Ibogaine and Iboga
Harm Reduction Information

Ibogaine is the main alkaloid of iboga, the root bark of the shrub Tabernanthe iboga

Last updated 10/28/2026

Please Read First

This page is educational. It is not medical, legal or professional advice, and I am not a physician or an attorney. This information was gathered from published harm reduction organizations, medical and legal sources, and my own training and experience, and I may have made mistakes. You are responsible for confirming anything here before you act on it, with a qualified medical provider and, for questions of law, an attorney. Laws and knowledge about psychedelics change quickly, and some of what is written here may have changed since the date above. Nothing here encourages anyone to break the law. It exists to reduce harm for people who will make their own choices. I do my best to keep up with current law and research, but I cannot promise that anything here is current or complete.

It is advisable to meet with a psychedelic-informed physician for an assessment before using any psychedelic or related substance.

Where this information came from: The sources listed under References, and my own training and experience.

This document was drafted with the support of Claude, an AI assistant. I reviewed it, and AI and I can both be wrong, so check anything that matters to you before you act on it.

What Ibogaine and Iboga Are

Ibogaine is the medicine in this library whose danger gathers in the heart. It is the main alkaloid of iboga, the root bark of the rainforest shrub Tabernanthe iboga [1][2]. People take iboga in Bwiti ceremony, and people take ibogaine for opioid withdrawal and for a very long, effortful look at their own lives. It slows the heart's electrical reset, and people have died of it, often within the first day or two, often with a heart condition, another drug in the body, or no monitoring at all [3][4]. Cardiac safety is the point of this whole sheet.

Names and Forms

Iboga means the plant or its root bark, and also the powder made from it. Ibogaine is one alkaloid inside that plant. Noribogaine is what the liver makes from ibogaine, and it stays in the body much longer [2]. The root holds roughly 6 percent indole alkaloids, with the root bark richest, and ibogaine is the most prominent of them, alongside voacangine, catharanthine and others [5].

Four forms matter. Ibogaine hydrochloride (HCl) is the purified crystalline salt, usually made by semi-synthesis from voacangine, a compound from a different tree, Voacanga africana, because wild iboga is scarce [2]. Total alkaloid extract (TA) is the plant's alkaloids pulled out together; it carries other iboga alkaloids, so by weight it has a lower ibogaine strength than the HCl, and one description puts it at about half [2]. Root bark (sometimes written rootbark) is the traditional material, ground to powder [6][7]. Iboga supplements and capsules are sold online [8]. What any of these contains is a safety problem, covered under Testing and Purity.

A related compound, 18-methoxycoronaridine (18-MC), is a laboratory cousin that researchers are studying because it seems to block the heart channel far less than ibogaine does [2][4]. It is not the subject of this sheet.

Where It Comes From

Tabernanthe iboga is an evergreen understory shrub native to Gabon, the Democratic Republic of the Congo and the Republic of the Congo [5]. Ibogaine and related alkaloids occur in other plants of the dogbane family as well [1]. Most iboga on the market comes from wild harvests, and the plant takes years to mature [9]. Where the supply comes from is an ethical question as well as a quality one, and it is covered under Ethics, Sourcing and Conservation.

French and Belgian explorers wrote about iboga in the 19th century, and two research teams isolated ibogaine in 1901 [6][2]. France sold it as Lambarene, a stimulant, until the sale of ibogaine products was banned there in 1966 [2]. In 1962 Howard Lotsof reported that it reduced his own and his friends' opioid craving and withdrawal, and he later won a US patent [2]. Sources disagree on when ibogaine entered US Schedule I: 1967 [1], 1970 [5][10] and 1975 [6].

In the 1990s the National Institutes of Health stopped its ibogaine research because of cardiovascular toxicity [11]. Deborah Mash ran an ibogaine clinic in St. Kitts from 1996 to 2005 and treated 277 patients [10]. A 2012 forensic review of 19 deaths became the reference point for what goes wrong [3], and a 2024 Stanford study of 30 veterans treated at a clinic in Mexico brought ibogaine back into public attention [12]. In 2025 and 2026 several US states funded ibogaine research, and an April 2026 executive order asked agencies to speed up research reviews [13][11]. The Legal Status section has the details.

Bwiti, and the People Who Hold This Plant

Bwiti is a religious path practiced by the Punu and Mitsogo peoples of Gabon and by the Fang, in Gabon and Cameroon [6][14]. It blends animism, ancestor honoring and, in some groups, Christianity [14]. Iboga root bark is pulverized and swallowed in large amounts in the initiation rite, and in smaller amounts in weekly night ceremonies with music, dance and drumming, led by a ceremonial elder called the N'ganga [6][5][14]. Bwiti healers also use it for pain and fever [6]. National Geographic reported in 2023 that an estimated 5

percent of Gabon's 2.3 million citizens practice Bwiti [10], and Bwiti is an officially recognized religion in the country [14].

I am an outsider to this tradition, writing from published sources. Bwiti is an oral tradition, and Wikipedia's article notes that what circulates in the West is often inaccurate and that some information has been shifted on purpose to protect secrecy [14]. Taking ibogaine in a clinic or retreat outside Gabon is a different thing from taking part in Bwiti, whatever the marketing implies.

Ethics, Sourcing and Conservation

Iboga is a sacred plant of living peoples, and the demand for ibogaine is now pulling on wild forests, on Bwiti communities and on the rules of a country. A person thinking about ibogaine is also choosing something about all of that, whether they mean to or not.

The plant and the people. The plant is a cultural keystone for the Bwiti [9]. Gabon declared iboga a cultural heritage reserve in 2000 [9]. The IUCN lists the species as Least Concern, but the evidence is thin: few biological studies, poorly documented wild populations, and slow maturity (uprooting is common) [9][5]. Named pressures are rising demand, overharvest, poaching, logging, mining and the loss of the elephants and gorillas that spread its seeds [9].

What is happening in Gabon. Gabon required an export permit from 2019 and allowed its first legal export in February 2023, under a framework modeled on the Nagoya Protocol, an international agreement on sharing benefits from genetic resources [10]. The United States is not a party [15][16]. On 5/22/2026 Decree 0239 claimed sovereignty over iboga, its derivatives and the traditional knowledge around it, and requires authorization and benefit-sharing agreements for commercial use, including compounds made abroad; the royalty fund had not been set up by late September 2026. On 9/18/2026 the Council of Ministers adopted a draft decree banning exports of iboga and its derivatives, which would also end the legal community trade; officials called it a provisional stopgap [15].

On the ground. The effects are mixed. Local prices rose about 800 percent in a decade of Western demand, and shortages hurt Bwiti practitioners [10][9]. The oldest trees go first, and Mongabay links trafficking to poachers who deal in other wildlife [15]. An association of villages in Ogooue-Ivindo province farms iboga and sold three legal orders to a Canadian company between 2023 and early 2025. Its president says the community was paid but sees none of the value created after the bark left, and was not consulted on the new framework; the company says shared funds are held in trust, and Mongabay could not verify the payments [15]. Blessings of the Forest and the Ceiba Foundation work on conservation and benefit sharing [17].

Voices worth hearing. Henri-Paul Moubeyi Bouale, a leader of Bwiti traditional associations, says revenue must reach the communities who kept the plant, and that outsiders are welcome in the deal [15]. Stephanie Moussounda (Maman Djedje), a traditional practitioner, said a Marseille laboratory once offered a low price per kilo for

bark; she asked for a patent in return and the deal fell through, and she wants traffickers prosecuted and healers left alone [15]. Delphine Minko, a Bwiti master of ceremonies, led the processing of the first legal harvest [10]. Denis Massande, a Pygmy association leader, warned that without regulation iboga could disappear and that Indigenous communities must benefit [10]. Gabonese people and groups disagree on how this should be handled, and I am not in a position to decide it.

What this means for a person deciding. Colorado law asks licensees the same questions, benefit sharing and documented ethical sourcing, as Colorado under Legal Status describes [18]. Ask any provider where the product came from (wild iboga, farmed iboga with a traceable community, or Voacanga-derived ibogaine) and whether anything went back to Gabon. Gabonese officials say online sales advertising Gabonese origin show that unauthorized trade continues [10].

About the Sources

PubMed and PubMed Central were open to me only now and then, so some studies are known through summaries or abstracts, and the reference list says which. The strongest sources on risk are the 2012 forensic review of 19 deaths, the 2015 Molecules heart review and the 2026 scoping review. Death counts differ because they cover different periods and settings, and a June 2026 preprint with the largest numbers has not been peer reviewed. Clinic safety claims are self-reported, and several legal sources are law firm explainers or advocacy groups, flagged as such. A few background lines rest on encyclopedia entries, and the reference list marks them as weak. What It Feels Like rests on a handful of interview and survey studies, mostly of people treated for opioid use, and on one magazine interview with two Europeans initiated into Bwiti in Gabon [19][20][21]. Several of those studies I could read only as abstracts or summaries, and the reference list says which.

What I did not find. DEA guidance on root bark or total alkaloid extract; controlled safety data on repeated small amounts over weeks; a published laboratory analysis of the iboga capsules and total alkaloid extracts on the market; a laboratory that says it reports ibogaine content and other alkaloids, or a verified Colorado drug-checking provider; and a reagent color chart for ibogaine, total alkaloid extract or iboga.

What It Feels Like

No one can promise you what a session will be. The sources describe a long, body-heavy, mostly eyes-closed experience that people compare to a waking dream: scenes and memories play on the inside while the body is too unsteady to do much, then a reflective stretch, then days of poor sleep and tender feeling. It is nothing like a short, bright psychedelic. Almost all of what has been written comes from people treated for opioid or other substance use, in clinics in Mexico, Brazil and New Zealand, with a few accounts from Bwiti initiation in Gabon. A ritual in Gabon is a different thing from a clinic. The risks that set

ibogaine apart are under About Ibogaine and Its Effects on the Body; this section keeps to what people describe.

The Body

Unsteadiness is the body's signature. About half of the people in one small interview study described impaired coordination, dizziness or vomiting [22], and 74 percent of a clinic survey endorsed physical discomfort [20]. Brazilian interviewees called the physical effects very strong and unpleasant [23], and four in five in the small study called the experience physically draining [22]. The measured counts of ataxia, headache and nausea are under Toxicity and the Mind.

Nausea and vomiting are common. Interview participants also describe disorientation, a changed sense of body temperature and body weight, and little appetite [19]. Sound and touch change too: buzzing, humming or ringing at the start (eight of ten in the small study) [22], and heightened sensitivity to noise and touch and tremor in the 499-person survey [24]. A faster or slower heartbeat is among the physical items people endorse [24]. What a person feels of the heart is not a measure of what it is doing, and the heart is covered under Heart, Blood Pressure and Body Temperature.

A few people describe the body as detached or not their own, or the surroundings as unreal; that was a weaker theme in the survey [24]. At the peak some people cannot stand or move for many hours [25]. Clinics keep people lying down in a monitored room, because the unsteadiness makes walking unsafe [12][26][27].

How a Session Moves

Providers describe three phases. Effects build slowly after the swallow, and a first stretch of vivid waking dreams follows, strongest with the eyes closed in the dark. A later reflective phase comes as the imagery fades, with intuition, insight and a review of one's life, often described as looking back over it in a clear light. A residual phase of calm, mental clarity and less need for sleep can last a day or more after the visions end [20]. The timings are under How Long It Lasts.

That is a clinic's map, and participants did not tell it that way. In the small interview study no one described distinct phases in their own words, and nine in ten found the experience hard to describe or recall in full [22], which suggests the three phases are a convention more than a lived structure.

In Bwiti initiation the ritual builds the shape: music, dancing and movement through the night, with guides asking the initiate what they see. Two Europeans initiated into Mitsogho cults say that moving and dancing was followed by more visions, and that the women's rite begins with a possession trance [21]. Music, mantras, perfumes, colors and movement are used on purpose to strengthen and guide the dreamlike state of the initiates [24].

Seeing and Hearing

With the eyes closed, people describe dream-like sequences: scenes, landscapes, faces, masks, characters, ancestors, entities, and sometimes frightening scenarios [19]. In the 499-person survey, narrative and symbolic visions and cosmic or archetypal visions (the origins of life, space, decay and rebirth) were separate themes [24]. In a clinic survey, 88 percent saw visions and 68 percent saw geometric shapes [20]; in the small interview study, seven in ten entered dream-like settings and eight in ten saw a mix of dark and joyful imagery [22].

With the eyes open, people describe stronger colors, geometric patterns, light trails and objects changing form [19][24]. Darkness, setting and suggestion strengthen the visions, according to one summary of Bwiti practice [14]. People usually know the images are internal: authors describe a dream state without loss of consciousness [20], and interviewees in an underground-use study describe a characteristic waking dream with vivid autobiographical imagery [28].

In Gabon the guides ask the initiate afterward what they saw, and certain sights count as signs that the initiation took. Two Europeans initiated there describe being asked, and being told that landscapes with high mountains at the edge mattered [21].

Hearing changes too. Most interviewees had more sensitive hearing, distortions and a deep link to music, and some heard chant-like sounds that helped them make sense of the experience [19]. Some people describe synesthesia, feeling sound or seeing music [24].

Feelings

The range is wide, sometimes inside one session. Reported feelings run from sadness, guilt, fear of dying, darkness and aloneness to acceptance, a lifted burden, interconnectedness and bliss [24][20][22]. In the clinic survey of 88 people, 46 percent said they worked through shame or guilt, 36 percent recalled difficult memories, 51 percent felt fear and 49 percent saw frightening images, while 26 percent felt bliss or ecstasy and 32 percent felt reborn [20].

In a study of 44 people treated for opioid use, cyclic visions led to confronting realizations of remorse and regret for how they had treated others, and then, for many, to release from guilt and worthlessness [29]. One of the Europeans initiated in Gabon felt fear on the first night and then found the main session smoother than ayahuasca, which she had taken before [21]; that is one person's comparison. A man treated near Tijuana described unpleasant visions of his past actions that he later felt helped him [30].

Catharsis and emotional release are named themes in the interview study [19].

Insight, Presences and the Self

Insight is central. People describe memory retrieval, a review of their lives and what the interviewers call self-psychoanalysis [19]. In the clinic survey, 67 percent said they gained

insightful knowledge about themselves and 64 percent said they experienced something sacred or spiritual [20]. All ten interviewees in the small study reported more self-acceptance and less self-criticism afterward, and seven in ten a more spiritual outlook [22]. In New Zealand, even people who did not stay off opioids often called the experience insightful [31]. On a mystical-experience questionnaire, 43 percent of 44 treated people reached the full-experience cutoff in more than five of seven domains [29], and among 30 veterans a stronger mystical-type experience went with larger PTSD reductions at one month, an association that does not show the experience caused the change [32].

Meetings with ancestors and entities are a named theme [19]. In three interview accounts, each person described a distinct impression of communicating with iboga or ibogaine itself, or with people met in the visions [33]. One European pediatrician initiated in Gabon describes leaving his body and floating as an energetic ball, being guided by the elders to open the doors he saw, feeling he could read the minds of the people around him, and staying aware enough of the room to answer them in French [21].

Ego dissolution and an observer quality are listed as subcategories in the interview study, without frequencies in the summaries I read [19]. In the 499-person survey the dissociation factor scored weakest [24], and the authors of the interview study say ibogaine differs considerably from the classic serotonergic psychedelics [19]. My own reading, an interpretation and not a finding, is that the self seems to watch its own inner film more than it dissolves into a field. One anthropologist proposes that the heart of the healing is a culturally shaped journey to an imagined unspoilt state in personal or collective history [34]; that is a theory.

When It Is Hard

The body is the first hardship: long exhaustion, unsteadiness, nausea and sensitivity to noise [22][23]. The mind is the second: frightening or violent imagery, guilt, grief, and confusion or disorientation in the middle [19][20]. Anxiety needed treatment in about a tenth of the veterans [12].

People who come in withdrawal, with trauma, or with other drugs in the body have a harder time. The Brazilian authors call it a very difficult and challenging experience in that population, and it may not generalize to others [23]. Combining substances confuses almost every account: one of the 20 people in the interview study was hospitalized with an arrhythmia and seizures after taking alcohol and benzodiazepines the day before [19], and a death in New Zealand is described under Deaths: What the Published Reviews Found [31]. The signs that need 911 are under Warning Signs.

What Shapes the Experience

The authors of an underground-use interview study argue that motivation and supportive aftercare decide whether change lasts [28], and people who did well described more change in how they coped with hard feelings [35]. Setting works on purpose in Gabon, where music, color, perfume and movement guide the visions [24], and the healers the

two Europeans knew forbade any other medicine during initiation [21]. In clinics, screening, magnesium and monitoring decide what the body goes through [12]. Almost everyone in these studies was a patient with a substance use history, so reports of what is hard are probably skewed toward people in a hard place.

The Days After

Many people describe a clear, calm stretch with less need for sleep right after the visions end [20], which also means poor sleep. People in the interview study felt happy, joyful and aware for days, and the effects can run for weeks or months: lasting happiness and clarity, better self-care, and a push to change relationships and work [19]. People who did well later named gratitude, authenticity, inner peace, joy and a sense of the sacred, along with difficulty integrating the experience and a need for more aftercare [35]; supportive relationships matter [19].

The two Europeans initiated in Gabon describe lasting changes: music heard differently, a stronger bond with colors and nature, less fear of being misunderstood and, for one, a lost job along the way [21]. Those are two personal accounts. How the experience bears on addiction and PTSD, with the honest numbers, is under Addiction and Misuse. Mania in the days after and what to watch for are under Preparation and Integration and Warning Signs.

How It Is Taken

Every source I read describes ibogaine as taken by mouth, as capsules, powder or, less often, a tea [7]. In Bwiti initiation the root bark is swallowed in large amounts [6].

Swallowed

Onset is slow (see How Long It Lasts). A slow start invites a second swallow when nothing seems to be happening. A clinic operator warns that several doses in one evening raise the total exposure because noribogaine builds up [27]. That is the single most useful thing to know about timing: with this medicine, waiting is part of the safety.

Forms You May Meet

The form changes the risk. Ibogaine HCl is purified, so the amount in a capsule can in principle be known. Total alkaloid extract and root bark vary from batch to batch, and the 2012 death review found that the two decedents who had no other drugs and no illness had taken crude extract or bark of unmeasured strength [3]. Alkaloid content in root bark varies widely, and counterfeit bark sold during shortages has caused at least one death [9].

In Gabon, ibogaine capsules are sold domestically as a food supplement [36]. In the Netherlands, iboga products are sold mostly online, and the public health institute advised against them in 2024 [8]. In 2015 Health Canada acted against several unauthorized ibogaine products from one distributor and had a serious report of abnormal heart rhythms

tied to one of them, Remogen [37]. A 2023 Interpol analysis, reported by Mongabay, found much of the trade illicit and online resellers nearly four times as many in 2023 as in 2021 [15].

Producers in Ghana and Mexico extract ibogaine from the Voacanga africana tree at low prices [36]. People who prefer iboga from Gabon argue that the whole plant carries more than ibogaine, and that is a claim I could not test [10].

Large Amounts and Small Amounts

I describe these in general terms only and give no amounts. Flood dose is community language for a single large treatment meant to produce the full experience and, in addiction settings, to interrupt withdrawal and craving. The monitored studies in this sheet (the Dutch study, the veterans study) were single large treatments, and they needed magnesium and constant ECG monitoring because of the heart effects described under Heart, Blood Pressure and Body Temperature [38][12].

Microdosing is community language for very small, repeated amounts. Low amounts have been used traditionally as a stimulant, for example by hunters to stay alert at night [5][14] [2]. In controlled low-dose research, effects were mild and short-lived (headache, nausea, changes in perception) and no serious events were reported [39]. Because noribogaine lingers for days and builds up with repeated intake [4][27], my reasoning is that daily use may add up in the body, and the heart channel risk is not known to be dose-free. PsychonautWiki advises against high amounts and repeated daily use [25]. This is an open question, not a safe harbor.

How Long It Lasts

The experience is among the longest in this library. Onset runs from roughly 30 minutes to 3 hours, the peak from about 18 to 36 hours, and stimulation and poor sleep can last 24 to 72 hours [25]. Erowid describes the strongest effects as lasting 24 hours or more, with a person unable to function for many of them [7].

The experience ends before the heart risk does. The elimination half-life is about 7 hours for ibogaine and about 24 to 50 hours for noribogaine, which lingers and reaches higher levels [2][4]. Case reports describe QT prolongation lasting from about 42 hours to 12 days after a dose [40], and a systematic review found up to 7 days [39]. In the 2012 review, people died between 1.5 and 76 hours after the last ingestion, about 25 hours on average, for many well after the visions [3]. In the Dutch study the ataxia peaked at 2 to 6 hours and cleared within 48 hours [41]; in the veterans study cerebellar signs cleared within 24 hours [12].

So the day after is a poor day to be unmonitored, and the week after is a poor week to add QT-prolonging medicines without asking a physician. The UVA bulletin recommends ECG monitoring for anyone who has taken it [42].

About Ibogaine and Its Effects on the Body

How It Works in the Body

Ibogaine acts on many systems at once (opioid, serotonin, sigma, NMDA and nicotinic receptors), and how that produces its effects is not worked out [2]. Its main metabolite, noribogaine, acts like a serotonin reuptake inhibitor and as an agonist at the kappa opioid receptor [2][25]. The experience is described as unlike a classic psychedelic [2].

The liver enzyme CYP2D6 does most of the conversion of ibogaine to noribogaine [2][4][40]. People with low CYP2D6 activity (poor metabolizers) build up more total exposure and for longer, which can intensify and prolong the heart effects [4][40]. The Dutch authors warned that poor metabolizers and people taking drugs that block CYP2D6 may face higher heart risk [41]. A 2022 mouse study adds that other drug transporters may change levels too, and its authors suggest genotyping and lower amounts for poor metabolizers; that is a suggestion from animal work, not a tested practice [43]. Allele frequencies for CYP2D6 differ across ethnic groups, and noribogaine can form without CYP2D6, possibly through other enzymes [43].

Ibogaine is also thought to be stored in body fat and released slowly, which fits reports of heart changes that last days [2][40].

Heart, Blood Pressure and Body Temperature

Ibogaine blocks the hERG potassium channel, which the heart uses to reset between beats. Blocking it lengthens the QT interval on an ECG, and a long QT can tip into torsades de pointes, a rhythm that can degenerate into ventricular fibrillation and cardiac arrest. The block happens at levels close to those found in human blood after treatment, and noribogaine blocks it too [4].

What it looks like in people. Case reports from 2009 to 2014 describe eight patients, aged 26 to 63, with QTc values from 480 to over 700 ms, most progressing to ventricular tachycardia or fibrillation and many to torsades [4]. A systematic review of 2015 to 2020 reports QTc from 512 to 788 ms, wide QRS complexes, low blood pressure and hospital stays averaging 7.8 days [39]. A 2026 review lists individual QTc values of 593 to 714 ms [40].

In a monitored trial the heart effect was close to universal. In the Dutch study of 14 people every one had QT prolongation, about half went above 500 ms, six had a QTc over 450 ms more than 24 hours later, magnesium was given to those above 500, and nobody developed torsades [38][41]. The veterans study saw no meaningful QT prolongation, with continuous five-lead ECG, magnesium before and after, and about one staff member for every two patients [12]. The two studies differ in people, preparation and amounts, so I cannot compare them; together they suggest that monitoring plus magnesium can be done and that it takes staff.

Heart rate and blood pressure. In one study of 39 people, 6 had significant bradycardia (slow heart rate) and 1 had significant low blood pressure [4]. About half of the Dutch group had bradycardia [38]. A clinic operator reports a typical drop of about 10 beats per minute and says very low rates may need atropine, and a high blood pressure episode in her clinic was controlled within an hour [27]. In the veterans study there was no meaningful slowing or instability [12].

Electrolytes matter. Low potassium was present in every fatal or arrhythmia case where it was measured, and low magnesium in about half [4]. Other flagged risk factors: female sex, a long baseline QT, a slow heart rate, existing heart disease, hERG gene variants, and drug interactions with methadone, alcohol, cocaine, benzodiazepines and opiates [4]. Persistent vomiting, diarrhea and poor eating before or after a session can lower potassium and magnesium; that is my inference from the pharmacology, and it is why clinics test electrolytes and give fluids [26].

Deaths: What the Published Reviews Found

The 2012 forensic review. Alper, Stajic and Gill reviewed every ibogaine-linked death they could find outside West Central Africa from 1990 to 2008: 19 people, 15 men and 4 women, aged 24 to 54. Fifteen took ibogaine for opioid detox (several also dependent on alcohol or cocaine, one on methamphetamine); two used it for spiritual or psychological reasons. Fourteen cases involved ibogaine HCl, two a crude alkaloid extract, two dried root bark, and one an unidentified powder. They died 1.5 to 76 hours after the last ingestion [3].

What they found. Twelve had medical problems (liver disease, ulcers, a brain tumor, high blood pressure with narrowed arteries, obesity). Benzodiazepines, cocaine, opiates or methadone showed up in 8 of the 11 people tested. Heart disease caused or contributed to six deaths. Three deaths in Mexico were certified as pulmonary embolism (a lung clot) that autopsies could not confirm. One person died in a seizure, probably from alcohol or benzodiazepine withdrawal. Most were treated by lay providers in unregulated places. Two decedents with no other drugs and no illness had taken crude extract or root bark of unmeasured strength. In 12 of the 14 cases with enough data, illness or other drugs explained or added to the death. The authors found no lethal dose or blood level and no distinct brain-toxicity syndrome, and noted that deaths fell after 2006, which may reflect more screening (blood chemistry and ECG), excluding people with heart disease, and stabilizing alcohol and benzodiazepine dependence first. They also thought US deaths were probably under-reported, since ibogaine is Schedule I there [3].

The heart reviews. The 2015 review added three sudden deaths since 2008 and the QT cases above, and recommended supervised use only, with continuous ECG for a period matched to noribogaine's half-life, pre-screening for QT, electrolytes, heart disease and medicines, and consent that names sudden cardiac death [4]. Three Dutch case reports in 2012 described long QT with breathing and heart problems [44]. A 2022 review counted about 58 further emergencies and deaths outside its studies (20 emergencies and 38

deaths), plus two deaths inside studies: one after informal use in 1990, possibly with heroin, and one in a medical setting with inadequate monitoring, a high amount and a stopped venlafaxine [45]. The New Zealand study had one death that a coroner thought very likely came from ibogaine, probably an arrhythmia, with ondansetron, diazepam and zopiclone also in use [31].

The 2026 preprint. Arns, Shinozuka and Barsuglia, who work with clinics, report 48 published deaths from 1990 to 2026. Where a cause was given, the heart was most common (16 cases), then poisoning from several substances (12). Twelve people had known heart disease. Of 19 with positive toxicology, 12 had opioids, 8 benzodiazepines and 6 cocaine; alcohol or benzodiazepine withdrawal was present in 7; ECG screening was documented in only 10. By setting, 27 were clinical, 9 were at home or unsupervised, 7 were underground and 3 were ceremonial. Separately, eleven clinics that followed safety guidelines reported 6 deaths within 72 hours among 10,382 people treated for opioid use, fentanyl being involved in three, and none among 8,689 treated for other reasons [46]. This paper is not peer reviewed, the clinic numbers are self-reported and unchecked, and the authors call the clinic death rate a lower bound. It fits the older reviews and does not replace them.

Other counts. More than 30 deaths in the medical literature, per the Associated Press [11]; and dozens worldwide with iboga and at least three in the Netherlands, per the Dutch public health institute in 2024 [8]. These are counts of reports, not rates. No one has a reliable count of how many people have taken ibogaine, so no one can give a reliable death rate.

What the reviews agree on. Four patterns recur. First, existing heart disease and a long QT put the heart in danger before the first swallow. Second, low potassium and magnesium, and a slow heart rate, make torsades more likely. Third, other drugs in the body (opioids including methadone and fentanyl, benzodiazepines, cocaine, alcohol, and withdrawal from the last two) are present in a large share of deaths. Fourth, the product and the setting decide a lot: unmeasured extract or bark, and no ECG, no physician, no defibrillator. Screening, fixing electrolytes, a long clean washout, and real monitoring address most of the failures that the papers describe. They do not address all of them; people who were screened and monitored have died too [46][31].

Toxicity and the Mind

Ataxia, nausea and vomiting. Severe unsteadiness (cerebellar ataxia) is expected, not rare: all 14 people in the Dutch study had it, some could not walk without help, and all the veterans had mild ataxia and tremor that cleared within 24 hours [38][12]. Nausea and vomiting are routine in the early phase [7]. In the veterans study about 40 percent had headache and 23 percent nausea [12]. A person who tries to walk alone falls, and vomiting while on the back is an aspiration risk. Longer-lasting effects reported in case series include slowed movement, drooping eyelids, slurred speech and memory loss [39].

Seizures. Seizures appear in three case reports in the 2015 to 2020 review [39], in one fatal 2012 case probably tied to alcohol or benzodiazepine withdrawal, and in a case with a brain tumor [3]. The Mash program excluded people with epilepsy [26], and the reviews list seizures with coma among reported acute effects [45].

Mania, psychosis and psychiatric history. Three people in an emergency room developed mania after ibogaine; none had a bipolar diagnosis, and two had used it for addiction and one for psycho-spiritual exploration [47]. Case series also report delusions, hallucinations, irritability and insomnia that lasted [39], and the Dutch institute lists acute psychosis among iboga's harms [8]. The Mash program excluded people with psychotic disorders [26]. A clinic operator describes people regressing to a child-like or violent state who need watching [27].

Liver. Liver disease was among the existing conditions in the 2012 deaths [3], a fatal case with cirrhosis is in the 2026 review [40], and the Mash program excluded liver disease and checked liver tests [26]. A clinic operator says liver function matters but that hepatitis C does not automatically rule someone out [27].

Brain toxicity. Very high amounts damaged cerebellar Purkinje cells in rats, and a primate study and a human autopsy case did not confirm it [2]. The 2012 review found no sign of a distinct neurotoxic syndrome in its 19 deaths [3].

Lingering effects. People in studies report better mood and lower craving, and case reports describe lasting insomnia, delusions and memory problems in some [39]. There is no good estimate of how often either happens.

Legal Status

Last checked 10/28/2026.

Federal

Ibogaine is a Schedule I controlled substance, listed at 21 CFR 1308.11(d)(21), DEA code 7260 [48]. The Cornell text I read lists Tabernanthe iboga only as another name inside the ibogaine entry and has no separate plant entry [48]. Wikipedia says the plant itself is unscheduled [5]. About the Sources lists the DEA guidance I could not find, and I will not tell anyone root bark or total alkaloid extract is legal; a preparation that carries ibogaine is the kind of material the Schedule I listing is written to reach, and that is my reading, not a ruling. Ibogaine has no approved medical use in the United States [5]. Sources disagree on when it was placed in Schedule I (see A Short History).

Recent developments. On 4/18/2026 a presidential executive order directed agencies to speed review of psychedelics for serious mental illness, ibogaine included, and ibogaine stayed in Schedule I [11]. On 10/5/2026 trade press reported that the FDA had opened a request for public comment on early-phase ibogaine trial design, asking in particular about heart and neurologic monitoring, care settings and stopping rules; comments close

11/20/2026 under docket FDA-2026-N-10429, and HHS is prioritizing adults with opioid use disorder and with PTSD [49]. The FDA accepted DemeRx's application for noribogaine, a different compound, for alcohol use disorder, per the company [50]. A commercial guide describes timelines for first US trials and for rescheduling, with no sources, so I did not use them [51].

Colorado

Colorado's Natural Medicine Health Act (Proposition 122, passed 11/2022) names dimethyltryptamine, ibogaine, mescaline (excluding peyote), psilocybin and psilocin in any form [52]. For adults 21 and older it removes state criminal penalties for possessing, using, transporting, buying and growing natural medicine for personal use, giving it away without payment, and sharing it in counseling, spiritual or community settings; it excludes selling [52]. This is state law only; federal law applies to everyone in Colorado.

The regulated, licensed program covered only psilocybin until 6/1/2026; after that the state may add DMT, ibogaine or mescaline only if the Natural Medicine Advisory Board recommends it [52]. On 9/18/2025 the board voted 5 to 2, with two abstentions, to recommend adding ibogaine to licensed healing centers, on condition of Nagoya Protocol benefit sharing and sustainable sourcing; the recommendation went to the Department of Regulatory Agencies [16].

HB 26-1325 passed the House on 5/13/2026 by 59 to 6 [53], was signed 6/4/2026 per a legal information site (the governor's release is dated 6/5/2026), and took effect 8/12/2026 [54][55]. It creates an ibogaine research pilot program in the state Behavioral Health Administration with up to five competitively chosen sites. Applicants must show a safe administration plan with medical screening and cardiac monitoring, a path to federal authorization such as an investigational new drug application, and a benefit-sharing plan with Indigenous communities connected to iboga. Pilot-site facilitators and clinicians get a liability shield, except for intentional misconduct, gross negligence or departure from accepted care [18][54]. The bill also lays groundwork for ibogaine in the regulated program, where regulators could require ECG, blood tests, genetic testing and continuous monitoring, and it treats semi-synthetic ibogaine derived from Tabernanthe iboga or Voacanga africana as natural medicine only on conditions and with board and state approval [18].

What it does not do. It does not open ibogaine to the public or change its federal status, and it needs federal authorization to operate [18][54]. The state puts in no tax money; key sections depend on the Behavioral Health Administration receiving at least $150,000 in gifts and grants before 1/1/2028 [18][56]. As of the effective date, no site had been licensed or had treated anyone [54]. I found no licensed ibogaine treatment in Colorado as of 10/28/2026.

Late amendments changed more than ibogaine. Westword and Vicente LLP report that they narrowed sharing (it must happen at the time of use) and banned advertising of

natural medicine and of paid harm reduction services, and paid support that transfers medicine is restricted [18][57][56]. Mind Medicine Law says personal-use rules for ibogaine itself are unchanged [54]; the accounts differ and I cannot settle them without the enrolled text. A campaign called Voted to Share sought signatures by 8/11/2026 to put the sharing section to voters; I could not confirm whether it qualified [56]. The Division of Natural Medicine adopted emergency rules effective 8/12/2026 on limited sales licenses, and its home page lists no ibogaine item [58].

Unsettled: whether lab-made or semi-synthetic ibogaine HCl falls inside the personal-use protection, since Proposition 122 says in any form and I found no ruling [52][18]. Selling or advertising ibogaine remains illegal, and federal law on importing and possessing it applies in Colorado.

Texas and Other States

Texas SB 2308, signed in June 2025, set aside $50 million for FDA-supervised ibogaine trials run through a partnership of a university, a hospital and a drug company, with private matching money and at least 20 percent of any future drug revenue to Texas [13][59]. UTHealth Houston, with UTMB Galveston, was selected to lead a two-year trial [13]. On 3/31/2026 state leaders announced that no drug company proposal met the terms and that Texas would run the research itself with in-state medical researchers; an analyst said reaching FDA approval would likely take more than $100 million [13].

Other states, from trade news and an advocacy tracker, so treat statuses as likely but not verified: Arizona HB 2871 (signed 6/2025, $5 million) and Indiana HB 1001 (2025, extends a psilocybin research fund to ibogaine); Mississippi HB 314 (signed 3/26/2026, consortium framework); Kentucky SB 77 (2026, enacted over the governor's veto); Oklahoma HB 3834 (approved 5/12/2026); West Virginia HB 4626 (vetoed 4/2026); and Tennessee and Louisiana bills that the tracker listed as awaiting a governor, with final outcomes that I could not confirm [60][61][62]. Maryland, Massachusetts, Missouri, New Hampshire, New York and Oregon bills were moving, and Ohio has a study committee [62]. These laws fund research. None of them makes ibogaine available to the public [60].

Outside the United States

Gabon's 2026 decree and draft export ban are described under Ethics, Sourcing and Conservation [15]. The UK controls it under the Psychoactive Substances Act [2]. A community wiki lists other countries with dates from 2009 to 2020 that may be out of date [25].

Mexico. Ibogaine is not illegal in Mexico, but it is not officially sanctioned medicine there, and quality varies widely, according to a 2018 WBUR report on a clinic near Tijuana, whose staff said they use continuous monitoring and a small test amount first; one clinic founder had moved his operation to the Bahamas over safety concerns [30]. At the best-documented end, the Stanford veterans study ran at a clinic in Mexico under a research protocol [12]. At the other end, a 2026 newsletter reports a patient's death at a Baja clinic

that the clinic attributed to an undetected synthetic opioid, and a first fatality in 17 years at another clinic [63].

Costa Rica. Retreats operate in what the Tico Times calls a legal gray area, mostly run by foreign operators, with an estimate of about 80 retreat centers [64]. The health minister has said they operate illegally despite government tolerance, per a newsletter [63]. A 40-year-old woman from New Mexico died in August 2024 after taking ibogaine at a retreat; investigators sent their file to prosecutors in March 2025, and a 2014 death of a Norwegian woman at another ibogaine facility there is also cited [64]. Family accounts in the newsletter say an IV could not be placed and staff gave police misleading accounts, while the coroner ruled natural causes; those accounts are disputed [63].

Canada. Ibogaine is not under the Controlled Drugs and Substances Act, and Health Canada lists it as a prescription drug that is not authorized for medical use. Practitioners can request it through the Special Access Program, and the law firm that wrote the explainer knows of no approvals [65].

Elsewhere. Treatment centers are described as working in a legal gray area in the Bahamas, the Netherlands, South Africa, New Zealand and elsewhere [2]. In New Zealand ibogaine is prescription only, and a 2018 follow-up study took place with two fee-for-service providers there [2][31]. A Dutch university psychiatry department ran the monitoring study described above [38]. A 2026 clinic-listing guide I read had no sources for its country claims, so I did not use them [51].

Contraindications

Contraindications are medicines and conditions that make a drug unsafe for a particular person. Evidence key: CT means controlled trial data, CASE means case reports, REPORTS means self-reports or community experience, and THEORY means expected from the pharmacology with no ibogaine report found; a drug named only for its pharmacology is my inference. Never stop a prescribed medicine on your own: one death in a medical setting followed stopping venlafaxine before ibogaine [45], so any change belongs with the prescriber.

Medications

Methadone, buprenorphine, heroin, fentanyl, oxycodone, morphine, codeine and other opioids. Methadone is named in the death and heart reviews as a QT-prolonging drug in the body [3][4]. The Dutch and Mash programs switched people to oral morphine first [41][26]. Fentanyl was involved in 3 of 6 deaths in the preprint's clinic cohort [46]; ibogaine given too early can potentiate opioids and slow breathing [63], and respiratory failure and death are reported with opioids [2]. CASE and CT (the study designs).

Benzodiazepines (diazepam, lorazepam, alprazolam, clonazepam) and zopiclone. Present in 8 of the 11 people tested in the 2012 review and in 8 of 19 positive tests in the preprint [3][46]. A fatal seizure probably followed benzodiazepine or alcohol withdrawal

[3]. A clinic operator says ibogaine is not a safe way to taper benzodiazepines quickly; slow tapers, sometimes with a long-acting benzodiazepine, are safest [27]. Zopiclone was among the drugs in the New Zealand death [31]. CASE.

Alcohol. Alcohol dependence, alcohol withdrawal and alcohol in the body appear in the death reviews and are a named risk factor [3][4][46]. CASE.

Cocaine, methamphetamine and other stimulants (amphetamine, methylphenidate, MDMA). Cocaine appears in the death reviews and the heart review's risk list [3][4][46]; methamphetamine dependence was recorded in one decedent [3]. Amphetamine and methylphenidate raise heart rate and blood pressure. CASE for cocaine; THEORY for the rest.

SSRIs and SNRIs (fluoxetine, paroxetine, sertraline, citalopram, escitalopram, venlafaxine, duloxetine). Noribogaine itself acts like a serotonin reuptake inhibitor [2], so stacking is plausible. Fluoxetine and paroxetine also block CYP2D6, which would raise ibogaine exposure (my inference; the Dutch authors warn about CYP2D6 inhibitors in general [41]); citalopram and escitalopram carry their own QT warnings, also my inference. Filter lists serious interactions with SSRIs [66], and a clinic operator says antidepressants need physician guidance on tapering [27]. THEORY and CASE (the venlafaxine death [45]).

Bupropion, quinidine, terbinafine and other CYP2D6 blockers. The named concern is slowed conversion to noribogaine and higher exposure [40][41]. I named these drugs from general pharmacology. THEORY.

MAO inhibitors (phenelzine, tranylcypromine, selegiline, moclobemide; harmine and harmaline in ayahuasca preparations; Syrian rue). Wikipedia and Filter list interactions with MAOIs as possible or serious without data [2][66]. THEORY.

Antipsychotics (haloperidol, quetiapine, ziprasidone, olanzapine, risperidone). A clinic operator names antipsychotics among medicines that interact with ibogaine and need physician guidance [27]. Several of them lengthen the QT interval on their own; that is my inference. THEORY.

Antiarrhythmics and heart rhythm drugs (amiodarone, sotalol, flecainide, dofetilide). Amiodarone was a possible confounder in one fatal case [40]. The others are QT or rhythm drugs by their pharmacology. CASE (amiodarone) and THEORY.

Other QT-prolonging medicines (azithromycin and other macrolide antibiotics, fluoroquinolone antibiotics, ondansetron, hydroxyzine, tricyclic antidepressants). Ondansetron was among the drugs used in the New Zealand death [31]. The rest are my pharmacology inference. A pharmacist can check any list of medicines against a QT drug database. CASE (ondansetron) and THEORY.

Beta blockers, verapamil, diltiazem, digoxin and clonidine. Ibogaine itself slows the heart in many people [4][38], and a slow heart rate is a named risk factor [4]. Adding drugs that slow it further is my inference. THEORY.

Diuretics (furosemide, hydrochlorothiazide), heavy laxative use and proton pump inhibitors (omeprazole). These drugs can lower potassium and magnesium, which matter to the heart (see the electrolyte paragraph under Heart, Blood Pressure and Body Temperature) [4]; that is my inference. THEORY.

Bupropion, tramadol, lithium and other drugs that lower the seizure threshold. Seizures appear in case reports [39]. The link between these drugs and ibogaine is my inference. THEORY.

Kratom and other opioid-like supplements. They are opioid-active and are treated that way here as an inference. THEORY.

Conditions

Heart disease of any kind, including thickened heart muscle, narrowed arteries, a past heart attack, heart failure, rhythm problems and fainting spells. Heart disease caused or contributed to six of the 19 deaths in the 2012 review [3], 12 of 48 in the preprint [46], and one early clinic death was attributed to hypertrophy [27]. CASE.

Long QT syndrome (inherited or acquired), a long QT on an ECG, and a slow heart rate. Long QT syndrome and a heart rate under 50 excluded people from the Mash program [26], and both are named heart risk factors [4][67]. CASE and CT (the study designs).

High blood pressure. Hypertensive heart disease was among the decedents' conditions [3], Erowid lists high blood pressure [7], and a clinic reports a hypertensive episode during a session [27]. CASE and REPORTS.

Low potassium or magnesium, including from vomiting, diarrhea, eating disorders, heavy alcohol use or some medicines. Low potassium was present in every fatal or arrhythmia case where it was measured [4][40]. CASE.

Liver disease and hepatitis. Liver disease was among decedents' conditions, a fatal case involved cirrhosis, and the Mash program excluded it [3][40][26]. A clinic operator says hepatitis C is not an automatic bar but liver function must be checked [27]. CASE.

Kidney disease. Erowid lists liver or kidney disorders as higher risk [7]. REPORTS.

Epilepsy, past seizures, a brain tumor, and alcohol or benzodiazepine withdrawal. Seizures appear in case reports and in one death [3][39], and the Mash program excluded epilepsy [26]. CASE.

Psychosis, schizophrenia, bipolar disorder and past mania. The Mash program excluded psychotic disorders [26], mania has followed ibogaine in people with no prior

bipolar diagnosis [47], and the Dutch institute lists acute psychosis [8]. Erowid advises caution with any history of psychological illness [7]. CASE.

Stroke, aneurysm, glaucoma and low blood sugar. Erowid lists them as higher risk, and the Mash program excluded stroke [26][7]. REPORTS.

Blood clots, clotting disorders and injection drug use. Three Mexico deaths were certified as pulmonary embolism, one decedent had a family history of clotting problems, and an early clinic death was attributed to pulmonary embolism [3][27]. CASE.

HIV. The Mash program excluded it and gave no reason in the paper [26].

Pregnancy and breastfeeding. Wikipedia says ibogaine should not be used in either, and the Dutch institute advises pregnant people to avoid iboga products [2][8]. Safe use is unknown.

Slow CYP2D6 metabolism (poor metabolizers). More exposure for longer is expected [4][40]. Researchers suggest genotyping and caution [31][43]. The Mash and Dutch work did not test everyone [40]. CASE and THEORY.

Female sex, obesity and a past peptic ulcer. Female sex is a named heart risk factor [4]; obesity and ulcer disease were listed among the 2012 decedents' conditions [3]. These are associations, not proven causes. CASE.

Recent opioid, fentanyl or nitazene use, and starting treatment in withdrawal. See Medications. Operators advise people not to start treatment in withdrawal [27], and recent fentanyl exposure calls for a long washout confirmed by quantitative testing [46]. CASE.

Emotional crisis. Erowid advises against use in emotional upheaval and for people solely responsible for others [7]. REPORTS.

Other Substances and Combinations

Combinations of medicines get their own document with a large warning at the top; this section is the short version for ibogaine. With this medicine the combinations are the main way people die, so the short version is longer than usual. Opioids, benzodiazepines, alcohol, cocaine and other stimulants are under Medications, where the death reviews that name them are cited.

Other psychedelics and plant medicines. A clinic operator links one death to combining ibogaine with 5-MeO-DMT, kambo, MDMA or ayahuasca; I could not verify the case [27]. A man in a news report took 5-MeO-DMT three days after ibogaine and described it as positive, which is an anecdote and not safety evidence [30]. Kambo causes vomiting and fluid loss, which can lower electrolytes, and ayahuasca preparations contain MAO inhibitors; both points are my inference.

Magnesium and other medical supports. Clinical protocols give magnesium intravenously, with ECG monitoring [12]. That is a clinician's tool. A supplement taken on one's own is not a substitute for monitoring, in my reasoning.

Addiction and Misuse

Physical dependence. Erowid says it is not physically addictive, is unlikely to cause psychological dependence, and has no reported withdrawal [7]. PsychonautWiki says it is not habit-forming, and then notes that adverse effects including addiction grow likelier at higher amounts, so its own page pulls two ways [25].

Addiction means loss of control, craving and use that continues despite harm, often with withdrawal. Misuse means use that raises risk or causes harm: using without screening, taking an extra swallow when nothing seems to happen, using other drugs to cope with withdrawal during a session, or treating ibogaine as a one-time fix with no follow-up. Ibogaine does not seem to cause dependence in the usual sense, yet it can be misused, and the cost of misuse is the highest in this library. That is my clinical lens.

Ibogaine as a Treatment for Addiction: What the Research Shows

Ibogaine is used, mostly outside medicine, to get through opioid withdrawal and to cut craving, and in research for PTSD, brain injury and other conditions. The honest summary: some studies suggest it can ease withdrawal and craving, and none of them is the kind of study that proves it.

A 2022 review found 24 human studies covering 705 people who received ibogaine or noribogaine. Almost all were non-randomized (open label, case series, observational or retrospective). The review saw signs that ibogaine reduces opioid withdrawal and craving for opioids and cocaine, and a small double-blind trial of 20 people found less cocaine craving after a single treatment; noribogaine trials showed withdrawal trends that were not statistically significant. The authors cautioned against strong efficacy claims [45]. A 2026 review agreed that no randomized, placebo-controlled trial of ibogaine for substance use has been completed [40].

Examples. In an observational study of 30 people with opioid dependence, withdrawal scores fell from about 31 to about 14 at roughly 77 hours, and half reported no opioid use in the prior 30 days at one month; improvement faded but held on some measures through 12 months [68]. In New Zealand, 14 people were followed for a year, only 8 completed every interview, urine tests were inconsistent and self-reported use was higher than the tests showed, and one person died during treatment [31]. In a retrospective survey of 88 people treated at one clinic in Mexico, 30 percent said they never used opioids again, 48 percent used less, and about 70 percent relapsed at some point; 41 percent had been abstinent for at least six months when surveyed [20]. Mash's series of 191 inpatients showed less withdrawal and craving [26][40]. In the 2024 veterans study (30 men, mostly with mild brain injury), disability, PTSD, depression and anxiety scores

improved a great deal at one month with no serious adverse events, under continuous heart monitoring and with magnesium; it had no control group and followed people for one month [12].

The Dutch study shows the other side. Fourteen people on methadone or buprenorphine maintenance were switched to morphine and then given ibogaine under monitoring. Withdrawal stayed low, but the heart effect was close to universal (see Heart, Blood Pressure and Body Temperature), and three asked to restart morphine because they felt it had not worked [38][41]. The authors judged the risk and benefit unfavorable for routine use [38]. The Carlat Report, a psychiatry newsletter, went further and advised methadone or buprenorphine, which have established evidence [41]; that is the newsletter's opinion, not a trial result.

Clinics quote their own success rates. One Mexican clinic told a reporter that about 40 percent of patients stay off drugs long-term, a figure drawn only from patients it keeps in touch with [30]. Treat numbers like that as marketing, not data. A related compound, oral noribogaine, has an FDA-accepted application for alcohol use disorder, with a phase 2 trial planned for 2027, per the company [50].

After a treatment ends, tolerance to opioids is lower than before, so a person who goes back to a previous amount of heroin or fentanyl is at higher overdose risk. That is my inference from general opioid pharmacology, not a finding from these papers. Each repeat treatment also repeats the heart risk.

Testing and Purity

What Is Really in the Product

Contents are the weak point. The 2012 review notes that unregulated extracts and bulk root bark have variable and poorly characterized composition [3]. The unauthorized and counterfeit products that have been reported are under Forms You May Meet.

Test Kits and Labs

DanceSafe says reagent kits can show that a sample reacts unexpectedly, and cannot confirm what a drug is, find more than one substance, measure strength or purity, or detect fentanyl. Plant material is very hard or impossible to test at home [69]. DanceSafe does not mention iboga or ibogaine [69], so a home kit tells you very little here.

A different kind of test matters more: toxicology on the person before treatment, which is covered under Choosing a Facilitator. Fentanyl test strips test a sample of a drug for fentanyl, not a person's body, and they give a yes or no and nothing about what else is there [69].

Transparency Testing runs mail-in analysis of powders, plant material and extracts, and does not accept liquids. Its site does not name iboga or ibogaine, so ask first whether it accepts alkaloid extracts [70]. DanceSafe says no US walk-in site offers confirmatory lab

testing [69]. For TA or HCl, a useful lab report would show the ibogaine content and the other alkaloids.

Preparation and Integration

No dosing or timing numbers are given here. Those are left to the sources and a medical provider. The best preparation is a medical assessment, and it may end with a no.

Before

Meet a physician who understands ibogaine, and tell them about every medicine, supplement and substance. Ask for an ECG with a QTc reading, blood tests for potassium, magnesium, liver and kidney function, and a review of every medicine against the lists under Contraindications [4][39][26][67]. A genotype test for CYP2D6 has been suggested by researchers [31][43]. Do not stop a prescribed medicine on your own [45].

Clear the body. Recent fentanyl or other opioids call for a long washout confirmed by testing, and dependence on alcohol or benzodiazepines needs medical stabilization first, not ibogaine as the way out [3][46][27]. One clinic describes preparation that starts well before treatment, with trust built with the team in advance [27].

Ask the questions listed under Choosing a Facilitator. Ask where the product came from and whether it is lab-measured. Arrange a sober person who stays and a way home. Think ahead about the experience itself: a long, effortful, often difficult look at your life, with nausea and unsteadiness, that people describe as hard [30][7].

Choosing a Facilitator

Ibogaine is mostly given outside the United States, in clinics and retreats in Mexico, Costa Rica, Canada and a few other places, and what the reports say about particular places is under Outside the United States. This section collects what the safety literature says a place should do. It is not a list of places and does not endorse any.

Screening in the Mash program. The Mash inpatient program reviewed each patient's history, exam, labs and ECG against set limits. It excluded heart rate under 50, long QT syndrome, stroke, epilepsy, psychotic disorders, heart and liver disease and HIV; switched opioid-dependent patients to oral morphine; gave IV fluids before treatment; ran continuous ECG telemetry from an hour before to 24 hours after; drew labs before and the morning after; and tracked adverse events for 7 days [26]. The article gives no QTc cutoff and does not discuss emergency equipment [26].

The veterans protocol and the guideline summary. The veterans study added magnesium before and after, continuous five-lead ECG, frequent blood pressure and oxygen checks, and about one staff member for every two patients for 12 to 16 hours [12]. A secondary summary of clinical guidelines names pre-treatment ECG review, blood and liver panels, a medication review, escalation to hospital for a dangerously long QTc or unstable rhythm, and a magnesium response above 500 ms; it gives no other cutoffs and

says it is not professional consensus [67]. A systematic review adds ongoing cardiovascular monitoring [39], and the 2015 review adds consent that names sudden cardiac death [4].

Fentanyl and nitazenes. Recent fentanyl use is a hazard that ordinary urine tests can miss: the Global Iboga Therapy Alliance has said that nitazenes and xylazine often escape standard toxicology and can stay in the body for a week or two, and that giving ibogaine too early can potentiate opioids and slow breathing [63]. The 2026 preprint recommends a long washout with quantitative toxicology before treating anyone with recent fentanyl exposure [46].

Emergency capacity. A CU Anschutz physician quoted in Westword said ibogaine studies need hospital-level monitoring and emergency capacity [57]. A Colorado advocate quoted by Filter said an experienced nurse is essential and a cardiologist is helpful but costly and rarely needed [66]; that is an advocate's view.

Questions to ask a place. My synthesis, not a published standard: before any treatment, a person can ask whether a physician is present the whole time, whether ECG monitoring is continuous, whether there is a defibrillator and staff trained to use it, how long it takes to reach a hospital with a cardiac unit, how the place handles fentanyl and nitazene exposure, what it does about potassium and magnesium, and what its own record of serious events and deaths is. A place that will not answer is giving you an answer.

What no one can tell you. There is no independent register of ibogaine clinics, deaths or serious events. Americans for Ibogaine, one of the groups that tracks the field, has no regulatory authority over clinics abroad [63]. The one large dataset, from eleven clinics, is self-reported and not peer reviewed [46]. When a clinic says no one has died in its care, as the Tijuana clinic did [30], that statement cannot be checked. The reviews show deaths did not stop where screening started; the number fell, and no one can say by how much [3][46].

During a session. A person should be lying down in a monitored place, with continuous ECG [12][26][27]. Do not walk alone, because severe unsteadiness is expected and falls are a plain risk [38]. Keep a basin close for vomiting and keep fluids going as the clinicians direct. Do not add other substances. Do not drive [7]. A sober sitter who stays and can call for help matters at every stage [7].

After

The heart risk continues after the visions. Ask about repeat ECGs and electrolyte checks over the following days [42][4][40]. Avoid adding QT-prolonging medicines or other substances during that window without asking a physician. Sleep is poor for a day or two [7]. Expect tiredness and emotional swings; watch for mania, with little sleep, racing thoughts and risky behavior [47].

Integration matters more with this medicine than most, because what people most often want from it is lasting change. Operators stress aftercare and family involvement [27]. A supportive therapist, a recovery community, and a physician who can discuss medicines for opioid use disorder with established evidence all belong in the plan [41]. Fireside Project offers free peer support by phone or text, including for making sense of an earlier experience [71]. If you used opioids before, your tolerance may have dropped; Addiction and Misuse explains why that matters.

If You Need Help Now

In a medical emergency, call 911. If you are in emotional crisis, you can call or text 988. Fireside Project has trained volunteers who talk with you by phone or text during and after a psychedelic experience, and DanceSafe sells kits for testing what you hold.

Warning Signs

Call 911 for fainting or collapse, chest pain, a racing, pounding, very slow or irregular pulse, shortness of breath, a seizure, unresponsiveness, or slow or stopped breathing. The danger of ibogaine is the heart, and the test is an ECG [42][4]. Do not wait it out: the heart risk outlasts the visions, as How Long It Lasts shows [3][40].

Tell the responders the word ibogaine, the time of the last swallow, the form (HCl, extract or bark), and everything else taken, and bring the product and packaging. Routine hospital urine drug screens do not detect ibogaine, so say it aloud, and ask for an ECG and potassium and magnesium levels [42][4]. If staff do not know ibogaine, they can call Poison Help at 1-800-222-1222 [72].

Seizure: call 911, put nothing in the mouth, move hard objects away, note the time, and roll the person onto their side when the shaking stops. Alcohol and benzodiazepine withdrawal raise the risk [3]. If opioids may be involved and the person is hard to rouse or breathing slowly, call 911; naloxone, if you have it and know how to use it, is standard first aid for opioids, and a dispatcher can guide you. This is general first aid and not ibogaine-specific; one fatal case in the literature had naloxone given [39]. If breathing stops, start CPR as the dispatcher directs.

Expected during a session: nausea, vomiting, tremor, headache and severe unsteadiness for hours [38][12][7]. Vomiting that does not stop, an inability to keep fluids down, or fainting on standing needs medical help, since potassium and magnesium fall; that is my inference from the electrolyte findings [4]. Mania in the days after (little sleep, racing thoughts, risky behavior), hallucinations or delusions that persist, or extreme agitation need urgent psychiatric evaluation or 911 [39][47].

For suicidal thoughts, call or text 988, any hour [73]. Fireside Project at 62-FIRESIDE (623-473-7433) is open daily from 11 a.m. to 11 p.m. Pacific time, which is noon to midnight Mountain time. Its volunteers are trained peers rather than clinicians, and it is not

a medical service or a suicide line [71]. Fireside can help with distress that does not ease after the medicine wears off; it cannot assess a heart.

Where to Find More Information and Support

Amounts, timing and combinations are best checked against these sources and with a medical provider, because they are updated more often than this sheet. Erowid, TripSit and PsychonautWiki include user reports and community writing, so read them as experience as well as research.

Erowid: https://erowid.org

DanceSafe: https://dancesafe.org

TripSit: https://tripsit.me

PsychonautWiki: https://psychonautwiki.org

Zendo Project: https://zendoproject.org

Fireside Project: https://firesideproject.org

MAPS: https://maps.org

Poison Help: 1-800-222-1222

For Ibogaine and Iboga Questions

Americans for Ibogaine, an advocacy organization that tracks state bills (it is not a regulator of clinics): https://www.americansforibogaine.org

ICEERS, which hosts iboga research papers and publishes harm reduction and legal support information: https://www.iceers.org

Chacruna Institute, on iboga conservation, ethics and plant medicine justice: https://chacruna.net

OPEN Foundation, a Dutch research foundation with an ibogaine research archive: https://open-foundation.org

Transparency Testing, mail-in lab analysis (ask whether it accepts alkaloid extracts): https://www.transparencytesting.com/

Colorado Division of Natural Medicine: https://nmd.colorado.gov/

Mailing Lists

Erowid Monthly, a free email list: https://www.erowid.org/about/about_announcements.shtml

Erowid Extracts, the members' newsletter: https://erowid.org/membership/

MAPS email newsletter: sign up at https://maps.org

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