Medical Psilocybin Training and Education Committee Meeting Minutes

Committee: Medical Psilocybin – Training and Education Committee
Date: January 23, 2026
Time: 1:00-3:00 PM
Location: Virtual Meeting
Chair: Brenda Burgard
Facilitator: Dominick Zurlo
Note taker: Katy Freytag
*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

Attendees

Augeri, Cathy, DOH
Batista, Carmen, DOH
Zurlo, Dominick, DOH
Martinez, Brenda V, DOH
Gonzales, Jorge, DOH
Truckner, Robert, DOH
Matthew Armstrong (Unverified)
Janine (Unverified)
Jason Burdge (Unverified)
Gallegos, Raymond, DOH
Brett Phelps (Unverified)
Francesca Banci
Deb Thorne, DMSc (Unverified)
Dr Lida Fatemi (Unverified)
Hanifa (Unverified)
shane mcdaniel
Eric Barlow (Unverified)
Jenn Romero
Deborah Weisner, LPCC (Unverified)
Brown, James
Eileen Brewer (she/her) (Unverified)
Catherine Warnock (Unverified)
Paul Walton (Unverified)
Kate Hawke
Evans, Gregory, DPS
Lisa Snyder (Unverified)
Patricia Stellamares
Lori Healy

Meredith McBranch (Unverified)
Schimmels, Ellen
Charles Hinson (Unverified)
Northwoods Panther
Taye Davis (Unverified)
Brenda Burgard
Brett Phelps (Unverified)
Montoya, Celina, DOH
Veracka, Rachel, DCA
Dr. Anne Metz LPC NMIT (Unverified)
Michael McDowell
James Hosobe (Unverified)
Ben Edwards (Unverified)
Aleutia Krikorian (Unverified)
Dan Jennings
Aleutia Krikorian (Unverified)
Taye Davis (Unverified)
Denali Wilson
Patricia Stellamares (Unverified)
Maureen Kolomeir
James Hosobe (Unverified)
Jarahson A (Unverified)
Marci Addy (Unverified)
Deborah Weisner, LPCC (Unverified)
Lisa Ginzburg (Unverified)
Katy Freytag

Agenda

1. Welcome and Introductions
2. Overview of Committee Purpose
3. Presentation of Draft Framework for Education & Training
4. Public Comments and Discussion
5. Next Steps and Scheduling

Key Discussion Points

1. Committee Purpose

- Establish education and training standards for psilocybin-assisted care in New Mexico.

- Ensure safety, ethics, cultural respect, and inclusion of indigenous and traditional practices.
- Align framework with NMDOH standards and evolving laws.

2. Draft Framework Highlights

- **Two-Part Structure:**
    - **Part 1: Education** – Foundational knowledge for all roles (history, neuroscience, ethics, safety, legal overview).
    - **Part 2: Training** – Skills-based, supervised practicum, role-specific pathways.
- **Intended Participants:** Mental health clinicians, indigenous healers, clergy, death doulas, medical providers, paraprofessionals, first responders.
- **Guiding Principles:** Safety, equity, cultural humility, trauma-informed care, interdisciplinary collaboration.
- **Training Components:** Preparation, facilitation, integration, ethics, scope of practice.
- **Reciprocity:** Recognition of prior training from other states/programs.
- **Oversight:** NMDOH Advisory Board with indigenous and community representation.

3. Public Comments & Suggestions

- **Multidisciplinary Approach:** Encourage cross-pollination among professions. In-person interactions foster deep interpersonal connections and meaningful wisdom sharing. Being physically present strengthens community bonds and creates more heartfelt relationships.
- **Role Clarity:** Define paraprofessionals and inclusion of non-licensed individuals with relevant experience.
- **Scope of Practice:** Emphasize robust training for vulnerable populations.
- **Curriculum Details:** Address total hours, ongoing education, affordability.
- **Accessibility:** Virtual and in-person options; accommodations for disabilities.
- **Practicum:** Include experiential learning; clarify if psilocybin use will be part of practicum.

- **Registry Proposal:** Centralized facilitator registry for accountability and harm reduction.
- **Definitions Needed:** Spiritual community, clinician roles, nondirective approach, trauma informed and somatic practitioners. practicums and about diagnosis.
- **Future Considerations:** Community outreach, cost structure, teacher training, rural access.

  Suggested change to wording: taking the mental health out and just leaving it as psilocybin assisted care.
- Regulation and law, for example, MD's LPN's that sort of thing went from a licensure.
- **From the chat:**
- It would be valuable to explore pathways for non-credentialed individuals who bring substantial lived and professional experience. Creating a structured way for them to participate could meaningfully support the legal model while honoring standards, safety, and scope of practice.
- Having a robust variety of faculty onboard is vital to delivering a solid certification program
- Are we considering psychedelic harm reduction training for law enforcement and emergency medical services? Like Denver is doing.
- Are we modeling the requirements after programs like IPI, CIIS, etc.?
- Facilitator registry
- Change medical professionals to healthcare professionals to include pharmacists & nurse practitioners.
- Mentorship over time is important; home groups, zoom calls offering seminars and break-out sessions, shadowing and hours in order to be certified and licensed also, have we thought about experiential training? this would be out-of-state or another legal molecule could be used…thoughts?
- Where would trauma-informed and/or somatic practitioners fit into the previous list of provider-types?
- Should there be a limitation on death doulas for psychotherapy etc. for non-end of life care?
- Is the physician list intended to be exhaustive of those authorized? I think that DOMs should be included by are not in the list.

- Don't forget about our deaf community. We will need interpretation (ASL) for both training and participation.
- Would the program allow psilocybin use for the practicum?
- CO has a distinguished educator role
- I wanted to recommend NM use specific language about potential reciprocity with other states' training programs and licensure. Colorado used fairly vague language about allowing people to be licensed who had gone through "substantively similar" programs, but didn't specific what that meant, and it has caused some issues about what counts and what doesn't. - Marci Addy, Program Director for Acadia Professional Learning, licensed in both OR and CO
- Please consider educators who are familiar with treatment protocols for pain specifically, as they are often different than those for mental health, but super common co-occurring with mental health.
- A lot of the didactic, seminar, home group, lecture pieces can be virtual with focus on in person practicums
- Would love to have a mobile clinic for rural and underserved communities!
- For new students in Phase 2: will the practicum hours be counted if they perform the practicum in another state? Ie Colorado, Oregon, other states in the future

Decisions & Action Items

- Post draft framework document for public review within a few business days.
- Collect written comments via email (include name, affiliation, and references).
- Schedule next meeting for **Friday, March 6, 2026, 1:00–3:00 PM**.
- Future meetings to focus on:
    - Definitions and scope of practice.
    - Practicum structure and experiential components.
    - Accessibility and equity considerations.
    - Teacher training and curriculum development.

Adjournment

Comments submitted by email

From: Anne Metz, PhD LPC NMIT (CO)
Annielmetz@gmail.com
Taos County Resident

Training Program Duration and Requirements

I recommend that training programs require a minimum of 150 hours with an experiential practicum component. New Mexico's program, as currently proposed, treats individuals with serious psychiatric conditions. Three of the four current qualifying conditions are significant and carry substantial risks including suicidality, relapse, and retraumatization. This is not a wellness or personal growth program—it is medical treatment for complex psychiatric presentations.

For this program to be successful, facilitators must be adequately trained to responsibly and safely navigate these clinical challenges. While individuals with less serious conditions may eventually access this program, the current qualifying conditions require a workforce prepared to manage high-risk scenarios. Anything less than 150 hours with practical application would inadequately prepare facilitators for the clinical realities they will face.

Risk Assessment and Safety Planning

The curriculum must include comprehensive training in risk assessment, specifically addressing suicidality and homicidality. Additionally, safety planning protocols should be integrated throughout the program. These components are essential to public safety and cannot be treated as optional or supplementary content.

Scope Limitations

If non-behavioral health professionals deliver these services, their approach must be nondirective. Advertising and providing treatment for mental health conditions will put practitioners at risk of legal action by licensing boards governing mental health treatment in the state. I recommend a two-level licensing process: one for clinical providers who have behavioral health licenses and are eligible to treat these conditions, and another for non-clinical providers who can provide nondirective treatment.

Public Safety Priority

Public safety must be established as the primary objective of this program. All curriculum development, competency standards, and supervision requirements should be evaluated through this lens.

Clarification of Facilitation vs. Psychotherapy
The document requires explicit clarification of what constitutes "facilitation" and how it differs from counseling and psychotherapy. This distinction is not merely semantic—it has legal and ethical implications.

Furthermore, the licensing restriction must be stated unambiguously: all professionals who are not licensed by the state to provide psychotherapy are prohibited from providing psychotherapy services. This applies universally, not exclusively to clergy. Any language suggesting otherwise creates confusion and potential liability.

From: James Brown
Jbrown9@phs.org

Therapeutic Harm Reduction Strategies
While harm reduction can be a way of supporting an individual who experiences substance misuse, it also consists of actions that an individual can take to reduce potential recreational harm. It is important to note that while harm reduction comes in many different 13 forms, not all harm reduction is the same.

Harm reduction within the general psychedelic community most commonly refers to helping clients understand the benefits or risks of the psychedelic substance they have decided to consume, which (in this context) is psilocybin. By providing information and education to clients, they can make informed decisions and hold realistic expectations about what they will experience within their journey (Pilecki et al, 2021).
Since licensed facilitators have boundaries regarding how they can further support the client beyond their journey, harm reduction is focused on providing information during the preparation and integration sessions, building rapport, utilizing empathy and understanding, and being authentic in interactions with the client (Gorman et al, 2021).
Within the general therapeutic treatment community, harm reduction is used to describe the idea that therapists will not deny treatment to an individual unless in severe situations where the facilitator would not feel comfortable treating the client; in other words, the therapist is meeting the individual "where they are at" in their treatment. As mentioned previously, the lack of a definition can create variance in training and treatment.

The strategies have been grouped and then themed according to time they are undertaken: (1) Preparatory strategies: knowledge seeking, mindset, setting, safety, body; (2) During the psychedelic experience: emotional support, music, modifying the environment and (3) After the experience (integration). Social setting and motivation for use were two key factors which were found to influence what harm reduction strategies were adopted. The intervention goal was to support users who may be suffering psychological distress during their psychedelic state.
Evaluative measures showed that approximately 50% of all episodes had resolved within 1–5 hours of arrival, suggesting the intervention was helpful for some people in reducing unwanted affective experiences such as fear, anxiety and sadness.

Participants were questioned regarding their use of preparation activities and consulted regarding their opinion on the perceived benefit of the presented preparation and enhancement strategies.

Drug checking as a harm reduction strategy

Presence of an emotional support person during the psychedelic experience emerged as a widely used harm reduction strategy

When applied to psychedelics, harm reduction involves providing accurate information, promoting safety, and supporting individuals before, during, and after their psychedelic experiences—without judgment or condemnation

https://pdxscholar.library.pdx.edu/cgi/viewcontent.cgi?article=8081&context=open_access_etds

https://pmc.ncbi.nlm.nih.gov/articles/PMC12495836/

https://www.sciencedirect.com/science/article/pii/S0278584625002957

https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/Documents/ELSI%20Draft-%20Harm%20Reduction%2012-12-2021.pdf

Harm reduction practices for psychedelics also include:

- **Journaling** to process and track emerging insights
- **Meditation** to sustain contemplative awareness
- **Creative expression** through art, music, or writing

- **Physical practices** like yoga to embody rather than merely intellectualize understanding

From: James Brown

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Emergency Preparedness and Response Recommendations for Psilocybin:
Management Approach

Supportive Care

- Provide a calm, quiet environment with minimal stimulation to reduce anxiety and agitation
- Monitor vital signs continuously
- Provide IV fluids if needed for dehydration
- Treat hyperthermia if present with cooling measures

Psychological Support

- Reassurance and verbal de-escalation for agitated patients
- Avoid physical restraints if possible as they may worsen psychological distress
- Consider psychiatric consultation for severe psychological reactions

Pharmacological Interventions

- For severe agitation or anxiety:
  - Benzodiazepines are first-line therapy
  - Consider lorazepam 1-2 mg IV/IM or diazepam 5-10 mg IV/IM
  - Titrate to effect for symptom control

Complications Management

- For persistent vomiting: antiemetics (ondansetron 4-8 mg IV)
- For severe myalgias: supportive care and hydration 2
- For rare cases of methemoglobinemia: consider methylene blue if symptomatic and levels >30%

Disposition

- Most patients can be discharged after 6-8 hours of observation if symptoms are resolving 3

- **Criteria for discharge:**
    - Resolution of hallucinations and altered mental status
    - Stable vital signs
    - Ability to tolerate oral intake
    - Safe discharge plan
- **Consider admission for:**
    - Persistent severe symptoms
    - Significant psychiatric symptoms
    - Evidence of rhabdomyolysis or other complications
    - Suspected co-ingestion of other substances

From: James Brown

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Screening and eligibility

- Diagnosis confirmed with a structured assessment
- Baseline symptom severity documented
- Medical history reviewed with focus on cardiovascular risk and seizure history
- Physical exam completed as needed
- Resting blood pressure and heart rate measured more than once if elevated
- Labs or ECG reviewed if your history suggests risk
- Personal history reviewed for psychosis, mania, severe dissociation and recent crisis
- Family history reviewed for schizophrenia-spectrum disorders, psychotic disorders and bipolar I disorder
- Current suicidality assessed with a clear threshold for exclusion or stabilization first (UCLA Health)

Medication and substance review

- Full medication list reviewed with doses and timing
- Over-the-counter meds and supplements included
- Serotonergic meds discussed with protocol rules and prescriber input
- Lithium and seizure risk topics discussed if relevant
- Stimulants, decongestants, nicotine and high caffeine use reviewed
- Alcohol and sedative use assessed for withdrawal risk
- A plan documented for any taper or washout, with relapse safeguards (PMC)

Preparation plan

- Preparation visits scheduled with clear goals
- Expectations discussed for perceptual changes lasting hours
- Coping skills practiced for fear, panic and loss of control feelings
- A plan documented for personal triggers and grounding techniques
- A written plan for what you want to focus on during the session (U.S. Food and Drug Administration)

Admission Session day plan

- Private room and minimized interruptions confirmed
- Staff roles defined for support and monitoring
- Vital sign monitoring schedule documented
- Nausea, headache and anxiety management plan documented
- Escalation thresholds documented for hypertension, agitation and confusion
- Transport home arranged in advance
- Discharge criteria documented, including no driving until the next day (clinicaltrials.gov)

Adverse reaction plan

- Steps for panic and agitation documented
- Steps for severe hypertension documented
- Steps for suicidality in the days after documented
- Who to call after hours and response time clarified
- When emergency services are used clarified (ScienceDirect)

Follow-up and integration plan

- First follow-up scheduled within a defined window
- Integration visits scheduled and attendance expectations set
- Daily self-tracking plan for sleep, anxiety and mood for at least one week
- Coordination plan with your clinician for medication management and relapse signals
- A plan to avoid major life decisions in the first week written down