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## Legalizing Marijuana, Psilocybin Mushrooms, and MDMA for Medical Use

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**Legalizing Marijuana, Psilocybin Mushrooms, and MDMA for Medical Use**

by

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## **Acknowledgments**

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### **Dedications**

This paper is dedicated to those who are suffering from medical conditions while serving the United States of America.

## Abstract

Knowing the countries drug history will allow the reader to understand how policies have changed throughout our countries short history. The Drug Enforcement Administration Drug Schedule, the Uniform Code of Military Justice, Department of Defense policies, the Air Force's drug policies and the Department of Veterans Affairs policies is what is holding back the legalization of medical marijuana, psilocybin mushrooms, and Methylenedioxyamphetamine (MDMA) for treatment options for federal employees, current military members, and veterans who suffer from chronic pain and Post-traumatic stress disorder. Being a change agent within your organization will help push for drug reform within the federal government. Ethical considerations should be used while determining if medical marijuana, psilocybin mushrooms, and MDMA are valid medical options for members of the federal government. This section will cover both sides of the medical marijuana debate, along with new research found using psilocybin mushrooms and MDMA. The last section will look into ethical leadership and how a leader can implement new changes ethically in their workplace. Laws, legislation, and policies are what dictate what our society can or cannot do. These are considered the norm of society, but what happens when society changes? Do citizens move forward and push new laws, legislation and policies? This is what is currently happening with the legislation of medical marijuana, psilocybin mushrooms, and MDMA. Multiple states have either made marijuana decriminalized, made medically legal, or made legal for recreational use. The federal government still hasn't made a push for the drug, while new research is showing how marijuana, psilocybin mushrooms, and MDMA can help with chronic pain, PTSD, and other medical conditions.

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## **Legalizing Marijuana, Psilocybin Mushrooms, and MDMA for Medical Use**

There are situations where using marijuana, psychedelic mushrooms or MDMA would have provided better treatment for military members who suffer from psychological and physiological chronic pain. With thirty-three states passing some type of new marijuana laws the federal government, the military, and veterans affairs need to relook the outdated laws, so federal employees can use these drugs for medical treatment. Researching the history of our nation's first drug policies, the Department of Defense's drug policies, the Department of the Air Force's drug policies, and the Department of Veterans Affairs's drug policies will help the reader understand why the drug policies we have now and how other federal agencies are dictated from federal law. Being a change agent in your organization can bring change to any policies that may be old and outdated.

Ethical considerations can be tricky when trying to implement a new change to a policy. This next section will cover how a leader would consider and apply the ethical principles to a new drug policy. The Department of Defense, the United States Air Force, and the Department of Veterans Affairs should allow their members to use marijuana, psilocybin mushrooms, and MDMA medically. With new medical research stating the use of these drugs is beneficial for chronic psychical and physiological diseases, ethical leaders should consider this new research when forming and implementing new drug policies. Current research will be introduced for the positive and negative benefits legalizing these drugs would bring to the agencies.

Public policies, laws, and court cases have influenced marijuana, psilocybin mushrooms, and MDMA for medical use. The Controlled Substance Act, *Gonzales v. Raich*, 545 U.S. 1, 2005, states with a Controlled Substance Act, Oregon's Measure 110,

Oregon's Measure 109, the United States Food and Drug Administration testing phase with MDMA and the Entheogenic Plant and Fungus Policy Act of 2020 have all provided new legislation in the United States by making marijuana, psilocybin mushrooms, and MDMA medically accepted, decriminalized, explaining how states can create their own drug policies and making the drug offense the lowest priority for law enforcement.

Applying new legislation and policies to the Department of Defense starts with Air Force Instruction 31-117 Arming and Use of Force policy. This policy dictates who and how a military member can bear arms. Forming new legislation for the federal government, Department of Defense and Department of Veterans Affairs could be accomplished by looking at other country's drug policies that have successfully decriminalized or allowed drugs to be legal for medical or personal use. The last step would be implementing the new policy and how federal agencies would apply ethical principles in the development, implementation, organizational and disciplinary actions.

### **The United States Drug History**

The history of the United States drug policy can be traced back recently in our nation's history. Looking throughout history will help the reader understand when certain policies were made and how these policies affected our nation. Major drug policy changes started to take place during the 19th century. In the 19<sup>th</sup> century, cocaine and opium were popular for medical and recreational use, oftentimes found in magazines as ads. The United States federal government did not have any laws or regulations for the use of cocaine or opium, with the exception of smoking opium. The problem became to grow rapidly when doctors were prescribing cocaine and opium to their patients for practically every medical treatment. The abuse of these drugs caused a social outcry for



the concern of these drugs. Lisa N. Sacco stated, “scholars identify the separation of federal and state power as a major reason for an unregulated U.S. drug market in the 19th century. Attempts to establish federal control over drugs were met with strong opposition from patent medicine firms and state officials” (Sacco, 2014, p. 2).

The United States federal government heard the social outcry, and The Harrison Narcotics Act was passed in 1914. This act was the first major legislation passed to control the imports, manufacturing, and distribution of cocaine and opium in the United States. A special tax was placed on these drugs by the Department of the Treasury, and each transaction's records were to be kept” (Sacco, 2014, p. 2). The Harrison Act allowed doctors to prescribe cocaine and opiates, but there was a grey area in the act, leading the act to be interpreted differently from person to person.

The Department of the Treasury viewed most cases of doctors prescribing cocaine and opium to their patients as unnecessary because most were patients who were known to have an addiction or abuse these drugs. The results from this lead to many doctors and patients being arrested and prosecuted under the Harrison Act. Many states and city clinics were shut down due to this grey area in the Harrison Act. The Harrison Act's common theme steered doctors and physicians to cease prescribing cocaine and opium due to the different interpretations. The Harrison Act ultimately directed cocaine and opium users to the black market.

The next major piece of drug legislation was the Marihuana Tax Act of 1937. Until 1937 marijuana was legal to consume. The Federal Bureau of Narcotics was created within the Department of the Treasury due to the popularity of marijuana use across the United States. Sacco stated, “During the course of promoting federal legislation to

control marijuana, Henry Anslinger, the first commissioner of the FBN, and others submitted testimony to Congress regarding the evils of marijuana use, claiming that it incited violent and insane behavior. Of note, Commissioner Anslinger had informed Congress that the major criminals in the United States are the drug addict; that of all the offenses committed against the laws of this country, the narcotic addict is the most frequent offender” (Sacco, 2014, p. 3). The results from Henry Anslinger’s statements lead to the creation of the Marihuana Tax Act and unofficially making marijuana illegal. This act created a regulation that required a very high fee tax stamp for every transaction involving marijuana. The tax stamps were barely given out by the government and shortly after the Marihuana Tax Act was passed marijuana was made illegal in the United States that same year.

Richard M. Nixon became President in 1969, shortly after winning the presidency his agenda focused on the still ongoing drug abuse in the United States, declaring America’s number one enemy was drugs. Throughout the 1960s recreational drug use skyrocketed within the American population and the military forces fighting in Vietnam. President Nixon’s war on drugs focused more on the law enforcement aspect of controlling illegal narcotics. In, 1970 the Comprehensive Drug Abuse Prevention Act was passed into law. This act was passed to combine all laws that regulated the production and distribution of all narcotics. These narcotics consisted of stimulants, depressants, hallucinogens, and other drugs that could be abused. Shortly, after this law was made effective, in 1973 the Drug Enforcement Administration, or what we know now as the DEA was formed to help enforce this new act.

## Drug Schedule

A new important section that came out of the Comprehensive Drug Abuse Act was the Controlled Substance Act. The Control Substance Act created what is known today as the drug schedule. The drug schedule classifies drugs into five different schedules based on their medical use and how likely the drug will be abused. According to the Drug Enforcement Administration's website, DEA.gov, "Schedule I drugs, substances, or chemicals are defined as drugs with no currently accepted medical use and a high potential for abuse. Some examples of Schedule I drugs are heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), 3,4-methylenedioxymethamphetamine (ecstasy), methaqualone, and peyote" (DEA, n.d.). Schedule II drugs are drugs with "a high potential of abuse; these drugs may also lead to psychological or physical dependence" (DEA, n.d.). Some examples of a Schedule II drug would be cocaine, methamphetamine, methadone, hydromorphone, meperidine, oxycodone, fentanyl, Dexedrine, Adderall, and Ritalin.

Schedule III are drugs that have a "moderate to low potential for physical and psychological dependence" ("Drug Scheduling," n.d.). Remember the lower you go on the schedule the less of a potential for physical and psychological dependencies. Examples of Schedule III drugs would be Tylenol with codeine, ketamine, anabolic steroids, and some testosterone booster. Next is Schedule IV. These drugs have a low potential and low risk of dependence. Examples of these drugs include Xanax, Soma, Darvon, Darvocet, valium, Ativan, Talwin, Ambien, and Tramadol. The last schedule the Drug Enforcement Administration has is Schedule V. Schedule V defined as having "lower potential for abuse than Schedule IV and consist of preparations containing

limited quantities of certain narcotics” (“Drug Scheduling,” n.d.). Examples of a Schedule V drug are cough medicine with less than two hundred milligrams of codeine. Some examples are Lomotil, Motofen, Lyrica, and Parepectolin. All of the schedule definitions and drug examples are current as of this year on the Drugs Enforcement Administrations website. The entire list of drugs and their schedules can be viewed by visiting the DEA’s website at [dea.gov](http://dea.gov).

The next piece of legislation to affect the United States didn’t come until 1984 when President Ronald Reagan was in office. Like President Nixon, President Reagan took his focus to continue the fight on drugs. During the 1980s the use and abuse of cocaine were at an all-time high. To combat this overuse President Reagan sign the Comprehensive Crime Control Act in 1984. This new act enhanced penalties from the prior Controlled Substance Act and created criminal forfeitures for felony drug convictions. This helped law enforcement fight this war on drugs by using those forfeitures. According to Sacco (2014), “These provisions allow the Attorney General to transfer drug-related forfeited property to federal, state, and local law enforcement agencies and retain the forfeited property for official use or for transfer to other federal, state, and local agencies related to federal law enforcement” (p. 8).

With new technology beginning to be developed in the mid to late 1980s, so was the use and manufacturing of synthetic drugs. The Anti-Drug Abuse Act of 1986 was passed to help fight synthetic drugs. This act amended a portion of the Controlled Substance Act by redefining the term controlled substance and for synthetic drugs to fall under Schedule I drugs temporality (DEA, n.d.). This act also identified criminal penalties for the simple possession of these controlled substances. The Anti- Drug Abuse

Act was most well-known for creating penalties for federal drug trafficking offenses. There were two types of mandatory prison sentencing based on the amount and type of drugs involved. This act also distinguished a different minimum sentence from crack cocaine versus powder base cocaine. The requirement for the more severe sentencing is one hundred times powder cocaine to crack cocaine. This new standard brought up an argument for fair sentencing. It was well known that most of the minorities used crack cocaine, where non-minorities groups used powder cocaine. This standard was changed in 2010 under the Fair Sentencing Act. The new standard is 18 times powder cocaine to crack cocaine (United States Sentencing Commission, 2017).

As the nation moves out of the 1980s, the country begins to see more laws and policies due to the many loopholes acts before had, making some drugs carry harsher sentencing or others not being permanently placed in the drug schedule. The biggest debate in the 1990s and early 2000s was permanently placing a drug on the drug schedule versus temporarily placing a drug on the drug schedule. The process that starts a synthetic drug to be placed on the temporary drug schedule begins with the Drug Enforcement Administration. The Drug Enforcement Administration's Attorney General looks at the history, addictiveness, and how often the synthetic drug is abused.

Based on the facts given the Attorney General decides whether or not to place the drug on the temporary drug schedule (DEA, n.d.). The synthetic drug can remain on the schedule for two years. After the two years, the Attorney General has the option to have it remain on the temporary drug schedule for an additional year or remove the drug completely from the temporary drug schedule or place the synthetic drug on the

permanent drug schedule. This clause and the process are what we know today, the Synthetic Drug Abuse Prevention Act of 2012.

Knowing a brief history of the United States drug policy will help the reader understand or argue why we have these policies and why the Department of Defense, the United States Air Force, and the Department of Veterans Affairs follow federal law. Some questions I want to address later are legalizing marijuana and psychedelic mushrooms for medical use for military members, military members who are receiving retirement or medical benefits from the Department of Veterans Affairs, and federal employees. Before I address this topic, I felt it was necessary to learn about the Uniform Code of Military Justice's current drug policies, the Department of Defense, The United States Air Force, and The Department of Veterans Affairs.

### **The United States Uniform Code of Military Justice**

The Uniform Code of Military Justice is a federal law that is enacted by Congress. These laws define the military justice system and list offenses. Military criminal offenses are located in the punitive article section. Article 112A Wrongful use, possession, etc., of controlled substances states. The article states “ any person who wrongfully uses, possesses, manufactures, distributes, imports into the customs territory of the United States, exports from the United States, or introduces into an installation, vessel, vehicle, or aircraft used by or under the control of the armed forces a substance described in subsection shall be punished as a court-martial may direct” (law. cornell, n.d.). The drugs that are covered under the article are opium, heroin, cocaine, amphetamine, lysergic acid diethylamide, methamphetamine, phencyclidine, barbituric acid, and marijuana. Also, any form of chemical make-up from the drugs listed under the article is unlawful for

military members, a common example military members did use and above was a synthetic form of marijuana called spice. Substances that are listed under the drug schedule from schedule I to V that are not covered above are off-limits to military members.

This law's effective date began after December 6, 1983, and any military member who committed an offense before the law becoming effective will not be charged under the new crime. This law also leads to the establishment of random urine analysis within the Department of Defense. The Secretary of Defense has the duty to establish procedures with drug testing and the procedures on the collection of a psychical specimen from the person to determine if the person has used a controlled substance. If found guilty the punishment for Article 112A can lead to a dishonorable discharge, forfeiture of all pay and allowance, and confinement of five to fifteen years.

### **Department of Defense (DOD) Drug Policy**

DOD Instruction 1010.09 is the drug-free workplace program drug policy. The instruction states this policy applies to,

“Office of the Secretary of Defense, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD. The term “Military Services,” as used herein, refers to the Army, Navy, Air Force, and Marine Corps, both Active and Reserve components and the National Guard (Department of Defense Instruction, 2012, p.1)”.

The Department of Defense currently conducts drug testing on all their employees randomly and also those who wish to become a federal employee. If an applicant refuses to take the drug test they will be eliminated from the hiring process. The drugs that are tested for are amphetamines, cocaine, marijuana, opiates, and phencyclidine. The DoD may test for other drugs listed under the schedule I or II list by the DEA. The only approved collection method is by urine. Collection officials must complete initial and refresher training in order to be able to collect a urine collection. Punishment for violating the DoD's drug policy may include reprimanding the employee in writing, suspension, completion of an employee assistance program for drug use, or employee termination.

#### **Air Force Instruction 44-121**

Air Force Instruction 44-121 covers the Air Force's drug abuse prevention and treatment program. The AFI states, "The Air Force does not tolerate the illegal or improper use of drugs by Air Force personnel. Such use is a serious breach of discipline; is incompatible with service in the Air Force; automatically places the member's continued service in jeopardy; can lead to criminal prosecution resulting in a punitive discharge or administrative actions, including separation or discharge under other than honorable conditions" (AFI 44-121, 2018). The Air Force does, however, offer a prevention and treatment program. This program's objective is to promote readiness, health, wellness, to minimize negative effects to the individual, their families, their organization, provide education, and restore the individual states to assist them transition to a life outside of the Air Force.



However, the squadron Commanders have the responsibility to make referrals for treatment of the individual. Command referral is based on the situation. If the individual has voluntarily disclosed information about their substance abuse then Commanders can grant limited protection. Protection will not be protected under the Uniform Code of Military Justice or when determining separation. The Air Force does not recognize voluntary disclosure if the member is apprehended for drugs, placed under investigation for drugs to give a urine sample where the results have returned positive or are pending, and advised for administrative separation for drug use.

### **Department of Veterans Affairs**

The last drug policy affects military veterans. These veterans who fall under the Department of Veterans Affairs are either retired veterans or veterans receiving medical benefits. The Department of Veterans Affairs must comply with federal law since the department falls under the federal government and is funded by the federal government. The Department of Veterans Affairs website stated, "Veteran participation in state marijuana programs does not affect eligibility for VA care and services. VA providers can and do discuss marijuana use with Veterans as part of comprehensive care planning, and adjust treatment plans as necessary" (Department of Veterans Affairs, n.d.).

Some useful information for veterans using the department's benefits are veterans will not be denied benefits because of marijuana use, they are encouraged to discuss their marijuana use, but will be recorded in the veteran's medical records. All clinical information is protected under patient privacy and confidentiality laws and regulations, medical staff can not recommend the use of medical marijuana. The Department of Veterans Affairs pharmacies will not fill prescriptions for medical marijuana and the VA

will not pay for medical marijuana. So, unlike the previous drug policies, the Department of Veterans Affairs has a more relaxed policy for veterans receiving medical benefits (Department of Veterans Affairs, n.d.).

### **Leadership: Complex Change Agent**

Adopting a new drug policy for all Department of Defense personnel starts at the bottom of the rank structure. Voicing opinions and researching why a new approach needs to change will help push top DoD leaders to introduce new policies. To change the current policies would require an act of congress, but with how our society is rapidly changing new research and leaders within the military can help push Congress to create new drug laws for federal employees, military members, and military members who are receiving treatment from the Department of Veterans Affairs. Thirty-three states allow the medicinal use of marijuana and other cannabis with eleven states legalizing marijuana recreationally. With a majority of the states who have already pushed through new legislation, other states now have the opportunity to view their drug policies and adapt them for their states.

Being a change agent as a leader can be challenging. The first step in becoming a change agent for legalizing marijuana and psychedelic mushrooms for federal employees and all military members is by creating a vision. Creating a vision can be as simple as stating the problem and describing how the change can help the greater good. The second step in becoming a change agent is by creating a buy-in system. Having a buy-in system will provide overwhelming support to help push new drug policies for medically affected members. This is done by providing research on how marijuana and psychedelic mushrooms and help medicate those who are suffering from physical or psychological

chronic medical conditions. Being a change agent within the federal government and the military will help push through new drug reform, so federal employees, military members, and veterans can receive proper treatment for any existing chronic illness that occurred while serving their country.

### **Medical Marijuana Research**

Medical research for marijuana has been ongoing for the past twenty years. Some argue the drug has a medicinal purpose, while others do not believe the drug has any medicinal purposes. The Drug Enforcement Administration stated, “Marijuana is properly categorized under Schedule I of the Controlled Substances Act (CSA), 21 U.S.C. § 801, et seq. The clear weight of the currently available evidence supports this classification, including evidence that smoked marijuana has a high potential for abuse, has no accepted medicinal value in treatment in the United States, and evidence that there is a general lack of accepted safety for its use even under medical supervision” (Chapman et al., 2013). The DEA has backed their drug schedule to state there is still no medical purpose for the drug, but with other more recent research coming to the table is it ethical for the DEA to ignore the medical profession's advice or the new research on the drug?

Doctor Peter Grinspoon (2020) recently released an article addressing the concern around medical marijuana. Doctor Grinspoon stated about eighty-five percent of Americans support the idea of legalizing medical marijuana. The article first took a look into medical marijuana without the high, this is known as cannabidiol or CBD. There are over one-hundred active components of marijuana. The general public is most familiar with tetrahydrocannabinol or THC that has the chemical that causes someone to “get high”. Doctor Grinspoon stated, “Patients do, however, report many benefits of CBD,

from relieving insomnia, anxiety, spasticity, and pain to treating potentially life-threatening conditions such as epilepsy” (Grinspoon, 2020).

As Doctor Grinspoon (2020) mentioned before CBD does not give the high when used like smoking or ingesting marijuana. CBD does also have health benefits for those who have chronic pain. This type of marijuana would give federal employees and military members proper chronic pain relief and from a leadership standpoint, CBD is ethical because the effects are not the same as smoking or ingesting marijuana. Members will still be able to conduct their missions effectively and not have to tend to their chronic pain as often. Although using CBD may have health benefits it also has some side effects.

Like any modern-day medicine, the side effects are typical, including nausea, fatigue, and irritability. Currently, CBD is being sold as a dietary supplement and the Food and Drug Administration does not regulate the safety and purity of the product. Doctor Grinspoon (2020) has pointed out that CBD is not the cure-all, but does have some medicinal purposes to relieve chronic pain and other medical conditions, with a side note that CBD still needs more research to be conducted on human studies to get an accurate result on the effectiveness of CBD.

Medical marijuana has been researched for a number of ongoing years. A study from 2017 raised whether marijuana or CBD acts as an effective treatment for chronic pain. The study's answer to the question was yes, proving both help control and reduce chronic pain. The study stated, “One of those studies found a dose-dependent effect of vaporized cannabis flower on spontaneous pain, showed the strongest effect size. The other study found that vaporized cannabis flower reduced pain without a dose-dependent effect. These two studies are consistent, suggesting a reduction in pain after cannabis

administration” (National Academies of Sciences, Engineering, and Medicine, 2017, p. 89). What these two different studies showed is a dose-dependent of marijuana being smoked does have a strong effect on acute pain, while a non-dose-dependant of marijuana helps reduces chronic pain.

A widespread medical condition in the military is posttraumatic stress disorder or PTSD. PTSD “is a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, or rape or who have been threatened with death, sexual violence, or serious injury” (American Psychiatric Association, 2013). Symptoms of PTSD include intrusion, avoidance, alterations in cognition, alterations in mood, alterations in arousal, and reactivity. Medical marijuana has been researched to see if this drug treats or helps symptoms associated with PTSD.

A study conducted by Betthausen et al. (2015) stated marijuana effects “provide a pharmacologic rationale for the use of cannabinoids to manage the three core PTSD symptom clusters: reexperiencing, avoidance and numbing, and hyperarousal. Data from 4-small studies suggested that cannabinoid use was associated with global improvements in PTSD symptoms or amelioration of specific PTSD symptoms such as insomnia and nightmares”. However, the study did indicate a large study is needed to fully understand the relationship between marijuana and PTSD. The conclusion stated there is evidence suggesting using marijuana and other cannabis products do have benefits in reducing anxiety, insomnia, and coping methods with PTSD.

Medical conditions marijuana is known to be used for are the pain of multiple sclerosis, and nerve pain. Opiates are commonly used to treat these conditions but are

known to have the terrible side effect of creating an opium addiction for the user. Using marijuana would have a lower likelihood of addiction for their user. Medical marijuana is also used as a muscle relaxant and is used by people with Parkinson's disease to slow the shakes and tremors the disease causes. The best benefit medical marijuana brings is the treatment for chronic pain and PTSD. The military and many other federal jobs are physical and mentally demanding that cause all sorts of medical conditions through the years of service. Medical marijuana would help relieve chronic pain, PTSD, or other types of medical conditions that have occurred. From an ethical standpoint, top leaders should consider this treatment for their employees, because the benefits outweigh the negatives.

### **Psilocybin Mushrooms**

Psilocybin is a natural compound found in psychedelic mushrooms. Psychedelic mushrooms are currently illegal and labeled as a Schedule I drug. The first psilocybin research was conducted in 2016 by a John Hopkins Medical research team. To their surprise, they found the compound psilocybin drastically relieved of anxiety and depression. Psilocybin creates an audio hallucination and also changes consciousness for a few hours after the drug is taken. The study conducted consisted of twenty-four people and was told not to use their antidepressants before the study's start. A GRID- Hamilton Depression Rating Scale was given to each person to complete before the study. The test's rating scale indicates levels of depression, one to seven being the least, eight to sixteen being mild, seventeen to twenty-three being moderate, and twenty-four and above being severe depression. Participant's average score rating was twenty-three, indicating moderate depression. The study was conducted from August 2017 to April 2017, where

treatment was two doses of psilocybin given exactly two weeks apart from one another (McMains, 2020).

At the end of the study, the members being tested were asked to take the GRID-Hamilton Depression Rating Scale again. After the study was concluded, the average score was eight, and most participants showed a decrease in their depression. What the most impressive statistic from the study was, “for the entire group of 24 participants, 67% showed a more than 50% reduction in depression symptoms at the one-week follow-up, and at the four-week follow-up, 71% of participants showed the same result. Overall, four weeks post-treatment, 54% of participants were considered in remission meaning they no longer qualified as being depressed” (McMains, 2020). This study was a huge breakthrough for treatment with depression and other depression-type conditions. According to the Anxiety and Depression Association of America, anxiety is the most common mental illness in the United States accounting for over forty-million individuals. The second is depression with almost eight-teen million adults being affected each year (Anxiety and Depression Association of America, 2017). Using psilocybin mushrooms as a treatment option for federal employees and military members is a valid treatment for combating depression and other depression-type illnesses that could lead to suicide. With the rapid rate of suicides in the Department of Defense and Veterans Affairs psilocybin mushrooms is an ethical treatment to help reduce the illness.

However, like any modern-day medicine, there are adverse effects of using psilocybin mushrooms. Although psilocybin is considered the least toxic drug there have been known lethal doses in animal experiments. Still, a regular dose of psilocybin for humans is very rare to lead to an overdose and death. Physical effects range from person

to person like any drugs. The negative effects can lead to dilated pupils, elevated blood pressure, increased heart rate, nausea, increased perspiration, numbing, and tremors. There are psychological effects as well. Like the physical effects, these symptoms range from person to person. The psychological symptoms can lead to anxiety, panic attacks, paranoia, mood swings, and Hallucinogen Persisting Perception Disorder, otherwise known as flashbacks from using the drug. Both negative symptoms of using the drug long term are rare and do not carry any physical or neurological damage (Drugpolicy.org, n.d.).

### **MDMA Treatment for PTSD**

MDMA is a synthesized hallucinogenic drug produced in 1912 and is currently a Schedule I Drug. The most common forms of MDMA are Ecstasy and Molly. The effects of MDMA lead to an enhanced sense of well-being, increased extroversion, emotional warmth, empathy toward others, a willingness to discuss emotional memories, and enhanced sensory perception. When taking MDMA, three brain chemicals are released from the brain, dopamine, norepinephrine, and serotonin. Dopamine causes the human body to increase overall energy, leading to more activity. Norepinephrine causes increased heart rates and blood pressures. Lastly, serotonin causes mood, appetite, and sleep changes. Large serotonin levels cause emotional closeness, elevated mood, and more empathy felt (Mithoefer et al., 2010).

There have been ongoing studies with MDMA as a treatment method for PTSD since 2000. One study was conducted in Spain with six women who suffered from PTSD. The six women received a low dose of MDMA and also psychotherapy sessions for treatment for two years. The study showed a decrease in symptoms associated with



PTSD, but with the test size so small statistical data could not be produced to explain the study's results. A second research study was conducted in 2010. In the study, Mithoefer (2010) stated, "Twelve treatment-resistant patients received two sessions with MDMA while eight patients received a placebo. The results showed that 83% of the patients in the MDMA group did not meet the criteria for PTSD anymore. A long-term follow-up demonstrated that treatment effects were stable over a 3.5-year period" (Mithoefer et al., 2010, p. 448).

These results were later replicated in two studies, showing MDMA decreases PTSD. In 2019 Mithoefer stated, "a pooled analysis on 105 patients showed that patients who received MDMA experienced significantly greater reductions in PTSD symptom, 54.2% of patients no longer met PTSD diagnostic criteria" (Mithoefer et al., 2019). The Mayo Clinic (2018) stated symptoms for PTSD included intrusive memories, avoidance, negative changes in thinking, negative moods, changes in physical reactions, changes in emotional reactions, and suicidal thoughts (Mayo Clinic, 2018). For PTSD the FDA has approved paroxetine and sertraline for treatment, however, the study has shown MDMA showed a better outcome for treatment method. The FDA has granted MDMA a breakthrough therapy designation for the treatment of PTSD (Mithoefer et al., 2010).

MDMA does have adverse side effects if not properly taken in a controlled setting. Negative side effects are anxiety, nausea, muscle cramps, blurred vision, chills, sweating, tight jaw, headache, and fatigue. There have been reported cases of anxiety when first taken, but it can be overcome with psychotherapeutic help (Mithoefer et al., 2019). Other cases have reported mood changes relating to depression. The biggest risk of taking MDMA is a rapid spike in the human's core temperature, leading to liver,

kidney, or heart failure, and even death. Mithoefer stated neither of these negative outcomes has occurred under a controlled setting with medical supervision (Mithoefer et al., 2019). Taking MDMA under a controlled setting would help those in the federal with PTSD receive help for their disease. MDMA would be an ethical treatment choice under a controlled setting with medical professions.

### **Ethical Leadership**

Being able to make these drugs legal for medical use in the federal government, Department of Defense, and Department of Affairs falls on ethical policy-making and ethical leadership. There are many positives outcomes for using marijuana, psilocybin mushrooms, and MDMA for chronic illnesses that occurred while servicing. The ethical consideration would be whether there are more positive outcomes than negative outcomes and how this research could be used to create ethical policies for members to receive treatment for their chronic illness. There is research that still needs to be conducted with larger test groups to get a full picture on whether these illegal drugs are valid treatment methods, but with the research that has already been conducted the results are pointed in the right direction and have spoken volumes for valid treatment options.

The first ethical decision a leader must make is will the medical benefits from marijuana, psilocybin mushrooms, and MDMA hurt or benefit the service member medically, and will others who do not need these drugs medically abuse the policy. A new ethical policy would have to be made to avoid the misuse of the drugs and ensure the safety of those who are medically taking the drugs. The ethical dilemma is these three drugs are Schedule I drugs. These drugs are also known to be a gateway for other drugs and a gateway for addiction. Making ethical choices and policies must happen at all

federal government levels, the defense department, and the Department of Veterans Affairs.

The first question asked is how leaders would implement to ensure ethical expectations and behaviors in others are met in the organization. This question is one of those questions where a leader can implement everything to ensure ethical expectations and behaviors are met in the workplace. Still, it boils down to what type of employees have been hired and how they will act when no one is watching. If a leader can have their employees buy into the organization's mission statement, core values, and policies, there will be fewer unethical acts and behaviors.

The Air Force and the other military branches accomplish this through basic training, where the mission statement, core values, policies, and how to properly act are enforced. If the standard isn't being met punishment is given out in the form of physical training. Most federal employees have some sort of military background as they receive a job after military service, so the mission statements, core values, policies, and how to properly act are still apart of them even after their service. Also, all federal agencies have their own set of mission statements, core values, and policies to help guide their employees to be ethical.

A leader should make strict guidelines that create a clear picture of ethical and behavior expectations in the workplace. Punishments would be clearly spelled out so there are no loopholes in the policies and the employees would understand what will happen if a violation occurs. Next, a leader should implement some type of training plan that includes ethical training and practical situations involving ethics associated with the new policies of medical guidance of marijuana, psilocybin mushrooms, and MDMA.

Lastly, instilling the agencies or unit's mission statements and core values would remind them of the standards that need to be met. This would be done during any type of training and signs would be posted around the workplace to remind what is expected with the new policies of allowing illegal drugs for medical treatment. This is a good starting point, but it ultimately falls on everyone to act ethically when no one is watching.

Promoting ethical accountability is placed on every employee but also has its role in a leadership position. Leadership must teach their employees that everyone is a sensor, meaning if you see or hear something is wrong, you are required to act and fix the problem. The federal government, Department of Defense, and Department of Veterans Affairs leadership could accomplish this by progressive paperwork, federal law statutes, and the Uniform Code of Military Justice. An example would be in the Air Force verbal counseling is the first step followed by a letter of counseling and then a letter of reprimand. All three of these have a staff level and a command level. Three command levels letter of reprimands constitute an Article 15 in the Uniform Code of Military Justice. Once a military member receives an Article 15 they are placed on a controlled roster and have an unfavorable statement in their personal records. Having this information in your records restricts the airmen from promotion, being stationed at another base, being selected for another position within your career field, and being selected for another career field. A leader could enforce this same model in a federal agency section and the other branches in the Department of Defense. This will allow lower-tier leaders to be accountable for their employees and will also keep them accountable as well.

Hiring boards and recruitment for the Department of Defense would have ethical questions asked about the new policy. Questions that would ask in the interview would be about what the agency's mission statement and core values mean to the applicant. This will give the board members and recruiters a fair idea of their values and where their ethics lay. Questions would also be asked regarding ethical situations. Once an individual is hired there would be a mandatory probation period of a year. This will give the board members and recruiters a fair idea of their values and their ethics. Any negative ethical actions during this probation period would call for immediate termination of employment.

A leader will not find out if their employees are ethical until the person is alone doing the job. This is when people's true colors show and their ethics are tested. Ethics is part of our everyday lives. Ethics is utterly important in a leadership or an administrator role. Knowing your mission statement and core values can help determine how a leader creates their code of ethics policy. An introduction is extremely important, as the new information will dictate how your employees will conduct themselves while at work. Laying out the policy and the punishment will ensure accountability at all levels is met. Ethical leadership is leading by example and doing the right actions and behaviors when no one is watching. Allowing marijuana, psilocybin mushrooms and MDMA is an ethical treatment method for medical conditions that leaders must take into consideration. Ethical leadership is making sure your employees are properly taken care of and should always be thought of when new decisions are made.

## **Controlled Substance Act**

The biggest piece of legislation that is blocking the federal government from legalizing medical marijuana, psilocybin mushrooms and MDMA is the Controlled Substance Act. This act created the drug schedule and placed drugs into five different schedules. The schedules are based on the drug's medical use, the potential for abuse, and safety or dependence liability. Currently, all three drugs are under the Schedule I drug, meaning the three are not medically accepted and their use could lead to the potential of abuse. However, with these drugs being a Schedule I drug new medical research could help the drugs be deleted from the schedule or change into a different schedule. This action can be made by the Drug Enforcement Administration, the Department of Health and Human Services, or by an interested party. The interested parties include the manufacturer of a drug, a medical society or association, a pharmacy association, a public interest group concerned with drug abuse, a state or local government agency, or by an individual citizen (DEA, n.d.).

There are certain considerations that are accounted for when a drug is decontrolled or rescheduled. The Controlled Substance Act stated a drug can be decontrolled or rescheduled under the following factors; “the actual or relative potential for abuse, scientific evidence of its pharmacological effect, if known, the state of current scientific knowledge regarding the drug or other substance, its history and current pattern of abuse, the scope, duration, and significance of abuse, what, if any, risk there is to the public health, its psychic or physiological dependence liability or whether the substance is an immediate precursor of a substance already controlled under this subchapter” (The Controlled Substance Act, n.d.). With new medical research being conducted with

marijuana, psilocybin mushrooms, and MDMA there is a possibility the federal government will decontrol or rescheduled making the drugs legal for medical use.

### **The United States Supreme Court Decision on Medical Marijuana**

The last United States Supreme Court Decision on medical marijuana was on June 6<sup>th</sup>, 2005, with *Gonzales v. Raich*. The background of the court case can be traced back to 1996 when California passed the Compassionate Use Act, which legalized the medical use of marijuana. The Compassionate Act was put into law, “to ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person’s health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief” (*Gonzales v. Raich*, 545 U.S. 1, 2005). The Compassionate Use Act also stated patients and their primary caregivers who are prescribed medical marijuana cannot be criminally prosecuted or have sanctions.

This new law opposed the federal Controlled Substance Act. The Drug Enforcement Administration or DEA seized prescriptions of medical marijuana at the patient’s place of residency. A group of individuals who were prescribed medical marijuana later joined forces and sued the DEA and U.S. Attorney General John Ashcroft in California’s Federal District Court. The group who sued argued, “The Controlled Substances Act, which Congress passed using its constitutional power to regulate interstate commerce exceeded Congress' commerce clause power. The district court ruled against the group. The Ninth Circuit Court of Appeals reversed and ruled the CSA

unconstitutional as it applied to intrastate medical marijuana use. The Ninth Circuit ruled using medical marijuana did not "substantially affect" interstate commerce and therefore could not be regulated by Congress" (*Gonzales v. Raich*, 545 U.S. 1, 2005).

This ruling was brought to the United States Supreme Court on June 28<sup>th</sup>, 2004. The question that was brought forth to the United States Supreme Court stated, "Does the Controlled Substances Act (21 U.S.C. 801) exceed Congress' power under the commerce clause as applied to the intrastate cultivation and possession of marijuana for medical use" (*Gonzales v. Raich*, 545 U.S. 1, 2005). Justice Stevens delivered the court's opinion with a six to three votes ruling the commerce clause gave Congress the power to make the crop growing and use of marijuana illegal, even with California's Compassionate Use Act.

Justice Stevens (2005) stated, "The fact that marijuana is used "for personal medical purposes on the advice of a physician" cannot itself serve as a distinguishing factor. Even if respondents are correct that marijuana does have accepted medical uses and thus should be redesignated as a lesser schedule drug the CSA would still impose controls beyond what is required by California law" (*Gonzales v. Raich*, 545 U.S. 1, 2005). Justice Stevens then stated the cultivation and possession of marijuana could not replace federal law because of the Supremacy Clause, stating if there are any conflicts between state and federal laws, federal law will be favored. The Supreme Court held that states who have medical marijuana laws do not affect the Controlled Substance Act. What this means is when a state legalizes a federally controlled substance the drug is no longer controlled under state law.



## **Marijuana under States Laws**

Along with the Controlled Substance Act, states have their own Controlled Substance Acts. The states often mimic the federal laws from state to state, because of the adoption of a statute called the Uniform Controlled Substance Act. With states adopting federal laws for drugs there is some overlap between drugs that are under control with federal rule and state rule. Some states have chosen to have fewer or more restrictions of control on drugs than the Controlled Substance Act. Joanna R. Lampe, a legislative attorney stated, “As of May 2020, all but three states have changed their laws to permit the use of cannabis for medical purposes. Eleven states and the District of Columbia have passed laws removing state prohibitions on recreational marijuana use by adults age 21 or older” (Lampe, 2020, p. 3). Some states have allowed medical marijuana by limiting THC content or banning the use of smoking medical marijuana. Other states have decriminalized the use of marijuana and have made the use of marijuana legal for recreational use. Idaho, Nebraska, and Kansas currently have no public cannabis programs.

The most recent state to adopt new marijuana laws was Virginia. On May 21<sup>st</sup>, 2020, the Governor of Virginia, Ralph Northam, signed into law the decriminalization of the possession of marijuana. The law states possession of marijuana up to an ounce will have a punishment of a civil penalty of no more than a twenty-five dollar fine. This new law still doesn't make marijuana legal, but instead makes small amounts no longer have a criminal penalty or jail time. Another law Virginia passed was allowing the possession of cannabis-derived products for medical use, such as CBD.

## **The Federal Government**

In order to make new marijuana changes Congress would have to draft and pass a new bill or revisit the Controlled Substance Act. The newest proposal to Congress has been to loosen the federal restrictions on marijuana or define the difference between federal and state regulations, making them more clearly to citizens and states. The details of the proposal called for the removal from the current regulation under the Controlled Substances Act or have marijuana labeled in a less restrictive Drug Schedule. This would help medical professions be able to prescribe the drug for medical uses. Another proposal for Congress was leaving marijuana as a Schedule I drug, but limit federal enforcement in states that have chosen to make the drug recreational, medically, or decriminalized (Lampe, 2020, p. 4).

A significant problem states are having with making marijuana legal is businesses that aren't able to place their profits into federal banks. In 2019 a bill was introduced called the Secure and Fair Enforcement Banking Act, which would allow marijuana dispensaries to put their profits in a federally insured bank. Banks who do accept money made from marijuana can be charged with money laundering. The reasoning why federally insured banks cannot accept profits from marijuana dispensaries is because the drug is still on the Drug Schedule and labeled under the Schedule I classification. The last proposal to Congress, "would seek to address specific legal consequences of marijuana's Schedule I status by, for example, enabling marijuana businesses to access banking services, facilitating DEA-approved clinical research involving marijuana and other

Schedule I substances, or removing collateral consequences for individuals in areas such as immigration and gun ownership” (Lampe, 2020, p. 4).

### **Psilocybin Mushrooms and MDMA**

There hasn't been a lot of legislation that has been passed or been proposed for psilocybin mushrooms and MDMA. According to the Multidisciplinary Association for Psychedelic Studies, “As Phase 2 of the Multidisciplinary Association for Psychedelic Studies' MDMA-assisted psychotherapy study comes to an end, the non-profit research and educational organization plans to meet this spring with the FDA to plan crucial Phase 3 clinical trials, which could lead to a new kind of prescription” (Jun, 2016). The third study phase with the Food and Drug Administration started in 2017 and the study will take up to five years, so this year the study could be completed. Once the studies are completed the FDA could approve or disapprove using MDMA for medical treatment for PTSD.

In 2020 Oregon voted to decriminalize illicit drugs. The bill Measure 110 passed into law making the possession of small amounts of cocaine, heroin, methamphetamines, and other illicit drugs a civil fine with a fine of one-hundred dollars and no jail time, making the act a class E violation in Oregon law. However, with this new law, illicit drugs are still illegal to produce and sell. According to Dustin Jones (2020), “Oregon also passed Measure 109, the legalization of psilocybin often referred to as magic mushrooms. Unlike marijuana, this measure only approves the use of psychedelics at licensed facilities for mental health purposes” (Jones, 2020). Measure 109 created a program for dispensing psilocybin mushrooms to citizens twenty-one years or older.

Also in 2020, Washington, D.C., passed the Entheogenic Plant and Fungus Policy Act of 2020. This act approved the decriminalization of psilocybin mushrooms and instructed law enforcement to make investigations and arrests involving psilocybin mushrooms the lowest priority for illegal drugs (District of Columbia, 2020). Five cities have also passed city ordinances in 2019 and 2020 stating the possession of psilocybin mushrooms for adults is the city's lowest priority for drug crimes. Oakland, California, Santa Cruz California, and Ann Arbor, Michigan passed in their local government to decriminalize psychoactive plants and fungi, making the possession of psilocybin mushrooms a civil penalty instead of a criminal penalty.

#### **Air Force Instruction 31-117 Arming and Use of Force**

With the legislation currently out proposing to make marijuana, psilocybin mushrooms, and MDMA legal, decriminalized, or medically legal the military has not gone to any steps to make any of these drugs legal for medical use. The Chief Master Sergeant of the Air Force JoAnna Bass was asked this question by an airman, “Medicinal use of cannabis is currently legal in 33 states and recreational use is legal in 11 states. In response to this rising trend and the possibility of federal legalization, what is your stance/opinion/outlook regarding cannabis use in the military/Air Force” (Oprihory, 2020)?

The Chief Master Sergeant of the Air Force stated her team would look into the issue for the question. A spokesman from the Air Force later responded for the Chief Master Sergeant of the Air Force with, “Following today’s engagement, CMSAF Bass wanted to clarify that although some state and local laws have legalized the medicinal and recreational use of marijuana, it is still prohibited for use by military members. At

this time, the Air Force does not plan to reexamine this policy” (Stefanek, 2020). With more medical research becoming available and the facts about how marijuana, psilocybin mushrooms, and MDMA affect military members with PTSD and chronic illness why haven't the military pushed for drug reform, so their members can receive proper treatment?

One regulation in the Air Force could be causing this nonexistent push for drug reform. The Air Force Instruction 31-117 Arming and Use of Force could cause problems within the Air Force if a new drug reform would be passed. This regulation applies to Security Forces members and other career fields within the Air Force who have to arm with a weapon, particularly with firearms. The instruction is updated every fiscal year, which is October for the Air Force. The first section that needs to be addressed is taking prescriptions. The 31-117 states taking prescriptions can medically impair the member's capability to use a firearm, but the use of a prescription does not always disqualify a member from being able to bear a firearm. The Commander's responsibility is to consult with a military physician to see if the medication will impair the member's capability to handle a firearm safely (AFI 31-117, 2020, p. 2). The outcome from this will dictate the member's capability of being able to bear a firearm.

With the effects of how marijuana, psilocybin mushrooms, and MDMA most if not all military physicians would deny an Air Force personal the ability to bear arms, but there is another section within the instruction that could help an individual with not being restricted to bear arms. The section states the “use of alcohol and drugs, while on duty, personnel will not consume any form of alcohol or use over the counter drugs or

prescription medications that impair their ability to handle a firearm, nor will they do so within 8 hours before duty or firearms training” (AFI 31-117, 2020, p. 2).

If drug reform is passed in the military and military physicians approve the effects of small medical doses of marijuana, psilocybin mushrooms, and MDMA do not last past eight hours or are not taking within the eight-hour window then a military member could be able to bear arms. This would benefit all military branches as each branch could adopt this policy into their own regulations. The second benefit would be personal not missing work shifts and cause shortfalls in work schedules. The mission would still be able to be completed daily and personal will still be able to deploy if the drugs could abide by the eight-hour rule for being able to bear a firearm.

### **Forming New Military Drug Policy**

Applying new policies to the Federal Government, Department of Defense and Department of Veterans Affairs would be tricky. Ultimately making a new drug policy would depend on the Federal Government, but once the new laws and policies are established other federal agencies would be able to adapt and apply the new drug policies to fit their needs. First looking at the Federal Government, a way the federal government could create new ethical principles in developing a new drug policy is looking at other countries that have decriminalized illicit drugs. One country that stands out the most about decriminalizing drugs has been Portugal.

Portugal decriminalized all drugs in 2001. What this means, is possessing drugs is still illegal for personal use, but carries no criminal penalties. The penalties are fines and community service. The Commission decides the penalties for the Dissuasion of Drug Addiction that is a group made of legal, health, and social work professionals (Murkin,

2014, p.1). According to George Murkin (2014), “The initial aim of the commissions, and of the decriminalization policy was to tackle the severely worsening health of Portugal’s drug-using population. Portugal complemented its policy of decriminalization by allocating greater resources across the drugs field, expanding and improving prevention, treatment, harm reduction, and social reintegration programs” (Murkin, 2104, p. 1).

The results from this new policy have been lower drug death and abuse. Portugal’s level of drug use is below the average of all European countries. Similar results could happen in the United States as more funding would be allocated towards prevention, treatment, harm reduction, and social reintegration programs. Since the start of the war on drugs in 1971, the Unites States has roughly spent over one trillion dollars on the prevention of drugs, drug courts, and incarcerated people charged with drug-related offenses (Pearl, 2018).

A second way the federal government could form ethical drug policies is by adopting their own state laws where medical illicit drugs are legal. Limiting small dosages of marijuana, psilocybin mushrooms, and MDMA medically will control the effects the drug has on the person and will have a less likelihood of being abused or causing an addiction. Medical drugs are the most likely route the federal government will take due to research that has been conducted within the past ten years.

Ethical development of a medical policy for the use of marijuana, psilocybin mushrooms, and MDMA would start with first comparing these drugs versus the current treatment options. A drug to compare to marijuana, psilocybin mushrooms and MDMA is opioids, which are used for chronic pain. The medical research provided earlier has stated marijuana, psilocybin mushrooms, and MDMA is a more ethical treatment option for

chronic pain and PTSD due to their low abuse and addiction rate when given in small dosages. Opioids are known to have a high abuse and addiction rate even when dosages are small.

After information on other countries' policies and medical research, the next step is to draft and implement the new policies in the Department of Defense and Department of Veterans Affairs. Assuming the federal government does start allocating funds to improving prevention, treatment, harm reduction, and social reintegration programs and passing policy that marijuana, psilocybin mushrooms, and MDMA can be used medically for federal agencies. Policies for the Department of Defense would have to state members can only receive medical treatment if there is a history of chronic pain and PTSD. The next piece that must be implemented is the waiting period between treatment and their duty status.

A safe time period would be the eight-hour rule the Air Force has implemented for those who bear arms and other career fields with a flying mission. This would be implemented DoD-wide to cover all military branches. As for the Department of Veterans Affairs, this new policy would affect those receiving medical treatment from Veterans Affairs Hospitals. Funding would be allowed to start funding medical treatment of those suffering from chronic pain and PTSD with marijuana, psilocybin mushrooms, and MDMA.

Laws, policies, research, and court cases are shaping the United States drug policy. As more research is done the likelihood of marijuana, psilocybin mushrooms, and MDMA being used medically will greatly be increased. Forming ethical principles in the development and implementation is important to avoid the misuse and addiction to the



drugs. Looking at other country's drug policies and state policies will help guide the federal government in forming their own policies to help those who served their country receive the best medical treatment options. The federal government's ethical decision is to allow the medical use of drugs to those who have given so much for their country.

### **Recommendations for Further Research**

There are recommendations for further research with marijuana, psilocybin mushrooms, and MDMA for medical treatment. Some suggestions for areas that need to be more focused on before allowing these drugs for treatment are addressing the research gaps in the areas of clinical research, health policy, health economics, public health, and public safety research. The National Academies of Sciences Engineering Medicine stated, “Achieving this objective will require coordination and collaboration among researchers and research groups; support from stakeholders at the local, state, and national levels; and the concurrent pursuit of several distinct research streams, including clinical and observational research and research in the areas of health policy, health economics, public health, and public safety” (McCormick, 2017, p. 395).

These studies should also help inform the public about minimizing harms and maximizing the advantages of marijuana, psilocybin mushrooms, and MDMA for medical treatment. To support this, more studies should introduce statistical information with larger sample sizes. Having larger sample sizes will truly identify the effects marijuana, psilocybin mushrooms, and MDMA has on a person with chronic pain or PTSD. The information would be used to benefit the medical professionals, make state policies, make national policies, and make public safety standards, so the general public would not be harmed by the medical use of these drugs (McCormick, 2017, p. 396).

## Conclusion

With thirty-three states passing some type of new marijuana laws the federal government, the military, and veterans affairs need to relook the outdated laws, so federal employees can use marijuana, psilocybin mushrooms, and MDMA medically.

Researching the history of our nation's drug history, the Department of Defense's drug policies, the Department of the Air Force's drug policies, and the Department of Veterans Affairs drug policies will help the reader understand why the drug policies our nation has now. Being a change agent in your organization can bring change to any policies that may be old and outdated.

Ethical considerations should be considered when implementing a new change to a policy or create new legislation. With new medical research stating the use of marijuana, psilocybin mushrooms, and MDMA are beneficial for chronic psychological and physiological diseases, ethical leaders should consider this new research when forming and implementing new drug policies. Current research has shown the positive and negative benefits of legalizing these drugs to the Federal Government and their agencies

Public policies, laws, and court cases have influenced marijuana, psilocybin mushrooms, and MDMA for medical use. The most significant influence for drug control has been the Controlled Substance Act. Recent legislation from Oregon's Measure 110, Oregon's Measure 109, the United States Food and Drug Administration testing phase with MDMA, and the Entheogenic Plant and Fungus Policy Act of 2020 have all brought positive new legislation in the United States. These new policies have made marijuana, psilocybin mushrooms, and MDMA medically accepted, decriminalized, or making the drug offense the lowest priority for law enforcement. The last step would be

implementing the new policy and how federal agencies would apply ethical principles in the development, implementation, organizational and disciplinary actions. A new drug policy is needed in the United States to help those suffering from chronic pain or PTSD.

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