Alaska Task Force for the Regulation of Psychedelic Medicines

Final Recommendations Report

June 2025

Approved by the Task Force by electronic vote on May 30, 2025

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About the Alaska Psychedelic Medicine Task Force

The Psychedelic Medicine Task Force was created through HB 228 to deliberate and make recommendations regarding potential implementation of therapeutic use of FDA-approved psychedelic medicine to treat certain mental health conditions. The Task Force was time-limited, and charged with producing a recommendations report to the Legislature in 2025.

Origin of the Task Force: Alaska House Bill 228 (2024)

In 2024, the Alaska Legislature passed House Bill 228, sponsored by Rep. Jennie Armstrong, with companion bill SB 166, sponsored by Sen. Dunbar, to establish a task force to identify implementation needs and potential barriers at the state level for future authorization by the FDA of prescription medications containing psychedelic substances. Use of these substances to treat conditions including anxiety, depression, and PTSD has grown in recent years, with initial promise as a treatment modality, and an emerging evidence base with best practices for psychedelic-assisted therapy.

The FDA is currently reviewing data from multiple clinical trials including use of psilocybin and MDMA, and likely to take action in coming years approving one or more of the therapies under consideration. A few states, including Oregon, Colorado, and New Mexico, have already taken steps to create a regulatory framework for medicinal use; others, such as Minnesota, have created similar task forces to consider what steps would be needed at the state level, following FDA approval of one or more therapies being evaluated, and prepare recommendations for policymakers and regulators.

Scope and Purpose

HB 228 directed that the Psychedelic Medicine Task Force, with defined membership of designated seats from a variety of perspectives and fields, meet at least four times to consider four topic areas identified in the bill. HB 228 directed that by the end of regular Legislative session (May 2025), the Task Force must produce a report of recommendations to deliver to the Legislature and Governor, to inform future policy decisions. Below is an excerpt of the bill, describing the purpose and scope of the Task Force:

> *Purpose*: To prepare for potential medicalization of psychedelic medicines by U.S. FDA; to make policy recommendations to the Alaska Legislature concerning insurance and licensure, given the unique nature of the administration of psychedelic medicines; and to ensure the state is prepared if psychedelic medicines become available for prescription.
>
> (1) assess potential use of psychedelic medicine in addressing Alaska's mental health crisis;
>
> (2) consider barriers to implementation and equitable access;
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> (3) consider and recommend licensing and insurance requirements for practitioners in the state if psychedelic medicines are federally reclassified and approved by the FDA; and
>
> (4) consider legal and regulatory changes that could be necessary in the state after federal medical approval of psychedelic medicines.

Task Force Membership

HB 228 directed appointment of two co-chairs, each from the Senate and House; designated seats for state agencies and other organizations named in the bill; and an option for the Task Force to select an at-large member, which the group did in its second meeting.

The following people serve on the Task Force. In the table below, the first affiliation listed corresponds with the organization, agency, or seat the person is designated from, with the person's additional professional or employment affiliations also listed for reference.

Name	Role	Affiliation
Sen. Forrest Dunbar	Co-Chair	Alaska Senate, HB 228 co-sponsor; Attorney
Rep. Justin Ruffridge	Co-Chair	Alaska House; Pharmacist
Dr. Robert Lawrence	Designated Seat	Chief Medical Officer, Dept. Health
Angela Laflamme	Designated Seat	Designee, Dept. Military & Veterans Affairs
Glenn Saviers	Designated Seat	Designee, Dept. Commerce, Community & Economic Development
Justin Heminger	Designated Seat	NAMI Fairbanks, Board Member
Ann Ringstad	Alternate	NAMI Alaska, Executive Director
Dr. Kristen Maves	Designated Seat	Alaska Native Health Board Designee #1; Southcentral Foundation, Pharmacist
Dustin Allen	Designated Seat	Alaska Native Health Board Designee #2; Knik Tribe, Clinical Supervisor
Lauree Morton	Designated Seat	Alaska Network on Domestic Violence and Sexual Assault, Deputy Director
Dr. Paula Colescott	Designated Seat	Alaska State Medical Association
Dr. Lisa Lindquist	Designated Seat	Alaska Psychiatric Assn.; Southcentral Foundation, Beh. Health Division Medical Director
Dr. Michael DeMolina	Designated Seat	Alaska Addiction Professionals Association; Wisdom Traditions Counseling
Dr. Sara Kozup-Evon	Designated Seat	Advanced Practice Registered Nurse Alliance
Dr. Brittany Karns	Designated Seat	Alaska Pharmacy Association
Jennie Armstrong	At-Large Seat	Former Alaska Representative; HB 228 sponsor

The Task Force was supported by legislative staff of the co-chairs, and a contracted facilitator to support the process:

- Arielle (Ari) Wiggin and Sethan (Seth) Tigarian, Office of Sen. Dunbar
- James (Bud) Sexton, Office of Rep. Ruffridge
- Tristan Walsh, Office of Rep. Armstrong (through December 2024)
- Anna Brawley, Tiny Birch Consulting (contractor)

Task Force Process

The Task Force was fully constituted in December 2024, with preparatory and logistics work to prepare for official meetings in 2025. The Task Force convened a total of six meetings:

- Meeting 1: Tuesday, February 4, 2025
- Meeting 2: Tuesday, February 26, 2025
- Meeting 3: Wednesday, March 19, 2025
- Meeting 4: Wednesday, April 2, 2025
- Meeting 5: Wednesday, April 16, 2025
- Meeting 6: Tuesday, April 29, 2025 (includes public hearing)

Meetings were held in person in Juneau at the Alaska Capitol, Butrovich Committee Room 205, as well as online, with most members participating by Microsoft Teams. Meeting proceedings were livestreamed and are available as recordings at http://www.akleg.gov, listed under the corresponding meeting dates as “Miscellaneous Meeting” of the Task Force.

The Task Force adopted Guidelines and Meeting Procedures (*see Appendix C*) in February for conducting meetings, and the process for adoption of recommendations and final approval of the report. The Task Force further adopted a more detailed voting procedure document in April, for conducting final votes by e-mail in May after its last meeting.

Public Comment

Given the time-limited nature and defined scope of the Task Force, the group was required to move swiftly and stay focused on achieving the intent of HB 228. The group also determined that having an opportunity for public comment in order to gather feedback on a draft product would be important. To meet this objective within the timeframe, the group prepared a working draft of the recommendations, and portions of the report still in progress, to publish for public comment over a 14-day period, including opportunity for public testimony at a Task Force meeting.

Timeline for public comment:

- Monday, April 21: Draft recommendations and report published, with a notice flyer to share with the general public and interested stakeholders.
- Monday, April 28: All written comments received by end of day were packaged and shared with the Task Force in the April 29 agenda packet.
- Tuesday, April 29: Task Force Meeting #6, with public comment period. Public comment was taken in person in Juneau, and via the telephonic legislative testimony system , as well as in writing by e-mail.
- Monday, May 5: Closing date for written public comment.

The Task Force received a total 8 written comments, and had 2 testifiers participate in the public hearing on April 29.

The public comment packet and all written comments received can be found in Appendix D.

Voting and Report Approval Process

As established at the beginning of the process, the Task Force officially voted on individual recommendations, with a final approval vote on the full report. Majority approval was required for all votes (at least 8 of 15 members voting “yes”).

The Task Force did not have an additional meeting scheduled after the public comment period closed, so voting was conducted electronically in two phases, using an online form for each member to record their votes. First, the group voted on each individual finding and recommendation to include in the report, with the voting period between May 12 and 19. Once the approved findings and recommendations were incorporated, the Task Force took a final vote to approve the report as written between May 21 and 27, officially completing its work and adopting a final report to transmit to the Legislature and Governor.

The process is described in detail in Appendix C, along with a summary of members’ votes.

About Psychedelic Medicine Therapies

See Appendix B, Bibliography for additional information and resources.

Overview of Psychedelic Medicines

Psychedelics (meaning “mind-manifesting,a term coined by Humphrey Osmond), are a varied group of plant-derived synthetic compounds that have in common the ability to produce sensory, perceptual, and cognitive changes without impairing attention or level of consciousness.

They do so by influencing communication networks in the brain that depend on a host of chemicals released by the billions of neurons in the brain. These chemicals are called neurotransmitters; these neurotransmitters affect the neighboring neuron by attaching to a particular receptor on that neuron eliciting its response. This communication between neurons is called neurotransmission.

Mescaline, psilocybin, and LSD belong to a class called *phenyethylamines*, which are considered the classic hallucinogens. These compounds influence Serotonergic neurotransmission by binding to the neurons which have the 5HT2 receptor on their surface membrane. Psilocybin has been researched for the treatment of Depression.

The most prominent subjective effects of the classic Hallucinogens are influenced by set and setting, that is, the expectations and personality of the person who uses hallucinogens, coupled with the environmental and social conditions of use. Mood can vary from euphoria and feelings of spiritual insight to depression with suicidal ideation, agitation, confusion, and paranoia. Perception usually is intensified and distorted, and alterations in the sense of time, space and body boundaries. While illusions (visual and auditory distortions of perception) are common, true hallucinations (perceptions that do not have any basis in reality) are not. Synesthesia, a blending of the senses wherein colors are heard, and sounds are seen is a common perceptual distortion. Cognitive function may range from clarity to confusion and disorientation, although reality testing usually remains intact. include alterations in perception, cognition, affect, sense of meaning, and/or sense of self.

Observation of the patient is necessary during use, due to the risk of unintended self-injury as the result of delusions or hallucinations or of suicide as the result of depression. Patients usually recover after several hours, and may be released into the care of a responsible relative or friend.

Physical side effects may include: increased heart rate, and blood pressure, tremor, seizures, nausea, vomiting, urinary retention, increased or decreased body temperature.

Withdrawal symptoms including fatigue, irritability, and anhedonia, are reported by about 10% of people who use hallucinogens.

There is a small group of compounds similar in structure, but whose pharmacology differs from the classic hallucinogens. They have been named *entactogens*, with the prototype being MDMA, Entactogen is derived from the roots “en” (Greek, within), “tactus” (Latin, touch), and “gen” (Greek, produce), connoting substances that “produce a touching within.” Entactogens

have a mechanism of action and subjective effects distinct from the classic hallucinogens. MDMA is being proposed for the treatment of PTSD. While these substances affect emotion and promote social interaction, they do not produce the major alterations in sensory perceptions that are typical of classic hallucinogens. These compounds have hallucinogenic as well as stimulant effects. Common side effects of MDMA include: grinding of the teeth, blurred vision, sweating, rapid heartbeat, increased blood pressure, restlessness insomnia, irritability, anxiety, nausea, and increased body temperature. Other side effects that may occur include cardiac arrhythmias.

Status of Applications for U.S. Food & Drug Administration (FDA) Approval

Multiple psychedelic-assisted therapies to treat specific conditions are moving through the review process by the U.S. Food and Drug Administration (FDA), and potentially approval for medical use. The goal of phase I studies is to establish initial safety in humans, which occurs after preclinical laboratory and animal testing have been completed. The drug is given to a small number of healthy volunteers. Side effects and dose ranges are determined. As of April 2025, there are 23 psychedelic compounds undergoing phase I trials registered with the FDA.

In phase II, the drug is tested in a small number of volunteers who have the condition the drug is intended to treat. Safety data across a range of doses is collected. Conclusions to efficacy cannot be drawn due to small sample sizes, but the information gathered guides the protocols for phase III studies. There are 31 psychedelic drugs in phase II trials registered with the FDA.

Phase III trials determine a drug's safety and efficacy in a large group of patients with the identified condition or disease. Due to the large number of patients required to complete the study, these typically occur at multiple study sites both within the U.S. and internationally. Typically two phase III studies are needed to provide sufficient evidence of efficacy.

There are six compounds in phase III studies registered with the FDA as of April 2025:

Study Entity	Compound	Relevant Condition
Compass Pathways	Comp360 (Psilocybin)	Treatment Resistant Depression
Usona Institute	Psilocybin	Major Depressive Disorder
Cybin	CYB003 (Deuterated Psilocybin Analog)	Major Depressive Disorder
MindMed	MM120 (LSD D-Tartrate ODT)	Generalized Anxiety Disorder
Awakn	Ketamine	Alcohol Use Disorder
Lykos Therapeutics	MDMA	Post-Traumatic Stress Disorder

Once a drug has completed phase III studies, a drug company will submit a New Drug Application (NDA) to the FDA. The FDA reviews information from preclinical studies through phase III studies, weighing the risk versus benefit of a given drug for the condition indicated. If approved, a pharmaceutical will be eligible for sale and marketing in the U.S. A typical review time for the FDA to decide on an application (NDA) is approximately ten months.

At times the FDA may grant an investigational drug Breakthrough Therapy Designation (BTD), the goal of which is to expedite development and review of treatments for serious or

life-threatening conditions for which there is an unmet medical need. For drugs that receive BTD designation, the FDA is more involved in the phase III study design, potentially shortening the time for review. Between 2017 and 2025, five psychedelic compounds have received BTD. These include MindMed's MM120 (LSD analog) for generalized anxiety disorder, Cybin Inc.'s CYB003 (psilocybin) for major depressive disorder, Compass Pathway's COMP360 (psilocybin) for treatment resistant depression, Usona Institute's psilocybin for major depressive disorder, and Lykos Therapeutics MDMA for post-traumatic stress disorder. In one instance, the FDA's final decision to reject the findings of the Lykos Phase III trial of MDMA assisted psychotherapy is available and based on the ICER report, listed in this report's bibliography (Appendix B).

Given the number of psychedelic compounds in phase III trials with the FDA that have breakthrough therapy designation, it is not unreasonable to imagine one or more FDA-approved psychedelic medicine therapies being available in our community by 2027.

Current and Emerging Best Practices for Psychedelic Medicine-Assisted Therapies

In accordance with HB 228, and informed by the Task Force's review of protocols such as those published by MAPS, (Multidisciplinary Association for Psychedelic Studies), ethical frameworks, and practitioner training models as proposed by the State of Colorado, the following best practices are recommended to guide the safe, effective, and culturally responsive use of psychedelic-assisted therapies in Alaska once federally approved.

As with all clinical guidance, the Task Force acknowledges that the evidence base may change over time, as further research studies and evaluations are conducted on these products and therapies. The information presented below is based on information current as of May 2025 and available to the Task Force, as well as a variety of sources in Appendix B.

Therapeutic Care Model

The preferred model for administering psychedelic medicines in a therapeutic setting follows a structured, tri-phasic process:

1. Preparation sessions focus on screening, consent, safety planning, and rapport-building.
2. Medicine sessions involve supervised administration of the psychedelic compound, followed by a period of observation by a licensed therapist during the acute effects of the psychedelic, in a controlled, supportive setting.
3. Integration sessions assist the participant in meaning-making, emotional processing, and translating insights into behavior change, both between medicine sessions and as a final phase of treatment.

This model has been consistently supported in practitioner manuals, ethics codes, and training curricula and is expected to reflect protocols outlined by the U.S. FDA and Drug Enforcement Administration (DEA) upon scheduling.

The American Medical Association (AMA) has also issued Category III CPT codes for psychedelic-assisted therapy, effective January 1, 2024.

- **0820T:** Continuous in-person monitoring and intervention during psychedelic medication therapy by the primary physician or other qualified healthcare professional; per hour.
- **0821T:** Each additional qualified healthcare professional providing concurrent monitoring and intervention; per hour.
- **0822T:** Clinical staff providing continuous in-person monitoring and intervention under the direction of a physician or other qualified healthcare professional; per hour.

The assumption in these billing codes is psychedelic-assisted therapy sessions are multi-hour interventions requiring continuous, in-person monitoring. Code 0822T also describes the participation of non-licensed clinical staff operating under direct supervision during a session, recognizing a potential role for supervised, non-licensed facilitators in psychedelic care delivery.

Professional Roles and Competency Standards

Best practice treatment delivery for psychedelic-assisted medication requires a multidisciplinary team consisting of licensed prescribers, trained facilitators, integration therapists, and program supervisors. Practitioners should demonstrate proficiency in:

- Trauma-informed, trauma-sensitive care
- Navigating states of consciousness
- Cultural and psycho-spiritual responsiveness
- Risk identification and emergency response
- Professional ethics and reflective practice.

Standards established by the State of Colorado are a useful model for consideration for non-licensed facilitators, who still require training and certification to perform this function. Colorado's regulatory structure provides a comprehensive and scalable model for non-licensed individuals, including those without formal degrees in counseling or mental health. Specifically, Colorado requires a minimum of 150 hours of didactic instruction covering ethics, trauma-informed care, safety protocols, and cultural competence; 40 hours of supervised practicum; and 50 hours of consultation. These requirements ensure that facilitators are adequately prepared to support individuals through psychedelic experiences with professionalism and clinical sensitivity.

Ethical and Safety Guidelines

All psychedelic care providers should adhere to a codified set of ethical standards, including:

- Voluntary, informed consent
- Maintenance of ethical and professional boundaries in pre-, post-, and during non-ordinary states
- Strict confidentiality and documentation practices
- Harm-reduction strategies for emotional and physical safety.

The Multidisciplinary Association for Psychedelic Studies (MAPS) Code of Ethics[1] and guidance from the American Psychedelic Practitioners Association (APPA), offer foundational frameworks.

Adaptations for Alaska's Geography and Populations

Given Alaska's unique geographic and health access challenges, existing best practices must be adapted to rural and remote communities. These may include:

- Telehealth platforms for preparation and integration
- Hybrid in-home models with safety protocols adapted from anticipated nationally approved standards

[1] MAPS Code of Ethics, adopted 2021, revised 2022: also listed in Appendix B, Bibliography. https://maps.org/wp-content/uploads/2022/06/MAPS_Psychedelic_Assisted_Psychotherapy_Code_of_Ethics_V4_22_June_2022_Final.pdf

- Clinic partnerships for medicine administration
- Respectful collaboration with tribal health entities and Indigenous providers.

Example Psychedelic Practitioner Credentialing Matrix

This table is an illustrative example of defined provider roles that could be recognized for delivering psychedelic-assisted therapies, as well as required experience, training, competencies, and applicable certification(s). This example is provided for consideration and based on Colorado's credentialing structure, and is not a specific recommendation of the Task Force.

Role	Experience Required	Practicum Hours	Training Hours	Required Competencies	Reference Requirements	Certification or Endorsement
Psychedelic Facilitator (Entry-Level)	None (Entry-level support role under supervision)	# hours direct observation Internship # hours Consultation	# contact hours in ethics, somatics, safety, documentation, cultural awareness	Basic understanding of psychedelic care, Ethics, boundaries, Trauma- Informed Care, Cultural Considerations, Support techniques	# personal or professional references	Completion of approved training program and supervisor sign-off
Certified Psychedelic-Assisted Therapy Practitioner (Licensed)	# years (# hours) clinical experience	# hours supervised Trauma-Informed / Trauma Sensitive practicum	# contact hours including pharmacology, trauma care, ethics, integration therapy	Trauma- informed care, altered states navigation, cultural humility	# references, # from a licensed supervisor	State-recognized certification or license in mental health field
Traditional Healing Practitioner (THP)	Community-recognized experience in traditional healing practices	Community-verified training or mentorship under recognized traditional practitioners	Flexible; documentation of oral/traditional transmission or cultural training accepted	Ability to guide healing practices using cultural and spiritual knowledge	# community-based references (tribal, spiritual, elder-based)	Endorsed by tribal council, spiritual authority, or cultural review board

Task Force Findings and Recommendations

The Task Force was directed to consider the four following topics, with recommendations about how to address these topics:

1. *Potential Therapeutic Use*
2. *Implementation and Access*
3. *Licensing and Insurance Requirements*
4. *Potential Legal and Regulatory Changes*

The Task Force has prepared the following findings and recommendations for policymakers, regulators, providers, and the general public regarding possible future actions by the State in response to FDA approval of psychedelic-assisted therapies.

All findings and recommendations in this report have been approved by a majority vote of Task Force members; individual members' votes are recorded in Appendix C.

Findings

1. **Finding 1**: The Task Force has reviewed the available literature on psychedelic medicine therapies, as well as their status in FDA review, and determined that the available evidence suggests there are potential therapeutic uses. While clinical studies are ongoing and the evidence base is evolving, there is particular focus on use of these therapies for veterans, survivors of assault and interpersonal violence, and others with treatment-resistant post traumatic stress disorder (PTSD).

2. **Finding 2**: The current evidence base and best practices indicate that effective use of psychedelic medicines for treatment of certain mental health conditions, such as treatment-resistant PTSD, means medicines are used in a treatment setting as part of an overall psychotherapeutic approach, and not simply self-administered. Furthermore, this requires a team approach, with potentially multiple provider types playing roles in the treatment process, from medical evaluation and psychological assessment, to prescribing medications, to ongoing monitoring during patient sessions. The team approach described in the research literature has included a licensed, professionally trained trauma informed therapist.

3. **Finding 3**: Both the federal and state government have systems for scheduling controlled substances. At the federal level, upon FDA approval, the U.S. Drug Enforcement Agency (DEA) would be expected to re-schedule the approved psychedelic substances. At the state level, if the DEA re-scheduled psychedelic medications as Schedule II, III, and IV controlled substances, the medications would be subject to the requirements (and exemptions) of the Alaska Prescription Drug Monitoring Program (PDMP).[2] Changes to the Alaska drug schedule, if necessary, will be recommended at the discretion of the Controlled Substance Advisory Committee per AS 11.71.120.

[2] See Alaska Board of Pharmacy statutes and regulations, pp. 56-58. Link: https://www.commerce.alaska.gov/web/Portals/5/pub/PharmacyStatutes.pdf

4. **Finding 4**: The current clinical evidence and experience with other behavioral health therapies indicates that a team approach to care is important, including a team of providers who may be playing distinct roles in the treatment, with differing types of licensing and credentials. For example, a medical doctor may be authorized to prescribe the medications, while other health professionals may be responsible for monitoring the patient during a medication session.

5. **Finding 5**: Consent is especially important with psychedelic therapy, and requires meaningful work to inform and educate the patient about the process, establish clear boundaries and informed consent before treatment begins, with decisions about how treatment will be provided, what type(s) of facilitator or other providers the patient will work with, determining consent for interaction before, during, and after treatment sessions (for example, what types of touch the patient consents to, or does not consent to), and generally establishing the patient has provided informed consent.

6. **Finding 6**: The Task Force discussed at length, but did not make a definitive recommendation, about whether a non-licensed facilitator model (such as one modeled on the regulatory structure in place in the state of Oregon) would be appropriate for use in Alaska. The group considered role(s) for non-licensed providers, and made recommendations for certification, but did not take a position on whether or not to consider an equivalent model to that of Oregon.

Recommendations

Recommendation 1: If and when psychedelic medicine therapies are FDA approved, the state should take action to allow for their use in Alaska, rather than prohibiting use.

Recommendation 2: Identify clinical working group(s) whose function is to regularly review updated studies and the evidence base to make recommendations, and rely on these entities to provide ongoing guidance on use of these therapies.

Recommendation 3: To the extent possible, reserve use of state statute for broad enabling language and key components of a regulatory structure, and leave most regulatory decisions to the relevant boards and agencies. Regulations still require robust public process in order to be adopted, but can be updated or modified more predictably and easily than statute changes, which require an act of the Legislature. It is likely that appropriate parameters for use of these therapies will change over time, as the evidence base matures and FDA approval may be granted for multiple therapies.

Recommendation 4: If and when psychedelic medicine therapies are FDA approved, the Alaska State Medical Board should update the Guidelines for Prescribing Controlled Substances to include appropriate use of psychedelic medication for approved indications.

Recommendation 5: If and when psychedelic medicine therapies are FDA approved, the Alaska Board of Nursing should develop and adopt an advisory opinion on the use of FDA approved psychedelic medications in non-acute settings.

Recommendation 6: If and when psychedelic medicine therapies are FDA approved, and if pending legislation to expand Pharmacist prescriptive authority (SB 147 introduced in 2025, or a future bill) is passed, the Alaska Board of Pharmacy should develop and adopt an advisory opinion on the use of FDA approved psychedelic medications in non-acute settings by pharmacists working under collaborative agreements.

Recommendation 7: Regulate uses of these products according to evidence-based treatment protocols. Depending on the therapies and substances approved for clinical use and subsequent guidance based on available research, there may be in the future multiple approved ways to administer these medications, such as micro-dosing (taking small amounts) or conducting a session via telehealth.

Recommendation 8: The State should consult with the existing Controlled Substances Advisory Committee (CSAC), established in AS 11.71.100, who should:

- Recommend regulations to the Board of Pharmacy regarding the prevention of excessive prescribing and the diversion of newly approved drugs.
- Evaluate the effectiveness of treatment resources for persons with existing substance use disorders stemming from use of the psychedelic class of drugs.
- Evaluate the enforcement policies and practices regarding crimes involving controlled substances.
- Review budget requests and recommend appropriations regarding the building out of regulations around handling of FDA approved psychotropic medications.

Recommendation 9: Align licensing and credentialing requirements for providers with treatment models in evidence-based therapies, with attention to what each provider is authorized to do.

Recommendation 10: Upon FDA approval and DEA scheduling, the State should fully mirror federal scheduling and Risk Evaluation and Mitigation Strategies (REMS) without adding duplicative or conflicting state rules, and follow any rules regarding whether DEA licensure is required for prescribers. This approach respects federal science and streamlines access for patients and providers.

Recommendation 11: In anticipation of FDA approval and DEA scheduling, the State should consider legislation that will prompt implementation actions at the state level to include the recommendations made in this report. Trigger legislation would require addressing several process and regulatory questions, such as the role and involvement of professional licensing boards, state agencies, and the Controlled Substance Advisory Committee.

Recommendation 12: To ensure safety and prevent diversion, the State should integrate psychedelic medicines into the Alaska Prescription Drug Monitoring Program (PDMP) upon federal scheduling. This would allow for real-time monitoring of prescribing and dispensing, with no major new cost to the State.

Recommendation 13: Prioritize veteran access to FDA-approved therapies, such as working with the U.S. Department of Veterans Affairs and Alaska health agencies to make veterans eligible participants in clinical trials, pilot programs and other opportunities for access. Support

provider education and outreach to VA personnel and community providers who serve veterans. Collaborate with federal, state, and nonprofit veteran service organizations to inform Alaska veterans about available therapies.

Recommendation 14: Develop a pathway for a non-licensed psychedelic facilitator role, with a State-issued certification requirement that includes any necessary required training for monitoring patients during treatment. Benefits of this pathway include increased access to psychedelic care that is a cultural fit to the preferences and needs of the patient as well potentially increasing access to psychedelic care by decreasing costs. A potential model for this role is the Community Health Aide Program (CHAP). Topics may include training in heart rate and oxygen level monitoring, emergency and first aid response if the patient experiences an emergency during treatment. State certification of non-licensed providers also provides regulatory and enforcement oversight by the State, which increases patient protection. Additionally, there may be other models to consider for practitioners, such as Traditional Healers; Tribal consultation should be conducted regarding how State regulation would intersect with the Tribal health system, and consideration of utilizing pilot programs.

Recommendation 15: The State should determine what training(s) and continuing education are necessary to maintain a license, endorsement on a license, certification, and/or demonstrating competency in their scope of practice, such as prescribing authority. The State should also consider how providers can access appropriate trainings and certifications based on FDA guidance and other clinical sources. If there is current federal guidance or requirements for training, the State should follow these; if this does not exist at the time of FDA approval, it may require the State to establish interim training requirements or guidelines to address this need.

Recommendation 16: In developing Alaska's training and certification framework for psychedelic-assisted therapy facilitators, the Task Force recommends modeling the standards established by the State of Colorado. Adopting a similar model in Alaska will support public safety, uphold ethical standards, and ensure statewide consistency while maintaining accessibility for rural and Indigenous communities.

Recommendation 17: Allow prescription and/or administration authority for any provider with existing authorizations for controlled substances, if the treatment is within their scope of practice and consistent with their training.

Includes: Physicians, physician assistants (PAs) with dispensing authority, advanced practice registered nurses (APRNs) with dispensing authority.
Pending/Potential: Pharmacists with dispensing authority (Alaska SB 147).
Excludes: Dentists, veterinarians, and optometrists.

Recommendation 18: Treatment and access to prescriptions should not occur through use of standing orders of medication. Regardless of setting and provider, the patient must first have undergone both medical and mental health assessment, to determine that the patient meets criteria for psychedelic assisted treatment.

Recommendation 19: The State must consider Alaska's unique geographic and health access challenges, particularly for rural and remote communities. Creating regulatory systems for provider licensing and credentialing, defining methods of accessing and delivering treatment,

and considerations for culturally appropriate practices, should take into account the challenges and limited capacity of rural health systems. This includes methods for patient access, such as whether preparation and integration sessions (non-medication sessions) could be conducted through telehealth; it also includes considerations for what provider types and pathways for certification exist, such as proposed analogues to the Traditional Healer role (*see Recommendation 14*).

Recommendation 20: A code of ethics should be created, or adopted by reference, for all providers engaged in psychedelic-assisted therapy, and integrate this code of ethics into any required licenses, certifications, or other roles who work with patients. This is important not only for upholding high standards of care, but also provides codified expectations on providers, given the nature of the therapy and potential for patient harms if violations of boundaries, consent, or other ethical issues occur.

Recommendation 21: The State should establish requirements for informing patients of their rights, as well as a venue and process for addressing grievances. For example, requiring postings or notices about patients' rights and what to expect; requiring a consent form signed by the provider and patient before treatment begins; publishing where and how to report grievances; and (likely through a certification or endorsement system for providers), establishing which entity(ies) have authority to take action in the case of grievances.

Recommendation 22: Health care payors (insurers) should uniformly and equally apply reimbursement rates for the same type of health care service or supply and for health care providers who are practicing within their scope of their license and who are authorized to bill for health care services or supplies under the current CPT codes adopted by the AMA or other industry standard method of coding.

Recommendation 23: Regarding determining the amounts to be billed: Medicaid Pharmacy and Therapeutics committee will need to consider the availability of this drug and determine the structure for prior authorization as well as what can be billed for.

Recommendation 24: The Medicaid Pharmacy and Therapeutics committee should consider the pricing of the medications that fall within the category of Psychedelic medication to be part of the Medicaid pharmacy benefits, rather than part of a "buy and bill" model which hinders access.

Recommendation 25: Advocacy should be considered to ensure active efforts by the American Medical Association, (AMA) and Centers for Medicare & Medicaid Services, (CMS) on developing billing codes that will promote sufficient reimbursement for psychedelic therapy delivery are vital to ensuring patient access post-FDA approval.

Appendices

The following appendices are available with the report:

Appendix A: Task Force Member Statements

Appendix B: Bibliography and References

Appendix C: Task Force process documents, meeting packets, notes, and voting records

Appendix D: Task Force public comment packet and received written comments

Appendices C and D are available as separate documents.

Appendix A: Task Force Member Statements

Each Task Force member had the opportunity to provide an optional statement, as an individual or on behalf of the organization they are representing in their seat. Three members' statements are provided below, in alphabetical order by the member's last name. Unless noted below, statements represent the member's individual views, not their organization.

Dr. Paula Colescott, M.D., FASAM, designated member of Alaska State Medical Association

Dissenting Opinion

As an Internal Medicine physician, specializing in Addiction Medicine, I have serious concerns regarding recommendations that have been proffered by this Task Force, which are primarily related to safety concerns.

Side Stepping Established Entities that are Safety Measures for the Patient:

1. It is unusual for a pharmaceutical to be made accessible by legislation rather than FDA 's Center for Drug Evaluation and Research (CDER) which gives regulatory approval based on the results of clinical trials, and extensive literature review.

   The use of psychedelics is a dramatic departure from currently available medical and behavioral therapies and raises unique challenges, that must be thoughtfully, and thoroughly examined by established agencies, such as the FDA, in concert with the Controlled Substance Advisory Committee, created under the authority of AS11.71.100, which is made up of various subject matter experts in the field of controlled substances, with expertise in medicine, law enforcement, and citizenry. The CSAC is charged with advising the Governor of the need to add, delete, or reschedule substances under Alaska law, and with evaluating the effectiveness of current programs, budget and appropriations, enforcement policies and procedures, treatment, counseling and regulations regarding controlled substances. The committee consists of 9 members: the Attorney General, the Commissioner of Health and Social Services, Commissioner of Public Safety, President of the Board of Pharmacy, a peace officer appointed by the Governor, a physician appointed by the Governor, a psychiatrist appointed by the Governor, and two individuals appointed by the Governor. These individuals serve for four years.

   Their recommendations are forwarded to the Legislature, Governor, and Alaska Court System. Although this may take time, these procedures are in place to ensure the safety of the community.

The formation of this task force has circumvented this important process, and is not a substitute for the expertise on this established advisory board in concert with the FDA's findings.

Due to time constraints, this task force was unable to make a comprehensive and critical review of the literature on this subject. However, the consensus statements provided by the Cochrane Review, American Psychiatric Association, American Medical Association, and ICER report on the Phase III trial of MDMA assisted psychotherapy in PTSD, are *

included in the Bibliography (Appendix B).

2. **The American Psychiatric Association** released a position statement on *The Use Of Psychedelic And Empathogenic Agents For Mental Health Conditions* in 2025. "The onus to characterize the potential harms of psychedelic treatment is a guiding principle in medicine (*Primum Non Nocere*—First do no harm). As with all therapeutic interventions, research is needed not only into their benefits, but also potential risks, including scrutiny in broad populations with psychiatric and medical comorbidities typically excluded from clinical trials. Among the known and potential harms of psychedelic treatments reviewed by Ghaznavi and colleagues include enduring perceptual disturbances, overuse, misuse and dependence, challenging experiences or "bad trips", acute and cumulative cardiovascular effects, and more. They also make recommendations for further research and monitoring." *For a copy of full articles: press@psych.org*.

3. As an example: consider Cannabis, still a Schedule I drug,

   Cannabis was first accepted for medical use, then decriminalized via legislative reform, and then sanctioned for recreational use in Colorado, despite continued DEA Schedule I status and the absence of FDA approval. The public was led to believe that cannabis was not harmful, but actually helpful for painful conditions, its addiction potential was minimized, withdrawal was advertised as non-existent, proponents claimed criminal distribution would cease since the product would legally be available, and that children would be safe because of an imposed age restriction to access cannabis. Furthermore, safety on the highways wouldn't be impacted by recreational use, since people were instructed and certainly wouldn't drive under the influence of highly potent, purified cannabis products, that soon were available in numerous cannabis shops in Denver.

   The Colorado Department of Criminal Justice has released several Hi-hidta.org reports which follow the fallout of these decisions by their legislatures.

   a. 52.5 million Americans used marijuana in 2021 vs. 17.5 million Americans used marijuana in 1992.
   b. Use is increasing across the board, but especially in young adults aged 19-30.
   c. 30% of marijuana users have some form of marijuana use disorder.
   d. Use before the age of 18 increases the likelihood of marijuana use disorder by seven-fold.

e. Legalization is associated with a 25% increase in marijuana use disorder among 12–17-year-olds.
f. Vaping marijuana is also up across the board, especially for youth.
g. Between 2017 and 2021, the percentage of 12th graders who vaped marijuana in the past year increased from 9.5% to 18.3%.
h. In the United States, there were 804,285 marijuana-related emergency department visits; these numbers have increased since 2011.
i. Marijuana users were nearly 25% more likely than non-users to go to the ER or be hospitalized (*Vozoras et al., 2022*). "Colorado has reported a 46% increase in hospitalizations due to cannabis hyperemesis cyclical vomiting in just five years after the legalization of recreational cannabis" g.s. (*Wang et al. 2021*)
j. Nationally, there were 2,473 in-home marijuana exposures involving children younger than 12 in 2020, up from 598 in 2018.
k. In 2020, 24.3% of drivers involved in traffic fatalities tested positive for marijuana, up from 14.8% in 2013.
l. One in four road deaths in Colorado involve marijuana.
m. 70 to 80% of marijuana sold in state-legal dispensaries in California was produced and grown Illegally.
n. People did die from the edibles from psychotic breaks, and self harm.
o. The IQ of kids tracked from early teens into their 30's were found to decrease based on the frequency of marijuana use.
p. Kids who used in school had a greater incidence of dropping out of high school, unwanted pregnancies, trouble with the law, and higher incidence of transitioning to using other substances like opiates.

Psychedelic reform is proceeding in a rapid, patchwork fashion, with state legislative reforms shifting the prospects of psychedelic treatment and illicit drug enforcement. Based on data from cannabis legalization, it is projected that most states will have passed legislation legalizing psychedelics by 2033–2037. Legalization sends a clear message to the youth that psychedelics are harmless and pose minimal risk. Because psychedelics have been controlled, we have no idea what the incidence of severe side effects to the public will be if increasingly made available.

Both the **American Psychiatric Association** and **American Medical Association** have voiced the following:

"The introduction of psychedelics is a dramatic departure from currently available medical and behavioral therapies and raises unique challenges that must be answered by further research, particularly addressing their use in populations that have previously been excluded in research trials and further defining long term effects of these agents in the general population.

Recommendation: Any recommendations forwarded to the Legislature should be formulated from the FDA's anticipated reports in conjunction with evaluation by Alaska's Controlled Substance Advisory Committee.

Regarding the Validity of Research on Psychedelics Used as Medicine

The current Task Force's report recommendations suggest that research has proven benefit and strongly supports the release of psychedelics in assisted psychotherapy; however, while both psilocybin-assisted therapy and MDMA-assisted therapy findings are promising, there are several challenges with psychedelic research that should be considered when interpreting the evidence.

A phase III trial by Lykos on the use of MDMA for the assisted treatment of PTSD, highlights these difficulties. This trial was rejected in 2024 by the FDA, after a report by the Institute of Clinical and Economy Research (ICER), released its findings.

The following two sections are an excerpt from the ICER report:

2.1.2. Trial Conduct Entwined with Ethical Concerns

The pool of therapists and, in some cases, trial participants appear to have pulled heavily from the existing community of those interested and involved in the use of psychedelics for possible psychological benefits ("the community"). This created multiple issues:

- We heard from various people that feelings around psychedelics lead the community to engage with them more like a religious movement than like pharmaceutical products, that these feelings were common in those participating in the MAPP trials, and these feelings were sometimes inculcated in patients participating in the trials.
- Functional unblinding is a particular concern in this trial. As noted, patients were able to identify when they had received MDMA. Unblinding of therapists was particularly likely given their experience with psychedelic medications. 40% of patients had prior experience with MDMA.
- We heard repeatedly about pressures to have the results of the MAPP trials be favorable. There apparently was a sense that such therapies are beneficial and needed and negative results could hinder progress. This led to some participants feeling pressured to report good outcomes and suppress bad outcomes when they were in the MDMA arms of the trials. Additionally, for those who were part of the community, some participants felt they could be shunned if they reported bad outcomes, or it could lead to future patients being denied the benefits of MDMA-AP. We heard that positive reports generated positive feedback and negative reports generated negative feedback. We heard this is a particular problem in people receiving MDMA as it makes them particularly suggestible and susceptible to context.

  Patients in the trials included therapists who had worked in this space, including some with very close relations with those running the clinical trials. This is unusual and heightens concerns about pressures to tailor reported results.

- We heard first- and second-hand reports of extremely severe negative outcomes for participants in the trials that do not seem to have been attributed to the treatment by the trial researchers. Some patients were told by their therapists that their negative outcomes were evidence they were responding appropriately and would eventually improve. Some patients were prevented from entering the long-term follow-up study, and felt this was done to keep these negative outcomes out of the data set.

- We heard of an event where, after the trial was completed and a participant was struggling, that they were told to take their own supply of MDMA at home. We heard secondhand reports of similar events. Even if this was only a singular event, it shows the clear breakdown of blinding, inclusion of participants anticipated to have access to their own supply of MDMA, and a disregard of good clinical trial practices.

- Physical boundary violation was reported concerning one therapist who subsequently became sexually involved with the participant. Nearly everyone we spoke with discussed how MDMA breaks down barriers, heightens suggestibility, and creates a substantial risk with any therapists who might choose to take advantage of patients.

- Additionally, some experts highlighted concerns about lack of long-term data regarding cardiovascular harms.

Because of these concerns, multiple experts felt that the harm with real-world implementation of MDMA-AP will be much greater than would be expected from the clinical trials. As a result, several experts felt that more study was required before moving forward with MDMA-AP.

2.1.1. Trial Conduct Separate from Ethical Concerns

We heard from multiple people that the CAPS-5 measures of improvement failed to capture participants overall response to MDMA-AP. We repeatedly heard about participants experiencing improvement or resolution in the single trauma identified for the CAPS-5 measurements while new issues became overwhelming following MDMA-AP (Assisted Psychotherapy). We heard this from multiple people in ways that leave us with no doubt that this occurred – that is, that there were participants who improved on the CAPS-5 outcome while worsening overall – but, as with many issues we encountered, we are unable to assess the frequency of these events.

We heard that therapy was not well standardized in the MAPP trials and, as a result, it is hard to be certain how to generalize from the results. However, we also heard that this problem exists in many trials of psychotherapies for various disorders where it can be hard to separate the effects of the specific therapist from those of the general therapeutic approach.

The VA Points Out Gaps in and Challenges with Psychedelic Research as Well

See: https://www.ptsd.va.gov/professional/treat/txessentials/psychedelics_assisted_therapy.asp

Excerpt: “Many existing studies on MDMA-AT and P-AT also include small sample sizes and maintain some risk of bias, particularly with lack of randomization and unexpectedly high response to low dose control conditions (59,73,74). Therefore, there is an urgent need for additional studies with Veteran participants within the VA medical setting, as well as additional studies on P-AT for PTSD and studies with larger, more diverse samples.”

Introducing Psychedelic-Assisted Treatment into Remote Areas Would Set a Dangerous Precedent

In current research designs, MDMA is given in a limited number of sessions (usually 1 to 3) that may last 6 to 8 hours, and are spaced 3 to 4 weeks apart if there is more than 1 session. A typical MDMA study will include preparatory sessions that take place before the first medication session. During this preparation a physical exam is performed, labs possibly drawn, with screening the patient for any exclusionary medical problems. Following, patients learn about what to expect when taking MDMA and how to respond to any feelings that arise. These sessions are followed by 6- to 8-hour long medication sessions. During these sessions the therapists focus on creating a sense of safety, while helping the patient turn inward. The therapy is non-directive and there is a focus on attending to what is happening in a patient's body. After an MDMA session there are several 90-minute psychotherapy integration sessions. The focus of these sessions is to develop a deeper understanding of insights gained during the MDMA session and any thoughts and feelings that came up on the impact of PTSD on the patient's life. The medication and integration sessions are repeated three times. The entire treatment takes about 18 weeks, if 3 medication sessions are given.

The recommendation of replacing a licensed, trauma informed therapist with years of training, with non-licensed facilitators, without degrees in counseling or mental health, who would be trained and receive a certification by an entity which does not presently exist, in the Alaska bush communities is not only reckless, but NOT best practice.

Would these facilitators have the skill set and expertise to first develop a therapeutic alliance with the patient, be familiar with and recognize the side effects of the hallucinogen, and then be able to respond to a frightened, severely physically agitated patient, under the influence of a mind-altering substance like MDMA, which could last for hours? Keep in mind that many villages in the bush do not have physicians, nurse practitioners, or physician assistants, or a Village Public Safety Officer (VPSO) available, should a serious event occur. Placing unseasoned individuals, who might have hours of “observing” the process, doesn’t mean they can facilitate one themselves.

As the Lykos trial made clear, patients are under the influence of psychoactive substances, making them vulnerable in ways that are somewhat unique to the modern clinical trial landscape. Facilitation of such treatment requires ethical and sound oversight to ensure patients are safe from potential harm, not only from the patients’ own actions, but also potentially from the actions of others.

Psychedelic treatment and monitoring in a village may not be practical, safe or therapeutic. The village may be the location of the participant’s prior trauma. In these tightly-knit groups, privacy

may be difficult to achieve, and the results of unexpected intrusion into a psychedelic experience could result in an adverse event or abrogate any perceived benefit. Additionally, alcohol and drug abuse associated with violence is disproportionally high in these peripheral communities. Since set and setting are important in making the foundation for a positive experience with psychedelics, the villages may not be ideal for this kind of intervention.

Recommendation: An excellent process for accessing care already exists for the Alaska bush community. Clients meeting criteria for psychedelic-assisted psychotherapy can be sent to Anchorage, where they can be treated by a multidisciplinary team of professionals, in an existing safe environment prepared for this treatment. Keep in mind psychedelic assisted psychotherapy isn't an emergency.

Risk for Drug Dependency

Although it is thought psychedelics have low risk potential for addiction, it is known that MDMA can cause dependency. If three sessions of MDMA are given, as outlined in certain protocols, its risk of this exposure leading to the patient continuing to seek out the MDMA, and subsequently developing dependency is unknown.

Recommendation: If and when such treatments are approved by the FDA, registries maintained by the Substance Advisory Board would record the acute and chronic side effects for any psychedelic used in a clinical setting.

Respectfully,
Paula J. Colescott M.D.

Sara Kozup-Evon, designated member of the Advanced Practice Registered Nurse Alliance

It was a privilege and a pleasure to participate in the Alaska Task Force for the Regulation of Psychedelic Medicines. I am especially grateful to the HB 228's sponsors for recognizing the value of Advanced Practice Registered Nurses (APRNs) in meeting the health needs of Alaskans, and the contributions of APRNs to health policy.

I would like to provide context for my No votes for inclusion of Finding 4 and Recommendations 2, 7 and 16. Please see each finding or recommendation, and my comments below.

> ***Finding 4****: The current clinical evidence and experience with other behavioral health therapies indicates that a team approach to care is important, including a team of providers who may be playing distinct roles in the treatment, with differing types of licensing and credentials. For example, a medical doctor may be authorized to prescribe the medications, while other health professionals may be responsible for monitoring the patient during a medication session.*

Comment: Interprofessional collaboration and a team approach are important values in the provision of psychedelic health care. However, I voted no on the inclusion of this finding due to the overly physician-centric wording of the finding with the use of only “medical doctor” in the example. It is valuable for the audience of this report to understand that high quality and effective psychedelic care, once FDA approved and rescheduled by the DEA, will be provided in Alaska at times without the involvement of a medical doctor. It is within the scope of Advanced Practiced Registered Nurses (APRNs) who have a certification in Psychiatric Mental Health Nursing and a license from the DEA to conduct a medical screening, psychological evaluation and provide psychotherapy. APRNs meet a critical need in the provision of health care in Alaska and it is valuable for the public to understand their independent practice.

> ***Recommendation 2****: Identify clinical working group(s) whose function is to regularly review updated studies and the evidence base to make recommendations, and rely on these entities to provide ongoing guidance on use of these therapies.*

> ***Recommendation 7****: Regulate uses of these products according to evidence-based treatment protocols. Depending on the therapies and substances approved for clinical use and subsequent guidance based on available research, there may be in the future multiple approved ways to administer these medications, such as micro-dosing (taking small amounts) or conducting a session via telehealth.*

Comment: There are important values to be communicated in each of these two recommendations. However I voted No on each because they potentially add unnecessary regulation on top of standards of care. Standard of care guides much of the practice of health care. The standard of care evolves over time through both research and clinical experience. It is common for high quality health care that is in line with the standard of care, to include practices and approaches beyond FDA approval. It is common for the state to regulate who can provide care, but it is unusual for the state to regulate how care is provided. Additional regulation increases costs, decreases access and is challenging to update as knowledge and clinical experience evolves. Decreased access to care has real world ramifications in the lives of Alaskans who suffer with treatment resistant mental health conditions.

> ***Recommendation 16****: In developing Alaska’s training and certification framework for psychedelic-assisted therapy facilitators, the Task Force recommends modeling the standards established by the State of Colorado. Adopting a similar model in Alaska will support public safety, uphold ethical standards, and ensure statewide consistency while maintaining accessibility for rural and Indigenous communities.*

Comment: It is likely that a standard of education will evolve in the professional preparation of therapists, nurses and physicians. Over time new clinicians will graduate with the skills necessary to provide psychedelic health care incorporated into a holistic treatment program. Additional requirements from the state will potentially increase cost and decrease access.

I robustly support Recommendation 14, the development of a non-licensed facilitator role in Alaska. However, the care this facilitator provides will exist within a team of licensed health care

providers. As such they will likely need different training from the Colorado program, which was designed for psychedelic experiences provided outside of the standard health care system.

Thank you for your consideration.

With gratitude,
Sara Kozup-Evon, DNP, PMHNP-BC
Doctor of Nursing Practice;
Psychiatric Mental Health Nurse Practitioner- Board Certified

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NAMI Alaska organizational statement, represented by Justin Heminger (member, board member for NAMI Fairbanks) and Ann Ringstad (alternate, Executive Director for NAMI Alaska).

NAMI Alaska Statement on Participation in the Task Force on Psychedelic Medicine

NAMI Alaska is honored to have participated in the Legislative Task Force convened following the passage of HB 228 (2024) to explore the regulation of psychedelic medicines in Alaska.

NAMI believes all individuals living with mental health conditions deserve access to effective, evidence-based treatments that promote recovery and wellness. In alignment with this, we support public policies that facilitate rigorous scientific research into both the potential benefits and risks of **Schedule I substances**, including psychedelic compounds, for mental health care.

At present, psychedelic substances such as psilocybin and MDMA remain **classified as Schedule I drugs** under the federal Controlled Substances Act. This means they are considered to have a high potential for abuse, no currently accepted medical use, and a lack of accepted safety for use under medical supervision. However, several substances are now undergoing **FDA-authorized clinical trials**, and some—like MDMA for PTSD—are in late-stage (phase III) studies, potentially paving the way for **future FDA approval**. Until such approval is granted, these treatments remain under investigation.

As more states move to decriminalize or legalize marijuana and other psychedelic substances, it is critical that state-level decision-making be grounded in **credible, peer-reviewed evidence** and **comprehensive public health planning**. NAMI Alaska stresses the importance of continued research before widespread adoption of these therapies.

We have greatly valued the depth of expertise shared by the Task Force members, especially professionals in medicine, behavioral health, pharmacology, and public health. Their insights have contributed to a robust discussion about the safe and ethical use of psychedelic-assisted therapy. We also appreciate the thoughtful consideration given to **Alaska Native healing traditions** and the role of Traditional Healers in culturally informed care.

Among the Task Force's most important recommendations is the need to **align licensing and credentialing standards** with evidence-based treatment models, ensuring that all providers operate within their scope of practice. Additionally, we support the exploration of a **State-certified, non-licensed facilitator role** that includes comprehensive training and oversight for patient support during psychedelic treatment. This could expand access to culturally relevant care while also reducing barriers and costs.

Once FDA approval is granted for specific psychedelic treatments, we urge the State of Alaska, the Legislature, and relevant regulatory bodies to move forward **thoughtfully and responsibly**, guided by science, safety, and equity.

We are confident that the Task Force's findings and recommendations will provide a strong foundation for Alaska's future decisions in this emerging area of mental health care.

Respectfully,

Ann Ringstad and Justin Heminger
NAMI Alaska, Inc.

Appendix B: Bibliography and Resources

The following bibliography of literature and resources on this topic was compiled by Task Force members. Where possible, a hyperlink is provided where the resource can be accessed electronically. Some resources, such as scholarly journal articles, may require subscription access to read in full.

Disclaimers: The information and perspectives presented in these resources do not necessarily represent the views or position of the Task Force, individual Task Force members, or any organization represented on the Task Force. Additionally, this resource list is not an exhaustive or comprehensive literature review of the topic, but does provide a sample of information and research currently available as of the time of publication of this report.

Alaska House Bill 228

Alaska House Bill 228: An act establishing the Alaska task force for the regulation of psychedelic medicines approved by the United States Food and Drug Administration; effective date, 2024.

Bill and supporting documents: https://www.akleg.gov/basis/Bill/Detail/33?Root=hb228

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Appendix C: Task Force Process Documents

The following documents are compiled in the order listed, available in a separate document.

1. Task Force Group Agreements, approved February 26, 2025
2. Task Force Voting Procedures, approved April 29, 2025
3. Preliminary Logistics Meeting on December 11, 2024: agenda, summary notes
4. Meeting 1 on February 4, 2025: agenda packet, summary notes
5. Meeting 2 on February 26, 2025: agenda packet, summary notes
6. Meeting 3 on March 19, 2025: agenda packet, summary notes
7. Meeting 4 on April 2, 2025: : agenda packet, summary notes
8. Meeting 5 on April 16, 2025: agenda packet, summary notes
9. Meeting 6 on April 29, 2025: agenda packet, summary notes
10. Task Force Member Vote Records on Recommendations (May 19, 2025) and Final Report Approval (May 30, 2025)

Appendix D: Public Comment Packet

The following documents are compiled in the order listed, available in a separate document.

1. Public comment flyer, published April 21, 2025
2. Public comment draft report, published April 21, 2025
3. Public comments received between April 21 and May 5, 2025