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The Fireside Database: Large-scale evidence from 25,419 psychedelic support interactions

Felix Schoeller[1,2]*, Marc Santolini[1,3,4], Dana Xiadani[1], Mickael Eskinazi[5,6], Ashwin Murali[1], David Esselman[1], Wyatt Houtz[1,7], Wesley Bellanca[1], Joshua White[1]

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Most psychedelic experiences occur outside clinical settings, yet as policy frameworks rapidly expand to accommodate nonclinical use, no systematic data exist on who seeks psychedelic support, under what circumstances, or what makes that support effective. We present the Fireside Database, a US-based dataset comprising 25,419 peer support interactions conducted by 220 trained volunteers at Fireside Project's Psychedelic Support Line between April 2021 and February 2026. The released resource integrates structured interaction logs with volunteer-coded metadata and 2777 caller satisfaction surveys across five outcome dimensions. Psilocybin was the most commonly reported substance (59.9% of coded interactions), while cannabis produced the highest distress rate (47.2%). The nested data structure—with 50 supporters each completing ≥10 surveyed interactions—supports multilevel modeling of individual supporter effects on caller outcomes. This resource enables research in psychedelic epidemiology, evidence-based training design, and the investigation of what makes psychedelic psychological support effective.

INTRODUCTION

The resurgence of psychedelic research has been accompanied by a parallel expansion of community-based support infrastructure that remains largely understudied. While clinical trials of psilocybin, MDMA (3,4-methylenedioxymethamphetamine), and other psychedelic compounds have generated growing evidence for therapeutic efficacy under controlled conditions (*1*–*5*), the vast majority of psychedelic experiences occurs outside clinical settings—in homes, at festivals, during ceremonies, and in moments of unexpected crisis (*6*–*8*). When distress arises in these naturalistic contexts, the support that people receive comes not from clinicians operating under standardized protocols but from peers: trained volunteers, trip sitters, and community members. Despite serving a far larger population than clinical trials, these community-based services have generated almost no empirical data. The field lacks even basic descriptive information about who seeks psychedelic support, under what circumstances, and what predicts satisfactory outcomes.

This gap is consequential for at least two reasons. First, the psychedelic therapy field currently trains practitioners according to theoretical models of technique—specific verbal and nonverbal interventions presumed to produce therapeutic effects (*9*, *10*). However, the broader psychotherapy literature has consistently demonstrated that individual therapist differences account for substantially more outcome variance than specific techniques (*11*–*13*), raising the question of whether the same pattern holds in psychedelic support. Second, drug policy is shifting rapidly in the US. Oregon's Measure 109 and Colorado's Natural Medicine Health Act have created regulated frameworks for psychedelic use, while New Mexico and New Jersey have enacted laws permitting limited medical or therapeutic access, and multiple US jurisdictions have decriminalized possession (*14*, *15*). Policymakers designing these frameworks need epidemiological data about the kinds of support people actually seek and the circumstances under which distress occurs. This creates an urgent need for evidence-based training and quality assurance frameworks (*16*, *17*).

The existing evidence base for psychedelic support practices is remarkably thin. Published reports from festival-based harm reduction services such as Fireside Project (*16*, *18*) and the Zendo Project (*17*) have provided valuable descriptive snapshots, but these operate in event-specific contexts with limited follow-up, no standardized outcome measurement, and no longitudinal tracking of individual provider performance. Clinical trial data, while methodologically rigorous, reflect highly selected populations, manualized interventions, and professional therapists operating under conditions that bear little resemblance to the contexts in which most psychedelic experiences occur (*1*–*3*). Between these two poles—festival snapshots and clinical trials—lies a vast and empirically vacant middle ground: the ongoing, day-to-day provision of psychedelic support through dedicated helplines and community services. It is precisely this middle ground that generates the most directly policy-relevant data because it captures the full spectrum of psychedelic experiences that people actually have and the support they actually seek.

Here, we present the Fireside Database, a research resource derived from the operations of Fireside Project, a US-based psychedelic peer support line that has operated continuously since April 2021. Fireside Project provides free, confidential support via phone and text message to anyone in the midst of a psychedelic experience or seeking integration support, staffed from 11:00 a.m. to 11:00 p.m. Pacific Time by trained volunteer supporters. The released database comprises structured interaction logs for 25,419 peer support interactions conducted by 220 trained volunteers, linked to 2777 postinteraction caller satisfaction surveys. To our knowledge, this represents the largest dataset of psychedelic support interactions ever assembled—exceeding the combined sample sizes of all published psychedelic clinical trials by an order of magnitude (*19*).

We describe the database in detail, present descriptive analyses that characterize the epidemiological landscape of community-based psychedelic support seeking, and demonstrate the database's utility for investigating individual supporter effects on caller outcomes. We conclude that by outlining the research programs, this resource is

[1]Fireside Project, Venice, CA, USA. [2]Institute for Advanced Consciousness Studies, Santa Monica, CA, USA. [3]Sorbonne Université CNRS, ERL U1338 Inserm, Paris, France. [4]Learning Transitions, Learning Planet Institute and CY Cergy Paris University, Paris, France. [5]Division of Adult Psychiatry, Department of Psychiatry, University Hospitals of Geneva, Thônex, Switzerland. [6]Faculty of Medicine, University of Geneva, Geneva, Switzerland. [7]Vision Point Systems Inc., Arlington, VA, USA.
*Corresponding author. Email: felix@advancedconsciousness.org

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designed to enable, spanning psychedelic epidemiology, public health policy, and evidence-based training design. The overarching aim is to establish this resource as a foundation for a new empirical science of psychedelic support—one grounded in the realities of naturalistic use rather than the controlled conditions of clinical research.

RESULTS

Database architecture and scope

The Fireside Database (Fig. 1) contains 25,419 interactions recorded between April 2021 and February 2026 (57 months of continuous operation). Interactions were conducted by 220 trained volunteer supporters. Each interaction record contains structured metadata including date, time, modality (voice or text), duration, call direction (97.5% incoming), call type classification, and the identity of the responding supporter (Fig. 2). The released resource comprises two linked data layers: (i) structured interaction logs with volunteer-coded metadata for 25,419 cleaned interactions and (ii) postinteraction caller satisfaction surveys (n = 2777; 10.9% response rate) measuring five outcome dimensions.

Epidemiological landscape of psychedelic support seeking

Volunteer supporters classified each interaction by type (section S3). The most common classifications were active psychedelic support ("client tripping"; n = 10,208; 40.2%), psychedelic integration support (n = 8155; 32.1%), and informational inquiries (n = 2687; 10.6%). A total of 2953 interactions (11.6%) were classified as "beyond scope," indicating among others medical emergencies (911 or 988 redirection), calls about substances outside the line's coverage, requests for preparation help, requests to buy drugs, or similar concerns outside the line's defined capabilities. Notably, 43 interactions (0.2%) were classified as reports of facilitator abuse, providing a quantitative estimate of this phenomenon in a community sample. An additional 432 interactions (1.7%) were classified as trip-sitting support (assisting someone supporting a person using psychedelics), and 223 (0.9%) were classified as sitter support, reflecting the layered ecology of psychedelic care in community settings.

Substance information was recorded for 15,596 interactions (61.4% of the cleaned database), with up to three substances coded per interaction (section S3). Psilocybin was the most commonly reported substance (n = 9348; 59.9% of substance-coded interactions), followed by lysergic acid diethylamide (LSD) (n = 2247; 14.4%), cannabis (n = 2004; 12.8%), ketamine (n = 1194; 7.7%), and MDMA (n = 682; 4.4%). The remaining interactions involved ayahuasca (n = 502; 3.2%), 5-MeO-DMT (n = 165; 1.1%), NN-DMT (n = 181; 1.2%), and a range of other substances including 2C-B (n = 48), *Amanita muscaria* (n = 53), San Pedro (n = 70), and iboga/ibogaine (n = 45).

Among major substances, pooled distress rates ranged from 40.7% (MDMA) to 47.2% (cannabis), with psilocybin at 42.2%, LSD at 41.8%, and ketamine at 40.9% (table S1). However, these pooled rates are confounded by substantial differences in call type composition across substances: Cannabis callers were predominantly in active-trip interactions (70.2%) with a minority seeking integration support (24.7%), whereas MDMA (28.2% active/66.3% integration) and ketamine (36.3%/59.0%) callers were predominantly in integration. Because active-trip interactions carry higher baseline distress than integration interactions, pooled rates reflect call type mix as much as substance effects. Stratifying by call type (Fig. 3A) shows that within active-trip interactions, distress rates ranged narrowly from 45.8% (psilocybin) to 49.6% (cannabis) and within integration interactions from 32.3% (LSD) to 38.8% (MDMA); no pairwise differences were significant within either stratum [two-proportion z-tests with Benjamini-Hochberg false discovery rate (FDR) correction, all P_FDR > 0.21). Once call type composition is accounted for, distress rates are broadly comparable across substances, consistent

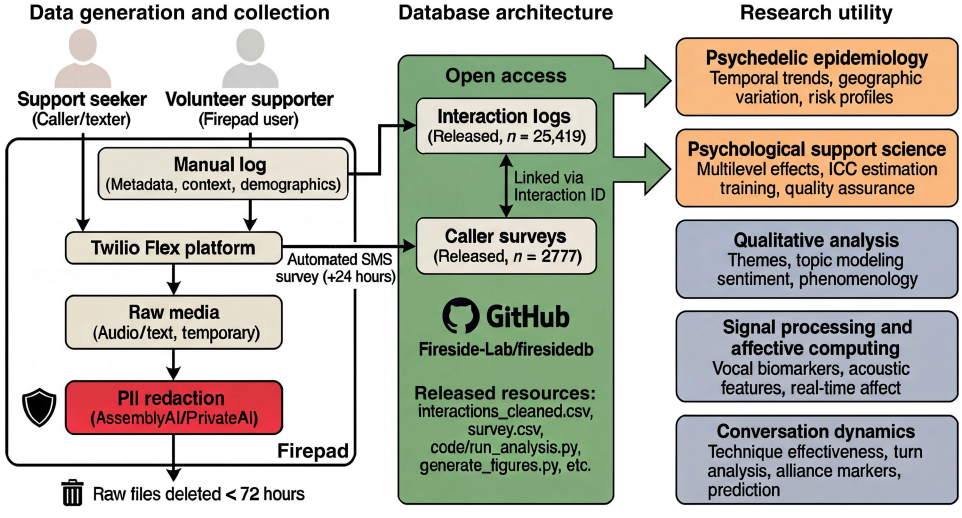


Fig. 1. Architecture of the Fireside Database. Left (data generation and collection): Each interaction is logged by the responding supporter in Firepad, Fireside Project's Twilio Flex–based platform. Raw audio and text are stripped of personally identifiable information (AssemblyAI and PrivateAI) and deleted within 72 hours, so no raw media enter the released resource. Middle (database architecture): The open-access release comprises two linked data layers, interaction logs (n = 25,419 interactions by 220 supporters, April 2021 to February 2026), and caller satisfaction surveys (n = 2777; 10.9% response rate), joined by a shared interaction identifier in a nested structure (interactions within supporters). The survey measures five outcome scales: supported, quality, met needs, call again, and recommend (item wording and response options in table S1). Right (research utility): Five research pathways the resource is designed to enable. Psychedelic epidemiology, psychological support science, and qualitative analysis draw directly on the two released layers; signal processing/affective computing and conversation dynamics additionally require the anonymized recordings and transcripts described in Materials and Methods (section S5).

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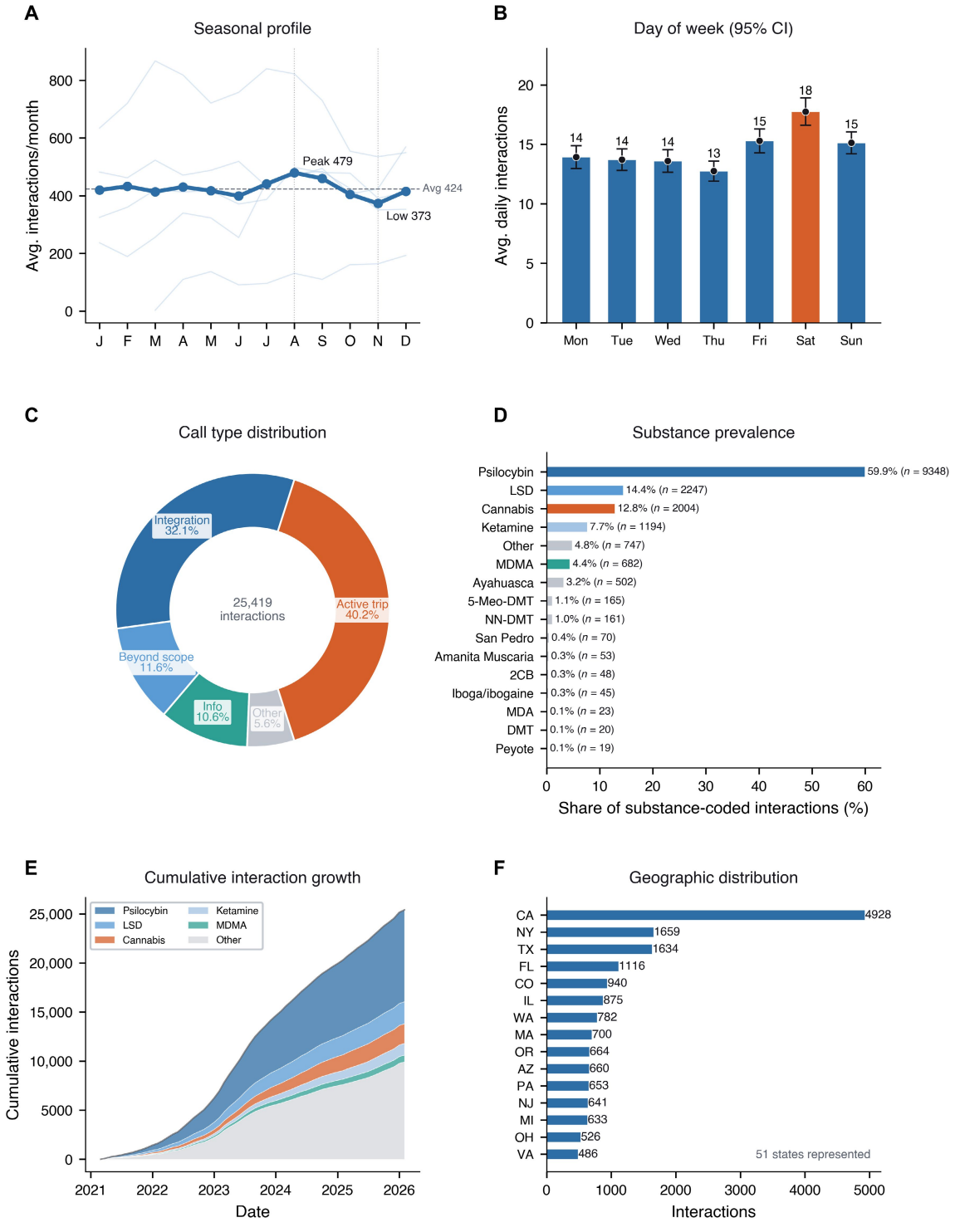


Fig. 2. Epidemiological overview of Fireside Project interactions. (**A**) Monthly interaction volume averaged across years (2021–2026), showing a seasonal peak in August (mean = 479) and trough in November (mean = 373), with individual-year traces in light blue. (**B**) Average daily interaction volume by day of week; Saturday (mean = 18/day) is highlighted as the peak day. CI, confidence interval. (**C**) Distribution of interaction types: active trip support (40.2%), integration (32.1%), beyond scope (11.6%), informational (10.6%), and other (5.6%). (**D**) Substance prevalence among 15,596 substance-coded interactions. Psilocybin accounts for 59.9% of interactions, followed by LSD (14.4%), cannabis (12.8%), ketamine (7.7%), and MDMA (4.4%); 15 substance categories are represented. (**E**) Cumulative interaction growth from April 2021 through February 2026 (solid line), with cumulative trajectories for psilocybin, cannabis, LSD, and ketamine shown as dashed lines. (**F**) Geographic distribution of survey respondents across the top 15 US states (of 52 states and territories represented). California accounts for the largest share ($n = 335$), followed by New York ($n = 131$) and Texas ($n = 121$).

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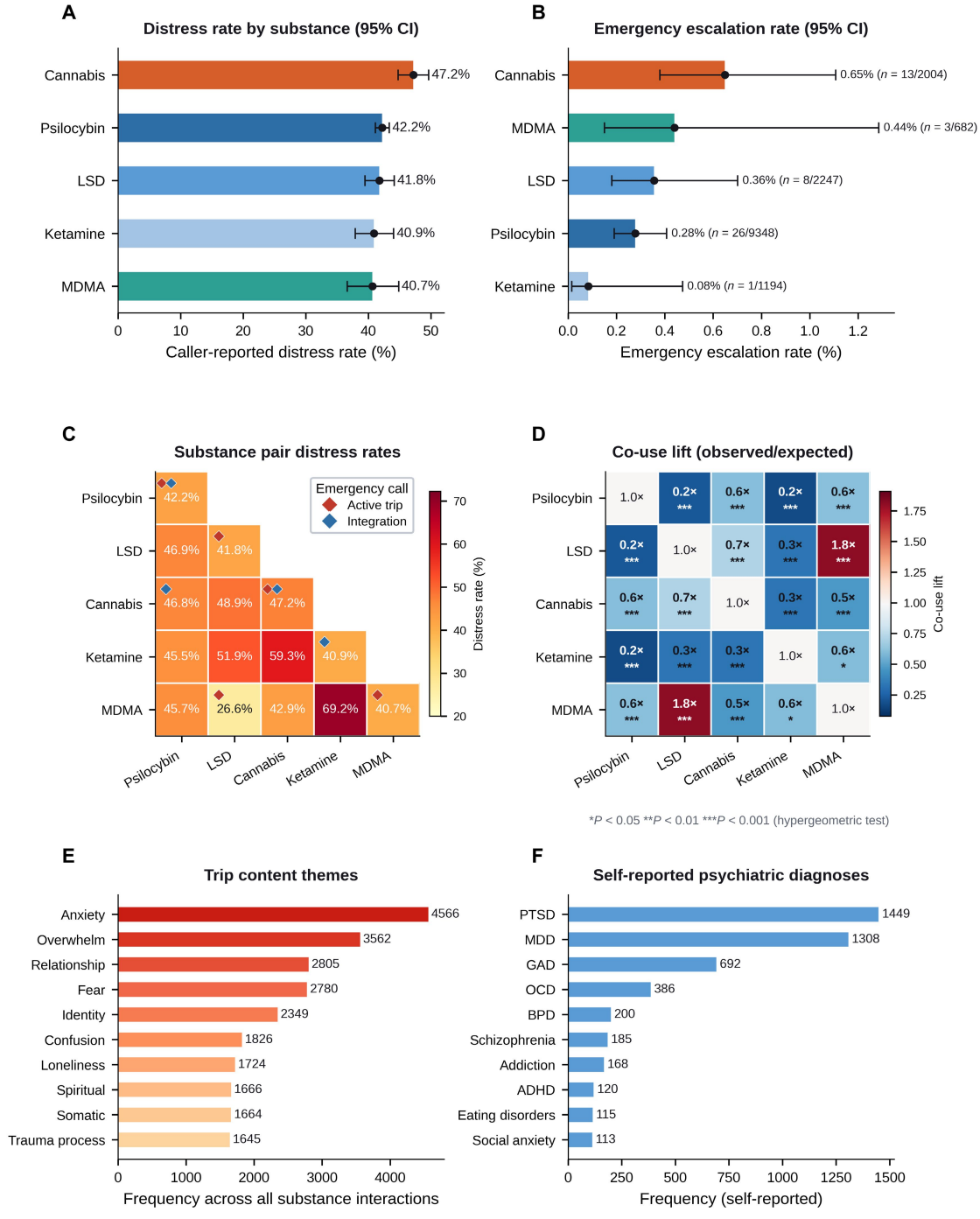


Fig. 3. Distress and safety signals across substances. (**A**) Caller-reported distress rates by substance and call type (active trip versus integration), with 95% Wilson score confidence intervals. Distress rates are higher during active-trip than integration interactions (~47% versus ~36%); within each call type, no pairwise differences across substances were significant (two-proportion *z*-tests with Benjamini-Hochberg FDR correction, all P_FDR > 0.21). The elevated pooled cannabis rate in earlier analyses reflected a higher proportion of cannabis callers contacting the line mid-experience (70.2%) rather than substance-specific risk. (**B**) Emergency service escalation rates (911 of 988 calls) by substance with 95% Wilson score confidence intervals: cannabis (0.65%, $n = 13$ of 2004), MDMA (0.44%, $n = 3$ of 682), LSD (0.36%, $n = 8$ of 2247), psilocybin (0.28%, $n = 26$ of 9348), and ketamine (0.08%, $n = 1$ of 1194). (**C**) Distress rate heatmap for single substances (diagonal) and co-use pairs (lower triangle; pairs with $n \geq 5$ and ≥ 5 distress-known observations). Diamonds indicate pairs with at least one emergency escalation, colored by call type: red, active trip; blue, integration; gray, other. (**D**) Co-use lift matrix comparing observed to expected co-use frequency under independence. Values of >1.0 indicate substances used together more often than chance; MDMA + LSD shows the strongest association (1.8×). Significance assessed via two-sided hypergeometric test (*$P < 0.05$ and ***$P < 0.001$); nonsignificant cells are visually muted. (**E**) Trip content themes across all interactions. Anxiety ($n = 4566$) and overwhelm ($n = 3562$) are most frequent, followed by interpersonal concerns, fear, and transpersonal/identity experiences. (**F**) Self-reported psychiatric diagnoses among callers. PTSD ($n = 1449$) and major depression (MDD; $n = 1308$) are most prevalent, followed by generalized anxiety disorder (GAD), obsessive compulsive disorder (OCD), and borderline personality disorder (BPD).

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with the interpretation that the need for support during or after psychoactive substance use is not concentrated in any single compound.

Interaction volume showed consistent operational patterns across the 57-month observation period (30 April 2021 to 10 February 2026). Monthly counts (table S4) ranged from 3 to 867 interactions (or 91 to 867 when excluding partial first/last months). Both voice and text were used [17,155 calls (67.5%) and 8264 texts (32.5%)], with modality varying by call type: client tripping, 65.5% call/34.5% text; integration, 72.8%/27.2%; and info, 52.8%/47.2%. Duration data were available for all interactions (section S9), with substantial heterogeneity (median, 6.1 min; mean, 28.8 min; SD, 82.8 min), consistent with diverse presenting needs.

Demographics of callers and supporters

Caller demographics were available from two sources: (i) volunteer-entered interaction metadata and (ii) postinteraction survey self-report. In interaction metadata, age was available for 3880/25,419 interactions (15.3%) and recorded in categorical bands (18 to 22, 23 to 30, 31 to 40, 41 to 50, 51 to 60, 61 to 70, and 71). Gender and race/ethnicity were recorded in interaction metadata for 2276 and 842 interactions, respectively. In the linked survey subsample ($n = 2777$), gender was classifiable for 2022 respondents: 46.8% male, 39.4% female, and 13.8% nonbinary/other. Race/ethnicity was classifiable for 1985 respondents: 68.4% white, 6.0% Asian, 5.8% Hispanic/Latino, 2.9% Black/African American, and 16.8% other/multiracial categories. State was inferred from area code–linked records for 23,913 interactions, spanning 50 US states plus Washington, DC; the largest shares were California (CA; 20.6%), New York (NY; 6.9%), Texas (TX; 6.8%), and Colorado (CO; 3.9%). The supporter workforce comprised 220 unique supporters over the 57-month observation window, with supporter interaction counts ranging from 1 to 641.

Self-reported psychiatric diagnoses were recorded in 7826 interactions (30.8% of the database). Among these, 4732 (60.5%) reported at least one diagnosis. The most prevalent were posttraumatic stress disorder (PTSD) ($n = 1449$; 18.5%), major depression ($n = 1308$; 16.7%), generalized anxiety disorder ($n = 692$; 8.8%), obsessive compulsive disorder ($n = 386$; 4.9%), borderline personality disorder ($n = 200$; 2.6%), schizophrenia ($n = 185$; 2.4%), substance use disorders ($n = 168$; 2.1%), attention-deficit/hyperactivity disorder ($n = 120$; 1.5%), eating disorders ($n = 115$; 1.5%), and social anxiety disorder ($n = 113$; 1.4%). The high prevalence of PTSD and depression is consistent with emerging evidence that individuals with trauma histories and mood disorders disproportionately seek psychedelic experiences (*20*–*22*). Notably, 185 interactions (2.4%) involved callers reporting a schizophrenia diagnosis, a population typically excluded from psychedelic clinical trials.

Among interactions with known social context ($n = 6998$), 66.3% of callers were alone, 26.4% were with one or a few close others, 2.7% were in a ceremonial group, and 2.3% were in a large group. Among active-trip interactions with known trip phase ($n = 6388$), 43.9% were postpeak, 33.3% were peak, and 22.8% were onset. Of those with known first-time status ($n = 11,888$), 9.8% reported that it was their first time trying psychedelics.

Facilitator abuse reports

A total of 43 interactions (0.2%) were classified as reports of facilitator abuse. Substance data were available for 27 of these interactions: Ayahuasca and psilocybin were each involved in seven cases, followed by ketamine (five), MDMA (three), cannabis (three), and 5-MeO-DMT (two). Ceremonial and plant medicine substances (ayahuasca, 5-MeO-DMT, San Pedro, and iboga/ibogaine) together accounted for 11 of 27 substance-coded cases (40.7%), a roughly tenfold overrepresentation relative to their 4.4% share of the overall database. Social context data ($n = 17$) reinforced this pattern: Seven callers (41.2%) reported being in a ceremonial gathering, compared with 2.7% in the full database. Of the six interactions with trip phase data, five were postpeak, suggesting that most callers contacted the line after the acute experience rather than during it. Presenting concerns ($n = 15$) were dominated by trauma processing (10 cases, 66.7%), far exceeding the base rate of ~6.5% across all interactions, followed by fear (seven), anxiety (six), confusion (six), and overwhelm (six). Among the 23 cases with diagnosis data, 8 (34.8%) reported PTSD, nearly double the 18.5% base rate in the broader database. No emergency escalations (911 of 988) were triggered by facilitator abuse interactions.

Caller satisfaction and outcome measurement

Postinteraction satisfaction surveys were completed by 2777 callers (10.9% of all interactions). Surveys assessed five outcome dimensions. Across all five, ratings were strongly positively skewed: 76.1% of respondents strongly agreed that they felt supported, 78.2% rated support quality as excellent, 66.8% reported that almost all needs met, 86.6% said that they would definitely call again, and 86.1% strongly agreed that they would recommend the service.

Outcome distributions were strongly positive overall but not uniformly so. In the current survey extract ($n = 2777$), 91 respondents (3.2%) disagreed or strongly disagreed that they felt supported, 61 (2.1%) rated support quality as poor, and 69 (2.4%) reported that none of their needs were met. Qualitative explanations from this lower tail suggest heterogeneous mechanisms rather than a single interpretation: Among codable poor-quality narratives ($n = 30$), the most frequent themes were impersonal or judgmental interaction tone (40.0%), perceived lack of helpfulness/fit (26.7%), and access-process breakdowns such as silence, delayed responses, or call interruption (23.3%); explicit expectation-scope mismatch (e.g., requests outside psychedelic crisis/integration support) was present but less frequent (10.0%).

Data structure for investigating supporter effects

A central analytic affordance of the Fireside Database is its capacity to support investigation of individual supporter effects—the extent to which systematic differences among supporters predict caller outcomes, independent of caller characteristics and interaction context. The database's natural nested structure (interactions within supporters) directly parallels the therapist effects literature in psychotherapy research, where intraclass correlation coefficients (ICCs) from multilevel models have consistently estimated that 5 to 10% of outcome variance is attributable to individual therapist differences (*11*–*13*).

The survey subsample provides well-powered data for future multilevel analyses. Of the 118 supporters who completed at least one surveyed interaction, 50 completed 10 or more, 25 completed 5 to 9, and 18 completed 3 to 4. This depth of nesting is comparable to or exceeds that of published therapist effects studies (*11*, *23*). Simulation studies have shown that reliable ICC estimation requires at least 30 providers with 10 or more clients each (*24*); the Fireside Database exceeds this threshold. Formal ICC estimation and multilevel modeling are planned as a primary aim of future work using this resource.

The distribution of survey data across supporters was moderately concentrated (Gini coefficient = 0.46; Fig. 4C), with the top 10% of

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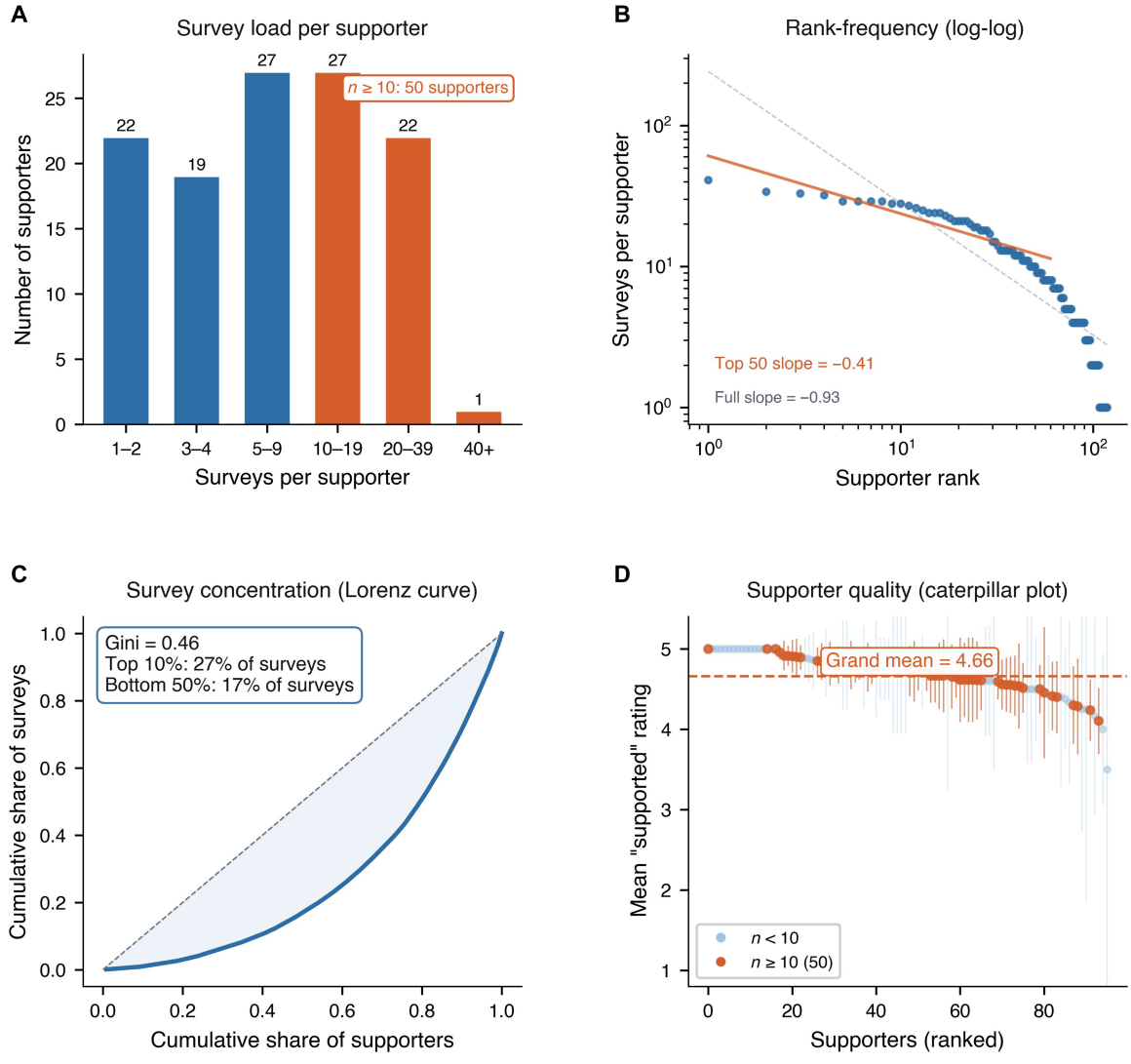


Fig. 4. Psychological support science. (**A**) Distribution of survey load across supporters. Bars indicate the number of supporters in each bin; orange bars highlight 50 supporters with ≥10 surveys, meeting the conventional threshold for multilevel modeling of provider effects. (**B**) Rank-frequency plot (log-log) of surveys per supporter (note: surveys represent ~11% of total interactions). The orange line fits the top 50 supporters (slope = −0.41), capturing the relatively flat linear regime before exponential cutoff at lower ranks; the gray dashed line shows the full-range fit (slope = −0.93, approaching Zipf's law). (**C**) Lorenz curve illustrating concentration of survey data across supporters. The Gini coefficient is 0.46; the top 10% of supporters account for 27% of all surveys, while the bottom 50% account for 17%. (**D**) Caterpillar plot of mean supported ratings by supporter (supporters with ≥3 surveys) with 95% confidence intervals. Orange points denote supporters with ≥10 surveys; the dashed line marks the grand mean (4.66 on a 1 to 5 scale). Variation across supporters is evident, consistent with provider-effect heterogeneity observed in psychotherapy research.

supporters accounting for 27% of all surveys and the bottom 50% accounting for 17%. A Gini coefficient of 0.46 indicates moderate inequality—roughly comparable to income distributions in the US economy—suggesting that survey opportunities are neither equally distributed nor monopolized by a small subset of supporters. The mean "supported" rating across supporters with three or more surveys was 4.66 on a five-point scale (Fig. 4D). The caterpillar plot shows visible variation in mean ratings across supporters, with some supporters consistently above or below the grand mean, a pattern consistent with provider-effect heterogeneity observed in the psychotherapy literature. However, these descriptive patterns do not constitute a formal test of supporter effects and should be interpreted with caution pending multilevel analysis.

DISCUSSION

The Fireside Database provides the first large-scale empirical window into community-based psychedelic peer support. Three sets of findings merit discussion.

An epidemiological portrait of psychedelic support seeking

The descriptive landscape revealed by this database challenges several assumptions that have shaped psychedelic policy and research. Once call type composition is accounted for, distress rates are broadly comparable across the major substances reported in this database, clustering near 47% within active-trip interactions and 36% within integration interactions with no significant pairwise differences within either stratum (Fig. 3A). This pattern suggests that the need for

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psychological support during or after psychoactive substance use extends across substance categories, rather than being uniquely attributable to any single compound. It also highlights that call type—whether someone is reaching out during or after their experience—is a stronger predictor of distress than which substance they took. This finding has immediate implications for crisis support training, which currently focuses almost exclusively on classical psychedelics: These data suggest that training programs should prepare supporters for distress across multiple substance categories.

Cannabis merits particular attention because it occupies a distinct policy position: It is the most widely legalized psychoactive substance in the US yet is largely excluded from both psychedelic harm reduction frameworks and mental health crisis infrastructure. The substantial volume of cannabis-related distress calls ($n = 2004$; 12.8% of coded interactions) indicates that cannabis-related psychological distress is a real and recurring phenomenon in community settings (*25*), regardless of whether the per-interaction distress rate differs reliably from that of other substances.

The higher pooled distress rate for cannabis is largely attributable to cannabis callers contacting the line mid-experience (70.2% active trip) more often than callers reporting other substances; within active-trip interactions alone, cannabis distress rates were not significantly different from other substances. The pooled rate should also be interpreted in light of selection effects inherent in crisis-line data. Cannabis is by far the most prevalent psychoactive substance in the US (*26*), and the Fireside Database selects for individuals in sufficient distress to seek support. The observed distress rate therefore reflects the proportion of help-seekers in distress, not the probability that a typical cannabis user will experience a crisis. Higher population prevalence means that even a low per-user crisis rate would generate a substantial volume of distressed callers.

The 43 reports of facilitator abuse (0.2%), while representing a small fraction of total interactions, provide the first quantitative documentation of this phenomenon in a community help-seeking sample. The pattern of these reports—clustering in ceremonial settings involving plant medicines, presenting primarily as trauma-processing calls, and involving callers with elevated rates of prior PTSD diagnoses—suggests that even modest surveillance through existing peer support infrastructure can detect harm occurring in unregulated psychedelic settings. These findings have implications for service design, safety monitoring, and the development of prevention strategies as psychedelic access expands and warrant dedicated follow-up research examining the nature, context, and consequences of reported abuse.

Supporter effects as a research framework

The descriptive patterns observed in the present data—visible between-supporter variation in mean ratings (Fig. 4D), moderate concentration of survey opportunities (Gini = 0.46), and a sample size exceeding published simulation thresholds for reliable ICC estimation—establish that the Fireside Database is well positioned to support formal investigation of supporter effects. The observed variation across supporters with 10 or more surveys suggests that systematic differences may exist, although the present analyses are descriptive and do not constitute a formal test of this hypothesis. This question has been extensively studied in psychotherapy, where the consistent finding is that therapist effects account for 5 to 10% of outcome variance, a contribution that typically exceeds the variance attributable to specific therapeutic techniques (*11*–*13*, *27*). The so-called "Dodo bird verdict"—that all bona fide therapies produce roughly equivalent outcomes—has directed attention toward common factors, particularly the therapeutic alliance and therapist interpersonal skills, as the primary drivers of effectiveness (*27*, *28*). If similar patterns are confirmed in psychedelic peer support, then the implications for training would be substantial: Rather than focusing primarily on technique repertoires, training programs might prioritize the selection and cultivation of relational capacities that differentiate effective supporters from less effective ones. This is consistent with the broader psychotherapy process literature, which has found that patients' perceptions of the therapeutic relationship are stronger predictors of outcome than technique adherence (*28*).

A resource for convergent science

The released interaction logs and surveys provide a foundation for multiple research programs. Epidemiological analyses can track temporal trends in psychedelic support seeking, model geographic variation, and identify substance-specific risk profiles. Multilevel modeling of supporter effects can estimate ICCs, examine temporal stability and concordance across outcome dimensions, and identify supporter characteristics associated with effectiveness. Natural language processing of the open-ended narrative responses can extract thematic structure from callers' own accounts of what made support effective or ineffective. Longitudinal analysis of supporter performance trajectories can illuminate how supporters develop over time, informing evidence-based approaches to training, supervision, and quality assurance.

Future research directions

The Fireside Database is designed to support at least three distinct research programs. First, formal multilevel modeling of supporter effects—estimating ICCs with appropriate covariates, testing split-half stability, and examining temporal persistence—will establish whether the pattern of significant provider effects observed in psychotherapy generalizes to psychedelic peer support. Second, epidemiological analyses can leverage the interaction logs to characterize temporal trends, geographic distributions, and substance-specific risk profiles with a level of statistical power unavailable in any existing dataset. Third, computational analysis of the qualitative narratives—using topic modeling, sentiment analysis, and natural language processing—can systematically characterize what callers value in support interactions and identify linguistic markers of effective versus ineffective support.

Limitations

Several limitations warrant consideration. The 10.9% survey response rate, while consistent with postcrisis service evaluation norms and comparable to response rates in emergency service satisfaction studies, introduces potential selection bias: Respondents may systematically differ from nonrespondents in ways that affect outcome distributions. It is plausible that callers with either very positive or very negative experiences were more likely to complete surveys, which would inflate the tails of the outcome distributions. However, the strongly positively skewed distributions suggest that, if anything, positive experiences may be overrepresented, which would attenuate rather than inflate estimated supporter effects.

Beyond survey nonresponse, a more fundamental source of selection bias operates at the level of service contact: The database captures individuals who chose to call a support line, not a representative sample of psychedelic or cannabis users. This selection is nonrandom—callers are, by definition, those experiencing sufficient distress, confusion, or need to seek help. As a result, the distress rates reported here reflect distress prevalence among help-seekers, not population-level risk.

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This distinction is particularly important for interpreting substance-specific distress rates. Cannabis, as the most widely used psychoactive substance in the US (*26*), draws from a far larger user population than psilocybin or LSD. A higher volume of cannabis crisis calls could reflect higher population prevalence rather than a higher intrinsic risk profile. Similarly, substance-specific distress rates cannot be compared directly with those from clinical trial populations, where participants are screened, supervised, and supported under controlled conditions. The Fireside Database is best understood as a window into community-level help-seeking behavior rather than as a tool for estimating population-level substance risk.

State of residence in the full interaction set was inferred from telephone area codes. Because mobile numbers are frequently retained across moves, area codes may not reflect a caller's current location, which can misclassify state and bias state-level counts toward regions of historical number assignment. Geographic estimates from the interaction logs should therefore be read as approximate. Self-reported state from the satisfaction survey (*n* reported in section S10) provides a more reliable, although smaller and potentially nonrepresentative, geographic measure; substantive geographic claims should rest on the self-reported data or treat the area code distribution as indicative only.

Researchers using this resource for epidemiological purposes should exercise caution in generalizing findings beyond the help-seeking population it represents. The database reflects the operations of a single organization and may not generalize to other psychedelic support services with different training models, populations, or operational contexts. Substance coding relies on caller self-report and volunteer classification, which may be inaccurate in acute crisis situations where callers may not know what they have consumed or may report inaccurately. Demographic data are incomplete limiting demographic analyses. The observational design precludes causal inference about the relationship between supporter characteristics and outcomes.

Despite these limitations, the Fireside Database represents an unprecedented resource for understanding an increasingly important but empirically neglected domain of psychedelic support practice. No comparable dataset exists in the published literature—in terms of sample size, longitudinal scope, or the integration of interaction metadata with standardized outcome measurement. As psychedelic therapies move toward mainstream adoption and policy frameworks evolve to accommodate nonclinical use, evidence-based approaches to community support must keep pace. The current regulatory moment is critical: Oregon's psilocybin services are operational, Colorado's framework is being implemented, and multiple other states are considering legislation (*14*, *15*). These frameworks will require empirical evidence about how community-based support actually works, who seeks it, and what differentiates effective from ineffective support. This database provides the empirical foundation for that work.

MATERIALS AND METHODS

Setting and data collection

Fireside Project operates a national peer support line providing free, confidential support to individuals in the midst of psychedelic experiences and processing past psychedelic experiences. The service is staffed by trained volunteer supporters (see details about training in section S1) and is accessible via phone call or text message. All interactions are fully anonymous and stored in a secure centralized operational database (Fig. 1). The Fireside Database encompasses all interactions recorded between April 2021 and February 2026. Data collection was part of routine service operations and quality improvement; research use was approved under institutional review board (IRB) exemption (see the "Ethics statement" section).

Informed consent procedure

Before every conversation begins, callers to the Psychedelic Support Line hear an automated notice stating that calls are recorded for training purposes after personal information is removed, with the option to press a key for more detail. Callers who request more detail hear a fuller explanation of how anonymized recordings are used, including to train volunteers and to develop a role-play simulation tool, and may opt out by pressing a designated key, which triggers deletion of their anonymized conversation within 15 days. Because callers may be in the midst of a psychedelic experience when this notice plays, callers are offered a postconversation opportunity to opt out. The day after each conversation, every caller receives a text message explaining how conversations are anonymized and used, with a link allowing them to opt out by checking a box, which likewise results in deletion of their recording. Independent of opt-out status, personally identifiable information is stripped from all recordings immediately after each conversation ends using software designed to distinguish personal identifiers from ordinary speech, and after a short window for caller feedback closes, the caller's phone number is permanently and irreversibly decoupled from the anonymized recording, making it impossible to link any recording to an individual.

Interaction metadata

Each interaction was coded by the responding volunteer supporter using a standardized form capturing: date and time, modality (voice or text), call direction (incoming or outgoing), call type (e.g., client tripping, integration, beyond scope, info, and missed call), substance(s) involved, interaction duration, social context (alone or with others), phase of psychedelic experience (come-up, peak, come-down, next day, and integration), presenting concerns, techniques employed, and caller demographics when voluntarily disclosed (age, gender, and race/ethnicity). See the Supplementary Materials for details (section S3). Supporter identity was recorded for each interaction (anonymized with volunteer IDs in this dataset), enabling analyses of within-supporter performance patterns. Self-reported psychiatric diagnoses were recorded for a subset of interactions ($n = 7826$; 30.8%), providing data on the clinical characteristics of callers.

Handling of facilitator abuse reports

When interactions were classified as reports of facilitator abuse, Fireside Project's protocol directed supporters to resources such as the SHINE Collective, a nonprofit that provides forums for peer support and education to survivors of psychedelic harm. Fireside Project did not independently investigate, verify, or adjudicate the reports, consistent with its role as a peer support service rather than a regulatory or investigative body. These interactions were included in the released database as coded by the responding supporter. No reports were excluded from the dataset. Fireside Project does not collect identifying information about reported facilitators to enable individual-level reporting to authorities; callers were informed of available reporting pathways and supported in their own decision-making regarding further action.

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Caller satisfaction surveys

The day after each interaction, callers were invited by text message to complete a brief satisfaction survey. The survey assessed five domains: (i) "I felt heard, understood, and supported during my conversation" (supported; five-point Likert: strongly disagree to strongly agree); (ii) "how would you rate the quality of support you received?" (quality; four-point: poor, fair, good, and excellent); (iii) "to what extent has Fireside Project met your needs?" (met needs; four-point: none, only a few, most, and almost all); (iv) "would you call Fireside Project again if you needed psychedelic support?" (call again; four-point: no definitely not, no i do not think so, yes i think so, and yes definitely); and (v) "I would recommend Fireside Project to others" (recommend; five-point Likert: strongly disagree to strongly agree). The survey also collected caller demographics including gender, race/ethnicity, veteran status, income level, and state of residence.

Data access and use

The released resource comprises deidentified interaction logs and survey responses. Interaction logs are deidentified by replacing supporter names with pseudonymous identifiers that preserve the nested data structure (i.e., interactions from the same supporter can be linked). Caller-identifying information (phone numbers and names disclosed during interactions) is stripped before release.

All deidentified data and all analysis code to reproduce manuscript figures and statistics, is available at https://dataverse.harvard.edu/dataset.xhtml?persistentId=doi:10.7910/DVN/QPPDPZ.

Ethics statement

This study was reviewed by an IRB (Advarra IRB; Pro00092114) and determined to be exempt from IRB oversight under 45 CFR 46.104(d)(4), which covers research involving the secondary use of existing data where individuals cannot be readily identified. The protocol (version 1.0, dated 15 December 2025) was reviewed and the exempt determination was issued on 13 January 2026. All analyses use deidentified or operationally collected data; no additional data collection from human individuals was conducted for this study.

Supplementary Materials

This PDF file includes:

Sections S1 to S13

Tables S1 to S10

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Competing interests: J.W. is the founder and executive director of the Fireside Project. F.S., M.S., D.X., M.E., A.M., and W.B. are affiliated with Fireside Lab, a research division of the Fireside Project. W.H. has served as a paid consultant for the Fireside Project for activities related to the creation and management of their data collection system within Firepad. The authors declare that they have no other competing interests. **Data, code, and materials availability:** All data and code needed to evaluate and reproduce the results in the paper are present in the paper and/or the Supplementary Materials. This study did not generate new materials. All deidentified data and all analysis code to reproduce manuscript figures and statistics, is available at the Harvard Dataverse https://doi.org/10.7910/DVN/QPPDPZ.

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Science Advances

The Fireside Database: Large-scale evidence from 25,419 psychedelic support interactions

Felix Schoeller, Marc Santolini, Dana Xiadani, Mickael Eskinazi, Ashwin Murali, David Esselman, Wyatt Houtz, Wesley Bellanca, and Joshua White

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