

—CHAPTER 14—

**A CONTEMPORARY HISTORY OF IBOGAINE IN  
THE UNITED STATES AND EUROPE**

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## I. Introduction

In 1995, Dr. Curtis Wright, then the U.S. Food and Drug Administration (FDA) ibogaine project officer, wrote “What’s clear is that a significant portion of the public we serve believes the drug merits investigation” (1). Wright’s statement intimates a relationship of public opinion to regulatory scientific policy. The statement was made at a time when the FDA, partly in response to highly motivated and organized public advocacy, was modifying its drug development process to accommodate the more rapid evaluation and approval of agents used to treat the human immunodeficiency virus (HIV) (2,3). As with treatments for HIV, ibogaine has been associated with a vocal activist subculture, which has viewed its mission as advocating the availability of a controversial treatment to a stigmatized and marginalized minority group of patients who suffer from a life-threatening illness.

Wright’s perception of significant public interest in ibogaine was derived from two related subcultural contexts. One such context is the medical subculture of the informal ibogaine treatment scene, and the other is the political subculture of advocacy for the development and availability of ibogaine. This chapter focuses on a contemporary history and description of the medical subculture of the informal treatment scenes of the United States and Europe, and the political subculture of ibogaine advocacy. The period of time spanned by the history presented in this chapter extends from the early 1960s to the present, and it is thus termed a “contemporary” history of ibogaine. Ibogaine has a long history of use as a ritual hallucinogen in Africa. However, the early 1960s marked the advent of the attempt to develop ibogaine as a treatment for substance dependence in the United States and Europe.

## II. Informal Ibogaine Treatment Scenes: History and Description

### A. OVERVIEW

Ibogaine is classified as a Schedule I drug in the United States, with a similar restricted status in Belgium and Switzerland. As a naturally occurring alkaloid that can only be patented with regard to use and not with regard to its structure, and with a mechanism of action that is unknown, ibogaine has been relatively unattractive to the pharmaceutical industry as a potential compound for clinical development. This has led to the existence of a distinctive, unofficial network

involving lay individuals conducting ibogaine treatments in nonmedical settings.

Two general types of ibogaine treatment exist. One type of treatment is oriented toward addiction, most commonly heroin dependence, and typically involves dosages in the range of 15 to 25 mg/kg (4-7). The other type of treatment, sometimes referred to as “initiatory,” involves a dosage on the order of 8 to 12 mg/kg, or approximately one half of that which is used for addiction, and is oriented toward the goal of facilitating psychotherapeutic or spiritual insight (8-10). The existence of these two types of treatment orientations indicates the importance of considering two aspects of ibogaine treatment, namely the pharmacological effects, and the psychological process and social setting.

## B. THE UNITED STATES

### 1. *H. Lotsof, NDA International, and ICASH*

*a. Initial Observations of the Effects of Ibogaine.* The setting in which the putative effect of ibogaine on opioid withdrawal was first noted was distinctly marginal with respect to the mainstream culture of medicine. Howard Lotsof serendipitously observed ibogaine’s effect on his own heroin dependence at age 19 in 1962. As described in the chapter by Lotsof *et al.* in this volume, he then administered ibogaine to a total of 20 individuals who were part of a lay network of drug users that ingested hallucinogens and somewhat systematically noted and compared their effects. This network appears to have been mainly motivated by curiosity and an interest regarding the subjective effects and possible psychotherapeutic applications of hallucinogens. The intellectual influences of the group included Aldous Huxley’s “Doors of Perception” (11) and the work of Timothy Leary (12). In 1962 and 1963, when the group was active, hallucinogens were not yet regulated (13,14). Lotsof described this period in an interview with the Yippie periodical, “Overthrow” (13):

*“The original work was conducted in 1962 and 1963 in New York, and this was prior to ibogaine being classified as a Schedule I drug. It was the early 60’s, there were no restrictions on LSD or mescaline or psilocybin. . . . The regulations pertaining to the restrictions on these drugs occurred in 1966 and 1967. We were not looking for a cure for heroin addiction or cocaine abuse. I was interested in psychoactive compounds and I established a research laboratory, S&L Laboratories, to procure drugs and administer them to interested persons . . .*

*. . . It was what was sweeping the country in the early 60’s, this enormous interest in psychoactive substances. . .*

*. . . We received ibogaine from both the United States and England, and what happened was this: I was given a dose of ibogaine from an associate of mine who was actually a chemist involved in a 1950’s LSD scene—most people don’t even know that there was a ‘50s LSD scene. . .*

. . . *It just happened at that time the FDA was beginning to investigate hallucinogens, and they realized that our laboratory was ordering large amounts of hallucinogens for experimentation, and they cut off our supplies. So we were not able to continue with this work.*"

Lotsof gave the initial dose of ibogaine to a friend. The group obtained more ibogaine and gave it at various dosage levels up to 19 mg/kg to a total of 20 individuals. A subset of 7 of these 20 individuals were heroin dependent and noted the alleviation of the symptoms of physical dependence and craving after taking ibogaine (4,7). Furthermore, 5 of these 7 individuals reportedly remained free of heroin for 6 months or longer following their treatment with ibogaine. All 7 individuals reported the alleviation of physical withdrawal from heroin, and the 2 individuals who returned rapidly to heroin use ascribed it to their continued identification with the role of the heroin addict, and not to persistent withdrawal symptoms. The activity of the group eventually ceased in 1963 when FDA and law-enforcement agencies eliminated the ability of S&L Laboratories, as Lotsof put it, "to procure drugs and administer them to interested persons" (13).

The setting in which the observation of the possible efficacy of ibogaine was made was unconventional, which led to its closure by federal regulatory agencies. Nonetheless, this was the methodological setting of the observation of the putative efficacy of ibogaine in opioid withdrawal and possibly other drug dependence syndromes. An important question is whether clinical observations regarding opioid withdrawal made in this setting can be methodologically valid. The idea of a lay psychotropic user's group as a means of drug discovery is quite unusual. However, there was a systematic aspect of Lotsof and the group's observation and documentation of effects at various dosage levels. An effect of ibogaine on the physical manifestations of opioid withdrawal, if present, might reasonably be expected to have been apparent to the members of this network of experienced users. Subsequently, there has been significant concordance between the observations reported within this original cohort and the ensuing clinical reports on ibogaine for the indication of opioid withdrawal (4-6).

*b. The Attempt to Develop Ibogaine.* In 1982, Lotsof formed a nonprofit corporation, the Dora Weiner Foundation, whose purpose was to promote the development of ibogaine. The nonprofit corporation was unsuccessful in attracting significant financial support. In 1984 it commissioned a review (unpublished) of the ibogaine research literature by Dr. Doris Clouet, who was eventually appointed Chief of the Opioid Pharmacology Branch at the National Institute on Drug Abuse (NIDA). On a psychological level, enlisting Clouet's involvement in project also represented the tactic of "normalization," reaching out to those with scientific credibility in order to offset the controversial and unusual image that ibogaine would surely have as a medication development

project. Clouet concluded that the mechanism of action of ibogaine did not appear to significantly involve direct opioid agonist or antagonist activity. The pharmaceutical industry responded unenthusiastically to Lotsof's attempts to develop interest in ibogaine. In addition to ibogaine being a naturally occurring plant hallucinogen originating from a highly irregular developmental setting, the pharmaceutical industry also generally viewed addiction as an economically unattractive area for medication development (15).

In 1986, Lotsof formed NDA International, a private company that issued shares of stock. He filed patents for the use of ibogaine in treating multiple dependence syndromes, including opioid (16), cocaine and amphetamine (17), alcohol (18), nicotine (19), and polysubstance dependence (20). He organized an international conference in Paris in 1987 and traveled to Europe and Gabon to secure sources of ibogaine. In the late 1980s, NDA established contact and provided ibogaine to researchers at the Department of Pharmacology at Erasmus University in Rotterdam, which resulted in the first paper indicating efficacy in an animal model of opiate withdrawal (21). The contact of Lotsof with the Erasmus University was provided by the Commercial Attaché of the U.S. embassy in Den Hague, who was aware of the newly formed Center for Addiction Research at the Erasmus University, whose mission was to develop creative approaches to addiction problems. As discussed below, the Erasmus collaboration also led to contact with the Dutch Junkiebond.

NDA International provided a small contract to the laboratory of Dr. Stanley Glick at Albany Medical College in 1989, which stimulated some initial pilot work with ibogaine. Subsequent research by Dr. Glick indicated the efficacy of ibogaine in animal models of opioid dependence (22,23). This marked the beginning of what is now a decade of work on *iboga* alkaloids in that laboratory. Lotsof reached out tirelessly to public and private sector scientists who might take an interest in the ibogaine project. A valuable contact was made with Dr. Charles Grudzinskas, who was provided with information about ibogaine while an executive at Lederle in 1990 and subsequently became Director of the Medications Development Division (MDD) at NIDA in 1991.

Ibogaine treatment could not legally be provided to humans in the United States, and patients recruited by NDA International were treated in the Netherlands starting late in 1991 until mid-1993. Prior to the advent of the NDA International treatments, an organization known as the International Coalition for Addict Self-Help (ICASH) began to provide treatments in the Netherlands in 1989. ICASH was an addict advocacy organization founded by Robert Sisko which described itself as having a self-help orientation in the tradition of European user self-help organizations, such as the Junkiebond in the Netherlands (14,24,25). ICASH made ibogaine treatment available to a network of heroin users in the Netherlands, among them the late Nico Adriaans, a cofounder of the Dutch Junkiebond (see below). This network of users included Dutch Addict

Self-Help (DASH), later known as International Addict Self-Help (INTASH), which provided approximately 10 ibogaine treatments to other Dutch addicts in 1990. Boaz Wachtel, a former medic in the Israeli Army, participated in the ICASH and DASH/INTASH treatments, as well as the treatments conducted by NDA International in the Netherlands. The results of the DASH/INTASH treatments were presented in publications from the Erasmus University group and a squatter's collective in Amsterdam (26,27).

A total of approximately 40 to 45 individuals were treated between 1989 and 1993 in the Netherlands involving NDA International and/or ICASH or DASH. The data from these treatments, together with the 20 subjects treated in the United States by Lotsof between 1962 and 1963, provide the principal source of the case study evidence that has been presented to the National Institute on Drug Abuse (NIDA) and the FDA (4). As indicated below, this total of approximately 60 cases may be a fraction of the total number of humans treated with ibogaine in diverse informal contexts in the United States and Europe.

The death of a patient in the Netherlands in June 1993 brought an end to treatments there by NDA International. The official Dutch inquiry was not conclusive regarding a causal role of ibogaine in the death (28). At the time of the death, the Dutch government was engaged in a protracted inquiry into the existing knowledge on experimental treatments for heroin dependence. The inquiry had been launched to provide background information for evaluating the experiment in heroin prescription (29). The death significantly decreased the enthusiasm to investigate ibogaine that did exist in official Dutch circles and stopped the development of a clinical trial protocol that had been quietly in progress at the Center for Addiction Research at Erasmus University. A small number of treatments were subsequently conducted by NDA International in Panama (30,31).

NIDA developed its own Phase I/II clinical trial protocol from October 1993 to December 1994. The resulting draft protocol involved single administration of fixed dosages of ibogaine of 150 and 300 mg versus placebo, for the indication of cocaine dependence. In March 1995, NIDA decided not to fund the implementation of the protocol it had developed. Opinions of consultants from the pharmaceutical industry were a significant influence in the NIDA decision not to fund human efficacy trials. The decision was naturally disappointing to the network of advocacy of ibogaine and indicated that the prospect for a U.S. clinical trial of ibogaine in the near future was no longer likely.

## 2. *Deborah Mash, the University of Miami, and St. Kitts*

Dr. Deborah Mash, Professor of Neurology at the University of Miami School of Medicine, became interested in ibogaine in 1991, after hearing presentations at a conference. In the context of the collaboration between NDA International and the University of Miami that began in 1992, she witnessed treatments arranged

by NDA International in the Netherlands. Mash undertook organizing a clinical trial of ibogaine, and in August 1993 she received approval of an Investigational New Drug Application from the FDA Advisory Panel chaired by medical review officer Curtis Wright. The Phase I dose escalation study protocol initially included only individuals with histories of having previously received ibogaine and called for these individuals to receive dosage levels of 1, 2, and 5 mg/kg. The study began in December 1993, but activity was eventually suspended, in the context of the unavailability of grant support. The relationship with NDA International had become strained and eventually involved litigation.

In 1996, Dr. Mash began an ibogaine treatment program in the Caribbean Island of St. Kitts. Treatments are oriented to the indication of addiction, mainly to heroin and cocaine. The program features medical supervision of the intake treatment process and includes cardiac monitoring, systematic collection of pharmacokinetic data, and the use of structured psychiatric interviews and rating instruments. The program attempts to remain in contact with patients for up to a year after the treatment by telephone or questionnaires, but it has not yet presented data relating to longer-term follow-up. As of the time of the writing of this volume, more than 150 patients have reportedly been treated in St. Kitts. In patients treated for the indication of acute opioid withdrawal with single dosages of ibogaine ranging from 600 to 1200 mg, physician ratings of withdrawal signs and symptoms appeared to indicate efficacy (5,32, see the chapter by Mash *et al.* in this volume), consistent with the case study literature (4,7,16,25-27,30,31).

### 3. *Eric Taub*

Eric Taub states he has arranged treatments conducted in the Caribbean since 1992 (33,34) and claims an estimated total of 310 such treatments, approximately 130 of which were sought for the treatment of addiction, predominantly heroin dependence. The remaining majority of treatments have been “initiatory,” involving nonaddicts seeking psychological or, as Taub puts it, “psychospiritual” insight as the therapeutic goal. He uses an overall range of doses of 9 to 12 mg/kg for an initiatory treatment, 12 to 18 mg/kg for cocaine dependence, and 20 to 24 mg/kg for dependence on heroin or methadone.

The majority of Taub’s treatments have been of the initiatory type, and he conceptualizes the personal work that his clients seek as an attempt to change a pattern of “reactive” or subconsciously determined behavior (33,34). In this regard he appears to be interested in conventional psychotherapeutic goals. A commonly pursued goal of conventional psychotherapy is to achieve insight as to how the processing of prior experience affects behavior, so as to allow greater conscious flexibility and spontaneity in adapting to the demands of the present, rather than subconsciously determined reaction.

Taub regards obsessive behavioral tendencies as particularly responsive to ibogaine treatment. He appears to identify a common attribute of pathologically

acquired or “learned” associations in addiction, obsession, and forms of “reactive” behavior that might conventionally be described as neurotic. A common attribute of these behaviors is an intense subjective motivational state elicited by an environmental cue or an internal representation, and a subsequent repetitive, inflexible behavioral response. Similar to the conceptualization suggested by Goutarel (35), ibogaine’s putative effect in facilitating psychotherapeutic change, as well as treating addiction, is viewed as involving attenuation of pathologically acquired or “learned” linkages that associate cues or internal representations with corresponding motivational states and behavior.

Taub reported that it is common for individuals who have taken ibogaine to reflect on and process the content of their experience for months afterward. This does not imply some sort of “flashback” or reexperience of the subjective state of being on ibogaine, but a continued interest in the meaning of the material that emerged during the ibogaine experience. He also noted that women seem to experience visual phenomena from ibogaine to a greater extent than men, possibly reflecting the greater bioavailability of ibogaine in females versus males noted in animal models.

Taub estimated that about 70% of addicts treated in their 20s or 30s, and 30% of those treated in their 40s or 50s, eventually return to their prior drug of dependence. He views ibogaine as creating a “window of opportunity” of diminished craving for several months after treatment during which time involvement in aftercare is essential to prevent eventual relapse. The idea of the post-treatment period as critical for processing the content of the ibogaine experience, gaining an appreciation of the psychological aspects of one’s addiction, and establishing participation in aftercare is shared by others who have been involved in the treatment of drug dependence with ibogaine (7,36).

#### 4. *The West Coast and Other North American Scenes*

There is apparently a network involving the use of hallucinogens, including ibogaine, as psychotherapeutic agents that has existed on the West Coast of the United States since the 1950s (8-10,14). This network has operated with a low profile, and there is no Web site. The focus of ibogaine use in this setting has mainly been psychotherapeutic and not the treatment of addiction, and it apparently has included the significant involvement of credentialed health professionals.

According to Stolaroff (10) in his book *The Secret Chief: Conversations with a Pioneer of the Underground Psychedelic Psychotherapy Movement*, the dosage of ibogaine administered by his informant was reportedly in the range of a total of 150 to 300 mg, as a single fixed dose, which did not frequently cause hallucinations. Some of the expectations and beliefs regarding the use of ibogaine in this setting appear similar those regarding LSD and other serotonergic hallucinogens (37-39), although ibogaine appears to be attributed with some distinctive features.

In agreement with the account of Taub above (33,34), Stolaroff's informant also described the phenomenon of patients reflecting on and processing the material that emerges during an ibogaine experience continuing for months after the session. This phenomenon is described as a relatively distinctive attribute of ibogaine relative to other psychedelics. Stolaroff's informant also attributed ibogaine with particular efficacy in "blocks":

*"This is a place where people will confront blocks, as a matter of fact, if they have been unwilling to accept them or believe them or often try to deny them. A truth that you're trying to deny. Ibogaine won't let you do that."*

The effect attributed to ibogaine as a psychotherapeutic agent in the above statement appears to involve particular efficacy in individuals with a behavioral set that is overly constrained, and has a general resonance with attributions of efficacy in changing "reactive" or obsessive behavioral patterns (33,34). Another putative ibogaine effect is the existence of a "window of opportunity" following ibogaine treatment, during which there may be a heightened interest and capacity for engagement in the psychotherapeutic process (7,10,33,34,36). Operationalizing and studying such effects, although challenging from a research perspective, could be relevant to optimizing patient management, if ibogaine were to be approved for clinical use.

### C. THE NETHERLANDS

#### *1. DASH/INTASH and the Center for Addiction Research at the Erasmus University*

Following his treatment in May 1990, ICASH provided Nico Adriaans with enough ibogaine to treat approximately 10 other addicts. These addicts were treated in the summer of 1990 by a group that referred to itself as DASH, and subsequently INTASH, which at that time consisted mainly of three individuals: Adriaans and his girlfriend, Josien Harms, and Geerte Frenken. The treatments were conducted at Nico Adriaans's apartment in Rotterdam. A description by Frenken, whose chapter is included in this volume, of these treatments reveals an attempt to create ritual (14):

*"We'd have the person come over the night before his treatment and introduce ourselves as Mamma and Papa Iboga, because the addict is the child going through rebirth. We would tell them about the African ritual the night before the treatment so that they'd totally know what they were going to face. We'd tell them that the Africans use it basically to guide people into adulthood so that they become more responsible people, and that's what we'd be doing. Making a person more responsible in life, so that he'd have control over drugs instead of drugs*

*over the person.*

*If the person was a shooter, we would let him or her take their last shot, then let her or him destroy their syringe, symbolizing the destruction of their addiction . . .*

*. . . We had a room with two doors, which was perfect. We'd move someone in through a door with the moon painted on it, into the room where they would have the experience, and then after treatment guide them out the doorway decorated with a sun."*

The treatments, mainly for heroin dependence, reportedly went smoothly and were successful in achieving the goal of alleviating the symptoms of acute withdrawal, and those treated denied craving and generally avoided heroin for weeks or months afterward. A focus group was formed of those who had been treated in an investigation conducted in collaboration with the Center for Addiction research at Erasmus University. Eva Ketzer, a physician intern attached to the center, facilitated the groups and compiled data for scientific publication (26). However, as time passed, the pull of the social network of the users, and possibly the gradual attenuation of the apparent effect on craving became increasingly evident.

*"[T]hey basically all slowly but surely fell back into their addiction. The people who were dealing the heroin were very powerful, socially. They had friends in the focus group going back ten, fifteen years—they went all the way back to hippie times together. They had been through all kinds of shit and they had this intense bond.*

*The leader of this group was a heroin dealer . . . In the end he won. After the ibogaine people realized they were alone, and discovered that the one thing they had in common was that every day, they used to sit at this guy's table and get together—and that this contact would happen because of smack (which was his income). In the end they all fell back into heroin to maintain the social contact, and the ibogaine was wearing off."*

The focus group eventually dissolved. The focus group experience appeared to indicate that it would be necessary to integrate ibogaine into conventional treatment settings, such as the therapeutic community, in order to produce lasting success. It was envisioned that in such a formal treatment setting, the addict patient could be involved in a therapeutic milieu that could protect against the social isolation that appeared to be a major determinant of relapse in the focus group cohort.

The dissolution of the focus group marked a stormy time at the Center for Addiction Research at Erasmus University. Adriaans and Harms were both employed as community field workers at the center. Their function was to

maintain contacts with the heroin addict populations and recruit their participation in center projects. The director of the center at that time, Dr. Charles Kaplan (a co-author of this chapter), had been introduced to Lotsof, and the ibogaine issue provided a unique opportunity for investigating innovative treatments. The idea was to initiate an ibogaine medication development project at Erasmus University that would start with animal Phase I studies and progress to clinical trials. However, the activist spirit of Nico Adriaans and Lotsof found common ground, and they undertook the initiative of providing informal treatment to Dutch addicts, an action that they felt was legitimized by the AIDS epidemic. (Nico Adriaans eventually died of AIDS in 1995 (40), and a foundation was established in Rotterdam that bears his name and continues his work.) Although Kaplan was sympathetic to this development, it went beyond what was officially permissible with regard to the ibogaine medication development project. Nonetheless, his assistant, Eva Ketzer, had been authorized to work with Adriaans to study the ongoing underground treatments. This *ex post facto* approach had been considered ethically acceptable since it simply organized a systematic way of observing the self-help initiative of the addicts themselves that already existed outside of the boundaries of formal addiction treatment in the Netherlands.

The tension between official institutional policy and the collective sentiments of the Addiction Research Center intensified with the appearance of sensationalist “success” stories in the international press, which focused an uncomfortably large amount of publicity on the center. This wave of publicity precipitated a controversy and displeased some of the members of the board of the Erasmus University and the private foundation that supported the Addiction Research Center. The underground informal ibogaine treatments were perceived as irresponsible and potentially dangerous, and they raised concerns with the publicity, which appeared to associate the center with the unauthorized ibogaine treatments. A backlash developed in official circles concerned with addiction and medical policy in the Netherlands, which ultimately resulted in the removal of Kaplan as director of the center in 1991. The staff at the Addiction Research Center persisted in attempting to develop a protocol for an ibogaine clinical trial for some time after the departure of its director, but it eventually abandoned the project.

DASH members, mindful of the apparent limitations of their treatment setting, became more focused on attempting to involve the professional drug addiction treatment community. In 1992, in conjunction with NDA International, four treatments were conducted that were observed by Dutch physicians affiliated with the Nederlands Instituut voor Alcohol en Drugs (NIAD) and by American physicians, including Dr. Lester Grinspoon of Harvard Medical School and Dr. Carlo Contoreggi of NIDA. The treatments went smoothly and impressed those present, but did not in themselves succeed in introducing ibogaine into the

conventional addiction treatment community in the Netherlands.

## 2. *Jan Bastiaans*

Dr. Jan Bastiaans was a major figure in the history of the psychotherapeutic use of hallucinogens (41-43). He was a professor at the State University of Leiden from 1963 to 1985. Active with the Dutch resistance during the Second World War, Bastiaans had a long-standing interest in the incorporation of pharmacologic methods into the psychotherapy of war-related trauma. In 1961, he began utilizing hallucinogens for this purpose and eventually treated approximately 300 patients with LSD and psilocybin. As with a number of other researchers who were interested in the possible medical use of hallucinogens, Bastiaans's work became increasingly stigmatized with the rise of the drug culture, and he eventually became the last remaining Dutch psychiatrist with official authorization to use hallucinogens clinically.

The individuals he treated included the Israeli writer Yehiel De-Nur, a survivor of Auschwitz who wrote under the name Ka-Tzetnik 135633 and published an account of his treatment (44). It appears that Bastiaan's clinical skills were well respected by his peers, but the controversy over hallucinogens left him isolated politically in his profession. Doubts existed as to the safety of hallucinogens and whether his methods were sufficiently well systematized to be as effective when utilized by others. A report published in 1987 on behalf of the State Department of Public Health concluded that the data was insufficient to systematically evaluate the effects of Bastiaan's treatment approach.

Bastiaans began working with NDA International in 1992 and was present at a total of 18 treatments from 1992 to 1993 (4). In June 1993, a patient died during a treatment, and Bastiaans, as supervising medical doctor, was asked to end his therapeutic practice by the Medische Tuchtraad, the Dutch supervisory board of the medical profession. The official Dutch inquiry into the case did not substantiate any charges of wrongdoing by Bastiaans, and noted uncertainty in determining the cause of death due to the lack of information regarding the toxicological significance of post-mortem ibogaine or noribogaine levels, as well as the possible involvement of surreptitious heroin use during the treatment (28). However, the adverse action of the Medische Tuchtraad apparently related to an administrative failure in obtaining official permission regarding the use of an experimental treatment. Bastiaans died in October 1997, and in his last years he had become bitter over the lack of recognition for his methods in the medical profession.

## D. OTHER EUROPEAN SCENES

### 1. *Slovenia*

According to Marko Resinovic (45), founder of the Slovenian Iboga

Foundation (46), a treatment scene has existed in Slovenia since 1995. He has estimated that approximately 150 people have been treated within multiple networks in Slovenia. The majority of those taking ibogaine have done so for the indication of opioid dependence, with a minority for psychotherapeutic reasons. The foundation's role is to provide information about the use of ibogaine and to assist individuals and their social or family networks in arranging the treatment situation. The foundation is also a source from which ibogaine can be purchased, and the price of the ibogaine for the treatment of a heroin addict is currently the equivalent of approximately US \$200 per gram. The scene in Slovenia seems loosely organized, with addicts often setting their treatments up individually. Outcomes in this scene have not been systematically tracked, and it is difficult to assess what the collective clinical experience with ibogaine has been in Slovenia. Dr. Andrej Kastelic, the head of the Center for Treatment of Drug Addiction in Ljubljana, Slovenia's main addiction treatment center, described variable results in the patients with whom he came in contact. He reported the apparent efficacy of ibogaine in acute withdrawal, but commonly with relapse to heroin use within days to weeks (47).

## 2. Denmark

A relatively large ibogaine scene is alleged to exist, or to have existed in Christiana, a former military barracks located in a suburb of Copenhagen turned squat and currently occupied by approximately 1200 people. This information was furnished to one of the authors of this chapter (K.A.) by Carl Waltenburg, a 45-year-old Danish man who describes a lifelong interest in hallucinogens as a psychological or spiritual paradigm (48). He has also apparently been involved with hallucinogens as an entrepreneur. He claims to have been associated with Christiana since its inception in 1972, and he first encountered ibogaine in the context of general interest in the psychotherapeutic or sacramental use of hallucinogens. He believes that ibogaine and serotonergic hallucinogens, such as LSD, share a common attribute of facilitating insight, but that ibogaine is distinctive with respect to its efficacy against the physical symptoms of opioid withdrawal. He also has described the use of low doses by nonaddicts for an apparent stimulant-like effect, similar to the use of tablets containing 8 mg of ibogaine which were marketed as Lambarène in France before being banned in 1970.

Waltenburg stated that in 1981, a European industrial manufacturer took an interest in ibogaine and created a 44 kg supply of alkaloid extract from 500 kg of *Tabernanthe iboga* root bark. He eventually obtained possession of this supply of the alkaloid extract, which he refers to as "Indra," and estimated that the total number of heroin dependent individuals who have received it through the Christiana network is approximately 1000. The Indra ibogaine extract is said to have been available through the Christiana network and more recently has been

sold via the Internet (49). The current price of a gram of extract is approximately US \$25. The alkaloid content of the Indra extract is said to be approximately five times that of dried, unextracted root bark, and total *iboga* alkaloid content is claimed to be on the order of 20%. The assertion that this alkaloid extract supply dates back to 1981, and the uncertainty regarding the conditions under which it has been stored raises questions regarding its content, stability, and whether samples taken from various physical locations within this supply are uniform. In January 2000, e-mails posted to the Ibogaine Mailing List (50) alleged that in London, a 40-year-old heroin addict who died had taken 5 g of Indra extract 40 hours prior to his death. At the time of the writing of this book, the official British inquest into the matter is in progress.

Waltenburg stated that he began to guide sessions in 1982 that involved a total of about 100 heroin users that year, with some treatments conducted simultaneously on groups of up to eight patients. The duration of sessions was typically 2 days. Subsequent to 1982, he guided about 70 more treatments until the present time, with the remainder of the total of 1000 treatments involving other guides who had acquired their experience in the Christiana network. Approximately half of these heroin dependent patients predominantly used the intravenous route, with the remainder smoking or snorting.

This account, while certainly interesting, conflicts significantly with accounts provided by other informants (51,52). The authors of this chapter have not been able to find any independent informant that confirms the existence of the putatively extensive Christiana ibogaine scene. The account of an informant referred to the authors of this chapter by the Danish Drug User's Union (51) is inconsistent with that of Waltenburg. Richard T. Lionheart, a Christiana resident of 28 years from the time of its inception, does not recall ever meeting Waltenburg. He was not aware of the use of ibogaine in Christiana, and certainly not on anywhere near the scale Waltenburg claimed. Lionheart provided a different account of how Christiana came to terms with its heroin problem. By 1979, Christiana was afflicted with a severe heroin crisis, and over one-third of its adult population was addicted (52). A policy termed "blockade" was adopted, under which all addicts were forcibly removed from Christiana and forbidden to return until they had been off heroin for 6 months. Detoxified heroin addicts were often sent to communes in the North of Denmark and were then permitted to return to Christiana after 6 months. After the imposition of the blockade policy, a "zero tolerance" policy toward hard drugs was imposed in Christiana. The cannabis dealers of Christiana were permitted, but not their counterparts who attempted to sell harder drugs. Lionheart stated that a number of "alternative" treatments had been considered for detoxification, including ibogaine, and were eschewed in favor of the "cold turkey" approach, apparently mainly on philosophical grounds.

*“We decided instead to use ‘cold turkey’ because it seemed to last the longest. There might be an aspect of difficult come difficult go.*

*A reason not to use ibogaine or acupuncture was to not send a signal of ‘Drugs are not so risky. If you get addicted you can always get to the reset button through ibogaine or acupuncture.’ It was a period of time when a lot of people in Denmark and especially in Christiania got addicted.*

*So we did things the hard way.”*

The above conflicting accounts exemplify some of the methodological difficulties and uncertainties of conducting a contemporary historical study. There simply is not enough distance from the historical phenomenon to assemble and sort through all the relevant evidence. Nevertheless, we can tentatively conclude that while the lack of confirmation raises doubts regarding Waltenburg’s account, it appears possible, given the apparent philosophical and power differences, that the use of ibogaine in Christiania could conceivably have occurred in a secretive context not revealed to those who imposed the “blockade” policy.

### 3. *The Netherlands*

While the addict self-help scene of the late 1980s and early 1990s no longer exists in the Netherlands, a newer scene emerged in late 1999. “Sara,” a mother of five children without a formal medical background, described treatments with ibogaine in her home located in the countryside outside of Amsterdam. She stated that as of November 2000, she had treated 15 individuals for the primary indication of opioid dependence, 5 for cocaine dependence, 2 for alcohol dependence, and 4 individuals whose motivation was “psychospiritual”. Most patients are from the United States. Her interest in ibogaine began with Eric Taub and Dan Lieberman’s visits to the Netherlands in 1999, and she herself took ibogaine in an “initiatory” session before beginning to treat others in December 1999. She usually used 3 to 6 g of “Indra” (49), an extract of *T. iboga* root bark. She has also occasionally used ibogaine hydrochloride at dosages of 300 to 500 mg to bring about a more rapid onset of action in patients who are already evidencing signs of opioid withdrawal. Her reason for combining the root bark extract and the purer hydrochloride appear to be pharmacokinetic. She described the hydrochloride as having a faster onset of action, which is desirable in patients who are verging on acute withdrawal, whereas the extract is described as having a more sustained peak effect and a slower onset of action.

The cost of the treatment at Sara’s home is approximately US \$600 to \$1000, and she described her main compensation for her role as “not a great income, but a great pleasure.” She has placed great importance on empathic contact between the treatment guide and the patient, and stated she sometimes takes a small dose of approximately 1/2 g of the extract to strengthen the bond with the patient and to maintain her own wakefulness through the all-night session. She believes that

her home setting is reassuring to many of her patients, who receive the treatment in a darkened room in her house. She noted that some patients prefer to speak about issues such as the negative self-image of the addict or their hopes for the future, while others prefer simply to be left alone to attend to their inner experience. She noted the importance of aftercare and for treated addicts to form new nondrug-centered social networks after treatment, and she believes that social isolation is a major factor involved in relapse. She has attempted to encourage treated addicts to maintain contact with one another in the form of support groups, but noted that the interest in this among the addicts she has treated appears to have been limited.

#### 4. *The United Kingdom*

An ibogaine scene began in the United Kingdom in 1998, apparently stimulated by among other things, the appearance of a lengthy article on ibogaine in the *London Times* Saturday Edition (53), distribution of the book *The Ibogaine Story* (14), and an ibogaine video by the ibogaine-advocating organization Cures-not-Wars (54) (see below) that circulated among members of the Green Political Party and others interested in drug policy reform. In 1998, activists Chris Sanders and Nick Sandberg formed their respective organizations, The Ibogaine Project (55) and Ibogaine.co.uk (56). They journeyed to Slovenia to purchase a supply of ibogaine, and treated an addict in the United Kingdom in December of that year.

The ibogaine treatment scene in the United Kingdom is loosely organized and not apparently centered around any single organization or individual. Ibogaine has been available in certain small shops in the United Kingdom and can be purchased via the Internet as well. It is estimated that as of late 2000, underground treatments were proceeding in London with a frequency of approximately one per week (57,58). The Ibogaine Project has been involved with activities related to political organizing such as influencing the Greens to officially include advocacy of ibogaine research and treatment in their agenda and lobbying the Lord Mayor of London to support an ibogaine treatment and research project involving local physicians. Ibogaine.co.uk has mainly been involved in advocacy in the form of activities such as distributing pamphlets and organizing lectures.

#### 5. *Italy*

A small scene has existed since 1994 in Italy involving a chemist who made local contacts in Africa and developed his own method of extracting ibogaine from root bark shavings (33). Approximately 35 to 40 people have been treated, predominantly for heroin dependence.

#### 6. *Czech Republic*

A treatment scene began in the Czech Republic in January 2000 (59). A total

of approximately eighteen opiate-dependent addicts and 60 nonaddicts were reportedly treated. The cost of the treatments was the equivalent of about US \$500. Nonaddicts received dosages ranging from 13 to 18 mg/kg, and addicts 20 to 22 mg/kg. The treatment provider terminated this activity approximately a year after beginning it, due to his impression that offering ibogaine treatment alone without systematic aftercare appeared to yield limited benefit.

### 7. France

G., who is discussed here anonymously due to uncertainty regarding the position of French authorities on the use of ibogaine in that country, was initiated into the Bwiti cult in 1980, and has conducted ibogaine sessions in France and Cameroon since 1998. In France, he has treated 11 people, one for heroin dependence, 1 for alcoholism, 6 for psychotherapeutic purposes, and 3 “out of curiosity.” The sessions have generally been at no cost. G. has usually conducted the sessions on his own, although a Gabonese Nganga (guide) did participate in one individual’s treatment, at a cost of approximately US \$1000. G. noted that drug and alcohol use seemed to be decreased for a variable length of time following ibogaine, regardless of the indication for which the session was sought. G.’s sessions in Africa are described further below.

## F. AFRICA

This chapter focuses on ibogaine use in the United States and Europe. However, the work of two individuals is discussed here who have been involved in arranging African Bwiti ceremonies predominantly on behalf of Europeans or Americans.

Dan Lieberman (60), an ethnobotanist based in South Africa and a Bwiti initiate, had been involved in arranging initiations for Europeans and Americans in Gabon, and also apparently treated heroin addicts in South Africa. He unfortunately died in an automobile accident in August 2000. It is estimated that Lieberman arranged approximately 20 ibogaine experiences in Africa (33). The following description emphasizes his respect for, and his experience of, the sense of community and empathy in the Bwiti ceremony (61):

*“The plant tends to throw one directly into a state of “sacred knowing,” a state unclouded by thought. The more profound the stillness experienced, the greater will the initiates insights be, and the more fundamental and abiding will the changes thus be... The Bwiti, who understand this state perfectly, have developed a culture of healing around this plant, which is embodied in their initiatory ceremonies. These are musical outpourings of ritualized compassion and caring, which show the indivisibility of healing, art, music, dance and religion in a most perfect and sublime manner.*

*These initiations are held for those people who request it, and only Bwiti initiates (those who have eaten of the plant) are able to initiate others. The Bwiti practitioners' entire lives are suffused with a consideration and an awareness of the interconnectedness of all things. They live in and around the temples, which are the center of village life, and have a respect for the sanctity of healing, and for the inherent potential for goodness in every human being. . . . The entire village takes part in the ritual, each individual having a specific role to perform, instrument to play, part to sing, and they know the ceremony intimately. It is a combined effort by the whole village, rich in cultural nuance and significance, and that you, as initiate, as neophyte, are the centre of all their focus, that you are the 'Banzie,' makes this a very powerful experience indeed."*

Lieberman clearly believed that the set and setting of ibogaine administration are important, and that the Bwiti ceremony, as he has experienced it in Africa, has significant implications for optimizing the use of ibogaine for the indication of addiction:

*"In personal communications and e-mail correspondence with various addicts who had undergone the iboga/ibogaine treatments, I found that inadequate or incompetent caregiving was often cited as a barrier to greater insight. (To the Bwiti this is the heart of the matter—the sanctity of the temple, its members, rites and accordances are the foundation of a successful and pure initiation.) For a more enduring effect, particularly for those staving off addictions, it seems that the setting is critical to the longer-term efficacy of the experience."*

G., whose activities in France have been previously discussed, has also arranged Bwiti initiations in Cameroon for a total of seven individuals, three of whom sought help for heroin or alcohol dependence and four who sought a "mystical experience." The cost of these experiences was approximately US \$1200 to \$2000. G. stated that he no longer arranges these ceremonies, because "for Westerners, staying with local people in their home and adhering strictly to the traditions is too hard" and that "Although it is bearable for someone who comes back cured of addiction, such is not the case for someone searching for a mystical experience and who discovers the infernal (and real) life of Africans. I discontinued initiations . . . I expect to have them in a context more suited to our poor little aseptitized bodies."

A problem with arranging "iboga tourism" is the lack of control over the conditions and circumstances of the ceremony, and there can be problems such as malaria, or unexpected negotiations regarding the fee at inopportune times (56). It should be kept in mind that there is considerable variability with respect to any number of factors such as experience, interest in initiates, and the manner in which the Bwiti ceremony is practiced by its adherents.

### III. The Political Subculture of Advocacy

There has been energetic public sector activism on behalf of ibogaine, much of which is associated with the lay NDA/addict self-help treatment network that originally accumulated the clinical case study evidence that was presented to the FDA and NIDA. In addition to interactions with NIDA and the FDA, ibogaine activism has encompassed activities such as participating in harm reduction or drug policy oriented conferences and engaging the media. Ibogaine advocates did network with activist organizations that had a history of utilizing aggressive and provocative tactics of civil disobedience that resulted in arrests of demonstrators. However, no arrests ever resulted from the generally calm and orderly actions and demonstrations that were staged on behalf of ibogaine.

Activists were regularly included in major NIDA and FDA meetings on the development of human research with ibogaine in the years of NIDA's ibogaine project from 1991 to 1995. Ibogaine advocacy sought to influence the public sector, which controlled policy and budgetary decisions of great importance for ibogaine's possible development. NIDA underwrote most of the research expenditures for preclinical and toxicological work on ibogaine's development as a pharmaceutical agent and weighed the possibility of funding its own human clinical trial. The FDA provided the regulatory authorization to permit going forward with clinical trials.

In the United States and Europe, there is a history of groups afflicted with an illness organizing in order to influence public policy through political activism. Examples of this include the health activists who have organized around AIDS or breast cancer (2,3,62,63). Such groups are bound by a sense of group identity, share a feeling of being marginalized, and have formed their disease specific agenda in the context of a preexisting political agenda. AIDS activists organized in the context of a preexisting gay political movement, and breast cancer activism in the context of feminism. The preexisting political base for the advocacy of ibogaine was that associated with drug addiction, and it included the European drug-user self-help unions, and harm reduction and AIDS activism communities in the United States.

The use of ibogaine originated in a medical subculture, involving individuals without formal medical training or credentials and the treatment of a stigmatized condition. Identification with marginalization and stigmatization is a resonant theme in the contemporary history of ibogaine and an important element of the group identity of those involved in ibogaine's advocacy. Advocates of ibogaine experienced themselves as having witnessed strong evidence of efficacy in themselves or others, but felt that their observations were discounted and their views excluded due to their lack of credentials. Many of its advocates believed ibogaine had not been developed because society has marginalized and

stigmatized addicts and did not want to expend resources to develop treatment, and furthermore discounted evidence of the efficacy of ibogaine because it originated from a nonmedical network involving addicts. Activism was a response to the perception of marginalization, and providing ibogaine treatment was viewed as a legitimate act of civil disobedience.

The ibogaine project drew a constituency from other activist groups whose collective identity also featured a sense of marginalization and whose agenda might accommodate ibogaine advocacy. The AIDS Coalition to Unleash Power (ACT UP) was the most tactically important alliance with a group possessing a related agenda. The shared agenda of ACT UP and ibogaine was to accelerate the development of treatment for drug dependence as a disorder causing an increased rate of transmission of HIV. The prospect of user self-help in the development of an effective, alternative and noncoercive treatment approach interested the Dutch Junkiebond. Some common ground existed with drug policy reformers who generally favored the development of treatment instead of incarceration and the drug war and because the scheduling of ibogaine and its stigmatization as a “psychedelic” arguably impeded ibogaine’s development. Issues of potential interest from an African-American perspective involved the community impact of the drug problem, and the ethical and outreach aspects of clinical research in the community, to the Afrocentric theme of the retrieval of a “lost” traditional medicine.

## A. ORIGINS AND ACTIONS

### *1. Activist Tactics*

The most significant activist tactic employed on behalf of ibogaine was simply to spread information. The advocates of ibogaine felt they had a strong case, with the apparent congruence of the human case reports and animal work indicating evidence for efficacy, and their convictions drew on their own personal experience and the collective experience of the network. The advocates of ibogaine were energetic with respect to the distribution of scientific literature, seeking contact with the media and networking with the drug policy and harm reduction activists. Arrangements were made for physicians or professional researchers to witness treatments, sometimes discreetly and confidentially. Individuals who had been involved in the treatments shared their first person perspective at conferences and meetings, and in interviews with the media. NDA International frequently mailed collections of reprints from the scientific literature on ibogaine to various individuals in industry, academia, or government, and also distributed them at conferences and meetings related to drug policy or harm reduction.

## 2. *Civil Disobedience*

The classic model of nonviolent civil disobedience advocated and exemplified by Mohandas K. Gandhi or Martin Luther King, Jr., involved the violation of the law in such a way as to challenge the onlooker to question the morality of the law or policy at which the action was directed. On the New York ACT UP Web page a piece titled “Why We Get Arrested” (64) bluntly summarized that activists who make use of civil disobedience to attempt to achieve change must “1) make absolutely clear what change is desired, usually by listing specific demands; 2) target a group or individual with the power to bring about the desired change; and 3) design actions so that the cost of resisting change is perceived by the person/group in power to be greater than the cost of giving in.” This approach appears to have been effective, and ACT UP employed these techniques repeatedly with significant success in gaining specific agenda items such as lowering the price of some medications from pharmaceutical manufacturers or accelerating the regulatory process of medication development at the FDA (3).

Advocates of ibogaine did not engage in this sort of civil disobedience, although some of the organizations with which they networked did. The classic paradigm of civil disobedience involves the deliberate, open violation of an unjust law. When advocating the development of ibogaine as a treatment, the advocates of ibogaine did not break the law and never were arrested in any action or demonstration. Treatments such as those arranged in the Netherlands or St. Kitts could not have legally been conducted in the United States, but could be conducted legally in accordance with local law. Also, the treatments for the most part were not “open” and subject to the bounds of confidentiality. Nonetheless, the perceived apprehension of the FDA or NIDA regarding possible civil disobedience on behalf of ibogaine may have been useful in gaining activists access and possibly influencing the development process of the ibogaine project, as for example the “Storm NIDA” action of July 1991, which is described further below.

## 3. *The Tactics of Political Theater and Confrontation*

Health activists, who have become accomplished practitioners of political theater, have drawn from a heritage of tactics once previously associated with the radical left. The Dutch Provos (as in provocateur), which originated in Amsterdam in 1965 (65), were a seminal influence in the tide of countercultural protest that eventually peaked in Berkeley, Mexico City, Prague, and at the Democratic Convention in Chicago in the summer of 1968. The Provos embraced an attitude of antiauthoritarianism, a sense of “no going back” to the past, and a general tactical approach of attempting to provoke furious, embarrassed reaction from the authorities with highly theatrical, and often absurd actions (66).

The Provos were a major constituent from which the American Yippies formed in 1967. In the Netherlands, the Provos also gave rise to the Kabouters (translated

**Who's Keeping the African Cure out of Harlem?**

**9:00 AM SATURDAY, MAY 1**  
**HARLEM STATE OFFICE BLDG--125th**  
**St. & ADAM CLAYTON POWELL BLVD.**  
**MARCH** OR HERB KLEBER'S DOWNTOWN OFFICES AT **10:20 AM**  
 for more info: Black Treatment Coalition (Rommel) 212-666-8000  
 Harm Reduction Coalition 212-677-4899

The poster is a collage of various elements. At the top, it features the title "Who's Keeping the African Cure out of Harlem?" in large, bold, black letters. Below the title, there is a collage of newspaper clippings. On the left, there are headlines like "Miracle Cure?", "Green Action", "SCIENCE/MEDICINE", and "nirereport". In the center, there are two portraits of men, identified as Dr. Herbert Kleber and Joe Califano. To the right, there is a map of Africa with labels for "CAMEROON" and "GABON REP. OF CONGO". Below the map, there is a botanical illustration of a plant with large leaves and small flowers. The bottom of the poster contains event information: "9:00 AM SATURDAY, MAY 1 HARLEM STATE OFFICE BLDG--125th St. & ADAM CLAYTON POWELL BLVD. MARCH OR HERB KLEBER'S DOWNTOWN OFFICES AT 10:20 AM for more info: Black Treatment Coalition (Rommel) 212-666-8000 Harm Reduction Coalition 212-677-4899".

FIGURE 1. An example of the tactics of provocation, this 1993 poster asks, "Who's keeping the African cure out of Harlem?"

as "gnome," "elf," or "dwarf"), which formed from old Provo factions and the squatters movement in 1970, and they became an important political force in the Dutch drug policy of separation of cannabis from hard drugs in 1976. This emergent strength of the drug policy movement contributed to the future political base of drug-user self-help unions and harm reduction.

Some prominent actions on the part of the Yuppies, the Junkiebond, and ACT UP exemplify a common related tactical heritage of the use of political theater to shock, inform, and engage. In 1967, the Diggers, a group which was eventually subsumed within the Yuppies, engaged in an action in which they threw dollar bills from the balcony of the New York Stock Exchange. As political theater, individuals lunging for dollar bills momentarily disrupted the normal business activities of the Exchange. The action succeeded in its goal of exposing and drawing attention to the elemental display of the psychology of greed, as the trading of vast sums of capital was momentarily disrupted by individuals lunging for dollar bills. A decade later, activists of the Dutch Junkiebond and squatter's movement scattered black and white photocopies of the colorful Dutch currency ("black money"), to expose the role, eventually verified by state prosecution, of a bank using real estate transactions to launder money made by drug dealers (14).

From their first action in 1987, ACT UP repeatedly targeted the New York Stock Exchange as a symbol of greed and corporate exploitation of the AIDS crisis (3).

In addition to attempting to establish a shared agenda with organizations that used such techniques, advocates of ibogaine attempted to make some use of confrontation and political theater, sometimes with questionable success. As illustrated in Figure 1, a 1993 poster inquired, “Who’s keeping the African cure out of Harlem?” and implied that Columbia Professor Herbert Kleber had “acted to put the brakes on ibogaine’s development.” Such an action was intended to raise the profile of ibogaine and contribute to an impression of a broader base of interest than likely existed at the time. However, Dr. Kleber is not known to have played a direct role in any decision regarding ibogaine at NIDA or the FDA. The action may well have been more related to ACT UP’s differences with Kleber’s Center on Addiction and Substance Abuse (CASA), regarding the issue of needle exchange, than to ibogaine. The incident illustrates a potential hazard of the diffusion of the focus of ibogaine activists in their attempt to combine their agenda with ACT UP.

#### *4. The Junkiebond and European Addict Self-Help*

The Dutch Junkiebond (Junkie “league” or “union”) formed in 1980 around the central focus of promoting the “normalization” of the image and status of drug users in society (40,67,68). The Junkiebond was effective in advocating for the involvement of drug users in policy making and improving the accuracy of their image in the media. The Junkiebond started the first needle exchange in response to hepatitis B in Rotterdam in 1981, and advocated additional harm-reduction policy innovations such as low-threshold methadone maintenance and the “safe stroll” or “tipplezone” for street sex workers (69). Drug-user self-help unions now exist in a number of other European Union countries such as Germany, Denmark, and Britain, and in Australia. Drug-user unions have not been as significant a development in the United States as they have in Europe.

Nico Adriaans, a cofounder of the Dutch Junkiebond, was treated with ibogaine in May 1990. His research work at Erasmus University had a strong policy-making objective, that of helping to provide access to the user community in research relevant to harm reduction policy development (70,71). He described his role in facilitating access of the addict community to researchers as “the tribesman who helps the scientist access and understand tribal culture” (40). This understanding is, in turn, essential for assessing the suitability of a given policy innovation for the target population. Adriaans believed that he had found a powerful policy transformation tool in ibogaine. He advocated ibogaine to other European user groups, but it had a limited impact, apparently due their greater interest in agenda items such as methadone maintenance or the legalization of heroin, as opposed to the development of an experimental treatment (14).

### 5. *Cures-not-Wars*

Cures-not-Wars (54) is an advocacy organization whose agenda includes ibogaine, harm reduction, and drug policy reform. As the name of the organization indicates, it advocates the development and availability of treatment over pursuit of the “Drug War”. Specific Cures-not-Wars agenda items include the decriminalization and medical use of cannabis. Cures-not-Wars and like-minded counterculture ibogaine activists contend that ibogaine is a victim of the “Drug War” mentality, which has impeded the development of an effective treatment for chemical dependence because of its status as a scheduled drug and a hallucinogen. Dana Beal, a coauthor of this chapter, is the founder of Cures-not-Wars. Beal’s interest in ibogaine began with meeting Howard Lotsof in 1973 and intensified due to the upsurge in heroin use the early 1980s. A former Yippie with experience in grass roots activism, Beal pursued alliances with other activists whose agendas would accommodate ibogaine. These alliances involved a core activist group, which evolved through multiple affiliations with other activist organizations with whom a shared agenda that included ibogaine could be established. Ibogaine activists in this group were successful in gaining access to major meetings and decision makers of the ibogaine project. They were an active presence at the NIDA and FDA ibogaine project meetings from 1991 to 1995 and were regularly included in meetings with officials in the FDA, NIDA, and the Office of National Drug Control Policy.

The alliances pursued by this group of ibogaine advocates included the Yippies; Rock against Racism, a movement of rock musicians and fans that began in Britain in 1978; the Green political party; and various factions of the drug policy reform movement. The alliances also included Jon Parker, an AIDS activist who played a pioneering role, often involving civil disobedience, in helping to establish needle exchange in the United States and who organized the first needle exchange in the United States in New Haven, Connecticut. Another was with African-American community leader Dhoruba Bin Wahad, who had been a leader of the East Coast Black Panthers. The most tactically important of these alliances with respect to NIDA’s ibogaine project involved ACT UP, as described in the following paragraphs.

### 6. *ACT UP*

ACT UP, formed in 1987, utilized tactics of civil disobedience and political theater that were effective in influencing the process of decision making regarding the development and availability of treatments for HIV (2,3). From 1991 to 1994, ACT UP supported ibogaine as an item on their agenda, taking the view that ibogaine’s putative effectiveness in heroin and cocaine dependence could possibly reduce the spread of HIV. This support may have been significant for the ibogaine project at NIDA, as evidenced by the apparent effect of the “Storm NIDA” action. In May 1990, ACT UP had organized a national action to

WEDNESDAY, JULY 10TH

**STORM N.I.D.A.**  
(THE NATIONAL INSTITUTE ON DRUG ABUSE)  
**FOR IBOGAINÉ**

8 AM • 5600 FISHERS LANE • ROCKVILLE, MARYLAND

212- 677-4899 703-548-WEED

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**PHARM ANALYTICA DAILY BRIEF (C)**  
**EXECUTIVE SUMMARY**  
November 12, 1990

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**INTERNATIONAL**  
**Event:** ibogaine, a rainforest alkaloid, has been reported to act as an addiction interrupter.  
**Significance:** There is a large potential market for effective addict detoxification products.  
**Conclusion:** If formal trials confirm initial anecdotal reports, ibogaine could become widely used in anti-drugs programmes.

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**INTERNATIONAL: Drug Addiction Research**  
**Event:** A rainforest alkaloid, ibogaine, has been reported to act as an addiction interrupter across a wide spectrum of abused substances including heroin, cocaine, amphetamine, nicotine and alcohol.  
**Significance:** There is a large potential market for pharmaceutical products for use in addict detoxification.  
**Analysis:** The use of pharmaceuticals in combatting addiction is well established, though often of limited success. The claimed effect of ibogaine in this context is qualitatively different from that of established treatments.

(over)

**Conventional Approaches**  
The best established approach uses opioid agonists, a drug which replicate the effect of opiates or reduce the severity of withdrawal symptoms. The best known of these is methadone, which has been used for 20 years and administered to over 100,000 patients worldwide. Methadone is typically administered either on a maintenance programme, which aims to stabilise the lifestyle of the patient without immediately removing the addiction, or on a detoxification programme, in which the dosage is progressively reduced.  
The use of methadone in addiction maintenance and detoxification is controversial. The efficacy of methadone is disputed: initial trials showing a success rate of 80-90% can no longer be duplicated, 20-30% being more typical today. Moreover, the idea of giving "free drugs" to addicts is unacceptable to many people, despite the successes of this approach in rehabilitating patients and reducing anti-social and criminal activity.  
Other promising pharmaceuticals include clonidine, which reduces withdrawal symptoms from opiates including heroin and methadone, and buprenorphine, which is similar to methadone, but has far milder withdrawal symptoms but a tendency to induce euphoria which may encourage abuse.

FIGURE 2. This 1991 "Storm NIDA" leaflet capitalized on the notoriety of a much larger ACT UP action that had taken place previously at the NIH.

"Storm the NIH" (National Institutes of Health) (3). One thousand protesters attended the action and demanded more AIDS treatments and improved representation of women and minorities in the planning and implementation of clinical trials. It was a substantial action, and was duly noted at the NIH.

The following year, ibogaine activists working within ACT UP created a "Storm NIDA" action on behalf of ibogaine and scheduled it for July 10, 1991. The event was advertised one to two weeks in advance with thousands of leaflets (see Figure 2), which were extensively distributed throughout the offices of the FDA and NIDA and intentionally leaked to the police, creating the impression of a large pending action, such as that of the previous year. Ibogaine did not, in fact, have a constituency that would draw a number of protestors anywhere near the size of the original 1990 Storm NIH event. As it turned out, the action was calm and involved a total of fewer than 20 demonstrators. However, NIDA on hearing of the pending action, immediately scheduled a meeting with the participants, and on July 9, the day before the action, notified the protestors that ibogaine had now been placed on the list of drugs to be evaluated as treatment for addiction (14,72). This effectively marked the beginning of the NIDA ibogaine project, which was active from 1991 to 1995.

Another action involving ACT UP participation was the summer of 1993, when about 40 people, including Philadelphia ACT UP, joined the New York contingent to picket FDA/NIDA at the Parklawn Building in Rockville on July 5. Activists believe that the picket and spirited activist participation in the August 1993 FDA review panel may have influenced the decision to resume Phase I clinical research that had been paused due to concerns about neurotoxicity.

The placement of ibogaine on the ACT UP agenda was a result of the participation and influence of ibogaine activists in the ACT UP Treatment and Data Committee. The Treatment and Data Committee served to track the medications development process and to interface with government and industry in trying to accelerate the development of drugs to treat HIV. A political/ideological division within ACT UP involving, among other issues, the relative priority of development of medications versus immediate social and healthcare needs led to a major realignment of ACT UP in 1994, with many who had served with the Treatment and Data Committee leaving ACT UP to form a separate organization, the Treatment Action Group. It was in the context of this political realignment that ibogaine was concluded to be nonessential to the ACT UP agenda, from which it was dropped in 1994.

## B. MEDIA COVERAGE OF IBOGAINE

The earliest media coverage for ibogaine as a treatment for drug dependence began in the alternative press with an article in the Yippie periodical *Overthrow* in 1985 (13). Subsequently, ibogaine has been covered in the mainstream media since the late 1980s. In general, the media coverage of ibogaine has emphasized the scientific story of the development of an agent originating from the African rain forest as treatment for addiction (73-75), with relatively less emphasis on the subcultural aspect of the informal treatment and advocacy networks. The

inclusion of ibogaine-treated addicts in the coverage mainly focused on clinical validation and human interest, and not the nonconforming nature of their activities as a medical or advocacy subculture. The reference to support for ibogaine's development by a "significant portion" of the public (*I*) at the beginning of this chapter is due in part to the coverage that ibogaine has received in the media. This was particularly true during the period of the NIDA ibogaine project from 1991 to 1995.

In addition to describing the aims and scope of the NIDA ibogaine project, the media have apparently been engaged by aspects of scientific theoretical thinking about ibogaine. In 1993, the French chemist Robert Goutarel published a monograph that suggested the hypothesis of a possible functional analogy between the action of ibogaine and rapid eye movement (REM) sleep. Goutarel suggested that ibogaine might work by diminishing the pathological linkages of drug-related stimuli to feelings of valuation and salience, and he suggested a process analogous to the reconsolidation of memory during REM sleep (35). Goutarel's hypothesis has a certain intuitive appeal, and apparently influenced media stories that emphasized the "dreamlike" nature of the ibogaine experience (14,73,76).

*The Ibogaine Story* (14) published in 1997, provided a social and cultural history of the development of ibogaine and the political subculture of ibogaine advocacy. Although intended for a general lay audience, the book also surveyed the topics of major significance from the scientific literature on ibogaine. The book attempted to engage interest by including creative scientific speculation such as Goutarel's work (35), or theoretical discussion regarding a possible relationship of quantum physics to a model of consciousness. A video also titled *The Ibogaine Story* included excerpts of television news productions, as well as the testimony of patients and treatment guides. Cures-not-Wars estimates it has distributed some 4,000 copies of the book in its final form, 2,000 copies of various preliminary versions of the book in the form of photocopies, and approximately 5,000 videos in the effort to promote and popularize ibogaine.

In a television interview in 1993 Frank Vocci, the NIDA official in charge of the ibogaine project stated, "I think that the bad press that LSD got in the 1960s is not going to help ibogaine, because I think the American people will expect that this is something gone awry, that the people in Washington are off their rockers, they really lost it." However, the media tended to place relatively greater emphasis on the scientific controversy regarding the question of ibogaine's effectiveness than on the potential social or political controversy of ibogaine as a hallucinogen. The media's coverage suggested the possibility that if the ibogaine project were to have produced favorable clinical results, its developers would not have been perceived as "off their rockers" solely because it involved the use of a hallucinogen.

### C. THE INTERNET

The Internet has played an important role in the increasing the globalization of the medical subculture of ibogaine. Various providers of treatment and sources of ibogaine offer Web sites devoted to ibogaine for the purpose of disseminating information. A Web site (58) summarizes the current availability of ibogaine and offers links to providers of treatment/sessions or sources of ibogaine, most of whom maintain their own Web sites.

With the exception of some countries such as the United States, Belgium, or Switzerland, it is presently generally possible to purchase ibogaine through contact with sources via the Internet in much of the world. The Internet functions as a sort of “underground railroad,” linking suppliers and treatment guides with those seeking ibogaine treatment, and it has likely been a factor in the increased availability and the decline of the price of ibogaine over the past several years.

Other Internet activity includes the Ibogaine Mailing List (50), which began in March 1997 and has had a significant reach in accessing and “binding” the networks associated with ibogaine. The correspondence of its contributors is archived, and is an informative resource regarding the collective ideas, beliefs, and expectations regarding ibogaine in the United States and European subcultures. Some of the more prevalent topics include the availability of treatment and the experiences of patients. The list also offers lively discourse that includes more esoteric and theoretical themes that illustrate ibogaine’s role as a subcultural intellectual phenomenon. Threads of discussions on the list include topics such as the sacramental aspect of ibogaine as an “entheogen,” linkages of the ibogaine concept to world historical religious cultures such as Gnosticism or Buddhism, and references to Bwiti, the sacred culture of ibogaine in Africa. The tone of some of the list correspondence suggests that ibogaine has become associated with a sacred or transcendent status in the subculture in the United States and Europe, much as it is associated with a sacred culture in Africa. Some excerpts taken from the list illustrate the transcendent or sacramental quality that some in the subculture have attributed to ibogaine:

*“I believe both NDE’s (near death experiences) and ibogaine can induce certain forms of archetypal experience relating to the creation of physical existence.”*

*“I did have some preconceived notions about ibogaine experience . . . like the Bwiti notion of ‘meeting your ancestors,’ what that became for me was to ‘see’ my past lives: the actual faces of them . . . Having done many psychedelics, I am convinced that ibogaine is a sacred substance . . . no hit of LSD or mushroom or cactus came close to where ibogaine took me. Period. Everything I experienced during the ibogaine I had already experienced; the ibogaine ‘trip’ was just what*

*I call the 'remembering' ."*

*"The Bwiti cover all bases. Their religion is so new and so utterly syncretic, I'm sure there isn't a religious belief structure in the world that isn't represented in it somewhere . . . and, as such, it does I guess stand a good chance of being adopted extensively, certainly in the States."*

#### IV. Conclusions

The unusual treatment and advocacy subculture in which ibogaine exists raises several issues. Participation in, or identification with, this subculture involves a belief in the efficacy of ibogaine, which appears to be sustained by word of mouth and Internet communication, in addition to published clinical reports. The ibogaine belief system is also an expression of the demand for alternatives for existing treatments for addiction. The sense of marginalization and stigmatization, with which some of ibogaine's advocates appear to have identified, is a shared general feature of the drug subculture. An awareness of why individuals choose to use ibogaine, and what they appear to have derived from it, could be useful in accessing the treatment-seeking behavior and motivations of hidden populations. Such knowledge could also be useful in designing the milieu of present treatment settings, and if ibogaine were to be approved, in devising manual-driven behavioral approaches.

The successes and failures of group activism for the development of a new pharmacotherapy of addiction provide an example of the problems, issues, and factors associated with the tactics of addiction health policy advocacy. To a significant extent, activism on behalf of ibogaine can be viewed as disease-specific advocacy, such as that associated with AIDS or breast cancer. Ibogaine is a theoretically interesting drug intended for a disorder with high collective societal cost and morbidity, but it is relatively unattractive to the private sector because it presents a limited apparent profit potential and significant developmental expense. The private sector's weighting of costs and long-term incentives can be irrational from the larger standpoint of society, a situation that public sector spending is intended to remedy. Because of limited private sector enthusiasm, the development of new treatments for addiction is particularly dependent on public sector spending relative to the development of treatments for other conditions. Public sector spending is subject to political factors, which may be influenced by disease-specific activism.

Activists viewed advocacy on behalf of ibogaine's development as necessary because the disorder it is intended to treat afflicts a marginalized group.

Preexisting movements, such as the drug user's unions in Europe and harm reduction and AIDS activists in the United States, contributed to the political base. A stronger user's movement in the United States might have benefited the political base for the development of innovative and experimental treatment for addiction, including ibogaine. Such an American user's movement might have provided a significant countervailing force for the development of new pharmacotherapy for addiction in academic research, government, and the pharmaceutical industry. Greater insurance reimbursement for the treatment of substance dependence could also provide an incentive for development of pharmacotherapy for addiction in the private sector, just as insurance reimbursement has motivated the pharmaceutical industry to develop drugs for HIV.

Ibogaine's advocates gained significant access to public sector decision makers involved in the development of addiction treatment. It is possible that they exerted significant influence, and that they still might do so in the future. It has been suggested that the reactions elicited by ibogaine's advocates may have been counterproductive in some respects (see the foreword by Kleber in this volume). As an example, AIDS advocacy apparently accelerated the development and release of drugs to treat HIV, but also been suggested to have discouraged companies and individuals from involving themselves with HIV (2). The current status of the lack of official approval can be cited as evidence that advocacy on behalf of ibogaine worked at cross-purposes to its development. On the other hand, it can also be argued that the political activist subculture may have positively influenced support for the allocation of public resources toward ibogaine's development. Perhaps more importantly however, the medical subculture of ibogaine did yield human experience that influenced the decision to pursue the significant body of preclinical work that was NIDA's ibogaine project. This medical subculture presently remains as a persistent, and an apparently growing phenomenon.

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