Kratom Regulation in North Dakota: A Clinical Perspective

Testimony Regarding HB 1628
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Thank you for the opportunity to provide a clinical perspective on HB 1628.

I am a psychiatric and addiction nurse practitioner and founder of The Ridge Treatment & Reentry Center, where we provide walk-in psychiatric and addiction care as well as residential and outpatient substance use treatment.

I want to begin by saying that I support the intent of this legislation. I strongly support removing synthetic, enhanced, and highly concentrated kratom products from the market. I also support age restrictions, labeling requirements, consumer education, and stronger oversight.

However, I am not comfortable supporting HB 1628 as currently written because I am not convinced we have adequately defined what we mean by “natural” or botanical kratom.

The distinction between natural and synthetic kratom sounds straightforward, but I don't believe it is that simple in the commercial marketplace. When most people hear “natural kratom,” they probably picture a dried or powdered leaf.

HB 1628, however, defines kratom to include not only the leaf but also material extracted from kratom leaf using a food-grade solvent, provided the 7-hydroxymitragynine concentration remains below the threshold established in the bill.

That concerns me.

A product can originate from a plant and still be extracted, concentrated, reformulated, or otherwise manipulated before it reaches the consumer. The important question isn't simply whether a product started as a leaf. It is what happened to that leaf before the product reached the consumer.

I worry that by creating a legal category of “natural kratom,” we may unintentionally give consumers a sense of safety that the term does not necessarily deserve.

At The Ridge, we see patients who have developed tolerance, escalating use, physical dependence, and withdrawal from kratom (both natural and synthetic).

I have treated withdrawal from virtually every substance we encounter in addiction medicine, and kratom withdrawal can be among the more complicated withdrawals we manage.

At the same time, there is very little established clinical guidance for treating it. We do not have a standardized, evidence-based protocol specifically for kratom withdrawal, and many healthcare providers have little experience managing it.

I am also concerned about how casually these products have been marketed.

I have treated patients with no previous addiction or drug-use history who walked into a vape shop looking for something such as cannabis gummies and were instead encouraged to try kratom for sleep or anxiety. They had no meaningful understanding that they could develop physical dependence or experience withdrawal when they stopped.

Consumers should understand that risk before they purchase the product—not for the first time when they are sitting in our clinic asking us to help them get off of it.

Rather than defining a broad category of botanical kratom and assuming everything within that category is appropriate for retail sale, I would recommend a narrower approach.

Initially, I would limit legal products to minimally processed kratom leaf, such as dried or powdered leaf and products containing that leaf.

I would prohibit or separately regulate extracts, concentrates, enhanced products, isolated alkaloids, and products in which the naturally occurring alkaloid profile has been intentionally altered.

I would also require:

- Independent, batch-specific laboratory testing before a product can be sold;
- Verification of mitragynine and 7-OH concentrations rather than relying solely on manufacturer labeling;
- Testing for contaminants, adulterants, residual solvents, and other substances;
- A certificate of analysis accessible to consumers, ideally through a QR code;
- Restriction to adults 21 and older;
- A clear warning that kratom may cause tolerance, physical dependence, addiction, and withdrawal; and
- Prohibition of unsubstantiated medical claims or retail recommendations that kratom treats anxiety, insomnia, pain, addiction, or opioid withdrawal.

I would also use the public-health education component of this legislation to educate healthcare providers—not just consumers—about recognizing and treating kratom

dependence and withdrawal. That is especially important in rural North Dakota, where access to addiction-trained providers is already limited.

Given what I see clinically, the obvious question is why I would not support an immediate ban on all kratom.

My concern is what happens to the people who are already physically dependent. A ban does not eliminate their dependence. It eliminates their access to the substance on which they are dependent.

We currently have limited clinical guidance for managing kratom withdrawal and relatively few providers experienced in treating it, particularly in rural communities. I worry about what people may turn to when faced with withdrawal and no realistic access to treatment.

For that reason, I am hesitant to support an abrupt prohibition of all botanical kratom without simultaneously having a plan to identify and treat the people who are already dependent.

I don't think our choices have to be either allowing the current kratom marketplace to continue or banning everything. There is a third option. We can dramatically narrow what is permitted while requiring much stronger evidence that the products remaining on the market are actually what they claim to be.

I support banning synthetic, enhanced, and manipulated products. I support restricting kratom to adults 21 and older. I support strong warnings, education, independent testing, and enforcement.

But I would be cautious about creating a broad legal category of “natural kratom” until we can clearly define what that means and reliably verify what is actually in those products.

If we are going to allow botanical kratom to remain available, I believe we should initially limit that availability to minimally processed leaf, build a rigorous testing and regulatory system, and improve our capacity to treat the people who have already developed dependence. We can always broaden that framework later as the science and our regulatory capacity improve.

It will be much harder to put the genie back in the bottle if we create a legal commercial market that turns out to be broader than we intended.

Thank you for the opportunity to provide a clinical perspective.