



# PSILOCYBIN THERAPY IN HOSPICE/END OF LIFE CARE

Implementation Considerations for New Mexico

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# APPROACHING PSYCHEDELIC FACILITATION

I serve as a facilitator, not a healer.

My role and desire is to support the relationship between the patient and the medicine, without overly directing or imposing. Facilitating a safe space for change and provide tools and framework for that change to occur.

As we bring this work into a Western medicine realm, we must be careful not to over-medicalize and lose what makes it effective.

We must remember to teach those we are certifying into this work that we are but hollow bones.

We are coming into this relationship not to be "healers", but to facilitate the relationship between patient and plant medicine or molecule, so that they can come into greater alignment and relationship with themselves...

I feel strongly about this. We have a unique opportunity in NM to look around at what has been done and how we can stay true to culture of our state.

- Facilitator ≠ healer
- "Hollow bone" approach
- Protect the patient-medicine relationship

# WHO I AM

- RN (SANE (Sexual Violence), addiction treatment leadership, hospice clinical director
- 2.5+ years as hospice clinical director (Red Willow Hospice)
- Background: inpatient drug and alcohol detox & multi-site residential DON
- Trauma-informed + somatic focus (IFS, TRE, bioenergetics)
- Spiritual/holistic study: shamanism, herbalism, energy work
- Psychedelic facilitator training (Naropa, 9-month program, 2024)
- Dr. Lida Fatemi's Conscious Physician Psychedelic Academy, 9-month program, certificate in NM winter 2026
- Elemental Psychedelics Ketamine-assisted Therapy Training June 2026
- 19 years in recovery
- 8+ years personal work with psilocybin, micro-dosing while utilizing a fulltime life practice
- Creator of nature-based retreats for embodiment and self-actualization

# WHY THIS MATTERS IN HOSPICE

- Existential distress
- Fear of death
- Loss of meaning
- Disconnection
- Hospice manages physical pain well, but existential suffering is often just as profound. Fear of death and loss of meaning are central drivers of distress.
- And also relieving emotional suffering can change the perception of pain.

# WHAT PSILOCYBIN CAN OFFER

- Reduced anxiety and depression
- Relief of death related anxiety/distress
- Support for life review
- Increased connectedness
- Greater acceptance
- Psilocybin can help patients move toward acceptance, connection, and meaning at the end of life.

# CORE PRINCIPLES

- Comfort Care and relief of suffering (Core Hospice Principle)
- Set and setting
- Intention and integration
- Trust inner intelligence of client and medicine relationship
- This work depends on the therapeutic container. Preparation and integration are often times more important than the dosing itself.

# POSSIBLE CLINICAL MODEL OVERVIEW

- Policies and procedures written and integrated into hospice model of care
- Screening and assessment
- Interdisciplinary group review
- Preparation sessions along with consent process
- Dosing session
- Integration 2-4 sessions
- Ongoing hospice care integrated into entire process

# ENTRY AND EDUCATION

- Introduced as an optional service
- Ongoing patient education
- Voluntary participation

# SCREENING AND CLEARANCE

- Medical evaluation (MD/NP)
- Nursing assessment
- Medication review
- Psychological screening
- Informed consent process

# INTERDISCIPLINARY REVIEW (IDG)

- Nursing
  - Medical providers
  - Social work
  - Spiritual care
  - Mental health support
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- All hospices are required to have an interdisciplinary group meeting with all required core disciplines every 2 weeks.

# PREPARATION PHASE

- 2-3 sessions (typical in models)
- Intention setting
- Education and expectations
- Emotional and existential preparation

# DOSING SESSION/MEDICINE JOURNEY

- Supportive, controlled environment (home environment)
- Trained facilitator present
- Clinical support available
- Co-created, patient-centered experience
- Use of micro-dosing in EOL care!

# CLINICAL SUPPORT CONSIDERATIONS

- Continuity of palliative care
- Symptom management available
- Monitoring as appropriate
- A possible hospice model could be that in the evaluation and assessment of medications and health status; a plan is put in place for pain control and any other medical conditions that may need to be addressed during the medicine session.
- All hospices have a comfort kit of medications in the home and available to patients as needed.
- Families and care givers are taught the use of these medications.
- They range from pain medication to nausea, vomiting and agitation medications.

# ADVANCE CARE PLANNING/DIRECTIVES

- Align with existing directives
- Emergency planning discussions (largely following advanced directives)
- Respect for patient wishes

# INTEGRATION PHASE

- Follow-up sessions
- Meaning-making
- Emotional processing
- Support for patient and family

# HOSPICE STRENGTHS

- Interdisciplinary care model
- Spiritual care integration
- Family-centered approach
- Bereavement support
- Volunteers available

# FAMILY AND COMMUNITY

- Family inclusion (when appropriate) When is that appropriate and is it possible in a hospice model?
- Education and support
- Community-based care models

## SAFETY CONSIDERATIONS: MOST RISKS CAN BE MITIGATED WITH THOUGHTFUL SCREENING, MEDICATION REVIEW, AND CLINICAL OVERSIGHT.

- Medication Interactions:
- SSRIs / SNRIs (may reduce effect)
- MAOIs (potential increased intensity)
- Antipsychotics (may blunt or stop effects)
- Benzodiazepines (reduce intensity; used for distress)
- Mood stabilizers (variable effects)
- Stimulants (may increase anxiety/BP)
- Opioids (generally safe, monitor sedation)
- Cardiovascular medications (monitor BP/HR)

# SAFETY CONSIDERATIONS

- Psychological Screening: This is really about meeting the patient where they are and creating the safest possible container.
- Screen for psychotic disorders
- Screen for bipolar I disorder
- Evaluate suicidality and safety risk
- Trauma history (with support planning)
- Cognitive status (e.g., dementia, delirium) Obviously unable to consent.
- Social support and environment
- Clarify expectations and intentions
  
- Remembering that the goal of hospice is comfort and relief of suffering, so making sure in evaluation of psychological status that we do not want to increase distress.

# TIMING CONSIDERATIONS

- No clear evidence-based cutoff
- Individualized clinical judgment
- Potential benefit across stages of illness

# IMPLEMENTATION CONSIDERATIONS

- Workforce and training requirements?
- Licensing pathways?
- Care settings (home vs facility) At this time, care will be in home settings, it is unknown at this point what facilities may allow this therapy.
- Documentation standards, hospices will handle this their own ways. This is not a Medicare covered program. Policies will be specific to hospices
- Equity and access, as this is not a Medicare funded therapy. I believe grant funding will be pivotal in access. Hospice clients will not be charged.
- Use of doulas and outside facilitators as supports... (most likely would be cash pay by family if integrated into care team. We are able to use doulas as volunteers.

# KEY POLICY QUESTIONS

- Who is eligible to provide care?
- What training standards are required?
- How is access ensured across rural areas? Hospice ideally suited to provide care across rural areas!
- How are cultural and spiritual practices included?

# ABOUT RED WILLOW HOSPICE

- Integrative, holistic, community-based teaching hospice
- Serving rural and underserved populations with a 50-mile radius around Taos, Santa Fe, and ABO
- Whole-person care model
- MAID-supportive program
- This model is grounded in real hospice work in Northern New Mexico.
- Red Willow Hospice 575-737-1811
- <https://www.redwillowhospice.com/>

# DR LARRY'S QUESTIONS

- Recognition/recommendation that EOL care is distinct from the other 3 diagnoses and specific rules and regulations are appropriate?
- Is there role for guide without facilitator training to be sole support person with close licensed clinician/therapist availability?  
Could the 'backup' be a licensed facilitator that is not a clinician or therapist?
- How do we support having a spiritual person present ?
- Would third party payers cover this for person in hospice or palliative care ?
- Required EOL psychedelic care training for which roles and what should the extent be?
- If we create a NM facilitator training, could we require 15 hours specific to EOL for all facilitators ?