New Mexico Medical Psilocybin Advisory Board

Training and Education Committee meeting, afternoon session

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And so in the meanwhile, while everyone is still coming in from the lobby, just as a reminder to everybody, we do record these meetings. It is recording currently. And so please make sure that language is appropriate. I'm Dominic Zerlo, and I am the director for the Center for Medical Cannabis and Psilocybin. And this is the training and education committee for the medical psilocybin I have an advisory board with Brenda Burgard as chair. And with that, Brenda, I will turn it over to you.

All right. Well, thank you, everyone, for coming today. We have a little bit of an agenda up here. So, Jorge, could you go ahead and...

Pull it up and see if we can get that together. I am. I am downloading that as we speak.

In the meantime, Brenda, do you want to do introductions?

Oh, yes. Thank you. Thank you for reminding me. I am Brenda Burgard for training, chairing the training and education here. And let's see, who do we have? Can you raise your hand and present yourself if you are on the board? Okay. Kate Hawk, you would like to present yourself?

Okay, it doesn't seem to be.

Oh, there we go. Okay, there we are. Okay, cool. Yeah, Kate, you can talk when you're ready.

Yeah, hi there. Thanks for... I'm disabling my mic. I'm Kate Hawk. I'm not on any board, but I am a participating part of this training and education committee. And in Santa Fe, just happy to be here today and pitch in as I can. Thank you. Thank you, Kate. And I want to add that we are forming a little, not a committee, but we're forming a group for helping out with the training and education because there's so many working parts to this.

They're part of the team that is helping me pull all of this information together and to present it to the public for comment and input. So... Let's see. Who's next? We have Dr. Larry. Larry.

Hi, everybody. Larry Lehman, member of the advisory board, chair of the end of life committee and very interested in training issues. So nice to be here.

Thank you, Larry.

Brenda, we have a couple of introductions in the chat that I can read. All right, please do.

Let's see.

We have Chris Piskuski from the Advisory Board, Advocate and Veterans.

Thanks, Larry. I mean, thanks, Chris. Thanks, Ray.

It's quite all right. And then we have Don Moser.

I'm having one of those days today.

Yeah, totally. And then we have Don Moser from Las Vegas, New Mexico. Glad to be here.

Thank you, Don.

Those are the only hands I see at the moment.

Okay, so let's go ahead and roll out the agenda. Anyone else here? Okay, I see a question. Anifa, she's on the alliance, the PMHA alliance. Dr. Lita Fatimi, founder of Conscious Physicians and Psychedelics Academy. And Ellen Schimels, she says, hello, everyone. Ellen Schimels, psychiatric mental health nurse practitioner, Army veteran, and clinical professor at Emory University living in Albuquerque, New Mexico, We have Gregory Evans from the committee and he's present. Let's see, I'll just rattle it off. Here we have Ann Metz, clinical facilitator, Colorado TOWS residents and director of Fluence Training Program in Colorado. And she will also be presenting today.

Thank you, Ann. Let's see, anyone else coming into the fold here for this meeting?

Just wait another minute or so. Okay, so let's go ahead and start with the agenda today. Okay, if we could pull down. So we can get the agenda here. Oh, here's Ian. Ian is here. Ian Dunn, who's also on the board. He's joining us today.

Right now I have the agenda pulled up for you.

OK, I'm not seeing the whole thing here. Can you just? scroll To the top of the page here. There we are.

Sorry about that.

Okay. Yeah. Alrighty. Thank you. So on today's agenda, we have for training and education agenda, we have Ann Metz, who's going to be presenting her education and training on here today. A couple of things that we're doing here is we're going to focus a little bit more on the practicum and didactic hour requirements. for reciprocity in the full program. And so we need some more consensus on that today. For example, reciprocity needs fewer didactic requirements and a 20-hour practicum full program with more didactic requirements and equal or more practicum.

So initially what we're thinking about here is 50 didactic hours core curriculum modules, 40 practicum hours. We were also thinking maybe 50-50 on this one too. A few of us in the other team that I have for the education and training. We're kind of really kind of almost there with the hours, but we're deciding that this looks the best right now. And that is with experiential with the medicine, practicing with other professionals, similar to the Colorado requirements, 80 supervised practice hours.

And I don't want to, I know a lot of people get mixed up with what's supervised look like for clinicians we when we say supervised hours that usually means someone who's um trained in supervision, but this has got a different definition to it. But it's usually the supervision is practice hours is someone there that has already gone through all of the education and training. You know, imagine being in a clinic and having like a director above you watching or making sure that you're doing your due diligence.

the practicum hours. So working with clients under supervision, this currently does not exist in other states. And instead, we require more didactic hours in this. Adding this portion provides a deeper and more robust learning experience because it's It's more of being there and working with the patient or the client that is the most vital part and holding space for patients. what is going on in the actual treatment of what someone is going through their experience.

And so I have a couple other things going on here for the agenda. Suggestion isYeah. Using existing programs and modules from existing education programs, kind of like a cherry picking thing to modify it for New Mexico to save time, reduce redundancy, and edit any inapplicable information that is not part of the New Mexico module competencies. So in other words, like if there's other things in modules from other education, places that don't really apply to New Mexico, but maybe there's some things that we can.

So it's really looking at other programs very closely and taking what they have. So we're not reinventing the wheel and trying to make it Uh... almost overload in the information. Core competencies, adding and addressing any needs in the core competencies, you know, looking over that. I think we've pretty much gone over the core competencies that will satisfy the DOH. If the DOH has any other addressing needs about that, you know, during these meetings, it would be good for us to hear from the department.

I would like to see a modular, on dosing. I don't know if we're there yet or not. I've only been able to go to some of these meetings, but I think that is one of the points that I think we're missing in that education part. Studying materials for classes, literature, data journals, online learning and testing programs, et cetera, et cetera. You know, what are the costs there? I don't know if we're there yet, but maybe we could have a discussion about it.

Reciprocity, when will the New Mexico modules be available for reciprocity? Addressing the other specialties, end-of-life care, addiction, ceremonial native practices, pastoral and spiritual medical specialties, including people who are specializing especially in pain and an adjunct to their professions. So in the end-of-life meeting, It was presented as an adjunct to their profession. So part of their learning, right, Larry? It was part of their additional learning.

Um,Can you hear me? Can I? Yes. There actually wasn't a decision on that. There was people who felt that the recommendation was for 15 to 20 hours. There were people who felt that that should be part of all of the programs. Other people felt that that could possibly be an add-on. So that was still under discussion. I think the idea is to try to see how this committee is looking at this and see how that would work.

If you're going to have 15 hours of end of life, you're not going to have 50 hours total. So you have to kind of look at how that would play out with with other recommendations and considerations.

Yes. And I think, you know, how the education and training is going to align themselves with other committees, too. So that's another big piece of the puzzle that we all have to kind of come together and kind of sync up with each other in that regard. And if that's at all possible, yes, Larry. No, I'm good. Okay. All right. So, um, I think this would be a good time. So I want to just make sure if Anne, are you ready to present?

Yes, absolutely. I'm happy to-You scared me.

I hope that's OK. I just unmuted myself and Jorge has the PowerPoint that I was going to use.

I sure do. And then yeah, that's quite right.

Thank you so much.

You are in presenter mode, so feel free to speak and I will put your document just Now, if you give me one second.

there you are how's that for you As long as you all can see, I can't see anything. But we're going to just Be cool with that.

There you go. Brenda, you can see this document via PowerPoint.

Yes, I can see it, thank you.

Great. Well, I'll just let you know when I want to switch. Just good afternoon, everyone. Thank you so much for this opportunity to talk to you today. A brief word on where I'm coming from here. So I've worked on fluence training programs, both Oregon and Colorado accredited programs. So I've seen firsthand how state models translate into classrooms, practicum sites, and graduates. which is another gold standard in psychedelic education. And I've also consulted with people who helped design that curriculum.

I consulted on the national certification standards for psychedelic education that was proposed through the National Psychedelic Association. I have no conflicts of interest here in New Mexico. I have no stake in any training program, healing center, or applicant. And really what I think I bring to this conversation is a network. People who have already run into these questions in Oregon and in Colorado.

And what I'm going to present today, I would say, are general recommendations. It's not really a finalized plan. I hope what I have to say sparks discussion and refinement. The recommendations that I've made draw on four sources. The first would be this committee's June 12th and June 25th drafts. the Healing Advocacy Fund's qualitative analysis of Colorado's training requirements, which were interviews with 24 program operators, graduates, indigenous scholars, and legacy practitioners, and a comparison of Oregon's 120 and Colorado's 150 hours of training.

And I also consulted with a number of experienced colleagues, including Memaru, which is a healing center that has a consultation model out of Boulder that I really like and think could be valuable. So I think the frame throughout all of this is really calibration. We want this program to be rigorous enough where it's defensible for the public and the legislature, but it's also lean enough so that the training stays accessible.

And with that in mind, we really have to be intentional about every hour that we require because cost to trainees is real. For a licensed clinician, 120-hour practicum isn't just unpaid time. client hour. And at typical clinical rates, 120-hour practicum is roughly \$18,000 to \$24,000 in lost revenue. And that's before tuition, supervision fees, and any travel. And that burden lands exactly on the clinicians that we want most in this program. And eventually it lands on the patients.

So next slide. Great.

And I'm on slide three with the 84 didactic hours. Does that work?

Could you go to slide two, actually? Yes, yes.

I was just there. Okay.

Sorry, sorry, sorry, sorry, sorry. Not quite all right. Four recommendations here, each with its own slide. My first recommendation really is a logistical one. I really think it would be meaningful and important to retitle practitioner as life provider.

Practitioner tells a patient nothing about training and it also collides with nurse practitioner. I think that licensed provider really names the qualification itself. Second is a single 84-hour didactic standard.

Third is a scaffolded practicum with a training permit. Both of these reduce hours relative to the current draft, and I'll make that argument directly. Structure and checkpoints, I think, ultimately protect the public better than raw hour counts. And of course, every hour that's added is a cost that's passed on to trainees and to the patients. And then fourthly, tie consultation sign-off to having presented two cases.

reduction and practicum hours defensible. Someone experienced evaluates the new permittee's own casework before they're able to practice fully independently.

And now we can go to slide three.

So didactic hours.

I think 84 hours really sits in the defensible middle. Oregon requires 120, and yet graduates in the Colorado analysis consistently said that the didactic portion still really lacked depth on any one skill. So what we can conclude really from that is that more hours did not necessarily buy depth. Colorado's 150 hours raises costs and access concerns. And I think it really risks pushing people outside of the regulated model. And it isn't clearly supported by outcome data.

So just the allocation broadly for the 84 hours, we would want to look at 25 to 30 hours of core psychotherapy skills and ethics. This is really consistent with the Colorado recommendation that ethics be about 20% of didactic time. Module on end of life care, that's about 10 to 15 hours. Trauma, eight hours. Medicine, dosing, and research literacy, about eight hours. The New Mexico module, six to eight.

Treatment modules, six to eight as well. Screening, suicidality and crisis response would be about five to eight hours. Somatic awareness and touch would be around four to six. And then history, historical and traditional use would be about three to four hours. Something that's new that's in this recommendation that's not in other programs would be to focus on challenging experiences, including conditions like HPPD, so thinking two to four hours.

And I think these ranges are really illustrative, but what we want really is the binding minimum of about 84 hours. One kind of point I wanted to make about the trauma hours, eight hours is not PTSD treatment training. That obviously is a much longer and extensive process, but it really would cover recognizing dissociation and trauma responses, somatic work, and how to deescalate. I think that wherever PTSD treatment would sit outside of a licensed provider scope, I think it's going to be important to have collaboration with a PTSD trained provider as required or requested. You'll notice that there are no tiers by professional background.

You know, I wanted to include the June 25th draft module by module test out, excluding, of course, the New Mexico module. without actually lowering the single quality bar. I'm happy to move on to the next one. I just think something else to imagine when we're talking about the didactic is that basically all of the Colorado interviewees said that they wanted the didactic to be more applied and have opportunities to practice rather than just provide PowerPoint presentations and lectures.

So I think that's really going to be something that should be integrated. And as we're evaluating programs is how much like practice are people having, or is this just a matter of how much practice are people having? Yeah. you know, listening to PowerPoint presentations like you're all so patiently doing right now. Okay, slide four. So, We're envisioning this as four steps where trainees are moving from lower risk to higher risk groups. And no one is able to complete their supervised practice without having real client contact. So just to start with step one.

So we're envisioning about 30 hours with well participants in a retreat or peer support model where there is preparation and integration for every participant. That's not an option, but I really feel like this is a developmentally appropriate place for people to start and could look similar to what they're doing already in Colorado and Oregon. So step two, this would be about 20 hours as the second chair or the second facilitator on at least two co-facilitated cases with a license, with a license permitted provider.

I would recommend that these be low acuity cases only, ideally nicotine use disorder or major depressive disorder, assuming that we can get that into the legislation for the spring. I would say that PTSD, Other substance use disorders should be excluded at this stage that developmentally they're not really appropriate where if the main facilitator is out of the room to go to the bathroom, the trainee is not really in a position.

appropriate person to be able to kind of support in the event of a crisis. About step three, about 12 hours of group practicum, really liked that recommendation. And I think given that this is likely going to be a common model here in New Mexico, that students should, that trainees should have an opportunity to practice that. And

then step four, this is for the licensed provider only have an opportunity to do 10 hours as the lead facilitator with a licensed provider as the second chair.

So part of this would require that there be a training permit created. And I imagine that the training permit would be issued at the completion of step one, and it would cover steps two, three plus the consultation period, two, three and four plus the consultation period. And so this really gives trainees a lawful pathway to get their required client contact. And I think it nicely mirrors the associate licensure structures that were supported in the Colorado analysis.

And it also signals to the public that a permittee practices under supervision. Something I would recommend for these placements during this process, the current draft requires that all hours be held in an approved healing center, which I think can potentially be a bottleneck for rural trainees. I really like the idea of the apprenticeship or the site supervisor model, similar to what they do for counseling licensure or direct entry midwifery.

And that may be worth discussing with the counter question of who is going to vet site supervisors. And ultimately, I think that's a committee for the decision for the committee. So this is where the financial reality that I named at the start does its work. So we're looking at a 62 to 72 hour practicum with structured checkpoints that keep the quality bar while cutting the cost burden of 120 hour requirement nearly in half.

Um, Yeah, so that's the practicum. And then slide five, if you could move on to that one, all right? Got it. So the consultation sign off. Sort of the problem, the current drafts, 10 hours of mentoring never require that the permittee has seen a client. So consultation groups in Colorado have allowed completion of these hours by attendance alone. And I would suggest that tying sign-off to presented cases really closes that gap.

And in place of the 10 hours, I would recommend 20 to 30 hours of supervision or consultation during the permit period, in addition to the practicum. And that sign-off would require that a trainee present at least two cases where the permittee personally worked with using the regulated medicine with standard evaluation forms on each. And each presentation would need to not just be like, oh, Jennifer did really well.

It would need to be a formal biopsychosocial case conceptualization with presenting concerns, risk factors, supportive factors, treatment considerations, and aftercare. This idea came to us through the memory, The Memoru model and Boulder, which was developed under the leadership of one of the lead principal investigators in the MAPS MDMA clinical trials. And that group is, of course, among the most experienced psychedelic therapists in the country. And they use the two case model to sign off on their consultees.

And I would say that the two cases really gives us an adequate basis for final evaluation. Yeah. You know, and just kind of one last addition, there would be also an end of life checkpoint. So before serving end of life participants independently, at least one co-facilitated end of life case needs to be, a trainee would need to do one case with the one end of life case and then at least present one in supervision. Okay. Um, Next slide.

So these were just some open questions that I came across in putting this together. First, indications and volume. The current indications really limit our patient pool and therefore placements and trainees getting through it. Obviously, major depressive disorders proposed for 2027. Generalized anxiety disorder might take a little bit longer, but broader indications, I think, that would materially change the practicum feasibility.

Second, addiction. Do we need a dedicated substance use disorder plan? Third, instructor vetting. who approve site supervisors if placements are decoupled from training programs. And fourth, just assuming that the FDA approval arrives with reduced therapy support requirements, longer state programs are probably going to face enrollment issues. And I think an 84-hour standard is probably easier to sustain.

and 150 when compared to training programs. Sorry, when Drug companies only require 20 to 30 hours of training. So that's what I have and I'm happy to answer any questions or if there are folks who would like to add anything. Thanks for your time.

Thank you, Anne. And yes, this opens it up for more questions here from the public here. Yes, thank you so much for this. This was... Really great to see what Colorado has been doing and you know this is the thing we need to have more information about. What is out there right now? And we don't want to get stuck in our own silo here on just kind of going over what we need to do here in New Mexico. But you guys are out there, you know, had this out there in Colorado for quite a few years now.

And so we should be actually learning from what you guys have been doing. going through basically. So I really appreciate what you've done here, Anne. This is really wonderful. So I'm going to open this up to any questions that people may have here.

Brenda, Ian has his hand up. Okay. Right in Hi, I just wanted to say thank you again for your presentation. It was really nice. I did have one question, so I just either clarification if I'm misunderstanding or we we can explore it further. But you have to go throughYeah. Like, you said, I can't remember the phrase you said, but essentially easier cases, right? Like the lighter loads, nicotine use disorder, if approved major depressive disorder.

And then they would go through harder ones before getting approved or would they just be approved for licensure without ever having like experience some of those more difficult case situations.

Erica, your mic has been enabled. You can unmute yourself when you're ready.

Sorry, it always makes me do something strange. I had a question. about practicum. I was curious at what point is the student eligible to start practicum so? Did they have to have been through a certain amount of didactic first or is it didactic needs to be complete and then they start their practicum?

As far as I know, as practicum goes, didactic seems to always come first. We In the education and training, that's usually what... What? The protocol is because you need that foundation of the education part of it. And then practicum comes later because you need to have that education foundation first. So we're still kind of looking at... you know, the hours, what will be, uh, implemented there as far as the education and training goes. So usually practicum usually comes later.

Okay, so in full didactic is completed in full before practicum begins. Just quick.

Yeah, yeah, I would imagine so because anyone who's done any type of, you know, clinical training, you want to be able to have people that, you know, you know, are educated and know what to expect instead of going in like, okay, if they're observing or if they have working with a client, they need to have that foundation. Okay. Okay.

I was just curious because in social work, it's partial, partial didactic. It's not the full program before entering practicum, but thank you.

That helps.

Yeah, and I think it's because, too, this is new. And so we want to be as safe as possible as far as all of the rules and regulations go to.

Sure. Thank you.

Hi, I apologize. Did someone answer Ian's question? I got booted off the meeting. Error on my part, I'm sure.

youNo, we didn't answer Ian's question. I think that was directed to you, Anne.

Yes. So the plan really is, you know, I mean, in terms of how we educate and train new clinicians, we usually work from a lower acuity to a higher acuity model. And so I think that that is what we're doing. but it makes sense developmentally in terms of this training program. And so that's why I am recommending yes, that people start out With lower acuity conditions and then, you know, as they're doing their supervised consultation hours that they would, you know, be able to work on more complex cases.

Perfect.

Thank you. I just wanted to make sure that they would eventually deal with complex cases before they were fully licensed to practice by themselves.

Yeah, I think as soon as they're in the consultation phase that they've completed the lower acuity and that they've had the supervision, 10 hours and the group that I think they could certainly take on more difficult cases.

Thank you. Who's next?

We have Lisa. Your mic has been enabled. Unmute when you're ready. What?

Thank you and great presentation. Thank you for putting this together. I completely agree on reducing the amount of didactic hours. Looking at Colorado program, we see a lot of people going through redundant content. A few things that I am missing in your presentation is the hours for integration and group work as well as the dosing. Is that part of the general core skills or you Isn't this supposed to be somewhere else?

Thank you for that question, Lisa. We are still looking at the, Finding out what the other committees are doing and working that in as we go along with education and training as far as integration and all of that, that will be in the training modules that will be putting together as far as everything else goes, as far as safety, ethics, and all of those other modules that need to be in the training will be there. It's part of the core competencies of the education and training.

And it's really a staple really to have those ethics and safety in there. So to not... you know, keep going over these, the competencies. They are in the competencies as far as the Department of Health goes. And other things too, I mean, are we, um We got to look at things that we're missing, too. I know there's I can see there's a lot of redundancy and a lot of these other programs and where we really want to not skip over things.

But then again, we want to make sure that we're doing our due diligence as far as training training goes. Also, too, I As we go along with all of these meetings, creating standards for the education and training would be optimal in focusing on the population of clinicians and practitioners out there. So we really need to, as we go along, this is still getting shaped and shaved and built on. So we're really working hard at trying to make sure that what we're going to be providing for the program is, yeah, there will be maybe some limitations, maybe there won't be, but we're doing our due diligence and trying to find out what we really need to start to build on in this program for education and training.

And who's next? Thanks, Anne. Yes. Dr.

Leda, your mic has been enabled. Unmute yourself when you're ready.

Thank you so much. Thank you so much. And that was a great presentation with some great solutions and very comprehensive. So thank you for that. And, you know, there was a comment about finishing all the didactics before going into practicum. I'm finding that combining practicum with didactic tends to be very effective.

We do the first trimester, the first three months, purely in preparation, ethics, indigenous practices, self-care, foundations, trauma-informed care, and really getting the practitioner going through their own self-discovery. does not yield good results usually. And so really paying attention to those codes of ethics that we have in our program of holding the practitioner to the highest standard of their own trauma processing and self-care.

And without any medicine and community building and group coaching, then we go into practicum for their own self experiential. I find that to be that to be essential. essential for us to understand what these medicines are and what they do before sitting for others. And then for six months after their self-experiential practicum, which we calculated to be 16 hours, after that, we do six months of integration in small group format. That is essential.

also with didactics for another six months. I find that many educational programs, They leave out experientials out of the equation for some time and that decreases engagement and retention of material. And when we include experientials as we go along, I'll give you a very simple example. of breath work in our first module we talk about we do the didactic and with everything is evidence-based with meditation and breath work that's the first conscious life practice that they get introduced to and they're held accountable to doing it in their own life and how and what is coming up for them from that lens of meditation and breath work.

But if we, you know, When they do it, and they stick with it, that's the only time they can really speak to a client about it and its benefits. And so the experiential part, I feel like is always an evolving part. It's always there, at least with what we do. Every program is different, of course. But I think it's really important, especially in psychedelics, to... to combine, to combine, maybe not from the very beginning, but at some point, maybe in the midpoint, for there to be a practicum opportunity. They gain a lot from it.

And that's the surveys and evaluations that we sent out was very positive in their professional development, in personal development, and so forth. And thank you.

Thank you, Dr. Alida. I appreciate the experiential part of it very much so. However, oftentimes with therapists often have to do their own work before they even, that would be the ideal, you know, for them to do their own work for themselves before they even attempt to take on clients because this has always been a sticking point for in the past. This is what I've heard that some people become clinicians and have never done any of their own therapy. So experiential is very important.

And I think it would be an important part of, especially people who are do not Oh. you know, or have not, uh, done any type of this work and that you're offering them an opportunity to discover things about themselves that they can be ready to be there and present for other people. Go ahead again, Dr. Fatemi.

Yeah, and I agree with you that it that you know for us to then. they need to have shown competencies before We can say, yes, you can now move on to a setting with supervised practicum with a client. So I do agree with you on that for sure, that people have to go through their own journey first. Yeah. Thank you.

Thank you, doctor. Who is next? Is it Kate Hawk? Are you next?

Hey, dear Mike has been enabled. Unmute yourself when you're ready. Okay, I'm unmuted again. Yes, well, there's so much I could agree with and so much to this conversation. I want to say thank you, Anne, for what you presented. You know, if we had to decide in this meeting, I'd say, and that was it. It's like, okay, we can live with that. We'll, you know, we'll see how it goes. And I hear what, you know, what you said, Lita. It's like, there's so much to say.

So much that's really important in doing this work with our personal experience and group support and having time to think things through and having some practice and then, you know, learning some more. And I think realistically, especially if we're looking at psilocybin, you quite possibly getting rescheduled next year. I think, you know, hey, let's make sure everybody has the essentials and let's also encourage more in-depth enriched programs that won't be required for the basics, but hopefully will be available, you know, more and more and ongoing, you know, professional peer support and, you know, you know, learning together. I'm still learning after all these decades. I'd also want to mention the Brain Futures study.

And I know, Dominic, you've talked to those folks and people are familiar with, they've just studied all these programs. And Anne, you know, you've been looking at things that have studied multiple programs. So I'm hoping they should have, you know, something available out of their study to look at this month, just as, you know, as a rationale and backup for how we are choosing these. And I appreciate, and I appreciate that you did have, like these came out of studies and groups that were, you know, there was a lot of input there.

So my question is how much time do we have? Because I know we want to have something for the advisory board to approve. and what the next meeting is in some weeks. So do we have that window to work with with

what we already have and have the people who really want to focus on this put all of our best information together and come up with something that we can feel solid about.

Thank you, Kate. Can you answer to that?

Yeah, thank you, Brenda. And Kate, thank you. I appreciate it. And actually with both of the things that have been presented today is we're actually not very far off. I think there's a few misconceptions and I'm not going to go into them right now because we really want to hear more from people.

And I actually don't think that we're very far off.

So the department is, as I mentioned this morning during the board meeting, is planning on moving forward with a hearing, so a rules hearing. at the end of August. And so that really doesn't leave a whole lot more time at this point. And a lot of what we've already done, what you're talking about was collecting what the topics are, collecting what they are and what they should be. And what I think really is kind of happening here is just some different ideas as far as approach, as far as how the training should be set up, but they're not really very different from what we actually have already in the proposed rules and some about length of time. And as I've said before, as we're, you know, we're happy to talk about adjusting those lengths of time. And so it might actually be beneficial to be able to show what we have there and say, what topics are we missing?

And then talk a little bit about what type, you know, how many hours do we need? Do we need to adjust? Talking about the practicum we have in the proposed rules that we had shared is that it includes the ability for those students to not just observe, but also to be facilitating, for example, or acting in the practitioner role. And so that's already in there. And the main reason we didn't break it out into separate, like separate sections, like saying, oh, 20 hours for this, 20 hours for that, is because you are going to have different needs depending on the student.

So, for example, going through a practicum or your internship as a counselor, what really happens is you have to complete those hours. And as you grow proficient, the people who are supervising you actually start giving you those harder and harder cases. And that should really be the situation here as well, where we're not trying to define in an artificial way. Here are separate individual blocks. to ensure the best experience possible for them.

And so that's really, you know, to really kind of talk about that, that really fits in. Because when we look at the model that Anne presented, which is a great model in many ways, you know, it still comes up to between 146 to 156 or 58 hours in total. And that's between all the practicum and not including the final 20 to 30 hours of the consultation. is it really including that falls right within that same timeframe. So it's really just a question of how do we adjust?

So, but timeframe wise, and even after we do, you know, put out what the draft rule is for the hearing, as we've talked about before with the previous set of hearings, we can still make adjustments, especially if it's as far as some of those hours or adding in a topic area that was missed, those sorts of things. far off from what people are talking about. It's just a question of, do we have all the topics that are needed?

And do we need to adjust the hours, for example, in the didactic somewhat? And so with that, I'll turn it back over to you, Brenda. Thank you.

Thank you. Thank you for explaining that, Dominic. Yeah, I think the hours and that kind of thing, I think we're coming closer and closer to a more definite number on what that's going to look like. And, you know, and creating a standardized structure where, you know, where the teaching and the curriculum, are going to fall in line with what the DOH has in the competencies. So I think what, however, You know, teaching style that you have, it just it has to have these elements in there, these actual subject matters in there, in the modules in order to be approved by, I guess, the would it be approved by the education system?

uh, for clinical practitioners or will DOH be part of that? You know, that's a question that I have.

I'm sorry, Brenda. Can you repeat that? I'm not quite sure what you mean.

Yes. Well, who will be overseeing the curriculum for the competencies for the DOH?

Gotcha. I understand. That's actually why those are the educational programs and they have to have that third party review.

Okay, yeah, thank you very much because I was just kind of, you know, I knew there was a third party in there, but I I just wanted to know uh all the things that they will be doing as far as oversight of the education and training.

Yeah, I mean, basically the educational programs, they'll submit to the department all of the criteria of what their curricula is, how they're, for example, the CVs or resumes of the instructors, what their plan for the syllabi are, all of that. But they still also will have a need to have that third-party evaluation that's looking to ensure that the curriculum is implemented with fidelity, that it's verified, and then that will also get submitted to the department for review.

And then the department will be the ones who actually certify then that training program.

Thank you for reviewing that, because I think, because I kind of knew it in the back of my head, but I think I had some...

parts in there that some questions that weren't really connecting for me so thank you for going over that so anybody else have any other questions or Any comments? I see Larry, who's next? Is it Chris?

Yes, that would be Dr. Larry. Larry, okay. Hi, Brenda. Thank you. Thank you for the opportunity. And thanks for all the work you put into that. It's actually really quite amazing. And I think it takes us a lot closer to where we need to go. I just want to make a couple of comments in particular. I agree with everybody about people need to do their own work. I actually think that's up to the program.

It's outside of the didactic. They need to say, when you're doing this training, we recommend that you have your own practice, that you do self-care. And so I think it's outside of the hours, but I think it's essential for the programs. For the way that you've outlined the number of hours, I think this gives us a template to actually have meaningful conversations. I mean, people have been saying, okay, you need 100, you need 50, you need whatever. But by looking at this, we can go, well, okay, which of these need more? Which of them need less? And I really like them. And I agree with Dom. I think that it's not far from what is written there.

But I honestly think this is better because it's more specific. to make some decisions like that would be really good. I found it very helpful to have it broken down to those smaller parts. Similarly for the practicum, I think this takes us well beyond what anyone's done in anywhere else in the country. I mean, it's really, if we can institute this, for instance, in Colorado, when you do the supervision, you don't really have to do anything, quite honestly.

You can like sit there in a room, be one of 20 people on a Zoom thing. You do that for 40 hours I mean, to be blunt about it, by requiring that people have to present two cases, it's much more like a, you know, an educational model where we feel like people have demonstrated the knowledge. And what I like about the supervision is, I mean, the practicum is I see two points for that. I see the co-facilitation where that's being done and you're being evaluated directly with someone doing that. And then I see the next part.

So I really like the gradiated, I think that we can be really taking the lead and having a quality practicum that's, I think, stronger than ones that are present in Colorado and Oregon. So anyway, thank you so much, Anne. I'm really excited to see this moving forward.

Thank you. Next, I believe is Chris, and then we'll go into the chat after this to see what comments are there.

Chris, your mic has been enabled. Unmute yourself when you're ready.

Hi, y'all. Well, for those that don't know me, I'm Chris Caldwell, founder, executive director for End of Life Psychedelic Care. So we are primarily an educational organization, and we've trained approximately 700 students to date.

So I do have a few questions. Brenda, really quick question first.

Is this subcommittee responsible for determining CE's No, not right now. I think that would definitely be there. Oh, yes, most definitely. So I think that's going to come later on as far as the education and training goes. Yes, there's been some discussion about CE, CEUs, and that sort of thing, and getting credited hours for that, especially for every two years when you have to renew your license and you're needing CEUs.

And as far as psilocybin goes, the ongoing training with that is, I think, essential with this particular program. All right, thank you. So yeah, a much longer sort of comment and question. For those who participated in the end of life subcommittee the other day, I was arguing for EOL being an adjunct training. So something in addition to the core training. And as such, had recommended nine competencies and effectively 19 hours of live instruction, which does include didactic plus experiential plus breakout sessions, a lot of interactivity in that. And then plus at least five hours on homework pre-recorded and other things that we just couldn't fit into the live sessions.

So I'm curious, the program here is recommending 10 to 15, which arguably, get somebody started, but I don't think it's going to be sufficient Um, For someone who wants to work closer to the end of life because we've talked about this being a pretty major continuum from initial diagnosis, all the way to the close to end of life so I would question that, but I think.

More importantly, Brenda and Dom, I was wondering, you know, we've been talking a lot about reciprocity and I'm not sure I totally understand it. So forgive me for that. But if if you want to have these programs in place to kick off the actual delivery of services by the end of the year and you're you're allowing reciprocity from Oregon and and Colorado training organizations, they don't provide end of life modules sufficient to train anybody.

They, you know, I teach one, teach one for Lisa. Thank you.

But, you know, that's a single, a single session. So I'm really curious as to how that may be handled. Oh, and one more comment, though, if you don't mind. So I can see, Larry, I concede that, you know, folding the end of life portion or module into, because I think you said 10 to 15 hours into the core makes it easier on the practicum and supervisory requirements. So I will say that. But yeah, the reciprocity is what's really interesting to me.

Thank you, Chris. I think after, because I attended Larry's meeting yesterday, that this is something that, yes, should definitely be in there because I think this is something that is... essential, even if someone who hasn't had any experience with learning end of life care or any type of study.

having something in the education part and one of the modules I think would be one thing that could be in there to just even as to introduce people to this, because it really has not been mentioned a whole lot, I think, in other programs. The other thing, too, is substance use programs. Like, for instance, I have a license in substance and addiction. Okay, next. And even though that that's a separate thing, you know, how is that going to look like for the psilocybin program. So there's still a lot on the table here to be discussed and put into learning modules as well. So, well, thank you for that, Chris. I really appreciate that.

Denali, your mic has been enabled. You may unmute yourself.

Hi, thanks everybody. And thank you, Anne, for the presentation. I thought it was really helpful to conceptualize some of, yeah, how to bridge, you know, where we are in the draft with where, you know, would really put us at the cutting edge of both, you know, quality and accessibility and safety. I think that you've struck a really strong balance. A couple of things I the department.

You know, perspective that we're close with the regulations, a couple of things jump out as missing between what was presented and what's in the drafts, at least the version that's been sent to the public. Big ones, I think,

especially given the conversation we had an end of life yesterday, is that, you know, specific, if we cannot create a specific version, certification requirement for people to provide care to vulnerable, specifically uniquely vulnerable populations, which I think was the perspective I heard, then I think it's that much more important that we have specific didactic requirements for those indications.

So I think from what's been presented, you know, that would be substance use disorder, end of life, suicidality, PTSD, that that be incorporated into curriculum requirements. And then I do really like this permit, like the training permit. model, but that would require incorporation within regulations. So it's a new permit type, whether we call it a training permit or a practitioner in training permit or some other name, it would be a new permit type.

And I do think it's important that it have a DOH permit designation because I think what's key to the affordability part of that model is that person can count as one of the two practitioners that's required under other sections of the department regulations. And then one final thought that I think is unique to us in New Mexico, I've been thinking a lot about, you know, whether we need some safety parameters around ways that people, yes, we need an expansion for practicums to be feasible.

for them to be operated on well patients, those without qualifying conditions. And within the training program, educators and students having that experience, that's very needed. And I appreciate from the presentation and consensus and conversation the need for experience with people who do have qualifying conditions. I think both are needed. And specifically within that qualifying condition, I think we maybe need to think about parameters for safety.

about whether the educational institution can certify a clinician or sorry, certify a diagnosis and medically clear someone just because I think they're there's perhaps an inherent incentive for people to be cleared so that people can get their educational hours.

Thank you, Denali. Yes, I think that what you're saying here is having a permit after, you know, people have gone through this program, you know, I think that's a very... and I think that is a very important part for this because I think that as far as going through a program like this, this is such a special thing. And especially with learning and going through all of the education modules and finally like coming out at the end of, you know, the program with 120 or 150 hours is quite a bit.

While you were talking, I was thinking to myself, I thought, you know, with these specialty types of things, especially end of life or substance use, maybe, having some type of internship with people that are going through the program that want to go into For example, end of life, maybe having some kind of other specialized training in that as like an intern. So I don't know. I was just thinking about that idea while you were talking that that could also be a possibility.

But then again, how much time is this going to take? How much is this going to cost? Maybe that's for later on as the program matures and develops. But I think having some of these other special things in the learning modules are at least giving students an idea of the other conditions that they could possibly work with if they choose to specialize in types of things. So, okay. I'll stop talking now. Who's next?

Okay. Admit. We have Chris. Chris.

Hello everyone. Thank you Anne for The presentation and I just wanted to say that I. I think that's a much more balanced approach I do like that in that model, Um, and facilitators are trained together and have the same requirements. I think that is. a Big piece of that and I think. that training side by side with clinical facilitators in Colorado is important. For me, Um, I think Um... you know, going down the rabbit hole of individual training for every qualified condition is going to be especially as that list expands, each are going to have their own Issues and I also think that if. We.

put too many training requirements for each of those qualifying conditions into the regulations it's going to limit accessibility through just how much training people have to do. And so. Although I am concerned that the

current regulations maybe don't have enough Um, training around PTSD or trauma I But think. it would be better for me to work with veteran organizations and people like firefighters from plant medicine to train and vet individual organizations who then we can refer specific patients to Um.

One question I do have is if we change these requirements, Are we going to look at changing our reciprocity since we don't have any in state certified programs. Well, Will people have to take additional practicum to receive reciprocity? And we may have covered this, but I just wanted to double check. Hmph.

Well, that kind of stumped me a little bit. So I think we're still, you know, we have some... uh, idea of what reciprocity will look like. If Dominic wanted to weigh in on that a little bit more, I'll hand it over to you, Dominic. Sure.

I mean, as far as reciprocity, I mean, again, what we really have right now is we're just stating that they have to do a crosswalk of the curriculum, whatever ends up being required in New Mexico. So in other words, showing that there is comparable coverage in each of the areas that'll be required in New Mexico. And once that is there, then the other piece would be, and this is to match the same thing that we're requiring even in-state up until December 31st of 27 is that 40 contact hours with patients to ensure that they actually do have some interactions with patients through their program or even if it's been beyond it, if their program didn't have quite as many hours from some of the other areas. And so that's actually the requirement for it.

So if we did change what the requirements in the curriculum in New Mexico are, change that aspect of the ressococin.

Thank you. Yeah. Okay.

Looks like we have Dr. Larry again. Larry, go ahead. Good. Thank you. I just wanted to convey a little bit what came from the end of life committee yesterday. I mean, there was a pretty strong feeling that end of life is a distinct enough set that really does need specific training. Many of the programs in Colorado have just a number, a few number of hours. So I think if we did reciprocity for now, that people probably would need to do an additional module somewhere to do that.

As far as long-term, I think. I think that there could be two approaches. In New Mexico, given we only right now have four indications, and personally, I think substance use will be probably the least one. I mean, I think having people spend, you know, 10, 15 hours on end of life, I would advocate would be reasonable to have at core. But I think they're very much going to continue to be a need for programs like Chris's, because there's people who are going to have trained in Colorado and Oregon and will need that.

If we do have end of life as strong an area here as I suspect it will be, I would hope that there would be a crystal ball for them to get more training at programs around the country, including yours, in end of life. Because honestly, 15 hours is even not that long if that's going to be your focus. So that's my thought on balancing that. Is it integrated or is it extra? Thank you.

Thank you, Larry. So that's, Next we have Lisa.

Lisa, your mic has been enabled. You may unmute yourself.

Thank you. I just wanted to agree with what Chris was saying earlier on the specialized training and redundancy of that. Considering that licensed practitioners and providers are all the licensed and experienced, I don't see a need for them to go through extra training and PTSD or depression because it's giving that all the trained in that modality.

and organizations in general uses non-directive approach I would assume they would not really work with those people and provide therapy during the skill set and session itself. And most of the work will be done after the session. So, and at this point, I think they're all qualified to do that.

I also agree with Chris Cudwell. about a need for standalone training on end of life. I think end of life is a very niche area that requires additional training. And what we offering in our general program is not enough to make someone a specialist in that department. Maybe generalist, yes, but not a specialist.

And also, I would love to see, and I made a comment in the chat, I would love to see a separate module for prescribers that would focus on prescribing and Diagnosing. clients.

Thank you. Let's see. Who's next?

I see Dominic's hand up. Yeah, thank you. I just wanted to go back to a point that was raised earlier about a training permit. And I just want to note that that really wouldn't be necessary with the model that we have and the way that we put the practitioner aspect in there. Just because that already would be covered as them being a registered student with an educational program where they have that ability to be a part of those training sessions, including to conduct them under supervision. So that sort of fits in with that training part. Now, Denali, you brought up, I think it was Denali, please forgive me if I am misremembering, but you brought up an interesting part about them, the students at that point counting towards part of the ratio.

And we can definitely take a look at that if that would be after they've completed so many hours to be a part of that rather than needing to create an entire other permit or certification level. But we could definitely look at that. I'll take that on back as well. So thank you. I just wanted to present that because that's already was part of the idea as far as not needing another permit with that practicum because those students already will have that kind of protection ability to be there as a part of being registered as a student with an educational program.

Thank you, Dominic. And I'll let's see, I'll take the last two and then I want to try to get into some of the comments in the chat after Ian. So next, I think it's Erica. Is that it?

Yes, Erica, your mic is enabled.

You may unmute yourself, Erica. There we go.

So I had a question about the document that was sent out to the public and there's been some confusion among us out here and then during the last meeting it sounded like there was some confusion in the committee as well. So I just wanted some clarification on the reciprocity because there are two different dates that have been set. One is the end of 2026 and one is June 2027. And I was wondering if I'm just missing the difference between those two dates, reciprocity for something different, number one.

And number two, I would suggest that reciprocity the June, the mid-June date would be much more feasible for many of us who are quite busy, but very invested and interested in this.

I think we did come to a consensus on June 27th, the year 20-no, not June 27th, butIt was, It's December 31st of 27.

And so we're seeing an earlier version where what we really said is we put it in as a placeholder because we wanted to have the conversation and the decision across the board was those dates that you really were seeing for reciprocity out of state and for the in-state programs, for example, all we put it all to December 31st of 27. So that way it allows the time for the infrastructure build.

Thank you so much. That means a lot.

Absolutely. And that's a part of it, too, is sometimes we have to put a placeholder in to have the conversations. That one specifically, or those dates, were placeholders. Sure. And we're following so closely.

Yeah. Some of us are following so closely, we're like, I appreciate that.

Thank you. You're welcome. Thank you. Yeah, the goal post keeps moving, right?

We got it. We got to kind of do it that way. Thank you, Dominic. Anything you want to add, Dominic, while you have?

No, I just put my hand up to answer that question.

Okay, thank you. And we'll take Ian next, and then I'm going to go into the chat and say whatever people have to say in the chat. Go ahead, Ian.

Yeah, so I just wanted to bring up because I've heard it come up a few times about people wanting more some sort of certification or specialization training. I just kind of wanted to remind people that generally like Um, of people that practice. So like eventually the psilocybin assisted therapy association or some other professional association will end up creating like certifications like we see with nursing and you can become a psychiatric mental health nurse.

You can become a critical care nurse. All nurses can perform the job of all other nurses but they can take a specialization route where it's then like an endorsement saying this person has completed extra training. But that doesn't need to be created here at the Department of Health. That will come naturally as the field progresses.

Thank you, Ian. I really appreciate that because it's the same for us therapists as well. For instance, I'm certified in autism and ADHD. There's certain things that you can go into and specialize in like other types of modalities for therapists, like EMDR and things of that nature. So, uh, As far as specializing and getting trained and all of that, I think if you already are in the medical field, mental health field, you already have a really great foundation for taking this program.

Already had other training in in psychedelics in general. So yeah, I think this is a Um... still developing and still needs, we're getting there closer and closer. So I wanted to go back to the chat. Let's see the beginning of the meeting here. It says, this is from Paul.

Paul Walton, on behalf of Amy Wong, could not be here but asked if she could make a comment, says, thank you for the opportunity to offer my perspective on what should be defined as a credible psilocybin facilitator training program. First, the curriculum must be clinically and trauma-informed. Second, ethics must be woven throughout the program, not confined to a single module. Facilitators need sufficient knowledge of trauma, disassociation, psychiatric risk, grief, concerns, substance use, and the populations they may serve, including people experiencing depression, PTSD, substance use concerns, serious illness, and end-of-life distress. They must be able to recognize complexities and individual vulnerability, understand the limits of their scope, and know when to consult, refer, pause, or decline to proceed.

Students should repeatedly engage with the consent, power, touch, boundaries, dual relationships, cultural humility, conflicts of interest, heightened suggestibility, Ethical competence means being able to perceive risks, tolerate uncertainty, seek consultation, receive feedback, and repair harm. It is an ongoing practice.

Third, programs need a meaningful practicum. Students should be observed practicing preparation, screening difficult conversations, boundary setting, crisis response, facilitation and integration. Competence should be demonstrated through supervised experience, not assumed from attendance or written assignments. Periodic practicum-based competency review at some regular interview would help facilitate keep these skills active.

Fourth, admissions and evaluation should assess interpersonal maturity, emotional regulation, self-awareness, self-reflective accountability, and the capacity to receive and integrate feedback. Facilitators should also participate in ongoing consultation or peer consultation groups. These practices demonstrate readiness to hold responsibility for vulnerable people. Ultimately, safety is not merely a protocol surrounding the intervention.

Safety is an essential ingredient in the intervention itself. A strong program prepares facilitators to bring sound judgment, accountability, humility, and respect for the full personhood of every participant. So I want to thank Amy for writing that. That encapsulates all the things that therapists need to know when they're doing the work.

And this program, I hope, will be able to have that in there in our modules.

Let's see. This is a previously from Ian, just a clarification approved new qualifying conditions like major depressive disorder will not require a new legislation. The board may recommend new qualifying conditions for the secretary's approval, assuming there is sufficient evidence. And then we go into the next slide. Let's see. The first trimester, this is by.

Dr. Fatemi, the first trimester is a CPPA, is didactic and personal discovery, trauma processing, and then we go into practicum, then we go back into didactic. So she's basically saying what she said previously to have this be kind of like an amalgam of didactic and practicum in the same language. Learning experience throughout the program. Vanessa says, I've been working on EOL for 20 plus years. One EOL session live does not seem to be enough truly to understand this complex time.

Anne previously said, "Prep and integration would be covered in the treatment modules and the core skills and ethics section." Um, Lisa talked about, I'd love to see a module for prescribers as well, and include all participants and your suggestions as peer support or retreat style, and what is experiential is my understanding. And then we have Jim Dodson.

I am a patient who experienced a successful outcome from this program four years ago. By choosing bring your own journey option, when my psychiatrist said I was treatment resistant, I felt like a death sentence. I asked if the psychedelic treatment successes I was hearing about were worth taking the risk. Absolutely, I was told. Although I would need to go it alone because it was illegal then, as it remains now.

Ten years of PTSD was worth the risk to me, and I am grateful for my psychiatrist had the courage to be so honest with me. Noting the medicine to have a trustworthy safety profile, I was encouraged to meet the mushroom alone and the safety and comfort of my own home. I returned to my psychiatrist in the following months, and finally I was treatment receptive. I spent the next two years in therapy. On the journey to individuation, that became transformative, giving me a new life of wholeness.

The consumption of the medicine is a private, intimate dance into the unknown. My psychiatrist told me that the brain hates uncertainty. Facing it alone in life is far harder than facing it alone with the mushroom. The lessons learned are inner direct where no facilitator can go. There's no reason to expect any adverse events that threaten life.

All the puffed up training expenses for therapists who pass those costs onto patients like me is why the programs are failing in Oregon and Colorado.

Only rich white patients are able to participate. Please allow the patient to choose the bring your own journey option. I do not want an audience, nor do I want to pay for unnecessary upgrades. I am not a commodity for new business model. I need healing to survive. Please respect my privacy in this matter. If other patients too choose to pay for someone to hold their hand and they can afford it, so be it.

But old men like me who cannot afford to pay That would make me a fluke. I believe the first year of this program should serve those who cannot pay. that would get noticed and set the bar. I continue my relationship with my psychiatrist who is an avid participant in this process. Practitioners are highly valuable and after the consumption but not so much during it. So this is very heartfelt. This is exactly what we're trying to understand as far as this program goes. And I really appreciate Jim's comment here.

I think we all understand where he's coming from. And then Gregory Evans was saying regarding well participants, I think we could write this into the recommendation to create a platform for program development and build in space for those well hours to be skipped for reciprocity experiences, doing a ramp up for legacy practitioners. Need to be clear about setting the education standards versus mitigating pathways for the ready workforce to be stood up quickly.

Um, And then Denali was talking about the DOH's recommended CE requirements in their draft rules right now. Don't remember the amounts. And then Gregory said certified clinicians, eight hours, two years. Facilitators, 20 hours, two years. Practitioners, 20 hours, two years.

Um, Let's see. New Mexico. This is by Anne. New Mexico hasn't adopted a non-directive approach of Colorado of Oregon. It is a treatment for condition X. Gregory Evans, just to be clear about, I hear the word being used, but there's not a medical prescription in this program. I would like to invite the committee to reinforce this language as the specified behind this. this. Okay. Denali Wilson. Thanks, Dominic. That's helpful. Yes, I think we can work in the registered student piece. I can work on recommendation language for incorporating them as one of the two people required to be present. And Dr. Fatemi said, thank you all for your hard work and care.

We're so fortunate to be in New Mexico and what an honor it is to serve our local community and take good care and have a lovely weekend. And Jim said, thank you, Jim, for saying that. the statement of his own experience in this. So after going through all of that, we're ready to take who's next for a comment or suggestions. Is that Catherine?

Yep. Thank you, Brenda, for reading those. Next, Catherine, your mic has been...

unmutedYes, hello. Can we speak one, Riddhi? Yeah, can you hear me? Yes. Yes. Okay. Awesome. So a couple of things I just wanted to say. The first is that I do. I do want to just make it like almost all be thinking about the fact that like adding all of this, this training, I think all this training that we're talking about is, is necessary. It's important, but I really struggle whenever I hear people talking about affordability and then we're talking about like, you know, hundreds of hours of training.

Like I don't, I'm not convinced unless there's subsidies by the state to help out with training. struggling to see how this is going to be more affordable than the other states, because we're talking about a lot of training here.

And so I think we need to be looking at how can we, what can we do around that?

And so one of the things that came to mind, which I don't think is much, but I just want to throw it out. I'm also hearing a lot about how end of life is very specialized. And I do agree that that is the case. It requires certain expertise that not, everybody, I'd say the majority of licensed counselors may not have, and social workers, etc. I'm almost wondering if it needs to be its own track, like it needs to have its own specialty, its own area of expertise, and its own training, so that we're not adding more training to everybody's plate, which I'm trying to think of ways to make it more affordable.

So I'm probably being devil's advocate here by even bringing this up. It can create complexity, but it might also make things more simple depending on how we want to look at it. But I'm just almost wondering if end of life deserves its own.

So anyway, thank you for listening.

Thank you, Catherine. Yes, I think I've been thinking a lot about this too, about specialties, because I... I think what you brought up here is having its own track and. What would that look like? What would training for psilocybin be in that track? And also too, for addiction too. Addiction is a thing that not very many therapists are trained in and it's a specialty onto its own. So maybe we should look at, you know, these later on down the road as specialties with their own types of training.

But however, yes, I think you're absolutely right. The affordability, the costs, you know, how much is all of this going to cost at this? You know, I don't think we really have a number yet on what that's going to be like, but we all think we all know that.

uh, having an affordable training and education format for everyone would be a wonderful thing to have. But we're just not there yet, I think, with the affordability numbers. But we still have to have that, you know, in the back of our brains somewhere. Like, yes, we would like to have all of the presents under the Christmas tree. We

just can't do it. But I think what you're saying is this is really worth looking at.

And maybe the training and education committee can take a look at that and see if, put our heads together and see if we can come up with something. Maybe there's something already out there that we don't know about and that could also be an adjunct type of education to the program. I don't know.

Is there a note? Hands up at this moment.

Okay, well, let me read this from Jim.

uh, Trainers feed off a therapist who pass it on to patients. None of it is affordable or needed. If the patient trusts their psychiatrist, that is all that is needed. Thank you for that, Jim. Thank you. And I do want to say this is a medical model here that we're looking at for New Mexico. And this is one of the things that is limiting in some respects. However, this is the program that we're working with at this point in time.

Okay, Desperate.

oh her mic I think she's having an issue with her mic.

As your mic is on mute.

Yeah, I got it. Yeah, thanks Brenda for pointing that out again. Oh, sorry. Yeah, thank you for pointing that out again. And, you know, it's one thing to try to hold on to, you know, the... pristine idealistic situation where you know a lot of us have been brought into the medicine um you know on our own with our own people whether it's out in the field in the mountain at someone's house or however it is um and then it there's also the track where this is the medical psilocybin which is being regulated by the state and again it is finding that middle ground of you know where at at some point government interference of this and now it there's this kind of moving back into this space and at this point again to reiterate that this is just the starting point and these are just the steps you know that we're we're gonna go for forward I do definitely appreciate you know this idea of Certifications my my sister is an RN and just recently got her flight certification so now she is one of those people who are flying to Roswell and so forth and transporting NICU back to Albuquerque.

And that was hard to come by. You know, you have to pass those tests in order to get the certification for those things. So they're very, very important and very valuable. So having this discussion about whether or not we have, you know, tracks for addiction. And then kind of back to Amy's point, which was a very long list of things of high expectations for ourselves. I want to say that initially I'm just kind of thinking like that's a lot of words, a lot of words and a lot of expectations and a lot of idealism in the places of like facilitators, trainers, people who are certified to hold space.

And none of them None of us as humans, I think, are able to uphold to that, but it is a great place to, to try to, to be and understand that. And again, going back to the middle ground, I'm just thinking about You know if there is somebody who is you know Indigenous or otherwise who has decided, you know the underground who wants to kind of come into this model, right? Someone from the underground from this more idealistic place wants to kind of come into enter into this legal framework You know the barriers that might be in place to doing so because what are those transferable skills?

What are those transferable ideas of these ideal of ideals that we have of how these facilities? they're supposed to be. And I feel like because of the colonialized capitalistic idea and expectations of what certification means, that does necessitate money to Jim's point. And it means having that language to say, you know, I hit all these metrics because this institution says that I have been able to hit all these metrics.

And ignoring the fact that like in a lot of places, our indigenous ancestral knowledge, these underground pathways in which we've come to this medicine, you Are those words necessarily like being recognized and is there a pathway forward for those people who are coming from the underground into the legal space? I just kind of wanted to just point that out is it was something that was just you know jarring to me I know that you know first

for instance as a massage therapist I see a list of criteria and my immediate trigger is I'm not doing that.

I just kind of wanted to point that out pathway forward that yes, there might be barriers. Yes, there might be. But how do we move past those challenges, both in the legalese, the words, the certification, the money, but we are trying to hold that space for all of these things. And we are trying to going to move forward with the legalization, not legalize into the wrong terms, but you know, this legal place where The government is kind of moving into the space of like, all right, I can't think of the word, but it's just trying to find that middle ground from what our idealized space is. And you're right. Nothing is essentially is affordable. I don't know why any of us are paying for anything.

We've come up with this system that, you know, we're the only living species that has to pay to live. Cats don't have to pay for anything. Dogs don't have to pay for anything. So yes, we've got ourselves into this mess, but this is our way to move out of that system, I feel.

So anyways, off my soapbox again. Thank you, Despa. Despa, I think that you were hitting on a lot of really important issues that need to be talked about here. Yeah. When we look at the medical system, You know, it has, you know, its format. And what does that mean? Like, you really spoke to me when you said, you know, when you're a massage therapist and you look at all that stuff and you go, wow. Yeah, you know, you are a person of integrity and honesty and truth.

So it comes naturally as a provider. But when it's... They're in black and white, and it's almost kind of like it's dictating to something that is set up on a pedestal for all of us to reach. And it's... You're exactly right. We're human beings when it comes down to it. And when we have to do all of these things, how are we going to... bring that into It's just that it just feels limiting. I think this is what I'm trying to get at.

When there's such a high bar here that and hoops that everyone has to jump through in order to do something that is Really so personal. especially if you have a very, very personal relationship with the medicine, you know, It just sterilizes it. I guess that would be the way to say it. But like you said, this is a medical program. This is the way it's set up. you know, maybe later on down the road, we can start to update But Work out a way to bring these people into from.

wherever they're coming from and have them Be part of this program. And I think this is, you know, this is just one step of many things to come, I think, as we. talk about these things in the meetings and start to bridge these gaps and create pathways that are much needed in this program.

I see Brenda. We do have Lisa. Lisa, your mic has been unmuted.

Great topic and talking about access would be helpful to understand the ratio of synchronous and asynchronous hours for the training.

Thank you, Lisa. We don't have, at least in the proposed rules, there is not a requirement for a particular ratio for synchronous and non-synchronous or asynchronous.

Are you planning to create created requirement or no?

That's not in the current proposed rules.

Okay, I will go back to the chat here again. Let's see. Larry Lehman said he agrees with DESPA that we should have a legacy pathway. Um, Gregory Evans says, I feel like if there were a psychedelic university with majors and specialized learning platforms, when it comes, when it, When it was coming of age, I may have chosen that path rather than managing my own learning. What we are building here right now is a pathway for the next generation to learn from the established knowledge base where it becomes embraced rather than having to be Lost in the shadows.

And Jim Dotson says, yes, does the bury the medical model if it does not respect the patient, let it fail. And how many like me have passed on in the last four years waiting for help that never comes. And Chris says, don't skip me, Brenda. Okay.

Chris had a comment saying, so do it. Oh, so do I, rather. Sorry, so do I. Brenda, we do have a hand up. We have a couple of hands up. Thank you for reading those. Gregory, your mic has been enabled. You may unmute yourself.

Well, here we are, folks. youIn the interest of time, I'm curious if the committee can come together and figure out what our deliverable is, what day we need it delivered, where we are at with with our focus and How we can end this meeting bringing all of this information together. I think we need to sit with it a little bit to get to the practicum hours, which is kind of the focus of this, our immediate need.

but You're just wondering how we can move forward from this point. And thank you, everybody.

Thank you, Gregory.

Brenda, we have a desk was hand up.

Hi, I just kind of wanted to, just to make a little bit of a clarification, you know, as being responsible for the position that I have on the advisory board, you know, to me that the point is to have a conversation and discussion as a pathway forward as we're bridging these two or several different worlds actually into something that we can support for our people. But access for everyone, you know, all at once as the gates are open, it will be a limited number of people.

That's the unfortunate fact of this matter. Where the idealized world of everything is, my kid wants to burn everything down. I totally agree. But before we can do that, when structures or systems are completely destroyed, Gone. There has to either way, there has to be a pathway forward to the idealistic place. Right. So nothing is is just like we'll burn it all down. It's not about, you know, completely annihilating all the systems that are in place.

It's about small things. steps that we can take. And in that small, it's like the seed of a cottonwood tree. So I say all the time, it's like, you know, within that cottonwood seed are multiple blueprints for endless amounts of cottonwood seeds. If we can just find that one small step towards that pathway to that idealized state where we're all living in harmony and bliss, right? That's the right place to go.

And it may be small, but I feel like we can get there if we are fully present to the work that we have. And it is a pathway, but it takes small steps.

Thank you, Jesper. Now I see Chris.

Yes, Chris. Chris, you're up. She did not forget about you. I my comment was so do I was in regards to I agree with Desbaugh that we should have a legacy pathways. I guess I guess that wasn't clear, but. I was Wondering if you know I think. Ann's presentation is to where we need to be than the original regulations in it. But I'm wondering if we shouldn't maybe take that, polish it up a little bit and Um, perhaps have a couple other people from outside of our state who are Uhm?

Skilled in this field, evaluate that and maybe present on it before we make a decision. And I know that Dominic wants to get something through in August, but I also think this is really important and worth taking our time on. We are... moving this program really rapidly. And I think one of the advantage we had was to look at other state access models and we've completely kind of thrown that out the door and are reinventing the wheel all by ourselves.

And so, I just think it's worth the time to have some other outside experts kind of evaluate what we're doing.

Thank you, Chris.

And I'd be willing to reach out to some people.

Oh, that would be wonderful. That would be a wonderful, wonderful thing. Thank you, Chris. I really appreciate that. And bringing them into what their knowledge base is to training and education. And yes, have them contact me and. we'll see what they have to offer. That'd be wonderful. Thank you. All right, any other comments or suggestions or... ideas I just wanted to say in the chat, Jim Dotson says, the legacy model has history while the medical model is built for profit and itemization.

And like I said before, this is the model that we're working with right now, Jim. And we're just trying to get this small step off the ground and Yeah, I hear this quite a lot from a lot of people. It's, yes, your comment is, I think we all understand that this is something that it's a difficult thing to bridge.

Yes, I see. And Jim also said that Larry said this beautiful program team. And then Jim said patients are ignored routinely. We are all used to it. Yes, we understand, Jim. Thank you.

We do have a couple of hands up.

Okay. Who's next?

Pete, your mic has been enabled. Yeah, thank you. I'm just, I need to get off this call in a couple minutes and wondering about the idea of the, you know, work group in between these sessions, if that's going to be something official that, you know, anybody who wants to participate can be part of, or if we just keep kind of working unofficially of those of us who are involved.

Kate, I think uh We are In some ways, working unofficially to gather information to create this working group is uh, This is a good question for Dominic. So, Dominic, I wanted to ask you if I wanted to form this group so that we could get more support with the education and training part. It's unofficial at this point in time. Do I need to have an official type of working group?

No, Brenda, that would be up to you to sort of format. I mean, just as a reminder to everyone, Chris alluded to it a little earlier, we had announced it earlier today, is that we are going to be moving forward with a proposed rule. So the sooner if there are specific topics to include in or suggestions as far as hours, we really need them sooner rather than later. of that after the rule gets published or the proposed rule rather gets published and even after the hearing of it. But this is a part of what we've really continuously sort of been asking is what are the topics exactly? What needs to be included in?

And so while it's great to have these baseline conversations, we really need to have that specific data. So if that group wants to get together to get those specific topics, hours. That would be wonderful. And then pass that on to us. Thank you, Dominic.

okay uh next is lisa I think, is it Lisa or Ian?

Ian's next actually.

Sorry, I was muted myself. Yes, it's Ian. Hi.

Yes, I just wanted to Respond to. Um, Jim. It is, it can happen where patients are exhausted ignored i'm not going to deny any patient story um but this is not the forum for that um you'll call your legislator, have them change the law. But our job is to enforce and carry out that legislative duty.

Help.

But I don't want to stifle your Passion. You are passionate about the problems that you have, and I want to encourage you to seek the proper forums and to seek your legislator and see what can be done to make things

better for patients. Thank you.

Next is Lisa. We're at the top of the hour.

This here makes an enable.

We have a number of students reaching out to us and asking if they can enroll into our Oregon or Colorado In programs can transfer that training later on into New Mexico and as I mentioned, As of now, we don't have a clear answer, so we tell them to wait, and I would love to get a little bit more clarification on this issue. oh that's a very good question um dominic what do you think about that one because i think um since our our training in education is uh not quite formed yet uh you know, what would you suggest?

As I've been saying since we first started on the pathway of implementing the program, is until we have the regulations and that they're clear with regard to those potential pathways for reciprocity, I could not in good conscience recommend someone go through the training. But it is up to them eventually. But if you do look at the draft, there is a pretty good outline of what reciprocity may look like.

And we'll be doing that hearing really in just, I mean, as we were talking towards the end of August. So we're really looking at about six weeks from now for that public hearing. So you should have that information soon, Lisa, and for those students. I was just gonna say Brenda, since we are at the top of the hour, we do need to set the next meeting. At this point.

Um Let's see. DOH will be meeting on the 14th. And then Larry has a meeting on the 14th. We could do the 21st, either in the morning or the afternoon. If that's possible.

The 21st currently is open from the department side. Okay.

How about The morning, the 9 to 11?

That would work from the department side.

Okay, so our next meeting will be from 9 to 11 on Friday, August 21st. Again, the DOH has their meeting on the 14th from 9. One to three. And Larry Lehman has his... his It is meeting from 9 to 11. Okay, that sounds... Great. Thank you very much. And thank you all for coming today and participating. Really appreciate every one of your comments and suggestions. This has been a very productive meeting. And thank you all for coming today. Hope to see you in all the other meetings that are coming down the pipe here.

So thank you again, every one of you for participating. And thank you, the board here in DESPA. Chris, Dominic, Jorge, Ian, and everybody, Gregory, Lisa, everyone that's participated and spoke up. And I know there's probably some people that I've missed, but thank you very much for coming today. I really appreciate your input.

And on behalf of the department, I also would like to thank everybody. Having this input and the information in these conversations really helps us to determine what's going to work best for the program. And of course, to continue to have the conversations and adjust things as needed as the future arrives. So thank you, everybody. I hope you all have a great weekend.

Hmm.

My initial response is, Fuck if I know.