Washington Psilocybin Workgroup Meeting #2

August 4th, 2022

Washington State Health Care Authority

Agenda

	Agenda Items	Lead
1.	Welcome & Roll Call Meeting Overview	Charissa Fotinos, MD - Medicaid Director
2.	Overview from WA Liquor and Cannabis Board	Jim Morgan, Chief Financial Officer – WA Liquor and Cannabis Board
3.	Overview of National Landscape	Duncan Stuard – Center for Evidence-based Policy
4.	Review Work Group Survey #2 Results & Facilitated Work Group Discussion	Mike Bonetto – Center for Evidence-based Policy
5.	Wrap up and next steps	Charissa Fotinos, MD - Medicaid Director

Welcome and Opening Business

- Roll Call
- Meeting overview

Scope

Over the course of 5 meetings, the workgroup will:

- Review Oregon rules
- Review systems and procedures of Washington Liquor and Cannabis Board
- Review social opportunity program
- Identify necessary expertise and capacity to implement functional requirements in Senate Bill 5660
- Identify possible options to integrate licensed behavioral health professionals

Timeline (approximate)

Task/Deliverable	Date
Workgroup Meeting #1	June 30, 2022
Workgroup Meeting #2	August 4, 2022
Draft of preliminary report	August 19, 2022
Workgroup Meeting #3	October 31, 2022
Preliminary report due to legislature	December 1, 2022
Workgroup Meeting #4	March 2023
Draft of final legislative report	April 2023
Workgroup Meeting #5	May 2023
Final legislative report	June 2023
Final report due to legislature	December 1, 2023

Overview from WA Liquor and Cannabis Board

Jim Morgan, Chief Financial Officer

State Legislation and Ballot Activity Regarding Psychedelic Drugs

Presented by Duncan Stuard, Center for Evidence Based Policy

Washington State Health Care Authority

Overview of State Legislation

- 21 state bills and ballot initiatives have been introduced across the country
  - 8 bills have been passed
  - 5 bills are actively in committee
  - 3 of the remaining 8 showed substantial support and were pushed to next session
- Much of the legislation has bipartisan co-sponsors
  - Republican and Democratic states have passed legislation, Texas being one of the first states to follow Oregon

State Legislation and Ballot Measure Status

STATE	STATUS	STATE	STATUS
California	Pushed to next session	New Jersey	Bill passed
Colorado	On ballot Nov. 2022	New York	Awaiting first hearing
Connecticut	Passed in budget bill	Oklahoma	Bill passed
Florida	Bill died in committee	Oregon	Ballot initiative passed
Georgia	Awaiting first hearing	Pennsylvania	Currently in House
Hawaii	Passed in Senate	Rhode Island	Pushed to next session
Kansas	Bill died in committee	Texas	Bill passed
Maryland	Bill passed	Utah	Bill passed
Maine	Passed Senate, failed in House	Virginia	Pushed to next session
Missouri	Awaiting first hearing	Washington	Bill passed
New Hampshire	Passed Senate, failed in House		

Analysis of Bills and Ballot Initiatives

- The 21 bills and ballot initiatives were divided into different categories, this presentation will cover the following themes:
  - Substances up for Approval
  - Research Directives
  - Public Availability and/or Target Diagnosis
  - Decriminalization Directives
  - Equity Approach
    - Washington's Social Opportunity Program
  - Bill Model Designations

Substances up for Approval

- States vary on which substances are proposed for therapeutic use
  - No mention of microdosing in any existing bills
- Some common models for how psychedelic substances are grouped:
  - Natural Medicine: DMT, ibogaine, mescaline, psilocybin, psilocyn
  - Therapeutic Medicine: MDMA, psilocybin, ketamine
  - Psychedelic Medicine: Psilocybin, DMT, ibogaine, mescaline, LSD, MDMA
  - Psilocybin Only: 12 bills refer exclusively to psilocybin
- Notable exceptions
  - Rhode Island includes buprenorphine in a psychedelic drug bill
  - Utah leaves the decision of substance inclusion to the workgroup

Research Directives

- 16 states have some form of research directive included in a bill or ballot initiative
  - 11 states propose establishing an advisory board
  - The remaining 5 leave research to an agency of state government, like the state Department of Health
- Advisory boards have general criteria for the knowledge/expertise of its members, such as experience in therapy, medicine, public health, drug regulation, and substance abuse issues
  - Only certain states have members specifically brought on for knowledge in Indigenous rights, equity, harm reduction, agriculture, and veterans
  - Other states do not meet the first or second set of criteria—appointments to these advising boards are filled by members of state Legislature and committee members

Public Availability and/or Target Diagnosis

- States vary on whether a medical diagnosis is needed to receive treatment
  - All states except Oklahoma require a minimum age of 21 (Oklahoma is 18)
  - Georgia and Maryland limit treatment to veterans with PTSD, etc.,
  - Connecticut restricts treatment to veterans, first responders, and healthcare workers
- States that require a diagnosis vary on which diagnoses should be eligible for psychedelic therapy
  - All states include depression, and most include anxiety and PTSD
    - Substance use disorder, traumatic brain injury, bipolar disorder, end-of-life treatment, migraines, and chronic pain are also included in some bills
    - Oklahoma makes the distinction of “treatment resistant” for depression and anxiety, which would restrict access for many individuals with those conditions
  - Utah and Washington refer to respective advisory workgroups to address the diagnoses to be treated

Decriminalization Directives

- States have attempted decriminalization with three separate approaches
  - Decriminalization of possession for low levels of the psychedelic drug
    - Possession under a certain amount is no longer a felony, there is usually a fine with no jail time
      - The amount that is decriminalized varies widely, from 4 grams (Missouri) to 28 grams (New Jersey) to 1.5 ounces (Oklahoma)
  - States may also reclassify the drug within the state, effectively removing it from the state Department of Health Schedule 1 drug classification (Hawaii, New York)
  - Separate decriminalization bills can be passed in the state that decriminalize drugs broadly

- Of the states that have decriminalization legislation, seven have possession bills, two have reclassification bills, and three have broad decriminalization bills

Equity Approach

- 11 states mention equity in legislation, but vary in the depth of proposed approaches
- California, Colorado, Connecticut, New York, and Pennsylvania call for the advisory board to incorporate equity in their respective programs
  - The equity section of the legislation in these states is short, outlining equity as a priority, but making no further mention of equity issues such as, insurance, cost-reimbursement, minority ownership, etc.
  - Only Colorado and New York propose advisory board members focused on equitable policy
- Hawaii and Maine call for the program to be “safe, accessible, and affordable”, but do not outline a process or directive to achieve this goal
- Maryland has a “$1 million, non-lapsing fund” to cover the treatment of eligible veterans in the state
- Missouri explicitly outlines that health care insurers and the department of corrections cannot be required to cover psychotherapy drug treatment
- Oregon has a designated equity sub-committee within its advising board
  - A separate “The Task Force on Psilocybin Health Equity” has been introduced by SB 1580 to further address equity concerns in the state

Washington's Social Opportunity Program

- In SB 5660, which did not pass, Washington introduced the Social Opportunity Program (SOP)
- The SOP's main objective is to identify distressed areas, using established criteria, and to administer assistance to individuals and entities
  - A distressed area is an area categorized as such by the Washington state Department of Labor
    - 50% of children participate in free lunch
    - 20% of households are under federal supplemental nutrition assistance program
  - An eligible SOP applicant is:
    - an entity where at least 51% of ownership is with individuals that have lived in a distressed area for 5 of the last 10 years
    - An entity where more than half of its employees reside in a distressed area
- Direct assistance would be provided for those who qualify seeking to either facilitate or participate
  - This assistance will come from state health services or through a partnership with outside organizations
    - State health services will provide reduced license fees and create eligibility for SOP applicants to receive points towards a license application score
  - Other criteria can be added to the SOP as seen fit by the facilitating department

Bill Model Designations (in progress)

- Identified seven models as broad categories to help conceptualize the variation in bills across the country
  - Some states have elected to use a hybrid approach, blending aspects of these models

1. **Medical Model:** Individual must have a diagnosis from a doctor that is included in the diagnoses specified by the state for psychedelic therapy
2. **Wellbeing Model:** Available to all above the age requirement, psychedelic therapy facilitators are not necessarily medical professionals, and no diagnosis or doctor's recommendation is needed
3. **Possess & Share Model:** Low level possession is legal at state level, individuals are allowed to cultivate, possess, and use certain psychedelics, as long as there is no sale of the drug and possession stays below state limits

Bill Model Designations (continued)

4. **Research Model:** Psychedelics are only used in a research setting; research institutions may cultivate and administer psychedelics to certain populations for research purposes
5. **Prescription Model:** Psychedelics are available to obtain by prescription for use outside a facility
6. **Decriminalization Model:** Bill does not propose any research or facilitation plan, but removes penalties on certain levels of possession, or decriminalizes/reclassifies the drug(s) at the state level
7. **To be determined by the advisory board:** The state will consider future legislation, or form its implementation plan based on the recommendations of the advisory board

Comments and Questions?

- What models are of interest, or have the most applicability to Washington?
- Are there any models that you like more detail on, or that warrant study by this workgroup?
- Anything you would add or revise to the proposed bill model definitions?

Appendix

Appendix A

STATES	BILL #	DATE OF INTRODUTION	BILL MODEL
California	SB 519	August 2021	Possess & Share Model
Colorado	Initiative 58	January 2022	Wellbeing Model/Possess & Share Model
Connecticut	Budget Bill	March 2022	To be determined by advisory board
Florida	HB 193	January 2022	Research model
Georgia	LC 48	March 2022	To be determined by advisory board
Hawaii	SB 3160	March 2022	To be determined by advisory board
Kansas	HB 2465	January 2022	Wellbeing Model/Possess & Share Model
Maryland	SB 709	February 2022	To be determined by the advisory board
Maine	SP 496	April 2021	Wellbeing model
Missouri	HB 2850	March 2022	Medical model
New Hampshire	HB 1349	January 2022	Decriminalization Bill

Appendix A cont.

STATES	BILL #	DATE OF INTRODUCTION	BILL MODEL
New Jersey	A 5084	December 2020	Decriminalization bill
New York	A09569	December 2021	To be determined by advisory board
Oklahoma	HB 3414	February 2022	Research model
Oregon	Measure 109	July 2019	Wellbeing model
Pennsylvania	HB 2421	March 2022	To be determined by advisory board
Rhode Island	H 7715	March 2022	Prescription model
Texas	HB 1802	March 2021	Research model
Utah	HB 167	January 2022	To be determined by advising board
Virginia	SB 262	January 2022	Decriminalization bill
Washington	SB 5660	March 2022	To be determined by advisory board

Appendix B

STATES	LINK TO LEGISTLATION/BALLOT MEASURE
California	https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB519
Colorado	https://leg.colorado.gov/sites/default/files/initiatives/2021-2022%2520%252358.pdf
Connecticut	https://www.cga.ct.gov/2022/TOB/H/PDF/2022HB-05396-R00-HB.PDF
Florida	https://www.flsenate.gov/Session/Bill/2022/193/BillText/Filed/PDF
Georgia	https://www.legis.ga.gov/legislation/62532
Hawaii	https://www.capitol.hawaii.gov/session2022/bills/SB3160_SD2_.pdf
Kansas	http://kslegislature.org/li/b2021_22/measures/hb2465/
Maryland	https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/SB0709?ys=2022rs
Maine	https://legislature.maine.gov/bills/getPDF.asp?paper=SP0496&item=1&snum=130
Missouri	https://house.mo.gov/Bill.aspx?bill=HB2850&year=2022&code=R
New Hampshire	https://www.gencourt.state.nh.us/bill_status/legacy/bs2016/bill_status.aspx?lsr=2618&sy=2022&sortoption=&txtsessionyear=2022&txttitle=psilocybin

Appendix B cont.

STATES	LINK TO LEGISTLATION/BALLOT MEASURE
New Jersey	https://www.gencourt.state.nh.us/bill_status/legacy/bs2016/bill_status.aspx?lsr=2618&sy=2022&sortoption=&txtsessionyear=2022&txttitle=psilocybin
New York	https://nyassembly.gov/leg/?default_fld=%0D%0A&leg_video=&bn=A08569&term=2021Summary=Y&Actions=Y&Memo=Y&Text=Y
Oklahoma	http://webserver1.lsb.state.ok.us/cf_pdf/2021-22%20int/hb/HB 3414%20int.pdf
Oregon	https://sos.oregon.gov/admin/Documents/irr/2020/034text.pdf
Pennsylvania	https://www.legis.state.pa.us/cfdocs/billinfo/billinfo.cfm?syear=2021&sind=0&body=H&type=B&bn=2421
Rhode Island	http://webserver.rilin.state.ri.us/BillText/BillText22/HouseText22/H7715.pdf
Texas	https://capitol.texas.gov/tlodocs/87R/billtext/pdf/HB01802I.pdf#navpanes=0
Utah	https://le.utah.gov/~2022/bills/static/HB0167.html
Virginia	https://lis.virginia.gov/cgi-bin/legp604.exe?221+sum+SB262
Washington	https://drive.google.com/file/d/1yoO5fO-7jL6FMVRtWQjmRctgxvXs_leG/view?usp=sharing

Review Workgroup Survey #2 Results & Facilitated Workgroup Discussion

Survey #2
13 respondents

Level of Support for Micro-dosing Recommendation

	Strong		Medium		Low	
	5	4	3	2	1	**Weighted Avg**
How strongly would you support including a recommendation for consideration of **micro-dosing** procedures and policies:	9	1	3	0	0	**4.0**

What, if any, additional feedback and recommendations do you have for the workgroup on how a **micro-dosing policy framework** could work?

- Reduce the waiting period from ~5 hours or eliminate the waiting period entirely. Promote access by those in end-of-life care

- Look at how people in Washington are doing microdosing or even non-microdosing and essentially putting some helpful and not onerous health and safety policies in place. Specially licensed centers to start

- Micro-doses to be obtained only through qualified providers (much like cannabis stores).

What, if any, additional feedback and recommendations do you have for the workgroup on how a **micro-dosing policy framework** could work? *(cont.)*

- Recommend following and completing further state sponsored study on the Stamets stack for micro-dosing. Additionally, recommend allowance for businesses to create microdosing level products to deliver medicine, whether in pill form or liquid form.

- I think we lack any good evidence that micro-dosing has any clinical effects at this point.

Level of Support for Clinical and Wellness Models

	Strong		Medium		Low	
	5	4	3	2	1	**Weighted Avg**
How strongly would you support recommending a **clinical model** for psilocybin:	2	1	4	2	4	**2.61**
How strongly would you support recommending a **wellness model** for psilocybin:	8	3	0	1	1	**4.2**

What, if any, feedback do you have for the workgroup to consider around **clinical vs. wellness models**?

- Why not both? Wellness model for 3 grams or less, clinical model for anything over 3 grams, including option for higher dose choices, like those over 10 grams.
- Clinical model will create equity issues (similar, I suspect, to Ketamine- even with regulated facilitators, this has become a for-profit business, for those that are inclined.
- The wellness model seems concerning, as it seems to follow a "consumer" model. This worries me as I think we don't have enough understanding to ensure safety at this stage.
- The more safe, structured access that is offered, the less people will seek illicit sources.

What, if any, feedback do you have for the workgroup to consider around **clinical vs. wellness models**? *(cont.)*

- Clinical model would be an improvement over the status quo, ideally psilocybin services should be made accessible to anyone who needs it. Psilocybin is safe enough in PK/PD metrics for most people to consume it without complications.
- There can be facilitators in the wellness model who have additional credentials, so that option can be there for those who need it.
- There should be provisions for facilitation to happen in people's homes or retreat centers.
- I'm in favor of the clinical model if it's the only foreseeable way to get this bill passed, otherwise the wellness model is more equitable, affordable, and accessible.

What, if any, feedback do you have for the workgroup to consider around **clinical vs. wellness models**? *(cont.)*

- Adopting a clinical model would substantially impair this bill by significantly raising costs and other unnecessary barriers to access by low-income and marginalized populations. There can be facilitators in the wellness model who have additional credentials, so that option can be there for those who need it.
- Strongly recommend going with a wellness model due to the equity and access concerns. Many people who do not fit a mental health diagnosis can benefit from psilocybin services, and many people who are not licensed medical professionals can be and are competent psilocybin service facilitators.
- In wellness model, recommend age 21 years and older

Level of Support for Tiered Training Structure

	Strong		Medium		Low	
	5	4	3	2	1	**Weighted Avg**
How strongly would you support recommending a **tiered training structure** designed for different populations (i.e., general wellness, spiritual experience, dual diagnoses, mental health):	2	7	2	1	1	**3.61**

What, if any, feedback do you have for the workgroup to consider around creating **population-based training designs**?

- I'd like our state to have the forethought of an apprenticeship training model, with 300-2,000 training hours before certification.
- Don't reinvent the wheel, don 't make this another profitable venture, and don't rely on colleges (who have too much bureaucracy and will take too long and cost too much)
- Conceptually support this approach, but it could be much more complicated to implement, communicate, and regulate (who decides what is spiritual?)

What, if any, feedback do you have for the workgroup to consider around creating **population-based training designs**? *(cont.)*

- We are not licensing clinicians here, so we shouldn't use that as a template. All the topics mentioned should be included in all facilitator's training.
- There is no research support for tiered training. Rather, there is considerable research to support an emphasis on experiential training for all facilitators / service providers working with all populations.
- I'm wary of too narrowly limiting this to certain medical professionals, Oregon's offering of training to anyone with the high-school diploma is a positive aspect.

Level of Support for Insurance Coverage

	Strong		Medium		Low	
	5	4	3	2	1	**Weighted Avg**
How strongly would you support including a recommendation for all psilocybin sessions be **covered by private insurance**:	8	2	3	0	0	**4.38**
How strongly would you support including a recommendation that **Medicaid explore legal and financial policies** for covering psilocybin sessions with state funding:	8	4	1	0	0	**4.54**

What, if any, feedback do you have for the workgroup to consider around **insurance coverage**?

- Insurance coverage is critical in order for psilocybin to be equitable.
- Strongly support subsidizing access to those with a mental health diagnosis who wouldn't otherwise be able to afford psilocybin services.
- Make insurance companies do what we want them too! They should follow our laws. (Why is acupuncture, for example, not covered?)
- Insurance and Medicaid coverage will be very important for ensuring access for low-income and marginalized populations.
- This is medicine and insurance should cover it. As a consumer, I'm willing to pay extra tax that would help fund low income and non-insured, including refugees to help cover or defray costs

What, if any, feedback do you have for the workgroup to consider around **insurance coverage**? *(cont.)*

- I can see this from both sides.. 1) equity concerns, if the cost ends up being prohibitive and 2) more expensive for all due to insurance / 3rd party payer involvement. If one gets a rx for Tylenol, it costs about $24 a bottle, vs $1 at the dollar store.
- There should be parity between expectations of Medicaid and private insurance for equity and access reasons.

Level of Support for Oregon's Model

	Strong		Medium		Low	
	5	4	3	2	1	**Weighted Avg**
How strongly would you support a **2-year implementation period**	5	5	2	0	1	**4.0**
How strongly would you support **passing decriminalization policy** concurrently	10	3	0	0	0	**4.77**
How strongly would you support **limiting psilocybin species to P.cubensis only**	0	1	3	1	8	**1.77**
How strongly would you support requiring **only a high school diploma** for facilitators	6	2	2	0	3	**3.62**

Level of Support for Oregon's Model (cont.)

	Strong		Medium		Low	
	5	4	3	2	1	**Weighted Avg**
How strongly would you support **limiting consumption to on-site service centers** only.	1	2	4	2	4	**2.54**
How strongly would you support recommending that Washington's policy similarly **not include exemptions** for personal, religious, or indigenous use?	1	1	2	1	8	**1.92**
How strongly would you support recommending that Washington's policy **not specifically target populations** with addiction, PTSD, and end-of-life diagnoses?	2	4	3	2	2	**3.15**

What, if any, feedback do you have on Oregon's model or **implementation of Measure 109?**

- Strongly support the implementation of home-administration by service providers and allow entheogenic use for religious leaders and clergy members. I believe the clinical research supports the use of psilocybin for specific populations, but also there may be people who find psilocybin beneficial for other use cases outside of these target populations. I wouldn't want it strictly limited to specific diagnoses.
- Exemptions should be granted to anyone who wants one on personal, religious, spiritual or philosophical grounds. There should be no "testing" of the sincerity of those claims.

What, if any, feedback do you have on Oregon's model or **implementation of Measure 109?** *(cont.)*

- WA's policy should specifically target populations with addiction, PTSD, and end-of-life diagnoses and should include exemptions for personal, religious, or indigenous use.
- Measure 109 should have explicitly stated that Training Programs do *not* need to get approval from the HECC (the Oregon version of WSAC). Getting HECC approval is costing training programs many thousands of dollars and not adding any quality to the services they are providing, as HECC does not understand psilocybin training. SB5660 should explicitly exclude the need for WSAC approval.

What, if any, feedback do you have on Oregon's model or **implementation of Measure 109?** *(cont.)*

- Given the early state of research, I have concerns about using these compounds for any indication. Seems there has to be some narrowing in use until we can better understand its mechanisms and effectiveness.
- High school diploma okay, with the additional training (where a college degree is NOT a prerequisite) -- End of life, addiction PTSD are a good target population.
- 2y implementation: Oregon said it wasn't enough, so we go 3 years?
  - Limiting species- I think species should be expanded beyond one single strain.
  - Apprenticeship model for training, even if applicant is only high school or GED grad.
  - Treatment centers, estimate and amount a hospice centers.
  - Personal, religious, indigenous- this would be acceptable following wellness model of less than 3 grams
  - Addiction, PTSD, end of life - this would be acceptable following clinical model, allowing dose greater than 3 grams.
  - Both wellness and clinical models can work side by side

Any additional feedback you wish to provide?

- We should develop policy that recognizes the human geography of entheogens like psilocybin fungi which people have been naturally forming spiritual/meaningful relationships with for millennia. We should keep the system as open as possible to recognize, honor, and respect traditional practitioners and facilitators. The state's job should should be to provide unbiased education and some mild health and safety regulation.
- Please include questions/focus on excluding the need to WSAC approval for SB5660 training programs. It costs many thousands of dollars and takes 2+ years to obtain.
- Language for both wellness and clinical models that provides for integration assistance and this be covered by insurance also. Additionally recommend rapid veteran focused use retreats asap.

Next Steps

Questions?

More information:
https://www.hca.wa.gov/about-hca/programs-and-initiatives/psilocybin-work-group

PsilocybinWG@hca.wa.gov

Washington State Health Care Authority