to psilocybin.

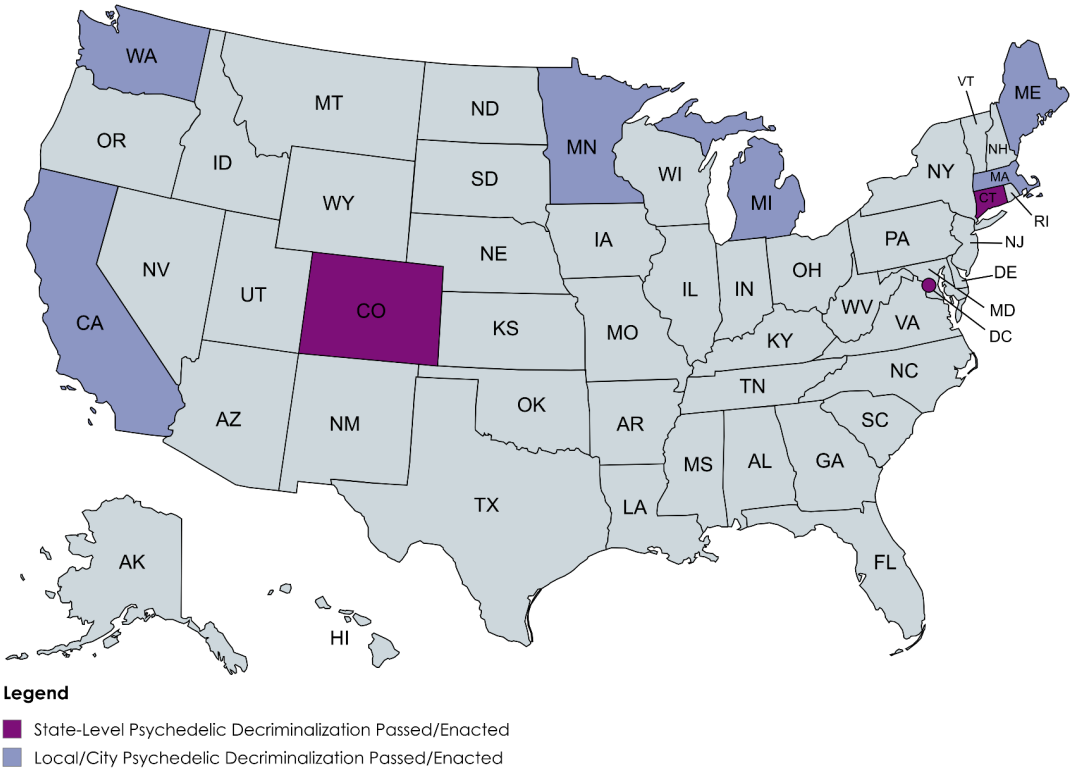

Figure 15. Psychedelic Decriminalization Legislation Passed or Enacted as of July 2025

Religious Use

Religious use models recognize the sacramental use of psychedelics by specific faith communities. The Native American Church, which uses peyote in its worship, operates legally under the protection of the American Indian Religious Freedom Act Amendments of 1994 (P.L.103-344). Groups such as the União do Vegetal (Hoasca® or ayahuasca) have won legal protection from Federal law enforcement for ceremonial use under the Religious Freedom Restoration Act of 1993 (RFRA) (P.L. 103-141). RFRA does not apply to the States. These exemptions are narrow, tied to specific lineages and practices, and do not permit general public access.

State Involvement: Low. Minimal state role unless legal or public concerns arise. Oversight tends to be reactive rather than proactive.

State Revenue Potential: Low. These models generate no significant direct revenue.

Costs:

- State: Legal oversight of religious exemptions.
- Private Sector: No market access or commercialization allowed.
- Society: Very narrow eligibility and limited public health integration.

Benefits:

- State: Simple to administer and respectful of constitutional rights.
- Private Sector: None directly.
- Society: Preserves cultural practices and provides a legal pathway for spiritual or religious use. May lead to beneficial health and societal impacts downstream. May integrate uniquely well with public health due to its organized, community-based, and collective nature.

FDA-Approved Use

This approach maintains the status quo, “wait and see.” The federal process leads, and Maryland would integrate through providers and payers. Psilocybin and MDMA are currently in late-stage trials, and federal rescheduling could occur within a few years. States taking this path avoid legal and regulatory conflict but offer no interim relief or access. It is the most cautious model, prioritizing federal alignment over innovation, public health urgency, and an approach tailored to the unique needs of the Marylanders.

State Involvement: Low. Integration into existing healthcare and insurance systems. Federal approval limits state effort to integration and monitoring.

State Revenue Potential: Low. Indirect via general economic activity; negligible direct revenue.

Costs:

- State: Initial implementation challenges (education, regulation), Delays in availability.
- Private Sector: High investment for R&D and trials, Limited to few players with IP and capital.
- Society: Limited competition may keep prices high. Slower adoption, resulting in more people with treatment-resistant mental health needs either have to continue to suffer or travel to other states that have already decriminalized or allow for supervised adult access or a medical model. This approach also results in the most people, of all the listed approaches, continuing to be involved in the criminal legal system.

Benefits:

- State: Long-term integration with insurance systems, Reduces enforcement burden.
- Private Sector: Federal legitimacy, Broad market once reimbursable, Pharma and biotech opportunities.
- Society: Standardized quality, Potential widespread insurance coverage, Clinical oversight, based on high-quality evidence of efficacy and safety. Broadly accepted framework for medical care, Highly trained medical professionals and facilities, Extensive and rigorous randomized controlled trial data clearly establishing the extended efficacy.

Other Concerns: MAPS/Lykos MDMA-Assisted Psychotherapy was delayed by the FDA in 2024, with earliest projected FDA approval now in 2027 or beyond. One 3-dose course of treatment is projected to cost $30,000. It is unknown what type of an ICER (Institute for Clinical and Economic Review) value assessment this treatment will receive or what level of insurance coverage will be adopted. If costs remain high, it is widely expected that insurance coverage will start low/limited and involve extensive prior authorization requirements, co-pays, and cost-sharing expenses, even among those well-insured. The limited number of certified therapists who can legally administer treatment will contribute to bottlenecks and access delays upon launch.

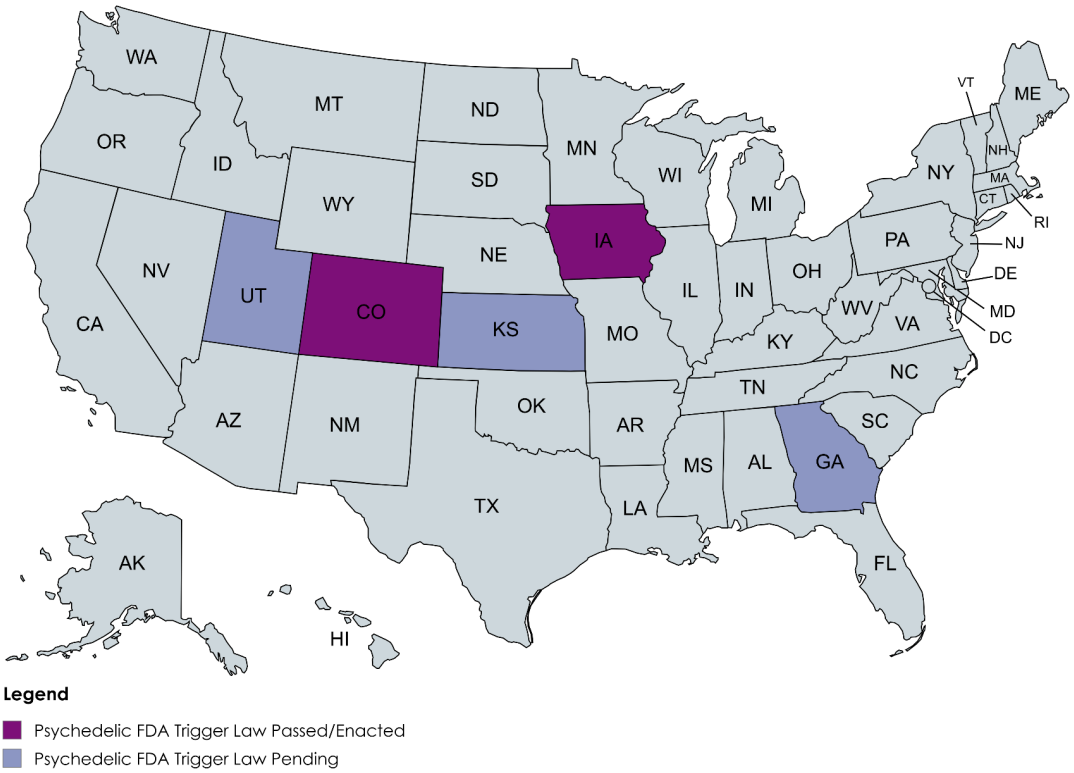

Figure 16. Psychedelic "Trigger Laws" Enacted as of July 2025

Policy Propositions

As part of its mandate to explore the responsible use of natural psychedelic substances, the Task Force developed a structured framework to evaluate potential policy features. (See Appendix 3: Design Considerations for further details.) This work culminated in a curated set of 85 policy propositions, each representing a discrete policy decision point that could inform future legislation in Maryland.

These propositions were developed following extensive literature reviews, policy analysis from other jurisdictions, expert testimony, and public stakeholder input. The initial list included 120 propositions, which were then thematically categorized, reviewed for redundancy, and ranked for relevance and priority. This process led to the refinement and consolidation of the list to 85 high-value propositions, spanning the seven access models identified earlier in the report.

Each proposition addresses a specific regulatory question, such as whether psychedelic use should require a medical diagnosis, what types of training facilitators should complete, how equity can be advanced in industry participation, or whether a use permit system should be implemented. The aim was to distill the complex set of decisions facing lawmakers into clear, actionable elements that could be independently evaluated and refined.

To assess each proposition, the Task Force employed a modified Delphi method—an evidence-based consensus process that uses iterative rounds of anonymous input from experts to refine and converge on recommendations. This approach promotes transparency, reduces groupthink, and allows for the identification of both strong areas of agreement and issues requiring further deliberation. Notably, the Delphi method was used internally to identify consensus among task force members; we did not seek to make generalizable claims beyond our specific mandate. A full explanation of the Delphi methodology used, including grading criteria and participation metrics, is provided in Appendix 4.

The results of this process are ongoing at the time of this interim report. Preliminary findings for each individual policy proposition from the first round of the Delphi process were presented at the Task Force's public meeting on June 5, 2025. The Task Force continues to actively receive input on these propositions from experts and the public while we finalize our recommendations in anticipation of our comprehensive report in October 2025. Additional policy propositions may also be considered using the Task Force's Delphi process as needed.

Cross Model Propositions

1. Access models should initially focus on psilocybin, with potential expansion to other natural psychedelic substances once initial programs are successfully established.
2. Multiple access models for natural psychedelic substances should be implemented initially, in a complementary fashion.
3. Use of natural psychedelic substances should be limited to adult residents of Maryland who have a formal qualifying medical or psychiatric diagnosis from a licensed health care provider.
4. Individuals who wish to access natural psychedelic substances outside of a regulated setting should first obtain a permit/license for use.
5. Individuals who wish to obtain a permit/license for use of natural psychedelic substances should first undergo an appropriate medical and psychiatric screening by a licensed health professional (e.g., similar to a Medical Examiner's Certificate for a Commercial Driver's License or a Medical Cannabis Registration).
6. Individuals who wish to obtain a permit/license for use of natural psychedelic substances should complete a mandatory education course and pass an exam.

7. Any access programs for natural psychedelic substances should be implemented in a way that is revenue neutral or revenue generating across all programs (i.e., losses from one or more programs may be offset by surpluses from others).
8. Maryland should clarify that lawful personal use or possession of natural psychedelic substances is not grounds for child abuse/neglect proceedings.
9. Maryland should protect individuals from discrimination in employment or housing based on their lawful personal use of natural psychedelic substances.
10. Maryland should establish an advisory board with representatives from diverse stakeholders to monitor any permitted access model for natural psychedelic substances.
11. Maryland should establish whistleblower protections for reporting violations in any permitted psychedelic access model.
12. Public education campaigns about safe use of natural psychedelic substances should be implemented in any approved psychedelic access model.
13. Educational materials emphasizing harm reduction should be provided to anyone receiving natural psychedelic substances through any approved access model at the time substances are received.
14. A comprehensive data collection and monitoring system should be established to track costs, revenues and outcomes across all approved models.
15. Any statewide monitoring system should exclude personally identifiable information about consumers of natural psychedelic substances.
16. De-identified data from the statewide data collection and monitoring system for natural psychedelic substances should be made readily available to the public.
17. Environmental sustainability requirements should be established for cultivation and production of natural psychedelic substances.
18. Maryland should take measures to ensure diverse participation in psychedelic industries and services (e.g., prioritizing applicants representing groups disproportionately impacted by drug policies enacted from 1973 to 2023).
19. Maryland should offer a low cost online training option that satisfies requirements for any access program that mandates training for providers, facilitators, users, or any other participants.
20. Maryland should implement a regular policy review process (e.g., annually) to adapt regulations for natural psychedelic substances based on emerging evidence.
21. All new psychedelic access programs should include a sunset provision requiring reauthorization after a specified period (e.g., 5 years) based on evidence of safety, efficacy, and equity impacts.
22. Local jurisdictions should be allowed to opt out of access models for natural psychedelic substances.

23. Consumption of natural psychedelic substances should be allowed in approved sites (e.g., an outdoor music venue with an appropriate permit, other sites specified by access models), but not in public spaces.

Deprioritization / Decriminalization

24. Law enforcement should make arrests for possession of natural psychedelic substances the lowest enforcement priority.
25. Maryland should establish clear quantity thresholds defining personal use amounts of natural psychedelic substances.
26. Maryland should establish harm reduction services for natural psychedelic substances (e.g., designated safe spaces for use of natural psychedelic substances, psychedelic first aid, and access to home test kits for purity and potency).
27. Law enforcement should make arrests for personal cultivation of natural psychedelic substances the lowest enforcement priority.
28. Law enforcement officers should receive specific training on deprioritization policies for natural psychedelic substances.
29. Law enforcement should update DUI protocols with available testing methods for psychedelic impairment.
30. If deprioritization of natural psychedelic substances is enacted, public education campaigns should clarify that deprioritization does not equal legalization.
31. Penalties for possession and personal cultivation of natural psychedelic substances should be reduced to civil infractions rather than criminal charges.
32. Penalties for possession and personal cultivation of "personal use" amounts of natural psychedelic substances should include protection from asset forfeiture.
33. Past convictions involving possession of natural psychedelic substances should be expunged.

Non-Commercial Peer Sharing

34. Qualified adults should be allowed to cultivate and gift small, specified quantities of natural psychedelic substances to other qualified adults without financial compensation, non-financial compensation, or bartering.
35. Sharing of cultivation knowledge and techniques for natural psychedelic substances to groups or individuals eligible to participate in peer sharing should be explicitly protected from state prosecution.
36. Peer sharing should be allowed only for specific species of natural psychedelic substances (e.g., Psilocybes cubensis), not broad categories (e.g., psilocybin-producing mushrooms).

37. Non-commercial cultivation and sharing of natural psychedelic substances should be limited to members of community-based organizations (e.g., member owned co-operatives) licensed by the state.
38. Peer sharing by community-based organizations should require documentation of the provenance and purity of natural psychedelic substances.
39. Community-based organizations facilitating peer sharing of natural psychedelic substances should be granted limited liability protections.
40. Any individuals or entities engaging in peer sharing natural psychedelic substances should be prohibited from making therapeutic or health claims.

Commercial Sales

41. Maryland should establish a regulated market for commercial sales of natural psychedelic substances.
42. Commercial sales of natural psychedelic substances should be allowed exclusively in person at state-owned outlets (e.g., a "state monopoly" like Alcohol Beverage Services in Montgomery County).
43. Commercial sales of natural psychedelic substances should be allowed in person at state-licensed dispensaries.
44. Commercial sales should be allowed only for natural psychedelic substances cultivated by state-licensed commercial growers.
45. Commercial sales should be allowed only to eligible adult Maryland residents who maintain an active license to use natural psychedelic substances.
46. All commercially sold natural psychedelic substances should undergo mandatory testing at state-licensed laboratories.
47. Marketing practices that target minors should not be allowed for natural psychedelic substances.
48. Commercial psychedelic packaging should include standardized warning labels.
49. Natural psychedelic substances should be packaged and sold in single-dose quantities clearly labeled for potency (i.e., to prevent consumers from inadvertently taking higher than expected amounts).
50. Commercial vendors should be prohibited from making therapeutic or health claims.
Here are Propositions 51 through 85, listed in numerical order with their exact text:
51. Maryland should establish production quotas for commercial producers of natural psychedelic substances.
52. Commercial vendors of natural psychedelic substances should be required to maintain detailed sales records.

53. Maryland businesses related to natural psychedelic substances should have state income tax deductions for qualified business expenses (e.g. as Maryland has done with cannabis businesses).

Religious Use

54. Maryland should take no specific action at this time to expand access to natural psychedelic substances for religious use, awaiting updates by the DEA to the petition process for religious exemptions from the Controlled Substances Act (CSA) under the Religious Freedom Restoration Act (RFRA).
55. Maryland should proactively provide established religious organizations protected rights to use natural psychedelic substances as sacraments under state law.
56. Production and cultivation of natural psychedelic substances should be allowed for Religious Organizations for use as sacraments.
57. Religious organizations should implement safety protocols for ceremonies involving natural psychedelic substances.
58. Maryland should establish regulations and certification for religious leaders who will administer natural psychedelic substances as sacraments.
59. Religious organizations who wish to use natural psychedelic substances should be required to register with state authorities.
60. Minors should be allowed to participate in ceremonies involving natural psychedelic substances with parental consent.
61. Religious use of natural psychedelic substances should be allowed only in designated worship spaces.
62. Religious organizations should maintain records of any adverse events related to natural psychedelic substances.

Supervised Adult Use

63. Licensed facilities should be established where adults can consume natural psychedelic substances under supervision by licensed facilitators.
64. Supervised use facilities for natural psychedelic substances should be mandatorily staffed by licensed facilitators.
65. Maryland should establish training and certification requirements for supervised use facilitators of natural psychedelic substances.
66. Requirements for supervised use facilitators of natural psychedelic substances should allow participation by licensed health care providers acting within the scope of their professional training.

67. Consumers should undergo medical and psychiatric screening by a licensed health professional before participation at supervised use facilities for natural psychedelic substances.
68. Consumers should be required to attend preparation sessions before supervised use of natural psychedelic substances.
69. Supervised use facilities should offer integration support after use of natural psychedelic substances.
70. Supervised use facilities for natural psychedelic substances should maintain specific staff-to-consumer ratios.
71. Group sessions at supervised use facilities for natural psychedelic substances should have maximum participant limits.
72. Supervised use facilities administering natural psychedelic substances should have specific safety equipment and protocols in place.
73. Supervised use facilities should maintain detailed records of natural psychedelic substances administered and adverse events.
74. Supervised use facilities for natural psychedelic substances should be required to offer sliding scale payment options.
75. Supervised use facilities of natural psychedelic substances should be subject to regular inspections.
76. Supervised use facilities of natural psychedelic substances should be prohibited from making therapeutic or medical claims.

Medical / Therapeutic Use

77. Licensed healthcare providers should be allowed to administer natural psychedelic substances for therapeutic purposes.
78. Medical use of natural psychedelic substances should require a formal diagnosis from a qualified healthcare provider.
79. Approved use of natural psychedelic substances for consumers at high risk of medical or psychiatric complications should be restricted to the medical/therapeutic use model.
80. Licensed health care providers should document an informed consent process including the risks, benefits, and alternatives prior to initiating therapy with natural psychedelic substances.
81. Protocols for medical use of natural psychedelic substances should require preparation, administration, and integration sessions.
82. Lawful administration of natural psychedelic substances should not constitute sole grounds for disciplinary action by professional licensing boards in Maryland.
83. Maryland should create a state-wide no-fault alternative to lawsuits related to lawful administration of natural psychedelic substances by authorized health care providers or

facilitators (e.g. the Florida Birth-Related Neurological Injury Compensation Association aka. NICA).

FDA-Approved Use

84. Maryland should automatically permit access to any FDA-approved psychedelic therapies once rescheduled by the DEA, on a provisional basis, pending the Maryland Department of Health's annual update and republishing of the state controlled substances schedule.
85. Maryland should take no specific action at this time to expand access to natural psychedelic substances for Maryland Residents, awaiting review of ongoing studies by the FDA and rescheduling of natural psychedelic substances by the DEA.

Challenges in the Work of the Task Force

The Maryland Task Force on Responsible Use of Natural Psychedelic Substances was created with an ambitious and forward-looking mandate: to evaluate whether and how the state might safely, equitably, and effectively create access to psychedelic substances for therapeutic, spiritual, and personal growth purposes. The work of the Task Force has been marked by a spirit of deliberation, openness, and principled caution. At the same time, this work has met serious challenges. This chapter outlines the most significant obstacles the Task Force has encountered to date and identifies emerging strategies to address them.

Barriers to Publicity and Outreach

The absence of a communications budget or staff has significantly hindered efforts to publicize meetings through official state channels. As an interim solution, **the Task Force created its own publicly accessible website** to host meeting announcements, recordings, and opportunities for public comment. The Task Force received news coverage from Fox 45, *Marijuana Moment*, *Montgomery Community Media*, and *Benziga*. Looking ahead, additional strategies under consideration include cross-posting announcements on other state and local government websites, utilizing existing local community discussion boards on social media, collaborating with public libraries, local health departments, and county councils to distribute physical and digital flyers, and enlisting student interns or volunteers to help maintain an outreach calendar and social media presence. These measures would support broader awareness and greater public participation.

Overcoming Reluctance, Stigma and Apathy

Identifying and engaging stakeholders—particularly those who have historically been opposed to drug policy reform—has proven difficult. In some cases, we expected to encounter reluctance stemming from skepticism about the legitimacy of psychedelics as a public health intervention. We also anticipated opposition rooted in concerns over safety, diversion, or the erosion of medical and licensing standards. To address this, the **Task Force is pursuing targeted outreach to professional associations and licensing boards**, offering confidential listening sessions to accommodate those hesitant to speak publicly, and maintaining a stakeholder registry to keep individuals and organizations informed of updates, comment periods, and

working groups. These efforts are intended to turn passive observation into active participation and create space for concerns to be addressed through transparent, data-informed dialogue.

No Maryland-based religious communities that use psychedelics sacramentally have responded to our requests for input. We suspect this lack of engagement stems from concerns about legal exposure, mistrust, and confidentiality. In response, **the Task Force established a secure and confidential communications channel and reached out to national religious freedom organizations** for help initiating dialogue with Maryland-based affiliates. The Task Force remains committed to co-creating policy recommendations that respect religious freedom while protecting public safety.

Protecting traditional and ceremonial use of psychedelics requires not just exemption from regulation but active partnership. Reciprocity in Maryland might include recognition of community-defined ceremonial practices, revenue-sharing from commercial programs to support traditional stewards, and consultation rights for Indigenous and diasporic communities. Meanwhile, the **Task Force is closely reviewing aligned efforts in Colorado, Minnesota and Alaska, and inviting commentary from experts** and national organizations experienced in the use of natural psychedelic substances as sacred medicine.

Aspiring to embody the mandate "Nothing about us without us," the Task Force will continue its good faith efforts to engage members of religious and tribal communities that would be affected by our recommendations. There may be complex reasons for the lack of engagement we have seen to date, and we are accountable for our part in that.

Absence of Specific Law Enforcement Data

Unlike more commonly tracked substances such as cannabis, offenses involving natural psychedelic substances are typically recorded by law enforcement without sufficient detail. For example, the Montgomery County Crime Lab combines "hallucinogens and stimulants" into a single category, grouping natural psychedelics alongside unrelated substances such as LSD, MDMA, ketamine, and methamphetamine—many of which are synthetic or not considered psychedelics. The Drug Enforcement Administration (DEA) does list psilocybin, psilocin, and psilocybin/psilocin as separate identifiers, but does not report separate counts for dimethyltryptamine (DMT) or mescaline. This lack of specificity makes it difficult to assess the true scope of law enforcement activity related to natural psychedelics. However, based on the limited data available and anecdotal input from law enforcement personnel, organized criminal involvement with these substances appears to be minimal.

Multiple Substances Under Study

While grouping psilocybin, psilocin, dimethyltryptamine (DMT), and mescaline together under the Task Force's mandate is a logical starting point—given their natural origins, serotonergic mechanisms, and relatively low risk profiles—it also introduces complexity to our analysis and recommendations. These substances differ significantly in pharmacokinetics and use contexts: for example, vaporized DMT produces effects lasting just 5–15 minutes, whereas oral mescaline may last 8–12 hours. As a result, the safeguards and regulatory frameworks appropriate for each may vary considerably, requiring the Task Force to examine them both individually and comparatively.

To manage this complexity, the Task Force decided early in our process to focus first on the substances explicitly named in its authorizing legislation, before considering others such as ibogaine. Although ibogaine is gaining interest for opioid use disorder—particularly following support from former Texas Governor Rick Perry—it presents substantially higher medical risks, especially related to cardiac toxicity. Preliminary results from the Task Force's first Delphi round indicate broad consensus around prioritizing psilocybin for initial program development, with the potential to expand to other natural psychedelics once foundational programs are safely and successfully established. This recommendation remains under deliberation and will be updated in the Task Force's comprehensive October 2025 report.

Emerging Consensus within the Delphi Process

The Task Force's initial Delphi round surfaced internal inconsistencies across its 85 policy propositions, which is an expected feature of the process at early stages. The following is a summary of high priority themes that the Task Force will continue to explore in subsequent rounds.

Medical screening

Some propositions advocate for restricting high-risk individuals to medical settings and requiring screening at supervised use facilities, while others remain inconclusive on the need for screening for those seeking permits. A possible resolution is to adopt a tiered screening framework, mandating clinical assessments for high-risk individuals and for those in supervised settings, while offering optional education-based screening for personal use.

Use permits

The debate centers on whether these should be mandatory. Some propositions call for required permits with testing and training components, while others suggest a more permissive approach.

The Task Force is considering a flexible permit model that allows individuals to gain legal protections through voluntary participation, while still offering decriminalized or informal pathways for others.

Therapeutic claims

While licensed providers are broadly supported in making therapeutic claims within their scope of practice, commercial vendors are not, and the permissibility for peer sharers remains unclear. A proposed solution includes a tiered claims structure, limiting therapeutic assertions to credentialed professionals, allowing informal experiential sharing by peers, and prohibiting misleading health claims by vendors, including predatory marketing practices that might target children or vulnerable groups.

Required Diagnosis

Some propositions support restricting medical models to individuals with a formal diagnosis, while others propose broader access without such conditions. The Task Force is exploring a structure where diagnosis is required for medical use, encouraged but not mandatory for supervised adult use, and not applicable to personal or peer-supported use models.

Preparation and integration

These activities are widely valued in the propositions, particularly for supervised and medical use, though enforcement remains an open question. The Task Force is examining models that require documentation in licensed settings while promoting accessible integration support—such as telehealth and community networks—for others.

Local Autonomy

One key concern is how to respect local autonomy while ensuring equitable statewide access. A potential solution would allow jurisdictions to opt out but only with justification and periodic review, alongside the creation of monitoring tools to identify access deserts. Additional recommendations include funding mobile services, subsidizing transportation, and expanding telehealth options. Although, permitting local jurisdictions to opt out creates an access issue – especially for people in more rural counties – that mobile and Telehealth services may not be sufficient to address.

Balancing Safety and Accessibility

The Task Force is acutely aware of the risks associated with both over- and under-regulation. Excessive restrictions may push activity underground, while insufficient oversight may invite

preventable harm. One model under discussion is a graded access system that aligns the level of regulation with the level of risk. The medical model would feature the highest degree of oversight, supervised adult use would be moderately regulated, and peer-supported or personal use models would include minimal formal regulation but be grounded in harm reduction principles and community-based accountability. Pilot programs, adverse event reporting, and accessible education are being considered as essential safeguards.

Equity and Inclusion

Ensuring broad, affordable, and equitable access is central to the Task Force's work. The Task Force is exploring licensing tiers with reduced fees for small and nonprofit providers, scholarships to train facilitators from historically excluded communities, and the creation of an independent Office of Psychedelic Equity to track implementation, monitor access gaps, and recommend corrective actions.

These efforts must move beyond symbolic gestures and address the structural barriers that have long excluded communities of the global majority—such as Black, Indigenous, and other people of color, as well as queer and trans individuals, neurodivergent people, and those with disabilities—from both healing and decision-making spaces. In this context, equity is not merely about inclusion; it requires a fundamental reimagining of how access, power, and knowledge are distributed. This includes scrutinizing who defines standards, who benefits from existing systems, and who remains marginalized due to financial, cultural, or systemic obstacles.

True access must be rooted in justice—not limited to the privileged few. Policies should emphasize contributions from lived experience, cultural knowledge, and community-led approaches. Addressing financial inequity is especially urgent, necessitating innovative funding mechanisms, community-led training opportunities, and durable infrastructure to support long-term participation and sustainability for both providers and participants. The work ahead demands transparency, vigilance, and a commitment to dismantling oppressive frameworks that risk replicating harm—even in spaces designed for healing.

Next Steps

As the Task Force enters the next phase of its work, several key deliverables remain in progress. The completion of these tasks is critical to ensuring that our final recommendations are well-informed, pragmatic, and responsive to the needs of Maryland's residents, institutions, and communities.

Collaboration with Johns Hopkins University

To help evaluate different psilocybin access models, a team of health economists affiliated with the Johns Hopkins Carey Business School and the Johns Hopkins School of Public Health is conducting a **scoping review of the literature to identify the key costs and revenues of different policy options**, and to **assess how these options might impact the state of Maryland, providers, and patients/consumers**.

As of July 14, 2025, **a scoping review of psilocybin economics in other U.S. states** has been completed; relevant studies include evaluations of Oregon's recent psilocybin policies and overviews of the psilocybin commercial landscape. A **scoping review of the cost drivers of various psilocybin policy options** has also been completed, with some frequently mentioned drivers including the psychotherapy component of psychedelic-assisted therapy and the cost of facilitator training.

Next steps include identifying key costs from cannabis legalization studies that may help inform the evaluation of psilocybin policy options. These different components will then be compiled into a **comprehensive, independent report for the Task Force** on Responsible Use of Natural Psychedelic Substances.

Ongoing Stakeholder Engagement

The Task Force will maintain and expand its commitment to stakeholder engagement, with a focus on groups that represent public health, safety, law enforcement, healthcare, and community perspectives. Consultations are planned or ongoing with the following key organizations:

- Chesapeake Region Safety Council
- Maryland Chiefs of Police Association
- Maryland Sheriffs Association
- MedChi

- Maryland States Attorneys Association
- Maryland Academy of Family Physicians
- Maryland Public Health Association
- Maryland/DC Society of Addiction Medicine
- Maryland Psychiatric Society
- Beckley Retreats
- Baltimore Psychedelic Society
- DanceSafe

In addition, the Task Force is conducting direct outreach to state agencies likely to be affected by psychedelic policy legislation. These include:

- Maryland Department of Health
- Maryland Cannabis Administration
- Maryland Department of Agriculture
- Maryland Department of Disabilities
- Maryland Department of Veterans Affairs
- Maryland Department of Human Services
- Maryland Department of Public Safety and Correctional Services
- Maryland Judiciary / Administrative Office of the Courts
- Maryland Office of the Attorney General
- Maryland Department of Commerce
- Maryland State Police and local law enforcement agencies

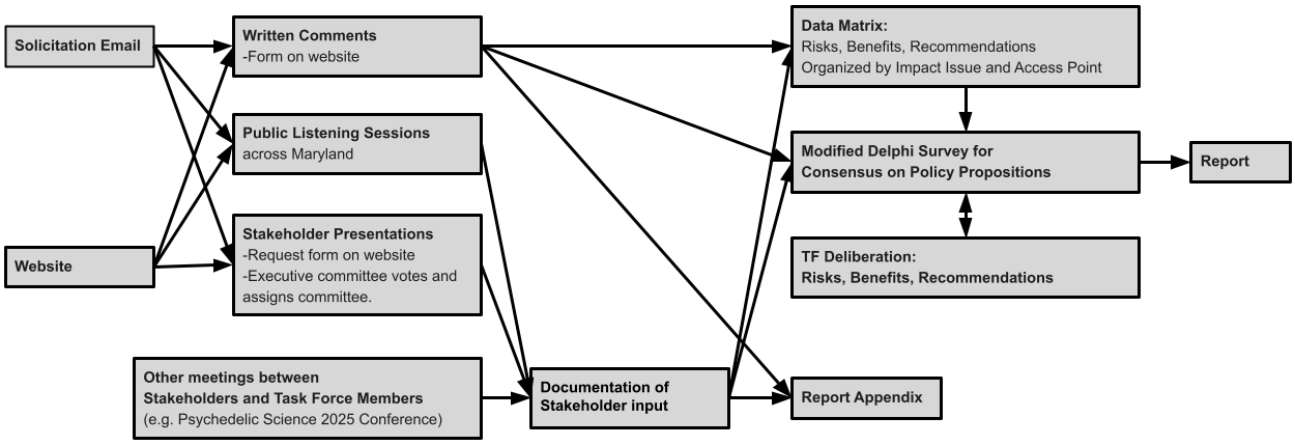

Figure 17. Workflow of Stakeholder Input Received by the Maryland Task Force on Responsible Use of Natural Psychedelic Substances

Legislative and Community Consultation

The Task Force will seek input from members of the Maryland General Assembly, including House and Senate leadership, relevant caucuses, and committee chairs. These discussions will help ensure that our final recommendations are legally sound, politically informed, and aligned with constituent priorities. We also continue to welcome feedback from the public through listening sessions and written comments submitted through the Task Force website.

October 2025 Report

A comprehensive report, which will incorporate the results of all committee work, policy proposition recommendations, stakeholder input, and lessons from other states, is scheduled for publication in October 2025. It will provide legislators and the public with a comprehensive framework to guide future policy decisions regarding the use of natural psychedelic substances in Maryland.

- The Task Force continues to gather and analyze data for a side-by-side comparison of the seven policy models under consideration, with assistance from a team of health economists at John Hopkins University.
- The Substances Committee is finalizing technical monographs on DMT and mescaline, continuing its earlier work on psilocybin. These documents are essential to understanding the distinct pharmacological profiles, public health considerations, and legal status of each natural psychedelic substance under review.
- The Task Force will complete the grading and recommendation process for all 85 current policy propositions and develop additional recommendations to address issues raised in the remainder of our engagement and consultation process.

A Call to Action

Dear Reader: Please help us understand your concerns! What type of policy would you be willing to support? What do you need more information on? Please reach out to Tim Hamilton of the Public Education and Legislature Support Committee via https:///tfnps.com/ on or before September 15, 2025.

Psilocybin / Psilocin Monograph

Summary

Psilocybin and its active metabolite psilocin are naturally occurring psychoactive compounds found primarily in some species of mushrooms. Psilocybin has a long history of traditional use in indigenous cultures and is currently the subject of renewed scientific interest for potential therapeutic applications across a range of domains including psychiatric, neurological, and immunological. Psilocybin acts primarily on serotonin receptors in the brain, producing altered states of consciousness characterized by changes in perception, cognition, and mood. While generally considered to have low physiological toxicity and addiction potential, psilocybin use carries psychological risks, particularly for individuals with certain mental health conditions, predispositions, or for those using in unsafe settings. Psilocybin is currently designated a Schedule 1 controlled substance by the U.S. federal government. Recent years have seen significant policy reforms at the state level with several jurisdictions decriminalizing or creating regulated access pathways for these substances with varying outcomes. This monograph provides an evidence-based overview intended to inform policy considerations around these compounds.

Mycology

Psilocybin and psilocin are found primarily in mushrooms of the genus Psilocybe, though they also occur in other genera including Panaeolus, Gymnopilus, Pluteus, and Inocybe.[1] Over 200 species across eight genera containing these compounds have been identified worldwide to date, with varying concentrations and distributions.[2] Psilocybe cubensis is the most commonly cultivated species.[3]

Psilocybin (4-phosphoryloxy-N,N-dimethyltryptamine) is a prodrug that is metabolized in the body to psilocin (4-hydroxy-N,N-dimethyltryptamine), which is the pharmacologically active compound.[4] Psilocybin content in dried mushrooms is highly variable, but typically ranges from 0.1% to 2.0% by weight, though some species may contain higher concentrations. [5][6][7] These mushrooms also have various levels of psilocin as well. Any potency analysis needs to account for both psilocybin and psilocin content.

Ethnomycology

Psilocybin mushrooms have been used in ritualistic and ceremonial contexts by indigenous cultures for centuries, particularly in Mesoamerica. Archaeological evidence suggests their use

dating back at least 3,000 years, with mushroom stone effigies from Guatemala and southern Mexico representing some of the earliest artifacts associated with mushroom ceremonies.[8][9][10]

The Mazatec, Nahuatl, and other indigenous groups in Mexico incorporated psilocybin mushrooms into religious and healing ceremonies, often under the guidance of spiritual leaders.[11] Western scientific awareness of these practices emerged significantly in the 1950s through the work of R. Gordon Wasson, who participated in traditional Mazatec ceremonies led by curandera María Sabina.[12] His accounts, published in Life magazine in 1957, introduced these practices to the broader public and scientific community, coinciding with the isolation and identification of psilocybin by Albert Hofmann in 1958. The compounds gained widespread attention during the 1960s counterculture movement, leading to increased recreational use and subsequent prohibition in many countries under the 1971 UN Convention on Psychotropic Substances, which classified psilocybin as a Schedule I substance.[13][14]

Meanwhile, María Sabina suffered significant social and personal consequences after introducing the cultural West to psilocybin. Her sacred healing practices were publicized without consent, leading to ostracization by her community, harassment by outsiders, and the loss of cultural privacy and autonomy. Her experience is often cited as a cautionary tale about cultural appropriation and the exploitation of Indigenous knowledge. There remains some ritualistic use of psilocybin-containing mushrooms in parts of Mexico, but indigenous use is overall diminishing and has been largely supplanted by an industry of psychedelic tourism.[15][16]

Mechanism of Action

Psilocybin itself is not directly psychoactive but is rapidly dephosphorylated in the body to psilocin, which is the active compound considered primarily responsible for psychoactive effects.[17] Psilocin acts primarily as an agonist (activator) for serotonin (5-HT) receptors in the brain, with particularly high affinity for the 5-HT2A receptor subtype.[18] This receptor activation is believed to be the primary mechanism underlying the psychedelic effects.

Short term effects typically begin within 20-40 minutes of ingestion, peak at 2-3 hours, and gradually diminish over 4-6 hours.[19] The subjective experience commonly includes altered visual and sensory perception, changes in thought patterns, emotional intensification, and in higher doses, profound alterations in the sense of self and reality. Longer term effects may result from promoting neuroplasticity and neural connectivity.[20] Some longer term effects, such as increases in prosocial behavior and relief from depressed mood and self-criticism, may be perceived as beneficial if they occur. Whereas other potential long-term effects – such as suggestibility, paranoia, and derealization – may be unwelcome or harmful.

Table 11. Comparison of High-Level Characteristics of Alcohol, Cannabis and Psilocybin

	Alcohol	**Cannabis**	**Psilocybin**
Commonly Found In	Beer, Wine, Liquor	Plant, Extracts, Oils, Edibles	"Magic Mushrooms" Psilocybe spp.
Route of Administration	Oral (Drinking)	Smoking/Vaping, Drinking, Eating	Oral (Eating)
Typical Use Frequency	Up to daily	Up to daily	Often 1-2 times per yr
Onset Time	5-15 min	15 min (smoked) 30min-2hr (edibles)	20-30 minutes
Effect Duration (1 dose) - how to quantify?	1 hour per drink	1-3 hour (smoked) 2-12 hours (edibles)	4-6 hours
Single Dose - how to quantify?	1.5 oz distilled spirit 5 oz wine 12 oz beer	Dosing of edibles ranges from <5mg (microdose) to 25mg, and in some cases >100mg in experienced individuals	<2.5mg (pure)/<250mg (dried mushroom) = microdose 2.5-10 mg/250mg -1gm = low dose >25mg/2.5 gm = treatment dose
Lethal Dose	10-25 drinks	In humans, there have been no recorded instances of fatal overdoses resulting from acute THC use.	In rats, >280mg/kg; in humans, no recorded instances of fatal overdose from acute psilocybin use
Positive Effects	Reduced anxiety, increase sociality, euphoria	Reduced anxiety, increase sociality, euphoria, increased creativity, pain reduction, anti-nausea	Increased sense of connectedness to self, others, and world, increased creativity
Negative Effects	Aggressiveness, disorientation, nausea, impaired cognition/decision making	Social isolation, impaired cognition/decision making	Social isolation, disorientation, nausea, impaired cognition/decision making
Tolerance	Yes (long term)	Yes (long term)	Yes (short term)
Withdrawal	Yes	Yes	No

Safety Profile and Public Health Considerations

A. Physical Health

a. Psilocybin has demonstrated a relatively favorable physiological safety profile compared to many other psychoactive substances. Common effects associated with psilocybin include hallucinations, nausea, vomiting, sweating, and physical or emotional discomfort.[21] These are typically short term and resolve as the active compounds are metabolized.[22]

b. *Toxicity:* The lethal dose (LD50) is estimated to be extremely high (approximately 280 mg/kg in rats), with very few confirmed cases of death directly attributed to psilocybin toxicity in humans.[23][24] The therapeutic index (ratio of toxic to effective dose) is wide.

c. *Cardiovascular effects:* Modest, transient increases in blood pressure and heart rate may occur, and this effect appears to be dose-dependent based on available data.[25] While generally not clinically significant in healthy individuals, these hemodynamic changes could pose risks for individuals with severe cardiovascular disease, poorly controlled hypertension, or a history of cardiac events.[26] FDA approved clinical trials have excluded those with significant cardiovascular disease including uncontrolled hypertension. A theoretical cardiovascular risk more relevant to chronic use (as with so-called microdosing) is that psilocybin activates a receptor (serotonin 2B) known to lead to heart valve disease. This is the same mechanism and risk that caused fenfluramine/phentermine (fen-phen) to be withdrawn by the FDA in 1997.

d. *Hepatic effects:* Unlike some psychoactive compounds, psilocybin demonstrates minimal hepatotoxicity. Standard liver function tests show no clinically significant alterations following controlled administration, and there is no evidence of long-term liver damage associated with periodic use.[27][28]

e. *Neurological considerations:* There is no evidence that psilocybin causes neurotoxicity or structural brain damage. Conversely, emerging research suggests potential neuroprotective properties through several mechanisms.[29][30] There is a theoretical risk that HPPD (discussed below) may have a neurological basis in susceptible individuals, although this is unconfirmed.

f. *Teratogenicity and reproductive health:* Limited data exists on effects during pregnancy or breastfeeding. Animal studies show no consistent evidence of teratogenicity at doses

equivalent to human consumption, but the precautionary principle warrants avoiding use during pregnancy due to the lack of controlled human studies. No evidence suggests impacts on long-term fertility or reproductive function.[31][32]

B. Mental Health

The psychological effects of psilocybin present both risks and potential benefits:

a. *Acute psychological distress:* "Challenging experiences," which while difficult hold redeeming value, or "bad trips," which have no redeeming value, can occur. These are characterized by anxiety, paranoia, confusion, and fear. These reactions are influenced by dose, setting, expectation, and individual susceptibility. Approximately 25-30% of individuals may experience significant anxiety or challenging psychological symptoms during high-dose psilocybin experiences, although these typically resolve within 24-48 hours.[33] Preparation, setting, and qualified supervision significantly reduce these risks.[34]

b. *Unprepared use and psychological impact:* Individuals using psilocybin without adequate preparation, in inappropriate settings, or with underlying psychological vulnerabilities face increased risks of adverse psychological outcomes.[35] The profound alterations in perception and cognition can be disorienting and frightening without proper context or support.[36] These risks increase substantially with higher doses.

c. *Behavioral responses to hallucinations:* Despite popular misconceptions, true hallucinations (perceiving stimuli that do not exist) are relatively uncommon with psilocybin compared to illusions and perceptual distortions (misinterpreting existing stimuli).[37] Research does not support the notion that individuals commonly "act out" hallucinations in dangerous ways. However, impaired judgment, altered perception, and general intoxication can lead to risky behavior if proper precautions are not taken.[38][39]

d. *Psychosis risk:* Psilocybin may precipitate or exacerbate psychotic symptoms in predisposed individuals, particularly those with personal or family history of psychotic disorders. However, large population studies have not found associations between psychedelic use and increased prevalence of psychotic disorders in the general population.[40][41] In FDA approved studies that screen for predisposition for psychotic disorder, there has not been any reported instigation of psychotic disorders among thousands of participants.

e. *Mania and mood disorders:* Case reports exist of psilocybin triggering manic episodes in individuals with bipolar disorder or predisposition to mania.[42][43] The serotonergic activity of psilocybin may potentially destabilize mood regulation in vulnerable individuals. However, a recent small clinical trial administered psilocybin to Bipolar II patients without any instigation of manic episodes, and with a significant reduction in depressive symptoms. However, the risk of manic episode instigation has not been eliminated.

f. *Hallucinogen Persisting Perception Disorder (HPPD):* This is a rare condition involving persistent perceptual changes -- such as visual snow, halos, or trails -- and symptoms of depersonalization or derealization following hallucinogen use, such as visual snow, halos, or trails.[44] HPPD is estimated to affect approximately 4% of psychedelic users, though severe cases are much rarer.[45] Risk factors may include pre-existing anxiety disorders and frequent use of multiple substances.[46]

g. *Therapeutic potential:* Clinical research has shown promising results for treatment-resistant depression, anxiety associated with terminal illness, obsessive-compulsive disorder, substance use disorders, and PTSD when administered in controlled therapeutic settings.[47] Meta-analyses suggest large effect sizes for depression and anxiety outcomes that often persist for months after treatment.[48] These findings remain controversial. The internal validity of randomized controlled trials for psychedelics has been questioned due to factors such as inadequate blinding, selection bias, and positive expectancy. This suggests that the therapeutic benefit of psychedelics for psychiatric conditions may be over-estimated in some studies.

h. *Possible Long-term risks: There is limited long-term research available, but no major risks have been consistently reported. Some cases of prolonged psychological distress have been observed in individuals with known predispositions.[49]*

C. Potential At-Risk Populations

A. Certain populations may face elevated risks from psilocybin use:
    a. *Individuals with psychotic disorders:* People with schizophrenia, schizoaffective disorder, bipolar disorder with psychotic features, or family history of these conditions may experience exacerbation of symptoms or precipitation of psychotic episodes. Current clinical trials typically exclude individuals with these conditions or strong family histories.[50]
    b. *Bipolar disorder and history of mania:* Individuals with bipolar disorder may be at risk for mood destabilization or manic episodes following psilocybin exposure,

however recent data on psilocybin for treatment of Bipolar Type II indicates some level of safety and efficacy.[51][52][53] Case reports document instances of psilocybin triggering manic episodes in previously diagnosed and undiagnosed individuals. There is also evidence that the bipolar medication lithium can have a serious drug interaction with classic psychedelics such as psilocybin which can lead to seizures.

c. *Cardiovascular conditions:* People with uncontrolled hypertension, history of stroke, myocardial infarction, significant arrhythmias, or severe heart disease may be at increased risk due to psilocybin's temporary effects on blood pressure and heart rate.[54]
d. *Seizure disorders:* Individuals with epilepsy or other seizure disorders may face potential risks, as psilocybin lowers the seizure threshold in animal models, though human data remains limited.[55][56][57]
e. *Personality disorders:* Those with borderline, paranoid, or schizotypal personality disorders may experience symptom exacerbation or particular difficulty integrating intense psychedelic experiences.[58][59]
f. *Recent trauma or psychological instability:* Individuals experiencing acute grief, trauma, or psychological crisis may find the intensified emotional states and psychological vulnerability during psilocybin experiences overwhelming, and some vulnerable individuals may have increased suicidality following psychedelic experiences.[60][61][62]
g. *Adolescents:* The developing brain may theoretically be particularly vulnerable to the effects of psychoactive substances.[63] Neuroplasticity and neurodevelopmental processes continue through adolescence and early adulthood, and the impact of psilocybin on these processes remains understudied. Given that adolescence and young adulthood is the typical onset for psychotic disorders, one risk is destabilization of those with such predisposition without sufficient age for such predisposition to be identified. Most research programs and emerging regulatory frameworks restrict access to adults 21 and older.
h. *Pregnant women:* Due to ethical limitations on research, effects on fetal development are not well understood, and use during pregnancy is not recommended. Limited animal studies show minimal teratogenicity, but the precautionary principle applies given insufficient human data.[64]

B. Individuals on certain medications:
    a. *Serotonergic antidepressants (SSRIs, SNRIs):* May attenuate psychedelic effects but could theoretically increase serotonin syndrome risk[65][66]
    b. *Monoamine Oxidase Inhibitors (MAOIs):* May significantly potentiate psychedelic effects and potentially increase life-threatening cardiovascular risks[67]

c. *Lithium:* Case reports suggest increased seizure risk when combined with psychedelics[68][69]
d. *Second Generation Antipsychotics (SGA):* Medications in this class (e.g. risperidone, quetiapine) block the target of psilocybin's effects (serotonin 5HT2A receptors), and as such may have direct pharmacodynamic interactions with psilocybin. [70][71]
e. *First Generation Anti-Psychotics (FGA):* Unlike SGA's that block serotonin 5HT2A receptors, FGA's such as haloperidol in particular has been shown to increase the psychotomimetic (psychotic like) effects of psilocybin.[72]
f. *Tramadol and other drugs that lower seizure threshold*: Potentially increased seizure risk[73]

D. Public Health

a. *Overall level of harm:* Data from the United Kingdom estimated that the total harm to individuals and society attributable to alcohol was one order of magnitude (10.3 times) higher compared to psilocybin mushrooms.[74]

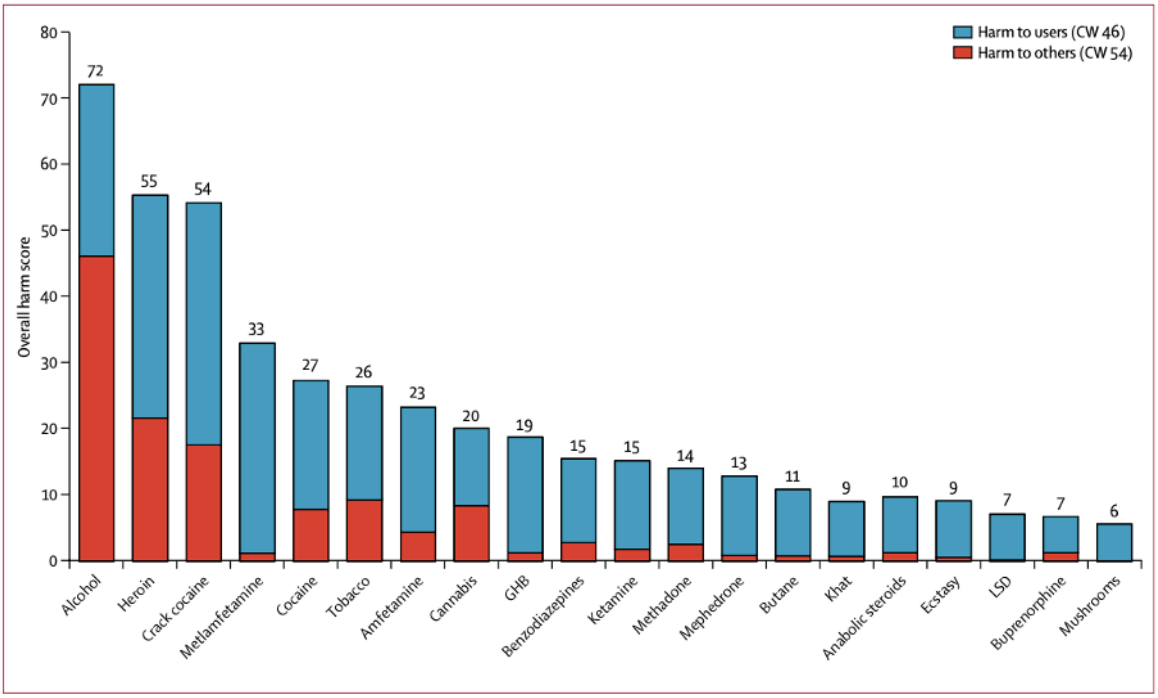

Figure 2: **Drugs ordered by their overall harm scores, showing the separate contributions to the overall scores of harms to users and harm to others**
The weights after normalisation (0–100) are shown in the key (cumulative in the sense of the sum of all the normalised weights for all the criteria to users, 46; and for all the criteria to others, 54). CW=cumulative weight. GHB=γ hydroxybutyric acid. LSD=lysergic acid diethylamide.

Figure 18. Drugs Ordered By Their Overall Harm Scores. Source: Lancet 2010; 376: 1558–65.

b. *Prevalence of use:* Unlike people who use cannabis and many other drugs, infrequent users of psychedelics account for most of the total days of use.[75]

   i. Among psychedelics, use of psilocybin has the highest past-year (3.1%) and past-month (0.9%) prevalence rates for U.S. adults. The past-year prevalence rates for use of all other psychedelic substances are under 1 percent, except MDMA (1.1.%).
   ii. The total number of use days for psychedelics is two orders of magnitude smaller than it is for cannabis. The past-year and past-month prevalence of cannabis are estimated at roughly 30 percent and 20 percent, respectively.

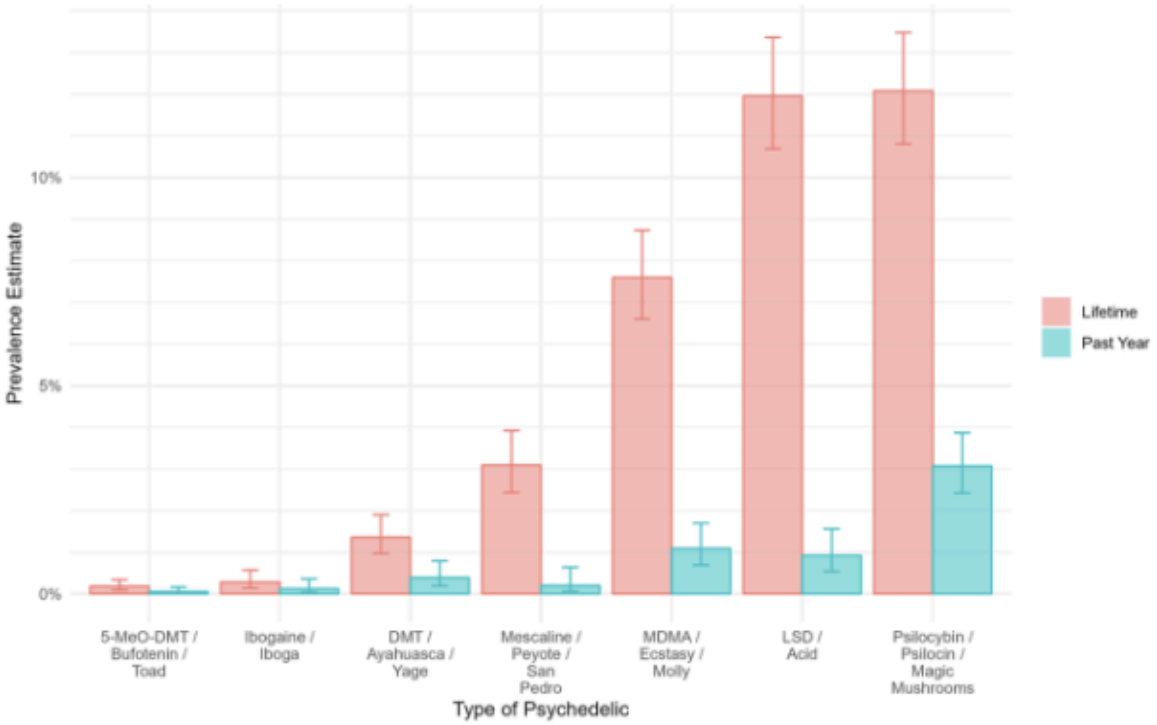

Figure 19. Lifetime and Past-Year Prevalence Rates for Various Psychedelic Substances Among U.S. Adults in 2023. Source: RAND Psychedelic Survey, 2023.

c. *Abuse and dependence potential:* Psilocybin has low abuse potential compared to many other psychoactive substances, based on the 8 regulatory criteria in the Controlled Substances Act.[76] The 2017 Global Drug Survey ranked psilocybin mushrooms as having the lowest emergency medical treatment seeking rate of all substances studied (0.2% of users).[77] Studies consistently demonstrate:

   i. Minimal physiological dependence
   ii. Rapid tolerance development (tachyphylaxis) making frequent use pharmacologically ineffective

iii. No evidence of compulsive use patterns typical of addictive substances
iv. No documented withdrawal syndrome

d. *Impaired driving and DUI concerns:* Psilocybin significantly impairs motor coordination, judgment, and perception for 4-6 hours after ingestion and in atypical cases longer, rendering driving or operating heavy machinery unsafe. Unlike alcohol, no standardized roadside testing method currently exists, presenting challenges for law enforcement and public safety. Limited data suggests psychedelic-involved traffic incidents are rare compared to alcohol and other substances, likely due to lower prevalence of use and users' recognition of impairment.[78]

e. *Emergency department visits:* Data from the Drug Abuse Warning Network (DAWN) and similar surveillance systems indicate:

i. Psilocybin-related ED visits comprise a small fraction of all drug-related emergency visits
ii. Most presentations involve psychological distress rather than medical emergencies
iii. Co-ingestion of other substances (particularly alcohol) is present in a majority of cases. Governmental assessments by the Netherlands on decriminalized psilocybin use shows a similar pattern.
iv. Most cases resolve with supportive care and without medical sequelae
v. Risk of self-harm or harm to others during these episodes is generally low, and this risk is further reduced with proper supervision.

f. *Pediatric access and exposures:* Accidental pediatric exposures to psilocybin mushrooms are rare but concerning when they occur.[79] As decriminalization and regulated access expand, considerations include:

i. Need for childproof packaging in regulated markets
ii. Public education about secure storage
iii. Potential confusion with edible non-psychoactive mushrooms (e.g. mushrooms are often blended into chocolate in the illicit market and in decriminalized municipalities).
iv. Age verification requirements in jurisdictions with legal access
v. Age-appropriate drug education programs

g. *Hallucinations and violent behavior:* Unlike some substances (e.g., stimulants, synthetic cannabinoids, PCP), psilocybin is not associated with increased aggression or violence in

epidemiological studies. The perception that psychedelics commonly cause violent behavior is not supported by evidence.[80][81]

i. A 2016 study of 130,000 US adults found no association between psychedelic use and increased violence
ii. Population studies show psychedelic users have similar or lower rates of antisocial behavior compared to non-users
iii. Rare cases of aggression typically involve individuals with pre-existing conditions or co-ingestion of other substances or individuals experiencing delusional symptoms

h. *Indigenous and religious use considerations:* As interest in psilocybin increases, several concerns arise.[82]
   i. Ethno-tourism impact on traditional communities, particularly in Mexico and Central America[83]
   ii. Cultural appropriation of indigenous practices without proper context or respect
   iii. Commercialization threatening the sustainability of traditional practices
   iv. Need for indigenous representation in developing regulatory frameworks
   v. Recognition and protection of established religious and traditional use in policy development

i. *Unregulated use and harm reduction:* In contexts where psilocybin remains illegal or unregulated, there are several points to consider.[84]

   i. Users lack access to quality control, accurate dosing information, and harm reduction resources
   ii. Potential adulteration with other substances, though less common than with manufactured drugs
   iii. Absence of screening for contraindications and vulnerable populations
   iv. Limited integration support following challenging experiences
   v. The provision of misdemeanors and felonies for psilocybin possession can create lifetime barriers to education, employment, and the ability to raise and support a family. These risks might outweigh the direct risks of psilocybin for some.

j. *Misidentification:* Foraging for wild mushrooms carries the risk of consuming poisonous species that may resemble psilocybin-containing varieties, potentially resulting in serious hepatotoxicity or nephrotoxicity requiring medical intervention. This risk increases with growing public interest in psychedelic mushrooms.

k. *Drug interaction risks:* Combining psilocybin with other substances presents various concerns.[85]
    - Alcohol: Increased nausea, disorientation, and impaired judgment
    - Cannabis: Intensified and potentially unpredictable effects[86]
    - Stimulants: Increased cardiovascular stress and anxiety

l. *Public education and risk communication:* As policy landscapes change, accurate public health messaging becomes essential to minimize harm, particularly regarding appropriate dosing and preparation, recognition and management of adverse reactions, contraindications and drug interactions, setting and supervision considerations, and differentiating therapeutic from recreational contexts.

m. *Risks of unethical facilitation and psychological vulnerability:* The altered state produced by psilocybin creates unique interpersonal dynamics requiring ethical safeguards:

    i. Facilitator misconduct: Documented cases in clinical trials, underground, and some ceremonial contexts reveal instances of sexual, emotional, and financial abuse of participants during their vulnerable psychedelic states and the aftermath. The heightened suggestibility and emotional openness during psilocybin experiences increases vulnerability to manipulation.[87][88]
    ii. Power dynamics: The guide-participant relationship involves inherent power imbalances that can be exploited without proper ethical frameworks and oversight.
    iii. Undue influence: Individuals under the influence of psilocybin may be more susceptible to suggestion and manipulation, potentially enabling coercive behavior or inappropriate influence.[89]
    iv. Cult-like dynamics: Charismatic leadership combined with psychedelic experiences has historically been associated with harmful group dynamics in certain contexts, as seen in some fringe spiritual groups in the 1960s-70s.
    v. Consent considerations: The altered state may compromise capacity for informed consent during the experience, necessitating clear advance directives and boundaries.[90]

n. *Policy implications:* Emerging regulated models increasingly incorporate ethical guidelines, facilitator screening, training requirements, supervision structures, and grievance mechanisms to address these concerns.[91]

o. *Microdosing considerations:* The practice of taking sub-psychedelic doses of psilocybin (typically 1/10 to 1/20 of a standard dose) on a regular schedule has gained popularity despite limited research:

   i. Current evidence: Placebo-controlled studies are still in early phases and show mixed results, with some suggesting claimed benefits for mood, creativity, and focus may be largely attributable to expectancy effects[92]
   ii. Prevalence: Nearly half (47%) of past-year psilocybin users reported microdosing on their last occasion of use.[93]
   iii. Methodological challenges: Self-experimentation and variable dosing complicate research interpretation
   iv. Safety profile: While acute toxicity risks are reduced at low doses, the long-term safety of chronic, repeated exposure remains understudied[94]
   v. Neurobiological effects: Sub-perceptual doses may affect neuroplasticity and receptor sensitivity through different mechanisms than full doses
   vi. Research gaps: Long-term effects on serotonin receptor systems, potential impacts on cardiovascular health (including heart valve disease) with chronic use, and optimal dosing protocols remain uncertain
   vii. Public health significance: Represents a distinct usage pattern requiring separate consideration in policy frameworks

p. Different forms and preparations: Various preparations of psilocybin present different considerations:

   i. Natural whole mushrooms: Contain variable concentrations of psilocybin (0.2-2%) and related compounds (psilocin, baeocystin, norbaeocystin) that may contribute to an "entourage effect"[95][96][97]
   ii. Fresh vs. dried mushrooms: Fresh contain higher levels of unstable psilocin but deteriorate rapidly; dried are more stable but lose some psilocin through oxidation. Fresh/dry has huge implications for dosing, as there is an approximately 10-fold difference in weight given that fresh mushrooms have high water content.
   iii. Synthetic psilocybin: Used in clinical research for precise dosing and quality control; eliminates variability and contamination risks but lacks potentially active secondary compounds
   iv. Extracts and concentrates: Offer more precise dosing than whole mushrooms but vary in preparation standards; concentrated forms may increase risks of overdosing compared to whole mushrooms

v. Psilocybin-infused products: Emerging in some markets with decriminalization; present challenges for dosage standardization and may normalize casual use[98]

vi. Policy implications: Different preparations may warrant different regulatory approaches regarding potency testing, labeling requirements, and access restrictions

q. *Substance testing protocols:* Quality control and harm reduction through testing present unique considerations:

- Testing methodologies:[99][100]
  - Thin-layer chromatography (TLC): Field-deployable but less precise than laboratory methods
  - High-performance liquid chromatography (HPLC): Gold standard for psilocybin/psilocin quantification
  - Mass spectrometry: Essential for identifying adulterants and contaminants
- Implementation challenges:
  - Limited infrastructure for consumer-accessible testing in most jurisdictions[101]
  - Legal barriers to testing services in prohibition contexts
  - Lack of standardized protocols specific to psilocybin-containing mushrooms
- Misidentification risks: Unlike synthetic compounds, mushroom identification requires mycological knowledge; testing typically confirms the presence of psilocybin but cannot identify toxic look-alikes
- Testing needs: Unlike substances like MDMA that face significant adulteration risks, psilocybin mushrooms are rarely adulterated but benefit from potency testing due to natural variability
- Regulatory considerations: States developing legal access programs must establish testing standards, particularly for commercial distribution

Conclusion

Psilocybin and psilocin are compounds of significant historical, cultural, and emerging therapeutic importance. Their primary mechanism of action through serotonin receptor agonism produces altered states of consciousness with potential therapeutic applications in mental health treatment. While generally demonstrating favorable physiological safety profiles, psychological risks exist, particularly for vulnerable populations. The regulatory landscape continues to evolve, with several states implementing various forms of decriminalization or regulated access programs. As research continues to expand our understanding of these compounds, evidence-based policy approaches that balance potential benefits with appropriate safeguards will be essential to maximize public health outcomes and minimize potential harms.

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Appendices

Appendix 1. Full Text of Authorizing Legislation for the Task Force

Chapter 793

AN ACT concerning

Task Force on Responsible Use of Natural Psychedelic Substances

FOR the purpose of establishing the Task Force on Responsible Use of Natural Psychedelic Substances to study and make recommendations related to the use of natural psychedelic substances; and generally relating to the Task Force on Responsible Use of Natural Psychedelic Substances.

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That:

(a) (1) In this section, “natural psychedelic substances” includes naturally derived psilocybin, psilocin, dimethyltryptamine, mescaline, and any other substance determined by the Task Force to be a natural psychedelic substance.

(2) “Natural psychedelic substances” does not include peyote.

(b) There is a Task Force on Responsible Use of Natural Psychedelic Substances.

(c) The Task Force consists of the following members:

(1) one member of the Senate of Maryland who shall be appointed by the President of the Senate;

(2) one member of the House of Delegates who shall be appointed by the Speaker of the House;

(3) the Secretary of Health, or the Secretary’s designee;

(4) the Secretary of Disabilities, or the Secretary’s designee;

(5) the Secretary of Veterans Affairs, or the Secretary’s designee;

(6) the Director of the Maryland Cannabis Administration, or the Director’s designee; and

(7) the following members, appointed by the Governor:

(i) one representative of the University System of Maryland, the Johns Hopkins University's Center for Psychedelic and Consciousness Research, or Sheppard Pratt;

(ii) one representative of a Native American tribe with experience in the religious and spiritual use of psychedelic substances;

(iii) one individual with expertise in behavioral health;

(iv) one individual with expertise in the treatment of substance use disorders;

(v) one individual with expertise in the treatment of chronic pain;

(vi) one individual with expertise in psychedelic–assisted psychotherapy;

(vii) one individual with expertise in psychedelic research;

(viii) one individual with expertise in access to care in underserved communities;

(ix) one individual with expertise in drug policy reform;

(x) one individual with expertise as a member of law enforcement;

(xi) one individual who is a patient with conditions that can be treated with psychedelic substances;

(xii) one individual with experience with the pharmacology of natural psychedelic substances; and

(xiii) one physician with experience with the appropriate use of psychedelic substances and other integrative medical practices.

(d) To the extent practicable, the membership of the Task Force shall reflect the socioeconomic, ethnic, and geographic diversity of the State.

(e) The Governor shall designate the chair of the Task Force.

(f) The Maryland Cannabis Administration shall provide staff for the Task Force.

(g) A member of the Task Force:

(1) may not receive compensation as a member of the Task Force; but

(2) is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(h) The Task Force shall:

(1) study:

(i) existing laws, policies, and practices relating to the use of natural psychedelic substances;

(ii) the best available science and data on public benefits of responsible access to and use of natural psychedelic substances;

(iii) opportunities to maximize public benefits of responsible access to and use of natural psychedelic substances;

(iv) the best available data on potential risks of access to and use of natural psychedelic substances;

(v) opportunities to mitigate potential risks of access to and use of natural psychedelic substances; and

(vi) barriers health care practitioners and facilitators may encounter relating to natural psychedelic substances, including barriers relating to insurance, restrictions by licensing and credentialing entities, zoning, advertising, and financial services;

(2) make recommendations regarding any changes to State law, policy, and practices needed to create a Maryland Natural Psychedelic Substance Access Program that enables broad, equitable, and affordable access to psychedelic substances, including:

(i) permitting requirements, including requirements regarding education and safety;

(ii) access to treatment and regulated support; and

(iii) production of natural psychedelic substances; and

(3) make recommendations to transition from criminalizing conduct involving natural psychedelic substances, including:

(i) punishing with civil penalties nonviolent infractions involving the planting, cultivating, purchasing, transporting, distributing, or possessing of or other engagement with natural psychedelic substances;

(ii) expunging the records of Marylanders with convictions for nonviolent criminal offenses relating to natural psychedelic substances; and

(iii) releasing Marylanders incarcerated for nonviolent criminal offenses relating to natural psychedelic substances.

(i) The Task Force may consult with experts and stakeholders in conducting its duties.

(j) On or before July 31, 2025, the Task Force shall submit a report of its findings and recommendations to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2024. It shall remain effective for a period of 2 years and 6 months and, at the end of December 31, 2026, this Act, with no further action required by the General Assembly shall be abrogated and of no further force and effect.

Approved by the Governor, May 16, 2024.

Appendix 2. Membership of the Task Force

	Professional Affiliations	Task Force Role
Substances Committee		
Benjamin Bregman, MD	1) Associate Clinical Professor of Medicine, Department of Psychiatry and Behavioral Health, George Washington University. 2) Owner of Washington Integrative Mental Health Services, PLLC 3) Contractor at Sunstone Therapies PC 4) Contractor at Avesta ketamine	Behavioral Health Expertise
Cynthia Macri, MD	Senior Vice President and Chief Medical Officer, EagleForce Health; U.S. Navy Captain (ret), Medical Corps; Vice President for Education and Integrative Health, Director of Board, Life A Vet	Designee of the Maryland Department of Veterans Affairs
Manish Agrawal, MD	CEO and Co-Founder, Sunstone Therapies	Physician with Experience with Appropriate Use of Psychedelic Substances
Dr. Matthew Johnson	Senior Researcher, Institute for Advanced Diagnostics and Therapeutics, Sheppard Pratt	University System of Maryland/Johns Hopkins University Center for Psychedelic and Consciousness Research/Sheppard Pratt
Models of Access		
Candace Oglesby-Adepoju (she/her), LCPC	Owner/Founder of Jurnee Mental Health Consulting. KAP Therapist and Supervisor at Prism Wellness. Trainer and Educator at Fluence Training. Contractor and Clinical Psychedelic Researcher	Access to Care in Underserved Communities Expertise
Kirsten Bosak	Director, Health and Behavioral Health Policy, Department of Disabilities	Designee of the Maryland Department of Disabilities
Mark White	Montgomery County Police (ret)	Law Enforcement Expertise
David Jun Selleh, LCPC, LPC	Ketamine-Assisted Psychotherapist with Expand Your Self Wellness. Psychotherapist with TheraHeal Group. Advisor with PsiloHealth	Psychedelic-Assisted Psychotherapy Expertise
Shane Norte	Founder of The Church of the People for Creator and Mother Earth	Representative of a Native American tribe with experience in the religious and spiritual use of psychedelic substances
Public Education and Legislature Support		
Timothy Hamilton	Business and Marketing Manager for the Maryland Park Service	Patient with Conditions Treated by Psychedelic Substances
Sen. Brian Feldman	Maryland General Assembly	Appointed by the President of the Senate

	Professional Affiliations	Task Force Role
Del. Ashanti Martinez	Member of Maryland House of Delegates	Appointed by the Speaker of the House
Laura Barrett	Founder, Ask Nurse Laura | Executive Director, National Clinical Director Consortium | Clinical Director, Connor Sheffield Foundation | Chair, Cannabis Nurse Task Force, Univ. of Miami | Adjunct Faculty, Univ. of Maryland & NYU	Chronic Pain Treatment Expertise
Andrew Coop, PhD	Professor and Associate Dean for Students, University of Maryland School of Pharmacy	Governor Appointed Chair; Pharmacology of Natural Psychedelic Substances Expertise
Regulations and Governance		
Shanetha Lewis	Executive Director of Veterans Initiative 22	Psychedelic Research Expertise
Khadyne Augustine, JD	Senior Policy Analyst, Maryland Cannabis Administration	Designee of the Maryland Cannabis Administration
Nishant Shah, MD, MPH	Maryland Department of Health and Behavioral Health Administration	Designee of the Maryland Department of Health
Eric Edward Sterling, JD	Eric E. Sterling, J.D., has been professionally involved in drug policy since 1980. Assistant Counsel, U.S. House of Representatives, Committee on the Judiciary, Subcommittee on Crime (1979-1989). Executive Director, Criminal Justice Policy Foundation (1989-2020). Natalie M. LaPrade Medical Marijuana Commission, Chair of Policy Committee (2013-2017). American Bar Association, Standing Committee on Substance Abuse for over 20 years. Advisory Boards: Law Enforcement Action Network; Students for Sensible Drug Policy. Lifetime Achievement Award, National Organization for the Reform of Marijuana Policy (2015).	Drug Policy Reform Expertise
Economic Impact		
Joey Nichols, MD, MPH, FAAFP	Canopy Family Care, Takoma Park, MD. Health Policy Scholar, Ethical Legal Implications of Psychedelics in Society (ELIPSIS) Program, Baylor College of Medicine.	Substance Use Disorder Treatment Expertise

Executive Committee

Scope: Coordination of Committee Deliverables

Chair: Dr. Andy Coop

Members:

- Dr. Benjamin Bregman, Substances Committee Chair
- Candace Oglesby-Adepoju, Models of Access Committee Chair
- Timothy Hamilton, Public Education and Legislature Support Committee Chair
- Shanetha Lewis, Regulations and Governance Committee Chair
- Dr. Joey Nichols, Economic Impact Committee Chair
- David Selleh, Project Management

Substances Committee

Scope: Study Pharmacological Factors, Scientific Literature Review

Chair: Dr. Benjamin Bregman (Behavioral Health Expertise)

Members:

- Dr. Cynthia Macri (Designee of the Maryland Department of Veterans Affairs)
- Dr. Manish Agrawal (Physician with Experience with Appropriate Use of Psychedelic Substances)
- Dr. Matthew Johnson (University System of Maryland/Johns Hopkins University Center for Psychedelic and Consciousness Research/Sheppard Pratt)
- John Plaster (Substance Use Disorder Treatment Expertise) - resigned and replaced with Dr. Joey Nichols

Key Deliverables Complete:

- Substances Template
- Psilocybin/Psilocin Monograph

Key Deliverables Ongoing:

- Dimethyltryptamine Monograph
- Mescaline Monograph
- Data Matrix: Impact Issue by Access Point
- Modified-Delphi Policy Proposition Deliberation

Models of Access Committee

Scope: Study Policy Frameworks in Other Jurisdictions

Chair: Candace Oglesby-Adepoju (Access to Care in Underserved Communities Expertise)

Members:

- Kirsten Bosak (Designee of the Maryland Department of Disabilities)
- Mark White (Law Enforcement Expertise)
- David Selleh (Psychedelic-Assisted Psychotherapy Expertise)

- Shane Norte (Native American tribe, religious and spiritual use of psychedelic substances

Key Deliverables Complete:

- Equity Definition
- Models of Access Comparison Chart

Key Deliverables Ongoing:

- Data Matrix: Impact Issue by Access Point
- Modified-Delphi Policy Proposition Deliberation

Public Education and Legislature Support Committee

Scope: Coordinate Ongoing Consultation with Industry Stakeholders and Maryland Constituents
Chair: Timothy Hamilton (Patient with Conditions Treated by Psychedelic Substances)
Members:

- Senator Brian Feldman (Appointed by the President of the Senate)
- Delegate Ashanti Martinez (Appointed by the Speaker of the House)
- Laura Barrett (Chronic Pain Treatment Expertise)
- Dr. Andrew Coop (Governor Appointed Chair; Pharmacology of Natural Psychedelic Substances Expertise)

Key Deliverables Complete:

- Task Force Website

Key Deliverables Ongoing:

- Public Listening Sessions
- Public Written Comments
- Data Matrix: Impact Issue by Access Point
- Modified-Delphi Policy Proposition Deliberation

Regulations and Governance Committee

Scope: Study Regulatory Concerns, Impact Issues
Chair: Shanetha Lewis, MS (Psychedelic Research Expertise)
Members:

- Khadyne Augustine (Designee of the Maryland Cannabis Administration)
- Dr. Nishant Shah (Designee of the Maryland Department of Health)
- Eric Edward Sterling (Drug Policy Reform Expertise)
- Andrew Garrison (Designee of the Maryland Cannabis Administration) - Replaced

Key Deliverables Complete:

- Impact Issues

Key Deliverables Ongoing:

- Public Listening Sessions
- Data Matrix: Impact Issue by Access Point

- Modified-Delphi Policy Proposition Deliberation

Economic Impact

Scope: Study Economic Risks/Benefits of Psychedelic Access
Chair: Dr. Joey Nichols (Substance Use Disorder Treatment Expertise)
Members:

- Mark White (Law Enforcement)

Key Deliverables Complete:

- Initial Economic Estimations by Access Point
- Modified-Delphi Survey Mechanisms

Key Deliverables Ongoing:

- Data Matrix: Impact Issue by Access Point
- Modified-Delphi Policy Proposition Deliberation

Appendix 3: State and Local Psychedelic Reforms, 2015 to 2025

Jurisdiction	Year	Measure / Bill	Type	Status	Overview
Alaska	2024	HB 228 / SB 166	Alaska Mental Health and Psychedelic Medicine Task Force	✅ Became Law (September 19, 2024)	Task force to study licensing and regulation of psychedelic-assisted therapy in anticipation of federal FDA approval; report due January 31, 2025
Arizona	2023	HB 2486	Psilocybin research grants and advisory council	❌ Died in committee	Proposed $30 million from state budget for psilocybin research grants and establishment of psilocybin research advisory council
Arizona	2024	SB 1570	Psilocybin therapeutic services regulatory framework	✅ Passed Legislature / ❌ Vetoed by Gov. Hobbs	Would have created regulatory framework for facilitated on-site psilocybin services, Arizona Psilocybin Advisory Board, and Psilocybin Control and Regulation Fund; vetoed due to concerns about premature clinical expansion and financial implications
Arizona	2025	HB 2871	Ibogaine clinical study funding	✅ Passed House (36-22)	Initially $10M, amended to $5M + $5M matching for ibogaine clinical study to treat TBI and PTSD; pending Senate consideration
Arizona	2025	SB 1555	Psilocybin advisory board	🟠 In committee	Refiling of 2024's Oregon-style psilocybin services; committee-revised to create psilocybin advisory board with annual safety/efficacy reports

California	2021	SB 519	Psychedelic decriminalization	❌ Died in Assembly Appropriations Committee (November 30, 2022)	Would have removed criminal penalties for possession and social sharing of psilocybin, psilocin, MDMA, LSD, DMT, ibogaine, and mescaline (excluding peyote); passed Senate 21-16 on June 1, 2021, but stalled in Assembly
California	2022	SB 58	Psychedelic decriminalization (revised)	❌ Vetoed by Gov. Newsom (October 7, 2023)	Would have legalized possession, transportation, preparation of psilocybin, psilocin, DMT, ibogaine, and mescaline (excluding peyote) for adults 21+; passed Senate 21-16 on May 24, 2023
California	2023	AB 941	End Veteran Suicide Act	🟠 In committee (as of July 1, 2024	Would authorize licensed clinical counselors to administer controlled substances to combat veterans; requires minimum 30 sessions with 12-hour duration sessions and 2-3 counselors present per patient
California	2025	AB 1103	VA psychedelics research exemption	🟠 Pending	Exempts VA-run psychedelics research from delays by California's Research Advisory Panel if DEA-registered
California	2025	SB 751	Veterans/First Responders Psilocybin Pilot	🟠Pending	Up to five counties to launch pilot partnered with UC system and mental health providers, funded by state special fund
California - Arcata	2021	Resolution No. 212-17	Local entheogen decriminalization	✅ Passed Unanimously(October 2021)	City council voted unanimously to deprioritize enforcement of entheogen prohibition
California - Berkeley	2023	City Council Resolution	Local decriminalization	✅ Passed	Resolution deprioritizing enforcement against natural psychedelic use and possession

California - Eureka	2023	City Council Resolution	Local entheogen decriminalization	✅ Passed unanimously (October 17, 2023)	Followed neighboring Arcata; decriminalized psilocybin and other natural entheogens; allows people to reach out to medical/mental health professionals without fear of reprisal
California - Oakland	2019	Resolution No. 87731 CMS	Local entheogen decriminalization	✅ Passed (June 2019)	Second city in U.S. to decriminalize; resolution decriminalizes all "entheogenic plants" including psilocybin, ayahuasca, and peyote
California - Oakland	2020	Resolution No. 88464 CMS	State decriminalization advocacy	✅ Passed unanimously (December 2020)	Urges state legislature to decriminalize entheogenic plants/fungi and allow local jurisdictions to authorize community-based healing ceremonies; supports Oakland Community Healing Initiative (OCHI)
California - Santa Cruz	2020	Resolution No. NS-29,867	Local entheogen decriminalization	✅ Passed (January 2020)	Decriminalized personal possession and cultivation of entheogenic plants and fungi
California - San Francisco	2022	Board of Supervisors Resolution	Local entheogen decriminalization	✅ Passed	Citywide resolution urging decriminalization and support for plant medicine access and education
Colorado	2022	Proposition 122 (Natural Medicine Health Act)	Natural medicine therapy + decriminalization	✅ Passed (54%)	Legalized regulated adult use of psilocybin and other natural psychedelics with phased licensing; immediate decriminalization of personal possession and use
Colorado	2025	HB 1063	Psilocybin "trigger law"	✅ Passed	Allows licensed medical professionals to prescribe psilocybin statewide once federally rescheduled by the FDA
Colorado	2025	SB 76	Product restrictions	❌ Filed	Allowed domestication conditional on FDA approval

Colorado	2025	SB 25-297	Data collection for psilocybin program	✅ Passed	Establishes data-collection requirement for Colorado's psilocybin access program starting July 2026; requires demographic and health outcome reporting
Colorado - Denver	2019	Initiative 301	Local psilocybin decriminalization	✅ Passed (May 7, 2019)	First city in U.S. to decriminalize psilocybin; made possession and use lowest law enforcement priority for adults 21+
Connecticut	2021	SB 1083	Psilocybin health benefits study	✅ Signed into law (June 2021)	Calls upon Department of Mental Health and Addiction Services to convene working group to study health benefits of psilocybin and examine therapeutic use under healthcare provider direction; report due January 1, 2022
Connecticut	2022	HB 5506	State budget with psychedelic therapy funding	✅ Signed into law (May 2022)	Budget earmarked funds for psychedelic-assisted therapy pilot program for veterans, retired first responders, and healthcare workers using psilocybin/MDMA at FDA-approved sites; establishes Connecticut Psychedelic Treatment Advisory Board
Connecticut	2023	HB 5102	Medicinal psilocybin use	❌ Referred to Joint Committee on Public Health	Would allow psilocybin use for medicinal and therapeutic purposes including physical, mental, behavioral healthcare
Connecticut	2023	HB 6146	Psychedelic assisted therapy pilot program	❌ Referred to Appropriations Committee	Would implement psychedelic assisted therapy pilot program with General Fund appropriation

Connecticut	2023	HB 6734	Psilocybin possession decriminalization	✅ Passed House (May 10, 2023)	Eliminates criminal penalty for possessing less than ½ ounce of psilocybin; requires temporary license loss for over ½ ounce when under 21; effective October 1, 2023
Connecticut	2025	HB 7065	Psilocybin possession decriminalization	✅ Passed House	Decriminalizes possession of less than ½ ounce psilocybin; passed House, pending Senate Judiciary action
Connecticut	2025	HB 5456 / HB 6380	Therapy pilot + decriminalization proposal	🟠Filed, in committee	Mirror of NY structures; under review
District of Columbia	2020	Initiative 81	Entheogenic plant decriminalization	✅ Passed (76%)	Made enforcement of laws against natural psychedelics (psilocybin, ayahuasca, ibogaine) the lowest police priority
Florida	2021	HB 725	Collateral Consequences of Convictions and Decriminalization of Cannabis and All Drugs Act	❌ Died in committee (March 2022)	Decriminalize personal use/possession of controlled substances in favor of civil fines and drug rehabilitation referral
Florida	2022	SB 348 / HB 193	Using Alternative Therapies to Treat Mental Health and Other Medical Conditions	❌ Died in committee (March 2022)	Would require study of therapeutic efficacy of MDMA, psilocybin, ketamine for depression, anxiety, PTSD, bipolar, chronic pain, migraines; modeled on Texas HB 1802
Georgia	2022	HR 896	House Study Committee on Alternative PTSD Treatment for Veterans	❌ Died in committee	Bipartisan proposal to create 5-member committee studying psilocybin-assisted therapy for veterans with PTSD, depression, and addiction
Georgia	2025	HB 382	COMP-360 trigger law	🟠 Pending	Trigger law rescheduling crystalline psilocybin to mirror federal status upon FDA approval

Georgia	2025	HB 717	Licensed psychedelic clinics	❌ Stalled in committee	Establishes licensed clinics for FDA-approved psychedelic-assisted treatments
Hawaii	2021	SB 738	Psilocybin therapy centers	❌ Deferred by Judiciary Committee	Would remove psilocybin/psilocin from Schedule I and establish designated treatment centers for therapeutic administration
Hawaii	2021	HCR 174 / SCR 208	Therapeutic Psilocybin Working Group	✅ Adopted (March 31, 2021)	Calls for Health Department working group to study psilocybin laws, research, and develop strategic plan for safe, accessible therapeutic psilocybin for adults 21+
Hawaii	2022	SB 2575	Psilocybin therapy legalization + review panel	❌ Died in committee	Remove psilocybin/psilocin from Schedule I, establish treatment centers, and create psilocybin review panel with annual reports until 2027
Hawaii	2022	SB 3160	Therapeutic psilocybin working group	✅ Passed Senate unanimously	DOH to create working group examining medicinal effects and developing strategic plan for therapeutic psilocybin access
Hawaii	2022	SCR 100 / SR 88	Therapeutic psilocybin working group resolutions	✅ Approved (amended)	Senate resolutions requesting DOH convene therapeutic psilocybin working group; amended to make access dependent on FDA approval
Hawaii	2023	HB 1340 / SB 1531	Breakthrough Therapy Advisory Council	✅ Recommended by committees	Establish Temporary Breakthrough Therapy Designation Advisory Council within 3 months of FDA breakthrough therapy approvals

Hawaii	2023	SCR 69	Beneficial Treatments Advisory Council	❌ Deferred	Requesting DOH establish advisory council for safe, accessible therapeutic psilocybin, psilocybin-based products, and MDMA for adults 21+
Hawaii	2023-2025	SB 1042	Mental Health Emerging Therapies Pilot Program	✅ Passed Senate / ❌ Pending House	2-year pilot program for public-private partnerships funding Phase 3 trials of FDA Breakthrough Therapy candidates including psychedelics
Illinois	2023	HB 0001 / HB 1143	Illinois CURE (Compassionate Use and Research of Entheogens) Act	❌ Re-referred to Rules Committee (April 5, 2024)	Proposal to remove psilocybin/psilocin from Schedule I, provide for record expungement, and allow licensing of manufacturers, service centers, and facilitators
Illinois	2023	SB 2353	Psilocybin research authorization	❌ Status unclear	Would authorize Department of Financial and Professional Regulation to distribute psilocybin for medical, psychological, and scientific studies despite Schedule I status
Illinois	2025	HB 1143	The Compassionate Use and Research of Entheogens Act (refiled)	🟠Pending	Third year filing by Rep. LaShawn Ford (D); would establish Illinois Psilocybin Advisory Board and allow lawful manufacturing, delivery, possession, and sales of psilocybin products with restrictions
Illinois	2025	HB 2992	Psilocybin-assisted therapy pilot	🟠 Under committee review	Sets up pilot program including regulatory board, cultivation standards, and licensing framework
Illinois - Chicago	2020	R2019-735	Expression of support for adult use of entheogenic plants	❌ Heard but not passed	Chicago's Committee on Health and Human Relations resolution calling for hearings on feasibility of entheogenic plants as alternative treatment options

Illinois - Evanston	2020	Evanston decriminalization proposal	Local entheogen decriminalization	❌ Proposed but status unclear	Council member Devon Reid announced intentions to sponsor legislation decriminalizing entheogenic plants with civil fines up to $100 or waived with rehabilitation/public service
Indiana	2023	HB 1166	Psilocybin research funding	❌ Introduced only	Did not pass committee
Indiana	2024	SB 139	Therapeutic psilocybin research fund	❌ Referred to Ways and Means Committee	Establishes psilocybin research fund administered by Indiana Department of Health to provide financial assistance to research institutions studying psilocybin for mental health and medical conditions
Indiana	2025	HB 1166	Psilocybin research program funding	🟠Pending	Republican-sponsored appropriations bill allocating up to $600,000 over 2025-2026 to fund existing psilocybin research program signed into law by Gov. Holcomb (R) in March 2024;
Iowa	2021	HF 480	Terminal illness psychedelic decriminalization	❌ Referred to Human Resources	Proposes decriminalizing DMT, LSD, peyote, psilocybin, psilocin, and MDMA for patients with terminal illness or life-threatening conditions
Iowa	2021	HF 636	Psilocybin Services Act	❌ Referred to House Public Safety Committee	Creates regulated psilocybin administration for adults 21+; deprioritizes prosecution of noncommercial entheogenic activities including ibogaine, DMT, mescaline, peyote, psilocybin
Iowa	2021	HF 459	Psilocybin/psilocin rescheduling	❌ Indefinitely postponed	Aimed to remove psilocybin and psilocin from Schedule I controlled substances

Iowa	2023	HF 240	Psilocybin/psilocin rescheduling	✅ Recommended by subcommittee (April 11, 2023)	Would remove psilocybin and psilocin from Schedule I controlled substances list
Iowa	2025	HF 351	Psilocybin rescheduling	🟠 Pending	Removes psilocybin/psilocyn from Schedule I entirely
Iowa	2025	HF 609	Religious freedom for psychedelics	🟠 Pending	Expands religious freedom protections to include psychedelics (psilocybin, peyote) in religious ceremonies
Iowa	2025	HF 620	PTSD psilocybin system	🟠Pending	Creates state-legal system for PTSD use of psilocybin including cultivation, testing, provider protections; capped at 5,000 participants
Iowa	2025	Compass Trigger Law	COMP-360 rescheduling	✅ Passed both chambers unanimously	Automatically reschedules COMP-360 upon FDA approval
Kansas	2021	HB 2288	Psilocybin cultivation/possession penalty reduction	❌ Failed	Aimed to reduce penalties for small quantities of psilocybin cultivation and possession
Kansas	2022	HB 2465	Legalized Homegrown Psilocybin Mushroom Act	❌ Died in committee (May 23, 2022)	Aimed at reducing penalties for individuals cultivating or possessing small quantities of psilocybin or psilocin; similar to failed 2021 HB 2288
Kansas	2025	HB 2218	COMP-360 rescheduling	🟠 Pending	Reschedules COMP-360 (crystalline psilocybin) to Schedule IV
Kentucky	2025	SB 240	Ibogaine research fund	🟠 Pending	Declares ibogaine worthy of clinical research, establishes Ibogaine Research Fund for opioid dependence and mental health treatment

Louisiana	2025	Senate Resolution (McMath)	Task Force on Alternative Therapies for Veterans	✅ Passed (June 12, 2025)	9-member task force to study psychedelic therapies for veterans, focusing on psilocybin, MDMA, ibogaine, and ketamine; report due February 1, 2026
Maine	2021	HP 713 (LD 967)	Drug possession civil penalty	❌ Failed Senate (14-18, June 30, 2021)	Would have made possession of scheduled drugs for personal use merely a civil penalty; passed House 77-62 but rejected by Senate
Maine	2021-2022	SP 496 (LD 1582)	Maine Psilocybin Services Act	❌ Failed House after Senate passage	Aimed to legalize facilitated psilocybin use at licensed service centers; voted down 8-3 by Health and Human Services Committee in February 2022, but Senate later passed it in April 2022 before House declined to advance
Maine	2024	LD 1914	Maine Psilocybin Health Access Act	🟠 Carried over to special session	Act allowing licensed psilocybin administration at service centers and decriminalizing personal possession/growing for adults 21+; passed House in April 2024, Senate carried over to special session May 10, 2024
Maine	2025	LD 1034	Psilocybin possession decriminalization	🟠 Carried over	Aims to decriminalize personal possession of one ounce or less of psilocybin for adults
Maine - Portland	2023	City Council Resolution	Local entheogen decriminalization	✅ Passed (October 3, 2023)	City Council voted to deprioritize local enforcement of laws against psychedelic plants and fungi
Maryland	2022	SB 709	Veterans psychedelic pilot program	✅ Enacted	Created a $1 million grant program for qualified researchers to provide psychedelic-assisted therapy to veterans with PTSD and TBI

Maryland	2024	HB 548 / SB 1009	Task Force on Responsible Use of Natural Psychedelic Substances	✅ Signed (May 16, 2024)	17-member task force overseen by Maryland Cannabis Administration to study "broad, equitable, and affordable access" to psilocybin, DMT, mescaline; report due 2025
Massachusetts	2021	HD 1494	Entheogenic plants task force	❌ Referred to House Rules Committee (June 9, 2022)	Establish interagency task force to study public health and social justice implications of legalizing possession, consumption, transportation, and distribution of naturally cultivated entheogenic plants and fungi
Massachusetts	2021	HD 1450 / SD 949	Personal use decriminalization	❌ Referred to Joint Committee on Judiciary (February 16, 2023)	Would remove penalties for adults to possess, ingest, obtain, grow, and give away up to 2 grams of psilocybin, psilocin, DMT, ibogaine, and mescaline
Massachusetts	2023	HD 3574	MDMA treatment service pricing	❌ Referred to Committee for Public Health (April 13, 2023)	Would establish maximum charge of $5,000 per MDMA treatment service unit for all registered MDMA service providers
Massachusetts	2023	HB 3605	Psilocybin facilitator licensing	❌ Referred to Committee for Public Health (March 30, 2023)	Committee for Public Health (March 30, 2023)Would require Department of Public Health to establish procedures for granting psilocybin facilitator licenses with 20-300 hours of training including 21 hours in-person practicum
Massachusetts	2024	Question 4	Legalization + home grow + decriminalization	❌ Failed (57% No)	Proposed regulation and decriminalization of multiple psychedelics
Massachusetts	2025	HD 4017	Licensed psilocybin therapy centers	🟠 Pending	Grassroots co-drafted bill for licensed therapy centers with clinician facilitators
Massachusetts	2025	HD 4196	Medical practitioner psilocybin pilot	🟠 Pending	Medical practitioner-led psilocybin pilot program

Massachusetts	2025	SD 1624	Broad-spectrum psychedelics pilot	🟠 Pending	Comprehensive pilot program covering multiple psychedelic substances
Massachusetts	2025	HD 3895	"No Harm No Foul" possession	🟠 Pending	Automatic dismissal for non-harmful psilocybin possession by adults
Massachusetts	2025	SD 870	Decriminalization with community support	🟠 Pending	Decriminalization framework with community support systems
Massachusetts	2025	HD 3368	Personal therapeutic access	🟠 Pending	Personal therapeutic access for qualifying medical conditions, up to 2g, until federal rescheduling
Massachusetts	2025	HD 4243	Equitable access task force	🟠Pending	Task force on equitable access to psilocybin and entheogens
Massachusetts	2025	HD 4017, HD 188, SD 323, HD 4243, HD 1003, etc.	Therapy pilots, decriminalization, task force	🟠 All pending or filed	Multiple bills varying by local advocates
Massachusetts - Cambridge	2021	City Council Resolution	Local decriminalization	✅ Passed	Official resolution directing police to make psilocybin and entheogen possession the lowest enforcement priority
Massachusetts - Somerville	2021	City Council Resolution	Local decriminalization	✅ Passed	Non-binding resolution passed unanimously, similar to Cambridge
Massachusetts - Northampton	2021	City Council Resolution	Local decriminalization	✅ Passed	Non-binding resolution expressing city support for decriminalization of entheogenic plants
Massachusetts - Amherst	2022	City Council Resolution	Local decriminalization	✅ Passed (June 2022)	Joined other Massachusetts cities in decriminalizing entheogenic plants and fungi
Massachusetts - Salem	2023	City Council Resolution	Local decriminalization	✅ Passed (May 11, 2023)	City Council voted to end arrests involving psilocybin and other entheogenic substances

Massachusetts - Easthampton	2021	City Council Resolution	Local decriminalization	✅ Passed (October 2021)	Voted 7-0 on resolution to support ending arrests for growing entheogenic plants and fungi
Massachusetts - Medford	2023	City Council Resolution	Local decriminalization	✅ Passed	Decriminalized personal possession of entheogenic plants and fungi
Massachusetts - Provincetown	2023	City Council Resolution	Local decriminalization	✅ Passed	Added to growing list of Massachusetts cities decriminalizing entheogens
Michigan	2021	SB 631	Entheogenic plant and fungus decriminalization	❌ Referred to committee	Would decriminalize manufacture, creation, delivery, and possession of entheogenic plants/fungi including DMT, ibogaine, mescaline, and psilocybin; prohibits commercial sales but permits reasonable fees for counseling/spiritual guidance services
Michigan	2022	Ballot Initiative	Comprehensive drug law overhaul	❌ Deferred to 2024	Would decriminalize possession of Schedule 1 and 2 substances and legalize cultivation, possession, use, and gifting of psilocybin, psilocin, ibogaine, peyote, and DMT for adults 18+; includes regulated sale and treatment system through hospital-designated entities
Michigan	2023	House Concurrent Resolution No. 5	Veterans psychedelic treatment support	❌Introduced	Urges Congress, DoD, and VA to invest in non-technology treatment options including psychedelics in clinical settings for servicemembers and veterans with psychological trauma
Michigan - Ann Arbor	2020	City Council Resolution	Local entheogen decriminalization	✅ Passed (September 21, 2020)	First Michigan city; unanimously decriminalized entheogenic plants and fungi, making enforcement lowest priority

Michigan - Detroit	2021	Proposal E	Local entheogen decriminalization	✅ Passed (61%)	Approved by voters; deprioritized enforcement of laws prohibiting natural entheogen use and possession
Michigan - Hazel Park	2022	City Council Resolution	Local entheogen decriminalization	✅ Passed (March 22, 2022)	Third Michigan city; unanimously voted for decriminalization and prohibited use of city funds for enforcement
Michigan - Ferndale	2023	City Council Resolution	Local entheogen decriminalization	✅ Passed (February 27, 2023)	Fourth Michigan city to decriminalize entheogenic plants and fungi
Michigan - Washtenaw County	2021	County Resolution	County-level entheogen decriminalization	✅ Passed	County-level decriminalization of entheogenic plants and fungi
Minnesota	2023	HF 1884 / SF 1954	Psychedelic Medicine Task Force	✅ Signed into law by Gov. Walz	Establishes 23-member task force to study and advise on legalizing psilocybin, LSD, and MDMA; included in omnibus health bill; initial report delivered February 1, 2024, final report due January 1, 2025
Minnesota	2025	HF 2699	Psilocybin personal use decriminalization	🟠 Pending	Eliminates criminal and civil penalties for personal psilocybin use/possession by adults 21+; allows personal cultivation, transportation, and non-remunerative exchange; establishes Psychedelic Medicine Board and public health education programs
Minnesota - Minneapolis	2023	Executive Order	Local entheogen decriminalization	✅ Passed (July 23, 2023)	Mayor issued executive order making entheogens lowest law enforcement priority

Missouri	2021 - 2022	HB 1176 / HB 2429	Right to Try expansion	❌ Referred to committee	Expand Missouri's Right to Try Act to allow terminal patients to use MDMA, psilocybin, LSD, DMT, mescaline, or ibogaine with doctor's recommendation; also reduces penalties for low-level possession
Missouri	2022	HB 2469	Multi-substance possession decriminalization	❌ Referred to Crime Prevention Committee	would create three-tiered penalty system reducing possession penalties for small amounts of MDMA, LSD, and psilocybin to infractions with $100 fines
Missouri	2022	HB 2850	Natural medicine legalization	❌ Public hearings completed	Would legalize ibogaine, plant/fungus-derived psilocybin, DMT, and non-peyote mescaline for medical conditions; provides healthcare provider immunity
Missouri	2023	HB 869	Psilocybin affirmative defense	❌ Not considered by committee	Would allow psilocybin use for treatment-resistant depression, PTSD, or terminal illness at approved locations with affirmative defense against prosecution
Missouri	2023	HB 1154	Psilocybin research program	❌ Placed on informal perfection calendar	Approved by House Veterans Committee 11-0; requires Department of Health to conduct USDA-approved psilocybin trials for PTSD, depression, substance abuse, and end-of-life care
Missouri	2023	HB 951 / SB 90	Veteran-focused research and pilot bill	❌ Stalled (no hearing before adjourn)	Proposed psilocybin pilot research framework
Montana	2022 - 2023	LC 2311	Interim study on psilocybin for mental illness treatment	❌ Died in process (May 2, 2023)	Interim study bill on psilocybin for mental illness treatment; placed on hold December 12, 2022

Montana	2023	LC 1208	Psilocybin treatment legalization	❌ Died in committee (May 2, 2023)	Would have legalized psilocybin use for certain mental health conditions including PTSD; would have established guidelines for cultivation, manufacturing/packaging, and administration
Nevada	2023	SB 242	Psychedelic Medicines Working Group	✅ Enacted (June 2023)	Directed Nevada Department of Health to establish working group to study therapeutic use of hallucinogens like psilocybin
Nevada	2025	SJR 10	Federal rescheduling resolution	🟠 Pending committee review	Joint Resolution urging federal rescheduling and research support
New Hampshire	2022	HB 1349-FN	Psilocybin possession decriminalization	❌Tabled (March 31, 2022)	Aimed to decriminalize possession or use of certain amount of psilocybin mushrooms by persons 18+ years old; referred to Criminal Justice and Public Safety committee
New Hampshire	2023	HB 328-FN	Multi-substance legalization	❌ Inexpedient to legislate (March 16, 2023)	Would have legalized possession and use of LSD, mescaline, psilocybin, and peyote for persons 21+
New Hampshire	2023	HB 216-FN Bills to remove DMT/etc.	State decriminalization proposals	❌ Failed / tabled	DMT removal repealed; traffic penalty amendment stalled in Senate
New Hampshire	2025	HB 528	Adult-use psilocybin legalization	🟠 Pending	Legalizes psilocybin possession/use for adults 21+; under Criminal Justice & Public Safety Committee review
New Jersey	2021	S3256	Psilocybin possession penalty reduction	✅ Passed (February 2021)	Reduced psilocybin possession penalty: one ounce or less now disorderly persons offense with up to 6 months imprisonment and $1,000 fine (previously third-degree crime with 3-5 years imprisonment and up to $35,000 fine)

New Jersey	2022	S2934	Psilocybin Behavioral Health Access and Services Act	❌ Referred to Senate Health Committee (June 2022)	Would authorize production and use of psilocybin for health and wellness; would decriminalize and expunge past offenses involving psilocybin production, possession, use, and distribution
New Jersey	2024	S2283	Psilocybin Behavioral Health Access and Services Act (amended)	✅ Approved by Senate Budget Committee	Introduced January 2024; amended to create only regulated facilitated access model for psilocybin after being approved by Senate Health and Human Services Committee
New Mexico	2023	HB 393	Psilocybin Advisory Group study	❌ Postponed indefinitely	Would have created advisory group to study feasibility of psilocybin treatment program for mental health and substance use disorders, establish treatment guidelines, and monitor similar programs in other states
New Mexico	2025	SB 219	Medical psilocybin access act	✅ Passed	Established a medical psilocybin advisory board to oversee rulemaking and clinical program development; therapy access slated to begin by end of 2027
New Mexico	2025	SB 410	Crystalline polymorph psilocybin trigger law	❌ Tabled indefinitely (February 19, 2025)	COMP-360 trigger law bill
New Mexico	2025	HM 58	Department of Health psilocybin study request	🟠Pending	Requests Department of Health study psilocybin-based treatment implementation including training requirements standardization, testing protocols, regulatory/legal barriers, and implementation frameworks

New York	2020	A10299	Psilocybin decriminalization	❌ Did not leave Health Committe	
New York	2021	A7928	Public psychedelic research institute	❌ Referred to Health Committee	Would establish public psychedelic research institute and psychedelic substances therapeutic research programs
New York	2021 - 22	A6065	Natural hallucinogen legalization	❌ Status unclear	Would have legalized adult possession and use of certain natural plant or fungus-based hallucinogens, remove prohibitions on possession, use, cultivation of DMT, ibogaine, mescaline, psilocybin, psilocin by adults 21+; includes supervision/guidance services and prevents state cooperation with federal CSA enforcement
New York	2021	A8569	Medical psilocybin training system	❌ Status unclear	Would enable medical professionals to receive training for psilocybin therapy administration, creating Oregon-style medical use system
New York	2023	A00114	Natural hallucinogen legalization with protections	❌ Referred to Health Committee	legalizes adult possession/use of psilocybin, psilocin, DMT, ibogaine, and non-peyote mescaline; includes employment, licensing, and child custody protections
New York	2023 - 2024	S 3520	Medical psilocybin grant program	❌ Re-referred to Finance Committee (January 3, 2024)	Relates to medical use of psilocybin and establishes psilocybin assisted therapy grant program; amended December 20, 2023
New York	2024	A10375	Regulated adult psilocybin use	❌ Status unclear	Would allow growth, cultivation, and regulated adult use of psilocybin for treatment of certain health conditions; provides for certification of support service providers and licensure of cultivators

New York	2025	S 495	State-supervised psilocybin therapy program	🟠Pending	Would create state-supervised program permitting licensed facilitators to provide psilocybin-assisted therapy to eligible patients
New York	2025	S 628	Natural hallucinogen legalization	🟠Pending	Would legalize adult possession and use of DMT, psilocybin, mescaline, ibogaine, and psilocin
New York	2025	S 1801 / A 3845	Veteran/first responder psilocybin pilot	🟠Pending	Pilot program for veteran and first-responder psilocybin therapy
New York	2025	A 3375	Clinically supervised psilocybin pilot	🟠 Pending	Naturally grown psilocybin pilot including in-home use with $5M grants
New York	2025	A 2142 / S 5303	Regulated permit system	🟠 Pending	Regulated permit/licensing system for adult non-commercial psilocybin use and cultivation
New York	2025	S 1817 / A 1522	Ibogaine addiction research	🟠 Pending	Office-led research into ibogaine for addiction treatment
New York	2025	S 4664	PTSD ibogaine study commission	🟠 Pending	Commission PTSD ibogaine study with report within one year
North Carolina	2023	HB 727	Breakthrough Therapies Research Grant Fund	❌ Re-referred to Appropriations Committee (May 16, 2023)	Would establish $5 million grant fund (plus $400,000 administrative costs) for MDMA research on PTSD in veterans, first responders, healthcare professionals, and domestic violence/sexual assault victims; psilocybin research on anxiety/depressive disorders with pain outcome measures

North Carolina	2025	SB 568	Mental health and psychedelic medicine task force	🟠 Pending	Would establish bipartisan task force to consider implementation barriers and recommend licensing/insurance requirements for practitioners upon FDA approval; final report due December 1, 2026
Oregon	2020	Measure 109	Psilocybin therapy legalization	✅ Passed (55.8%)	First state to legalize adult-use psilocybin therapy. Established licensing, facilitator training, and two-year rulemaking process culminating in 2023 program launch
Oregon	2020	Measure 110	Drug decriminalization	✅ Passed (58.5%)	Decriminalized possession of small amounts of all drugs including LSD, MDMA; reclassified offenses and redirected cannabis tax revenue to treatment services
Oregon	2022-24	Local opt-outs (various cities/counties)	Local bans on psilocybin centers	🟡 Mixed (most passed opt-out)	Cities blocked therapy centers locally
Oregon	2025	HB 2387	Psilocybin program updates	✅ Passed	Refined facilitator licensing, client consent, and safety protocols within the Oregon Psilocybin Services program
Oregon	2025	SB 907	Regulatory improvements to existing program	❌ Filed	Updated licensing, board composition
Oregon	2025	HB 3817	VA-linked ibogaine PTSD access	🟠Pending	VA-linked ibogaine PTSD access pathway including cardiac screening and controlled administration

Pennsylvania	2021	HB 1959	The Public Health Benefits of Psilocybin Act	❌ Referred to Health Committee	Introduced by Rep. Tracy Pennycuick (R) with 20 co-sponsors; would authorize clinical study of psilocybin-assisted therapy for PTSD, TBI, and mental health conditions with priority for veterans, first responders, and families; would authorize limited cultivation under state law; modeled after Texas HB 1802
Pennsylvania	2022	HB 2421	Psilocybin Data Act	❌ Presumed dead (not reintroduced 2023-24)	Introduced by Rep. Tracy Pennycuick (R), referred to Health Committee; provides framework for research and clinical studies of psilocybin and psilocybin-assisted therapy to optimize public health benefits; renamed version of HB 1959
Rhode Island	2022	HB 7715	Psilocybin and buprenorphine decriminalization with therapeutic use	❌ Held for further study (April 13, 2022)	Would decriminalize possession of up to one ounce of psilocybin and buprenorphine (no civil penalty, unlike marijuana's $150 fine); would allow practitioners to prescribe/dispense psilocybin therapeutically with Health Director empowered to promulgate rules
Rhode Island	2023	HB 5923 / S 0806	Uniform Controlled Substances Act amendment	✅ Passed House Judiciary Committee (12-2) / ✅ Passed House / ❌ Referred to Senate Judiciary	Would permit possession of less than one ounce of psilocybin and secure cultivation at residence for personal use; includes FDA rescheduling trigger provisions for Department of Health to establish cultivation, distribution, and medical prescription rules; amended with sunset clause for July 1, 2

Rhode Island	2025	HB 5186	Personal legalization + therapeutic access	❌ Held for further study	Personal/cultivation legalization plus FDA-dependent therapeutic access program
Texas	2021	HB 1802	Psychedelic research (veterans)	✅ Passed	Required the state to study psilocybin for PTSD among veterans in partnership with Baylor College of Medicine
Texas	2023	HB 4288	Alternative PTSD therapies study	❌ Referred to Public Health Committee (March 21, 2023)	Would conduct studies on MDMA, psilocybin, and ketamine for PTSD in veteran population
Texas	2023	HB 4423	Psilocybin research council	❌ Status unclear	Would conduct studies on MDMA, psilocybin, and ketamine for PTSD in veteran populations
Texas	2025	SB 2308	Ibogaine clinical trials funding	🟠 Pending	Authorizes $50M in state-backed matched funding for FDA-approved ibogaine clinical trials; establishes consortium with IP stake and veteran-focused funds
Texas	2025	HB 4561	Ibogaine clinical research pilot	✅ Signed	Gov. Abbott signed bill to fund and facilitate ibogaine research for opioid use disorder; aims to advance to clinical trials
Utah	2023	SB 200	Psilocybin therapy legalization	❌ Filed as "bills not passed" (March 3, 2023)	Would have legalized psilocybin therapy for adults 21+ with certain psychiatric diagnoses; would have provided state regulation of psilocybin production and therapy
Utah	2024	SB 266	MDMA and psilocybin pilot program	✅ Became law (March 2024	Creates pilot program for two healthcare systems (Intermountain Health and University of Utah Health) to offer MDMA and psilocybin treatments; program has yet to come to fruition

Utah	2025	SB 248	Crystalline psilocybin trigger law	🟠 Pending	Trigger law for crystalline psilocybin plus provider authority to offer psilocybin/MDMA therapy in clinical settings
Vermont	2021	H 309	Entheogenic plant and fungi decriminalization	❌ Referred to Judiciary Committee	Would decriminalize compounds found in plants and fungi used for medicinal, spiritual, religious, or entheogenic purposes, including psilocybin, psilocin, mescaline, peyote, DMT, and ibogaine
Vermont	2023	H 371	Psilocybin decriminalization with therapeutic workgroup	❌ Heard by House Judiciary Committee (February 24, 2023)	Would decriminalize psilocybin possession and distribution and establish workgroup to investigate therapeutic potential
Vermont	2023	H 439	Plant and fungi compound decriminalization	❌ Referred to Judiciary Committee (March 1, 2023	would remove mescaline, peyote, psilocybin, psilocin, ibogaine, DMT, and containing plants/fungi from "Hallucinogenic Drugs" and "Regulated Drug" definitions; proposed effective date July 1, 2023
Vermont	2023	S 114	Psychedelic Therapy Advisory Working Group	✅ Signed into law by Governor (May 29, 2024)	Establishes working group to examine psychedelic use for physical/mental health improvement and make recommendations for state therapeutic program similar to Connecticut, Colorado, or Oregon; report due November 15, 2024
Vermont	2025	H 189	Advisory board for personal-use benchmarks	🟠Pending	Establishes advisory board for personal-use benchmarks (LSD, psilocybin); under-limit possession becomes harm-reduction

Vermont	2025	HB 452	Psilocybin decriminalization and therapeutic program	🟠Pending	Would decriminalize possession, cultivation, and noncommercial personal use of psilocybin mushrooms by adults; would establish state-licensed "Psilocybin Therapeutic Consultation Program"
Virginia	2022	SB 262	Psilocybin possession decriminalization	❌ Passed by indefinitely (January 31, 2022)	Would reduce psilocybin/psilocin possession penalty to civil fine of max $100 for adults 21+; Senate Judiciary Committee voted to pass by indefinitely
Virginia	2022	HB 898	Multi-substance possession decriminalization	❌ Shelved (January 24, 2022)	Would reduce penalties for psilocybin, psilocin, ibogaine, and peyote possession from Class 5 felony to civil offense with max $100 fine for adults 21+
Virginia	2023	HB 1513	Medical psilocybin prescription	❌ Left in Courts of Justice Committee	Would allow psilocybin possession with valid prescription for refractory depression, PTSD, or end-of-life anxiety; would prohibit prosecution of healthcare practitioners and pharmacists
Virginia	2023	SB 932	Virginia Psilocybin Advisory Board	✅ Passed Senate (25-15, February 7, 2023) / ❌ Status unclear in House	Would establish 12-member advisory board, reclassify psilocybin from Schedule I to Schedule III, and develop strategic plan for therapeutic access
Virginia	2024	SB 229	Breakthrough Therapies for Veteran Suicide Prevention Act	✅ Passed Senate / ❌ Failed House	Earlier version of psychedelic therapy bill for veterans; passed Senate but didn't make it out of House

Virginia	2025	SB 1101	Breakthrough Therapies for Veteran Suicide Prevention Act	✅ Passed Senate (40-0) / ❌ Killed in House (18-0)	Established 6-member state advisory council to study FDA breakthrough therapies (psilocybin, MDMA) for veterans; Senate unanimous approval but House Rules Committee killed bill
Virginia	2025	SB 1135	COMP-360 crystalline psilocybin trigger law	✅ Passed Legislature / ❌ Vetoed by Gov. Youngkin (March 24, 2025)	Would direct Virginia Board of Pharmacy to promulgate regulations for prescribing, dispensing, possessing, and using crystalline polymorph psilocybin (COMP-360) upon FDA approval and DEA rescheduling; Youngkin vetoed as "premature," saying state should wait for federal action
Washington	2025	SB 5201	State-licensed psilocybin therapy services	🟠Pending/Stalled	State-licensed psilocybin therapy services for adults 21+; sponsored by Sen. Salomon with co-sponsors
Washington	2025	HB 1281	Pilot psilocybin therapy for veterans/first responders	🟠 Pending	Pilot psilocybin therapy pathway for veterans and first responders via medical professionals
Washington	2025	HB 1433	Regulated psychedelic access with equity focus	🟠 Pending	Regulated access bill emphasizing cost equity and insurance inclusion
Washington	2025	HB 5204	University of Washington ibogaine study	🟠 Pending	UW-led ibogaine study for opioid use disorder in partnership with licensed Mexican clinic; sponsored by Salomon, Trudeau, Nobles
Washington - Seattle	2021	Resolution	Local entheogen decriminalization	✅ Passed (October 4, 2021)	Largest U.S. city to decriminalize psychedelics; made enforcement of laws against natural psychedelics the lowest police priority
Washington - Port Townsend	2021	Resolution	Local entheogen decriminalization	✅ Passed (December 20, 2021)	Made investigation, arrest, and prosecution of adults engaging in entheogen-related activities a low enforcement priority

Washington - Jefferson County	2023	Resolution	County-level entheogen decriminalization	✅ Passed (May 2023)	County commissioners unanimously approved resolution to make psychedelics enforcement among lowest priorities
Washington - Olympia	2024	Resolution	Local entheogen decriminalization	✅ Passed (August 13, 2024)	State capital city unanimously approved resolution declaring entheogen enforcement as lowest law enforcement priority
Washington - Tacoma	2025	Resolution	Local entheogen decriminalization	✅ Passed (January 28, 2025)	Third largest city in Washington; unanimously approved resolution to deprioritize enforcement and support statewide decriminalization
West Virginia	2021	HB 3113	Psilocybin rescheduling	❌ Stalled in committee	Proposed removing psilocybin and other substances from Schedule I; reached Health and Human Resources committee before Legislature adjourned without scheduling
West Virginia	2023	HB 2951	Multi-substance rescheduling	❌ Stalled in committee	Proposed removing Schedule I status of THC and psilocybin from West Virginia Code
West Virginia	2025	HB 3344	Ibogaine clinical trials grant program	✅ Passed House / ❌ Pending Senate	Establishes grant program to fund ibogaine clinical trials for FDA approval
West Virginia	2025	HB 3343	COMP-360 crystalline psilocybin trigger law	✅ Passed House / ❌ Pending Senate	Compass Pathways-backed trigger law to reschedule crystalline polymorph psilocybin upon FDA approval

Appendix 4: Design Considerations for State-Level Psychedelic Policy Legislation

This document outlines key design considerations for state-level legislation to expand access to psychedelic substances for therapeutic, personal, or ceremonial use. It was developed to support legislators and policy advisors by compiling a comprehensive set of questions that reflect best practices in public policy design, drawing on Bardach's Eightfold Path to Policy Analysis and additional frameworks such as Equity and Inclusion and the Learning Health System model. Each section presents foundational questions to guide high-level legislative decisions—distinct from regulatory implementation—and is informed by emerging state-level policy efforts, stakeholder testimony, and legal precedent. Steps 1-6 are relevant to the work of the Task Force. Steps 7 and 8 are the sole purview of the Maryland General Assembly.

1. Define the Problem
   - What problem does the legislation seek to solve, and why is action needed now?
   - What unmet health, social, or justice needs are associated with current psychedelic prohibition (e.g., mental illness, incarceration, inequity)?
   - What harms result from the status quo (e.g., untreated PTSD, underground markets, racial disparities)?
   - What populations are most impacted by the current policy and who is excluded from existing services?
   - What is the public demand or political pressure for change?

2. Assemble the Evidence
   - What do existing research trials, real-world data, and pilot programs show about the safety and efficacy of psychedelic use or therapy for mental health problems?
   - What evidence supports alternative uses (spiritual, personal growth, end-of-life care)?
   - What types of data are lacking (e.g., long-term safety, public health impacts), and how can the legislation acknowledge this?
   - What lessons can be drawn from other states or countries?
   - What does disaggregated data show about how current laws affect BIPOC, LGBTQ+, low-income, disabled, and indigenous communities?
   - What does the best available evidence say about the public health benefits of responsible access to psilocybin, DMT, mescaline, and psilocin?
   - What are the short-term and long-term risks associated with nonclinical use of these substances?

- How can adverse outcomes be monitored and mitigated?
- What issues specific to each natural substance must be considered in order to formulate effective policy?

3. Construct the Alternatives

3.1. Scope of Legalization or Decriminalization

- Will the legislation permit medical-only use, licensed therapeutic use, spiritual or ceremonial use, personal adult use, or decriminalization?
- Which models of legalization or decriminalization are most suitable (e.g., grow-and-give, supervised use, religious exemptions)?
- Should Maryland pursue state-licensed supervised use (as in Oregon/Colorado), user permits, or some combination?
- Should Maryland decriminalize possession and use entirely? For what quantities?
- Should criminal penalties be replaced by civil fines or eliminated?
- Should the state expunge records and release individuals incarcerated for nonviolent psychedelic-related offenses?

3.2. Supply Chain and Use Models

- Will the policy create a regulated supply chain, permit home cultivation, or rely on community-based models?
- Will Maryland permit production or sales? If so, what regulatory model should be adopted (nonprofit, state-licensed, cooperative, etc.)?
- Will cultivation for personal use be permitted?
- What types of products (e.g., whole mushrooms vs. extracts) and use formats (e.g., microdosing, ceremonial use) will be allowed?

3.3. Access and Participation

- Will access be through licensed professionals, trained facilitators, peer guides, or self-use?
- Will local governments be allowed to opt out or regulate access (e.g. time, place and manner) within their jurisdiction?
- Which populations will be eligible to access psychedelics (e.g., adults 21+, patients with qualifying diagnoses, end-of-life patients, spiritual practitioners)?
- Will specific populations be prioritized for access (e.g., Veterans, terminally ill patients, historically underserved communities)?
- How will costs to users be controlled?

3.4. Workforce and Facilitator Standards

- What are appropriate education, certification, and safety training requirements for facilitators?
- Should Maryland create licensure for facilitators, trip sitters, or integration coaches?
- What role should existing professional licensing boards (e.g., for social work, psychology, counseling, nursing) play in approving or overseeing psychedelic facilitation?
- Could collaborative practice agreements (e.g., between licensed medical providers and facilitators) provide an appropriate oversight mechanism without requiring full licensure?
- How can the legislation balance the need for rigorous training and oversight with the need to control costs for practitioners and prevent excessive burdens that will be passed on to patients?
- Should the state offer subsidized training, scholarships, or sliding-scale licensing fees to expand access to underrepresented or lower-income practitioners?

3.5. Public Health Data and Oversight

- What infrastructure is needed to track use, benefits, harms, and equity impacts?
- How will data be used to adjust laws, policies, and regulations over time?
- How can Maryland collect data while respecting privacy and informed consent?

3.6. Legal and Regulatory Mechanisms

- Will the law set possession or dosage limits?
- Will certain substances (e.g., ibogaine) be excluded or subject to higher scrutiny?
- Will there be penalties for unlicensed distribution or advertising?
- Will the bill include protections for state-licensed facilitators, patients, or growers from federal interference?
- Will new agencies or advisory councils be created?
- Are there constitutional constraints (e.g., public funds for private services, scope of practice)?

4. Select the Criteria

- What criteria will be prioritized in evaluating alternatives? (e.g., public health benefit, equity, feasibility, public support, cost, legal defensibility)
- How will equity be defined and measured in this context?
- What level of risk is acceptable, and how will trade-offs be assessed (e.g., between innovation and safety)?
- What approaches will the legislation adopt to ensuring safety (e.g. precautionary, risk-benefit, proportionate, patient-centered, learning health system, etc?)
- How can Maryland ensure equitable access across race, income, and geography?

- How should Indigenous perspectives and spiritual practices be included and respected?
- What reciprocity and protections should be offered to Indigenous communities?

5. Project the Outcomes
    - How might the policy affect mental health outcomes, drug-related arrests, racial disparities, and health equity?
    - What impact could the policy have on youth perception and use, if any?
    - Could the policy lead to commercial exploitation, increased costs, or access inequality?
    - Will the policy shift burdens or resources to other systems (e.g., EMS, law enforcement, public health)?
    - What community benefits might arise from new jobs, research, or treatment access?

6. Confront the Trade-offs
    - Does the policy balance innovation and caution? What compromises are being made regarding access vs. control?
    - Are protections for marginalized groups balanced with feasibility of implementation?
    - Could inclusionary goals (e.g., equity licensing) delay implementation, and is that acceptable?
    - How will policymakers balance local control with statewide consistency?
    - What ethical tensions arise between religious freedom, commercialization, and cultural protection?

7. Decide
    - How will the legislation clearly articulate its intent, priorities, and implementation expectations?
    - Will the bill establish a new program, amend existing law, or delegate details to regulatory agencies?
    - What declarations of legislative intent, findings, or guiding principles will be included?
    - Is there bipartisan or cross-sector alignment to support passage?
    - Will the bill require periodic review or sunset clauses?
    - Will implementation be phased (e.g., Veterans first, then broader access)?
    - Will a state agency or new body be tasked with rulemaking and oversight?
    - Will there be a structured rulemaking timeline and opportunity for public comment?

8. Message
    - How will the legislative narrative honor both scientific and Indigenous knowledge systems?
    - How will the bill distinguish therapeutic use from recreational use, especially in youth messaging?
    - Will the policy be positioned as a compassionate, evidence-informed response to a public health challenge?
    - How will legislators explain the rationale for inclusion, expungement, or legal exceptions?

Appendix 5. Delphi Process Methodology

Purpose

This white paper outlines the methodology employed for the Maryland Psychedelic Therapy Policy Task Force modified Delphi process. The process aims to develop evidence-informed policy recommendations regarding the implementation of psychedelic therapy services in Maryland. Through a systematic consensus-building process, the Task Force will evaluate policy propositions across seven access models: Deprioritization, Non-Commercial Peer Sharing, Commercial Sales, Religious Use, Supervised Adult Use, Medical/Therapeutic Use, and FDA-Approved Use.

Study Design

Modified Delphi Method

To generate evidence-based policy recommendations regarding access to natural psychedelic substances, the Task Force employed the modified Delphi technique. We selected this technique as an internal tool to efficiently reach consensus, not as a research methodology. We make no claims that our findings generalize beyond the scope of our authorizing legislation. This method was selected because it:

- Allows for anonymous evaluation of policy propositions
- Minimizes the influence of dominant voices
- Enables structured feedback between rounds
- Provides a systematic approach to measuring consensus
- Supports both quantitative and qualitative data collection
- Results in specific, graded policy recommendations

Panel Composition

The panel for this Delphi process consists of the 19 appointed members of the Task Force. Task Force membership was determined by the authorizing legislation, and all Task Force members were invited and encouraged to participate. Studies employing the modified Delphi technique routinely require much larger sample sizes in order for the results to be considered generalizable. However, since we are not employing the modified Delphi technique as a research method, it is not appropriate to compare our sample size with research norms.

Proposition Generation

Based on comprehensive literature reviews and stakeholder input, 120 policy propositions were developed across the seven access models identified by Task Force members. These initial 120 propositions were sorted by themes and prioritized. Redundant and low priority items were dropped, resulting in 85 propositions. Each proposition describes a potential policy feature that could be encoded into Maryland law.

Rating Dimensions

Each proposition was rated on two dimensions:

1. Desirability: The extent to which implementing the proposition would be beneficial for Maryland (1 = Not at all desirable, 9 = Extremely desirable)
2. Feasibility: The likelihood that the proposition could be successfully implemented within the next 5 years (1 = Not at all feasible, 9 = Extremely feasible)

Panelists were also asked to complete an importance allocation task, distributing 100 points across various factors (e.g. political viability, financial sustainability, equity, etc.) to indicate which criteria most influenced their feasibility and desirability judgments.

The electronic Delphi survey was administered using a secure online platform. Each panelist was permitted to complete the survey multiple times, with the option to revise their earlier responses based on written comments provided anonymously by other panelists.

Response Rate and Participation Goal

The target response rate was set a priori at 75% rounded to the nearest whole number (i.e., at least 14 of 19 members). Reminders and follow-up communications were used to maximize participation while maintaining voluntary and anonymous responses.

Survey Administration

The Delphi process consisted of three rounds.

Round 1: Task Force members rated all propositions on both dimensions (desirability and feasibility) using the 9-point Likert scales and optionally provided qualitative feedback for ratings in the neutral (i.e. 4-6) range. This round was conducted asynchronously through the electronic survey platform.

Round 2: This round featured structured deliberation conducted via videoconferencing. Propositions were prioritized for discussion based on the level of consensus reached in Round 1, with particular focus on:

- Propositions with emerging but incomplete consensus, defined as:
    - 50-79% of ratings in either the 7-9 range (emerging positive consensus) or 1-3 range (emerging negative consensus)
- Propositions with high desirability but varied feasibility ratings, defined as:
    - ≥75% of desirability ratings in the 7-9 range AND <50% of feasibility ratings within any single tertile range (i.e. 1-3, 4-6, or 7-9)
- Propositions with significant polarization in responses, defined as:
    - ≥25% of ratings in the 1-3 range AND ≥25% of ratings in the 7-9 range AND IQR ≥ 4

During these deliberation sessions, Task Force members engaged in moderated discussions of selected propositions. During each discussion, members used an interactive presentation software (Mentimeter) to anonymously re-rate propositions. Visualizations of the live rating distributions were shared with the group in real time to illustrate emerging patterns of consensus. This approach allowed for meaningful dialogue while preserving the benefits of anonymous rating to minimize groupthink or social pressure.

Round 3: Following the deliberation sessions, panelists completed a final asynchronous survey to review and refine their ratings of all propositions based on further reflection. Panelists were required to provide justifications for any ratings outside of the consensus position of the group at the start of the round. This final round focused on solidifying consensus for the final recommendations.

Between-Round Analysis and Feedback

Between rounds, the research team:

- Calculated descriptive statistics for all ratings
- Identified emerging consensus patterns
- Summarized qualitative justifications
- Highlighted areas of agreement and disagreement
- Prepared visualizations to aid interpretation

This information was shared with Task Force members to inform subsequent rounds of rating.

Analysis Plan

Quantitative Analysis

- Median and interquartile range for each proposition
- Percentage of ratings in each tertile range (i.e. 1-3, 4-6, 7-9)
- Assignment of consensus level based on the thresholds above
- Sensitivity analysis to assess the impact of weighting schemes from the importance allocation task or Task Force member attributes

Qualitative Analysis

- Thematic and content analysis of justifications for outlier ratings
- Identification of recurring concerns or opportunities
- Analysis of proposed modifications to improve proposition acceptability
- Grouping of consensus positions into “constellations” of mutually reinforcing recommendations

Consensus Definitions

Consensus definitions and thresholds were specified a priori as follows. Thresholds for panelist counts were rounded up or down to the nearest whole number. At target levels of participation, the magnitude of the threshold between moderate and strong consensus ranged between 2 and 3 panelists.

Strong Consensus:

- ≥80% of panelists rating the proposition in the 7-9 range (for positive consensus) OR 1-3 range (for negative consensus)
- AND Median score ≥7 (for positive consensus) or ≤3 (for negative consensus)
- AND Interquartile range (IQR) ≤2

Moderate Consensus:

- <80% and ≥65% of panelists rating the proposition in the 7-9 range (for positive consensus) or 1-3 range (for negative consensus)
- AND Median score ≥7 (positive) or ≤3 (negative)
- AND IQR ≤3

No Consensus:

- <65% agreement in either the 7-9 or 1-3 ranges
- OR median in the 4-6 range
- OR IQR >3

Translation to Recommendation Grades

Final consensus ratings were translated into recommendation grades as follows. Results were synthesized in a format that enables legislators and stakeholders to evaluate the most promising elements of psychedelic policy for Maryland.

- Grade A (Strongly Recommended): Strong consensus on both desirability AND feasibility
- Grade B (Moderately Recommend): Strong consensus on desirability AND moderate consensus on feasibility
- Grade C (Conditionally Recommended): Moderate consensus on desirability AND any consensus on feasibility
- Grade S (Needs Further Study): Any consensus on desirability AND no consensus on feasibility
- Grade L (Long Shots): Any consensus on desirability AND any consensus on infeasibility
- Grade W (Warning): Any consensus on undesirability AND feasibility
- Grade X (Not Recommended): Any consensus on undesirability AND infeasibility
- Grade I (Insufficient): No consensus on desirability