To the Honorable Members of the Senate Committee on Public Health and Welfare

Subject: SB 497 adding kratom to Schedule I under the Uniform Controlled Substances Act.

Greetings,

My name is John Adams. I am a disabled veteran that lives in Junction City Kansas. I am writing concerning the proposed addition of Kratom to Schedule I under the Uniform Controlled Substances Act.

I believe this move would be very detrimental to myself and other kratom users in Kansas. I have been dealing with chronic pain since I broke my wrist and hurt my back in 1998. I have been prescribed potent NSAIDS (800 mg pills of ibuprofen and then 500 mg pills of naproxen). These led to damage to my digestive tract which I still deal with today. I had to discontinue their use. I was then put on opioid pain killers. First it was Vicodin and then I was put on stronger Percocet. While these did help the pain, the side effects were horrible. I found kratom in 2016. Since I started taking all natural, unadulterated kratom powder, my pain is manageable and I do not have the awful side effects from opioids or digestive tract damage from powerful NSAIDS. If you were to make natural kratom illegal it would significantly reduce my quality of life. I would most likely have to start opioids again. I do not want that.

I support regulated kratom. I also want to point out that the junk people get from gas stations and other shady sources are NOT kratom. They are usually extracts from kratom that are then concentrated in a lab and sold as kratom. Again, this is NOT kratom. My source for kratom has their product lab tested and I can view the results by scanning the package. This ensures I am getting safe kratom and I know exactly what is in it.

I respectfully request that you do not make kratom a schedule I drug and instead regulate it for safety. Concentrates from chemicals found in kratom should not be allowed to be called kratom and frankly most should not be for sale. Banning natural kratom will only hurt people. Regulating it and ensuring it is safe would be much more beneficial.

Thank you for your time and consideration.

V/r,

John Adams

Doctors for Drug Policy Reform

Feb 15, 2026

Senate Committee on Public Health and Welfare
Kansas Legislature

Public comment on Kansas SB 497

Chair Senator Beverly Gossage and Committee Members:

My name is Bryon Adinoff, MD. I am an addiction psychiatrist and neuroscientist. I am appearing on behalf of Doctors for Drug Policy Reform (D4DPR), an international organization of several hundred physicians and medical professionals committed to advancing evidence-based drug policy.

Prior to relocating to Colorado in 2018 following my retirement from full-time academia, I served as Distinguished Professor of Alcohol and Drug Abuse Research at the University of Texas Southwestern Medical Center in Dallas. For more than 30 years, I was also a physician with the U.S. Department of Veterans Affairs. I have published extensively on the neurobiology and treatment of addictive disorders and currently serve as Editor-in-Chief of The American Journal of Drug and Alcohol Abuse. I am also a Clinical Professor at the University of Colorado Anschutz Medical Campus.

I am here to provide public health considerations regarding Senate Bill 497, which proposes to prohibit kratom and 7-hydroxymitragynine (7-OH). D4DPR is not taking a formal position on this legislation but believes it is important to offer health-focused analysis for consideration.

Public Health Context

The United States continues to face unprecedented harms from an increasingly toxic and unpredictable illegal drug supply. Nearly 100,000 Americans die annually from opioid-related overdoses, most involving fentanyl or other synthetic opioids in unregulated markets.

In this context, policymakers must carefully weigh not only the potential harms of a substance, but also the consequences of prohibition.

Relative Risk and Mortality Data

Kratom (derived from *Mitragyna speciosa*) contains several alkaloids, including mitragynine and 7-hydroxymitragynine (7-OH). 7-OH is a partial opioid receptor agonist and is pharmacologically distinct from full opioid agonists such as heroin, fentanyl, or oxycodone. Partial agonists activate opioid receptors with a ceiling effect that may limit respiratory depression compared to full agonists.

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Available data suggest that fatal overdose from kratom used alone appears to be rare relative to opioid-related mortality. A 2019 report identified 11 deaths between 2011 and 2017 associated with kratom exposure, with only two involving kratom alone. During that same period, more than 200,000 Americans died from opioid-related overdoses.

This does not imply kratom is risk-free. Kratom is a psychoactive substance with potentials for misuse. However, from a public health perspective, relative risk is an important consideration when evaluating policy responses.

Considerations Regarding Prohibition

History demonstrates that prohibition of psychoactive substances often shifts markets rather than eliminating demand. When a legal or semi-regulated product is removed:

- Consumers may turn to illegal markets.
- Product purity becomes unpredictable.
- Potency may increase.
- Contamination risks rise.
- Research becomes more difficult.

The United States has extensive experience with these dynamics in the context of alcohol prohibition and the modern "War on Drugs." The emergence of fentanyl as a dominant force in the opioid supply is, in part, a function of enforcement pressure favoring more compact, potent substances.

Recent research of 5000+ individuals using kratom, 73% endorsed using kratom primarily for self-treating pain and 42% for improving emotional or mental health conditions (42.2%). Of those with a substance use disorder (synthetic opioids, methadone, benzodiazepines, or heroin), 95% used kratom after discontinuing illegal or other drugs.

When access to a psychoactive substance is eliminated, substitution to other available substances commonly occurs. The public health implications depend heavily on what those alternatives are.

Research Considerations

In 2016, the Drug Enforcement Administration proposed scheduling kratom as a Schedule I substance but withdrew the proposal after substantial scientific and public opposition. Schedule I classification requires investigators to navigate significant regulatory barriers, increasing cost and time required to conduct research.

If kratom has therapeutic potential—whether in pain management or as a lower-risk alternative to more dangerous opioids—those questions should be addressed through rigorous scientific study.

Regulatory Alternatives

Legislatures are not limited to a binary choice between unregulated availability and total prohibition. Concerns regarding product variability, marketing practices, youth access, and high-potency derivatives are legitimate. Psychoactive substances warrant oversight. The public health question is not whether oversight is needed, but what form of oversight most effectively reduces harm.

Kratom should be thoughtful regulated, including:

- Age restrictions
- Product testing and labeling requirements
- Licensing of manufacturers and retailers
- Surveillance systems to monitor adverse events

Careful consideration of demonstrated harm, relative risk, likely substitution patterns, and research implications is essential when evaluating Senate Bill 497. Public health decisions should aim to minimize real-world harm while remaining grounded in evidence and proportionality.

Bryon Adinoff, MD
President, Doctors for Drug Policy Reform
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I was a big opioid user and katrom helped me get clean and sober and I have been taking kratom for 12 years now and it's a life saver

Stephanie Ballard

This is a response to the proposed kratom ban I was employed in the surgical field as a professional for over 20 years. Over the years I've taken several anatomy and physiology courses and I am somewhat familiar with how chemicals work physiologically and neurologically. I use kratom on a regular basis and for me it provides some alertness with effects similar to a cup of tea or coffee. When and if you research the independent medical studies that have been published you will learn (as long as it's been lab tested) that kratom used alone has very little or 'if any at all' harmful side effects and It is my personal opinion that kratom actually provides some emotional and physical benefits and I've heard this from lots of other folks that I have spoken with that use or have used kratom in the past. I have used kratom personally off and on for 10 years and have never experienced any harmful effects or any type of harmful withdrawals when stopping. It's been my experience when lab tested kratom used alone is perfectly safe. I feel when it has been lab tested and regulated it's about as harmless as coffee or tea. 'I'm asking' please go through the medical documentation and research kratom use by itself without any added outside chemicals. And please note: All of the medical documentation that I have personally researched where kratom has been called harmful looks as though it was being mixed with alcohol and or pharmaceutical prescription narcotics such as benzodiazapine's (lorazepam, Clonazepam ect...) or other substances entirely. I do feel regulation is important and I also feel kratom should be lab tested and approved for citizens safety and also to make sure no other harmful chemicals are mixed in with the kratom. When researching the medical documentation please look at kratom usage by itself where it has not been mixed with other substances such as alcohol or other harmful prescription or street drugs. I do agree with regulations and keeping citizens safe and I feel that all products need to be lab tested for public safety. I also feel there should be an age limit to purchase kratom. I feel a full kratom consumer protection act would save jobs and will financially benefit governments, the public and the tax payers alike and finance's will not be needlessly wasted prosecuting their own peaceful citizens . I feel if we could somehow put a complete ban on alcohol, cigarettes and some of the harmful pharmaceutical medications it would help our children and adults alike in our society far more than anything else. Also several years ago a bill named CJ's Law was introduced in the state of New Jersey. The claim is that kratom caused a death. I'm guessing it didn't and here is some personal research I did. This is only one particular case but there are lots of them similar to this. I feel it's important to know the truth 'I read that CJ's bill stems from a mother who experienced the death of her son (A 33 year old male) that ingested a Kratom/Adderall combination and experienced a cardiac arrest (Heart attack) Please note: Adderall is a amphetamine, (A Central Nervous System Stimulate) (similar drug category as amphetamine) and has a history of causing tachycardia, atrial fibrillation and other cardiac issues. It's hard to say what exactly happened without seeing a toxicology report and I'm very sad someone died but I'm

guessing kratom was not the culprit in this situation and many situations similar this. Please reconsider this ban and please research the medical documentation exclusively when kratom is used by itself. Thank you for listening

Rick Blazier

Good Afternoon,

I am respectfully requesting to testify remotely at the hearing on Monday morning regarding SB 497 (oppose). I am the director of external affairs for Holistic Alternative Recovery Trust (HART), a national advocacy group dedicated to ensuring continued access to kratom and 7-OH.

HART recognizes the legitimate public health concerns surrounding kratom, its alkaloids and certain high-potency extracts now proliferating on the market – as well as attendant concerns surrounding potentially unsafe manufacturing practices and misleading advertising.

At the same time, based on our research, we believe that a blanket ban on kratom and 7-OH products constitutes a disproportionate response that is largely unsupported by available data. We know from historical experience that outlawing kratom-related products will do little to protect consumers from potentially adulterated or mislabeled products, forcing them instead into the illicit market where products are wholly unregulated. What I hope to provide is data-supported background on what an effective, targeted regulatory framework might look like – one that addresses harms while preserving adult access to kratom and capped amounts of 7-OH. This includes establishing regulatory guardrails such as: limits on the per-serving potency of extracts, strict product-type differentiation, product standards and testing requirements, labeling requirements, risk transparency, robust quality controls, and civil penalties for non-compliance.
A rational response will encompass these and other elements, while eschewing blanket bans on all products containing 7-OH, which will unintentionally criminalize many consumers.
Thank you for your consideration. I will submit written testimony in PDF format separately. Given the exigencies of time, I wanted to get this request in to you before the week was over.

Have a great weekend.

Sincerely,

John Cleveland

Holistic Alternative Recovery Trust

20 Fayette Street

Boston, MA 02116

You should totally oppose SB 107. If not you'll just bring heroin back. Be sure to do your research on what you plan on banning.

Sent from my iPhone

Dominic Agee

I was born in KS and travel back and forth to help my parents. My husband and I use a small amount of Kratom daily to sleep well. Without it, my husband can barely sleep at all. And as retired law enforcement, it also helps me tremendously with stress and allows me to focus on getting tasks done. My father absolutely relies on Kratom for pain management.

We can both tell you that if you haven't tried Kratom yourself, do it. You will clearly see that it is nowhere near a Schedule I drug. You don't get high from it. If you're in pain, this natural plant helps. If you're not, you can benefit from energy and motivation, or relaxation and sleep. There is no overdosing on Kratom! This is media hype and not supported by a fair analysis of any general problems that a handful of people had. Mourning families naturally want to place blame somewhere. You can't always hold the street drug dealers responsible for other substances in a person's system, so they go after the Kratom companies.

Kratom is unique in that its partial-agonist properties are self-regulating against taking too much. And if you do take too much? Buzziness or nausea. The same effect you would get from downing too many cappuccinos. This is not Schedule I material, or any drug class for that matter.

Let the people who benefit from it decide what is proper for them. Require warnings and responsible use. But this is not a street drug...you will never see anyone selling it on a street corner. It is an incredible botanical that has been used for centuries across the world. And being that it belongs to the coffee family, I can still take it if I drive...it actually saved me on a road trip once where I needed the energy to stay up longer! It's all about responsible use. I wouldn't even drive if I were loaded up on cold medicine.

Please help protect this plant instead of regulating it!!!

Alea Doty

We respectfully oppose SB 497

The kratom rule

Sent from my iPhone

Good morning,

My name is Crystal. I am a 50 year old mother & grandmother from KS. I live with constant pain from different things such as multiple types of arthritis & endometriosis just to name two. My Dr had me on multiple pain meds for YEARS and I hated it!! My life was meaningless! I was finally able to wean myself off using Kratom. I try not to use more than 5 tsp a day. However, it is only possible that I'm here & productive because of kratom! The pills would have killed me a long time ago! So what Kansas needs to ask, do you want the numerous deaths of prescription overdoses on your record???

Crystal Gregory

To committee senate welfare and public health members,

I ask that you do not designate natural leaf kratom as an unlawful drug. Distinctions can be made between natural kratom leaf and kratom extracts and semi-synthetic substances such as large concentrations of 7-OH and pseudo MP. Regulations that are fair and reasonable can restrict access to the more harmful semi-synthetic drugs that harm kratom's reputation. Regular kratom has been used safely in southeast Asia for centuries and it is not currently scheduled nor pending scheduling in the United States under the controlled substances act. Ask that you vote against SB497 and I appreciate all of the members that acknowledged this message.

Nicholas Gruschow

Chairperson and Members of the Senate Public Health and Welfare Committee,

I respectfully submit this written testimony in opposition to SB 497, which proposes to classify kratom and delta-8 THC as Schedule I controlled substances in the State of Kansas.

As the owner of a locally operated CBD and hemp retail business in Manhattan, Kansas, I have built my business on transparency, compliance, and public safety. We work closely with local authorities, follow all applicable state and federal guidelines, and ensure the products we carry are lab-tested and legally compliant under the 2018 Federal Farm Bill framework.

SB 497 would not target bad actors — it would instead penalize responsible, law-abiding small businesses and criminalize products that are currently legal and widely used by Kansas adults. A Schedule I classification is the most restrictive category under Kansas law, reserved for substances deemed to have high abuse potential and no accepted medical use. Applying that classification to kratom and hemp-derived cannabinoids would eliminate regulated retail access without offering a viable regulatory alternative.

From a policy standpoint, prohibition is unlikely to eliminate demand. Instead, it risks pushing consumers toward unregulated online markets or illicit sources where product testing, labeling accuracy, and age restrictions do not exist. That outcome would undermine public health goals rather than strengthen them.

If the Legislature's concern is consumer safety, the more balanced solution is structured regulation — not criminalization. I strongly support reasonable safeguards such as:

- Age-restricted sales through licensed specialty retailers
- Mandatory third-party lab testing
- QR code traceability and transparent labeling
- Child-resistant packaging requirements
- Clear serving size and potency standards
- Record-keeping and enforcement mechanisms

These measures would protect Kansas consumers while preserving economic opportunity for small businesses that operate responsibly.

Kansas has an opportunity to implement thoughtful regulatory standards that align with federal hemp policy and evolving national cannabis reform efforts. A blanket Schedule I designation would move the state in the opposite direction and impose significant economic harm without demonstrable public safety benefit.

I respectfully urge the Committee to oppose SB 497 and instead pursue a regulatory framework that balances consumer protection, public health, and economic fairness.

Thank you for your time and consideration.

Sincerely,

Raymond S. Hanning

Owner/Operator Top Shelf CBD

Manhattan, Kansas

Kratom has changed my life so much for the better. I've had 2 neck surgeries within the past almost 6 years. I was on Oxycodone, Lyrica, muscle relaxers, depression and anxiety meds. I was just laying around the house in pain all day. Kratom has helped me get my life back. I have been able to get off all of my prescription meds except for thyroid medicine. I don't even have to take depression and anxiety medication anymore! My husband and I adopted my sister's baby 4 years ago and I'm able to keep up with her and play on the floor with her. I have a 18 year old and a 15 year old who have both told me they love that I found something that actually helps me so I'm not just sleeping all day and not in pain all the time. Please pass the KCPA. There should be regulations not bans on Kratom. It truly has saved so many lives.

Thank you, Jennifer Hatfield

Sent from my iPhone

I am hoping against the ban because I think that kratom and 7OH help me with my anxiety and depression as well as my pain. I also have a good friend that has her own business and kratom and 7OH are her lively- hood. Her business is far from a "gas station". I think the ban would be unfair because people can openly buy and sell pot products legally and pot and alcohol are no safer than kratom and 7OH. Kratom and 7OH also make me not want to use alcohol which is a huge plus for me. Thank you for listening. Respectfully, Linda Hepler.

Dear Senate Committee Members,

I OPPOSE SB497!

My name is Shannon. I know that you are discussing kratom in your community. I wanted to reach out and tell my success story. I have been taking natural leaf kratom for many years now. I have had many issues with my lower back due to working in healthcare as a CNA. Over time, lifting and moving patients caused a number of issues and resulted in a considerable amount of pain. I went to many different doctors in hope of finding ways to ease my chronic lower back pain. I have had MRIs, CAT scans, and X-Rays and I was formally diagnosed with degenerative disc disease. There is no permanent solution to my immense pain.

Because the pain was so severe, I was put on a pain medication regime to try and reduce the extreme pain I was experiencing. Unfortunately, OTC medication, prescribed pain medication and even injections did not work. I decided to stop taking everything since there was no point in medicating with no results. That's when I discovered natural leaf kratom. My doctor and I spoke about it. He said he had other patients that were using natural leaf kratom for their pain management. My doctor was excited that it was helping my pain and that it was safe and non-addictive. My lower back pain went from a steady 10 to a 0! It was a miracle! Kratom has drastically improved my quality of life. I was able to return to work without suffering on a daily basis.

The FDA announced in their July 29, 2025 press conference that they are not interested in banning natural kratom. They asked the DEA to consider scheduling 7-OH since it is a public health emergency. I was very happy to hear that announcement because there are many people in Massachusetts that are just like me that need access to natural leaf kratom. I would never take 7-OH due to the fact that it has no safety data and no science to back it.

It is important that you understand the difference between natural leaf kratom and 7-OH. These synthetic products should be removed from store shelves, but it is critical that consumers have access to natural leaf kratom. There are many just like me who rely on kratom for their health and well-being. Even the Rhode Island legislature reversed their 2017 kratom ban once they saw the

science and the safety profile of natural leaf kratom. As of April 1, 2026, kratom will be legal in RI, but 7-OH will continue to be illegal.

Please pass good regulation that protects your citizens by banning 7-OH and other synthetics but allows safe access to natural leaf kratom.

💥Below are some great facts and information on the difference between kratom and 7-OH.💥

- Natural leaf kratom products are from the actual plant. Natural leaf kratom contains only trace amounts of 7-OH. 7-OH is not found in the freshly plucked leaf. It forms in these trace amounts as it dries.
- The Kratom Consumer Protection Act only allows products that contain less than 2% of 7-OH in their ingredients. This falls in line with the natural plant.
- 7-OH products are created by taking that trace alkaloid and shocking it with a myriad of chemicals. It creates a completely new product that is synthetic.
- 7-OH products are marketed to sound like opioids. They are often marketed to be appealing to teens.
- 7-OH is 14x+ stronger than morphine. Watch this video. You will see how powerful these products are. https://drive.google.com/file/d/1jIg8ISDaETPwl_qFe27pJBwrkC9wdeAy/view?usp=sharing
- 7-OH products cause quick dependence/addiction due to their short half-life. The withdrawals from 7-OH are brutal.
- There was zero science and safety data present when 7-OH hit the market two years ago. Natural leaf kratom has over 450 peer-reviewed studies showing its safety and effectiveness. Including a study from the FDA.
- Poison control report that calls regarding kratom/7-OH have doubled in the last two years. Guess what? 7-OH has been on the market for 2 years. Poison control does not ask if the person has consumed kratom or 7-OH. They consider them the same, which they are NOT the same.

- As you know, naloxone may be needed to reverse an opioid overdose. Naloxone will reverse a 7-OH overdose because it is an opioid. Kratom is a partial agonist, and naloxone will not reverse its effects because it is not an opioid.
- 7-OH has been shown to suppress breathing in rats. Kratom does NOT suppress breathing.
- Almost all deaths seen throughout the country are a result of consumers combining 7-OH with other substances including alcohol.
- You cannot overdose from kratom. There is a ceiling effect. If you take too much kratom your body instantly vomits. This is not the same with 7-OH.
- The FDA and HHS have made it very clear that they do not want to ban NATURAL LEAF KRATOM. They are only interested in scheduling 7-OH. Please listen to this short clip that clearly shows this. **Short Video Segment Quoting FDA Commissioner Makary regarding 7-OH and Kratom:** 8-6-25 Makary.mp4 - Google Drive

Thank you so much for taking the time to listen to my story and to read these facts.

Yours Truly,

Shannon Hareld

Hello, I just have a few thoughts in regards to S.B. 497.

I am a responsible user of plain leaf kratom. I wholeheartedly understand the concern regarding the synthetic derivatives of what they deceitfully call "kratom" now. This is a major concern for me and many in the kratom community. We believe it does nothing more than give kratom a bad image.

I ask you to please leave natural plain leaf kratom alone. A lot of people use it to be productive members of society, including myself. It is also important to note that all kratom users understand that there are drawbacks to the plant. It is not a cure-all. There are side effects, just like with everything else. There are also side effects to tobacco and alcohol as well, yet those remain readily available. I promise you that more people die from smoking and alcohol than kratom. Do not take away our liberty to choose as we see fit. Also, banning nature seems unnatural.

James S

Dear Senate Committee on Public Health and Welfare My name is Brian Lawrie and I live in Wichita, KS.

I would like to voice my opposition to SB 497. I am a long-time kratom user myself. I am a 46-year-old father, husband, business owner and productive tax paying member of society. Kratom has helped me like so many others in Kansas off and on for many years now with anxiety and depression.

Kratom is a natural plant and has nothing to do with fentanyl and is not a synthetic substance. It should not be lumped into this bill. Like so many other good things in this world bad actors take something good and turn it into something bad like 7-0h. I feel it would be wrong to blanket criminalize kratom that is truly helping so many in Kansas.

Please take some time to look at the bill that KCMO just recently passed that makes perfect sense implementing restrictions and bans of kratom's byproducts but not kratom itself. It is similar to restriction bills so many other states have passed. Oklahoma and Nebraska is a couple of the many states who have passed common sense restrictions on kratom.

This plant helps so many like myself. I think it would be a mistake to criminalize this plant. You would be doing so much more harm than good. I feel restrictions on kratom like so many other states have done makes much more sense than making it a schedule 1 substance. Something like the kratom consumer protection act is what many other states have done. There is currently HB2230 and I am all for that. It just makes much more sense to me.

Thanks for reading this and I hope you can make the right choice and reject SB497 Thank you, Brian Lawrie.

Chairperson and Members of the Senate Public Health and Welfare Committee,

I respectfully submit this testimony in opposition to SB 497, which seeks to classify kratom and delta-8 THC as Schedule I controlled substances in Kansas.

As the owner of a locally operated CBD retail business in Manhattan, Kansas, I've always prioritized transparency, safety, and full cooperation with local enforcement. Our business has consistently passed all compliance checks and taken every measure to ensure products on our shelves meet state and federal requirements.

SB 497 would severely penalize responsible operators and criminalize products that are currently legal, tested, and used safely by many Kansans. It does not represent thoughtful regulation — it represents overreach. Small businesses like mine would be forced to discontinue safe, lawful product lines overnight, with no regulatory alternative in place.

Furthermore, placing delta-8 THC into Schedule I directly contradicts the direction of federal cannabis reform and ignores the hemp-derived framework established under the 2018 Farm Bill. Criminalization of these compounds while federal agencies move toward broader rescheduling simply doesn't make sense from a public policy standpoint.

I strongly support regulation: requiring products like kratom and hemp-derived cannabinoids to be sold only in age-restricted stores, not gas stations; requiring lab testing, QR code traceability, child-proof packaging, and proper record-keeping. That is the future of responsible retail — not Schedule I criminalization.

Please consider the long-term harm this bill could cause to small businesses and Kansas consumers alike. I urge the committee to oppose SB 497 and pursue a regulatory framework that balances public safety with economic fairness.

Thank you for your time and consideration.

Sincerely, Jeremy L. Meek Owner, Top Shelf CBD Manhattan, Kansas

To whom it may concern:

I am writing to respectfully urge you to oppose banning kratom. Placing kratom into Schedule I is a blunt approach that risks increasing harm by pushing adults toward unregulated markets.

States should take steps toward a safer path through age limits and labeling requirements. A more effective approach would be harm-reduction regulation, including:

- **21+ enforcement and retailer compliance**
- **Accurate labeling and ingredient disclosure**
- **Product testing for contaminants**
- **Manufacturing standards and enforcement against bad actors**

Please do not turn honest, proud and hard-working American citizens into criminals overnight. I urge officials to pursue a regulatory framework that protects public health without unintended consequences.

My name is Marc and I am a 40-year-old male. My experience with Kratom and its legality is the focus of this letter. I have been sober 8 years with help of Kratom and CBD.

I have had a long and treacherous battle with substance abuse. I have had multiple recurring bone tumors on the medial side of my tibia below my knee. The diagnosis and subsequent surgeries started at the age of 14. I have had six major surgeries on my right leg. Three of which were for tumor removal and the other three for MRSA treatment and debridement. My knee is completely damaged from the tumor destroying the top of my tibia and the MRSA completely eating away at my meniscus and cartilage. I have severe chronic and acute pain in that leg because of this. I am not a candidate for a knee replacement due to the bone being too damaged and not a stable site for the new artificial joint. I have also been in a severe car accident that lacerated my left arm, broke the fibula in my left leg, and tore the meniscus in my left knee.

The treatment of these ailments came with a lot of prescribed narcotic pain medications on a regular basis from age 14 on. My tolerance to these medications started to grow astronomically over 15 years and they stopped working effectively. I eventually was buying OxyContin on the street and abusing them heavily. This eventually led to IV heroin and cocaine use and the loss of anything of real value I had. I struggled with this crippling addiction for many years. I tried methadone, Suboxone, Vivitrol, complete abstinence and had NO significant success with any of them. Finally, I found that a strong 12 step recovery was what I needed, and it would work temporarily but the physical pain I suffer from would become too much and I would relapse on opiates. 8 years ago, I found kratom and decided to try it for pain relief. It helps me with pain, it helps me sleep, curbs craving, allows me to function and participate in activities of daily living without being in extreme pain. I do not have extreme tolerance building problems with kratom like I did with traditional opioids. The side effects are extremely minor and do not impair my judgment or ability to function.

I am up at 4:30 AM every day and at the gym by 4:45 cycling for an hour. I have lost weight in a healthy fashion due to my exercise and diet change that kratom has helped me make. I am much more positive about taking care of myself and am able to be present for life. My pain hasn't completely vanished, but it is manageable due to kratom. I am the healthiest and happiest I have ever been in my entire life! My spiritual growth has been a big factor as well in my 8 years of sobriety along with kratom. I have found that these two things working in harmony have literally saved my life! I am a completely different person, and my family has their son back. I do not want to die and the fact that this harmless plant is being targeted makes me scared for my life. Let's focus on alternative rehabilitation and recovery methods. Let's focus on the fentanyl and other analogues specifically...NOT A NATURAL BOTANICAL! Please...let's take a step back here and look at the success stories and reanalyze things.

Making this plant illegal will immediately criminalize innocent Americans that will suffer if kratom is taken away. The war on drugs has been a failure and taking away such a helpful tool people use to avoid lethal prescription drugs and heroin/fentanyl will cause even more deaths. People have bad reactions to everything. The number of hospitalizations and deaths from acetaminophen is astronomically higher than deaths supposedly caused by kratom. People are almost always having issues from polysubstance use where kratom is not the only drug in their system.

Thank you for taking the time to read this. I hope you show empathy for chronic pain and recovering addicts that use this plant. Let's work with the American Kratom Association on advocating for safe manufacturing practices to ensure adults have access to pure and unadulterated kratom products in the USA.

Sincerely,

Marc Perdue

Email: mperedue98550@gmail.com

KRATOM TRADE ASSOCIATION

KRATOM: FACT VS. FICTION

More than 2 million Americans safely consume Kratom to improve their health and well-being and have done so for decades. It is regulated by the U.S. Food and Drug Administration (FDA) as a dietary supplement, and people who consume Kratom report doing so for the same reasons as people who drink coffee, tea, or other caffeinated beverages. Surveys show that Kratom consumers are educated, middle-income, employed, and have health insurance. Despite being used responsibly for decades in the United States, there are many misconceptions about Kratom, making it difficult to tell fact versus fiction.

FICTION: Kratom is an opioid just like heroin.

FACT: Drugs like heroin, oxycodone, and other "classic" opioids are full opioid agonists, meaning they fully bind to and activate the brain's receptors. Kratom, on the other hand, is a partial agonist, producing milder effects with lower dependence and abuse potential. Evidence suggests Kratom does not cause respiratory depression like other opioids, a common cause of fatal overdoses.

FICTION: Kratom should be classified as a Schedule I controlled substance, ranking it higher than cocaine and methamphetamine.

FACT: Schedule I substances are without accepted medical use and have a high potential for abuse. Published analyses have shown that Kratom does not meet the test to be a Schedule I drug and does not fit into the FDA's 2017 abuse potential assessment guidance. Respondents to official surveys from the federal Substance Abuse and Mental Health Services Administration do not report abusing Kratom or seeking treatment for Kratom dependence, refuting claims from treatment clinics that Kratom abuse is prevalent. While many independent scientists have said Kratom holds the potential to address pain, scheduling Kratom will make any further research on the product virtually impossible.

FICTION: Kratom is highly addictive and prone to abuse.

FACT: Similar to coffee, tea, and other caffeinated drinks, consumers may become dependent on Kratom with daily use, which is not the same as addiction. Many people need a cup of coffee to wake up in the morning, but we wouldn't say that they're "addicted" to coffee. "Withdrawal" symptoms of Kratom are comparable to those of caffeine, nicotine smoking cessation aids, or antidepressants. Unlike substances with high abuse potential, increasing the dosage of Kratom does not lead to exponentially stronger euphoriant effects.

FICTION: Kratom is responsible for more than 44 deaths according to the U.S. Food and Drug Administration (FDA).

FACT: There are no deaths directly linked to Kratom consumption. Recently published studies found no evidence of deaths linked to Kratom, and publicly-available data show that nearly all of the recently reported fatalities were found to have multiple substances present in their system at the time of death and/or prior health issues. Contrast this with the fact that more than 115 Americans die daily from opioid overdoses, according to The National Institute on Drug Abuse, while millions consume Kratom safely and responsibly.

FICTION: The Kratom industry has no production standards or consumer safety protocols.

FACT: Kratom is regulated by the FDA. To provide consumers with safe, high-quality products, the Kratom Trade Association requires its members to adhere to a strict set of principles, sets product testing protocols exceeding Good Manufacturing Practice (GMP) guidelines, and assists manufacturers in obtaining GMP facilities certifications. The organization also supports age restrictions and labeling guidelines outlining responsible use.

Sources: Henningfield, J. E., Fant. R. V., & Wang, D. W. (2018). The abuse potential of kratom according the 8 factors of the controlled substances act: Implications for regulation and research. **Psychopharmacology, 235**(2), 573–589.
Pinney Associates. (November 28, 2016). Assessment of Kratom Under the CSA Eight Factors and Scheduling Recommendation.
Kruegel, A. C., Gassaway, M., Kapoor, A., Váradi, A., Majumdar, S., Filizola, M., Javitch, J., & Sames, D. (2016). Synthetic and Receptor Signaling Explorations of the Mitragyna Alkaloids: Mitragynine as an Atypical Molecular Framework for Opioid Receptor Modulators. **Journal of the American Chemical Society,138** (21), 6754–6764.
Grundmann, O. (2017). Patterns of Kratom use and health impact in the US — Results from an online survey. **Drug and Alcohol Dependence,176**:63-70.

To the Members of the Committee,

My name is Jordan Richard. I am the author of *The Truth About Kratom: Life-Saving Plant or Botanical Menace?* and a documentary filmmaker who has spent years investigating kratom policy, science, and history. I have interviewed leading researchers, former federal health officials, regulators, law enforcement representatives, critics of kratom, and the people whose lives are directly affected by these decisions. I have also traveled internationally, including to Indonesia, where I visited the villages where kratom has been used traditionally for generations.

I am writing to urge you to reject any ban on natural kratom leaf and instead adopt a policy that regulates natural kratom responsibly while banning products built around isolated or concentrated 7-hydroxymitragynine.

In 2024, the U.S. Food and Drug Administration released its first formal scientific review of kratom. In that review, the FDA concluded that kratom does not appear to pose the level of public health risk that it has often been portrayed as having. This was not a marketing statement, and it was not an approval. It was a scientific assessment.

During discussion of this bill, it has been claimed that this FDA study was funded by the kratom industry. That assertion is simply not credible. The FDA does not accept industry funding to generate or manipulate its own safety reviews in this manner. Suggesting otherwise undermines the integrity of the agency itself. If there were legitimate evidence that the FDA's analysis had been compromised, that would be a national scandal. There is none.

What is being overlooked in this debate is that kratom is being blamed for harms associated with a different class of products altogether. Natural kratom leaf is not the same as products that isolate and artificially elevate 7-hydroxymitragynine. These high-potency formulations did not exist historically and do not reflect how kratom has ever been traditionally used.

Even federal officials have acknowledged this distinction. When the state of Ohio moved toward banning kratom, Robert F. Kennedy Jr. intervened and urged regulators to reconsider, recognizing that banning the leaf would create more harm than benefit. That intervention alone should signal that this administration is not targeting natural kratom.

Similarly, former Assistant Secretary for Health at the U.S. Department of Health and Human Services, Dr. Brett Giroir, publicly stated that the greatest public health threat posed by kratom would be banning it outright. His concern was not theoretical. Removing lower-risk alternatives drives people toward far more dangerous substances and destabilizes lives.

I am not asking Kansas to ignore risk. I am asking Kansas to regulate correctly.

Regulating natural kratom with age restrictions, testing requirements, labeling standards, and alkaloid limits protects consumers. Banning isolated and high-potency 7-hydroxymitragynine products addresses the real source of emerging harms. Doing one without the other is ineffective. Doing both is responsible governance.

Kratom has not changed. What has changed is how certain products are being manufactured and marketed under its name. Kansas has an opportunity to separate fact from fear and adopt a policy that protects public health without repeating the mistakes of prohibition.

Please regulate natural kratom. Please ban 7-hydroxymitragynine products. Do not punish responsible adults or destabilize families by banning a plant that federal officials and scientific evidence increasingly recognize as lower risk.

Respectfully submitted,

Jordan Richard

Lora Romney – Patient Testimony

I am sharing my story with you today so that you can understand the human side of kratom and how your decision will impact the lives of thousands who rely on this botanical. I am a very normal 55-year-old wife, mother, grandma, and conservative voice. At 42 years old I joined the ranks of the chronic pain community with my diagnosis. I feel compelled to explain to you how natural kratom has changed my life and allowed me to function. I also feel it is extremely important to stress that natural kratom is very different from synthetic 7-OH. I know that protecting your citizens is your entire goal. By banning 7-OH you are ensuring that the problem synthetic products are off your shelves. By regulating kratom, you are allowing safe access for those who rely on kratom.

I am a patient with Atypical Trigeminal Neuralgia (ATN). This disease causes severe facial nerve pain that never stops. It presents in my sinus regions on both sides. Imagine an ice cream headache that never goes away. This is what I experience daily. This disease is called "the suicide disease" because it can be one of the most painful conditions to live with.

I have been struggling with ATN for the past 13 years. I have tried everything to control my pain: brain surgery, a nerve stimulator implant in my face, blocks, lidocaine infusions, chiropractic, acupuncture, physical therapy and over 30+ medications to try and decrease this pain. I was referred to a pain clinic after my neurologist exhausted all options for me. Under the care of a pain physician, I was given two oxycodone per day.

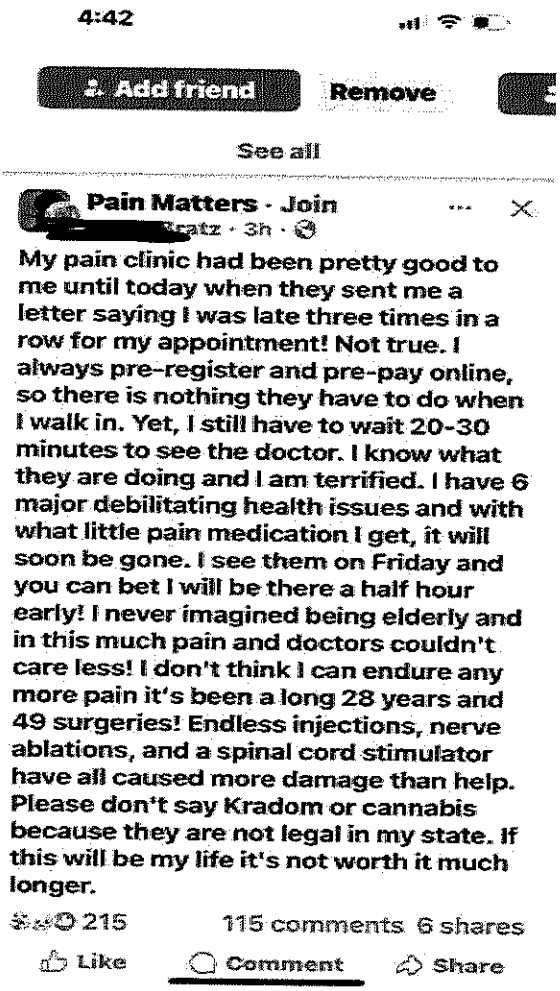
This dose of oxycodone was not enough to control my excruciating pain. It gave me relief for approximately 4-5 hours. This meant that for 16 hours of the day and night, I did not have any pain control. I suffered immensely. Since I had tried all available options to control this pain, I began looking at alternative solutions. I heard about the plant kratom that many were using successfully to help control their TN pain. I decided to try it. Amazingly enough, I got instant relief. My pain did not go away, but it moved from an 8-9 to a 2-4 with the use of a low dose of kratom. I still have very bad days where nothing really helps, but the majority of the time, I can function very well. I am an 8-year kratom consumer. Kratom has allowed me to discontinue my daily opioid prescription!

Patients like me need pain control options. I read stories every day of patients who are being forced off their pain medication and given no other options. While taking acetaminophen or ibuprofen for pain control works for some, when people have severe illness and pain, these over-the-counter meds do not help. What is not understood by many lawmakers and physicians is that you cannot survive at constant 8-10 level pain for an extended period of time without snapping. Mentally this amount of pain changes your brain, and suicide becomes a real option. We don't want to die. We want to live! I don't take kratom to get any sort of a high. In fact, the reason I love kratom is that it makes me feel more normal! There is no physical craving for this supplement. The only craving I have is the desire to have my pain drop a few points.

Pain patients are the silent minority in this country. We are the ones who have no voice. We are hidden away in our homes, unable to work, go to lunch, and even drive a car at times. All we are asking for is compassion and access to medication and natural supplements that give us some quality of life. Sometimes I lay awake at night thinking about the real possibility that kratom could become illegal. What would I then do for pain control? That is a thought that haunts me. Opioids are no longer

available to most patients. I could not live at level 9-10 which is what I would be at without pain control. The answer for me was Kratom. I am grateful every day that it is legal and that I have the option to use this supplement.

Just this week I came across this post. It perfectly summarizes the terrifying position that pain patients are being put in by having their access to pain medication taken away. Notice the last two sentences. It says it all.

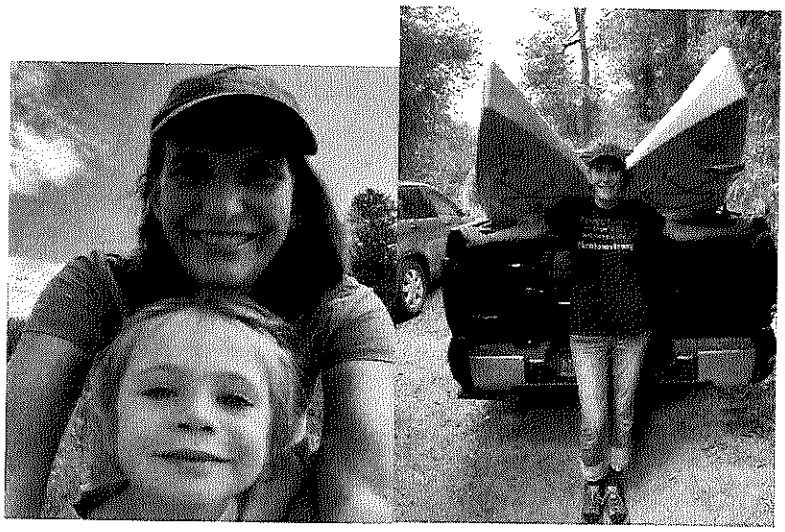


Please give pain patients a voice! Regulate kratom instead of banning it! Currently the adverse events being reported are most frequently coming from 7-Hydroxymitragynine (7-OH) synthetic products and not from pure kratom. 7-OH products SHOULD be banned since they are not kratom. Please do not assume that these products are the same. 7-OH is NOT kratom.

By regulating and not banning kratom, you are showing those that rely on kratom to treat their pain, anxiety and even drug withdrawals with kratom truly matter. You have the power to keep us functioning so we can give back to society and take care of our families. Thank you!

Lora Romney
[redacted]
loraromney@gmail.com

Before Kratom – Uncontrolled pain, surgeries, procedures (Cephaly device pictured....trying to control the pain)



With Kratom – Controlled pain, living life, being a grandma

International Plant & Herbal ALLIANCE

PLANTS AND HERBS IMPROVING PEOPLE'S LIVES

February 11, 2026

Dear Senate Committee Chair & Members –

I am writing in opposition to SB497.

This bill outlines a full ban of natural kratom and synthetic 7-OH products. Passing a comprehensive ban will hurt those in your community that rely on kratom to control their pain and those that use kratom as a harm reduction tool to stay off illicit drugs and alcohol. I have found that there is often significant confusion—especially when it comes to distinguishing between natural kratom and synthetic 7-hydroxymitragynine (7-OH).

By way of introduction, my name is Lora Romney. I am a 9-year kratom consumer who uses natural kratom to manage severe chronic facial pain (Trigeminal Neuralgia). Kratom has been a critical part of my health journey. I am also a kratom advocate, educator, and the president of the International Plant & Herbal Alliance (www.plantsandherbals.org).

I deeply respect your commitment to public health and safety, and I urge you to consider the complexity of this issue carefully. A comprehensive ban on kratom could have serious unintended consequences—especially for individuals like me who rely on natural kratom to manage chronic pain, reduce anxiety, and support harm reduction. Like many others, I've found that kratom not only improves quality of life but also helps consumers avoid more dangerous alternatives such as opioids or illicit substances. Thoughtful regulation—not prohibition—is the most effective path forward.

I have found there is often great confusion between natural kratom products and potentially dangerous semi-synthetic derivatives, such as 7-hydroxymitragynine (7-OH). These semi-synthetics are not kratom. They are chemically created from one trace metabolite of the kratom plant. They are 14 times more powerful than morphine and science has shown they can cause respiratory depression similar to opioids. 7-OH (and other synthetically derived kratom alkaloid products) had no safety record prior to market entry, and to date, there has been no science confirming any safe use of these products. They absolutely need to be removed from your store shelves.

On July 29, 2025, the FDA held an emergency press conference warning of the public health threat posed by 7-OH products and announced they were working with the DEA to begin scheduling these synthetic compounds. Commissioner Marty Makary made clear that the FDA is not targeting natural kratom. He stated:

"We are not targeting the kratom leaf or ground kratom. We are targeting the concentrated synthetic byproduct that is an opioid."

Since the FDA press conference, the 8-Factor Analysis has been completed on 7-OH. The findings are that 7-OH products should be schedule one. We are awaiting action from the DEA. Since 7-OH did not pass the 8-Factor Analysis, we expect an emergency scheduling for these products. In the meantime, it would be in your state's best interest to pass good regulation that protects consumers instead of withdrawing this lifeline from everyone.

Nineteen states have passed versions of the Kratom Consumer Protection Act. This good regulation does the following:

1) Age restriction (typically 21+)
2) Strict GMP regulations for safe packaging and distribution.
3) Appropriate labeling based on requirements for dietary supplements: ingredients, serving size, warnings, etc.
4) Language that restricts the amount of 7-hydroxymitragynine (or other synthetic kratom derivatives) allowed in the product (Less than 2% or 1 mg/serving). "A kratom product cannot be sold if it contains more than 2 % 7-hydroxymitragynine of the product's total alkaloid fraction. This will mirror the FDA's recommendation from the July 29 press conference and effectively remove all 7-OH products (and other synthetics) from store shelves.

Please OPPOSE SB497 and instead opt for good regulation! Ban or schedule 7-OH and other synthetic derivatives but keep natural kratom legal. Thank you!

Sincerely,

Lora Romney
President
International Plant & Herbal Alliance
[redacted]

Outlook

[Draft] **Kratom Ban is bad for Kansas**

From

Draft saved Wed 2/11/2026 11:02 AM

To Public.Health.Welfare@senate.ks.gov <Public.Health.Welfare@senate.ks.gov>

I'm just some guy that drinks kratom tea as many others do coffee to work for focus and for energy. scheduling a plant product alongside synthetic 7OH analogs is irrational, bad policy and will lead to more harm than good. Kansas lawmakers need a science-based approach to articulate the facts and move forward. Regulation is a far more benign even helpful stance if we wish to protect the life liberty and happiness of the people of Kansas.

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Dr. Michele Ross
OPPOSE SB 497
Kansas Senate Committee on Public Health and Welfare
Monday, February 16, 2026, 8:30 AM Room 142-S

Dear Chairwoman Gossage and Members of the Committee,

My name is Dr. Michele Ross. I'm an addiction scientist and court-qualified expert on kratom and 7-OH. I strongly **oppose** making kratom or its alkaloids mitragynine and 7-hydroxymitragynine, also known as 7-OH, a Schedule 1 drug in Kansas.

Kratom and 7-OH products are responsibly used by over 20 million Americans and over 180,000 residents of Kansas.

The average kratom or 7-OH consumer is a college-educated working parent in their mid-40s. 8% of 7-OH consumers are VETERANS, 2% are current or retired law enforcement, and 12% are healthcare professionals. These are not recreational products, they are used for chronic pain and addiction recovery.

Kratom and 7-OH are not a danger to our communities, these products are a safety net for those who have faced serious obstacles obtaining treatment for chronic pain or substance abuse or simply prefer plant-based medicine over pharmaceuticals. Criminalizing kratom and 7-OH won't reduce drug overdoses, it will drive them up. PEOPLE. WILL DIE. We need regulations, not bans or jail time.

Making kratom or 7-OH Schedule 1 will leave consumers 3 options - suffering, street drugs, or suicide. A research study of over 1500 7-OH consumers confirms this - 17% said they would consider suicide if 7-OH and kratom were banned and 25% said they would obtain opioids like fentanyl or heroin from the illicit market, which carry a much higher risk of addiction and overdose.

A kratom or 7-OH ban doesn't make residents of Kansas safer - it merely drives them to more dangerous sources or substances just so that they can go to work or take care of their families.

The downstream costs will be borne by Kansas in the form of more overdoses, increased ER use, more addiction clinic costs, lost workforce participation, and preventable deaths.

To keep Kansas residents safe, regulate, don't ban kratom or 7-OH. Pass regulations including enforcement of 21+ age gating, adulterant testing, packaging requirements, etc. These tools protect public health without destabilizing people who are already managing pain or recovery.

Thank you,

Dr. Michele Ross, PhD, MBA
442-237-8624

Policymaker Brief: Do Not Make 7-OH a Schedule 1 Drug

Historically, when Kansas has amended Schedule I of the Kansas Uniform Controlled Substances Act, it has generally done so in coordination with, or subsequent to, federal scheduling actions under the Controlled Substances Act. Kansas's scheduling framework, codified at K.S.A. 65-4101 et seq., authorizes the Secretary of the Kansas Department of Health and Environment to add substances to Schedule I through rulemaking when consistent with statutory criteria. In practice, however, Kansas has typically harmonized its schedules with federal determinations made by the U.S. Drug Enforcement Administration rather than acting as an early or independent first mover on novel or emerging compounds.

When Kansas has exercised its authority to schedule substances, it has generally done so in response to clearly documented patterns of abuse or following federal control under the Controlled Substances Act. This approach has focused primarily on synthetic analogues, novel psychoactive substances, or compounds already subject to federal scheduling or emergency control. Kansas has not historically used Schedule I to independently prohibit plant-derived alkaloids or metabolites that remain unscheduled under the federal Controlled Substances Act, even where their regulatory status under the Federal Food, Drug, and Cosmetic Act has been the subject of dispute or agency interpretation. Accordingly, placement of 7-hydroxymitragynine (7-OH) into Schedule I under Kansas law would represent an independent criminalization decision rather than routine statutory harmonization with an existing federal controlled substance determination.

Kansas law expressly requires consideration of statutory factors before a substance may be placed into Schedule I. Under K.S.A. 65-4102 and related provisions, the Secretary must evaluate criteria substantially similar to the federal eight-factor analysis prior to initiating scheduling through the state rulemaking process.

The required factors include:

(1) Its actual or relative potential for abuse;
(2) The scientific evidence of its pharmacological effect, if known;
(3) The state of current scientific knowledge regarding the substance;
(4) Its history and current pattern of abuse;
(5) The scope, duration, and significance of abuse;
(6) The risk to public health;
(7) Its psychic or physiological dependence liability; and
(8) Whether the substance is an immediate precursor of a substance already controlled.

Because Kansas law incorporates these evidentiary considerations into its scheduling process, any proposal to add 7-OH to Schedule I would represent a significant policy determination that

must be supported by a documented administrative record addressing each statutory factor. Placement of a naturally occurring alkaloid or metabolite into Schedule I without prior federal scheduling would mark a departure from Kansas's historical pattern of alignment and structured review.

7-HOPE Alliance has provided an abbreviated eight-factor analysis for the purpose of informing state and federal policymakers regarding the public health impact of 7-OH product use and the evidentiary considerations relevant to any Schedule I proposal under Kansas law.

8-Factor Analysis of 7-hydroxymitragynine (7-OH)

Introduction

Kratom is a botanical product made from the leaves of the Southeast Asian tree *Mitragyna speciosa*, which has been used for generations for pain relief, energy, and to ease opioid withdrawal symptoms. The kratom plant contains more than 50 naturally occurring alkaloids, of which mitragynine is the most abundant.

7-hydroxymitragynine (7-OH) is one of these naturally occurring alkaloids and is present in small amounts in the plant. It is known to have pain relieving, anti-inflammatory, antioxidant, and even anti-cancer abilities, showing promise as a therapeutic for HER2+ breast cancer (Akbar et al., 2025; Arief et al., 2025; Kampmeyer et al., 2025). In addition, 7-OH is formed in the human body as a metabolite of mitragynine following kratom ingestion, meaning exposure to 7-OH occurs whenever kratom is consumed.

In recent years, some manufacturers have produced products containing standardized or concentrated amounts of 7-OH, which exist alongside traditional kratom leaf products and differ in formulation and dose. This analysis evaluates 7-OH in light of its biological origins, pharmacology, real-world use, and public health impact to determine whether it meets the statutory criteria for Schedule I placement under Kansas law.

Factor 1: Actual or Relative Potential for Abuse

The available evidence does not support the conclusion that products containing isolated or concentrated 7-hydroxymitragynine (7-OH) have an abuse potential comparable to substances traditionally placed in Schedule I. Substances placed in Schedule I are typically associated with rapid escalation of use, strong reinforcement, compulsive binge patterns, widespread diversion, and significant public safety impacts. These features have not been demonstrated for 7-OH products at the population level.

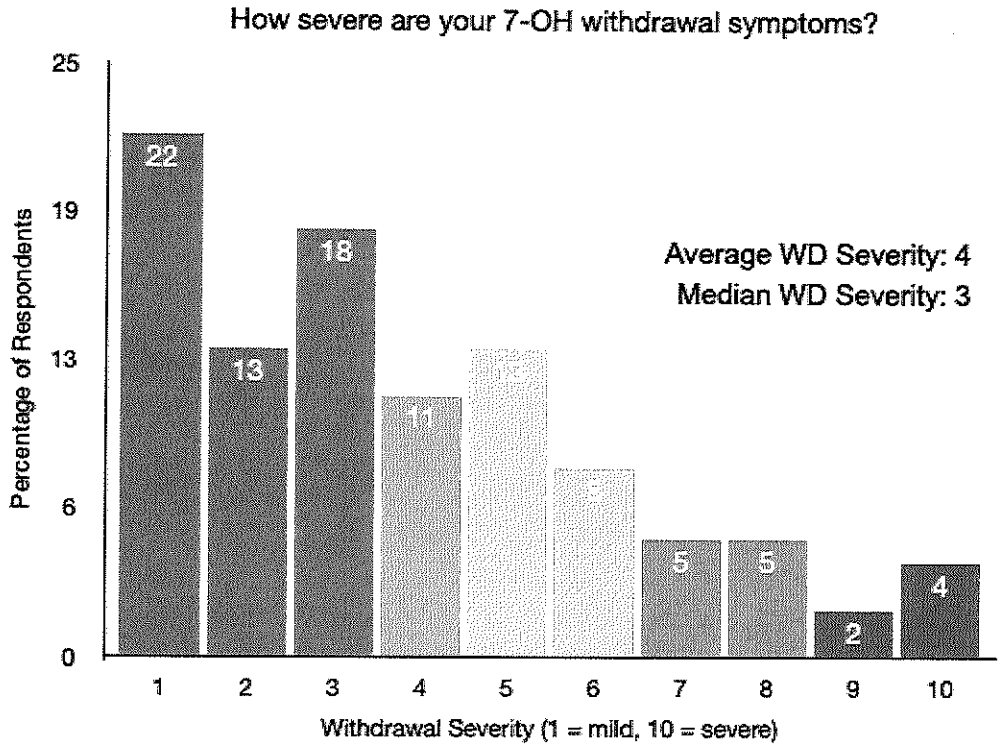
Mechanistic and behavioral evidence supports a dose- and formulation-dependent risk profile rather than an inherently high abuse liability. Pharmacological studies show that 7-OH is a G

protein-biased partial mu-opioid receptor agonist with low intrinsic efficacy, poor oral bioavailability of approximately 2.5%, restricted penetration into the brain, and constrained engagement of reward pathways associated with high-abuse opioids (Obeng et al., 2021; Chiang et al., 2025; Yusof et al., 2019).

Neurochemical and behavioral studies further indicate that 7-OH does not robustly activate mesolimbic dopamine signaling or enhance brain reward function in the manner observed with heroin or fentanyl, and at higher doses may impair reward signaling rather than reinforce it (Behnood-Rod et al., 2020; Gutridge et. al., 2020; Manus et al., 2025). These properties mechanistically limit the magnitude and reinforcement profile of 7-OH relative to full opioid agonists, even where opioid-like effects are present. 7-OH was even found to reduce binge alcohol drinking in mice (Gutridge et. al., 2020). This does not mean 7-OH is risk-free, but it does distinguish its abuse potential from that of high-efficacy opioids.

Human behavioral data are consistent with this interpretation. Available sales and consumer-use data indicate repeated, measured use patterns, most commonly for self-treatment of chronic pain (74%) and mental health symptoms, rather than rapid escalation, widespread diversion, or compulsive binge use that typically precipitates emergency scheduling actions (Ross, 2025; Ross, 2026).

In an October 2025 research survey of 1,521 adults who had used 7-OH products, most respondents did not consider themselves addicted, 31% reported no withdrawal symptoms at all, and reported withdrawal severity was predominantly mild to moderate rather than severe (Ross, 2026). No respondents reported overdose requiring medical attention despite widespread and repeated use. These patterns are more consistent with substances such as kratom, cannabis, or caffeine than with heroin or fentanyl, and they indicate the presence of manageable risk rather than the uncontrolled abuse profile implied by Schedule I placement.



(Ross, 2026)

Observational studies of kratom use, in which 7-OH exposure occurs both naturally and metabolically, show that problematic use is more strongly associated with frequency and cumulative exposure than with specific alkaloids or formulations (Garcia-Romeu et al., 2020; Rogers et al., 2024). Although these studies are not specific to isolated 7-OH products, they provide important context for evaluating abuse potential at the population level and caution against assuming Schedule I–level risk absent clear epidemiological signals.

Taken together, the current scientific and behavioral evidence indicates that any abuse potential associated with 7-OH products is context-specific and dose-dependent, not categorical or extreme. On this record, Factor (1) does not support placement of 7-hydroxymitragynine in Schedule I.

Factor 2: Scientific Evidence of its Pharmacological Effects

The pharmacological effects of 7-hydroxymitragynine (7-OH) are often oversimplified and misrepresented in policy discussions. 7-hydroxymitragynine (7-OH) interacts with the mu-opioid receptor, but its pharmacological effects differ in meaningful and well-documented ways from classical opioids typically placed in Schedule I. In multiple human receptor systems, 7-OH

behaves as a partial agonist with lower intrinsic efficacy than full opioid agonists such as morphine or fentanyl, meaning it produces a ceiling on receptor activation even at higher receptor occupancy (Obeng et al., 2021).

In head-to-head functional assays using human mu-opioid receptors, the maximal effect of 7-OH is substantially lower than that of morphine, placing it closer to partial agonists like buprenorphine than to high-efficacy opioids (Obeng et al., 2021; Kruegel et al., 2016). In addition, 7-OH is an antagonist at the delta opioid receptor and kappa opioid receptors, reinforcing its utility to reduce alcohol and substance abuse, rather than promote it (Guttridge et. al., 2020).

Claims that 7-OH is unusually potent or dangerous relative to morphine are not supported by modern, human-relevant pharmacological evidence. Widely repeated assertions that 7-OH is "13x more potent than morphine," including those disseminated by the U.S. Food and Drug Administration (FDA), rely on a 24-year-old guinea pig gut tissue assay (Takayama et al., 2002). Potency estimates derived from this *ex vivo* smooth-muscle model are highly context-specific and not considered translational measures of human opioid risk. Subsequent research using human mu-opioid receptor systems and contemporary functional assays consistently shows that 7-OH is a partial agonist with lower intrinsic efficacy and reduced maximal opioid signaling compared to morphine, producing ceiling effects that constrain pharmacological impact (Kruegel et al., 2016; Váradi et al., 2016; Obeng et al., 2021). Conflating assay-specific potency with clinical danger has therefore materially distorted public and regulatory discussions of 7-OH and does not reflect the totality of the pharmacological evidence.

Pharmacokinetic evidence further constrains the real-world implications of 7-OH's receptor activity. Orally administered 7-OH exhibits poor bioavailability due to extensive first-pass metabolism, with only a small fraction of the dose reaching systemic circulation (Chiang et al., 2025; Maxwell et al., 2021). Studies examining blood-brain barrier transport show that 7-OH has limited penetration into the central nervous system and restricted distribution within brain tissue compared with mitragynine and classical opioids, reducing its ability to engage central pathways involved in reward and respiratory control (Yusof et al., 2019).

Importantly, available toxicological data do not demonstrate a defined lethal dose for orally administered 7-hydroxymitragynine. In supplementary toxicology studies reported by Smith et al. (2019), oral administration of 7-hydroxymitragynine to mice did not produce a calculable LD50, meaning that a lethal dose could not be established under the conditions tested. This finding is notable because orally active opioids with high intrinsic toxicity typically exhibit a measurable LD50 in standard rodent models. While absence of an LD50 does not imply absence of risk, it indicates that acute oral lethality occurs at doses beyond those tested and contrasts with the toxicity profiles of classical opioids used as Schedule I comparators.

Consistent with these pharmacological constraints, there is no controlled human evidence demonstrating that oral 7-OH produces respiratory depression, overdose risk, or lethality

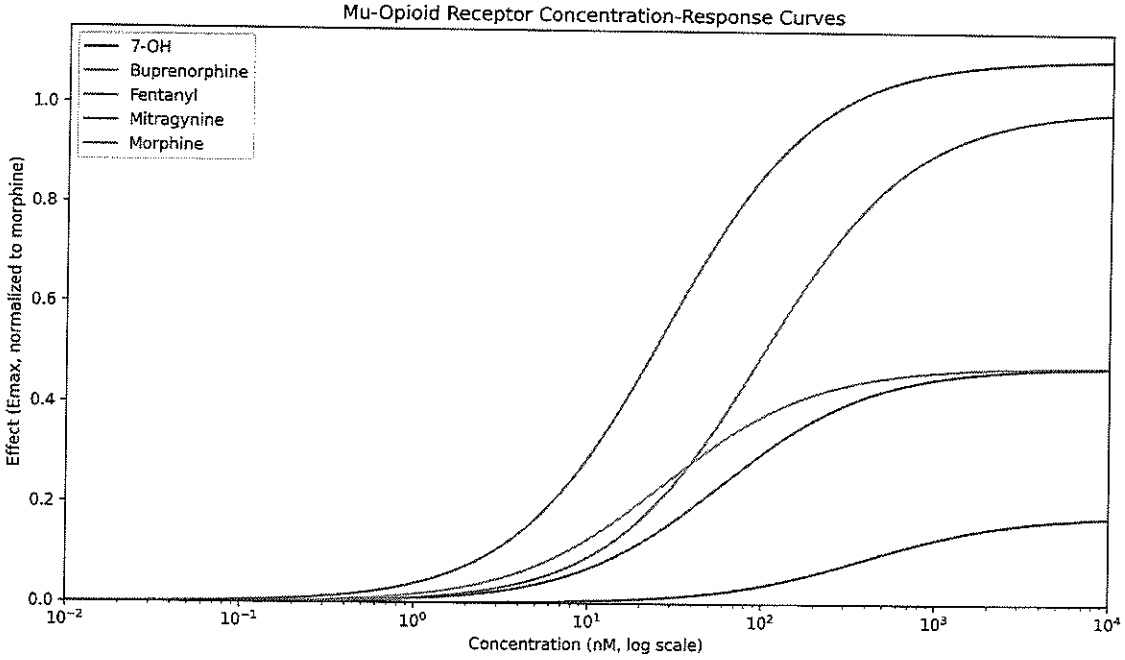
comparable to morphine. Assertions of heightened respiratory danger derive primarily from intravenous rodent models or isolated human case reports involving extreme dosing and multiple co-ingested substances, which cannot be used to establish human-equivalent risk (Hill et al., 2022; Zuarth Gonzalez et al., 2025; Pullman et al., 2025). Taken together, the primary scientific evidence shows that while 7-OH has opioid activity and is not risk-free, its pharmacological profile does not support treating it as a high-efficacy opioid comparable to Schedule I substances.

Factor 3: Current State of Scientific Knowledge

The current scientific understanding of 7-hydroxymitragynine (7-OH) is incomplete, evolving, and frequently mischaracterized in policy discussions. While there is a substantial preclinical literature describing receptor binding, signaling pathways, and pharmacokinetics, there is a relative absence of controlled human data establishing dose-response relationships, comparative addiction risk, or population-level public health outcomes specific to isolated or concentrated 7-OH products. As a result, claims that the risks of 7-OH are well established or settled are not supported by the structure of the existing evidence base.

A significant source of confusion has been the repeated propagation of incorrect or oversimplified pharmacological claims through secondary sources. Most notably, the assertion that 7-OH has "14–22 times greater" mu-opioid receptor binding affinity than morphine is false and reverses what primary receptor-binding data show. In the most relevant head-to-head human receptor studies, morphine binds the mu-opioid receptor far more tightly than 7-OH, with Ki values differing by approximately one to two orders of magnitude in favor of morphine (Obeng et al., 2021; Váradi et al., 2016; Todd et al., 2020). This numerical inversion appears to have arisen from confusion between comparisons of 7-OH versus mitragynine and later misapplication of that ratio to morphine. Once repeated in reviews, case reports, and regulatory summaries, the error has taken on the appearance of scientific consensus despite being directly contradicted by primary data.

Beyond binding affinity, the scientific literature makes clear that receptor binding alone does not determine clinical risk. Functional efficacy, signaling bias, route of administration, metabolism, and central nervous system exposure all materially influence real-world effects. Primary functional assays show that 7-OH behaves as a partial mu-opioid receptor agonist with lower maximal efficacy than morphine or fentanyl in human receptor systems and functions more closely to buprenorphine, an opioid abuse treatment (Obeng et al., 2021; Kruegel et al., 2016). Pharmacokinetic studies further demonstrate poor oral bioavailability and restricted brain penetration, which limit the magnitude, speed, and duration of central opioid signaling (Yusof et al., 2019; Chiang et al., 2025). These constraints are well documented in the literature but are often omitted from policy summaries that focus narrowly on opioid receptor interaction.



(adapted from Varadi, 2021)

Importantly, there is no robust human clinical literature establishing that 7-OH produces rates of addiction, overdose, or respiratory depression comparable to Schedule I opioids. Existing human evidence consists primarily of isolated case reports involving extreme dosing, non-representative formulations, or multiple co-ingested substances, which cannot be generalized to typical use of oral tablets or used to establish population-level risk (Reif et al., 2025; Pullman et al., 2025). Animal studies, particularly those using intravenous administration, provide valuable mechanistic insight but do not establish human-equivalent risk when divorced from route, exposure, and pharmacokinetic context (Hill et al., 2022; Zuarth Gonzalez et al., 2025).

Taken together, the current state of scientific knowledge supports a cautious and proportionate regulatory approach rather than categorical conclusions. The evidence base does not justify treating 7-OH as a well-characterized, high-risk substance analogous to heroin or fentanyl. Instead, it reflects an emerging and still-developing literature with known uncertainties, documented misstatements, and clear gaps in human data. In this context, Schedule I placement would outpace the science rather than reflect it.

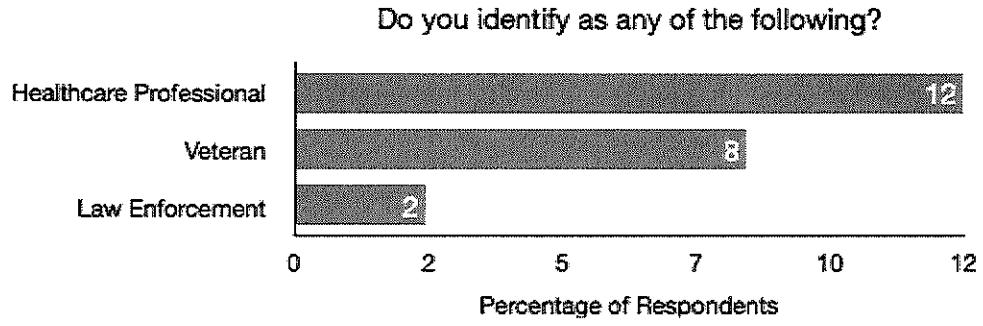
Factor 4: History and Current Pattern of Abuse

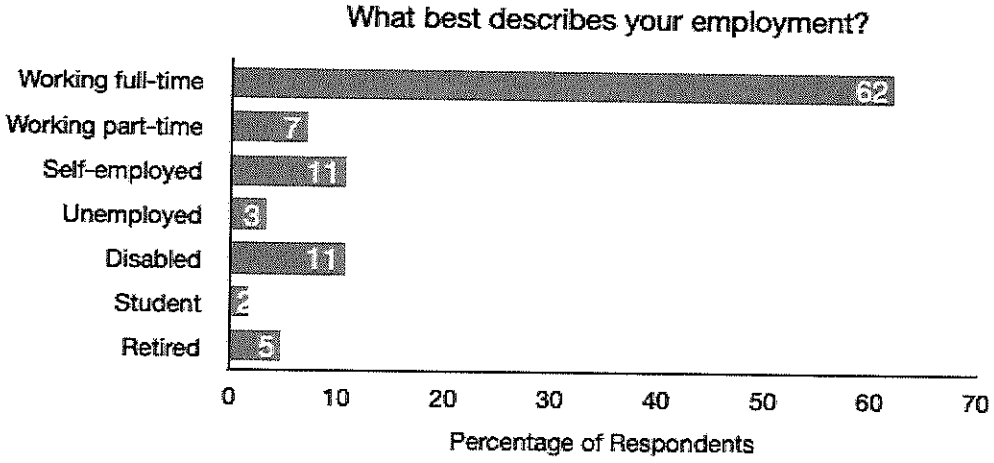
The history and current pattern of use associated with 7-hydroxymitragynine (7-OH) do not resemble the abuse trajectories of substances traditionally placed in Schedule I. Exposure to

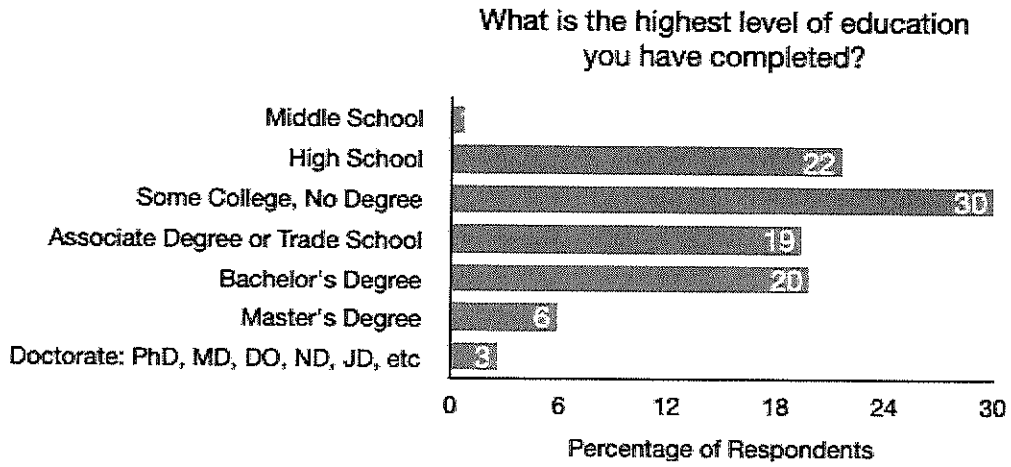
7-OH has occurred for many years through kratom consumption, which is estimated to involve more than 20 million users nationwide. During this period of widespread and sustained exposure, there has been no corresponding emergence of a distinct pattern of severe abuse, rapid escalation, or population-level harm attributable specifically to 7-OH.

Since late 2023, higher-concentration 7-OH products have emerged, with an estimated one million consumers nationwide and over one billion servings sold. Despite this scale of exposure, there is no documented pattern of widespread diversion, escalating compulsive use, or community-level harm comparable to heroin, fentanyl, or other Schedule I substances. While isolated adverse events and dependency concerns warrant regulatory attention, the overall history and current pattern of use indicate managed, consumer-driven use rather than uncontrolled abuse, supporting targeted regulation rather than Schedule I classification.

The average consumer of 7-OH products is a 41-year-old employed, college-educated caucasian male with children, versus a young adult or unemployed person (Ross, 2026). This is similar to published research on kratom users (Garcia-Romeu et al., 2020). Surprisingly, 12% of 7-OH consumers surveyed were healthcare professionals, 8% were veterans, and 2% were current or retired law enforcement (Ross, 2026).

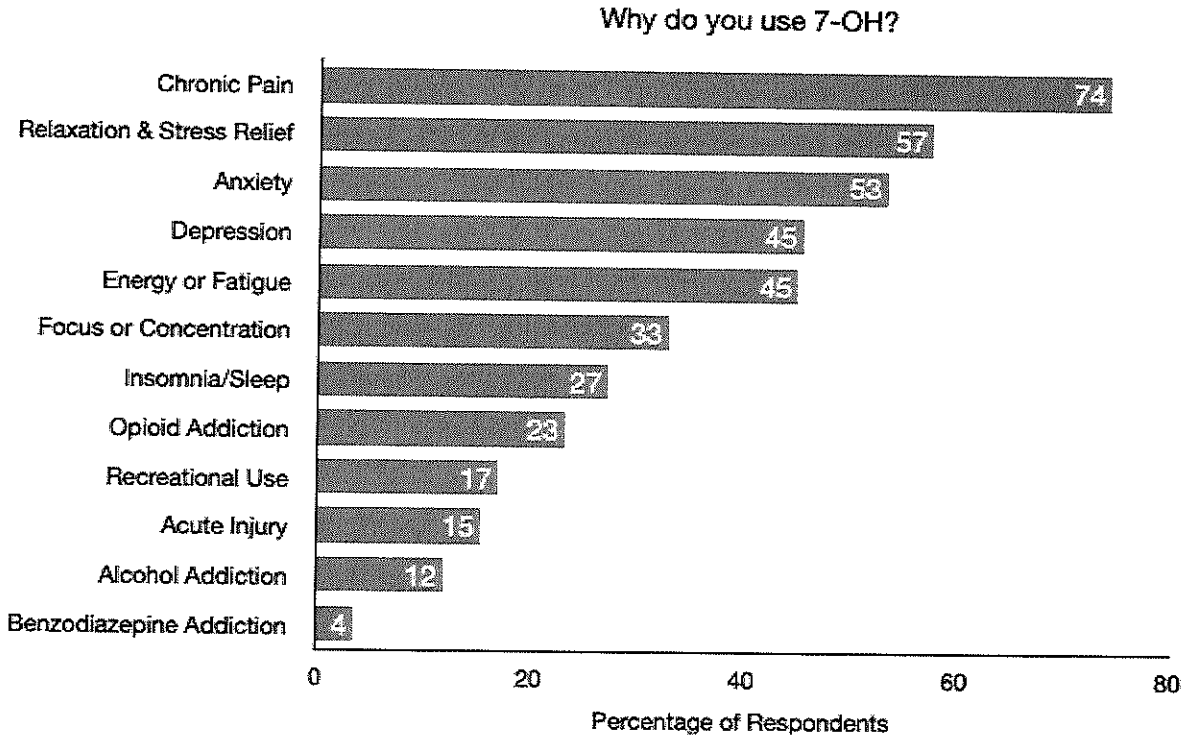






(Ross, 2026)

Available data indicate that these products are primarily used by adults for self-management of chronic pain (74%), mental health symptoms, or as substitutes for prescription or illicit opioids (23%), rather than for recreational intoxication (Ross, 2026). 97% of people using 7-OH for chronic pain found it very effective (Ross, 2026).



(Ross, 2026)

Reported use patterns are generally stable and intentional, not characterized by binge use, widespread diversion, or the types of compulsive behaviors that historically prompt emergency scheduling actions (Ross, 2026). This pattern is consistent with survey findings and observational research on kratom-related products more broadly (Garcia-Romeu et al., 2020; Rogers et al., 2024).

Public discussion has highlighted a small number of overdose deaths in Los Angeles County in which 7-OH was reported as present. In these cases, mitragynine was also detected, no quantitative concentrations were disclosed, and no evidence of specific 7-OH product use was documented. Each death involved multiple co-ingested substances independently associated with overdose risk such as alcohol, cocaine, and benzodiazepines. Under accepted forensic toxicology standards, these cases are consistent with polysubstance overdoses in which 7-OH detection may reflect ordinary kratom use and expected metabolism rather than a distinct pattern of 7-OH product abuse (Hughes et al., 2024; Los Angeles County Department of Medical Examiner records).

Overall, the historical record shows sustained and widespread exposure to 7-OH without evidence of an emerging abuse epidemic or a shift toward high-risk use patterns. The available data support the conclusion that current patterns of use do not meet the threshold implied by

Schedule I placement and are more appropriately addressed through targeted regulatory oversight rather than criminal prohibition.

Factor 5: Scope, Duration, and Significance of Abuse

The scope and duration of exposure to 7-hydroxymitragynine (7-OH) are substantial, but the scope and significance of abuse are not. Millions of Americans have been exposed to 7-OH for many years through kratom use, and more recently through 7-OH products, without evidence of sustained, large-scale abuse patterns comparable to substances in Schedule I. At least 20 million Americans use kratom products. Nationally, more than one million adults are estimated to have used 7-OH kratom alkaloid products, with over one billion servings sold. If 7-OH abuse were widespread, severe, or escalating, that signal would be evident at this scale of exposure.

Instead, available evidence indicates that problematic use occurs in a minority of users and is generally limited in severity (Ross, 2026). Only 9% of survey respondents reported feeling high after using 7-OH, and this is correlated with a small percentage of consumers who may be abusing the compound (Ross, 2026).

Reported adverse outcomes are rare relative to the size of the exposed population, and there is no evidence of sustained increases in emergency department utilization, overdose mortality, motor vehicle accidents, or criminal activity attributable specifically to 7-OH (Kedzierski, 2023). The absence of a population-level harm signal over a prolonged period of exposure weighs strongly against the conclusion that 7-OH abuse is significant in scope or duration.

Isolated adverse events, including the Los Angeles County deaths that have received public attention, do not alter this assessment. These cases lack quantitative toxicology, confirmed product exposure, and causal attribution, and all involved multiple co-ingested substances known to drive overdose risk. Such cases are not evidence of a widespread or significant abuse problem and should not be used to infer population-level risk.

Taken together, the scope and duration of 7-OH exposure are large, while the scope and significance of abuse remain limited. This disparity is inconsistent with Schedule I classification, which is reserved for substances that produce widespread, severe, and socially disruptive abuse. The evidence instead supports proportionate regulatory approaches that address specific risks without criminalizing a large and identifiable consumer population.

Factor 6: The Risk to Public Health

The public health risk associated with 7-hydroxymitragynine (7-OH) must be evaluated in terms of both direct harms from use and indirect harms resulting from regulatory action. The available evidence does not show that 7-OH use is driving a population-level public health crisis comparable to those associated with Schedule I opioids. Despite widespread exposure over many years, there is no evidence of sustained increases in overdose mortality, emergency

department utilization, or community-level harm attributable specifically to 7-OH (Garcia-Romeu et al., 2020; Rogers et al., 2024).

Public health data reinforce this point. In 2023, the National Poison Data System recorded only 12 kratom-related exposure calls in Kansas out of more than 20,923 total Poison Control Center Call cases, just 0.06 percent (America's Poison Centers, 2024). By contrast, nearly 3,012 cases, about 14.4 percent, involved analgesics, including prescription opioid painkillers and common over-the-counter drugs like Tylenol. Even with an estimated one million 7-OH consumers nationwide and at least 9,000 in Kansas, adverse events remain rare relative to use. This is not the profile of a substance driving a public safety or public health crisis.

Where adverse outcomes have been reported, they overwhelmingly involve polysubstance use. This includes the Los Angeles County deaths in which 7-OH was detected alongside multiple central nervous system depressants, stimulants, or illicit drugs, without quantitative toxicology or confirmed product exposure. Epidemiological and forensic literature consistently show that polysubstance use, particularly combinations involving alcohol, benzodiazepines, and opioids, is the dominant driver of fatal overdose risk (Jones et al., 2014; Kandel et al., 2021). Attributing such outcomes to a single detected compound in the absence of concentration data risks misdirecting public health interventions away from the true sources of harm.

Consistent with this, controlled animal toxicology studies have not identified a lethal oral dose for 7-hydroxymitragynine, further distinguishing its acute toxicity profile from that of high-risk opioids driving overdose mortality (Smith et al., 2019).

The potential public health consequences of placing 7-OH in Schedule I are substantial and foreseeable. Prohibition would criminalize a large population of adults who currently use kratom or 7-OH products for pain management or to reduce reliance on illicit opioids, displacing them into unregulated markets with far higher overdose risk. Extensive evidence from opioid policy demonstrates that sudden loss of access to lower-risk alternatives increases transitions to fentanyl and other illicit opioids, with predictable increases in morbidity and mortality (Cicero et al., 2014; Wakeman et al., 2019). This is not just theory, as there was a **300% increase in overdose deaths in Florida following an Emergency Schedule 1 ban of 7-OH** in August, 2025.

Population-level epidemiologic evidence further indicates that prohibiting kratom-related products may worsen opioid-related outcomes rather than reduce them. Blair, 2022 found that enactment of kratom bans was associated with statistically significant increases in opioid overdose mortality in multiple states, including Indiana, Vermont, Wisconsin, Arkansas , and Alabama, with no protective effect observed in any state. The author concluded that public health policies banning kratom, implemented with the intent of reducing addiction and harm, did not mitigate the opioid epidemic and in several cases were associated with increased opioid mortality (Blair, 2022).

More broadly, evidence shows that Controlled Substances Act scheduling does not reliably reflect real-world drug harms. Broman, 2025 found a weak negative correlation between CSA schedule placement and expert-assessed harm (Broman et al., 2025). Drugs responsible for the greatest mortality and social harm, including fentanyl, methamphetamine, crack cocaine, heroin, and alcohol, ranked highest in overall harm, while several Schedule I substances ranked among the least harmful. These findings demonstrate that punitive scheduling frequently misclassifies risk and can amplify harm through criminalization and legal consequences rather than reduce it. In this context, placing 7-OH in Schedule I would replicate a well-documented policy failure by prioritizing classification over evidence-based public health outcomes.

For individuals who do not transition to illicit opioids following a 7-OH ban, unmanaged pain, psychological distress, and increased suicide risk represent additional, well-documented harms. These concerns were explicitly cited by the U.S. Department of Health and Human Services in 2018 as reasons for declining to recommend Schedule I placement of mitragynine and 7-hydroxymitragynine (Grior, 2018).

Over 32,837 people signed a Change.org petition urging lawmakers to halt a proposed national ban on 7-OH, indicating public resistance to prohibition-oriented policy actions (7-HOPE Alliance, 2025).

In this context, Schedule I placement is likely to increase public health risk rather than reduce it. A regulatory approach focused on product standards, dosage limits, labeling, and surveillance would better protect public health while preserving the ability to monitor and respond to emerging risks. The evidence does not support treating 7-OH as an immediate public health threat warranting the most restrictive classification available under state or federal law.

Factor 7: Psychic or Physiological Dependence Liability

The evidence indicates that 7-hydroxymitragynine (7-OH) can produce some degree of physical dependence at sufficient doses, but its dependence liability is constrained and does not resemble that of Schedule I opioids such as heroin or fentanyl. At the pharmacological level, 7-OH functions as a partial mu-opioid receptor agonist with lower intrinsic efficacy than full agonists, a property associated with a ceiling effect on receptor activation and reduced severity of dependence and withdrawal compared with high-efficacy opioids (Kruegel et al., 2016; Obeng et al., 2021). This mechanism limits the intensity of neuroadaptations that typically drive severe opioid dependence.

Human behavioral data reinforce this distinction. In a survey of 1,521 adults who reported using 7-OH products, most respondents did not consider themselves addicted, and reported withdrawal symptoms were predominantly mild to moderate rather than severe (Ross, 2026). Only a minority reported functional impairment related to dependence, and no respondents reported overdose requiring medical intervention despite repeated use (Ross, 2026). These

findings are inconsistent with the dependence profile seen in heroin or fentanyl users and are more closely aligned with substances such as kratom, cannabis, or caffeine, where physical dependence may occur but is generally manageable and non-disabling.

Observational research on kratom use provides additional context, as 7-OH exposure occurs both naturally and metabolically in that population. Studies consistently report that while some users experience tolerance and withdrawal, symptoms are typically limited in severity and rarely meet criteria associated with severe opioid use disorder (Garcia-Romeu et al., 2020; Smith et al., 2022). Case reports describing problematic 7-OH product use involve atypical exposure scenarios, extreme dosing, or co-occurring substance use disorders and do not establish generalizable dependence risk for the broader population (Reif et al., 2025).

The presence of some dependence liability does not justify Schedule I placement. Many legally regulated substances produce physical dependence and withdrawal yet are managed through dosage controls, labeling, and clinical guidance rather than prohibition. The combined mechanistic evidence and human survey data indicate that any dependence potential associated with 7-OH is dose-dependent, limited in severity for most users, and amenable to risk mitigation through regulation. On this record, Factor (7) does not support classifying 7-hydroxymitragynine as a Schedule I substance.

Factor 8: Whether the Substance is an Immediate Precursor of a Substance Already Controlled

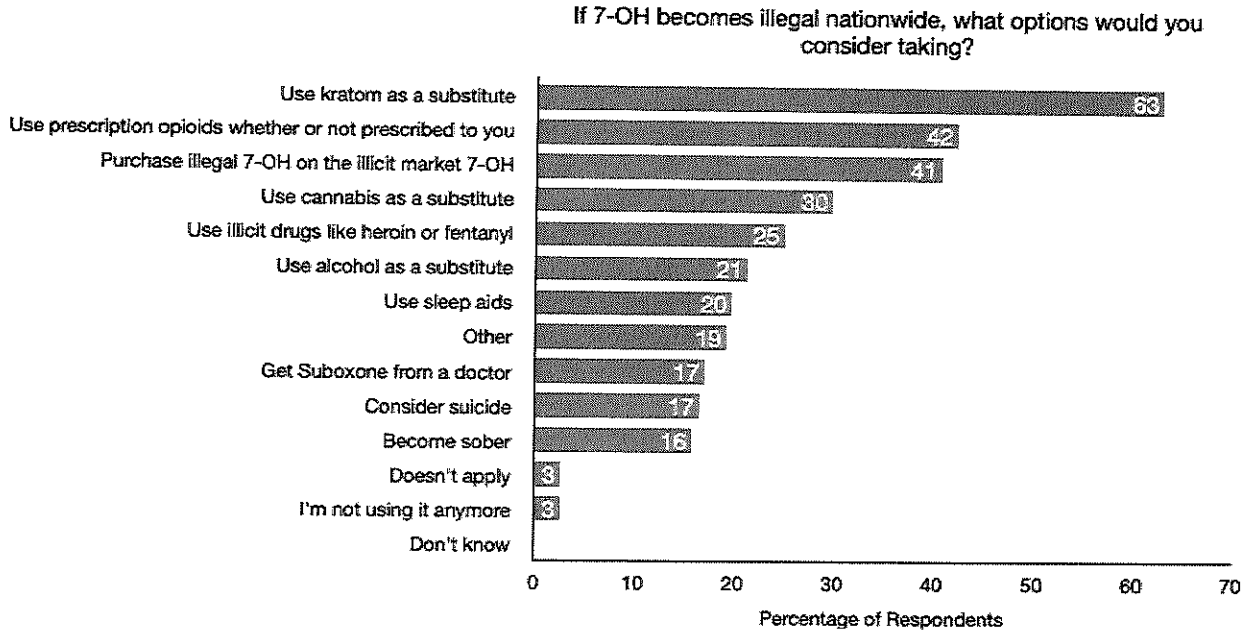
7-hydroxymitragynine (7-OH) is not an immediate precursor to any substance controlled under federal law. It is not used to manufacture heroin, fentanyl, or any other drug listed in the Controlled Substances Act (CSA), and it does not function as a chemical intermediate or feedstock in the production of any scheduled substance.

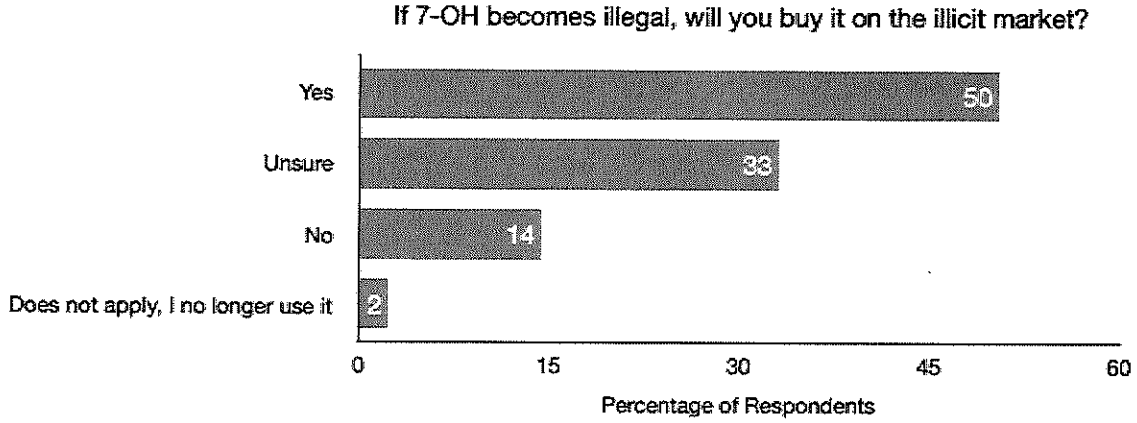
Fiscal Impact of Scheduling

The fiscal consequences of this approach are substantial. Removing access to 7-OH for more than 1 million Americans risks driving increased opioid overdoses, higher emergency room utilization, expanded demand for addiction treatment, greater Medicaid expenditures, lost workforce participation, and increased disability and unemployment. There are also severe human costs with direct fiscal impacts, including elevated suicide risk among individuals who lose effective pain or withdrawal management.

In fact, a recent survey of 1521 7-OH consumers completed in October 2025 found **17% of 7-OH consumers would consider suicide if 7-OH was banned, 25% said they would use illicit drugs like heroin or fentanyl, and the majority said they would buy 7-OH from the illicit market.** The downstream costs of overdose care, long-term addiction treatment, and

preventable death far exceed any speculative benefit of prohibition and will ultimately be borne by taxpayers.





(Ross, 2026)

Scheduling Recommendation

Based on the totality of the evidence across all eight factors, 7-hydroxymitragynine (7-OH) does not meet the statutory or scientific criteria for placement in Schedule I. The record does not demonstrate a high or uncontrollable abuse potential, severe or widespread public health harm,

or dependence liability comparable to Schedule I opioids. Instead, the evidence shows a pharmacologically constrained compound with dose- and formulation-dependent risks, substantial uncertainty in the human data, documented misstatements in secondary sources, and a long history of widespread exposure without population-level harm.

A Schedule 1 ban of 7-OH is the most punitive regulatory outcome at a time when the evidence base is still evolving. Schedule 1 is not a temporary measure; it is a rigid framework that restricts research, eliminates regulatory flexibility, and makes policy correction difficult even if assumptions prove wrong. A no vote does not endorse unregulated access. It preserves the Legislature's ability to evaluate evidence, distinguish between product types, and pursue solutions that genuinely improve public safety. Exercising restraint here reflects responsible governance and ensures that federal and state government do not impose irreversible criminal penalties without clear, compelling, and quantitative evidence that such action is necessary.

This conclusion is reinforced by epidemiologic evidence showing that state-level kratom bans have been associated with increased opioid overdose mortality rather than reductions in harm (Blair, 2022). This risk is compounded by evidence that the Controlled Substances Act (CSA) itself is poorly aligned with expert assessments of drug harms, making Schedule I placement an unreliable and often counterproductive public health tool (Broman et al., 2025). For these reasons, scheduling or banning 7-OH is not recommended.

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2/10/26

Dear Members of the Kansas Legislature,

I am writing to share my personal experience in regard to Kansas HB2765 and SB497.

I suffer from significant cervical spine issues involving the C5–C7 vertebrae, including bone spurs, herniation, and spinal narrowing. The chronic pain and limited mobility associated with this condition have greatly affected my daily life. There was a period of time when the pain left me discouraged, inactive, and unable to fully participate in normal activities. I love gardening and working on landscaping, and there were several years I was not able to do these things for more than a short period of time.

Since using 7-hydroxymitragynine (7-OH), I have experienced meaningful improvement in my quality of life. It has provided pain relief that allows me to move more freely and function more normally. In addition to reducing discomfort, it has helped restore the energy and motivation that chronic pain had taken from me. I was previously unable to travel long distances or sit in a vehicle for extended periods, which limited time with family. I am now able to travel farther and participate more fully in life.

Because my pain is better managed, I have been able to begin exercising again. I am more active, more engaged, and able to enjoy time with my husband, including outings and adventures I previously would have avoided due to pain. Simply put, I feel like I can function again. Living with chronic pain takes a serious toll on mental and emotional well-being, and losing the ability to take part in normal life can be devastating.

I respectfully ask that this product not be removed entirely from legal purchase. Instead, I encourage lawmakers to consider reasonable regulations such as age restrictions, limits on where it can be sold, and labeling requirements. These types of measures can promote safety and consumer awareness while still allowing responsible adults access.

I am concerned that making 7-OH a controlled substance could unintentionally push people toward unregulated, illicit sources as they try to manage pain and remain functional. Unregulated products carry far greater risks due to unknown ingredients, contamination, and lack of quality control. I also worry that removing access for people who rely on it for daily functioning could contribute to worsening physical and mental health outcomes for some individuals already struggling with chronic pain.

I understand that safety is important, and I support thoughtful oversight. I simply ask that decisions consider the real-life impact on people like me whose quality of life has improved significantly.

Thank you for your time and for considering my perspective as you evaluate HB2765 and SB497.

Sincerely,
Carrie Scott

Dear Senate Public Health and Welfare Committee,

My name is Venus Usher from New Castle, Delaware. I am writing in strong opposition to SB 497.

This bill would criminalize kratom, and I cannot overstate how devastating that would be for people like me.

For years I was prescribed opioids for severe pain. They controlled my life. When that stopped, I was placed on Suboxone. Suboxone destroyed my teeth and caused long term damage that I am still dealing with today. I even spent 10 days in rehab after a week in the hospital, that's where they sent me. That 17 years of my life was humiliating, painful, and isolating.

Plain leaf kratom gave me my life back 9 years ago.

Because of kratom, I am no longer trapped in that cycle. My pain is manageable. My mind is clear. My family finally has hope again. For the first time in years, we've been able to talk about traveling and do normal things together without fear of prescriptions being cut off or withdrawals controlling our schedule.

If Kansas schedules kratom as a Schedule I substance, you are not protecting people like me in your state. You are pushing us back toward opioids or the illicit market. That is not public health. That is harm.

Please do not ban a plant that has allowed so many of us to step away from far more dangerous substances. Regulation and safety standards make sense. Criminalization does not. You are hearing from people all over the United States because many consumers do not realize these bans are moving forward until it is too late. Most people are not watching legislative calendars every day. They will simply go to purchase their plain leaf kratom, as they have responsibly for years, and suddenly find it gone. Laws like this move quietly, but the impact on real families is immediate and life-altering.

I respectfully urge you to vote no on SB 497.

Thank you for your time and consideration.

Sincerely,
Venus Usher
New Castle, Delaware

Good morning im writing a submission for why kratom should be kept legal for February 16ths kratom bill proposal, This safe plant has helped change my life, it got me off of prescribed Adderall for ADHD, the Adderall was making me a zombie, but the kratom gave me my life back, this is not a problem, this is a solution to a problem, the opiate epidemic, this safe plant is not something we should criminalize, especially when it legitimately helps people and dosent cause deaths,

is there anything I can sign or do to petition against this up coming kratom bill??

Seth Wikoff

To the Members of the Kansas State Legislative Committee,

I am writing to respectfully oppose any proposal that would impose a blanket ban on kratom in the State of Kansas. I do so as a licensed pharmacist and healthcare professional with formal training in pharmacology, therapeutics, and medication safety.

When used responsibly and at appropriate dosages, kratom has demonstrated meaningful physical and psychological benefits for many individuals. It is commonly used by adults for pain management, mood support, and as an alternative to more dangerous substances, including opioids. For some Kansas residents, kratom represents a harm-reduction tool rather than a public health threat.

That said, I acknowledge—and agree—that certain **synthetic, highly concentrated, or adulterated kratom products warrant closer regulatory review**. Products that are chemically altered, misleadingly labeled, or marketed irresponsibly should be scrutinized to ensure consumer safety. However, these concerns do not justify a sweeping prohibition of all kratom products.

A blanket ban would disproportionately harm law-abiding Kansas residents who use kratom responsibly and would likely drive use into unregulated markets, increasing rather than reducing public health risks. History has repeatedly shown that prohibition often eliminates quality control, transparency, and consumer protections—outcomes that run counter to public safety goals.

The State of Kansas does have a legitimate role in protecting residents from unsafe products. However, that role should be exercised through **measured, evidence-based regulation**, not overreaching bans that limit personal autonomy and burden responsible consumers. Policies such as age restrictions, product labeling standards, purity testing, and restrictions on synthetic derivatives would better balance safety with individual choice.

As a healthcare professional, I strongly encourage the legislature to pursue thoughtful regulation rather than prohibition and to leave informed decision-making in the hands of Kansas consumers whenever possible.

Thank you for your time, consideration, and commitment to evidence-based public policy.

Respectfully,

Marc Wilson PharmD

Good afternoon my name is Brandon Zoeller. I am the owner of Cbd American Shaman in Lawrence Kansas. I have three part-time employees and I have been in business for nearly 8 I am a member of the Chamber of Commerce in Lawrence as well as a contributing member of the Lawrence community. We have participated in several fundraisers to help our local police department purchase bulletproof, canine vests along with donations to our local humane shelter with Cbd dog treats to help with Fourth of July week to help with shelter pets.We do not sell minors. We do not market our products to underage people We believe in safeguard rails for our industry 21 and older to purchase products child proof Containers third-party lab testing American made Hemp American made manufacturing. We are opponents of SB497 to turn Kratom and Delta eight products into a controlled one substance in Kansas along the same level as heroin, cocaine and fentanyl. Our average customer is over 40+ years old they are looking for alternatives to alcohol and prescription medication to ease their aches and pains, or to simply get a quality night of sleep. History tells us that restricting Americans freedom of choice and invoking prohibition has never worked in our State or country. It results in negative side effects usually leading to criminal activity. We believe that this is a very shortsighted attempt to hamper our industry and offering quality products that consumers desire in Kansas.

Thank you so much for considering letting me give testimonial on Monday, February 16 at 8:30 AM

Sincerely, Brandon Zoeller Cbd, American Shaman Lawrence, KS 785-550-7483

Hi. I am just writing to help prevent a ban on Kratom . I am a disabled Veteran with PTSD and my wife got me to take this stuff 7 years ago. I find life very hard sometimes and am unable to calm down. I start scanning and scanning and scanning, cannot sleep and I am scared sometimes , stress doesn't help. I take zoloft, and somedays it does enough, and somedays it doesnt.This stuff helps me chill out without having to get a drink beer or reach for a bottle of pills. I dont wanna take xanax everyday, I dont wanna drink to chill out and I do use medicinal THC sometimes, but it makes me even more on edge sometimes, so I feel worse. I have only ever used the powder stuff and that's all I plan on ever using. If I take too much, I puke, then I drink water. There is a "ceiling " effect so if you take too much you vomit, that's it. I have used it quite a few times in my life and I just feel nauseous and have to drink some water, that's it. I also have back pain from an old sports injury, and it helps that too. My wife uses it for her crushed sciatica pain because she had a spinal fusion surgery, they left a bone shard in her spine, then had to get a laminectomy to remove it. She suffers every single day of her life and doesnt wanna take pain killers, so she drinks a little kratom tea. If she wasn't able to get the stuff she probably wouldn't be here. Some days she can get away with taking a bunch of ibuprofen but some days she cant and somedays she doesnt get out of bed. If you would make this stuff unobtainable you would not only make her suffer but you would make a disabled Army veteran that served The United States Of America suffer mentally and physically. I would also have to watch her suffer and that would make my mental health suffer because military people find it very hard not being able to help their loved ones. I think you should make it so that you have to be at least 18 years old, or 21 like alcohol and THC stuff, in order to buy it. You should also only sell powder. I don't know, nor have I ever tried anything other than the kratom plant leaf.

Opposition to SB 497: Adding kratom and delta-8 THC to schedule I of the uniform controlled substances act.

As a migraine sufferer for over 20 years, I have worked with primary care physicians, neurologists, and headache clinics to treat my symptoms. This treatment has included multiple prescribed medications, as well as behavioral therapy such as meditation and relaxation techniques. In addition to migraines, I have been diagnosed with depression and general anxiety disorder for the same duration. Medication and therapy have been partially effective.

About 7 years ago, I discovered kratom. As a botanical supplement, kratom has been incredibly effective in helping my manage my migraine symptoms - to the degree that I no longer take prescription migraine medication. Likewise, kratom has been, by far, the most effective aid to manage my depression. Therefore, kratom, as a biological supplement, is majorly instrumental in my personal management of these conditions.

An accidental consequence of my kratom consumption is an almost complete cessation of alcohol consumption. In the past, I have extremely enjoyed alcohol for relaxation, recreation, and distraction from depression symptoms. Without trying to, I have decreased my alcohol consumption by at least 90%. The âurgeâ is absent, and the effect of consumption seems less conducive to habitual use.

As a working parent of 3 children, I am subject to typical challenges with fatigue and low energy. Kratom is hugely effective in management of these issues. Kratom also assists with motivation when depression, migraines, fatigue, childcare, and career demands leave me drained and dispirited.

Now that I have shared my experiences regarding my personal use of kratom and its impact on my life, it should be apparent why I oppose the threatened ban. This supplement has demonstrably improved my well being and enjoyment of life. If I put myself into the shoes of a KS resident, I know that a ban would see those personal life improvements vanish. I see this ban as a very real threat to KS residentsâ and visitorsâ rights to pursue happiness. I fail to see a justification of this ban from a harm reduction perspective.

Should this measure to ban kratom (natural leaf) move forward, I will cease all travel and tourism activities in KS. My tourism dollars will no longer contribute to KSâs economy. I am one person, with one family, but I know I am not alone in these sentiments. Should a ban move forward, I will endeavor to avoid travel to or through KS altogether.

While a kratom ban in KS would be personally devastating for me as a visitor, I know that it will literally contribute to the deaths of KS consumers leveraging kratom as a tool to manage opioid addiction. Kratom supports the management of opioid withdrawal without the dangers of overdose and respiratory depression associated with other opioids. I donât foresee black market kratom as widely leveraged. Kratom isnât very strong compared to illegal street opioids. Who will risk selling or buying kratom (if illegal) if so many more powerful illegal opioids are already available?

Stripped of kratom, a tool used to safely manage addiction to hard opioids, addicts will simply switch to options like street heroin, with all the overdose threats in full effect. Fentanyl lacing already causes so many overdoses, and kratom orphans, deprived of their legal botanical tool, will be thrust into the eager arms of the street drug community. Opioid overdose deaths will increase as a direct consequence of a kratom ban.

A kratom ban seems to offer little in the way of benefits or harm reduction, and a great deal of detriments to individual rights to choose what substances to consume - rights which are currently codified for similar substances such as alcohol, nicotine, caffeine, and, increasingly, marijuana. Careful consideration of the enormous potential harm to be wrought by a kratom ban is crucial. Any reasonable and unprejudiced individual who evaluates the actual evidence around kratom (as opposed to anti-kratom propaganda disseminated by those with questionable motives and conflicting interests) will recognize that a banâs absence of harm reduction, coupled with the detrimental (even fatal) impact introduced by such a ban demolishes the validity of the argument for kratom prohibition.

Please oppose SB 497: Adding kratom and delta-8 THC to schedule I of the uniform controlled substances act.