

Testimony H.783, Brenda Siegel, Newfane.

I do not support h.783 as drafted. I would suggest that the exemption from landlord tenant law be removed from the bill until such time as there is the ability to understand and implement what would be a proper balance of landlord (Recovery Home Operators) and Tenant (Residents) rights and protections. This gives the opportunity for the zoning and certification to pass this session and also the appropriate attention to be paid to the balance of landlord and tenant rights when giving an exemption with such strong consequences. I want to be clear that this opposition is not because the bill does not go far enough, but, rather, because the bill itself poses a serious risk to those in recovery and the destabilization drafted into law will cause Re Incarceration, Homelessness and Death. I don't say this to be alarmist, but, rather because that is the nature and reality of the effect of destabilization in this population.

As currently drafted, this bill codifies into law a practice that caused one of my nephews strongest re occurrences. I had to ask myself, would Kaya still be here, if what you are asking to codify into law had not happened to him. I had to be honest with myself, that he might. This means that I understand the risk and understanding the risk means that I must oppose this bill. I went back and looked over the research, as well as stories that I had heard when deciding what would be the best practice for this population and based on what I understand, the most up to date science and what we are learning about the effects of destabilization, I believe this bill is not a good first step, it is a step backwards. I worked with the stakeholders group all summer and fall to come to an agreement and we did. The bill as introduced represented that agreement. While it was not perfect, it recommended a strong compromise between a diverse stakeholders group. I would have been one of the strongest supporters and champions of that bill. I do not come lightly to a decision that reverses my position. This current draft does not come close to the spirit of that agreement.

First, I believe as drafted it is discriminatory against a class of individuals who according to the dsm have a disability. However, that alone is not where my concern lies. This bill is dangerous and will cause harm, it is not the direction that we want to be heading on the treatment and recovery of folks with substance use disorder. It will not save lives, and I say this not for effect, but, because it is the reality of the disease. The risks of this bill will include re incarceration, destabilization, loss of medications and death for some.

While I would support a well researched, strong bill that provides the strongest system for recovery homes in the country, I simply can not support this. It is just too dangerous.

Again, I suggest that the exemption be removed from this bill and the bill focus for this session on zoning and certification. This will give time to discover the the nuances of this disease and then have the second look be by housing once the protections for landlord and tenant are both in balance. As currently drafted there is a loss of rights for tenants and no drafted protections or oversight. I see this as too big a risk to take with a population that is already vulnerable.

In Person Testimony on H.783:

The best model is one that does not remove people from their homes for choosing Buprenorphine over heroin.

The success rate of using buprenorphine to treat Opioid Use Disorder is extremely high with or without a prescription as compared to abstinence models. It is the gold standard of treatment in Opioid Use Disorder. Continuous access to Buprenorphine is important to remaining in recovery.

There are many factors that lead to folks choosing or having no choice but, to access Buprenorphine without a prescription: Here are some.

1. Lack of Transportation.
2. Homelessness.
3. Lack of Insurance.
4. Institutional Trauma.
5. Long commute to and from the "Hub".
6. Living in a county where there is not a HUB. Or a county where there are no or very few prescribers and thus they have reached the cap patients that they are allowed to treat with MAT.
7. Being removed from the program for missing an appointment or having a recurrence. In some parts of the state, folks are not allowed back on the program for up to thirty days or banned permanently, leaving them to either self medicate illegally or choose Heroin laced with fentanyl.
8. They tried an abstinence based model and it did not work because the success rate of that model is low . They are about to have a recurrence and they can choose street Buprenorphine or Heroin in that moment. If the ability to communicate has not been cut off one could in this situation after getting through that moment ask for help, but, if there is fear of removal, they most certainly will not try to access that help.
9. Not having a valid ID and not having the resources to access one.
10. Shame and stigma of admitting that they have the disease, not wanting to be listed in as someone with Opioid Use Disorder.
11. Having obligation with children or work that prevents you from accessing the hub in the time frame that it is open to access.
12. Severe Mental Illness or PTSD.

In each of these cases, the solution is NOT to remove people from the stability of a recovery home or not allow them in, but, rather to support them in finding a prescription. I find a position that says, we should remove these folks instead of support them in a safe and legal recovery to

cause unintentional harm, destabilization with the result being often re occurrence (relapse), reincarceration and death. All of this when just helping the tenant obtain a prescription would solve the problem.

Research shows that Non Prescribed Buprenorphine is an important and common pathway to recovery.:

1. Prior buprenorphine experience is associated with office-based buprenorphine treatment outcomes.

<https://www.ncbi.nlm.nih.gov/pubmed/23722632/>

2. Excerpt: Testimony on H. 162 Before the House Committee on Human Services House of Representatives, State of Vermont April 30, 2019 by Joshua M. Sharfstein, M.D. Professor of the Practice in Health Policy and Management Johns Hopkins Bloomberg School of Public Health Noa Krawczyk, 4th Year Doctoral Candidate Johns Hopkins Bloomberg School of Public Health

Evidence indicates that in areas with wide access to oxycodone, heroin, and other dangerous opioids, people use non-prescribed buprenorphine primarily to alleviate opioid withdrawal and to reduce cravings for opioids. For example:

- Two studies in Baltimore, published in 2009 and 2013, found more than 9 in 10 people who use non-prescribed buprenorphine did so for self-medication or to alleviate withdrawal. In one of the studies, only 2% of people reported using buprenorphine for euphoric effect; in the other study, none did.
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- A study in Cambridge, Massachusetts, published in 2010, found that the primary reasons for using non-prescribed buprenorphine among people presenting for care were for to alleviate withdrawal (72%) and reduce cravings (92%) and rarely for euphoria (4%). The researchers concluded “these data ... suggest that the use of illicit buprenorphine rarely represents an attempt to attain euphoria. Rather, illicit use is associated with attempted self-treatment of symptoms of opioid dependence, pain, and depression.”

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- A study in Providence, Rhode Island, published in 2018, found the most commonly reported motivation for using non-prescribed buprenorphine was to alleviate withdrawal (40%) and self-treatment of opioid use disorder (39%), much higher than reports of seeking euphoria (12%).

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Daniulaityte R, Falck R, Carlson RG. Illicit use of buprenorphine in a community sample of young adult non-medical users of pharmaceutical opioids. *Drug and Alcohol Dependence*. 2012 May 1;122(3):201-7.

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Gwin Mitchell S, Kelly SM, Brown BS, et al. Uses of diverted methadone and buprenorphine by opioid-addicted individuals in Baltimore, Maryland. *Am J Addict*. 2009 ; 18(5): 346–355.

11

Genberg BL, Gillespie M, Schuster CR, Johanson CE, Astemborski J, Kirk GD, Vlahov D, Mehta SH.

Prevalence and correlates of street-obtained buprenorphine use among current and former injectors in Baltimore,

MD. *Addict Behav*. 2013 Dec; 38(12)2868-73.

12

Schuman-Olivier Z, Albanese M, Nelson SE, et al. Self-treatment: illicit buprenorphine use by

opioid-dependent treatment seekers. *J Subst Abuse Treat*. 2010; 39(1):41–50.

13

Carroll JJ, Rich JD, Green TC. The More Things Change: Buprenorphine/naloxone diversion continues

while treatment remains inaccessible. *J Addict Med*. 2018 12(6): 459-465.

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As a participant in a qualitative study told researchers, “I just eat Suboxone ‘cause it doesn’t necessarily give me a buzz, but it helps with the mental state, you know, it helps me feel

regular and it’s not like I’m taking it to get high.”

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When people try non-prescribed buprenorphine to alleviate withdrawal or reduce cravings, evidence and experience indicates that they feel better and become more interested in

entering treatment and obtaining both a consistent supply of medication as well as other services.

In the aforementioned Baltimore study, nearly all participants who used non-prescribed buprenorphine were interested in receiving drug treatment. In the Rhode Island study, people who had sought buprenorphine treatment were also more likely to have used non-prescribed medication in the past.

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This effect has also been seen here in Vermont. When one of us visited Burlington in March, he heard from an emergency department physician at the University of Vermont that

people were asking for treatment with buprenorphine after trying non-prescribed buprenorphine on the street.

As a participant in a 2017 qualitative study stated, “I’ve taken Suboxone illegally, and I’ve found that I’ve done very, very well on it. So, I’m looking for a Suboxone provider.”

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Third, H.162 should lead to fewer people being arrested due to their addiction, resulting in fewer associated adverse consequences to their health and well-being.

Arrest and incarceration have harmful health impacts. These include the risk of physical and sexual assault, poor ventilation and nutrition, overcrowding, and stress from incarceration

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Daniulaitye R, Falck R, Carlson RG. Illicit use of buprenorphine in a community sample of young adult

non-medical users of pharmaceutical opioids. Drug and alcohol dependence. 2012 May 1;122(3):201-7.

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Genberg BL, Gillespie M, Schuster CR, Johanson CE, Astemborski J, Kirk GD, Vlahov D, Mehta SH.

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20

Carroll JJ, Rich JD, Green TC. The More Things Change: Buprenorphine/naloxone diversion continues

while treatment remains inaccessible. *J Addict Med.* 2018 12(6): 459-465.

17 Carroll JJ, Marshall BDL, Rich JD, Green TC. Exposure to fentanyl-contaminated heroin and overdose risk

among illicit opioid users in Rhode Island: A mixed methods study. *International Journal of Drug Policy.* 2017; 46: 136-145.

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National Research Council and Institute of Medicine. (2013). *Health and Incarceration: A Workshop*

Summary. A. Smith, Rapporteur. Committee on Law and Justice, Division of Behavioral and Social Sciences and

Education and Board on the Health of Select Populations, Institute of Medicine.

Washington, DC: The National

Academies Press.

<https://legislature.vermont.gov/Documents/2020/WorkGroups/House%20Human%20Services/Bills/H.162/Written%20Testimony/H.162~Joshua%20Sharfstein~John%20Hopkins%20Bloomberg%20School%20of%20Public%20Health~4-30-2019.pdf>

Finally, lives are lost with the removal from a recovery home, I am 100% aware of this because it happened to Kaya, this was not the time that he died. However, one of his absolute worst recurrence's happened at that time. We can not continue to operate as if penalization or destabilization somehow changes the outcome. It does not. Support in stability and recovery is what changes the outcome.

I have no way of knowing which of the times that our flawed system, which time that we were told by VDH the experience that we were having, we were not having. I don't know which time that the system failed and led to a recurrence would have been the time that Kaya survived. I

don't know if it was when Maple Leaf closed without warning leaving him without Buprenorphine and Lamictal, his bipolar medication. I don't know if it was one of the times he was removed from the MAT program at the Brattleboro Retreat because he did not have the transportation to get there or because he had valid and severe institutional trauma. I don't know if it would have been when a prescriber agreed to prescribe and then they never even made the first appointment. I don't know if it was when they hung five years over his head for breaking into my fathers house. I don't know which part of our flawed system, prevented Kaya from being here today to tell his own story. I don't know which part prevented me from ever hugging him or hearing his laugh again.

However, I do know the helplessness of sitting in a packed room listening to VDH tell us that there "are no delays in access to treatment" when we know that they are, with family member after family member of many folks standing up and saying "that was not our experience". I do know what it is like to know that my family members are purchasing illegal buprenorphine because when your child is dangling off of a cliff and the only option you have to save them is to access illegal buprenorphine, then you do that. I do know what it is like to be standing on the street listening to the words "Brenda, you are Kaya's emergency contact. I am calling you because he was found dead this morning." I know what it is like to have the morgue call and say "Brenda Siegel, we have your loved one here." I know what it is like to scream on the downtown street and fall to the ground in the town I have known and grown up in. I know what it is like to tell a mom, my sister in law, that her child died and listen to her scream. I know what it is like to stand next to my brothers grave and watch the coffin of his son, of a baby I once held, a child that I loved and was a huge part of his upbringing be lowered into the ground and know that my brother and his son with twenty years between them, did not receive the help that they needed, my brother for his mental illness and Kaya for his Mental illness and Opioid Use Disorder to survive and they and we tried really hard. We used absolutely every tool available to us. I know what it is like after he had a year in recovery, to watch OUR system, right here in Vermont derail a child in my family and to lose him two weeks later. I know what it is like to now live with the reality that I am never going to get him back and the pain of that being near impossible to contend with.

I spent much of the last two years talking to folks in active use, many experiencing homelessness, folks we don't hear from enough in this building. While anecdotal, it is important to note that there are huge barriers to treatment, including medically assisted treatment. This was my families experience as well.

That is why I am here today and why I worked with a stakeholders group on my own time and at my own expense, because I don't want anyone else ever to experience what I have and yet, in the time since Kaya Siegel died, roughly 200 more with 200 more families just like mine have lost their lives, in Vermont. Despite our effort and some good policy, the deaths have failed to go down.

I know almost everyone in this committee, outside of this committee. I believe that we all want the same thing. To get it we have to accept the realities of this disease. The reality of this disease is that people have many reasons to use illegal Buprenorphine and many of them are the fault of a flawed system. We all want people to move to a valid prescription and the most safe way to do that is to help them access that prescription not to remove them from their home and create another fire they have to put out.

This is the most responsible way to move forward and I hope that this committee will this provision as suggested by the advocates and dismas house that supports the reality of the disease. One more family is one more too many. We all agree that we want this to stop, we must use the best practice to ensure that happens. Support in accessing prescription IS that best method.