# Medical Psilocybin – Dosage, Administration & Clinical Practice Committee

Date: January 30, 2026

Time: 8:00 PM – 9:36 PM (1h 36m)

Chair: Ian Dunn

Facilitator: Dominick Zurlo, DOH

Purpose: Review and adopt definitions for dosage levels and discuss clinical practice considerations



## Attendees & Introductions

Ian Dunn (Chair) – Overview of objectives and framework

Dominick Zurlo (DOH) – Administrative support

Jorge Gonzales (DOH) – Facilitator for introductions

Committee Members & Public Participants:

- Scott Folkman – Professor of Chemistry, expertise in potency and impurities
- Lara Marcucci – Peer Support Worker, nonprofit founder
- Chris Peskuski – Advisory Board Ambassador
- Brenda Burgard – Advisory Board, Education & Training Chair
- Lawrence M. Leeman – Advisory Board, psilocybin research
- James Brown – Doctor of Pharmacy, trained in Oregon
- Vincent Espinoza – LCSW, facilitator-in-training
- Eileen Brewer – Researcher, patient advocate
- Dan Jennings – Advisory Board, Research & Continuous Improvement Chair
- Kate Hawke – Advisory Board, end-of-life care, research collaborations
- Gregory Evans – Independent researcher, analytics/genomics
- Ellen Schimmelz – Psychiatric NP, educator
- Matthew Armstrong – Psilocybin advocate

# Agenda

Review Committee Role:

- Advisory capacity to Medical Psilocybin Advisory Board
- Expand community input, incorporate expertise, increase participation

Presentation by Ian Dunn:

- Objectives: Define dosage levels and relevant terminology
- Key Concepts Introduced:
    - Maximum Theoretical Psilocin (MTP): Combines measured psilocin + psilocybin (converted stoichiometrically)
    - Available Psilocin Fraction (APF): Ratio of psilocin to total psilocin equivalents
    - Onset Profile Categories: Provisional classifications for clinical planning
    - Dosage Levels Proposed: Sub-perceptual, mild perceptual, therapeutic perceptual, high dose

# Discussion Highlights

- Chris Peskuski: Prefer psilocybin equivalency over psilocin; terminology change to 'sub-hallucinogenic'
- Larry Leeman: APF lacks validation; avoid burden on growers; microdosing definitions premature
- Gregory Evans: Proposed acronyms PCN and PBCE framework; detailed dosage ranges
- Eileen Brewer: Lower doses relevant for pain/end-of-life care; avoid rigid definitions
- James Brown: Emphasized simplicity and patient individuality; include both psilocin and psilocybin
- Adrian Martinez: Shared real-world dosing trends; potency variability
- Shane McDaniel: Warned against 'paralysis by analysis'; keep framework simple
- Dominick Zurlo: Clarified guidelines vs regulations; flexibility for future research

# Votes & Decisions

- Adopt Definitions: Maximum Theoretical Psilocin (MTP) and Available Psilocin Fraction (APF) approved (10 in favor, 1 opposed)
- Dosage Levels: Not finalized; members invited to submit recommendations by Feb 2
- Next Meeting: Scheduled for Feb 27, 2026, at 1:00 PM (after legislative session)

## Action Items

- Committee Members: Submit dosage framework proposals and public comments to medicalpsilocybin@doh.nm.gov by Feb 2
- Department: Prepare module for reciprocity training differences; draft guidelines incorporating adopted definitions

## Key Themes

- Need for flexibility and data-driven evolution
- Balance between scientific rigor and practicality
- Importance of patient safety, informed consent, and cost considerations

**Public comments submitted by email**

From: Shane McDaniel, shmcdaniel@msn.com

Ian,

I spoke about this today but we still seem to have people that want to impose testing requirements that will effectively ensure that the cost to cultivate will be so high that the people that need this healing the most are going to be priced out. Please let me know that this will not be tolerated. I have been in contact with Adrian in Colorado since before he even cultivated his first batch for therapeutic use and the testing required in Colorado and Oregon has done exactly what I fear will happen here in NM. The next issue is this additional testing will do nothing to add to safety or add to the effectiveness of treatment but instead it will simply benefit the people that run and work in the labs by requiring unnecessary testing. That's akin to letting the fox build the gate to the henhouse.

Thanks for all you do.

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From: Anne Metz, annielmetz@gmail.com

Hello —

I would like the following included in the minutes from the 1/30 meeting:

The program guidelines must include a clearly defined upper limit on psilocybin dosing.

This is not a recreational or wellness program — it is a medical treatment program for specific clinical conditions, and protocols need to reflect that.

Oregon caps dosing at 50mg of psilocybin analyte per session, and Colorado's rules allow products up to 50mg. New Mexico should align with this standard. A 50mg cap provides the necessary range to account for individual variation, including the well-documented blunting effects of serotonergic and GLP-1 medications, while still establishing a meaningful upper boundary grounded in the experience of the two states that have already built regulated programs.

It is important to note that clinical trials — which use synthetic psilocybin in controlled settings — have worked exclusively in the 25–30mg range. The 50mg cap in state-regulated programs reflects the practical realities of natural medicine, where mushroom potency varies and facilitators need room to dose up accordingly. But 50mg should be the ceiling. Allowing dosing beyond what other regulated programs permit, without any supporting research at higher thresholds, would place vulnerable populations at unnecessary risk and undermine the credibility of the program.

New Mexico can lead by being both practical and responsible — matching the 50mg standard while ensuring that facilitator training and clinical oversight keep actual dosing conservative and evidence-informed.

Anne Metz, PhD LPC
Licensed Clinical Facilitator in Training in CO
Taos County Resident

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From: Deborah L Thorne, thornedl@gmail.com
*DMSc, MS, BS, BA, PA, CIPP, CPAT*
*Doctor of Medical Science*
*Board Certified Physician Associate*
*Medical Integrative Acupuncturist*
*Certified Integrative Psychiatry Practitioner*
*Certified Psychedelic-Assisted Practitioner*

Hi there,

I'm providing a sample dosing guide as was given to me when I trained in Oregon through IPI. Hope this helps. I found it easy to understand and useful.
Overall comment for today's dosing discussion…**keep it simple.**

Thanks,
Debra

Product Information
Dosing
A local expert has provided this dosing recommendation along with a description of the effects
at various doses (results may vary):
1-5mg - Mood enhancement & crisp concentration. Considered a micro dose. (non-psychedelic)
5-10mg - Mild euphoria & visual enhancements. Considered a very light psychedelic dose. May
border on perceptible/non-perceptible.
10-15mg - Colors become more vivid with some closed and open eye visuals.
15-25mg - Kaleidoscopic visuals & mild visual disturbances.
25-35mg - Intense sensory distortions & ego dissolution.
35-50mg - Complete altering of senses & higher likelihood of ego dissolution.
Psilocybe Cubensis - the species the OHA has allowed manufacturers to grow
Sourced from southern Mexico where it has long been used in indigenous ceremonies, this species is associated with Maria Sabina, a Mazatec curandera. She was the first contemporary
Mazatec shaman to allow westerners to participate in psychedelic mushroom veladas (healing
ceremonies), and is credited with introducing western culture to psychedelics. It is an ancient
mushroom, with a deep and rich history.
Fees - All fees for psilocybin products will be paid directly to the service center, Conscious Encounters. Refunds for unopened products will be processed by the end of day. Any opened,
not consumed products will be disposed of by the service center per OHA guidelines.
Itemized price of psilocybin product and applicable taxes as defined by 333-333-5180
Product Price Taxes Total Price
24 MG Psilocybin $75.65 $11.35 $87.00
10 MG Psilocybin $31.30 $4.70 $36.00

5 MG Psilocybin $16.52 $2.48 $19.00
Total Cost 34 MG
(Depending on variation of mg chosen
by the student and inventory available)
$106.95 - $108.69 $16.05 - $16.31 $123.00 - $125.00
Space Use Fee
$20.00
(The service center charges a space use fee in the amount of $20
because psilocybin services include both a product and service

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**Committee meeting chat**

My name is Ellen schimmels. I'm a psychiatric nurse practitioner and Army veteran. I've been a mental health nurse for 28 years trained in psychedelic assisted therapy through integrative psychiatry institute. I'm also an educator. Happy to share my expertise as needed. Thank you

If on a computer – click on the "hand" icon near the top of the Teams window (it says "Raise" under the icon)

If on the Teams app on a phone, please press the ellipses (three dots) in the menu and then the "hand" icon will appear, and you can select it

If you are joining through voice only on a phone, press *5 to raise or lower your hand

Once your name is called, you will be able to unmute:

To unmute/mute on Teams on a Computer or on the Teams Phone App click on the microphone icon:

On a computer it is in the upper right area of the Teams window.

On a phone it is usually in the lower left of the Teams App, however, different models of phone (Apple, Android, etc…) may have the mute/unmute icon in a different location:

Telephone: voice only - press *6 to unmute/mute

My name is Matthew Armstrong. Ojibwe descendent and psilocybin advocate. I do not have a medical background.

Happy to serve though

Psilocybin Dosage Definitions

Definition of Maximum Theoretical Psilocin (MTP)

Maximum Theoretical Psilocin (MTP) is a standardized chemical measure representing the maximum theoretical quantity of psilocin that could become systemically available following complete conversion of psilocybin to psilocin. MTP is expressed in milligrams of psilocin equivalents.

Unless otherwise specified, all dose ranges are expressed in milligrams of psilocin equivalents (MTP)

MTP Calculation

MTP = (measured mg of psilocin) + (measured psilocybin mg *0.719)

Note: The conversion factor (0.719) reflects the molecular weight ratio of psilocin to psilocybin.

Definition of Available Psilocin Fraction (APF)

Available Psilocin Fraction (APF) describes the proportion of a product's MTP that is present as free psilo cin at the time of administration.

APF reflects chemical composition only. While differences in psilocin and psilocybin pharmacokinetics suggest potential associations with onset and duration, APF is not intended to predict individual clinical response or therapeutic outcome.

APF =

mg of psilocin

MTP

Interpretation and Clinical Significance

Higher APF values indicate a greater proportion of immediately available psilocin and are associated with a higher likelihood of earlier onset and more prominent early psychoactive effects.

Lower APF values indicate a greater proportion of psilocybin requiring metabolic conversion and are associated with a higher likelihood of delayed onset and extended duration.

The Committee emphasizes that:

APF reflects chemical composition only

Actual onset, intensity, and duration vary substantially based on individual physiology, route of administration, and contextual factors

APF should be interpreted alongside MTP, dose, and patient-specific considerations

Onset Profile Categories (OPC)

Each dose shall be categorized using APF as:

Rapid-Onset Dominant: APF ≥ 0.40

Balanced: APF 0.20–0.39

Sustained-Onset Dominant: APF < 0.20

Advisory Note

These categories are descriptive and provisional. The Committee recommends their use for clinical planning and monitoring, not as determinative classifications. Thresholds should be revisited as outcome data accumulate. OPC thresholds are heuristic and do not imply discrete biological or clinical boundaries.

Dosage Levels

Subperceptual dose:

Definition: A dose intended to produce minimal to no meaningful alterations in perception, cognition, or sensory processing

Dose Limits:

Total daily dose ≤ 2.5 mg MTP

Total weekly dose ≤ 7.5 mg MTP

Onset Guidance:

Subperceptual dosing should utilize Sustained-Onset Dominant or Balanced products

Rapid-Onset Dominant products are discouraged for subperceptual use due to disproportionate early psychoactivity

Perceptual dose

Definition: A dose expected to produce noticeable perceptual, emotional, or cognitive

Mild Perceptual:

Total dose: 2.5mg MTP to 10mg MTP

Therapeutic Perceptual:

Total dose: 10mg MTP to 30 mg MTP

Onset Guidance:

For Rapid-Onset Dominant products, dosing should initiate at the lower end of the applicable range.

Balanced and Sustained-Onset Dominant products may utilize the full range as clinically appropriate.

High Dose

Definition: A dose range expected to produce marked alterations in perception, cognition, and self-referential processing. High-dose administration is considered evidence-limited and is not supported by current randomized clinical trial data as therapeutically superior to lower doses.

Dose Range:

Total dose: >30mg MTP

Restrictions:

High dose administration should not be construed as standard therapeutic dosing and should be reserved for circumstances with explicit clinical justification and enhanced monitoring. For additional restrictions we defer to the Patient Qualification & Safety Committee.

Onset Guidance:

Rapid-Onset Dominant products (APF ≥ 0.40) shall be administered with extended preparatory observation, due to faster ascent and earlier peak intensity.

Initial high-dose administration using Rapid-Onset Dominant products shall employ conservative titration, with incremental dosing and sufficient observation intervals to assess early psychoactive effects.

Balanced products may be administered using standard high-dose protocols with appropriate supervision.

Sustained-Onset Dominant products (APF < 0.20) may require longer monitoring periods prior to peak effect due to delayed onset and extended duration.

Data Collection and Continuous Improvement

The Committee recognizes the importance of systematic data collection to support evidence-informed refinement of dosage frameworks, onset profile categories, and safety guidance.

All data collection, outcome tracking, analysis, and continuous improvement activities related to psilocybin dosing, onset profiles, and clinical outcomes shall fall under the authority of the Research & Continuous Improvement Committee.

it will go in today

share the link Gregory

How to submit written public comments:

Please send written public comment to the program email at:
medical.psilocybin@doh.nm.gov

If referencing documents from other sources/websites, do not include the document, only a working hyperlink; and explain the context.

If a document is sent without context, it will not be considered public comment and will not be included.

Please remember to include your full, legal name and any organizational affiliations you may be representing (if any) on the documents.

It will then be included in the meeting record.

To be included, please send your comment by Monday, February 2nd at 5:00 PM.

this is my reccomendation

Range PCN (mg) Characteristics

Micro 0.1–0.4 Non-psychedelic; no cognitive impairment; supports structured daily/rotational protocols; promotes sense of well-being

Threshold ~1.5 Perceptual boundary; first noticeable effects; may include subtle body sensations or mood shifts

Mini-dose ~3 Light perceptual effects; social/functional dose; enhanced sensory awareness without full psychedelic experience

Pre-Therapeutic

(Window) 3–7 Transitional zone between mini-dose and full therapeutic; territory requiring further characterization; self-directed work boundary

Therapeutic 7–18 Full psychedelic experience; clinical dosing range; requires facilitation and appropriate set/setting

Supra-Therapeutic >18 High-dose territory; requires experienced facilitation and robust safety protocols

Will there be a difference in potency within the same cultivar (for example Golden Teacher) between different cultivators depending on grow conditions and other factors?

I appreciate the recognition of the complexities and nuances. I applaud efforts to give maximum meaningful information while preserving flexibility for appropriately dosing people with unusual tolerance or other conditions.
**shane mcdaniel (Unverified)**

Will there be a difference in potency within the same cultivar (for example Golden Teacher) between different cultivators depending on grow conditions and other factors?

potentially (possibly likely) this is a great conversation for Propagation.

https://www.notion.so/PCN-Dosage-Visualization-2f8a2b7222dc807d90d4f3706b9101eb?source=copy_link

can anyone confirm if this link is viewable?

yeah Gregory i would agree more with your dosage recommendation especially in the microdose levels

.1mg as apposed to1.0mg psilocin much more practical

opposed*

can we get Barry Dungan or Scott Folkman to weigh in on the commonality of using Psilocin Normalization in the industry.

in the body

there needs to be an approved universal metric i vote psilocin as the most comprehensive metric Psilocin EQ is that metric

It would be great to see a micro-dosing program, maybe a stand-alone program. Amongst others, our veterans and first responders are taking pharmaceutical depression and anxiety medications, SSRIs, etc. Micro-dosing can help get people off of these pharmaceutical medications. Additionally, some veterans and first responders are going back to work and receiving more trauma where micro-dosing can help without some of the negative side-effects.

Treating micro-dosing as other medications that allow people to be adults and take responsibility for there medication treatment and to not take more than prescribed that would lead to impairment.  Thanks!

I agree with Shane.

the way i see authorizing Micro dosing happening is an itterative one.  If we write the language now.  put the frame work for where it could exist.  as we roll out the program and collect data we will absolutely be able to collect the data on potency analysis to help build the effectiveness for safe use

*functional kinesiology = muscle testing for a substance

I would like loudly not put any regulatory language on dictating max dosage.

maybe we leave dosing to open and just come up with guidlines for testing for known triptamine content

I am in favor of having both the psilocin and psilocybin being reported for increases in analysis data and enhanced public safety.

yet to be determined

Testing should probably be done for psilocybin, psilocin, baeocystin, norbaeocystin, and aeruginascin. They all have different pharmacokinetics and potencies. Further research is needed for better understanding of their independent and entourage effects. But if the concentration of each of these is known and reported for each 'batch', they can each be reported which prevents some confusion with the definitions.

I would love to have access to vagal tone measure and gut health prior to and after dosage to define the human element of the equation.

More appreciation for this sensible, well informed process! There are several lenses that we're looking through- scientific, therapeutic, public perception, lawmakers. Observations from groups in Colorado: with the same batch of mushrooms some participants with apparently similar bodies had roughly half the effect on twice the dose.

I agree with MTP Definition

Definition of available psilocin fraction
Add Definition of available psilocybin fraction
I also agree on excluding the others for entourage effect if its cost effective

I agree with MTP as that is what is actually being regulated

I do agree with giving practitioners a jumping off point based on what we do know. They can titrate up or down as needed just like someone would do with any other medication to treat the patient. Like personally I'm a lightweight. .5 grams of dried psilocybe cubensis is a perceptual dose for me and I'm not 90lbs soaking wet. We know that it's not based on weight in many cases. I do love that there is a great sensitivity for not creating rules that will later need to be changed as we learn more which is often more difficult. We also don't know if there are other compounds in psilocybin containing mushrooms that have therapeutic benefit because there hasn't been a ton of research on it. We might learn that in the future.

Sorry. Type o. Including them for the entourage effect if cost effective.

Great conversation. Need to jump off

thanks larry

just have doctors approve the home for approved location

Thanks for the clarification Dominick

Also, I know that the group that is discussing practitioner training is considering whether to allow those who have already been trained in programs designed for access in other states. When we talk about what to use for measurements, we need to know how others have already been trained if they are to be included. If what NM outlines is different, it might mean that additional training on dose is required.

I have lots of research around non-psychoactive and minor alkaloids if anyone wants to get into.  please reach out.

**Gregory E.**

I have lots of research around non-psychoactive and minor alkaloids if anyone wants to get into.  please reach out.

I would like to know more about the minor alkaloids

I strongly reccomend using PCN as it is more commonly used than MTP

Contact information:

- Email: Medical.Psilocybin@doh.nm.gov
- Program Website: https://www.nmhealth.org/about/mcpp/mpp/
- Advisory Board Website: https://www.nmhealth.org/about/mcpp/mpp/mpab/

Medical Psilocybin

Can we vote seperatly

may i comment

i would like to comment before the vote

out of state people can't vote right?

Thank you