Medical Psilocybin Patient Qualification & Safety Committee – Meeting Minutes, Chat and Public Comments

Meeting date: February 20, 2026
Format: Virtual meeting
Chair: Ian Dunn
Minute Taker: Ismail Zoutat, DOH

**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. Call to Order and Opening Remarks

Recording & conduct reminder. Staff reminded participants the meeting was being recorded for the public record and requested appropriate language and limited video use to avoid inappropriate background content.

Call to order. Chair Ian Dunn called the meeting to order and reiterated that the committee serves in an advisory capacity—stress-testing ideas and forwarding recommendations to the Board.

2. Review of Agenda

The Chair outlined that the committee would (1) review a proposed Clinical Support Framework for patient placement into appropriate support levels, and (2) discuss program exclusions; time was expected to allow only one additional topic after the framework vote.

3. Agenda Item: Clinical Support Framework

The Chair presented a four-tier structure intended to calibrate clinical support to patient risk rather than unnecessarily exclude participants:

Tier 1 – Standard eligibility: Proceed with standard protocol; no additional support requirements identified by screening.

Tier 2 – Enhanced clinical support: Additional preparation/screening and risk-mitigation steps beyond standard protocol.

Tier 3 – Specialist-supported: Specialist involvement and/or co-management for higher complexity/risk presentations (discussion focused on the type of specialist and whether two clinicians are required).

Tier 4 – Not appropriate at this time: Insufficient support can be safely provided; intended as "not now" rather than permanent exclusion, with possible reconsideration if circumstances change.

Key discussion themes included:

- Standard protocol still in development; committee emphasized that Tier 1 should not be interpreted as 'no support needed' for all cases.
- Tier 3 staffing: mixed views on requiring two clinicians vs. allowing one clinician when the facilitator holds an independent behavioral health/medical license within scope.
- Specialist definition: need to define which specialists can sign off for specific conditions (e.g., psychiatry, psychiatric mental health NP, other independently licensed mental health clinicians).
- Access concerns: participants noted limited psychiatry availability in New Mexico and cautioned against overly narrow specialist requirements that could restrict access.
- Language and clarity: request to define terms used across tiers (especially 'psychosis') and distinguish history vs. active presentation.
- Cost and training: concerns that requiring a second clinician may increase patient costs; also noted that any co-facilitator/specialist should have appropriate psilocybin-specific training.
- Timeline: a request was made to consider timelines for reassessments or sign-offs; Chair noted timeframes were not yet specified and could be revisited during diagnosis-by-tier work.

Dr. Lehman requested clarifying language to ensure Tier 1 does not imply that additional support cannot be required for safety (e.g., complex PTSD or uncontrolled substance use). The Chair proposed and posted an amendment indicating that either the patient and/or the provider may request additional clinical support at the time of assessment.

4. Vote: Adoption of Clinical Support Framework

The committee voted to adopt the four-tier Clinical Support Framework with the Tier 1 clarification amendment.

Result: 10 in favor; 0 opposed. Motion carried. The Clinical Support Framework (as amended) was adopted by the committee.

5. Exclusion Criteria vs. Psychiatric/Neurological Conditions

Given time constraints, the Chair asked whether the group preferred to address program exclusions or psychiatric/neurological conditions. Participants indicated a preference to proceed with exclusion criteria.

6. Proposed Program Exclusion Criteria

The Chair introduced an initial set of disqualifying conditions and medications, noting that the draft mirrored elements used in other jurisdictions (e.g., Oregon) and was intended for committee refinement.

6.1 Additional items raised for consideration

- Age restrictions: participants asked whether the program should be limited to adults; the Chair indicated limited evidence in children and leaned toward an adult-only approach absent stronger data.
- The chair introduced a recommendation that patients need to be over the age of 18, the vote was 10 in the affirmative, 3 in the negative.
- Uncontrolled/'unmanaged' diabetes mellitus: suggested as an exclusion unless appropriately managed and medically cleared.
- Seizure history and uncontrolled seizures: discussed as a safety concern; uncontrolled seizures included in the Chair's proposed list.
- Informed consent capacity: proposed addition—exclusion for inability to provide informed consent (raised by Alan).
- Cardiovascular contraindications: Dr. Lehman and Dr. Lyda recommended moving certain cardiovascular conditions (e.g., uncontrolled hypertension, moderate-to-severe CHF and related serious cardiac disease) into exclusions rather than "refer to cardiology."
- Terminology: participants requested more trauma-informed language than 'psychosis'; alternatives suggested included 'active psychotic episode' and 'psychotic spectrum.'
- Stimulant use: recommendation to explicitly treat active stimulant use (e.g., cocaine/amphetamine intoxication or active use) as a contraindication/exclusion, given cardiovascular effects.
- Pathways for 'not now': participants emphasized that exclusions should not communicate hopelessness; suggested referral language and potential for future reassessment when clinical circumstances change.

6.2 Chair's initial exclusion list

- Use of lithium in the past 30 days (washout concept discussed).
- Active psychosis / active psychotic episode (language to be refined).
- Acute intoxication.
- History of hallucinogen-induced psychosis (raised; request for evidence noted in chat).
- Uncontrolled seizures.
- Uncontrolled diabetes mellitus.
- Current suicidal or homicidal ideation with intent/plan or inability to maintain safety.

The Chair invited feedback on whether any items should be removed; no requests to strike items were raised at that point. The committee then focused on additions and clarifications (e.g., informed consent, cardiovascular conditions, stimulant-related contraindications, and wording).

7.0 Next Meeting

The next meeting date was planned for March 4th 2026 at 09:00.

8.0 Adjournment

Meeting adjourned at 10:40

DOH Staff

Adrian Estrada, DOH
Jonathan Mouchet, DOH
Brenda Martinez, DOH
Dominick Zurlo, DOH
Robert Truckner, DOH
Ismail Zoutat, DOH
Raymond Gallegos, DOH

Participants and Public Attendees

Ian Dunn
Lawrence M Leeman
Shane McDaniel
Kate Hawke
Ellen Schimmels
Don Moser
Donna Jojola
Keyena McKenzie
Michele
Sanchez
Hána Rose
Eric Barlow
Marcus Ryals
Zoe Spyralatos
James Brown
Anne Metz
Kayla McClellan
Dr Lida Fatemi
Meredith McBranch
Lisa Ginzburg
Vincent Espinoza
Dan Jennings
Craig Dougherty
Keyena McKenzie
Court Wing
Eileen Brewer
Keyena McKenzie
Deborah Thorne
Matthew Armstrong
Debbie Traynor

Committee Chat

Reminder:
This meeting is being recorded
Please remember to keep language appropriate as the recordings are made public on the Advisory Board Website

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

Is it possible to get a copy of the tiers to read on my own screen?

can you make this larger?

Clinical Support Framework

Adopted: XX-XX-XXXX

WHEREAS, the Patient Safety & Qualification Committee is authorized to recommend to the Board patient eligibility, safety, and oversight standards to ensure the responsible provision of psilocybin services; and

WHEREAS, the clinical support associated with psilocybin administration varies based on medical, psychiatric, and neurological history; and

WHEREAS, a tiered clinical support framework allows clinical oversight and regulatory safeguards to be proportionate to patient support needs while preserving access to care; and

WHEREAS, graduated requirements for stabilization, monitoring, and specialist consultation enhance patient safety without imposing unnecessary barriers on lower-risk patients;

THEREFORE, BE IT RESOLVED, that the Patient Safety & Qualification Committee hereby adopts and recommends to the Board the following **Clinical Support Framework** to be applied to all patients, except end-of-life care patients, seeking participation in the Medical Psilocybin Program:

Tier 1. Standard Support

- Proceed with standard protocol.
- Patients without any Tier 2, Tier 3, or Tier 4 criteria

Tier 2. Enhanced Clinical Support

- Patients meeting criteria in this tier remain eligible for participation. These conditions indicate a need for additional clinical consideration, which may include stabilization where appropriate and thoughtful support planning. The specific approach should be guided by practitioner judgment and the individual patient's clinical context.
- Documentation required for Tier 2
    - A risk mitigation plan, to be available to the facilitator/administrator of psilocybin
    - A comprehensive medication review
    - A documented monitoring plan

Tier 3: Specialist Supported Care

- Patients meeting criteria in this tier may participate only with the required Tier 2 documentation and documented consultation and concurrence of two (2) practitioner signatories prior to administration:

1. the primary psilocybin practitioner responsible for the patients care; and
2. a licensed specialist practicing within their scope of licensure and possessing expertise relevant to the identified condition (e.g., psychiatrist, psychiatric mental health nurse practitioner, cardiologist, neurologist, or other appropriately credentialed clinician)

Tier 4: Not Appropriate for Participation at This Time

- Patients meeting criteria in this tier are not appropriate for participation in the Medical Psilocybin Program at the time of evaluation due to safety or ethical considerations. Placement in this tier does not constitute a permanent exclusion and may be reconsidered if clinical circumstances change.

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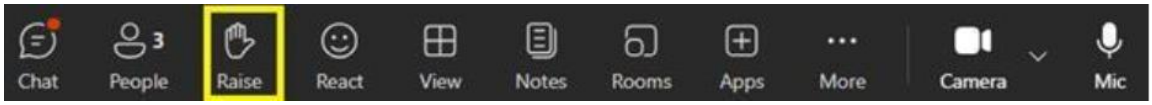

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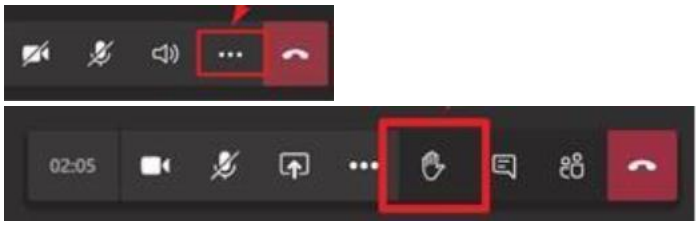

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Is it possible to get a copy of what was sent out this morning?

100%

i agree

That is what was sent out this am.

Thank you! that's helpful context! Thank you Ellen

I think it would be important to have a list of specialists who are approved to be in this role

Yes i would say it's important to have the medical specialists to be certified in psilocybin

Hello. My name is Matthew. I am not sure if everyone had to introduce themselves earlier in the call. I am an Ojibwe descendant and psilocybin advocate. Just here to serve on the subcommittee and observe. Thank you.

Dr Lida Fatemi

I think it would be important to have a list of specialists who are approved to be in this role

Because clinicians/practitioners would need to be certified through the program, there would be lists of those who are certified made available.

I agree with Larry - and include all cardiac conditions - ischemic cardiomyopathy, coronary artery disease, etc

Dementia also seems like an issue for informed consent

depending on the severity of dementia

Agreed

early dementia where patients are still consentable should be fine and in fact might benefit them greatly

yes

two people could meet needs for support, yet that makes it harder to meet needs of Diversity, Equity, and Inclusion

Yes, the word Pyschosis is not a trauma-informed "word" from a social work perspective

"history of psychosis" includes delusional disorder

it seems like it would be impractical to have such a board of all physicians

HB99 fo med mal was passed

The Malpractice Bill passed house and senate. Just needs Governor to sign from what I understand.

Sounds like an excellent idea to have a board - particularly if this consult would not cost more for the patient.

Such a great point, Dr. Leeman! High risk of re-traumatization, relapse, etc.

Consider social workers as trauma-informed specialists

Yes, patient self-determination is the first step in effective social work practice

...which applies to client choice of treatment

I'm so sorry, I missed the beginning of the meeting, but does this document create a world where other conditions will be difficult to add later? There's going to be a lot of work in adding conditions at any rate since the bill says "other conditions approved by the department" and other workgroups have already begun discussing what to add

Tier 2 and 3 patients should require more preparation (2-3 preparation sessions instead of 1 (Tier1)) and more follow-up (2-4 sessions) than Tier 1 (1-2).

Yes, distribution of services is another area of social work specialization

I have a concern about a limited number of gatekeepers who would enable access to this medicine. As a naturopathic doctor for 25+ years using homeopathy and botanical medicines in all forms is still met with tremendous resistance and skeptiscism. Take up by those able to approve access has the potential to dog down utilization as they bring themselves up to speed on research supporting psilocybin medicine. Conversely, will those eligible as gatekeeprs be able to keep up with screening those interested in and who could benefit from medical psilocybin? Or will their practises become revolving doors of folks seeking approval for care?

Michele

Tier 2 and 3 patients should require more preparation (2-3 preparation sessions instead of 1 (Tier1)) and more follow-up (2-4 sessions) than Tier 1 (1-2).

In my opinion, there should always be at least 3 prep sessions, never just one.

Catherine Warnock (Guest)

In my opinion, there should always be at least 3 prep sessions, never just one.

I think it would depend on the patient. That's a lot of added expense too.

Eileen Brewer

I think it would depend on the patient. That's a lot of added expense too.

I disagree. Cultivating a relationship with the client is important and proper prep is a high indicator to successful outcomes. Just like integration, prep is so critical!

This is where a pyscho-social assessment comes in...again another specialization of social workers

I have to go about to start our class for the academy - thank you so much for a rich converstion

Technically, there are 3 interactions (initial inquiry, medical and psychiatric screening, preparation session(s), and then actual dosing session). With higher risk (tier 2-3), the practitioner makes a determination on additional prep sessions.

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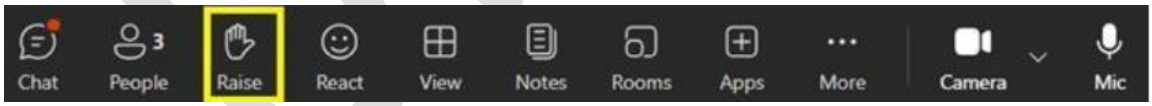

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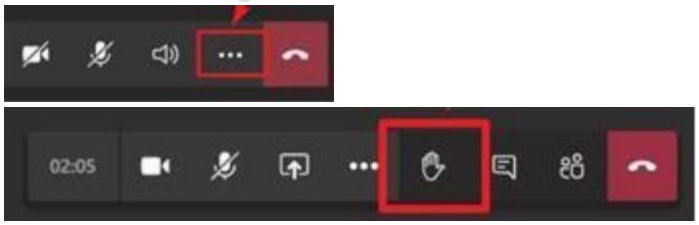

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Part of a complete medical screening, a prescriber should acquire previous medical records

Yes, people will need safety plans with ALL of these conditions.

They provider should decide if they need more support for Tier 1

Tier 1: Proceed with standard protocol. Patients or provider may request additional clinical support at the time of assessment.

Agreed, making tiers for assessment is essential

Clinical Support Framework

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Exclusion criteria

is there a standard set for assessment?

inability to provide informed consent

Agree with what Catherine said about seizure disorders.

Multiple case reports and a recent trial show low-dose psilocybin is effective in reversing the symptom profile of Type II diabetes Uncontrolled hypertension

Placement of Proposed Exclusion Criteria Within the Clinical Support Framework

Adopted: XX-XX-XXXX

Using the Clinical Support Framework adopted by the Patient Qualification & Safety Committee, the following criteria are recommended for placement in Tier 4: Not Appropriate for Participation at this time.

Disqualifying Medications

Used lithium in the past 30 days

(Oregon Health Authority [OHA, n.d.)

Disqualifying Conditions

Active psychosis

(Oregon Health Authority, n.d.)

**Oregon excludes individuals with psychotic disorders from participation in psilocybin services, without distinction between active and inactive presentations (OHA, n.d.)

Acute Intoxication

History of hallucinogen induced psychosis

Uncontrolled Seizures

Uncontrolled Diabetes Mellitus

Current suicidal or homicidal ideation with intent, plan, or inability to maintain safety

(Oregon Health Authority, n.d)

Regarding Diabetes. Are we talking about Type 1 or Type 2 or both.

Thank you Dr. Leeman

I think we should use what we call it from a diagnostic perspective

psychotic-spectrum?

?

active psychotic episodes?

does a history of hallucination induced psychosis indicate that it will be a probability in the future? Is there research to support that? I don't think it should be an exclusion criteria

I like "psychotic-spectrum" languaging

Agree active stimulant use as contraindication

When there is a hard stop, this is where a social worker can be referred to the client for supportive services

No "hard stops!" There needs to be hope for these people. "Not now"

Wasn't stimulant use disorder one of the diagnoses included?

Acute intoxication makes sense though

Could say active stimulant use within last 5 days 18+ best at this time as per studies

Agree with Larry about no upper age limits

Has HPPD in extreme cases ever been considered as an exclusion in other state programs?

HPPD isn't an exclusion criteria in CO or OR

HPPD more in LSD not psilocybin

ketamine can be a great prep tool for macro dosing of psilocybin.

HPPD? History of postpartum depression?

hallucinogen persisting perceptual disorder

Hallucinogen Persisting Perception Disorder

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Having not looked at the available evidence against, I could certainly see appropriate application of supervised medical psilocybin for in-patient psychiatric care of adolescents and teens

I don't agree with limiting this to 18+ because children under 18 who need end of life care may benefit from this

Can we see the entire section of the document? It seems to be cut off on our end

maybe take out the extra notes from OR?

High-risk medically for pregnant women and children is one perspective. What about cultural considerations? Where have cultures been working with psilocybin among all populations?

corrections which, not where

I agree that ceremonally, psilocybin is administered as young as 8 years old. This is why I wanted us to have this discussion. I do believe that psilcoybin can help teenagers but we don't have studies.

Then we need to do research and get these studies on the table

Agree with age 18 until more data . FDA has stated will support such studies on future

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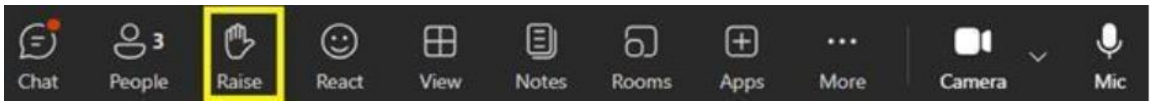

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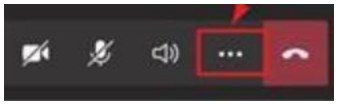

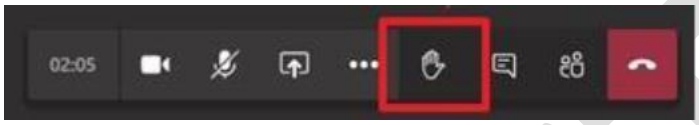

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If a minor is treated that results in a dire consequence, this presents a huge liability for all involved Please share reference on psilocybin and diabetes Both, frankly. Let me pull up references…

Placement of Proposed Exclusion Criteria Within the Clinical Support Framework

Adopted: XX-XX-XXXX

Using the Clinical Support Framework adopted by the Patient Qualification & Safety Committee, the following criteria are recommended for placement in Tier 4: Not Appropriate for Participation at this time. All participants in the MPP should be 18 years of age or older.

Disqualifying Medications

Used lithium in the past 30 days

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**Oregon excludes individuals with psychotic disorders from participation in psilocybin services, without distinction between active and inactive presentations (OHA, n.d.)

Acute Intoxication, especially cocaine and amphetamines (within the last 5 days)

History of hallucinogen induced psychosis

Inability to provide informed consent

Uncontrolled Seizures

Uncontrolled Hypertension

CHF

Uncontrolled Diabetes Mellitus

Current suicidal or homicidal ideation with intent, plan, or inability to maintain safety

(Oregon Health Authority, n.d)

References

- Oregon Health Authority. (n.d.). *Psilocybin services: Accessing psilocybin services in Oregon*. State of Oregon. https://www.oregon.gov/oha/ph/preventionwellness/pages/psilocybin-access-psilocybin-services.aspx

pregnancy

I thought pregnancy was on there

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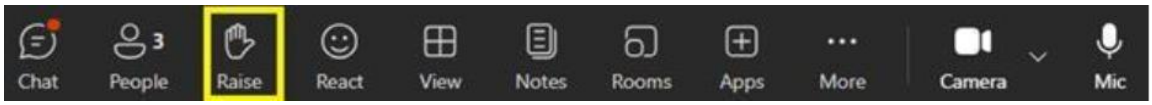

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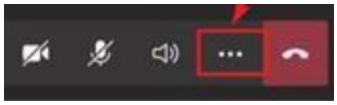

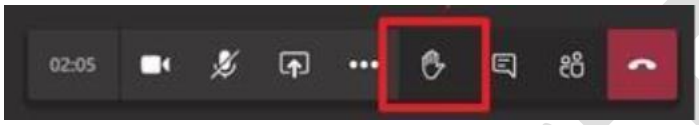

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ischemic heart disease?

valvular disease?

I think it might be useful to have time to review literature before voting on this

https://pubmed.ncbi.nlm.nih.gov/41475502/

Larry, was it you who suggested specifically moderate or severe CHF? Rather then just CHF?

https://pubs.acs.org/doi/10.1021/acsptsci.5c00202

yes, let's review literature before voting

Is the angina - active angina at the time would be contraindicated.

Clinical Support Considerations

The following categories are intended to guide Committee discussing regarding patient stability and appropriate safeguards. Inclusion in this list does not imply exclusion from participation or assignment to a specific tier.

Psychiatric conditions:

Mood Disorders:

- Bipolar I/History of manic episodes

Psychotic & Thought Disorders:

- History of psychosis
- Delusional Disorders
- Impaired Reality Testing

Personality & Dissociative Disorders:

- Borderline Personality Disorder
- Dissociative Disorders (DID, Dissociative Amnesia, DPDR)
- Delusional Disorder

Suicide and Self Harm Risk:

- History of recurrent or recent self-harm or self-injurious behaviors

Neurological & Cognitive Conditions:

- Dementia or moderate to severe cognitive impairment
- History of traumatic brain injury with residual deficits
- Seizure disorders, particularly if poorly controlled, recent, or associated with a loss of consciousness.

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History of hallucinogen induced psychosis

Inability to provide informed consent

Uncontrolled Seizures

Uncontrolled Hypertension

Moderate to Severe CHF

Prolonged QTc interval

Structural, valvular, and cardiac hypertrophy

Clinically significant uncontrolled hypertension

Uncontrolled Diabetes Mellitus

Current suicidal or homicidal ideation with intent, plan, or inability to maintain safety

(Oregon Health Authority, n.d)

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https://pmc.ncbi.nlm.nih.gov/articles/PMC10888174/

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pregnacy

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Uncontrolled Seizures

Uncontrolled Hypertension

Pregnancy/Breast Feeding

Moderate to Severe CHF

Prolonged QTc interval

Structural, valvular, and cardiac hypertrophy

Clinically significant uncontrolled hypertension

Uncontrolled Diabetes Mellitus

Current suicidal or homicidal ideation with intent, plan, or inability to maintain safety

(Oregon Health Authority, n.d)

References

- Oregon Health Authority. (n.d.). *Psilocybin services: Accessing psilocybin services in Oregon*. State of Oregon. https://www.oregon.gov/oha/ph/preventionwellness/pages/psilocybin-access-psilocybin-services.aspx

Placement of Proposed Exclusion Criteria Within the Clinical Support Framework

Adopted: XX-XX-XXXX

Using the Clinical Support Framework adopted by the Patient Qualification & Safety Committee, the following criteria are recommended for placement in Tier 4: Not Appropriate for Participation at this time. All participants in the MPP should be 18 years of age or older.

Disqualifying Medications

Used lithium in the past 30 days

(Oregon Health Authority [OHA, n.d.)

Disqualifying Conditions

Active psychosis

(Oregon Health Authority, n.d.)

**Oregon excludes individuals with psychotic disorders from participation in psilocybin services, without distinction between active and inactive presentations (OHA, n.d.)

Acute Intoxication, especially cocaine and amphetamines (within the last 5 days)

History of hallucinogen induced psychosis

Inability to provide informed consent

Uncontrolled Seizures

Uncontrolled Hypertension

Pregnancy

Moderate to Severe CHF

Prolonged QTc interval

Structural, valvular, and cardiac hypertrophy

Clinically significant uncontrolled hypertension

Uncontrolled Diabetes Mellitus

Current suicidal or homicidal ideation with intent, plan, or inability to maintain safety

(Oregon Health Authority, n.d)

References

- Oregon Health Authority. (n.d.). *Psilocybin services: Accessing psilocybin services in Oregon*. State of Oregon. https://www.oregon.gov/oha/ph/preventionwellness/pages/psilocybin-access-psilocybin-services.aspx

Friday at 10

Patient Qualification & Safety – Friday February 20th from 9:00-11:00am; Ian Dunn, Chair.

End of Life Care – Friday February 20th from 1:00-3:00pm; Larry Leeman, Chair.

Dosage, Administration & Clinical Practice - Friday February 27th from 1:00-3:00pm; Ian Dunn, Chair.

Research and Continuous Improvement – Friday March 6th from 9:00-11:00am; Dan Jennings, Chair.

Training and Education – Friday March 6th from 1:00-3:00pm; Brenda Burgard, Chair.

Equity, Access, and Cultural Considerations – Wednesday March 11th from 1:00-2:15pm; DezBaa', Chair.

Propagation Committee - Wednesday March 11th from 3:00-5:00pm; Chris Peskuski, Chair.

- The above 3/11/26 meeting will be held online and in-person in Albuquerque (Location TBD)

Propagation Committee - Wednesday March 18th from 3:00-5:00pm; Chris Peskuski, Chair.

- The above 3/18/26 meeting will be held online and in-person in Santa Fe (Location TBD)

Microsoft Virtual Events Powered by Teams
Microsoft Virtual Events Powered by Teams

yes

can we do it another day since attending so many on one day is too much

That could work

that works

That works.

Psilocybin has shown modifications in satiety and hedonic controls, so yes, they are likely also causing changes in Type II diabetes that way as well, as we have seen in the studies involving eating disorders...
Thanks

Great work on these drafts, G-Ian.Dunn! Really fantastic.

If anyone is in the Las Cruces area March 6-7...please join our healers gathering at Medicina Del Sol then an EOL film on Saturday

Thanks

Bye Thanks!

Public Comments submitted by email

To: The NM DOH Psilocybin Advisory Board, and Ian,

Here are my comments, concerns, and references in regard to Psilocybin and Psilocin Contraindicated with Medications and Health Conditions for intent on Harm Reduction:

Psilocybin and Psilocin Contraindications to Administration:

The following are the notable exceptions and contraindications:

- Uncontrolled Hypertension
- Pregnancy
- Uncontrolled or Unstable Cardiovascular Issues/Disease
- Schizophrenia
- Bipolar Spectrum Disorders
- Borderline Personality Disorder
- Current or recent Suicidal Ideation (within the past month) or behavior (within the past 6 months)
- Active Hallucinations
- Active Mania or Hypmania
- Active Delusions

- Active Paranoia
- Active Angina
- Inability to Provide Informed Consent
- Uncontrolled Seizures
- Storke in the last 3 – 6 months
- Self-reported hypersensitivity to psilocybin or another serotonergic psychedelic

Psilocybin may prolong symptomatic amplification for days, weeks, or even months, particularly with higher dosages.

Although rare, cases of suicidal ideation and auto mutilation have occurred in patients with mental or psychiatric disorders.

Some people experience side effects because they mix their mushrooms with other substances. Any drug that works on your serotonin system could interact negatively with mushrooms. The following drugs could interact with mushrooms:

- Stimulants: Stimulants like Amphetamines, Methamphetamine, and Cocaine can increase blood pressure, have adverse cardiac effects and increase the likelihood of increased anxiety.

(HPPD) – Hallucinogen Persisting Perception Disorder

Is a rare condition where an individuals continues to have/experience visual disturbances after using psychedelics. HPPD has been found to be more prominent in adolescent brains. HPPD has been found to be dose-dependent. It is more common with higher doses and with psychedelic that have a longer duration of action.

In patients with co-occurring depression (with or without anxiety) HPPD symptoms persisted longer and treatment outcomes were more often negative. Thus, unlike the acute stages of psychedelic drug intoxication, which may be accompanied by altered states of consciousness, HPPD is rather characterized by changes in the content of consciousness and an attentional shift from exogenous to endogenous phenomena.

Thank You,
James Brown Pharm.D, Rph, IDSP