New Mexico Medical Psilocybin Program

Recommendations on Education and Training Requirements for Facilitators and Licensed Providers

Prepared for the Training and Education Committee — Draft for Discussion, July 17, 2026

Purpose and Framing

This document offers general recommendations, not a finalized plan, for the didactic and supervised-practice requirements for Facilitator and Licensed Provider (currently "Practitioner") permits under the Medical Psilocybin Act. It is intended to give the committee a defensible starting point for discussion.

These recommendations were developed from four sources: the committee's 6-12-26 draft training requirements and 6-25-26 draft outline for educational program applications and evaluation; the Healing Advocacy Fund's qualitative analysis of Colorado's psilocybin training requirements, based on interviews with 24 Oregon and Colorado training program operators, graduates, Indigenous scholars, and legacy practitioners; a comparative review of existing state standards (Oregon's 120-hour and Colorado's 150-hour requirements); and consultation with colleagues with direct experience in psilocybin training and supervision, including the case-presentation sign-off model used by Memoru, a healing center and consultation program in Boulder, Colorado.

The central design question is calibration. Oregon requires 120 hours of training, yet graduates interviewed in the Colorado analysis consistently reported that the didactic portion still did not allow enough time to go deep on any particular skill area. At the other end, Colorado's 150-hour requirement raises serious cost and access concerns, risks disincentivizing participation in the regulated model, and is not clearly supported by outcome data. The recommendations below aim for the defensible middle.

Recommendation 1: Retitle "Practitioner" as "Licensed Provider"

The permit title "Practitioner" is confusing and communicates nothing to the public about the holder's training and education. It also overlaps with existing licensure shorthand — most notably nurse practitioner — inviting the public to misread the credential in either direction. "Licensed Provider" communicates the distinguishing qualification directly — a professional license permitting delivery of medical, counseling, mental health, or behavioral health care — and pairs cleanly with the Facilitator title so patients can see the relationship between the two roles at a glance. This document uses Licensed Provider from here forward, retaining "Practitioner" only where quoting the current drafts.

Recommendation 2: Didactic Hours

Adopt a single state-level standard of 84 didactic hours for both Facilitator and Licensed Provider permits, with the curriculum allocation below.

This standard is high enough to treat trauma, suicidality, touch, ethics, and end-of-life care as standalone content areas with real depth, and low enough to keep training accessible in a state where trainees will pay out of pocket without federal student loans. Rather than tiering hour requirements by professional background, the existing test-out mechanism in the 6-25-26 draft (module-by-module examination, excluding the New Mexico module) lets experienced licensed clinicians move efficiently through material they have already mastered without lowering the standard

itself. This preserves a single quality bar while addressing the legitimate concern that licensed mental health professionals should not pay to repeat their graduate training.

Content area	**Hours**	**Notes**
Core psychotherapy skills and ethics	25–30	Holding therapeutic space; co-therapy skills (working as a dyad, role differentiation, communication between co-facilitators); transference and countertransference; power dynamics; boundaries; doing one's own work. Especially critical for permittees without a prior therapy background. Consistent with Colorado stakeholder recommendation that ethics comprise roughly 20% of didactic hours.
End-of-life and palliative care	10–15	Colorado requires end-of-life content; most existing programs include almost none. Includes physiological fragility of palliative patients and existential processing. Facilitators and Licensed Providers who will see end-of-life participants are required to have end-of-life practicum experience.
Trauma	8	Standalone requirement, not nested in other modules. Recognizing dissociation and trauma responses; somatic-based trauma work; verbal and non-verbal de-escalation. This module is not PTSD treatment training: additional training is needed to treat complex PTSD, and if PTSD treatment is outside the Licensed Provider's scope of practice, collaboration with a PTSD-trained provider is recommended or required.
Medicine, dosing, and clinical research literacy	8–10	Practical pharmacology (contraindications, interactions, metabolism), dosing, and how to find and read the psilocybin literature.
New Mexico module	6–8	Medical Psilocybin Act, patient flow, documentation, informed consent, cultural competency and sensitivity, SERT. Retained as drafted in the 6-12 outline; required of all permittees including reciprocal applicants.
Treatment models	6–8	Individual and group treatment models, group dynamics, and New Mexico-specific delivery models.

History and traditional use of psychedelics	3–4	Indigenous and traditional use of psilocybin and other psychedelics, lineage and reciprocity considerations, and the history of Western psychedelic research. Complements the New Mexico-specific history in the New Mexico module; the Colorado analysis emphasizes grounding in traditional practice, both historical and contemporary.
Somatic awareness and therapeutic touch	4–6	Safety touch and supportive touch, consent scripts, and role play. Colorado stakeholders recommended 4–6 hours as a standalone area.
Challenging experiences	2–4	Recognizing and supporting challenging experiences during and after administration sessions, distinguishing difficult-but-productive material from adverse events, post-session follow-up, and hallucinogen persisting perception disorder (HPPD): recognition, participant education, and referral.
Screening, suicidality, and crisis response, presented within the context of major and treatment-resistant depression	5–8	Practicing intake and screening conversations (not only memorizing contraindications), suicidality, referral out, and psychedelic emergencies.
Total	**84**	**Recommended single state-level standard. Component ranges are illustrative; the binding minimum is the total.**

Two notes on this allocation. First, transference and countertransference deserve explicit emphasis in the core skills block; they arise in psilocybin work in distinctive forms and are especially hazardous for providers who have not encountered them in a prior clinical container. Second, the Colorado analysis recommends that didactic delivery lean heavily on role play, scenario work, and small-group interactive learning rather than asynchronous content; the program application requirements could ask programs to demonstrate how skills are practiced, not just presented.

Recommendation 3: Practicum Structure and Training Permit

Reduce the overall practicum totals in the 6-12-26 draft (currently 100 hours for Facilitators, 120 for Practitioners) and scaffold the sequence so that trainees progress from lower-risk to higher-risk settings, and so that no one can complete supervised practice without real client contact:

1. Initial facilitation experience with well participants (approximately 30 hours). Two to three sessions as a facilitator in a retreat or peer-support model. This gives trainees supervised exposure to non-ordinary states before they work with clinical populations. Preparation and

integration sessions are required for each participant.

2. Co-facilitated cases with low-acuity clients (approximately 20 hours). A minimum of two cases co-facilitated with a licensed, permitted provider, including administration sessions and associated preparation and integration sessions. The practicum student holds a training permit at this point (issued on completion of step 1) and serves as the second person in the co-facilitation pair. Cases should involve low-acuity presentations — ideally nicotine use disorder or major depressive disorder. PTSD and other substance use disorders are not appropriate at this stage; end-of-life cases are addressed in Recommendation 4.

3. Group practicum (approximately 12 hours). Direct participation in group preparation, administration, and integration sessions, consistent with the group session minimums already in the 6-12-26 draft. A group requirement is novel among state programs but important given the group treatment models expected in New Mexico.

4. Supervisory hours, Licensed Providers only (10 hours). The trainee serves as the lead facilitator during administration and same-day therapy sessions, paired with a licensed, permitted provider acting as the secondary provider, and demonstrates supervisory skills in that role. Reduced from the 20 hours in the 6-12-26 draft.

Practicum total: approximately 62 hours for Facilitators (steps 1–3); approximately 72 hours for Licensed Providers (steps 1–4). This is a deliberate reduction from the 100/120 hours in the current draft: the scaffolded sequence, the training permit below, and the case-presentation checkpoint in Recommendation 4 provide stronger quality assurance than raw hour counts, at lower cost to trainees. Consultation hours in Recommendation 4 are in addition to, not part of, the practicum total.

Training permit. On completion of step 1, students should be issued a time-limited training permit authorizing them to practice under supervision — first as the second member of a co-facilitation pair during steps 2 and 3, and then while completing the consultation and case-presentation requirements in Recommendation 4. The full Facilitator or Licensed Provider permit issues only when all requirements are met. This mirrors the associate-license structures widely endorsed in the Colorado analysis, gives trainees a lawful pathway to accrue the client contact the practicum and sign-off require, and signals clearly to the public that a training permittee is practicing under supervision.

On placement logistics: the current draft requires all practicum hours to occur in an approved Healing Center. Given New Mexico's geography and the likely concentration of Healing Centers in a few population centers, the committee should consider an apprenticeship or site-supervisor model, similar to counseling licensure or direct-entry midwifery, in which an approved supervisor at an approved location can host practicum students who are not enrolled at a co-located training program. The Colorado analysis flags practicum placement as a major logistical bottleneck in Oregon and suggests a placement consortium as one remedy.

Recommendation 4: Supervision and Consultation Sign-Off

The mentoring requirement in the 6-12-26 draft (10 hours of post-graduation consultation with program faculty) is a good foundation but, as written, does not require the new permittee to have seen any clients. Consultation groups elsewhere have permitted path-of-least-resistance completion in which a trainee attends the required hours without ever presenting their own casework.

Recommended requirement: 20–30 total hours of supervision or consultation completed during

the training permit period, in addition to the practicum hours above, with sign-off tied to case presentation. Require each new Licensed Provider and Facilitator to present a minimum of two cases of clients they have personally worked with using regulated medicine, with the consultant or supervisor completing a standardized evaluation form on each. Each case presentation should take the form of a biopsychosocial case conceptualization, including a discussion of presenting concerns, risk factors, supportive factors, treatment considerations, and recommendations for aftercare. This mirrors the model used by Memoru, a healing center and consultation program in Boulder, Colorado, whose consultation program was developed under the leadership of one of the lead principal investigators in the MAPS-sponsored MDMA clinical trials and among the most experienced psychedelic therapists in the country. In Memoru's model, candidates must present two cases from their regulated-medicine practice so that consultants have an adequate basis to complete the required end-of-consultation evaluation. Pairing the consultation hours with a two-case-presentation requirement gives the state a meaningful competency checkpoint at modest administrative cost.

End-of-life work merits an additional checkpoint: before serving end-of-life participants independently, a permittee should complete at least one co-facilitated end-of-life case and present at least one end-of-life case in supervision or consultation. This pairs with the end-of-life practicum requirement noted in the curriculum table.

Supporting Evidence from the Colorado Qualitative Analysis

Findings from the Healing Advocacy Fund analysis that bear directly on the numbers above:

- Nearly all interviewees said supervised practice hours should be substantially increased relative to Oregon, and that didactic content should be supplemented with skill-building, role play, and scenario work rather than more information delivery.
- Trauma, suicidality, and touch were recommended as standalone hour requirements (minimums of roughly 5–6 hours for trauma, 5 for suicidality, and 4 for touch), and ethics as approximately 20% of total didactic hours.
- Screening was flagged as a practiced skill, not a memorized list: most clients arrive with diagnoses and medications, and facilitators must be able to conduct attuned intake conversations and refer out.
- Stakeholders warned in both directions: against a race to the bottom on cost, and against hour totals so high that they create access barriers and push providers and patients outside the regulated model.
- Continuing oversight after training — associate-style supervised periods, ongoing consultation, and peer support groups — was widely endorsed and supports the training permit and Recommendation 4.

Open Questions for the Committee

- Indications and volume. The current approved indications limit the pool of patients, and therefore practicum placements and trainee volume. Broader indication approval (particularly MDD, which has been proposed for addition in 2027, and GAD, which may take longer as studies remain in process) would materially change practicum feasibility.
- Federal timeline risk. If FDA approval arrives with reduced therapy-support requirements, longer state training programs may face enrollment pressure; the 84-hour standard is easier to defend and sustain in that scenario than Colorado's 150-hour model.

- Addiction and substance use disorder training. The current allocation addresses substance use only within screening and treatment models. Given that nicotine use disorder is an approved indication, the committee should decide whether a dedicated plan for addiction/SUD teaching is needed and where it belongs in the curriculum.
- Instructor vetting. If practicum placements are decoupled from training programs through an apprenticeship or site-supervisor model, the committee will need to decide who vets and approves site supervisors and instructors.