H.162: An act relating to removal of buprenorphine from the misdemeanor crime of possession of a narcotic

H.162[1] is a bill that would decriminalize misdemeanor possession amounts of non-prescribed buprenorphine. It does so by removing buprenorphine from the section of 18 V.S.A. § 4234 pertaining to misdemeanor possession of depressant, stimulant, or narcotic drugs. Felony possession amounts of buprenorphine are not addressed in H.162 and therefore remain intact.[2] Similarly, H.162 makes no changes to current law with regards to penalties for sales, dispensing, or driving under the influence of buprenorphine.

The House Judiciary committee proposes to amend H.162[3] with additional language that provides civil penalties and access to diversion programs for people 18 years of age and under who possess misdemeanor amounts of buprenorphine. The process mirrors that in place for marijuana and alcohol possession by those under 21. House Judiciary's language would also sunset the new statute after two years, allowing the legislature to reassess these changes at that point.

Opioid use disorder (OUD), medication-assisted treatment (MAT), and buprenorphine

The National Institute on Drug Abuse defines addiction as "a chronic, relapsing disorder characterized by compulsive drug seeking, continued use despite harmful consequences, and long-lasting changes in the brain."[4] Criteria for the diagnosis of Opioid Use Disorder (OUD) include cravings, the need for increasing amounts of opioids, withdrawal, inability to cease using opioids, and interference with work, family, education, recreation, and/or physical health and

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[1] Vermont General Assembly, *An Act Relating to Removal of Buprenorphine from the Misdemeanor Crime of Possession of a Narcotic*, H.162, As introduced, 2019, https://legislature.vermont.gov/Documents/2020/Docs/BILLS/H-0162/H-0162%20As%20Introduced.pdf.

[2] Felony charges are for 100 times the benchmark unlawful dosage, as maintained by the Vermont Department of Health (http://www.healthvermont.gov/sites/default/files/documents/pdf/REG_regulated-drugs.pdf). The benchmark unlawful dosage for buprenorphine is 36 mg.

[3] Vermont General Assembly, *Proposed Amendment to An Act Relating to Removal of Buprenorphine from the Misdemeanor Crime of Possession of a Narcotic*, Draft 1.4 -- H.162, 3/15/ 2019, https://legislature.vermont.gov/Documents/2020/WorkGroups/House%20Judiciary/Bills/H.162/Drafts,%20Amendments%20and%20Summaries/H.162~Michele%20Childs~Draft%20No.%201.4,%203-15-2019~3-15-2019.pdf.

[4] National Institute on Drug Abuse, "The Science of Drug Use and Addiction: The Basics," National Institutes of Health, July 2018, https://www.drugabuse.gov/publications/media-guide/science-drug-use-addiction-basics.

safety.[5] Opioids include both prescription drugs of varying strengths and illegal drugs such as heroin.

Forms of treatment can include counseling, residential settings, detoxification, and abstinence, but today most experts -- from the World Health Organization to the Centers for Disease Control and Prevention -- agree that Medication-Assisted Treatment (MAT) is the gold standard for those struggling with OUD.[6] MAT for this disorder includes methadone, buprenorphine, and extended-release naltrexone. Again and again, these medications have been shown to reduce fatalities and infectious diseases, retain people in treatment, cut down on opioid use and criminal behavior, increase employment, and improve quality of life.[7]

Methadone works as an opioid agonist, binding to opioid receptors in the brain and eliminating withdrawal symptoms and relieving cravings. It is highly-regulated and can only be accessed as treatment for OUD in Opiate Treatment Program settings certified by the federal government, usually with onsite daily dosing requirements. Extended-release naltrexone acts as an opioid antagonist, blocking the activation of opioid receptors. Naltrexone will prevent opioids from producing a feeling of euphoria if consumed, but requires detoxification prior to administration and may not help to address cravings. For some struggling with OUD, the requirements associated with these medications may present obstacles.

Buprenorphine acts as a partial agonist and can be prescribed in outpatient settings, in the form of a pill or sublingual film. It binds to opioid receptors, but with more modest effects than methadone and has what is often described as a built-in "ceiling effect" that limits risks for overdose, dependency, and abuse. For many, it is the most accessible form of treatment for OUD, because of its combination of outpatient access and effectiveness when prescribed at adequate doses.[8]

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[5]IT MATTTRS2 Colorado, "DSM-5 Criteria for Diagnosis of Opioid Use Disorder," American Society of Addiction Medicine, accessed March 26, 2019, https://www.asam.org/docs/default-source/education-docs/dsm-5-dx-oud-8-28-2017.pdf?sfvrsn=70540c2_2

[6] German Lopez, "There's a highly successful treatment for opioid addiction. But stigma is holding it back," Vox, November 15, 2017, https://www.vox.com/science-and-health/2017/7/20/15937896/medication-assisted-treatment-methadone-buprenorphine-naltrexone.

[7] Alan I. Leshner and Michelle Mancher, *Medications for Opioid Use Disorder Save Lives*: *A Consensus Study Report of the National Academies of Sciences, Engineering, Medicine*, National Academies Press, March 20th, 2019, p. 33, https://www.nap.edu/read/25310/chapter/4#35; National Institute on Drug Abuse, "How Effective Are Medications to Treat Opioid Use Disorder?," National Institutes of Health, June 2018,https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/efficacy-medications-opioid-use-disorder.

[8] Jennifer R. Velander, "Suboxone: Rationale, Science, Misconceptions" *Ochsner Journal* vol. 18,1 (2018): 23-29, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5855417/; SAMSHA, "Buprenorphine," U.S.

The most common form of buprenorphine for OUD is Suboxone, with includes both buprenorphine and naloxone, an opioid antagonist that is often used for overdose reversal. The inclusion of naloxone helps to protect against abuse, by blocking opioid receptors. So, for example, someone attempting to inject Suboxone would not be able to obtain a feeling of euphoria and would instead trigger withdrawal symptoms.

Non-prescribed buprenorphine use

Buprenorphine is an important medication in Vermont's hub and spoke treatment program,[9] and supervised use in medical settings is encouraged. However, while over 8,000 Vermonters have received treatment for opioid use disorder,[10] it has been estimated that many more are struggling with OUD without access to treatment -- perhaps more than twice those numbers. Treatment access has been expanded throughout the state and waiting lists and times have been reduced, but there are still many reasons that Vermonters struggle to access treatment. An evaluation of Vermont's hub and spoke system identified obstacles in the form of "transportation problems, dosing hours conflicting with [participant's] work schedule, child care problems, a desire to avoid hub treatment, and a lack of available spoke prescribers."[11]

For many Vermonters who cannot access medically-supervised treatment, or aren't ready to access treatment, non-prescribed buprenorphine can be a lifeline. Study after study shows that the majority of people using non-prescribed or illicit buprenorphine do so to reduce withdrawal symptoms, self-treat substance use disorder, and/or avoid using more dangerous opioids. Some users of non-prescribed or illicit buprenorphine do attempt to abuse the substance, but these same studies show that for individuals seeking a "high," buprenorphine is almost never a drug of choice due to its diminished ability to produce a feeling of euphoria.[12]

Department of Health and Human Services, March 21, 2019, https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine.

[9] Blueprint for Health, "Hub and Spoke," State of Vermont, accessed March 26, 2019, https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke.

[10] Anne VanDonsel, Shayla Livingston, John Searles, "Opioids in Vermont: Prevalence, Risk, and Impact," Vermont Department of Health, October 27, 2016, http://www.healthvermont.gov/sites/default/files/documents/2016/12/ADAP_Opioids_Prevalence_Risk_Impact.pdf.

[11] Richard A. Rawson, *Vermont Hub-and-Spoke Model of Care for Opioid Use Disorder: An Evaluation,* Vermont Center on Behavior and Health, December 2017, p. 132, http://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Hub_and_Spoke_Evaluation_2017_1.pdf.

[12] Theodore J. Cicero, Matthew S. Ellis, Howard D. Chilcoat, "Understanding the Use of Diverted Buprenorphine," *Drug and Alcohol Dependence* Volume 193, 1 December 2018, Pages 117-123, https://www.ncbi.nlm.nih.gov/pubmed/30359928; Alexander R MLABazazi, et al. "Illicit Use of Buprenorphine/Naloxone among Injecting and Non-injecting Opioid Users" *Journal of Addiction Medicine* vol. 5,3 (2011): 175-80, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3157053/; Allen Bennett et al,

Even for those using buprenorphine in this way, it remains a safer alternative to more deadly opioids such as heroin or fentanyl. Fentanyl's death toll in Vermont continues to rise -- 2018 marked the state's highest number of accidental-opioid fatalities and fentanyl was indicated in three out of four such deaths.[13]

Several witnesses submitted written testimony to the House Judiciary committee describing their experiences using non-prescribed buprenorphine as they were approaching readiness to seek medically-supervised treatment for OUD.[14] One wrote, "Looking back, I now realize that inducting myself into MAT treatment with the use of non-prescribed buprenorphine showed me how different my life could be. I was no longer in constant fear of overdosing, and for the first time in years I was free of the torturous withdrawal symptoms that set in every few hours between uses. Slowly but surely, my body and mind began to heal. Eventually, I was ready to take the huge step to find a medical provider that would prescribe to me."[15]

This individual's experience of non-prescribed buprenorphine providing a pathway to medically-supervised and effective treatment is backed up by research that shows, *"*patients with prior use of non-prescribed buprenorphine had significantly higher odds of remaining in treatment through 6 months than patients who were naïve to the medication upon treatment entry.*"*[16] Longevity in treatment is closely tied to improved recovery outcomes.[17] Thus, evidence suggests that prior use of non-prescribed buprenorphine is actually a greater indicator of success than only accessing MAT under the supervision of a medical provider.

"Non-Prescribed Buprenorphine in New York City: Motivations for Use, Practices of Diversion, and Experiences of Stigma," *Journal of Substance Abuse Treatment* , Volume 70 (November 2016), 81 - 86, https://www.journalofsubstanceabusetreatment.com/article/S0740-5472(16)30006-X/fulltext; Zev Schuman-Olivier et al, "Self-treatment: Illicit buprenorphine use by opioid-dependent treatment seekers,"*Journal of Substance Abuse Treatment* , Volume 39 , Issue 1 (July 2010) , 41 - 50, https://www.journalofsubstanceabusetreatment.com/article/S0740-5472(10)00075-9/fulltext.

[13] Vermont Department of Health, "Opioid-Related Fatalities Among Vermonters," February 2019, http://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Data_Brief_Opioid_Related_Fatalities.pdf.

[14] Vermont General Assembly, House Committee on Judiciary, Documents & Handouts, H.162, accessed March 26, 2019, https://legislature.vermont.gov/committee/document/2020/18/Bill/194807#documents-section.

[15] Jess Kirby, Written Testimony to House Judiciary Committee, Vermont General Assembly, February 28, 2019, https://legislature.vermont.gov/Documents/2020/WorkGroups/House%20Judiciary/Bills/H.162/Written%20Testimony/H.162~Jess%20Kirby~Letter%20of%20Support~2-28-2019.pdf

[16] Laura B. Monico et al. "Prior Experience with Non-Prescribed Buprenorphine: Role in Treatment Entry and Retention" *Journal of Substance Abuse Treatment* vol. 57 (2015): 57-62, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4561018/.

[17] "Conclusions of the National Academies Committee," *Medications for Opioid Use Disorder Save Lives*: *A Consensus Study Report of the National Academies of Sciences, Engineering, Medicine*, National Academies Press, March 20th, 2019, https://www.nap.edu/resource/25310/032019_OUDconclusions.pdf.

One of the proposed downsides of non-prescribed buprenorphine (and other forms of low barrier access) is that it's dangerous or ineffective without accompanying counseling. In fact, there is a growing body of research that suggests that counseling does not provide additional benefits for patients with OUD in the forms of retention in treatment, abstinence, or other measures when compared to MAT alone.[18] While there are certainly studies demonstrating its value, research does not appear to support counseling as an *essential* component of MAT.

Local experience decriminalizing buprenorphine possession

A partnership between the Chittenden County State Attorney's office, area law enforcement, and the Chittenden County Opioid Alliance's CommunityStat Rapid Intervention Team led to a decision not to arrest or prosecute for buprenorphine possession in June of 2018.[19] Officials involved in this program cite no issues with the practice of functionally decriminalizing buprenorphine possession. In fact, while overdose fatalities increased statewide in 2018, Chittenden County saw a 50% reduction in deaths from the previous year after implementing this strategy along with a number of others rooted in science, treatment access, and harm reduction.[20]

Representative Selene Colburn
March 27, 2019

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[18] Laura Amato et al, "Psychosocial Combined with Agonist Maintenance Treatments Versus Agonist Maintenance Treatments Alone for Treatment of Opioid Dependence," Cochrane database of Systematic Reviews, October 5, 2011, https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004147.pub4/full; Sarah E. Wakeman, "Waiting for Addiction Treatment," Harvard Medical School CME Online *Lean Forward,* May 3, 2017, https://leanforward.hms.harvard.edu/2017/05/03/waiting-for-addiction-treatment-a-deadly-proposition/.

[19] Alicia Freese, "Burlington to Ease Access to Opioid Medication, *Seven Days,* June 13, 2018, https://www.sevendaysvt.com/vermont/burlington-to-ease-access-to-opioid-addiction-medication/Content?oid=16884183.

[20] "Opioid Deaths Down 50% in Chittenden County," *Burlington Free Press,* February 15, 2019, https://www.burlingtonfreepress.com/story/news/2019/02/15/opioid-deaths-down-50-percent-chittenden-county-vermont/2882146002/; Ellie French, "Chittenden County Opioid Deaths Drop 50%," *VT Digger*, February 14, 2019, https://vtdigger.org/2019/02/14/chittenden-county-opioid-deaths-drop-50-percent/.