From: Dr. Trish Singh
To: Clark, Jacob, DOH
Subject: [EXTERNAL] RE: Public Comment on Proposed 7.35.3 NMAC — Patients, Certifying Clinicians, Practitioners, Facilitators, Healing Centers, Other Approved Locations, and Educational Programs
Date: Wednesday, September 16, 2026 1:56:22 PM

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New Mexico Department of Health
Office of General Counsel
Medical Psilocybin Program

To the New Mexico Department of Health:

My name is Patricia Singh, PhD, LPCC. I am an independently licensed behavioral health clinician in New Mexico, a New Mexico Board-Approved Clinical Supervisor, and the Owner and Executive Director of A New Awakening, an outpatient behavioral health organization serving individuals with substance use disorders, including individuals involved in New Mexico's criminal justice system. I am also a co-founder of Trip HōM, a psychedelic-care organization. I have completed psychedelic-assisted therapy training through the California Institute of Integral Studies and hold Colorado Natural Medicine Facilitator and Handler credentials.

I appreciate the Department's work to develop a thoughtful, clinically responsible regulatory framework for implementing the Medical Psilocybin Act. My comments focus on several implementation issues arising at the intersection of behavioral health, substance use disorder treatment, justice-system involvement, clinician training, and equitable access.

1. Clarify and preserve the transitional pathway for experienced practitioners

I strongly support rigorous education and competency standards for practitioners. I also appreciate that the proposed rule recognizes that experienced clinicians and psychedelic practitioners may enter New Mexico's program with substantial prior education and supervised experience.

Proposed §7.35.3.10 provides a pathway for applicants who completed qualifying educational programs in other jurisdictions and permits recognition of certain government-approved programs and programs developed in collaboration with institutions of higher education or government-approved psychedelic research studies.

Proposed §7.35.3.19(H) further provides that applicants meeting specified requirements and applying by December 31, 2027, may satisfy a reduced practicum requirement by demonstrating at least 40 hours of documented contact time rather than completing the full New Mexico practicum.

This transitional pathway will be important to New Mexico's ability to build a competent initial workforce without requiring experienced professionals to unnecessarily duplicate

training and supervised clinical experience.

I respectfully request that the Department provide clear guidance regarding:

- the documentation required to establish equivalency of education completed outside New Mexico;
- whether documented preparation, administration/facilitation, integration, supervision, and practicum experience obtained through another regulated state program may be credited toward the transitional requirements;
- how established psychedelic-assisted therapy programs completed before New Mexico's educational programs existed will be evaluated; and
- what forms of logs, supervision records, patient-contact documentation, or other records will be accepted to establish the required 40 hours of contact time.

I also request clarification of an apparent inconsistency within the proposed rule. Section 7.35.3.10(D)(1) describes the reduced practicum pathway as requiring at least 40 hours of contact time with a minimum of two separate individual sessions and **two separate group sessions** involving preparation, administration, and integration. Section 7.35.3.19(H), however, describes at least 40 hours with a minimum of two separate individual sessions and **one group session** involving preparation, administration, and integration.

I respectfully request that the Department reconcile these provisions in the final rule so prospective applicants clearly understand the transitional practicum requirement.

2. Provide implementation guidance for qualified patients involved in the criminal justice system

Substance use disorders are expressly included among the qualifying conditions under the Medical Psilocybin Act. The Act also contains unusually important protections for individuals involved in the criminal justice system.

Section 26-2D-10 NMSA 1978 provides that a person serving a period of probation or parole, or who is in the custody or under the supervision of the state or a local government pending trial as part of a community-supervision program, shall not be penalized for participation in the Medical Psilocybin Program.

As a behavioral health provider who has worked extensively with justice-involved individuals with substance use disorders, I believe implementation guidance in this area would be valuable to patients, clinicians, courts, probation departments, diversion programs, and treatment providers.

I respectfully encourage the Department to clarify that:

- justice-system involvement does not itself disqualify an otherwise qualified patient;
- a referral originating from a treatment court, probation department, diversion program, behavioral health provider, attorney, or other justice-system participant does not itself make participation involuntary;

- participation in medical psilocybin treatment must remain voluntary and based upon independent clinical determination of eligibility and medical appropriateness;

- declining medical psilocybin treatment should not itself result in an adverse consequence within a state or local treatment, diversion, probation, or community-supervision program; and

- the protections provided by the Medical Psilocybin Act apply consistently throughout program implementation.

Clear guidance would help prevent inconsistent interpretations across jurisdictions while protecting both patient autonomy and the integrity of the Medical Psilocybin Program.

3. Protect substance use disorder confidentiality in justice-system referrals

The proposed educational requirements appropriately include training regarding 42 CFR Part 2. This is particularly important because substance use disorder is a qualifying condition and because some patients may enter the program while participating in treatment courts, diversion programs, probation, reentry services, or other justice-related programs.

I encourage the Department to provide implementation guidance on exchanging information between Medical Psilocybin Program providers and justice-system referral sources.

Such guidance should distinguish between information that may lawfully and appropriately be disclosed pursuant to a valid authorization or other applicable legal authority and detailed clinical information that should remain protected.

Participation in a justice-related program should not, by itself, result in automatic disclosure of a patient's subjective psychedelic experience, therapeutic disclosures, trauma history, family information, dosage information, psychotherapy content, or other protected clinical information.

Clear guidance concerning 42 CFR Part 2, HIPAA, applicable state confidentiality requirements, and properly structured releases of information would help clinicians collaborate appropriately with justice-system partners while preserving the confidentiality necessary for effective substance use disorder treatment.

4. Preserve integration with existing behavioral health and healthcare systems

Medical psilocybin treatment should function within a broader continuum of care rather than as an isolated episode.

Many patients with substance use disorders already receive behavioral health services through Medicaid, commercial insurance, public programs, or other healthcare coverage. Assessment, ongoing SUD treatment, psychotherapy, medical evaluation, preparation, integration, relapse-prevention services, and continuing behavioral healthcare may constitute independently medically necessary healthcare services when delivered by appropriately licensed and credentialed professionals and when applicable payer requirements are satisfied.

I encourage the Department to ensure that its final rules and subsequent guidance do not inadvertently require independently provided healthcare services to be financially bundled into the cost of psilocybin administration when those services are otherwise appropriately provided

and reimbursable through existing healthcare systems.

Integration with existing healthcare infrastructure could substantially improve continuity of care and affordability while allowing treatment-equity resources, philanthropy, and other access mechanisms to cover costs not otherwise covered.

This will be particularly important for Medicaid beneficiaries, economically disadvantaged patients, rural communities, and justice-involved individuals.

5. Monitor the access impact of administration-session staffing requirements

Proposed §7.35.3.20(H) generally requires at least one practitioner and one facilitator during an individual administration session and establishes staffing ratios for group administration sessions. I appreciate that the proposed rule also allows the Department to waive or decrease the staffing requirement when the specified ratio presents a barrier for patients and safety concerns are otherwise alleviated.

I support maintaining appropriate safety standards. I also encourage the Department to develop a transparent and clinically grounded process for obtaining such a waiver.

Requiring two certified professionals for every individual administration session could materially increase treatment costs and reduce access, particularly in rural areas and for patients relying on the Treatment Equity Fund or philanthropic assistance.

Clear waiver criteria based on patient risk, practitioner qualifications, treatment setting, emergency planning, proximity to emergency medical services, and other relevant clinical factors could preserve safety while preventing staffing requirements from becoming an unintended barrier to access.

6. Preserve meaningful access through "other approved locations"

I support the proposed framework allowing temporary certification of "other approved locations" when a patient cannot be transported to a healing center, when medical necessity supports another location, to improve access in rural and frontier counties, or to enable treatment in a natural environment.

This flexibility is particularly relevant in a geographically large and rural state such as New Mexico.

I respectfully request that the Department clarify, either in the final rule or subsequent implementation guidance, that an otherwise qualified patient is not excluded from utilizing an approved location solely because the patient is participating in probation, parole, diversion, treatment court, specialty court, reentry, or another state or local community-supervision program, provided that the patient and location otherwise satisfy applicable statutory and regulatory requirements.

Conclusion

New Mexico has an opportunity to build a medical psilocybin program that is clinically rigorous, accessible, integrated with existing healthcare, and responsive to populations that have historically faced significant barriers to treatment.

As the Department finalizes 7.35.3 NMAC, I respectfully encourage it to preserve the transitional pathway for experienced clinicians, reconcile the 40-hour practicum provisions, provide clear guidance concerning justice-involved patients and confidentiality, preserve integration with existing behavioral healthcare, establish transparent staffing-waiver criteria, and protect meaningful access through other approved locations.

These clarifications would support patient safety while helping New Mexico develop a qualified workforce and an accessible continuum of care for individuals with substance use disorders and other qualifying conditions.

Thank you for the opportunity to provide public comment and for the Department's work implementing the Medical Psilocybin Act.

Respectfully,

Patricia Singh, PhD, LPCC
Owner & Executive Director
A New Awakening

Co-Founder
Trip HōM

New Mexico Licensed Professional Clinical Counselor
New Mexico Board-Approved Clinical Supervisor
Colorado Natural Medicine Facilitator & Handler

Dr. Patricia Singh, PhD, LPCC
A New Awakening, INC
400 Gold Ave **SW Suite 1200**
Albuquerque, NM 87102