Brenda Siegel-Testimony H.225 Joint Session Senate Judiciary & Health and Welfare

For the record, I am Brenda Siegel from Newfane Vermont. Most of you first got to know me when I ran for Governor in 2018. What you may not know is that I made that decision on March 7th of 2018 and then on March 8th of 2018, the very next day, my nephew, Kaya Siegel, whose upbringing I was a big part of, died of an overdose, after a year in recovery. He was the son of my brother, Johnathon Siegel who died just over 20 years before him, also while using heroin. With 20 years between their deaths the support still did not exist to help them survive. Kaya had severe bi-polar and anxiety, as well as trauma. Trauma caused by him being abused while in an institution. Not only was it impossible for my large and involved family to find the adequate mental health supports that he needed in Vermont, but throughout the 7 years of his battle with Substance Use Disorder, the most prominent recurring theme was that he could not consistently access Burprenorphine, this life saving medication for folks with Opioid Use Disorder that we are discussing today.

What I am about to describe still exists today and I want to be clear about that. We as a family would search and search to find providers. Finding none, family members would help access buprenorphine illicitly, just to help him to not use Heroin sometimes. Just to help him not die. He would finally get on a program, but due to unnecessary and archaic rules that require folks to go receive their dose daily and him living in a rural community, not having transportation, and having institutional trauma, he would miss one day and then be removed from the program for 60 days, a barrier that absolutely still exists today. The length of time that you are removed from the program differs according to which area of the state you are in. Also, if an outpatient treatment center closed without notice or a provider left the area, he would lose his medication and have nowhere to turn in order to immediately access this medication that he needed to survive. Leaving his family to once again help him access it illicitly. All of this stigma based policy led to one thing every time, relapse. And he often would have to endure incredible shame and stigma in order to access inadequate MAT services. The same services that are available today and continue to come with enormous barriers with the exception of a phenomenal low barrier program at Safe Recovery in Burlington.

There remains incredible barriers to accessing that treatment. (Including in Burlington) Some of those barriers include, lack of transportation, fear of losing your children, threat of job loss, long commutes, sometimes as much as three hours round trip every single day, shame, having been kicked off a high barrier program, lack of insurance, lack of funds for co-pay, lack of ID (this I have heard time and time again from people experiencing homelessness), believing that you are not worthy of survival, not being allowed to access the ER programs due to missing an appointment following your last ER visit and so on.

I want to address the concern that criminalization is sometimes used as a tool to enter treatment. I did not think that I would talk about this today. However, I want to be clear that criminalization of this disease was the straw that broke my nephew. It would be wonderful to think that in all or even most cases coercion into treatment works. However, the most recent and relevant data is showing us that when folks suffering from this disease are entered into the criminal justice system, there are more bad outcomes than good. Specifically, it shows that the most already stable, including mental health, income, housing and so on, participants are primarily who find success and that these folks would also likely have had as strong or stronger outcomes if this work had been done by building support and connections, rather than through the criminal justice system. In fact that same data shows that particularly white people with access to services are more likely to be successful and still not as successful as outside of the criminal justice system.

We have to remember that court diversion is in fact part of the criminal justice system. If one fails court diversion, it becomes a fine or a criminal charge. Often people with Opioid Use Disorder are told, “if you just do the right thing everything will be fine”. “If you just don’t use drugs”, “if you just complete diversion”, “if you just go to treatment”. But the truth of the disease is that it doesn’t operate by those rules and so, what we are asking in a criminal justice setting is often medically impossible. The criminal justice system is not where this disease belongs. The shame and stigma of that system can be an incredible hurdle to people getting treatment and in fact can cause relapse or hiding the disease or even fear of raising their hand to ask for help. Conversely, Harm Reduction has been proven to be a very strong path into the treatment setting.

In my nephew’s case, the criminal justice system, after a year in recovery, caused him to go into a shame spiral. He was the healthiest I had seen him in years when I went with him to court that morning. I watched him go into that spiral and he was dead three weeks later. In his life my family tried to coerce Kaya into treatment. The court tried to coerce Kaya into treatment. It didn’t work. What worked, the two times that he did find sustained recovery, was meeting him where he was at, showing him that we loved him no matter what and offering him compassion and love. That is what worked. Though ultimately the disease took his life, those times when he had sustained recovery were gifts to our family. Time that we had with him, free of that peril that we would not have otherwise. It mattered to have those times of sustained recovery.

There is not a single benefit to criminalizing people who choose this life saving medication over heroin that is almost definitely laced with fentanyl and risks their lives

every single time.We should be encouraging and celebrating that choice because it is often the first step to entering traditional sustained recovery.

I want to talk a little about the benefit and safety of Buprenorphine. The testimony that I will submit in writing will have attached several articles that address the safety of Buprenorphine along with the indicated use when people use it unprescribed. There will also be a summary of the research and analysis done by John's Hopkins University with reference to the published and peer reviewed studies. These articles reference well over dozens of studies, many of which address some of what we heard about today, diversion of prescribed, why people use Illicit buprenorphine, fear of people who are opioid naive having access and more. It is important to note that the majority of these studies are published and have been peer reviewed. In House testimony the Health Commissioner referenced a study that it appears has not been published (or I have not been able to find it) nor has it been peer reviewed to my understanding. It comes to a completely different conclusion than dozens of studies done by reputable researchers and reputable institutions, so, it would be important to not consider such a study without a thorough peer review. I will get to my concerns with that in a moment.

First, as you have heard today, it is important to understand that Buprenorphine is a "partial agonist" meaning that it does not bind to the Opioid Receptors in the way that a traditional opioid does, thus it does not run the same risk of addiction, nor does it provide the same type of euphoria that is often the relief people with severe mental illness or trauma feel when they use heroin or other opioids and need to replicate. Additionally, if one is opioid dependent, then they will not get a euphoric effect from the medication at all. I want to repeat that, if one is opioid dependent then they do not at all get a euphoric effect from the medication.

The medication also has a built in safety protocol in several ways.

1. It has a ceiling, which means there is only so much of the medication that is active and then it is leveled out, making it unlikely to abuse. In addition Buprenorphine does not cause respiratory depression. This means that risk of overdose is almost non existent. In fact ER visits according to studies that I am looking at here, that include Buprenorphine are extremely rare in the first place and when they do happen, include a different drug or medical issue, that is the actual cause of the visit. In other words it is extraordinarily rare for Buprenorphine to be the primary reason for that visit.

2. It is interruptive to being able to have a euphoric effect from heroin or other opioids if one tries to combine other opioids with buprenorphine. Therefore it is uncommon to do

so. Thus further protecting from overdose. It also staves off the cravings so that desire no longer exists.

3. The most readily available form of Buprenorphine is Suboxone which has Naloxone in it, the primary drug present in Narcan. For those of you that don't know, Narcan is the medication indicated to stop an active overdose. Which means on those rare occasions that someone does try to use another opioid (which they will quickly find out does not have an effect), in combination with buprenorphine, the naloxone on board helps prevent the overdose.

So what is the benefit of Buprenorphine? It reduces cravings. It stabilizes people with Opioid Use Disorder and it allows them to live a more stable life. It reduces the risk of overdose. Most importantly, it keeps people who are at imminent risk of dying, alive. When used unprescribed it is an important and essential Harm Reduction measure and each and every person in Vermont and across the country at risk of dying today of this disease deserves this life line immediately. It can not wait.

I want to address a few of the concerns that we heard brought up today.

Will this take away an access point to entering formal treatment?

The answer to this is no. What the research has shown over the last several years in dozens of studies is that about 80% of people who enter traditional treatment settings, have used or actively self medicate with non prescribed Buprenorphine and they self report that it was the first step on their path to recovery in most cases. Interestingly, it is found that folks are 65% more likely to find sustained (long term recovery) if they have experience with Buprenorphine non prescribed.

I want to refer us to two pieces of information here:

1. Dr. Shafer, from Townshend VT. sent in testimony that should be on your webpage in your committees and in it he said:
   "We have seen many of our clients with serious opiate addiction histories successfully transition themselves to buprenorphine obtained from street sources. Some of them have been through detox programs which did not include buprenorphine induction, and they realized they could not maintain sobriety without medication-assisted therapy. Others put themselves through detox withdrawal from opiate pills or heroin/fentanyl after a terrifying overdose experience, and transitioned successfully to the buprenorphine. Their stories are

individual but in each case the buprenorphine they obtained on the street was the lifeline to survival.

In our experience, those who have come to us after weeks or even months or years of self-medicating have proved to be our most committed and dependable patients. They have already demonstrated their commitment to sobriety. They have experienced the transformative normalcy of once daily dosing without sickening swings of withdrawal and relief. Many have already picked up the threads of their lives, pursuing education, reuniting with family, holding steady jobs. They come to us saying they "want to get legal" and get on with her lives."

2. This is one of the many examples of articles referencing studies that found that use of non prescribed buprenorphine is associated with more success in long term treatment.

The article cited here is: Demystifying buprenorphine misuse: Has fear of diversion gotten in the way of addressing the opioid crisis?, Substance Abuse, DOI: 10.1080/08897077.2019.1572052

"For some, illicit buprenorphine use may provide a gateway to treatment: Research has found that illicit buprenorphine users were more interested in and more likely to initiate treatment but generally reported being unsure about where to go to obtain it legally.48 Individuals with prior experience using buprenorphine, either prescribed or non prescribed, have also been found to fare better in the treatment induction process and have better treatment retention rates than those who are buprenorphine naïve.49,50 One study found that patients with prior experience using non prescribed buprenorphine had significantly higher odds of remaining in treatment for at least 6 months, with qualitative data identifying that those with prior experience had a higher perceived effectiveness of buprenorphine based on their history of nonprescribed use.51 Another study demonstrated that those with a history of nonprescribed buprenorphine use prior to entering a treatment program had higher rates of abstinence from other illicit substances after 6 months of treatment.52"

These are the studies & articles referenced in the above quote:

[48] Fox AD, Chamberlain A, Sohler NL, Frost T, Cunningham CO. Illicit buprenorphine use, interest in and access to buprenorphine treatment among syringe exchange participants. J Subst. Abuse Treat. 2015;48(1):112–116.

[49] Cunningham CO, Roose RJ, Starrels JL, et al. Prior buprenorphine experience is associated with office-based buprenorphine treatment outcomes. J Addict Med. 2013;7(4):287–293.

[50] Whitley SD, Sohler NL, Kunins HV, et al. Factors associated with complicated buprenorphine inductions. J Subst Abuse Treat. 2010;39(1):51–57.

[51] Monico LB, Mitchell SG, Gryczynski J, et al. Prior experience with non-prescribed buprenorphine: Role in treatment entry

and retention. J Subst Abuse Treat. 2015;57:57–62.

[52] Alford DP, LaBelle CT, Kretsch N, et al. Collaborative care of opioid-addicted patients in primary care using buprenorphine: five-year experience. Arch Intern Med. 2011;171(5):425–431.

Concern about Buprenorphine being available on to Opioid Naive folks:

It is important to be clear that the majority of folks who access non prescribed buprenorphine, it comes from a family or friend who is trying to help someone who currently can not access a prescription and that this bill does not change the access points or availability of this medication on the street nor does it make sale legal. In fact we heard in testimony from the child psychiatrist that this is not a concern that there will be more access for youth, it is just not how young people first access opioids.

I want to start by saying that as someone who has experienced burying first my brother, then his son, I take this very seriously and would never be promoting legislation that would put the children in my family at risk of meeting this same fate and I would be lying if I did not say that my family has an expanded risk due to the trauma that we have faced. However, this bill helps protect, not harm our children. It indicates that people under 21 will go through the same process as those who are caught with cannabis or alcohol. This means that we are in fact putting in place a system that supports our children. I want to add that because of the safety profile of buprenorphine, that we went over just a moment ago, if for some reason, my son or any of my nieces and nephew's trauma from having experienced the death of their brother and cousin ended up with them seeking to self medicate, then I would pray with all of my heart that they tried buprenorphine rather than heroin or oxycontin, because they would then not die of a fentanyl overdose that day, because it can't be tampered with, because it would not bind to their opioid receptors in as strong of a way on that first touch and because I would then have a chance to get them help them survive, before I had to bury yet another child in my family. A chance that I was not afforded with either my brother or his son.

In an attached document that outlines the testimony from Joshua Sharfstein from John's Hopkins University, he does address this concern with relevant data.

Treatment Availability:

I have addressed this in large part a few moments ago, but to recap. Many people can not access treatment, for many of reasons. Some of those reasons include, lack of transportation, lack of insurance, lack of funds for a co-pay, fear of the losing their kids, parenting obligations, fear or threat of losing their job, shame, not wanting or being able to put on record their disease, not having an ID, not being able to meet requirements for

high barrier programs, being removed from programs and more. One really interesting thing to note is that dozens of published and peer reviewed studies indicate that use of non prescribed buprenorphine in an exceptionally high number of patients as a critical part of their path to recovery and furthermore that those who had used unprescribed buprenorphine had a far higher success rate in attaining sustained (or long term) recovery. So, in fact this bill as it is drafted, very much follows the science.

Again in Dr. Shafer from Townshend's written testimony he states:

"In our experience, those who have come to us after weeks or even months or years of self-medicating have proved to be our most committed and dependable patients. They have already demonstrated their commitment to sobriety. They have experienced the transformative normalcy of once daily dosing without sickening swings of withdrawal and relief. Many have already picked up the threads of their lives, pursuing education, reuniting with family, holding steady jobs. They come to us saying they "want to get legal" and get on with her lives.

It is vital that you be aware that <u>for anyone who is opiate tolerant, the "risk" of using a buprenorphine product is Zero</u>. It does not matter what the dose or whether it is mixed with other drugs such as benzodiazepines, stimulants, hallucinogens --- the additive risk is Zero.

On the flip side, it is critical to remember that the price of heroin/fentanyl relapse is often death. Anything that obstructs access to buprenorphine for a recovering addict seriously raises the specter of overdose death."

In addition, I have heard the notion that anyone can go to an emergency room. That is only true in some parts of the state and it is important to note as well that this is only a 3 day supply, and you need insurance to access it. In most cases if that person does not make it to their outpatient follow up, or can not find an outpatient follow up, they are not allowed to go back to the emergency room for a period of time that could be up to 60 days. So, again in that time frame are we asking people to risk their lives fentanyl laced heroin until they are deemed worthy of medication? Because these folks are opioid dependent, they will have to choose something.

I would also like to register a few concerns with the written testimony Commissioner Levine put on record in the House. First and perhaps most importantly, if any of the concerns that he indicated were actual and serious concerns then he would not believe that this would be a "slam dunk in any other state except ours" were he Health Commissioner in those states. If people in NH deserve this life saving measure, then so do people in VT. Also, I would note that while overdoses increased 38% in Vermont, they decreased in a few states, in those states more aggressive public health measures have been acheived. In fact the national average increase, as we heard from State's Attorney George, was 28%, but our deaths increased 38%. He speaks of risks like

endocarditis and infection along with a bunch of other scary sounding risks, but ignores that this population is already at a high risk for those diseases and in fact the risk is far greater with heroin that is almost always laced with fentanyl. In fact you can see in Doctor Sharfer, (Prescribing Doctor, Townshend) that there is no additive risk for people who are Opioid Dependent:

"It is vital that you be aware that for anyone who is opiate tolerant, the "risk" of using a buprenorphine product is Zero. It does not matter what the dose or whether it is mixed with other drugs such as benzodiazepines, stimulants, hallucinogens --- the additive risk is Zero.

On the flip side, it is critical to remember that the price of heroin/fentanyl relapse is often death. Anything that obstructs access to buprenorphine for a recovering addict seriously raises the specter of overdose death."

-Timothy Shafer, MD, Townshend Vermont

Additionally several studies have shown that injection is not used in most cases because it is not effective due to the structure of the compound. So, in fact, use of non prescribed buprenorphine greatly reduces the risk of endocarditis, infection, hepatitis c and so on.

It is also critical to point out that those fears that we heard in testimony, would have played out in Chittenden and Addison County since 2018 had they been real risks, because this very policy has been going on in those two counties since then. Therefore these risks seem to be unfounded due to two years of this policy already occurring in two counties in our state with none of the warnings coming to pass.

The study that we will hear Dr. Levine reference today, to my knowledge is not published or peer reviewed (perhaps I am wrong and we will hear more today). This study comes to a completely different conclusion than dozens of published and peer reviewed studies and so it is hard for me to believe that. Dozens of studies from all over the United States and world, from renowned researchers and from renowned research institutions have found the benefits that you heard in testimony and debunked many of the fears and myths of why folks use non prescribed buprenorphine and those risks. Since an Opioid dependent person experiences no euphoria from this medication, it can not then be used recreationally by that opioid dependent person. They might use respond to the word "recreational" when ask, because perhaps they are not using it consistently yet. The fact is that they are choosing a life saving medication, instead of heroin on those days and on those days, they will not die. I think we all understand science well enough to know why it is so important that all of the data that we consider be both published and peer reviewed. I today have referenced data from dozens of peer

reviewed studies and journals and I will provide a list of several studies with some summaries as well.

I also want to take this moment to say that before I lost my nephew and began to advocate on this issue around the state and country, I was a family member in the audience of those community meetings with the health department. With them saying that there are “no wait times” and family member after family member in our community standing up and saying “but hold on, we had to wait”. There are still waits, in the best case scenario, an er is available for a 3 day prescription that you still need insurance for or that can’t adequately connect to a service that will work for you and that you can not come back to in 3 days to keep the prescription. Other than that, it usually a minimum of 72 hours before you can get in, in those 72 hours someone might use heroin up to 17 times, risking their lives up to 17 times and left with little choice due to their Opioid Dependence. The state is most often a minimum of a week or more. In some parts of the state the distance to travel and the barriers mean the wait is even longer, we heard in testimony of five days, several weeks, when the retreat closed their program up to six weeks. I have heard these stories in nearly every part of the state in the time since my Nephew’s death.

The resistance over this legislation with the Health Department is very reminiscent to the resistance that they had for some time about Narcan. We now understand Narcan for what it is, an essential part of saving lives. This bill is an essential part of saving lives too. We need to make that connection, it is a public health measure of harm reduction for a community that is in crisis now.

What is it so hard to become a prescriber?

There are many road blocks to becoming a prescriber. Biden has recently removed one road block, but the barriers to treating patients currently will be high and continue to limit providers in our state. The rules continue to perpetuate that stigma which is a deterrent for many providers. These barriers do not exist to prescribe full agonist opioids, only MAT. There is a requirement that all providers get something called the X Waivor. This means that all providers have to register with the DEA. The initial “training requirement” from the XWaivor process has been removed, however in order to become a full prescriber one still has to get up to 24 hours of training. Again training that is not required for full agonist Opioids that cause actual opioid dependence. The limit of primary care physicians to treat only 30 patients remains and in fact in order to have the first year of 30 patients count toward increasing ones practice, providers will still have to complete the training, so, it actually has not been removed. Can you imagine if your primary care doctor could only treat thirty of their patients with high blood pressure? Or

only 30 with diabetes? Or only 30 with pain that indicates necessity for traditional opioids. This policy also encourages rules around the administration of Buprenorphine that create high barriers for an incredibly vulnerable population, such as many of the things we heard today like, removal from MAT programs for a relapse or even for missing one appointment. As I stated earlier people in Vermont are having to travel 3 hours EVERY day to access Buprenorphine because there are no providers near them or the rules for access require them to go to a particular location. Imagine if you lost your medication because you forgot, did not have transportation to, had to care for your kids or just had to cancel an appointment? Imagine if we took blood pressure medicine away when people ate steak or didn't exercise. Or insulin away because a diabetic keeps eating sugar? Or anti depressents or anxiety medication because the person did not get therapy? Yet, we take buprenorphine away for countless reasons, from barriers, to relapse. We take it away for people with the disease experiencing the exact symptoms of the disease. Then we do not give people immediate access, they are often kicked off for a period of time, the length of time depends on where you are in the state. Does that mean we want people in this situation to choose heroin, again almost definitely laced with fentanyl, until we allow them on medication again?

University of Vermont and John's Hopkins University have both recently done research on the effectiveness of buprenorphine with and without a prescription. What we know, according to several studies, is that people are 65% more likely to be able to sustain recovery with buprenorphine and that a huge percentage of folks that access recovery, utilize MAT for some or all of their journey. In addition in the neighborhood of 80%, according to several published and peer reviewed studies, utilize un prescribed buprenorphine prior to entering treatment. Also, found is that people who have utilized non prescribed buprenorphine are 60% more likely to be successful in sustained or long term recovery upon obtaining a prescription than their counterparts who have not previously used it with a prescription. That means that MAT, even, when folks are still using other substances is an important part of sustained recovery. That was almost universal in the research that has been published and peer reviewed. Additionally we know that the medication does not know if you jumped the incredible hurdles to access it, it doesn't even know how you accessed it. The medication just works, just as medications for other illnesses work.

Buprenorphine saves lives. ALL of the data tells us that it that it saves lives. There is no legitimate argument that buprenorphine is not life saving. Currently people can not always access it for all of the reasons I discussed before. So the question that we are really asking is should we continue to criminalize this disease? Should we continue to criminalize and keep in the shadows folks who are getting up and making a choice of this life saving medication over heroin that will certainly be laced with fentanyl? Or

should we send the strong and clear public health message that if you are suffering with opioid use disorder we want you to survive. We will not arrest or prosecute you for making the life saving choice of Buprenorphine over Heroin. That we believe you are worthy of surviving this disease. Because I don't know about you, but I am tired of our family, loved ones, friends and neighbors dying. Nationally the opioid related deaths increased in the neighborhood of 28% in 2020. In Vermont our opioid related deaths increased 38%. People need a lifeline now, not in 6 months or a year. Now. People will die if we don't get it to them.

Every life lost is another preventable death. Another family experiencing trauma that they did not have to. Another human being who died because our system failed them.

It has been just over three years since I received the phone call from my nephew's boss at work that he had died after a year in recovery. Three years since I fell to the pavement in the middle of a snow storm on Elliot St in Brattleboro. Three years since I told his mama that her baby had died. Three years since my heart shattered and my world changed forever. And in those three years, I have heard this same story over and over again. Not a day has gone by since he died, where I have not had tears well up in my eyes at least one time. He needed a lifeline that our state never offered him. It is beyond time for us to work to break down the barriers to survival that exist in our state. Kaya deserved to survive. My brother deserved to survive. Let's make sure others do.

Not only am I urging you to pass H.225, but I am urging you to pass it this session. Right now in Vermont we are losing on average three people a week. So between now and January people will die and you all have the power to give folks one more tool for survival. You have the power to save some of those lives. Please pass H.225 as drafted now. You do have the power to do something and I begging you, because once our family members die, we do not get them back.