Opponent of SB 497

Good afternoon. Today I want to present evidence on why Delta-8 THC and kratom do not meet the requirements for placement into Schedule I under the Kansas Uniform Controlled Substances Act.

First, let's understand what Kansas law requires. Under K.S.A. 65-4102, when the Kansas Board of Pharmacy determines whether to schedule, reschedule, or delete a substance, they must consider eight specific factors: the actual or relative potential for abuse; the scientific evidence of its pharmacological effect; the state of current scientific knowledge regarding the substance; the history and current pattern of abuse; the scope, duration and significance of abuse; the risk to the public health; the potential to produce psychological or physiological dependence; and whether the substance is an immediate precursor of a substance already controlled. These are evidence-based criteria that require careful consideration, not assumptions.

Let's look at Delta-8 THC. This cannabinoid is chemically similar to Delta-9 THC but significantly less potent. When we apply Kansas's scheduling factors, there is no evidence showing abuse potential higher than many currently legal substances. Delta-8 is widely used by Kansans for pain relief and anxiety management. The safety concerns we see stem primarily from unregulated manufacturing practices, not from the molecule itself. This is a quality control and regulation issue, not a Schedule I issue.

Regarding kratom, the federal government's own position is quite telling. In 2018, the Department of Health and Human Services rescinded its scheduling recommendation for kratom, acknowledging that the FDA had failed to meet the burden of proof required for Controlled Substances Act scheduling. Importantly, HHS explicitly warned of significant risk of adverse public health consequences if kratom were to be banned. On the international level, the World Health Organization Expert Committee reviewed kratom in 2021 and found "insufficient evidence" to recommend international scheduling. The WHO recognized kratom's traditional medicinal use in Southeast Asia and found only mixed and limited evidence regarding abuse liability.

Both of these substances share documented uses that Kansans rely on: pain management and chronic pain relief, support for opioid withdrawal and addiction treatment, and management of

anxiety and depression. Thousands of Kansans currently use these substances for health-related purposes.

From a safety standpoint, when we consider the factors required under K.S.A. 65-4102—the risk to public health, the scope and significance of abuse, and the current scientific knowledge—neither of these substances show profiles that would warrant Schedule I classification. When adverse events do occur, they typically involve product contamination or polysubstance use, not the substances themselves. We have decades of traditional use establishing clear safety patterns, and these substances are demonstrably much safer than many currently legal substances, including alcohol and tobacco.

The public health consequences of scheduling would be severe. It could force users toward more dangerous alternatives, would eliminate a critical harm reduction pathway for people trying to reduce opioid use, and would criminalize thousands of Kansans who are currently using these substances legally and safely. Again, HHS itself explicitly warned of these significant risks.

In conclusion, when applying the eight factors required under K.S.A. 65-4102, neither of these substances meet the criteria that would justify Schedule I placement. Federal agencies and international health organizations have reviewed the evidence and declined to schedule them. Better regulation—not Schedule I classification—is the evidence-based approach that protects public health while respecting the needs of Kansas citizens. Thank you.

Inga Selders