

From: [Mary Curry](#)
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 Santa Fe, and I am also a clinician. I am writing to comment on proposed rule 7.35.3 NMAC ahead of the October 2, 2026 hearing.

I specialize in the treatment of traumatic stress, and there is a preponderance of evidence based practice and practice based evidence that full dose treatment and microdose treatment can attenuate suffering and result in a cure for PTSD and other chronic and debilitating psychological conditions.

I plan to attend the hearing. If the opportunity to make a public statement, I will speak to my position that an Integrated Behavioral Health and Primary Care Coordinated Model is the ideal model for the New Mexico Psilocybin Program.

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.

Instead, I propose an Integrated Mental Health and Substance Abuse and Medical model that is Client/Patient centered.

The entry point of screening and diagnosis is a licensed mental health professional that has

completed a certification to provide psilocybin treatment.

Utilize a screening tool that identifies the psychological and medical conditions that are considered counter indications. If a medical condition (e.g. high blood pressure or other heart condition) the client/patient is responsible for meeting with their physician for clearance to proceed with treatment.

Integrated models have been very successful in New Mexico. I was part of the team that designed the Statewide HIV/AIDS integrated model and the Statewide SBIRT model. These two models utilized Behavioral Health as the point of entry.

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.

Instead, the eligible client/patient process occurs with a certified psilocybin clinician, either directly with their own client/patient, or in collaboration with a referring clinician or medical provider.

Thank you for considering my comment.

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