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June 18, 2026

Timothy Carroll
House Clerk
State House, Room 145
Boston, MA 02133

Michael D. Hurley
Senate Clerk
State House, Room 335
Boston, MA 02133

Dear Clerk Carroll and Clerk Hurley,

Pursuant to Section 150 of Chapter 178 of the Acts of 2024, please find attached a report on the findings and recommendations of the working group to review alternative therapies for mental health treatments for veterans.

Sincerely,

Eric Goralnick

CC:
Senator John Velis, Senate Chair of the Joint Committee on Veterans and Federal Affairs, and Senate Chair of the Joint Committee on Mental Health, Substance Use and Recovery
Representative Joe McGonagle, House Chair of the Joint Committee on Veterans and Federal Affairs
Representative Mindy Domb, House Chair of the Joint Committee on Mental Health, Substance Use and Recovery

Legislative Mandate

The following report is issued pursuant to Section 150 of Chapter 178 of the Acts of 2024, summarized as follows:

…The secretary of veterans' services, in coordination with the executive office of health and human services, shall convene a working group to review alternative therapies for mental health treatments for veterans. The working group shall: (i) study whether psychedelic therapy is associated with improved outcomes among veterans with diagnosed mental health disorders; (ii) evaluate literature, research trials and expert opinions to determine if psychedelic therapy is associated with improved outcomes regarding mental health treatment for veterans; and (iii) issue recommendations regarding the provision of psychedelic therapy to treat veterans with mental health disorders in the commonwealth. As used in this section, "psychedelic therapy" shall mean the use of psilocybin, ketamine, or 3,4-methylenedioxymethamphetamine under the direction of a health care provider to treat mental health disorders. The secretary shall appoint the following members to the working group: 2 members who shall represent medical centers or hospitals in the commonwealth that serve veterans; 2 members who shall represent health insurance companies; 2 members who shall represent veterans' services organizations; 1 member who shall represent an organization currently studying the subject matter of alternative therapies for mental health treatment of veterans; 1 member who shall represent the Center for the Neuroscience of Psychedelics at Massachusetts General Hospital; and such other members with experience in behavioral health or veterans' services as the secretary deems necessary. The secretary shall designate a chair of the working group from the membership of the group… the working group shall file a report of its findings and any recommendations with the clerks of the house of representatives and the senate, the joint committee on veterans and federal affairs and the joint committee on mental health, substance use and recovery.

Report of the Veterans Alternative Therapy Working Group

Members:

Franklin King, MD, Chair
Representing the Center for the Neuroscience of Psychedelics at Massachusetts General Hospital

Michael Allard
Representing a veterans' services organization

Colin Beatty
Representing an organization currently studying the subject matter of alternative therapies for mental health treatment of veterans

John Bradley, MD
Representing medical centers or hospitals in the commonwealth that serve veterans

Christine Cugini
Representing a veterans' services organization

Sharmin Ghaznavi, MD, PhD
Representing medical centers or hospitals in the commonwealth that serve veterans

Paul Jones
Representing health insurance companies

Rob McLaughlin
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Paul Morrissey, MD
Representing medical centers or hospitals in the commonwealth that serve veterans

Roxanne Sholevar, MD
Representing experience in behavioral health or veterans' services

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Introduction

A. Mandate and Scope

Section 150 of Chapter 178 of the Acts of 2024, commonly referred to as the HERO Act, directed the Secretary of Veterans' Services, in coordination with the Executive Office of Health and Human Services, to convene a Working Group to review alternative therapies for veterans' mental health. The Working Group was charged with three tasks: to study whether psychedelic therapy is associated with improved outcomes among veterans with diagnosed mental health disorders; to evaluate the available literature, research trials, and expert opinion bearing on that question; and to issue recommendations regarding the provision of psychedelic therapy to treat veterans with mental health disorders in the Commonwealth. This report presents the Working Group's findings and recommendations in response to that charge.

The term "psychedelic" refers to a broad and pharmacologically heterogeneous class of psychoactive substances that alter perception, cognition, and mood, typically through agonist activity at serotonin 2A receptors or related mechanisms. The classical psychedelics include psilocybin, lysergic acid diethylamide (LSD), dimethyltryptamine (DMT), mescaline, and the ayahuasca preparations in which DMT is the primary active alkaloid. MDMA, though pharmacologically distinct, acts primarily through monoamine release rather than direct serotonin receptor agonism; it is nevertheless grouped with psychedelics in the clinical and policy literature given its comparable capacity to induce non-ordinary states of consciousness and its relevance to the same therapeutic contexts. Ketamine occupies a different pharmacological category entirely as a dissociative anesthetic acting on NMDA glutamate receptors, but is included in this report's scope by statutory definition and because of the overlapping clinical populations and therapeutic models it shares with the classical psychedelics.

These compounds differ in their pharmacology, clinical applications, and regulatory status. Ketamine is a dissociative anesthetic with an established legal and clinical infrastructure in the United States and is the only psychedelic-adjacent agent currently available for routine clinical use. Psilocybin and MDMA, like most other psychedelics, are classified as Schedule I controlled substances under federal law. Both have received Breakthrough Therapy designation from the Food and Drug Administration, reflecting the agency's determination that preliminary clinical evidence suggests substantial improvement over available therapies for serious conditions. These distinctions carry significant implications for access, research design, and implementation and are addressed throughout this report. The statutory definition governs this report's findings and recommendations; the evidentiary review in Section I, however, draws on the broader scientific literature, including trials and studies involving LSD, ayahuasca, DMT, and ibogaine where that evidence informs mechanisms of action, therapeutic models, or safety considerations relevant to the compounds under review.

B. The Treatment Gap

Veterans in the United States bear a disproportionate burden of mental illness. Post-traumatic stress disorder (PTSD), major depressive disorder (MDD), alcohol use disorder (AUD), and traumatic brain injury (TBI) are each substantially more prevalent among veterans than in the general population, and they frequently co-occur.[1] Suicide rates among veterans have consistently exceeded those of age- and sex-matched civilians,[2] a disparity that has persisted despite decades of programmatic investment. In Massachusetts, veterans receive mental health care through VA

medical centers, the Department of Veterans' Services, and a network of community-based providers whose collective capacity has not kept pace with the severity or complexity of need. The limitations of current standard-of-care approaches transcend matters of clinical opinion, as they are documented in the outcomes data. Trauma-focused psychotherapies such as Prolonged Exposure and Cognitive Processing Therapy are effective for a meaningful proportion of patients, but response rates are incomplete,[3] dropout rates are high,[4] and a substantial subset of veterans with PTSD derives little lasting benefit from available first-line treatments. Pharmacotherapy for depression and PTSD offers modest average effects, with high rates of partial response and treatment resistance.[5–8] For alcohol use disorder, approved pharmacologic agents show clinically meaningful but limited efficacy.[9]

This treatment gap is the context for this report. The Working Group was convened because a growing body of clinical evidence suggests these treatments may benefit patients for whom conventional approaches have failed, and because veterans are already seeking them out: through research trials, nonprofit programs, and medical travel abroad, in the absence of any framework within the Commonwealth to support safe or regulated access. The question before this Working Group is not whether to engage with this evidence, but how to engage with it responsibly. Recent state-level task forces have reached similar conclusions about the need for action. Reports in Minnesota and Maryland have each recommended state-regulated access programs for psychedelic therapies alongside targeted reforms to criminal penalties, reflecting a broader shift toward multi-pathway policy approaches.

The federal context has also shifted since this Working Group was convened. On April 18, 2026, a federal executive order directed acceleration of psychedelic-assisted treatments for serious mental illness, citing the veteran suicide crisis as its primary justification.[10] The order directs ARPA-H to allocate at least $50 million to support and partner with states developing programs to advance psychedelic treatments for serious mental illness. The executive order also directs the Attorney General to initiate rescheduling review for Schedule I substances that have completed Phase 3 trials, and establishes priority review and encourages Right to Try access pathways for compounds with Breakthrough Therapy designation.[1] Its relevance to this report is practical: a Massachusetts program capable of qualifying as a federal partner may offer greater value to the Commonwealth's veterans than one that is not, and the rescheduling directive makes the absence of a state scheduling conformity mechanism a near-term consideration rather than a purely hypothetical one. Both points are addressed in the sections that follow.

C. Approach to Evidence and Decision-Making

This report draws on a range of relevant evidence: randomized controlled trials, observational studies, systematic reviews, epidemiological data, and expert clinical judgment. The Working Group regards randomized controlled trial evidence as the strongest available basis for causal inference about treatment efficacy, while recognizing that RCT methodology presents particular challenges in the context of psychedelic research. The impossibility of true double-blinding—given the distinctive subjective effects of these compounds—complicates interpretation of placebo-controlled designs.[11] The structured therapeutic context in which most psychedelic-assisted treatments are delivered makes it difficult to isolate the pharmacologic contribution from the psychotherapeutic one.[12] In addition, the historical prohibition on research into Schedule I substances has constrained

[1] Breakthrough Therapy designation has been granted to several psychedelic-based therapeutics, including MDMA (for PTSD), psilocybin (for depressive disorders; e.g., Compass Pathways and Usona Institute), next-generation psilocybin analogs (e.g., Cybin's CYB003), 5-MeO-DMT, and LSD. Other compounds, including DMT and ibogaine, have not received this designation to date.

the evidence base in ways that reflect regulatory history rather than the intrinsic limits of the science.[13,14]

These methodological considerations do not undermine the existing evidence. They do, however, counsel against treating absence of a certain kind of evidence as equivalent to evidence of absence. Where the Working Group identified findings supported by convergent evidence across independent sources, it has stated them directly. Where the evidence is limited, preliminary, or contested, those limitations are described explicitly rather than obscured. The aim is to present an account that reflects the current state of knowledge with precision, acknowledges areas of uncertainty, and provides the legislature with a clear basis for decision-making under conditions where the evidence remains incomplete.

A related point concerns the relationship of this report to federal regulatory frameworks. FDA approval is a meaningful signal: it represents a rigorous, standardized evaluation of safety and efficacy for a defined indication. However, it is not the only legitimate basis for clinical judgment or policy action. For example, ketamine, the only compound in this report's scope that is currently FDA-approved and in widespread clinical use, illustrates the point: its most common contemporary psychiatric application—intravenous infusion for depression—is an off-label use not covered by its approved indications as an anesthetic. State legislatures and medical licensing bodies regularly make policy judgments about treatments that precede, outrun, or exist outside of FDA approval pathways. This report does not advocate for circumventing federal regulation; however, it does insist that federal regulatory status is one input into the analysis, not the boundary of it.

D. Working Group Membership

The Working Group was convened pursuant to the membership requirements specified in Section 150(b) of the HERO Act.[15] Members were appointed to represent medical centers serving veterans, health insurance companies, veterans service organizations, organizations currently studying alternative therapies for veterans, the Center for the Neuroscience of Psychedelics at Massachusetts General Hospital, and behavioral health and veterans services more broadly. The chair was designated by the Secretary of Veterans' Services from among the membership.

The Working Group includes Chair Franklin King, MD (MGH Center for the Neuroscience of Psychedelics); Michael Allard (Home Base, a Red Sox Foundation and Massachusetts General Hospital Program); Colin Beatty (ControlZ Health); John Bradley, MD (VA Medical Center); Christine Cugini (Massachusetts Veterans Service Officers Association); Sharmin Ghaznavi, MD, PhD (MGH Center for the Neuroscience of Psychedelics); Paul Jones (Blue Cross Blue Shield of Massachusetts); Rob McLaughlin (Massachusetts Association of Health Plans); Paul Morrissey, MD (VA Medical Center); Roxanne Sholevar, MD (Dana-Farber Cancer Institute). The membership spans clinical medicine, health system administration, insurance policy, veteran services, and behavioral health. The diversity of professional backgrounds and institutional perspectives has shaped the Working Group's deliberations and is reflected in the range of considerations addressed in this report.

E. Organization of this Report

This report is organized into four substantive sections followed by recommendations. Section I briefly reviews the evidence base for psychedelic-assisted therapies, with attention to the conditions most prevalent among veterans, the limitations of existing trial designs, and the conceptual distinctions that bear on how evidence is generated and interpreted. Section II examines access, implementation, and the Massachusetts-specific context, including the current regulatory landscape, insurance and reimbursement, veteran-specific access pathways, and the experience of other jurisdictions that have moved to regulate psychedelic therapies. Section III addresses the veterans

community directly, including attitudes toward mental health and psychedelic treatment, the role of community and peer networks, and equity considerations relevant to any expansion of access. Section IV summarizes the bills currently at various levels of debate within the Massachusetts Legislature as of April, 2026.

The report concludes with the Working Group's findings and recommendations. Consistent with the statute's mandate, recommendations are directed at the provision of psychedelic therapy for veterans within the Commonwealth. They are intended to be actionable for the legislature and the relevant executive agencies, and they are grounded in the evidence and analysis presented in the preceding sections.

I. Efficacy and Safety

A. Evidence Base

A significant focus of the Working Group was discussing the evidence base concerning psychedelic-assisted therapies, which is primarily concentrated in PTSD, major depressive disorder and treatment-resistant depression. Across these conditions, and across the three compounds that are the primary focus of this report, the evidence is broadly convergent. Multiple phase 2 and phase 3 randomized controlled trials have found large effect sizes for MDMA-assisted therapy in PTSD, with approximately 67 percent of participants no longer meeting diagnostic criteria following treatment. Psilocybin-assisted therapy has demonstrated clinically meaningful improvements when compared to placebo in depressive disorders across several, but not all[16] trials, including for major depressive disorder[17] and treatment-resistant depression.[18] Evidence for other indications, including generalized anxiety disorder, is emerging but remains preliminary and more limited in scope.[19] Psilocybin-assisted therapy has also shown efficacy for alcohol use disorder,[20] cocaine use disorder,[21] and nicotine addiction[22] in randomized trials. Safety profiles across these compounds, in controlled clinical settings, have been consistently favorable: adverse effects are largely transient, serious adverse events are rare, and pharmaceutical-grade compounds administered in clinical research settings have not been found to negatively impact neurocognition or lead to dependence.[23] This clinical safety record is consistent with population-level epidemiological data: a large national survey-based study found no association between lifetime psychedelic use and increased rates of mental health problems, including psychosis, depression, or anxiety, even after controlling for demographic and substance use variables.[24] These findings are at odds with the assumptions underlying the Schedule I classification of these substances.

The trial literature has well-recognized structural constraints that bear on how these findings should be interpreted. True double-blinding, the universal standard in clinical research, is not achievable in psychedelic trials, because participants who receive an active dose almost universally know it.[11] Investigators have attempted to address this through various design features, such as including independent evaluator blinding for primary outcomes, that parallel standards applied to rigorous psychotherapy trials, which face the same limitation.[25] The impossibility of pharmacological blinding does not necessarily invalidate the evidence; it means that effect size estimates may incorporate expectancy effects to a degree that cannot be fully disaggregated.[12,26] Additional limitations include small sample sizes in early trials, short follow-up periods relative to the chronicity of the target conditions, underrepresentation of racially and socioeconomically diverse populations, and the exclusion of populations with significant medical comorbidities, traumatic brain injury, or complex polypharmacy — characteristics that are common in veterans with combat-related mental health conditions.[27,28] These gaps mark areas of uncertainty that ongoing and forthcoming trials are designed to address, while the overall signal in the existing evidence base remains consistent.

Ketamine occupies a distinct position in this landscape. Unlike the Schedule I drugs psilocybin and MDMA, ketamine is a FDA-approved anesthetic with an established record of off-label clinical use for treatment-resistant depression and suicidal ideation, with effects observed within a day of administration, albeit with limited durability.[29,30] Intravenous ketamine and the intranasal esketamine formulation (Spravato) are used in clinical practice, including at VA facilities, for depression refractory to other interventions. For PTSD specifically, a multi-site randomized clinical trial in veterans and active duty service members found that ketamine did not significantly outperform control in reducing PTSD symptom severity.[31] While ketamine administration is commonly delivered in a medical context and without specific psychological support, many private practice sites, including in the Commonwealth, offer it as a form of psychedelic-assisted therapy.[32] Despite growing interest in this modality, including a KAP program in development at MGH, rigorous trial data are lacking regarding the efficacy of KAP and its distinction from standard medical administration. Finally, ibogaine, which will be discussed later in this report, is available outside of the United States in certain countries, but currently, clinical trial evidence to support its use is lacking.[33]

The regulatory context for MDMA warrants direct acknowledgment. In June 2024, an FDA advisory committee reviewed the MDMA-assisted therapy application and voted against approval, citing concerns about functional unblinding, the inability to disentangle the effects of MDMA from the accompanying psychotherapy, and limitations in durability and generalizability of the findings.[34] Functional unblinding refers to the likelihood that participants and investigators can infer treatment assignment based on the noticeable subjective effects of the drug, which can introduce expectation bias and complicate interpretation of outcomes. In August 2024, the FDA issued a Complete Response Letter declining approval, concluding that the application did not provide substantial evidence of effectiveness or adequately establish safety.[35] The agency identified deficiencies in the reliability of the safety data, insufficient evidence of durability, and trial design features that limited interpretability, including selection bias and expectation effects. MDMA-assisted therapy therefore remains without an approved indication in the United States and is currently limited to research settings. At the same time, several psychedelic agents are approaching New Drug Application submission, and FDA approval of one or more compounds within the near term is plausible, pending regulatory evaluation.

B. Conceptual and Definitional Ambiguities

The Working Group's discussions reflected the broader division within the field between drug-centered and drug-assisted paradigms, which is a central division within contemporary psychedelic research; this distinction underlies many of the conceptual and practical ambiguities in the field. A persistent difficulty in evaluating these treatments is the lack of agreement on what, precisely, they are. In one framing, they are treated as primarily pharmacologic interventions, with the therapeutic context reduced to a minimal role of monitoring and safety oversight, analogous to a technician ensuring appropriate administration.[36] In another, more widely held among groups with sustained clinical and research experience, these treatments are understood as experiential and psychotherapeutic processes in which the drug serves to facilitate a structured engagement with emotion, memory, and meaning, requiring preparation, guidance, and integration by skilled clinicians.[37] A related divergence concerns the status of the subjective effects themselves. In some accounts, these effects are regarded as liabilities to be attenuated through pharmacologic refinement.[38] In others, they are understood as the principal mechanism through which therapeutic change occurs.[39] This tension between pharmacologic reductionism and experiential engagement has concrete consequences for trial design, therapist training, reimbursement models, and regulatory

frameworks, and it continues to shape how findings are generated, interpreted, and compared across studies.

The weight of evidence increasingly supports the view that the subjective effects of classical psychedelics are not incidental to their therapeutic impact but are central to it. In a series of foundational studies, Griffiths and colleagues showed that psilocybin reliably produced experiences of unusual intensity and personal significance, and that the depth of those experiences predicted clinical outcomes at follow-up.[40,41] Participants frequently rated these sessions among the most meaningful experiences of their lives, a finding replicated across sites and populations. The implication is not merely descriptive: if therapeutic change is mediated in part by the quality and depth of the experience, then approaches that constrain or dilute that experience through a minimally supportive context may predictably weaken outcomes.[42] This does not resolve the drug-centered versus drug-assisted distinction, but it establishes that it has empirical consequences. Current expert consensus reflects this, generally treating the experiential dimension as therapeutically relevant and in need of support rather than suppression, pending further clarification of mechanism.[39] A single therapeutic model is unlikely to be optimal across the range of psychedelic compounds, given their pharmacologic and experiential differences.

C. Standards, Guidelines, and Workforce Preparation

The Working Group devoted substantial attention to questions of standards, training, and workforce preparation, recognizing these as central to the safe and effective implementation of psychedelic-assisted therapies. There are currently no uniform practice standards, accrediting bodies, or widely accepted training curricula in the United States. Instead, a heterogeneous landscape has emerged, ranging from academic programs to commercially marketed certificates with minimal oversight. This variability reflects not only a lack of coordination but a deeper absence of consensus about the nature of these treatments and the competencies required to deliver them.

Surveys indicate that many mental health professionals express interest in psychedelic therapy but report being underprepared to provide it, and that existing educational opportunities remain limited.[37,43] Clinical trials have been conducted in small, highly selected samples under fixed protocols with intensive monitoring; real-world care will need to serve more heterogeneous populations with comorbidities, coordinate across disciplines, and individualize treatment in ways that current evidence does not fully guide. As these treatments move toward broader availability, this gap between trial conditions and clinical practice represents a central implementation challenge.

This gap raises a key unresolved question: the distinction between the minimum level of support required to ensure safety during administration and the therapeutic model associated with optimal clinical outcomes. These are not equivalent. Ensuring physical safety during a dosing session is a lower threshold than the preparation, relational engagement, and integration processes that appear to contribute to therapeutic benefit. The appropriate level of support may vary by compound and context. Shorter-acting interventions may primarily require monitoring for safety, whereas longer-duration or multi-session approaches appear more dependent on the quality of the therapeutic frame. How far support can be reduced before safety or efficacy is compromised remains uncertain, in part because trial designs have emphasized isolating pharmacologic effects, leaving the contribution of the therapeutic context less well characterized. The effectiveness of any state-level access pathway will depend in part on establishing clear clinical, ethical, and operational standards in advance of implementation. In the absence of appropriate oversight—such as an independent commission or expert advisory body—there is a risk that access models could be shaped by commercial or non-clinical interests rather than by best practices in patient care.

The workforce challenge is substantial. Psychedelic therapy is inherently multi-professional, requiring medical oversight for screening and drug administration, psychotherapeutic expertise for

preparation and integration, and in many models, paired staffing during dosing sessions. Existing training programs have not been systematically evaluated for their impact on outcomes, and few jurisdictions have established formal credentialing pathways. The absence of clear scope-of-practice standards, including the role of non-licensed facilitators, remains an active policy question. At the same time, different models of care carry different resource requirements, and there may be pressure—particularly in for-profit or commercially-driven healthcare settings—to adopt lower-intensity approaches. These uncertainties are compounded by the fact that clinical trials have excluded individuals with common comorbidities, including cardiovascular disease, histories of mania or psychosis, and significant polypharmacy, all of which are prevalent among veterans. Standards for managing these populations in practice remain largely undefined and represent a priority as access expands.

D. Risk and Safety

Risk and safety were a central focus of the Working Group's discussions, including the implications of greater medical complexity in veteran populations for clinical risk assessment. The following summarizes the current evidence base considered by the group. Classical psychedelics, including psilocybin and LSD, are generally well tolerated at standard doses in appropriately selected patients, producing transient increases in heart rate, blood pressure, and respiratory rate that are typically mild and resolve without intervention as drug effects subside.[44] In controlled clinical settings, they have demonstrated a favorable safety profile, with adverse events usually mild to moderate and serious events rare.[44] They are not associated with physiological dependence and have low misuse potential relative to other psychoactive drug classes, though abuse can occur. The cardiovascular safety profile at standard doses in healthy, screened individuals is well established; rare serious cardiac events have been reported, primarily in recreational contexts involving high doses or drug combinations.[45] Safety in individuals with underlying cardiovascular disease remains largely uncharacterized.

The more common clinically significant risks are psychological. Acute anxiety, panic, and distress during dosing are the most common adverse effects and are usually manageable with support, while more serious reactions, including transient psychotic or dissociative states, are rare in screened populations. Clinical trials have excluded individuals with a personal or family history of psychotic illness or bipolar I disorder. Observational data have not shown a consistent link between psychedelic use and increased psychotic symptoms after accounting for other factors.[46–48] Risk appears to vary by individual: people with bipolar disorder or a tendency toward mania may experience worsening symptoms, whereas findings in those with other forms of vulnerability to psychosis are mixed and do not consistently show harm.[46] As access expands beyond carefully screened populations, careful attention to risk, particularly related to bipolar-spectrum illness, will be important. Hallucinogen persisting perception disorder (HPPD) involves the recurrence of perceptual disturbances after the acute effects of a psychedelic have resolved. It appears to be extremely rare in clinical trials, and its causes and clinical significance remain poorly understood.[49]

MDMA, as a stimulant and entactogen, has a more pronounced cardiovascular profile than classical psychedelics, with expected increases in heart rate, blood pressure, and temperature. Observational data from chronic recreational use raise concerns about potential effects on heart valves with chronic use, although the relevance of these findings to limited therapeutic dosing remains uncertain.[50] Ketamine's risk profile differs. Dissociative effects are more pronounced at higher doses, and repeated use carries risk of psychological dependence and tolerance, requiring careful clinical management.

Ibogaine warrants separate consideration given its distinct safety profile. Unlike classical psychedelics, it carries a meaningful risk of dangerous heart rhythm disturbances, which in rare cases

can be fatal.[51] Approximately three dozen ibogaine-associated deaths have been reported over the past three decades, occurring primarily in uncontrolled or medically unsupervised settings and often involving identifiable risk factors such as high doses, use of other substances, electrolyte abnormalities, pre-existing heart disease, and lack of monitoring.[52] Available evidence suggests that risk may be reduced with careful medical screening and monitoring, although these data are limited and not derived from randomized trials. At the same time, evidence for therapeutic benefit—primarily in substance use disorders and in small studies in veterans with traumatic brain injury—remains limited to naturalistic or uncontrolled studies.[33] Both its risks and potential benefits therefore remain incompletely characterized.

The distinction between clinical and recreational contexts is central to interpreting psychedelic risk. Risks in unregulated settings—unknown dosage, adulteration, lack of screening, and absence of support—are substantially higher than in controlled environments, and most serious adverse events in the literature arise from recreational use. At the same time, recreational data illustrate the range of possible experiences. In a survey of 1,993 individuals describing their most challenging psilocybin experience, 39 percent rated it among the five most difficult of their lives, with some reporting lasting psychological distress. At the population level, US poison control center contacts for psilocybin exposures increased approximately three-fold between 2013 and 2022, largely after 2019, paralleling increased availability.[53] Most cases did not result in serious medical outcomes, but the trend remains a relevant public health signal as access expands through decriminalization and regulated adult-use frameworks.

Clinical safety in psychedelic-assisted therapy depends not only on substance effects and patient selection, but on the structure of care delivery. The clinical trial evidence summarized above reflects models that include careful screening, structured preparation, continuous support during dosing, post-session integration, and, importantly, direct involvement in trial design, therapist training, and personnel support throughout. As access expands beyond research settings, variation in how these elements are implemented may become an important determinant of risk. Models that reduce or omit these components, particularly in the interest of scalability or cost, may increase the likelihood of adverse psychological outcomes and limit the capacity to manage them effectively. For this reason, involvement of experts in mental health, psychedelic research, and other related fields—who, equally importantly, are free of commercial conflicts of interest—will be key to ensuring that standards governing preparation, therapeutic support, and follow-up care are central to safety, rather than ancillary considerations.

E. Evidence Standards and Policy Judgment

At times, debates within the Working Group surfaced around the limits of evidence. The question is not only what constitutes "evidence," but what decisions that evidence is meant to inform. The FDA standard—demonstration of safety and efficacy in controlled trials for a defined indication—remains the appropriate benchmark for marketing approval. The decisions before a state are often different in scope. They may include whether to authorize or regulate access, establish clinical frameworks, support research, or implement pilot programs. These determinations draw on a broader evidentiary base, including clinical trials, observational data, historical experience, and public health considerations, with appropriate attention to the relative strength and limitations of each.

Accordingly, the relevant question is not whether a compound meets the FDA standard for approval, but whether the totality of available evidence is sufficient to support a given policy action. In some cases, this may justify a limited, closely monitored program; in others, it may inform regulatory, educational, or research-oriented initiatives. Such actions do not substitute for the federal approval process or resolve questions of efficacy at the level required for marketing authorization.

They operate alongside it, within a distinct policy domain that requires judgment under conditions of incomplete but evolving evidence.

II. Access and Implementation

Evidence of clinical benefit is necessary but not sufficient to ensure patient access. Psychedelic-assisted therapy presents a distinct implementation profile: it is resource-intensive, legally complex at the federal level, often not reimbursed by insurance, and dependent on a workforce that does not yet exist at scale. These barriers operate independently and compound. Addressing them will require engagement with payment systems, licensing frameworks, and the experience of jurisdictions that have moved further than Massachusetts toward regulated provision. This section examines each domain in turn.

A. Insurance and Reimbursement

Psychedelic-assisted therapy in the United States is, with limited exceptions, a cash-pay treatment. Psilocybin and MDMA remain Schedule I controlled substances under federal law, with no established pathway for insurance coverage. Ketamine-assisted psychotherapy is available in the Commonwealth, but is largely confined to private practice settings that are financially inaccessible for many patients. Prospects for MDMA-assisted therapy coverage were delayed by the FDA's August 2024 rejection of the Lykos Therapeutics application, though several psychedelic agents are in late-stage clinical development. In the near term, access remains limited to those able to self-fund, while many patients who might otherwise be candidates for these treatments, including veterans with treatment-resistant conditions, remain outside routine coverage pathways.

Ketamine provides the clearest illustration of both the possibilities and the limits of the current reimbursement environment. Racemic intravenous ketamine is used off-label for treatment-resistant depression and acute suicidal ideation in a growing number of clinical settings, including within the Veterans Affairs healthcare system. By contrast, esketamine (Spravato), the intranasal formulation approved by the FDA in 2019 and subsequently for monotherapy in 2025, has an established coverage pathway and is reimbursed by Medicare, Medicaid, and many commercial plans when administered in a certified healthcare setting. This contrast reflects a structural feature of US reimbursement policy: FDA approval confers a coverage pathway that off-label use does not, regardless of comparative evidence. At the same time, it demonstrates that coverage for administered psychoactive treatments can be established once the regulatory predicate exists. The Spravato model relies on a Risk Evaluation and Mitigation Strategy (REMS) governing administration, monitoring, and dispensing—a framework with precedents in other high-risk medications and one that may inform coverage pathways as other psychedelic therapies approach regulatory approval.

The VA's experience with ketamine provides the most directly relevant domestic precedent for veteran populations. In 2025, the VA established both national protocol guidance for IV ketamine in treatment-resistant depression and severe suicidal ideation and a parallel coverage framework allowing its use under defined clinical criteria.[54] Together, these steps represent meaningful institutional movement toward integration of a novel treatment modality, while leaving implementation to individual sites. In practice, access remains uneven and dependent on local capacity and clinical leadership.

The Working Group discussed the challenges of delivering high-quality psychedelic-assisted therapy in appropriate clinical settings under current reimbursement constraints. A useful structural parallel arises in the case of anti-amyloid biologics for Alzheimer's disease, where the primary challenge is not only the price of the drug but the need to support an associated care delivery

system, including infusion capacity, specialist oversight, safety monitoring, and follow-up. Psychedelic-assisted therapy presents a comparable problem: medication costs may be modest, while the personnel and time required for preparation, dosing, and integration are substantial and do not align easily with existing billing models.

The billing infrastructure for psychedelic-assisted therapy is in early but concrete development. Fee-for-service reimbursement is poorly suited to the treatment model, as no existing Category I CPT code captures an extended dosing session requiring continuous in-person monitoring by qualified clinical staff. In June 2023, the American Medical Association's CPT Editorial Panel established three Category III CPT codes (0820T, 0821T, 0822T) for continuous in-person monitoring and intervention during psychedelic medication therapy, effective January 1, 2024.[55] These codes describe psychological and clinical support provided by qualified healthcare professionals and support staff in a monitored setting. Category III codes do not confer coverage, but they enable standardized documentation and data collection, forming an early step in the progression toward broader reimbursement. Their use by early-adopting providers will be important in generating the utilization data required for future coverage determinations.

Over the longer term, bundled payment models, in which a single negotiated payment covers a full course of treatment, may offer a more coherent reimbursement structure than fee-for-service billing. Massachusetts has experience with such models through its Alternative Payment Contract frameworks and ongoing behavioral health payment reforms, which in some settings operate under total cost of care arrangements. These models can allow interventions with higher upfront costs to be supported when they reduce downstream utilization, though their applicability to novel, resource-intensive treatments remains to be established. In this context, potential downstream effects, such as reductions in psychiatric hospitalization or other high-cost services, become relevant to reimbursement decisions even when not directly captured within existing billing structures.

The Group Insurance Commission and MassHealth likely will be central to any access strategy in Massachusetts, both because veterans are enrolled in these programs and because state payer decisions often shape broader market adoption. At the same time, coverage within the VA follows a distinct pathway, with separate formulary and policy processes. Developing models that can function across both civilian and VA systems, with their differing administrative and legal structures, represents a central operational challenge for implementation.

B. Models of Care and Delivery

There is no single established model of care for psychedelic-assisted therapy. Current approaches vary in structure, intensity, and setting, with implications for workforce, cost, and scalability. Most protocols share a common arc consisting of preparatory sessions prior to dosing, a guided dosing session, and integration sessions afterward, in which patients work through and consolidate the experience in a therapeutic context. Individual, clinic-based delivery remains the predominant model in both clinical trials and current practice; this model is resource-intensive, typically involving multiple preparatory and integration visits and continuous in-person support during dosing, often with two facilitators present. It has the strongest evidentiary base to date but presents clear challenges for scalability.

Group delivery formats represent a meaningful opportunity to improve resource efficiency without necessarily compromising outcomes. Group preparation and integration are already incorporated into some clinical trial protocols and community-based programs, and group dosing has been piloted for both psilocybin and MDMA. Outside the United States, group and cohort-based formats are common in a number of psychedelic treatment settings, reflecting both cultural practice and resource constraints. In the United States, further development of group models is underway, including a recently funded study of group MDMA-assisted therapy in veteran

populations at Massachusetts General Hospital. Early protocol development and real-world evidence suggest that these models are feasible and may allow substantially greater throughput while preserving key therapeutic elements.[56,57] Work within the VA system and affiliated programs has similarly explored higher-capacity group formats with reduced per-patient staffing requirements.[25] Whether group dosing is non-inferior to individual delivery remains an open question, but existing evidence supports continued development of group-based approaches as a potential pathway to scalable provision. For veteran populations, shared experience within group settings may confer additional therapeutic value, as discussed further in Section III.

Clinic-based delivery, in which a dedicated setting provides the full treatment arc, remains the dominant operational model. Integration into broader behavioral health systems—such as primary care behavioral health, collaborative care, or intensive outpatient programs—remains largely prospective but is likely to be important for long-term scalability. The VA system, with its established behavioral health infrastructure, presents both opportunities and constraints: the capacity to support multi-session care models exists, but formulary, credentialing, and administrative structures may limit rapid adaptation to novel treatment paradigms.

C. Licensure, Regulation, and the Massachusetts Legal Context

The legal landscape for psychedelic therapy in Massachusetts is currently defined primarily by federal law. Psilocybin and MDMA remain Schedule I controlled substances, with all associated restrictions on prescribing, possession, and administration. Clinical use is available only within FDA-authorized research settings, namely, clinical trials, Expanded Access programs, compassionate use authorization, and in the case of ketamine, through off-label prescribing under the physician's professional authority. No Massachusetts statute currently authorizes psychedelic therapy provision outside of federally approved research frameworks for psilocybin or MDMA. The Commonwealth's legislature is separately reviewing several proposals that would change this; this report is intended to inform that review.

Several states have acted ahead of federal law to create regulated access frameworks. Oregon's Measure 109, passed in 2020 and implemented beginning in 2023, created a licensed services model for psilocybin that does not require a clinical diagnosis: participants access psilocybin services in licensed facilities facilitated by licensed psilocybin service providers. The Oregon Health Authority has developed a regulatory structure that governs facility licensing, facilitator training and licensing, product testing, and session protocols. Colorado's Proposition 122, passed in 2022, established a natural medicine program with a broader scope that includes psilocybin, psilocin, dimethyltryptamine (DMT), ibogaine, and mescaline, and created a similar regulated service model. Both frameworks are operational, accumulating real-world experience with oversight, safety monitoring, access equity, and integration of service providers with clinical systems. New Mexico is expected to follow soon, with the recent passage into law of the Medical Psilocybin Act of 2025, which establishes a medical program administered through the state's health system. These models differ in structure, with Oregon operating as a public health service model outside of conventional medical care and Colorado and New Mexico moving toward more clinically integrated approaches, but all provide emerging experience with regulation, safety monitoring, and access that is relevant to the development of clinical frameworks in Massachusetts.

International models extend the evidentiary landscape further. Jamaica and the Netherlands have long permitted psilocybin retreat programs operating outside the Schedule I restrictions that apply in the United States, and these settings have treated substantial numbers of participants, including many US veterans, with safety records that inform risk assessment in nonclinical contexts. Mexico has become a destination for ibogaine-assisted treatment, primarily for opioid use disorder but with a substantial veteran population, operating under Mexican law in clinical settings not

subject to US federal scheduling. Australia has taken a different approach, with the Therapeutic Goods Administration allowing authorized psychiatrists to prescribe psilocybin for treatment resistant depression and MDMA for posttraumatic stress disorder within a regulated medical framework, since 2023. The Czech Republic has also moved toward a clinical model, with legislation passed in 2025 permitting psilocybin for depression.

A related concern raised by members of the Working Group is that early-stage state programs, particularly those that limit the number of authorized sites or create concentrated points of access, may generate strong incentives that shape how care is delivered in practice. In capacity-limited models, licensure can confer substantial strategic and financial advantage, which may in turn create pressure to prioritize scalability, throughput, and cost containment. Absent clear safeguards, these pressures risk favoring lower-intensity service models that omit core clinical elements, particularly preparation and integration, which are central to both safety and therapeutic effect. Members noted that other states have taken more extended and resourced approaches to these questions. Maryland and Minnesota have each undertaken multi-year task force processes to develop recommendations for psychedelic policy, and New Mexico is implementing a medical psilocybin program following substantial deliberation among clinical experts, regulators, and stakeholders. These efforts reflect the complexity of designing safe and effective access pathways and underscore the importance of sustained expert input.

For this reason, the development of any state-level program would benefit from governance structures that are both independent and substantively expert-driven. Advisory input alone may be insufficient; effective oversight requires a body with recognized clinical, research, and ethical expertise in psychedelic-assisted therapy, and with defined authority over standards of care, credentialing, site approval, and outcome monitoring. Such structures would help ensure that program design is guided by clinical considerations rather than by operational or financial incentives, particularly in early implementation phases where the long-term direction of care models is likely to be set. These considerations extend beyond veteran-specific programming and apply to the broader design of any state-regulated access framework.

D. Equity, Access, and the Risk of a Two-Tiered System or Insufficient Psychological Support/Therapy

The Working Group discussed the likelihood that, absent deliberate policy intervention, access to psychedelic-assisted therapy in the United States will remain highly stratified. Current pathways—self-pay clinical services, medical tourism, and retreat-based contexts—are accessible primarily to those with financial means and the ability to navigate them. Veterans seeking treatments such as psilocybin or ibogaine currently face substantial out-of-pocket costs, often in the range of several thousand to tens of thousands of dollars, with no insurance coverage and limited veteran-specific financial support. Nonprofit programs, including Veterans Exploring Treatment Solutions (VETS), the SEAL Future Foundation, and other veteran-focused initiatives, have supported access for a modest number of veterans, primarily in international settings. These programs address a real need and have reported meaningful outcomes, but operate at a scale far below the level of unmet demand.

Avoiding the emergence of a durable two-tiered system will require explicit design choices. Payment models that rely on out-of-pocket costs restrict access to higher-income patients. Facility models concentrated in high-cost urban centers limit geographic reach. Workforce requirements that rely exclusively on highly credentialed clinicians constrain supply and increase cost. None of these outcomes is inevitable, but each reflects policy decisions about how treatment is structured and delivered. A further dimension of this risk is that differences may emerge not only in who can access care, but in the nature of care delivered. Psychedelic-assisted therapy depends on structured preparation, support during the experience, and integration afterward. Models that reduce these

elements in the interest of cost or scalability may expand nominal access while offering a substantively different intervention from those studied in clinical settings. This raises the possibility of a two-tiered system not only in access, but in the quality and therapeutic depth of care available.

States that have moved toward regulated access have begun to address these issues through requirements to assess geographic and demographic disparities and to develop affordability frameworks, and through stakeholder input prior to implementation (via extensive state psychedelic task forces in Maryland, Minnesota, and Hawaii, and, in New Mexico, the Medical Psilocybin Program's Psilocybin Advisory Board and related committees). Massachusetts has experience with similar approaches in behavioral health policy that may be brought to bear in this context.

For veterans, the most direct pathway to broad and equitable access would be through the VA system, but this depends on federal action. Expansion of access will require changes to VA formulary policy, adjustments to federal scheduling that permit treatment outside research protocols, or dedicated appropriations for veteran-focused programs. The VA is currently conducting clinical trials of MDMA and psilocybin, but infrastructure for routine clinical delivery remains early. The pace of federal progress will shape the trajectory of VA-based access, while any state-level framework will need to operate alongside and, where possible, align with that system.

III. Veterans and the Veterans Community

The clinical evidence for psychedelic-assisted therapy exists within a broader social context. How treatments reach patients, and which patients they reach, depends in part on how mental illness is understood, the stigma attached to specific treatments, the informal networks through which people learn about and access care, and the degree to which institutional systems are trusted. In the veteran population, these factors take a distinct form. Any provision model intended to function in practice must account for that context.

A. Mental Health in the Veteran Population: Scale and Persistent Gaps

Massachusetts is home to approximately 274,000 veterans, the majority residing in the greater Boston metropolitan area. In recent years, however, veterans have been relocating in increasing numbers to more affordable regions in central and western Massachusetts, the South Shore, and Cape Cod, where service infrastructure has not kept pace with population distribution.[58] A 2025 assessment conducted by the RAND corporation found that veterans outside Boston face longer travel times to specialty care, thinner provider networks, and greater reliance on informal peer networks to navigate available services.[58] This geographic mismatch bears directly on psychedelic therapy provision: a model concentrated in Boston, as any initial rollout is likely to be, will have limited reach in more rural counties such as Berkshire, Hampden, Franklin, and Bristol, where veteran suicide rates are often highest.[59]

The mental health burden in this population is not captured by any single measure, but several figures are illustrative. Among OIF/OEF veterans, 15 percent meet criteria for PTSD in a given year and 29 percent over their lifetime, rates higher than those observed in earlier veteran cohorts and in the general population.[60] Among veterans receiving VA care, prevalence is higher still: in fiscal year 2024, 14 percent of male and 24 percent of female veterans carried a PTSD diagnosis.[60] In Massachusetts, a large nonprofit provider reported that 60 percent of veterans in its PTSD-focused programming had co-occurring substance use disorders.[58] While not a national estimate, this figure reflects the clinical complexity of treatment-seeking in the state.

Suicide data for Massachusetts veterans follow the national pattern but with local specificity. In 2023, 62 Massachusetts veterans died by suicide.[61] The veteran suicide rate, at 22.5 per 100,000, was substantially higher than the general population rate of 11.5 per 100,000, though lower than the

national veteran rate of 35.2, consistent with Massachusetts's lower baseline suicide mortality. Method patterns are notable: 39 percent of veteran suicides involved firearms, compared with 22 percent of suicides in the general Massachusetts population, reflecting both higher firearm ownership among veterans and the greater lethality associated with firearm use.

Over the five-year period from 2018 to 2022, 327 current military personnel and veterans died by suicide in Massachusetts, a rate 1.7 times higher than that of civilians, with the highest rates concentrated in more rural counties despite lower absolute numbers.[59] Among these decedents, 56 percent had a current mental health diagnosis and 39 percent were in active treatment at the time of death. More than a third of veteran suicide decedents in Massachusetts were receiving mental health care when they died: being in the system was not enough.

The 2025 RAND assessment identified a related problem: a lack of comprehensive, integrated mental health and substance use treatment options, with provider shortages contributing to longer wait times across government, nonprofit, and private systems.[58] The VA Boston Healthcare System, which serves more than 65,000 veterans across eight locations, conducts nearly one million outpatient visits annually, and hosts the largest VA research program in the country, including two divisions of the National Center for PTSD, is a nationally significant institution. It is, however, one part of a statewide system with documented gaps, particularly in co-occurring disorder treatment and in communities distant from its primary campuses in Jamaica Plain, West Roxbury, and Brockton.[58]

These gaps form the context for considering psychedelic-assisted therapy in Massachusetts policy. The question is not whether the Commonwealth faces a veteran mental health burden, but whether the current set of treatments is adequate to address it. The persistence of elevated suicide rates despite two decades of increased VA investment, the prevalence of treatment-refractory PTSD, and the high rates of co-occurring substance use disorders that complicate response to standard interventions all point in the same direction. Psychedelic-assisted therapy is not a comprehensive solution, but the evidence reviewed in Section I suggests it may benefit a meaningful subset of patients for whom existing treatments have not been effective.

B. Attitudes Toward Mental Health, Substance Use, and Psychedelics in the Veteran Community

Any account of veterans' attitudes toward psychedelic therapy must begin with what is actually known—which is less than public discourse suggests. Much of the conversation has been shaped by advocates, enthusiasts, and veterans who sought treatment, found it beneficial, and were willing to speak publicly about it. This is a self-selected group. Their visibility reflects real demand for alternatives to existing treatments, but it does not represent the distribution of opinion across the broader veteran population. This point was raised within the Working Group and warrants emphasis: provision models and communication strategies that assume a uniformly receptive veteran community are unlikely to reflect reality.

Available evidence indicates that veterans hold complex and sometimes contradictory attitudes toward mental health care. Military culture has long emphasized self-sufficiency and emotional control, norms that often persist after separation and may be reinforced by perceived or actual professional and social consequences of seeking care. Across studies, a consistent gap emerges between perceived need and treatment engagement, finding that many service members who screen positive for mental health conditions did not initiate care despite recognizing symptoms. VA and survey data from post-9/11 veterans similarly identify stigma—concerns about being seen as weak or treated differently—as a leading barrier, alongside structural factors such as access and logistics.[62] Earlier findings in returning Iraq veterans show a similar pattern, with stigma-related

concerns outweighing more practical barriers.[63] Across this literature, stigma is not peripheral to the treatment gap but one of its defining features.

The 2017 RAND survey of Massachusetts veterans found that post-9/11 veterans and current National Guard and Reserve members reported the highest rates of behavioral health problems, with 35 percent screening positive for PTSD, 24 percent for depression, and 42 percent reporting binge drinking, alongside the greatest unmet need for employment and other services.[64] These veterans were also the most financially precarious, with 24 percent reporting difficulty covering basic expenses. The 2025 assessment confirmed that health care resources remain concentrated in the Boston metropolitan area, and that veterans relocating to more affordable regions encounter sparser service infrastructure and routinely travel 45 to 90 minutes for specialty care.[58] Access to psychedelic therapies will depend on whether covered, regulated pathways exist within Massachusetts; they will not be reached by provision models designed around a well-resourced, treatment-seeking minority.

Attitudes toward substance use further complicate the picture. Military culture is not uniformly opposed to intoxicant use. Alcohol use is widely normalized within many military and veteran communities and, in some cohorts, exceeds civilian patterns, including higher rates of binge drinking.[65] At the same time, attitudes are shaped by a clear distinction between sanctioned and unsanctioned use. Illicit drug use is subject to criminal and administrative penalties during active duty, and zero tolerance drug testing policies influence perceptions that often persist after separation. As a result, psychedelics are frequently understood within the category of illicit drugs regardless of their pharmacology or therapeutic context. Clinical terminology does not necessarily override that framing; the distinction between psilocybin and "mushrooms" is not uniformly meaningful. The idea of these substances as medically supervised, structured interventions is therefore not self-evident for many veterans.

At the same time, there is genuine interest in psychedelic therapy within segments of the veteran community, and it has a specific character. For some veterans, particularly those who have exhausted available treatments without adequate relief, psychedelic therapy is understood as a different kind of intervention, one that engages meaning and the subjective dimensions of trauma in ways that do not resemble standard pharmacotherapy or manualized psychotherapy. Accounts from veterans who have sought treatment through nonprofit programs often emphasize this distinction. The appeal is not only symptom reduction, but the sense that the treatment reached aspects of their experience that prior care had not. This is clinically relevant. It points to a gap in the current treatment portfolio and helps explain why demand has developed outside institutional frameworks and in spite of legal and financial barriers.

The realistic picture, then, is a veteran community with high rates of mental health need, complex and variable attitudes toward treatment and substance use, a meaningful segment with firsthand experience of or genuine interest in psychedelic therapy, and a larger segment for whom these treatments remain unfamiliar or associated with stigma. Provision models and communication strategies will need to account for such heterogeneity.

C. How Veterans Currently Encounter Psychedelic Therapy

In the absence of federally approved, routinely available psychedelic-assisted therapy, veterans have developed alternative pathways to access these treatments. The existence of organized, informal access reflects two realities: unmet clinical need and veteran-driven efforts to address it outside institutional systems. It also reflects risk. The settings in which veterans access these treatments vary widely in clinical rigor, screening practices, and capacity to manage adverse events.

The nonprofit sector has emerged as the primary organized pathway. Organizations including Veterans Exploring Treatment Solutions (VETS), the Heroic Hearts Project, and the

Mission Within have, over the past decade, supported veterans in traveling to Mexico and other international sites to receive ibogaine and 5-MeO-DMT, typically for PTSD and alcohol use disorder. These programs often provide preparation and post-treatment integration support, loosely mirroring the structure of clinical trial protocols. Observational studies of Special Operations Forces veterans treated through these pathways have reported reductions in PTSD symptoms and alcohol use, with generally favorable safety profiles in screened populations.[33,66] These findings are not controlled clinical evidence, and the selection effects are substantial: participants are motivated, screened, and supported in ways that differ from the broader veteran population. At the same time, the consistency of findings across multiple datasets in populations with significant comorbidity and prior treatment failure adds to the evidentiary context.

Medical tourism represents a second pathway, largely limited to veterans with financial resources. Ibogaine treatment in Mexico and psilocybin retreats in Jamaica or the Netherlands typically cost several thousand dollars per course, with little veteran-specific financial assistance outside a small number of nonprofit-supported placements. This cost barrier produces a pronounced selection effect, concentrating access among veterans with greater financial means, mobility, and access to information networks. In the absence of formal regulation, veterans rely heavily on peer recommendations to navigate these options, a form of informal quality assurance that functions unevenly and may not reach those who are more isolated.

Ketamine is the primary psychedelic-adjacent therapy currently available through formal medical channels. VA Boston, consistent with national VA policy, has expanded access to both esketamine (Spravato) and intravenous racemic ketamine for treatment-resistant depression. The evidence for ketamine's antidepressant and anti-suicidal effects is reviewed in Section I; its relevance for a population with elevated suicide risk is substantial. At Massachusetts General Hospital, a ketamine-assisted psychotherapy program is in development, with planned collaboration with the Home Base clinic for veterans. More broadly, ketamine has established a precedent within VA Boston for the clinical use of an altered-state-inducing intervention. The associated safety protocols, staffing models, and treatment setting requirements constitute institutional infrastructure that may be partially adaptable as other psychedelic therapies become available.

Underground facilitation, meaning psychedelic sessions conducted outside organized programs and often led by individuals without clinical credentials, is also present within the veteran community, though its prevalence is difficult to estimate. This pathway carries the greatest risk. Medical screening is inconsistent, the setting and level of support vary widely, and capacity to manage adverse events is limited. No policy will eliminate this entirely, but the availability of safe, regulated, clinically supervised alternatives is likely to reduce reliance on it by providing a legitimate option for veterans who would otherwise seek treatment outside formal systems.

D. The Role of Peer Networks and Community Strengths

Structural features of the veteran community have direct implications for how psychedelic therapy should be delivered. Veterans maintain strong informal peer networks that cut across geography, branch, and era of service. These networks function as channels for information, sources of social support, and pathways into care. Their influence on treatment engagement is well established. Veteran peer support specialists are already a recognized workforce within the VA, and the 2017 RAND assessment of Massachusetts veterans identified strengthening veteran-to-veteran connections as a core recommendation, based on participant reports that they valued engagement with others who had faced similar challenges.[64]

In the context of psychedelic therapy, peer networks have played an outsized role precisely because formal pathways have been limited. Veterans often learn about treatments such as ibogaine through other veterans, select programs based on those recommendations, and interpret their

experiences in peer conversation.[33] This reflects a broader feature of military culture in which shared experience carries particular weight and trust flows toward those with similar backgrounds.

The therapeutic implications follow. When preparation and integration are central to outcome, peer structures are not ancillary but can function as part of the treatment process. Veterans are more likely to disclose, engage, and sustain participation when working alongside others with shared experience, and peer relationships can support initiation, adherence, and maintenance of care.[67,68] This aligns with broader evidence that group cohesion and therapeutic alliance contribute to outcomes in trauma treatment.[69] Existing programs already reflect this approach. The Home Base Intensive Clinical Program, for example, combines individual therapy with group-based treatment and embedded peer support to leverage shared experience and improve engagement.[70]

Any provision model for Massachusetts should engage directly with the veteran peer support infrastructure that already exists. Home Base, a partnership between Massachusetts General Hospital and the Boston Red Sox Foundation, is a prominent example, but it operates within a broader ecosystem. Local Veterans Service Officers, identified in the 2025 RAND assessment as frequent first points of contact for veterans navigating care, and collaborative networks such as the Greater Boston Veterans Collaborative, function as trusted intermediaries.[58] Designing psychedelic therapy provision to leverage these networks, rather than treating them as downstream communication channels, is likely to improve both access and durability of outcomes.

E. Stigma, Cultural Shift, and Media Representation

The Working Group discussed the gap between the public narrative around veterans and psychedelics and the more varied distribution of attitudes within the veteran population. The public discourse about veterans and psychedelics has accelerated substantially over the past five years. Documentary films including *In Waves and War*, *From Shock to Awe*, and *The Fight of a Lifetime* have brought individual veteran accounts to wide audiences, as has coverage on *60 Minutes* and *PBS NewsHour*. In Congress, members including United States Representatives Dan Crenshaw, Jack Bergman, Alexandra Ocasio-Cortez, Morgan Luttrell, and Sen. Cory Booker, have been vocal advocates, lending the issue bipartisan legislative momentum. The April 2026 federal executive order represents the most significant federal signal to date. Collectively, this advocacy has produced a narrative in which veterans are among the most compelling and visible cases for these treatments.

That narrative is not wrong, but it is incomplete. Veterans represented in this discourse are overwhelmingly those who sought treatment, found it beneficial, and were willing to speak publicly. This selection bias matters for policy: it produces an impression of broad, enthusiastic veteran support that does not accurately reflect the distribution of attitudes in the population. Veterans who are curious but have not sought treatment are more likely to be held back by stigma, cost, uncertainty about safety, or limited awareness of available options than by principled opposition. Reaching that population is likely to require different approaches than the advocacy-driven public communication that has characterized this field to date.

In addition, as discussed above, veterans represent a unique clinical population that is in many respects at potentially higher risk of adverse outcomes from psychedelic treatments, particularly in uncontrolled or improperly supported settings. The Maryland Task Force on Responsible Use of Natural Psychedelic Substances, reporting in October 2025, identified veterans as a particularly important population for whom clinical pathway oversight is essential, given elevated rates of PTSD, traumatic brain injury, chronic pain, and suicide risk, and the potential for interactions between psychedelic treatments and VA-prescribed pharmaceuticals.[71]

The longer trajectory is nonetheless reasonably clear. Post-9/11 veterans, now in their 30s and 40s, came of age in a cultural context in which cannabis legalization was already underway and

psychedelic research was beginning to receive mainstream scientific attention. The 2017 RAND survey found that behavioral health problems are highest among this cohort, with 35 percent screening positive for PTSD and 42 percent reporting binge drinking, indicating that they also carry the greatest clinical need.[64] As this cohort ages and as psychedelic therapy accumulates a broader clinical track record, the population of veterans who would seriously consider these treatments if they were available, safe, and recommended by credible sources is expected to grow. Policy designed with that trajectory in mind is likely to be better positioned than policy calibrated only to the current moment.

F. National Landscape

On April 18, 2026, a federal executive order directed the acceleration of psychedelic drug research and access for serious mental illness, citing veteran suicide as a central concern, with more than 6,000 deaths annually over the past two decades and a rate higher than that of the civilian population.[10] The order includes priority review for psychedelic compounds with FDA Breakthrough Therapy designation, direction to FDA and DEA to reduce administrative barriers for Schedule I research, instructions to develop patient access pathways within existing federal law, and a directive to the Attorney General to begin rescheduling review for any Schedule I substance that completes Phase 3 trials for a serious mental health disorder. It also directs the Advanced Research Projects Agency for Health to allocate at least $50 million to partner with states that are developing programs in this area. A Massachusetts program, whether a pilot, research framework, or regulatory approach, would potentially improve the Commonwealth's ability to participate in that funding.

The history of how these substances were scheduled is directly relevant to how their current status is interpreted. Psilocybin and MDMA were placed in Schedule I in the early 1970s under the Controlled Substances Act through a process that was overtly shaped by political considerations and occurred prior to the development of modern evidentiary standards for drug scheduling. As a result, their placement did not rest on the kind of systematic scientific evaluation now expected for determining abuse potential, medical use, and safety. The current rescheduling framework, however, requires precisely that level of evidence to remove a substance from Schedule I. In effect, contemporary research is tasked with overturning a classification that was not originally established through comparable scientific standards. This structural mismatch has contributed to a regulatory environment in which policy has constrained scientific assessment, and helps explain why states have begun to act in advance of federal reform.[13]

Several states have enacted or are developing regulated access frameworks, each reflecting a different judgment about how these substances should be governed. Oregon's Measure 109, implemented beginning in 2023, established a licensed services model in which psilocybin is not classified as a medical treatment and is administered by trained facilitators outside of a diagnostic framework. Colorado's Proposition 122 created a broader "natural medicine" program that includes a regulated access model alongside a potential clinical pathway. New Mexico has enacted legislation oriented toward a medical model and is in the process of developing a system of state-regulated psilocybin services, though implementation is still underway. In January 2026, New Jersey enacted legislation (NJ A3852), providing $6 million in state funding to establish psilocybin programs at three hospital-based sites, with an explicit emphasis on clinical delivery and data collection. New York State Assembly is actively considering a permit-based framework (A2142). In parallel with access models, multiple states have directed public funding toward psychedelic research. The Texas legislature recently authorized a $50 million initiative (Senate Bill 2308) to support ibogaine research, one of the largest state-level investments to date. Other states have similarly allocated funding for research and pilot programs, reflecting a broader shift toward public-sector engagement in this area even in advance of federal approval pathways.

State-appointed task forces have also recommended legislative change that extends beyond single-model access programs. The Minnesota Psychedelic Medicine Task Force (2025) recommended, by a two-thirds supermajority, a state-regulated clinical program for psilocybin, decriminalization of personal possession, and dedicated research funding for MDMA, psilocybin, and LSD. The report also identified limitations in Oregon's program, including high costs associated with the regulatory structure and patterns of utilization that include out-of-state participants able to pay those costs. The Maryland Task Force on Responsible Use of Natural Psychedelic Substances (2025) recommended a multi-pathway framework combining decriminalization, a licensed clinical access pathway, supervised adult-use settings, and a personal permit system, explicitly recognizing that no single model is likely to meet the full range of clinical and non-clinical use cases.

Early outcomes data from operating state programs is limited but informative. A naturalistic study of adults participating in Oregon's regulated psilocybin services program (Gow et al., 2025) found improvements in depression, anxiety, and wellbeing at 30 days post-session among 88 participants, including individuals concurrently taking psychiatric medications. This was an observational, non-randomized study and does not constitute evidence of efficacy in the regulatory sense. The reported adverse event profile was favorable, with transient perceptual symptoms reported by two participants at one day and none persisting at 30 days. While limited, such data provides real-world information on safety, tolerability, and patterns of use in populations that differ substantially from those enrolled in clinical trials. These data exist only because state programs have been implemented, and similar initiatives in Massachusetts would allow the Commonwealth to generate evidence in its own population, including veterans with comorbidities typically excluded from trials.

IV. Overview of Proposals in Massachusetts

In the 2025-2026 session of the Massachusetts Legislature, approximately one dozen bills were filed that collectively span the range of available reform options. They fall into four categories, each representing a distinct policy instrument with different implications for access, oversight, and the veteran population specifically. Importantly, none of the bills under consideration enact full legalization (ie, the commercial marketing and/or sale of psychedelic drugs) of any psychedelic agent.

Decriminalization. Three bills reduce or remove criminal penalties without creating affirmative access pathways. H.1726 ("No Harm No Foul Act") permits courts to dismiss simple possession complaints when a defendant 21 or older caused no visible harm to others — a judicial discretion provision rather than a blanket decriminalization. H.1858 and its Senate companion S.1113 establish a $100 civil penalty for possession of one gram or less, with explicit exemptions for veterans, first responders, individuals with qualifying diagnoses, and any person who demonstrates therapeutic or spiritual purpose to a court; fine revenue is directed to community harm reduction programs. H.2506 makes possession, cultivation, and transfer of limited quantities lawful for veterans, law enforcement personnel, and individuals with qualifying conditions, excluding those with defined disqualifying conditions. It also mandates a Department of Public Health public education requirement, including publication of a publicly accessible explanation of the law, associated risks of personal use, and a clinically grounded list of qualifying and disqualifying conditions, while explicitly stating that the Commonwealth does not authorize or recognize psilocybin as a medical treatment. None of these bills creates supervised access. Their primary effect for the veteran population is to reduce the legal exposure that attends the informal access pathways veterans are already using.

Regulated Service and Access Programs. Three bills create affirmative access frameworks. H.4986 establishes a five-site nonprofit pilot with locations in western Massachusetts, central Massachusetts, the North Shore, the South Shore, and Metro Boston. That distribution addresses the access equity problem documented in the 2025 RAND assessment: a program concentrated in Boston would reproduce existing service disparities at smaller scale.[58] Licensed facilities must be operated by trained medical professionals, include affordability provisions, and report outcomes data to the legislature. H.2203 routes access through university-led pilots operating via FDA-authorized research pathways, with VA facilities and other community-based providers explicitly named as eligible sites; it requires peer-reviewed outcomes reporting and a MassHealth coverage feasibility analysis. H.4050 establishes a regulated permit-based access system with licensed cultivation, certified support services providers, health screening requirements, and a required educational course. The model is structurally similar to Oregon's in separating access from conventional medical treatment, though it allows more flexible, non-clinic-based use. It includes equity provisions, a tax framework, and protections for permit holders' professional licenses and parental rights.

Any regulated service model will need to account for a structural constraint the pending legislation has not fully resolved. Federal law prohibits Medicare-participating facilities from administering Schedule I controlled substances. A Massachusetts psilocybin service center must therefore be structured outside Medicare-participating facility status for as long as psilocybin remains federally scheduled. Massachusetts health facility licensing designations vary in whether they carry Medicare participation requirements, and the interaction between applicable state licensure categories and this federal constraint will require careful attention in regulatory design. This will affect which entities are able to seek licensure under any future program. It also underscores that program structure will, in practice, shape not only access and safety but the types of organizations able to participate in the emerging system.

Research Authorization and Funding. H.2203 incorporates a substantial research dimension through its university investigator model, use of FDA authorized pathways, and MassHealth feasibility mandate. The recent federal executive order directing ARPA-H to partner with states developing programs in this area may increase the significance of this category, though the scope and implementation of that provision remain uncertain. State investment in psychedelic research infrastructure may position the Commonwealth to participate in emerging federal state partnerships, including funding, technical assistance, and data sharing.

The value of that investment depends on how it is designed. Research conducted at a scale sufficient to answer substantive questions, led by investigators with the clinical expertise to identify those questions, and carried out in populations that reflect the real world complexity of veteran mental health, including comorbidities and prior treatment histories that clinical trials often exclude, is categorically different from underpowered work whose primary function is to provide supervised access. The Commonwealth's interest in maintaining that distinction is both scientific and reputational.

Study and Planning Legislation. H.1624 establishes an interagency task force to study the public health and social equity implications of full legalization of psilocybin and other entheogens, including ayahuasca, ibogaine, and mescaline, with findings due in June 2026. Its scope exceeds this Working Group's statutory mandate, encompassing criminal record expungement, indigenous traditional use, and racial equity alongside clinical access. This approach is consistent with actions taken in other states that have convened formal task forces to study psychedelic policy prior to implementation. S.1263 operates partly in this category as well, establishing planning infrastructure designed to be ready when the federal landscape changes.

Automatic Rescheduling upon Federal Action. A category of action not embodied in any pending bill is a standing rescheduling conformity provision, in which state law automatically aligns Massachusetts controlled substance scheduling with federal rescheduling that follows FDA approval, without requiring a separate legislative cycle. The federal executive order's directive to the Attorney General to initiate federal rescheduling review for Phase 3 complete products highlights the absence of such a parallel mechanism for the Commonwealth as a near term practical gap. Existing proposals address related issues in more limited ways, for example through conditional repeal tied to federal scheduling changes, but do not establish a general conformity framework. The structure of any such provision would have implications for market dynamics, depending on whether it is applied broadly or limited to specific substances or product categories.

Across all of these categories, veteran specific design requires deliberate attention. Several pending bills reflect awareness of the veteran population as a priority: H.2506's explicit veteran exemption, H.4986's geographic distribution aligned with the RAND access findings,[58] H.2203's naming of VA facilities as eligible sites, and veteran representation requirements in multiple advisory board provisions. What these provisions do not yet fully address are financial access barriers, including the 24 percent of post 9/11 Massachusetts veterans who report difficulty covering basic expenses and are unlikely to be reached by programs that are nominally available but unaffordable in practice; facilitator training requirements specific to combat related trauma; and the integration support infrastructure that veteran peer networks can provide when programs are designed to engage them.

V. Recommendations

The Working Group is statutorily obligated to provide recommendations to the Commonwealth. In doing so, the group sought to balance several considerations. It supports continued research into psychedelic therapies and recognizes the current funding landscape, which has been constrained and largely dependent on philanthropic support, though there are indications this may evolve at the federal level. The group further acknowledges that multiple states have begun to pursue policy approaches to psychedelics, including both research funding initiatives and regulated access programs, and that these efforts are proceeding in parallel with, rather than subsequent to, federal regulatory action. At the same time, the Working Group emphasizes that the legislative proposals currently under consideration in the Commonwealth are not limited to veteran-specific interventions but instead represent broader policy frameworks that would apply to the general population. As such, comprehensive evaluation of these proposals extends beyond the original charge and resourcing of this body, which was convened to address issues specific to veterans. Accordingly, the following recommendations focus on process, safeguards, and conditions that would better support responsible policy development, while ensuring that the needs of veterans are meaningfully incorporated. They reflect the range of considerations the Working Group examined and are intended as a framework for responsible development rather than as an endorsement of any specific legislative proposal.

1. **The Commonwealth should support the continued development of rigorous, well-designed research on psychedelic therapies.** While state-funded research may offer a constructive pathway forward, such efforts should be developed in consultation with experienced investigators and relevant stakeholders to ensure that funded studies are appropriately designed, adequately powered, and capable of generating meaningful and generalizable data. Absent such

coordination, there is a risk that limited public funds could be allocated to small or methodologically constrained studies that do not substantively advance scientific understanding or inform policy.

2. **The Commonwealth should, prior to implementing any statewide psychedelic access program, convene a dedicated, well-resourced advisory or task force structure with relevant expertise.** This body should include individuals with demonstrated experience in psychedelic clinical research, mental health care delivery, ethics, regulatory policy, and lived experience, as well as representation from veteran communities. Several states have adopted analogous approaches, either by convening task forces prior to legislative action or by embedding advisory structures within program design, reflecting recognition of the complexity of these interventions and the need for careful, expert-informed development.

3. **The Commonwealth should ensure that veterans are meaningfully represented in any broader policy development processes related to psychedelics.** Given that most legislative proposals under consideration are not specific to veterans, it is unlikely that any major policy change will be confined to this population. Ensuring that veterans have a defined role in shaping program design, implementation, and evaluation is therefore essential to addressing their specific needs, including considerations related to trauma, access barriers, and integration support.

4. **The Commonwealth should recognize that FDA-approved psychedelic therapies, if and when they become available, are likely to be associated with substantial costs and regulatory constraints that may limit accessibility.** The Working Group discussed that, given current patterns of use and expressed need—including among veterans—it is unlikely that all demand for psychedelic care will be met through FDA-approved channels alone. Policy development should therefore consider the broader ecosystem of access pathways, while maintaining appropriate safeguards and attention to safety, quality, and equity.

5. **Any state-authorized licensing or designation of entities to deliver psychedelic services should be subject to rigorous, expert-driven review processes and robust conflict-of-interest safeguards.** Under current federal law, institutions that participate in federal funding programs, including those accepting Medicare, are not able to participate in the delivery of Schedule I substances. This structural constraint limits participation to non–federally affiliated entities and, in the context of limited-license models, creates conditions for significant market concentration. In such an environment, there is a foreseeable risk that financial incentives may drive participation by entities for whom financial return may take precedence over clinical quality. Careful attention to selection criteria, transparency, and oversight is therefore essential.

6. **In particular, proposals that would authorize a small number of designated or licensed centers to provide psychedelic services warrant careful examination of selection criteria, market structure, and clinical oversight requirements.** Limiting authorization to a small number of sites may be justified as a means of piloting new models of care in a controlled and evaluable manner. At the same time, such approaches may concentrate both clinical accountability and financial benefit within a small number of entities, while also amplifying the consequences of inadequate clinical standards or oversight. Absent a robust and transparent selection process grounded in clinical expertise and therapeutic standards, such models carry a heightened risk of both inequitable access and variable quality of care.

7. State-authorized service center models may offer a more flexible and potentially more cost-accessible alternative to strictly medicalized delivery pathways, but their effectiveness and safety are highly dependent on implementation. Early experience from jurisdictions such as Oregon suggests that regulatory design choices can substantially influence cost, accessibility, and program uptake, with some models remaining financially out of reach for many individuals. If the Commonwealth elects to pursue or authorize such models, careful attention should be paid to regulatory burden, pricing structures, clinical oversight, and integration support, to avoid replicating barriers to access while maintaining appropriate protections.

8. State-level service centers may also provide an opportunity to generate real-world observational data on patterns of use, therapeutic intent, and implementation challenges outside of tightly controlled clinical trial settings. While such data cannot substitute for randomized controlled trials, it may offer complementary insights into how psychedelic therapies are experienced and delivered in practice, including factors that influence safety, effectiveness, and accessibility across diverse populations. Incorporating mechanisms for data collection, evaluation, and transparency into any service center model would strengthen its potential contribution to the broader evidence base.

9. The Commonwealth should ensure that any movement toward psychedelic service delivery is accompanied by the development of clear standards for training, supervision, and clinical practice. As noted elsewhere in this report, there is currently no uniform system of accreditation or standardized training in psychedelic-assisted therapy. Premature implementation of access programs without defined competencies, supervision structures, and accountability mechanisms risks inconsistent practice and potential harm, particularly in populations with complex clinical presentations, including veterans.

10. The Commonwealth should support the development of accurate, evidence-informed public education regarding psychedelic substances and their risks and potential uses. Current public discourse is characterized by both substantial enthusiasm and persistent misconceptions, including confusion between clinical, supervised use and unsupervised or recreational contexts. As access expands through research, decriminalization, or regulated service models, there is a need for clear, accessible information addressing expected effects, potential risks, contraindications, and the importance of preparation, setting, and post-experience integration. Such efforts should incorporate harm reduction principles and be tailored to populations with distinct needs, including veterans, for whom stigma, prior substance use frameworks, and reliance on peer networks may shape how information is received and acted upon.

11. The Working Group did not reach consensus on proposals to decriminalize psychedelic substances. Members noted, however, that the current federal scheduling framework was not constructed on the basis of contemporary scientific evidence, and that a number of jurisdictions, including municipalities within the Commonwealth and several states, have adopted decriminalization measures for certain substances. Available data from these jurisdictions have not, to date, demonstrated clear increases in drug-related harms attributable to such policy changes. Policy decisions in this domain should therefore be informed by a balanced consideration of the evolving scientific evidence base, public health and epidemiological data, and the broader social and legal consequences associated with punitive approaches to substance use.

12. Finally, the Commonwealth should recognize that the development of psychedelic policy represents a complex and evolving area that intersects with clinical science, public health, law, and ethics. As such, durable and effective policy will require iterative evaluation, ongoing stakeholder engagement, and a willingness to adapt as new evidence emerges. Within this process, ensuring that the perspectives and needs of veterans are consistently incorporated will be critical to achieving equitable and responsible outcomes.

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