Longitudinal Trends in Cannabis and Polysubstance Consumption Among New Mexico Residents

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Contents

Contents 2

Executive Summary 5

General Population Findings 5

Registered Medical Cannabis Patients 6

Section 1. Research Design and Background 7

1.1 Background 7

Cannabis Program Overview 7

Psilocybin Program 7

Prior Research Conducted for the New Mexico Department of Health 8

1.2 Research Design 8

Section 2. Survey Participant Demographics 10

2.1 Demographic Information 10

Section 3. Cannabis Patterns of Use 12

3.1 Cannabis Use and Prevalence 12

3.2 Cannabinoid Preferences 15

Section 3 Summary 15

Section 4. Polysubstance Use 16

4.1 Polysubstance Use 16

4.2 Substance Use Behaviors Which May Be Considered Problematic 17

Section 4 Summary 19

Section 5. Registered Medical Cannabis Patients 19

5.1 Medical Cannabis Program Participation 19

5.2 Consumption Patterns 20

5.3 High THC Potency Consumption 22

5.4 Managing Cannabis Dose 23
5.5 Medical Program Enrollment and Maintenance 24
5.6 Costs Associated with The Medical Cannabis Program 25
5.7 Online Patient Portal 26
5.8 Conditions for Medical Cannabis Use 28
5.9 Medical Program and Dispensary Satisfaction 30
Section 5 Summary 32
Section 6. Consumer Access 33
6.1 Transportation 33
6.2 Access and Barriers 38
Section 6 Summary 39
Section 7. Public Health 40
7.1 Driving Under the Influence of Cannabis 40
7.2 Cannabis Storage and Use Inside the Home 43
7.3 Cannabis Experiences and Perceptions of Use 47
7.4 Medical Provider Interactions 48
Section 7 Summary 50
Section 8. Cannabis as a Replacement for Other Substances 51
8.1 Prevalence of Cannabis as a Replacement 51
Section 8 Summary 52
Section 9. Follow-Up Survey 53
9.1 Follow-Up Survey Participant Characteristics 53
9.2 Substance Use Consumption Trends 54
9.3 Substance Use and Risky Behavior 55
9.4 Change in Alcohol Use 57
9.5 Change in Other Substance Use 61
Section 9 Summary 62

Section 10. Psilocybin Survey 63
Executive Summary 63
10.1 Patterns and Correlates of Psilocybin Use 63
10.2 Change in Psilocybin Use Patterns and Corresponding Effects 65
10.3 Psilocybin Use and Prescription Medication Adherence 66
10.4 Psilocybin Use as a Replacement Substance 68
Section 10 Summary 69
Appendix A 70

Executive Summary

This report details the methods and results of a two-timepoint research study commissioned by the New Mexico Department of Health and conducted by Cannabis Public Policy Consulting between March and May 2026. The goals of this research study were threefold. First, this study intended to capture general population patterns of cannabis use and medical cannabis patient experiences in New Mexico. Second, this study aimed to assess prevalence and exploratory outcomes associated with the intentional use of cannabis as a replacement for other substances among people who exhibit substance use behaviors which may be potentially risky, as a replication of our 2024 and 2025 survey studies (please refer to Section 9). Finally, exploratory investigations regarding the prevalence of psilocybin use in New Mexico and outcomes associated with its use as a replacement for other substances were also included as topics of interest (please refer to Section 10). This is the New Mexico Department of Health's sixth annual survey of medical cannabis patients and individuals who consume cannabis in New Mexico. The present report builds on findings from previous survey issuances, and relevant comparisons to past surveys are included throughout the report. Findings from this study are projected to inform policy efforts and offer critical insights to patients, healthcare providers, and public health professionals.

Main findings from the current survey study are presented below. These findings are more thoroughly described throughout the document.

General Population Findings

- Cannabis use patterns have remained highly stable across survey years, with most participants reporting at least monthly cannabis use and nearly half reporting daily use. Product preferences, cannabinoid preferences, and overall consumption behaviors have shown little variation over time, suggesting a mature and relatively stable consumer market.
- Therapeutic cannabis use extends beyond participation in the medical cannabis program, with a majority of respondents (patients and nonpatients alike) reporting cannabis use for medicinal purposes.
- Consumer satisfaction with the regulated cannabis market remains high, with respondents reporting positive experiences with product quality, variety, potency, and

availability. However, pricing consistently received lower satisfaction ratings than other aspects of the market.

- Cannabis impaired driving remains a notable public health concern, with perceptions of impairment varying considerably, suggesting some consumers may underestimate the effects of cannabis on driving performance.
- Cannabis substitution remains a common motivation for use, with approximately one-quarter of respondents reporting using cannabis to reduce, replace, or stop the use of another substance.
- Findings from the longitudinal surveys provide preliminary evidence that intentional cannabis substitution is associated with more favorable alcohol-related outcomes among individuals with potentially risky alcohol use behaviors. Consistent patterns observed across survey years suggest cannabis substitution may be associated with reductions in alcohol consumption frequency and binge drinking occasions. However, additional research with larger sample sizes is necessary to further examine and clarify these relationships.

Registered Medical Cannabis Patients

- Approximately one-quarter of survey respondents were enrolled in the New Mexico Medical Cannabis Program. This patient sample includes both newly enrolled (40% enrolled within the past 12 months) and long-term medical patients (60% enrolled >12 months).
- Medical cannabis patients indicated more frequent cannabis consumption than nonpatients, and commonly utilize cannabis to manage their mental health, sleep-related concerns, and chronic pain.
- Use of high-THC cannabis products remained widespread among medical patients, reflecting continued demand for higher-potency products within the medical cannabis patient population.
- Medical cannabis patients were substantially more likely than nonpatients to report discussing cannabis-related health and safety topics with healthcare providers.
- Satisfaction with the Medical Cannabis Program and medical dispensaries have remained high across survey administrations, with most patients indicating intent to remain enrolled despite availability of the adult-use market.

Section 1. Research Design and Background

1.1 Background

Cannabis Program Overview

New Mexico established its Medical Cannabis Program in 2007 through the enactment of the Lynn and Erin Compassionate Use Act, which authorized the medical use of cannabis for patients with qualifying medical conditions. Initially designed as a relatively limited medical access program, the Medical Cannabis Program has expanded substantially over time through the addition of qualifying conditions, increases in patient enrollment, and the development of a regulated commercial cannabis market.

New Mexico's cannabis market currently operates within a dual medical and adult-use framework. In April 2021, the state enacted the Cannabis Regulation Act, legalizing adult-use cannabis and establishing a regulated commercial market for non-medical sales. Adult-use sales officially began in April 2022. Despite the expansion of the adult-use market, the Medical Program remains an important component of New Mexico's broader cannabis regulatory framework. Registered patients continue to benefit from several patient-specific protections and accommodations, including tax exemptions on medical cannabis purchases, higher possession limits, and access to medical-only products and services.

Psilocybin Program

In April 2025, New Mexico enacted the Medical Psilocybin Act (Senate Bill 219), establishing a regulated medical psilocybin program. The legislation establishes a regulated program for the medical use of psilocybin to treat qualifying conditions including major treatment-resistant depression, PTSD, substance use disorders, and end-of-life care. In light of these legislative developments and the New Mexico DOH's anticipated role in the establishment and maintenance of the future program, several questions related to psilocybin use were incorporated into the 2025 and 2026 survey instruments to obtain preliminary data on patterns of psilocybin use and associated outcomes among cannabis consumers in New Mexico.

Importantly, because the primary purpose of these survey studies was to assess cannabis consumer and patient experiences, all respondents included in the psilocybin-related analyses also reported cannabis use. As such, findings related to psilocybin use may not be generalizable to the broader population. However, existing literature indicates substantial overlap between cannabis and psilocybin use among adults, [1] suggesting this population may provide meaningful preliminary insights into emerging patterns of psychedelic use and associated health outcomes.

Prior Research Conducted for the New Mexico Department of Health

This research builds upon a multi-year partnership between Cannabis Public Policy Consulting (CPPC) and the New Mexico Department of Health (DOH) focused on evaluating cannabis consumer experiences, patient outcomes, and emerging substance use trends in New Mexico. The present study represents the sixth consecutive year of CPPC's statewide medical cannabis patient survey efforts, the third year conducting a two-timepoint longitudinal survey design, and the second year incorporating exploratory questions related to psilocybin use and associated outcomes. Collectively, these studies provide an evolving evidence base intended to inform public health research, program development, and policy decision-making within New Mexico's changing cannabis and psychedelic policy landscape.

1.2 Research Design

To qualify for participation in this study, respondents must have reported currently residing in New Mexico and consuming cannabis within the past year. In total 1,979 individuals responded to the survey invitation and entered the survey. Of these, 1,169 did not complete the full survey. Of these 810 complete responses, an additional 138 respondents were removed during post-survey data cleaning due to data quality concerns, including speeding, straight-lining, and inconsistent response patterns. A total of 672 respondents met all qualifying criteria to participate in this study and completed the full survey. For further information about our research methodology, please see Appendix A.

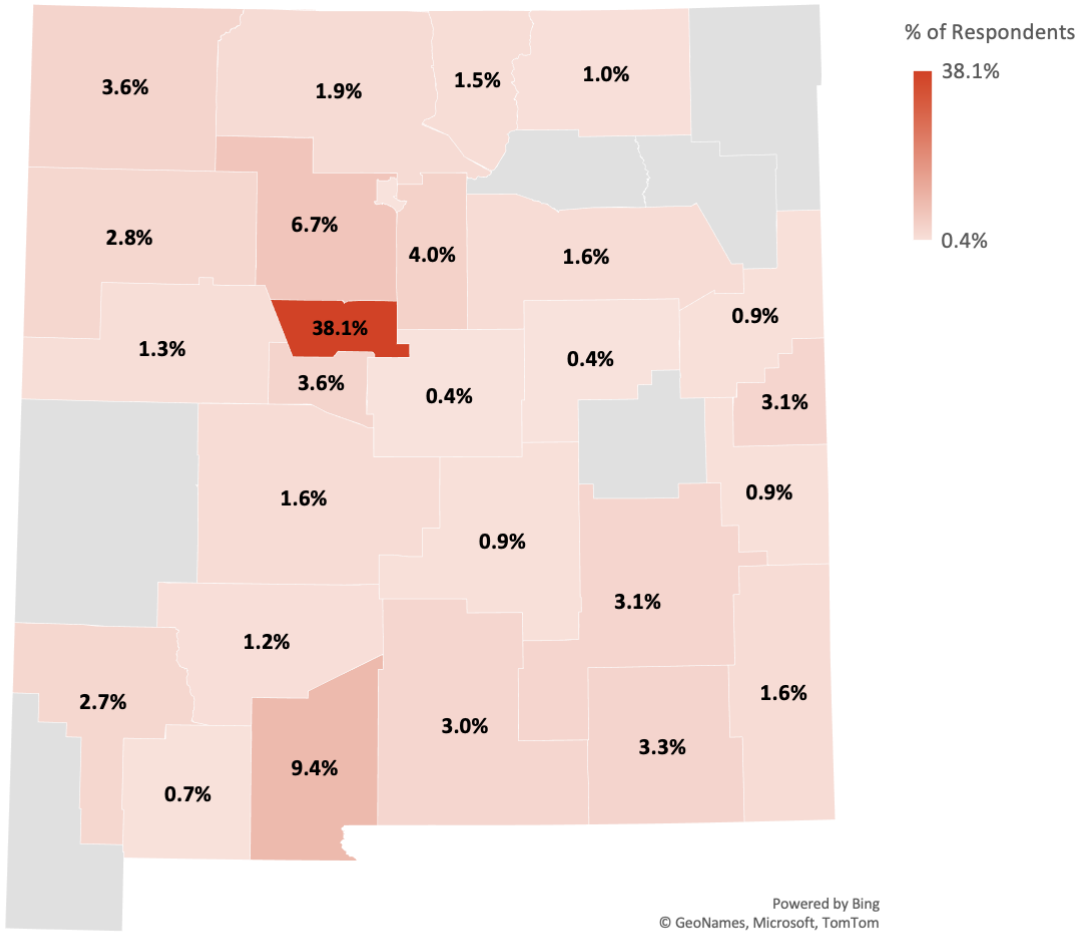
Figure 1 displays the geographic distributions of survey participants by county. Survey participants were represented across nearly all counties in the state, with responses collected

[1] Lake, S., & Lucas, P. (2025). Co-use of psychedelics with other substances: Findings from the global psychedelic survey. Journal of Psychopharmacology, 39(5), 453-462. https://doi.org/10.1177/02698811241292956

from all but six counties. The percentage of survey participants residing in each sampled county is almost perfectly correlated with the percentage of actual New Mexico residents in each county (r = .98), which suggests our recruitment of New Mexico residents is geographically consistent with actual county populations in the state. Demographic characteristics between the survey sample and the population of New Mexico matched by 95% as shown in Table 1. Together, these correlations strengthen our confidence that the findings shown in the report are likely to accurately reflect trends in the state of New Mexico.

Since the total population of cannabis consumers in New Mexico is unknown, information presented in this report is not intended to be generalizable to all cannabis consumers in the state and we cannot make direct comparisons to the broader population. In addition, these results should not be interpreted as estimates of cannabis consumption prevalence among the general population of New Mexico, as this sample contains exclusively individuals who reported past year cannabis consumption.

Figure 1. Geographic Distribution of Survey Respondents in New Mexico.



Section 2. Survey Participant Demographics

2.1 Demographic Information

Table 1. Demographic Distributions.

Demographic Characteristic	Survey (n 672)	New Mexico
Age (Median)	40	39
Race		

Demographic Characteristic	Survey (n 672)	New Mexico
American Indian, Native American, or Alaska Native, alone	6.8%	11.4%
Asian, alone	0.6%	2.1%
Black or African American, alone	4.6%	2.9%
White, alone	78.3%	80.5%
Native Hawaiian or other Pacific Islander, alone	0.3%	0.2%
Two or more races	4.5%	2.9%
Decline to answer	4.9%	--
Hispanic ethnicity	40%	49%
Gender Identity		
Male	43.3%	49.8%
Female	54.9%	50.2%
Transgender man/trans man/female-to-male (FTM)	0.1%	--
Transgender woman/trans woman/male-to-female (MTF)	0.3%	--
Nonbinary	1.0%	--
Agender	0.1%	--
Genderqueer/gender nonconforming	0.1%	
Family Income (Median)	$47,500	$64,059
High School Degree or Higher	95.5%	88.0%

The survey received 1,979 entries, with 810 complete responses. Table 1 presents the demographic characteristics of the final analytic sample (n=672), consisting of respondents who met the study's inclusion criteria and passed all data quality checks and cleaning procedures. Additional information about sample selection is provided in Appendix A. Key demographic characteristics of the survey respondents and the general New Mexico population reported by the U.S. Census Bureau are shown in Table 1. [2] Most of the survey respondents were White (78.3%) and slightly more identified as female (54.9%). Median household income of the survey sample was slightly lower than the population ($47,500 and $64,059), despite receiving higher levels of educational attainment (95.5% and 88.0%)

[2] U.S. Census Bureau. (n.d.). *QuickFacts New Mexico*. U.S. Department of Commerce. Retrieved April 30, 2026, from https://www.census.gov/quickfacts/fact/table/NM/PST045224

Not listed in Table 1: Among the final analytical sample (n=672), 40% indicated being of Hispanic ethnicity. Eight percent of respondents indicated they currently reside on Native American tribal or pueblo land in New Mexico. Nearly 15% of the sample indicated being an enrolled member of a federally recognized tribe in New Mexico. Among these individuals, most were enrolled members of Navajo Nation (26%), Taos Pueblo (12%), and Zuni Pueblo (6%). Seven percent of the full sample indicated they have served in the U.S. Armed Forces, military reserves, or National Guard. On average, respondents reported there were three individuals residing in their household and 60% reported having one or more children under the age of 18 living in their household. Eighty-seven percent of respondents had active health insurance at the time of taking this survey.

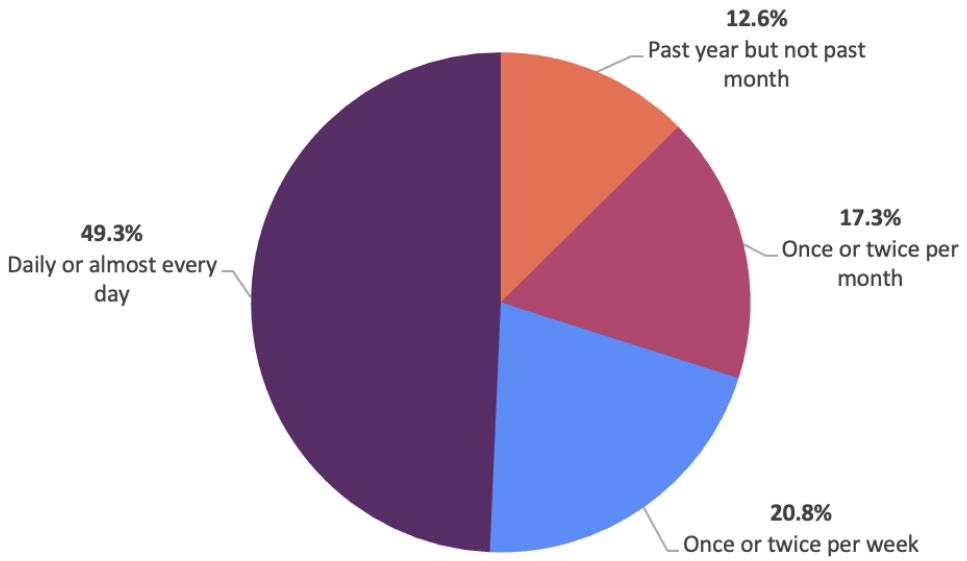
Section 3. Cannabis Patterns of Use

3.1 Cannabis Use and Prevalence

To qualify for participation in this study, respondents must have reported consuming cannabis in the past year. Among the full sample of past-year cannabis consumers, 87.3% (n = 587) of participants reported consuming cannabis at least on a monthly basis, and 49.3% (n = 331) consumed cannabis daily or almost every day.[3] Survey respondents included individuals who indicated they are actively registered as a medical cannabis patient in the state of New Mexico (26%; n = 175), as well as individuals not enrolled in the Medical Cannabis Program (74%; n = 497). A thorough breakdown of data from medical cannabis patients is presented in Section 5 of this report. Among individuals not enrolled in the Medical Cannabis Program (n = 497), cannabis use motivations remain diverse, with 41% (n = 204) reporting use for a combination of medicinal and recreational purposes, 16% (n = 77) reporting primarily medicinal use, and 44% (n = 216) reporting exclusively recreational use. These findings suggest many individuals in the state use cannabis for therapeutic purposes without participating in the formal Medical Cannabis Program.

[3] These data are not intended to provide an estimate of cannabis consumption prevalence among the general population of New Mexico, as our sample contains exclusively individuals who consumed cannabis in the past year.

Figure 2. Cannabis Use Frequency.



All survey participants were asked about the cannabis product types they used or consumed in the past month. Among all survey respondents, flower products were the most frequently consumed product, with 77% (n = 515) of participants consuming a flower product at least once in the past month. Edible products were also widely used, with 63% (n = 425) of participants consuming an edible product at least once in the past month. Fifty-eight percent (n = 391) consumed a vape product, 40% (n = 266) consumed a concentrate product, 25% (n = 167) used a tincture product, and 34% (n = 227) used a topical cannabis product at least once in the past month. Among past-month consumers of each respective product type, flower products were consumed most frequently, with an average of 15 use days within the past month. Vape products were used an average of 14 days of use, followed by 11 days for concentrate products, and 10 days for edible products. Product use days are not exclusive, and participants may have consumed different product types on the same day. These findings have remained stable throughout the survey administration years, as shown in Table 2.

Among those who consumed flower, vape, and concentrate products, participants typically consumed cannabis containing 25–30% THC and 10–15% cannabidiol (CBD). [4] Among those who consumed edible and tincture products, participants typically consumed 10–20 mg/THC per dose or serving of these products. Across all product types, participants reported consuming

[4] Only respondents who indicated they were “very” or “somewhat” confident in the THC and CBD potency in their products were included in this analysis.

cannabis an average of three times per day on days they used cannabis. These findings indicate participants generally prefer moderate-potency cannabis products and engaged in cannabis consumption multiple times throughout a typical use day.

A subset of participants (n = 90) received a question inquiring about their use of cannabis while pregnant and/or breastfeeding. Among these individuals, 27.8% (n = 25) indicated that they have consumed cannabis while pregnant or breastfeeding; however, most qualifying participants indicated never having used cannabis while pregnant or breastfeeding (72.2%; n = 65). Among those who indicated using cannabis at least once while pregnant/breastfeeding, 14.4% (n = 13) indicated that they consumed a flower product, 12.2% (n = 11) consumed an edible product, 8.9% (n = 8) vaped cannabis, 7.8% (n = 7) consumed a concentrate product, 2.2% (n = 2) used tincture products, and 5.5% (n = 5) used topical products. Product options were not exclusive, such that participants could have selected multiple product options.

Table 2. Consumption Patterns (Days in the Past Month) Among Past-Month Cannabis Respondents in New Mexico, Separated by Survey Administration Year.

New Mexico Survey Sample Year	SMOKE (FLOWER)	EDIBLES	VAPE	CONCENTRATES
2026	15 days	10 days	14 days	11 days
2025	15 days	9 days	13 days	10 days
2024	15 days	8 days	12 days	11 days
2023	17 days	10 days	11 days	11 days

Table 3. Past-Month Consumption Patterns Among Those Who Consume Cannabis in New Mexico, Presented in Means.

Typical Product THC Potency (Flower, Concentrate, Vape Products)	Typical Product CBD Potency (Flower, Concentrate, Vape Products)	Typical mg/THC Consumed per Dose/Serving (Edible and Tincture Products)	Average Use Occasions per Day
25–30%	10–15%	10–20 mg/THC	3 times per day

3.2 Cannabinoid Preferences

Participants overwhelmingly prefer their cannabis to include primarily THC, with 45% (n = 304) preferring THC dominant products (e.g., 2:1 ratio of THC to CBD) and 23% (n = 156) preferring their products to only contain THC. Nine percent (n = 63) prefer their products to contain an equal ratio of THC to CBD, and 7% (n = 44) prefer their products to be CBD dominant (e.g., 2:1 ratio of CBD to THC). Few prefer their products to only contain CBD (2%; n = 10). Fourteen percent of respondents (n = 95) prefer their products to contain an "alternative" cannabinoid, such as cannabigerol (CBG), and cannabinol (CBN). Unlike the 2025 survey in which medical patients reported greater preference for THC-dominant products whereas nonpatients preferred THC-only products, there were no notable differences in cannabinoid preferences when comparing registered medical cannabis patients to nonpatients in the present sample. Similarities between these two groups likely reflect the comparable cannabinoid profiles represented among commonly used products.

Section 3 Summary

- All participants in this survey reported past-year cannabis consumption as a function of survey inclusion criteria. Among the full sample, approximately 87% of participants reported consuming cannabis at least monthly, and 49% of the full sample consumed cannabis on a daily basis.
- A majority of cannabis consumers utilize cannabis for therapeutic purposes, even among those who are not enrolled in the New Mexico Medical Cannabis Program.
- Flower products were the most frequently consumed cannabis product type, with participants reporting an average of 15 days of use in the past month, followed closely by vape products at 14 days of past-month use.

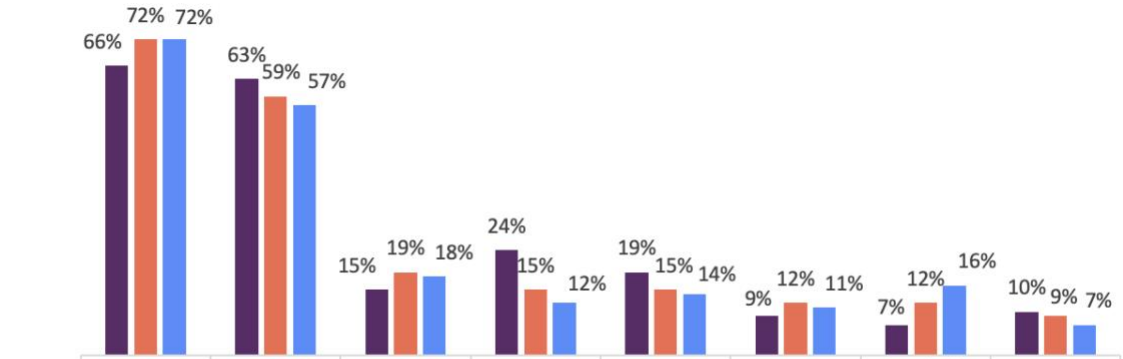
- Cannabis consumers overwhelmingly preferred THC-focused cannabis products, with little evidence of meaningful differences in cannabinoid preferences between medical cannabis patients and nonpatients.
- Cannabis consumption patterns have remained remarkably consistent across survey administrations, indicating a high degree of stability in consumer preferences and use behaviors over time.

Section 4. Polysubstance Use

4.1 Polysubstance Use

To obtain a holistic perspective of participants' substance use behaviors, participants were asked about their use of substances in addition to cannabis. Alcohol and tobacco were the most commonly used substances, aside from cannabis. Approximately 66% (n = 446) of participants consumed alcohol and 63% (n = 426) used a tobacco product at least once within the past month. Among those who used these substances, alcohol was consumed on an average of 16 days per month, and tobacco products were used on an average of 17 days in the past month. Compared to the 2025 and 2024 surveys, we observe patterns that the frequency of tobacco use has increased, whereas the prevalence of alcohol use has declined. However, among respondents who reported consuming alcohol in the past month, the frequency of alcohol use increased substantially, rising from an average of 10 use days in 2025 to 16 use days in the present data. **This pattern indicates that while overall participation in alcohol use may be declining, those who drink are doing so more frequently.** We also observe an increase in the prevalence of past-month Delta-8 product use compared to the 2025 and 2024 surveys. This may be reflective of product experimentation or product pricing, but should be explored further in future research to determine whether this finding reflects a trend in the market or a temporary fluctuation.

Figure 3. Percentage of Participants Reporting Past-Month Substance Use, Not Including Cannabis.



	Alcohol	Tobacco	Stimulants	Delta-8	Opioids	Psilocybin	Synthetic Cannabinoids	Ketamine
2026	66%	63%	15%	24%	19%	9%	7%	10%
2025	72%	59%	19%	15%	15%	12%	12%	9%
2024	72%	57%	18%	12%	14%	11%	16%	7%

4.2 Substance Use Behaviors Which May Be Considered Problematic

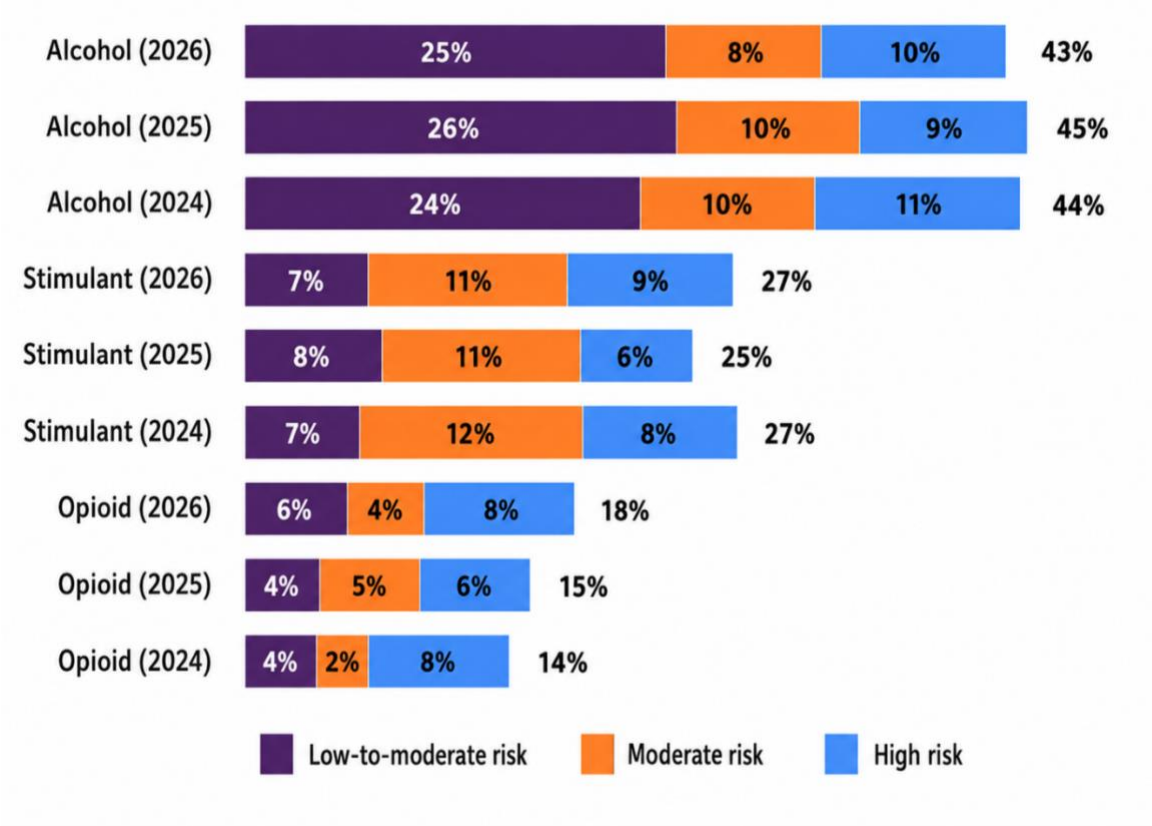
A modified version of the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST-Lite) was used to screen for potentially risky substance use behaviors. The ASSIST is a World Health Organization-endorsed framework used to identify risk of substance use disorders among the general population.[5] This screening tool assesses substance use behaviors within the past 3 months. Although the full ASSIST scale includes many legal and illicit substances, we only included questions about the use of alcohol, stimulants, and opioids for the purpose of this study. Scores are separated into risk behavior categories, including low risk, moderate risk, and high risk. Scores are calculated separately for each substance by summing affirmative responses. Alcohol scores range from 0-4 whereas stimulant and opioid scores range from 0-3. Scores of 1 indicate low risk, scores of 2 indicate moderate risk, and scores of 3-4 indicate high risk.

Screening for potentially risky substance use was first introduced in the 2024 survey to enhance our understanding of polysubstance use patterns and to assess the extent to which cannabis may be used as a substitute for other substances being used in potentially risky ways. Since

[5] Stevens, M. W. R., Harland, J., Alfred, S., & Ali, R. L. (2022). Substance use in the emergency department: Screening for risky drug use, using the ASSIST-Lite. *Drug and Alcohol Review, 41*(7), 1565–1576. https://doi.org/10.1111/dar.13513

2024, respondents screening for potentially risky substance use has remained remarkably consistent, suggesting stable patterns of substance use behaviors within the sampled population. In the present survey, 43% (n = 287) of the full sample qualified for potentially risky alcohol use (compared to 45% in 2025 and 44% in 2024). Among the present sample, 25% (n = 168) qualified for low-to-moderate alcohol risk, 8% (n = 52) for moderate alcohol risk, and 10% (n = 67) for high alcohol risk. Potentially risky stimulant use was indicated for 27% (n = 179) of participants in the present sample (compared to 25% in 2025 and 27% in 2024). Among the present sample, 7% (n = 46) qualified for low-to-moderate stimulant risk, 11% (n = 73) for moderate stimulant risk, and 9% (n = 60) for high stimulant risk. Potentially risky opioid use was indicated for 18% (n = 120) of all participants in the present survey (compared to 15% in 2025 and 14% in 2024). Among the full sample, 6% (n = 42) qualified for low-to-moderate opioid risk, 4% (n = 25) for moderate opioid risk, and 8% (n = 53) for high opioid risk.

Figure 4. Percentage of the Total Sample Qualifying for Risky Alcohol, Stimulant, or Opioid Use, Separated by Survey Year.



Section 4 Summary

- Alcohol and tobacco were the most commonly used substances aside from cannabis, with approximately two-thirds of participants reporting past-month use of each substance. While the prevalence of alcohol use has declined compared to 2025, alcohol consumers reported more frequent use, suggesting drinking may be becoming more concentrated among a smaller group of users.
- Screening results from the ASSIST-Lite indicate a substantial proportion of participants engage in substance use behaviors that may be associated with elevated risk, particularly for alcohol. In the current survey, 43% of participants screened positive for potentially risky alcohol use, 27% for stimulant use, and 18% for opioid use.
- Patterns of potentially risky substance use have remained highly consistent across survey administrations since screening was first introduced in 2024, suggesting stable rates of problematic substance use behaviors within the sampled population.
- The consistency of both polysubstance use and ASSIST-Lite screening results across survey years provides further evidence substance use behaviors among New Mexico cannabis consumers have remained relatively stable over time.

Section 5. Registered Medical Cannabis Patients

5.1 Medical Cannabis Program Participation

In the present sample, 26% (n = 175) of respondents indicated they are actively registered as a medical cannabis patient in New Mexico. We also inquired about past participation in the Medical Program among those who indicated they are not actively registered. Among those not actively registered, 15% (n = 103) indicated they *used to be* registered as a medical cannabis patient in New Mexico, but are no longer registered, and 59% (n = 394) have never been registered as a medical cannabis patient in New Mexico. Among the 103 respondents who were previously registered in the program but are no longer active, the most commonly endorsed reason for non-renewal was the cost of recertification from a certifying healthcare provide (30%). Other frequently cited reasons included higher cost of medical cannabis products (11%), and concerns over purchasing/possessing a firearm (10%). Among those who selected the “other” response option

(15%), common explanations for non-renewal included the legalization of recreational cannabis in the state and simply not getting around to renewing.

Table 4. Length of Time Enrolled in the New Mexico Medical Cannabis Program.

Recency of Enrollment	% (n = 175)
In the last month	8.6%
1-3 months ago	11.4%
4-6 months ago	10.9%
7-12 months ago	8.0%
Between 1 and 2 years ago	13.7%
2 to 3 years ago	17.1%
More than 3 years ago	30.3%

Findings presented throughout the remainder of Section 5 include data only from those who are actively registered as a medical cannabis patient in New Mexico (26%; n = 175). This sample includes both newly enrolled and long-term patients, with 40% (n = 68) reporting enrollment in the Medical Cannabis Program within the past 12 months, 31% (n = 54) who have been enrolled for 1–3 years, and 30% (n = 53) enrolled for more than 3 years.

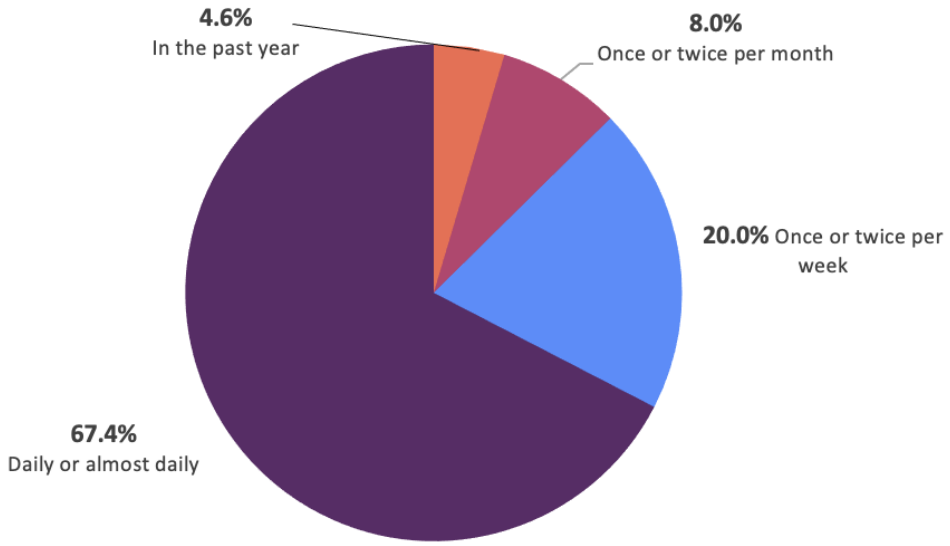
5.2 Consumption Patterns

Among registered medical cannabis patients in this sample, 43.4% (n = 76) reported their cannabis use is exclusively for medicinal purposes and 53% (n = 93) reported consuming cannabis for both recreational and medicinal purposes. These patterns have remained fairly consistent since 2023, indicating relatively stable motivations for cannabis use among registered patients over time, which is especially notable when examining this timeline against the maturation of the adult-use cannabis market. Importantly, however, we do observe a slight increase in the use of cannabis solely for medical purposes among registered medical patients in the present data compared to prior years.

Table 5. Reported Purposes for Cannabis Use Among Medical Cannabis Patients.

Purpose for Use	2026 %; n = 175	2025 %; n = 242	2024 %; n = 224	2023 %; n = 192
100% medical	43.4%	33.9%	38.8%	42.2%
75% medical, 25% recreational	22.3%	21.9%	21.6%	19.8%
50% medical use, 50% recreational	25.7%	29.3%	25.6%	18.8%
25% medical use, 75% recreational	5.1%	8.3%	9.7%	7.3%
100% recreational	3.4%	6.6%	4.4%	12%

Figure 5. Past-Month Cannabis Consumption Among Medical Cannabis Patients.



Medical cannabis patients in this sample reported more frequent cannabis use compared to nonpatients, with 95% (n = 167) consuming cannabis at least on a monthly basis, and 67% (n = 118) consuming cannabis daily or almost every day. This is a stable finding when compared to our previous surveys. Patients indicated consuming cannabis a median of three times per day.

Table 6 summarizes general cannabis consumption patterns among medical cannabis patients who reported consuming each respective cannabis product at least once within the past month. Flower products were the most favored method of consumption, with 87% (n = 152) of sampled

medical patients reporting use within the past month and an average of 17 days of use during this period. Edible cannabis products were also widely used, with 76% (n = 133) of patients reporting past-month edible consumption and an average of 13 days of past month use. Those consuming vape products within the past month (70%; n = 123) reported an average of 16 days of use, and those consuming concentrate products (55%; n = 97) reported an average of 13 days of use. Compared to nonpatients, medical patients were significantly (*ps* < .001) more likely to report past-month use of tincture and topical products (40% and 54% vs. 20% and 27%). Medical patients also used these products significantly more frequently (*ps* < .001), averaging 10 days of tincture use and 13 days of topical use in the past month, compared to 5 and 7 days, respectively, among nonpatients. These patterns are consistent with the therapeutic applications of tincture and topical cannabis products.

Table 6. Past-Month Cannabis Consumption Patterns Among Medical Cannabis Patients.

Medical Patients Survey Year	Smoke (Flower)	Edibles	Vape	Concentrates
2026 Survey	17 days	13 days	16 days	13 days
2025 Survey	16 days	11 days	14 days	11 days
2024 Survey	14 days	9 days	11 days	10 days
2023 Survey	18 days	12 days	13 days	11 days

Medical patients were asked why they prefer their cannabis product of choice, the most commonly reported reason was its effectiveness in managing their condition or symptoms (40%; n = 183), taste/flavor preferences (14%; n = 64), or a general preference for the method of use (13%; n = 60). Other frequently endorsed reasons included only purchasing products on sale or at a discount (11%; n = 48) and product serving sizes aligned with individual needs (8%; n = 36). There were no differences in product preference reasonings as a function of product type. These data parallel findings from 2025 and 2024.

5.3 High THC Potency Consumption

The proportion of high-THC-potency [6] consumption among medical cannabis patients in our surveys continues to rise. In 2025, 79% of medical patients reported intentional use of high-THC-potency cannabis, and in the present sample, **92% (n = 161) of medical cannabis**

[6] High-potency cannabis was defined as any product containing over 35% THC or 20 mg/THC or greater, including any type of vaping or dabbing oil, concentrate, and extract products.

patients reported use of high-THC-potency cannabis products. These differences in high-potency cannabis use among medical cannabis respondents between 2025 and 2026 were statistically significant ($p < .001$). Nearly three-quarters of patients (72%; n = 126) cited their use of high-THC-potency cannabis products as for medicinal purposes, and 20% (n = 35) use for purposes other than medicinal. Only 8% (n = 14) of medical patients in this sample indicated they do not use high-THC-potency products at all. Although high-potency cannabis use is not exclusive to medical cannabis patients, individuals who use cannabis for medical purposes but are not registered in the medical program were significantly less likely, on average, to report consuming high-potency products overall, with approximately 34% (n = 126) of these respondents indicating no use of these products ($p < .001$).

When asked why they consume high-THC-potency products, medical cannabis patients most frequently reported use of these products because they are most effective for their medical condition(s) or symptoms (31%; n = 50). A large portion also indicated high-potency products had been specifically recommended by a certifying provider or healthcare provider (22%; n = 35), suggesting many patients view higher-potency products as an important component of their therapeutic cannabis regimen. Other commonly endorsed reasons included a personal preference for products producing more pronounced effects (13%; n = 21) and cost-related considerations (12%; n = 19), which may reflect a desire to maximize the perceived value or effectiveness of purchased products.

5.4 Managing Cannabis Dose

Beginning with the 2025 survey, medical cannabis patients were asked about strategies they use to maximize the effectiveness of their medical cannabis over time. Consistent with findings from 2025, many patients in the current sample reported actively modifying their cannabis use patterns to help preserve therapeutic benefits. Specifically, 61% (n = 107) reported taking periodic breaks from their medical cannabis use, 45% (n = 79) gradually increase their medical cannabis dose over time, and 55% (n = 96) intentionally alternate days of use to maintain its effectiveness. Medical cannabis patients were statistically significantly more likely to report taking periodic breaks from their cannabis use compared to participants who consume cannabis for medical purposes but are not registered as a medical cannabis patient in New Mexico ($p < .001$) and slightly more reported intentionally alternating days of cannabis use to maintain its effectiveness; however, this difference did not quite reach statistical significance ($p = .07$).

For the most part, these strategies were not associated with substantial differences in overall cannabis consumption patterns reported elsewhere in the survey when compared to patients who do not use these strategies. Since most of our survey questions capture cannabis use during the past 30 days, patients may not have used these strategies specifically within the past 30 days, but implemented them over longer periods of time. Future research may help clarify how these self-management practices influence cannabis use patterns and symptom management over time.

5.5 Medical Program Enrollment and Maintenance

Patients who enrolled in the Medical Cannabis Program within the past 12 months (n = 68) were presented with questions inquiring about their enrollment experiences. Only these individuals who had recently enrolled in the program were invited to respond to these survey questions, to minimize potential recall bias. Across survey waves, patients reported consistent patterns in how they choose a provider to provide them with a medical cannabis recommendation, with most indicating they either met with a provider at a dispensary (*32% in 2026, 24% in 2025, 19% in 2024, 27% in 2023*) or spoke with their primary care provider (*31% in 2026, 38% in 2025, 32% in 2024, 35% in 2023*). It has also been common for patients to receive a recommendation for a provider from a friend, patient or social worker (*22% in 2026, 21% in 2025, 24% in 2024, 17% in 2023*). In contrast, relatively few patients reported identifying providers through online searches (*4% in 2026, 7% in 2025, 9% in 2024, 4% in 2023*). There were no statistically significant differences in the proportion of patients selecting each source for cannabis recommendations across survey years.

When selecting a provider, patients also consistently reported prioritizing provider knowledge about their condition or symptoms (*78% in 2026, 69% in 2025, 72% in 2024, 81% in 2023*) and provider knowledge about cannabis (*66% in 2026, 66% in 2025, 64% in 2024, 78% in 2023*). Cost (*75% in 2026, 66% in 2025, 77% in 2024, 59% in 2023*), provider availability (*69% in 2026; 60%, 67% in 2024, 79% in 2023*), and distance to the provider (*59% in 2026, 50% in 2025, 59% in 2024, 51% in 2023*) were also commonly endorsed as important factors influencing provider selection.

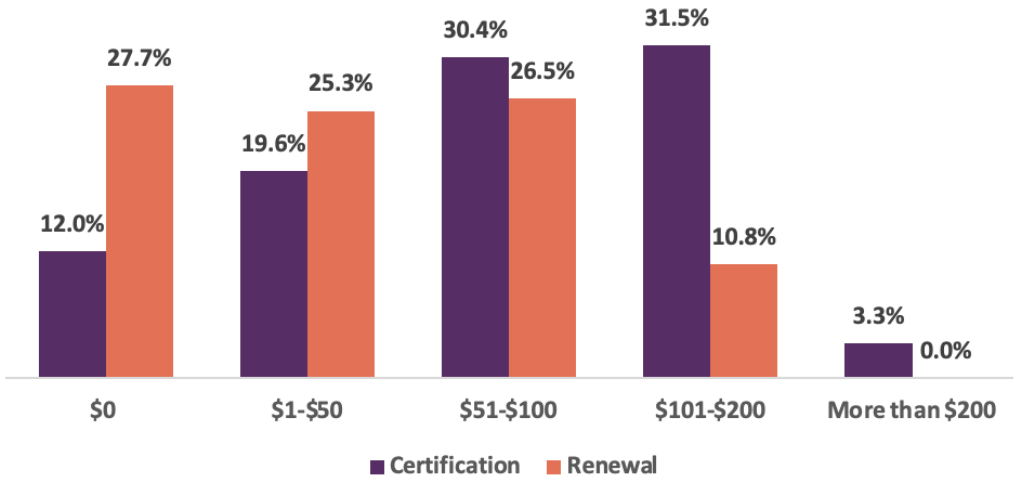
Additionally, there have been no notable differences in patient satisfaction with their medical provider across the 2023-2026 surveys. Most patients report positive experiences with the provider who certified them for the program, including feeling as though their questions and

concerns were taken seriously (*76.5% in 2026, 77% in 2025, 79% in – 2024, 83% in 2023*), the provider spent enough time with them during the appointment (*75% in 2026, 70% in 2025, 72% in 2024, 76% in 2023*), and the provider listened carefully to what they had to say (*72% in 2026, 66% in 2025, 74% in 2024, 74% in 2023*). **Taken together, these findings suggest patients rely on trusted interpersonal or healthcare-related sources when seeking medical cannabis recommendations, and value providers who are both knowledgeable and accessible.**

5.6 Costs Associated with The Medical Cannabis Program

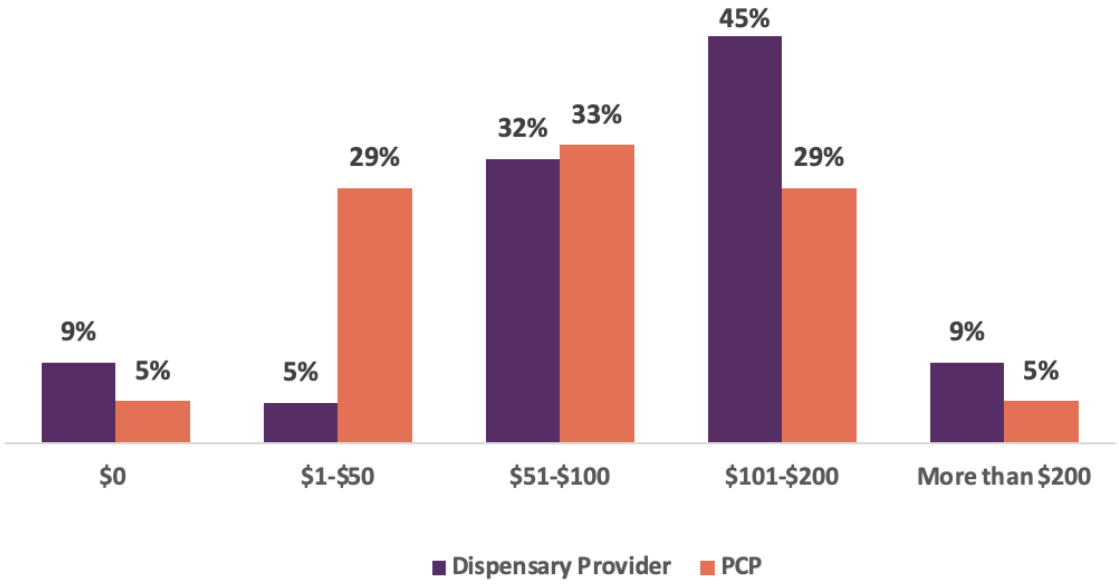
Given the importance of cost in patients' decisions about where to obtain a medical cannabis recommendation, the present survey included additional questions about the cost of recommendation and renewal/recertification appointments to better understand the financial burden associated with participation in the Medical Program. In general, patients reported their initial recommendation appointments to be slightly more expensive than renewal appointments. Approximately 30% (n = 28) reported paying between $51-$100 for their recommendation appointment, while an additional 31.5% (n = 29) reported costs between $101-$200. Relatively few patients (12%; n = 11) indicated their recommendation appointment was free of charge, whereas nearly 28% (n = 23) reported their renewal appointment was $0.

Figure 6. Cost of Certification and Renewal Appointment.



We also examined how certification appointment costs varied by provider type among the two most commonly selected provider types. Given the small sample size (n = 43) and the restriction to participants who enrolled in the Medical Program within the past 12 months, we are limited in the types of statistical tests and interpretations we can make. Descriptively, we see patterns such that dispensary-based certifications were slightly more concentrated in higher cost categories, whereas PCP-based certifications were somewhat more concentrated in lower-cost categories. Mid-range costs ($51-$100) were similar across groups. Future research with a larger sample is needed to fully evaluate potential differences in certification costs by provider type.

Figure 7. Certification Appointment Costs, by Provider Type.



5.7 Online Patient Portal

Based on the timing of our surveys, we have had a unique opportunity to examine patient experiences with the enrollment and renewal process as the New Mexico DOH shifted from paper applications to the Online Patient Portal. In April 2023, the Department completed this transition and fully discontinued paper applications after first launching the Online Patient Portal in 2020.

Nearly 50% (n = 84) of the present patient sample indicated enrolling in the Medical Program using the Online Patient Portal and 29% (n = 51) renewed their registry identification card using

the Portal. Nearly one-quarter (23%; n = 40) of patients indicated they have not used the Portal to enroll or renew their medical cannabis card and have only used the paper applications. This represents a decline from 2025, in which nearly 30% of patients had no experience renewing or enrolling through the Portal, which is likely attributable to the higher proportion of recent enrollees included in this survey sample.

Table 7. Average Ease of Enrollment and Renewal Rating by Survey Year (1 = Extremely Easy and 10 = Extremely Difficult).

Year	Enrolling	Renewing
2026	4.2	4.0
2025	3.8	4.2
2024	4.3	3.4
2023	3.7	--

Among those who have used the Portal to enroll in the Medical Cannabis Program within the past 12 months or renew their registry identification card, patients rated the process of enrolling in the program as easy, at 4.2 out of 10 and renewing their cannabis registry identification card at 4.0 out of 10, when provided a scale of 1 (extremely easy) to 10 (extremely difficult). Reported patient satisfaction with the enrollment and renewal process has remained stable since 2023, with most reporting easy to moderately-easy experiences enrolling and renewing their cannabis registry identification card. **Overall, these data indicate the transition away from paper applications has been relatively smooth, with patients reporting few additional challenges during the process.**

All medical cannabis patients in New Mexico have access to the Online Patient Portal, regardless of whether they enrolled in the Medical Cannabis Program or renewed their identification card using the Portal. To assess general use of the portal, all patients in this sample were asked about their frequency of logging on to the Online Patient Portal for purposes such as reviewing sales history, checking their available units, etc. Approximately half of the patient sample (52%; n = 91) reported using the Online Patient Portal on at least a monthly basis, with 7% (n = 12) using on a daily basis and 22% (n = 39) using on a weekly basis. Twenty-eight percent (n = 49) have used the portal within the past year, but not past month. These results are nearly identical to our findings from 2025 (*7% daily, 23% weekly, 23%*

monthly) and 2024 (*9% daily, 21% weekly, 21% monthly*), indicating consistent usage of the Portal among patients.

5.8 Conditions for Medical Cannabis Use

Patients reported the health conditions or symptoms for which a medical provider recommended they use cannabis (i.e., qualifying conditions), as well as the health conditions or symptoms for which they currently use cannabis without a medical provider recommendation (i.e., nonqualifying conditions). Please refer to Tables 8 and 9 for detailed information. Anxiety disorder (70%; n = 122) was the most commonly reported qualifying condition in the patient sample, followed by post-traumatic stress disorder (53%; n = 92), and insomnia (49%; n = 85). Among use for conditions not recommended by a medical provider, sleep (69%; n = 121), anxiety (59%; n = 103), pain (58%; n = 101), and depression (57%; n = 99) were the most common. The top four conditions for use remain consistent across all survey years (2023-2026) for both qualifying conditions (anxiety disorder, post-traumatic stress disorder, insomnia, and severe chronic pain) and non-qualifying conditions (sleep, anxiety, pain, and depression).

Collectively, these results indicate patients are primarily using cannabis to manage symptoms related to mental health, sleep disturbances, and pain. Notably, this pattern persists regardless of whether cannabis use was formally recommended by a medical provider, highlighting many patients' view of cannabis as an important self-management tool for conditions with a substantial impact on daily functioning and quality of life.

Table 8. Percentage of Sample Reporting Obtaining a Medical Provider's Recommendation for Qualifying Conditions: Registered Patients from 2026-2023.

Condition/Symptom	2026 Patients (%, n = 175)	2025 Patients (%, n = 242)	2024 Patients (%, n = 224)	2023 Patients (%, n = 192)
Anxiety disorder	70%	65%	60%	79%
Post-traumatic stress disorder	53%	48%	41%	62%
Insomnia	49%	55%	54%	57%
Severe chronic pain	34%	41%	42%	41%
Inflammatory autoimmune-mediated arthritis	19%	25%	23%	20%
Intractable nausea/vomiting	18%	19%	25%	19%
Obstructive sleep apnea	18%	17%	16%	17%
Painful peripheral neuropathy	17%	15%	20%	15%

Condition/Symptom	2026 Patients (%, n = 175)	2025 Patients (%, n = 242)	2024 Patients (%, n = 224)	2023 Patients (%, n = 192)
Epilepsy/seizure disorder	15%	16%	18%	14%
Damage to the nervous tissue of the spinal cord	14%	18%	17%	22%
Opioid use disorder	14%	15%	19%	13%
Autism spectrum disorder	13%	20%	13%	13%
Cancer	13%	13%	21%	12%
Severe anorexia/cachexia	12%	15%	13%	11%
Alzheimer's disease	9%	14%	15%	7%
Amyotrophic lateral sclerosis (ALS)	9%	12%	14%	7%
Crohn's disease	9%	12%	18%	10%
Glaucoma	9%	10%	14%	12%
Multiple sclerosis	8%	10%	16%	9%
Hepatitis C infection currently receiving antiviral therapy	7%	9%	12%	6%
Inclusion body myositis	7%	9%	13%	8%
Spinal muscular atrophy	7%	12%	17%	11%
HIV/AIDS	6%	11%	9%	8%
Hospice care	6%	10%	13%	11%
Huntington's disease	5%	10%	10%	8%
Parkinson's disease	5%	10%	10%	10%
Spasmodic torticollis (cervical dystonia)	5%	8%	12%	8%
Ulcerative colitis	5%	11%	14%	9%
Lewy body disease	3%	12%	9%	5%
Friedreich's ataxia	2%	10%	7%	7%

Table 9. Percentage of Sample Reporting Cannabis Use for Conditions Without a Medical Provider's Recommendation: Registered Patients 2026-2023.

Condition/Symptom	2026 Patients (%, n 175)	2025 Patients (%, n 242)	2024 Patients (%, n 224)	2023 Patients (%, n 192)
Sleep	69%	68%	60%	69%
Anxiety	59%	59%	53%	68%
Pain	58%	53%	59%	59%
Depression	57%	55%	49%	59%
Headaches or eye pain	42%	35%	30%	37%
Appetite/weight	29%	29%	24%	34%
Inflammation	29%	33%	28%	32%

Condition/Symptom	2026 Patients (%, n 175)	2025 Patients (%, n 242)	2024 Patients (%, n 224)	2023 Patients (%, n 192)
Nausea	29%	29%	25%	30%
Reducing alcohol use	24%	28%	25%	25%
Reducing tobacco use	22%	22%	23%	24%
Reducing other drug use	21%	20%	17%	21%
Spasms	21%	19%	21%	20%
Reducing prescription antidepressants	18%	23%	16%	23%
Skin issues	16%	13%	13%	8%
Opioid use disorder treatment	15%	17%	15%	13%
Opioid withdrawal symptoms	14%	17%	15%	10%
Preventing/alleviating opioid withdrawal	12%	15%	12%	13%
Another type of substance use disorder	11%	13%	15%	9%
Other	5%	7%	7%	4%

5.9 Medical Program and Dispensary Satisfaction

Nearly half (47%; n = 83) of patients in this sample reported purchasing adult-use cannabis within the past year. Accordingly, patients were asked about their experiences obtaining cannabis from both medical and adult-use dispensaries. These questions aimed to help us better understand patients' purchasing behaviors and satisfaction shopping at licensed dispensaries near them. Patients reported high ratings of satisfaction with medical cannabis purchased from nearby dispensaries, a stable finding across the 2023-2025 surveys (see Table 10). When specifically asked about the medical cannabis available to them, nearly three-quarters of respondents expressed satisfaction with the THC potency in medical cannabis (75%; n = 132), quality of medical cannabis (74%; n = 129), number of units available for purchase (72%; n = 126), and variety of medical cannabis product types (71%; n = 125). In addition, many patients perceived the legalization of adult-use cannabis to have had a positive impact on the medical cannabis market. Specifically, 62% (n = 108) reported legalization has improved the supply of medical cannabis products and 61% (n = 107) indicated legalization has improved product pricing, with only 11% (n = 20) reporting a worsening of the supply and 7% (n = 12) reporting a worsening of product pricing since legalization.

Collectively, these findings suggest medical cannabis consumers generally perceive the regulated market as providing high-quality products, sufficient variety, and adequate potency options. However, pricing remains a comparatively more mixed area of evaluation, reinforcing prior findings that economic barriers continue to likely shape patient experiences within regulated cannabis markets.

Table 10. Percentage of Patients Reporting Satisfaction with Medical Dispensaries, Separated by Survey Year.

Dispensary Attribute	2026 (%; n = 175)	2025 (%; n = 242)	2024 (%: n = 224)
THC potency in medical cannabis	75%	75%	72%
Quality of medical cannabis	74%	78%	77%
Number of units available to purchase per 90-day period	72%	--	--
Variety of medical cannabis product types	71%	77%	73%
Availability of cannabis strains	69%	71%	67%
Supply or stock of medical cannabis product types	69%	75%	68%
Pricing of medical cannabis products	65%	69%	62%
CBD potency in medical cannabis	63%	60%	58%

These positive experiences with the medical cannabis marketplace may contribute to why most patients in this sample report intending to remain enrolled in the Medical Cannabis Program. Nearly all medical patients in this survey plan to remain in the Medical Program when their card is due for renewal (89%; n = 155), with few indicating they do not intend to remain in the Medical Program (6%; n = 11) or were unsure about renewing (5%; n = 9). Patients most commonly reported their primary reason for staying in the Medical Cannabis Program is due to lower costs of medical cannabis products (29%; n = 45), tax exemption when purchasing medical cannabis products (16%; n = 25), and general preference for the types of products available for medical cannabis patients (16%; n = 24). These findings parallel results from 2025, indicative of stability in patient motivations for program participation. The consistency of these patterns across survey years may indicate sustained patient satisfaction with the Medical Cannabis Program and continued perceived value in maintaining medical cannabis access despite the availability of adult-use cannabis.

Table 11. Reasons for Intending to Renew Registration in the Medical Cannabis Program.

Reason	2026 (%; n = 175)	2025 (%: n = 242)
Lower cost of medical cannabis products	29%	26%
Tax exemption of medical cannabis products	16%	11%
Prefer types of products available as a medical cannabis patient	16%	16%
Benefit from medical provider interactions	15%	19%
Higher quality of medical cannabis products	11%	12%
Reduced stigma of purchasing medical cannabis products	5%	8%
Higher possession limits when outside the home	5%	2%
Access to cannabis when under 21 years	2%	3%

Section 5 Summary

- Approximately one-quarter of respondents were actively enrolled in New Mexico's Medical Cannabis Program, while a majority had never participated. Among former patients, recertification costs, product costs, and firearm-related concerns were among the most commonly cited reasons for leaving the program.
- Medical cannabis patients reported frequent cannabis use, with two-thirds consuming cannabis daily or almost daily. Flower, vape, and edible products remained the most commonly used product types, while tinctures and topicals were used more frequently among patients than nonpatients.
- Use of high-THC-potency cannabis products continued to increase among medical patients, with more than 90% reporting intentional use of these products.
- Mental health conditions, sleep disturbances, and pain remained the primary reasons patients used medical cannabis. Anxiety disorder, post-traumatic stress disorder, insomnia, and chronic pain were the most common qualifying conditions, while sleep, anxiety, pain, and depression were the most common conditions patients managed outside of their formal medical recommendations.
- Patients generally reported high levels of satisfaction with New Mexico's Medical Cannabis Program and medical cannabis dispensaries. Most intended to remain enrolled in the program, citing lower product costs, tax exemptions, product availability, and continued access to medical cannabis benefits despite the presence of the adult-use market.

Section 6. Consumer Access

6.1 Transportation

Findings presented in the following sections include data from the full sample of participants, including patients and nonpatients, unless otherwise specified. Transportation to nearby dispensaries was overwhelmingly dominated by vehicle use among respondents. Nearly four in five respondents (79%; n = 528) reported traveling to and from dispensaries by car, suggesting access to legal cannabis retailers remains heavily dependent on private transportation. In contrast, relatively few respondents reported utilizing alternative forms of transportation, including public transportation (6%; n = 38), walking (8%; n = 56), bicycling (2%; n = 15), or rideshare services and taxis (2%; n = 13). An additional 1% (n = 7) of respondents indicated a medical caregiver assists them in obtaining cannabis, while 2% (n = 15) selected “other” forms of transportation.

Collectively, these findings suggest dispensary access may be closely tied to automobile accessibility and broader transportation infrastructure. The comparatively low reliance on public transit, rideshare services, and active transportation methods may reflect geographic dispersion of dispensaries, consumer purchasing patterns that favor larger or less frequent purchases, or the location of dispensaries in areas more easily accessed by private vehicles.

Table 12. Transportation Types Used to Access Nearest Dispensary.

Transportation Type	% (n 672)
Car	79%
I walk	8%
Public transportation (e.g., bus)	6%
Bicycle	2%
Rideshare service (e.g., Uber, Lyft) or Taxi	2%
Other	2%
A medical caregiver helps me get cannabis	1%

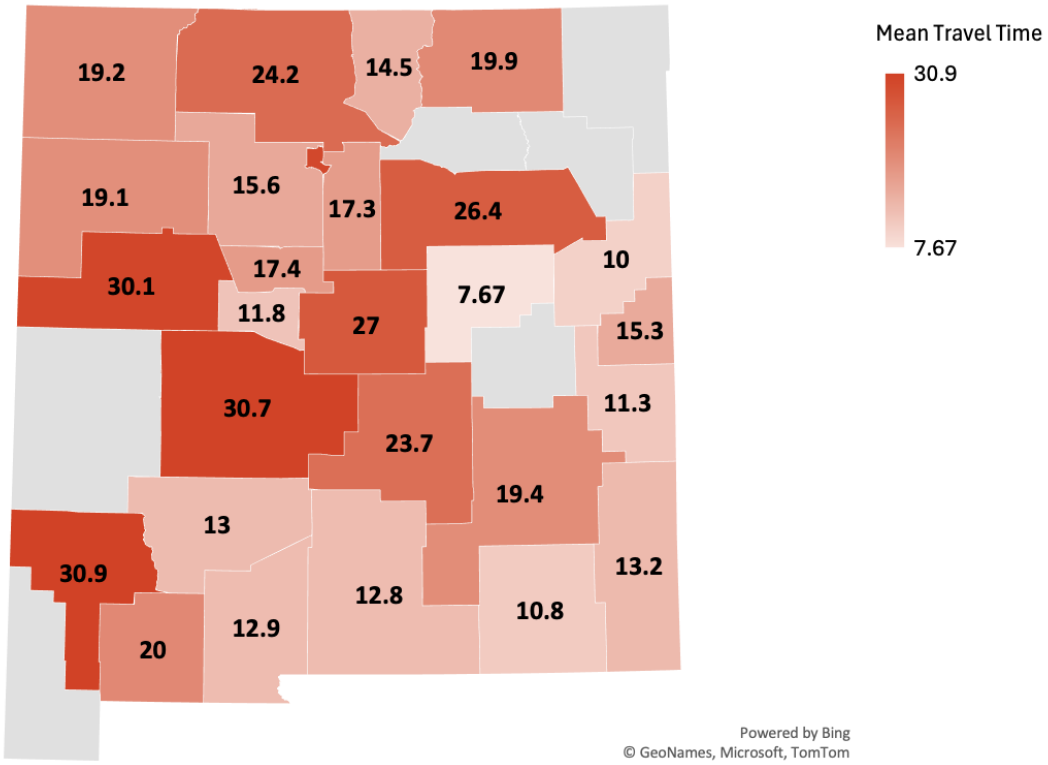
Reported travel times to dispensaries were relatively short overall, with respondents reporting a median travel time of 12 minutes and a mean travel time of 17 minutes to the closest dispensary near them. The difference between the median and mean indicates most consumers access dispensaries within a relatively brief travel window, while a subset of respondents likely travel substantially farther distances, increasing the overall average travel time. Similar to findings from the 2024 and 2025 surveys, medical patients in the present sample reported a higher travel time on average (21 minutes) compared to nonpatients (16 minutes). Consistent with past surveys, these differences were statistically significant ($p < .001$).

These findings from the total sample may indicate that regulated cannabis retailers are geographically accessible for many consumers, particularly those located in more urban or densely populated areas. However, the higher mean relative to the median also suggests uneven access across the sample, with some consumers potentially residing in areas with fewer nearby dispensaries or facing transportation-related barriers.

County-level analyses revealed substantial geographic variation in reported travel times to dispensaries. Mean travel times ranged from approximately 7.7 minutes in the lowest-access burden counties to over 30 minutes in the highest-access burden counties, suggesting notable disparities in proximity to regulated cannabis retailers across regions. Several counties, particularly those located in more rural or geographically dispersed areas, demonstrated mean travel times exceeding 25 to 30 minutes, whereas other counties reported average travel times closer to 10 to 15 minutes.

The spatial distribution of travel times suggests access to dispensaries is not uniform across the state and may be shaped by factors such as dispensary density, population distribution, transportation infrastructure, and local regulatory environments. Counties with longer average travel times may reflect areas with fewer licensed dispensaries or greater physical distance between consumers and retail locations. In contrast, counties with shorter travel times may indicate higher retail concentration or greater urban accessibility.

Figure 8. Mean Travel Time (in Minutes) to Closest Dispensary, per County.



To examine differences in travel time to and from dispensaries across urban and rural communities, zip code and county-level data were used to assign Rural-Urban Continuum Codes (RUCC) to each participant in the sample. RUCC classifications, developed by the United States Department of Agriculture (USDA) Economic Research Service, categorize U.S. counties according to metropolitan status, population size, and adjacency to metropolitan areas. Respondents in the current sample represented 7 of the 9 RUCC categories.

Table 13. Mean and Median Travel Time in Minutes by RUCC Category Description.

RUCC Category Description	Mean Travel Time (Minutes)	Median Travel Time (Minutes)	Std Dev	Minimum Travel Time	Maximum Travel Time
Metro - Counties in metro areas of 250,000 to 1 million population	17.6	14	14.8	1	90
Metro - Counties in metro areas of fewer than 250,000 population	14.2	10	12.1	1	69
Nonmetro - Urban population of 20,000 or more, *not* adjacent to a metro area	15.7	10	15.6	1	90
Nonmetro - Urban population of 5,000 to 20,000, adjacent to a metro area	22.4	15	20.6	1	90
Nonmetro - Urban population of 5,000 to 20,000, *not* adjacent to a metro area	15	7	17	3	65
Nonmetro - Urban population of fewer than 5,000, adjacent to a metro area	13	12	8.9	4	30
Nonmetro - Urban population of fewer than 5,000, *not* adjacent to a metro area	19.7	12	21.8	1	90

Results demonstrated meaningful variation in dispensary travel times across levels of urbanicity. Respondents residing in metropolitan counties with populations between 250,000 and 1 million reported a mean travel time of 17.6 minutes (median = 14 minutes), while those in smaller metropolitan counties with populations under 250,000 reported a lower mean travel time of 14.2 minutes (median = 10 minutes). Among nonmetropolitan areas, travel times were generally more variable and, in some cases, substantially longer. Respondents living in nonmetro counties with urban populations between 5,000 and 20,000 who were adjacent to metropolitan areas reported the highest mean travel time in the sample (mean = 22.4 minutes, median = 15). Similarly, respondents in nonmetro counties with fewer than 5,000 residents who were not adjacent to metropolitan areas reported elevated travel times (mean = 19.7 minutes, median = 12).

Standard deviations across several rural categories were notably large, indicating substantial within-group variability in access. For example, the standard deviation among respondents residing in nonmetro counties with fewer than 5,000 residents not adjacent to metropolitan areas was 21.8 minutes, suggesting some consumers lived relatively close to dispensaries, but others experienced considerably longer travel burdens. Maximum travel times frequently approached or reached 90 minutes across multiple RUCC categories, further underscoring disparities in geographic accessibility.

Collectively, these findings suggest that access to regulated cannabis retailers varies meaningfully across the rural-urban continuum. Although metropolitan respondents generally reported shorter and more consistent travel times, several rural and nonadjacent communities experienced substantially greater travel burdens. These disparities may reflect lower dispensary density, greater geographic dispersion, transportation limitations, or local policy environments that constrain retail availability. The findings indicate physical accessibility may remain an important structural determinant of participation in regulated cannabis markets, particularly among consumers residing in rural areas.

To further examine whether broader regional infrastructure patterns influenced dispensary accessibility, RUCC categories were collapsed into two higher-order groups: (1) Metro/Metro-Adjacent counties, which were hypothesized to have greater transportation and retail infrastructure, and (2) Rural/Non-Adjacent counties, which were hypothesized to have comparatively less infrastructure and retail access.

Results indicated minimal differences in reported travel times between these groups. Respondents residing in isolated nonmetropolitan areas reported an average travel time of 16.7 minutes, while respondents residing in metropolitan or metro-adjacent areas reported an average travel time of 17.5 minutes. A paired t-test comparing the two groups indicated that the difference in travel times was not statistically significant, suggesting dispensary travel burden did not meaningfully differ between these broader classifications of urban and rural residence.

These findings suggest, despite observed county-level and RUCC-specific variability, overall dispensary accessibility may be more geographically distributed than initially expected. In other words, while some rural or isolated counties experience elevated travel burdens, these differences may not systematically translate into significantly longer average travel times when

rural communities are examined collectively. This pattern may reflect the strategic placement of dispensaries near transportation corridors, regional travel norms in rural communities, or the possibility of some consumers willing to travel comparable distances regardless of metropolitan status when accessing regulated cannabis products.

6.2 Access and Barriers

Respondents were asked to identify barriers to accessing regulated cannabis products, with results stratified by patient status and survey year. Across both patients and nonpatients, expensive cannabis prices emerged as the most commonly reported barrier over time. Among patients, the proportion identifying high prices as a barrier declined steadily from 59% in 2023 to 42% in 2026. A similar pattern was observed among nonpatients, decreasing from 63% in 2023 to 43% in 2026. **These findings indicate cost remains a central obstacle to regulated market participation, while perceptions of affordability may be improving over time as the market continues to mature.**

Table 14a. Reported Barriers Endorsed by Patients.

Barrier	2026 (n = 175)	2025 (n = 242)	2024 (n = 224)	2023 (n = 192)
Expensive prices for cannabis products	42%	51%	56%	59%
A lack of dispensaries near me	18%	20%	27%	12%
Crowded dispensaries and/or long lines at dispensaries	20%	33%	35%	28%
Lack of supply or stock of cannabis	28%	32%	35%	34%
Stigma associated with cannabis use	18%	23%	24%	30%
A lack of transportation options to get to and from a dispensary	22%	26%	21%	25%
Getting help from a medical caregiver	15%	—	—	—
% reporting at least one barrier	65%	70%	73%	75%

Table 14b. Reported Barriers Endorsed by Nonpatients.

Barrier	2026 (n = 497)	2025 (n = 506)	2024 (n = 358)	2023 (n = 376)
Expensive prices for cannabis products	43%	45%	47%	63%
A lack of dispensaries near me	10%	11%	10%	19%
Crowded dispensaries and/or long lines at dispensaries	13%	12%	11%	19%
Lack of supply or stock of cannabis	17%	18%	16%	26%
Stigma associated with cannabis use	16%	15%	15%	25%
A lack of transportation options to get to and from a dispensary	18%	19%	16%	32%
Getting help from a medical caregiver	11%	—	—	—
% reporting at least one barrier	58%	57%	60%	75%

Several additional access-related barriers demonstrated notable differences between patients and nonpatients. Significantly more patients reported barriers related to dispensary operations and product access, including crowded dispensaries or long lines, lack of product supply, and insufficient nearby dispensaries compared to nonpatients in the present sample (*ps* < .05). Specifically in 2026, 28% of patients reported lack of supply or stock as a barrier compared to 17% of nonpatients, while 20% of patients reported crowded dispensaries or long lines compared to 13% of nonpatients. Patients also more frequently reported transportation-related barriers, with 22% indicating a lack of transportation options in 2026 compared to 18% of nonpatients. Medical patients were also more likely to report a lack of nearby dispensaries compared to nonpatients (18% vs 10%), which may be related to their longer reported transportation times to dispensaries, as discussed in Subsection 6.1.

Notably, a substantial proportion of respondents across all survey years continued to report experiencing at least one barrier to accessing cannabis. Although this percentage declined over time, particularly among medical patients, barriers remained common in 2026, with 65% of patients and 58% of nonpatients reporting at least one obstacle to access. **Collectively, these findings suggest that while access conditions may be improving over time, structural and economic barriers to regulated cannabis participation remain prevalent, particularly among medical cannabis patients who may rely more consistently on dispensary access for therapeutic purposes.**

Section 6 Summary

- While access to regulated cannabis retailers appears relatively strong for many consumers, physical accessibility remains uneven across the state. County-level analyses suggest dispensary density, transportation infrastructure, and local geography continue to influence consumer access to regulated cannabis products.
- Expensive cannabis prices remained the most commonly reported barrier to accessing regulated cannabis products among both medical patients and nonpatients. However, the proportion of respondents identifying cost as a barrier has declined steadily since 2023, suggesting perceptions of affordability may be improving as the market matures.
- Medical cannabis patients consistently reported more barriers to access than nonpatients, including concerns related to product availability, dispensary supply, transportation, and long wait times. Despite these challenges, reported barriers have generally declined across survey years.
- Medical cannabis consumers reported high levels of satisfaction with product quality, product variety, potency, availability, and purchase limits. Pricing remained the lowest-

rated market characteristic relative to other measures, reinforcing findings that cost continues to play an important role in shaping consumer experiences within the regulated market.

Section 7. Public Health

7.1 Driving Under the Influence of Cannabis

Across the current and prior surveys, we assessed driving under the influence of cannabis (DUIC) as an important cannabis-related public health outcome. DUIC was defined as driving a motor vehicle within two hours of cannabis consumption. Existing research consistently demonstrates acute cannabis intoxication can impair neurocognitive and psychomotor functioning in ways that negatively impact driving performance, including slower reaction time, impaired tracking ability, increased lane weaving, and elevated crash risk. [7] As the regulated cannabis markets continue to expand, monitoring DUIC behaviors remains critical for informing public health education and prevention efforts.

Compared to findings from the 2025 survey, the current 2026 data suggest modest improvements in DUIC prevalence overall, particularly among nonpatient consumers. In 2025, approximately 36% (n = 273) of the overall sample reported at least one DUIC day within the past month. In the current survey, 46% (n = 80) of patients and 31% (n = 156) of nonpatients reported at least one instance of driving within two hours of cannabis consumption during the prior 30 days. Conversely, the majority of respondents reported no DUIC behavior during the prior month, including 54% (n = 95) of patients and 69% (n = 341) of nonpatients.

Patterns of frequent DUIC behavior remained relatively consistent with prior years. In the current survey, 7% (n = 13) of patients and 4% (n = 19) of non-patients reported DUIC behavior on all 30 days of the month. Similarly, higher-frequency DUIC categories were consistently more common among patients than nonpatients, suggesting medical cannabis consumers may continue to engage in DUIC behaviors at elevated rates relative to adult-use consumers. This pattern is broadly consistent with prior survey findings indicating medical patients often

[7] Busardò, F. P., Pellegrini, M., Klein, J., & di Luca, N. M. (2017). Neurocognitive correlates in driving under the influence of cannabis. CNS & Neurological Disorders-Drug Targets, 16(5), 534-540. https://doi.org/10.2174/1871527316666170424115455

consume cannabis more frequently overall and may perceive themselves as less impaired due to tolerance or therapeutic use patterns.

Prior analyses from the 2025 survey demonstrated individuals reporting more frequent DUIC behavior were significantly more likely to believe they could drive safely despite being heavily intoxicated after cannabis consumption. **Taken together, the current findings continue to support the need for targeted public education and harm reduction messaging focused on cannabis-related driving impairment, particularly among more frequent consumers who may underestimate the effects of acute intoxication on driving performance.**

Table 15. Days of DUIC within 2 Hours of Consumption.

DUIC Days	Patient (n = 175)	Nonpatient (n = 497)
0 Days	54%	69%
1 Day	7%	5%
2 Days	7%	5%
3-5 Days	9%	7%
6-9 Days	5%	4%
10-19 Days	6%	4%
20-25 Days	2%	1%
25-29 Days	2%	0%
All 30 Days	7%	4%

Respondents were asked to rate, on a scale from 1 to 10, the level of cannabis intoxication at which they believed they could still drive safely, where 1 represented “completely sober” and 10 represented “heavily intoxicated.” The mean response across the sample was 3.38, suggesting that, on average, respondents believed only low levels of intoxication (i.e., levels near the lower end of the 10-point scale) were compatible with safe driving, and being heavily intoxicated would not be conducive to safe driving.

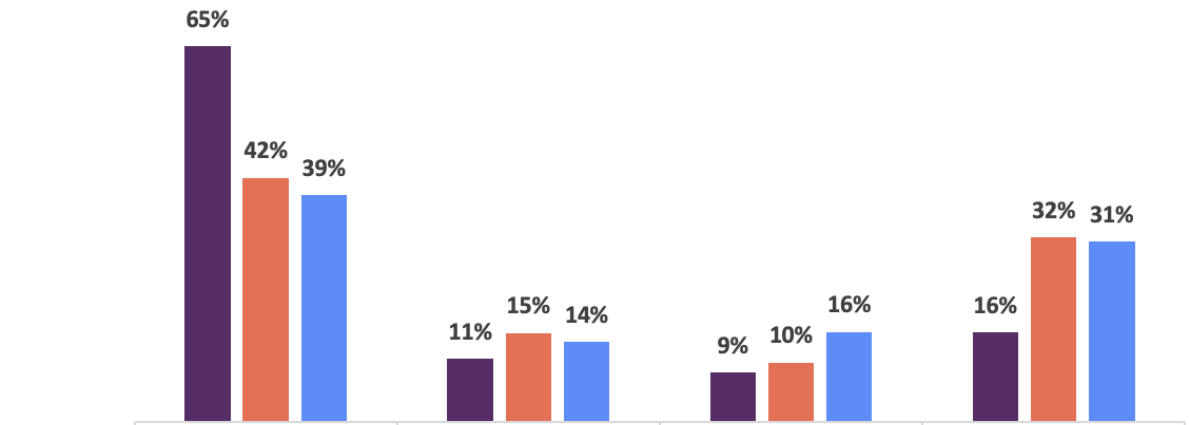
Perceptions regarding the level of cannabis intoxication compatible with safe driving varied across respondents, though the distribution of responses generally clustered toward the lower end of the intoxication scale. Among nonpatients, the largest proportion of respondents selected

“1” on the 10-point scale (41.2%; n = 205), indicating many believed an individual should be completely sober in order to drive safely after consuming cannabis. Similarly, 38.3% (n = 67) of patients selected “1,” suggesting substantial agreement across groups that driving should ideally occur with little to no intoxication. However, a meaningful subset of respondents believed some degree of intoxication was compatible with safe driving. Among nonpatients, approximately 38% (n = 190) selected values between 2 and 5, while among patients this proportion was approximately 38% (n = 66). Smaller but notable percentages of respondents endorsed higher intoxication thresholds. For example, 7.2% (n = 36) of nonpatients selected “10,” indicating a belief that even heavy intoxication may still permit safe driving, while 7.4% (n = 13) of patients selected “8.” Overall, patient responses appeared somewhat more distributed across moderate-to-higher intoxication categories relative to nonpatients.

These findings suggest substantial heterogeneity in perceptions of cannabis-related driving impairment. While many respondents endorsed conservative beliefs regarding intoxication and safe driving, others appeared to perceive cannabis impairment as manageable or compatible with driving performance, particularly at moderate intoxication levels. Such perceptions may help explain patterns observed in self-reported DUIC behavior.

Across the 2025 and 2026 surveys, respondents who reported consuming alcohol, cannabis, or opioids were asked how often they arranged for a designated driver (DD) when they knew they would need to travel within two hours after substance use. Data presented in Figure 9 represents the frequency with which respondents who use each respective substance utilize a DD from the present sample. Overall, alcohol users consistently reported the highest rates of designated driver utilization, while cannabis users reported comparatively lower rates across both survey years.

Figure 9. Use of Designated Driver After Consumption of Alcohol, Cannabis and Opioids.



	Always	Usually	Sometimes	Rarely
Alcohol	65%	11%	9%	16%
Cannabis	42%	15%	10%	32%
Opioids	39%	14%	16%	31%

In 2025, 58% of alcohol consumers reported “always” arranging a designated driver, compared to 43% of cannabis consumers and 37% of opioid consumers. Similar patterns emerged in 2026. Among respondents who reported using each substance, nearly two-thirds of alcohol consumers reported “always” using a designated driver, compared to 42% of cannabis consumers. Cannabis consumers also reported higher rates of “rarely” arranging a designated driver relative to alcohol consumers.

These findings suggest respondents engage in more consistent transportation-related harm reduction practices following alcohol use compared to cannabis use. The comparatively lower reliance on designated drivers among cannabis consumers may reflect differences in perceived impairment, beliefs regarding functional tolerance, or broader social norms surrounding cannabis intoxication and driving. Collectively, the findings reinforce other survey results suggesting some consumers may underestimate the impairing effects of cannabis intoxication on driving performance.

7.2 Cannabis Storage and Use Inside the Home

Respondents were asked to report how frequently they engaged in several cannabis-related consumption and storage behaviors during the past year, including cannabis use while driving,

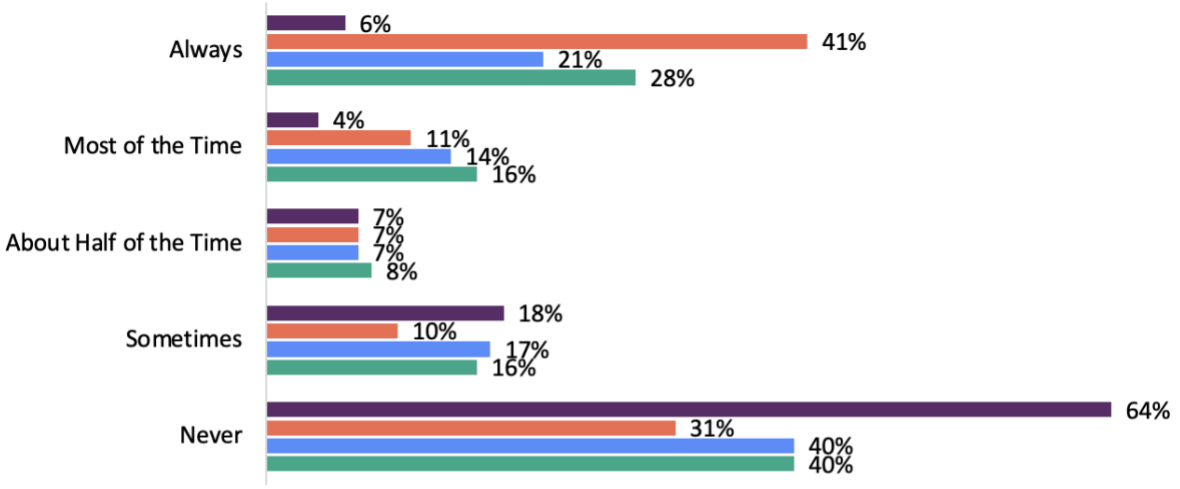
in-home cannabis smoking or vaping, and safe cannabis storage practices. Overall, the findings suggest substantial variability across behaviors, with respondents generally reporting safer storage practices more consistently than transportation-related risk behaviors.

Safe cannabis storage emerged as the most consistently practiced behavior in the sample. Approximately 41% (n = 276) of respondents reported they “always” stored their cannabis in a locked, safe location, while an additional proportion indicated they did so “most of the time” (11%; n = 74) or “about half of the time” (7%; n = 47). However, 31% (n = 205) reported they “never” stored cannabis in a locked location, suggesting a sizable minority of consumers may not consistently engage in secure storage practices. These findings may have important implications for accidental exposure prevention, youth access, and broader household safety.

In contrast, cannabis use while driving was comparatively uncommon. Nearly two-thirds of respondents (64%; n = 433) reported they “never” smoked or vaped cannabis in their car while driving. Nonetheless, a smaller subset of respondents reported engaging in this behavior with some regularity, including approximately 6% (n = 42) who indicated they “always” consumed cannabis while driving and additional respondents who reported doing so “sometimes” or “most of the time.” These findings are consistent with other survey indicators suggesting a minority of consumers may continue to engage in potentially risky driving-related cannabis behaviors.

In-home cannabis use behaviors were more common overall. Approximately 28% (n = 191) of respondents reported they “always” smoked cannabis inside their house, while 21% (n = 144) reported they “always” vaped cannabis indoors. Smoking and vaping inside the home also demonstrated relatively similar distributions across the remaining frequency categories, suggesting indoor cannabis consumption remains a common behavior among many consumers.

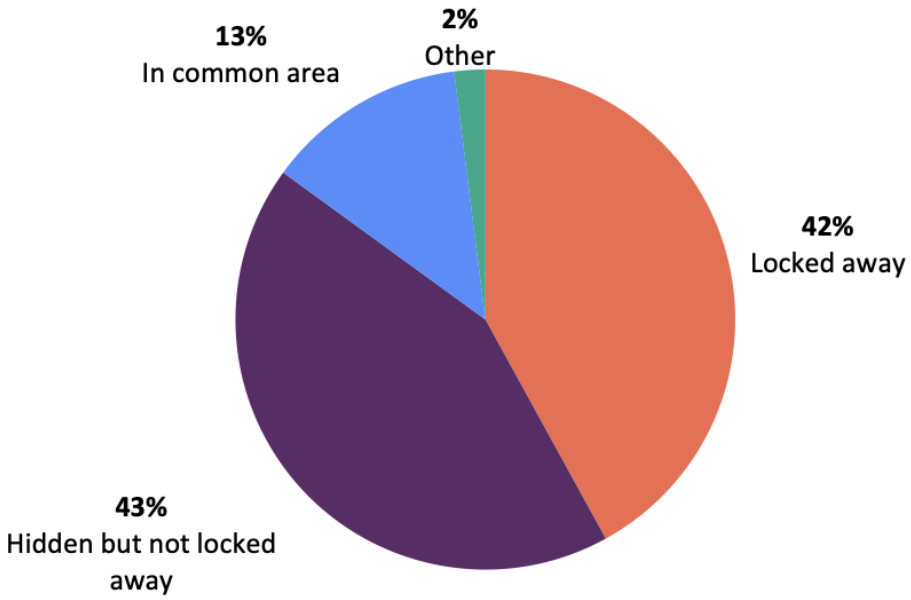
Figure 10. Frequency of Past-Year Engagement in Various Consumer Behaviors.



	Never	Sometimes	About Half of the Time	Most of the Time	Always
I smoked or vaped cannabis in my car while driving.	64%	18%	7%	4%	6%
I stored my cannabis in a locked, safe location.	31%	10%	7%	11%	41%
I vaped cannabis inside my house.	40%	17%	7%	14%	21%
I smoked cannabis inside my house.	40%	16%	8%	16%	28%

Respondents were separately asked where they typically keep cannabis products within their home environment. Overall, findings suggest while many consumers take at least some precautions to limit visibility or access to cannabis products, fully secure storage practices were not universal. Approximately 42% (n = 280) of respondents reported storing cannabis products in a locked location, indicating fewer than half of consumers consistently utilize the most secure storage option. An additional 43% (n = 290) reported keeping cannabis products hidden from others but not locked away, such as in an unlocked drawer or cabinet. While these practices may reduce visibility, they may not fully prevent unauthorized access, particularly among children, adolescents, or visitors within the household. Notably, 13% (n = 87) of respondents reported storing cannabis products in a common area and/or in plain sight, suggesting a meaningful minority of consumers may engage in relatively low-security storage practices.

Figure 11. Cannabis Storage Practices Within the Home.



Collectively, these findings suggest that although many consumers attempt to store cannabis products discreetly, secure locked storage remains inconsistent across households. From a public health perspective, these patterns may have implications for accidental exposure prevention, youth access, and broader household safety. The findings further support the continued need for public education emphasizing the importance of secure cannabis storage practices, particularly in homes with children or other vulnerable individuals.

Open-ended responses for “Other” (n = 15; 2.2%) regarding cannabis storage practices provided additional context into how respondents conceptualize and manage cannabis storage within the home. Several respondents indicated they do not routinely keep cannabis products in their home at all, often because they use cannabis infrequently or purchase only small quantities as needed. Others described relatively informal storage practices, including keeping cannabis in bedside tables, bedroom nightstands, dressers, trays, refrigerators, or freezers.

Collectively, the open-ended responses suggest substantial heterogeneity in how consumers approach cannabis storage, ranging from intentional avoidance of in-home storage to casual or convenience-based placement within common household locations. Notably, many responses reflected storage practices that prioritize accessibility or routine use rather than secure locked containment. These qualitative findings complement the quantitative results indicating while

many respondents attempt to keep cannabis hidden, fewer consistently utilize locked storage practices. From a public health perspective, the findings suggest consumers may conceptualize “safe storage” differently, with some emphasizing discretion rather than restricted access or childproof security.

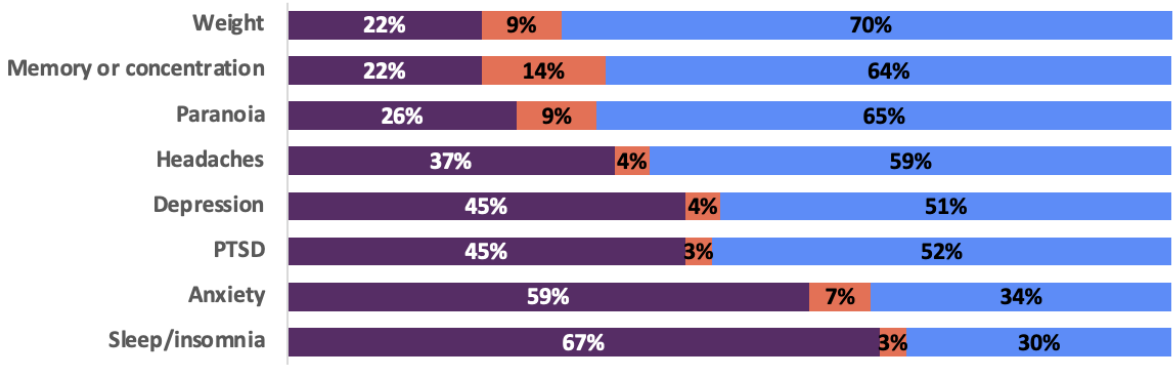
7.3 Cannabis Experiences and Perceptions of Use

All respondents, both patients and nonpatients, were asked to report perceived changes in physical and mental health symptoms as a function of their cannabis use. The majority of symptoms were rated as "no change" by most respondents. Sleep/insomnia and anxiety were the exceptions, with 67% and 59% of respondents reporting improvement, respectively. PTSD and depression also showed positive trends, with roughly half of respondents reporting perceived improvement in each (49% and 46%). Headaches saw modest improvement (38%), while memory/concentration, weight, and paranoia were each rated "no change" by around 65–70% of respondents.

Worsening was uncommon across all symptoms, with no symptom exceeding 10% except memory or concentration, in which 14% of respondents reported worsening. Compared to 2025 survey data, current trends are similar overall, with worsening rates generally lower across all symptoms. The share of respondents reporting worsening in at least one symptom or experience has also declined year over year — from 53% in 2023 to 48% in 2024, 35% in 2025, and 27% in the current sample.

Across age groups, younger respondents (<30) were most likely to report worsening symptoms. This pattern was strongest for memory or concentration (22% worsened vs. 6% in the 60+ group), paranoia (15% vs. 2%), and anxiety (13% vs. 2%). Older respondents, by contrast, tended to report stable symptoms overall. The elevated worsening rates among younger respondents may warrant targeted attention in conversations with medical providers to enable earlier support when symptoms occur.

Figure 12. Perceptions of Change in Physical and Mental Health Symptoms Associated with Cannabis Use, Among the Full Sample.



	Sleep/insomnia	Anxiety	PTSD	Depression	Headaches	Paranoia	Memory or concentration	Weight
Improved	67%	59%	45%	45%	37%	26%	22%	22%
Worsened	3%	7%	3%	4%	4%	9%	14%	9%
No Change	30%	34%	52%	51%	59%	65%	64%	70%

7.4 Medical Provider Interactions

Substantial differences emerged between patients and nonpatients in the likelihood of discussing cannabis-related health and safety topics with a doctor or other medical provider. Across all assessed domains, medical cannabis patients were statistically significantly (*ps* < .001) more likely than nonpatients to report having received provider counseling or education related to cannabis use, which is consistent with previous survey findings.

The largest differences were observed for topics related to cannabis dosing, safe storage practices, and cannabis-drug interactions. Approximately 41% (n = 71) of patients reported discussing safe storage practices with a healthcare provider compared to 19% (n = 92) of nonpatients. Similarly, 37% (n = 65) of patients reported discussing cannabis and potential drug interactions, compared to 16% (n = 78) of nonpatients, while 34% (n = 59) of patients reported receiving guidance related to cannabis dosing compared to 13% (n = 63) of nonpatients. Patients were also more likely to report discussions related to cannabis-impaired driving and broader health risks. One-third of patients (32%; n = 57) indicated a provider had discussed driving under the influence of cannabis (DUIC), compared to 15% (n = 72) of nonpatients.

Discussions surrounding cardiac risk factors and cannabis consumption were also more common among patients (29%; n = 50) relative to nonpatients (11%; n = 53).

Although rates remained comparatively low overall, patients were substantially more likely than nonpatients to report discussions regarding cannabis use disorder (23% [n = 40] vs. 6% [n = 32]) and Cannabis Hyperemesis Syndrome (CHS) (20% [n = 35] vs. 8% [n = 41]). Similarly, 27% (n =47) of patients reported discussing cannabis use during pregnancy with a healthcare provider compared to 12% (n = 61) of nonpatients.

Collectively, these findings suggest **medical cannabis patients may have greater exposure to cannabis-related clinical counseling than nonpatient consumers**, likely reflecting increased interaction with healthcare systems and medical providers. **However, even among patients, fewer than half reported receiving counseling across most assessed topics, indicating substantial gaps in cannabis-related patient education remain.** These findings highlight the continued need for provider training and standardized clinical guidance related to cannabis use, impairment, dosing, safety practices, and potential health risks.

Table 16. Percentage Of Patients and Nonpatients Reporting Speaking to Their Medical Provider about a Variety of Cannabis Health Topics.

Cannabis Health Topic	Patients (% Yes; n 175)	Nonpatients (% Yes; n 497)
Safe storage practices for cannabis	41%	19%
Cannabis and drug interactions	37%	16%
Cannabis dosing	34%	13%
Driving under the influence of cannabis	33%	15%
Cardiac risk factors (e.g., coronary artery disease, stroke, etc.) and cannabis consumption	29%	11%
Consuming cannabis while pregnant	27%	12%
Cannabis use disorder	23%	6%
Cannabis Hyperemesis Syndrome (CHS)	20%	8%

Respondents were also asked to rate their comfort level disclosing cannabis use to a healthcare provider on a 10-point scale, where 1 represented “not comfortable at all” and 10 represented “very comfortable.” Overall, respondents reported relatively high levels of comfort discussing cannabis use with medical professionals, with a mean score of 7.5 and a median score of 9. Nonpatients had a lower mean of 7.40, albeit not much smaller than patients at 7.86. These

means were not quite statistically different, but trending towards significance (p = 0.057). Overall, patients were slightly more likely to report a higher comfort in disclosing cannabis use to their healthcare provider.

Section 7 Summary

- Driving under the influence of cannabis (DUIC) remained relatively common, with 46% of medical cannabis patients and 31% of nonpatients reporting at least one instance of driving within two hours of cannabis consumption during the past month. Frequent DUIC behaviors were more common among patients, including 7% who reported DUIC on all 30 days of the month.
- While many respondents believed driving should occur only when sober, perceptions of cannabis-related driving impairment varied considerably. Cannabis consumers were also less likely to consistently use designated drivers than alcohol consumers, suggesting some individuals may underestimate the impairing effects of cannabis intoxication on driving performance.
- Safe cannabis storage practices were common but not universal. Approximately 42% of respondents reported storing cannabis in a locked location, while 43% reported keeping cannabis hidden but not locked, and 13% stored cannabis in common areas or plain sight.
- Medical cannabis patients were substantially more likely than nonpatients to report discussing cannabis-related health and safety topics with healthcare providers. However, even among patients, fewer than half reported receiving counseling on topics such as safe storage, cannabis-drug interactions, cannabis dosing, or driving under the influence of cannabis.
- Although average comfort discussing cannabis use with healthcare providers was high, the higher median score relative to the mean suggests most respondents were very comfortable with disclosure, while a smaller subset reported substantially lower levels of comfort.

Section 8. Cannabis as a Replacement for Other Substances

8.1 Prevalence of Cannabis as a Replacement

Since 2024, a primary goal of our surveys has been to assess the prevalence for the intentional use of cannabis as a replacement for other substances. Given this goal, all participants were presented with a question asking, "*Was at least part of why you started using cannabis because you wanted to reduce, replace, or stop the use of another substance?*" with response options of "yes" and "no." One quarter of participants (26%; n = 172) responded "yes" to this question. These findings are similar to the 2025 and 2024 surveys, in which 29% and 30% of participants reported using cannabis to reduce, replace, or stop the use of another substance.

Among participants who indicated they have discussed their use of cannabis for this purpose with a medical provider (n = 113; 66%), most indicated these discussions occurred specifically with a primary care provider (n = 64; 57%), mental health provider (n = 50; 44%), or substance use treatment provider (n = 42; 37%). Fewer indicated speaking with a medical specialist (e.g., neurologist, cardiologist, oncologist, rheumatologist; n = 23, 20%) or pharmacist (n = 13; 12%). Response options were not exclusive, such that participants could have selected multiple response options.

These participants were then presented with follow-up questions inquiring about the number of days within the past month they consumed cannabis for these purposes, and the specific substances they used cannabis to replace. Participants reported consuming cannabis to reduce, replace, or stop the use of another substance approximately half of the days within the past month (14 days on average), which mirrors our findings from 2025. Table 17 presents the substances participants reported using cannabis to reduce, replace, or stop. Consistent with previous surveys, alcohol remained the most commonly reported substance for which cannabis was used as a substitute, with around half of participants (51%; n = 77) indicating they have used cannabis to reduce, replace, or stop alcohol consumption. Overall, substitution patterns have been largely stable across survey years. However, we observe increases in the proportion of participants reporting cannabis use as a replacement for opioids (50%) in the present sample,

suggesting a potential increase in the use of cannabis as an alternative to prescription pain medications.

Medical cannabis patients were significantly more likely, on average, to report consuming cannabis for the purpose of reducing, replacing, or stopping the use of another substance, compared to nonpatients (35% and 22%; $p < .001$). Registered patients were also more likely to report consuming cannabis for this purpose more frequently within the past month compared to nonpatients (18 days and 12 days; $p < .001$). These effects are consistent with the therapeutic motivations that often characterize medical cannabis use. **Specifically, patients may be more likely to intentionally incorporate cannabis into broader symptom-management or health-related strategies.**

Table 17. Substances Participants Reported Using Cannabis to Reduce, Replace, or Stop Within the Past Month, Separated by Survey Administration Year.

Substances	2026 (%; n 172)	2025 (%; n 218)	2024 (%; n 173)
Alcohol	51%	55%	52%
Opioids/pain medication	50%	40%	46%
Sleep medication	46%	45%	46%
Tobacco	44%	48%	43%
Antianxiety medication	43%	42%	42%
Stimulants	42%	39%	34%
Antidepressant medication	39%	34%	36%
Antipsychotic medication	29%	30%	23%
Other	8%	11%	9%

Section 8 Summary

- Approximately one-quarter of respondents (26%) reported they began using cannabis, at least in part, to reduce, replace, or stop the use of another substance, a finding that has remained stable since 2024. Among these respondents, cannabis was used for substitution purposes on an average of 14 days per month.
- Alcohol remained the most commonly reported substance participants used cannabis to replace, followed by sleep medications, antidepressants, tobacco, opioids/pain medications, and stimulants. These substitution patterns have remained generally consistent across survey years.

- Medical cannabis patients were significantly more likely than nonpatients to report using cannabis to reduce, replace, or stop the use of another substance (35% vs. 22%) and reported doing so more frequently (18 days per month vs. 12 days per month).

Section 9. Follow-Up Survey

9.1 Follow-Up Survey Participant Characteristics

Participants who screened for problematic alcohol, opioid, and/or stimulant use via the ASSIST Lite scale in the population-level survey (also referred to as “baseline”) were invited to participate in a follow-up survey, which occurred approximately 1 month following the population-level survey, in May 2026. The goal of the follow-up survey was to evaluate changes in substance use as a function of intentional use of cannabis to reduce, replace, or stop the use of another substance, among individuals who qualified for potentially risky use of alcohol, opioids, and/or stimulants. In total, 210 participants from the population-level survey qualified to participate in the follow-up survey, and, among these respondents, 86 completed the follow-up survey. It is important to note participants were unaware of the eligibility criteria and specific objectives of the follow-up survey. As a result, they had no incentive to modify their responses based on the underlying aims of the study, reducing the likelihood of response bias. Participants were appropriately compensated for their time and effort on both the population-level survey and the follow-up survey via monetary payments following survey completion. Key demographic characteristics of the follow-up survey respondents are shown in Table 18.

Table 18. Follow-Up Survey Demographic Distributions.

Demographic Characteristic	Survey (n 86)
Age (Median)	37.5
Race	
American Indian, Native American, or Alaska Native, alone	9.3%
Asian, alone	--
Black or African American, alone	4.7%
White, alone	76.7%
Native Hawaiian or other Pacific Islander, alone	1.2%
Two or more races	5.9%
Decline to answer	2.3%
Gender Identity	
Male	55.8%
Female	40.7%
Transgender man/trans man/female-to-male (FTM)	--
Transgender woman/trans woman/male-to-female (MTF)	1.2%
Nonbinary	--
Agender	2.3%
Genderqueer/gender nonconforming	0.1%
Family Income (Median)	$42,500
High School Degree or Higher	96.5%

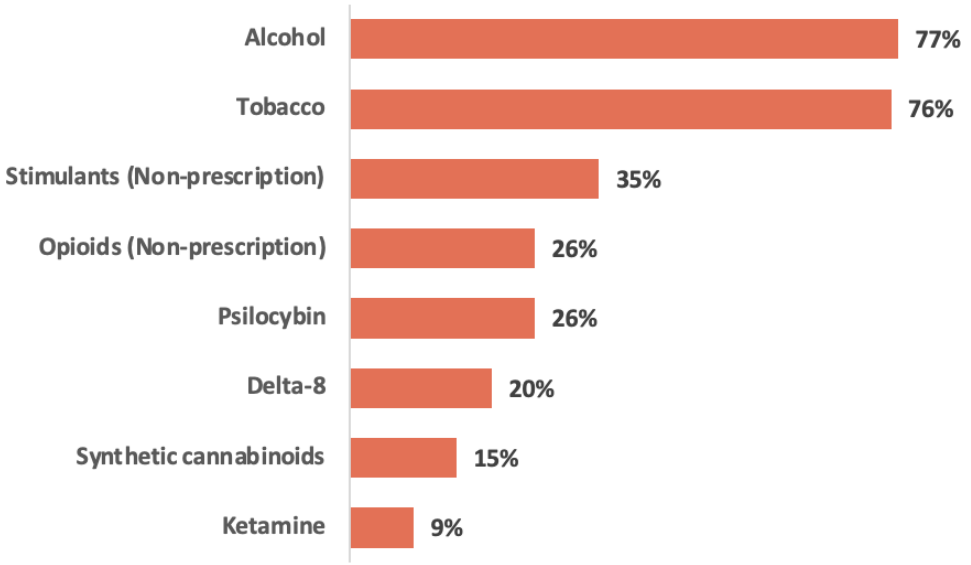
9.2 Substance Use Consumption Trends

Ninety-three percent (n = 80) of participants who completed the follow-up survey reported consuming cannabis within the past month, with 56% (n = 48) reporting daily or near-daily use. Approximately 28% (n = 24) of respondents in the follow-up survey indicated being registered as a medical cannabis patient in New Mexico.

Figure 13 displays the past-month prevalence of polysubstance use among participants in this follow-up sample. The most common substances consumed by participants in the past month, aside from cannabis, were alcohol (77%), tobacco (76%), and non-prescription stimulants (35%).

The follow-up sample is characterized by a high prevalence of concurrent substance use, with 92% of participants reporting past-month polysubstance use (i.e., consuming more than one substance). This pattern is consistent with findings from previous surveys and is likely attributable to the study's eligibility criteria of qualifying for potentially risky use of alcohol, stimulants and/or opioids.

Figure 13. Percentage of Follow-Up Sample Reporting Past-Month Polysubstance Use, 2026.



9.3 Substance Use and Risky Behavior

Among participants who completed the follow-up survey, 76% (n = 65) qualified for having used alcohol in a risky way in the baseline population-level survey, 57% (n = 49) qualified for having used stimulants in a risky way, and 35% (n = 30) qualified for having used opioids in a risky way via the ASSIST-Lite scale. At follow-up, 59% (n = 51) qualified for having used alcohol in a risky way, 37% (n = 32) qualified for having used stimulants in a risky way, and 30% (n = 26) qualified for having used opioids in a risky way. Altogether, fewer respondents qualified for potentially risky use behaviors of each substance at follow-up. These changes from baseline to follow-up were statistically significant for alcohol and stimulant use (p = .001), providing evidence that these changes were unlikely to be due to chance alone. Importantly, these findings are consistent with patterns across previous longitudinal survey waves. We consistently observe reductions in the proportion of the sample meeting criteria for risky use at follow-up across substances, with the largest and most consistent declines occurring for alcohol-related risk qualifications (Figure 14).

Figure 14. Percentage of Follow-Up Sample Qualifying for Having Used Alcohol, Stimulants, and Opioids in a Risky Way from the Baseline Survey and Follow-Up Survey, 2026.

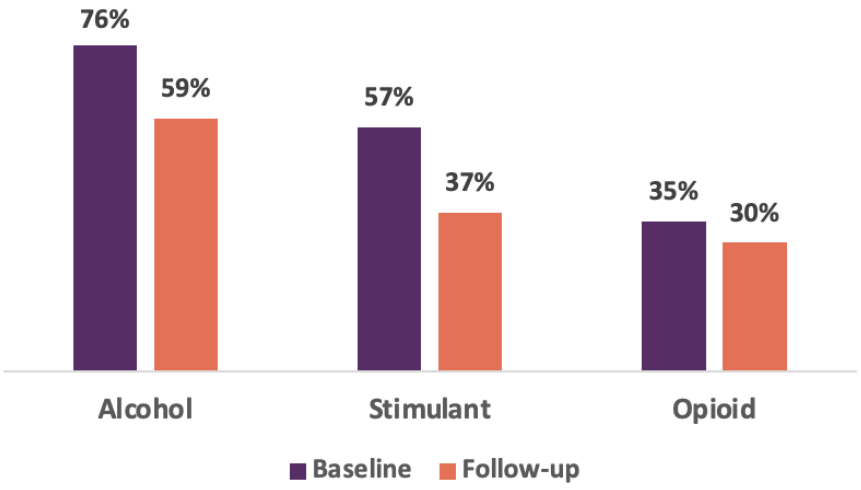
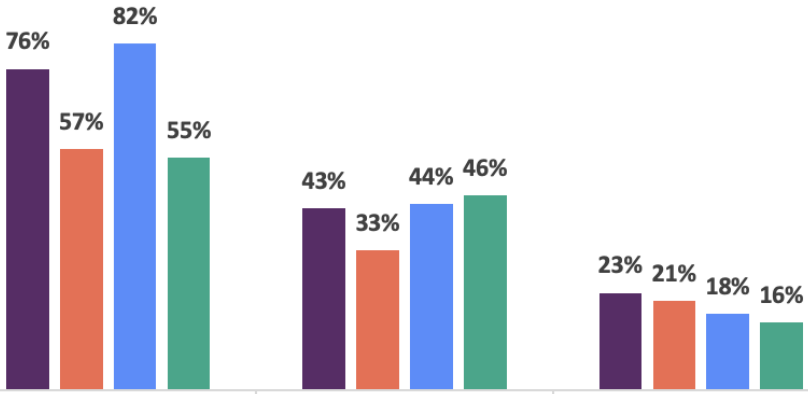


Figure 15. Percentage of Follow-Up Sample Qualifying for Having Used Alcohol, Stimulants, and Opioids in a Risky Way from the Baseline Survey and Follow-Up Survey, 2025 and 2024.

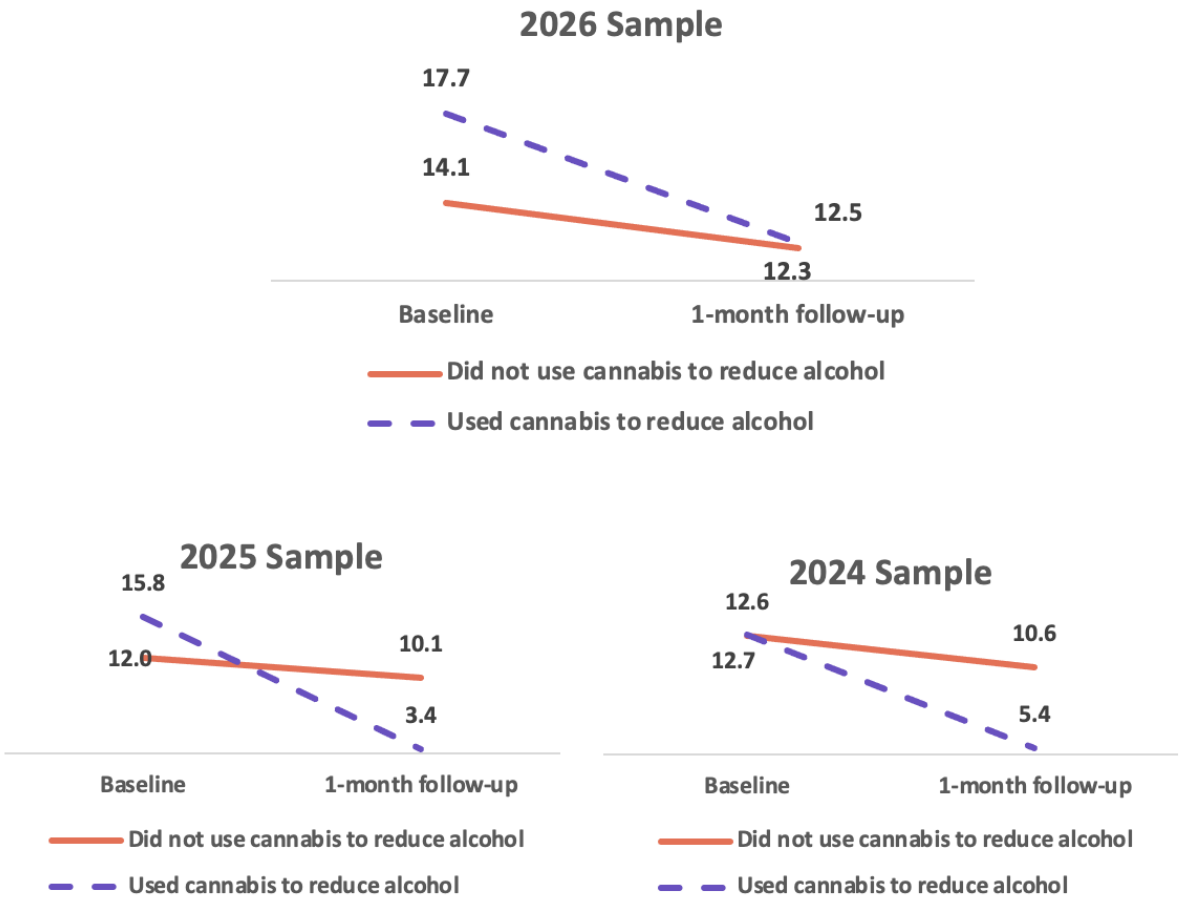


	Alcohol	Stimulant	Opioid
Baseline (2025)	76%	43%	23%
Follow-up (2025)	57%	33%	21%
Baseline (2024)	82%	44%	18%
Follow-up (2024)	55%	46%	16%

9.4 Change in Alcohol Use

Among participants who qualified for potentially risky use of alcohol at baseline, changes in the number of past-month alcohol use days between baseline and follow-up were assessed as a function of intentional cannabis substitution. In the 2024 and 2025 surveys, those who used cannabis to reduce, replace, or stop their use of alcohol had a statistically significant reduction in past-month alcohol use days between the baseline and follow-up surveys. In the present sample, these significant effects were not replicated. However, when controlling for covariates (age, income, mental health, and cannabis use days), we do observe a greater decline in the average number of past-month alcohol use days from baseline to follow-up amongst participants who intentionally use cannabis to reduce or replace their alcohol use (17.7 past-month use days at baseline and 12.5 days at follow-up) compared to those who do not use cannabis with this purpose (14.1 past-month use days at baseline and 12.3 days at follow-up). Across each survey wave, we observe trends that, when controlling for covariates, participants who intentionally use cannabis as a replacement for alcohol consistently decreased their past-month alcohol use days on a greater scale than participants who do not use cannabis for this purpose.

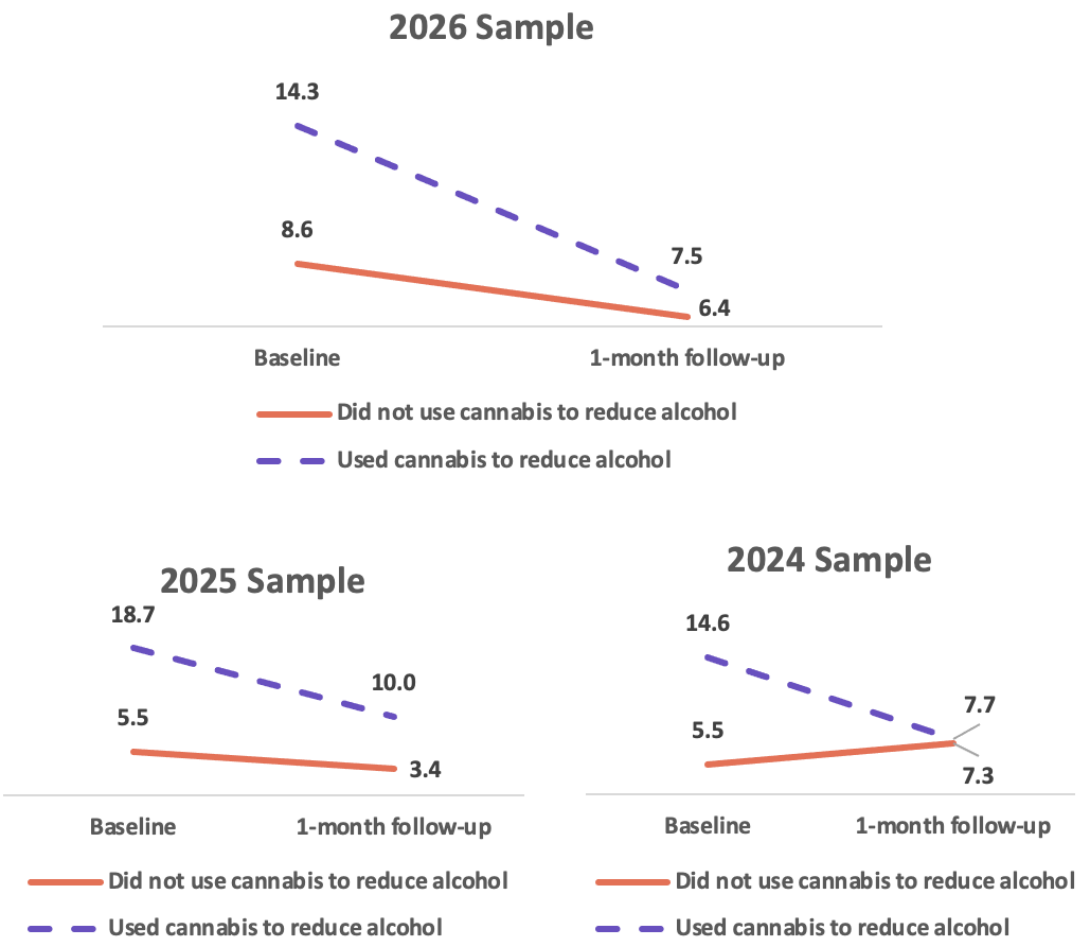
Figure 16. Change in Number of Past-Month Alcohol Use Days Between Those Who Do vs. Do Not Use Cannabis to Reduce Alcohol Use (Among Those Who Met Criteria for Use of Alcohol in a Risky Way at Baseline), Separated by Survey Year.



In the 2024 and 2025 survey studies, we discovered *trends* (i.e., did not meet statistical significance) that, among those who qualified for using alcohol in potentially risky ways, those who intentionally use cannabis as a replacement for alcohol exhibited reductions in past-month binge drinking occasions from the baseline and follow-up surveys compared to those who did not use cannabis as a replacement for alcohol. Similar trends were identified in the present survey—among participants who qualified for using alcohol in potentially risky ways, participants who intentionally used cannabis as a replacement for alcohol reported a decline in the number of binge drinking occasions in the past month compared to those who do not use cannabis as a replacement ($F(1, 57) = 4.30$, $p = .043$, $\eta_p^2 = .070$). These effects did reach statistical significance in the present data. As presented in Figure 17, in the 2026 sample, when

accounting for covariates (age, income, mental health, cannabis use days), those who did not report using cannabis as a replacement for alcohol reported 8.6 binge drinking occasions within the past month at baseline, and 6.4 occasions at follow-up. Those who did report using cannabis as a replacement for alcohol reported 14.3 binge drinking occasions within the past month at baseline, and 7.5 occasions at follow-up. Similar to our findings of past-month use days, we also observe similar trends that, across survey waves, participants who intentionally use cannabis as a replacement for alcohol consistently decreased their past-month alcohol binge drinking occasions on a greater scale than participants who do not use cannabis for this purpose.

Figure 17. Change in Number of Past-Month Binge Drinking Occasions Between Those Who Do vs. Do Not Use Cannabis to Reduce/Stop Alcohol Use (Among Those Who Met Criteria for Use of Alcohol in a Risky Way at Baseline), Separated by Survey Year.



Due to the relatively small samples sizes within our individual longitudinal survey waves, datasets from 2024-2026 were combined to improve statistical power and further detect potential differences in subgroups. Since this project has involved survey replication across multiple years, combining datasets provided an opportunity to evaluate whether observed patterns were consistent across samples while also improving statistical precision. This is a common strategy in exploratory and longitudinal research when individual studies are methodologically comparable. The combined longitudinal survey provided a total of 211 respondents who completed both the baseline and follow-up surveys between 2024 and 2026. This combined dataset is used for the following analyses, unless otherwise specified.

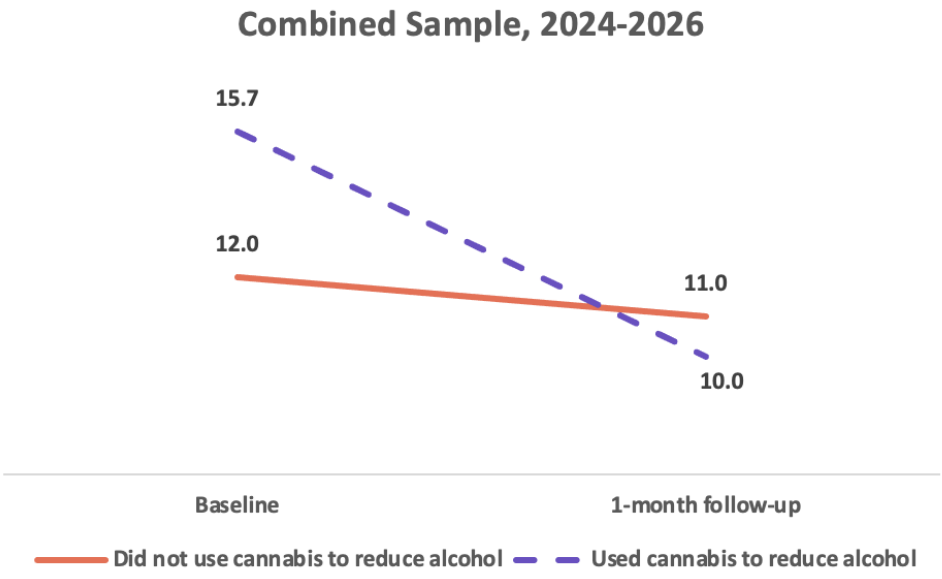
Past-month alcohol use days were investigated as a function of cannabis substitution behavior among participants who qualified for having alcohol in a risky way via the ASSIST-Lite scale. Statistically significant interaction effects emerged as a result of cannabis substitution behavior. Specifically, those who used cannabis to reduce, replace, or stop their use of alcohol had a statistically significant reduction in past-month alcohol use days between the baseline population-level survey and the follow-up survey compared to those who did not use cannabis to replace alcohol, when accounting for covariates including age, income, anxiety, depression, and cannabis use days ($F(1, 155) = 8.837$, $p = .003$, $\eta_p^2 = .054$). Participants endorsing using cannabis as a substitution for alcohol exhibited a decrease in past-month alcohol use days from 15.7 days at baseline to 10.0 days at follow-up, demonstrating an average reduction of 5.7 days per month. In contrast, those who did not endorse cannabis substitution demonstrated a much smaller reduction, decreasing from 12 past-month days at baseline to 11 days at follow-up.

A linear regression model was also conducted to further examine whether intentional cannabis substitution predicted change in past-month alcohol use days among those qualifying for potentially risky alcohol use behaviors. In this model, cannabis substitution status significantly predicted the number of past-month alcohol use days at follow-up when controlling for covariates (age, income, mental health, cannabis use days), suggesting the observed differences were not solely attributable to higher baseline consumption among those using cannabis for the purposes of substitution ($F(8,148) = 7.712$, $p < .001$).

Overall, participants who endorsed cannabis substitution exhibited different alcohol-use trajectories relative to those who did not endorse substitution behaviors. **Although the present results do not establish causal effects, the moderate effect size suggests cannabis**

replacement behavior may be meaningfully associated with differences in alcohol use outcomes among those who exhibit potentially risky alcohol use behaviors.

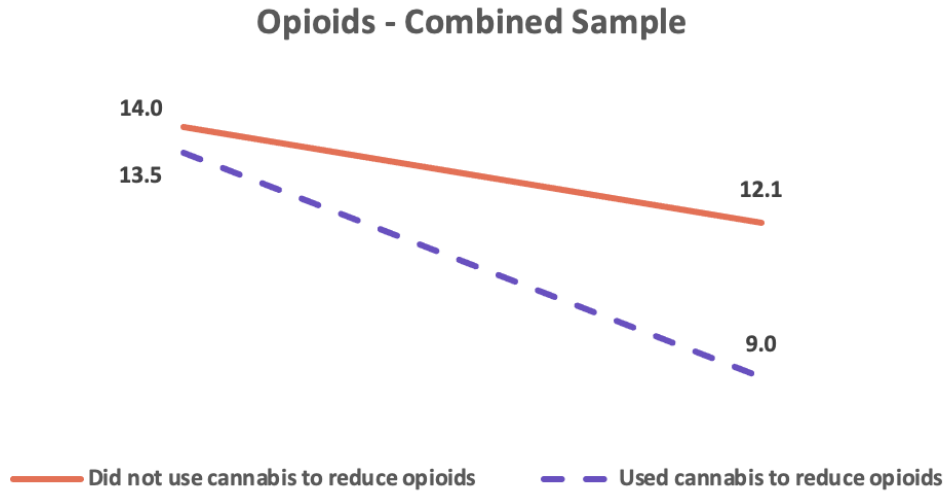
Figure 18. Change in Number of Past-Month Alcohol Use Days Between Those Who Do vs. Do Not Use Cannabis to Reduce Alcohol Use (Among Those Who Met Criteria for Use of Alcohol in a Risky Way at Baseline), Combined Sample.



9.5 Change in Other Substance Use

A repeated-measures ANOVA was conducted using the combined dataset of data from 2024-2026 to examine changes in past-month opioid and stimulant use days as a function of cannabis substitution behavior among participants who qualified for having used these substances in a risky way via the ASSIST-Lite scale. Among respondents who screened for potentially risky use of opioids, adjusted means indicate those using cannabis as a replacement for opioids exhibited larger reductions in their past-month opioid use days (13.5 days and 9.0 days) compared to those who also screen for potentially risky use of opioids but do not use cannabis as a replacement substance (14.0 days and 12.1 days). The data showed a *trend* toward larger reductions among replacement users, but this difference did not reach statistical significance after adjusting for covariates. It is important to interpret these results with a level of caution. To confidently generalize these results to a broader population, replication in studies with larger sample sizes is necessary.

Figure 19. Change in Number of Past-Month Opioid Use Days Between Those Who Do vs. Do Not Use Cannabis to Reduce Opioid Use (Among Those Who Met Criteria for Use of Alcohol in a Risky Way at Baseline), Combined Sample.



Section 9 Summary

- 86 participants who screened for potentially risky alcohol, stimulant, and/or opioid use completed a follow-up survey approximately one month after the population-level survey.
- The proportion of participants qualifying for potentially risky substance use declined between baseline and follow-up, including alcohol (76% to 59%), stimulants (57% to 37%), and opioids (35% to 30%). Reductions in risky alcohol and stimulant use were statistically significant and consistent with findings from prior survey waves.
- Among participants who screened for potentially risky alcohol use, those who intentionally used cannabis to reduce, replace, or stop alcohol consumption generally demonstrated larger reductions in alcohol use over time than those who did not use cannabis for this purpose. In the combined 2024–2026 dataset, cannabis substitution was associated with a statistically significant reduction in past-month alcohol use days (15.7 to 10.0 days) compared to non-substitution participants (12.0 to 11.0 days).
- Participants who intentionally used cannabis as a substitute for alcohol also demonstrated greater reductions in binge drinking occasions over time. In the 2026 sample, binge drinking occasions declined from 14.3 to 7.5 per month among substitution participants, compared to a decline from 8.6 to 6.4 occasions among non-substitution participants.
- Findings from the longitudinal surveys provide initial evidence that intentional cannabis substitution is associated with more favorable alcohol-related outcomes among individuals with potentially risky alcohol use behaviors. The consistency of findings across survey years suggests cannabis substitution may be associated with reductions in alcohol use and binge

drinking occasions. However, additional research with larger sample sizes is necessary to further examine these relationships.

Section 10. Psilocybin Survey

Executive Summary

In April 2025, New Mexico enacted legislation to establish a regulated medical psilocybin program, which is set to be implemented by the end of 2027. Due to these legislative priorities and the New Mexico Department of Health's involvement in the establishment and maintenance of this future program, several questions were included in our 2025 and 2026 surveys to obtain preliminary data on the prevalence of psilocybin use frequency and associated outcomes. Importantly, due to the nature of the primary goals for our survey studies, all participants included in this section of the report also consume cannabis, which may impact the generalizability of our findings related to psilocybin use. However, extant literature indicates a notable overlap between psilocybin and cannabis use among adults.[8] Please note, survey respondents were not asked about dosage levels; therefore, our survey does not provide information regarding the dosage of psilocybin at therapeutic levels.

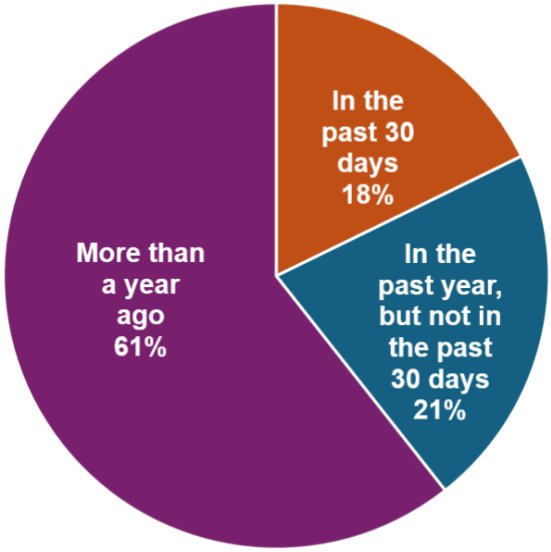
10.1 Patterns and Correlates of Psilocybin Use

In the sample of 672, **57% of participants indicated no psilocybin use in their lifetime. To contextualize this finding, recent (2023) national data suggest 87.9% of US adults have not used psilocybin in their lifetime**. [9] This comparison serves to emphasize the uniqueness of our population of survey respondents. Importantly, because eligibility was restricted to individuals reporting past-year cannabis consumption, these findings should not be interpreted as population-level estimates of psilocybin use among New Mexico residents.

[8] Anderer, S. NIH: Adults still using marijuana and psychedelics at record levels. *JAMA 332*(16),1323. https://doi.org/10.1001/jama.2024.19688

[9] Rockhill, K. M., Black, J. C., Ladka, M. S., Sumbundu, K. B., Olsen, H. A., Jewell, J. S., ... & Monte, A. A. (2025). The rise of psilocybin use in the United States: a multisource observational study. *Annals of Internal Medicine*, *178*(7), 1052-1054.

Figure 20. Percentage of Survey Respondents Reporting Psilocybin Use.

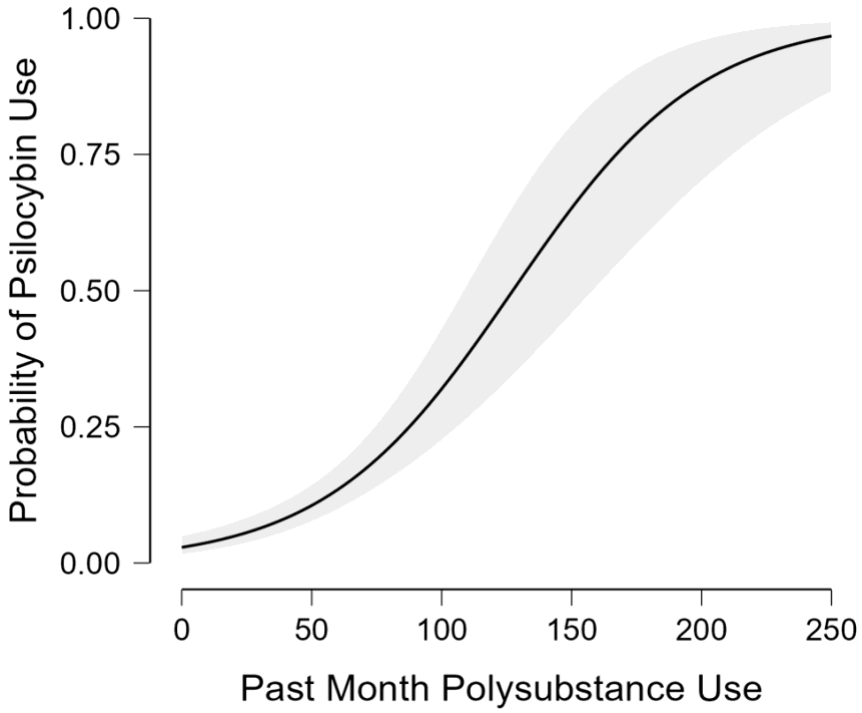


In our recent New Mexico sample, among the 43% (n = 287) who indicated lifetime use of psilocybin, 61% said their last psilocybin experience was more than a year ago. Among those who indicated any history of use, 113 indicated using psilocybin within the past year on at least one occasion, and 54% of these said they had used it on ten or fewer occasions. Twenty-two percent of survey respondents reported using psilocybin on two or fewer occasions. Also, of those who have used psilocybin in the past year, 51.3% reported microdosing.

One important question is whether consumers of psilocybin are using it for purposes distinct from those which motivate other substance use. In our sample, **polysubstance-use frequency in the past month is a strong and significant correlate of psilocybin use frequency** ($r = 0.50$, $p < 0.001$). This demonstrates that the general predilection for substance use is strongly interrelated to the use of psilocybin, and this finding runs parallel to our 2025 report.

Figure 21. Probability of Psilocybin Use Relative to Past-Month-Use Frequency (In Days) Of All Other Substances (e.g., Alcohol, Opioids, Etc.).

Grey Shaded Area Is The 95% Confidence Interval.



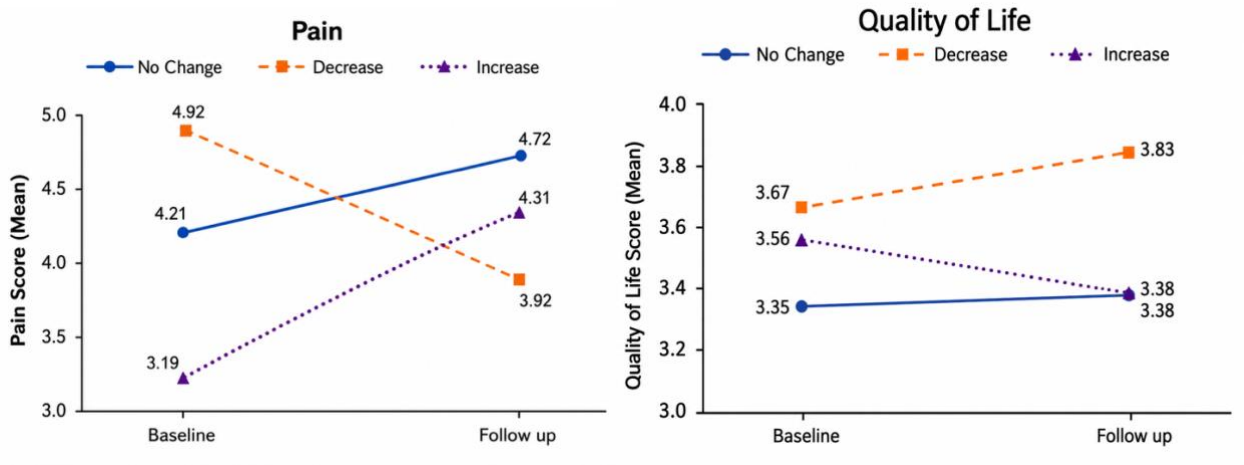
Given that young age is a determinant of polysubstance use, we used age as a covariate in a logistic regression to understand whether polysubstance use increases the odds of psilocybin use beyond what can be attributed to young adulthood. Indeed, polysubstance use remained a strong predictor and significantly increases the odds of using psilocybin the past month when age was accounted for in the statistical model ($p < 0.01$). Figure 21 demonstrates the conditional probability of using psilocybin based upon the summed frequency of using other substances in the past month.

10.2 Change in Psilocybin Use Patterns and Corresponding Effects

Of the 86 participants who completed the follow-up survey, **28 noted a change in their psilocybin use across timepoints**; 43% (n = 12) escalated use and 57% (n = 16) decreased use of psilocybin. To examine how changes in psilocybin use influence subjective ratings of wellness, we used mixed linear modeling in a repeated measures fashion to examine the effect of psilocybin use; psilocybin-use frequency (in days), per timepoint, was used as a covariate in the model, and participant ID served as the random effect. Interactive (psilocybin use x

timepoint) effects were discovered for “pain interference with daily activities” and “quality of life” (*p*s < 0.05). These are depicted below as between-group changes across the two timepoints. **Those who abated their psilocybin use witnessed a decrease in pain and an increase in quality of life. Those who increased their use experienced an increase in pain and a decrease in the quality of life.** It is not surprising pain and quality of life are inversely related; what may be somewhat novel is the inverse relationship between these measures of life satisfaction and the frequency of psilocybin use. Given that psilocybin consumption was not a manipulated variable (i.e., not an experimental design), causal inferences between psilocybin use and the subjective ratings cannot be inferred. The findings regarding pain are similar to the 2025 report.

Figure 22. Subjective Ratings of Pain (Interference with Daily Activities) and Quality of Life.



Of those who indicated no change in use (n = 58), 33 reported no use of psilocybin. Those who decreased their use (n = 16) and increased their use (n = 12) of psilocybin show distinct changes across timepoints relative to one another. Using a similar mixed-linear modeling approach, no interactions were discovered for changes in psilocybin use frequency across timepoints for generalized anxiety (GAD-2), depression (PHQ-2), nor for the frequency of alcohol or tobacco consumption.

10.3 Psilocybin Use and Prescription Medication Adherence

Frequent use of psilocybin is interrelated with the use of other substances which have high potential for abuse. We questioned whether more frequent use of psilocybin is associated with the misuse of prescription medication from this survey question, “*Think about*

the past month... about how many days did you take more than the prescribed number of pills of your prescription medication(s)?" Multiple-choice options to this question contained antidepressants, anxiolytics, stimulants, sleep medications, antipsychotics, and medications for pain. If participants selected a prescription for any of these medications, they were then introduced to a slider in which they could select the number of days in the past month in which they took medications more often than prescribed.

More frequent use of psilocybin was positively correlated with taking all medications more often than prescribed, and these included: pain, antidepressants, stimulants, anxiolytics, sleep medications and antipsychotics (*r*s between 0.45 and 0.78, *p*s < 0.001). Hierarchical linear regression was used to determine which medication was most strongly associated with more frequent psilocybin use. **The overuse of pain medication was strongly associated with psilocybin use** ($t = 11.14$, $p < 0.001$); in fact, it was so strongly associated with psilocybin use that it out-competed the association of psilocybin with all other medications. One possible interpretation is those who use psilocybin more frequently may be prone to abusing substances with great abuse-liability, such as pain medications. To examine this further, we analyzed whether those who use psilocybin are more likely to indicate a history of SUDs. Psilocybin use frequency in the past month was correlated with CUD severity, ASSIST scores, and using medical assisted treatment for AUD (all *r*s < 0.35, *p*s < 0.01).

We also inquired about using medications *less* frequently than prescribed. **Psilocybin use frequency was correlated with using less frequent medication use, but these correlations were weaker than what was found for using medications more often than prescribed** (*r*s < 0.36, *p*s < 0.05). Hierarchical linear regression modeling determined that taking antipsychotic, anxiolytic, and stimulant medications less frequently than prescribed was associated with more frequent psilocybin use (*t*s > 4.48, *p*s < 0.05). An interpretation of this finding is that psilocybin may serve as an intentional or unintentional replacement for these medications. Another interpretation is that the psychological conditions which these medications are used to treat are episodic; freedom from symptoms of these conditions may permit some individuals to seek out psychedelic experiences. A third interpretation is that participants may be aware of medical contraindications and therefore avoid their medications on days when they elect to use psilocybin.

Several interpretations exist, and conclusions cannot be made about the reasons why **medical noncompliance is associated with more frequent psilocybin use**. To reiterate, using psilocybin more frequently is associated with taking medications both *more* and *less often* than what is prescribed. Although these results may seem contradictory, they are nearly identical to those found in 2025. Survey respondents have shown a repeated pattern of adjusting their prescriptions and titrating their dose frequency, and this pattern systematically coincides with the tendency to use psilocybin *more* frequently. One possibility is psilocybin users are attempting to improve their health by altering the variety of substances they consume. The next section examines whether psilocybin is used as an explicit substitute for various medications.

10.4 Psilocybin Use as a Replacement Substance

From the sample of 672, **20.4% reported using psilocybin as a replacement for other substances, and 65.1% of those who have used it as a replacement reported speaking with a medical provider** about their plan which is identical to the percentage (65%) from the 2025 report. The majority (66.8%) referenced speaking to a substance-use treatment provider, but whether this includes speaking to their primary care (53.4%) or mental health provider (33.4%) was unclear because the survey did not exclude professionals with overlapping specialties (e.g., primary care provider with expertise in MAT, for example).

When making comparisons with 2025 data, see Table 19, although notable differences exist across timepoints, the small sample size from 2025 prevents any assertion about changes in utilization across years.

Table 19. Percentage Using Psilocybin as a Replacement for Each Substance, Separated by Survey Year.

Psilocybin as a replacement for...	2026 (n 137)	2025 (n 37)
Alcohol	52%	49%
Tobacco	57%	65%
Cannabis	62%	49%
Opioids	52%	35%
Antidepressants	47%	49%
Anxiolytics	61%	52%
Stimulants	52%	51%
Sleep Medications	38%	48%

Psilocybin as a replacement for...	2026 (n 137)	2025 (n 37)
Antipsychotics	52%	11%

If those who are using psilocybin do so because they are searching for alternatives to traditional pharmaceuticals, then one might expect having registered as a medical cannabis patient would be correlated with whether psilocybin is sought as a replacement for other substances. Indeed, if a participant indicated ever having been a medical patient, they were significantly ($p < 0.001$) more likely to seek out psilocybin as a replacement substance; this finding runs parallel to what was indicated in the 2025 report.

Section 10 Summary

- Lifetime psilocybin use was indicated among 43% of the sample of New Mexico cannabis consumers, with 61% indicating their most recent use was over a year ago and 39% indicating this use was within the past year.
- Among respondents who reported past-year psilocybin use, more than half indicated using psilocybin on multiple occasions, suggesting repeated use is common within this population.
- More frequent psilocybin use was associated with the use of other substances with elevated abuse potential, including alcohol and prescription pain medications, as well as higher rates of prescription medication overuse.
- Medical noncompliance, including taking more medication than prescribed, was associated with more frequent psilocybin use across several classes of prescription medications, including anxiolytics, antidepressants, and stimulants.
- Approximately 20% of respondents reported using psilocybin as a substitute for pharmaceuticals or other substances, such as alcohol and tobacco. Among those using psilocybin for substitution purposes, nearly two-thirds (65%) reported discussing their interest in doing so with a healthcare provider.
- Longitudinal findings suggest participants who reduced their psilocybin use over time reported improvements in pain and quality of life, while those who increased their psilocybin use reported less favorable outcomes. These findings generally parallel results observed in the 2025 survey.

Appendix A

Respondents were sourced for the population-level survey from Cint. Cint hosts the world's largest consumer network for digital market research, consisting of over 800 research panels recruiting from a larger population of over 30 million active U.S. residents. Our recruitment approach aligns with a quantitative form of purposive, stratified non-probability sampling. We simultaneously stratify samples by state and key demographic variables within Cint to inform appropriate allocation across strata.

Eligibility criteria:

- Eligibility criteria for participation in this study included being 18 years of age or older, residing in New Mexico, and reporting past-year cannabis consumption.

Screening process:

- *To minimize potential selection bias, we use neutral survey labels and descriptions to reduce the likelihood of attracting respondents based on specific interests that could skew recruitment.*
- Potential respondents were first routed to Cint's Marketplace Screener where they were met with several screening questions to verify eligibility for participation in the survey.
- Only those who met these eligibility checks could proceed with the full survey.

Full survey quality controls:

- Additional screening questions were included in the full survey to ensure eligibility and consistency in respondents' answers. These questions included age, state of residence, zip code of residence, and data quality verification checks.
- Bot and attention checks were included throughout the survey to confirm we were only capturing real people who were attentive to the survey.
- Respondents who did not meet the eligibility criteria were automatically disqualified from participation and routed out of the survey.

Post-survey data cleaning:

- Standardized data cleaning procedures were conducted as a final verification method to ensure all participant responses met the eligibility criteria, data quality, and security checks.

Survey sample breakdown:

- In total 1,979 individuals responded to the survey invitation and entered the survey. Of these, 1,169 did not complete the full survey. Non-completion occurred for a variety of reasons, including automatic termination due to failed bot-detection, security-verification, or state-verification checks, as well as voluntary attrition prior to completion. Following

the conclusion of data collection, an additional 138 respondents were removed during post-survey data cleaning due to data quality concerns, including speeding, straight-lining, and inconsistent response patterns. This leaves a final sample of 672 participants.