Decriminalization of Diverted Buprenorphine in Burlington, Vermont and Philadelphia: An Intervention to Reduce Opioid Overdose Deaths

Health Policy Portal

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In June of 2018, two of us, the chief of police of Burlington, Vermont, and the state's attorney who prosecutes Burlington's criminal cases, announced that we would not arrest or prosecute people for misdemeanor possession of unprescribed buprenorphine, the partial agonist medication shown to be highly effective at treating opioid use disorder (OUD). We were the first public officials in the United States to *de facto* decriminalize the possession of a controlled substance in response to the nation's opioid crisis. In January, citing this decision, the third author, Philadelphia's district attorney, announced that he too would no longer prosecute people for illicitly possessed buprenorphine.

It is worth considering why two county prosecutors and a chief of police concluded that not enforcing an unambiguous and longstanding drug law was a critical public health intervention. Arguments favoring the decriminalization of illicit psychoactive drugs are not new and have evidentiary bases in harm reduction. Our motives in doing so were threefold: first, to correct the error of criminalizing a person struggling with opioid addiction for possessing an effective means to treat it, second, to reduce stigma against the use of partial agonist medications to treat OUD, and third, to compensate for a serious gap in medication-assisted treatment capacity. Government officials with the discretion to enforce laws should not underestimate their ability to shift critical societal and public health norms with the choices that they make. Our use of discretion was an effort to save lives.

Despite the efficacy of buprenorphine-based treatments for OUD, their use remains highly stigmatized.[1] As an opioid similar to the ones it replaces, buprenorphine effectively regulates withdrawal symptoms, but it does not — as with all agonist-based treatments — eliminate physical dependence.[2] This dependence is often misunderstood as "addiction in another form" by those who advocate for behavioral interventions only, an approach with a much less successful track record. Yet, at least some of the stigma surrounding buprenorphine is owing to the fact that its unprescribed possession carries the same potential criminal penalties as heroin and fentanyl. In either case, buprenorphine is qualitatively different than its full agonist relatives in that its unsupervised use carries a much lower fatal overdose risk.[3] It also allows people to live substantially normal lives while adhering to treatment. These pharmacological characteristics should be reflected in our criminal laws, and until they are, we have a good reason not to apply the existing ones. Every day a person consumes buprenorphine instead of a riskier opioid is a day when her chances of fatal overdose are significantly reduced. This is a desirable outcome regardless of the medicine's provenance.

Despite its proven ability to save lives, buprenorphine-based treatment is also not as widely available as it should be. Physicians cite fear of buprenorphine diversion by their patients as a dangerous problem, and one of the reasons why they do not prescribe the medication in the first place.[4] Many have reservations about welcoming people who suffer from OUD into their waiting rooms, even if they are likely to encoun-

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About This Column

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ter them when they present with other illnesses. Further disincentives stem from the highly restrictive state and federal regimes that regulate buprenorphine,[5] such as fear of censure by state medical boards for errors in prescribing practice, and prosecution by the Drug Enforcement Administration for facilitating diversion. Many communities have waiting lists for buprenorphine-based treatment as a result, or it is not available in a manner that provides for good adherence and retention.

This stigma and these disincentives yield what Holtgrave would describe as an *adverse public health event*, in which "a group of persons is... inadequately protected from an avoidable public health harm by the public health system."[6] One result has been a staggering national death toll. Another is a thriving black market for diverted buprenorphine, in which people attempt to protect themselves. People with OUD report turning to illicit use of the medication for many reasons: some because they fear the risk of a fatal overdose but are not ready for the structure and demands of formal treatment, and others because they do not have the means to seek such treatment.[7] Some alternate the use of buprenorphine with illicit opioids based on the availability of funds or their drug of choice. Others, in the throes of addiction, do not see themselves as in need of treatment, but believe that buprenorphine is an acceptable alternative to stronger opioids. Regardless, few people seek the medicine as their recreational substance of choice, very few report it as the initial cause of their addiction, and most people surveyed report they would prefer to obtain the medicine lawfully.[8]

Vermont lawmakers are considering legislation that would by remove partial agonists from the schedule of drugs subject to misdemeanor sanction. The deregulation of an opioid to prevent the deaths caused by more lethal ones is not a perfect solution. It is, however, a rational one, and it is more effective than the present alternatives. There are ongoing natural experiments in Vermont and Philadelphia that will demonstrate if the *de facto* decriminalization of buprenorphine by law enforcement officials can help save lives in a time of profound crisis.

In the midst of an overdose mortality crisis, it is important to portray partial agonist medications not only as an essential component of treating OUD, but also as a prophylactic for the prevention of overdose deaths.[9] If fears of censure and penalty prevent the medical community from establishing widespread, low barrier access to these medications, then the officials empowered to censure and penalize can send strong signals across their spheres of governance by rejecting such an approach. If physicians and patients shy away from these medications due to stigma, then the government should not reinforce this stigma by treating these medications as if they are criminally indistinguishable from the drugs they were designed to save people from.

In 2018, Chittenden County, Vermont, home to Burlington, witnessed a 50% decline in opioid overdose deaths from their peak in 2017 (17 deaths vs. 34), while overdose deaths increased 20% in the remainder of the state.[10] Preliminary county data from 2019 suggest that this decline has been sustained. To achieve this reduction, the community engaged in several evidence-based interventions at once, many of them novel. It established low barrier access to buprenorphine at its syringe exchange and the local medical center's emergency department. It eliminated the waiting list for medication-assisted treatment, and successfully lobbied for comprehensive access to multiple modalities of addiction treatment in the state's prison system. Naloxone, the opioid overdose reversal drug, was widely distributed. A policy of non-arrest and prosecution for unprescribed buprenorphine was among these interventions, but it is nearly impossible to tell what its relative impacts were. Still, all of the interventions had a common premise: when a medication exists that is proven to save lives, people in need should have access to it, doctors should be at the ready to provide it, and there should be no stigma or fear of penalty in taking it. With firm support from the prosecutor's office, innovators in Philadelphia are taking similar evidence-based, comprehensive measures in an attempt to save lives, including a path-breaking effort to open a safe consumption site for the supervised used of illicit opioids and other drugs.

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References

1. S.E. Wakeman and J.D. Rich, "Barriers to Medications for Addiction Treatment: How Stigma Kills," *Substance Use & Misuse* 53, no. 2 (2018): 330-333.
2. J.R. Velander, "Suboxone: Rationale, Science, Misconceptions," *The Ochsner Journal* 18, no. 1 (2018): 23-29.
3. M. Doernberg, N. Krawczyk, D. Agus, and M. Fingerhood, "Demystifying Buprenorphine Misuse: Has Fear of Diversion Gotten in the Way of Addressing the Opioid crisis?" *Substance Abuse* 40, no. 2 (2019): 148-153.
4. *Id.*
5. B. Andraka-Christou and M.J. Capone, "A Qualitative Study Comparing Physician-Reported Barriers to Treating Addiction Using Buprenorphine and Extended-Release Naltrexone in U.S. Office-Based Practices," *International Journal of Drug Policy* 54 (2018): 9-17.
6. D.R. Holtgrave, "Public Health Errors: Costing Lives, Millions at a Time," *Journal of Public Health Management and Practice* 16, no. 3 (2010): 211-215.
7. Velander, *supra* note 2.
8. T.J. Cicero, M.S. Ellis, and H.D. Chilcoat,. "Understanding the Use of Diverted Buprenorphine," *Drug and Alcohol Dependence* 193 (2018): 117-123.
9. Wakeman, *supra* note 1.
10. K. Jickling, "Opioid Deaths Rise in Vermont but Plummet in Chittenden County," *Seven Days*, February 14, 2019.

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