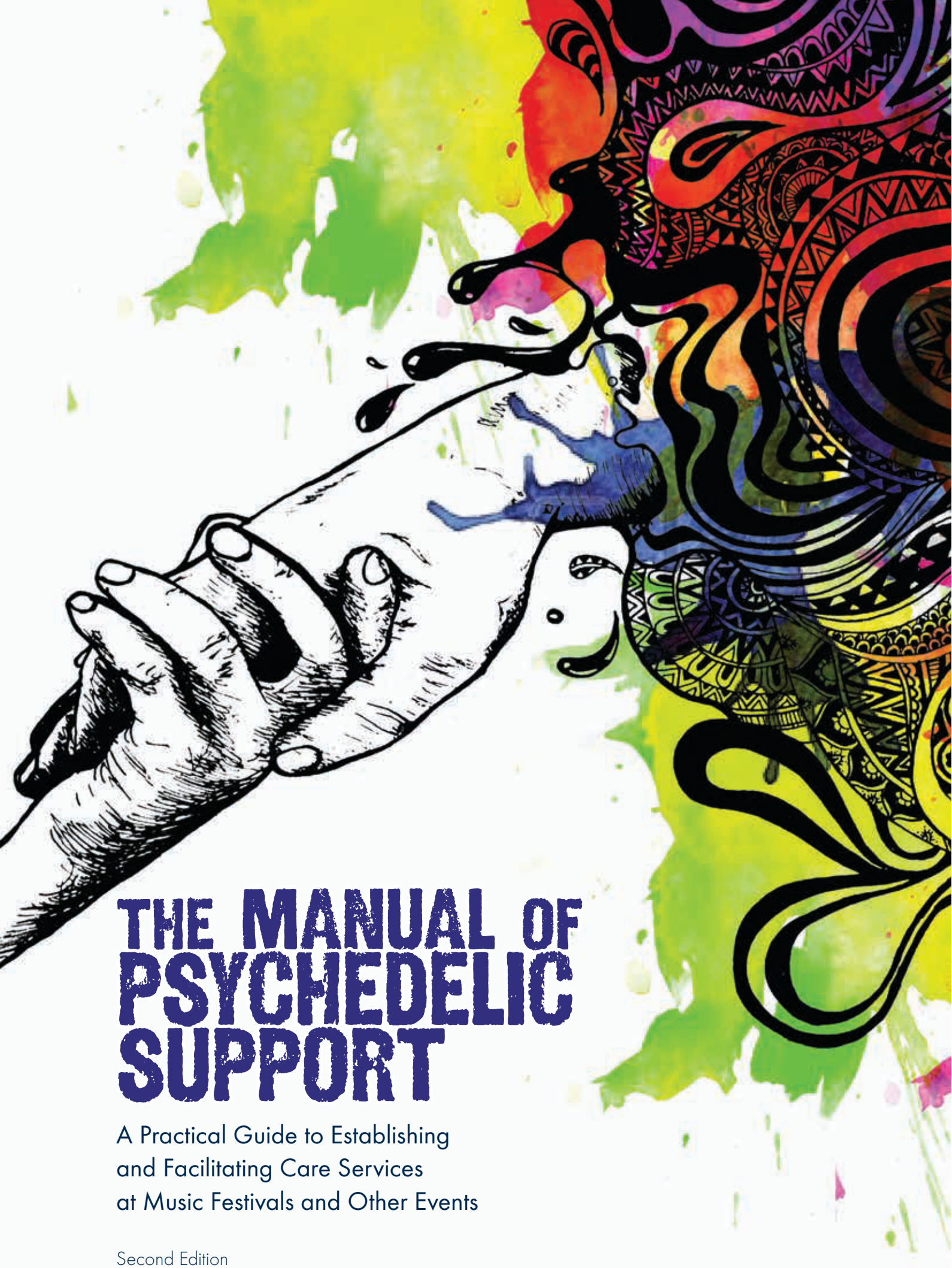

THE MANUAL OF PSYCHEDELIC SUPPORT

A Practical Guide to Establishing
and Facilitating Care Services
at Music Festivals and Other Events

Second Edition

Multidisciplinary Association for Psychedelic Studies (MAPS)

THE MANUAL OF PSYCHEDELIC SUPPORT

GWYLLM LLWYDD • *The Chemist* (dedicated to Sasha Shulgin), 2013 • multimedia, digital collage

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Sales of this book will help fund psychedelic harm reduction.

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EDITORS

ANNIE OAK — Founder of the Women's Visionary Congress and the Full Circle Tea House

JON HANNA — Co-founder of Mind States

KAYA

SVEA NIELSEN — Psychologist, Vision Board Coach, Nikken Consultant, and Mama of fine organic children

TWILIGHT

ZEVIC MISHOR, PhD

FOREWORDS

FIRE & EARTH EROWID — Co-founders of Erowid Center, Erowid.org, and EcstasyData.org

DIOGO RUIVO — Founder of Good Mood Productions and the Boom Festival

RICK DOBLIN, PhD — Founder & Executive Director of the Multidisciplinary Association for Psychedelic Studies (MAPS)

ALICIA DANFORTH, PhD — Clinical Psychedelics Researcher

SAM CUTLER — Former Tour Manager for the Rolling Stones and the Grateful Dead

AUTHORS

ALEXANDRE QUARANTA, PhD — Writer, Tantric Yoga Teacher, and Lucid Dreaming Trainer

ALICIA DANFORTH, PhD — Clinical Psychedelics Researcher

ANNIE OAK — Founder of the Women's Visionary Congress and the Full Circle Tea House

BEN ATKINSON — Critical Incident Debriefer/Crisis Care Worker

BEN HOLDEN — Board Member & Lead Volunteer for KosmicAid, and Harm Reduction Outreach Worker (Leeds, United Kingdom)

BERRY

CHRISTOPHER J. WARD

CONSTANCE RODRIGUES — Clinical Psychologist, Somatic-Psychotherapist, Pilot for KosmiCare Boom Festival (2010), Teacher & Co-founder of the Portuguese Center of Jungian Studies

CONSTANTINOS EFSTRATIOU

DANIEL LEUENBERGER	Trance-lator, DJ Almacalma, and Daddy
ELISSA HARWOOD	Researcher
EMMA METCALF	
GASTONE ZANETTE (Gas), MD	Anaesthesiologist
GRACE LIEW	
IGOR DOMSAC	Psychonaut, Artist, Father, and Founder of Alter Consciens
ISLA CAMILLE DUPORGE	
JACK LIEBERMAN	
JACOB POTKONYAK	
JOAN OBIOLS-LLANDRICH, MD, PhD	Psychiatrist and Anthropologist
JOÃO GONÇALVES	
JON HANNA	Co-founder of Mind States
JONAS DI GREGORIO	
KAI SCHULZE	
KARIN SILENZI DE STAGNI	Coordinator of KosmicAid
KAYA	
KIM PENDERS	
LEVENTE MÓRÓ	Coordinator for DÁT2 Psy Help
LINNAE PONTÉ	Former Director of Harm Reduction (Zendo Project) for MAPS
MARC B. AIXALÀ	
MARIA CARMO CARVALHO	Lecturer at the Faculty of Education, Catholic University of Portugal at Porto, and Pilot & Research Coordinator for KosmiCare Boom Festival (2010)
MARIANA PINTO DE SOUSA	Researcher for KosmiCare Boom Festival
MIMI PELEG	Director of Large Scale Cannabis Training at MECHKAR Israel, and Clinical Research Associate for the MAPS
MINTY DE LA PLAYA	
NATACHA RIBEIRO	
RICK DOBLIN, PhD	Founder & Executive Director of MAPS
SNU VOOGELBREINDER	Ethnobotanical Author and Psychonaut
SVEA NIELSEN	Psychologist, Vision Board Coach, Nikken Consultant, and Mama of fine organic children
TIMOTHY BAKAS	
TOM SHUTTE	Psychotherapist
TRACY DUNNE	Secretary & Care Service Leader for KosmicAid
TWILIGHT	
XAVIER URQUIAGA A.	
VINCE CAKIC	
ZEVIC MISHOR, PhD	

ARTISTS

ALEX GREY	http://www.alexgrey.com
ALLYSON GREY	http://www.allysongrey.com

FRED TOMASELLI	http://www.jamescohan.com/artists/fred-tomaselli
GWYLLM LLWYDD	http://www.gwyllm-art.com
JON HANNA	http://www.mindstates.org
LUKE BROWN	http://www.spectraleyes.com
LUKE GRAY	http://www.lukegray.net
MARK HENSON	http://www.markhensonart.com
MARTINA HOFFMANN	http://www.martinahoffmann.com
NAOTO HATTORI	http://www.naotohattori.com
ROBERT VENOSA	http://www.venosa.com
SHANNON THERON	http://plus.google.com/+ShannonTheron/posts
SHANTIQ	http://www.saatchiart.com/shantiq
VIBRATA CHROMODORIS	http://www.vibrata.com
ZEVIC MISHOR, PhD	

PHOTOGRAPHERS

DAVID ARNSON	Founder of the Insect Surfers and the Raw Power Rangers
EROWID	http://www.erowid.org
GREG MANNING	
JEN ZARIAT	http://www.zariat.com
JOHN COCKTOASTEN	
JON HANNA	Co-founder of Mind States
LEANDRO REINALDO	Anaesthesiologist, Medical Doctor
MADDIE RADNAN	Co-founder of Yo! Mad Dreadlocks, BSc. (Hons) Student, and Psychonaut
SUSANA SANTOS	Social Worker
VIBRATA CHROMODORIS	http://www.vibrata.com
ZEVIC MISHOR, PhD	

DESIGN TEAM

BLAKE HANNA	**Proofreader** • Educator and Cat Whisperer
DAVE KING	**Web Design** • Co-director of Breaking Convention
JON HANNA	**Art & Photography Editor** • Co-founder of Mind States
LUKE GRAY	**Cover Artwork** • http://www.lukegray.net
MARK PLUMMER	**Book & Cover Design**
SARAH JORDAN	**Production**

CONTRIBUTORS

ANA PAULA SILVA COSTA	
D.J. SIMMS	
DAVE KING	Co-director of Breaking Convention
GWYLLM LLWYDD	http://www.gwyllm-art.com
IKER PUENTE	
JOANNA TARNAVA	

Appendix B

MONITORING, EVALUATING AND RESEARCHING—RECOMMENDATIONS FROM AN ACADEMIC PERSPECTIVE FOR AN EVIDENCE-BASED APPROACH TO PSYCHOACTIVE CRISIS INTERVENTION

Maria Carmo Carvalho

Mariana Pinto de Sousa

Implementing a successful care service doesn't solely depend on your capacity to guarantee a skilled and trained team, appropriate intervention strategies, or adequate resources. Furthermore, an appraisal of these factors frequently isn't really formed until well after work in the field has commenced. This seems to be the case with all interventions occurring where guidelines and experiences haven't been systematically reported and documented, as often occurs in the case of psychedelic support. It is every intervention agent's responsibility to contribute in order to change this scenario.

The only way of doing so is to *monitor* your activity, making sure you have accomplished your intervention goals, and to share the product of your work with your colleagues. This is the kind of approach that will allow you to grow from spontaneous and informal action into an evidence-based care service. Please note that some topics in this Appendix are also covered in Chapters 10, "Running the Service" and 15, "Risk Management and Performance Improvement".

Specific motives that justify keeping a detailed account of the work done by a care service are diverse and may vary from one context to another. In this chapter we briefly present central arguments for recording the results of your project, and we offer short instructions and practical examples on how to implement this process. We will go over three important reasons for researching, monitoring, collecting feedback, and documenting your psychedelic care service.

After carefully examining the legal landscape within the jurisdiction of the event, you should consider recording the results of your interventions for clinical purposes. The diversity of guests and situations you will encounter, and the need to pass on information to a team colleague during interventions, are only a couple of the reasons why you should think about this kind of data collection. In "Feedback and Monitoring" below, we will provide examples of basic information you could collect to allow an effective transmission of relevant clinical details during a guest's stay at the care space. We will also emphasise how this effort can contribute to growing knowledge in the field of psychedelic support.

Another valuable benefit to documentation is that it provides a means for evaluation. The only way to assess a project's efficacy is to plan goals and measure your outcome. Did you achieve what you initially set out to attain? Advanced intervention team leaders are those who have studied their own processes and efficacy, who continuously improve their strategies, and who aspire to standardised (yet evolving) intervention guidelines that help in future implementations. This means that even though socialising and passing on knowledge to the larger community of colleagues who share your interests is always relevant, the product of evaluation efforts is primarily directed at yourself as a care service leader, and at your promoting entities (such as the event organisation) and other partners.

Evaluation may be conducted in various ways. You may choose to study intervention processes, intervention outcomes, or both; you may choose to use quantitative indicators, qualitative approaches, or both. The important thing to keep in mind is that you will guarantee appropriate evaluation as long as you make sure you are addressing your project's specific goals whilst designing your evaluation process. This means there is no optimal single way of evaluating—it is always good as long as you make sure it is appropriate for you project's characteristics. Since it is impossible for us, without knowing your project's specific goals, to present targeted suggestions on how to perform evaluation, we will share some basic principles and present examples based on our experiences in "Evaluation" below.

Finally, where legal considerations do not preclude the ability to do so, you may wish to consider using your care service for scientific research purposes. Care services for psychedelic support at recreational settings present unique opportunities to get in touch with research subjects who can be difficult to sample elsewhere. Data regarding their personal backgrounds and experiences is a potentially precious contribution to scientific knowledge in many diverse domains (including pharmacology, health studies, psychology, anthropology, sociology, criminology, and more) and research themes (risk behaviour, drug use patterns, life trajectories, transpersonal experiences, psychopathology, and so forth). Implementing research is a demanding task, and it is clearly not an essential requirement for the effective facilitation of a psychedelic care service. So our purpose here is simply to present examples of what *could* be achieved, should you have the required resources and skills, and decide to go ahead with conducting some manner of scientific study. We develop this approach under "Research" below.

1. Feedback and Monitoring

Gathering basic information about your guests and their experiences at the care service ensures you get feedback about what is happening, allowing you to monitor your interventions in the field. That information is useful for clinical purposes, since it provides you with an opportunity to get to know your guests and decide how to best respond to their needs. In the field you will encounter a diversity of individuals presenting varying requests, symptoms, and predicaments. It is often the case that you will expect some of these situations, whilst others may catch you off-guard. During care work you will also find the need to pass along information from a guest to a colleague or team lead who replaces you in the next shift, or to medical personnel who become involved with a guest's care. There is much variation between care services in terms of event type, number of care team members, and complexity of team management. As an event and its corresponding care service increase in size, the challenges posed to gathering data about guests are also expected to increase.

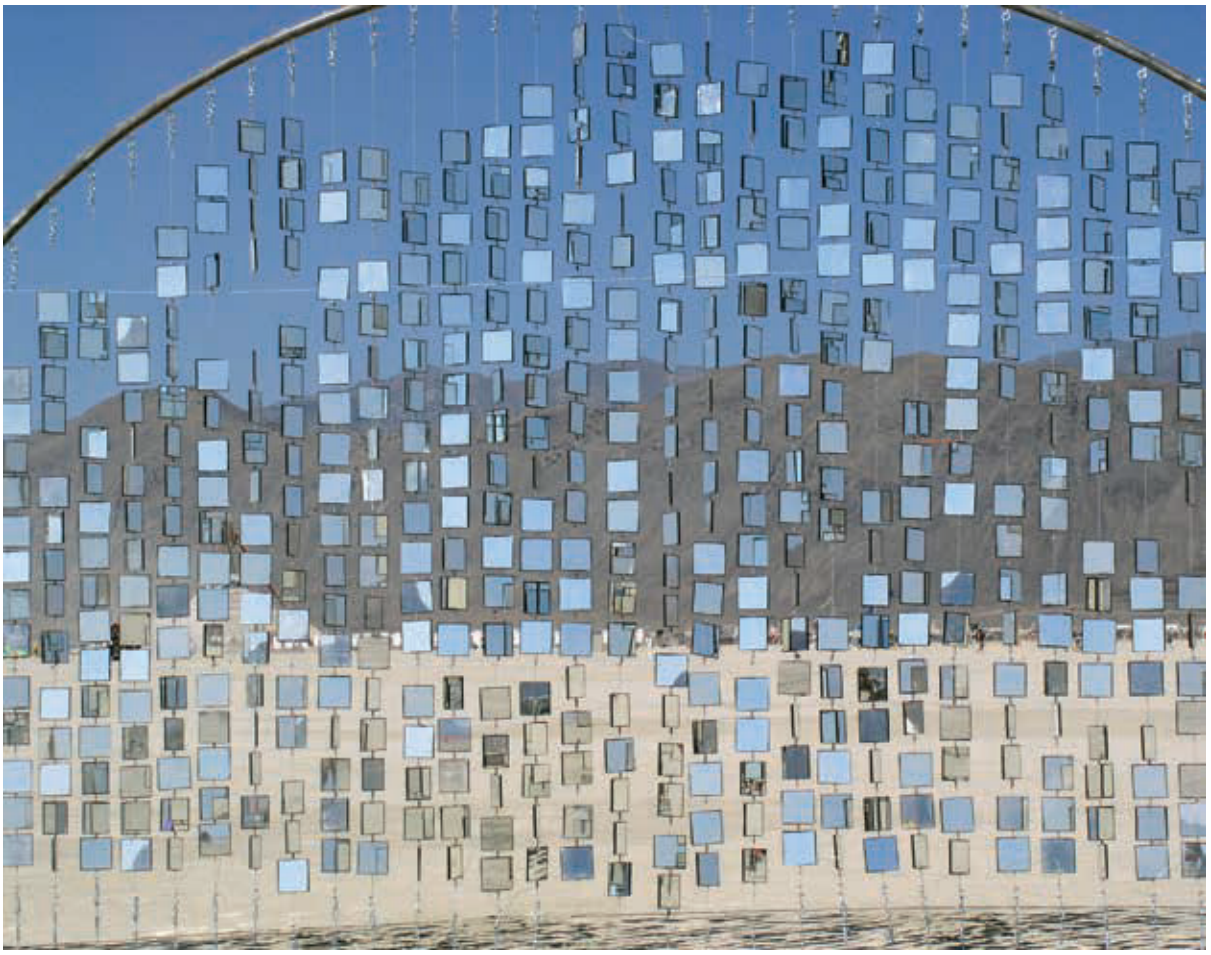
Below we outline some of critical aspects you should consider regarding data collection. When building your data collection forms, you should endeavour to use easily manageable formats that facilitate consultation of the information whilst in the field (when you need it), and provide a structure for future data analysis (if applicable). We will present suggestions on how to do this, along with practical examples.

There are a couple of distinct options for keeping track of the work being done. You may choose to monitor individuals and open a single care record for each uniquely named (identified) *person*. Or, you may choose to record each individual *visit* attended to by the service, regardless of the identity of the guest. These two options present different implications if the same individual comes to the service on more than one occasion. In the first option, you identify your guest, open the record only once, and always use the same record if the guest visits again at a future time. In the second option, you assume you are only accounting for the situations that received help regardless of the guest's identity, so you open a new record for each situation attended, even if some of these records may refer to the same person. The recommendations we present below refer to the first option. In our opinion, it is useful to know what happened in the previous visit(s) when dealing with a repeat customer; how did the guest respond to the earlier intervention(s)? However, keeping track of all your guests might be a difficult challenge, especially at larger events.

IDENTIFYING GUESTS

You must find some basic method for identifying your guests, even though the collection of personal data is potentially concerning within the operation of a care service related to the use of illegal substances (see Chapter 3, "Legal Considerations"). As shown in Figure 1, "Data Collection Regarding Guests' Identification", we suggest you collect data concerning the guest's *name* or *nickname*, *age*, and *nationality*. Approaching guests using their *names* is an important strategy for building rapport. Frequently, *age* can be estimated; if you don't have a way of knowing a guest's age precisely, use this alternative. *Nationality* helps you decide on which language the care giver should use whilst interacting with the guest; when possible, care service staff should make efforts to communicate in a guest's native tongue. When you are assembling a team, knowledge of guests' expected nationalities (based on the known pattern of attendance for that festival) is useful for planning the languages required by the care service.

You should also include a checkbox that informs you if it is the first time a guest has been at the service during the event, whether they have visited the service previously, or if you simply can't determine that information accurately. From our experience, *distinguishing between first admissions and re-admissions poses a major challenge*. The only way of solving this is to gather data concerning guests' identification as well as information about the number of previous occasions they visited the service.



The Arc of Reflection *by Amy Stabler was a twenty-foot tall arc of mirrors built on the playa at the 2003 Burning Man Festival. Photo by Jon Hanna.*

Finally, we also suggest you ask about the guests' previous attendances at that particular event. From our experience of evaluating a large-scale care service (KosmiCare at Boom 2010), we noticed that 68% of the guests were visiting the event for their first time (Carvalho, Pinto de Sousa, Frango, Carvalho, Dias, & Veríssimo 2011). This poses the possibility that guests less familiar with a particular event's dynamics might be the ones more likely to find themselves in need of assistance.

INFORMATION ABOUT ARRIVAL

You should try to gather as much information as possible about how your guest arrived at the care service (see Figure 2, "Data Collection on Arrival"). If the individual didn't walk in alone, identify *who brought the guest* (this person may also be able to provide relevant information about the situation and how the guest was found); the *date* and *time* the guest arrived; and *which care giver* was assigned to the case. Also keep a running list of the other care givers who followed. As the number of guests increases, these are the crucial pieces of information that help you situate a new arrival and sometimes determine whether the guest has been at the service before.

VISITOR DEMOGRAPHICS	
1. Name:	
2. Age: ☐ Actual ☐ Estimated	3. Gender: ☐ Male ☐ Female
4. Nationality and language(s) spoken:	
5. Number of times at the service: ☐ One ☐ Two or more	6. Number of times at the event: ☐ One ☐ Two or more

FIGURE 1: Data Collection Regarding Guests' Identification

People who first encounter a guest in trouble are the ones who are often most able to offer details that will help in understanding the guest's needs, particularly in situations where the individual isn't communicating verbally. At large-scale events, a guest might be brought in by other event services in the field (including medical and security services), by other staff at the event, by care service staff, by friends, or by a well-meaning passer-by. If the guest has lost consciousness at any point or if they have trouble recalling what happened prior to the admission, they will probably ask you about the circumstances that brought them to the service once they become more coherent. To be able to offer this feedback is frequently reassuring for the individual. In cases where the guest was brought in by friends, it is very important to keep track of and stay in touch with these people—they are the ones most likely to provide relevant information such as which substances were consumed, their quantities, the time(s) of ingestion, combinations, and any details on medical and/or psychiatric history. Most of all, friends may be able to offer reassurance and grounding for the guest who is likely to be suffering from all the insecurities that an unexpected and painful experience usually brings up.

People who first encountered a guest in trouble are the ones who are often most able to offer details that will help in understanding the guest's needs, particularly in situations where the individual isn't communicating verbally.

The date and time of a guest's arrival have implications for team organisation that surpass the mere identification of the situation attended. From our experience evaluating a care service, these data have helped us realise that the care service was receiving more guests on specific days of the event, which was a large scale festival that lasted for a total of eight days. In our example of Boom 2010, these were the days immediately following the beginning and immediately preceding the end of the event. Data on times that guests were received furthermore allowed us to understand that the number of guests at the care space peaked during the afternoon (15:00 to 23:00) (Carvalho et al. 2011). Future editions of the same intervention at the same event might take advantage of this information to improve human resource management.

Information regarding *substance use* is central at this point and you should allocate specific attention to a number of details including not only the substance names, but also quantities, timing of ingestions, the setting/context of

ARRIVAL			
7. Date:	8. Time:	9. Care Giver #1:	10. Care giver #2:

11. Guest was brought in by: ☐ Him-/herself ☐ Friend ☐ Paramedics ☐ Care giver ☐ Other	
12. If brought in by friends, did they stay with the guest?	
13. Describe the guest's physical condition	
14. Describe the guest's psychological condition	
15. Describe presented symptoms and their severity	
16. Describe relevant physical or mental health history	

17. Regarding guest's psychoactive substance uses, describe each product, quantity of ingestions, ingestion day(s), ingestion time(s), ingestion context (where, with whom), and ingestion method (oral, smoked, injected, other)

Product	Quantity	Day	Time	Context	Ingestion method
17-a.					
17-b.					
17-c.					
17-d.					
17-e.					

18. This guest was brought in because he/she was: ☐ having an intentional but difficult experience related to PAS ☐ having an accidental experience related to PAS ☐ having a personal crisis not related to PAS ☐ having a mental crisis concurrent with PAS use ☐ having a mental crisis without any PAS use ☐ not having any sort of crisis (explain reason in 18-a)	18-a. Any additional notes related to question #18:

FIGURE 2: Data Collection on Arrival Related to the Use of any PsychoActive Substances (PAS)

ingestions (where, with whom), method of ingestions (how), and if interaction with alcohol existed. From our experience, some substances are being used in such high prevalence that their consumption is frequently under-reported. This happens because guests tend to consider their common use as normalised behaviour that, in their perception, seems less relevant. This is the case primarily with alcohol and cannabis. Knowledge of these, however, is important for intervention; for example, a guest may have been ingesting stimulants (such as amphetamine or cocaine) alongside alcohol (a depressant), which can affect treatment choice. Our documentation has found substance use to be the most common source of symptoms presented by guests, even though other factors, including contextual emotional effects and health or psychiatric history, may also be of prime importance.

...some substances are being used in such high prevalence that their consumption is frequently under-reported.

A final aspect to consider at the initial stage is a summary description of *symptoms* presented and an evaluation of the *type of crisis situation*. Symptoms and their evolution during intervention will also be part of a distinct section of the record that is solely dedicated to intervention. However, a summary of the most visible signs of distress

presented by the guest upon arrival will allow for a quick overview of the situation and aid initial decision-making. From our experience, you can expect a wide variety of crisis situations that present for assistance. At Boom Festival 2010, from an approximate total of 120 guests who visited the care service, we noted that 76% presented situations related to difficult intentional experiences with a psychoactive substance (PAS); 8.3% were mental crises that also involved the use of a PAS; 7.4% of situations didn't correspond to any sort of psychological crisis (for example, information and first aid requests); 5% related to mental (psychiatric) crisis without PAS use; 2.5% related to accidental experiences with a PAS; and 0.8% had to do with personal crisis (due to emotional and contextual factors) not related to a PAS (Carvalho et al. 2011). Knowledge of this breakdown helps you better prepare the team in terms of training emphasis.

In our experience, psychiatric situations, whether involving PAS use or not, tend to be the most demanding on a care service's resources, and are the ones you will probably feel least prepared to deal with. They are also the ones with higher probability for unsuccessful intervention, occasionally even resulting in the transfer of the guest to a medical/psychiatric facility. These guests are more likely to arrive earlier in the event, and they tend to stay for longer periods of time. They are also more likely to require prescription drugs. Despite these challenges, and provided that there is appropriate medical/psychiatric assessment and supervision, in our opinion the care service remains the most suitable place to attend to these individuals' needs at an event. To better respond to these situations, the help of qualified staff is essential. The skills required have to do not only with adequate medical and psychiatric training, but also with a good understanding of the dynamics of recreational drug settings and substance-using communities.

INTERVENTION PROCESS DESCRIPTION

This is perhaps the richest section of your data collection, since it provides feedback on clinical decisions, contains detailed qualitative content to evaluate the success of the intervention, and gathers knowledge about your guests and their PAS experiences for research purposes.

We suggest you gather information on a number of general topics that summarise your guest's episode, and then simply record in the most systematic way possible what happens, following a timeline of the guest's stay at the care space (see Figure 3, "Description of Intervention Process").

We suggest you gather information on a number of general topics that summarise your guest's episode, and then simply record in the most systematic way possible what happens, following a timeline of the guest's stay at the care space...

INTERVENTION		
19. Summarise the psychological issues that the guest was dealing with during the intervention:		
20. Describe the guest's primary emotional states during the intervention in chronological order (for example: hyper alert, anxious, calm, etc.):		
21. Summarise therapeutic strategies used with guest that seemed to help most (for example: listening; sitting with quietly; talking; music therapy; walking around; holding; wanted to be left alone, etc.). Also describe strategies used that were less helpful:		
Date:	Time:	Care giver:
Date:	Time:	Care giver:

FIGURE 3: Description of Intervention Process

Take notice of two aspects: the* date and time *the guest left, and* how *the guest left.

Whilst previous sections should be completed at the moment of arrival, the intervention section should be filled out during the course of care, and completed just after the guest's situation has resolved and the guest has left the care space. In this process you should register information that tells a "story", with a clear time sequence of major events, guest reactions, and care givers' decisions and their impact on the guest.

As for general topics, we suggest you try to start with a short summary of the psychological issues the guest was dealing with when intervention began, the guest's primary emotional states, and how these developed. Also include a short summary of any therapeutic strategies to which the guest responded positively. After this, simply register all major reactions, events, therapeutic decisions and strategies, and their impact on the guest, along a timeline.

INFORMATION ABOUT DEPARTURE

Your basic records for Feedback and Monitoring of intervention should conclude at the time your guest leaves the care service. Take notice of two aspects: the *date and time* the guest left, and *how* the guest left. Date and time allow you to know how many hours were spent in the care space, and thus the average length of intervention per guest or type of situation—for the care service as a whole—may eventually be calculated. For example, at KosmiCare's intervention at the 2010 Boom Festival we concluded that 52% of all guests attending the care service stayed for between one and five hours. This means that all remaining guests (48%) stayed at the care service for a minimum of six hours, which represents a considerably more lengthy intervention (Carvalho et al. 2011).

DEPARTURE			
22. Date and estimated number of hours that the guest stayed at the care service:			
Date:	Time of arrival:	Time of departure:	Approximate number of: ☐ hours _____ ☐ days _____
23. Indicate how guest was released from the care service:			
☐ On his/her own ☐ Escorted by friends/relatives/partners ☐ Escorted by care giver ☐ To off-site medical or mental facility	☐ Other (describe) _____		
24. Describe guest's current psychological condition:			
25. Describe guest's current physical condition:			

FIGURE 4: Data Collection on Departure

Knowing how your guest left the care service is an important indicator to evaluate your intervention efficacy. Following the above example, we established that 67% of the guests left the care service on their own, which largely indicates intervention success. Guests may also leave with friends, partners, or relatives; be escorted by a care giver back to camp; or, less frequently, be transferred to another health service outside the event.

It might also be useful to consult your intervention process notes and have a small summary describing the guest's psychological and physical condition on departure (Figure 4, "Data Collection on Departure").

INFORMED CONSENT

When personally identifiable data is being collected, we recommend you ask guests to sign an informed consent document (Figure 5, "Example of an Informed Consent Form"). You may present a small text with a general overview of your feedback and monitoring goals, or your evaluation goals, or even your overall research purpose. Consider including a request for a contact email that allows you to check up on the person at a future date, if that is relevant to your intervention or research. This request should ideally be presented by someone other than the care giver assigned to the guest.

You should expect a range of different reactions when an informed consent request is presented. It may be that the person feels grateful and is willing to contribute to your work in any way possible; it may be that the guest finds it okay to give the information but wants to leave the care service as quickly as possible, and isn't interested in taking the time to

Consider including a request for a contact email that allows you to check up on the person at a future date, if that is relevant to your intervention or research.

INFORMED CONSENT

All of the guest data collected at this care service is kept 100% confidential.

Within that framework of confidentiality, we are conducting scientific research that will help us increase and share knowledge regarding the use of psychoactive substances within a variety of social environments, and the unique—and sometimes challenging—mental spaces that can be inspired by the consumption of psychedelics. Information concerning your experience whilst at the care service is of great importance for us. We would very much appreciate if you agreed to allow us to use—within an entirely anonymous context—the data collected during your stay for research purposes. Please indicate your preference and sign below:

☐ **YES** I have been informed about the objectives of this research project, and **I agree to the anonymous use of information** collected during my stay at the care service.

☐ **NO** I have been informed about the objectives of this research project, and **I DO NOT agree to the anonymous use of information** collected during my stay at the care service.

If you agree to participate, we would be interested in checking back in with you in a few months. If that would be okay, please neatly print your email address below.

EMAIL: _____

SIGNATURE: _____ **DATE:** _____

FIGURE 5: Example of an Informed Consent Form

You should expect a range of different reactions when an informed consent request is presented.

read and sign a document; or it may be that the guest totally rejects (and sometimes regards with intense suspicion) the idea of his/her information being used in the future. From our experience, verbal consent can be considered valuable for our purposes—if this is the case, register what occurred so you will know later why the document wasn't properly signed. If you find yourself in the scenario where a guest totally refuses to cooperate, we recommend that you destroy all personal information (for example name, age, nationality, and any notes that contain information referencing personal data, such as the names and phone numbers of friends), but retain a global record of the situation so that you can still use it as a simple indicator of the project's activity.

See Chapter 3, "Legal Considerations", for a further discussion regarding consent and record keeping. *Please note that informed consent documentation may not be deemed valid and/or legally binding when signed by an individual in any altered/intoxicated state.*

2. Evaluation

Data collection suggestions presented above for Feedback and Monitoring purposes already constitute a valuable contribution to your intervention evaluation. In the following, however, we will give a broader overview on what may be accomplished through evaluation, the questions you can expect to answer, and further indicators you may want to consider. We'll start with a short introduction to the origins of evaluation practice and what its general goals are.

Systematic empirical methodologies for intervention evaluation began to appear in the 1950s, mostly in the fields of

education and human resources (Illback, Zins, Maher & Greenberg 1990). Flaherty and Morell (1978; cited in Illback et al. 1990) refer to a number of factors that led to the increased concern for evaluating interventions, such as: guaranteeing that public funding would be distributed according to worthy criteria; researchers' increased concern for public matters; limited resources available for social sciences; and the need to improve methodologies available for evaluation itself. These factors combined have been contributing to an evolution in the way that planning and evaluation of interventions has been implemented over the last few decades.

Recognition of the importance of evaluation has been followed by the understanding that this effort should not focus on the *results* alone of intervention, but also on the process through which intervention implementation occurs (Illback, Kalafat & Sanders 1997). From here, consensus arose around the idea that programme evaluation should contribute in determining intervention efficacy and the efficiency of strategies used for programme implementation. The way to achieve this should be through the gathering of systematic information on a programme's activities, characteristics, and results (Almeida & Mourão 2010).

The purpose of evaluation should therefore be, on the one hand, to determine whether goals and expected results have been achieved, and on the other hand, to gain insight into how the programme could be improved (Almeida & Mourão 2010).

Regarding methodology for developing such evaluation, the literature suggests a combination of qualitative and quantitative approaches. There is, however, a growing trend to favour qualitative methodologies. In our own work we have been placing increasing emphasis on strategies such as observation, in-depth interviewing, focus-groups, and content analysis, since these methods seem to provide rich and detailed information concerning process and programme implementation (Illback et al. 1997).

The three main stages for evaluating an intervention programme consist of *Programme Planning*, *Process Evaluation*, and *Outcome Evaluation*. For each of these stages we will provide examples of our own approach employed in the evaluation of KosmiCare at the Boom Festival in 2010 (Carvalho et al. 2011). That evaluation will serve as an example to help you visualise each of the steps involved; however, it does not constitute a one-size-fits-all evaluation plan, as each evaluation effort must be designed according to a particular project's characteristics and context.

The purpose of evaluation should therefore be, on the one hand, to determine whether goals and expected results have been achieved, and on the other hand, to gain insight into how the programme could be improved.

The research assistants had no involvement with actual intervention care. Additionally, a group of four external evaluators was present during all intervention stages, assisting in adjusting the process and making on-site decisions about evaluation methods.

PROGRAMME PLANNING

Every programme should begin with thorough planning of the intervention being implemented. This means that the first task has to do with clearly stating intervention goals and strategies. However, these are not always easily definable; therefore, we suggest you reflect on what your intervention problem is, and who your target group is. We commonly refer to this stage as *evaluation of needs and available resources*.

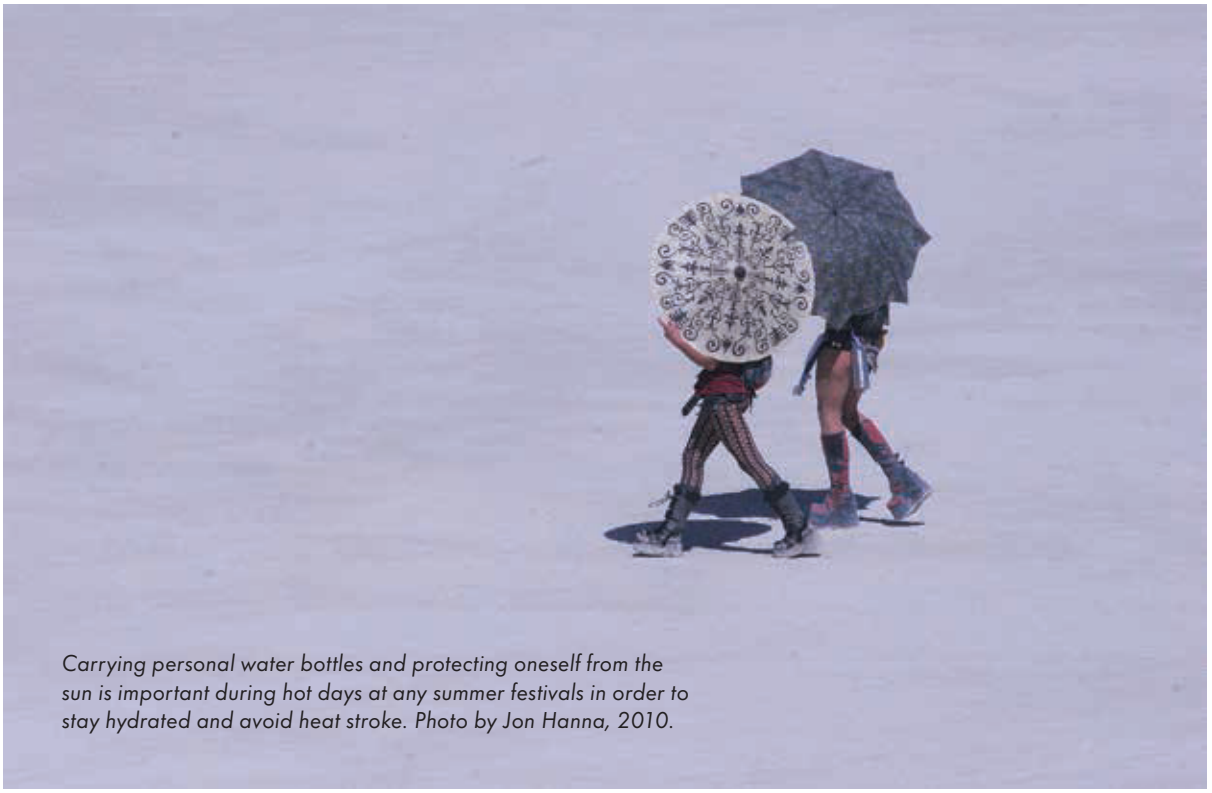
At this stage you should consider who will conduct evaluation. There are two alternatives: evaluation conducted by an external agent, meaning a person who isn't involved in the intervention itself (as a care giver, for example); or evaluation conducted by a person who *is* responsible for some aspect of the intervention, and assumes an additional evaluation coordination role. The people responsible for evaluation will be in charge of collecting information alongside the team responsible for implementation (care givers) and the target group (guests). This can happen through in-depth interviewing, observation, questionnaires, checklists, written reports, or a combination of several strategies.

At our project we decided that evaluation was to be managed by a leadership team member. This person had the primary responsibility of organising the intervention team and care space. Occasionally this individual would also be involved in assistance with guests as needs required. This person supervised data collection, which was performed by a group of three research assistants, who took turns in eight-hour shifts. During this period they helped care givers collect information about guest identification, arrival details, intervention specifics, and departure. At the moment a guest was about to leave, and provided that informed consent had been granted, they would also conduct a small interview assessing guest satisfaction with the intervention. The research assistants had no involvement with actual intervention care. Additionally, a group of four external evaluators was present during all intervention stages, assisting in adjusting the process and making on-site decisions about evaluation methods. These consultants also had no involvement with intervention care. After the event, they produced a comprehensive report, which contained valuable insights about the care service's intervention.

Another requirement is that you *characterise your intervention problem* and *develop a conceptual framework*. This means you should describe the nature, scope, and localisation of the intervention problem you'll focus on (Kröger, Winter & Shaw 1998). National or local surveys and scientific publications are useful resources to consult when structuring your framework.

After clarifying this, succinctly present your ideas on the theories that support your opinions on causes, development, and control of the situation that requires intervention. Whilst doing this, clearly state why you set those *particular goals* to achieve, and the *methods* for achieving them (Kröger et al. 1998). Goals and methods are appropriately stated when they describe a clear picture of the expected effects that should be produced by the intervention and describe how those effects will be produced.

At our project we assumed our intervention problem concerned the potential risk for development of a mental health problem subsequent to an unresolved psychoactive substance–induced crisis in a recreational setting. Even though no epidemiological data of this particular problem was available for our intervention context, we counted on data from national and international surveys that showed increasing PAS use in recreational settings (EMCDDA 2006; EMCDDA 2009; Balsa 2008). We also counted on currently accepted interpretations of this trend that conceptualise it as a highly normalised behaviour, especially among youths' perceptions of their drug-using habits (Parker, Aldridge & Measham 1998; Parker, Williams & Aldridge 2002). Additionally, we could refer to crisis intervention models (Hoff & Adamowski 1998; Kanel 2003), the transpersonal psychology approach to psychedelic emergency (Grof 2008), and *harm reduction and risk minimisation* approaches to PAS use in recreational settings (Hedrich 2005; Marlatt 1998), as valuable contributions that helped us consolidate our programme's conceptual framework.



Carrying personal water bottles and protecting oneself from the sun is important during hot days at any summer festivals in order to stay hydrated and avoid heat stroke. Photo by Jon Hanna, 2010.

The care service project we were undertaking had occurred during number of previous editions at the specific event we attended. It was closely supported by that event's organisers, who actively promoted the project. It was the organisers' perception that such a service made sense at an event attended by tens of thousands of participants from all over the world who frequently chose to experience altered states of consciousness. We assumed that our project would contribute to the well-being of the participants, not only by diminishing the negative impact of unresolved difficult experiences with PAS, but also by taking the opportunity to encourage personal growth that might arise from such experiences.

With regard to *intervention methods*, reflect on whether the strategies you plan to use are the most appropriate for the attainment of your intervention goals. You can do this by considering aspects such as: Is there empirical evidence for the efficacy of these strategies? Or, is the intervention timeline appropriate for their implementation?

Another important task is to analyse, understand, and deliver what you need, in terms of *resources* for programme implementation. Aspects you should consider are: (1) A trained and skilled team; (2) Work schedule; (3) Budget; (4) Logistics (Where and how will the care space be settled? What materials do you need to assemble it and make it appropriate? What intervention equipment is required?).

At our project, intervention strategies were based on crisis intervention and psychedelic emergency principles, the most basic therapeutic technique consisting of *sitting* and *facilitating* the experience for the guest. The method for performing these techniques has been the subject of a considerable amount of literature, even though it is rare to find effectiveness reports of its use and impact. Programme coordinators tried to overcome this limitation through the recruitment of skilled and experienced staff, and by offering the team training that was conducted by experienced teachers. Despite the extended length of the festival, the care team was staffed to provide 100% coverage on every day of the event, which allowed us to maintain a positive therapeutic approach with the guests.

The planning stage was also fundamental for ensuring resources. Even though inevitable challenges arose in this area, with central elements sometimes failing and teams having to adjust to difficulties as they came up during intervention, we had several key items in our favour. The organisers supported us with the majority of our budget; we operated in partnership with a governmental agency that provided staff for implementation and consultancy; we had a university-provided budget and resources for evaluation and research;

and a number of non-governmental organisations assisted us with pro bono consultancy and harm reduction services that complimented and enhanced our interventions. With this support, the care team itself was able to concentrate on logistics, assembling the care space, and ensuring that it was ready on schedule for the event opening.

After you plan your intervention methods, we suggest you focus on your *target group*. Characterise the demographics of the target involved as thoroughly as you can. Think about the scope of the problem that involves them and what led you to choose that particular group or context. Think about the numbers you expect to cover; think about how you plan to contact, recruit, and motivate volunteers and other partners such as event organisers or public entities (Kröger et al. 1998). Also consider whether intervention has support from any potential intermediate or indirect target-groups; these are the groups or persons that, even though not directly served by intervention, may also benefit from it.

At our project we could predict the major demographics of our target group due to past similar interventions. In those previous events, even though no planned evaluation had been implemented, there were efforts to monitor and collect feedback about operations. That data proved valuable, as it allowed us to anticipate various factors such as age, gender, nationality, PAS-use patterns, and other considerations that influenced our intervention strategies (Nielsen & Bettencourt 2008; Ventura 2008). As the intervention unfolded, we noticed that our work wasn't solely benefiting guests in crisis, but also event staff members who became increasingly aware of PAS-related issues. They brought guests to our care service and wanted to know more about how to respond when finding someone in difficulty.

Keep in mind that *evaluation of needs* means that you are already aware of the dimension of your intervention problem and whether that dimension justifies the intervention and resources you plan to allocate to it. Consider such things as an estimation of how many people are affected, and present arguments in favour of your particular intervention to the relevant bodies. Questions you should be answering at this stage include: (1) How many people are affected by this problem? (2) How many new situations are expected and how frequently do they come up? (prevalence and survey data); (3) What is the result of the "status quo" of *not* providing any intervention? (4) How can the need for intervention be described? (5) Are there different opinions about the need for intervention? (6) How has the need for intervention been assessed? (7) Is there knowledge regarding other related interventions in the field? And if so, can benefit be obtained by following their efforts? (Kröger et al. 1998). The main points presented under "Programme Planning" above have been summarised in Figure 6, "Tasks for Programme Planning".

As the intervention unfolded we noticed that our work wasn't benefiting guests in crisis alone, but also event staff members who became more aware of PAS-related issues.

PROGRAMME PLANNING CHECKLIST	
☐ 1. Characterise intervention problem	☐ 4. Decide on intervention methods
☐ 2. Clearly state goals and objectives	☐ 5. Characterise target-groups
☐ 3. Decide who does evaluation	☐ 6. Assess and guarantee resources

FIGURE 6:
Tasks for Programme Planning

At our process evaluation of a care service at a large scale event, we decided to gather information on our implementation through multiple approaches...

Process Evaluation

The central purpose of process evaluation is to determine whether intervention produced the expected results. Through this we promote process improvement, as areas in need of development are identified. Moreover, we can identify difficulties in procedures, and obstacles that emerged during programme implementation. We also document strengths and aspects in which the programme was effective. When we perform process evaluation, our trust in perceived benefits is increased because we are confident that results are directly associated with interventions that were implemented and not with random happenstance (Illback et al. 1997).

In developing process evaluation, one follows a planned methodology. This consists of obtaining answers to several questions: (1) Which variables and indicators will offer us useful information on intervention implementation? And what kind of information (qualitative and/or quantitative) do we intend to collect? (2) What methods and instruments will we use to collect that data (interviews, questionnaires, observation checklists, and so forth)? (3) Where, when, and for how long will we collect data regarding the intervention process? (4) Who will provide this data? (5) How will data be analysed?

These concerns strongly resemble the questions any scientist asks when planning a research project. What is particular here is that you will be planning research that has a specific intention: to know more about how intervention is occurring and how it can be improved in the future. Whilst scientific research has a global audience and community composed of every person studying the same problem or its analogue (academically or for intervention purposes), evaluation research is primarily aimed at a more restricted audience of programme coordinators, partners, and the team itself, as these stakeholders will benefit most from its results in the future.

At our process evaluation of a care service at a large-scale event, we decided to gather information on our implementation through multiple approaches, and through a combined use of qualitative and quantitative indicators. Observation checklists were created that allowed close monitoring of the intervention received by each guest. Even though it was the care givers' responsibility to provide this input, research assistants frequently assumed the lead in soliciting, documenting,

GUEST SATISFACTION QUESTIONNAIRE					
	Totally agree	Agree	Don't know / Can't tell	Disagree	Totally disagree
26. I consider I have been helped by the care services					
27. I consider the care space had all the appropriate conditions to satisfy my needs during my stay					
28. I consider the care services had well-prepared, efficient staff to help me deal with my situation					
29. I consider care givers were helpful, caring, and available to satisfy my needs during my stay					
30. Please feel free to comment below on any aspect(s) related to your experience at the care service					

FIGURE 7: Guest Satisfaction Questionnaire

and maintaining information for all guests at the care space. Additionally, our implementation was retrospectively evaluated through care team feedback subsequent to the interventions.

When you plan *process evaluation for implementation monitoring*, consider including information about indicators such as: (1) Intervention strategies; (2) The target group (how many and their demographics); (3) The target group's exposure to intervention (intervention duration and number of activities/interventions delivered) (Kröger et al. 1998). At our project, these indicators were approximately the same as we described above under "Feedback and Monitoring".

Process evaluation also contributes to *assessing programme efficacy*. This is obtained through the measurement (quantitative or qualitative) of the reaction of the subjects and their attitudes towards the programme: Did they accept intervention? Did they identify with the goals of the programme? Did they obtain benefit from intervention? These are just some examples of questions you can attempt to answer to help assess efficacy through process evaluation (Kröger et al. 1998). Consider what indicators you need in order to answer these questions, and how to collect this data.

Did they accept intervention? Did they identify with the goals of the programme? Did they obtain benefit from intervention?

FIGURE 8: Care Giver's Assessment of Treatment Outcome

DEPARTURE				
31. Do you consider that this guest was helped by the care service?				
Yes, much	Yes, a little	Don't know / Can't tell	No, not much	No, not at all
32. Please include other comments below (for example, guest's verbalisations regarding his/her experience at the care service)				

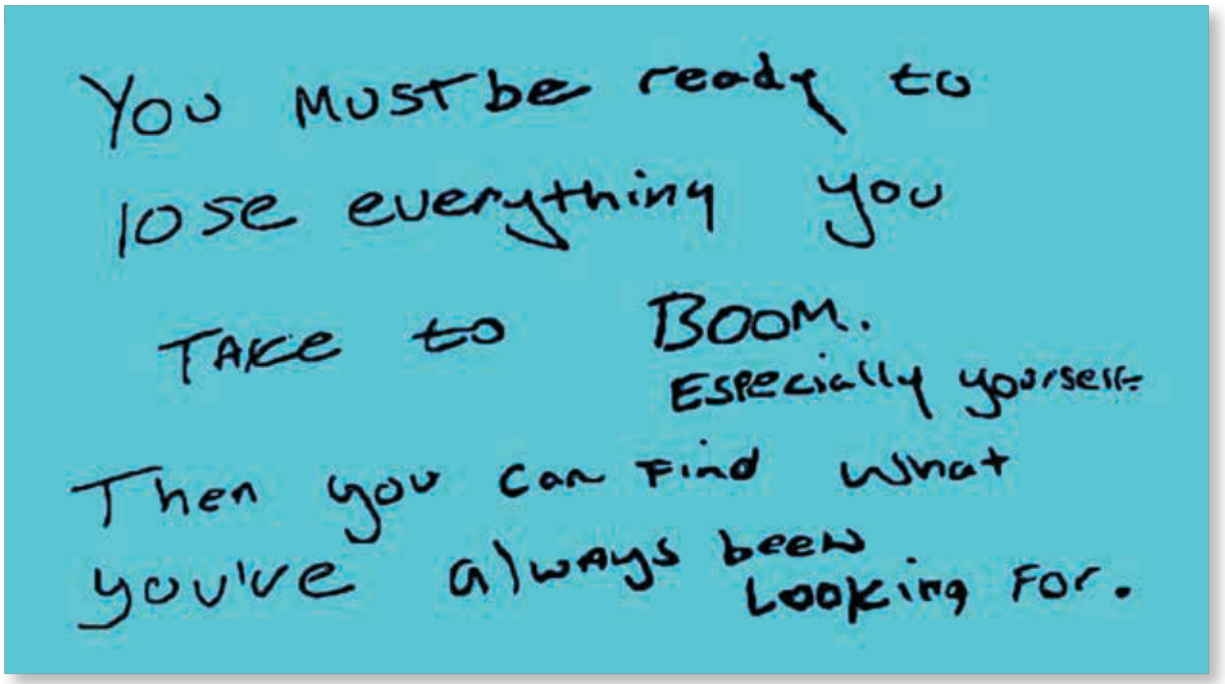


FIGURE 9:
Message left by a care service guest after an intervention in KosmiCare at Boom, 2010. Photo by Constance Rodrigues.

Our project included a guest satisfaction Likert-scale questionnaire for this purpose (Figure 7, "Guest Satisfaction Questionnaire"). Additionally, guests also expressed their view of the intervention's impact verbally and in writing, by responding to structured questionnaires we provided. Care givers also provided their perceptions regarding the degree of successful intervention for each guest (Figure 8, "Care Giver's Assessment of Treatment Outcome").

Process evaluation also includes data collection regarding team satisfaction and involvement, possible unexpected side-effects arising from intervention, and discrepancies between programme planning and programme implementation (Illback et al. 1997). You may choose to monitor these aspects through retrospective or through naturalistic methods. Retrospective monitoring occurs when data concerning implementation is collected through subjects and team members; naturalistic monitoring occurs when you directly observe and record the intervention process (Illback et al. 1997).

At our project, each care team member was invited to express their thoughts about the project by filling in a form that allowed for both "closed" (Figure 10) and "open" (Figure 11) responses. Closed items were "multiple choice" questions; care givers picked one answer from several possibilities presented. Open items required team members to express themselves in terms of SWOT Analysis, providing feedback regarding a project's Strengths, Weaknesses, Opportunities, and Threats (this data was later analysed through descriptive statistics and content analysis).

CARE TEAM SATISFACTION QUESTIONNAIRE					
	Totally agree	Agree	Don't know / Can't tell	Disagree	Totally disagree
1. Care service training was of an appropriate duration					
2. Care service training had well-prepared sessions					
3. Care service training content was relevant					
4. The content of the care service training contributed to my preparation for intervention					
5. Care service training was well organised					
6. Care service physical work conditions (lighting, temperature, comfort, etc.) were appropriate					
7. Guests' acceptance of intervention was positive					
8. Intervention met its purposes effectively					
9. Care givers' work was effective.					
10. Organisational support to the care service was effective.					
11. Care service implementation levels were high.					
12. The climate and cooperation in the care service team was very positive.					
13. Working conditions were appropriate.					
14. Care space capacity was appropriate for intervention's needs.					

FIGURE 10:
Care Team Satisfaction Questionnaire

At our project, each care team member was invited to express their thoughts about the project by filling in a form that allowed for both "closed" (Figure 10) and "open" (Figure 11) responses.

FIGURE 11:
Care Team Satisfaction through S.W.O.T. Analysis

CARE TEAM SATISFACTION / S.W.O.T. ANALYSIS					
Please fill in the following table referring to Strengths (S), Weaknesses (W), Opportunities (O), and Threats (T) of given topics.					
	Training	Team	Work conditions	Organisers	Implementation
Strengths					
Weaknesses					
Opportunities					
Threats					

PROCESS EVALUATION CHECKLIST	
☐ 1. Plan process evaluation (as you would prepare scientific research)	☐ 4. Include team satisfaction assessment
☐ 2. Include implementation monitoring indicators	☐ 5. Consider measuring side-effects and discrepancy
☐ 3. Include programme efficacy indicators	☐ 6. Discuss results

FIGURE 12: Tasks for Process Evaluation

Figure 12, "Tasks for Process Evaluation" lists some of the main points discussed above under "Process Evaluation". To end, we suggest that when you report and discuss process evaluation results you focus on the following (Kröger et al. 1998):

- Compare intervention plan, intervention implementation, and evaluation results.
- Reflect on any discrepancies and their impact on the intervention.
- Identify the intervention's strengths and weaknesses and compare it with other interventions you have researched.
- Formulate suggestions for any future intervention and for future process evaluation approaches to the same intervention.

The central purpose of outcome evaluation is to determine to what level the original goals for intervention were attained. An essential requirement is to ensure that your goals and objectives have been stated clearly from the start of the programme.

Outcome Evaluation

The central purpose of outcome evaluation is to determine to what level the original goals for intervention were attained. An essential requirement is to ensure that your goals and objectives have been stated clearly from the start of the programme. According to Illback, Kallafat, and Sanders (1997), however, the success of an intervention should be determined more by the subjects' perception of intervention efficacy than by the measurement of goals achieved. For this reason, it is also crucial to consider guest satisfaction for the purpose of outcome evaluation. We have presented a number of items above referring to guest satisfaction that may be used simultaneously as process and outcome measures.

Whilst *planning* for outcome evaluation, contemplate the following questions: (1) What do you consider to be the intervention's result indicators and how do you plan to measure them (through which instruments)? (2) What type of data (quantitative or qualitative, or both) do you intend to analyse? (3) What guarantees exist regarding the quality of those instruments (for example, if you use standardised instruments, are they objective, reliable, and trustworthy?) (4) Where, when, and how do you plan to collect those data? (5) How do you plan to analyse the results? (Kröger et al. 1998).

At our evaluation of a care service at a large-scale festival, we intended to measure if our goal of contributing to diminished mental health risk following a psychoactive substance–related crisis had been achieved. We determined that to accomplish this we could obtain a quantitative and standardised measure of guests' mental state through a symptom checklist on arrival at the care space and again on departure. Even though we had other more qualitative and indirect measures for intervention outcome (such as care giver perception and guest satisfaction, already presented above), we wanted to complement these with more direct and quantitative measures of our intervention.

Whilst performing a mental state exam (through instruments such as the *Mini-Mental State*,[1] for example) our attention should focus on the presence of symptoms and signs, and not so much on formally diagnosed "syndromes". Consequently, this exam consists of a discrete "instantaneous" assessment of an individual's operative functioning (Fugas 2011; Baños & Perpiñá 2002) which, unlike formally diagnosed "syndromes", might suffer alterations at any moment. Traditionally, a mental state exam is performed by a psychotherapist who observes a patient whilst conducting a clinical interview (Trzepacz & Baker 2001). But in our case, we had some challenges to overcome. Considering PAS produce modified states of mind that can have an impact on speech, data collection through an interview could be extremely challenging or not even possible. Another aspect was the immediate nature of the crisis intervention setting; this meant that all data had to be collected during the guests' time at the care space, as there was no expectation of further contact after their departure. Finally, we had to recognise that using standardised instruments was usually an impossible request for guests undergoing the often mentally distorting effects of PAS.

So we decided to build a new instrument—the *Mental State Exam Checklist* (*MSEC*) (Carvalho, Carvalho, Frango, Dias, Veríssimo, & Llandrich 2010)—consisting of 74 items that were evaluated by a trained observer (the care giver assigned to the guest). The 74 items were organised into eight sub-scales of dimensions: (1) Appearance, attitude; (2) Psychomotor behaviour; (3) Consciousness, alertness, attention, and orientation; (4) Language and speech; (5) Thought process; (6) Self-awareness; (7) Affect and emotions; (8) Physiological functioning. In this way we could ensure an unobtrusive

1 The *Mini-Mental State* exam was developed in 1975 (Folstein, Folstein & McHugh 1975), and it has been used as an auxiliary to the diagnosis of cognitive functioning problems. It consists of a series of requests and tasks that subjects must solve. Performance on these tasks can be quantified, yielding a final score.

description of the mental condition presented by a guest possibly under the influence of PAS. These results would be analysed later through descriptive statistics, allowing us to obtain the quantitative outcome indicator we were aiming for.

Creating a new checklist meant that we wouldn't be using a reliable and trustworthy data-collection instrument with proven results and quality standards. However, we could in this manner ensure maximum adjustment to our intervention programme's characteristics and contribute to a scientific research path that could be explored in the future.

If you intend to collect data through a standardised questionnaire that produces a quantitative measurement of a given outcome indicator, you must consider issues such as sample selection and sample demographics. Also consider the number of guests who may leave the intervention without completing their questionnaires.

Once sampling issues are solved, guarantee that your measures are suited to answer questions such as: (1) How did intervention affect the subject group's behaviour (directly and indirectly)? (2) Are there any specific sub-groups among your targets that intervention affected differently (for example, different age groups or genders)?

The main points discussed above for "Outcome Evaluation" are listed in Figure 13, "Tasks for Outcome Evaluation". Whilst discussing outcome evaluation results, we suggest you consider analysing a variety of aspects (Kröger et al. 1998), such as:

- Possible discrepancies between expected versus actual results, reasons for these discrepancies, and their impact on intervention.
- Compare results obtained with others from different studies and discuss their relevance and significance.
- Reflect on the degree to which your results are directly related to intervention and not to other random/indirect effects. (Can you find any other alternative explanations for your results other than the intervention?)
- Discuss how negative results can be explained.
- Formulate suggestions for future interventions and methods for developing outcome evaluations of similar programmes.

FIGURE 13: Tasks for Outcome Evaluation

OUTCOME EVALUATION CHECKLIST	
☐ 1. Make sure you have clearly and concisely formulated intervention objectives	☐ 4. Chose measures, data collection instruments, type of data, and data analysis strategies
☐ 2. Include indicators related to target's perception of intervention efficacy (qualitative and/or quantitative)	☐ 5. Guarantee appropriate sampling
☐ 3. Include indicators that measure intervention effects on target groups' behaviour	☐ 6. Discuss outcome results

3. Research

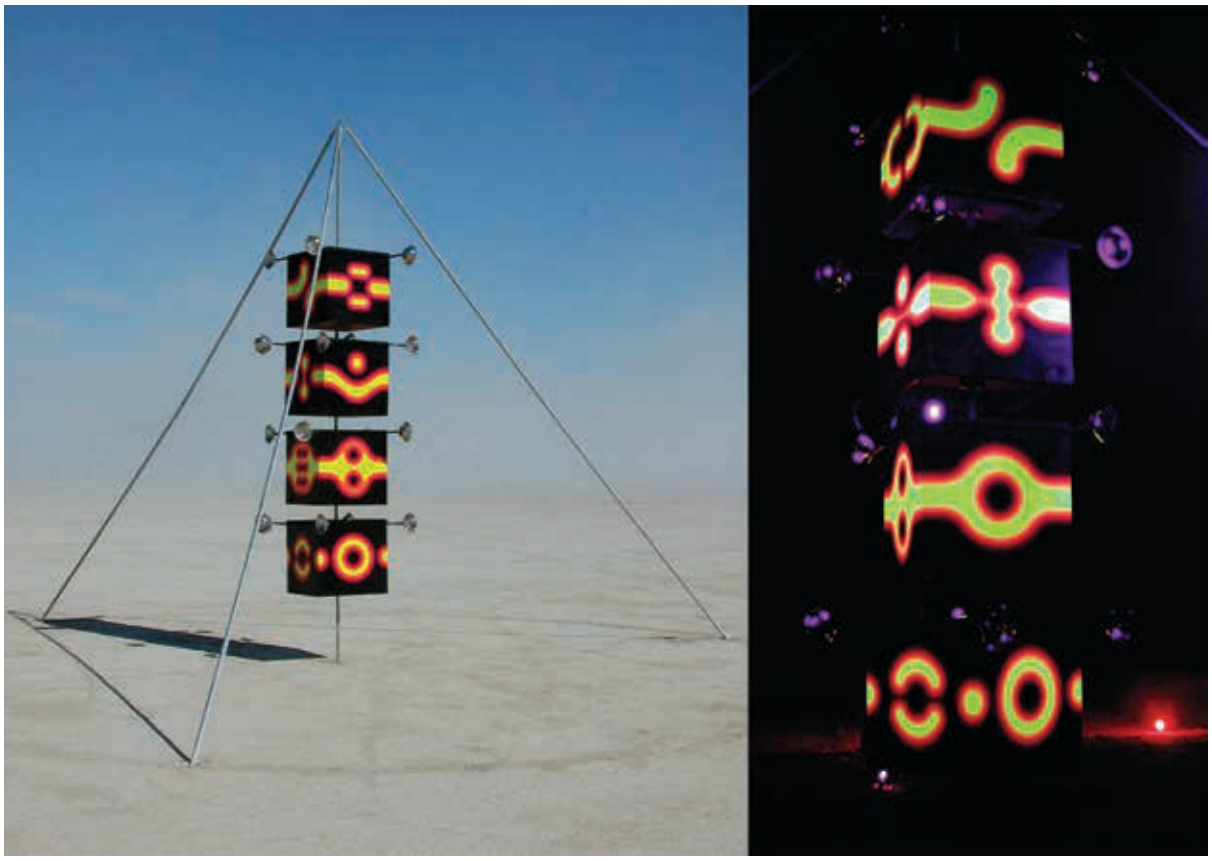
Earlier in this chapter we described the demanding nature of scientific research. We also stated that monitoring/feedback, evaluation, and scientific research have different objectives, and that contribution for the sake of scientific research may be a lower priority, given the scope of implementing a care service for psychedelic emergencies. Reasons to consider undertaking scientific research—for those who have the appropriate skills and resources—were also mentioned.

We do not wish to gloss over the highly specific scientific research method steps that require lengthy and comprehensive training. We simply want to share how research opportunities might arise in this field of intervention, and describe how they were developed in our own case.

You might have noticed above how the same indicators and questions contribute towards distinguishable objectives. Basic data monitoring that concerns, for example, your subject demographics may also provide valuable input that allows you to better characterise the subject population for process evaluation. Indicators and questions may also serve as a starting point for developing a more in-depth research project. You may want to consider the feasibility of following up on people who attended the care service, and how they perceived the benefits, if any, from their interventions. You may want to take the opportunity to study these individuals' life-trajectories with biographic research into their life histories, including experiences with psychoactives and other aspects you deem relevant.

In our case, an opportunity arose that allowed us to develop the *Mental State Exam Checklist* we created for outcome evaluation. We have decided to research the instrument's validity and psychometric properties by replicating its use within a sample of controls who are not under the influence of PAS, and outside of a recreational setting (Fugas 2011).

We realise that our exposition of scientific evaluation may seem exceedingly academic or overwhelming to some readers. Nevertheless, we would like to encourage you to always develop at least some form of monitoring and evaluation of your work, regardless of the scope of your project. If you need to apply for public or private funding, it is likely that you will be asked to present this kind of data. Keep in mind that the principles of monitoring and evaluation are fundamental to the deliberate improvement of the quality of your work, as is open communication with others on the topic. We encourage you to incorporate monitoring and evaluation into your work to achieve better results for your project, your team members, your event, and ultimately, for your guests and the quality of care they receive.



Wind Oracle *by Vibrata Chromodoris and David Shamanik had four rotating cubes suspended by a fifteen-foot steel tripod. The cubes featured mystical symbols that aligned according to the wind patterns in order to answer one's questions. Photographed on the playa at the 2003 Burning Man Festival by Vibrata Chromodoris.*

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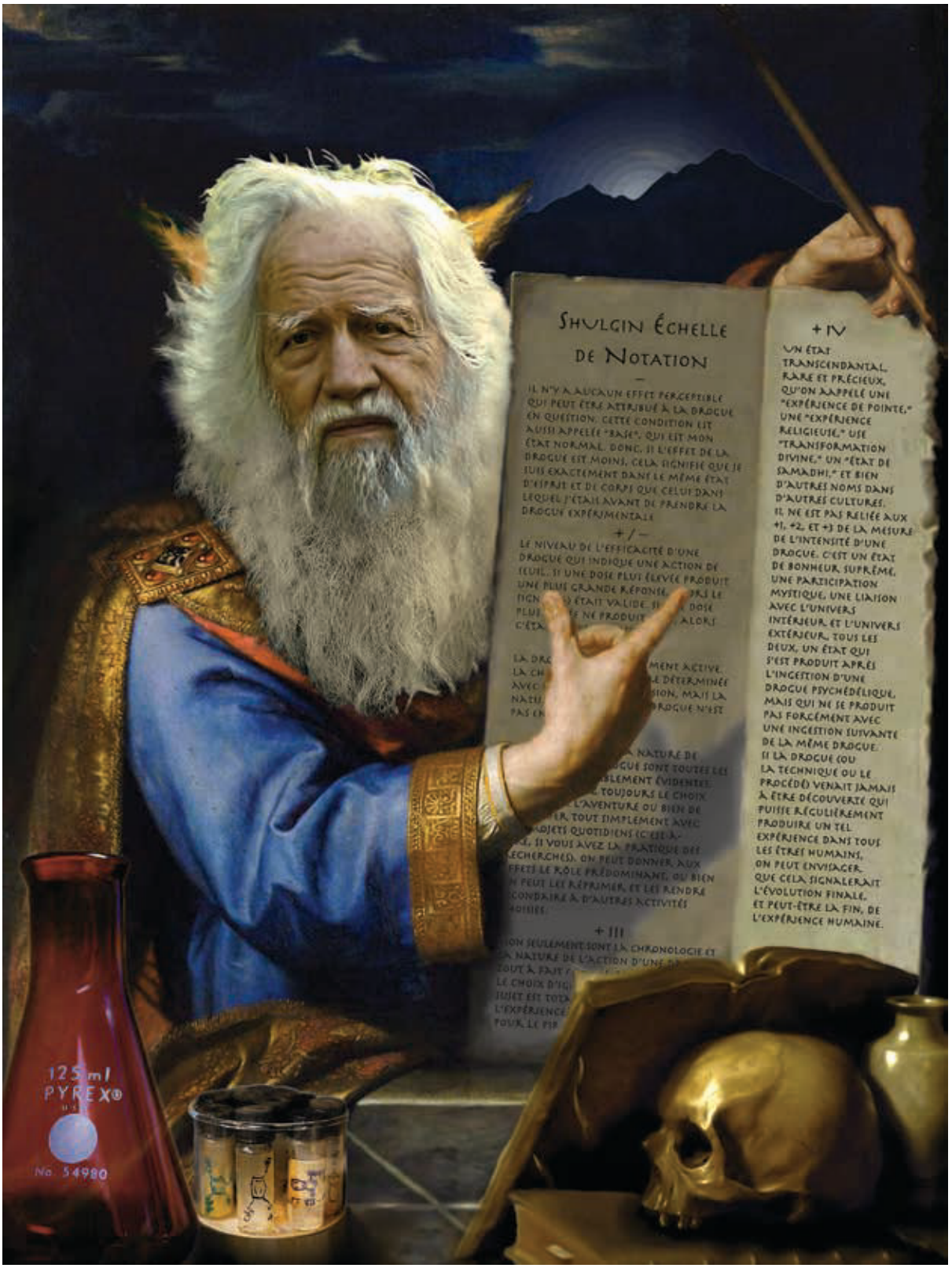

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