

The Co-Use of Methamphetamine and Opioids Among Patients in Treatment in Oregon, USA

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September 2019

NDEWS is supported by the National Institute on Drug Abuse of the National Institutes of Health under award number U01DA038360. This content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health (NIH).

National Drug Early Warning System

Highlights from the NDEWS Serenity Lane Hotspot Study

ABSTRACT

This report discusses findings from a Hot Spot site visit conducted to investigate emerging patterns in methamphetamine and opioid co-use at the Serenity Lane treatment program in Eugene and Coburg, Oregon. The qualitative study has the following key findings:

- Regional/geographic information is important for understanding patterns of methamphetamine use locally
- Patients experience stigma related to methamphetamine, opioids, and the use of medication assisted treatment
- Rationales and motivations regarding the co-use of methamphetamine and opioids include: 1) methamphetamine is seen as a safer alternative than heroin; 2) methamphetamine is seen as a strategy to detoxify or titrate the effects of heroin; 3) methamphetamine is seen as a financially beneficial way to maintain a desired high; and 4) there is easy access to purchasing methamphetamine and heroin in combination
- Polysubstance use, with both methamphetamine and heroin as the primary drug used, tends to be concentrated in young adult treatment cohorts

The findings of this study have the following public health implications:

- If methamphetamine is considered an important strategy or resource for opioid users to mitigate the effects of opioids, then we must continue to develop harm reduction strategies that address the needs of methamphetamine users and make these widely accessible in the same way that resources for opioid users have recently expanded.
- If people who co-use methamphetamine and opioids and are on MAT are subject to compounded forms of stigma, then further education and training initiatives must be developed to ensure that the harms of stigma can be reduced both inside and outside of treatment contexts.
- We must continue to conduct research that is generalizable, but that can also account for important local/regional nuances that are the drivers of emergent trends in drug use and patterns of use.

The report below outlines detailed qualitative findings and includes three in-depth case studies from patient participants.

OVERVIEW

In March 2019, CESAR released a report summarizing findings from an analysis of urine specimens obtained from patients admitted to a Medically Supported Withdrawal Program at Coburg Inpatient Hospital Unit, part of the Serenity Lane treatment program with sites in Eugene, Oregon and Coburg, Oregon (Billing et al., 2019). De-identified urine specimens that were going to be discarded (n=103) underwent laboratory testing for an expanded panel of drugs. The initial report can be found [here](#). The following key findings from that report formed the basis of the current study:

- Almost two thirds (61%) of the 103 specimens were found to contain methamphetamine, and these specimens came from persons who were, on average, 5 years younger than the persons who tested negative for methamphetamine.
- A set of comparisons of methamphetamine positive and negative specimens revealed that in both younger and older persons, non-fentanyl opioids, likely stemming from

heroin use, were almost 3 times more common in methamphetamine positive specimens than in methamphetamine negative specimens.

The NDEWS Coordinating Center (NCC) staff decided to pursue further examination of these findings through the initiation of a HotSpot study in the Serenity Lane programs. NCC staff wanted to assess whether there was an important emerging trend or other critical data regarding the use of methamphetamine alone or in combination with opioids among the clients.

This report presents initial analyses of qualitative data collected. A future report will provide additional analyses of the complete dataset.

STUDY DESCRIPTION

A qualitative hotspot study was designed by Dr. Andrea M. Lopez, a medical anthropologist, Professor, and affiliate with the Center for Substance Abuse Research at the University of Maryland. Site visits at two locations of the Serenity Lane treatment program were conducted by Dr. Lopez and her Research Assistant, Mary Howe, who each have approximately two decades of front-line experience working with people who use drugs in both research and direct-service capacities. The two sites were: 1) Serenity Lane Treatment Center in Eugene, Oregon (Site 1) and 2) Serenity Lane Inpatient Hospital and Residential Treatment Center in Coburg, Oregon (Site 2). Site visits were conducted on May 29-30, 2019. The study had the following aims:

Aim1: To assess the experiences, motivations, and outcomes of combined methamphetamine and opioid use from the perspective of people who are current or former drug users

Aim2: To assess the experiences, motivations, and outcomes of combined methamphetamine and opioid use from the perspective of clinicians and direct service providers who engage with people who use drugs or people in drug treatment

METHODS

Qualitative methodologies were selected as the primary data collection approach in order to explore experiences, motivations, and outcomes of methamphetamine use and methamphetamine use in combination with opioids that could not be captured through quantitative methods but that would supplement the findings from the toxicology reports. We partnered with leadership at Serenity Lane to recruit patients for a qualitative study that included focus groups with both patients and staff. In addition, we invited participation in in-depth, semi-structured interviews with patients and staff purposefully recruited because of their knowledge of methamphetamine use or previous experience with using methamphetamine and opioid use in combination. Eligibility requirements for patients were the following: 1) 18 years of age or older; 2) history of methamphetamine or opioid use; and 3) enrolled in a Serenity Lane program. Eligibility requirements for staff were the following: 1) 18 years of age or older; 2) staff member of one of the Serenity Lane drug treatment programs; and 3) knowledgeable about methamphetamine and opioid use in the community. We conducted one focus group with patients at Site 1 (n=6) and two focus groups with staff (n=12), one at Site 1 and one at Site 2. We also conducted in-depth semi-structured interviews with patients purposefully sampled at Site 2 (n=3) and staff at both Sites (n=6) who had extensive knowledge about methamphetamine and opioid use in the community.

The majority of the staff members interviewed were also in long-term recovery and so provided important insights from their perspectives as counseling staff, but also as people with previous lived experience of methamphetamine and opioid use. Focus group participants were provided refreshments as part of their participation. Patients participating in one-on-one interviews were provided \$25 compensation for participation. All interviews were audio recorded and transcribed by a professional transcriptionist. Data were analyzed and aggregated by Dr. Lopez into the findings presented below, using thematic analysis and principles of grounded theory. All study activities were approved by the Institutional Review Board at the University of Maryland, College Park.

Table. 1

Study Activity	Type of participant	Number of participants
Focus Group 1	Patients	6
Focus Group 2	Staff	6
Focus Group 2	Staff	6
Semi-structured Interviews	Staff	6
	Patients	3

RESULTS

Three primary domains of interest were identified within the qualitative dataset: 1) regional or geographic findings important for understanding patterns of methamphetamine use locally; 2) forms of stigma related to methamphetamine, opioids, and the use of medication assisted treatment; and 3) rationales and motivations regarding the co-use of methamphetamine and opioids. Staff reported that polysubstance use, with both methamphetamine and heroin as the primary drug used, tends to be concentrated in their young adult treatment cohorts.

I. Regional and Geographic Findings Regarding Methamphetamine Use

- Though methamphetamine use is widespread throughout the state, participants identified regional hotspots where methamphetamine use is particularly prevalent: Southern Oregon (Roseburg, Oregon) and Springfield, Oregon.
- In these regional hotspots there is widespread methamphetamine use, including intergenerational and familial use
- Methamphetamine use is often tied to intergenerational trauma
- In Southern Oregon, many people worked in the logging industry. Because of the demands of physical labor related to this industry, people were using methamphetamine widely to help with physically-demanding work. The decline of the logging industry has resulted in people turning to the methamphetamine industry as an income-generating strategy and for recreational use
- Local idioms for methamphetamine include: “shit” and “white”

An important local contextual factor was identified during data collection regarding the period in time in which the original urine samples were collected, between December 2017 and February 2018. At this time, the Serenity Lane treatment program accepted patients who were covered under a coordinated care organization (CCO) that contracts to provide health care to low-income Oregon patients under the Oregon Health Plan. This patient population was largely comprised of people with complex treatment needs, including long histories of homelessness, involvement in street drug scenes, and histories of trauma and

sexual violence who were from the Roseburg, Oregon area. The CCO contract was for a punctuated amount of time, during the period in which urine samples underwent enhanced toxicology analysis. This CCO is no longer under contract with Serenity Lane, so these patients were not part of our qualitative study. Future research about methamphetamine use and methamphetamine and opioid use in combination in Roseburg, Oregon may be warranted, since staff identified these patients as being an important contextual factor in the initial reporting period.

II. Stigma related to methamphetamine, opioids, and medication assisted treatment

Participants described self-shaming and externally-imposed shaming of their methamphetamine use. Shame and stigma were experienced in health care settings, including emergency rooms.

As one participant recounted: “You kind of feel sorry for the opiate addict like, ‘Oh, they have pain, and they’re covering it up. They’re not hurting anybody. They’re just sitting there.’ Whereas meth, it’s like ‘That’s a psychotic person. That’s a dangerous, insane person.’”

Another participant recounted: “I have seen people locally turned away because they’re meth users from emergency care in a life-threatening situation that wasn’t related to their meth use. It’s heartbreaking.”

Participants described the importance of a recent Oregon-wide mandate to provide medication assisted treatment (MAT) in what were previously abstinence-focused group and individual counseling. Some participants discussed that patients who are not on MAT can impose stigma on those patients on MAT because they are not perceived as being “really clean.”

One staff participant reported: “I’ll have guys that call out other guys that they’re in the same recovery house. They really know each other. They’ve been living together for six months and all this stuff. And say, ‘I have a concern for you. My concern is that I really hope you can get off suboxone. I don’t want to see you on it indefinitely...’ ‘You’re not really clean because you’re still on this thing.’”

In addition, some participants theorized that people’s methamphetamine use increases when they start MAT such as suboxone because people were no longer able to experience a high because of suboxone’s pharmacological composition: ...“I think something we noticed when we started prescribing a lot of suboxone...people’s meth use went up because they still wanted to get high. Now they couldn’t do opiates, so then they started doing meth.”

III. Strategies/Motivations Regarding Dual-use of Methamphetamine and Opioids

Regarding the dual-use of methamphetamine and opioids, participants reported motivations and strategies in four key domains: 1) methamphetamine as a safer alternative than heroin use, 2) methamphetamine use as a way to help detoxify off of heroin or to titrate the effects of heroin, 3) financially beneficial reasons related to maintaining a desired high, and 4) easy access to purchasing heroin and methamphetamine in combination.

Methamphetamine as a safer alternative than heroin use

Participants described a perception, especially in the context of the upswing in opioid overdose deaths in the area in previous years, that methamphetamine was a safer alternative to heroin, for continued drug use. Overdose rates spiked dramatically in the early

2010s locally and the Serenity Lane population was greatly impacted—approximately two dozen patients from Serenity Lane in that era experienced fatal overdoses. As one staff member recounted: “I’ve treated guys in my groups that had half a dozen friends that had overdosed by the time they were 25 years old.” Thus, some people conceived of their methamphetamine use as less risky because, though the risks of overamping on stimulants is definitely a concern, there was not a risk for a fatal overdose in the same way as with opioid use.

Focus group participants reported the following:

- “I think when I was using, it was just the possibility of overdose that comes with heroin, and with meth you’re just going to get really weird. But in that delusional state...that did seem like the safer alternative for me...”
- “...I think a lot of people who start out with heroin feel like meth is a, for some reason, safer alternative. So they go, ‘Well, I’m not doing heroin anymore, but I can start doing meth.’ And then they end up wanting the heroin still, so they end up doing them both.”
- “Most of those young men are starting to use meth with heroin as this way to come down a little bit and not overdose, because there were so many young people overdosing.”

Methamphetamine use as strategy to detoxify or titrate effects of heroin

Some participants described strategically using methamphetamine and heroin in combination in order to help with detoxification from heroin that was self-managed and also to titrate the effects of their heroin use.

One participant recounted that they had felt an urgency to stop using heroin, but while not formally in treatment, used methamphetamine as a way to help with the effects of opiate withdrawal:

“This needs to happen [stopping use of heroin]. I don’t want to stop doing drugs. So I’m going to try do to as much of this [methamphetamine] as possible to stay up past the point where I feel like I’m going to die [from heroin withdrawal]. And then you lose some days in there, and then all of a sudden you’re off heroin.”

Another recounted:

“My husband was an opiate addict. He never really got too deep into heroin, thank god, but oxycodone—six years. We started using it [methamphetamine] more because when he was coming down and withdrawing off of heroin...we couldn’t get any pills. I would go ‘Here you go so you’re not so sick.’ And then of course I took it [methamphetamine] along with him. But that’s how I usually see meth and I think that heroin and meth pretty much go hand-in-hand.”

Others used methamphetamine as a way to titrate down from the effects of heroin use and to maintain functionality during the day for work and other routine activities:

- “It seems to be a little more socially acceptable...‘It’s not so bad. I can do a little meth to go to work in the morning. At least I’m not injecting heroin.’”

- “I think it’s a functional situation. ‘I can’t be completely out of it.’ So they’re doing the speedballing or the mixing that they can do to get themselves functional but at the same time be under the influence of opioids.”
- “I’ve seen them do both where it’s they do speedballs, goofballs, whatever you want to call it. And I’ve seen where—I’ve heard people say that they use heroin and they needed a pickup, so they would do meth, and vice-versa. In my personal experience, I would do heroin, and I would need something to get me up and be productive—if you want to call it ‘productive’—and reduce my anxiety. I’ve also heard a lot of people detoxing off heroin and they use meth...”

Financially beneficial reasons related to maintaining a desired high

Some participants recounted that mixing drugs was financially beneficial because it would extend or enhance one’s high: “Financially, probably, because you get higher, and if you mix heroin with meth, it gets a little cheaper for the high.”

Easy access to purchasing methamphetamine and heroin in combination

Several participants attributed the co-use of methamphetamine and heroin as simply being related to access. Both drugs were readily available from local drug dealers and dealers would frequently advertise both. This was especially true of methamphetamine: “Dealers almost giving meth away. You buy heroin and you get meth more easily—less times you have to pay for it.”

CASE STUDY SUMMARIES

We conducted in depth interviews with patients whose primary drugs of choice were heroin and methamphetamine use in combination. A summary of their strategies and motivations regarding dual-use of methamphetamine and opioids are presented below in narrative form, in order to give more holistic perspective on the role of co-use in the lives of people who use drugs. Case Study data was collected among patients at Site 2, Serenity Lane Inpatient Hospital and Residential Treatment Center.

Case Study 1:

P03 is a 27-year-old white man, who had been using heroin and methamphetamine in combination for approximately three years, since 2016. Before he started using these drugs in combination, his primary drug of choice was alcohol. P03 started using the two in combination when he met his partner. They had been sober together for approximately one year before both starting to use both methamphetamine and heroin. P03 reported that over the last three years, he considered heroin to be his primary drug of choice and that meth was originally more situational. In the two months before the interview, he transitioned to using meth and heroin together every day, by injecting heroin and smoking meth. He recounted:

“So for me, the thing that’s gotten me up every day, you know—heroin is what I’ve been desperate to get. And meth has kind of been nice to throw in the mix when it’s available. I think pretty much every dealer I’ve ever known or worked with or sold for does both. Most of the time they’re both [sold] in little plastic baggies.”

P03 described the local heroin that is available as both “tar” and “gunpowder” and that there is a presence of fentanyl. He said about fentanyl: “Every time I’ve gotten it, that I’ve known

it's been in there, the person told me 'like hey, be careful. Just do an eighth of what you normally do because this will kill you'...I have taken that advice pretty seriously."

As P03's tolerance to heroin use increased, methamphetamine use became essential to boosting his high:

"I ended up relying on meth a lot more because I wasn't getting high so much off of heroin anymore. You know, because with heroin you get to the point fairly quickly if you're using a lot consistently, where it stops working as well as [it] did before. Or obviously build a tolerance and you don't really feel so much like you're getting high anymore. But later on, it was more like, you know, do a shot of dope and get well and be good. But then I'm not really high. So then I would a little while later start doing more meth just to try to add something to that...but the same thing happens with meth where it's not as effective. So yeah, I kind of went from, you know, both going together, being really intense, to me trying to use meth to just make—do a little extra something because neither of them are working all that well."

Case Study 2:

P02 is a 24-year-old white woman who started using drugs at the age of 13. Drugs were always readily available to her or "fronted" to her from her partner who was also a drug dealer. Meth, heroin, and benzodiazepines are all her drugs of choice. She said:

"On the streets I would try to get off heroin and smoke meth instead, but then it was always giving me too much anxiety and panic attacks. And then I'd use the heroin and I'd be too sleepy and then use the meth...I've always hated it, but I used it to stay awake so I could drive and work. But detoxing off meth was hard because it was never just meth. It was always the heroin too."

P02 also described particular challenges from a treatment perspective that she experienced as a result of her co-use:

"So, I went to treatment this last time, it was mostly just for meth...and I remember being jealous that the heroin users had Suboxone. So I was super jealous that people could have that and it helped with withdrawal."

Similar to other participants, P02 mixed heroin and methamphetamine to achieve some level of functionality to perform her everyday tasks:

"My goal of using heroin was to nod out. Which it's why it's super triggering that people can nod out [in groups where others are on MAT]. But I still had to function and go to work and drive and I'd be rolling down the windows and smacking myself trying to wake up to drive. So then that's when the meth came in and it bounced me out to a sense. The meth would, you know, make your heart rate, make you not hungry, make you awake. So it kind of had the adverse effect of the heroin, which is why I used them together. But everyone I knew that did heroin always did meth too."

Case Study 3:

P01 is a 28-year-old white man who had approximately three years of "clean time" before his recent relapse. He had been on a six-month drug run before checking himself into the

treatment center. He described meth as being extremely accessible locally and that “dealers give it away.” He recounted:

“I think that a lot of people, although they don’t necessarily IV them together, I think typically if you do heroin, you do meth. These days, I think everybody does both...Like, when I was a junkie, my life sucked. But when I combined them, it took me to a whole new level of...I think it was because I have such a low tolerance to meth, that I could shoot up very little of it and be majorly affected. And when combining just a little bit of meth with just a little bit of heroin, I felt like the effects were longer. And I got more out of a little...A lot of the time that I was using heroin, I sold heroin. So, I was okay with using. But there’s also long periods of time where it’s like I’m scraping by with \$5 off heroin.”

P01’s regular drug use became highly focused on co-use:

“There would be days when I would be completely dope sick, pocket full of heroin and not meth, and I would not use just heroin. I would wait and wait and wait until I could find meth to combine them. And I feel like combining them made me a whole different slave to it. And it was weird things. Like, I never picked my face before when I used heroin. Never picked my face before when I used meth. When I use them together, I just destroy my body...I like just doing heroin. But combined, I just feel like there’s nothing else on this—it’s like the most evil thing on this planet, is those two combined.”

P01 also used heroin at times when he was overamping on methamphetamine as a way to “come down” from intense moments of stimulation:

“That’s why I don’t like shooting up meth. Because I feel like every time, I overamp. And then I’m immediately just weird, delusional. So, what got me into using last time I was doing a lot of meth by myself, which I absolutely hated. But I needed to use. So by the end of about four or five days, it was like ‘Okay, I need to go to sleep now and feel normal.’ So I was like ‘I’m going to pick up some heroin and sleep it off.’ Anytime I do meth by itself, I don’t stop using it unless I have heroin.”

LIMITATIONS

Findings must be considered in light of the following limitations: The study has a small sample size and is therefore neither representative nor are findings generalizable. The strength of qualitative data, however, are that they allow investigation of potentially emergent issues and patterns of interest that can inform the design of timely future research. Further, the study relied on purposeful sampling conducted over a two-day site visit. Longitudinal research and/or studies conducted with a population of people who use drugs both in treatment and out of treatment may be warranted to capture more diverse experiences.

CONCLUSION/NEXT STEPS

This preliminary analysis is responsive to the larger NDEWS goals of identifying emergent trends in drug use and patterns of use. We found that conducting the qualitative site visit contributed a scientific “value-added” to our original quantitative findings (Lopez et al. 2013).

We identified important geographical/regional nuances about the cross-sectional sample that was originally analyzed in the quantitative study. The initial quantitative study examined urine samples that were collected between December 2017 and February 2018. Our qualitative study identified that there was a significant shift in the patient population at Serenity Lane, which included patients from the Roseburg, Oregon area, who entered Serenity Lane during that time period because of momentary insurance coverage through a coordinated care organization that provides health care to low-income Oregon patients. Thus, our qualitative study was able to provide insight on the partial picture of the initial quantitative analysis and explicate the nuances of the findings in a local context. For instance, it may be the case that this pattern of co-use was associated with this specific patient population that was at Serenity Lane for a punctuated period of time. This triangulation of quantitative and qualitative data is essential to identify limitations within each approach, but taken together provides a more holistic picture of the co-use of methamphetamines and opioids. This triangulated finding indicates that further research with people from the Roseburg, Oregon area may be useful to examine whether there is a geographically-concentrated pattern of the co-use of methamphetamine and opioids.

Further, people who use drugs have strategies and motivations for the co-use of methamphetamines and opioids that are not captured in quantitative analysis. They engage in co-use because methamphetamine is considered a safer alternative than heroin, because methamphetamine can be used to titrate the effects of heroin, and because of issues related to access. A comprehensive understanding of these motivations and strategies is critical information that spurs questions about the development of interventions for people engaged in co-use of methamphetamines and opioids. This population may need to be considered for tailored treatment needs and harm reduction strategies. These motivations cannot be not captured in quantitative analysis, but are the crucial drivers of emergent patterns of co-use that must be documented in real time.

IMPLICATIONS OF FINDINGS FOR PUBLIC HEALTH

The findings of this study have the following public health implications:

- If methamphetamine is considered an important strategy or resource for opioid users to mitigate the effects of opioids, then we must continue to develop harm reduction strategies that address the needs of methamphetamine users and make these widely accessible in the same way that resources for opioid users have recently expanded.
- If people who co-use methamphetamine and opioids and are on MAT are subject to compounded forms of stigma, then further education and training initiatives must be developed to ensure that the harms of stigma can be reduced both inside and outside of treatment contexts.
- We must continue to conduct research that is generalizable, but that can also account for important local/regional nuances that are the drivers of emergent trends in drug use and patterns of use.

PLANS FOR ADDITIONAL ANALYSES

This report represents an initial analysis of transcripts examined through purposeful sampling methods. Our team intends to conduct an additional enhanced analysis with more of the data to further understand the impact of regional issues on people's co-use of methamphetamine and opioids and strategies/motivations for co-use. This study has also piqued research questions about the unique forms of stigma (including self-shame and externally imposed) that people who co-use methamphetamine and opioids experience. In

addition, the study sparks questions about harm reduction training capacity to address the specific strategies/motivations that people employ with co-use.

ACKNOWLEDGEMENTS

We thank the patients and staff at Serenity Lane who participated, without whom this study would not be possible. We also thank the work of the administrative staff at Serenity Lane who coordinated the site visit, provided confidential interview spaces, and recruited patient and staff participants for focus groups and in-depth interviews at both sites. Our research team was received very warmly by staff and they facilitated two productive days of data collection for our team. We also thank the NDEWS staff, particularly Dr. Eric Wish, Erin Artigiani, Amy Billing, and Marwa Al-Nassir. We also thank the administrative staff at Serenity Lane, including Dr. Eric Geisler, who established a collaborative relationship long before this site visit, which ensured that our short site visit was a success. We are grateful to Mary Howe, who along with Dr. Lopez, conducted the site visit and collected all data. This report was produced by Dr. Lopez, with input from Dr. Wish and Erin Artigiani.

Citations

Billing, A.S., Artigiani, E.E, Hippolyte, T., and Wish, E.D. (2019). **Drug Early Warning Signals (DEWS): Serenity Lane - Coburg, Oregon.** Office of National Drug Control Policy. Washington, DC: Executive Office of the President

Lopez AM, Bourgois P, Wenger LD, Lorvick J, Martinez AN, Kral AH. Interdisciplinary mixed methods research with structurally vulnerable populations: case studies of injection drug users in San Francisco. *Int J Drug Policy*. 2013 Mar;24(2):101-9. PubMed PMID: [23312109](#); PubMed Central PMCID: [PMC3954115](#).

Appendix

- A. Instrument #1- Focus group with people recruited from program sites
- B. Instrument #2- Qualitative interviews with staff
- C. Instrument #3- Qualitative interviews with people in treatment

Instrument #1- Focus group with people recruited from program sites

Introduction script:

Thank you for joining us for this focus group to better understand methamphetamine and opioid use in this community. Today we would like to hear from you to better understand how and why people are using these two types of drugs together. We expect the focus group to take about an hour to an hour and a half. We have provided some refreshments for you to enjoy while you are here, so please help yourself.

The first thing we are going to do is go over the consent form. I am going to read it aloud to everyone. Please follow along with me. There will be time for questions at the end.

[Interviewer goes over consent and answers any questions]

Before we begin, this is just a reminder that anything that is said in this focus group should be kept confidential. We will not be recording your name—but you will get a pseudonym or “fake name.” I am going to pose some questions to the group and ask for responses. When you would like to share, please raise your hand, and I will call on you. I ask that you not mention other individuals by name during the focus group. Just a reminder that participation is totally voluntary and your decision regarding whether to participate will not affect your drug treatment or any of your rights at the Serenity Lane program.

Topical areas for interviewers:

General topic: methamphetamine use

- 1) In our initial study of 103 people coming in to the hospital inpatient unit for Medically Supported Withdrawal, we found that 61% of those people had been using methamphetamine. So we want to open up the discussion to hear about methamphetamine use in this area:
 - What do you know about meth in this area?
 - Tell us about when meth started showing up in this area and whether you have seen anything related to meth change over time.
 - Are there certain groups of people or certain areas where meth is more common?
 - Why are people using meth?
 - Tell us about how people are using meth around here (e.g., injecting, snorting, smoking)
 - Have you ever heard of the term “overamping?” Tell us what you’ve heard.
 - What forms is meth available in? Does it look different than it has in the past?
 - What does the packaging look like?
 - What is it called on the street?
 - How much does it cost to purchase?

General topic: Combining methamphetamine with opioids

- 2) Next we want to talk about why some people might be using methamphetamine with opioids like heroin, fentanyl, or pills.
 - How are these drugs being marketed? Are some drugs being disguised as or mixed with other drugs?
 - Are users combining these drugs when they use them (e.g. speedballs)? Do dealers sell them already combined?
 - Why would people combine these drugs?

- Probes: they like the high; they use one to counter the effects of the other; they use one to taper another; to treat health or mental health symptoms, etc.
- What is the high like? What's it like to come down?
- How do people's drug use practices change when they are using these drugs in combination? (Probe for concerns about overdose and overdose response)
- Can you talk about what people need most when they are using this in combination? (Probe for ways people take care of themselves, health/mental health issues to look out for, etc.)

General topic: Health Services and Treatment Needs

- 3) Now we want to talk about what it's like to seek services or treatment when you use both methamphetamine and opioids
 - Tell us about what it's like to seek treatment when you use both methamphetamine and opioids?
 - Is there anything you would like treatment providers to know about seeking treatment for these substances?

Instrument #2- Qualitative interviews with staff

Background (for baseline information and to build rapport)

- Tell me about your background in drug treatment.
 - How long and in what capacity do you work here?
 - What are some important things to know about drug use in this area?
 - What are some of the challenges you face in doing this work? What are some things you're proud of?

Work with people who use drugs

- Now I would like to talk about the people that you see in this treatment program.
 - What types of drugs do they use?
 - What are some of the biggest issues they face with respect to their drug use?
 - In a sample of 103 people entering the inpatient program, we found that 61% of people in the sample showed methamphetamine use. What are your initial thoughts on this finding? Why might we be seeing this trend at this point in time?
- What changes in drug use have you noticed over time?
- What are some of the key phrases (slang) in the people you serve?
- What are some of the health risk behaviors? How have these risky practices changed?

Knowledge about methamphetamine use

- Walk me through the unique treatment needs of people who use methamphetamine.
 - Are there certain protocols or treatment modalities you follow?
 - What are the challenges they face in a treatment program?
 - Is there any unique programming or methods employed to address their needs?

Knowledge about opioid use

- Walk me through the unique treatment needs of people who use opioids.
 - Are there certain protocols or treatment modalities you follow?
 - What are the challenges they face in a treatment program?
 - Is there any unique programming or methods employed to address their needs?

Working with people using drugs in combination

- Walk me through your thoughts about why people are using methamphetamine and opioids in combination? (Probes: to "come down" from one or the other; to address health/mental health needs; because of a desirable high)
- From a treatment perspective, are there unique needs or treatment modalities?
- Can you discuss some of the motivations you encounter for why people are seeking treatment for this right now?
- Have you had to change anything about how you provide services to people who are using these drugs in combination?

Introduction script:

Hello and thank you for agreeing to meet with me to learn more about participating in an individual interview. Although I led the focus group, I would like to reintroduce myself. My name is Dr. Andrea Lopez and I am visiting Serenity Lane today to learn more about methamphetamine and opioid use in Oregon. Your responses in the focus group were of particular interest to me and I asked to meet with you to learn a bit more from you on this topic. If you agree to participate in an interview, I will be asking you questions about your general experiences with drug use, your preferences for using some drugs together and your experiences using drug treatment for these issues. The interview will last approximately an hour. You will not be asked for your name and your name will not be linked to any of your responses. Your participation is completely voluntary. Neither your decision regarding participation nor your individual responses will be shared with Serenity Lane staff. Your choice regarding participation will not affect the treatment or services you receive by the Serenity Lane program in which you are enrolled. If you agree to complete the interview, you will be paid \$25.00 for your time. Are you interested in learning more about the interview?

Instrument #3- Qualitative interviews with people in treatment

Background information

- To start, I'd like to hear a little bit about you.
 - Where are you from and how long have you been in the area?
 - Tell me about what your life is like right now and what you're doing to get by?
 - Who are the people in your life that you can turn to for support?
- How long have you been involved with Serenity Lane?
 - Tell me about how you ended up seeking services here?
 - Tell me about your experience has been thus far.

Drug Use History

- Can you walk me through your drug use history? Probes: different drugs used; modes of ingestion; periods of different drug use
- Talk to me about your drugs of choice and how you got started using them.
- Tell me about how the types of drugs you use shifted over time.
- Have you noticed any changes in the drugs available in your area in recent months/years? If so, what?
- Did you usually use by yourself or with others?

Using methamphetamines and opioids in combination

- How are these drugs being marketed? Are some drugs being disguised as or mixed with other drugs?
- We are interested in understanding why people might be using methamphetamine and opioids in combination. Can you talk to me about combining these drugs?
 - How did you start combining these?
 - Why did you initially want to use them together?
 - Tell me about the effects that come from using these in combination
 - Tell me about any concerns or issues that come from using them in combination
- Some people use opioids to "come down" from methamphetamine. What are your thoughts on this? Can you tell me about times when you have done this in your own life?

Treatment experiences and needs

- Can you tell me about your experiences seeking and accessing treatment for drug use over time?
- Walk me through what it was like to enter treatment for methamphetamine and opioids in combination
 - Probes: was it easier/where there unique challenges?
- Were there different things you needed based on the fact that you had been using both methamphetamine and opioids?
 - Probes: different needs around detox, MAT, counseling or supportive services, managing symptoms, managing stressors and withdrawal