

From: [Dr. Scott Shannon](#)
To: [Clark, Jacob, DOH](#)
Subject: [EXTERNAL] Psilocybin program.
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Dear Mr. Clark,

I am writing regarding the proposed rules for New Mexico's Medical Psilocybin Program. I am a psychiatrist and psychedelic researcher in Colorado, where our clinic has extensive experience with ketamine-assisted therapy and regulated psilocybin services. I have authored many publications in this arena and frequently speak to professional audiences on these exact topics.

I strongly support New Mexico's effort to create a medically responsible psilocybin program. I am concerned, however, that two proposed requirements may add substantial cost and delay without meaningfully improving patient safety.

First, requiring every patient to obtain an in-person certification from a clinician with a New Mexico controlled-substance registration appears unnecessarily restrictive. The Medical Psilocybin Act defines a qualified patient in relation to a clinician's judgment that the person is medically appropriate based on a qualifying diagnosis, and the statute itself does not appear to make prescriptive authority the central clinical safeguard. The data coming out of Oregon's model demonstrates an inordinately low adverse event rate without any restrictions of this kind. From a medical/psychiatric viewpoint the additional certification is simply not needed. This added layer will of course add cost to the system and reduce access.

For psilocybin, the more important safety assessment occurs during preparation and immediately before administration. That assessment needs to consider current medications, cardiovascular status, psychiatric history, changes in health, and other risk factors that may affect whether treatment should proceed. The practitioner who prepares the patient and will be present for treatment is often in the best position to make that assessment.

A more proportionate model would allow an appropriately licensed practitioner to document the qualifying diagnosis and require consultation or medical clearance from a physician or other prescriber when defined risk factors are present—for example, significant cardiovascular disease, uncontrolled hypertension, complex medication interactions, or a history suggesting elevated psychiatric risk. This concentrates medical resources where they actually improve safety rather than requiring an additional evaluation for every patient.

Second, I would reconsider requiring a separate Department of Health approval before treatment can begin. If a qualified clinician has already determined that the patient meets the statutory requirements, an additional administrative review by individuals who have not examined the patient adds little clinical information. A potential delay of several weeks can be particularly consequential for patients with treatment-resistant depression or those receiving end-of-life care. This will needlessly restrict volume and access to care. Our experience in Colorado and those in Oregon highlight the viability of a clinical program without this

restriction and volumes have been much lower than anticipated in both programs, amplifying the concern over access.

A notification or registration model would accomplish the Department's legitimate oversight and data-collection goals without making DOH approval another clinical gate. The Department could retain strong authority to establish standards, audit records, monitor outcomes, investigate adverse events, and enforce compliance.

These distinctions are particularly important because psilocybin under this program is administered in an approved, supervised setting. The risk-management problem is therefore quite different from medical cannabis or another medication that patients take home and use independently.

Good regulation should increase safety while keeping unnecessary barriers as low as possible. In my experience, safety in psychedelic medicine is best achieved through careful preparation, appropriate screening, skilled supervision, clear escalation criteria, and thoughtful follow-up—not by adding duplicative administrative checkpoints.

I encourage the Department to reconsider these two provisions before finalizing the rules.

Thank you for considering these comments.

Sincerely,

Scott Shannon, MD
Psychiatrist and Psychedelic Researcher
Colorado

Scott Shannon, MD
scott.shannon@wholeness.com