New Mexico Medical Psilocybin Advisory Board

Advisory Board Meeting · July 9, 2026

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Speaker labels are inferred from roll call and hand-off cues (“Thank you, X. Y?”). A plain name means the attribution is well supported. **“Chair / department (assumed)”** marks a procedural line that could be the chair or the department. **“Unknown speaker”** marks a turn that could not be attributed. Nothing was invented where a speaker was unclear.

Name corrections: Zurlo (Dominic Zurlo), Leeman (Larry Leeman), Peskuski (Chris Peskuski), Dezbaá. Committee name normalized to “Training and Education.”

Unknown speaker

In the waiting room to join on in. In the meantime, good morning, everybody. It looks like our recording has started. And while everybody is still coming on in through the From the waiting room and joining on in, my name is Dominic Zurlo with the New Mexico Department of Health and we are here today to assist the board with the logistics of this meeting. And so with that, just as a reminder to everybody, because we are recording this meeting and it is a public meeting, please remember to keep your language to be appropriate for being posted online because we do post these onto our website.

So at this point, I'll turn the meeting on over to Ian Dunn, who is the chair for the Medical Psilocybin Advisory Board.

Ian, the meeting is yours.

Good morning, everyone. My name is Ian Dunn. As the chair of the Medical Psilocybin Advisory Board, I call this meeting to order at 9:02 a.m. Mountain Daylight Time. Before we dive into the text and introductions of today's meeting, I wanted to outline two operational guardrails for today's session just to ensure equity and proper time management and respect for everyone's schedule.

So first regarding public comment, our standard operating procedure is to keep public comment separate from active board participation. During our last session, a member of the public was inadvertently called on. During our working discussion today, we are returning strictly to our standard format where public comment will occur exclusively during its designated slot at the end of the meeting.

Secondly, regarding time management, we will adhere strictly to our scheduled hours today. We did have some board members that were unable to make it to the final vote of the day. So we just want to protect everyone's external commitments and we will not call or conduct any formal votes after our scheduled adjournment time.

So I will now turn over to the department to call roll to introduce the rest of the board members.

Chair / department (assumed)

Or Chris, you had a question?

Chris Peskuski

Yeah, thank you Ian. I was wondering if we could also during roll call, Talk about the appointed positions that everybody was designated for.

Cheers.

just for public awareness and so we can clarify that for everybody on the board too.

Yes, if you would like, you may share what you were appointed for, as well as any other information you think the public would like to know about you.

Well, can we have the other, can we have the board members?

But I don't think that's ever been publicly acknowledged what roles everybody was appointed for.

Sure, I'm gonna once again turn it over to the individual board members and say, if you would like to share, you may.

Otherwise, I'm not going to say you are required to, but again, we will turn over to introductions.

If it's okay with you, Ian, this is Dominic. And with Chris, I have no problem with going ahead and going through that part as we go through the roll call. We can outline that aspect of it if that's fine with you.

That's fine with me.

Okay.

All right. So with that in mind, we'll go ahead and start. And so, and I'm just going to go down the list that we have here. So Brenda Burgard, who is the behavioral health appointee.

Hello, everyone.

Brenda Burgard

I am Brenda Burgard. I am a licensed LPCC counselor, art therapist, and I'm also president of the DCRIM For psychedelics in New Mexico, I have a private practice here in Albuquerque and I chair the Training and Education here for the Department of Health.

Thank you, Brenda. Chris Peskuski, who is the veteran appointee.

Good morning, everyone.

You all know who I am, thank you. Happy to be here.

Dan Jennings, who is an at-large appointee and also an advocate.

Thanks, Dan Jennings, the chair of the Research and Continuous Improvement Committee, vice chair of the board, and also a city councilor here in Hagerman, New Mexico, and director of 100% Chavez County Initiative.

Thank you, Dan. And Dezbaá, who is the tribal member appointee.

Hi, And then Ian Dunn, who is the advocate appointee.

Good morning, everyone.

Ian Dunn

My name is Ian Dunn. Happy to be here and happy to help the community.

And Larry Leeman, who is with UNM as well and is an at-large appointee. Hi, everybody. Good to see everybody today. I'm a professor of family medicine, addiction medicine, master of public health, and a psilocybin researcher. Thank you.

And Ryan Keenan, who is the designee for the HCA appointee.

Apologize all for that.

Keenan Ryan

My name is Keenan Ryan. I am our acting chief medical officer for New Mexico Medicaid. I am covering for Dr. Alana Dances, who was our Medicaid director and former primary care provider out of Albuquerque, New Mexico.

And my apology, Keenan, for switching your names around.

You know, my life just exists. It's kind of a Schrodinger box situation. I just have two first names. It's whichever one happens at that time.

I appreciate your grace on that. Thank you.

And those are the board members who are present. Did I miss anybody?

I believe I have that right now.

I believe that was everyone. So I will go ahead and turn it over to the department for what you guys wanted to present.

Before we do that, Ian, just to introduce the department members who are here today, and I'm just going to go down the list. It's in no particular order. Myself, Dominic Zurlo, I'm the director for the Center for Medical Cannabis and Psilocybin. We have Kathy Augeri, who is our project manager, related with IT and other items similar. Kathy Freitag, one of our health educators. Raymond Gallegos, our analysts, Jorge Gonzalez, who is our medical psilocybin program manager, Brenda Martinez, who is our center deputy director, Jonathan Mouchet, who is our management analyst and actually helps to set up all of these meetings and could not do what we do without any of these folks, but especially Jonathan from the logistics side, Rosalie Nava, who is our health education program manager, Leslie Peterson, who is our compliance officer, Cyrus Routman, who is our environmental scientist.

And we have Dr. Robert Truckner, who is our medical director. And then we have a new individual joining us today. We just started yesterday with an intern. His name is Vicente Roybal, and he is going to be interning with us through the summer to learn about psilocybin and to help us with some of the projects related to this. And so thank you, everybody, and welcome to the team, Vicente.

you Excuse me, Dominic. I'm not sure if you introduced Raymond.

Yes, I did. Raymond, one of our analysts. Yes. Thank you, Jorge, though, for checking because that was my next question. Did I catch everybody? Sometimes it's a little difficult to see on the long list of people that we have to make sure I have everybody.

Did I miss anybody from our team?

Okay, and so just to let everybody know, The next item, and it is actually the document that we had sent out on Tuesday. And let me just pull that up on the screen. So please give me just a moment to switch.

Files?

And just for a note, anybody who signed up after Tuesday, I just sent that out to you guys just now, so.

Thank you, John. Okay.

And so here is the rules. And again, as I had stated last week or two weeks ago, these are still being drafted. We are still working through them. You will see that some of the different sections are now put more into the regulatory format. Some of the other sections are not yet into that regulatory language format, but we are continuing. And thank you to everybody who has been providing comments.

and comments we are working through them and to see about either addressing them whether it's adding some in there have been quite a few that have been added we've had some comments for example with regard to you know with some of the certifications like BLS or CPR and we've made some adjustments on that for example it's been raised by a couple of people that if someone also has an EMT license for example would we need to have them go through CPR classes again, and we've added that on in.

So you will see some of those kinds of changes that are added on into here. There are some others that have been suggested since we sent this out on Tuesday that we may be adding on in, and we're awaiting some language and some other information. For example, there's been some requests with adding some additional cultural considerations as far as for training or with adding continuity of care plans.

And some other similar items. And so, again, we are going through those kinds of comments and everything on that. And then I would like, before I start diving into the document itself, I would like to apologize because it was me who actually called on other individuals outside the board. And part of that was I've gotten so used to us working in the various committees and having that feedback automatically and at that point in time that that was me who had done that.

My apologies to the board, because I just my brain was working from that standpoint of, yes, we're looking at feedback and wanting to get feedback. And so my apologies to the board and to everybody present, because that was my error. But it was done out of a place of trying to be as transparent and trying to have those conversations as we continue. So what I do want to make sure that everybody does know is that we are continuing to have those conversations.

Dominic Zurlo

The vast majority of this last two weeks since the previous meeting has been almost all having conversations about how can we help and adjust the rules? How can we have conversations to be able to make this the best set of rules and the program possible? So I just wanted to go ahead and start with that. Now, in the interest of time to make sure that we are able to get through everything today, of the document, but I will put the major portions there. So for example, the very top of the document, you can see it has some of the items that are just required within regulations about authority, duration, effectiveness, effective date, those sort of things. I'm not going to put those items up, but I will start with the next set.

or with the first section.

So that is now in the chat.

And so this portion is with regard to the application requirements for the educational programs. And in essence, what it includes, oh, I'm sorry, I didn't see. Chris, you have your hand up. I'm sorry, I guess I'm confused. I thought on the agenda, it said we were gonna talk about the three items that we didn't discuss last week. If you would like, we can go directly to those. We're going to do that as we go through the document. My understanding was they were put on the agenda to make sure that we did discuss them as we went through the document.

I don't have any issue with that.

I don't know. I'm just, I'm, I'm confused because I, I thought that was what was on the agenda. So are we shifting from that, Ian? Is this a...

Department, or is this an advisory board meeting?

So the reason he was going to go through the rest was not because it had substantial changes, but because the changes were just to basically translate from regular speak to regulatory language. It wasn't in an attempt to change anything. It was just as an attempt to inform. But we can just focus on the things that were adjusted and that we need to resolve. I think they were just trying to go through the entire document to create a flow.

That way we're all reminded of what is included and that kind of thing.

So are we rediscussing these items or are they up for debate and vote? Or are we just going through them for informational purposes?

for informational purposes.

And just to be clear, it's up to the board. If you would prefer for me to just go to those specific items, I can most certainly do that.

I'll go ahead and defer to the board? Would you guys like to review the updates that they had made to make it regulatory language or would you just like to review the three items on their own? you Larry? Sorry, you thought Dezbaá was first.

I didn't see that. Hi. Yes, okay.

I just wanted to, I will say, I'll propose that we do go just quickly through those. Just, you know, we're taking an anatomy class. We want to understand the whole body and where we're at as opposed to just kind of going in and operating on the appendix type of situation. So if anyone else has a disagreement with that, then that's fine. Okay. Thank you, Larry.

Larry Leeman

I agree with Des, but I actually think the whole thing is sort of up for discussion.

I mean, you can't sort of say one part of a document is not because they actually affect each other.

So I think those three are core areas of controversy. But I think if people have a problem with other things, it's still game to mention that.

Right, and what I meant by those are areas is those are the three that we need to complete by the end of the meeting. And then of course, if discussion naturally comes up as we're going through the informational portion, people can contest that, but for the purposes of just What we need to resolve today, it's those three. issues. But I agree with you and Dezbaá that we should know what beast we're getting into.

Chair / department (assumed)

Dan?

Dan Jennings

I am fine with going through the whole document, but if we don't get to those three, then we have done a disservice. So I want to make sure that we have time to dig into those three and really have good discussion on those specific things. Perfect.

And then Dominic, do you think we can get through this fast enough to still resolve the three issues?

I believe we can. As I said, I'm not going to be reading through each of the sections. It's more to just ensure that there aren't any other questions for topics that may have been missed. And that was just the original idea, but that we were going to ensure that we focus on those three areas as we approach, as we get to those. But again, I'm It is up to the board.

I think we have a pretty broad consensus that we'd rather just hear the whole piece. So if you could just continue with that, thank you. Okay.

Dominic Zurlo

Thank you, everybody. And so this first section, it's just really the application requirements for the psilocybin educational programs. The information in there has not changed with regard to it. The one thing that we did adjust was to put in for the documentation demonstrating that they have two faculty members who hold practitioner and facilitator certificates is to extend that out and 30th because some of the comments we got was December 31st would be a little too short. So we did extend that on out.

Um, And that's really the only real change within this section. Any questions? questions Okay. Okay. The next part was again the required reporting and curriculum approval. And then there is a section about if a program wanted to relinquish their certification as a program and I'm putting that into the

chat now. And so again, this part didn't, there were no actual changes within here, any substantive changes, just really clarifying it, rearranging it a little bit and adding it on in and also to ensure and clarify that yes, programs do have the ability to relinquish their certification if they wish.

Any questions on here? And this just is really about what the programs would be required to submit updates to their curriculum, changes in faculty locations, and that the approval process is that they have to submit it through the electronic system to the department with all of the requirements previously listed.

Okay. And then the evaluation and assessment by the department. And you will notice that since last time we have combined some of the different aspects of this. So for example, all of the assessment actually, because it's all similar for all the different types of certifications we're looking at for this with locations. show the educational programs, healing centers, and other locations and how those will be evaluated and assessed. And so going through that, we have the ability to do site on-site inspections.

We heard very clearly from the last meeting and since to ensure that we did have, and it was simply an oversight, but to ensure that only if there were, for example, practicums occurring treatment, that it would happen at that time only with written consent from the patients so that we ensure that we are valuing and being respective of the treatment process. Any questions on this part? Brenda. Um, what occurred to me was, would there be any training for example, a death doula, And could that be something that, could be there where a student would be in home with a death doula or death doula is the student, or does this have to be at a certified facility you know, clinic.

Great question, Brenda. And please forgive me if I'm misinterpreting your question. But I think what you're getting at is for the practicum, could the practicum student be doing this also in a home setting, for example, along with the death doula or other appropriate provider? And would that count as part of that? And the answer to that is yes. Am I understanding that correctly? Yes.

Thank you. Yes.

Where that, that's why we actually have the other approved locations phrase, because it's not just necessarily healing centers. And we do have that as part of, with the practicum, you'll see that, that it has to just be at a practicum or at a healing center or other approved locations in order to cover exactly that kind of situation. It also would help, for example, if in a more rural area where there may be a lack of practitioners, where a location can be approved temporarily, for example, community center or a local nonprofit who is offering their space to be able to have people go through their treatment, through their journeys especially in those spaces and this would allow for the department to be able to approve those and those also serve as practicum sites.

Okay.

So, um, Would that be, you know, hopefully that wouldn't be a long process, like if it was in someone's home, for instance, or? Okay.

for example, take the priority. Okay. Thank you. Yeah, great question. Thank you. Any other questions on that evaluation and assessment portion? Okay, the next portion is on the third party evaluators. And we haven't changed very much with regard to this section either. We did make some

clarifications in the language with that. We have had several conversations with different educational programs or potential educational programs discussing what exactly a third party evaluation is.

and talking about how that actually does fit within the standards for curriculum development and educational programs. And we recognize that that may not have been the case in many other areas within the psychedelic education community. But one of the things that we are trying to do as a part of this process is to elevate it to really those best practices with regard to education overall. And so this is something that we are leaving in.

about CMEs and we did look at that and understanding that if there were also full evaluations that would occur of the curriculum itself and as we looked into the different CME programs and CEU programs and had discussions with several people who actually offer them and who actually help to I'm not sure award is the right term, but who offer them two programs to be able to offer CMEs for it, is those evaluations just were not happening.

While there are evaluations, for example, pre and post evaluations of the students and did they learn information, they're not actually evaluations of the curricula. So we are still looking into that aspect to see if that portion, if there is a potential alternative path. But at this point, it really, is relying upon having that third-party evaluator. And I do know that there are some concerns as far as cost with regard to that. Evaluation of programs always does come with a cost. We are trying to make sure that this is done in a way that's going to be as cost-effective as possible.

And that's a part of why it's not a department-determined third-party evaluators, but why the criteria for what that evaluation has to be is included in here. that it is following those kinds of best practices with curriculum evaluation and also ensuring that things remain confidential. But we are still continuing to explore those areas and to see on those. And just as a reminder, as was mentioned in the beginning of the board meeting, at this time, it can only take comments or questions from board members.

So, Any questions from the board regarding this or comments? Okay, thank you everyone. And then the next set are the requirements for certifying clinicians, practitioners, and facilitators. And I'll have that here in just a moment into the chat. OK, and so we're going to This has changed a little bit. The overall topics have not really changed. We did get some feedback on some language where we did make some adjustments. For example, some people had asked if we would add therapeutic into some aspects of it, be a little bit more clear in some of the language.

And so we have done that. We are going to continue to go through as with the other portions to sort of see if there's any additional clarifications. We did also adjust it to make it a little bit more clear. or some of the areas where there were some comments with regard to changing things a little bit with regard to what is different between the facilitator and the therapist. And so we did make some adjustments in there, for example, with facilitator, we added on in to the specific module, things like the peer facilitation ethics, how to work as part of the care team, what it means to be present with a patient, really to be looking at those areas and to clarify a little bit more that the aspect about, you know, we're not asking facilitators to be therapists, but ensuring that That is just from an informational standpoint, but talking about some of the basic concepts of psychotherapy.

And then, for example, with the practitioner certification, adding in a little bit more as far as education of specific psilocybin therapeutic modalities and working as part of a care team as well to ensure that that's in there. Um, And then as I had kind of mentioned earlier, we did add in on this version, we do have where we did make it so that people who have the additional trainings as far as basic life support, we added in, it could be an OR with cardiopulmonary resuscitation and AED certification. The other thing that, as I mentioned at the very beginning, had kind of come in from a couple of different people.

And in fact, I saw another email just this morning that had this request, is to add EMS certification into that list. And so we are going to add EMS into this certification with regard to the basic life support and CPR.

Okay. Hmm. you

And then the final part was the continuing education requirements, and that has actually remained the same with regard to the clinicians completing a minimum of eight hours of CMEs and the practitioners and facilitators 20 hours, and that is for every two years for both of those. And then I see we have a couple of questions, so I'll start with Larry.

Larry Leeman

Thank you, Don. I appreciate it.

I don't think 25 hours didactic is adequate for the, for the practitioners if they haven't had evidence of other training. I think that There's a couple of things. It's well below like with any program in the world that I have seen is like...

And I think by adding more practicum, we don't obviate the need for more of the didactic. And I think even just, you know, in our end of life committee, you know, we actually think that people need almost that much in end of life if they're going to offer that. So I think there should be a reconvening of a meeting with people who are either psychedelic therapists or have been trained and really go over that.

Chair / department (assumed)

Because I think 25 is far from adequate. I don't think it needs to be 150, but I think that's, 25 is too low. Thank you, Larry. Chris?

Chris Peskuski

I agree with Larry that25.

Hours of didactic training doesn't seem nearly adequate for. Um, any of these roles and I'm also concerned that. The training that the certifying clinicians are going to have to take is going to severely limit Um, the number of the already few, uh, People with a. Um that are willing to participate in this program. And And Ultimately, I don't, see How facilitators are really going to be utilized to any type of their potential in this model.

This seems to be very therapeutic centered and not Allow people with.

Life experience to apply. peer support skills to this space. So.

Chair / department (assumed)

Thank you, Chris. Dezbaá.

Dezbaá

I just wanted to clarify the language of adding the EMS component to it that it is in addition to as opposed to as a. Like, okay. NOT AN ADDED ON, Additional must have requirement, but that is also considered as an additional pathway. Does that make sense? I just wanted to make sure that that was a clarification between the two.

Sure. Since that portion is not actually in the text, yes, Dezbaá, it is an or. So, for example, someone could have basic life support certification or the CPR and AED certification or EMT, EMS certification.

Chair / department (assumed)

That was all. Thank you. Brenda?

Brenda Burgard

Brenda, if you're speaking, we can't hear you.

I'm sorry, I agree that we should have more practicum hours than less didactic. That, yeah, experience, knowing how to do all of this is crucial to everything here.

And Ian. So I'm currently on the fence about. more practicum or didactic. Only on the grounds that these are already licensed professionals that can provide a lot of aspects of therapy. And so it's not like we have to, they have to reinvent the wheel and learn how to redo everything. They do have to live learn how to apply in certain scenarios, but they already have a huge number of clinical hours that they must go through in order to get and maintain their licensure.

So I do support that maybe it should be a little higher than 25. I just don't think it needs to go crazy.

And one thing to clarify, the 25 is for that combined section. So that's the portion, that's the module that is both practitioner and facilitator. There is the additional five hours, both in the practitioner and the five in the facilitator, which was how we had presented it last time. It's just it got broken out into those two different sections.

Chris Peskuski

I'm sorry, Chris.

I think Larry was first.

I'll let him go first. Sure. Larry? Larry, if you're speaking, you're still on mute. Thank you.

Seems like an auto-mute here. So thank you about that. I just wanted to be clear. My understanding of the regulations is that people need to be licensed providers, but for instance, an internist, family doctor, palliative care doctor, we're certainly not requiring that people are all therapists. I would not have the assumption that they have two years of therapy training there. That's really important.

I think we should be limited to that. And I also just want to say that having worked with a lot of therapists and different people, this is just a whole nother ballgame, honestly. I mean, psychedelic therapy is really different than CBT therapy or different things. And I really do think it's its own area.

And I want to be careful.

I mean, you know, I mean, one criticism that this would leave is very, okay, it takes you two years to be a therapist, but if you want to be a psychedelic therapist, it takes you 50 hours. So I just want to, again, advocate for more training. And I liked Paul's idea about looking at what each module might need. Like, what do you need to do end of life? What do you need to do others? Anyway, just to make that again.

Thank you, Larry. And then back to Chris. Again, I agree with Larry about the, The requirements and the training level for therapists and other mental health professionals, I don't think this is covered under their traditional training in any way, although there is some overlap in some sections of it, I guess.

The other thing I want to bring up is that we're offering reciprocity from other state approved organizations, and we've literally like recreated the wheel and this just seems like this, there's this dissonance between those two things like if we're saying that the other. States have Have done their due diligence and.

put together program training programs That can, I'm sorry, there's an echo.

Can somebody mute? Like, all I can hear is my own voice. Oh, yeah, sorry.

Yeah, so Larry, the auto, the thing that's auto muting is me sometimes because your mic feeds back a lot. So if you could just remember to mute after you're done talking.

Thank you, sorry. All right. It seems like there's this dissonance between those two ideas that we can offer reciprocity because other states have done. done the work to certify these training programs and then we're Completely going against everything that those programs have put together, it just. Doesn't make sense to me.

Yes, Bob. Hi, sorry. Yeah, in that regard, you know, because I had to, again, go like from Massachusetts to New Mexico. I think it's just more like a department thing as far as my understanding is, you know, we have to base our own rules on our own standards.

Like, off. thoughts and ideas. And yes, it would be great to have a consensus amongst all the states of like what we're going to do.

But really, I think it just kind of comes down to these are the rules and the regulations that we have recommended or that we're stating and et cetera, you know, at the very end.

And, you know, it would be up to the deciding person that, you know, they feel that that's been covered with whatever education, whatever hours and years of being able to have that the person who's seeking reciprocity will be able to get like it's granted through um but you know moving forward like i i get that there's a lot that we're trying to like hold together at the same time there's like our rules there's like state rules there's a reciprocity there's like you know life um experience and education and

what could be you know transferred to this and you take a little bit out of that and i think just understanding that like we're trying to find just a of all those things and not also like hold, I mean, we're holding this dearly because this is going to hopefully end up being the rules and the regulations.

But, you know, I understand that it's a lot to try to like hold together, you know, and finding the middle ground is very difficult.

But at least in my understanding is that reciprocity is that, you know, whatever is covered based on the number of hours.

I mean, it's the same for any job when you're trying to, you know, they require four bachelors for four years, but you know, this person has been working in this job for 20 years, but they don't have it. I mean, it's up to that regulating thing deciding, you know, it's a 20 years life experience without a degree just as important and as equivalent to four years of like not having that life experience, you know, is viable.

I mean, I know maybe that's not part of the discussion, but that was just, I get it. I get it's a lot to try to like hold together. Okay.

Thank you, everybody. I appreciate it. Just as a note with regard to this is, again, parts of the hours are we are hearing from a wide variety of different people, some who have said we actually should have more like 200 or 300 hours. and others who are saying this should be very minimal, for example, just a weekend on it. And so we are trying to figure out some of that middle ground and trying to determine it.

And we'll continue to do that throughout not only the rule process, but also as the program continues to develop and is implemented to ensure that if there are things that need to be adjusted, that they are indeed adjusted. Chris?

All right, I'm just curious.

Like I've been to all the training and Education Committee meetings, I think, and I haven't heard that range coming across in those committee meetings, and it seems like where do I need to go to find? the people that are are talking about, you know, these vastly different training requirements.

Thank you, Chris. Some of those have actually been in some of the meetings where we have had people suggest that it should just be, you know, that weekend training would be sufficient for individuals. Some of it has been in other conversations that we've had, including, for example, conversations with, not that saying that that was your viewpoint, but when we've had conversations with you and other board members and other members in the community.

Brenda. Oh, Brenda, I think you remuted yourself. You were unmuted for a moment.

I think that probably with the testing parts of it, like if you have experience, I think, you know, that should be one of the questions that you should be asking yourself. We should be asking everyone, have you had experience with this medicine? And I think this is something that I don't think we've really even talked a whole lot about in any of these meetings because It would be great as a prerequisite But, you know, that's...

that can open up a whole can of worms there too. But I think, um, That should be like one of the questions, especially for people who've had a lot of experience with this medicine, that that should be one of the questions. And I guess applying for, you know, you know, uh, this, I guess it's going to wind up being a license of some sort, that it should be counted as something, because a lot of people with experience, that's all they're going to need is a weekend for, you know, the practicum, and other people were going to need a lot more practicum hours.

So I just wanted to throw that out there for food for thought.

Sorry, I muted my mic and then forgot to unmute it. Thank you, Brenda. Ian? Yeah.

Dominic Zurlo

I just wanted to bounce off that idea. I think we try to get people with experience via the reciprocity pathway. We can't just say how many years of experience do you have because everyone will have 100. So if there's no way to verify, so we, I think we're trying to use the reciprocity to say, hey, if you can show me any governmental tribal entity that said you have practiced, that we can validate.

We can say, you know, this was issued, this was a possible, whatever mechanism that we have to use versus, um, asking for experience, I think is so unverifiable. but its meaning is not really there. Bye. I'm happy to hear from everyone else. Thank you. Thank you, Ian. Dezbaá?

Dezbaá

On that note, two notes. And then just as a reminder that this is for the medical psilocybin pathway. When it comes to people who are interested in providing care through the medical psilocybin pathway that is regulated by New Mexico. Just leave it at that. and Also time, it is 9:48 and we haven't even gotten to the other three points. I propose that we maybe table going through this. I will just say that this is probably the reason why in the previous meeting that we had that we should have more discussion on this because it's already taken 40 minutes to try to get just through the reading.

And I'm not arguing that we shouldn't have done this. I think that this was very needed to be able to realize discussion we actually really need to have on this. But just time, 9:48.

Thank you, Dezbaá. And Keenan, you are next. Thank you. I realize that I am just a covering designee, so I don't want to drive policy here, but I'll just get this as a background.

there's going to be variability across the board of whatever you try and benchmark for training hours, right? And so what I tried to do was think of what's the most applicable clinical situation we've seen in the past.

And so you might say the prescribing of buprenorphine, which is a medication for opioid use disorder, can be used for pain, et cetera.

It had a separate pathway than traditional controlled substances.

And so then that has since been removed.

But if you look at the previous X waiver, They've required already licensed professionals in the field so nurse practitioners physicians assistants etc so similar to what you have here to receive 24 hours

of training just for this one specific agent and so I'll just put that there for you guys to make your own decision on, but I think that's probably your best benchmark that I can think of to say that this is kind of a standard used without the medical facility.

I understand this is different. There are different things that need to be taken into account, That's my two cents and I'll be quiet.

Thank you, Keenan. I thought I saw another board member with a hand up, but I'm not sure who it was.

That was me.

Dominic Zurlo

I just was going to say that I know we're coming to the practicum next, so I think that's one of the things we wanted to hit. Yes, and it is exactly so. Unless there's an objection, I'll move forward to the practicum, which is part of one of those main topics. And so I'm putting that section into the chat. Once again, and there was a lot of conversation with regard to this in the last meeting. What again it comes down to is we have flipped.

Chris Peskuski

I'm sorry, Chris?

No, go ahead. Continue. I just have a, I know I'm gonna have a question right after that. Bye. Thank you.

Thank you, Chris. And I'll come back to you then. I appreciate it. And so anyway, with regard to this is so for the purposes of this, we do still have that remaining the same. Some of the questions that came up was the amount of hours. And part of this is because we have reduced down that didactic. So we have kind of flipped it. What we were hearing from various members of the community is that the practice was very important.

It even come up during some of the meetings and talking about, you know, how many patients, how many people really should be seen by facilitators and practitioners to be able to get a good sense of what was happening. And, you know, when we look at it, you know, it's 100 hours as far as for the practicum with an additional 20 for the practitioners. And then and that these can be completed, as was asked earlier.

Dominic Zurlo

in any of the approved locations. So that includes healthcare, or I'm sorry, the facilities and or other approved locations. So homes, things like that, temporary locations as we have those. So both healing centers and other approved locations. And then one of the portions that has been brought up, and I see there's a question even about it, is the waiver of the practicum. include that, the waiver of the practicum.

or the practicum hours for individuals who are doing reciprocity, so long as they were able to show that they did have the 40 hours on that reciprocity. And that's actually in a different section. But I bring it up here because one of the things that we did add after talking with people in hearing is to ensure

that we did have something similar for programs and people who might be going through training currently in New Mexico.

What we have added is a similar waiver as far as those practicum hours, If someone has been trained by a program that is approved in New Mexico, approved by June 30th of 2027, and that that person would be able to then meet those same requirements, and they would have to demonstrate the 40 hours of contact time, which is the same as what we have with regard to reciprocity. Now, again, part of this with both reciprocity and for allowing this with New Mexico homegrown programs is essentially to have those requirements to be able to do this and to help build the infrastructure for the program.

And so we think that by adding that on in, then we would have that actually extended out there for that time period, which if, for example, these rules are approved in the fall, would provide about eight to nine months with regard to that. Now again, this isn't the reciprocity section. So if we have items about reciprocity, we'll get to those here shortly.

Chair / department (assumed)

I probably closed it. That's okay. Okay, Larry.

Larry Leeman

Thank you, Dom. Yeah, I have a lot of thoughts about the practicum to share. I bring part of this from the experience of having done practicum in another state. I think There's a couple of things that need to be looked at. One is that practicum in general does not happen with people that have the diagnoses in our program. And I do not think it would be appropriate for a novice to be starting out doing sessions with people with any of these four conditions. They happen with people who are other trainees.

I think that's really appropriate. It's safe. It's probably less stress for everyone. And so I'm strongly in favor of a fix-it bill that actually allows for the training using psilocybin for trainees that will both would give some if some training doesn't have any psilocybin experience they would gain that but people could do that and I would suggest that people are required to have two of those sessions that would reflect what Colorado does the other issue that again I'm in favor of a lot of practical trainings a few things one is the way it's written you don't actually have to be doing anything it says you can just be observing so They're your whole eight hours observing if I'm reading it correctly.

So I'd like to see it revised that say that you can start out observing, but you actually have to be being observed and being, you know, supervised, you know, at a certain point in time. So you're not just sitting in a room and not, you know, not being observed. The other issue, the big concern is the cost for doing this. And I think really for the whole program, we need to look at some cost analysis.

When the people do the practice in Colorado, the cheapest I've seen is it's costing, \\$200 and that's for people sitting for two sessions and having one. So potentially we're talking about, you know, a big expense. So I think in general, we should start having a cost effectiveness. We shouldn't be adding anything without figuring out how much it's going to cost. So those are my main concerns, make it available to be done with trainees, specify that when people are doing that, that some of it actually has to be where you're actually being the, the provider training and then figure out how expensive it

is.

Thank you very much.

Thank you, Larry. And just as a note, that portion about them not just sitting and watching, observing, it also does include the conducting and that it is supervised is actually in the first paragraph of it in paragraph A. So it's supervised practice and then the opportunities to go through those.

Maybe I'm reading this wrong, but it says to experience, observe or conduct. So I don't see that we're actually preventing someone just observing.

We can change that to and conduct.

That would be beautiful. Thanks, Valerie. I appreciate it. Thank you.

Chair / department (assumed)

I appreciate it. Thank you. Chris.

Chris Peskuski

Yeah, I know we talked about this before, but Can you explain why there's the wording same day therapy sessions in that again? This is a real hang up for me. There shouldn't be therapy going on adjacent to a psilocybin administration session.

Sure. Thank you, Chris. Part of it is because it is some of the language with regard to regulations and potential billing with the idea that these portions may be able to be billed other than the administration itself. So the administration portion, as we all know, would not be able to be billed, but the other hours potentially could be billed under some of the therapeutic codes. We're still working through some of that.

the reason for that language itself. And we understand that it's, and that's a part of the training is that this is sitting with the individual, that it should be patient-centered, that it should be based upon the needs of the patient. And to an extent, that is a part of what therapy is. And so that's why it actually has that aspect there. Because if we are able to get that approval for payments for those aspects of the services, this language could be very, official in that.

Yeah, I'm concerned that that it kind of blurs the lines, but I'll let that go for now. My next, uh, Part is in here you have. Students participate in or observe preparatory and integrative therapy sessions like that. This is another. spot where we are not acknowledging that facilitators might have a role in this process at all. Because not all preparation or integration is therapy. um And then. I guess I'm...

Also kind of hung up on the difference between integrative therapy and post integrative therapy.

I'm sorry, Chris, maybe that's just because it's the post integration therapy simply refers to the sessions that happen after administration. So it's the, you know, basically the preparation sessions and then the post integration therapy. So the post just refers to the timeframe of when they occur. Larry.

Larry Leeman

Yeah, Chris brings up something and I just may need clarity myself, but is there anything here that prevents a facilitator from doing the integration sessions by themselves? Is there a requirement that the license provider is present at all of the facilitator And I guess the other way to deal with some of what Chris is bringing up, if some of this could say therapy/facilitation sessions, but I think I need clarification on the question if the facilitator can do the facilitation without the licensed provider there.

I'm sorry, Larry, you're asking if the facilitator can do the sessions without the practitioner. Is that correct?

Deintegration session, yes.

Yeah, again, there's nothing in the rule that actually stops that.

Okay, good. Because I think it may be appropriate for that to happen with the license provider not being present at all the integration sessions. Thank you.

And as a note, this is just as it pertains with regard to practicums. And so that separate section, the part B, is really just the additional section or I'm sorry, it's just the allocation that the students, so that's both practitioners and facilitators having at least 20 of those hours being with regard to the preparation and integration sessions.

Thanks for the clarification. It does sound like it answers the question if the facilitators can have integration without the lessons provider, but we might want to make sure we're clear about that as well. Outside of practicum. Sure. you Chris? Yeah, so. That's I'm curious why there has to be the therapy sessions language in this section. We can do this all with preparatory and integration And how that looks is up to the care team And in the rules, it makes it, appear like this needs to be done by the therapist or this is therapy, which is not always the case.

Sure, we can take that language out then, Chris, especially in this because, you know, we do define what the integration or the post integration sessions are. It's really just a descriptor. But if that makes you feel more comfortable, we can take that on out. And as you can see, I'm doing that right now. Thank you. Does that help? Yes, thank you. Thank you. And I appreciate it. You know, we do want to ensure that we have, you know, that we have this to be inclusive.

None of it is meant to be exclusive. Okay, that's fine.

It just seems like a lot of the conversation, and I'm not disregarding what anyone's saying, it's all very important, but it seems like a lot of the conversation is like a billing process. word language issue and understanding that this is a medical psilocybin pathway that is being regulated by New Mexico. And as much as a lot of us, I'm assuming, speaking for a lot of us, whereas we realize that these sessions, these journeys, and our own experience in coming to the medicine has not been and does not look as clinical as what it sounds like, that that is That is not like necessarily I feel like this is a middle ground pathway between Western medicine and government saying this is wrong. You're sinful.

You're a horrible person for doing this and you're going to be thrown in jail and then there's also the Other side of it. So completely two different spectrums and that this is a middle ground. Like where do these two converge, the confluence between these two vastly different ways of thinking and finding that middle ground will be, you all are, we're all doing, you all are doing a very good job of

understanding that.

Yes, now we have to do billing language and understanding where that Western model and way of thinking is coming in to meet with I don't remember being regulated and regular, you know, had this many practicum hours, you know, years ago or whenever the last session that I or anyone else has had. So just kind of wanted to point that out. Thank you, Dezbaá.

Dezbaá

Thank you, I really appreciate what you said. Do you wanna just point out since we are here, Two of the, I mean, one of the things we were discussing and that we had pulled aside was the practicum hour volume. Since we are still here, I just want to redraw everyone's attention to that practicum hour volume. What changes would we like to see there? Because that was an area where we hadn't fully resolved.

Chair / department (assumed)

Larry.

Larry Leeman

Yeah, I may be slightly repetitive, but I don't think we can actually resolve that without the legislative bill that allows for people to be able to work as trainees. I think the numbers are not realistic without that. I think with that, they become more realistic. So I think there are LinkedIn issues. And I know it's awkward because we can't as a group be, you know, making and proposing bills, but I do think that's linked into this question.

Chair / department (assumed)

Thank you, Larry. Chris?

Chris Peskuski

I know a lot of people want to see the hours reduced for the practicum, but unless the we balance that with the shift to the didactic hours, I don't think that would be responsible at all. And so if we are. Willing to open up discussion back on that section, then maybe we can find a little bit more balance, but. Um. as it stands now, I think that's the only thing that will actually help train our people.

Chair / department (assumed)

Thank you, Chris. Ian?

Ian Dunn

Thank you, Larry and Chris. Alrighty. If we need to make changes to the didactic, that's fine, but we just need to come up with a consensus within the law. Um, and in order to provide a program. So... Assuming that the law doesn't change, at least until January. on a good day. We have to find so. How does the board feel? I've heard from Chris, I've heard from Larry about the hour requirement, but I haven't heard from Pretty much anyone else and I just want to in regards to that specific thing I have heard from you guys. I wasn't not listening but.

in regards to those hours. So I just kind of want to see how everyone's feeling.

Dan? Thank you. Did not know prior to this. What was the didactic hours requirement before this draft of this rule? That was proposed.

It was the same hours. The didactic has not changed on it. The only thing that changed was we shifted it to break it out into that other module for the practitioners.

Okay, good. Because I think I might have just misunderstood. I, for some reason, have thought that these practicum hours had similar hours in the didactic hours as well, meaning that it would be double the amount of time. So I feel personally with this because I hear a lot of people saying that, number of hours required is very low on the didactic, but I wonder if the, so is there a balance between the two? Is there, is everybody okay with the number of hours for the practicum, that the didactic is low or that the practicum should be less than the didactic more? I feel that a lot of the practicum brings in a lot of what the didactic has taught and has been practiced.

That's, and again, I'm coming from, this is naive to me. I'm just bringing this in from my own naivete. I'm okay with the hours as long as it is the true practice of those things that was learned in the classroom. Thank you, Dan. Brenda?

Brenda Burgard

I think with the didactic, there's going to be a lot of learning, like book learning with the didactic and teaching there. where the rubber meets the road here is practicum. People, if you're, if you're, Learning something in the classroom, it's totally different than hands on. And so the hands on is going like Dan said, it is a learning experience in itself. So, um. I would like to see just a little bit more of the practicum hours.

The didactic is going to come with all of the learning that has to be done here in the education and the curriculum. So you're going to learn by doing hands on and that's That's how I've always had practicum done that way, being thrown in and you do it and that's how you learn. But yes, I agree with Dan that there has to be a little bit balance, but I'm leaning more towards more practicum hours.

Chair / department (assumed)

Thank you, Brenda. Ian?

Ian Dunn

And I just want to say I agree with Brenda. When I was in nursing school, we When you're taught something on a PowerPoint, everything's in a perfect world. The patient only has one condition. They're only on one medication. And it's so easy to deal with. But when you actually get into the hospital room and you have to look at an ECG where they're breathing, so it's messing with the line and it's not adhered correctly, and you actually have to interpret, that's where learning really happens because in the classroom it's too normal, it's too...

I was focused on just trying to show you the one condition and I agreed that where the... craziness comes from is the practicum where that dealing with adverse experiences is practicum, at least from my nursing experience. Thank you, Ian. Larry?

Larry Leeman

Yeah, it's actually really different than the way you're describing in a psilocybin session. The typical psilocybin session, the person is within for most of the whole six hours. There's very little conversation. You're just basically holding space, learning how to provide their needs, whether to go to the restroom.

Occasionally something comes up, but there's not a lot of, it's not like taking care of like a person in a hospital. It very much is they're within and you're just sitting there holding space. That teaching that you're describing actually is happening there. It happens more in the prep and the integration. Some of what I think is important in the didactic has to do with our four specific conditions so that people, like about end of life, I mean, some of the important issues are like making sure that there's adequate family support. There are issues that don't really come up during the session. So I'm just pushing back a little bit on the idea that the practicum, it's not like the same as a nursing training.

I think it's different here. honestly, regardless of what number of sessions we have, there's an excellent chance that no one will have, you know, certainly like anything that's, they may have a challenging personal experience, but they're unlikely to have something that's like an adverse event type experience.

So they need to be prepared for that didactically.

Chair / department (assumed)

Thank you, Larry. Chris.

Chris Peskuski

I just wanted to say I agree with Larry and there's a lot that goes into this didactically that adds to your overall knowledge and just preparedness for this whole experience that you you. might not get from I mean, eventually you'll get it through practical experience, but I think there's some hard lessons that you Could avoid through. A little bit more didactic learning.

Chair / department (assumed)

Thank you, Chris.

Chris Peskuski

So the one thing I will say is, again, as we were looking at what the hours really both for practicum and the didactic, it was about balancing. Because we were hearing in various committee meetings and also in other conversations with people that, you know, different people have vastly different perspectives, that the didactic was too much or too little, the practicum too much, too little. And so really, we did try to thread that needle and try to come up with as good of a balance as possible.

And so that's really what we've done here.

And of course, if there are some adjustments, We do understand that.

But again, it was to try to figure out what would be that balance. And we did hear from quite a lot of people that it was practical experience and that the biggest concern was really about being able to complete the hours in a timeframe as well as the cost. And that's a part of why we didn't want to really

exceed, you know, too many hours combined between the two different types.

where and why we have them at this point. But again, if the board feels, you know, that some adjustments should be or could be made, then Definitely, we can look into that.

So Why don't we go ahead and take a vote. If you are not okay with the current minimum practicum hours, please raise your hand at this time. Again, if you are not okay with the current Practicum hours, please raise your hand.

Point of clarification, Dominic, do we need a second follow Robert's rules for this? I apologize. I don't know the process. That's up to the board. Okay.

It gets confusing when you're putting the knot in there is the move to approve as they are.

So the move is, okay. Do we need further discussion on like, do we need to change something or are people okay with it? So it was an objection to the current Practicum hours.

I'm willing to vote for the current hours. I just want to be heard that I think it's not practical until we have a bill that allows people to work with trainees and that I think that we need to actually figure out the cost of this and I'm concerned that we haven't actually done those two. Thank you.

All right, so again, I'll rephrase that. Any objections?

I am opposed to the current educational standards as they exist. If I have to vote against the practicum hours, for to state that, then that's what I'm going to do. Okay.

Okay. I guess to clarify too, because I'm also against the current didactic hours. So is that a vote no on this or are we just talking about the practicum in this vote?

So we're working on just the practicum hours. If you have any objections to the practicum hours, raise your hand.

Alrighty, and please lower your hands. And Ian, just as a clarification for the public is this is just for board members. All right, so it looks like we have two that are in objection of the current Rules. Is everyone okay with moving to adopt these practicum hours for the time being? minus those two, obviously.

I would like it to be noted that I do not think that this is feasible without an additional bill and that that's my strong recommendation. So maybe it's an abstention at this point in time.

Without objection, the record shall reflect that you requested an amendment to the legislation in order to properly effectuate those practical powers.

Thank you again. I appreciate that very much.

All right, Brenda. you You're muted. Still muted. Brenda, you're muted at the moment. If you could unmute yourself. What is this? Yeah, I agree with Larry. I agree with Larry on this, that we need just a little further discussion on this. And I think we'll be able to kind of get some balance here on this. what we need to do here. And if I may, we do have the section in there, if you notice, and I had mentioned it just very briefly, but down in Section G, which does allow for the department to waive or suspend the practicum hours as needed in order to help build the initial infrastructure.

And some of that was included in based upon, for example, what Larry is talking about and to do that. implemented, it does indeed show that doing these minimum hours is too onerous or expensive or other I think Dominic froze. I concur with that. I thought it was me, so I'm glad it's not. Oh, there we go. You're back. Am I back? Am I back? Okay, I'm back. Thank you. Sorry, Dr. Dr. Rob was handing me his headphones so that I could speak through his mic, but thank you, everybody.

Larry Leeman

I'm not sure where I had frozen, but basically what I was saying is exactly for the purposes that Larry, for example, was bringing up is that we do have Section G, which is a waiver of practicum requirements, so that if we found that some of these practicum requirements were onerous or too expensive or any of those, the program could actually waive them. in order, and if, for example, legislative changes or things like that, in order to help facilitate the building of the infrastructure for the program.

And so we did put that in specifically for some of these concerns because we did want to ensure that as things are implemented, that if we have to make adjustments, we can, and we can do that as a reduction without having to go back through the rulemaking process at that point. I hope everybody was able to hear all of that. Did I freeze again? Yeah, I think we heard all that. Yes.

So is the question on whether or not we want to vote This is table the discussion. Is that where we left off? I think that the freeze threw off the flow, unfortunately. Yes, so the question was whether we wanted to vote on this or continue discussion. So if you would like to vote at this time, please raise your hand.

All right. And then if you would like to table this for later discussion. Please raise your hand.

With a unanimous vote, we tabled the practicum hours. And you can lower your hands at this time.

Ian, just to be clear, I think some of us may be voting because it's the didactic hour. So I think you're getting a mixed vote on here.

Okay, so...

If I may, the real question that we just need to know is, do we have the permission to continue to move forward with regard to this? And again, I would say just with regard to the practicum hours, with understanding that, yes, there potentially could be changes. We are still working with and continuing to have conversations with regard to it. Um, and, um, And as far as the hours, again, as we've talked about, if some of those need to change, we've been asking.

And so what I would really suggest is what type of hours people would need on that. So I'll leave it to you all to decide if, you know, if this is getting tabled or if we are moving forward. Larry?

Yeah, I just wonder if given this, whether this would be appropriate to go back to the subcommittee to actually have a focused discussion, which may easily take like an hour about what we're recommending as number of hours, if that seemed reasonable. And, Dama, I would ask you whether that would be problematic in the timing of the process to take the time. I think it would be worth it to try to have, you know, have more of an agreement among the advisory board.

Thank you, Larry. Just as a note, if it's simply talking as far as number of hours, I think that those can definitely be adjusted as the process continues to move forward. Chris.

Chris Peskuski

Yeah. I don't think we can separate these issues if we lower the if we lower the practicum hours without balancing it with the didactic somewhere, And I feel like those are woefully inadequate to begin with. Like all of this is connected and there's accessibility issues that also come up. for me in this with how many patients are actually going to be available for people to do practicums and I just think.

that We need to think this through. more thoroughly.

Chair / department (assumed)

Thank you, Chris. Dan?

Dan Jennings

Thank you. Yeah, I'm going to echo Dr. Leeman and Chris on this. I think that it does make sense to go back to the committee, but for both the didactic and the practicum, but on a very legitimate, not like I think it should be more, it should be this. And I think there needs to be a definitive consensus to the number of hours. But because I think we just get into this and go, I feel it should be more, I feel it should be less.

It needs to be a specific and those numbers are arbitrary. There needs to be at least some consensus on those numbers because there's no reason for us to split hairs here, my opinion.

Thank you, Dan. Ian? I would say I think we should just go ahead, given that we already pushed back the reciprocal deadline to June. we this should not be that large of an issue and if it does start to create you know a systemic barrier we would see that before the rules to allow the easier out of state um mechanisms to take over so I think we have so much time that we can allow it. Otherwise, again, we're getting into the issue of when you're picking arbitrary numbers, kind of like Dan said, it's always going to just kind of well, I feel this way, I feel this way, because I have also been in the training and education meetings, not all of them, but most of them, to hear the swaying of back and forth that the 120 has gone through to get there.

I fear sending it back to committee is just going to end up with another number and then we're going to end up feeling different at that time.

Chair / department (assumed)

Thank you, Larry.

Larry Leeman

I would agree with Dan's that it goes back to the committee with a very specific focus and the charge of sorting out the number of issues. I would also suggest an approach to be used that we use an end of life committee, which is to bring in several experts. And I think we could do that. We can invite someone from California Institute of Integral Studies. Let's just not have it sort of like a, I think you

think, let's bring in some people that have experience and ideally don't have, you know, any kind of a commercial conflict in their form.

Chair / department (assumed)

found that very helpful in the end of life committee to to bring in some experts to to to do that Thank you Larry.

Larry Leeman

So what I'm hearing regardless is that to send it back to the committee. Okay. Well, and I believe we have a, there is an educational and training committee meeting that is set for the next Friday, the 17th. Correct. Would you like to bring And while we could talk about it there, but never mind. Okay. Thank you, Brenda. Keenan? Yeah, I would just say so that. to continue this to help get to a discussion like Dr. Leeman was saying.

Is it sufficient to have people from another state and would that be the accepted authority the board members feel comfortable with? Is there any benchmarking to other license types, medical cannabis, end of life that should also be used? Just be very clear here right now what those pieces are to make the decision there so that the cycle can, the decision can be made and you can guys move forward is all I suggest.

Thank you, Kenan. Ian? So I guess my suggestion, Would you guys like to flip the training and education, the medical psilocybin advisory board meeting on the 17th? That way the training and education goes first and then we can review whatever they come up with if they come up with a resolution to this issue. Just to clarify Ian, you're talking about switching the times on Friday that those meetings are happening, correct? Right. Yes.

Brenda, you had your hand up. Yeah, I just got a little confused, that's all. Thanks.

Larry, you know, in this with total respect for you, but I think that you're hearing from your board that they want to have this go back to the committee and have a discussion and a plan. And I don't think you're hearing that they want to have it all figured out by next week. And so I would ask you to respect the opinion and as the chair.

To clarify, I do respect the opinion. I was trying to allow the deference to the training and education committee before our next meeting since they were scheduled on the same day. But thank you.

Thanks, Ian. I appreciate it.

Chair / department (assumed)

Alrighty, and then we can continue, Dominic.

Dominic Zurlo

OK, the the next aspect and this one is is the educational program and continuing.

with mentoring requirements and their record keeping. And so the record keeping is of course pretty standard, keeping their syllabi, all of that information. And of course, you know, items such as start and completion date for students. And then the mentoring requirement, and this has not changed

since earlier or since the previous discussion, is that the educational programs would need to provide students after they graduate with a minimum of 10 hours of mentoring sessions.

And so that has not changed on there. Are there any questions with regard to this?

this section.

Okay, and then the next part, and this was the next section really for discussion, and this is on reciprocity. As I had kind of mentioned earlier, we did have a little bit of changes with this. And the main one that we did is, as I mentioned in the beginning, is including the aspect for programs that are current in New Mexico that are starting up here and for allowing them to be able to also essentially have reciprocity.

And then we do have the waiver of the practicum requirements reciprocity, they do still have to show that they have 40 contact hours with regard to this, with regard to psilocybin treatments. And then again, as mentioned earlier, is it also does have that waiver so that the department, if this does indeed show, prove to be an issue or a concern, the department can waive some of those practicum requirements if needed.

And then outlining just how those programs actually get approved is essentially they get submitted as an individual is requesting that reciprocity, they submit that the document or that the program is either already on the list. And as we've stated, we did include and specify that if it is a program already approved in Oregon or Colorado, that it would be automatically on that list, but also allows or other possibilities, including, for example, other states as other states get have psilocybin and medical psilocybin programs that they also could be approved.

And then it has the same Same certification timeline as far as for educational programs in the state as far as they would be have a two-year approval it once they were approved. So once a program is on the list, they have a two-year approval for that. So that way if other individuals later on are submitting their reciprocity, they don't have to submit all of the other requirements.

Does that?

Just a reminder, when were these going to be presumably rolled out to have people applying by the December 31st deadline?

And then also time, it's 1036.

Yes, thank you. I appreciate it, Dezbaá. And as to the first question is, you know, if we are able to move forward, then we would be looking at this being implemented in the fall. And so it would give individuals several months to be able to complete these requirements. And again, this is for people who have already graduated from other locations. After the December 31st deadline, the reciprocity stays the same with the exception that they would need at that time to complete the full practicum hours required in New Mexico, whatever those end up being.

Chair / department (assumed)

Dan?

Dan Jennings

Can I ask a question? Because again, my naivety on this. So in other states, the patients, the qualifying individuals in those states are not necessarily patients like we would have here, meaning end of life patients. drug-resistant, excuse me, anyway, the four that we have. So is there any concern that we have that the 40 hours that they have in another state doesn't necessarily fit the patients we would have.

Just worth the question.

Dominic Zurlo

Absolutely. Thank you, Dan. This really is a compromise. We need to, in many ways, start somewhere. And so we did make this match with what we're doing for the, you know, the New Mexico-based programs as well for that first time frame, except the time frame for this to accept it with just the 40 hours is shortened, of course, because it's only until the December. And again, if the board feels we should extend that on out, we can.

And that's also where the waiver of the practicum requirement If the department feels we have to push that forward a little bit, make that a little bit later in order to help some individuals to be able to practice in New Mexico who've already been practicing and gone through the training, we can do so. So that's a great question. There's always any time there's a new program starting that there's, you know, that possibility.

And so I think this is a good compromise to ensure that there is some of those considerations with regard to, People have already done in other states and, you know, what we're going to be requiring for programs here internally as well.

I hope that helps.

Chair / department (assumed)

Okay, Chris.

Chris Peskuski

So I thought we had changed the dates. that we were going to accept reciprocity to but I'm seeing in here for the price of the product, hours that that is still December 31st is. Or is that?

That was for the internal, so New Mexico based programs that we put it at the June mark. But again, you know, we can consider extending this on out further. That wasn't, and it may have been something that someone had recommended through the chat in the last one, but it wasn't one, at least that I had heard as far as a change when we had the discussion last.

So I think. People that are just beginning programs in other states are going to have a hard time even meeting this timeline for practicum. or even an approved program for reciprocity. So I think we should extend the deadlines out.

Are there objections to that?

So, Chris, I'm assuming you meant to the June 30th?

either June or December 27, when the programs was meant to roll out. Um, Initially.

Larry? Thank you, Chris, by the way. Thank you. Larry? But Larry, you are still muted.

Third time's the charm. So the I'm involved because we send people to other programs for research. What Chris says is really true. I mean, at this point in time, the next cohorts are starting in the fall. They won't finish till like March of 27. And then it takes a while to get the practicum done. And so I think, you know, actually, December 31st, 2027 would be reasonable because I think people should have ability to start the program you know at this point since they haven't had any guidance up till now The one thing I would just suggest is if we do that to 2027, that we do the same with regard to the New Mexico programs.

I would agree with that, Tom. Okay, and so if that's the case, unless there's objection from people, 'cause again, this is just sort of reviewing and no objection here, Okay, Ian.

Ian Dunn

I don't have an objection. I can wait a second.

Sure, no, no, it sounds like there's none, so we'll make those changes and we'll go back to the other section and make those changes as well. But go ahead, Ian.

Yeah, I just wanted to add actually remind that December 31st is not the original deadline. It's what's known as a legislative backstop. Meaning if we are getting close to that date and we have not finished the program, We have not done our jobs. So I just want that reminder there that that is not the goal date. That is the hard deadline when we have to have this program implemented. That's why we're okay with saying, okay, maybe we can try for earlier because we can absolutely not try for later.

Just as housekeeping too, we've got a little over 15 minutes right now left for the meeting. Just as a reminder.

Dominic Zurlo

Thank you, Johnny. You beat me to it. And so I was going to ask, are there any other questions with regard to this? OK, and so and again just with With regard to with the time, the next sections actually have not changed. And it's really just about the testing out of the didactic portions. And then as well as the prohibitions as far as for certifying clinicians, facilitators and practitioners, that really just, again, that a patient can't be treated by someone they're related to, for example.

The testing out, that's really just that the educational programs have to offer a way for people to be able to test out. Okay, and next is Dezbaá. And by the way, Dezbaá, if you're asking as far as that third part, it's actually just in the next section.

Oh, no. I would just say for thoughts on this deadline issue, is it easier to have an earlier deadline and then be able to move it up as opposed to having a later deadline and then pushing it back? So for instance, is it better to keep it at December 1st and then if we need to revise, move it up to March? Or is it better to have it further out and then be like, oops, we really should have moved this back to December?

like, you know, departmental logistics, Sure.

To be honest, it really was as they were based off of suggestions from various people as far as what they thought length of time would be. But the December 31st, 27 is not problematic.

Yeah, I guess I guess I'm just like, you know, as we're moving forward, um, If we need to revise something, is it easier to have the deadline at December 31st and say like we actually need to extend it down to March of 2027? Is that like an easier fix as opposed to starting out later and moving it back?

I think in this particular case, it's not a problem. Yeah, in some areas it would be, but I think for this one that's not an issue. It's a great question. Thank you, though. Larry?

Larry Leeman

Thank you. Yeah, it's maybe moot, but I think the reason to give that date now is so people can feel comfortable enrolling in the programs and knowing they'll have enough time to get it done because it is a commitment for people. So I think if we let them know they have until December 27, they'll be more comfortable making their life plans. Okay.

Dominic Zurlo

Okay, and so the next step is application processes. And so the first part, this is just the general portion of it. And so I'll do this portion first. which is Really just the applications have to go through the electronic system that we will be developing and are in the process of doing. And that they'll have to do renewals every two years for their certifications. And then just really, again, that they may voluntarily relinquish their certification at any time just by providing written notice.

And that they consent, that people who are certified and organizations consent to have their information published through the department. Oh, and I'm sorry, I copied it into the chat, but forgot to hit send. My apologies, everyone.

Any questions with regard to that?

Okay.

And then the next part are the specifics. Now, for a lot of the different applications, they are pretty much the same. So I will, I'm just going to go over the one here, because this is the one where we do have the additional questions, and it's with regard to the certifying clinician. And this one, what we do have on this, and this is where the questions keep coming up, is that the certifying clinician, oh, and I should note that we did hear, by the way, They didn't like the term diagnostic clinician, that they felt that it didn't cover everything. So we did change that to certifying clinician throughout the rules and or the proposed rules. And so we did make that change on there.

So thank you for those suggestions. And but with regard to this, essentially what everybody would need to do is do the completed W-9 form, the documentation of their professional license. and then the completion of the certifying clinician training requirements or that they have tested out of the didactic portions, documents of continuing ed if it's a renewal, and then attestation with regard to not being a registered sex offender and that we will deny or revoke if someone is.

And then there, certificate or verification of results of their New Mexico controlled substance number. And then their personal data, which is really just to track and ensure it's the same person, which is date of birth, driver's license, phone, legal names, affiliation, consent forms. So the area that, and the others are very similar, have essentially the same items. The main difference, and I'll put that in the chat, is what we were talking about before is about ensuring that in the other is they have their basic life support or CPR, or as I mentioned before, came in after we had sent this on out, the EMT training certification and of course HIPAA certification. Otherwise the others are all the same.

The difference being that with the clinician, the certifying clinician is the New Mexico controlled substance number. And I know there's been a lot of question about that, about why we are requiring that, Licenses have the ability to be able to diagnose some of the conditions. And yes, that is true. For example, a social worker can diagnose with regard to PTSD and depression, for example. But the main reason for the controlled substance number is because it is a treatment that is occurring with a medication.

And so with that, the The certifying individual, in this case, the clinician, does need to have a controlled substance number. And that's something that, you know, with it being a medical program, that is part of what ensures that there is that medical evaluation, that medical certification to be able to have it with regard to this. And so at this point, any questions? or comments. Chris.

Chris Peskuski

I've got several. But I think we'll start out with So, Some of the liability issues, I think, with this... I, I'm concerned that putting the access point through a doctor is going to Um. Make it very risky for clinicians to certify anybody into this program because they're going to be subject to malpractice. I believe and I think all the liability should lie in the room where the patient's being treated because ultimately all the risk mitigation comes from proper preparation, administration techniques and integration techniques.

And if we. Why would a clinician sign off on a patient when he's not gonna be necessarily in the room when all of that happens. And when something goes wrong, the last thing I want to say see is everybody doing this. I think it needs to be very clear where the liability lies. Um. The access issues for this are, I just think very It's troubling. Like my wife hasn't been able to get a primary care practitioner for over a year now and we live in Albuquerque and she's got great insurance through Sandia Labs.

The access outside of Bernalillo County is going to be Cze■■! unattainable Um. I I think you all keep pointing towards cannabis as a how this program rolls out. I'm saying we can do the same thing, but I see a major issue with the propagation piece of that. In cannabis, you get a user or a patient through and certified into the program, and now they've become a daily user. And so the supply chain stuff just doesn't work out when you have Somebody who might be using a half an ounce a year if they continue to come back.

So, There's just a lot of things you know, massive program sustainability aspect to that. And I think with the Huge shortage of primary care. or people with these licenses in New Mexico. coupled with the amount of risk and the training that they have to take to enter the program, it's just going to make

this completely inaccessible. And I think it, uh, I think it completely kills this program. And, uh, I would recommend that we look towards a model of consultation Um.

where the practitioners are required to consult with Um, to determine medical readiness in Circumstances where that's necessary and allows for continuity of care for practitioners to work with doctors that are already treating patients. And I think it solves a lot of these issues of liability and accessibility. Thanks.

Chair / department (assumed)

Thank you, Chris. Dan?

Dan Jennings

I got to really lift up what Chris said. From rural area, my big concern, and I know we're not at this point yet, but just further down in the document as I'm reading it, is that I would have to find this person who is a doctor, who has a CS, who has gone through the program, and I physically have to travel to them. client relationship with the patient and conduct an in-person physical or mental evaluation. So therefore, I would have to find that person who was going to be in Albuquerque or Santa Fe, maybe even Los Gatos, but it won't be here. And I could not do it via tele.

The only time I could is if I get recertified. So therefore, I feel that from an equitable standpoint, I feel that I would be very limited in my home hear from that. Plus, if you're a provider that, or if you're a patient that is an end-of-life, that means that end-of-life patient must go to that physician that is in that. So, I mean, I'm sure that they might be part of the same team, but I'm not assuming that in every part of the state that would be the way that that would work. So, if my mom who died of cancer would need to go and get this, she would physically not be able to be in this program.

So, I'm Thank you, Dan. Ian? In a rare turn of events, I'm going to side with them on the grounds that upon doing My evaluations, psilocybin appears very safe and one of the models I was comparing it to was the Washington DC medical cannabis model which allows you to self-certify. So what if we could provide them with a list of contraindications, say, "Hey, you got any of this?" If they say no, then we can move them on.

I do, in a perfect world, I would love to have everyone have access to someone with the New Mexico controlled substances number in an ideal world. everyone would have access to healthcare, but unfortunately this is the real world. And I think that even some of the conditions that my committee in patient qualification and safety has been looking at was existential distress associated with a life limiting illness.

That's not in the DSM-5. That doesn't need to be vetted to be done by someone with diagnostic, I could self-certify, yes, I have been living with existential distress. I have treatment-resistant depression. I tried X, Y, Z. So I think that could allow more access. in the program as well. Thank you. Thank you, Ian. Brenda?

Brenda Burgard

I, too, agree with Ian on this point and everyone else on the panel here that It just seemed to be this whole week was me trying to find doctors and psychiatrists for my patients currently. For example, for

Adderall, the. The hoops that people have to jump through just to get the medical clearance and then try to find a psychiatrist to prescribe because doctors don't want to prescribe Adderall. There's quite a few of them that will push that onto the psychiatrist by the time.

Uh, I see my client, we're looking at anywhere between three and six months of this type of bottleneck that that's been happening. So, yeah, to me. As Ian said, this is the real world and I think that we really need to think all of this again.

Thank you. Thank you. Keenan. Just throwing out some possibilities, is it possible to only all behavioral health providers and allow through telemedicine? Would that be a... meaningful compromise. to allow some sort of recommendation or referral without being restrictive. I remember back seeing patients, we actually had to fill out referrals and medical marijuana cards and that had to be an in-person signature on a piece of paper, right?

So I understand that's very, and not wanting that, but it does provide some level of referral and oversight that occurs. And some therapists may not have a controlled substance 'cause they're not prescribing or they might be a psychologist without it, but they could still say that you have PTSD, for example, that would be within their scope and could refer. So just throwing out some options along this spectrum between Complete in-person controlled substance versus no all self-certified.

I think there could be a happy medium in there.

Thank you, Keenan. And just as a note, we are at 11 o'clock. And so what I am hearing is that you would like us all to bring that on back. We shall indeed and look at other possibilities with regard to it. Perfect.

Dominic Zurlo

And then just to summarize, and board members correct me if I'm wrong, we are going to send the practicum hours to the Training and Education Committee. We extended the reciprocity deadline. And then What's the final action on the certifying clinician?

So Ian will take that back to here in the department to reconsider. Perfect.

Alrighty. And then is everyone still good for the meeting on the 17th?

Well, and I wanted to check in on that as well. If we did, in fact, want to switch the times for the board meeting, which is currently scheduled at nine on the 17th with the training and education, which is currently at one.

Yeah.

Johnny, I would recommend we just leave them as they are, because people have already scheduled.

unless the board disagrees.

I'm not seeing disagreements, so. Okay.

Alrighty and then if the department is able to stay for public comment that would be great. If any of the board members need to leave I completely understand but thank you all for being here. I will go

ahead and Move on to public comment.

So if there are individuals who would like to who would like to speak as far as from the public, all you need to do is raise your hand and we will call on individuals in order. Just as a reminder, you do have three minutes to speak during public comment and we'll go ahead and start going through the list.

Okay, and so I see Kate Hawk, you have your hand raised.

And let me make sure you're you're.

Sorry, I'm trying to switch screens. Oh, there you go. Perfect. You got it before I did, Kate. Thank you. Go ahead. Yeah, great. Thank you.

And I am just going to quickly say what I put in the chat and say thank you to everyone who's spoken up and acting with integrity. This is a tough situation. And I'm glad you're giving yourself some time to take a little more time that'll save us in the long run. So yeah, that's pretty much it. I mean, this has just been a couple of rough weeks and I know it has been for some other people too. So I appreciate that we're moving ahead together and I need to get on another call. Thanks so much.

Thank you, Kate. And it looks like next we have Elizabeth England Kennedy. Your mic is enabled. You can go on ahead and speak.

I'd like to thank I'm sorry, there's an echo. I haven't used Teams in a long time. I'd like to thank everybody. You've obviously put in a lot of time and effort and careful consideration on all of these issues. I'm a little puzzled because Ian is talking still about a hard deadline on December 31. Should that exist, I recommend going back to the legislature and giving the explanation of we need cost-benefit analysis.

We're still discussing what specific terms mean. We're still looking at... what reciprocity means and how we're going to go through that. There are serious concerns about access and equity, particularly in rural areas. And I'm thinking of Lee County right now and the difficulties there. I don't see inclusion of community health workers and roles they might play or education they might get. Same with extension agents.

Ian Dunn

I'm wondering whether the Department of Higher Education might be a useful consultant as well as Ann and possibly somebody from Oregon as well. I will write up something and send that, I'm assuming, to Ian and Dominic that's got more detail. And then you can disseminate as you see best. And thank you for staying past 11 to hear our concerns as well.

Dominic, you're muted.

Dominic Zurlo

Thank you, Johnny. Thank you, Elizabeth. I do appreciate that. Any public comment sent afterwards should be sent to the medical psilocybin email, and I will actually put that in the chat so that you have that information. Dominic, I'm sorry. I already see Jorge has already put it into the chat as well as Ian. So everybody was on that. So thank you, everybody. And thank you, Elizabeth, again. Okay. Next up, we have Denali.

Denali Wilson

Um, Good morning, everybody. Just want to thank the advisory board and department for the continued transparency and commitment to public participation in this rulemaking process. I do really appreciate it. And like Kate, want to acknowledge that the past few weeks have felt tense and that that tension is difficult. So much of the transformative potential of psychedelics, psychedelic medicines is about an increased capacity to move through difficulty. And I remain really confident that this is a hard thing that we will move through together. And I think this meeting just made that feel even stronger.

I want to say that, you know, criticism of specific policy choices is offered not in an adversarial spirit, but offered because we have a shared commitment to building the healthiest, most accessible that we can and because that shared commitment carries with it a responsibility to name design barriers honestly when we see them and so I'm just really grateful that the board is taking some time to consider this further.

Chair / department (assumed)

Thank you. That's all for now and looking forward to discussing in committee. Thank you, Denali.

Denali Wilson

Next is Trina Zahler. Trina, your mic is enabled, so you should be able to unmute it and go ahead.

Everyone, good morning. Can you hear me?

Yes, we can. Thank you.

So, thank you for the meeting. It was good to hear some of the concerns that were presented that I share about what I perceive as low didactic hours and some I'm seeing some serious concerns about the way that the practicums are set up by the current legislation. having to practice with actual patients. And so harp on those concerns, but I wanted to add a couple of additional details that may be important for us to think about, and that's about the question of the payment for services.

and trainees are involved and transparency about them being involved and the status or permission to have observers. in like Social work practicums There are some that are unpaid. There are plenty that are unpaid, but there are also practicums that do have an a payment for that internship. And When I think about trainees being involved with actual patients, I think if the trainees are paying an educator to provide those practicum hours and you have patients also potentially paying for services.

It makes me wonder if the patients are going to be paying the same full payment as another or whether by having a trainee involved in their care, if that is going to be a lower cost service. If not, is the educator taking in all of those fees paid or is there something that will be allowed for the regulation so that there can be paid internships potentially, that may not when someone is simply in an observer role, but when they are being observed.

That seems to me as a way to prevent systems from being predatory and wanting to have as many trainees as possible. and making additional money from that. And it also makes it just more cost effective for people who genuinely want to be trained But giving all those free hours can be a real

burden to their life and their families. And then the additional piece... I would love to see that patients are given the opportunity to opt out of being observed, that there's full transparency about what that plan is.

Having been in a room, practicum rooms, where there were a lot of observers in the room, that shifts the dynamic. It really changes the dynamic. the openness and the healing that is possible. And I think it's important that we be intentional with that. And I think that it's important that we figure out what A sensible limit could be to the number of trainees being allowed to observe in that same session.

So thank you for hearing me out.

Chair / department (assumed)

I wanted to make sure that these were heard and have a wonderful day. Thank you for all your hard work. Thank you, Trina.

Do we have any additional comments? Okay, I do not see any. I will turn it back to you, Ian.

Ian Dunn

Well, thank you guys all for being here, for participating in our meeting, for giving us your public comments, for just showing up today. It is so much easier to not go to things than it is to go to them. So thank you for being here. To my fellow board members, I know you guys are not paid. You are doing this out of the kindness in your hearts, out of the appreciation for the state of New Mexico. So thank you to all of the people of the state of New Mexico.

Thank you for showing up to the committee meetings, for helping us draft these, for giving us questions that we may not have considered otherwise. So I just appreciate every single one of you from the bottom of my heart. Thank you again. I will now go ahead and adjourn this meeting. We shall meet again at July 17th at 9am.

And thank you on behalf of the department. We really appreciate the feedback and the comments and thank you for being here.

Yeah.