Dosage Administration & Clinical Practice Committee Meeting Minutes, Chat & Public Comments

Location: Microsoft Teams

Date: 02/27/2026

Time: 1:00 pm

Organizers: Johnathan Mouchet, Brenda Martinez, Dominick Zurlo, Katy Freytag, Jorge Gonzales, Cathy Augeri, Carmen Batista, Adrian Estrada, Robert Truckner, Raymond Gallegos, Rosalie Nava, Miranda Durham, Ian Dunn (Chair)

Attendees: Chris Peskuski, Don Moser, Stephanie Moberg, RLT, Gregory Evans, Catherine Sanchez, James Blackford, Erik Baca, Lance Trujillo, Shane McDaniel, Tessa Cappelle, Kate Hawke, Marcus Ryals, James Brown, Melanie Wikes, Catherine Warnock, Des Garcia, Angela George, Alex Lucas, Vincent Espinoza, Debbie Traynor, Nathan Rosecrans, Eileen Brewer, Eric Barlow, Mary Curry, Shaina Fawn, Alyiah Doughty, Michael McDowell

**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. **Welcoming Regards**
    - The meeting was called to order at 9:02 AM by Chair, Ian Dunn. The Chair welcomed participants.
2. **Reminders**
3. **Review & Adoption of Dosage Levels**
    - Mini Dose
    - Threshold Dose
    - Moderate Dose
    - High Intensity Dose
    - Ranges will be part of safety, will be adjusted then. Make changes to overlap the ranges.

- Other Dosage: Any administered dose exceeding the High Intensity Dose range shall require a Psychedelic Utilization Review. Facilitators and providers shall have the freedom to use the higher dose; however, they shall report to the department on outcomes.

4. **Public Comment/Questions**

- Chris- Include Psychedelic term in every dose? Leave High Intensity? Could differ from patient to patient
- James- administration length on? How long should it last? Consider ranges to overlap
- Gregory- Reducing the moderate does from 21.9 to 18
- Dominick-this is more for the guidelines, the decisions will be for the medical practitioners/facilitators
- James-is this one whole dose or can it be split?
- Nathan-please clarify the dose ranges- role of provider/moderator, other medications don't have caps
- Dominick- makes recommendation to add another category other dosage as determined by facilitator or medical professional
- James- category two should be in review- need utilization review (high doses)
- Chris-negative outcome should be reviewed or investigated
- Gregory- recommend EDI

5. **Voting**

- In support of document-10 count
- Against document-0 count
- **Dosage guidelines are adopted, Dosage definitions adopted**

6. **Next/ Future meeting date**

- Next Meeting: Preparation & Administration Protocols
- Public Comment submission deadline Monday March 2, 2026, at 5 pm.

- The next Committee meetings were suggested for every two weeks. The next tentative being for Monday, March 16, 2026, at 9:00 am. No objections recorded.
- **The Chair confirms the next committee meeting for Monday, March 16, 2026, at 9:00 AM.**

7. Adjournment

- The meeting was adjourned by Chair Ian Dunn on Friday Feb 27, 2026, at 3:03 pm.

Minutes submitted by: Carmen Batista, Health Educator NMDOH MCPP

Committee meeting 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

Dose Categories

Mini Dose:

Range:

- 1-3.9 mg MTP (≈1.4-5.6mg of psilocybin)

Clinical Characterization:

- Mood enhancement
- Subtle affective brightening
- No perceptual distortion

Psychedelic Classification:

- Non-Psychedelic
- No expected alteration in sensory processing, ego boundaries, or reality testing.

Threshold Psychedelic Dose:

Range:

- 4-6.9 MTP (≈5.6-9.6mg of psilocybin)

Observed Effects:

- Mild Euphoria
- Early sensory amplification
- Subtle visual enhancement

Psychedelic Classification

- Very light psychedelic dose

Clinical Interpretation

- Represents the transition point from non-psychedelic to perceptible psychedelic effects

Effects may border on perceptible vs non-perceptible depending on individual factors

Moderate Psychedelic Dose:

Range:

- 7-21.9 mg MTP (≈9.74-30.5mg of psilocybin)

Observed Effects:

- On the low end of this range colors become more vivid with some close and open eye visuals. On the high-end pts may experience kaleidoscopic visuals & mild visual disturbances.

Psychedelic Classification

- Moderate to full psychedelic experience

Clinical Interpretation

- Overlaps with the most commonly studied therapeutic dose range

- Consistent with fixed-dose clinical trials demonstrating reliable psilocin exposure and therapeutic outcomes.

High-Intensity Psychedelic Dose:

Range:

- 22-36 MTP (≈36-50 mg of psilocybin)

Observed Effects

- Intense sensory distortions
- Marked alteration of self-referential cognition
- Increased likelihood of ego dissolution

Psychedelic Classification:

- High-intensity psychedelic dose

Clinical Interpretation

- Corresponds to upper-range dosing reported in depression, PTSD, and substance-use disorder trials
- Psychological intensity and variability increase substantially
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How to raise your hand to speak:

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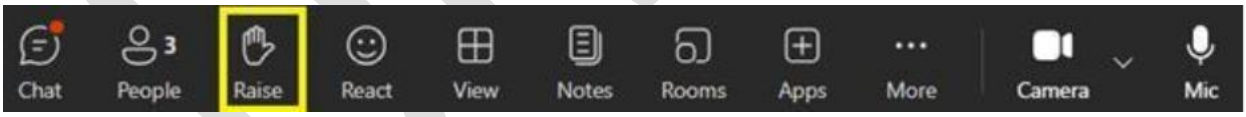

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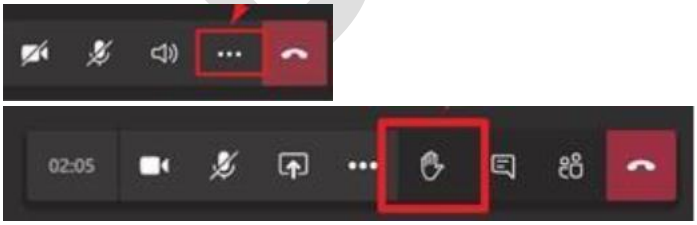

- If you are joining through voice only on a phone, press *5 to raise or lower your hand

How to Unmute:

- 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

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and onset?

That sounds good. Thank you

I like the idea of giving leeway in a range.

How levels of dosage are defined would it even effect the providers? If these are just definitions and would'nt place any handicaps or extra procedure with the facilities administering the medicine, would it matter?

oh, you are saying that now, nevermind

I agree. Being able to split a dose will be an important aspect for a patient and facilitator.

High-Intensity Dose:

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Mixed feelings about the cap in the definitions: yes, some people need much higher doses and this will be allowed in any case. On the other hand, it would be helpful to state what the usual "high dose" range is.

One more potential language change is to remove Intensity in dosage range as it is very subjective and based on so many variables.

Other Dosage

- Psychedelic Utilization Review. If a dosage not listed in one of the other categories is used. The department shall review a the high dose usage.

I like that James

Other Dosage

- Any administered dose exceeding the High Intensity Dose range shall require a Psychedelic Utilization Review. Facilitators and providers shall have the freedom to use this; however, they should report to the department on outcomes.

I have a million acronyms in my head EDI?

Chris Peskuski

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Ego-Dissolution Inventory

I appreciate the balance of research and bureaucracy.

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i agree to leave this doc as "definitions"

W/out the edi

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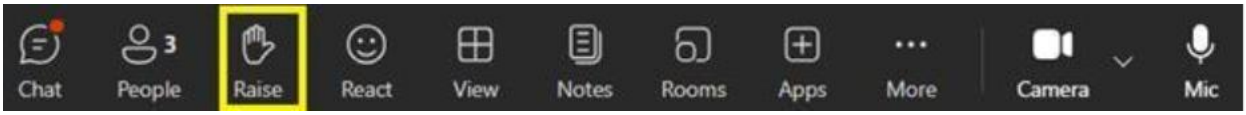

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Set and setting

I came in late. But was "booster dosage" discussed?

I think "booster dosage" was discussed as "Other Dosage."

I coule be mistaken, though.

*could

Contraindications and safety plans for preparation

I think starting at Preparation would be appropriate.

Thanks for this.

How to submit written public comments:

- Please send written public comment to the program email at: medical.psilocybin@doh.nm.gov and include the committee's name in the subject line.
- If referencing documents from other sources/websites:
    - Do not include the document, only a working - accessible hyperlink;
    - Documents must be sent with context provided (i.e. do not simply send a research article);
- The comment must relate to the topics discussed in the meeting.
- Documents are limited to no more than 3 pages (letter size) in length and must be in10-point font or larger.
- Please remember to include your full, legal name and any organizational affiliations you may be representing (if any) on the documents.
- To be included, please send your comment by 5:00 PM the day after the meeting.

Asap Or powder

Sorry, I am not meaning to raise my hand. I think my button is stuck/frozen. Apologies.

Patient Qualification & Safety – Wednesday March 4th from 9-11am; 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.

- @ West Mesa Community Center 5500 Glenrio Rd NW, Albuquerque, NM 87105

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

- @ Garrey Carruthers Building (Yucca Room), 1209 Camino Carlos Rey, Santa Fe, NM 87507

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

End of Life Care – Friday April 3rd from 1:00-3:00pm; Larry Leeman, Chair.

Microsoft Virtual Events Powered by Teams
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What does the patient need to know before doing this

👍

Thank you everyone.

Thank you all for your hard work.

Thank you everyone!

https://www.nmhealth.org/about/mcpp/mpp/mpab/

Psilocybin Advisory Board

So grateful to see this develop.

Thanks, everyone. This is inspiring!

Public Comments submitted by email

To Ian, the dosing, administration, and clinical practices committee, the DOH Psilocybin Program and Board Members,

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.

Pre-preparation

1. Readiness, Motivation/Expectation
2. Contraindications with medications & health conditions (tapering off of medications for the use of psychedelics)
3. Support network for during experience, and more importantly integration
4. Legal considerations
5. Individual Patient Safety Plan Completed

Preparation – considerations for the set and setting

- Dosage – initial, booster, min-max amounts, testing compounds
- Who is there (facilitator/solo, individual/dyad/group)
- Where administered
- Supports
- Clearing of responsibilities
- Obtaining consent
- Work with client on how they resource themselves during experience, and to allow self- witnessing

Administration - During the psychedelic experience (facilitator):

- Checking on onset of action, & effects on the patient (both psychological and physical)
- Non-directive approach
- Following the Patient Safety Plan
- Use of music (headphones), eye shades, breathwork as facilitation tools, and essential Oils also can be helpful.
- Supporting transpersonal/mystical/multiplicity experiences - don't question just follow, allow expansion and exploration

- Administration Session should be allowed to occur in the following setting: (Home, Hospice, Retreats Indoor and Outdoor, Centers) to allow access and equality for all New Mexicans. We need to allow a variety of setting to allow for the unique demographics and population disbursed throughout the state.

Set and Setting - The physical and social environment plays a crucial role in shaping the psilocybin experience or journey. A well-thought-out setting can help ensure safety and comfort. Choose a location that is familiar and comfortable, free from distractions and interruptions. Consider the ambiance—soft lighting, calming sounds, and comfortable seating can enhance relaxation. Incorporating these elements of set and setting can significantly influence the depth and safety of your psychedelic experience. As research into psilocybin continue to occur and grow, understanding these factors becomes increasingly important, emphasizing the need for thoughtful preparation and care in psychedelic practices.

(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.

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. 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. 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:

The 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

Thank You,

James Brown Pharm.D, Rph, IDSP