F.A.C.E. ADDICTION MARYLAND

FAMILY ADVOCATES COALITION TO END ADDICTION IN MARYLAND

Testimony to Support
HB 1229:
Public Health – Kratom Consumer Protection Act

Health and Government Operations Committee
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As I am sure you are already aware, Maryland is ranked 5th in the nation for overdose deaths and 80% are opioid-related deaths.

I would like to talk about one solution for problematic opioid dependence, and that is methadone –the gold standard, according to the very well-funded methadone lobby.

There are 30 plus studies that show 20% to 70% depending on the study and where it was done, that show that those enrolled in methadone treatment are using other drugs –most notably heroin (40% to 60%), And this mirrors what we hear from consumers of treatment services. According to nearly 20 studies, methadone maintenance patients are also at a higher risk of death from overdose, even when under the care of a provider, and this statistic also mirrors what users tell us.

We Know, Our Children Know, What Works –Scientists Know What Works –But it is becoming evidently clear to me the more I come to Annapolis –That We Allow What Doesn't Work.

One has to ask themselves --WHY?

Well, we allow what doesn't work because it is profitable. Last time I checked the average dose of methadone wholesale cost $1, Medicaid pays a clinic $80 per week per patient AND the average patient spends an average of 6 minutes per day in so-called "treatment".

This is what our regulated FDA-sponsored pharma-backed system offers us.

We have chosen profits over lives. It costs billions per year for a drug to become approved by the FDA.

According to the American Kratom Association, there are more than 180,000 Marylanders using kratom and one third are using it as an opioid replacement therapy –that's more than 60,000 Marylanders. And yet, no one has died from using kratom.

IT IS HIGH TIME THAT EVIDENCE-BASED SCIENTIFICALLY SUPPORTED ALTERNATIVE THERAPIES FOR OPIOID ADDICTION WERE ACKNOWLEDGED, ACCEPTED, AND CONSUMER-PROTECTED!

In CONCLUSION…

You have an obligation to your constituents –who are trapped in the nightmare of addiction to find a way out. I implore you to do the research, look at the science, understand the impact that this bill will have on your most vulnerable constituents. If you are willing to look at the science, and you are willing to choose people's lives over profits, then you can only make one choice when it comes time to vote –and that is to support HB 1229.

Kratom – Science

Kratom is a tree native to Southeast Asia –particularly, Thailand, Malaysia, Myanmar, Indonesia, and Borneo, that produces a leaf that is used in these countries as a natural analgesic and treatment for opiate addiction. Kratom leaves have been traditionally used by the people of Southeast Asia for their medicinal properties. Their use as an aid for opiate withdrawal and a cure for opiate dependence was first reported by a Dutch settler in 1897.

Pharmacologically, Kratom contains over 25 alkaloids (a group of naturally occurring chemical compounds), some of which act as opioid receptor agonists –able to impact the brain's opioid receptors and effect mood, pain levels, and anxiety. Mitragynine, the alkaloid found in Kratom that is chiefly responsible for impacting the brain's receptors in this manner, has been used for methadone detox in New Zealand.

Although it has been reported to produce a mildly euphoric effect, Kratom is not an opioid and does not produce a 'high' like opioids. It is one of the only plants, not derived from the opium poppy, which is capable of acting on the opioid receptors in the brain to counteract pain. The pain relief produced from ingesting the Kratom leaves –in the form of chewing the leaf or mixing the dried leaf powder in drinks or food, has been compared to using other opioid analgesics, including opium, morphine, or OxyContin.

Interestingly, although Kratom has a similar action as many opioid pain medications, it is not nearly as addictive. It also has a unique characteristic in that a low to moderate dose will usually be stimulating, while a high dose is sedating. This is apparently because the active alkaloids have both stimulant and sedative effects.

Those who use Kratom to self-detox, report that they are able to switch directly from opiates to Kratom, and then gradually reduce their Kratom use without suffering the challenging effects of opioid withdrawal. They report decreased muscle pain; reduced cravings; decreased depression and anxiety; less fatigue and lethargy; reduction or elimination of chills, sweats, shakes, and restless legs syndrome; normal sleep patterns; elevated levels of motivation; and increased feelings of wellness and happiness. Depending on their dose, they describe their experience as either energizing or relaxing.

Proponents agree that it is far less powerful and much less addictive than the prescription opioids –methadone and buprenorphine, that are currently used for opioid detox or maintenance.

KRATOM

BENEFITS

- Used to substitute for methadone or buprenorphine due to its lower potential for fatality (Boyer et al, 2008; Fluyau and Revadigar, 2017; Trakulsrichai et al, 2015) and its capacity to manage opioid withdrawal symptoms (Boyer et al, 2007; Cinosi, 2015; Feng et al, 2017; Hassan, 2013; Ismail, 2017; Prozialeck, 2016; Swogger, 2015; Vicknasingam, 2010)
- Less toxic than methadone as a harm reduction measure, and less harmful than many prescription opioids as a pain reliever (Prozialeck, 2016) –is less physically dependent, and has no correlation with respiratory depression or constipation (Prozialeck, 2016; Varadi et al, 2016)
- Used as an anti-depressant to elevate mood and alleviate depression and anxiety (Cinosi, 2015; Prozialeck, 2016; Swogger, 2015)
- Reduces fatigue (Fluyau and Revadigar, 2017)
- Does not impair social functioning despite dependency (Cinosi, 2015; Singh et al, 2015)

RISKS

- Although milder than opiate withdrawal, kratom is associated with some dependence, craving and withdrawal symptoms (McWhirter and Morris, 2010; Cinosi, 2015; Singh, 2014; Suwanlert, 1975; Trakulsrichai et al, 2015; Yusoff, 2016)
- Side effects associated with short term use include dry mouth, nausea, vomiting, weight loss, constipation, involuntary eye movements, tremors, muscle spasms / aches, insomnia, temporary erectile dysfunction, itching, sweating, watery eyes/nose, hot flashes, fever, diarrhea, or high blood pressure. Psychological withdrawal symptoms commonly reported are irritability, restlessness, tension, anger, sadness, nervousness, hostility, aggression, or impaired cognition (Apryani, 2010; Cinosi, 2015, 2017; Fluyau and Revadigar, 2017; Trakulsrichai et al, 2015)
- Side effects associated with chronic use include those associated with short term use (above), plus tremors, eventual anorexia, hyperpigmentation, and hair loss. Psychological withdrawal symptoms may include psychosis, delusions, and hallucination (Cinosi, 2015; Feng et al, 2017; Singh, 2014; Suwanlert, 1975; Trakulsrichai et al, 2015)
- High doses may cause death, arrhythmia, seizures or coma in rare instances, particularly when used in conjunction with other drugs (Anwar, 2016; Cinosi, 2015; Nelsen, 2010; Fluyau and Revadigar, 2017; Karinen, 2014; Trakulsrichai, 2013), as well as liver toxicity (Drago et al, 2017; Kapp et al, 2011)