To: New Mexico Department of Health

Re: Public Comment on NMAC 7.35.3, Medical Psilocybin Program Rules

From: Anne L. Metz, PhD, LPCC

Date: September 22, 2026

I am a licensed professional counselor in New Mexico and a resident of Taos County. I am a licensed Natural Medicine Facilitator in Colorado and Director of an Approved Facilitator Training Program there, with a background in risk assessment research and clinical facilitation experience under Colorado's regulated psilocybin program. I submit the following comments on the draft rules.

1. The certifying clinician model treats risk as a fixed, one-time determination, when clinical risk is dynamic

My prior published research on risk assessment in criminal sentencing centered on a core finding that also applies here: risk is not a fixed trait established at a single point of contact, it is a probability that shifts with new information over time. Treating a certifying clinician's one-time, pre-treatment clearance as the safety mechanism for the whole course of care builds the same error into this program that risk-assessment research has spent decades correcting in other fields.

The risks most relevant to psilocybin-assisted therapy — psychological readiness, same-day contraindications such as pregnancy or intoxication, a patient's state on the day of administration — are not visible at intake and cannot be cleared in advance. The practitioner who is actually with the patient through preparation is in the better position to identify and respond to risk as it develops, referring out for medical consultation only where a specific factor (certain medications, uncontrolled hypertension, a psychotic disorder history) falls outside their own scope of practice. Requiring every patient to clear a separate certifying clinician encounter before treatment can begin, regardless of whether any risk factor is present, does not make the program safer; it substitutes a single checkpoint for the ongoing clinical judgment that actually manages risk, and adds cost and delay for patients who have no risk factors at all. In rural counties where a certifying clinician may not be reasonably available, it may foreclose access to care entirely.

2. The patient application places the greatest burden on the patients least able to carry it

A state-level patient application adds a procedural step between diagnosis and care. That step is not neutral in its effect: it falls hardest on the rural, elderly, disabled, and low-income patients this program is meant to serve — people who may lack reliable internet access, transportation to submit paperwork in person, or the time to navigate an additional bureaucratic process on top of managing a serious psychiatric condition. A patient with treatment-resistant depression or a terminal diagnosis is the patient least equipped to absorb delay. Given that psilocybin is administered only in supervised sessions and a patient never possesses it outside that setting, the application does not serve a possession-authorization purpose the way it does in New Mexico's medical cannabis program. It functions only as an access barrier, and should be removed.

3. A 2:1 facilitator ratio is unworkable given New Mexico's existing behavioral health workforce shortage

New Mexico already has some of the most severe behavioral health workforce shortages in the country, particularly outside Albuquerque and Santa Fe. Oregon requires no more than a single facilitator for standard individual sessions, scaling to lower ratios only for high-dose group administration. Colorado sets no comparable ratio requirement for individual sessions at all. A 2:1 requirement does not just raise the cost of an individual session; in a rural county with one or two behavioral health providers total, it may make it functionally impossible to staff a session at all. This provision should be reconsidered with New Mexico's actual provider distribution in mind, not modeled on assumptions about staffing availability that do not hold outside urban areas.

4. Landlord permission introduces friction into the patient's home that no other form of home-based clinical care requires

Home health, hospice, and in-home mental health treatment are all delivered routinely in patients' rented homes without requiring landlord sign-off, because the presence of a clinician providing care is not treated as a property concern. As written, the "other approved locations" provision would require a renting end-of-life or homebound patient to obtain a signed statement from their landlord before receiving psilocybin therapy in their own home — a requirement with no counterpart anywhere else in New Mexico's behavioral health system, and one that risks delaying or blocking care for exactly the patients least able to travel to a healing center. I support revising this provision so it does not apply to end-of-life patients, other patients receiving in-home care, or long-term care facility residents.

5. Cumulative effect on clinician participation

Taken together, these provisions raise the cost, staffing burden, and administrative overhead of participating in New Mexico's program well above what Oregon's or Colorado's programs require. The more likely outcome is that clinicians decline to take regulated-access patients and instead limit their practice to FDA-approved synthetic psychedelics once available, bypassing the state program entirely. This leaves the majority of New Mexicans who would seek treatment through the regulated program without a clinician willing to see them.

I look forward to participating in the October 2, 2026 hearing and am glad to provide additional detail on any of the points above.

Respectfully submitted,

Anne L. Metz, PhD, LPCC