



September 28, 2026

New Mexico Department of Health
Medical Psilocybin Program
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VIA EMAIL

RE: *Comment on Proposed NMAC 7.35.3*

To the New Mexico Department of Health:

The Psychedelic Bar Association (PBA) is a professional association of lawyers and legal professionals committed to the creation of a world where safe, legal, access to psychedelics brings healing, equity and justice for all. The New Mexico Working Group of the Psychedelic Bar Association formed earlier this year in order to offer issue-area expertise during the development of the state regulated program in New Mexico. We are eager to support the success of the New Mexico state regulated access program and are grateful for the opportunity to provide feedback on NMAC 7.35.3.

Our feedback covers the following issue areas:

1. Access issues
2. Safety, liability, and risk management considerations
3. Other recommendations

Access Issues

Provider-to-patient Ratios

Proposed NMAC 7.35.3.20(H)(5) would require "a minimum of one practitioner and one facilitator for individual patient sessions[.]" This rule would require that patients pay for two certified individuals to be present during the entire duration of any individual administration session. We believe that the presence of a second paid individual will

be unnecessary to ensure patient and public safety in a majority of cases, and a rule that requires the hiring of a second individual in all cases would often increase the financial barriers to care without benefit. We submit that a better approach would be to require only a single certified individual. While there may be circumstances in which having a second paid provider is indicated for a particular patient through information learned during screening, we believe that imposing a 2-provider requirement on all patients would create undue cost burdens to a majority of patients without improving client or public safety. By contrast, Oregon's and Colorado's programs require only one facilitator to be present during an individual administration session, and there are no known harms that have come from the lack of a second individual to serve as "back up" out of over 20,000 administration sessions in Oregon and estimated 1,500 in Colorado.

In the context of group administration sessions, draft NMAC 7.35.3.20(H)(5) would require "a minimum of one practitioner for every eight patients and a minimum of one facilitator or qualified student for every two patients." While the ratios required by this rule would allow patients to reduce their costs over individual administration sessions, we are concerned that the amount of administration support required under this draft rule is still out of proportion to the amounts needed to promote patient and public safety.

Establishing mandatory minimum provider-to-patient ratios is problematic because it does not allow the providers to make individualized assessments of the patients and determine how much support is actually needed for particular patients. Tort law, and potentially other DOH regulations, will establish a professional standard of care that does not permit providers to unreasonably defer to these minimum ratios when the idiosyncratic factors of a particular patient group indicate that more administration assistance is needed than required by the regulatory minimums. Adherence to these ratios will not be a safe harbor for civil or professional liability. In other words, *providers will not be able to evade liability when they make or approve of decisions in which the minimum ratios are unreasonably relied upon, regardless of where DOH sets them.* Accordingly, providers of group administrations will have to make safety assessments for patient groups that evaluate the idiosyncrasies of that particular group irrespective of the existence of mandatory minimum ratios.

Additionally, minimum ratios will also create in some providers a cognitive bias known as an "anchoring effect" in which those providers show less diligence or thoroughness in evaluating the relevant safety considerations and instead fully or partially defer to the regulatory minimums. To prevent this, New Mexico should adopt rules that

encourage provider vigilance in ensuring supervision is safe in proportion to the particular risks of the particular patient groups.¹

Mandatory ratios do not give providers flexibility to offer or receive psilocybin services where the costs of safeguards are proportionate to the safety needs of a particular group. The proposed minimums would create paywalls that prevent and deter people from taking psilocybin within the safe and legal container of the Medical Psilocybin program, and work against the objectives of equity and affordability.

If New Mexico wishes to nevertheless adopt minimum ratios, it should consider the examples of Oregon and Colorado. Both states have imposed ratios that consider a patient's dose as a proxy for the minimum amount of support that may be required during group administration.

Oregon has adopted the following ratios²:

Dose (mg of psilocybin analyte)	Minimum Facilitator-to-client Ratio
Less than 5	1 to 25
5 – less than 10	1 to 15
10 – less than 15	1 to 8
15 – less than 25	1 to 6
25 – less than 35	1 to 4
35 – 50	1 to 2

Colorado has adopted a less progressive system, but one that still recognizes that lower-dose sessions will not require as much support. Colorado regulations require 1

¹ We suggest that the list of factors that should be considered by providers when determining the amount of support needed during administration include: 1) the amount of psilocybin being consumed by the patient; 2) the trauma history of the patients; 3) the types of activities the group intends to engage in; 4) the group and its members' prior experience with psilocybin, other psychedelics, or other non-ordinary states of consciousness; 5) the relevant experience and skill of the providers who are administering or supporting the session; 6) the provider familiarity with the clients participating in the session; 7) any physical or behavioral health condition of any patient that increases the likelihood of requiring support during the session; 8) the patients' relevant experience or training in psychedelic peer-support; and 9) any other risk or safety factors that the provider(s) knew or should have known about.

² OAR 333-333-5230.

facilitator to every 8 clients if all clients take 2 mg or less; and 1 facilitator to every 4 clients if any client takes more than 2 mg.³

In short, requiring two providers for individual administration sessions, and establishing minimum provider-to-client ratios for group administration sessions would raise paywalls and make it more difficult for patients to access psilocybin. This exclusionary impact would be most acutely felt on low-income New Mexicans who could otherwise benefit from medical psilocybin but for the unduly high price tag. We encourage DOH to drop the 2-provider requirement for individual sessions, and allow providers to make individualized assessments of group session participants, rather than impose arbitrary minimum ratios.

Certifying Clinician Role

The certifying clinician role design will unreasonably limit patient access. The design requires every patient to see a specifically-permitted DOH provider, who must also hold a New Mexico Controlled Substance Number (and therefore must be a prescribing physician). The encounter must be in person, with few limited exceptions for telehealth. An in-person prescribing physician exam is not an accessible design, especially in a state with a very large rural population and a long-standing provider shortage. Though prescribing physicians should be welcomed into the licensure of the program, to limit access to people who are treated in-person by this small pool of providers is to unnecessarily limit access. We are also concerned that this will create a service gap that will act as an incentive for profit-motivated license holders to dominate the space and charge unreasonable rates (this has been well-documented in the medical cannabis space that similarly limited access to prescribers).

In 2020, the New Mexico state population was 2,120,220, and there were 12,020 DEA-registered prescribers and 351 DEA-registered dispensers. [Current records](#) indicate that there are 29,115 registered members with the Board of Pharmacy in New Mexico, of which less than half have a NM controlled substance number and are registered DEA prescribers. This is a narrow pool of potential persons that could serve as certifying clinicians under the current proposed regulatory requirement of 7.35.3.9(D)(2) requiring certifying clinicians to have a NM controlled substance number.

Requiring a NM controlled substance number effectively filters out many prospective certifiers through a pre-selective regulatory barrier. The regulation narrows the pool of potential certifying clinicians to a small group of risk-tolerant prescribers. Requiring clinicians to have a NM controlled substance number will likely create a small and limited cohort of specialized, independent, and/or advocacy-drive clinicians who must

³ 4 CO Code Regs 755-1 § 617(G).

navigate frictions between the state and federal levels. The frictions between state and federal law creates risk for holders of federal DEA registrations that in many cases are prerequisites for practice in the state among that already limited pool of persons with a NM controlled substance number. This friction may invite more risk-tolerant parties into practice, having an inverse effect upon the statute's intention of risk mitigation. Ultimately, by mandating an NM CS number, the state effectively excludes more accessible low-risk healthcare pathways and funnels the state's medical psilocybin gatekeeping into a highly restricted, self-selective, exclusive subset of risk-tolerant clinicians. Such clinicians may be more prone to acting outside of traditional risk adverse healthcare settings, and their limited number may exacerbate issues of access in an already medical resource scarce environment.

If access along with risk mitigation are motivating factors for the state, then broadening the doorway for certifying clinicians should be a priority. However, requiring a NM controlled substance number prematurely shuts the door for most, effectively having an adverse impact on the state's intended risk mitigation and proposed scale of access. The narrow threshold that a NM controlled substance number requirement creates could actually promote a small number of highly-risk tolerant certifying clinicians operating outside of traditional risk adverse healthcare settings. A small number of highly risk tolerant certifying clinicians operating outside of traditional risk adverse healthcare settings would be considerably less accessible for the New Mexico public in need. This might also create more risk exposure for parties already suffering from complex mental health problems deemed treatable under the statute.

By limiting the number of certifying clinicians through a NM controlled substance number requirement the State's proposed regulation creates scarcity driven incentives by an inverse risk tolerance among proposed certifying providers that contradicts the regulation's intended goal of promoting risk mitigation and access for New Mexico's population in need. Removing a NM controlled substance number will allow for a broader subset of certifying clinicians that would bring into play more traditional risk-adverse healthcare settings that would promote the state's regulatory goal or risk mitigation through wider reaching treatment in more accessible lower-risk healthcare settings.

Patient Application Process

NMAC 7.35.3.8 would require a certifying clinician to submit an application to DOH for prior approval to treat a patient. NMAC 7.35.3.25 would allow DOH to deny or suspend patient eligibility, although there is no reference in the rules to the criteria by which DOH would assess the application.

Without knowing the criteria by which DOH would evaluate patient eligibility, we cannot comment as to the appropriateness of its role in determining patient eligibility on an individual patient basis. However, we generally do not believe that it should be DOH's role or responsibility to make individual eligibility decisions. If DOH does not trust certifying clinicians to make appropriate decisions, DOH should create training or other requirements in order to ensure that those decisions are made correctly. We are concerned that redundancies in determining eligibility will unnecessarily add layers of review, delay care, add arbitrariness into decision-making, and/or increase the costs of administering the program.

"Other Approved Location" Provisions

We applaud the Department for explicitly identifying the needs of patients with disabilities, patients in rural communities, and others in the design of the "other approved locations" provisions. The provision reads, "Such locations may be certified if a qualified patient is unable to be physically transported to a healing center, for other reasons of medical necessity, for purposes of improving patient access in rural and frontier counties, or to enable treatment to occur in a natural environment setting." NMAC 7.35.3.11(B). Because the provision is written as a list of reasons, anything not included would be presumed to be excluded. We recommend either adding a catch all provision (e.g. "or any other reason the Department justifies approval") or to fully anticipate and enumerate reasons for other approved locations that may otherwise be excluded (for example, affordability).

The landlord permission requirement in draft regulations for "other approved locations" should include an explicit exemption for patients seeking care in their own home. The Medical Psilocybin Act makes the medical use of psilocybin legal under state law, and ongoing federal illegality does not justify the landlord permission requirement. Landlords, even those who are supportive of their tenants and of the Program, are unlikely to provide written approval to engage in conduct that remains federally illegal on their premises. Such an attestation would amount to written proof in a legally binding document of aiding and abetting the possession and/or distribution of a Schedule I substance, exposing even the most well-intentioned and supportive landlord to civil and criminal liability. The requirement also creates an opening for exploitation. Landlords who understand that a written approval is a regulatory prerequisite may use that leverage to extract unfair terms or higher rent from tenants lawfully seeking care in their home.

There is also concern that requiring landlord approval for in-home administration would violate patient privacy, HIPAA, and/or state and federal fair housing and civil rights laws, which greatly limit landlords' authority to even inquire into their tenants' disabilities or their medical decision-making. The Medical Psilocybin Act regulations should not

prioritize the property rights of landlords above patient privacy interests and protection against discrimination.

Safety, Liability, and Risk Management Considerations

Clarifying Discussion of Risk Requirements

Regarding patient enrollment and application, the requirements of NMAC 7.35.3.8(A)(7)(c) and (B)(8)(b) that clinicians and patients “discuss the risks of and benefits of medical psilocybin usage” is extremely vague and likely to be interpreted differently by different clinicians. In order to help providers with clarity, we recommend the NM DOH create a non-exhaustive list of particular risks that must be disclosed in order to obtain a patient’s informed consent. One example to look to for guidance is Oregon’s [OAR 333-333-5040](#). Additionally, we recommend the NM DOH standardize the disclosures and their conversations to aid in the uniform administration of medical psilocybin and subsequent data collection regarding program outcomes. NM DOH can look to Oregon for an example of where this has been done well. (see, e.g., Oregon’s [OAR 333-333-5050](#) and its [Client Information Form](#))

Differentiating Between Challenging Experiences and Medical Emergencies in Didactic Training

In 2017, Baylee Ybarra Gatlin died at a festival after psychedelic harm-reduction providers failed to identify that she was experiencing a medical emergency and not merely a “bad trip.” Ultimately, a jury found that the medical screener and the harm-reduction training provider were liable for her death.

While it is unclear whether Ms. Gatlin’s death involved psilocybin, this tragedy highlights the importance of training to identify the rare medical emergency that can arise within the provision of psychedelic care. The required education for certifying clinicians, practitioners, and facilitators should require specific training on differentiating between difficult experiences, or “bad trips,” and medical emergencies.

Other Recommendations

Evaluation of Training Programs

Proposed NMAC 7.35.3.12(A)(19) requires training programs to obtain a “third-party evaluation report that is conducted by a qualified third-party evaluation team.” Third-party evaluators are described in draft NMAC 7.35.3.16 and must be a team of at least three individuals, who, when added together, have expertise in psilocybin therapy, medical and research, and educational curriculum.

Allowing training programs to assemble their own panels of experts to approve of their curriculum is problematic in terms of both the rigor and the integrity of the review. Additionally, it is unclear whether and how DOH rules intersect with NM Higher Education Department regulations. To the extent that compliance with HED regulations is contemplated under DOH rules, DOH should cross-reference HED rules for which compliance is necessary to provide clarity for training programs.

Due Process and Burdens of Proof

When challenging either an adverse determination concerning patient eligibility or a disciplinary action against a certificant, Proposed NMAC 7.35.3.27(L) would put the burden of proof on the appellant to show that the action made or proposed by DOH should be reversed or modified. Such a rule, particularly as applied to certificants, would likely expose DOH to legal challenges and civil liability.

Certificants will have a property interest in their certificate pursuant to Fourteenth Amendment jurisprudence, and that property interest cannot be taken without due process. The burden of proof must be on DOH to remove professional privileges, not on the certificant in order to maintain them. While the State may be able to provide a temporary pause on certificants' activity upon a finding of a public health or safety risk, the restraint must be temporary and the certificant must be offered a post-suspension hearing in which the state bears the burden of proof. See, e.g., *Barry v. Barchi*, 443 U.S. 55 (1979).

Misrepresenting Native American Traditional Use of Psilocybin in New Mexico.

Draft NMAC 7.35.3.18(A)(3) would require training "on the social, cultural and historical aspects of psilocybin use, including traditional use by Native American and other populations in New Mexico[.]" This rule suggests that Native peoples indigenous to NM have traditionally used psilocybin, but we are unaware of any evidence of such use in the state. While we applaud the effort and uplifting the Indigenous origins of psilocybin and other natural psychedelics, it can be harmful and offensive to misrepresent the traditional practices of Native peoples. We recommend changing the rule to require education about other traditional use of other psychedelics by Native peoples who have traditionally inhabited New Mexico, including peyote, and traditional use of psilocybin-containing mushrooms in present-day Mexico.

[Signature page follows.]

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Respectfully Submitted,



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