Mapping the Journey: Baseline Assessment for the New Mexico Medical Psilocybin Program

Prepared by:
Cannabis Public Policy Consulting LLC
in Partnership With
Advocates for Human Potential Inc.,

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NMHealth
CENTER FOR MEDICAL CANNABIS & PSILOCYBIN

CANNABIS PUBLIC POLICY CONSULTING

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Contents

Executive Summary 1

Intentions of Psilocybin Use and Its Effects 1

Programmatic Insights 2

Healthcare Access 2

Section 1. Research Methodology 3

1.1 Research Design 3

1.2 Participant Geographic and Demographic Distributions 3

Section 2. Psilocybin Use Patterns 7

2.1 Prevalence and Frequency of Use 7

Product Use Frequency 7

2.2 Dose and Consumption Behavior 9

Microdosing 9

Average Costs of Psilocybin Experiences 10

Product Variety 10

Doses Across the Variety of Products 11

2.3 Motivations for Prior Use 12

2.4 Symptoms and Experiences 14

Acute Effects 14

Adverse Events in the Aftermath of Use 15

2.5 The Use of Facilitators 18

The Prevalence of Supervised Experiences 18

The Impact of Guides on Psilocybin Effects 18

Facilitator Preparation and Aftercare 20

Section 2 Summary 20

Section 3. Programmatic Interest and Implementation 22

3.1 Overall Program Awareness and Interest 22
3.2 Qualifying Conditions and Use Cases 25
3.3 Preferred Care Models and Settings 28
Therapeutic Approaches 28
Preferred Psilocybin-Assisted Therapy Facilitators 30
Importance of Various Characteristics of Psilocybin-Assisted Therapy Facilitators 31
Preferred Care Settings 32
3.4 Willingness-to-Pay for Psilocybin-Assisted Therapy and Equity Fund Allocation Analysis 33
Section 3 Summary 39
Section 4. Healthcare Access, Utilization, and Barriers 40
4.1 Access to Medical and Support Services 40
4.2 Barriers to Healthcare Access 41
4.3 How Individuals Access Healthcare Information 44
4.4 Other Equity Considerations 46
Section 4 Summary 51
Section 5. Psilocybin Perceptions and Areas for Education 52
5.1 Perceptions of Psilocybin-Assisted Therapy and the New Mexico Medical Psilocybin Program 52
5.2 Perceptions of Psilocybin Safety and Effectiveness 56
Section 5 Summary 60
Section 6. Considerations for the New Mexico Medical Psilocybin Program Based on the Evidence 60
Educational Campaigns and Online Resources 60
Longitudinal Data Collection System 61
Confidential Reporting System for Patient Safety and Professional Conduct 62
Equity Fund Eligibility and Allocation 62

Future Research 64
Appendix A 65
Eligibility criteria: 65
Screening process: 65
Full survey quality controls: 65
Post-survey data cleaning: 65
Survey sample breakdown: 65

Executive Summary

This report details the methods and results of a research study commissioned by the New Mexico Department of Health and conducted by Cannabis Public Policy Consulting and Advocates for Human Potential between April and May 2026. The goals of this research study were to better understand how New Mexico residents are using, or intend to use, psilocybin to help inform implementation of the state's Medical Psilocybin Program. Specifically, the study aimed to identify patterns of psilocybin use (including factors such as dosing, potency, route of administration, and side effects) and understand prospective patients' needs by identifying the most important questions, concerns, and informational gaps among those in interested in the New Mexico Medical Psilocybin Program. Findings from this study will be used to provide evidence-informed guidance and critical insights to support the development and implementation of the New Mexico Medical Psilocybin Program.

Main findings from the current study are presented below. These findings are more thoroughly described throughout the document.

Intentions of Psilocybin Use and Its Effects

- Nearly 60% of the present sample indicated lifetime use of psilocybin, with 35.5% reporting use within the past two years. Importantly, due to inclusion criteria to participate in the study, this should not be interpreted as population prevalence of psilocybin use in New Mexico.
- Microdosing was common among recent users, with nearly half of past month consumers reporting microdosing psilocybin.
- Whole mushrooms and processed edible products (e.g., chocolates) were the most commonly consumed forms of psilocybin among participants.
- Many participants endorsed psilocybin use for mental health and personal well-being purposes, suggesting that interest in psilocybin extends beyond recreational use.
- More frequent psilocybin use was associated with a greater number of reported adverse events during the seven days following psilocybin consumption.

Programmatic Insights

- Awareness of the Medical Psilocybin Program remains limited, with about one-third of respondents indicating familiarity with the program prior to the survey; however, interest in the program is high with nearly all respondents indicating interest in the program after learning about it.
- Respondents favored multidisciplinary treatment teams, established therapeutic approaches, and facilitators who are experienced, trustworthy, and trauma informed.
- Community-based clinics were the preferred treatment setting, underscoring the importance of accessible, locally available services across New Mexico.
- Affordability represents one of the greatest barriers to program access, with nearly half of interested respondents indicating being unable or unwilling to pay out-of-pocket treatment costs.
- Annual household income was a significant predictor of willingness to pay, suggesting that many individuals who could benefit from treatment may be unable to access it without financial assistance.
- Respondents anticipate logistical challenges with participation in the program, with 71% expecting difficulties participating due to transportation needs, time away from school or work, and other logistical considerations.

Healthcare Access

- Barriers to broad healthcare access were widespread, with nearly three-quarters of respondents reporting experiencing at least one barrier to accessing healthcare in the past year, most commonly related to service availability, cost, and transportation.
- Healthcare utilization patterns and anticipated program participation barriers were generally similar across rural and urban communities, suggesting financial and logistical barriers may be more influential than location alone.
- Trusted sources of healthcare information differed as a function of past psilocybin experience, highlighting the need for diverse outreach and education strategies.

Section 1. Research Methodology

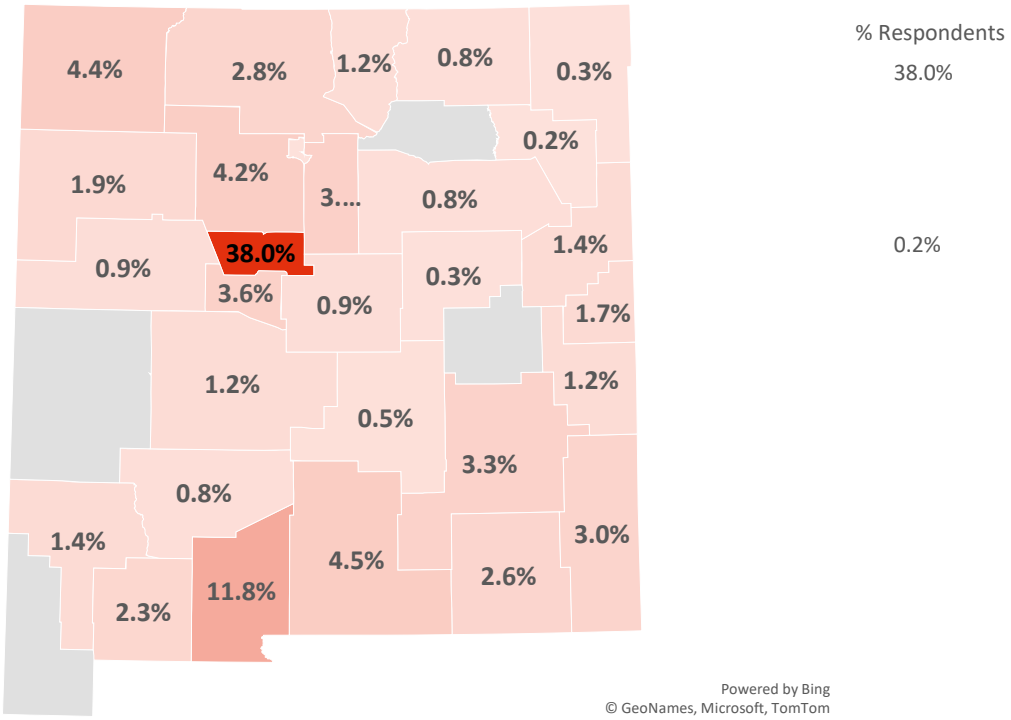
1.1 Research Design

To qualify for participation in this study, respondents must have reported being 18 years of age or older, currently residing in New Mexico, and either using psilocybin within the past two years *or* expressing interest in the New Mexico Medical Psilocybin Program. In total, 1,932 individuals responded to the survey invitation and entered the survey. Of these, 1,129 did not complete the full survey. Of the 803 completed and qualifying responses, an additional 161 respondents were removed during post-survey data cleaning due to data quality concerns, including speeding, straight lining, and inconsistent response patterns. A total of 642 respondents met all qualifying criteria to participate in this study and completed the full survey. For further information about our research methodology, please see Appendix A.

1.2 Participant Geographic and Demographic Distributions

Figure 1 displays the geographic distributions of survey participants by county. Survey participants were represented across nearly all counties in the state, with responses collected from all but four counties. The percentage of survey participants residing in each sampled county is almost perfectly correlated with the percentage of actual New Mexico residents in each county (r = .98), which suggests our recruitment of New Mexico residents is geographically consistent with actual county populations in the state.

Figure 1. Geographic Distribution of Survey Respondents in New Mexico



Zip code and county-level data were used to assign Rural-Urban Continuum Codes (RUCC) to each participant in the sample. RUCC classifications, developed by the United States Department of Agriculture (USDA) Economic Research Service, categorize U.S. counties according to metropolitan status, population size, and adjacency to metropolitan areas[1]. Counties in New Mexico represent 8 of the 9 RUCC categories, and respondents in the current sample represented 7 of the 8 RUCC categories in the state. Most participants resided in metropolitan areas of the state (RUCC codes 2 and 3; 66.7%).

[1] U.S. Department of Agriculture, Economic Research Service. (2025, December 30). *Rural-Urban Continuum Codes*.

Table 1. Survey Participant Distribution by RUCC Categorization

RUCC Code	RUCC Code Description	% of Sample (n = 642)
2	Metro - Counties in metro areas of 250,000 to 1 million population	46.7% (n = 300)
3	Metro - Counties in metro areas of fewer than 250,000 population	19.9% (n = 128)
4	Nonmetro - Urban population of 20,000 or more, adjacent to a metro area	4.5% (n = 29)
5	Nonmetro - Urban population of 20,000 or more, *not* adjacent to a metro area	12.5% (n = 80)
6	Nonmetro - Urban population of 5,000 to 20,000, adjacent to a metro area	9.0% (n = 58)
7	Nonmetro - Urban population of 5,000 to 20,000, *not* adjacent to a metro area	6.5% (n =42)
8	Nonmetro - Urban population of fewer than 5,000, adjacent to a metro area	--
9	Nonmetro - Urban population of fewer than 5,000, *not* adjacent to a metro area	0.8% (n = 5)

Demographic characteristics between the survey sample and the population of New Mexico matched by 94%. Taken together, the geographic and demographic correlations strengthen our confidence that the findings shown in the report are likely to accurately reflect trends in the state of New Mexico. Key demographic characteristics of survey respondents and the general New Mexico population reported by the U.S. Census Bureau are shown in Table 2. Most of the survey respondents were White (77.7%) and slightly more were female (55.1%). Median household income of the survey sample was slightly lower than the population ($42,500 and $64,059), despite receiving higher levels of educational attainment (94.1% and 88.0%).

Not listed in Table 2: Six percent of the final analytical sample (n=642) indicated they have served in the U.S. Armed Forces, military reserves, or National Guard. Approximately 5% indicated residing within the boundaries of a Tribal Nation or Pueblo in New Mexico, 1.6% reside on Off-Reservation Trust Land, and 86.4% live outside of tribal land boundaries. Thirteen percent of the final sample indicated being an enrolled member of a federally recognized tribe in New Mexico. All supplementary demographic data points are consistent with American Community Survey and other Census data[2].

[2] https://www.dws.nm.gov/Portals/0/DM/LMI/Tribal_Pop_Emp_Status_Data.pdf

Table 2. Demographic Distributions

Demographic	Survey (n 642)	New Mexico
Age (Median)	39	39
Race		
American Indian, Native American, or Alaska Native, alone	7.0%	11.4%
Asian, alone	0.5%	2.1%
Black or African American, alone	3.4%	2.9%
White, alone	77.7%	80.5%
Native Hawaiian or other Pacific Islander, alone	0.2%	0.2%
Two or more races	1.2%	2.9%
Decline to answer	5.5%	--
Hispanic ethnicity	37%	49.4%
Gender Identity		
Male	43.1%	49.8%
Female	55.1%	50.2%
Transgender man/trans man/female-to-male (FTM)	0.6%	--
Transgender woman/trans woman/male-to-female (MTF)	0.2%	--
Nonbinary	0.3%	--
Two Spirit	0.2%	
Other/Prefer not to answer	0.5%	
Household Income (Median)	$42,500	$64,059
High School Degree or Higher	94.1%	88.0%

The survey received 1,932 entries, with 803 complete responses. Table 2 presents the demographic characteristics of the final analytic sample (n=642), consisting of respondents who met the study's inclusion criteria and passed all data quality checks and cleaning procedures. Additional information about sample selection is provided in Appendix A.

Section 2. Psilocybin Use Patterns

2.1 Prevalence and Frequency of Use

Product Use Frequency

The most recently published national estimate of lifetime prevalence of psilocybin use is 12.1%.[3] In the past year, 11 million US adults have reported using psilocybin, which translates to roughly 4%.[4] In contrast, our current New Mexico sample displays an exaggerated percent of lifetime consumers (57.8%; *n* = 371), and past-year reports of prevalence (12.3%) also surpass the national estimates. Given the limitations of state-specific data, and recognition that the current study is among the first of its kind, there is no feasible way to know if the figures identified in our sample are an artifact of the sample and methodology (e.g., inclusion criteria included use of psilocybin within the past two years or interest in the New Mexico Medical Psilocybin Program), or if New Mexico residents have significantly higher prevalences than the national average. However, estimating the true prevalence of psilocybin use across New Mexico was not the primary goal of our study; without question, we were able to recruit the intended survey population with success.

Table 3. Psilocybin/Psilocin Use Frequency and Percent of the Overall Sample

I have consumed psilocybin in the past…	Frequency	Percent	Percent of consumers
week	36	5.6%	9.7%
month	66	10.3%	17.8%
year	79	12.3%	21.3%
two years	47	7.3%	12.7%
three-five years	36	5.6%	9.7%
more than five years ago	107	16.7%	29.0%
I have never consumed	271	42.2%	--

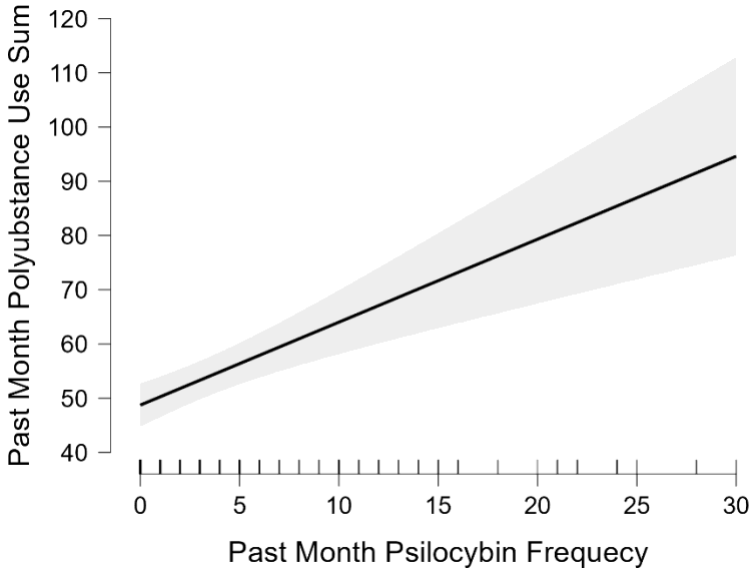
Frequency of psilocybin use in the past month was strongly related to the use frequency of all other substances with abuse liability (cannabis and its hemp and synthetic analogs, tobacco, alcohol, stimulants, and opioids). The relationship between psilocybin use frequency and past month polysubstance use was determined using a linear regression when age, education, and

[3] Karilynn M. Rockhill, Joshua C. Black, Michael S. Ladka, et al. The Rise of Psilocybin Use in the United States: A Multisource Observational Study. *Ann Intern Med*.2025;178:1052-1054. [Epub 22 April 2025]. https://doi:10.7326/ANNALS-24-03145

[4] U.S. Psychedelic Use and Microdosing in 2025: Insights from a Probability-Based and Nationally Representative Survey | RAND

income were included as covariates. After accounting for demographic differences, people who used a greater number of other drugs also tended to use psilocybin more often. For each additional type of drug used, respondents reported using psilocybin approximately 1.5 more days. This relationship was statistically significant ($t = 4.5$, $p < 0.001$, $B = 1.5$). While education and income were not orderly related to psilocybin use, younger age was related to more psilocybin use (ts ~ -2.5, ps < 0.05). Taken together, **these findings from the regression suggest that psilocybin is used more often by those who frequently use many substances with high abuse-liability and are younger**.

Figure 2. Relationship Between Polysubstance Use and Psilocybin Use Frequency in the Past Month



Indications of poor mental health often correlate with substance use frequency, and symptoms of mental illness can correspond to psilocybin use. [5] A comparison of those who indicated a history of any lifetime use of psilocybin ($n = 371$) versus those without history ($n = 271$) exemplifies this in that depression and PTSD symptoms were more prominent in those with a history of psilocybin use (ps < 0.05, ds = 0.2). To explore whether past month use frequency of psilocybin is related to anxiety, depression, and PTSD, a linear regression was performed using scores from the GAD-2, PHQ-2, and 4-item PTSD scale, respectively. Age was included as a covariate, as was income and education, because these are demographic correlates of

[5] Karilynn M. Rockhill, Joshua C. Black, Michael S. Ladka, et al. The Rise of Psilocybin Use in the United States: A Multisource Observational Study. *Ann Intern Med*.2025;178:1052-1054. [Epub 22 April 2025]. https://doi:10.7326/ANNALS-24-03145

substance use. The scores from each of these survey assessments of mental health were not interrelated with psilocybin use frequency (*ps* > 0.05), although there was a slight trend that more severe depression and less severe anxiety were correlated with psilocybin use when age, income and education were included in the model.

The relationship between use frequency of psilocybin and the prevalence of adverse events is explored in later sections. Lifetime psilocybin use was more strongly correlated with lifetime use of other psychedelics ($\rho = 0.6$, $p < 0.001$) than with substances which carry potential for problematic use such as cannabis ($\rho = 0.3$, $p < 0.001$).

2.2 Dose and Consumption Behavior

The table below displays reports of respondents' most recent psilocybin dosing experience among those who used psilocybin within the past two years, regardless of the product type and irrespective of the frequency of use. Most people in the survey reported using a moderate dose.

Table 4. Most Recent Dosage and Definitions

Dosage	Frequency (n = 228)	Percent
Microdosing: a small fraction of a regular dose that is much lower than you would take to feel psychedelic effects (trip or hallucinate)	53	23.2%
Moderate: an amount that produces noticeable effects, but you remain able to function and interact	**109**	**47.8%**
Journey: an amount that produces strong, immersive psychedelic effects that may limit interaction with surroundings	61	26.8%
I don't recall	5	2.2%

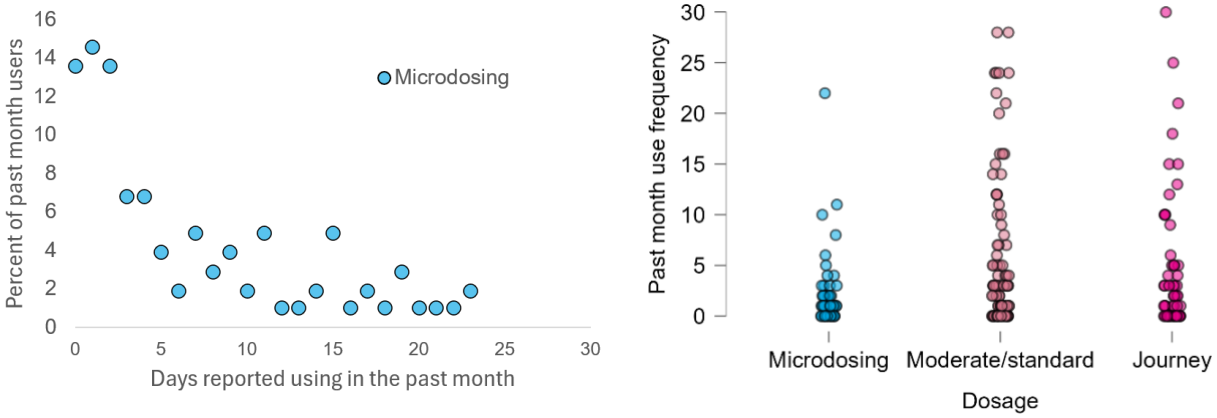
Microdosing

According to the recent RAND studies, 47-69% [3,6] of US adults who have consumed psilocybin in the past year have reported microdosing. In our survey in New Mexico, 46.5% of those who reported using psilocybin in the past month reported microdosing. Figure 3 (left side) illustrates

[6] Kilmer, Beau, Michelle Priest, Rajeev Ramchand, Rhianna C. Rogers, Ben Senator, and Keytin Palmer, Considering Alternatives to Psychedelic Drug Prohibition, RAND Corporation, RR-A2825-1, 2024. As of December 17, 2025: https://www.rand.org/pubs/research_reports/RRA2825-1.html

the use frequency of those who indicated microdosing and they reported microdosing on five or fewer days in the past month. Roughly 1% report using it more than 20 days in the past month. Figure 3 (right) contains individual values for each most-recent dosing condition to show the distribution of frequencies. The figure demonstrates that those who report most recently microdosing consume psilocybin *less* frequently than those who use it at higher doses. This was confirmed by one-way (corrected) ANOVA which found that those who most recently microdosed differed from the other two groups (*p*s < 0.05). The importance of this finding is that those who opt to microdose may represent a special type of psilocybin consumer who tends to use it more sparingly.

Figure 3. Past-Month Use Frequency per Preferred Dose Condition



Average Costs of Psilocybin Experiences

In response to, "*In total, about how much did you spend on psilocybin mushrooms and other products containing psilocybin or psilocin products in the past month?*" The most frequent answer (27.2%) was that they spent no money in the past month. If they had spent money, the median amount was between $30.00 and $40.00, with the modal amount being between $20.00-$30.00. None of the past month users reported spending money on services or retreats.

Product Variety

To examine the consumption of the variety of psilocybin/psilocin products available to consumers, we asked: "*Now, think about the last time you used psilocybin mushrooms or products containing psilocybin or psilocin. Which product did you use?*" Whole mushrooms and processed edibles were the most frequently consumed, with the rare report of the consumption of truffles. To explore how consumption of these products relates to public health, the use of these products related to adverse events is analyzed in later sections.

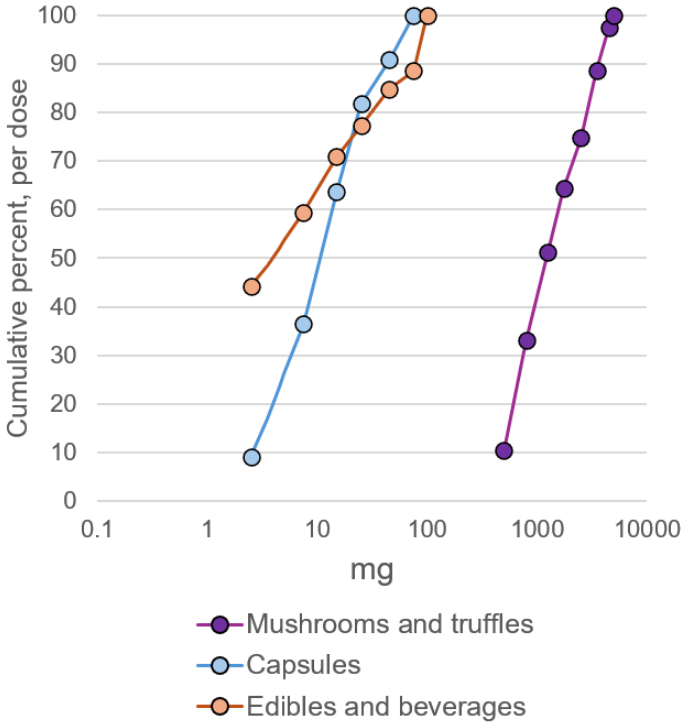
Table 5. Percent of Past Month Consumers Reporting Each Method of Self-Administration

Products Consumed	Frequency (n = 102)	Percent
Whole mushrooms	**64**	**62.7%**
Truffle (sclerotia; the underground form of the mushroom)	12	11.8%
Tea or other drink	33	32.4%
Processed edibles (e.g., chocolates)	42	41.2%
Capsule, tablet, or extract	22	21.6%

Doses Across the Variety of Products

The average doses for whole mushroom and truffle are usually procured in grams, while capsules, and edibles/beverages in milligrams. In Figure 4, we have provided this as a cumulative percentage of those surveyed to display similar patterns across products. The lines are approximately parallel, which suggests that with each stepwise logarithmic increase in drug dose there is a similar and corresponding increase in the percent of the population reporting consuming that dose.

Figure 4. Percent Reporting Dosage, per Product



Median and mean doses (by weight) for whole mushrooms and truffles were 1,250 and 1,959 mg. Median and mean doses for capsules were 15 and 21.8 mg, and 17.5 and 22.1 for edibles/beverages, respectively.

These estimates should be interpreted with caution. Respondents generally do not know the precise amount of psilocybin, the primary psychoactive compound, contained within the products they consume. Psilocybin concentration can vary across mushrooms, truffles, capsules, edibles, and beverages, meaning that the reported weight of a product does not necessarily correspond to a standardized amount of psilocybin or psychoactive exposure. Additionally, because products are measured and consumed using different units and there is no uniform standardized dosing scale across product types, the values presented in Figure 4 are most useful for identifying relative patterns in self-reported dosing rather than directly comparing equivalent psilocybin doses across products.

2.3 Motivations for Prior Use

In our effort to understand the reasons for past psilocybin use, we asked participants with past two-year use of psilocybin: "*What are your goals or intentions for using psilocybin mushrooms or a product containing psilocybin or psilocin? Please select all that apply.*" Response options were not exclusive such that participants could select multiple reasons for use. The most frequently reported reason was for "fun," which we clarified as "to temporarily increase or enhance your sense of joy, pleasure, or play, possibly at a party or other social gathering." Of those who indicated using it for fun (*n* = 126), only 17 participants (13.5%) reported using it exclusively for that purpose and did not select any other reason. The second most frequently reported intention for using psilocybin was as a "mental health treatment," which was defined as "to decrease symptoms associated with a mental health condition, such as depression." Of those using it for this reason (*n* = 101), 11 participants (11%) used it exclusively for this purpose.

Table 6. Goals of Psilocybin Use

Intentions for use	Freq. *n* 228	%	Used for fun *n* 126	Used for mental health *n* 101
Fun	**126**	55.3%	100.0%	50.0%
Mental health treatment	**101**	44.3%	42.5%	100.0%

Intentions for use	Freq. *n* 228	%	Used for fun *n* 126	Used for mental health *n* 101
Spiritual growth	85	37.3%	37.8%	50.2%
Personal development	84	36.8%	43.3%	49.8%
Curiosity	77	33.8%	40.2%	47.0%
Cognitive enhancement	63	27.6%	33.9%	49.5%
Interpersonal bonding	54	23.7%	27.6%	45.8%
To avoid physical pain/discomfort	42	18.4%	17.3%	41.3%
Community	36	15.8%	18.9%	37.5%
Improved physical health	31	13.6%	16.5%	39.1%
Other	6	2.6%	1.6%	17.0%

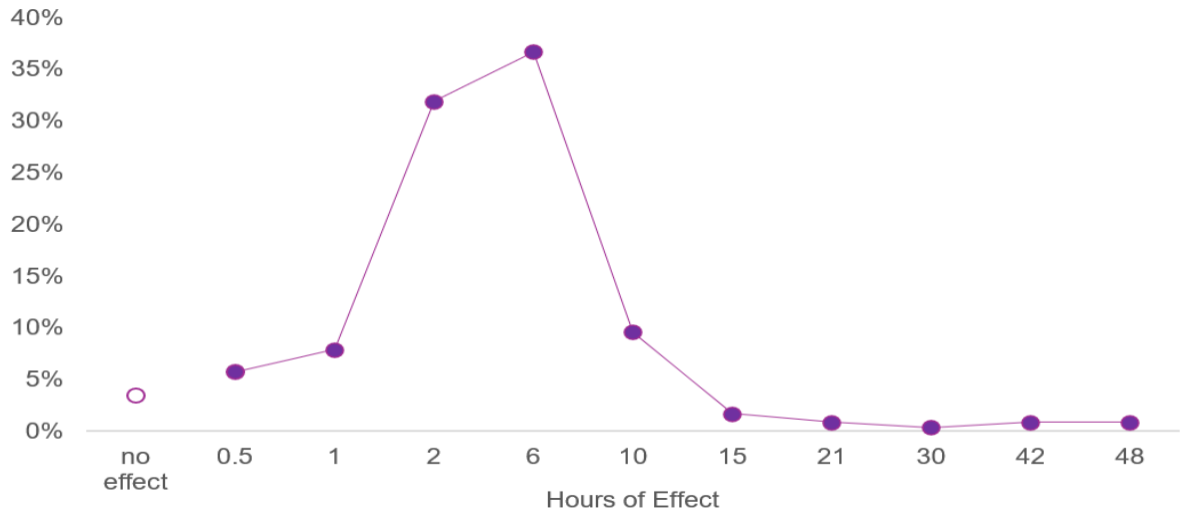
Although it makes sense that people would have a variety of reasons for using any medicinal or recreational substance, how people prioritize the reasons for their substance use is important to understand. For instance, whether use is driven by the pursuit of pleasure or to escape pain or discomfort helps to identify psilocybin's place among those substances used more medicinally than recreationally. Therefore, we explored the goals of use for those people who indicated seeking fun and for the betterment of mental health since these were the most frequently reported objectives. In Table 6 above, it is evident that a higher percentage of people who have the goal of bettering their mental health are capitalizing upon it for a myriad of other purposes. The finding that psilocybin is so often used for the purposes of relieving psychological discomfort emphasizes the multifaceted and important role that psilocybin can play beyond that of a recreational substance used in nightlife or social contexts.

2.4 Symptoms and Experiences

Acute Effects

The immediate subjective effects of psilocybin would be expected to follow from the time-course of drug action. Although the pharmacokinetic profile can be extremely variable [7] and dependent on product and dose, half-lives for psilocybin (dihydrate capsule) doses of 15-30mg are ~1.8 hours, and blood plasma concentrations reach 20% of initial value (mg) within 8 hours.[8] Our findings presented below in Figure 5 approximate these blood plasma concentrations that have previously been reported in that the subjective experience of drug action begins to abate for many participants after 6 hours.

Figure 5. Responses to the Question, "The Last Time You Used Psilocybin Mushrooms or a Product Containing Psilocybin or Psilocin, How Many Hours Do You Think the Effects Lasted?"

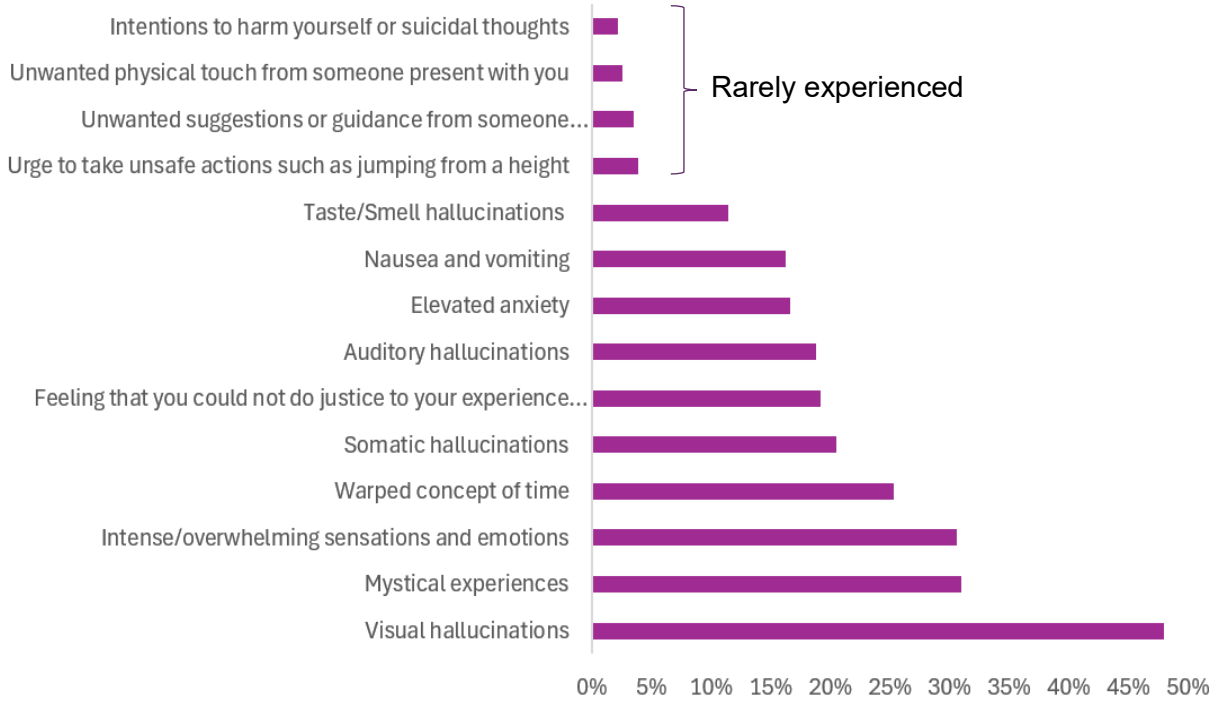


Symptoms reported (n = 228) of experiences were during the use of psilocybin mushrooms or a product containing psilocybin or psilocin in the past year. The sum of these symptoms was correlated to dose (micro vs. standard/typical vs. journey dose; $r = 0.3$, $p < 0.001$). As shown in Figure 6 below, the most frequently reported subjective effects are visual hallucinations, mystical experiences, and emotional overwhelm.

[7] Meshkat, S., Al-Shamali, H., Perivolaris, A., Tullu, T., Zeifman, R. J., Zhang, Y., Burback, L., Winkler, O., Greenshaw, A., Husain, M. I., C. Reichelt, A., Vermetten, E., Jha, M. K., Jetly, R., Loebenberg, R., & Bhat, V. (2025). Pharmacokinetics of Psilocybin: A Systematic Review. *Pharmaceutics*, *17*(4), 411. https://doi.org/10.3390/pharmaceutics17040411

[8] Holze, F., Becker, A.M., Kolaczynska, K.E., Duthaler, U. and Liechti, M.E. (2023), Pharmacokinetics and Pharmacodynamics of Oral Psilocybin Administration in Healthy Participants. Clin Pharmacol Ther, 113: 822-831. https://doi.org/10.1002/cpt.2821

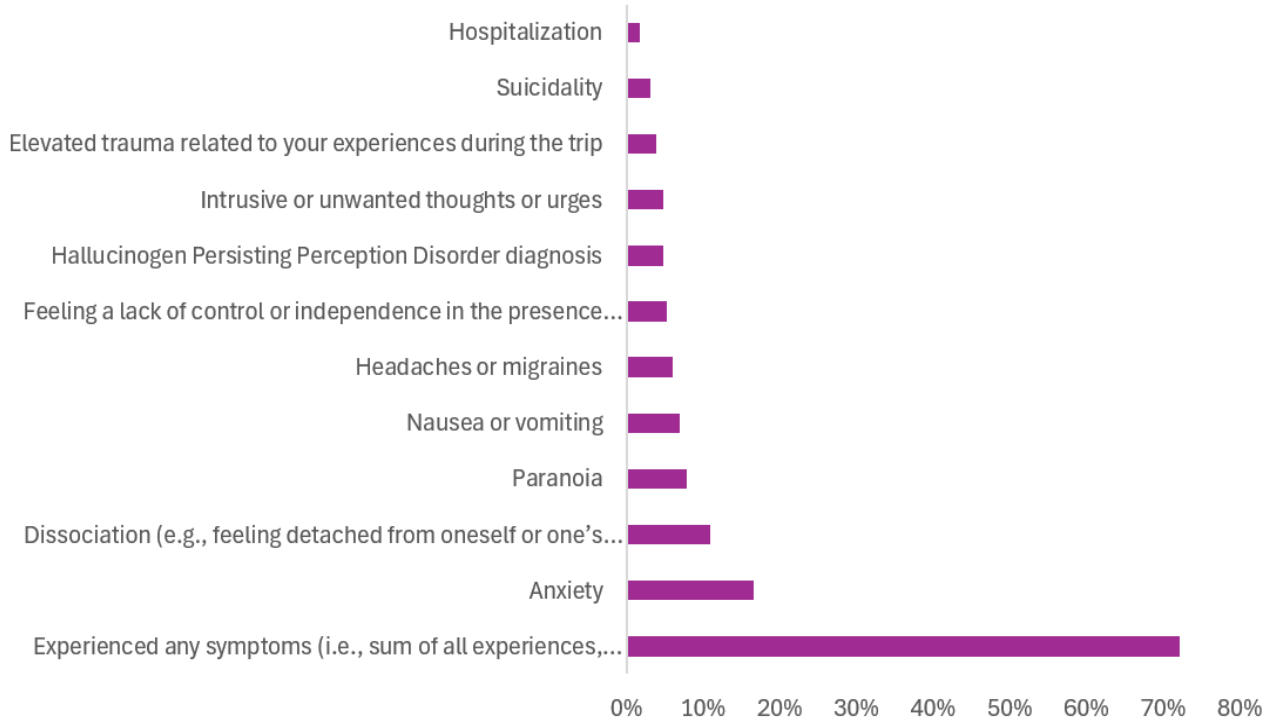
Figure 6. Experiences During One's Use of Psilocybin Within the Past Year



Adverse Events in the Aftermath of Use

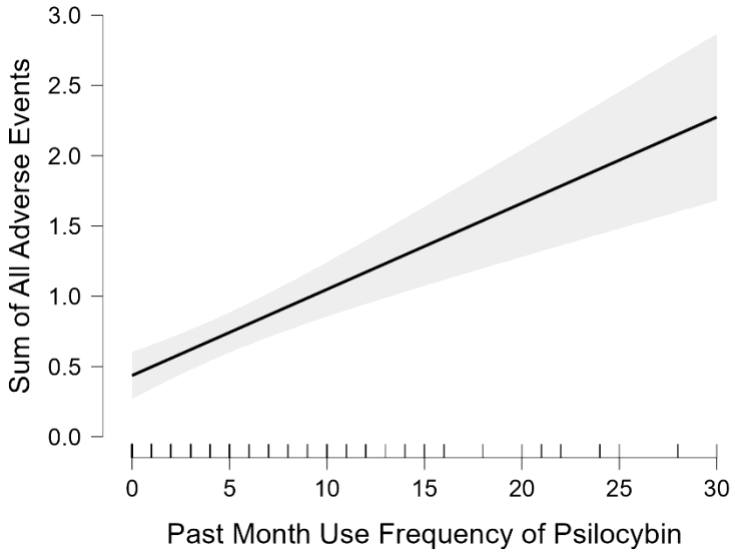
Symptoms occurring during the psilocybin dosing experience might be expected to relate to the symptoms in its aftermath. These adverse reactions reported within seven days after using psilocybin are listed in the figure below. Over 70% experienced some of the symptoms in the aftermath, which the participants directly attributed to their use of the substance. **The most frequently reported were anxiety (17%) and dissociative events (11%).** The sum of these adverse events was positively correlated with the sum of symptoms experienced during the psilocybin experience ($r = 0.3$, $p < 0.001$). There was a strong correlation between reports of anxiety during the psilocybin experience and the sum of all adverse events in its aftermath ($r = 0.6$, $p < 0.001$).

Figure 7. Percent of Respondents Experiencing Adverse Reactions Within Seven Days of Psilocybin Use



A hierarchical regression was used to determine whether dosage (e.g., micro versus journey), frequency of psilocybin use, age, and product type (e.g., tea) were related in an orderly fashion to adverse events reported in the seven-day aftermath of psilocybin use. The consumption of truffles in the past month was a strong predictor of the sum of adverse events ($p < 0.001$); but, this finding is somewhat tempered by the low number of participants reporting having used truffles ($n = 12$) in the past month. **The frequency of psilocybin use in the past month was a robust predictor of adverse events in which more frequent use was associated with more adverse events** ($t = 7.3$, $p < 0.001$). Younger age was also related to experiencing more adverse events ($t = -2.6$, $p < 0.01$). Interestingly, dose (i.e., microdose, journey, etc.) was unrelated to the experience of any aftermath symptoms. The findings that more frequent use of psilocybin is related to adverse events suggest these events are not likely experienced by those who seek it as an infrequent medical aid, but rather those who use it more frequently. This frequent use is not likely microdosing, or that would have been evident in the statistical analysis above.

Figure 8. Relationship Between Past Month Use of Psilocybin and Sum of Adverse Events Experienced Within Seven Days of Use



We further questioned whether the use of antidepressants to treat depression or PTSD was interrelated with adverse events since the combination with other 5-HT agonists (i.e., any classic psychedelic) would lead to serotonin syndrome. There were 88 people in the sample who indicated SSRI or SNRI use for the treatment of two distinct psychiatric conditions (MTRD and PTSD), and 30 of these people had used psilocybin in the past two years. Although the presence of adverse events was elevated relative to their counterparts who did not use an SSRI or SNRI prescription, it failed to surpass the standard threshold for statistical significance (t = 1.9, p = 0.06). Although there were a significant number of people (n = 225) who indicated using herbal or natural remedies (e.g., echinacea, St. John's wort, turmeric) as a portion of managing their health, this was not explored as a contributor to adverse events because those who use these products were much less likely to use psilocybin frequently ($p < 0.05$).

We recommend future directions for survey research to include a follow-up question to the adverse reaction block: "*Which of the following products contributed to your unpleasant symptoms?*" with the various forms of psilocybin/psilocin products listed as response options. We also recommend including a question with a list of pharmaceuticals and OTC herbal products (e.g., valerian root) which are serotonergic agonists to explore the possibility that adverse events are related to serotonin syndrome.

2.5 The Use of Facilitators

The Prevalence of Supervised Experiences

Of the 228, 53 (23.2%) reported exclusively microdosing. The other 175 were asked to indicate with whom they experienced their psilocybin the last time they consumed it (e.g., facilitator, in a group, etc.). Most reported using it while alone (39.4%) or in a group of others who were also using it (34.9%). Facilitators were used on 13.1% of all occasions. The use of spiritually trained facilitators (shaman or spiritual/religious leader) was rare (n = 2). Supervision during the experience by at least one sober person was reported by 9.7% (i.e., "I took them in a group or pair and at least one person who was sober"). Of those who responded to an open-text option, many indicated taking it with a romantic partner, and one noted taking it "with my mom."

The Impact of Guides on Psilocybin Effects

The symptoms reported occurring during psilocybin dosing experiences in the past year, and those occurring in the aftermath, were never directly linked to the experience of guides. In other words, although we asked about whether the most recent experience involved a guide, we cannot know whether the symptoms reported are from that most recent guided experience or from a cluster of experiences which did not involve a guide. Therefore, there is no way of knowing whether the use of a guide has a direct impact on these symptoms. However, as a preliminary assessment of the impact of guides, we can explore whether having used a facilitator is systematically associated with any of the reported symptoms.

The cluster of symptoms selected below represents our best guess on how the presence of medical, non-medical and spiritual guides might impact the overall experience. For instance, we would expect the presence of a medical professional or spiritual guides might temper symptoms of anxiety, but they do not appear to do so (Table 7, below). Furthermore, the guidance from a spiritual leader was expected to be associated with more mystical experiences than those who sought out psilocybin without that type of guidance. Since those who indicated using under the guidance of a spiritual leader were few, it is impossible to draw any conclusions; the two participants who reported using a spiritual guide described only unfavorable outcomes and no symptoms of mystical experience.

In our previous National Behavioral Health Survey (N = 1,298 past-year consumers of psilocybin) which asked similar questions, we found that being in the presence of any professional or non-professional guide (including spiritual) more than doubled the odds of

experiencing unwanted physical touch, and this is why it is explored in the table below. Indeed, this current sample in **New Mexico displays the same concerning trend; unwanted physical touch was most predominantly experienced by those who hired a professional guide.**

Table 7. Prevalence of Acute Symptoms During the Psilocybin Experience Presented by Guidance Category

Symptom	Alone (n 69)	Medical professional (n 11)	Non medical professional (n 10)	Shaman or spiritual facilitator (n 2)	Group with others using (n 61)	Group, sober supervision (n 17)
Unwanted physical touch from someone present with you	2.9%	**18.2%**	**10.0%**	0.0%	0.0%	0.0%
Unwanted suggestions or guidance from someone present with you	2.9%	0.0%	10.0%	50.0%	3.3%	5.9%
Mystical Experience	15.7%	36.4%	20.0%	0.0%	14.8%	23.5%
Anxiety	11.4%	18.2%	10.0%	0.0%	11.5%	5.9%

The symptoms reported to occur during a psilocybin experience were assessed relative to whether guidance was received by any professional, regardless of whether they were medically trained, spiritually trained, or uncertified (i.e., non-medical professions). In this analysis, guided experiences are defined as anyone who had one or more other person present with the intent to guide the journey (n = 101). This clustered grouping resulted in a sizeable-enough number of participants (n = 23) to assess how guidance was related to the drug experience and compare it to others who did not receive professional guidance. The sum of all symptoms present during the experience of psilocybin did not appear to be impacted by the presence of a facilitator (p > 0.05). On average, the feeling that one "could not do justice to the experience" and a warped concept of time were *less* likely to be reported by those with recent professional supervision (ps < 0.05, ds > 0.5).

A handful of symptoms were *more* likely to be reported when a facilitator was present, such as "intentions to harm yourself," "the urge to take unsafe actions such as jumping from a height," and unwanted physical touch (all ps < 0.05, ds > 0.2, from parametric and non-parametric independent t-tests).

The sum of all adverse events was reported *more* frequently when a facilitator was present ($p < 0.001$, $d = 0.6$). There were some concerning findings. Suicidality, anxiety, feeling of elevated trauma, feelings of a loss of agency, and intrusive urges were all more apparent when a facilitator was present (ps < 0.05, ds > 0.2). Furthermore, nausea was also more frequently reported in the aftermath of consuming psilocybin if a facilitator was present, but this was not reported during the psychedelic experience.

A striking between-group (i.e., facilitator versus no facilitator) finding was those who reported using a facilitator for their most recent experience reported consuming psilocybin more frequently. Those who used a facilitator reported using it on an average of 9 days in the past month, relative to those who didn't report having used a facilitator (3.7 days, $p < 0.05$, $d = 0.6$). This is surprising because it might be expected that those who use infrequently would be more prone to seeking guidance. One possibility is those who use it more frequently and are therefore more prone to experiencing side effects and adverse effects, are seeking out the assistance of a facilitator in an attempt to manage those symptoms.

Given that the sum of concerning adverse effects was statistically more demonstrated with a facilitator present in past psilocybin use, it is likely beneficial for the New Mexico Department of Health to create an easy to access reporting system for adverse effects of patients. Patient protections, including anonymity in reporting, will need to be considered carefully.

Facilitator Preparation and Aftercare

Of the 23 participants who reported using a facilitator, 20 reported having some preparation experience, and the average amount of time spent in preparation was between one and three hours. In response to the survey question about an aftercare meeting or integration plan, of the 20 who had a formal preparation, 17 reported aftercare planning. None of these failed to follow through with their aftercare plan.

Section 2 Summary

- Psilocybin is used more often by those who frequently use many substances with high abuse-liability.

- 57.8% of the present sample indicated using psilocybin at least once in their lifetime, with 228 (35.5%) reporting use within the past two years. Importantly, past-use estimates should be approached with some caution and are not intended to provide estimates of psilocybin use prevalence across New Mexico.
- Nearly half of past-month psilocybin consumers reported microdosing psilocybin in the past month. Those who microdose consumed psilocybin less frequently than those who consume at higher doses.
- Among respondents who spent money on psilocybin in the past month, the median spending amount was between $30.00-$40.00. No past month consumers in our sample reported spending money on psilocybin services or retreats.
- Psilocybin was most often consumed in whole mushroom (36.8%) and processed edible (e.g., chocolates) forms among those consuming in the past month.
- While most people use psilocybin as a recreational substance, it is evident that a higher percentage of people who have the goal of bettering their mental health are capitalizing on it for a myriad of other purposes.
- Survey findings on the reported time course of drug action were generally consistent with findings reported in experimental and laboratory studies.
- The most frequently reported subjective effects of consumption are visual hallucinations, mystical experiences, and emotional overwhelm.
- The most frequently reported adverse events in the seven days after the psilocybin experience were anxiety and dissociative events. There was a strong correlation between reports of anxiety during the psilocybin-dosing experience and the sum of all adverse events in the aftermath of use. More frequent psilocybin use was associated with more adverse events.
- The use of facilitators during the psilocybin experience is associated with increased reports of unwanted physical touch and elevated trauma and anxiety.
- To advance public health and consumer protections, future survey research should include direct questions regarding: (a) events that transpire during facilitator experiences, (b) adverse events related to truffles versus other products, and (c) the use of supplements and pharmaceuticals which may be contraindicated with psilocybin.

Section 3. Programmatic Interest and Implementation

3.1 Overall Program Awareness and Interest

To assess awareness, interest, and potential reasons for treatment, all survey respondents (*n* = 642) were shown the following informational prompt:

"*New Mexico became the third state in the United States to regulate psilocybin-assisted therapy treatment for specific medical conditions. To qualify for this treatment, patients must be diagnosed with a qualifying condition. This treatment model requires psilocybin to be administered orally in an approved therapeutic setting with a trained and permitted healthcare provider present. Implementation of this regulated program will be complete in 2027, with the first patients expected to be seen in December 2026*."

Among the total sample, fewer than one-third of respondents reported being aware of New Mexico's Medical Psilocybin Act. Specifically, 31.8% (*n* = 204) were aware of the Act, while 62.6% (*n* = 402) were not aware and 5.6% (*n* = 36) were unsure. These findings suggest a substantial awareness gap and point to the need for broad public education and outreach efforts as the state prepares to implement the Medical Psilocybin Program.

Conversely, just under two-thirds (59%; *n* = 385) of the total sample indicated they would be interested in participating in psilocybin-assisted therapy, with only 2% (*n* = 18) stating they would not be interested. The remaining 37% (*n* = 239) stated they *may* be interested in the program. Taken together, these findings suggest that although awareness of New Mexico's Medical Psilocybin Act remains relatively low, there appears to be substantial interest in the program once individuals are informed of its existence and structure. As implementation approaches, educational initiatives may therefore serve not only to increase awareness, but also to facilitate engagement among potentially eligible patients.

Participants who were not interested in the Medical Psilocybin Program were asked about reasons for their disinterest. Data from the small subset of respondents from the full sample who

indicated no interest participating in psilocybin-assisted therapy (*n* = 18) were analyzed, as well as responses from 330 survey entrants who did not complete the full survey due to failure to meet inclusion criteria (i.e., did not consume psilocybin in their lifetime or did not express interest in the Medical Psilocybin Program). Data are presented in Table 8. Across both groups, the most commonly endorsed reasons for disinterest reflected either a lack of personal relevance or discomfort with the treatment experience itself. Nearly half (46.6%) of the subsample of survey entrants and one-third (33.3%) from the full survey sample reported that psilocybin-assisted therapy was simply not something they were personally interested in, while 29.2% and 27.8%, respectively, stated they did not have a condition that could be treated through the program.

Other commonly endorsed reasons included feeling uncomfortable with the idea of being under the influence of a psychedelic substance in the presence of someone with whom they did not have a strong pre-existing relationship (22.7% survey entrants and 22.2% full survey sample) and concerns about side effects (22.7% survey entrants and 16.7% full survey sample). These findings from both groups suggest that barriers to participation may be driven more by perceived personal fit, therapeutic context, and comfort with the treatment experience than by broad concerns regarding safety or oversight.

Table 8. Reasons for Disinterest in the Medical Psilocybin Program

Reason for Disinterest in the Medical Psilocybin Program	% Endorsed; No Psilo Use or Interest in Program (n = 330)	% Endorsed; Lifetime Psilo Use but no Interest in Program (n = 18)
It's not something I'm personally interested in	46.6%	33.3%
I do not have a condition that can be treated by psilocybin-assisted therapy	29.2%	27.8%
I feel uncomfortable with the idea of being under the influence of a psychedelic in the presence of someone I do not have a strong relationship with (e.g., a provider new to my case)	22.7%	22.2%
I have concerns about side effects	22.7%	16.7%
I'm unsure if psilocybin-assisted therapy is effective	13.7%	11.1%
My religious or personal beliefs discourage it	12.5%	11.1%
I'm unsure if psilocybin for medicinal purposes is effective	12.0%	0.0%
I do not trust medication or therapies not approved by the FDA	10.2%	0.0%
I do not trust the state government in safely regulating psilocybin-assisted therapy	9.0%	5.6%
Psilocybin is a federally illicit (illegal) substance	9.0%	5.6%
Other reason	7.0%	5.6%
I'm worried about cost	5.5%	5.6%

Reason for Disinterest in the Medical Psilocybin Program	% Endorsed; No Psilo Use or Interest in Program (n = 330)	% Endorsed; Lifetime Psilo Use but no Interest in Program (n = 18)
I do not trust licensed providers to safely administer psilocybin-assisted therapy	4.7%	5.6%
Unsure/NA	3.8%	0.0%
I have tried psilocybin and/or psilocybin-assisted therapy, and it did not work for me	0.9%	0.0%

Those who indicated interest in psilocybin-assisted therapy (*n* = 624), were asked what health condition, if any, would they be interested in treating through the program (see Table 9).

Table 9. Health Conditions Participants Report Interest in Treating Through Psilocybin-Assisted Therapy

Listed Health Conditions (Select All That Apply)	% Endorsed
Major Treatment Resistant Depression	11.2%
Post-Traumatic Stress Disorder	39.7%
Substance Use Disorder	22.1%
Anxiety and/or depression related to terminal illness [9]	40.2%
Major Depression (not treatment resistant)	31.1%
Obsessive Compulsive Disorder (OCD)	14.4%
Headache disorder (e.g., cluster headaches, migraines)	23.7%
Eating disorders (e.g., anorexia nervosa)	7.5%
Neurological conditions	13.6%
Chronic pain (i.e., persistent pain generally lasting 3 months or longer)	32.4%
Acute pain (i.e., pain that comes on suddenly and lasts for a short period, usually tied to a specific injury, illness, or procedure)	20.4%
Other (please specify):	3.4%
I do not have any of these conditions, but would still be interested in psilocybin-assisted therapy	8.8%

Among respondents who expressed interest in psilocybin-assisted therapy, a wide range of health conditions commonly discussed in the emerging psychedelic literature were endorsed. The most frequently reported conditions were anxiety and/or depression related to terminal illness (40.2%; *n* = 251) and post-traumatic stress disorder (39.7%; *n* = 248). Approximately

[9] The unexpectedly high endorsement rate suggests some participants may have responded based on a history of anxiety or depression, rather than history specific to anxiety and/or depression related to a *terminal illness*. Accordingly, results pertaining to this condition may be less reliable than those for other assessed conditions and are presented with a level of caution in our interpretation.

one-third of respondents reported living with chronic pain (32.4%; *n* = 202) or major depression that was not treatment resistant (31.1%; *n* = 194).

Other commonly endorsed conditions included headache disorders, such as cluster headaches and migraines (23.7%; *n* = 148), substance use disorders (22.1%; *n* = 138), and acute pain conditions (20.4%; *n* = 127). Smaller proportions of respondents reported obsessive compulsive disorder (14.4%; *n* = 90), neurological conditions (13.6%; *n* = 85), and major treatment-resistant depression (11.2%; *n* = 70). Eating disorders were reported by 7.5% (*n* = 47) of respondents, while 3.4% (*n* = 21) identified another condition not listed in the survey.

Among those who responded with "other", ADHD and anxiety and depression not related to terminal illness were identified by more than one respondent. Other conditions included autism spectrum disorder, emotional trauma, bipolar, coping with cancer, and grief. Physical health conditions listed in "other" response option included fibromyalgia, multiple sclerosis, shingles pain, HIV related pain, and eyesight.

Notably, 8.8% (*n* = 55) of respondents indicated they did not have any of the listed conditions but would still be interested in participating in psilocybin-assisted therapy. Public interest in psilocybin-assisted therapy may extend beyond the conditions currently being considered within regulated medical frameworks. Overall, these results highlight the breadth of *perceived* need and interest across a diverse set of health concerns, several of which align with existing or emerging evidence bases for psychedelic-assisted therapies. Given that the Medical Psilocybin Act allows for the inclusion of other health conditions in the future, some of these conditions that are not already eligible for treatment may be considered should evidence evolve over time.

3.2 Qualifying Conditions and Use Cases

The New Mexico Medical Psilocybin program has approved the use of psilocybin for select qualified medical conditions, including Major Treatment-Resistant Depression, Post-Traumatic Stress Disorder (PTSD), substance use disorder, and anxiety and/or depression resulting from a terminal illness (e.g., end-of-life anxiety). To help further estimate the number of New Mexico residents who may be eligible to participate in the Medical Psilocybin program, survey participants were asked to self-report whether they have any of these conditions. Among all respondents, 65.7% (*n* = 422) indicated having at least one of these conditions – 10.0% indicated having Major Treatment Resistant Depression, 42.5% had PTSD, 21.7% had a

substance use disorder, and 34.8% had anxiety and/or depression resulting from a terminal illness. Response options were not exclusive, such that participants could select more than one option – a total of 32% (*n* = 205) selected more than one condition.

Importantly, the prevalence observed in our sample for several of these conditions is notably inflated relative to the population. For instance, the national prevalence of PTSD in the U.S. is approximately 6%-8%.[10] This likely reflects the study's inclusion criteria, which required either previous psilocybin use or interest in participating in the New Mexico Medical Psilocybin Program. The elevated rate of PTSD in the present sample may reflect the disproportionate representation of individuals experiencing mental health concerns. Additionally, the unexpectedly high endorsement rate of anxiety and/or depression resulting from a terminal illness warrants cautious interpretation. It is possible that some participants may have responded based on a history of anxiety or depression, rather than history specific to anxiety and/or depression related to a *terminal illness*. Interest in psilocybin-based interventions may also have contributed to the inflated prevalence estimates observed across several qualifying conditions; however, these estimates still likely reflect the characteristics of individuals who are most interested in or likely to engage with the Medical Psilocybin program.

Table 10. Distribution of Self-Reported Qualifying Conditions Among Survey Respondents

Self Reported Qualifying Condition	Total Reporting Yes % (n)	Total Reporting Formal Diagnosis % (n)
Major Treatment Resistant Depression	10.0% (64)	7.5% (48)
PTSD	42.5% (273)	36.3% (233)
Substance Use Disorder	21.7% (139)	14.3% (92)
Anxiety and/or Depression Resulting from a Terminal Illness[11]	34.8% (224)	24.3% (156)

[10] U.S. Department of Veterans Affairs. (2025, March 26). *How common is PTSD in adults?* National Center for PTSD. https://www.ptsd.va.gov/understand/common/common_adults.asp

[11] The unexpectedly high endorsement rate suggests some participants may have responded based on a history of anxiety or depression, rather than history specific to anxiety and/or depression related to a *terminal illness*. Another possibility is that survey respondents anticipated emotional instability as a result of an eventual diagnosis of life-ending illness. Accordingly, results pertaining to this condition may be less reliable than those for other assessed conditions and are presented with a level of caution in our interpretation.

Participants then received questions inquiring about whether they have been formally diagnosed with this condition by a licensed provider, if they plan to be evaluated formally by a licensed provider if they are self-diagnosed, and how they are currently treating or managing their condition.

Major Treatment Resistant Depression: Among the 64 participants who indicated having Major Treatment Resistant Depression, 75% (*n* = 48) reported they have been formally diagnosed by a licensed provider, and 25% (*n* = 16) reported they are self-diagnosed. Among those who are self-diagnosed, most indicated they were interested (*n* = 7) or maybe interested (*n* = 7) in being formally evaluated for this condition by a licensed provider. Among individuals who have been formally diagnosed by a provider, respondents commonly endorsed taking prescription antidepressant (45.8%; *n* = 22), making lifestyle changes that allow them to manage their symptoms (37.6%; *n* = 18), undergoing talk therapy (27.1%; *n* = 13), utilizing rapid acting therapeutics (14.7%; *n* = 6), undergoing EMDR therapy (14.7%; *n* = 7), and using nonprescription substances (27.3%; *n* = 13) to manage or treat their depression. Most participants (60.6%; *n* = 29) indicated using more than one option to treat or manage their major depression, and 23% (*n* = 11) indicated they are not currently treating or managing their depression.

PTSD: Among the 273 respondents who indicated having PTSD, 85.3% (*n* = 233) reported they have been formally diagnosed by a licensed provider, and 14.7% (*n* = 40) reported they are self-diagnosed. Most individuals who were self-diagnosed indicated interest (52.5%; *n* = 21) or some interest (32.5%; *n* = 13) in being formally evaluated for this condition by a licensed provider. When asked how they manage or treat their symptoms, respondents who have been formally diagnosed with PTSD commonly endorsed taking a prescription medication (35%; *n* = 82), making lifestyle changes (31.6%; *n* = 71), taking a nonprescription substance (28.9%; *n* = 58), undergoing talk therapy (22.8%; *n* = 54), undergoing trauma-focused psychotherapy (10.8%; *n* = 26), or being in peer-support groups (6.6%; *n* = 14) to manage their PTSD symptoms. A total of 58 respondents (24.9%) indicated they are not currently treating or managing their PTSD.

Substance Use Disorder: Among the 139 respondents who indicated having a substance use disorder, 66.2% (*n* = 92) reported they have been formally diagnosed by a licensed provider, and 33.8% (*n* = 47) indicated they have self-diagnosed themselves with this condition. Most individuals who were self-diagnosed reported interest (36.2%; *n* = 17) or some interest (40.4%;

n = 19) in being formally evaluated for this condition by a licensed provider. Respondents who have been formally diagnosed with a substance use disorder commonly endorsed taking a prescription medication (35.9%; *n* = 33), making lifestyle changes (33.7%; *n* = 31), taking a nonprescription substance (20.7%; *n* = 19), undergoing talk therapy (18.5%; *n* = 17), utilizing inpatient or residential treatment facilities (16.3%; *n* = 15), utilizing peer support groups (16.3%; *n* = 15), utilizing harm reduction services (15.2%; *n* = 14), or taking rapid-acting therapeutics (7.6%; *n* = 7) to treat or manage their substance use disorder. One-fifth (21.7%; *n* = 20) indicated they are not currently treating or managing their substance use disorder.

Anxiety and/or depression resulting from a terminal illness: Among the 224[10] respondents who indicated having anxiety and/or depression resulting from a terminal illness, 69.6% (*n* = 156) reported they have been formally diagnosed by a licensed provider, and 30.4% (*n* = 68) indicated they have self-diagnosed themselves with this condition. Among individuals who were self-diagnosed, most reported interest (35.3%; *n* = 24) or some interest (25%; *n* = 17) in being formally evaluated for this condition by a licensed provider, whereas 39.7% (*n* = 27) indicated no interest in being formally evaluated for this condition. Respondents who indicated being formally diagnosed indicated taking a nonprescription substance (24.4%; *n* = 38), undergoing talk therapy (16.0%; *n* = 25), taking a prescription medication (10.3%; *n* = 16), utilizing peer support groups (9.6%; *n* = 15), working with specialized providers (8.3%; *n* = 13), taking rapid acting therapeutics (7.7%; *n* = 12), or receiving comprehensive end-of-life support (5.8%; *n* = 9) to manage their symptoms. A total of 48 respondents (30.8%) indicated they are not currently treating or managing their symptoms associated with anxiety and/or depression resulting from a terminal illness.

3.3 Preferred Care Models and Settings

Therapeutic Approaches

Respondents who indicated interest in psilocybin-assisted therapy were also asked about the types of therapeutic approaches they would prefer to accompany psilocybin-assisted therapy. Cognitive Behavioral Therapy (CBT) emerged as the most commonly endorsed approach, with just over half of respondents (51.0%; *n* = 281) indicating interest in providers helping patients identify and reframe negative patterns of thinking. This preference suggests that many individuals may favor structured, skills-based therapeutic models that offer practical tools for understanding and managing their experiences. Similarly, CBT is a common form of therapy

that many respondents may actively utilize in other treatment or care plans and is also among the more frequent therapies utilized in existing psilocybin-assisted therapy clinical trials.

Approximately one-third of respondents expressed interest in several other therapeutic modalities, including Facilitator Guided Imagery and Music (38.1%; *n* = 210), somatic and body-based approaches such as breathwork, mindfulness meditation, yoga, and attention to bodily sensations (38.1%; *n* = 210), Acceptance and Commitment Therapy (ACT) (35.2%; *n* = 194), and supportive humanistic or interpersonal psychotherapy, in which providers primarily offer reassurance and a supportive presence during dosing sessions (34.3%; *n* = 189).

Less commonly endorsed modalities included psychoanalysis (27.4%; *n* = 151), exposure-based approaches such as Exposure Therapy or Eye Movement Desensitization and Reprocessing (EMDR) (23.8%; *n* = 131), and Relapse Prevention Therapy (23.2%; *n* = 128). Notably, these therapies are not frequently utilized in existing clinical trials of psilocybin-assisted therapy. Very few respondents selected another therapeutic approach not captured by the predefined options (1.6%; *n* = 9), and 73 individuals selected an exclusive response option of "None of the Above".

These findings suggest that prospective participants may not view psilocybin administration as a standalone intervention, but rather as one component of a broader therapeutic process. The diversity of preferences observed also highlights the potential value of maintaining flexibility in approved therapeutic models, allowing programs to accommodate patient needs, provider expertise, and evolving evidence regarding the optimal integration of psychotherapy and psilocybin-assisted treatment.

Table 11. Interest in Types of Therapies Alongside Psilocybin Dosing

Type of Therapies (Select All That Apply)	% Endorsed
Acceptance and Commitment Therapy (ACT) (e.g., providers help patients stop avoiding difficult thoughts and instead accept them while moving toward their values)	35.2%
Supportive Humanistic or Interpersonal Psychotherapy (e.g., providers act as a listening presence during the dosing session, providing reassurance rather than analysis)	34.3%

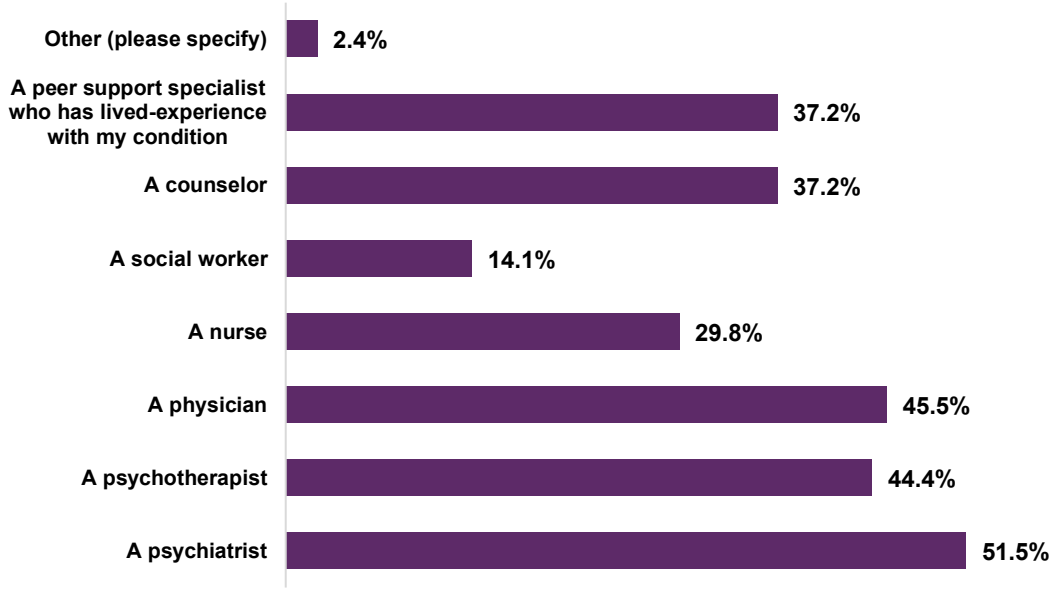
Type of Therapies (Select All That Apply)	% Endorsed
Cognitive Behavioral Therapy (CBT) (e.g., providers help reframe negative thought patterns)	51.0%
Facilitator Guided Imagery and Music (GIM) (e.g., providers help patients explore inner imagery evoked by music during the session)	38.1%
Somatic and body-based approaches (e.g., providers help patients focus on breath-work, focusing on physical sensations or experiences, Mindfulness Meditation, yoga or other meditative approaches)	38.1%
Relapse Prevention Therapy	23.2%
Psychoanalysis (e.g., Freudian-like therapy with a focus on unconscious motivations)	27.4%
Exposure Therapy or EMDR (i.e., eye movement desensitization and reprocessing)	23.8%
Other	1.6%

Preferred Psilocybin-Assisted Therapy Facilitators

Following this question, respondents indicating interest in psilocybin-assisted therapy were asked about their preferred care provider to facilitate the care. Preferences regarding provider type suggest that respondents favor multidisciplinary approaches to psilocybin-assisted therapy. Psychiatrists were the most commonly endorsed provider type (51.5%; *n* = 306), followed by physicians (45.5%; *n* = 270) and psychotherapists (44.4%; *n* = 264). The high endorsement of psychiatrists may be due to their familiarity with pharmacotherapies and managing side effects. Notably, more than one-third of respondents expressed interest in receiving care from counselors (37.2%; *n* = 221) as well as peer support specialists with lived experience (37.2%; *n* = 221), indicating that experiential knowledge and therapeutic rapport may be valued alongside formal clinical credentials. Nurses were endorsed by nearly one-third of respondents (29.8%; *n* = 177), while social workers received lower levels of endorsement (14.1%; *n* = 84). Of the eligible respondents, 30 selected an exclusive “None of the Above” option, while 14 suggested an “other” option. The listed “other” options ranged widely from doctor, pharmacist and neurologist, to Shaman, licensed body worker and lightworker.

Collectively, these findings suggest that prospective participants may prefer care models that integrate both medical oversight and psychosocial support rather than relying exclusively on physician-led approaches. As New Mexico finalizes program implementation, these preferences may inform decisions regarding future facilitator eligibility, team composition, and workforce development.

Figure 9. Preferred Provider Types for Psilocybin-Assisted Therapy

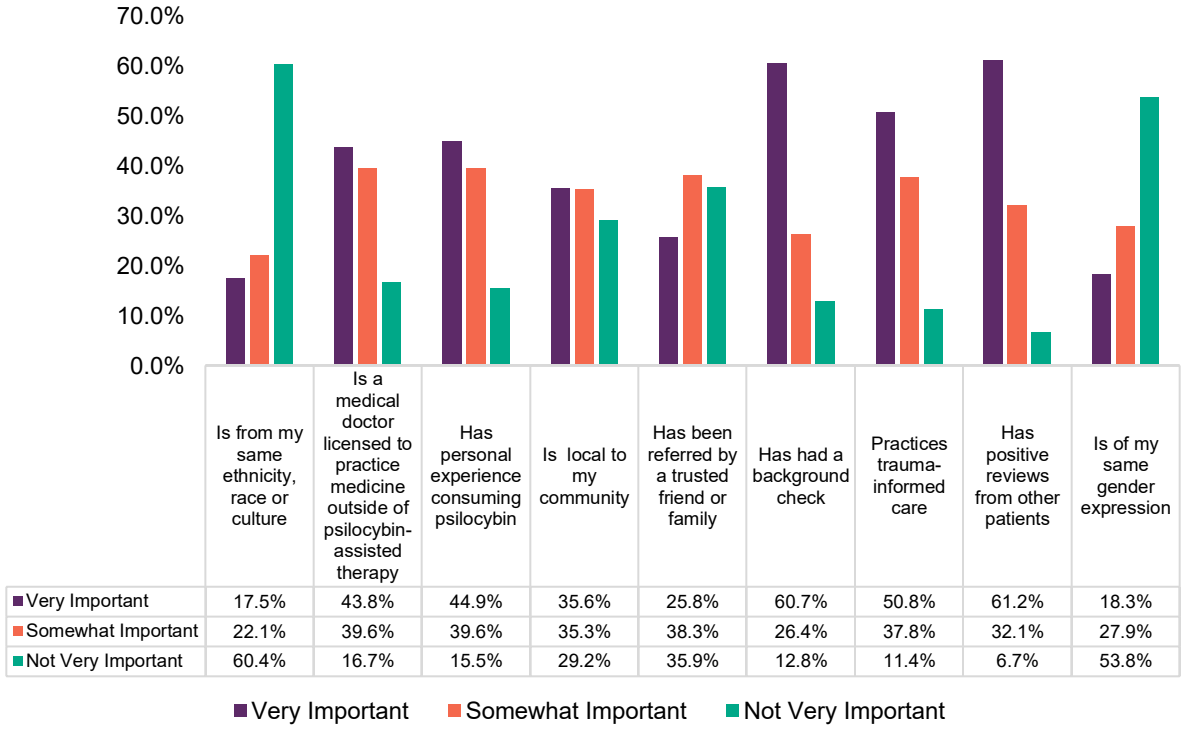


Importance of Various Characteristics of Psilocybin-Assisted Therapy Facilitators

Respondents who indicated they were or may be interested in psilocybin-assisted therapy (*n* = 624) appeared to prioritize trust, safety, and competence over demographic concordance when considering characteristics of psilocybin facilitators. Positive reviews from other patients (61.2%; *n* = 382), background checks (60.7%; *n* = 379), and trauma-informed care practices (50.8%; *n* = 317) emerged as the characteristics most frequently rated as very important. Nearly half of respondents (44.9%; *n* = 280) indicated it was very important for facilitators to have personal experience consuming psilocybin, with more than four in five considering such lived experience at least somewhat important. Although medical licensure was also highly valued, demographic characteristics such as shared race, ethnicity, culture, or gender expression were comparatively less important. **Prospective participants may place greater emphasis on trustworthiness, experiential credibility, and protocols designed to ensure safe and compassionate care**

than on provider identity alone. These preferences largely mirror the New Mexico DOH's priorities in facilitator training standards and regulatory requirements as safety is of the utmost importance.

Figure 10. Participants' Reported Importance of Facilitator Characteristics



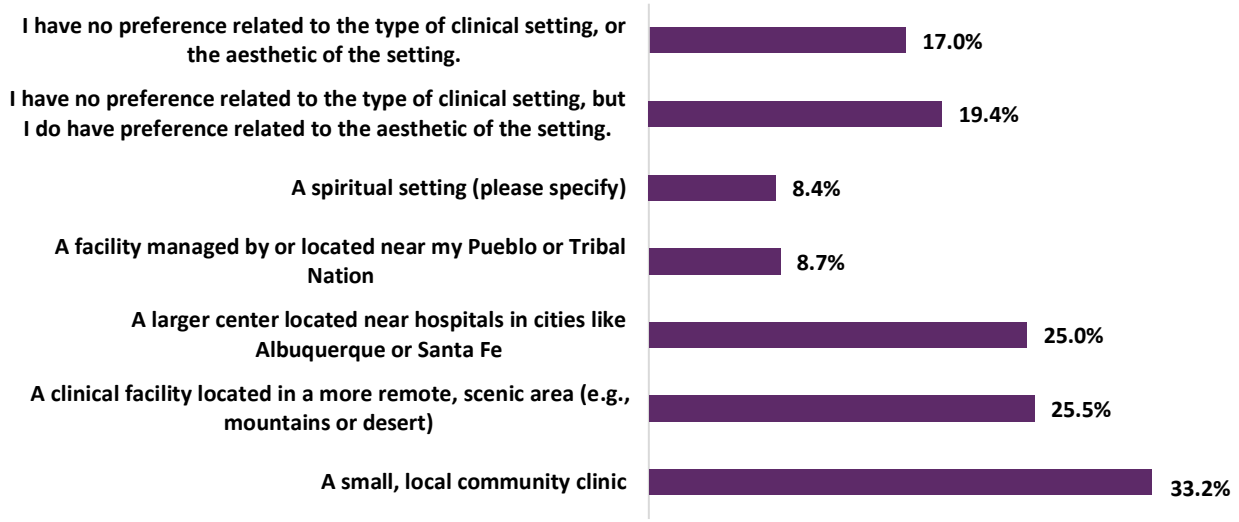
	Is from my same ethnicity, race or culture	Is a medical doctor licensed to practice medicine outside of psilocybin-assisted therapy	Has personal experience consuming psilocybin	Is local to my community	Has been referred by a trusted friend or family	Has had a background check	Practices trauma-informed care	Has positive reviews from other patients	Is of my same gender expression
Very Important	17.5%	43.8%	44.9%	35.6%	25.8%	60.7%	50.8%	61.2%	18.3%
Somewhat Important	22.1%	39.6%	39.6%	35.3%	38.3%	26.4%	37.8%	32.1%	27.9%
Not Very Important	60.4%	16.7%	15.5%	29.2%	35.9%	12.8%	11.4%	6.7%	53.8%

Preferred Care Settings

Preferences regarding treatment settings suggest that respondents interested in psilocybin-assisted therapy favor accessible, community-based models of psilocybin-assisted therapy. Small, local community clinics emerged as the preferred setting (33.2%; *n* = 207), exceeding both larger centers located near hospitals (25.0%; *n* = 156) and remote, scenic clinical facilities (25.5%; *n* = 159). These findings indicate that prospective participants may prioritize convenience, familiarity, and integration within their local communities over highly medicalized or retreat-style environments. Notably, nearly one in five respondents (19.4%; *n* = 121) reported that while the type of clinical setting itself was not important, the aesthetic qualities of the environment underscored the continued importance of "setting" in shaping expectations surrounding psychedelic care. As such, offering multiple service models, while ensuring broad

geographic accessibility, may best align with patient preferences as New Mexico implements its Medical Psilocybin Program.

Figure 11. Participant's Preferred Care Settings



The vast majority of the 8.4% of respondents who selected a spiritual setting suggested nature or somewhere relative to nature as their preferred other setting. Others included more traditional spiritual settings including churches, monasteries, and nondenominational places of worship.

3.4 Willingness-to-Pay for Psilocybin-Assisted Therapy and Equity Fund Allocation Analysis

Because psilocybin-assisted therapy is not currently FDA-approved, and because psilocybin is still a Schedule 1 substance under the Controlled Substances Act, the New Mexico Medical Psilocybin Program may not accept insurance, and patients may be required to pay out-of-pocket for all required services, which includes preparation, administration (dosing), and follow-up integration sessions.

After being made aware of this specification, respondents who indicated a level of interest in the program (n = 624) were asked how much they would be willing to pay (in U.S. dollars) for psilocybin-assisted therapy, with response ranging from $1 to $15,000 or "Not willing or able to pay out-of-pocket." We selected a wide scale for the willingness to pay given that there is no real way to currently project the costs of the services, inclusive of all the requirements still being

considered in regulations. However, reports out of Oregon have varied with costs as high as potentially $12,000.[12] **Of the 624 respondents, 290 indicated they were unwilling or not able to pay out-of-pocket, suggesting that just short of half of those who expressed some level of interest in the program would not be willing to pay for services when understanding that insurance will not contribute to covering costs**. For this population, we assigned $0 value for willingness to pay to ensure our model adequately reflects this position.

Reported willingness-to-pay estimates remained highly variable even after the highest responses were reduced to the value at the 95th percentile to limit the influence of unusually high estimates. Although the median respondent reported a willingness to pay $19.50 for psilocybin-assisted therapy, the mean remained substantially higher at $1,047.50, with a third quartile value of $673.80 and maximum value of $7,699.50. These findings suggest that heterogeneity in willingness to pay reflects more than a small number of extreme responses and instead may indicate meaningful segmentation in the prospective market for psilocybin-assisted therapy. While many respondents may require lower-cost or subsidized treatment options to access care, a sizeable subgroup appears willing to pay amounts comparable to prices observed in other states' early implementation. As New Mexico develops its program, these findings may support consideration of equity funds and other pricing models designed to balance affordability with financial sustainability.

Understanding the financial barriers prospective patients may face is critical to implementation planning. Regression analyses examining associations between willingness to pay, income, rural and urban geographic codes, and other demographic characteristics were conducted to identify factors associated with affordability and potential barriers to participation.

The purpose of this analysis was twofold. First, it was intended to estimate the economic value prospective participants place on psilocybin-assisted therapy and identify the degree to which willingness to pay varies across populations. Second, the analysis was designed to inform future implementation and equity planning by identifying populations that may experience disproportionate financial barriers to access under self-pay models. These findings may help inform the development of New Mexico's equity fund by providing preliminary evidence regarding which populations may benefit most from financial assistance and the approximate

[12] Joralemon, V. (2026, February 19). *The twelve-thousand-dollar question: Who picks up the tab for psychedelics?* Health Affairs Forefront. https://doi.org/10.1377/forefront.20260212.550697

level of support that may be required on a per-person basis to facilitate equitable participation in the program. Understanding these relationships can help policymakers balance program sustainability with broad and equitable access as the Medical Psilocybin Program is implemented.

To evaluate the determinants of financial access for psilocybin-assisted therapy, a multiple linear regression model was constructed.[13] The dependent variable, willingness to pay (WTP), was transformed using a log(y + 1) formulation to accommodate a heavy right-skew and preserve zero-dollar responses without introducing missing-data bias. The final model demonstrates robust overall fit, explaining a highly respectable share of behavioral variance for public health survey data.

In this categorical factor model, the intercept represents the predicted valuation for a baseline reference respondent. This baseline individual is defined as:

- Living in a household earning under $50K annually
- Residing in a non-metro area, with an urban population of 20,000 or more
- Have not used psilocybin in their lifetime, and
- Have no current eligible diagnosed clinical conditions (e.g., end of life anxiety, SUD, MTRD, or PTSD)

The model indicates that this baseline individual in our sample has a predicted willingness to pay of roughly $138 out-of-pocket for psilocybin-assisted therapy services.

Household income operates as a distinct and significant structural determinant of willingness to pay ($p < 0.001$). Compared to the lower-income baseline (i.e., under $50k), households earning $50,000–$99,999 exhibit 3.24x expansion in out-of-pocket willingness to pay for psilocybin-assisted therapy services when compared to the baseline individual. For households earning over $100K, willingness to pay increases by roughly 17x the baseline. In absolute dollar terms, holding all other variables constant, predicted willingness to pay scales from:

- Household income under $50K - $138.27 to
- Household income between $50-$99K - $450.90, and peaks with

[13] To ensure that a linear regression was the appropriate analysis, we conducted standard diagnostic tests to verify the assumptions of linearity, independence of errors, homoscedasticity, and residual normality, as well as screening for multicollinearity.

- Household income over $100K - $2,356.84

Age was also found to be a statistically significant negative predictor, wherein the older a person is, the less they are willing to pay for these services ($p < 0.001$). For every single additional year of age, a respondent's out-of-pocket willingness to pay drops by a steady 6.0%. This largely signals that cash-based demand for psilocybin-assisted therapy services is overwhelmingly concentrated among younger demographics. Additionally, those who consumed psilocybin in the past week ($p = 0.02$) or month ($p = 0.005$) demonstrated a statistically significant premium compared to the baseline individual. This echoes findings described earlier in this report that demand for psilocybin is generally greater among younger New Mexico residents.

Surprisingly, rurality had no statistically significant impact on willingness to pay. Neither dense population centers nor small rural towns structurally altered an individual's willingness to pay for psilocybin-assisted therapy services. Most notably, the *eligible* diagnostic conditions listed in the New Mexico Medical Psilocybin Act failed to exert any detectable impact on financial willingness to pay. This means there was no explanatory relationship between those who have been diagnosed or self-diagnosed with end-of-life anxieties or depression, major treatment resistant depression, substance use disorder, or PTSD and willingness to pay for psilocybin-assisted therapy services.

Collectively, these findings reveal a severe structural mismatch, wherein clinical need is decoupled from financial ability or willingness. This is further congruent with the evidence observed in other states; that psilocybin-assisted therapy or other state-based medical psychedelic markets have structurally accommodated to those willing to pay high costs. Without the Equity Fund, it is very possible that the market would favor young and affluent populations as opposed to those who may be of the highest need but of lowest means.

Given that the model identified those in households earning under $50K have virtually no out-of-pocket purchasing aptitude compared to the other income groups, the $50K household income may be an evidence-based starting point for receiving equity funds. However, most public assistance program eligibility standards do not reflect household income but rather percentage of the Federal Poverty Level (FPL). FPL also reflects household income while accounting for household size. Importantly, our survey did not inquire about the number of people in each household.

There are two ways in which we may derive an FPL cut-off criterion for eligibility of the equity fund using this data. The first method uses the *average* New Mexico household size and

translates the $50K income benchmark into the percentage of Federal Poverty Line (FPL) for the average New Mexican.

According to the U.S. Census, the average household size in New Mexico is 2.48 people (3 people).[14] Using this average household size to represent a typical household in New Mexico, for a family of 3, 100% federal poverty line (FPL) is $27,320. Using this figure as our denominator to identify how household income of $50,000 may translate to an FPL criterion results in 183% FPL. As such, the FPL that may serve as an evidence-based criterion for receiving equity funds may be cut off at roughly 200% if looking to accommodate to the *average* New Mexican household earning under $50,000 annually.

A second method that may be more personalized is a sliding scale matrix based on the household size, using the same method as above but for each of the household sizes, shown in Table 12.

Table 12. Sliding Scale of Equity Funding Based on Household Size

Household Size	100% FPL Baseline	% of FPL that is $50,000
1 (Single Adult)	$15,960	313% FPL
2	$21,640	231% FPL
3 (Average NM Household)	$27,320	183% FPL
4	$33,000	151% FPL

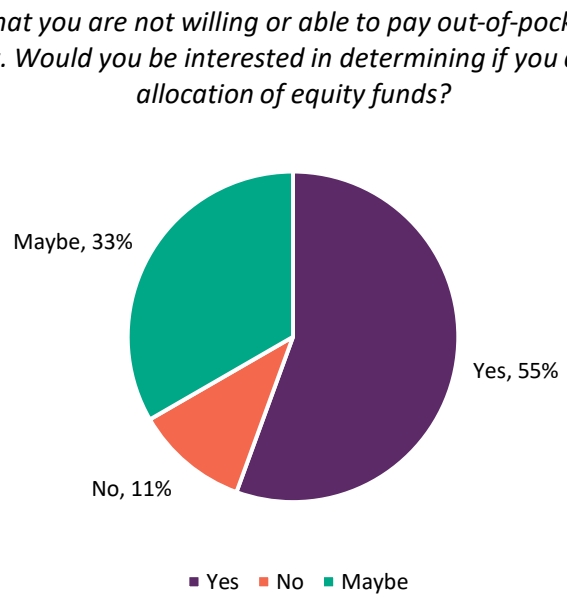
The Medical Psilocybin Treatment Equity Fund has $630,000 legislatively allocated for FY27, the first year of the program implementation with the ability to receive donations and additional appropriations. Because there is no feasible way to empirically forecast the average costs of services for the program, one way to identify an empirical amount that individual grants need to be for those who qualify would be to bridge the gap between the willingness to pay out of pocket for the baseline individuals (those earning under $50K annually and within a certain % of the federal poverty line) and the high income earning group (those earning over $100K annually). Given that high income earners are willing to pay nearly $2,500 for out-of-pocket services, it is plausible that the majority of the market will naturally settle around their average costs. The

[14] U.S. Census Bureau. (n.d.). *QuickFacts: New Mexico*. Retrieved August 19, 2026, from https://www.census.gov/quickfacts/fact/table/NM/PST045224

difference between these two groups' willingness to pay is $2,219 ($2,357-$138), suggesting that there is a substantial gap between the two groups and grant funding may need to address parity. However, the total cost of the services absorbed by the patient will be directly influenced by their health insurance, and what is covered under their insurance. For example, some insurances may cover at least diagnostic/intake sessions which may result in a lesser total out of pocket cost burden. Ability to utilize insurance for some extent of the services in addition to the out-of-pocket costs for utilizing insurance (e.g., partial coverage or co-pays) should be considered prior to allocation of grant funding.

For the 290 respondents that indicated they were not willing or able to pay out of pocket costs ($0), a surprising 11% reported not having an interest in learning if they would be eligible for the Equity Fund. This may be due to having limited interest in fulfilling the administrative duties required to prove eligibility or perhaps a disinterest in being named on a government list for a federally illicit substance.

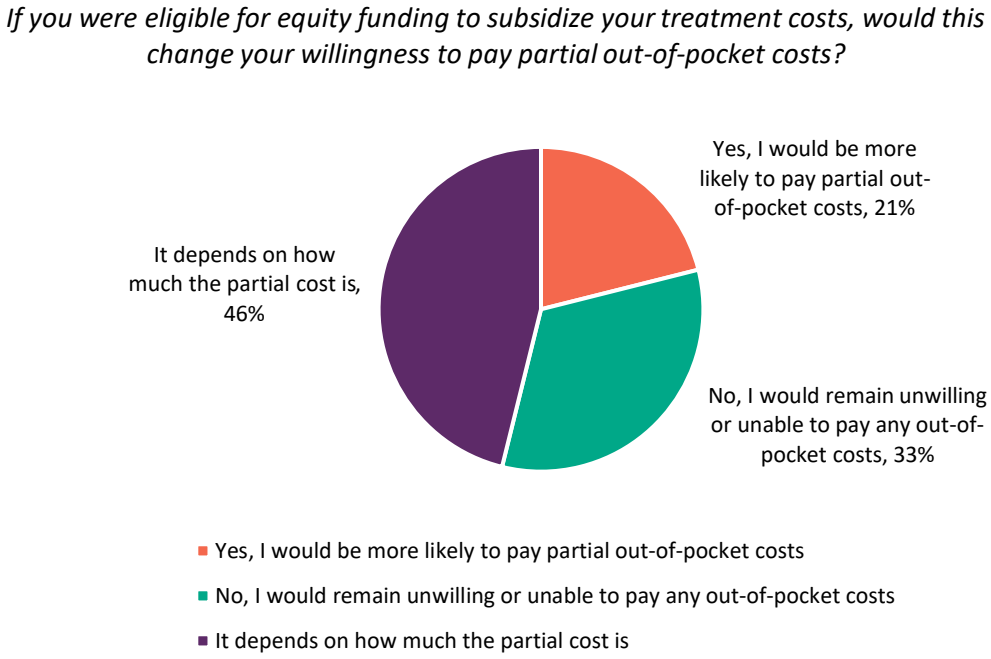
Figure 12. Participants Interest in Determining if They Meet Equity Fund Eligibility



Of the ~66% (*n* = 191) who reported that they are or may be interested in determining if they would be eligible for equity funds, only 21% reported that it would change their willingness to pay out of partial costs should they be eligible, suggesting they may be willing to pay some amount if subsidized. Separately, 11% indicated that grant funds may change how much they would be willing to pay out of pocket, but it would depend on the size of the subsidy. However,

33% noted that it would not change their ability to pay any costs, suggesting that the grant would need to cover the entirety of costs. Taken together, these findings suggest that equity funding may best be utilized to cover the majority of the cost of services for a smaller number of individuals as opposed to smaller subsidies to accommodate to a larger share of individuals.

Figure 13. Participants Willingness to Pay Out of Pocket if Subsidized



Section 3 Summary

- Program awareness remains low (32%), but interest is high once respondents learn about the program, with nearly all respondents reporting interest or potential interest in participation.
- PTSD, chronic pain, depression, and substance use disorder emerged as the primary use cases, suggesting substantial demand across multiple qualifying and emerging conditions.
- A large proportion of respondents reported at least one qualifying condition, indicating a sizeable potential patient population upon implementation.
- Participants preferred integrated care models, favoring established therapeutic approaches, multidisciplinary provider teams, and facilitators who are trustworthy, trauma-informed, and experienced.
- Community-based clinics were the most preferred treatment setting, highlighting the importance of accessibility and local service availability.
- Affordability represents a major implementation challenge, with nearly half of interested respondents unwilling or unable to pay out-of-pocket costs.

- Income, rather than clinical need, was the strongest predictor of willingness-to-pay, reinforcing the importance of the Medical Psilocybin Treatment Equity Fund to ensure equitable access.
- A significant structural mismatch exists between clinical need and ability to pay. While qualifying conditions did not predict willingness-to-pay, income was the strongest determinant of affordability, suggesting the Equity Fund will be critical to ensuring access for lower-income patients.
- Findings support considering eligibility thresholds around households earning less than $50,000 annually (approximately 200% FPL for the average New Mexico household).

Section 4. Healthcare Access, Utilization, and Barriers

4.1 Access to Medical and Support Services

Understanding respondents' healthcare utilization is important for identifying potential barriers to healthcare access and informing equitable implementation of the Medical Psilocybin Program. To address this, respondents were asked about their health insurance coverage, and the types of healthcare and treatment approaches they typically utilize. Nearly all respondents reported having some form of health insurance (93.9%; *n* = 603). Medicaid was the most commonly reported source of coverage (49.7%; *n* = 319), followed by employer-sponsored health plans (25.2%; *n* = 162). Additional sources of coverage included Medicare (18.4%; *n* = 118), individual or BeWellNM plans (12.5%; *n* = 80), military of Veterans Affairs (VA) health plans (3.7%; *n* = 24), Indian Health Service (3.0%; *n* = 19), and student health plans (0.6%; *n* = 4).

With respect to healthcare utilization, participants overwhelmingly utilize Western/conventional medicine (79.9%; *n* = 513), but many also use other approaches, including herbal or natural remedies (e.g., echinacea, St. John's wort, turmeric; 35.0% [*n* = 225]), homeopathic remedies (e.g., arnica, Oscillococcinum; 26.8% [*n* = 172]), complementary therapies (e.g., yoga, meditation, energy healing, Tai Chi; 25.5% [*n* = 164]), and traditional Eastern medicine (e.g., acupuncture, Traditional Chinese Medicine, Ayurveda, shiatsu; 18.8% [*n* = 121]).

Among respondents who reported accessing or receiving healthcare services within the past 12 months (76.3%; *n* = 490), the most commonly utilized setting was an in-person visit to a doctor's

office or community clinic (70.0%; *n* = 343). Respondents also frequently reported receiving care at a hospital or emergency department (40.8%; *n* = 200), at an urgent care center or retail clinic (34.9%; *n* = 171), via a telehealth visit (31.0%; *n* = 152), or phone call with a provider (20.4%; *n* = 101). A small proportion reported receiving care through a home visit (7.6%; *n* = 37). Respondents reporting psilocybin use within the past two years were statistically significantly less likely to have indicated attending an in-person doctor's appointment within the past year (60% vs 75%; $p < .001$); however, no other differences in how respondents utilize healthcare services were identified as a function of psilocybin use.

4.2 Barriers to Healthcare Access

Nearly three-quarters (73.8%; *n* = 474) of participants who had accessed healthcare services in the past year reported experiencing at least one barrier to access healthcare or medical services. Among individuals reporting at least one barrier, availability (e.g., difficulty getting an appointment or long wait times) was most frequently endorsed as a barrier (47.5%; *n* = 225), followed by cost (35.4%; *n* = 168%), and transportation issues (30.6%; *n* = 145). Forty percent (*n* = 259) of the total sample reported experiencing more than one barrier to access healthcare services in the past year. Despite this, a minority of respondents described accessing healthcare as somewhat difficult (14.3%; *n* = 70) or very difficult (5.5%; *n* = 27), suggesting that many individuals are able to navigate barriers to care even when such barriers are present. There were no differences identified in ease of access ratings and types of barriers to access healthcare services as a function of psilocybin use status among respondents.

Table 13. Percent of Survey Respondents Endorsing Each as a Barrier to Access Healthcare Services

Barrier to Access Healthcare Services	% Reporting at Least One Barrier (n = 474)
Availability ***(e.g., difficulty getting an appointment or long wait times)***	47.5%
Cost	35.4%
Transportation ***(e.g., lack of reliable transportation or distance to the clinic)***	30.6%
Time ***(e.g., clinic hours conflict with work or childcare schedule)***	29.1%
Trust ***(e.g., concerns about the quality of care or past negative experiences)***	21.5%
Physical or mobility limitations	11.0%

Barrier to Access Healthcare Services	% Reporting at Least One Barrier (n = 474)
Communication *(e.g., language barriers or difficulty understanding medical information)*	8.4%
Cultural differences	5.3%
Difficulty finding childcare	4.9%

To examine healthcare access across urban and rural communities, a multiple linear regression was conducted to examine whether age, income, RUCC classification (urban/rural location), past month polysubstance use, and sum of reported barriers to access healthcare services predicted perceived ease of healthcare access. Reporting a higher number of barriers was significantly predictive of greater perceived difficulty of accessing healthcare services (B = -0.4, p < 0.001). Higher income (B = 0.1, p < .05) and residing in a less metropolitan location (B = .087, p < .05) were associated with greater ease of access. Age and past month polysubstance use were not significant predictors. The direction of the relationship between urban/rural location and ease of healthcare access was unexpected; therefore, the relationship was further investigated using a correlation between the two variables. Results indicated a small, but statistically significant positive correlation (r = 0.115, p < .05), suggesting that respondents in the sample who resided in less metro/urban counties reported slightly easier access to healthcare services than respondents residing in more urban counties. Importantly, the effect size of this relationship was small and should be interpreted with caution. This finding may reflect differences in *perceived* versus *objective* access to care, whereby individuals residing in different geographic settings may have varying expectations for what constitutes accessible healthcare. Regardless, it is optimistic that in the present sample, individuals residing in less metro locations appear to be relatively satisfied with their access to healthcare services in New Mexico.

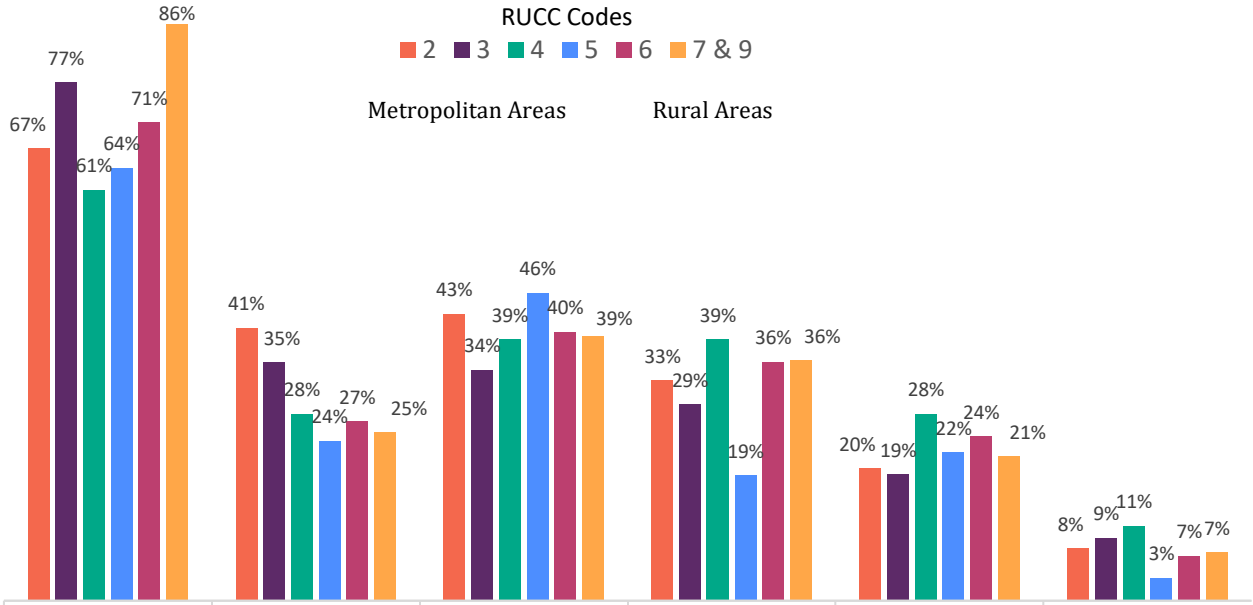
A multiple linear regression was also conducted to examine predictors associated with the number of endorsed barriers to access healthcare. As expected, perceived ease of healthcare access was the strongest predictor of reported barriers, with respondents reporting easier access also reporting fewer barriers (B = -0.4, p < .001). Older age was also associated with fewer reported barriers (B = -0.2, p < .001), while higher-income respondents reported slightly more barriers (B = .19, p < .05). Additionally, respondents reporting a greater number of health diagnoses reported significantly more barriers to healthcare access (B = 0.1, p < .01), which

makes sense as individuals managing multiple health conditions often require more healthcare services and have a greater number of interactions with providers, which can increase opportunities to encounter barriers. Urban/rural status and past month substance use were not associated with the number of barriers reported.

Interestingly, no associations were found between ease of access to a cell phone, laptop, or the internet and either number of reported barriers to healthcare access or the perceived ease of accessing healthcare services. This is likely attributable to the very small proportion of the sample reporting limited access to these services (cell phone = 2.3% [*n* = 15]; laptop = 19.2% [*n* = 123]; internet = 2.3% [*n* = 15]). The disproportionate sample sizes limit the analyses that can be conducted; therefore, our current sample provides limited opportunity to evaluate these relationships.

Given the unexpected finding that respondents in less urban communities reported greater ease of access to healthcare services, we examined past-year utilization of different healthcare service types across RUCC categories to explore whether patterns of healthcare utilization varied by location. Due to small sample sizes, respondents in RUCC categories 7 and 9 were combined for this analysis. Across all RUCC categories, we observe high utilization of in-person visits at doctor's offices or community clinics. Although a greater proportion of respondents residing in RUCC categories 7 and 9 reported utilizing these services compared to those in RUCC category 1, these differences were not statistically significant. We do observe significant differences such that individuals in more metro areas reported greater utilization of in-person urgent care services compared to those in nonmetro areas, suggesting that urgent care clinics may be more accessible in metropolitan communities. There were no notable differences in utilization of all other healthcare service types across metro/rural areas in the state.
The figure below demonstrates a large degree of variability across RUCC categories, especially for those who seek in-person medical assistance from a doctor or urgent care. Access to a variety of services appears especially problematic in RUCC 5, and for this category, patients may be forced to seek out ER or hospital treatment as a means of compensating for the absence of other services.

Figure 14. Percentage of Survey Respondents Utilizing Each Healthcare Service in the Past 12 Months, By RUCC Category (2 = Metro Areas of 250,000 to 1 million Population; 9 = Urban Population of Fewer than 5,000)

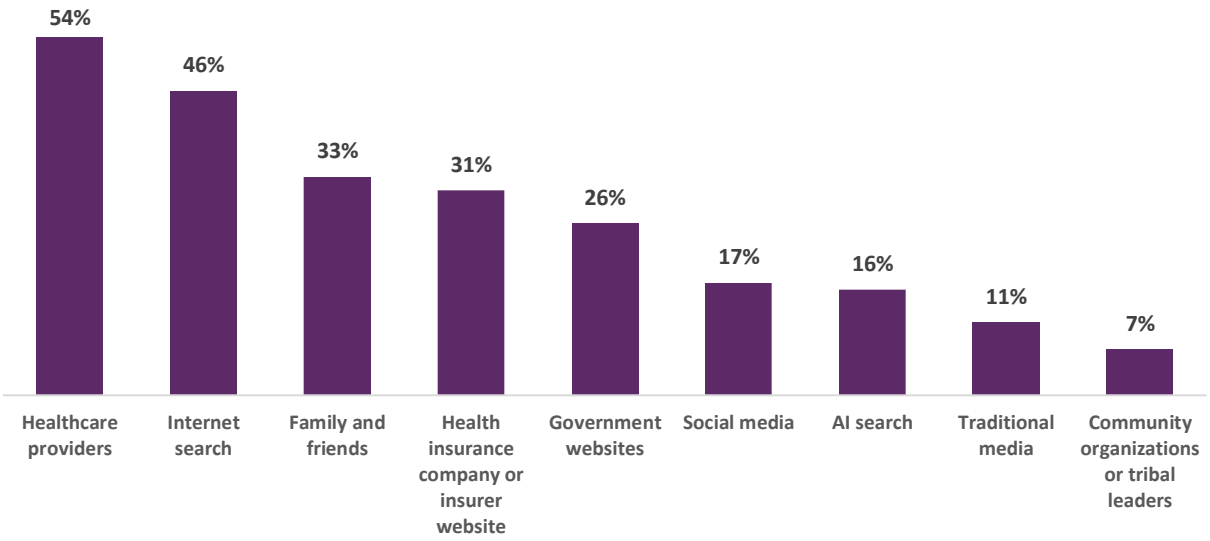


	In-person doctor	In-person urgent care	In-person hospital or ER	Telehealth	Phone call	Home Visit
2	67%	41%	43%	33%	20%	8%
3	77%	35%	34%	29%	19%	9%
4	61%	28%	39%	39%	28%	11%
5	64%	24%	46%	19%	22%	3%
6	71%	27%	40%	36%	24%	7%
7 & 9	86%	25%	39%	36%	21%	7%

4.3 How Individuals Access Healthcare Information

All survey participants were asked about where they prefer to get information about healthcare or medical services. Most receive information from healthcare providers (54%) or via internet searches (46%). Many also receive information from family and friends (33%), health insurance companies (31%), and government websites (26%).

Figure 15. Where Participants Prefer to Receive Information About Healthcare or Medical Services



To inform future outreach and education efforts, we examined whether respondents with and without a history of psilocybin use differed in the sources from which they obtain healthcare information. On average, respondents who did *not* report psilocybin use within the past two years were significantly more likely to prefer receiving healthcare information from healthcare providers, and respondents *with* past two-year use of psilocybin were more likely to indicate a preference for receiving healthcare information from social media (22% vs 14%; $p < 0.05$), community organizations or tribal leaders (11% vs 5%; $p < .05$), and traditional media sources (e.g., the news, newspapers) (15% vs 9%; $p < .05$). To further examine these relationships, a series of logistic regression models were conducted controlling for age, income, and past-month polysubstance use. These analyses confirmed significant associations between psilocybin use history and preferences for specific information sources. Specifically, no lifetime psilocybin use or less recent use predicted preference for receiving healthcare information from healthcare providers, whereas more recent psilocybin use predicted preference for receiving information through social media and traditional media channels ($ps < 0.05$). Furthermore, when separately asked about the extent to which they trust certain entities, significantly fewer respondents, on average, with use of psilocybin within the past two years reported trusting their personal doctor or healthcare provider, and these respondents also reported greater trust in press and media (e.g., newspaper, television, news, magazines) and social media (e.g., TikTok, Facebook, Instagram, Reddit) entities. Importantly, respondents were asked about general trust in each

entity, rather than trust specifically related to healthcare information. However, these findings are indicative of a general pattern towards differences in trusted and preferred sources for information among those who do and do not consume psilocybin. Together, these findings suggest that future outreach efforts may benefit from utilizing multiple communication channels tailored to specific target audiences, as preferred sources of healthcare information appear to vary according to one's substance use patterns.

Preference for specific information sources also appeared to vary by age. Among the full sample, preference for receiving information from healthcare providers increased with age, with the highest proportion of preference for this source observed among adults aged 65 and older. Adults aged 65 and older also demonstrated a higher preference for government websites compared to all other age groups (*ps* < .05). Stratified analyses indicated that these age-related differences were more pronounced among participants with a lifetime history of psilocybin use. Specifically, the positive association between age and lower preference for healthcare providers was stronger among those with lifetime history of psilocybin. Within the psilocybin use group, preference for healthcare providers was lowest among the youngest participants (ages 18-29), although a level of caution is warranted given smaller cell sizes in older age strata. Altogether, younger individuals, particularly those with a history of psilocybin use, appear less oriented towards traditional medical sources such as healthcare providers compared to older adults. These findings are consistent with the broader literature demonstrating higher levels of institutional trust in the healthcare system and physicians among older adults. [15,16]

4.4 Other Equity Considerations

All survey participants were asked, "*Which of the following, if any, would make it easier for you to get the healthcare or medical services you need?*" The most frequently endorsed options included more providers accepting their insurance (35%), more appointment times (34%), and more healthcare providers in my area (33%). Notably, one-fifth (21%) of the sample expressed a desire for greater availability of in-home healthcare visits. Given that only 7.6% of the full sample reported utilizing in-home healthcare services in the past year, this finding may indicate unmet demand for these services rather than a lack of interest in existing options. Among those

[15] Cecconi, C., Adams, R., Cardone, A., Declaye, J., Silva, M., Vanlerberghe, T., Guldemond, N., Devisch, I., & van Vugt, J. (2025). Generational differences in healthcare: the role of technology in the path forward. *Frontiers in public health*, *13*, 1546317. https://doi.org/10.3389/fpubh.2025.1546317

[16] Bell, R. A., Arcury, T. A., Ip, E., Grzywacz, J. G., Nguyen, H., Kirk, J. K., ... & Quandt, S. A. (2013). Correlates of physician trust among rural older adults with diabetes. *American journal of health behavior*, *37*(5), 660-666. https://doi.org/10.5993/AJHB.37.5.10

who selected the “other” response option, other commonly endorsed strategies were related to cost (reducing cost of healthcare, especially among those without insurance), improving general difficulties associated with in-person appointments, and assistance with applying for insurance and Medicaid.

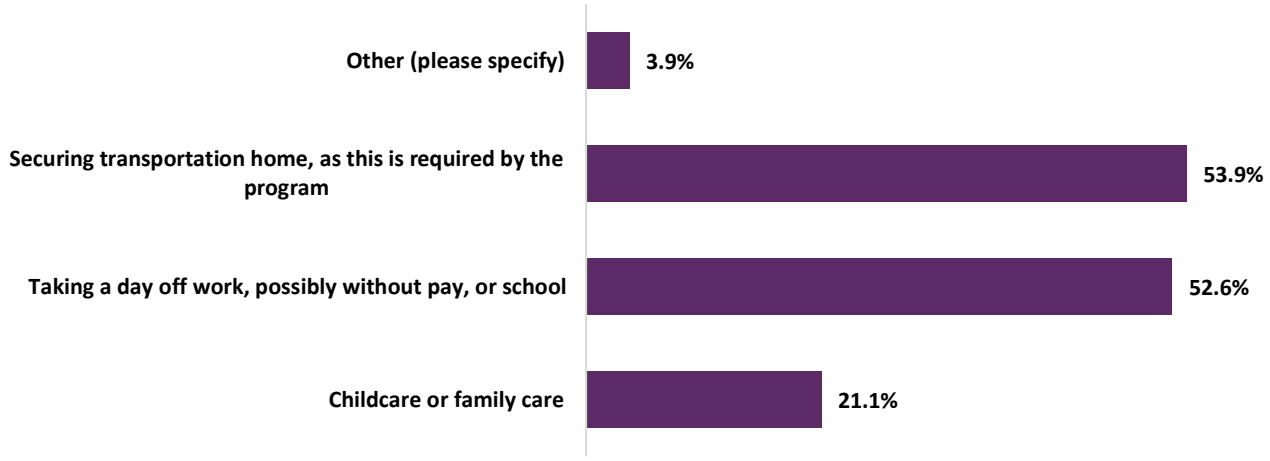
Table 14. Percentage of Respondents Endorsing Strategies to Improve Healthcare Access

Strategies to Improve Healthcare Access	% Yes (n = 642)
More providers in my area accepting my insurance	35%
More appointment times that fit my schedule	34%
More healthcare providers in my area	33%
Transportation services to take me to and from in-person visits	25%
The option for in-home visits	21%
Help with understanding my health insurance	19%
More reliable internet for telehealth visits	17%
Providers who speak my language	8%
Childcare support during appointments	7%
Help caring for an older adult during appointments	5%
Other	4%

In addition to inquiring about how access to healthcare may be improved generally, respondents who indicated interest in psilocybin-assisted therapy services were also asked about challenges they may experience when receiving psilocybin-assisted therapy provided that the standard administration session can last 6-8 hours, which requires significant time away from work and family. Of the 624 eligible responses, 456 respondents (71%) reported a concern or challenge.

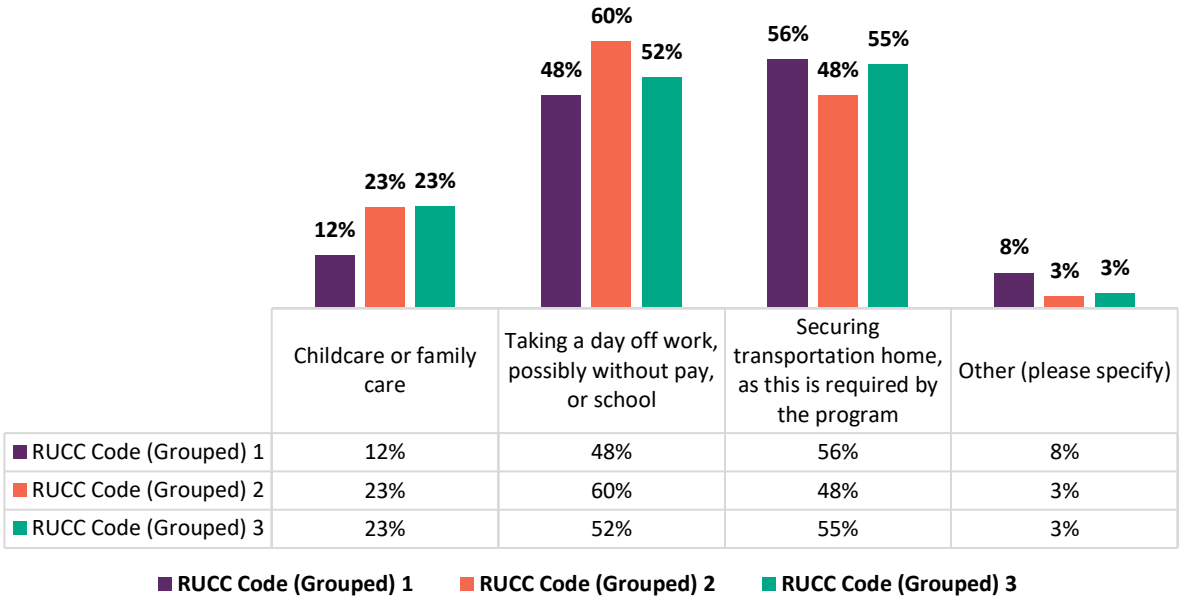
The majority of respondents who reported a possible challenge noted that both securing transportation (53.9%; *n* = 246) and taking a day off work or school (52.6%; *n* = 240) would be a challenge for them. Childcare or family care also emerged as a challenge, albeit less frequently endorsed (21.1%; *n* = 96).

Figure 16. Perceived Challenges to Access Psilocybin-Assisted Therapy



When examining how these responses may differ based on RUCC codes re-grouped by Metro areas (RUCC categories 2 and 3; *Group 1*), Nonmetro areas with an urban population of 20,000 or more (RUCC categories 4 and 5; *Group 2*), and Nonmetro areas with a population of fewer than 20,000 (RUCC categories 6-9; *Group 3*) results are consistent with few exceptions. RUCC group 2 had more endorsements in challenges of taking off from work (60%), and Group 1 had less endorsements in concerns about child or family care (12%). Using a Chi-Square test, we evaluated the global relationship between the RUCC code groups and the challenges reported. Results of this test found no overall statistical difference across geographic groups, such that respondents in each RUCC code endorsed these options at statistically similar rates.

Figure 17. Perceived Challenges to Access Psilocybin-Assisted Therapy, Separated by RUCC Groups



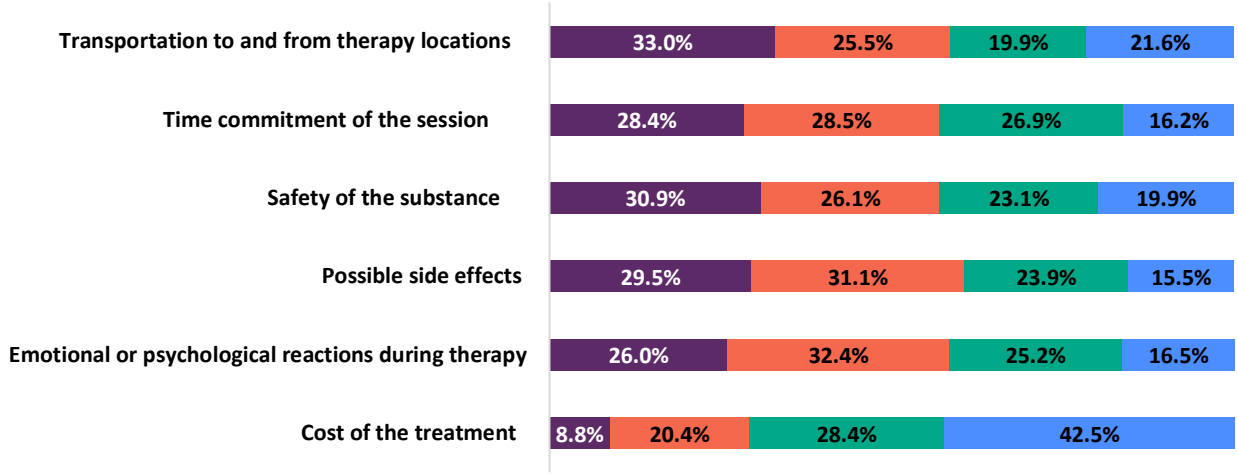
	Childcare or family care	Taking a day off work, possibly without pay, or school	Securing transportation home, as this is required by the program	Other (please specify)
RUCC Code (Grouped) 1	12%	48%	56%	8%
RUCC Code (Grouped) 2	23%	60%	48%	3%
RUCC Code (Grouped) 3	23%	52%	55%	3%

Among the “other” options provided, the most frequently cited challenge was pet or animal care. Given these results, it may be beneficial for the Equity Fund to be extended to consider options for other ancillary elements in addition to the direct care services. This may include transportation coverage such as reimbursing for rideshares or outright providing transportation, providing subsidies for pet, child or family care, or compensating patients for their missed wages to attend services. However, reimbursement programs like these carry ongoing administrative costs related to individual processing. Therefore, their implementation should be considered only when the expected improvements in patient access outweigh these administrative expenditures and support the equitable stewardship of available equity funds.

In addition to perceived challenges, we asked those who expressed interest in the program (n=624) if they had any concerns with the following presented in the figure below. Overall, respondents expressed concerns across all aspects, although the magnitude of concern varied by topic. Cost of treatment emerged as the greatest concern, consistent with the willingness to pay analysis in Section 3. Concerns regarding possible side effects, emotional or psychological reactions during therapy, the safety of the substance and the time commitment required were also commonly cited with at least some concern. Collectively, these findings suggest that

financial affordability, treatment expectations, and logistical requirements represent important implementation considerations as New Mexico's Medical Psilocybin Program is rolled out.

Figure 18. Participant Concerns About Psilocybin-Assisted Therapy Dosing Sessions



	Cost of the treatment	Emotional or psychological reactions during therapy	Possible side effects	Safety of the substance	Time commitment of the session	Transportation to and from therapy locations
Not at all Concerned	8.8%	26.0%	29.5%	30.9%	28.4%	33.0%
A Little Concerned	20.4%	32.4%	31.1%	26.1%	28.5%	25.5%
Somewhat Concerned	28.4%	25.2%	23.9%	23.1%	26.9%	19.9%
Very Concerned	42.5%	16.5%	15.5%	19.9%	16.2%	21.6%

Using an ordinal logistic regression model, we aimed to identify if concern for these elements may decrease with income increasing. Time commitment and transportation were found to be highly dependent on socio-economic status in different ways. Those in households earning between $50-$99K annually have 49% lower odds of reporting elevated concern regarding these two structural barriers (OR = 0.51, p <0.001) than those in households earning under $50K. This largely affirms what was identified in the willingness to pay analysis, further suggesting that those in households earning under $50K a year may be a priority group for equity funding, and that grant funding may be extended to ancillary costs like transportation.

Interestingly, those in households earning over $100K annually have 1.56x higher odds (OR = 1.56, p < 0.05) of being more severely concerned about the time commitment than those in households earning under $50K. Given the presumed high salary, this may be due to high pressure jobs, or jobs with limited paid time off policies. Because these high earners had higher

on average willingness to pay for services, service centers may be well positioned to offer services on the weekend to accommodate to this specific cohort's concerns.

Section 4 Summary

- Nearly three-quarters (73.8%) of participants reported experiencing at least one barrier to access healthcare or medical services within the past year, with availability, cost, and transportation being most frequently cited as barriers.
- Healthcare utilization patterns were largely similar across urban and rural communities in the state, despite metropolitan residents reporting higher use of urgent care services.
- Information preferences and trusted sources varied by psilocybin use history, with recent users favoring social and traditional media sources, while non-users preferred information from healthcare providers. These patterns may reflect a broader preference among psilocybin users for non-traditional approaches to healthcare.
- Nearly three-quarters (71%) of respondents interested in the Medical Psilocybin Program indicated anticipating challenges with participating in the program, including transportation issues and time needed to take a day off work or school. There were no differences in expected challenges associated with participation in the program when examined by rural/urban location.
- Structural barriers were disproportionately reported by lower-income respondents, suggesting that transportation assistance and other equity-focused funding mechanisms may be critical to ensuring equitable access to services.

Section 5. Psilocybin Perceptions and Areas for Education

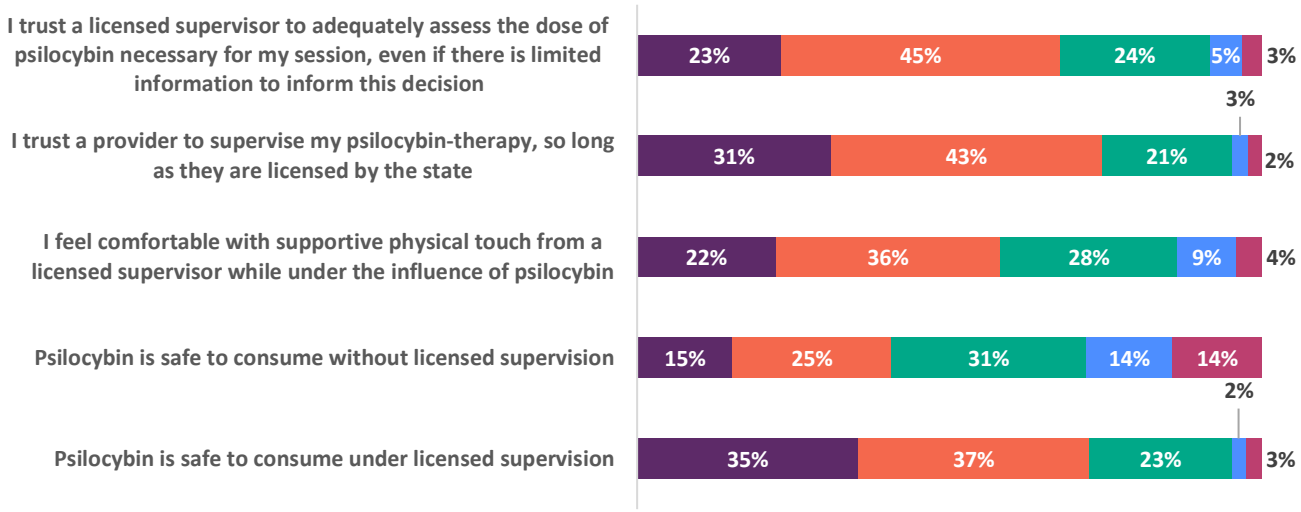
5.1 Perceptions of Psilocybin-Assisted Therapy and the New Mexico Medical Psilocybin Program

All survey participants (*n* = 642) were asked to indicate their level of agreement to a variety of statements about psilocybin and the New Mexico Medical Psilocybin Program, to better understand public perceptions and identify areas where targeted education may be warranted. The first set of questions primarily inquired about perceptions of safety as they relate to supervised psilocybin use. Nearly three-quarters (72%) of participants agreed with the statement, "*Psilocybin is safe to consume under licensed supervision"* whereas fewer (40%) agreed with the statement, "*Psilocybin is safe to consume without licensed supervision*." Relatedly, 74% of participants indicated agreement with the statement, "*I trust a provider to supervise my psilocybin-therapy, so long as they are licensed by the state*" and 68% agreed with the statement, "*I trust a licensed supervisor to adequately assess the dose of psilocybin necessary for my session, even if there is limited information to inform this decision*." **Together, these findings indicate participants generally perceive psilocybin as safer when used within a professionally supervised setting than when used independently.** The high levels of trust reported in licensed providers further indicate broad support for the role of trained professionals in facilitating psilocybin-assisted services. Emphasizing licensing requirements, safety protocols, and provider training may help foster public confidence in the New Mexico Medical Psilocybin Program.

Relatively fewer (58%) participants agreed with the statement, "*I feel comfortable with supportive physical touch from a licensed supervisor while under the influence of psilocybin.*" This question was included in the survey because supportive touch during psilocybin-assisted therapy is a topic of growing discussion within the field, as individuals undergoing psilocybin-assisted therapy may experience intense emotions, heightened feelings of connectedness, or even distress during dosing sessions. Supportive touch is intended as a potential means of conveying safety and emotional support, such as a comforting touch on the shoulder or providing assistance with mobility during a session. However, should department regulations

allow for supportive touch, clear policies regarding supportive physical touch during dosing sessions are imperative as individuals under the influence of psilocybin may be in an altered state of heightened vulnerability. Ethical discussions have increasingly focused on the risks of nonconsensual touch, boundary violations, and sexual misconduct by facilitators or therapists. These discussions have called for clear policies regarding informed consent prior to administration sessions, means of physical contact, comprehensive facilitator training, ongoing supervision, and robust protocols for reporting and addressing ethical violations. **Ensuring participant safety and autonomy through well-defined policies should be a critical component of the New Mexico Medical Psilocybin Program.**

Figure 19. Participant Perceptions of Psilocybin



	Psilocybin is safe to consume under licensed supervision	Psilocybin is safe to consume without licensed supervision	I feel comfortable with supportive physical touch from a licensed supervisor while under the influence of psilocybin	I trust a provider to supervise my psilocybin-therapy, so long as they are licensed by the state	I trust a licensed supervisor to adequately assess the dose of psilocybin necessary for my session, even if there is limited information to inform this decision
I strongly agree	35%	15%	22%	31%	23%
I agree	37%	25%	36%	43%	45%
I do not agree or disagree	23%	31%	28%	21%	24%
I disagree	2%	14%	9%	3%	5%
I strongly disagree	3%	14%	4%	2%	3%

These data were further examined by lifetime psilocybin use status. Significantly more participants with lifetime psilocybin use reported more favorable perceptions of psilocybin safety and greater trust in licensed supervision than participants without prior use (*ps* < .05). The largest differences were observed for beliefs regarding the safety of psilocybin consumption without licensed supervision, with 55.5% of lifetime users agreeing that unsupervised use is safe compared to only 20.3% of non-users. Lifetime users also expressed greater confidence in the safety of supervised administration (82.7% vs. 57.9%), greater comfort with supportive physical touch during dosing sessions (66.8% vs. 46.1%) and greater trust in providers' ability to determine appropriate dosing (76.8% vs. 55.0%).

Table 15a. Perceptions of Psilocybin Safety Under Licensed Supervision, by Psilocybin Use Status

"Psilocybin is safe to consume under licensed supervision."

Psilocybin use status	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
Lifetime Psilocybin Use	46.6%	36.1%	12.7%	1.6%	3.0%
No Psilocybin Use	19.9%	38.0%	36.9%	3.0%	2.2%

Table 15b. Perceptions of Psilocybin Safety Without Licensed Supervision, by Psilocybin Use Status

"Psilocybin is safe to consume without licensed supervision."

Psilocybin use status	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
Lifetime Psilocybin Use	22.1%	33.4%	29.1%	8.6%	6.7%
No Psilocybin Use	5.9%	14.4%	33.9%	21.0%	24.7%

Table 15c. Comfort With Supportive Physical Touch During Psilocybin Administration, by Psilocybin Use Status

"I feel comfortable with supportive physical touch from a licensed supervisor while under the influence of psilocybin."

Psilocybin use status	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
Lifetime Psilocybin Use	25.3%	41.5%	21.6%	7.5%	4.0%
No Psilocybin Use	17.7%	28.4%	37.6%	11.8%	4.4%

Table 15d. Trust in State-Licensed Psilocybin Therapy Providers, by Psilocybin Use Status

"I trust a provider to supervise my psilocybin therapy, so long as they are licensed by the state."

Psilocybin use status	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
Lifetime Psilocybin Use	31.8%	46.6%	17.3%	2.7%	1.6%
No Psilocybin Use	29.9%	38.7%	25.8%	2.6%	3.0%

Table 15e. Trust in Licensed Supervisors to Determine Psilocybin Dosage, by Psilocybin Use Status

"I trust a licensed supervisor to adequately assess the dose of psilocybin necessary for my session, even if there is limited information to inform this decision."

Psilocybin use status	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
Lifetime Psilocybin Use	26.1%	50.7%	17.8%	3.2%	2.2%
No Psilocybin Use	18.8%	36.2%	32.5%	7.7%	4.8%

Additional survey questions specifically related to the Medical Psilocybin Program were included. Respondents were generally in agreement of psilocybin use as a clinical treatment, with 54.7% (*n* = 351) of the full sample indicating agreement to the statement, "*Psilocybin can be used as a treatment for mental illness, but only when it is administered by a clinician*." However, a sizeable proportion of the sample indicated they "*neither agree nor disagree*" to this statement, suggesting general uncertainty regarding the use of psilocybin as a mental health treatment among the full sample. Similarly, 58.7% (*n* = 377) of the full sample agreed to the statement, "*The clinician must be a specially trained and licensed professional with an advanced degree in psychology, social work, or medicine*." Agreement to this statement and the rating of confidence in one's knowledge about the two items differed by psilocybin use status. Specifically, participants with use of psilocybin in their lifetime were less likely to agree to the second statement that a clinician must be a specially trained and licensed professional and also reported higher ratings of confidence in their answers to both questions, on average, compared to those without psilocybin use history (*ts* = -2.1 - 3.7; *ps* < .05). Greater perceived confidence may reflect direct experience with psilocybin, and as a result, these individuals may be less likely to view clinical credentials as a necessary prerequisite for administering psilocybin. Conversely, individuals without prior psilocybin experience may place greater emphasis on

professional training and licensure, and perceive less confidence in their own knowledge about psilocybin due to a lack of direct experience.

Table 16a. Perceptions of Psilocybin as a Treatment for Mental Illness, by Psilocybin Use Status

"Psilocybin can be used as a treatment for mental illness, but only when it is administered by a clinician."

Psilocybin use status	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
Lifetime Psilocybin Use	23.7%	30.5%	29.1%	9.4%	7.3%
No Psilocybin Use	22.9%	32.5%	32.8%	7.4%	4.4%

Table 16b. Perceptions of Training and Licensure Requirements for Psilocybin Clinicians, by Psilocybin Use Status

"*The "clinician" must be a specially trained and licensed professional with an advanced degree in psychology, social work, or medicine."*

Psilocybin use status	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
Lifetime Psilocybin Use	26.1%	29.1%	28.6%	9.2%	7.0%
No Psilocybin Use	32.5%	31.0%	23.6%	7.4%	5.5%

Table 16c. Confidence in Knowledge About Psilocybin Treatment and Clinician Requirements, by Psilocybin Use Status

"I am confident in my knowledge about the two items above."

Psilocybin use status	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
Lifetime Psilocybin Use	32.6%	30.2%	25.6%	7.3%	4.3%
No Psilocybin Use	22.1%	27.3%	32.1%	10.7%	7.7%

5.2 Perceptions of Psilocybin Safety and Effectiveness

When administered in controlled clinical settings with appropriate screening, preparation, and supervision, there have been few reports of serious adverse events following psilocybin dosing. However, psilocybin is not without risk - common acute symptoms of psilocybin include anxiety, headache, nausea, dizziness, and elevated blood pressure. Individuals with a history of

psychosis or psychotic disorders are at higher risk of experiencing adverse psychological reactions, and risk may occur in individuals with certain cardiovascular conditions. Psilocybin may also interact with common prescription medications, including antidepressant and antipsychotic medications. Continued research is needed to better understand psilocybin's risks, contraindications, and safety profile across diverse patient populations. As access to psilocybin expands, it is important to ensure that individuals are well informed about its potential benefits, risks of harm, and limitations prior to use. As a function of these considerations, several questions were included in this survey to assess current knowledge about the safety and risks of psilocybin to inform knowledge gaps and areas for targeted education.

Respondents with lifetime use of psilocybin held more favorable views of psilocybin's effectiveness as a treatment and reported greater confidence in their knowledge about psilocybin compared to those without lifetime use. A majority of respondents with history of psilocybin use (58.5%) agreed with the statement, "*Clinical trials of psilocybin as a treatment for mental illness consistently shows that it is very effective*" compared to 40.3% of those without a history of use. Furthermore, nearly half of respondents without history of use (46.1%) selected "*neither agree nor disagree*" to this statement, compared to only 26.7% of those with lifetime use, indicating those without personal experience may be less certain about existing evidence regarding psilocybin's therapeutic potential. A similar pattern emerged for the statement, "*The scientific evidence supporting the use of psilocybin for depression is much stronger than antidepressants*," in which more than half of respondents with lifetime use (53.3%) agreed with this statement, compared to 32.8% of those without a history of use. Respondents without prior use were also more likely to indicate uncertainty about their knowledge, with 51.3% selecting "*neither agree nor disagree*." In fact, lifetime use of psilocybin was significantly associated with stronger agreement for each statement about psilocybin's effectiveness as a medicine, when controlling for demographic variables, other substance use, and preferred healthcare information sources (*ps* < .05). These findings may reflect the influence of positive expectancies among individuals with prior psilocybin experience, as direct experiences perceived as beneficial may contribute to more favorable beliefs about the substance.[17] There is growing

[17] Montes, K. S., Witkiewitz, K., Pearson, M. R., & Leventhal, A. M. (2019). Alcohol, tobacco, and marijuana expectancies as predictors of substance use initiation in adolescence: A longitudinal examination. *Psychology of Addictive Behaviors*, *33*(1), 26. https://doi.org/10.1037/adb0000422

recognition within psychedelic research of the need to understand, manage, and account for expectancy effects within clinical trials.[18]

Stark differences in perceived confidence in knowledge emerged as a result of psilocybin use history. Approximately 60.7% of respondents with history of use reported confidence in their knowledge of these topics, compared to 32.8% of those without prior use. Across each question, respondents with a history of psilocybin use were significantly more likely, on average, to endorse stronger agreement to each statement, and greater confidence in their perceived knowledge compared to those without a history of use (*ts* = 3.38 - 6.08, *ps* < .001).

Table 17a. Perceptions of Psilocybin's Effectiveness for Treating Mental Illness, by Psilocybin Use Status

"Clinical trials of psilocybin as a treatment for mental illness consistently shows that it is very effective."

Psilocybin use status	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
Lifetime Psilocybin Use	22.1%	36.4%	26.7%	8.4%	6.5%
No Psilocybin Use	11.1%	29.2%	46.1%	6.6%	7.0%

Table 17b. Perceptions of Evidence for Psilocybin Compared With Antidepressant Medications, by Psilocybin Use Status

"Compared to antidepressant medications, scientific evidence supporting the use of psilocybin for depression is much stronger than antidepressants."

Psilocybin use status	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
Lifetime Psilocybin Use	18.3%	35.0%	30.2%	8.4%	8.1%
No Psilocybin Use	9.6%	23.2%	51.3%	8.1%	7.7%

[18] Szigeti, B., & Heifets, B. D. (2024). Expectancy effects in psychedelic trials. *Biological Psychiatry: Cognitive Neuroscience and Neuroimaging*, *9*(5), 512-521. https://doi.org/10.1016/j.bpsc.2024.02.004

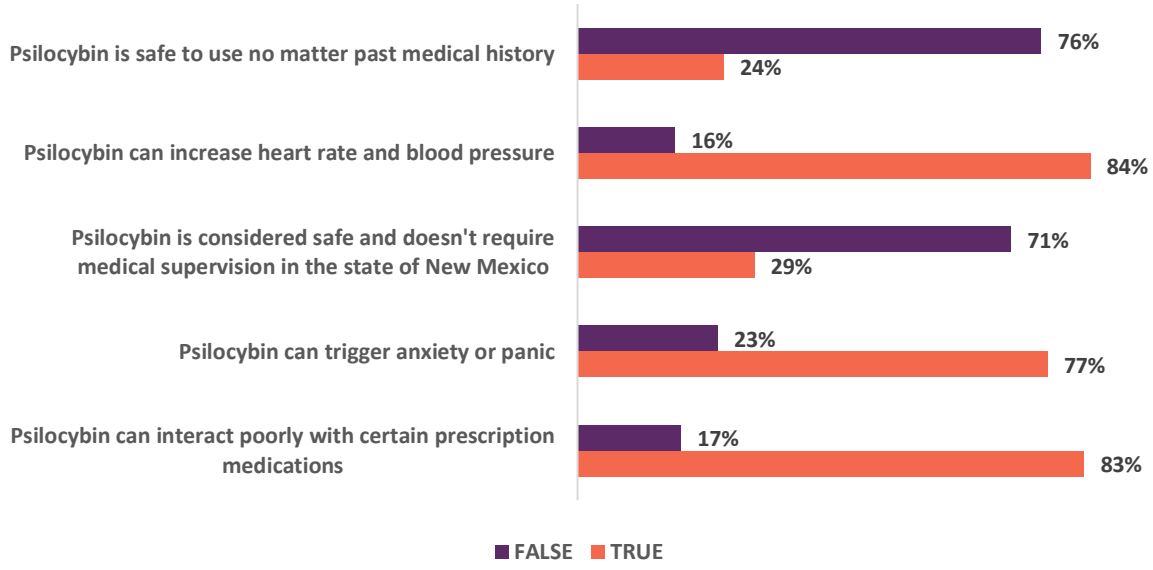
Table 17c. Confidence in Knowledge About Psilocybin's Effectiveness as a Medicine, by Psilocybin Use Status

"I am confident in my knowledge about the two items above."

Psilocybin use status	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
Lifetime Psilocybin Use	27.8%	32.9%	21.0%	10.0%	8.4%
No Psilocybin Use	12.9%	19.9%	39.9%	11.4%	15.9%

Interestingly, when presented with a separate series of true/false statements related to the safety of psilocybin, no significant differences in responses emerged as a function of psilocybin use history. These questions served as a knowledge indicator of psilocybin safety, to inform general knowledge and potential areas for public health education. Past month polysubstance use significantly predicted likelihood of correctly answering these questions, when controlling for demographic variables, rural/urban status, and psilocybin use history (B = -0.1, $p < .05$). Specifically, individuals reporting more frequent past month polysubstance use demonstrated lower scores on the knowledge test, suggesting that this population may uniquely benefit from targeted educational efforts regarding psilocybin safety and the Medical Psilocybin Program.

Figure 20. Psilocybin Knowledge Check



Section 5 Summary

- Respondents reported substantially greater confidence in supervised versus unsupervised psilocybin use and expressed high levels of trust in licensed providers, underscoring the importance of communicating program safety standards and provider qualifications throughout implementation of the Medical Psilocybin Program.
- Prior psilocybin users expressed greater confidence in their knowledge about psilocybin, were less likely to view specialized training and licensure as essential for providers, and held more favorable views of psilocybin's effectiveness as a treatment compared to those without lifetime use.
- Individuals reporting more frequent past month polysubstance use demonstrated lower scores on the psilocybin knowledge test, suggesting that this population may uniquely benefit from targeted educational efforts regarding psilocybin safety and the Medical Psilocybin Program.

Section 6. Considerations for the New Mexico Medical Psilocybin Program Based on the Evidence

Outside of understanding past and current psilocybin use within the New Mexico population, a primary goal of the current study was to identify policy and program relevant considerations that would be consistent with both those in New Mexico who expressed interest in the Medical Psilocybin Program, and existing literature. Based on the analysis provided in the current study, we have prepared a series of considerations for the Department of Health, Center for Medical Cannabis and Psilocybin during the development and implementation of the program.

Educational Campaigns and Online Resources

First, educational campaigns focused on both the existence of New Mexico's Medical Psilocybin Program and the current clinical evidence supporting psilocybin-assisted therapy would likely benefit all stakeholder groups. With 66% of respondents reporting that they were unaware of the program, there is a substantial opportunity to increase public awareness while simultaneously providing accurate, evidence-based information regarding the therapeutic applications, risks,

and limitations of psilocybin-assisted therapy. Results from the psilocybin knowledge assessment demonstrated variable accuracy and generally neutral to low confidence among respondents with no prior psilocybin experience, suggesting that educational efforts may be most effective when targeted toward individuals who are psilocybin-naïve. Additionally, across the questions related to preferred care models and therapy types, many respondents indicated that they were not sure what would be best for their needs, suggesting they may be open to education on the topic.

Campaigns should also be tailored to the channels through which New Mexicans are most likely to seek health information. Respondents identified healthcare providers as their most trusted source of medical information, followed closely by internet searches. Accordingly, the Department may consider developing educational materials and provider toolkits for physicians, behavioral health providers, and other healthcare professionals to facilitate informed conversations with potentially eligible patients. These efforts could be complemented by an accessible online resource center that provides evidence-based information on qualifying conditions, the treatment process, potential benefits and risks, and program eligibility requirements.

Longitudinal Data Collection System

Adverse events during administration are not uncommon. Interestingly, respondents who had previously consumed psilocybin with a facilitator present, including a medical professional, were found to report more total adverse events than those without a facilitator. This finding was statistically significant, highlighting a true relationship between facilitated vs. unfacilitated psilocybin consumption and adverse effects or symptoms. As the program requires a licensed supervisor, this finding is important and it may suggest that some level of acute adverse events or experiences may be expected.

Some literature has suggested that adverse effects can occur well after care is complete, and for a minority, symptoms may temporarily worsen or persist beyond the treatment period.[19,20] Over 70% of those who had consumed psilocybin in their lifetime within our sample experienced

[19] Simonsson, O., Carlbring, P., Carhart-Harris, R., Davis, A. K., Nutt, D. J., Griffiths, R. R., ... & Goldberg, S. B. (2023). Assessing the risk of symptom worsening in psilocybin-assisted therapy for depression: A systematic review and individual participant data meta-analysis. *Psychiatry Research*, *327*, 115349. https://doi.org/10.1016/j.psychres.2023.115349
[20] Bremler, R., Katati, N., Shergill, P., Erritzoe, D., & Carhart-Harris, R. L. (2023). Case analysis of long-term negative psychological responses to psychedelics. *Scientific Reports*, *13*(1), 15998. https://doi.org/10.1038/s41598-023-41145-x

some of the symptoms in the 7 days following their dosing, which the participants attributed to their use of the substance. This included psychiatric and physical symptoms that were severe enough to warrant hospitalization among some. However, in many instances within literature and our sample, positive effects have also been observed, which is equally important.

As this program is statutorily directed to be efficacious, capturing both the acute and long-term effects of treatment is imperative. Prioritizing a longitudinal data collection system that captures patient experiences during treatment and at multiple follow-up timepoints in the weeks and months thereafter would strengthen the Department's ability to evaluate real-world effectiveness, identify delayed adverse events, monitor recovery trajectories, and determine which patients benefit most from treatment. Such a system would not only enhance patient safety through ongoing surveillance but also provide an empirical foundation for continuous quality improvement, evidence-informed policy decisions, and future refinements to program eligibility, clinical protocols, and best practices.

Confidential Reporting System for Patient Safety and Professional Conduct

While 58% of respondents indicated that they would be comfortable with supportive touch during a psilocybin experience, 18.2% of those whose psilocybin use was guided by a medical professional reported experiencing unwanted physical touch from someone present during the experience. Patients may experience heightened emotional openness, psychological vulnerability, and increased reliance on facilitators during and immediately following administration. These altered states can create inherent power imbalances that may influence a patient's ability to recognize, respond to, or report inappropriate conduct in the moment. Providing a *confidential* mechanism to report concerns after services are complete strengthens patient protections, reinforces professional accountability, and enables the Department to identify emerging patterns, monitor provider conduct, inform quality improvement efforts, and prioritize compliance and enforcement activities where appropriate.

Equity Fund Eligibility and Allocation

Financial accessibility is likely to be one of the largest barriers to participation in New Mexico's Medical Psilocybin Program as demonstrated in other states and our analysis. Survey findings

indicate nearly half of respondents interested in the program would not be willing or able to pay out-of-pocket for services after learning insurance coverage is unavailable.

Regression analyses demonstrated that household income is the strongest determinant of willingness to pay, while the qualifying medical conditions themselves were not associated with greater financial willingness or ability to pay. Using average New Mexico household size, respondents earning less than $50,000 annually correspond approximately to 183% of the Federal Poverty Level (FPL). As such, an eligibility threshold near 200% FPL represents an evidence-informed starting point for equity fund eligibility, while recognizing policymakers may ultimately adopt a sliding-scale approach better accounting for household size.

Although the actual cost of psilocybin-assisted therapy in New Mexico will not be known until services become operational, survey findings provide a data-driven starting point for establishing minimum grant awards. Respondents from households earning less than $50,000 annually demonstrated a predicted willingness to pay approximately $138 out of pocket, compared to approximately $2,357 among households earning over $100,000 annually. Assuming market prices ultimately settle near what higher-income consumers are willing to pay, the difference between these groups offers an evidence-based benchmark for considering financial assistance levels for lower-income patients. However, financial assistance values will largely depend not just on price, but if some of the services for the program may be covered by health insurance, how much of the costs would be covered, and if the equity fund applicants have health insurance.

However, findings also suggest that many prospective patients would remain unable to access treatment even if only partial financial assistance were available. Approximately one-third of respondents who reported no willingness or ability to pay indicated that grant funding would not change their ability to contribute toward treatment costs, suggesting that substantial or full subsidies may be necessary for many eligible patients. Rather than distributing modest subsidies across a larger number of recipients, policymakers may wish to consider providing larger per-person awards that meaningfully reduce or eliminate financial barriers for those with the greatest need given this information. Equity Funding may also be beneficial if allocated for costs related to child and family care, pet care, and transportation for services.

Future Research

Clinical Outcomes. Perhaps the most important future research priority is establishing a longitudinal patient outcomes registry. While clinical trials have demonstrated promising efficacy for psilocybin-assisted therapy under controlled conditions, considerably less is known about its effectiveness in routine clinical practice. Standardized patient-reported outcome measures should be collected before treatment, immediately following treatment, and at multiple follow-up intervals (e.g., 1, 3, 6, and 12 months) to evaluate symptom improvement, functional recovery, quality of life, durability of treatment effects, and delayed adverse events.

Equity Fund Evaluations. The Medical Psilocybin Treatment Equity Fund should undergo ongoing evaluation to determine whether financial assistance reaches the intended populations and effectively reduces barriers to care. Future studies should examine application rates, approval rates, demographic characteristics of recipients, geographic distribution of awards, utilization of services following receipt of funding, and whether grant size adequately offsets financial barriers.

Licensed Facilitators and Center Performances. As the provider network develops, future evaluations should assess implementation outcomes across facilitators and service centers, including treatment types, completion rates, patient satisfaction, referrals, adverse event rates, complaint patterns, and patient retention. Such analyses may identify best practices and opportunities for continuous quality improvement without focusing solely on compliance or enforcement.

Appendix A

Respondents were sourced for this survey from Cint. Cint hosts the world's largest consumer network for digital market research, consisting of over 800 research panels recruiting from a larger population of over 30 million active U.S. residents. Our recruitment approach aligns with a quantitative form of purposive, stratified non-probability sampling. We simultaneously stratify samples by state and key demographic variables within Cint to inform appropriate allocation across strata.

Eligibility criteria:

- Eligibility criteria for participation in this study included being 18 years of age or older, residing in New Mexico, and reporting psilocybin use within the past two years *or* interest in the New Medical Psilocybin Program.

Screening process:

- *To minimize potential selection bias, we use neutral survey labels and descriptions to reduce the likelihood of attracting respondents based on specific interests that could skew recruitment.*
- Potential respondents were first routed to Cint's Marketplace Screener where they were met with several screening questions to verify eligibility for participation in the survey.
- Only those who met these eligibility checks could proceed with the full survey.

Full survey quality controls:

- Additional screening questions were included in the full survey to ensure eligibility and consistency in respondents' answers. These questions included age, state of residence, zip code of residence, and data quality verification checks.
- Bot and attention checks were included throughout the survey to confirm we were only capturing real people who were attentive to the survey.
- Respondents who did not meet the eligibility criteria were automatically disqualified from participation and routed out of the survey.

Post-survey data cleaning:

- Standardized data cleaning procedures were conducted as a final verification method to ensure all participant responses met the eligibility criteria, data quality, and security checks.

Survey sample breakdown:

- In total, 1,932 individuals responded to the survey invitation and entered the survey. Of these, 1,129 did not complete the full survey. Non-completion occurred for a variety of reasons, including automatic termination due to failed bot-detection, security-verification,

or state-verification checks, as well as voluntary attrition prior to completion. Following the conclusion of data collection, an additional 161 respondents were removed during post-survey data cleaning due to data quality concerns, including speeding, straight lining, and inconsistent response patterns. This leaves a final sample of 642 participants.