September 10, 2025

Senate Chair William J. Driscoll Jr.

House Chair Marjorie C. Decker

Joint Committee on Public Health

24 Beacon St., Room 130

Boston, MA 02133

Dear Chair Driscoll, Chair Decker, and Members of the Joint Committee:

My name is Jeffrey A. Singer. I am a Senior Fellow in Health Policy Studies at the Cato Institute. I am also a medical doctor specializing in general surgery and have been practicing that specialty in Phoenix, Arizona, for over 40 years. The Cato Institute is a 501(c)(3) non-partisan, non-profit, tax-exempt educational foundation dedicated to the principles of individual liberty, limited government, free markets, and peace. Cato scholars conduct independent research on a wide range of policy issues. To maintain its independence, the Cato Institute accepts no government funding. Cato receives approximately 80 percent of its funding through tax-deductible contributions from individuals. The remainder of its support comes from foundations, corporations, and the sale of books and other publications. The Cato Institute does not take positions on legislation.

I appreciate the opportunity to share my thoughts on **S. 1609** with the Committee. This bill would regulate the production and restrict the sale of kratom and ban the sale of one of kratom's active ingredients, 7-hydroxymitragynine (7-OH), as a standalone product.

For centuries, communities in Southeast Asia have prepared teas from the leaves of *Mitragyna speciosa*—commonly referred to as kratom—for relief of pain and anxiety. The plant's primary active compounds, mitragynine and the more potent 7-hydroxymitragynine (7-OH), interact with opioid receptors in the brain. In the

United States today, people widely use kratom, often as a substitute for prescription opioids or to mitigate symptoms of withdrawal. They obtain it in a variety of forms, including teas, capsules, powders, concentrated extracts, and increasingly, as 7-OH products sold through convenience stores, vape shops, smoke shops, and online platforms.

In 2016, the Drug Enforcement Administration proposed classifying kratom as a Schedule I substance.[1] However, the agency withdrew its proposal after strong opposition from patients and researchers.[2] Like alcohol, cannabis, nicotine, and opioids, people can develop dependence on kratom or 7-OH and may go through withdrawal or what is medically recognized as kratom use disorder. Since 7-OH is much more potent than kratom, many consumers now seek semi-synthetic 7-OH through easily accessible stores and online sources.

While kratom and 7-OH have opioid-like properties and can cause respiratory depression, fatal overdoses are very rare.[3] In the few cases where coroners found kratom or 7-OH in overdose deaths, other substances were almost always involved. Nearly two-thirds of these cases also involved fentanyl, about one-third involved heroin, and just under one-fifth involved prescription opioids or cocaine.[4] Additionally, 80 percent of the decedents had a documented history of substance misuse, and 90 percent were not receiving medical care for pain at the time of death.

When state governments enact prohibitions on kratom or 7-OH, individuals can often obtain the products by traveling to jurisdictions where they remain legal. In the case of Massachusetts, which borders five states, it is unrealistic to expect limitations on kratom sales and a ban on 7-OH to have any effect.

Consider the commonwealth's recent experience with a menthol cigarette ban. On June 1, 2020, Massachusetts became the first state to implement a ban on flavored tobacco products, including menthol cigarettes. A 2023 analysis by the Reason Foundation found "millions of additional cigarette sales in the six-state region of Massachusetts and its bordering states." These bans "primarily sent buyers to other states and illicit markets."[5]

There is no reason to expect that doing the same thing again, only this time regarding kratom and 7-OH, will produce a different result.

A federal ban would pose an even greater public health risk. It would drive the market entirely underground. Drug trafficking organizations already maintain robust distribution networks for heroin, fentanyl, cocaine, and methamphetamine. Having

lost significant revenue due to marijuana legalization, these groups would likely welcome the opportunity to expand into supplying 7-OH.[6]

Just as Massachusetts' menthol ban shifted purchases across state lines without reducing overall consumption, a similar ban on kratom or 7-OH would only divert purchases elsewhere or into illicit markets.

Prohibition on the state or national level will not eliminate consumer demand; it will only heighten the risks associated with use. As we have witnessed with counterfeit prescription opioids laced with fentanyl, illicit markets cannot guarantee product strength, purity, or authenticity.[7] Cartels that would distribute 7-OH are the same organizations mixing fentanyl, methamphetamine, and cocaine into other substances, increasing the likelihood of contamination and polydrug exposure. Public health outcomes will not improve by forcing kratom or 7-OH users into illicit markets.

Instead, policymakers should prioritize evidence-based strategies: providing accurate information about risks, expanding access to harm reduction tools, and ensuring treatment options for those with substance use disorders.

For example, naloxone—the well-known antidote to opioid overdose—is also effective in reversing overdoses related to kratom or 7-OH. The Food and Drug Administration authorized over-the-counter access to intranasal naloxone in 2023, but the less expensive injectable form should also be available, as has been successfully implemented in Italy and Australia.[8] Meanwhile, Massachusetts lawmakers have taken steps to make injectable naloxone more accessible to patients by allowing pharmacists to dispense it with a physician's standing order. The state's federal representatives should pursue legislation requiring the FDA to permit over-the-counter injectable naloxone.

Similarly, policymakers should increase access to methadone treatment by allowing clinicians to start and oversee therapy in their offices, as is common in countries like Australia, Canada, and the United Kingdom. This approach has been safe and effective for over fifty years.[9] Boston-area pilot programs where primary care clinicians prescribe methadone have demonstrated success.[10] The state's federal representatives should advocate for legislation that permits clinicians to prescribe methadone in their clinics for people with opioid use disorder, as well as, potentially, kratom use disorder.

Public education programs, along with sensible regulations, such as age restrictions, public use restrictions, or restrictions on operating vehicles while under the influence, can reduce harms and protect public health.

However, if kratom sales are severely curtailed and 7-OH is consigned to prohibition, they will become new commodities for drug cartels to market.

Respectfully submitted,

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Cato Institute

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[1] https://www.dea.gov/press-releases/2016/08/30/dea-announces-intent-schedule-kratom
[2] https://www.uspharmacist.com/article/the-dea-changes-its-mind-on-kratom
[3] https://nida.nih.gov/research-topics/kratom
[4] https://www.cdc.gov/mmwr/volumes/68/wr/mm6814a2.htm#:~:text=Data%20on%2027%2C338%20overdose%20deaths,%25%20of%20kratom%2Dinvolved%20decedents.
[5] https://reason.org/commentary/the-effect-of-menthol-bans-on-cigarette-sales-evidence-from-massachusetts/
[6] https://time.com/3801889/us-legalization-marijuana-trade/ and https://insightcrime.org/investigations/marijuana-fades-sinaloa-organized-crime/
[7] https://www.nytimes.com/2022/05/19/health/pills-fentanyl-social-media.html
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[10] https://www.nejm.org/doi/full/10.1056/NEJMp1803982