Mason Marks, MD, JD

February 28, 2024

Senate Committee on Health & Welfare, Vermont General Assembly

Re: S.114

Honorable Committee Chair, Vice-Chair and members of the Senate Committee on Health & Welfare:

Thank you for considering S.114, an act relating to removal of criminal penalties for possessing, dispensing, or selling psilocybin and establishment of the Psychedelic Therapy Advisory Working Group. Though I write to express my personal opinions only, and not those of my employers or other entities, my professional experience informs my comments. As a medical doctor and full-time law professor, I teach courses on drug law and psychedelic law at Harvard Law School and the Florida State University College of Law. In 2021, I co-founded the Project on Psychedelics Law and Regulation (POPLAR) at the Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics at Harvard Law School. Much of my time is devoted to studying state and federal psychedelic legal reforms.

As proposed, S.114 has two primary effects. It removes psilocybin from the statutory list of illegal substances in Vermont (though psilocybin possession would remain illegal at the federal level). S.114 also creates a work group to study potential creation of a supervised adult use program for psilocybin (psilocybin would remain illegal federally despite this potential regulation).

Decriminalization entails reducing or eliminating criminal penalties associated with a substance and related activities such as possession. Decriminalization is increasingly popular throughout the country and the world. In the US, about two dozen cities have decriminalized psilocybin. They include the District of Columbia, Denver, Detroit, Seattle, San Francisco, and nine cities in New England, including Portland, Maine, and Cambridge, Somerville, and Medford, Massachusetts. These cities are joined by the states of Oregon and Colorado, and internationally by the Netherlands, Portugal, Vancouver, British Columbia, and others. These jurisdictions believe that criminalizing substances does not prevent people from using them. If drug prohibition worked, the US would have no opioid overdose deaths instead of alarmingly high rates of opioid-related overdoses and deaths. Many public health experts believe criminalizing people who consume substances merely pushes them into the shadows, which can be counterproductive. They may become less likely to discuss substance use with healthcare providers or seek education on how to reduce risk. Research suggests that psilocybin appears relatively safe for most people. Nevertheless, there are some risks, as there are with any substance. In the seemingly rare instances where people would benefit from medical assistance after consuming psilocybin, when criminalized they may be less likely to seek medical support. In other words, criminalization can exacerbate any risks associated with psilocybin and other substances.

Like decriminalization, establishing a work group to study supervised psilocybin use is also becoming popular. Minnesota, Hawaii, and Washington State are among the states taking this

methodical approach. There are other paths. Oregon and Colorado established programs for supervised use without fully analyzing their implications. Oregon's psilocybin program is the only state program currently operating, and Colorado's should open next year. So far, it appears most Oregon psilocybin clients come from out of state. Instead of providing affordable access to psilocybin as a mental health option, the program largely created a psychedelic tourism industry. Further, although proponents of Oregon's program promised it would be self-sufficient by 2023, it nearly went bankrupt by the end of 2022. Last year the state legislature bailed it out with $3.1 million in public funds. Regulators had asked for more than twice that amount, which gives a glimpse of how expensive state-regulated psilocybin programs can be.

Establishing a Vermont work group is sensible because it can study why Oregon's program costs so much for taxpayers and clients. Currently, the average cost of a single dose of psilocybin in Oregon ranges from about $1,200 to $3,500. Health insurance will not subsidize these costs because psilocybin remains a Schedule I controlled substance at the federal level. Regulating supervised psilocybin use creates many other unresolved conflicts with federal law. For instance, supervised use blends aspects of conventional healthcare with the sale and administration of Schedule I controlled substances far more than state medical marijuana programs have. In most medical marijuana programs, conventional healthcare has little or no involvement. There is no marijuana in the room with doctors, and patients purchase cannabis products outside the conventional healthcare system, at medical marijuana dispensaries.

Blending Schedule I controlled substances with conventional healthcare has become a significant concern in Georgia. The state's unusual marijuana law allows pharmacies to dispense marijuana products. In December, the federal Drug Enforcement Administration (DEA) sent a letter to Georgia pharmacists warning them not to dispense marijuana. The supervised use of psilocybin in state-regulated programs further blends healthcare and a Schedule I controlled substance. Unlike in medical cannabis programs, state-licensed psilocybin service centers and facilitators, often acting as healthcare providers, dispense psilocybin to people on the premises and monitor them for hours. Accordingly, these programs could become targets for the DEA and other federal agencies. Further complicating matters, healthcare facilities that receive funding from Medicare or Medicaid are unlikely to allow psilocybin on their premises for fear of losing federal funding. I discuss these issues in a recent article in the Journal of the American Medical Association, *State-regulated psychedelics on a collision course with FDA*.

These legal and public health challenges should be analyzed during the drafting phase of psilocybin legislation. The work group proposed by S.114 creates opportunities for those discussions. In the meantime, decriminalization may be equally important. It poses far fewer conflicts with federal law because Congress and federal agencies cannot force states to enact laws or enforce the federal Controlled Substances Act (CSA). Moreover, state decriminalization does not impede federal efforts to enforce the CSA. Instead, it can promote open discussion of risks and benefits among healthcare professionals and the public.

Sincerely,

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Health Law Professor