

**From:** [Jessica Riley](#)  
**To:** [Clark, Jacob, DOH](#)  
**Subject:** [EXTERNAL] Public comment on proposed 7.35.3 NMAC, October 2, 2026 hearing  
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To the New Mexico Department of Health:

I am a New Mexico resident in Rio Rancho, and I am also a renter, a clinician, and a hospice or palliative care worker. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing. My husband was a paramedic/firefighter for 10 years, and I have seen firsthand the damage that years of repeated trauma can leave behind. First responders see things most people could never imagine, yet alcohol, responsible for roughly 178,000 deaths a year from excessive use, is legal, normalized, and often treated as an acceptable way to cope. It almost took my husband's life. Meanwhile, substances like cannabis and psilocybin have spent decades being stigmatized despite growing research into their therapeutic potential. Psilocybin is not a cure-all, but it deserves serious, responsible study, especially for EMS, fire, law enforcement, and veterans who spend their careers carrying the weight of everyone else's worst days. We should be asking why numbing trauma with alcohol is socially acceptable, while exploring treatments that may actually help people process that trauma is still considered taboo. I ask the department to make the following changes in the final rule. 1. The property-owner statement, 7.35.3.11(B)(9). Add to paragraph (B)(9) of [7.35.3.11](#): "This provision shall not apply to end-of-life patients or others seeking in-home care, or to long-term care facility residents." The landlord interest that justifies the cannabis provision, smoking on the property, is not present in a supervised psilocybin session administered by a licensed facilitator. Federal illegality alone does not justify it either: New Mexico has already chosen to depart from federal law on this. Giving landlords the power to block care for vulnerable and disabled patients is contrary to that choice, and leaves the department exposed under state protections against discrimination. 2. The certifying clinician, 7.35.3.8 and 7.35.3.9(D). Remove the certifying clinician design. In its place, regulate around the specific contraindications, medical histories and medications that warrant clinical review. Where a risk factor is identified, require an attestation from a clinician whose scope of practice fits that risk that screening was conducted and benefits outweigh risks. The design exceeds the Act and misunderstands where the risk is. The most significant risks in psilocybin-assisted therapy are psychological, or medical risks that must be screened on the day of administration, such as intoxication. A one-time "prescriber" gateway misses them. It also creates a clinical encounter whose only purpose is program entry, which insurers will treat as lacking independent medical necessity, inviting claim denials and clawbacks. 3. The patient application, 7.35.3.8. Strike the patient application process. It has no legal or policy justification in a supervised-use program. It adds administrative burden for the department, lengthens the wait for care, creates another store of patient data that can be accessed without consent or unlawfully taken, and further stigmatizes patients. Thank you for considering my comment.

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