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POLICY DIRECTIVE 2021-15: POLICY REGARDING METHADONE

I. Introduction and Background

America is in the midst of a devastating opioid epidemic. Since 1999, the annual number of drug overdose deaths in the United States has more than quadrupled.[1] Nearly 70% of those drug-overdose deaths involve opioids.[2] And Michigan has been hit particularly hard. Since 1999, the number of opioid deaths in Michigan has increased by *more than 17 times*.[3] In Michigan, moreover, opioid overdoses account for nearly 80% of all drug-related deaths.[4]

Historically, opioid users have been stigmatized (and criminalized). But opioid addiction[5] does not stem from moral failings, or a failure of willpower. Opioids—which include prescription medications like oxycodone and hydrocodone, as well as illicit drugs such as heroin and fentanyl analogs—are a class of drugs containing molecules that bind to naturally occurring opioid receptors in the human brain.[6] Opioid use can thus fundamentally alter the brain's reward structure. They can cause a massive release of dopamine, the brain's "feel-good" chemical.[7] And that, in turn, can lead to addiction—defined as continued drug use and a loss of control despite negative consequences.

Opioids can be as dangerous as they are addictive. Though opioids are often prescribed for pain relief, opioids can lead to fatal overdose by causing depressed respiratory drive (leading the body to stop breathing).[8] High potency opioids, such as heroin and fentanyl, are responsible for tens of thousands of deaths in the United States each year.[9]

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[1] Centers for Disease Control and Prevention, *Understanding The Epidemic* (Mar. 19, 2020), *available at* https://www.cdc.gov/drugoverdose/epidemic/index.html.
[2] *Id*.
[3] Michigan Health and Hospital Association, *Michigan Hospitals Are Fighting This Deadly Epidemic, available at* https://www.mha.org/Issues-Advocacy/Opioid-Epidemic.
[4] National Institutes of Health, *Michigan: Overdose Related Deaths and Related Harms* (April 3, 2020), *available at* https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state/michigan-opioid-involved-deaths-related-harms
[5] Or, the DSM-V term: "opioid use disorder."
[6] *See, e.g.,* National Institute on Drug Abuse, *Opioids, available at* https://www.drugabuse.gov/drug-topics/opioids.
[7] The Mayo Clinic, *How Opioid Addiction Occurs* (Feb. 16, 2018), *available at* https://www.mayoclinic.org/diseases-conditions/prescription-drug-abuse/in-depth/how-opioid-addiction-occurs/art-20360372.
[8] Centers for Disease Control and Prevention, *Preventing an Opioid Overdose: Know the Signs, Save a Life, available at* https://www.cdc.gov/drugoverdose/pdf/patients/Preventing-an-Opioid-Overdose-Tip-Card-a.pdf.
[9] National Institutes of Health, *Overdose Death Rates* (Mar. 10, 2020), *available at*

Because opioids cause a physical chemical dependency more quickly than other drugs causing addiction—and often result in permanent changes to neurochemical balance—recovery from opioid addiction can be particularly difficult. To be sure, abstinence-based treatment approaches, under which a person is expected to completely abstain from substance use, have been successful for many people. But many people suffering from opioid addiction experience long-term depression and insomnia, sometimes persisting years after cessation from opioid use.

For many, a more viable path to recovery involves medication for addiction treatment ("MAT"), also known as Medications to Treat Opioid Use Disorder ("MOUD"). Under a MAT approach, abstinence from illicit opioids is aided by longer-acting opioid medications that help to stabilize brain chemistry, relieve physiological cravings, and block the euphoric effects of opioids.[10] According to the U.S. Department of Health and Human Services, "MAT has proved to be clinically effective and to significantly reduce the need for inpatient detoxification services."[11] Research has demonstrated that those who received opioid agonist treatment (buprenorphine or methadone) for opioid addiction are significantly less likely to be victims of a fatal opioid overdose than those who do not.[12] What is more, treatment with methadone or buprenorphine decreases overall opioid use, criminal activity, and infectious disease transmission.[13]

In Policy Directive 2021-07, effective January 13, 2021, this Office issued new policies regarding the unauthorized use, possession, and small-scale distribution of buprenorphine—a particularly effective medical treatment for opioid addiction.[14] As explained in that Policy, buprenorphine:

(1) Does not cause the same physiological effects as drugs like heroin that fully activate the brain's opioid receptors;

(2) Does not generally cause addiction; and

(3) Is not typically used recreationally. Instead, "[a]lmost everybody takes it to manage their addiction, to stave off withdrawal, to self-treat."[15]

Against that backdrop, the Policy Directive concluded:

[I]t makes little sense to continue prosecuting people for the unauthorized use,

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https://www.drugabuse.gov/drug-topics/trends-statistics/overdose-death-rates.

[10] U.S. Department of Health and Human Services, *Medication Assisted Treatment (MAT)* (Sept. 1, 2020), *available at* https://www.samhsa.gov/medication-assisted-treatment.

[11] *Id*.

[12] Matthias Pierce, Sheila M. Bird, Matthew Hickman, John Marsden, Graham Dunn, Andrew Jones, & Tim Millar, *Impact of treatment for opioid dependence on fatal drug-related poisoning: a national cohort study in England,* Addiction 111, 298-308 (2015).

[13] National Institutes of Health, *Policy Brief: Effective Treatment for Opioid Addiction* (Nov. 2016), *available at* https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction.

[14] *See* Policy Directive 2021-07, *Policy Regarding Buprenorphine, available at* https://www.washtenaw.org/DocumentCenter/View/19156/Buprenorphine-Policy.

[15] Peter Hirschfeld, *Health Experts Push To Decriminalize Addiction Treatment Drug*, Vermont Public Radio (Mar. 22, 2019) (quoting Burlington, Vermont police chief Brandon Del Pozo).

> possession, or sale of buprenorphine. Deterring people from using buprenorphine (or from selling it to people fighting addiction) will cause many to backslide. Without buprenorphine, some will turn back to more dangerous opioids, like heroin and fentanyl analogs. Some will die of overdoses. And those who don't will once again become mired in a struggle with a severe chemical dependency—ruining their lives, if not ending them.[16]

In addition to buprenorphine, another medication prescribed to people receiving treatment for their opioid use disorder is methadone. Methadone is "a long-acting opioid agonist," and is used to reduce "opioid craving and withdrawal and blunts or blocks the effects of opioids."[17] Like buprenorphine, "[m]ethadone is safe and effective, when taken as prescribed."[18]

There are, however, several differences between buprenorphine and methadone. Buprenorphine is an partial opioid agonist, which means that it "activate[s] the opioid receptors in the brain, but to a much lesser degree than" drugs such as heroin and oxycodone.[19] Methadone, however, is a full opioid agonist, which means that it fully activates the brain's opioid receptors. What is more, a short-term study has found that "the risk of overdose death per thousand people in treatment was lower for buprenorphine than for methadone."[20] These factors counsel in favor of a more cautious approach for methadone than for buprenorphine.

Yet there are compelling factors pointing in the opposite direction. As an initial matter, buprenorphine does not work for everyone. Many patients receiving methadone treatment are patients who had already tried buprenorphine—and for whom buprenorphine was not effective. Indeed, a meta-analysis of 31 studies evaluating the relative effectiveness of methadone and buprenorphine concluded that methadone is superior to buprenorphine in retaining participants.[21]

In addition, buprenorphine is a medication that is significantly more likely to be prescribed to people in treatment who are white, employed, and have some college education.[22] Methadone, by contrast, tends to be more frequently prescribed to Black and Hispanic people, as well as people of lower socioeconomic status.[23] It is the mission of this Office to ensure that justice is dispensed evenhandedly—regardless of race and socioeconomic status. It would run

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[16] Policy Directive 2021-07, *supra* n. 14, at 5.
[17] U.S. Department of Health and Human Services, *Methadone* (Sept. 1, 2020), *available at* https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/methadone.
[18] *Id.*
[19] U.S. Department of Health and Human Services, *Pharmacological Treatment, available at* https://www.ihs.gov/opioids/recovery/pharmatreatment/.
[20] Bell, James R., et al., Comparing Overdose Mortality Associated with Methadone and Buprenorphine Treatment, Drug and Alcohol Dependence, U.S. National Library of Medicine, *available at* https://pubmed.ncbi.nlm.nih.gov/19443138/
[21] Mattick RP, et al., Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence, Cochrane Database of Systemic Reviews 2014, Issue 2, Art. No.: CD002207. DOI: 10.1002/14651858.CD002207.pub4.
[22] Hansen, Helena B., et al., Buprenorphine and methadone treatment for opioid dependence by income, ethnicity and race of neighborhoods in New York City, Drug and Alcohol Dependence, Volume 164, 2016, Pages 14-21, *available at* https://doi.org/10.1016/j.drugalcdep.2016.03.028.
[23] *See id.*

contrary to that mission to prosecute people in recovery for unauthorized use of methadone (a medicine that is frequently used by people of color and those of lower socioeconomic status), while declining to prosecute cases arising from unauthorized use of buprenorphine (which is more frequently used by people who are white and of higher socioeconomic status).

What is more, both methadone and buprenorphine are indisputably *far* safer than opioids such as heroin and fentanyl. And though methadone does carry a higher risk of overdose than buprenorphine, the Center for Disease Control (CDC) reports that "the rates of drug overdose deaths involving methadone . . . from 2006 through 2019 . . . decreased on average 6% per year."[24] Thus, as with buprenorphine, deterring people from using methadone (or from providing it to people receiving addiction treatment) will cause many to backslide. Without methadone, some will turn back to more dangerous opioids, like heroin and fentanyl analogs. Some will die of overdoses. And those who don't will once again become mired in a struggle with a severe chemical dependency—ruining their lives, if not ending them.

Given all of this—and given this Office's general belief that substance-use issues should be treated as health issues, not as criminal matters—the Washtenaw County Prosecutor's Office will extend its existing policy on buprenorphine to methadone. In short, as with buprenorphine, the Prosecutor's Office will no longer prosecute the use or possession of methadone.

Cognizant of the increased risk of overdose in methadone cases, the Prosecutor's Office will continue to prosecute those who engage in large-scale sale, for profit, of methadone—or whose distribution activities threaten to harm others. Absent circumstances that indicate a risk to public health or safety, however, the Prosecutor's Office will no longer prosecute cases involving small-scale distribution of methadone, particularly where the evidence indicates that the methadone was being used to assist with recovery.

II. Policy Directive

1. Use and Possession: The Washtenaw County Prosecutor's Office will no longer file criminal charges for unauthorized use or possession of methadone. Assistant Prosecuting Attorneys (APAs) are prohibited from authorizing any such charges.

2. Distribution: In addition, the Washtenaw County Prosecutor's Office has a general presumption against filing criminal charges relating to the unauthorized small-scale distribution of methadone. Many people who are unlawfully distributing methadone are in active addiction, and are sharing life-saving medicine to others suffering from addiction. It is not in the interests of justice, public safety, or public health to charge such conduct.

APAs may, however, opt to file charges against large-scale manufacturers or distributors of methadone who are engaged in the black-market sale of methadone for profit. Methadone is a medicine that should ideally be taken with a prescription, and as part of a medically supervised recovery program. A large-scale, for-profit methadone manufacture or sales operation might

[24] Hedegaard H, Miniño AM, Warner M. Drug overdose deaths in the United States, 1999–2019. NCHS Data Brief, no 394. Hyattsville, MD: National Center for Health Statistics. 2020. https://www.cdc.gov/nchs/products/databriefs/db394.htm#Suggested_citation

deter people from obtaining and using medicine in a manner that is most amenable to long-term recovery.

In addition, charges may be warranted even for small-scale distribution of methadone, if the methadone was being sold in a manner that puts the community at risk. Charges may be warranted, for example, against a person who seeks to make a profit by selling "excess" methadone-containing pain-management drugs. Distribution charges are also likely to be appropriate if the distributor is an adult selling to minors.

APAs should not, however, adopt an inflexible age-based standard. A 19-year-old (an adult) who is sharing methadone with a 17-year-old friend (a minor) who is also dealing with addiction should not be treated the same way as a 40-year-old who is selling methadone to middle schoolers for profit.

3. Small and Large Scale Cases Defined: A key guiding philosophy of the Prosecutor's Office is that every case is different, and that APAs should exercise their discretion when determining whether to authorize charges in a case.[25] For ease of administration, however, APAs should consider Michigan treatment guidelines when determining whether a methadone-related case is a "small scale" case (such that charges will presumably be inappropriate) or a "large scale" case (such that charges may be appropriate).

Michigan allows patients to possess up to 13 take-home doses of methadone.[26] The standard methadone dose is up to 100 mg. As a result, APAs should presume that any case involving 1300 mg of methadone or less is a "small scale" case that will not warrant charges under this Policy. That said, as with any case, there may be additional factual circumstances (e.g., evidence that a person in possession of less than or equal to 1300 mg of methadone was planning to sell that methadone to children) that could warrant charges even if a "small scale" amount of methadone is involved.

4. Other Substances: Nothing in this Policy should be interpreted to prohibit charges relating to other controlled substances. If, for example, the evidence demonstrates that a person possessed, sold or manufactured a "designer drug" which contains both methadone and fentanyl, an APA may authorize charges, if they are supported by the evidence and in the interests of justice.

In determining whether a charge is in the "interests of justice," APAs should be aware that methadone is frequently contaminated by other substances, and it may be the case that methadone possessed by a person in recovery may be contaminated. The spirit of this Policy, however, is not to criminalize those who are in recovery from possessing or using methadone as a means of assisting with recovery.

5. Forensic Processing and Confiscation: Nothing in this Policy shall be interpreted to prohibit

[25] *See* Policy Directive 2021-01, *Policy Eliminating "Zero Tolerance" Policies and Setting Standards for Plea Bargaining Conduct and Diversionary Opportunities, available at* https://www.washtenaw.org/DocumentCenter/View/19065/Zero-Tolerance-Policies.

[26] Michigan Managed Specialty Supports and Services Program FY20, *Treatment Policy 04: Off-Site Dosing Requirements for Medication Assisted Treatment, available at* https://www.michigan.gov/documents/Treatment_Policy_04_Off-Site_Dosing_147368_7.pdf.

or discourage the forensic processing, or confiscation and destruction, of any contraband seized as a result of any law enforcement action.

6. Other Charges Not Covered By This Policy: Nothing in this Policy shall be interpreted to prohibit or discourage the filing of charges that are not covered by this Policy.

For example: if, following a lawful search of a home, an officer discovers methadone and also discovers a weapon that links a suspect to a homicide, the Prosecutor's Office may, consistent with this Policy, file homicide charges if the evidence dictates.

7. Charges Should Be Supported by Evidence and in the Interests of Justice: Nothing in this Policy shall be interpreted to mandate or encourage the filing of charges that are not covered by this Policy. If an APA believes that filing charges other than those covered by this Policy are not supported by the evidence, or are not in the interest of justice, the APA should not file those charges.

8. Provision of Addiction-Related Services: Nothing in this Policy shall be interpreted to preclude the provision of treatment or resources to individuals who possess, use, or sell methadone, including, but not limited to, through a Law Enforcement Assisted Diversion and Deflection (LEADD) program.

9. Expungement: The Prosecutor's Office will not contest any application for expungement where the underlying charge was for the possession, use, or distribution of methadone.

10. No Substantive Rights Created: This Policy is an exercise of discretion by the Washtenaw County Prosecuting Attorney's Office. Nothing in this Policy purports to affect the legality or propriety of any law enforcement officer's actions. Nothing in this Policy shall be interpreted to create substantive or enforceable rights.

11. Exceptions: All cases are different, and this Policy accordingly provides guidance that is presumptive only. Requests for deviations from this Policy shall be made in writing, and require the approval of the Chief Assistant Prosecuting Attorney or the Prosecuting Attorney. A deviation from this Policy will be granted only in exceptional circumstances, and where public safety requires that deviation.

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