New Mexico Medical Psilocybin Advisory Board

Full Advisory Board meeting, morning session

July 17, 2026, called to order 9:02 a.m. Mountain

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. you you And so here we go.

I don't think that's a bad idea at all. Free community courses. Honestly, you should have to like... go through Like... approval approval Yes.

As usual, good morning everyone. This meeting is being recorded and so as usual, we want to ensure that we are able to post it to the website publicly. So please remember to keep your language to appropriate language for a public meeting. And this is the Medical Psilocybin Advisory Board with Ian Dunn as the chair. I am the Dominic Zerlo. I am the director for the New Mexico Department of Health Center on Medical Cannabis and Psilocybin. And with that, I turn the meeting over to you, Ian, as the chair.

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 Daily time. I want to welcome my fellow board members, the Department of Health staff, and the members of the public who are joining us today. We have some ground to cover this meeting as we work toward finalizing our pragmatic rules. So thank you all for your time and dedication.

We will begin with roll call and introductions. I will turn over to Dominic Zerlo and the department to take for the board members and introduce the program staff present today.

Thank you, Ian. And I'll just go ahead and go down the list. We have Brenda Burgard.

Morning every morning. Good morning, everyone. I'm Brenda Burgard. I'm the chair for training and education. And I wanna thank you all for coming today. Let's roll up our sleeves today and really take a look at what we have on the agenda today and have some conversation about it. Thank you all for being here today.

Thank you, Brenda. Next we have Chris Piskuski. Chris?

Good morning, everyone. Chris Diskuski here. I think you all know who I am by now. I'm happy to be here. Thank you.

Thank you, Chris. And Dan Jennings, good morning. Good morning, Dan Jennings, Vice Chair of the Board and the Chair of the Research and Continuous Improvement Committee. Good morning. Thank you, Dan. Dezbah, good morning. Hi, I'm Jasba, I chair the Equal Rights Equity Access and Cultural Considerations Committee.

Good morning. Thank you, Desmond. Ian Dunn, good morning.

Good morning, everyone. My name is Ian Dunn. I am chair of the Medical Psilocybin Advisory Board, as well as the Patient Qualification and Safety Committee and the Dosage Administration and Clinical Practice Committee. Happy to be here.

Good morning Ian, thank you. And Keenan Ryan. Good morning all. Keenan Ryan, I'm the acting chief medical officer for New Mexico Medicaid. Also a pharmacist by training, now director of pharmacy. I am the voting designee for the board member, Lana Dances, who is our acting Medicaid director. Uh, She wishes she could be here more often, but as you can imagine, it's a It's more to his time in Medicaid these days.

Thank you, Kenan, and good morning. Larry Lehman.

Good morning. Yeah. Hi everybody.

Larry Lehman, board member, chair of the end of life committee. psychedelic researcher and therapist at UNM. Good to see everybody. Okay, I believe those are all the board members. Did I miss anybody? No, that is everybody, all seven. And so from the department side, as I mentioned earlier, I'm Dominic Zerlo. I'm the director for the New Mexico Department of Health Center for Medical Cannabis and Psilocybin.

And joining us from the department and the program side, we also have Jorge Gonzalez, who is our medical psilocybin program manager. We have Brenda Martinez, who is our Deputy Director for the center. We have Raymond Gallegos, who is an analyst with our program. Johnny Mouchet, without whom we would not have these invites for the program and is our management analyst. We have Rose Nava, who is our Health Education Program Manager.

Cyrus Routman, who is our environmental scientist, Vicente Roybal, who is an intern with the program, and Dr. Robert Truckner, who is our medical director for the program. We do also, as we are continuing with working on the program and looking at implementation, we have some of our other program staff who are joining the SEED because they're also going to be doing things, for example, from potential patients, providers, and providing some information.

So with that, we also have DeAnza Aragon, who is one of our team on our patient services side. And so to be able to be here and hear a little bit of what's happening. So thank you, everybody. And I'll turn it back over to you, Ian.

Thank you. So to review the agenda of what we are going over today, we are going to recap what we did cover in the last meeting that we updated. One of our three core requirements that we needed to solve was the implementation deadline. We pushed it back to December of 2027. What we still needed to vote on was the. to actually defer the educational curriculum to the training and education committee.

the in-person medical exam requirement and then the controlled substance number, which Dominic had deferred to the had rechecked in with the Secretary of Health and reassessed and he may have updates on that we will hear what he heard back um And then other business has an ending with the public comment. Any additions, changes? to the agenda.

Cool. So without objection, we will go ahead and move forward. So as a recap on the last meeting, kind of went over that briefly, but we had moved forward to push that reciprocal practicum hour requirement to December 2027. We will now go ahead and if there is not objection, we can move to a vote on to defer the training and education practicum and didactic hours to the training and education committee for them to solve to reassess and re-come together and have time to come up with those updated standards. Are there any objections to holding the vote?

Cool. All right. So we'll go ahead and move to defer those to the Training and Education Committee. If you are in favor of moving those practicum and didactic hours back to the Training and Education Committee, please raise

your hand at this time.

Cool. I see seven hands. Perfect, you can lower your hands at this time. While I know there is not Casper the ghost in the room with us, I do have to give option. If anyone would object to this, please raise your hand at this time. No, Casper, the motion is adopted. We will send that back to the Training and Education Committee. And then we will work on the updates from the department. So what did you hear back, Dominic?

Oh, you're muted.

Thank you so much, Ian. That's what happens when you go to try to copy and paste some items into the chat. So the first thing I wanted to do, because I know this was one of the questions that had come up specifically was with regard to the in-person portion. And so I'm putting that language, what we have adjusted into the chat. And essentially, just to kind of go over this is, that there would be the certifying clinician would still need to conduct an in-person exam of the patient within the previous six months. So not necessarily at that appointment where they are doing that. They could do that final appointment as telehealth if they have seen that patient in person in the previous six months.

In addition to that, they could also do telehealth or telemedicine if they have done a review of the medical records pertaining to the diagnosis for the qualifying condition from a clinician who has examined the individual in person within the previous six months. Or if that is burdensome, they can do the same thing, but make sure that they have a formal consult with a clinician who has conducted an in-person exam in the previous six months.

So this allows that the safety aspect is there, that the patient has had an examination in the last six months, but it doesn't necessarily need to be the certifying clinician who has performed that exam, but they are consulting with them, or through that formal consult process. And so at that point, I'd just like to say what people think about that. And that would help, especially I think in rural areas, situations that Larry had brought up regarding end of life, all of those kinds of situations.

Oh, and I should, as a reminder, just the board protocols are that this portion is discussion for the board at this time, not public comment. Public comment will be at the end. So with that in mind, Ian, go ahead.

Yeah, I was just curious. So there are several professionals that can perform an assessment, obviously a physician. Would a... an RN who typically performs head-to-toe assessments be able to provide that assessment material or would it have to be another like MDNP, Yo.

That kind of thing. Great question Ian and it's actually why we have the language clinician which actually fits within the statutory language on it and so that would cover for example those particular licensures.

Chris. Go ahead, Chris. So how broad are the gaps Are we trying to make certifying clinician? Can you? break it down. Um, A little bit for me, so I'm understanding. who would be able to conduct this. Sure. So the certifying clinician, at least with the definition that we have currently, is an individual who it is within their scope of practice or scope of work to be able to diagnose and who has a CS number.

And so that's what that would limit for that certifying clinician. But again, remember the consult with the other clinician or the medical records may be from someone else with a different licensure. So We're just adding another layered to this or we're, I don't see how this helps. Now, we're adding other options for the certifying clinician to be able to ensure that there has been a medical exam, but not necessarily to do that part in person themselves, that they could do that through telemedicine.

as long as they have either the patient records or do the consult with someone who has performed that exam.

So if I'm understanding this right, we're going to have. We're still gonna have the certifying clinicians under this proposal. We'll still have the certifying clinicians. Pretty much with the same role they had in the last model, but now they'll just be able to consult with your primary care or an RN who's done a evaluation on you. That's

correct.

How will the liability work with this? Because this still puts a certifying clinician in the chain of liability, which infuses where that liability lies. this process. And it. How does it? But I still don't think this helps encourage anybody to become a certifying clinician when all of the risk mitigation comes from you know, the preparation, and administration practices and the integration from the facilitator and the practitioner.

So, I don't, really think this helps. In any way. So to answer the question, it doesn't change the liability. Any individual who is performing or engaged with regard to a controlled one substance does have to assume that liability. But as we've sort of talked about before, we've had that situation for almost two decades with cannabis, and that has not been an issue or a problem. But you don't do cannabis with somebody who's performing all the risk mitigation for that practice.

Thank you. Hmm. At the same point, the clinical or the certifying clinician is simply certifying that the individual has been medically clear. They are not actually conducting any of the administration or administration sessions. So that liability still would reside where it has throughout the entire process with those individuals. With you're saying all the liability lies with the with the facilitator and theAre you a practitioner?

JOHN MUELLER: No, I'm saying that it hasn't changed that. Having this simply ensures that the patient has had an exam to ensure that they medically are able to go through the treatment. That's all that it does.

um ryan you're next thank you i'm sorry my apologies it throws me off every time when i see uh the last name comma first name so my apologies keenan i get it it's it's the way the state reports our email you know our zoom pieces as you know A lot of my initial questions were actually answered by the questions Chris asked, so thank you for that. the initial certifying physician is providing that they're one medically clear and two have diagnoses appropriate for this is that correct That's correct. Okay, so it should be those two pieces that they are healthy enough.

To investigate this, obviously the final determination should be made by the facilitator and the member patient together, informed decision making to make that on them, but that they're healthy enough, potentially do this, medical risks are probably pretty minimal, but say if they have uncontrolled hypertension, et cetera, should not be looking at it. And then Ah that they have one of the approved diagnoses as we set forth, right?

Okay.

Ah, that's helpful, thank you.

Thank you, Kim.

Ian, you are next.

Yeah, so just to clarify, 'cause I think it kind of kind of addresses Chris's point.

So typically in medical torts, We have...

a duty and a breach. So in this case, the duty of the a certifying clinician is to evaluate their health records and their current physiological state.

So a breach could only happen if they failed those duties. Therefore, if like the facilitator, the risk mitigator down the line has a duty and they breach it, then that would be on them. It wouldn't be on the facilitator.

the Certifying clinician, am I understanding that correct?

That is my understanding as well. Larry?

Yeah, two comments. One on the risk part of it. What Ian says is sort of true, but it doesn't actually usually help in a lawsuit. They bring anybody in, including the person who is cleaning the hospital room. So it doesn't usually

help in that way. I don't know if there is actually a way to actually be clear in the stipulation, actually that even says this individual is not responsible. I wonder if there's some way we can be more protective of that clinician there. That's really a question for any of our lawyer friends that might be on the call.

The other question is, it's come up several times that some of the requirements for the CS number has to do with psilocybin being a Schedule I substance. slam dunk I think almost almost everyone thinks that by the middle of 2027 if not sooner it will no longer be a schedule one it'll be a schedule three and I just wanted to you know get an idea if that would allow for a different approach when you're in schedule three than when you're in schedule one I think that's a question for you Dom Yeah, if that were to happen, that could definitely be re-evaluated.

And let me just then share from my own knowledge from being a researcher on some of the phase three. I mean, the, oh, there's not a slam dunk when we thought this was true with MDMA. That is the overwhelming feeling that's likely to happen. So it may be important for us to be just considering that as we move forward. Thank you.

Thank you, Larry. Chris. I'm curious.

So my understanding of psilocybin is that it is incredibly safe. And I think that some of the cardio vascular issues that we are concerned or are concerned Um, and that are commonly brought up are vastly overblown. I'm wondering, Dr. Lehman, if you can speak to the safety of psilocybin and where the real physical risks lie.

Dr. Lehmann, would you like to respond? Sure. Thank you, Chris. It's not a one minute answer, but I'm going to try to give it a so much shorter answer. I think it's true psilocybin on the risk of substances is very low. There's been charts. There's almost no risk for, for instance, for addiction. The issues come up with people that have comorbidities. If you have someone who already has some cardiovascular issues and you raise their blood pressure, then they could find themselves having angina or even a stroke. So I think there's in those situations, which should be reasonably easy to screen for. So I think that'd be part of it. I think that there are other risks that have to do with mental health and with challenging experiences. That's probably the greater situation.

I mean, one way, and unfortunately, I'll be honest, I don't think all these are getting recorded. literature because I keep hearing about cases, but the concerns that happen are people being transported to the emergency room for challenging experiences, which part of the risk there actually becomes iatrogenic at the point when that happens. They're not unlikely to get an antipsychotic treatment admitted to a mental health hospital. So in some of those, the medical system creates those risks.

I am aware of also, that there are no cases of serotonin syndrome. There seems to be one that I've heard about anecdotally that occur. So those are rare. But I think, Chris, in general, I would support what you're saying. This is a very safe substance. We have tens of thousands of people now in Oregon that have used it in just a handful of issues. I would say it is a very safe substance. Chris, did I answer that?

Yeah, I think so. And you're, I guess, I'm still struggling with the necessity of having somebody with a controlled Um. Substance license number. having to be involved in the screening and medical safety of such a safe substance. Yeah, I would, well, I'll go on a little bit of a limb. So I would say that that would not be necessary for everyone. It probably wouldn't be necessary for someone with just major depression.

I think it would be essential for somebody who had opioid use disorder. And so I think that in the system, if I was designing a system for scratch, I would go back to doing it based on an indicator. and say these indications need that. So that's what I would do. So this is not exactly how I would design it. And I think to be realistic, I mean, we're being required to do this by the executive division.

And so I think that's why we're here. And even though some of us don't agree with it, I think it's going to be hard to change that. I do think, though, that this is why I brought up the scheduling. Yeah. may be a major way that we can revise things in the coming year. But no, I would not require it for everybody, Chris. And just to be clear,

so I will go back for a moment to the part about the controlled substance number is at this point, you know, I did bring the concerns that were expressed previously back to the secretary. We had a discussion about it. We have talked with the attorneys as well for Department of Health.

And really this being a medical program that is going to be a requirement that the department is putting forward. And so, Just to let everybody know, it is a medical program, does need to go through that. The part Larry just talked about with regard to doing it for different considerations, we understand that we can't actually do that for one condition, but not for another within a regulatory framework. It has to be done across the board for that.

And so with that in mind, because there are circumstances, especially with some of the comorbidities, where people do need to have that medical clearance, do need to have that. That is something that is going to be proposed in the rules for the department. So just to clarify that, that is going to be an aspect. I did bring it back, as I mentioned, to the secretary. And that is, however, going going to be a part of it.

So within that framework, We need to look at this language within that and to see is this going to allow for that additional options, especially with regard to rural areas and with other areas such as end of life and other things to be able to provide that access. So with that, Keenan. Can I just ask one question, Dominic? For members from the DUH who have this historic knowledge, is this the same requirement that was required for medical marijuana when we started or medical cannabis when that program was started? Do you know?

Yes it is. It has always been required for the certifying clinicians to have a CS number.

Perfect. That's good to know. I think that helps establish that we're really following existing protocol. If it wasn't in there, I would make a strong argument for it to not be here, but as a standard, I'm okay with that.

I do think it's important to separate out clinical risk and the legal risk. I think we keep using risk and they kind of get mixed together. I think the clinical risk, as Dr. Lehman said, is These are safe nets and safer than a lot of Other agents we give that aren't even controlled substance. There's plenty of non-controlled prescription medications that are way more toxic, I would say, than these.

That said, I wouldn't recommend someone who recently had a heart attack Uh...

to be ready for this until they're cleared by a cardiologist, right? Like, I think that's what we want this sort of finding physician piece to say is that, oh yeah, you're, The risk is short term while you're on this guided experience, you could have some high blood pressure that could cause an urgency or emergency depending on the state of your cardiovascular system. We just want to make sure that you're healthy enough to go through that specific piece at that time.

So I hope that kind of helps clarify what, what, I was trying to... Explain earlier and if I'm speaking out on something that's a little different than you see Dr. Leeman or anybody else, please,Please inform me. Okay. Thank you, Keenan. I would like to defer to Dr. Truckner from the department. Dr. Truckner. Thank you. Thank you, Keenan. I think you answered my question. Chris, the medicine may be safe, right? It's not a toxic medication.

But the worry is the safety, the health status of the people who are taking the medication. Right? But we are going to have in general, a much sicker population if you want to use that they're going to have other comorbidities. And as Keenan's example, if you had a recent heart attack, do you want to do that? If you have diabetes, do we need to make sure that's clear? So the medication may be safe, We are gonna have a different patient population in the state and I generally expect that they're gonna have higher illness burdens. so to speak.

So that's why I believe this is necessary. Thank you. Thank you. And next we have Despa. That's fine. Hi, thank you Kenan and Doctor Trepner for those explanations as well as Larry.

Larry's point You know, it sounds like to assess actually three different kinds of risks.

One, the risk of the substance itself. Two, the legal risk, as Kenan pointed out. And then three, as Dr. Truckner also kind of is associated with the legal risk, is the health risk of the person.

Aside from the substance itself, right? So one is, dependent on the other. But to that point and what Larry had talked about earlier, you know, as long as the substance is, you know, and then maybe this is completely over overdone, but you know, as long as the substance is remains a control of, you know, a class one, right? Schedule one. This is how these are going to be conducted, which then alleviates this idea, right?

I think Larry, to your point that in the future as a schedule three, THEN THAT'S That kind of eliminates itself, kind of like a BCC in some ways of this idea of the substance. I don't know if that makes more sense. And I don't know if that's even necessary, but I think that's what I hear Larry was kind of getting at as far as you know, it's, this is way now, but allowing us to be able to, as it's moving forward, then this is when, when it will be reevaluated.

Thank you.

Dan Jennings. I appreciate it. And the question I was going to ask, and I just noticed that Kenan put in the chat that he's away. But so my question of this is, this would be an additional expense for a patient to go through because they've already seen their primary physician. They've already got a diagnosis. They've already been, you know, they're through their medical evaluations there. So this would be somebody else.

So the question I was, is this like an E&M visit? Is this something that can be covered under basic insurance evaluation and management? insurance, Medicaid possibility that the clinician that we're talking about here Could be billable back to insurance. Like I said, I just don't want to, I mean, it's going to be an additional expense. So I just wanted to check on that. Sure. Thank you, Dan. And I'm going to defer to Dr. Treppner since he's more of an expert on that aspect than I am.

Yeah, hi, Dan. Yeah, that should be available. That really should be available. fill the one door in the validation management code. I appreciate it. Thank you. Chris. I guess I just want to challenge this notion that our population is going to be so much more vulnerable than the populations in Colorado and Oregon. I've talked to too many people working in both of those states that are working with very sick people.

They are able to do these evaluations at a much lower level and effectively and work through consultation with people's Yep. people's existing the air teams. You know, you can buy a ticket to Burning Man for the same price that you can go get treatment in Oregon or Colorado. So I'm just... I'm really struggling with that. thought process that our population is so much sicker than and more vulnerable than the people that are doing this safely and effectively in Colorado and Oregon.

Thank you. Larry? Larry, you're still on mute. Thanks. That was what I was thinking about. Here's my global thoughts on this here. I mean, I think I've already given my thoughts on how I would design a system if I was given ultimate power. Clearly, none of us have ultimate power, and we're kind of dealing with the requirements of the legislative and the governor and the fact that it is a medical bill.

I see that there are a couple of things that may happen.

future. We may get rescheduled into Schedule 3. I think that's extremely likely. And so a question I would have maybe for Dom is like, you know, what is the actual, you know, process then for us to change the process if that happened? The other issue that also there's concerns are is that the process that we're developing will be a big bottleneck. And I don't know. I mean, we have opinions either way.

I think it might be. I don't know. Again, if it was, what would be the for us to change the certifying clinician. Because I think if we can appreciate that we have a way of changing that and that we're likely to have a schedule three drug, maybe we can move forward with, you know, apparently all we're really going to be allowed to do is to do this approach. And maybe we can have unity on that, even if we don't all agree with the approach.

Thank you, Larry. It would be a similar process as far as with doing rule changes where what we essentially would do is go through the publication of the proposed rule, have the public hearing, and then make those changes based upon the feedback and public comment from that public hearing. Did you have something else? No, I think that answered both questions. Thank you, Dom. And again, I'd like to defer to Dr.

Treppner. help me out here is that I mean I am I've had a DEA license forever and I just never really paid attention to what it allows and doesn't allow isn't a schedule three drugs still require a DEA license?

You know, I'm just not sure. It's a... It requires a different kind of right now. There's probably like three people in the state that have a Schedule 1 license. And I think right now we're all at UNM. So they're very strictly regulated. Partially, it's based on a fallacy. It's based on the idea that the Schedule 1 drugs have no benefit and are abusable. And this one is... Neither, which is true about this one. So I think it will get moved out of there.

Yeah, that was really a question that I had as far as how that would change in the state. I think it changes somewhat about how the way view different drugs. But yes, you still need a DEA license, but you wouldn't need a Schedule 1 DEA license. Thank you. Yeah, so I guess my main point is even if we reschedule it for most of us, quote, normal physicians who don't have the special license, I will still, for a Schedule III drug, for me to prescribe it, I'll still need a DEA.

Therefore, I'll see us licensed in the state of New Mexico. Right? Bye. Yeah, that would be true. But I think this isn't really a prescription. This is like a form that we're completing. So I think that may be the difference. I totally agree with you. Your robot wouldn't change that part of it. We also don't even know exactly how, for instance, if psilocybin, how it's going to be managed. It's unlikely to be a prescription that you bring to a pharmacy. It's likely going to go through like a REMS process.

Chris.

Okay, so. Are we requiring One of those three people with a Schedule 1 DEA license to do this? No. Nope. So But this is like completely contradictory. We're saying you need a DEA license to prescribe because it's a schedule one substance, but we're not requiring the people with the schedule one substance To do this,No, Larry, were you gonna say something? yeah I mean Chris that's a great question and there's a lot of contraindication to this we're basically dealing with the state program that is um is sanctioning the use of something that's a federal substance based on state law so that's why there's seem to be those contra contradictions there um um I think there's awareness that it's extremely unlikely.

It's always possible if you had some change of heart in an administration that they could come down in any of the three states. I think that's... extremely unlikely to happen. But I think that's the contradiction. The Schedule 1 is based on a federal law that we can't change. But if it's changed into Schedule 3, in general, people start viewing it as a different drug. So the question would be more, if it was moved into Schedule 3, would that change some of the political realities about a medical bill and being able to establish another process?

There's another part that was in my question, really, which was, if it turns out, that we probably will know within six or nine months, whether this is a big limitation, how hard is it to change it? In other words, if this moved ahead in January '27 and six or nine months later, it was found to be a big obstacle, which I think is a reasonable concern, but I don't think we know that'll happen. How hard would it be to change that?

Part of this I'm putting in the context of that I'm very much hoping that there's going to be a fix-it bill because what's going to be presented in the training committee this afternoon is impossible to do adequate training without having the ability for people to use psilocybin in the training. And I think one of the hopes of that fix-it bill is that it'll include major depressive disorder, which deals with another major limit.

I mean, I think that was our intention to do that, having been part of the bill formation. that gets changed, it'll probably triple the number of people who are eligible based on the criteria. It'll make training easier. It'll also mean that there are more people that are being treated that are not quite as sick. So I think a lot may be

changed. And personally, I suspect that we're going to be revisiting things after that bill revision. That's my own prediction.

Didn't the Didn't the bill, didn't statute remove this substance from the schedule one? List. I don't remember it reclassifying it. So it only does so for the purposes of treatment within the program. But part of what this is, is that with it still being Schedule 1, we still have to have those assurities because it is a medication. And so with that, that is why it actually has the CS number. Because while it is not a prescription, it is essentially treated as such going through this process, even though it is not a prescription on either a federal or state level.

Having that requirement actually helps to bolster that aspect that it is similar, although it is not a prescription, that the certification is similar, but not a prescription. And so, Dr. Tretner. Chris, I think to try to answer your question, first, no, you're not going to. let's go back a couple steps the reason we developed three pathways for a patient to be able to enter the program is because we heard your comments saying, hey, getting to see a certifying physician may be a hardship for a lot of people.

So by giving three different options, you can live in some small town in New Mexico.

Silence.

And if I'm a certifying clinician, I can talk to your doc and say, hey, Tell me about patient X. Show me their medical records. Okay, that seems reasonable. So this was our attempt, and I think it's completely reasonable to open up the ability for patients who don't have access immediately close to a certifying clinician. It gives three different options. Now, to go back to answer your question about controlled substances, I think, Chris, in the world of medicine, a large number of physicians, a large number of nurse practitioners, and a few others all can qualify for a DEA license.

So there's actually a fairly large pool of healthcare providers who have or qualified for a DEA license. So that's not really a barrier for this at all. I hope that helps answer the question.

Chris, go ahead. Can we okay I feel like this got dodged and did Does statute remove psilocybin from schedule one substance list in New Mexico? So as I said, Chris, it removed it for purposes of the program, but it did not completely remove it from Schedule 1. But again, the issue is that it's still treated as a prescription. Prescriptions are actually not written for Schedule I with, as Larry said, except for very rare circumstances. It's really on the Schedule III level.

on that aspect. And so, but what we're trying What we have seen with medications such as cannabis that are illicit on the federal level but legal on the state level, the certification from the provider is treated similarly to a prescription. And so that's why We're doing the same sort of situation here because then that helps to create that same pathway that we would with any other medication. And because the bill is showing this and treating this as a medication and a medical program, That's why that's a part of why that aspect is there.

so that it follows that same already established pathway. But my point is we're we're setting up this program so and it was descheduled for this program. It wasn't rescheduled. It was the same situation that we experienced with cannabis. And so that's part of why we're following that same pathway.

That's Bob.

Okay. So I think, and I probably have this wrong myself, but What it sounds like is... I guess I'm just trying to understand when I'm hearing the medication, the prescriptions, right? So there's a difference between why an RN and a nurse practitioner can prescribe medications, right? So there are certain scopes, I guess, of who can actually prescribe a medication. Nurse practitioners can, RNs can't, they can only administer.

So that's like one layer. The next layer is like the classification of the substance is federal level, right? Schedule 1. And as I'm hearing it in New Mexico, it's because there's like an addendum to that for the purposes of medical use and treatment within the state because the state then has decided for itself that we are going to be moving

this forward regardless of what the federal is doing, you know, kind of sort of like the right hand, left hand kind of situation.

So we're able to then, you know, have our own rules and regulations and saying that we're going to use this substance for this medical purpose. So there's kind of like two, I don't want to say conflicting, but two different pieces and layers. One where it's a medication, one where it's a schedule one classification. But with the addendum, then it kind of moves it into this like, middle ground gray area.

Am I kind of understanding it a little bit as like the two different or three different sides?

Yes, overall yes. And Ian?

Would The whole controlled substance part seems to. cause issues, would it Make it better if we just did the dangerous drill drugs license, which is to prescribe everything other than controlled blood pressure medication, antibiotics. Anything that has to be done under the license, like someone has to supervise and care for your health, With that... be better for anyone?

Chris.

Could you elaborate on that and who holds these licenses and how many are there? And I guess I also would like to know how many people with DEA licenses are actually in New Mexico. Do we have those statistics?

I'll defer to Dr. Tretenor. Yeah, Keenan may have a better answer because he's got all that data. But Chris, most medical practitioners can qualify for a DA license or a controlled substance number. So that number really shouldn't be a bottleneck, by the way. And Larry, you have your hand and then we'll go to Keenan. Yeah, thanks. Yeah, this is some clarification for myself. And if I need clarification, I have all these licenses.

It's kind of interesting. So the controlled substance that we're requiring, is it the state controlled substance license or is it a DEA license? I have a general DEA license. I have a Schedule 1 DEA and I have a state controlled substance. But there are people that have the state controlled substance that don't have any DEA license. And I'm just trying to clarify what... which license you need to have for the certifying clinician form. Thank you, Larry.

It's the state controlled license. controlled substance license. Is that Okay, and Denali, I guess I'd ask Denali, she's mentioning different variations, different licenses, and mentioning GLPs and different ones are not scheduled and prescribing. My understanding, and again, I may be ignorant here, is that I need that controlled substance license from the state to prescribe anything, but maybe that's incorrect.

Well, Yeah, we'll go to Keenan and then to Dr. Trefner. Yeah, so if we're in the state of New Mexico, you don't need a controlled substance license or DEA license to prescribe non-controlled medications. It's determined by the scope of your, whatever, professional licensing board. For example, I had pharmacist clinician license. I still have it. I just don't have an active protocol since I moved to the state where I could basically prescribe any antibiotic I wanted.

medications related to the treatment of infectious disease processes, but did not hold a controlled substance license and therefore didn't prescribe any of those agents. So that's the distinction. I would say that making it a controlled substance license in the state is the right If the requirements that you have to have one of those definitely at the state level and not requiring a federal one because I think that requires There's more jeopardy there if you're going to be using something that's still a Schedule I on the federal system and making that our licensure mechanism for it. So just to add those pieces, as Dr.

Tucker said, the amount of people that were like me that had prescribing but not controlled substances is pretty small.

Okay, Dr. Trucker.

Yeah, Larry, I'm like you. I've had a bunch of licenses, not the schedule one, but I've worked in 10 states and I've never had to have a state controlled substance license before. So to be honest, maybe Keenan knows this answer. I don't know why I need a state controlled substance license and how it differs from my federal TPA license. Keenan, do you have any insight into that?

Because the state regulates controlled substances on their own schedule different that they require that, and that's a requirement of the state, some joint authority there. What the rationale for that was, I'm not exactly sure. I'm not sure if that's specifically to allow us to diverge. From the federal DEA schedule. And so I would be guessing, to be honest. I just know, like you, that it's required.

And I actually reached out to the pharmacy board and asked that question and I haven't heard back from the inspector yet, so. Larry. yeah i mean just just to address part of what denali is bringing up which i think um Can we specify that you do not need a DEA license, that you just need the state-controlled substance license? It's not both of these? I mean, will that... Maybe that's already clear to some people, obviously it's not clear to me.

And would that increase the number of providers and be acceptable to everybody? There is not a provision that you must have a DEA license within this proposed set of regulations. So we don't need to specify it separately otherwise.

Okay. Hmm. Thank you. Hello. Thank you. ---This is a question for, hi, thank you everyone.

It looks like Denali just updated the chat. It says it appears that you have to have a DEA license to get a CS number in New Mexico so that. is So it's based on a federal regulation.

Which if I'm like, you know, it's just good for me or anyone else to know. It's like, okay, how do I obtain this? I know that there's not necessarily a flow chart. I'm all about the flow chart. I wanna know what I need to do in order to get the thing that I'm trying to get. And if there's not a flow chart, I get lost. So I get frustrated, I get angry. Brenda? Just to be clear, so it looks like you have to have both in order to prescribe psilocybin.

Well, from a regulatory standpoint, it's just the controlled substance number. As Denali is stating in the chat that you have to have a DEA license to be able to get that. And again, we have reached out as far as to the Board of Pharmacy about that. But I really want to reiterate at this point that we did bring these concerns back to the secretary. We did go over those aspects and the concerns, but the department at least is going to move forward from a regulatory standpoint with that as a requirement Thank you. Not to fog your day.

Not to flog a dead horse, which I may be doing here, but if I understand Denali, what you're writing there, that's not for a controlled substance, it's for a PMP account. A PMP account is simply so that you can look up prescriptions for controlled substances on an account. So I don't think what you posted there answers the question. I don't know the answer to the question, but I don't think that the PMP is not equivalent to a CS.

Sorry to jump everyone.

That is correct, Larry. I'm in the Board of Pharmacy's rules right now trying to build on this specific piece for you. Pretty well.

And Ian. So as I am also now trying to drill down on the Board of Pharmacists website, I found what I would need to apply for a CS number and it does not have a DEA requirement and then on the DEA's website a state license is required for a DEA license. So I don't think it would be a catch-22 and no one has a DEA license. So... Thank you. That was all I had. I had just been researching. Thank you.

Thank you. Dr. Truckner. Yeah, right. I think in a second, I'm going to leave the CS license, DA license. In this state, my understanding from talking to one individual who isn't the inspector person who has apparently all authority, it was... You can apply for a CS license in this state for up to a year, but then you have to get a DEA license. So in this state, again, I've worked in lots of states and this is an unusual state.

In general, at some point to have a CS license, you're going to have to have a DEA license. Getting a DEA license is just answering some questions and writing a large check. it's not that difficult to get. And the second question, Chris, I wanted to bring it back to liability just for a second. If we're, let's take Colorado, for example. And so, as you said, they've gone through thousands and they just check with their regular doc.

So, You want to go on a journey, you go to your regular doc, they seem to say, sure, you're fine. They don't have any real particular knowledge about psilocybin. They haven't been trained about psilocybin. And then they come to you and you as a facilitator, given their journey, then something goes south. And so... The liability, if I'm a malpractice lawyer, I'm going to have a field goal. Because you're going to say you are certified by a physician who has no knowledge of psilocybin.

Um, And, you know, the lawsuit is going to win. It really is. At least here, the certifying clinician is going to go through education specifically about psilocybin. So there is going to be a protective layer there. So if something goes south, Chris, your liability disappears. facilitated. Yeah, it's there, but I would believe a lot more is going to land on me as the sort of phone Okay. Because I will have a malpractice policy.

Thank you. Chris. Yeah, it's not... I think really how Colorado works in general. As a facilitator or a clinical practitioner up in Colorado or clinical facilitator rather, you will do all of the. processes and then if there's any kind of contraindications, then you can. Consult with the patient's doctor or consult with somebody that couldn't help them. You know titrate medicines or check for safety of certain contraindications. It's not a certifying clinician.

nobody certifies you from that point. If you work with a patient as a facilitator that is That is, the liability remains with you. It's ultimately up to you to determine the appropriateness. Of the patient and you're trained to do that.

Any additional comments?

All right, that's all I have. I'll turn it back over to you, Ian.

Alrighty, well, so if you're interested Is there any more discussion between the board? Does anyone have anything else that they would like to say? Are there any objections to moving forward on a vote on the CS number requirement? Chris? Yeah, I just wanna say, I don't think, That.

This any of the new regulations increase access. I still see this as a major bottleneck. I don't see this as I also see this as. Uhm? shifting liability where to a larger circle of people where it needs to remain in the room with the patient. And I think this ultimately just sets up signature mills that actually do not Um, Do not. provide any extra layer of safety at all. Thank you. Thank you. Does that?

Okay, so again, kind of for clarification, what it sounds like is that What we're actually voting on is where... we place the CS1 requirement. Where we're actually placing that language, what in what part of the process that we're actually placing it because. Um... There it has it just has to be and what it sounds like I'm hearing from Chris is kind of slightly different is like if we're voting on the CS requirements. Are we...

It sounds like from what I hear Chris is saying is that there shouldn't be a requirement. And that it's providing more of an added layer to... uh how this is getting administered in the process, right? But what I'm hearing from the The department is that we have, that's not what we're voting on. We're only strictly voting on where in the process we're actually placing it and giving it a little bit more room to breathe and a little more leeway that it doesn't have to be the starting point. It could be anywhere kind of sort of more loosely tied to it.

And I just kind of wanted to make that clarification because if our hands are tied as far as like it has to be in the regulations, then I can understand that we're voting to like where we're placing it. And I just wanted to make that clarification. Question. So you. Currently we're voting to put it kind of almost on an outside gate to the program. They basically would check in ideally with their primary care. If they are not registered, then it would be a third party online service that would review their medical records and then go on from that.

But just as a clarification, it's not a CS1, it's just a controlled substance number. There's only three people with that CS1 in the stay-in. I don't think Larry has enough time. So, um, But anyway, Larry.

Yeah, I mean, this may not affect how you're invoked, but I do want to clarify something is that, you know, if it was possible to just have prescriptive authority, but not a controlled substance license, which is not, I don't, I'm trying to figure out how many people are in that category. I know people that work with all healthcare systems are required to have a CS license. I think people often are for reimbursement.

So I feel a little like maybe we're doing, different things. And I would actually ask Chris then too. I mean, Chris, if it, if it said that you needed to have prescriptive authority, but you didn't have a controlled substance license, would that change your feeling? I have a feeling it wouldn't. And so I feel like maybe we're, we're debating the wrong thing, you know? Yes, I understand what you're saying and I might need a little more information about how broad that then makes makes this might. You know my main concerns are about accessibility and I don't think.

under these regulations, this makes it accessible and increases safety in any meaningful way. And I feel like it's a bottleneck that'll ultimately kill this program and just make it unsustainable from a full I mean, my wife can't even get a primary care,Thank you. And we live in Albuquerque and this is not shifting anything Uhm? from from, you know, making her be able to see a physician or a doctor that's taken this specialized training that is willing to accept a large amount of risk, especially because they're They're not doing any of the risk mitigation.

They're not writing a prescription and sending people home. They are going to need to, I mean, if I were a licensed holder and a certifying clinician, I would only be willing to sign off on this for 10, people working with care teams that I was familiar with because they're the ones that are going to really make sure that this is safe and that I'm not gonna get sued for malpractice because if I just sign a paper and they go work with somebody, Um, I don't know.

that that's going to go well. And I think there's a lot of uncertainty in that whole process considering this program is barely standing up. And so how do you even bet that? But I mean, how much more broadly will that open up? Um, The practitioner pool or the certifying clinician pools. This is Larry. I I don't think it's going to open it up very much more, but I'm curious. I know Denali has mentioned in the past that she knows a DOM that's in that category, but I don't think there are very many people in that category.

So I think before we get too fixated on the CS versus prescribing facility, it would help to know that. It does sound like we don't really have a choice actually at this point in time, to be honest, but I think it's important to know. The other question, this is actually for Anne, if she's still on the call, Anne Metz.

He says, usually people are referred to Colorado psychiatrists. I think that's probably for things like TRD and PTSD. How hard is that to get people in Colorado psychiatrists to see people? How is that playing out in Colorado as far as the malpractice and liability concerns? And I don't know if you're on the call and still open to commenting on that.

Because it has specialized information, I will make an exception this once to allow for public.

input and your microphone has been unmuted.

Sorry about that. It clicked on and off. My name is Dr. Ann Metz. I'm a clinical facilitator in Colorado. And in general, the way that the workflow happens in Colorado is that people are referred to individual providers, usually if they have any risk factors at all or any contraindications that are sent to a clinical facilitator. And in the course of screening, if it warrants medical clearance or any sort of approval, there are a couple of designated psychiatrists in Colorado. Herman Ascandi is one of them.

He's one of the Prattie facilitators. He has his own healing center. And he typically can do a consultation within the week. So I think the way it's worked, and it's worked quite well, is that there are just people that are sort of on

call and do it as a consultation business for different healing centers in the state. But it's really only in cases where there are, it's not necessarily for treatment resistant depression or PTSD. It's when people have pretty significant medical complications and we wouldn't want someone who has an MD to sign off on whether or not this is appropriate.

I would say that Herman's opinion, and he might be a great person to bring into a meeting, really is that if someone's able to walk up the stairs without any difficulty, They're usually okay to do psilocybin. So I think that some of the caution that we have around The contraindications for psilocybin and also the medical complications might be a bit overblown. In practice, Colorado's had very few medical issues that have come up, and the screening process seems to be working quite well.

Thank you, Anne. I appreciate people allowing Anne to speak. Yeah, I just want to clarify too what I said. I think it is the mental health concerns and the challenges that I think are more seriously of a worry than I would agree. I know her mom well, actually. I would agree that we're cardiovascularly, if you can walk up three flights of stairs, you're probably at low risk, although there would be some exceptions, such as the person who had a heart attack and had angioplasty or something. So there are specifics. Thank you very much.

Chris, sorry.

Yeah, and I just want to point out that you know the Colorado program allows for doctors and psychiatrists to focus on the patients that really need it rather than. trying to bog them down seeing every individual patient that it'll be unnecessary. Get the extra layer of safety where it's needed and let you know, let this be handled at the lowest level possible otherwise. Perfect.

Then Ryan, I mean, Keenan. Okay.

We could make a fun coffee drinking game for this every time. We could all be highly caffeinated. Chris? Let me ask something, if you don't mind, if what you're envisioning. I think the line and volume of individuals between people with a controlled substance license versus people who have are allowed to prescribe So an active prescriptive authority, which is probably harder to actually pull than a controlled substance.

license, like that's a much harder piece to pin down. versus Um... What I'm hearing from you, and I don't want to put words in your mouth, so tell me if this is really what you're getting at. It almost sounds like you would prefer a system of self-referral. And that's hard. And then I guess that's what I'm asking about. These people don't need to have a certified provider. They can just show up for request therapy.

Is that what you're trying to... Is that what you see as the point? Because I think that's... That creates a separate bottleneck about who can diagnose because you would have to have these indications and that may not be all the people that provide the service. So I'm just putting it out there, but I'd like to hear your opinion. No, I... I see a system in which people could show up with a diagnosis to, uh,Yep.

practitioner, I guess is the word we're using here. And then at that point they would be medically screened and psycho logically screen for the program and any contraindications then would be required to Um, And have various levels of commonality consultation involved said. allow the patient to participate. And if they don't exist, then the practitioner at that point would be able to Um. to be able to proceed just based on the diagnosis.

At one point we had the certifying clinician just holding diagnostic authority, And that seemed to be broad enough. And I, again, don't understand necessarily why who all that opens it up to, but it seemed to be broad enough to where the accessibility issues were not concern at that point and so if we were to move back to diagnostic authority as being a Um, you know the person that clears i might be more amenable to it but Under the current regulations, I just don't see.

how we can Sustain a program you know even even from a. from a propagation standpoint, I don't think there's going to be enough people for a grower to even be in business. So. That's kind of how I'm approaching this. Yes,

if I if I may. So I think we are probably talking about similar things, just a different word. So the certifying Provider in your mind. Because the diagnosis has no relation actually to the referral to treatment. Is that a fair way to say it?

Again, I'm trying to better understand. I'm not trying to say that's what you're saying. Yeah, I mean this. I think this is going to be limited to a very few number of doctors and nurse practitioners who are willing to accept the risk. Take the training. And We're already critically short on doctors. And so I don't, I think that the vast majority of people would have any relationship with these certifying clinicians.

at all Yeah, and. I appreciate that. I think the question in my mind is, do we create something new that's never been done before? Or do we look at what we've done that's the most similar and apply that? And so I would say a lot of those arguments you're saying were also things people brought up about medical marijuana licenses. Previously. I remember working in clinics before it was decriminalized and we had this pharmacist come in for it, but our physicians that we saw saw these patients with And while there were some people who chose not to do it, it was largely for an age cutoff. They wouldn't do it for anyone under 25.

for some neurocognitive development reasons. this wasn't the issue. And so, I am voting designee. I am not the official member on the board, so I will stop here, but I would just say that this has worked in the past and we've seen it work and provide access and so We could do something completely new and we take more risk that way. We use the system we've used in the past. We have some, nothing's perfectly safe, but some safety in that system.

I would counter that this is not marijuana and again all the risks mitigation comes from preparation, proper preparation. proper administration techniques, and then integration care after the administration of the medicine. You're not sending somebody home with a prescription of marijuana, which they're performing themselves. the care team, the practitioner, the facilitator are going to have a very large role in how well the medicine works.

And if we just open this up to where doctors are signing a paper saying you're medically cleared, go work with whoever you want, it's going to open the door for a lot of risk involved in that process. And I don't I don't think doctors are going to be as willing to accept that risk as they were with medicinal marijuana, where it's just a basically a prescription and take two of these and call me in the morning.

This is totally different. kind of ballgame Thank you.

as an example, In agreement with Keenan, we Someone has to check in and so we're talking about this like it's a program ending decision to require controlled substance licenses and in reality, I think this year there's what 70,000 patients, Dominic you can correct me if I'm wrong. But in the ballpark of that, and so it's able to maintain a patient population. If we had a similar, you know, you have to get a renewal every month, year, maybe two years, then we could maintain the same amount of physicians that are maintaining the medical cannabis program, assuming that there is a huge crossover in those types of patients.

Oh, 60,000, my mistake. But We can definitely support a... market been large enough to sustain the program. I don't think a controlled substance requirement is going to be cataclysmic. Thank you. And then Desva. I think I just kind of wanted to get clarification with because we were talking about different risks and like we're using the same word for different like categories and I just wanted to understand from Chris like what was the risk that.

Is really concerning because to me in my mind, you know identified like the legal the legal risk the health risk like heart problems Etc. I mean three flights of stairs versus like the actual medicinal risk and when you use the word risk Which one of those three particularly is like the troubling aspect of it? Or is there like an even completely different category of risk in in? you know, It came to me and then it left as far as like this idea of the medical person signing off and then it's opening up risk like we're in that and I understand like we have a lot of desire to kind of sort of be patriarchal as in not the patriarchal but um when you're being fatherly and and then it's kind of like the role of the government in general is like Hey, we know better than you as far as...

Like your health and everything is concerned. It's very very Patriot patronizing. I can't remember is a patriarchal work, but and I get it um And I and I totally understand kind of coming at it from like this own agency our own accountability our own responsibility But then it's just like where do we meet in that middle ground again? It's the middle ground of these of patient responsibility medical responsibility government responsibility And then also like, yeah, let's trust the universe to like take care of us all.

And I know that's where eventually all of us are probably trying, when I say all of us, I'm talking about the psilocybin kind of environment and those in meditation practice type people is that we're trying to trust that these things will be okay. And that's where at least I'm trying to come from. But how in my agency, and I feel like Chris is doing this, and we're all doing this, To the best of my ability and to what is falling on my consciousness, right, to be able to be thinking about the whole universe and the whole world and all those constituents of the state, where in that universe What idea of risk are we falling in for you that is preventing this kind of like meeting in the middle ground?

OK, well, I'll start with your last comment there. I don't think we're meeting in the middle ground anywhere. We're still requiring access through. controlled license number, which is the big hiccup or big access issue to begin with. As far as risk goes, It's all tied together, right? So if medical... uh, the, certifying clinician signs off on a patient, he goes, And that patient then goes and works in a, with a practitioner and facilitator that is unknown to the certifying clinician. They don't properly prepare him.

The patient isn't ready for the medicine. say freaks out, hurts himself and others. And next thing you know, everybody's pointing the finger everywhere else with liability issues. Like who's responsible for this? I And then... So now we've got malpractice issues for the certifying clinician and the practitioner and facilitator. And, um. And then we also have an unwell patient. Whereas we shift the liability to where it belongs in the room with the patient.

right from the start, then There's nowhere to pass the book. It's like it belongs here. And we can also weed out where where harm. Happens.

Okay, yeah. So, but at least just from what you said in clarifying, It sounds to me a little contradictory of the idea of that The medicine itself, there is no risk factors. Like in that statement, it just said that like if the patient then has an episode, right, where they then have the episode of the low risk, right? First it's saying low risk, there's no risk to the medicine. But then now we're saying they had an episode.

So where does the liability fall? But I hear that it was like we're eliminating the idea of risk. The risk falling back on the person falls fully on the person, which is Someone else might have a better way of... perceiving this, but. If we're putting it fully on the person, then we're actually doing a disservice of the program itself. And that's kind of where I'm falling a little deeper uh I'm certain as to like.

the, I'm not, I'm, um, I'm trying to understand like And I'm not saying that there isn't an issue. I totally got it But if anyone else can see here what I'm saying as far as that kind of flow go through of like where this the liability is falling that's kind of the whole point of why we're making the rules and regulations because if we're going to then have the liability on the person Let's just say the real world, that's non-governmental use of medical psilocybin. That's true, right?

I'm sorry, like if a friend of mine had a bad trip, You know, And it was me, right, that was facilitating this and my friend or something. Yeah, I would feel really bad about like my friend having a bad trip, but then I would also kind of like mitigate this and I don't know I guess it's like blame shifting of my friend to say that they had a bad trip and that I wasn't involved in it with that just like where if I was like representing the government then yeah, it would be Unfortunately on me that like, you know, did I did I did I adhere to all the protocols?

Did I administer the right amount? did I have like all of the procedures and metrics pointed out and then signed off on it and And yeah, then yeah, I guess that does open me up to my friend saying, hey, it was your fault.

Right. And I totally understand that. But then with this, it's just like the person themselves, because they accepted all the risks, right? for this, for the use and the trip and the journey, And I think maybe that is part of the issue, is just like, wherein does the government take some of the responsibility for, you know, quote, protecting us from ourselves, which is another can of worms.

Yeah, I don't know. I'm not really getting to a point, but I was just trying to kind of get to a place of clarity of understanding, like, What's the hang up? where are the issues that we need to look at and what is actually our due diligence and duty to responsibility in having the conversation, making the recommendations to the department for the rules that are then going to be, you know, possibly affecting and or supporting.

Let's hope like, let's maybe using the language of supporting our New Mexico residents and anyone else who is going to be here and possibly into the future. not cover everything, but in what ways are we actually supporting that rather than creating barriers maybe is like the with the idea is that I'm trying to come at how are we supporting accountability, how are we supporting responsibility, how are we supporting access, um in the best way possible. And I know that that's where we're all heading towards. I'm just, you know, I get, we get stuck on the language.

We get stuck on the ifs, ands, and thens, and we're not computers. And thank God we don't have computers deciding who is getting this medicine. Please. I'll just say that. Okay. That's it. I would.

say one of my big hangups with, and I think I, Might be able to clarify what I'm getting at here is. Physical safety is the smallest part of that, and we're putting it into the gatekeeping function of psilocybin. So these Certifying clinicians are in charge of the physical safety of the patient, which represents a tiny fraction of the risk and then puts them at the forefront of the chain of liability for this program.

when the psychological safety is far more important And when we... When we start this program out, going through a certifying clinician who's a doctor that is Not trained to. Handle that. and is certifying them to go work with a patient or a care team that is responsible for that portion that liability can come back on them for something they shouldn't be responsible for and represents a very small portion of the risk involved in this whole program and it.

And I wanna just mention also that yes, okay, cannabis has grown to where we have 60,000 patients in the program, but cannabis had a huge advantage over this in that Once you got somebody in the program, they were a daily user. And so they might be doing an ounce, you know, using an ounce a week or a month, uh, But regardless, they keep consuming this whereas somebody comes into this they might use a half an ounce in a year if they keep coming back so from a propagation standpoint you don't have the advantage of having consistent product moving And, uh, And again, not being able to sustain that business Um, if we limit the accessibility as much as I think this will.

So I do think this kills the program if we continue going down this road.

Thank you. And Brenda? Thank you, Desba and Chris, for all of these questions, because this we can only take so much, um, risk or think about so much risk and think about all of these different things. But when it comes down to training and education, that's where it all falls. Because if you have a staff of people that are educated, as a clinician, And a therapist, we always take a risk when we have clients. We never know.

We never know how people are going to be when we're treating them. And so. It's a it's a It's worth considering and not taking assumptions about, but being prepared for all of these risks. That's where training and education comes in because we do our due diligence in keeping people safe as far as their mental health goes, their physical health goes. However, we do have to start to step into the ring of fire here and start to understand that This.

The profession of medical and mental health is a big risk with all of this. And yeah, I understand where does the responsibility lie if something goes wrong? That is... for the legal part of that, we never know. It is a infinite

amount of scenarios we can come up with. And I'm glad, Chris, that you're bringing up all of this stuff because it really helps us take a really hard look at what is happening here.

However, in the beginning, we have to take these precautions. I understand that. And because of, you know, New Mexico has these two, the DEA license and the CS license, that it's overrated. overkill maybe in some places, but it also too speaks to keeping everyone safe, including the patient and the provider. So this is where education comes in. And so if we do our due diligence and being careful and trying to make sure that Everyone knows that we are Getting into territory that.

anything can happen. We know that as a clinician myself, You know, anyone can be sued in any part of this chain. So I get what you're saying. You know, where does the true liability fall? It could fall on me. It could fall on another caretaker or a team member in this group of people that are taking care of a client. I'm just going to leave it at that. And, you know, I really do appreciate your questions, Chris, because that's where I think a lot of this falls.

We all take a risk in the profession that we're in, and we're doing our best to try to keep everyone safe as much as possible. That's all I have to say. Thank you. Thank you. And then Keenan.

Yeah, I I thanks, but I think those that's really high on the on the money. I would just say that there's no way to remove the certifying provider. from liability unless they're not involved in the process. because there's a bad experience like we were talking about in an outcome. You could say you misdiagnosed them and they have this bad experience because they didn't really have PTSD. get so effective i'm just making up i'm not saying that's a legitimate reason but you could have these things and then you could or included in a lawsuit, right?

So, If If that's the goal, and that's truly what we're talking about removing certified physicians, but that means diagnosis and a lot more assessment goes on the treating the facility predictiveness, which I actually think might be a bigger Um...

rate limiter to access compared to the model as it exists now.

because the diagnosis portion is not going to be able to be done by as many provider groups. And that actually might limit access in the long run.

So I... No system is perfect and to get to that's the thing, it does have the healthcare system having some paternalism over individuals.

And I get that. And that's an important thing that we have to weigh.

but I think this is, Until it's approved by the DEA and then a lot of places can do it, which will also be detrimental to the small grower market because the, for example, Medicaid could then cover it, but we will only cover the synthetic DEA approved version. And so, I think this is the best in between, but I think if we're unable to come to an answer here, I think we're kind of. you I wouldn't say going in a circle, but I think we need data to answer the question is what I'm hearing, because I think we're on opposite sides.

Not opposite sides, but we're of differing opinions and we need data. How many providers are there? Those are the things that will help us make a better data-driven decision. So I just throw that out there. And the last thing I will say to you is my anecdotal experience with healthcare providers Because they are more interested in psilocybin-based therapies than I would say cannabis-based therapy. They probably feel it's safer and has better data and evidence.

the idea that there'll be less inclined to prescribe this. Maybe that's true. And again, we would need data to answer that, but my personal experience that more people would be in favor of this than cannabis, which can have more negative side effects by fog. So I'll just put that up there.

Thank you. And I guess the question I have for Brenda is, let's imagine a scenario where we took out the doctor requirement. We're going to then be imposing contraindications assessment onto a therapist. Would you feel comfortable accepting the liability for ensuring someone does not have medical contraindications? That's a very good question. Um, If that were the case, um... If I'm working with a if I'm working with a patient and I'm doing an assessment And I asked them, you know, hey, do you have.

any you know, physical issues. And let's say they do. And I have to use my professional opinion and either say, okay, I think, how long has it been since you've seen a doctor? Number one. Two, do you have a doctor or someone, a nurse practitioner, someone who can do an actual physical exam on you? So I'm going to do my due diligence with that. Of course, if and I have had clients that not that they withheld information, they simply forgot information. Oh, yeah.

I, you know, Yeah, I had a, you know, a thing, a medical thing a while back. Okay, what was that? You know, but they'll forget. And then maybe along the line, they remember and we're in the middle of this and it's like, oh, hey, sorry, but I have to deny you. Um. I do it all the time. I think that if I see any red flags, I say, okay, you need to see your doctor. You need to see a psychiatrist before we go any further with finding the proper treatment for you.

Do I feel comfortable with that? Personally, yes, because I trust that because of my years of training, that's what I have to fall back on. If I had a physician In the wings, yes, that would make me feel even better because right now it's a gunshot. I have to say, okay, what kind of insurance do you have? If you have an insurance that has a list of physicians there. I don't think, you know, any of those physicians have had any psilocybin training. Let's see, you know, what the process is. So it will go through all of these things. It has to in order to provide safety and education too for the patient.

Because I want to make sure that the patient is ready for something like this. For me, it's no different. If I have someone that comes to me, they know there's something wrong with them and I have a feeling that they have bipolar, I'm going to refer them to a psychiatrist, a list of psychiatrists that they can go to. In the meantime, I'm still working with that client until they can get a full assessment on that.

So that's kind of how it has been working for me and I think many other therapists. especially in the mental health part of it. Now, if it were something that came to me and they said they had a diagnosis that they were going to only live for six months, Now, I would have to, I would say, you know, go through all the questions and say, hey, would you like to have end-of-life care? And they want to go through the psilocybin program.

I would have to go to the list of people that are providing that. So I think to answer your question, do I feel comfortable about... whether or not having a physician on the team, yes, I would feel more comfortable. Where does the liability land? We don't know. That's where the risk lies. So it's just like anything else. If I am diagnosing somebody with ADHD and they need to have a full assessment and they want to get a prescription for that, that's that's the right protocol to go by.

So I hope I answered your question with this. Yes, thank you. I am going to get to Desva and Dan. I'm just going to ask that you guys keep it a little bit short. We are running out of time and we still have to get to public comment. Thank you. And sorry, I will try to be quick. So I just want to say that was a good question, Brenda. Thank you for answering. And just kind of, I know it's not the same as psilocybin, but as a massage therapist, whenever someone comes in to me and I, you know, we have the little mini questionnaire, so it's not a diagnostic tool, but we do ask, you know, do you have any contraindications? Are there any medications that I should be aware of?

Sometimes I'm very specific if it's like heart or blood thinners, depending on their age and their presenting or in any injuries, should be aware of prior for them getting onto my table, right? So that's my due diligence and my responsibility. But that's like the second layer after they have, you know, fill out their health questionnaire and, you know, double checking with them. Because sometimes people don't, you know, they forget.

Then as they're on their table, I assess the body, I decide, you know, hey, this doesn't look very good. I ask them questions. There's that third layer. You know, I've done my responsibility. And based on responsibility, I just wanted to read this really quickly. This is one of my favorite quotes, and it's from Admiral Rickover. Responsibility is a unique concept. You may share it with others, but your portion is not diminished. You may just delegate it, but it is still with you.

If responsibility is rightfully yours, no evasion or ignorance or passing the blame can shift the burden to someone else. Unless you can point your finger at the man who is responsible when something goes wrong, then you have never had anyone really responsible. So again, the aim for all of us here is to be as responsible to the best of our ability and our capacity. And we are human. And this is, you know, the regulatory process.

It's fallible. There are some problems. But, you know, with our full consciousness, you know, I'm definitely hoping that that's why I'm extending the conversation and asking the questions of Chris. Like, where in this are we like, you know, the process of conversation will eventually get us to like an understanding of each other. And then, Thanks, Ian.

Real quick, on your patient safety committee, did you all come up with tiers of types of contraindications for the treatment? Yes. I thought it had some discussion on that. So I'm curious as like, I know that if there are tiers of like, as a patient comes in and says, I don't have any of these things, that's a very low risk patient that may be able to be referred directly into a facilitator. But if there were tiers of patients that have other contraindications, could that not be the trigger that moves them into needing this clinician role? Just curious, put it out there.

I know we don't have time to get into it, wanted to ask.

I think that would violate equal treatment under the law if you are treating the people that are healthier and in a more expedited fashion, that would end up becoming an equal treatment issue. But we do need to set the next meeting date and then we can turn on to public comment. I'm going to let everyone hear from the public. Oh, sorry, Dominic.

Yeah, Ian, I just wanted to, before it moves on to the public comment, I just wanted to thank everybody. I appreciate all of the conversation. I appreciate the different viewpoints. I think it's very important. And I think what it really comes down to is it really does show that we are trying to create the best program possible. And while we may not always have the same viewpoints, the passion, the concern is definitely evident, hear it. I do want to let everybody know that because of some of the timing issues, in order from, you know, to be able to meet the goal of having the first patients in December, we are going to move forward with a regulation hearing. And we are looking at the end of August. Now, of course, we still have some of the training.

And so some of those aspects that are being developed and considered. And so we still do have those portions. And I'm looking forward to that, especially this afternoon. to see some of that. But I did want to make sure that everybody knew we are moving forward from the department standpoint with setting that regulatory hearing. Because again, we just need to make sure that we also provide enough time for people to be able to get training and to be able to register in the program and move for all of that.

So I just want to make sure and let you know that that part is happening, is going to be moving forward. So thank you. Alrighty.

So let's go ahead and set the next date. When does Meeting next sound good for all of you.

I know Dominic, you're out the week of the 20. Seven. 29th.

It's the week of the 27th, that's correct. And mostly out or traveling through that. As I mentioned in one of the other meetings, Dr. Truckner and I were invited by SAMHSA to a conference looking at data gaps with regard to psilocybin. And so we'll actually be traveling to DC and back and the conference, of course, that week. So we won't be available at the department, or at least I will not be available during that week. But if you're looking as

far as for potential Fridays, the following Friday on the 14th, the end-of-life care actually did take the morning slot already on that and has scheduled for that.

But the afternoon is open on that day, on the 14th, if you were looking for a similar pattern. If not, there's also the 21st.

Does the 1:00 PM and the 14th work for everyone? Seeing thumbs up already. If there are no objections, so we will meet on the. 14th out one. Alrighty, and then I will turn over to the department to call for public comment. This is Larry. Can I have one other comment here?

Yes. So sorry. Is there anyone that's on the call that has the ability to sort out the answer to the question of how many people are there that have procurative authority without controlled substance license? I realize it doesn't actually affect the immediate decision, but it does seem an important thing to know in the future. I'm not sure if that's something that Keenan, I don't know if you have access to that information, advocating for prescriptive authority as the bar.

And so it would help to know if that would change things much. I'll just put up this is probably a discussion for RLD. Regulatory Licensing Division, which covers all boards except medical, which should have a controlled substance and nursing. And I think there's some variation within that, but all almost all other I should say all, but a lot of the other health professions will be regulated through that and they could tell you who has prescriptive authority and to what scope, right?

Like emergency medical technicians have some prescriptive authority, but it's very different different than just broad scale perspective practices. It's very structured. So probably a discussion with Dr. Culpepper with the Regulatory Licensing Department. Okay. Thank you, Keenan. Thank you, Larry. Shall we move to public comment? Yes. Okay. For individuals who are interested in providing public comment, you can just go ahead and raise your hand.

The information on how to do that is in the meeting chat, and then we will call on individuals in order. All right, and we have three minutes per comment. And because we're low on time, I will give a time check when there are 30 seconds remaining in your time. But we'll begin with Greg. Your mic has been enabled.

This has been a wonderful debate and Complicated issue New subject. Question for the department. Will the program's outcome data and cultivation compliance software be openly bid for this program or has a vendor already been selected?

So this is actually public comment.

It's not actually question time, but just to answer as far as for the research purposes is collecting data that has not been determined at this point as far as for creating the patient registry aspects. We are continuing to move forward with our current vendor that we have for other programs.

All right, and Kate Hawk, your mic's been enabled.

Yeah, I'll try to make this one minute. Thanks, everybody, for wrestling with all of this. You know, we've heard the... parallels with medical cannabis and just haven't really heard discussion involving medical ketamine. I've worked with ketamine-assisted therapy for quite a few years. And really, as far as the path went, people found I wanted to do ketamine-assisted therapy, usually not... hearing about it through their doctor, but finding a practitioner like me, I worked closely with a doctor who could prescribe.

And of course it was ketamine, so it had to be a regular prescription. So I think that in the team, the concept of teams, people will have relationships between providers and medical people. And so there will be multiple entry points as long as the system is clear and covers everything that's needed. For worse, it would be worthwhile to look at what's being done with ketamine. Thank you.

Thank you, Kate. Denali, your mic is enabled.

you Hi, good morning everyone. Two really quick things I think that came up.

One, there was this question of whether the encounter with a certifying clinician could be billed. And I understand that as it's currently operating under the medical cannabis program, that is a billable encounter. I'm a little bit worried about the way that the regulation reads, specifically because it's requesting that the provider evaluate. It's essentially designing the encounter specifically for the entry into the medical psilocybin program.

So if I were the federal government overseeing our Medicaid system, or if I were payer, I would look at the regulation and say, actually, this encounter only happened for the prescription of a Schedule I substance and deny the claim or claw it back if it had already been made and came up in an audit. So I think similarly, there was a lot of conversation about liability, and I agree with the consensus of the board that there's only so much we can do to limit that.

But I do think that the requirement to provide, you know, a risk and benefit analysis does increase the liability from the provider. And I just made a note that that member Ryan from HCA mentioned that the you know, that really it's the medical, it's the, the medic, it's an assessment of medical risk that we want. We've gone beyond that by requiring that there be a risk and benefit analysis. I think that if it were revised to just require an assessment of medical risk, one, that's going to create less risk of clawbacks and two, you know, less other professional liability on the certifying clinician.

And then I just want to say, I think I, have been primarily, you know, the proponent that we maybe look at prescriptive authority instead of the controlled substance number. And I recognize that this may be my own provider bias. So it's my primary care provider that I've had for a long time and trust and rely on for medication management, you know, doesn't have the CS number. I appreciate the recommendation that we maybe go to RLD.

get a connection to Dr. Cold Pepper.

Thank you Denali. And Amy, your mic is enabled.

Amy, if you're speaking, we cannot hear you. Hi, can you hear me now?

Yes. Okay, great. Thank you.

Good evening.

I want to thank the SILA 7 Advisory Board for the careful deliberation they're doing today and hear the really kind of catch that you're in that you have to have this qualifying person in there or language in there as well as the concerns about bottlenecks.

One thing that I will say is that I agree with Brenda that the training and education really needs to be the point. at which facilitators develop that ongoing ethical practice that really needs to be something that's tracked and people can't be trained really just in one weekend to facilitate.

They really need an ongoing kind of layering process of that ethical consideration because it's ongoing, it's nonstop. And it requires an enhanced level of ethical practice and informed consent all the way through so that the client themselves or this journeyer themselves also develops that framework and compass inside themselves. So that is not necessarily the facilitator saying yes or no. It's also the client being informed enough that they're going, "I'm double thinking this.

I'm thinking about whether to proceed given my medical or my complexity in my comorbid diagnoses if they have complex trauma or something like that and they don't have a stable system around them. So I just wanted to say that I teach a 96 hour program at Southwestern. And that is, it's like people usually finish all those classes within

two years, two and a half years. Now we could do that sooner for for a facilitator training program, but I still think that people need to have an ongoing kind of layering process because ethics is not just learned in one weekend.

or practice in one weekend. It's a continual coming back. And so an ongoing facilitator practicum that might be periodically need to happen would be also something that I would recommend for the education training. I can't be at the afternoon meeting. Sorry, Brenda, hopefully make a future one. Sorry. Thank you.

Okay, are there any other individuals who wanted to provide comment? If not, back to you, Ian.

Alrighty. Well, on behalf of the board, we thank everyone for who showed up today to listen, to participate, all of the board members who are here. Thank you guys so much for taking time out of your day to be here with us. I know all of you have very important jobs. So just thank you again to the Department of Health. Thank you for hosting this video call, for sending out the invite links, for being our point of contact for legal issues, for that kind of thing.

So we really appreciate all of the work that goes on behind the scenes and to all of the general who have just been supporting this program from the bottom of my heart, we thank you and have a wonderful rest of your weekend.

And on behalf of the department, to everyone and to the board members, thank you as well and look forward to seeing those who will be in the meeting this afternoon and have a great weekend as well if we don't see you there.

Hmm.