Rx Drug Abuse
& Heroin Summit

Concurrent Opioid and Methamphetamine Use in Rural Communities: Perspectives Among People Who Use Drugs

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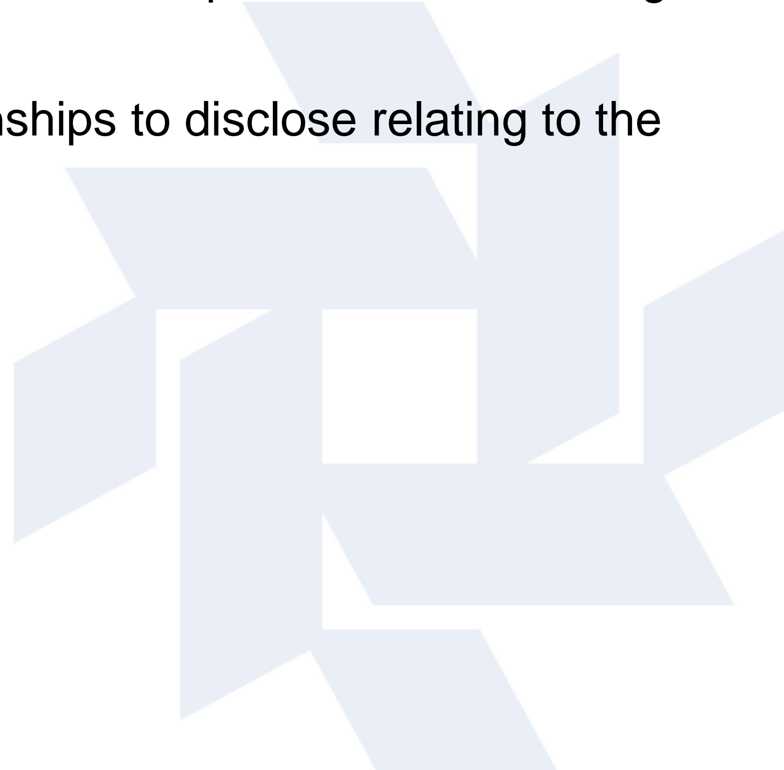
Faculty Disclosures

- P. Todd Korthuis, MD, MPH, has no financial relationships to disclose relating to the subject matter of this presentation.
- Gillian Leichtling, BA, has no financial relationships to disclose relating to the subject matter of this presentation.



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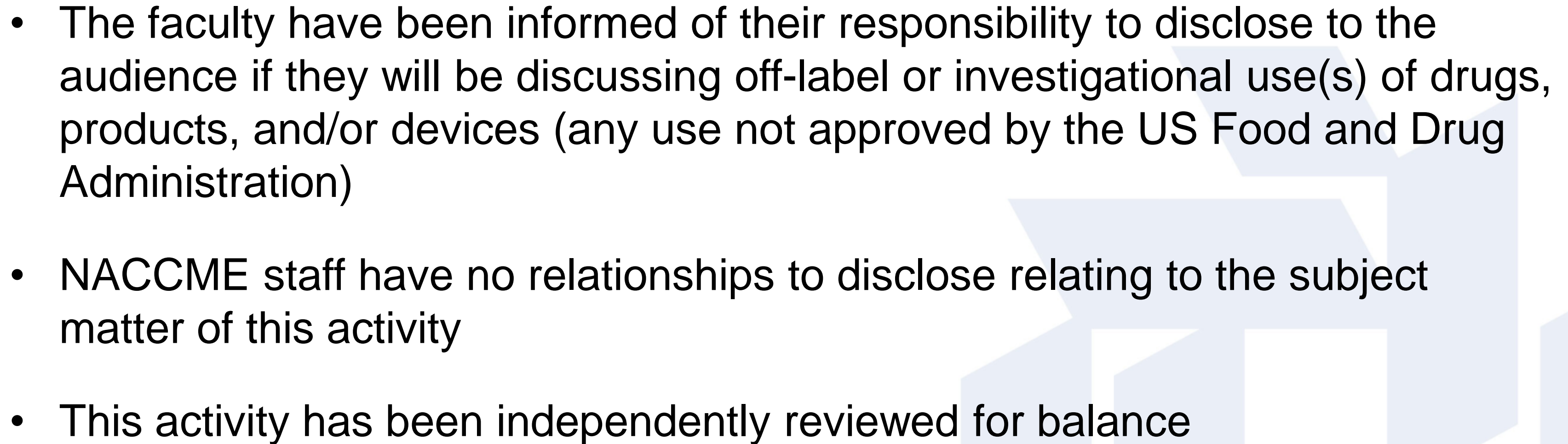

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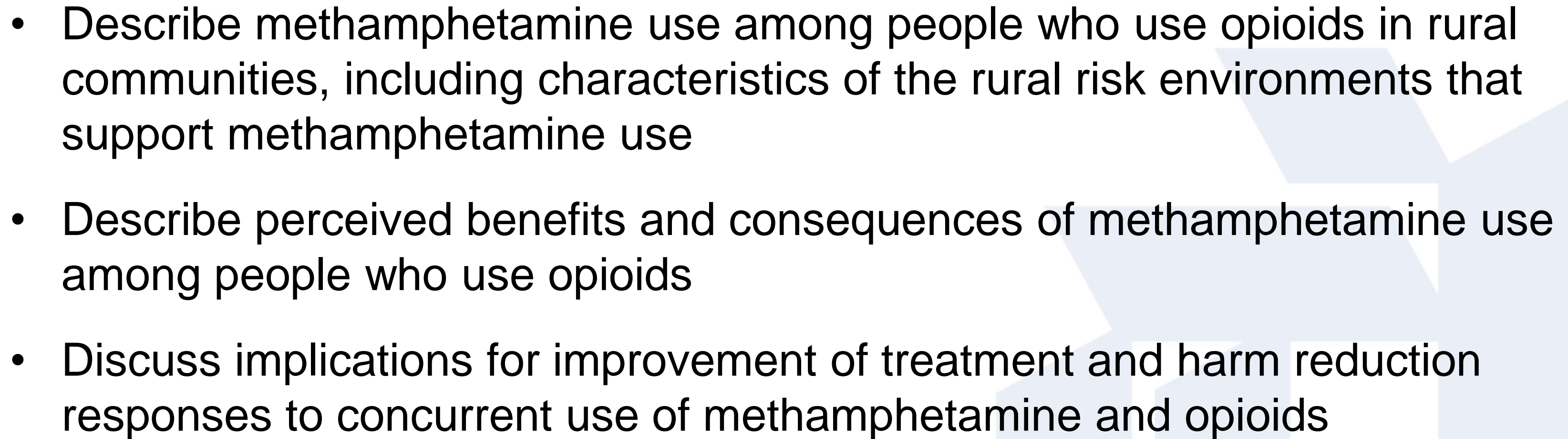
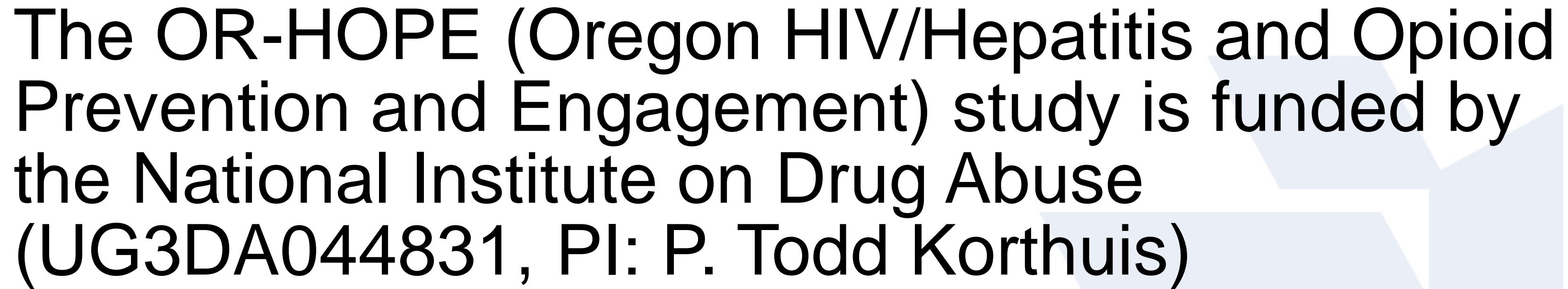
Learning Objectives



- Describe methamphetamine use among people who use opioids in rural communities, including characteristics of the rural risk environments that support methamphetamine use
- Describe perceived benefits and consequences of methamphetamine use among people who use opioids
- Discuss implications for improvement of treatment and harm reduction responses to concurrent use of methamphetamine and opioids

Disclosures



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Background

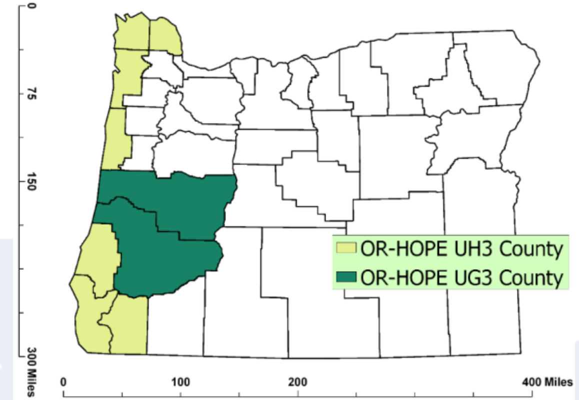
- Methamphetamine use among people who use opioids increased from 19%→34% between 2011–2017[1]
  - The Western US has highest prevalence in country: 63%[1]
- Amphetamine-related hospitalizations also increased[2]; overdose deaths increased 37% 2016–2017[3]
  - Half of all psychostimulant-related OD deaths involved opioids,[3] including synthetic opioids[4]
- Especially problematic in rural communities:
  - More likely to use methamphetamine, initiate substance use younger, and engage in riskier drug use behavior[5,6]

[1]Ellis et al., 2018; [2]Winkelman et al., 2018; [3]Kariisa et al., 2019; [4]Jones et al., 2018; [5]Dombrowski et al., 2016; [6]Grant et al., 2007

Study Setting

Two pilot counties (Lane, Douglas) in Oregon

- Each close in size to Connecticut
- Extend from Pacific Ocean to east of the Cascade Mountains
- 50% of land controlled by US Forest Service BLM
- Opioid overdose rates exceed state average
- Include rural addiction treatment deserts



Methods

Survey

- Recruitment March 2018 to April 2019 using respondent-driven sampling (RDS).
  - Seed participants recruited from syringe service programs and provided with 3 “referral coupons” to invite others.
  - Eligible referrals enrolled and provided 3 coupons to invite others.
- Survey administered by study staff using a tablet computer.
  - Items included substance use, sexual and injection risk, and treatment utilization history
- Honorarium of $25

Heckathorn, 1997

Interviews

- Recruitment July to September 2018 by peer support specialists at outdoor field locations, syringe services, and by invitation to survey participants
  - Sixty-minute semi-structured interviews by study staff
  - Similar domains to the survey.
- Honorarium of $50.
- Used NVivo software; thematic analysis with a semantic, inductive approach.

Guest, MacQueen, & Narney, 2011; Miles, Huberman, & Saldana, 2014

Participant Inclusion Criteria

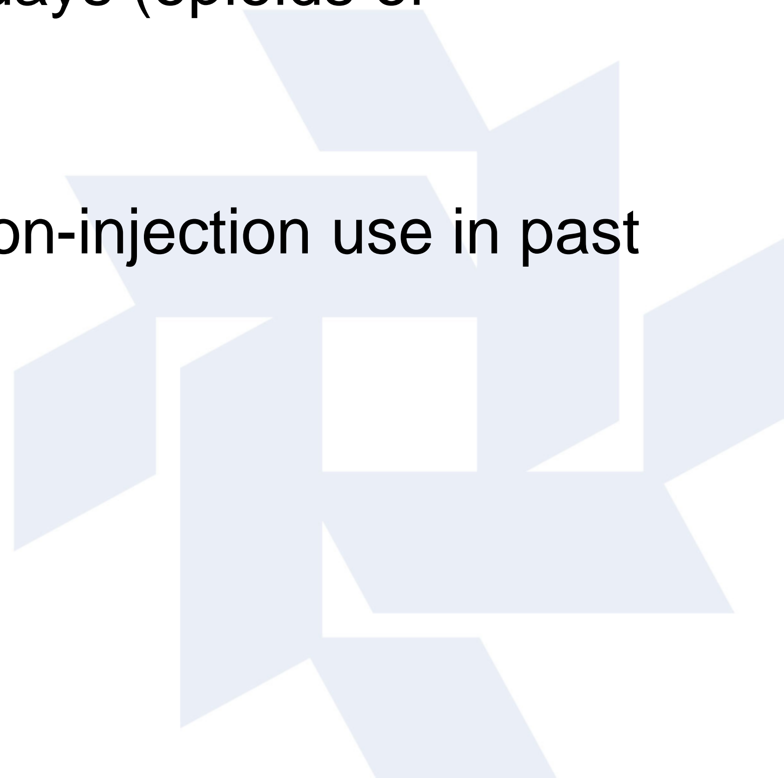
- Any injection drug use in past 30 days (opioids or methamphetamine)

OR

- Recreational prescription opioid non-injection use in past 30 days

AND

  - Live in study area
  - Age $\geq$18 years
  - English-speaking



SURVEY RESULTS

Survey Sample (N=177)

Gender/Race/Ethnicity

57% Male
82% White
89% Non-Hispanic

Age Group

26% <30 years old
38% 30-39 years old
23% 40-49 years old
13% 50+ years old

In previous 6 months:

68% homeless
50% incarcerated
36% on community supervision

Substance Use & Overdose History

Stated drug of choice

41% Heroin

51% Meth

8% Other

Overdose experience

41% Ever overdosed

Age of first injection use Mean (SD)

Opioids	Meth
25 (10)	**22 (8)**

Past 30-day Substance Use

77% used an opioid

↓

Of these, **96% also used meth**

↓

Of these, **85% had injection use** (meth or opioid)

↓

Of these, **47% co-injected** meth and opioids (goofballs)

Injection Use and Hepatitis C

Hepatitis C Status (N = 171)

23% Already known positive
27% New positive
50% Negative

Injection behaviors

60% of people who currently inject had shared syringes or equipment in past 30 days

Among people who inject, percent who had shared equipment in past 30 days by Hep C status:

Already known positive	New positive	Negative
64% shared	73% shared	51% shared

INTERVIEW RESULTS

Interview Sample (N=52)

Gender

54% Male
44% Female
2% Other

Age Group

23% <30 years old
39% 30-39 years old
6% 40-49 years old
22% 50+ years old

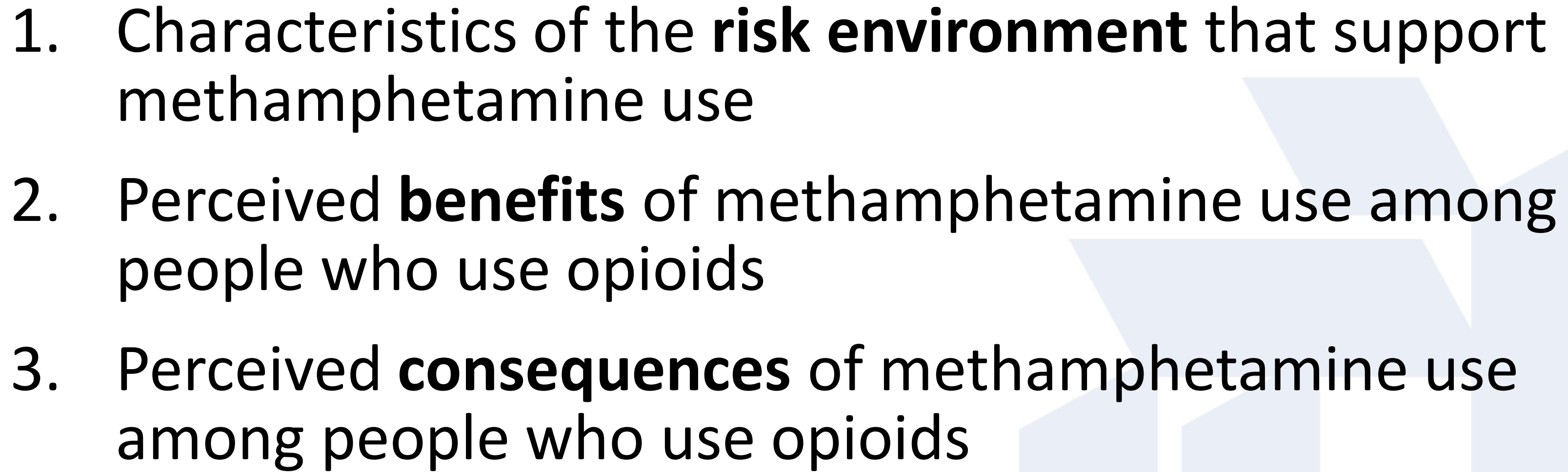
Ethnicity

94% Non-Hispanic
4% Hispanic
2% Don't Know

Race

94% White
4% Multiracial
2% American Indian

Three Emergent Interview Themes



1. Characteristics of the **risk environment** that support methamphetamine use
2. Perceived **benefits** of methamphetamine use among people who use opioids
3. Perceived **consequences** of methamphetamine use among people who use opioids

Risk Environment

Early exposure to meth (early or mid-adolescence)

- ***I was eight years old and my parents kept an old metal first aid kit on top of the fridge.*** *When I got to where I could get into it, I found it had crank and marijuana and cocaine in it. I didn't really know what to do with it, so I told my neighbor, who was 12 or 14. He had done drugs before...he taught me how to smoke pot and snort crank and coke.*
- ***I was 12 years old...I was at my friend's house****...he brought out white dope [meth] and he gave it to all of us. I snorted it, and my life has never been the same ever since then.*

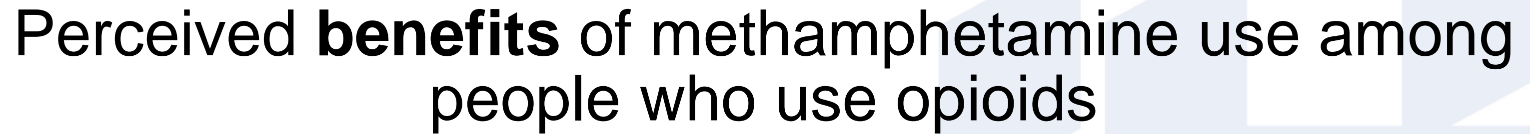
Widespread availability and low cost of meth

- ***I don't have to pay** for [meth]; I just have to ask for it… when I was in the methadone clinic, they were talking about the opiate epidemic…**it's not opiates. It's meth.** They're just looking over it. They're not even seeing what's really here.*
- *The price of meth has gone down ... **It's hard to even give it away because everybody wants to do heroin** instead…. I would prefer to do the heroin, but people give meth away nowadays pretty much…*
- *The primary thing is heroin, but then **meth I just use if I can't find heroin or heroin is too expensive**. Most of the time, you need at least $20 to get a point, so if you don't have $20, you just have $5 and all you can get is meth.*

Lower stigma relative to heroin

- ***Meth is very popular.*** *Heroin isn't as popular; people have this stigma that it's the devil's drug, a bad drug. The people who use it, they're really treated like crap.* ***You get treated really badly if you're a heroin addict****...*
- ***There's less of a societal stigma in this area for meth versus heroin****. The societal stigma of heroin in this area is very, very frowned upon, where if you had somebody using $20 on meth and somebody using $20 on heroin, they're going to look down on the guy using heroin first in this area.*

Perceived Benefits



Meth to relieve opioid withdrawal

- *Most heroin addicts are using meth at the same time, or they will dabble in meth because…**you don't feel so sick**.*
- *If I couldn't find opiates, then **I found out that you could use meth and it would help [with opioid withdrawal] a little bit**. So I started substituting that with meth.*
- *When I was coming off methadone…the **only thing that helped was meth**…I didn't even have to get high.*
- *I'm getting out of [buprenorphine] program, they're titrating me down rapidly, and so I've been sick for a week…**I've been doing so much more meth just to try to deflect the pain**…they're too hard to come down from. It's just you can't do it without another drug… especially if you have a job or responsibilities or kids.*

Meth to aid in intentional reduction of opioid use

- *We quit - me and my mom - doing heroin and started doing meth, pretty much.* ***That's how we came off of [heroin].***
- *I used meth, actually, with my ex. He's like,* ***"We're going to get off pills,"*** *…So then I used meth to help with my withdrawals.*
- *When I do heroin now, it's not every day… because* ***I don't like to get sick****...One time I went to jail, and… I believe my heart was going to explode from the sickness. I hadn't done meth for almost 13 or 14 years… Somebody had passed around a meth pipe… within a week I was banging meth again. So that's why I guess I do heroin less now, is because I do methamphetamine…* ***I've toned down the heroin use because I've lost… A lot of my friends have died, and the endocarditis****…*

Meth for opioid overdose reversal

- *They were trying to get him to be coherent enough to do a shot of white [meth],* ***because Narcan is an upper…So is white, so they can do a shot of white.***
- *It was heroin, and she told me… "Careful. This stuff is really good," and so she split the shot in half. I didn't really think it was any big deal, so…I added right around a half a gram of meth to mine. In our eyes,* ***we all think that if you have meth in your shot of heroin, you're not going to die*** *just because it's that helper that's going to keep your heart going, which is not always true.*

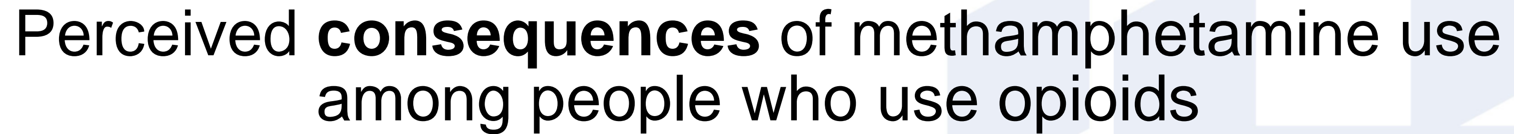
Meth to enhance functioning

- *I work in [timber industry job]. My job is super fast-paced…I don't shoot methamphetamines to get high or to freaking go out and rob or pillage.* ***I use it as a tool so that I can work my 10-and-a-half-hour day*** *with it and go home and still be a husband and do what I need to do all day long. I can't just go home and go to bed because I'm tired. I've got other shit I have to do…I have a family I have to look after.*
- *The heroin breaks me down, and then I need to get back up again, so I do more meth…So* ***if I have to go to work, I'm going to do meth to get up****. I'm going to work and get my job done, and then if I want to come down, then I'm going to do heroin.*

Preference for combined effects

- *I think that it's a yin and yang kind of thing, that they go well together. Meth will freaking get you kooked out mentally, and heroin will fuck you up physically more because it'll kill you… So therefore, [together]* ***they make you feel good, like yin and yang.***
- *I don't think [heroin] does anything to the meth. It just does something to me… I just get less pain, because with meth I still get pain, but with* ***the heroin it takes some of that pain away. Then I can enjoy the meth a little bit better.***

Perceived Consequences



Meth use leading to discharge from medications for opioid use disorder

- *I like the people, the staff and the other patients. It's like my family almost. It's my only social outlet anymore…but…some of the new policies about* ***if you use meth then you get kicked out.*** *After a couple UAs you get kicked out.*
- *I only recently started using the heroin again a couple months ago because…my wife got* ***kicked out of the methadone clinic because she kept peeing dirty for white [meth]…****when you come up with dirty UAs and stuff, they only allow that for so long. Then they start to wean you off the methadone and kick you out…She was starting to get sick and going through freaking opioid withdrawal super bad, so…I got heroin…Then I was starting to use the heroin part-time with her…So then we both started using the heroin,* ***and here we are; both sick again****.*

Risk of fentanyl adulteration/contamination of meth

- *Yeah, I think that **everything is being cut with [fentanyl], which doesn't make sense because white is an upper.** Meth is an upper, not a downer. Why would you put a downer in an upper? But it's highly addictive, is what I hear… Like I'll do some white and it'll make me tired, but I'll want to do more.*
- The dope is different these days… **Now [meth] has been mixed with so many different opioids,** and every time I smoke that, it's a comedown. I sat there the other day… shooting a load and falling asleep directly afterwards.

Discussion

Summary

- **Methamphetamine use pervasive** among people using opioids in rural communities
  - Nearly all people who use opioids also used meth
  - Most injected opioids and meth separately; nearly half had injected simultaneously
- **Syringe sharing and hepatitis C** common among people who inject
  - Majority of people with hepatitis C had recently shared injection equipment

Summary

- **Perceived benefits** of meth use
  - Less expensive, more available, and less stigmatized than heroin
  - Relieves opioid withdrawal, helps reduce opioid use, enhances functioning, and combines well with opioids
  - Can prevent or reverse opioid overdose
- **Perceived consequences** of meth use
  - Involuntary discharge from medications for OUD
  - Risk of adulteration with fentanyl

Limitations

- Study was limited to two rural Oregon counties with endemic methamphetamine use.
- Policies and practices reported by treatment providers regarding polysubstance use and positive urinalysis not examined here.
- Influence of social determinants of health (e.g. gender, race, poverty) not examined here.

Implications for Rural Areas

Community Level

- Need for greater **access to medications for OUD** to reduce meth use as opioid taper/withdrawal support

Provider Level

- Need for **tailored treatment** for concurrent opioid-meth use and education on **alternatives to discharge** from medications for OUD

Individual Level

- Need for **overdose education** addressing methamphetamine misperceptions and risks

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Fentanyl, Heroin & Illicit Drugs Track

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