Medical Psilocybin - End of Life Care Committee Meeting Minutes:

Location: Teams

Date: 01/08/2026

Time: 15:00

Attendance: Johnathan Mouchet, Jorge Gonzales, Cathy Augeri, Dominick Zurlo, Ismail Zoutat, Adrian Estrada, Brenda Martinez, Lawrence Leeman, Robert Truckner, Danielle, Don Moser, Jason Juntunen, Joel Rosen, Brenda Burgard, Trina Zahller, Barak Wolff, Janine, Lisa Ginzburg, Janet Salcido, Marcus Ryals, Jenn Katma, James Hosobe, Herk Rodriguez, Chris Pekuski, Meredith McBranch, Brenda Burgard, Lorain Kosktranchuk, James Brown, Aarn Ashe, Catherine Warnock, Katie Hawke, Jennifer Johnson, Ben Edwards, Asher, Dan Jennings, Lida Fatemi, Van R Warren, Sophia Archibald, Denali Wilson, Joanna Leffeld, Roxroy Reid, Jeff Steinborn, Lorian Kostranchuk, Dan Huson.

Minute Taker: Ismail Zoutat

**This meeting was recorded. For specific details pertaining to the meeting, please refer to the recording located on the Medical Psilocybin Advisory Board Website: Psilocybin Advisory Board*

Agenda items

1. Welcome
    - Dominick Zurlo opened the meeting, welcoming participants, informing them that DOH will post a recording of the meetings within 5-10 business days.
    - The Chair, Dr. Leeman, welcomed attendees and stated two objectives for the inaugural meeting: participant introductions, and the development of a shared vision for the committee's scope and responsibilities. Dr. Leeman introduced himself as a University of New Mexico professor specializing in family medicine, obstetrics, addiction medicine, and psychedelic-assisted therapy research.
2. Committee Member Introductions

- Participants introduced themselves sequentially. Attendees included hospice physicians, pharmacists, nurses, therapists, social workers, chaplains, death doulas, educators, nonprofit leaders, and public members.
- Herc Rodriguez
    - Small business entrepreneur; opened a mushroom grow in downtown Albuquerque; open to opportunities.
- Kate Hawke
    - Trauma therapist for over 40 years; MAPS member since 1980s; works with death and expanded states of consciousness, including psychedelics.
- Danielle
    - End-of-life guide and death doula; founder of NM Death Care Network (501c3) providing care for those who cannot afford it.
- Asher
    - Beginning career as hospice chaplain; interested in integration into hospice care.
- Jen Katma
    - Corporate/public policy communications, chaplaincy, psychedelics; interested in educating chaplains and hospices.
- Catherine Warnock
    - Licensed professional counselor based in Las Cruces; Offers harm reduction-focused practitioner training.
- James Brown
    - Doctor of Pharmacy; trained in Oregon psilocybin program; 13+ years in palliative care.
- Meredith McBranch
    - Returning to school for clinical psychology; interested in psychedelic-assisted therapies; committed to equitable access.
- Brenda Burgard

    - Licensed practitioner; Advisory Board for Training and Education; President of Decriminalization of Psychedelics NM.

- Lisa Ginzburg
    - Director of Changa Institute; provides certification in psilocybin facilitation; recommends additional training for end-of-life clients.
- Joel Rosen
    - Family physician; offers medical aid in dying and ketamine-assisted therapy for end-of-life anxiety.
- Aaron Ashe
    - Supports people outside traditional systems; focuses on death and rebirth; grief work and men's retreats.
- Jason Juntunen
    - PMHNP student at UNM; strong interest in medical psilocybin therapy.
- Lida Fatemi
    - Former academic hospitalist; founder of ABQ Hospice; co-founded Conscious Physicians Psychedelics Academy.
- James Hosobe
    - Pharmaceutical scientist; collaborates with AZ DOH on psychedelic research
- Van R. Warren
    - Doctor of Oriental Medicine; death doula; main concern: accessibility.
- Barak Wolff
    - End of Life Options NM; advanced care planning; supports medical aid in dying info for clinicians/hospices.
- Trina Zahller

    - Licensed clinical social worker; 12 years in hospice/palliative care; enrolled in IPI psychedelic therapy training.

- Jennifer Johnson
    - RN, Clinical Director at Red Willow Hospice; developing end-of-life psychedelics program; completed Naropa facilitation program.
- Dan Huson
    - Rose City Laboratories; licensed psilocybin testing; study on tea preparation and boiling constituents.

3. Review of Bylaws, Scope and Responsibilities

- The Chair reviewed draft bylaws establishing the committee's advisory role, focus on safety and ethics, membership expectations, and quorum standards. He emphasized that end-of-life care is distinct from disease-based indications, as it represents a life process rather than a diagnosis.
- Out-of-state participants may attend and contribute but would not count toward quorum or voting. Conflicts of interest must be disclosed, with recusal where appropriate.
- Six proposed scope areas were outlined later expanded to seven. Each area was discussed with participant questions and responses as summarized below:
- Definition and Scope of End-of-Life Care
    - Question raised by Dr. Lida Fatemi: Asked whether eligibility would rely strictly on CMS hospice criteria, noting that many hospice patients lose capacity to consent. The Chair indicated the committee should define end-of-life care more broadly, potentially beginning at diagnosis of serious or terminal illness rather than late-stage hospice. Trina Zahller supported inclusion of palliative-stage patients and emphasized earlier intervention to address existential distress.
- Therapeutic Team Development
    - Denali Wilson emphasized the importance of creating an entry-level facilitator role for accessibility and affordability and raised the question of whether statute allows or requires

certification development. The Chair encouraged the committee to define the ideal care model first, then address legal and regulatory pathways.

- Inclusion of Family and Caregivers
    - Comment by Van Warren that dying is relational, and supported the inclusion of family members, while noting legal complexities. Danielle asked whether family participation could extend into bereavement and grief support following death. Dr. Leeman stated that end-of-life care may reasonably include caregivers and partners and encouraged development of the best care model before legal interpretation.
- Sites of End-of-Life Care
    - Dan Huson encouraged home-based care whenever possible to meet end-of-life patients where they are.
- Education and Workforce Development
    - Multiple participants including Jennifer Johnson, RN, and Catherine Warnock, LPC, emphasized specialized hospice training, affordability, and integration of existing programs.
- Ongoing Review and Updates
    - The Chair emphasized ongoing monitoring of scientific literature, state programs, and international models.
- Development of Optimal Care Plans at the end of life
    - Trina Zahller requested explicit inclusion of preparation and integration support. The Chair proposed adding a seventh scope area covering full therapeutic care planning.

4. Voting Outcome
    - Dominick Zurlo asked whether any participant objected to adoption of the bylaws including the newly added scope area. No objections were raised. The bylaws were formally accepted by consensus.
5. Future meetings: Frequency, length and next date

- The Chair, proposed biweekly meetings to maintain momentum. Participants expressed support in the chat.
- Dominick Zurlo confirmed the next meeting date as **January 22, 2026**, at 3:00 PM.
- No objections were raised

6. Proposed Structure
    - The Chair proposed incorporating short educational presentations at each meeting and forming informal working groups aligned to scope areas.
    - James Hosobe supported inviting subject-matter experts and offered to connect Arizona researchers.
    - James Brown recommended focused discussion on pharmacokinetics, polypharmacy, and screening tools for elderly and end-of-life populations.
    - The Chair acknowledged all suggestions and affirmed their relevance.
7. Adjournment
    - The Chair thanked participants for their engagement and emphasized the committee's significance.
8. The meeting was adjourned.

Email submission(s):

To: Dr. Larry Lehman and the DOH Department of Psilocybin,
Date: January 9, 2026

I wanted to submit the following comments and recommendations.

Thank You,
James jnbrown400@comcast.net

End of Life Committee Ideas & Notes

Research Articles, Resources, & References:

https://pmc.ncbi.nlm.nih.gov/articles/PMC10106897/

https://www.ccjm.org/content/92/4/248

https://pmc.ncbi.nlm.nih.gov/articles/PMC8542741/

https://onlinelibrary.wiley.com/doi/full/10.1002/ccr3.9305

https://pubmed.ncbi.nlm.nih.gov/37305379/

https://www.sciencedirect.com/science/article/pii/S0163834325002348

https://pubmed.ncbi.nlm.nih.gov/36184377/

https://pubmed.ncbi.nlm.nih.gov/35756295/

https://pubmed.ncbi.nlm.nih.gov/36263513/

What is Psilocybin?

Psilocybin *(4-phosphoryloxy-N,N-dimethyltryptamine)* comes from certain types of mushrooms found on nearly every continent. The mushrooms, which are also known as shrooms or magic mushrooms, are typically consumed dried or powdered. Psilocybin is part of a group of drugs called psychedelics—or hallucinogens—that have the potential to change a person's sense of reality, leading them to see, hear, and feel things that are not happening in real life, or to experience reality in a different way.

The mushrooms have a long history of use. There is evidence that indigenous people in Central America used them for healing and spiritual rituals as far back as 3000 B.C. Scientists began studying psilocybin decades ago, along with related substances like lysergic acid diethylamide (LSD), to examine their potential to treat mental illness, including substance use disorders.

Now, there is a new surge of interest in discovering how psilocybin works and its potential to help treat conditions such as depression, post-traumatic stress disorder (PTSD), addiction, pain, and neurodegenerative disorders. Individuals are also curious to see how psilocybin might affect their way of thinking and living. According to a survey published in 2021 of more than 7,000 people, some 7%—or about 500 people—reported having used psilocybin mushrooms in the past year. People who use them may hope to have fun, to improve their well-being, or to self-treat a medical disorder such as depression or anxiety.

How does Psilocyin work?

When a person takes psilocybin, their body converts it to another substance, psilocin. Psilocin attaches to and activates receptors, or binding sites, for the brain chemical serotonin, primarily the serotonin 5-hydroxytryptamine 2A (5HT2a) receptor. Researchers think this action is responsible for much of a person's subjective experience when they take the mushrooms.

The substance also affects how the brain works and how different brain regions communicate with each other. These altered patterns of brain activity contribute to a person's profound change in consciousness. Some regions increase in activity and connectedness while others decrease. Studies suggest that psilocybin can temporarily disrupt communication among regions of the brain known as the default mode network, which is most active when we self-reflect. Reducing a person's sense of self-awareness may lead to a greater feeling of openness and increased connectedness to the world.

What are the Effects?

Psilocybin has a wide range of potential effects. A person's personality and expectations of the experience at the time they take the drug—called the "set"—and the surrounding people and environment—called the "setting"—play a role in how they respond to it. Also important are the amount taken and potency (concentration and strength), as well as a person's age, unique biology, sex, personality, and history of drug use. Effects may include:

Altered Perception

Magic mushrooms typically cause shifts in how a person perceives reality. People may see colors, shapes, or scenes; hear things that aren't real; or lose their sense of time and space.

Mood and Perception Changes

A person taking psilocybin may have what's called a mystical experience, where they enter a dreamlike, euphoric state, perhaps having visions or reliving memories. They may have a different sense of self, feeling that they have no personal boundaries and are one with the universe – what some researchers call "oceanic self-boundlessness". This experience can be blissful, but it may also be frightening, and cause fear or panic.

Physical Effects

Psilocybin can cause many effects, some of them unpleasant. See "Is Psilocybin Safe?" for more information.

Safety?

Psilocybin has a low level of toxicity, which means that it has a low potential of causing potentially fatal events like breathing problems or a heart attack. However, studies show there are health risks associated with taking psilocybin, particularly when unsupervised and outside of a research study and clinical supervision. These include:

Dangerous Behavior

People may do higher-risk things after taking mushrooms in an unsupervised environment—driving dangerously or walking in traffic, for example—as they may be less aware of their physical surroundings and have an impairment in their ability to think clearly.

Physical Side Effects

Psilocybin typically raises blood pressure and heart rate, which may be dangerous for people with heart conditions. People may also experience side effects like agitation, confusion, vomiting or nausea, which may be severe and require medical attention. There is also the risk of misidentifying mushrooms and taking a toxic mushroom instead of psilocybin.

Fear

Some people who take magic mushrooms have extreme fear, anxiety, panic, or paranoia as they experience its hallucinogenic effects, which is known as a "bad trip."

Mental Health Issues

The risk of mental health problems such as psychosis or suicidality in supervised clinical settings among people who participate in research on psilocybin is low. However, poor mental health outcomes may be more likely outside of clinical use. For more information, see "What is the Relationship Between Psychedelic and Dissociative Drugs and Mental Illness?"

Hallucinogen Persisting Perception Disorder (HPPD)

More commonly called flashbacks, HPPD is when people experience the same images or scenes they saw when they were under the influence of a substance. Flashbacks can be brief, or they can reoccur for years after an experience with a substance. Studies suggest flashback episodes are rare and when they do occur are not always a negative experience.

Effects on the Mind and Body?

- **Effects vary widely.** Effects of psychedelic and dissociative drugs may be difficult to predict and depend on many factors. These include the amount taken and potency (concentration and strength), as well as a person's unique biology, age, sex, personality, mood, expectations, mindset—commonly

called “set”—and environment, or “setting.”[3,11] Using psychedelic and dissociative drugs that contain contaminants or using them in combination with other substances may also produce effects not associated with using these drugs alone.[12]

- **Psychedelic and dissociative drugs temporarily alter thought patterns, mood, and perceptions of reality.** People who use these substances report feeling strong emotions, ranging from intense happiness and a feeling of connectedness to fear, anxiety, and confusion.[1,3] Many people who use psychedelic drugs, such as psilocybin and LSD, report seeing vibrant shapes, colors, and scenes and reliving vivid memories.[10] People who use dissociative drugs, such as ketamine and PCP, describe experiencing distorted vision and hearing.[6]
- **Dissociative drugs can make people feel “detached.”** Many people who use dissociative drugs report feeling as though they are floating or are disconnected from their body.[13]
- **People may experience adverse health effects.** Physical side-effects of these substances, such as headache, nausea, or changes in heart rate, are generally not life-threatening.[14] However, illicitly manufactured or processed drugs may be contaminated with colorless and odorless fentanyl or other dangerous substances that can cause serious adverse events, including overdose and death.[15] Psychedelic or dissociative drugs may also produce adverse or debilitating psychological effects such as fear or anxiety.[3,16] Research is ongoing to better understand short- and long-term health effects of psychedelic and dissociative drugs. For more information, see “Are psychedelic and dissociative drugs safe?”
- **Using psychedelic and dissociative drugs has been linked to dangerous behavior and injuries.** People using these drugs may have impaired thought processes and perception that cause them to behave in unusual and sometimes dangerous ways. This may lead to injuries and other safety issues, particularly if there is not another individual present who can help prevent or respond to an emergency.[14] For more information, see “Are psychedelic and dissociative drugs safe?”

Psychedelic-assisted therapy?

Is when the use of psychedelic or dissociative drugs is integrated with other treatments, mainly talk therapy. Though more research is needed, scientists theorize that these substances promote brain changes that have the potential to promote healthy thought patterns, potentially supporting the effectiveness of talk therapy.

For example, some of these substances have mood effects that may boost the success of talk therapy. They may promote trust, sociability, and openness to suggestion; lessen anxiety; and reduce a person's worrying or self-talk. These effects may also help people to work through challenging emotions or experiences with their therapist. Changing the patterns of a person's brain activity may also disrupt habitual and potentially negative paths of thought and behavior, helping people adopt new and more positive ways of thinking. For more information, see "How do psychedelic and dissociative drugs work in the brain?"

A typical approach is to administer these drugs in one to three sessions, combined with counseling, in a relaxing setting designed to help the patient be receptive to new perceptions, thoughts, and feelings, including mystical-type experiences.

Adverse Effects?

- **Effects vary widely.** Effects of psychedelic and dissociative drugs may be difficult to predict and depend on many factors. These include the amount taken and potency (concentration and strength), as well as a person's age, unique biology, sex, personality, history of drug use, mood, expectations, mindset, and surroundings (sometimes called "set and setting").[3,10,11] Using psychedelic and dissociative drugs that contain contaminants or using them in combination with other substances may also produce effects not associated with using these drugs alone.[12,13,15]
- **Short-term physical side effects are typically mild or moderate but may require professional care.** People who take psychedelic or dissociative drugs may experience short-term side effects such as a headache, abdominal pain, nausea or vomiting, high blood pressure, rapid heartbeat, trembling, and diarrhea.[4,29] These are typically mild or moderate but may require medical care.[30] Importantly, reported cases of side-effects likely represent

only a very small number of people who use psychedelic or dissociative drugs, and most people who use these drugs do not seek emergency services.

However, related data can provide insights on the side effects that may lead people to seek help. For example, according to U.S. poison control hotline data from 2000-2016, the most common negative short-term effects experienced by people who called in about using LSD and psilocybin were agitation, rapid heartbeat, pupil dilation, confusion, and vomiting. An analysis of these data found about 17% of these callers (600 people) who had used LSD and 6% of callers (363 people) who had used psilocybin mushrooms were admitted to critical care.[31]

- **Adverse reactions include fear and anxiety.** People may also feel extreme emotions such as fear, confusion, or panic. These challenging experiences are also known as having a "bad trip."[32] Research on the extent to which such experiences occur and their impact on health is limited, in part because definitions and reporting of these experiences vary.
- **Using psychedelic and dissociative drugs has been linked to dangerous behavior and injuries.** People using these drugs may have impaired thought processes and perception that causes them to behave in unusual or dangerous ways. This may lead to injuries and other safety issues, particularly if there is no one else present who can help prevent or respond to an emergency.[14] In a survey of almost 2,000 people who took psilocybin outside of a medical setting and had a challenging experience, 11% said they had put themselves or others at risk of harm.[33] More research is needed to better understand the impact of psychedelic and dissociative drugs on driving, operating heavy machinery, or performing other tasks that could be dangerous if impaired.
- **Emerging evidence suggests certain psychedelic and dissociative drugs may contain dangerous adulterants.** For more information, see "Can psychedelic and dissociative drugs be adulterated with fentanyl and other dangerous contaminants?"
- **Fatal overdoses and serious adverse effects are rarely associated with typical use of commonly used psychedelic and dissociative drugs.**[14,34,35] A

2004 analysis of multiple studies estimated that psilocybin and LSD both have a safety ratio of 1000, meaning that the lethal dose of either drug is about 1000 times larger than a person would typically take for non-medical use.[36] However, some psychedelic and dissociative drugs—including NBOMes,[37,38] ibogaine,[39] and PCP[40] —have been associated with a small number of reported deaths and serious adverse health effects. Though more research is needed, evidence to date shows that fatal overdoses involving these substances are typically associated with taking very high doses or using combinations of drugs, particularly combining these substances with alcohol, or being placed in excessive physical restraints while displaying unsafe behavior.[16] More research is needed to understand to what extent certain psychedelic and dissociative drugs may be mixed with contaminants (such as fentanyl) that may cause an overdose. For more information, see "Can psychedelic and dissociative drugs be adulterated with fentanyl and other dangerous contaminants?"

- **Drug interactions may influence effects.** Though more study in this area is needed and reported cases are exceedingly rare, some researchers suspect psychedelic drugs may interact with other drugs or medications a person has taken, including prescription medicines that also increase levels of the hormone serotonin in the brain. Too much serotonin in the brain is called serotonin toxicity or serotonin syndrome. Symptoms are typically mild but can be life-threatening in rare cases.[41,42]
- **Use of some psychedelic and dissociative drugs rarely cause a condition called hallucinogen persisting perception disorder (HPPD).** Some people report recurrently perceiving the same images or scenes and having the same mood changes they experienced when they were under the influence of a psychedelic or dissociative drug sometime in the past. These perceptions, or "flashbacks," are typically mild and brief, lasting for seconds or minutes and occurring within a week of taking a substance.[43] However, people with HPPD report that these episodes last longer and can reoccur even years after an experience with a substance, causing distress and other problems that impact their lives.[44,45] Research on HPPD so far is limited and has relied mainly on self-reports on types and doses of the drugs believed to

have caused these symptoms. More research is needed to assess how and why HPPD occurs and to find ways to help prevent and treat it.

- **Some psychedelic and dissociative drugs have been associated with specific long-term health problems.** Research shows that long-term use of ketamine may cause ketamine-induced uropathy, a treatable but potentially serious condition that causes symptoms similar to those of a urinary tract infection.[46] Limited research also suggests using MDMA (considered by some to have psychedelic properties) may be associated with mild or moderate heart valve disease, in which one or more of the four valves controlling blood flow from the heart do not function normally.[47] In an analysis of studies conducted from 2015 through 2020, ibogaine use was associated with long QT syndrome, in which the electric impulses that control heartbeats function irregularly.[48]
- **Research on long-term mental health effects of psychedelic and dissociative drugs is ongoing.** More research is needed to better understand the long-term impacts of psychedelic and dissociative drugs on mental health. Mental health complications from psychedelic and dissociative drugs are currently extremely rare in clinical research settings, in part because these studies are highly controlled and participants are screened for existing mental illnesses.[32] For more information, see "What is the relationship between psychedelic and dissociative drugs and mental illness?"