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“Like Yin and Yang”: Perceptions of Methamphetamine Benefits and Consequences Among People Who Use Opioids in Rural Communities

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Abstract

Objectives: The objective of this study was to investigate methamphetamine use among people who use opioids in rural Oregon communities to explore reasons for use and perceptions of methamphetamine consequences.

Methods: We conducted interviews and surveys with participants who inject drugs or misuse prescription opioids in 2 rural Oregon counties with high opioid overdose rates. Survey participants were identified through participant-driven sampling initiated in syringe service programs and field outreach (n = 144). Semi-structured interviews with participants were recruited from the same locations (n = 52).

Results: Of 144 surveys completed, 112 reported using opioids in the past 30 days; 96% of the 112 also report methamphetamine use. Among the 124 reporting injection drug use, 50% indicated they injected both methamphetamine and heroin in the past 30 days. Interview participants reported early exposure to methamphetamine and indicated that methamphetamine was more widely available, less expensive, and less stigmatized compared to heroin. Participants reported using methamphetamine to improve work-life functioning and because they enjoy the high produced from simultaneous use. Several participants reported a conscious effort to shift to methamphetamine from heroin as a harm reduction strategy.

Some participants reported being involuntarily discharged from treatment for opioid use disorder due to methamphetamine use. Several participants perceived methamphetamine as conveying overdose prevention or reversal benefits, while fentanyl contamination in methamphetamine was reported or suspected.

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Conclusion: As rural communities respond to evolving drug supply and demand, there is increasing need for public health efforts to address the emerging issue of concurrent methamphetamine and opioid use.

Keywords

heroin; injection drug abuse; methamphetamine; opioids; qualitative research; rural

Polysubstance use among people with opioid use disorder (OUD) has received little attention despite most people with OUD reporting use of one or more additional substances in the past year.¹ Recent studies demonstrate increases in concurrent use of methamphetamine and opioids, which includes use of both on separate occasions as well as simultaneously.^{2–5} Methamphetamine-related emergency department visits⁶ and amphetamine-related hospitalizations have risen in the US,⁷ with the Western region experiencing higher rates.^{6,7} Between 2016 and 2017, overdose deaths involving psychostimulants increased 37%; approximately half were associated with opioids.⁸ Studies have found concurrent use is associated with increased risk of overdose compared to injection of heroin alone.^{3,9} Finally, synthetic opioids—the main driver of increased opioid overdose deaths—may be increasingly involved in psychostimulant-related deaths.¹⁰

Factors unique to rural communities increase susceptibility and vulnerability to drug use and associated harms.^{11,12} Rural residents typically initiate drug use at younger ages, are more likely to use methamphetamine, and engage in riskier drug use behavior.^{13,14} While prevalence of concurrent use is high, little is known about motivations for methamphetamine use among people who use opioids. One study found that among people entering OUD treatment, respondents reported using methamphetamine to cope with opioid withdrawal, increase energy to function, and enjoy the high produced from co-injection²; however, this study did not focus on rural communities. Our study explores perceptions of methamphetamine use among people who use opioids in rural communities impacted by high rates of opioid overdose.

METHODS

Data comes from 2 high-needs rural Oregon counties (ie, Douglas, Lane) that served as pilot sites for the Oregon HOPE study, part of the National Rural Opioids Initiative to address OUD, hepatitis C, and HIV.¹⁵ From 2015 to 2017, the opioid overdose death rate was 6.2 per 100,000 in Douglas and 10.0 per 100,000 in Lane.¹⁶ Access to substance use treatment is low due to few treatment providers and long travel distances. The pilot included risk assessment surveys and semi-structured interviews with individuals aged 18+ years who injected any drug or used opioids to get high in the past 30 days. The study was approved by the OHSU Institutional Review Board and granted a Federal Certificate of Confidentiality.

Survey Participants and Procedures.

People who use drugs (N = 144) were recruited March 2018–April 2019 using participant-driven sampling.¹⁷ Seed participants were recruited from local syringe service programs and given 3 “referral coupons” to distribute in their social network. Eligible referrals were

enrolled and provided 3 coupons to invite their peers, and so on. Surveys regarding substance use, sexual and injection risk behaviors, and treatment and service utilization history were administered by study staff (ie, peer support specialists, research assistants) using tablet computers. Participants received an honorarium of \$25.

Interview Participants and Procedures.

July to September 2018, interview participants (N = 52) were recruited by peer support specialists at the syringe service program, outdoor field locations, and by direct invitation to the small number of individuals participating in the survey during interview recruitment. To reach service-seeking and non-service-seeking populations, the team selected locations identified by survey participants as frequented by substance-using populations. Interviews were conducted in semi-private or private locations (eg, public parks, mobile outreach van, community-based service locations). The interview protocol consisted of open-ended questions with probes exploring the same domains addressed by the survey. Interviewers were 4 research associates/assistants with training in qualitative data collection, experience interviewing people who use drugs, and backgrounds in social work, anthropology, developmental psychology, and public health. Before recruitment, the team jointly completed an interviewing skills refresher and completed mock interviews. Participant demographics were monitored for variation in gender and age during recruitment. After 2 rounds of interviews, the team determined that saturation had been attained. Participants received an honorarium of \$50. Interviews, lasting approximately 60 minutes, were audio-recorded, transcribed, and uploaded into NVivo software (version 12.1) for analysis.

Analysis

We used descriptive statistics to report survey responses of participant characteristics. We used thematic analysis with a semantic, inductive approach to analyze the interviews.^{18,19} We read and familiarized ourselves with the data to create the initial codes and used an iterative process to refine the codebook. Two team members (RB, CP) coded the remaining transcripts independently, using the NVivo memo function to track questions for discussion. We met regularly to assess consistency in coding and resolve discrepancies. Coded data were then grouped into emergent themes.

RESULTS

Participants

Of 144 survey participants, the majority were male (56.9%), 30+ years (72.9%), and non-Hispanic White (79.9%). Seventy-eight percent used opioids in the past month; nearly all (96%) also reported using methamphetamine. Among those who indicated concurrent use, 56% noted heroin, 36% methamphetamine, 6% prescription opioids, and the remaining 2% some other drug (ie, cocaine, Buprenorphine) as their primary drug for getting high. We also asked about injection drug use. Out of 144 survey participants, 124 reported injection drug use in the past 30 days. Among those 124, 50% reported injecting both methamphetamine and heroin. Finally, 57% of those who injected both in the past 30 days reported simultaneous co-injection (ie, goofball).

The majority of interview participants were male (53.8%), 30+ years, and non-Hispanic White (see Table 1). Survey data provides a sense of prevalence of concurrent use; interview data provides insights into concurrent use. Three themes related to methamphetamine use emerged from interview data including (1) environmental characteristics support methamphetamine, (2) perceived benefits of methamphetamine, and (3) perceived consequences of methamphetamine.

Theme 1: Environmental Characteristics Support Methamphetamine—

Participant interviews illustrate how environmental factors in rural communities foster use of methamphetamine through early exposure, widespread availability, low cost, and decreased stigma relative to heroin.

Early Exposure

Participants reported early exposure to methamphetamine; with many indicating first use in early or mid-adolescence, and most reporting they received methamphetamine from a friend or family member.

I was 8 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.

Availability and Low Cost

Participants described methamphetamine as a pervasive presence in their communities. They noted that, in comparison, heroin is harder to find and more expensive than methamphetamine. Because methamphetamine is “everywhere” and inexpensive, participants reported using it as a substitute for heroin.

I don't have to pay for [meth]; I just have to ask for it...I remember when I was in the methadone clinic, they were talking about the opiate epidemic. I looked up and laughed and they were like, “Why are you laughing?” I was like, “Because it's not opiates. It's meth.” They're just looking over it. They're not even seeing what's really here.

I'm a heroin addict stuck in a meth town.

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...

Lower Stigma Relative to Heroin

While participants reported that both methamphetamine use and heroin use are stigmatized, they described greater perceived acceptance of methamphetamine use.

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.

Theme 2: Perceived Benefits of Methamphetamine—Participants perceived multiple benefits of methamphetamine use, including providing relief from opioid withdrawal, reducing opioid use, reversing opioid overdose, enhancing functioning, and increasing enjoyment of effects.

Opioid Withdrawal Relief

A common perceived benefit was the use of methamphetamine as a temporary coping mechanism for opioid withdrawal symptoms until participants could access opioids again.

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.

Most heroin addicts are using meth at the same time, or they will dabble in meth because it helps you feel better too. When you're sick, use meth, and that sluggishness, burnt-down, drugged-out goes away. It gives you more energy and you feel a little bit better. You don't feel so sick.

Participants also reported using methamphetamine to cope with opioid withdrawal when they had trouble maintaining access to medications for opioid use disorder (MOUD) due to jail or titration.

When I was coming off methadone... the only thing that helped was meth. I don't know why...I didn't even have to get high.

I'm getting out of the [buprenorphine] program, they're titrating me down rapidly, and so I've been sick for a week. They say I'll be sick for weeks more...I've been doing so much more meth just to try to deflect the pain... It's just you can't do it without another drug. I feel like you can't do it without another, especially if you have a job or responsibilities or kids. There's no way.

Reducing Opioid Use

While many participants used methamphetamine temporarily to cope with opioid withdrawal symptoms, some participants used methamphetamine in efforts to quit using opioids.

We quit - me and my mom - doing heroin and started doing meth, pretty much. That's how we came off of it.

I used meth, actually, with my ex. He's like, "We're going to get off pills," because we were both taking pills together...I was like, "Why didn't you have any

withdrawals, really?” He had been doing meth...So then I used meth to help with my withdrawals, and it really did help quite a bit.

Other participants used methamphetamine to reduce frequency of their opioid use, which they perceived as more harmful than methamphetamine use. Participants expressed fear of physical dependence on opioids, withdrawal symptoms, overdose, and risk of other health conditions.

I usually use meth a lot more than heroin. I try not to use too much heroin for too long if I can help it, because then I get just more physical symptoms from withdrawal. So if I don't have it one day, then it won't be quite as devastating to me. I won't be so controlled by it...

When I do heroin now, it's not every day...because I don't like to get sick...the dope sickness...I do heroin less now, 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 heart condition...I've known 30 people that have gotten that. Really, honestly, the survival rate on that I hear is really, really low.

Opioid Overdose Reversal

Some participants expressed belief that methamphetamine can prevent or reverse an opioid overdose due to the drug's stimulant properties. When talking about a recent overdose experience, 1 participant reported adding methamphetamine to his heroin in advance in an unsuccessful attempt to prevent an overdose.

It was heroin, and she told me...“Careful. This stuff is really good,” so she split the shot in half. I didn't really think it was any big deal, so I went downstairs in the bathroom and 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.

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.

Enhancement of Functioning

Another common perceived benefit of methamphetamine was improvement in ability to function. Ability to function emerged in the context of having enough energy to “get things done” as well as in reference to being able to attend to other life responsibilities. A few mentioned using methamphetamine to help them function in jobs that were labor intensive or required them to work long hours.

I work in [an 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 ½ 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.

Pleasurable Effects

Participants used methamphetamine together with heroin because use of both—either sequentially or simultaneously—produced a more enjoyable high. Those that co-injected methamphetamine and heroin (ie, “goofball”), reported that the combination enhanced euphoria. Others noted that the energy they got from methamphetamine enabled them to enjoy the “buzz” from heroin longer.

It's a yin and yang kind of thing...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. Meth will just make you 51/50...[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.

Theme 3: Perceived Consequences of Methamphetamine—Participants reported perceived consequences of methamphetamine use including risk of discharge from MOUD treatment (methadone, buprenorphine) and potential adulteration of methamphetamine with fentanyl or other opioids.

Discharge From Treatment

Participants indicated that a negative consequence of using methamphetamine was risk of being discharged from MOUD treatment. One participant's story highlighted how specific policies in treatment programs regarding abstinence can potentially increase risk of relapse.

I like the people [at the methadone clinic], the staff and the other patients. It's like my family almost. It's my only social outlet anymore and my only connection with a group of people or organization anymore. I love it in that way, 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...my wife got kicked out of the methadone clinic because she kept peeing dirty for white [methamphetamine]... 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 went out and started buying. 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.

Fentanyl Adulteration Risk

While risk of fentanyl adulteration in heroin is well known, some participants reported experience with fentanyl in methamphetamine. Several reported symptoms (eg, sleepiness, nodding off) after using methamphetamine that could indicate presence of fentanyl. A few participants speculated that opioids are added intentionally in order to increase the addictive qualities and get people “hooked” more quickly.

I think that everything is being cut with [fentanyl], which doesn't make sense because white [methamphetamine] is an upper. Meth is an upper, not a downer. Why would you put a downer in an upper? But it's highly addictive... Like I'll do some white [methamphetamine] and it'll make me tired, but I'll want to do more. It's the difference between me personally wanting to do more and the little lizard addict... in my brain that's saying, “Do more.”

Because of the opioids that are mixed in with the methamphetamine now, it's more of a draw to it. So when people don't have their methamphetamines, you have people who are right there, looking for their heroin and something for their comedowns, for their bodies.

DISCUSSION

Concurrent methamphetamine and opioid use in this rural study population is pervasive. Similar to other studies, we found that people who use opioids have multiple reasons for using methamphetamine – enhance their high, increase their ability to function, and cope with withdrawal.² Motivations in our rural population appear similar to motivations in urban populations in other studies. However, consequences may be even greater in rural communities due to lack of treatment options. Use of methamphetamine to cope with opioid withdrawal or to stop using opioids is particularly concerning. Currently, 29.8% of rural residents compared to 2.2% of urban residents live in a county without a buprenorphine provider²⁰; rural residents often travel great distances to access methadone.^{21,22} Increasing access to MOUD in rural communities could mitigate barriers associated with limited treatment options.

While expansion of MOUD in rural communities is critical, our findings indicate that accessibility of existing services must be simultaneously addressed. Provider education and tailoring of treatment for people with polysubstance use is needed. Research demonstrates that low threshold treatment services that do not base enrollment on abstinence increase accessibility and effectiveness of MOUD in urban environments²³ and could be utilized in rural environments.

With amphetamine-related hospitalizations on the rise, use of methamphetamine to prevent or reverse opioid overdose suggest need for education on methamphetamine overdose risk and symptoms (eg, agitation, labored breathing, arrhythmia, hyperthermia) as well as on the increased risk of overdose related to concurrent use. Community-based harm reduction strategies could help address these needs as well as increase uptake of evidence-based strategies for opioid overdose prevention such as distribution of fentanyl test strips and naloxone.

Our study also suggests several areas for future research. Recent studies suggest that people who report heroin use may be more likely to report concurrent methamphetamine use compared to those who report misuse of prescription opioids.^{2,5} Few of our respondents reported prescription opioids as their primary drug; future research should seek to understand concurrent methamphetamine use among those reporting use of heroin versus prescription opioids. High prevalence of methamphetamine use among people using any opioids observed in our study suggest need for research to improve access to evidence based treatment for polysubstance use and to address factors in rural communities such as transportation barriers, community stigma, and social norms around drug use. Research should also address misperceptions about benefits of methamphetamine use as well as identify promising practices to expand treatment of methamphetamine use disorder.

Limitations of our study should be noted. We focused on 2 rural Oregon counties; findings may not be generalizable to rural communities in other regions of the country. We did not interview individuals who use drugs in urban settings. We also did not explore how social identities (eg, gender, race, class) interact to increase or protect against risk. A future research agenda should include an intersectional lens to examine drug use in rural communities.

CONCLUSION

Our work expands upon the growing literature examining concurrent use of methamphetamine and opioids. Exploring the interplay between methamphetamine and opioid use in rural communities demonstrates need for interventions that address the unique characteristics of rural communities. Research and interventions that focus on creating environments which ameliorate conditions underpinning increased risk are critical.¹¹ Our findings highlight complexities of addressing drug use in rural communities and call for stronger partnerships among medical, substance use treatment, and public health organizations to better support rural communities.

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TABLE 1.

Characteristics of Interview Participants

Characteristic	N = 52
Gender	
Men	28 (53.8%)
Women	23 (44.2%)
Other	1 (1.9%)
Age [years] (Mean, SD)	
< 30	12 (23.1%)
30–39	20 (38.5%)
40–49	3 (5.8%)
50–59	7 (13.5%)
60+	4 (7.7%)
Missing	6 (11.5%)
Ethnicity	
Not Hispanic	49 (94.2%)
Hispanic	2 (3.8%)
Missing	1 (1.9%)
Race	
American Indian/Alaska Native	1 (1.9%)
White	49 (94.2%)
Multiracial	2 (3.8%)