The Truth About Addiction

An interview with Dr. Jeffrey Kamlet

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Over the past five decades, Ibogaine has transitioned through several stages here in the West. Currently, the Ibogaine community is in disarray, mainly due to disorganization, misinformation, and improper training. I recently interviewed Dr. Jeffrey Kamlet who was named the 'World Safety Expert on Ibogaine'. In this discussion, Dr. Kamlet shed light on a wide range of recovery topics, including Ibogaine, pharmaceutical maintenance drugs, twelve step programs, and more.

Jennifer: *You are a leading expert in the field of recovery worldwide, and you have treated and helped thousands of lives. You are a unique practitioner because you work with recovery modalities from all ends of the spectrum, ranging anywhere from Suboxone to Ibogaine. Could you please tell me about your history in the field of recovery and what led you to the discovery and use of Ibogaine as a method of addiction treatment?*

Dr. Kamlet: I became interested in addiction medicine in approximately 1997. A friend of mine who was an addiction doctor said, "Jeff, why don't you join the American Society of Addiction Medicine?", so I went to one of their conferences. They were running a detox center on Mount Sinai and I began helping. We had, in my opinion, one of the best detox programs in the country. We were using liquid opiates every four hours around the clock for detox. We were using opiates to get patients off other opiates, which is still the current U.S. model of treatment. We were very successful because people were also going to 90-day residential program and NA meetings following detox. Back in those days there were very few treatment centers. That's when I was

introduced to Dr. Deborah Mash who told me, “I have a drug that can treat opiate withdrawals in 24 hours”. I had read about Ibogaine, but I was skeptical of articles written by PHD’s who have to ‘Publish or Perish’. I saw addiction medicine to be a new and exciting field where a person like myself could actually rise in the ranks quickly and make a difference. I saw a lot of room for improvement in the opiate detox models that were being used in the United States at that time.

At that time, Dr. Mash, Ph.D., had just started working with Ibogaine. She had treated a couple patients with Howard Lotsoff in Panama, but they didn’t really know what they were doing. She then received permission to do a clinical trial in St. Kitts. Even though it was a legitimate study, the patients were going to have to pay ten to fourteen thousand dollars to spend ten to fourteen days there. When you do a clinical trial in the U.S., you aren’t allowed to charge anybody money, but since nobody was funding this study, the patients had to pay. I was excited and honored to work with Dr. Mash whose reputation on brain chemistry and addiction had been widely published.

For the next approximately seven years we went to St. Kitts once a month. We’d treat anywhere from ten to fourteen patients per trip, we would treat four a day, and we started to learn. We learned how to pre-screen, stabilize the patients, stabilize them on opiates prior to their flood dose, how to administer Ibogaine, how to use the music, and how to care for them post treatment.

We also noticed the possible dangers associated with flood dosing. This is when I noticed the QT prolongation, hypotension, eradycardia, and bizarre t-wave changes on EKG. Back then nobody was looking at QTC prolongation. Most of what was learned about the drug originated from my observations in association with Dr. Mash who was a PHD, not an MD. Information on how to administer this drug safely primarily came from my observations, and much of the theory of how Ibogaine was working on the brain came from Dr. Mash’s work, and others. I was a previous E.R. director who was board certified in addiction medicine and also had an interest in entheogenic drugs. So, the meeting of Dr. Mash and myself was truly serendipitous.

Jennifer: *The most important element needed to bring credibility to Ibogaine is the science to back the claims. Can you tell me about the work you did with Dr. Deborah Mash? What was the goal of this work and did any positive changes result from it?*

Dr. Kamlet: The whole idea back then was that we were going to collect enough data and then Dr. Mash and I were going to go in front of the FDA, show them this data, and it was going to be so good that they couldn't ignore it. Dr. Mash and I had co-lectured at several major addiction conferences, but we had little proof except for our word and patient testimonials.

Seven years and three hundred and something patients later, we had a massive amount of legitimate, super-scientific, ethical data.; provable data that was so good I thought it would hardly be believed. I was quoted as saying," In my opinion, Ibogaine is the most important discovery of addiction medicine". What it takes to do in ninety days in a U.S. model, I could do in *one day* with Ibogaine. Not only can I detox you, but I can get you past post-acute withdrawal, and have a patient who is ready for change.

This is the example I was using, "If you got busted, were thrown in the jail cell for ninety days and went into a cold-turkey withdrawal, the day after Ibogaine you would be where you were ninety days into a cold turkey detox". Essentially, it's throwing you ninety days ahead of the curve.

Ibogaine is not a cure for addiction. Many people were relapsing and coming back. The ones who went to rehab and/or NA meetings seemed to have a much greater sustainable recovery rate. It's an interesting thing because most of them said that they had already been to treatment and they've been going to meetings, "I've been detoxed twenty times before and those meetings don't work for me". But after Ibogaine, most of them decided to go to rehab and to meetings. Many of them went to a rehab called C & G Holistic, which was in Miami. One of the owners would come down on every round with us, his name was John Giordano. He ran a good aftercare program; a lot of the patients would go back with him and we had a whole Post-Ibogaine recovery community in Miami. This was very encouraging for us because post-Ibogaine patients became teachable.

So, we finished the study. Six months went by and I start asking about the data. More time went by, but for some reason that I still don't understand, the data never came out. I believe that if that data would have been released in the early 2000's as promised, that Ibogaine would be available in the United States today.

Dr. Mash, myself, and a team of many other competent professionals with credentials started this study with the intention that we were going to give this data away as our gift to the world, but the data was never released by Dr. Mash.

Then, there was an explosion of unregulated Ibogaine clinics opening outside the U.S., and as quoted in the medical literature, the 'Vast Uncontrolled Experiment' began.

I have a joke that I tell, "What happens when you give a heroin-addicted sociopath Ibogaine? He gets clean and opens up an Ibogaine clinic!" That's not to say all clinics are bad, but many were and continue to be.

Ever since day one, all I ever wanted to do was to make Ibogaine affordable, safe and available to anyone that needs it in the United States. So, let's say this is done as a one-day procedure at a hospital, I would think the cost could be approximately two-to-three thousand dollars, administered safely with cardiac monitoring, doctor at the bedside, etc. A trained physician could treat twenty patients at a time per day. That was all I ever wanted to see and it's what I hope to see while I'm still on this planet.

Unfortunately, I just don't see that happening. We live in a capitalistic society where we don't have a health-care system, we have a *sick*-care system, run by Big Pharma whose motives are to turn profits for their shareholders as opposed to finding cures for illnesses.

When the Ibogaine clinics started opening, at first, I kept all the information I knew to myself. I really believed we were going to go before the FDA with the data and I didn't want to give this information to bad providers. When I realized that wasn't going to happen, I started going around to all the Ibogaine conferences telling them everything that I knew, "This is what I know about Ibogaine, this is how you give it safely, you need constant cardiac monitoring, you need fluids, magnesium, you need to monitor QT prolongation, don't take a patient who's liver enzymes are two and a half times normal, don't take a patient who's QTC is 480 or above, etc. etc." In addition to prescreening, psycho-social history, physical exam, complete lab tests, safe treatments, and effective aftercare. If clinics were going to treat patients with Ibogaine anyway, let me at least help them understand a safe, effective model of treatment and possibly even scare those away who were incapable of providing proper safety during treatment.

I started to explain how to get people off Methadone and Suboxone by calculating half-lives, something so simple that a third grader could understand it. Patients on very long-acting opiates could not go directly to Ibogaine flood dosing because there should not be any opiate in the patients' system to compete with Ibogaine metabolites for the opiate receptor sites. The half-life

of Methadone and Suboxone is twenty-four hours. Let's say the person is taking 8mg of Suboxone, tomorrow you have 4mg left in your system (and maybe you need a little bit of Oxycodone), the next day you have 2mg left, the next day you have 1mg, the next day you have a half milligram, the next day a quarter milligram, the next day you have an eighth, and the next day you can be treated. After hearing this at various lectures I gave, clinics were telling people that they need to get back on short-acting opiates for thirty days before they could be treated because the lay providers could not understand the pharmacokinetics of long-acting opiates. I got many calls from patients asking how they could get a thirty-day supply of short-acting opiates. I would ask them what the clinics were telling them about where they could get short-acting opiates, and they were telling patients to go buy heroin or the Oxy that they bought on the street as they did before! How absurd!

This is the value of someone like myself. I can legally do your switchover from long-acting to short-acting opiates in the United States, and then you would arrive at the clinic outside the U.S. ready to be treated.

Very few clinics in Mexico are licensed as an actual addiction clinic and can legally supply large amounts of morphine to stabilize patients pre-flood dose. I don't know how the other clinics are getting their opiates. I've had people tell me that they went to clinics who were driving around bad neighborhoods in Tijuana trying to buy Oxycodone, et. al., because they were going into withdrawals…crazy stuff!

They say there's been nineteen Ibogaine deaths, but that's not true. In my opinion, there have been many more Ibogaine deaths, possibly even into the hundreds, because deaths in foreign countries and deaths through the Ibogaine underground are not reported.

I have a folder of complaints about Ibogaine providers and clinics that I've been keeping for the last ten years, claiming sexual molestations, abuses, financial rip-offs, ineffective treatments, patients going home in withdrawals and clinics not answering the telephone. There was even one place claiming that they had the 'Triple Guarantee', but when you got home and were in withdrawals or relapsed, they would never answer their phone again. One clinic was selling Ibogaine followed by Ayahuasca seven days later, until they had a patient die while on Ayahuasca. In my model, I think that is insane.

I had a patient once tell me that a clinic was explaining how to get back on short-acting opiates, so he asked if he could use Benzodiazepines (Valium) and they told him to use all the Benzos you want! He showed up and was taking 100mg of Valium a day! I said, "WHY?!", he said because the person who answered the phone for the clinic told him it was okay. Now that patient was opiate-free but had a Benzodiazepine habit which Ibogaine would not be able to help with.

I know I got a little off track here, but that is how I got involved with Ibogaine. Once I realized the data wasn't going to be released, I decided to meet all the providers and go to all the Ibogaine conferences. Dana Beal started small conferences in New York, then we grew to GITA (The Global Ibogaine Therapy Alliance), and then we started working on ethics and scientific planning. So, there were a lot of good people with good intentions, but they still didn't really understand the addiction side of this. I am giving Ibogaine to people who want to treat their addiction, I am not giving Ibogaine to people who want to have a spiritual experience, nor am I treating PTSD or depression, I am strictly treating addiction. Yet sometimes with Ibogaine you do get a bonus, the visionary component can be like receiving years of good therapy done in one day.

What makes Ibogaine so special, as compared to every other plant teacher out there? **Ibogaine is the only substance on the planet that will ameliorate opiate withdrawal in less than twenty-four hours.** That makes it the most important discovery right now in addiction medicine as we face an opiate usage and death tsunami across the United States and the world. We have 75,000 opiate deaths per year in the United States at present. Could you imagine the outcry if 75,000 people died from the Zika Virus? This is a 'miracle drug' that shouldn't even go through clinical trials, it should just be brought out tomorrow on an emergent basis because everybody knows it works. Unfortunately, that will not happen in the near future because the pharmaceutical lobby and others don't want to see this drug come out.

Jennifer: *Harm Reduction seems to be an oftentimes overlooked element in recovery, but in my advocacy work it seems clear that recovery is oftentimes a slow process with many small goals and improvements. What Harm Reduction tools do you implement in your practice?*

Dr. Kamlet: I am a full 110% believer in Harm Reduction. The great majority of people cannot afford Ibogaine and will never be able to afford proper Ibogaine treatments. So, if you're in the streets, robbing people for heroin and sticking needles in your arm, guess what…going on Suboxone is a tremendous improvement on your life. I have patients on Suboxone who go to work every day, nobody knows they are on anything, they act 'normal', the drug doesn't tell you to take more of the drug, and you can't possibly die from it unless you mix it with other drugs (especially Benzodiazepines). This, in my opinion, is Harm Reduction. Getting pain patients on lower doses of pain medication is also Harm Reduction.

Methadone can be Harm Reduction, but I think Suboxone is better than Methadone. There is no such thing as a blocking-dose of Methadone. I've been involved with Methadone since 1984, I sat on the board of the National Association of Methadone Advocates, and there is no such thing as a blocking dose of Methadone. People are always wanting to take larger doses of Methadone, and I don't care if you are taking one thousand milligrams a day, you can still shoot dope while you're taking it. Methadone is difficult to get off of, but it's a hell of a lot better than going to jail or being in the streets and dying.

I tell people all the time, even if you're still using, go to an NA meeting. There's no rule that says you have to be clean to go to a meeting, they say "If you used a drug today then please don't raise your hand to share because we want to hear from you, not the drug". Where else are you going to find hope? You aren't going to find hope on a Methadone line, or in the Suboxone doctor's office.

Every month I have three to four Suboxone patients who have detoxed to zero, because I have a protocol, a way of cutting the films where I can taper a Suboxone patient. If you're on 16mg of Suboxone it may take up to eighteen months to do this if you need to do it comfortably, but it can be done. While you are tapering you need to go to meetings. Otherwise, you're never going to have the fortitude to get through this long, difficult process.

In the United States, where we do pharmaceutically assisted detox, this is where a lot of people make a mistake. Let's say you're taking 4mg of Suboxone. The detox protocol says that every day we are going to bring you down 1mg, or every week or every month. When you go from 4mg to 3mg, I just cut you back by 25%. And then you go from 3mg to 2mg, it's the same 1mg, but I just cut you back by 33% of your total dose. Now you go from 2mg to 1mg, you're getting sicker and sicker, and you don't understand it because it's the same 1mg, but it's 50% of your total dose. So,

anytime a detox or a rehab gives you a standard dose to go down every day or every few days, the patient is eventually going to get sicker and sicker. When we originally started doing detox, I came up with the concept of reducing the percentage of the total dose, so if someone is doing a detox, we are going to reduce their dose 5% at a time. You can't do this when you're taking solid pills, but when you're using liquid medication like Dihydromorphone or Morphine, or even Dihydrocodone, I can literally pour you 1.18mg, or whatever it might be. This way you can keep your reductions calculated by percentage. Remember, if you take 16mg of Suboxone today and you take 16mg tomorrow, on that second day you really have 24mg in your system, because you have the 16mg that you took plus 8mg left over from day one. On the third day, you have the 16mg that you took, 8mg left over from day two and 4mg left over from day one. So, by the time you get up to day ten, you might be taking only 16mg a day, but you have about 30mg in your system. I noticed that if I cut people back on their dose no quicker than every ten to fourteen days and keep the cut back less than 20% of their total dose, they don't go into major withdrawal because they have so much back-up drug on board.

When Suboxone first came out it only came in a tablet form and only in two dosages of 2mg and 8mg. That made tapering very difficult. If the intention of the drug company was for people to detox off this drug, should there not have been a 1, 2, 3, 4, 5, 6, 7, and 8mg dosage? However, when they came out with Suboxone film, I could take a piece of film and fold it into eight perfect little squares. I take an 8mg film and I fold it in half, and then fold it in half again, and I open it up and I've got four pieces of 2mg. Then I fold it on the horizontal and I have eight squares of 1mg each. Now I can tell the patient to take a scissor and cut 1mg or a half milligram off that film, and that's their cut back.

I do clinical trials in my office. Drug companies hire me and my clinical team to help bring out new drugs, such as asthma drugs, antibiotics, last year we did a clinical trial on the flu vaccine, this sort of thing. I know a lot about doing clinical trials. I was involved in some of the original clinical trials on Suboxone and other like products to be used for Medicated Assisted Treatment (MAT). Before these drugs ever came out, I saw how they worked. One of the makers of a Suboxone product used to pay me to speak, because I was one of their Scientific Board Members. When that company first came out with their drug, I was given one of the first MAT DEA licenses in the United States. I was sent around the country to teach other doctors how to use Suboxone and

then Vivitrol, another drug used to prevent alcohol and opiate relapse in patients who have already been detoxed.

The drug companies were telling everyone, the government included, that patients would be off opiates in thirty days because we were going to use Suboxone to detox them. That was said to get the drug approved by the FD and the DEA. *Now* what they are selling is, "Stay on Suboxone forever!". Why? Because they want to make a fortune.

I have patients coming into my office tell me that they are getting Suboxone from doctor so-and-so, right down the road. Then why are you coming to me? Because they went back for a follow-up visit and told that doctor, "I only needed 4mg of Suboxone to feel okay, but you told me I needed 16mg, and on 16mg I was too sedated. I only need 4mg.", and the doctor would actually yell at them for not taking 16mg, stating, "You're going to relapse!" I hear this all the time.

Many doctors don't care, they just want the patient to come back every month; here's my $200, here's your prescription. Many others are just not experts. The training to prescribe Suboxone is very minimal in an attempt to make this drug available to as many people as possible. I only know of one other doctor that asks the patient, "Are you here to get off this drug or are you here to stay on it?" Recently in the U.S., nurse practitioners can receive permission to prescribe MAT. The government and the drug manufacturers' reasoning for this was to make the drug more accessible in areas that access to physicians was limited. However, I ask the question, "Are these practitioners who are not consummately trained in addiction medicine really able to prescribe this drug properly?"

I've had patients that were sixty years old and have been taking opiates for forty years that want to stay on MAT forever, and since they're old and sick, that's okay! If that works for you, that's fine. But when a twenty-one-year-old kid comes to me and says he would like to stay on Suboxone forever, that's absurd! I tell them, "Let's do a slow taper". Sometimes it takes twelve months, sometimes it takes sixteen months, sometimes it takes eighteen months, but we do taper them. And those who go to meetings and therapy while they are tapering, do better. Under U.S. law, there *must* be a therapeutic component to medicated assisted treatment for opiate dependents using products like Suboxone. However, that is infrequently the case.

It's interesting, Narcotics Anonymous at their next world convention is actually voting on a law to be more accepting of Suboxone and Methadone patients. In other words, the rooms didn't know what to do with Suboxone patients; are you considered to be in recovery using Suboxone, or are you considered to be still using? That paradigm is shifting now to welcome Suboxone patients into the meetings, which in my opinion is a huge step forward.

I've been telling people on Suboxone for years to go to meetings and make connections with people in recovery. How can I tell my patients to work a program based on rigorous honesty and then tell them to lie about being on Suboxone? This is why I tell drug users not to go to AA meetings, because you are stating that you're an alcoholic, and you are not. In NA, it states, "Let there be no mistake about this, alcohol is a drug."

Find a sponsor who is open minded enough to say, 'I will sponsor you as long as you are cutting back on your Suboxone dosage'. Unfortunately, not all people will do that, some people won't sponsor you because you're on Suboxone. The most important thing is to just be honest with your sponsor.

So, this is a very successful model that I have, because most patients can't afford Ibogaine or anything like it. Especially the way I do Ibogaine, it becomes very expensive. I see you for a week or two and do the physical and psychological work that must be done before a flood dose, including labs and cardiology clearance. Then I stay with you twenty-four hours around the clock during and after your treatment. Then, ongoing contact for as long as the client wishes for post-Ibogaine aftercare treatment. It isn't a money maker for me because the days that I'm there are days that I'm not in my office. I still have a staff in the office, still paying rent, still paying salary, and I'm not seeing the patients that pay my bills. So, the figure that I came up with is one that breaks it even, that way I'm not paying out of pocket. That's what I did back with Dr. Mash as well, I didn't want to get paid for being there, but I did need to cover my expenses.

Jennifer: *When people come into your office addicted to opiates, what is your preferred method of treatment, Suboxone or Ibogaine? And why?*

Dr. Kamlet: We have no choice. In other words, in the United States model there is only one thing a doctor can do on an out-patient basis for a patient addicted to opiates, and that's MAT.

I am also certified in pain management. I see a lot of patients with cancer and terrible diseases. Some were addicts but we managed their pain in a way that they don't go off to the races. But when somebody comes in and says, "I have a problem with opiates, I'm an addict", in the United States model I cannot by law give an opiate to an opiate addict to detox them on an out-patient basis. That's against the law. You also cannot give Methadone to an opiate addict unless it's in a Federally Licensed Methadone Clinic that is highly overseen by the DEA. There are two Methadone treatment programs in all of Miami. How many millions of people live in Miami, and there are two Methadone clinics, and they make a fortune, at $12/day per patient.

The only thing I can do is offer everybody MAT, but I tell everybody about Ibogaine. The great majority of my patients live off an $800 disability check a month, so taking Ibogaine is out of the question. Nor would I recommend anybody, in good conscience, reach out to the Ibogaine underground, or buy Ibogaine from a website; it's just too risky.

When a patient asks me about Ibogaine and can't afford proper safe treatment, I tell them to go to a Narcotics Anonymous meeting. Almost everybody is there for opiates and at the end of the meeting they will say, "If you have a year or more, raise your hand". This is to show the new-comer that this program really works. All these people raise their hands, and none of them took Ibogaine, so there's a lot of ways to get clean.

You can't pick a treatment modality for a client until you meet the client. What's the level of motivation? What's the support system? Are they dual diagnosis? It has to be custom-tailored. However, I am limited to what I can put on my menu, here in the United States, it's only Subutex or Suboxone or other similar Buprenorphine products.

Jennifer: *What is the difference between Suboxone and Subutex, and which do you prefer working with? Also, are shots like Vivitrol safe to use, and will the patient go into withdrawals if they abruptly stop using it?*

Dr. Kamlet: Subutex, or Buprenorphine, is a synthetic opiate which is a mixed opiate-agonist and antagonist. That means if an addict took it with other opiates, it would throw them into withdrawal. Thus, patients starting medicated assisted treatment must first be in withdrawal to start Buprenorphine containing products. Subutex is pure Buprenorphine and it has the potential for injection. Suboxone is Buprenorphine mixed with Naltrexone. Thus, if it was injected it would throw the patient into narcotic withdrawal. Suboxone and similar drugs are preferred to pure Buprenorphine to prevent anybody from injecting it. Subutex and Suboxone are both given sublingually, and it is absorbed by the veins under the tongue. According to the DEA and the FDA, Buprenorphine containing Naltrexone is always the preferred treatment due to the fact that its less abusable.

In my personal practice, when I am transferring a patient from heroin to medicated assisted treatment, I give them Subutex for the first seven days and then switch them over to Suboxone. 98% of the Naltrexone in Suboxone is deactivated sublingually, but even that 2% can make the transition from heroin or Oxycodone more difficult. So, to ensure a smoother transition to a safer drug, Subutex is typically used for induction only.

Vivitrol is a completely different type of product. Vivitrol is long-acting Naltrexone given as a once a month shot. It was first approved by the DEA for alcoholics who were sober to prevent alcohol relapse. Many years later, it received FDA approval to be given to opiate addicts who were opiate-detoxed to prevent relapse. Caution needs to be taken here because if a patient still has opiates in their system when they receive their first Vivitrol shot, they will be thrown into long-term intractable opiate withdrawals which could last anywhere from days to weeks. Thus, in my practice, all patients must show they have no opiates in their urine drug screen before receiving their first shot of Vivitrol.

I helped do the clinical trials for Vivitrol and I personally was very skeptical at first. The use of a pure opioid-antagonist to prevent opiate relapse was counter intuitive to me. Yet, after many years of observing patients who received Vivitrol, regardless whether they go to treatment, NA, or do nothing, the Vivitrol group does better in each instance. However, this may be placebo effect.

It is my opinion that patients who do a flood dose of Ibogaine should not take a shot of Vivitrol post Ibogaine for at least sixty to ninety days after the flood dose. You may ask why…If the bi-product of Ibogaine, whether its Nor-Ibogaine or 18MC, is working as a pseudo irreversible

agonist of Mu and Kappa opioid receptors, and Vivitrol is given, they both may be competing for the same receptor sites. My experience has been that people who take Vivitrol immediately after Ibogaine lose that sixty to ninety-day post Ibogaine "window of opportunity" and cessation of post-acute withdrawal syndrome (PAWS).

Jennifer: *The Ibogaine community made its introduction in the 60's when Howard Lotsoff accidentally discovered its ability to combat opiate withdrawals. Since then, it seems to have gone through several stages, including the underground communities in the early 2000's and now the global outbreak of unregulated clinics. Currently, myself and many others are seeing the flaws in the community as a whole and our goal is to improve the credibility and efficacy of the Ibogaine industry. Do you believe it is possible to transform this controversial community into a well-respected alternative medical community?*

Dr. Kamlet: Honestly? No, because we have no authority to force anybody to do anything. And you can't teach somebody ethics.

There are some people out there who are really good, ethical people, who have really good Ibogaine clinics. They pick and choose clients, and they turn away those who aren't a good candidate. They're very loving and try to do their best. When they have a problem, they call me, they ask me if they should take this patient. This may be about half of the Ibogaine community. And *still* in the best-case scenario, people can die at their clinics.

Some say, "Well, I treat addicts that would have died anyway", but to me that's not an answer. I've done Ibogaine treatments for twenty-two years and I've never killed anybody. I've never had a single patient even go through an E.R.

This can be done in a way that is 100% safe. Nobody needs to ever die from an Ibogaine flood dose if done in a proper medical model by trained licensed medical professionals. This could be done properly in the U.S., under a strict medical-psycho-social protocol. I don't see that happening in the U.S. anytime soon, nor are we going to be able to stop bad clinics from opening up.

I ask this question, “What is a successful Ibogaine treatment?” Is ‘success’ when a patient goes home and they aren’t in opiate withdrawal? Shouldn’t success be that the patient was clean for six, twelve, eighteen, twenty-four months? That’s success to me.

Everybody selling Ibogaine as a ‘cure for opiate addiction’ is lying. Ibogaine is not the ‘cure’ for anything. It’s a way to facilitate detox and a way to get through post-acute withdrawals with a lot less suffering. But please don’t think that you can *just* take Ibogaine and never use again.

Some people are going to say, “I know a guy that did Ibogaine and never did any recovery work and stayed clean!”. Well yeah, every once in a while I meet a young man, someone who is twenty, thirty, or thirty-five years old, just got caught up in the Oxy fad, not *really* an addict, just more or less got caught up by mistake. These guys are going to take Ibogaine and they aren’t going to use again because they aren’t really addicts.

But when you’re talking about people who have relapsed six, seven, eight times before, who may be IV users that may also smoke crack, and when it comes to usable drugs for them, “One is too many and one-thousand is never enough”. So, to say Ibogaine is going to ‘cure your addiction’ is a lie. The last patient I had return from an Ibogaine clinic for treatment was seen by me in my office today and had twenty-two days opiate free. He has not made it to an NA meeting yet but the physical transformation that took place is remarkable. This patient had been to fourteen prior detox and long-term rehabs in the U.S. before taking Ibogaine for the first time twenty-two days ago. He looked like a walking skeleton before taking Ibogaine and now looks like the poster child for good health. The key question to ask is, “Will this person achieve sustainable recovery?” Ibogaine post-flood dose provides a widow of opportunity for change. It is *critical* in the treatment process that the provider comes to an agreement with the patient as to what the post-flood dose aftercare plan will be to ensure that change takes place during that window of opportunity.

Jennifer: *You are currently practicing in the state of Florida which recently approved the use of medical Marijuana. Do you feel that this particular plant medicine is beneficial in addiction treatment, or do you feel that it’s recreational use can be counter-productive to a person in recovery?*

Dr. Kamlet: I don't personally use marijuana, but I was the head of Scientific Planning to get this drug legalized in Florida. I did the television commercial free of charge to get it legalized, and I took a lot of heat for this because there were a lot of people in Florida that didn't want to see this get approved.

I have one of the first Florida Cannabis Prescribing Licenses and I have several patients in my practice who are being treated for legitimate pain. They suffer from severely painful diseases, and they have been able to get off their pain medication using medical Cannabis. So, this does work.

Can Cannabis help somebody who is in recovery? I've been asking myself this since 1995. If you are a real serious heroin or crack addict, and in recovery you decide, "It's ok, I can have a drink", even though you were never an alcoholic, or, "I can smoke pot because pot keeps me calm", it has been my experience that true addicts who think they can socially have a drink or smoke pot eventually go back to using their drug of choice. Sometimes quickly, sometimes slowly. In my opinion, once a true addict decides it's okay to change their consciousness and use any drug, its like jumping off a twenty-story building and passing by the fifteenth floor and saying, "So far, so good".

In my opinion, however, this does not hold true for entheogenic drugs i.e. plant teachers. When those drugs are given in the appropriate setting with the safety and respect that they demand, it is very rare that they become abusable and never cause dependency. However, there are those who will abuse these drugs too. In my opinion, it's the person's job to take the knowledge that they attained from these plant teachers and incorporate that information into their everyday life. However, I too frequently see something that I have called 'Instant Shaman Syndrome'. For example, a patient takes Ibogaine, has a life changing experience, and now feels it's their mission in life to give Ibogaine to everybody they meet and will personally use Ibogaine on a frequent basis themselves. In my opinion, daily intake of even small amounts of Ibogaine for no diagnostic purpose is abuse of the drug.

Now that there is medical Cannabis I can prescribe extremely high CBD and very low THC for those people who don't like the psychoactive part. There is a way it can really benefit them. Looking at people who get clean off opiates, even the ones that attend NA but still smoke pot, I've

been keeping a mental note of the statistics of how many times those people relapse. For some reason, I don't know why, the people who smoke pot or drink eventually relapse with their drug of choice, sometimes quickly, sometimes slowly.

I've been really curious about this, and I've been asking myself two questions: Why do 12 steps work; why is nothing as successful as this? And why does an opiate addict in recovery that smokes pot or drinks eventually relapse?

I think when you're working a program and you commit to being free from all mind-altering chemicals, and then when you make the decision that, 'Its ok for me to change my consciousness' by the use of the substance, you've already set yourself up for relapsing. I've noticed that over the last twenty-two years, it may take six months, it may take twelve months, but sooner or later they relapse.

I am not saying that NA is the only way to stay clean, but it is free, available everywhere, and it works. It is available in ninety-six countries and the literature is published in eighty-six languages. No theology that is not organized, as NA has no leaders or structure, has ever spread this quickly. How could it be if it didn't work? Twelve step critics may quote statistics that the success rate of twelve step programs is only 3-6%, I counter that with 3-6% is much better than 0%'. "Twelve steps and harm reduction models work because relapse has a 100% failure rate for dead people."

Once you're in recovery, I suggest to people the following, "Alcohol is a drug, Cannabis is a drug; how about you stay free from all drugs."

Additionally, other entheogenic drugs should not be used for at least six months post-Ibogaine, nor should any patient be given a second flood dose within ninety days after their initial flood dose.

Jennifer: *Overall, there seems to be a lot of deficiencies in the recovery community as a whole, and the reason I say this is because of the growing addiction rates and the revolving doors that most programs seem to be. What do you think the biggest challenge is in this field and what needs to happen to start seeing a decline in drug use worldwide?*

Dr. Kamlet: As rehabs got to be very profitable, the rehab business became just as crooked as the pharmaceutical industry, and as crooked as illicit Ibogaine clinics. There are some really great rehabs, and there are some that are not.

We had a problem here in Florida, everybody started opening rehabs with their own drug-testing labs, and as soon as the insurance ran out, they would take the patient out, get them high, say "Oh, this patient relapsed", and re-admit them. People would come to Florida from all over the country, and say, "Wow, I'm in South Florida, great!". But now their ninety days is up, and the insurance says, "Go home", and they don't want to go home. So, they go out and relapse, three days later they show up at another rehab, and they get another ninety days. Well, the insurance companies got hip to this.

Right now, there's no medical insurance policy sold in the state of Florida that includes addiction benefits. Every patient that's coming for rehab is coming from out of state. Rehabs were actually incentivizing patients to come; giving them free housing, free plane tickets, even paying for patient's medical insurance. The rehab business has become just as crooked as every other business. That's not to say there aren't good rehab clinics out there. There are some tremendously good residential treatment centers, there are some tremendously good Ibogaine clinics, and there are some tremendously good doctors out there. Unfortunately, they are not the majority.

It's really tough for the mother, father, sister or brother to help the patient try to figure out their way through this maze of recovery websites and advertisements. Oftentimes, the people with the best websites don't necessarily have the best clinics.

I visited many, many rehabs over the last twenty-two years doing site visits. When I recommend a place to a patient it's because I know it's a good fit for that patient; it's not 'one size fits all'. One patient may do well at one place and another patient may do well at another place. It depends on many factors, such as age, motivation, etc. But again, it's become a monster. Everything good eventually becomes corrupted. Ibogaine was an amazing thing, but it got corrupted. Rehab was an amazing thing, but it got corrupted.

We talk about the opiate epidemic now. I watched a segment on television of President Trump blaming prescription drugs for the opiate epidemic. Well, that was true in 2002. President Bush

was president, his brother was governor of the state of Florida, and Perdue came out with a new pharmaceutical called Oxycontin.

There was actually a 180mg dose of oxycontin.

Prior to this, the strongest pain-pill available was Percocet, 5mg of Oxycodone combined with 325mg of Tylenol. Suddenly, there's a pill that has thirty-two Percocets in one pill, and you can crush it, snort it, shoot it, or smoke it.

The 180mg was rapidly taken off the market because many patients were dying, immediately, but the 80mg Oxycontin stuck around for a year and everybody started buying them. Florida didn't have a prescription data bank, so a patient could go to ten different doctors and get ten different prescriptions. All of these upper-class people who would never think of going to the ghetto to buy heroin, and wouldn't even know where to buy it, were now snorting, shooting and smoking Oxys.

This is when it really went into high gear.

Oxycontin was already out for many years. Eventually, it lost its patent. Sixty Oxycontin pills costed $800 at the pharmacy because it was a brand name. Generic Oxycontin came out and it was only like $400, half the price.

Then, President Bush Jr. gave Perdue Pharmaceutical an Exclusive Second Patent and said that nobody can make the generic.

Normally, Exclusive Second Patents are only for miracle drugs, like if a company discovered the cure for cancer, and it cost them so much money to develop it that they couldn't make their money back in eight years; that's the only reason a company ever gets an Exclusive Second Patent.

What did the Bushes have to do with Perdue pharmaceutical? Perdue is the most powerful lobby in Washington, period. The president of the U.S. and the governor of Florida were both Bushes at the same time, and suddenly Florida became the 'Pill Mill State'.

Perdue got fined $880 million dollars in the federal court for telling their drug reps to lie to the doctors that this was a less addicting pain pill, claiming that since it's long-acting, it's less addictive. They were in the doctors' offices every day, giving free lunches and pens and pads.

It was *proven* that Perdue told their drug sales people to lie to the doctors and make up their own statistics. So, they were fined $880 million dollars in a federal court. They had made $8 billion dollars profit. The judge's last statement was, "I can't believe that nobody's going to jail for murder here." Then, rival drug companies decided to come out with the 30mg generic Oxycodones, and they were *really* cheap.

Suddenly, pill mills start popping up all over the state of Florida. Ninety percent of all of the opiate prescriptions being written in the United States were coming from the state of Florida. There were more store-front pill clinics in Florida then there were McDonalds.

There were doctors with degrees from Harvard that had essentially sold their souls to the devil. An eighteen-year-old patient would walk in and say, "I have a back ache", they'd go get an MRI, and no matter what the MRI would show, they would walk out of the clinic with two-hundred-and-forty 30mg Oxycodones. The pills were being dispensed by the doctors in the same office, so the money wasn't being made by seeing the patients, the money was being made by dispensing the pills. They'd usually also get ninety Xanax along with that, and on the news every day you would see people outside of store-front pill mills shooting up in the cars.

I testified in a couple of legal cases where the doctor was writing eighty prescriptions a day, which means he'd have to be seeing a patient every sixteen seconds, you know, this kind of stuff. *And* we had no state data bank, so a patient could see ten doctors in a day and end up with two-thousand-four-hundred Oxycodones *in a day*.

People from all over the country started coming to Florida to go to the pill mills to get their Oxys. This is how the opiate epidemic spread to Vermont, New Hampshire, places that never saw heroin or opiates ever before were now being affected by opiates, because of the state of Florida.

This went on for many more years. Mothers were on the steps of Tallahassee every day saying, "You're killing our children!", and none of the politicians would do a thing about it.

Finally, the US government got fed up with Florida. Other states like Georgia, South Carolina, and North Carolina were telling the government, "You have to do something about Florida, they're killing everybody!" So, the Oxy clinics were shut down and a state data bank was made.

So, I said, “Wait a minute! You’ve got 300,000 plus Oxy addicts in the United States and now you’re taking away the Oxy?! What are you going to do? You are creating the perfect business model for the drug cartels to flood the United States with super pure heroin and get everybody addicted to heroin!”.

And that’s exactly what happened.

Now Oxy was no longer around. Oxy became 3% of the problem, and heroin became 97% of the problem.

And then it gets even worse…now the heroin is no longer heroin! Its fentanyl! Fentanyl is ten times more potent than Morphine, Car Fentanyl is one-hundred times more potent than Morphine, and to date over one-hundred-and-eighteen other analogs of Fentanyl have been found in so-called bags of heroin in the streets of Miami. Lately, there is no heroin at all in the heroin, it’s all Fentanyl. Thus, the name ‘Opiate Epidemic’ in my opinion needs to be changed to the ‘Fentanyl Overdose Epidemic’ if we are truly going to save lives. Aside from the increase in heroin usage, born out of the Oxycodone enigma, the true reason for the massive increase in opiate deaths in the last three years is illicit use of Fentanyl coming from China or being manufactured in Mexico. One eighteen-wheel cargo container filled with Fentanyl is enough to kill every person alive today in the United States. It’s the Fentanyl, not the heroin or the Oxycodone, that’s killing our children. With a pandemic of opiate dependents and an explosion of opiate deaths, should not Ibogaine be given emergency drug approval instantly? It would *if* our intention was to truly help, as opposed to make profit.

And this is the current problem.

My question is, why did the state of Florida allow this to happen? When I came to Florida in 1988 there were eight heroin overdose deaths a year, and now it is estimated that there are approximately eight opiate overdose deaths a day, mostly due to Fentanyl contaminated heroin.

I ended up speaking to many politicians telling them, “If you do this, if you shut down all of these clinics, and you start this data bank which is something you should have done fifteen years ago, you need to make Suboxone free for everybody! There should be a federal grant!”. I told them they had just created the perfect business model for the drug cartels. I asked them what they were going to do with the myriad of Oxycodone addicts that could no longer get Oxycodone? They

can't just stop! This is not cocaine, this is not methamphetamines, these people are going to be deathly sick.

I used a quote from Alan Ginsberg's book, "I saw the best minds of my generation running naked through the ghetto looking for a fix". I said that in front of Senators and Congressmen in Florida. Nobody cared. They were all making a ton of money. You couldn't even get elected without the pharmaceutical companies backing you.

There are four-thousand permanent pharmaceutical lobbyists in Washington. In a capitalistic society, how will we ever have a solution to a problem like this, because it's not about saving lives, it's about making money.

The pharmaceutical companies might be interested if we could find a way that people could take Ibogaine every day, and yes, I do believe that people can safely take a little bit of Ibogaine every day. I believe Ibogaine can be given as a shot as relapse prevention every month. I also believe that Ibogaine can be used to help detox people without flood dosing them. All of this is possible with the proper studies.

But, why would they want to get people off a drug that they are making money on? The drug company motto is, "No drug is a good drug unless you have to take it forever".

I have a whole lecture that I give to patients regarding Ibogaine. I tell them yes, we are treating addiction, but I also don't want them to forget that what they are taking is a sacrament. At scientific conferences I'll ask, "What is the most potent hallucinogen on the planet?", everyone always says DMT, 2CB, LSD, etc. I say, "No, you're all wrong, its oxygen", and everyone looks at me like I'm crazy. I say, "What if I took your oxygen away? This hallucination of womb-to-tomb will disappear." We are in a paradigm where we are limited by our five senses, but there is energy right out there. Dolphins navigate by sonar, bats can see infrared, birds can detect electromagnetic fields; and we can't. Under the use of these sacraments, it is allowing us to tap into other places that are very real; just as real as this. These are sacred places, and the entities that exist there are very benevolent.

Jennifer: *I'd like to thank you for taking the time to speak with me today. I have always respected your presence in the Ibogaine community because you have always been a voice of reason amongst the chaos and corruption. Thank you for sharing your expansive knowledge with us and please keep us informed as you continue with this pioneering work. It is people like yourself that have the ability to give Ibogaine the credibility it needs and deserves, and we are grateful that you are continuing to do the great work that you do.*

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Dr. Kamlet is available to do private Ibogaine consultations in his office in Miami or via secure internet medical protocol. Please remember, Ibogaine is still a Class I drug in the U.S., which means it has a 'high potential for abuse and no medical benefit'. Thus, all treatments must be done outside of the U.S., in countries where usage of Ibogaine is legal.

"Caveat emptor", meaning, "Let the buyer beware". Please do your homework before choosing your pathway to recovery.