

Buprenorphine Decriminalization: H.225
Commissioner Mark Levine – Key Points
4/6/2021

Introduction –

- Health supports the concept and motivation behind this bill:
 - People with a substance use disorder have a chronic illness, and we want to help them get well, and most importantly, keep them alive.
- Data on the impacts of decriminalizing buprenorphine is limited and often contradictory.
 - Studies are ecological and descriptive and do not account for specific treatment environments such as we have here in Vermont. I do, however, believe that the literature is broader than you may have heard to date – especially when it describes the motivations of those who use or seek buprenorphine through diversion.
- I will speak to the health implications of this bill. It also has judicial and legal implications, better articulated by experts in law and law enforcement. And I will raise several provocative points, because I believe that all issues need a fair hearing, and because I want you to consider what I will term possible unanticipated consequences of the proposed legislation. This is not an easy topic to discuss nor to come at from a fully evidence-informed standpoint, and if you sense ambivalence in some of my comments, it is real.

As commissioner of health, I am responsible for considering the health implications for all Vermonters that may result from system and policy decisions, including:

- Vermonters who are not using opioids yet, but who may be exposed to that opportunity due to prescription drugs becoming available on the street through diversion.
 - Remember how this opioid crisis started: overprescribing and diversion of strong narcotics like Oxycontin. The reason we have a Prescriber Rule is to decrease the amount of prescription opioids circulating in the population.



- Buprenorphine can be the first drug a person uses; it can also be the first drug a person injects
 - Buprenorphine is 30 times stronger than oral morphine. Due to this strength, dependence can develop quickly.
 - Though a lot has been made of the fact that many users of illicitly obtained buprenorphine are trying to alleviate withdrawal symptoms, there is also literature showing 50+/-% using to get high. And very recent data from the DISCERNE study that VT is participating in to address Hepatitis C and HIV from injection drug use showed an 85% rate of using to get high in the over 400+ subjects surveyed, at least a third of whom were Vermonters.
- Vermonters with substance use disorder who are in treatment (~8,000 people), they may be destabilized by this legislation because it creates a greater incentive to divert some of their medication – which means they will not get the appropriate effective dose they need for themselves. It is also well known in the treatment community that if there is less drug available to an individual with OUD because he or she has sold some of it, the remainder may be injected to allow that individual to have full bioavailability of the remaining drug. This of course would then expose that individual to the many complications of injection drug use, including bloodstream infections and endocarditis.
 - It often takes years for a person to seek treatment – once in treatment, we want to ensure the best possible environment for them, which significantly impacts their ability to achieve recovery.
- Vermonters who are further along their path to opioid addiction, and at high risk of overdose
 - They *may* benefit from access to buprenorphine on the street as they are less likely to overdose when using buprenorphine compared to some other opioids.
 - They will be more likely to continue a pattern of use outside of treatment instead of being rapidly referred to treatment.
 - At least some – and potentially many – may still be using buprenorphine to get high, putting themselves and others at risk as a result.
 - And some of them, the literature tells us, may be more prone to use benzodiazepines (to dampen the euphoria) which increases their risk of adverse consequences.
- Prescribers
 - If patients are further incentivized to divert their prescription, prescribers may have a harder time ensuring successful treatment for their patients – this puts them in a difficult ethical situation when they suspect diversion is occurring. And I have direct confidential information from some current prescribers that indicates they might question their continued participation as a waived clinician should such a bill be passed. I urge you to solicit and hear their testimony.

- I need to pause now and make an important point. If I were Commissioner of *any* other state in the US I would be *unequivocally* for this bill as a potentially important public health measure, knowing there would still be uncertainty. But this is Vermont. We do not know what “flooding the streets” with buprenorphine (as some have characterized this strategy) means in a state with no waiting lists and true capacity to treat all. We have a legacy of developing a nationally renowned hub and spoke system, with abundant protections built in – how disruptive could this be to this system that we and others praise so often? Could there be more negative consequences than positive? In every other state, people are literally dying because they cannot immediately access care – perhaps the diverted buprenorphine they can choose to access is their only chance to survive. A true bona fide harm reduction strategy. I am skeptical that would be the case here.
- And if I were to make a comparison of VT to another setting, it might be France. In VT we believe 1.6-1.8% of the adult population is on MAT. In France it is 2-3%, thought to be 50% of its OUD population. The French experience with buprenorphine (Primary care prescribing model with little to no training but some early observational dosing) has expanded access to substitution therapy and reduced the overall harm associated with untreated opioid dependence, including reductions in overdose. However, diversion has been a significant concern, with possible strategies to reduce diversion including the use of other treatment options (combination buprenorphine/naloxone or methadone), increased patient monitoring, shorter duration of prescriptions early during treatment, and enhanced training of the clinicians involved in buprenorphine and opioid dependence treatment. All things that informed the VT model. The goal is to balance access to effective care with medical controls. And the greatest predictor of success seemed to be the quality of the relationship between the treatment provider and the patient.

Health reasons for supporting this bill –

- We do not want to criminalize those with an illness.
 - You can access pre-trial services in every county of the state.
- We want to ensure people are using the safest possible medication in the safest possible way, even when using illicitly.
 - Buprenorphine, if used as it is prescribed and not injected, poses a lower risk for overdose.
 - However, buprenorphine is much stronger than many other opioids and can induce dependence faster.
 - Providing reasons for people to not otherwise turn to drugs like heroin and fentanyl is an important public health objective.
 - However, a safer and effective treatment tool does NOT mean it is benign.

- “To date, no trials have evaluated the efficacy of buprenorphine alone, without medication management, as the minimal standard of care. Thus, there are no data on the number or types of individuals who may respond to buprenorphine without medication management and monitoring.” (Carroll & Weiss, 2017)

Health reasons to be cautious about this bill –

- Decriminalizing buprenorphine could and probably will incentivize diversion.
 - Unlike heroin or fentanyl, in Vermont prescription is the only original source of buprenorphine - therefore, every single milligram of buprenorphine on the street is diverted medication.
 - Most patients on buprenorphine are Medicaid patients, and therefore in more financial need than most Vermonters – this bill would further increase demand on the street and increase the risk that a patient sells their drugs for the cash.
- It will dis-incentivize treatment.
 - When a patient diverts their medications, even to a friend or other person in need, that patient is then destabilized (likely not getting their appropriate effective dose)
 - Someone who uses diverted buprenorphine may be less likely to find their way to our treatment systems and recovery supports.
 - In Vermont, in comparison to other states, we have successfully worked with providers to reduce the total dose to the minimum possible amount – this means that there is not extra in a patient’s prescription to sell while still getting all the benefits of the medication for themselves. We excel at this.
 - And I have already pointed out the risk regarding complications of the injection route.
- And very importantly, and I want to emphasize this, we lose a critical intervention point. Whatever is decided with regards to this bill, there must be immediate opportunity for the apprehended individual to be immediately connected with resources or services. Whether that be the case worker at the BPD or the social worker embedded in the state police barracks.
 - Often the criminal citation for holding non-prescription buprenorphine is what gives a person an incentive to go through pre-trials services and engage in treatment – this is how we work with law enforcement and the criminal justice system to make sure those who are ill with this disease get care, while those who profit by this epidemic can be prosecuted accordingly.
 - This is a key point, so to be clear – Currently, the criminal citation goes away when the person enters treatment. There would be no criminal record, misdemeanor or otherwise, specific to having been cited for possession of buprenorphine.

- Vermont has developed, over many years, the sequential intercept model (?)
- And we cannot lose track of the fact that this is a medical treatment for a chronic disease condition. Best practice dictates that patients have a medical exam, blood work to check for liver problems before being prescribed buprenorphine – this, of course, is not happening outside of formal treatment.
- It will increase the availability of opioids out on the street.
 - Increased potential for people to start using.
 - Increased potential for people to abuse.
- When injected, [buprenorphine may have a high potential for heart infection.](#)

Conclusion –

- We will continue to strive for universal access to treatment. Right now, we remain skeptical that the potential health benefits outweigh the potential costs in this bill.
- We believe that focusing on ensuring that those with misdemeanor possession charges for ANY opioid are diverted to pre-trial services would be a more impactful investment of our efforts.
- I have recently gone on record as stating we must be innovative, bold and courageous in addressing this crisis. Fortunately, in Vermont we have been and continue to be. I don't think we should create a scenario where we might unravel some of the past good work that has been done and jeopardize the success of the hub and spoke system for the sake of appearing innovative.
- Recognizing the reality of drug use, and developing new approaches to work within this reality, is not the same as policies that result in additional opioids being available on the street.
- We must be thoughtful and ensure that policy decisions we make are the right decisions for all Vermonters, including –
 - those with opioid use disorder who are in treatment.
 - those who are using opioids and not yet in treatment.
 - those who are not using, but may be at greater risk of starting to use.