Supplement

Qualitative Interview Guide for Patients with OUD in their first year of methadone treatment

Introduction: My name is Ashish Thakrar and I am a researcher and doctor at Johns Hopkins University. We would like to understand patient experiences with methadone. To do this, we are interviewing people who are in their first year of treatment. We would like to understand your experiences on methadone and your long-term plans about methadone. This conversation will likely take about 45 minutes. There are no right or wrong answers, but rather different points of view. Please feel free to share your point of view, you should feel free to tell us what you think and not what you think we want to hear. In fact, the more honestly and openly you answer the questions, the more helpful it will be to our project and to the patients who can benefit from receiving help in the future.

I am planning to recording audio from the session because I don't want to miss any of your comments so please remember to speak up. We will create a written summary of this session that will not include any names or information that would identify you. We value your willingness to speak openly to us and we will respect your privacy. If anything comes up that you would like to discuss with me further, you will be given my contact information at the end of this meeting so we can talk about any other thoughts or issues that you may have. I will do my best to use language carefully and sensitively during the interview. We are focusing on opioids, but if other drugs or alcohol come to mind during the conversation, please share.

Finally, because we have a variety of topics to discuss today, I may move our discussion along to make sure we address all the important issues. I will do my best to be polite. Any questions before we begin?

START recording

We will start recording now. For the record this is interview number _________ (insert unique study ID).

I. Transition question & anchor on current treatment episode (5 mins)

1. To start, pretend you are talking to a friend who had never heard of methadone. What would you tell him/her if (s)he asked you, 'What is it like to be on methadone?'
2. Think back to the day you enrolled at this methadone clinic: what was going on in your life at that time?
3. Tell me about your experience so far on methadone. How has it been?

II. Reasons & rationale for discontinuing

I'd like to transition to a different topic. The main purpose of this interview is to understand how patients decide to continue or stop methadone. Most doctors and counselors recommend long-term treatment with methadone. That said, we also understand many patients will stop earlier than expected. We would like to understand how patients like you make that decision to continue or stop.

4. Could you tell me about a time, either now or in the past, when you thought about stopping methadone?
    a. Probing questions: Why? What was going on in your life? What were you thinking about? Who were you thinking about? Why did you continue?
5. Back when you started methadone, how long did you plan to take methadone for? Why?
    a. Probing: How have those factors changed since you started?
6. You mentioned you've been taking methadone now for about *** weeks/months. What are your plans moving forward?
    a. Probing: Is methadone a part of that plan? Why/why not?
    b. [If not answered directly] For how long would you like to take methadone?
        i. How did you pick that amount of time?

    ii. [If a range]: How will you know when the right time to stop is?
7. Most doctors and counselors recommend taking methadone for at least a year and to continue for longer if it's still working. It sounds like it has been helpful for you. Why stop a good thing?
8. Next, I'd like to ask you how a few specific aspects of methadone care play a role in your decision to continue or stop methadone in the future
   [Possible prompts, not a checklist:]
   a. How has the methadone clinic itself impacted your thoughts on when to stop methadone in the future?
      i. Location? Travel? Clinic staff? Patients? Counseling at the methadone clinic? Other services have you accessed from the clinic?
   b. How has your methadone dose or the number of take-homes you get impacted your thoughts on continuing or stopping methadone in the future?
   c. Now, putting aside the clinic and thinking about just the medication itself: how has the medication itself impacted your thoughts on continuing or stopping methadone?
      i. How it feels? Side effects?
   d. How have other people in your life influenced your decision to continue or stop methadone?
      i. Family? Friends? NA/AA or other peers in recovery? Clinic staff?
      ii. Is anyone encouraging you to stay on or to stop methadone?

III. What comes next?

9. You've been diagnosed with OUD/opioid addiction for which you're receiving treatment with methadone. You've said that at some point you'll want to stop methadone. What will be the status of your addiction when you decide to stop methadone?
   a. Probing: How will that factor into your decision to stop? What would recovery mean for you?
10. After you stop methadone, what will you need for your opioid use disorder?
    a. What would treatment/recovery look like?
11. Methadone is not the only medication for opioid addiction. Two other medications are buprenorphine, also known as Suboxone, or naltrexone, also known as Vivitrol. Are you familiar with both of these?
    a. [If yes, skip to next question]
    b. [If no…] Can I share how we explain these medications to patients who have never heard of them? *Buprenorphine is an opioid like methadone that can also block the effects of other opioids. Compared to methadone, it is less sedating and has a lower risk of overdose. It can be taken as dissolvable strips or dissolvable pills once or twice daily. Patients can pick up buprenorphine from regular pharmacies. Buprenorphine can also be given from a doctor's office as a once-a-month injection at a doctor's office. Naltrexone is an opioid blocker. Patients on naltrexone do not feel the effects of opioids. It can be given as a pill taken once daily and prescribed to regular pharmacies. It can also be given from a doctor's office as a once-a-month shot.*
    c. If, at some point, you would like to stop methadone, what would you think about transitioning to suboxone (also known as buprenorphine)?
       i. Probing: Advantages? Downsides? Once-a-month-shot?
    b. If, at some point, you would like to stop methadone, what do you think about transitioning to naltrexone (also known as Vivitrol)?
       i. Probing: Advantages? Downsides? Once-a-month-shot?

IV. How could methadone change?

You've mentioned that you've thought about stopping methadone *** times and that you think you will eventually stop after ***.

12. What would need to change for you to want to stay on methadone?
    a. Probes: When? How often? Clinic suggested? Benchmarks? Ownership?
    b. Adapting: would those changes have mate
13. There are other countries where patients can pick up methadone from a pharmacy instead of from a methadone clinic. What do you think about this?
    a. If you could pick up your methadone from a pharmacy instead of from a clinic, how would this change your thoughts about whether to continue or discontinue methadone in the future?

Closing*:* Thank you very much for your time. Again, this information will be helpful in learning how to best care for people like you. Is there anything else you would like to mention that I did not ask you? Do you have any questions?

Thank you again. Here is my contact information {provide info}. Please call me If you need more information or any other issues come up because of our discussion. Also, can we contact you in the future if we have more questions that come up as we interview other people?

Great, please take a moment to fill out this brief survey.

STOP recording

Date: 6/9/2021
Principal Investigator:
Geetanjali Chander, MD MPH
Application No.: IRB00275457

FOCUS GROUP INTERVIEW GUIDE

Protocol Title: Patient & Clinician Rationales for Stopping Methadone in the First Year

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Thank you for participating in this discussion. By joining this group you are consenting to participate in this study.

We will do everything we can to maintain your privacy. Since we are talking together, during the discussion we will be able to see who is speaking. But to encourage everyone to speak openly, please do not talk about this discussion outside of the focus group.

We will audio record this discussion. The audio recording will be transcribed by an outside company that has agreed to keep all data confidential. This audio recording will be destroyed after it is transcribed. We will only use these audio recording for the purposes of this research. It will not be used for advertising or non-study related purposes. Though we are careful to not attach your name to the interview or questionnaire, there is a chance of loss of confidentiality.

To maintain your privacy, please avoid using names and start each comment by stating the number you were assigned. For example, when answering a question please start by saying, "I am Participant #3…"

This study is entirely voluntary. If you do not want to join the study, it will not affect your job or employment in any way. If you agree to participate in the study, there will be a brief survey at the end of this conversation asking you some basic information about your age, race/ethnicity, gender, position, and length of time working at the methadone clinic. After the discussion, we will send a fruit basket to you as a token appreciation for your time.

Are there any questions? If you agree to participate, please say "yes" now.

Focus Group Interview guide:

I. Reasons for seeking to discontinue methadone

IA. Experience of being on methadone

1. To get us started, think about patients you've known who asked to stop methadone in the first year of treatment.
   a. How often does this occur?

IB. Reasons for stopping

1. Why do these patients want to stop methadone?
   a. How would they describe what it's like to be on methadone?
   b. What are some of the barriers to methadone treatment for these patients?
2. What did methadone change about their lives?

   a. Areas to explore: opioid use, other drug use, alcohol use, smoking, jobs, relationships, education, religion/spirituality, well-being, self-care
3. What do these patients think about the clinic itself?
   a. Areas to explore: neighborhood, traveling to the clinic, clinic staff, other patients, counseling
   b. How do these patients feel about their methadone dose?
   c. How do these patients feel about the number of take-homes they get?
4. Thinking about taking the medication itself – how does methadone make these patients feel?
   a. Areas to explore: likes/dislikes, how often do they miss a dose, how often have they shared?
5. What do these patients' family and friends think about them being on methadone?
   a. Is anyone encouraging them to stop or stay on methadone?

IC. Comparison to expectations

1. Why did these patients decide to start methadone in the first place?
2. How long did these patients expect to stay on methadone when they started?
3. Did the experience of being on methadone match their expectations?

II. Perceptions of alternative MOUD programs

I'd like to transition to thinking about different ways of prescribing methadone. As you know, methadone is prescribed to patients in a different way than other medications. Patients have come to special clinics to get doses and they often have to come multiple times a week.

IIA. Alternative methadone structures

1. There are other countries where patients can pick up methadone from a pharmacy instead of from a methadone clinic.
   a. What do you think about this?
   b. What is good about this option?
   c. What is less good about this option?
2. If the US regulated methadone so that patients could get it from a pharmacy instead of clinic, how would this change the experience of being on methadone for patients
3. Would any changes to how methadone is prescribed change patients' decisions to discontinue methadone?

IIB. Ideal MOUD program

Now let's think even more broadly. Imagine you could wave a magic wand and create your ideal treatment for opioid addiction. This could include a new medication that you could create and it could include any other form of treatment like counseling, groups, therapy, medical care, or other social work services.

1. If you could wave a magic wand and create an ideal treatment for opioid addiction, what would it look like?

IIC. Perceptions of buprenorphine and naltrexone

Buprenorphine is an opioid like methadone that can also block the effects of other opioids. Compared to methadone and other opioids, it is less sedating and has much lower risk of

overdose. Buprenorphine can be taken as dissolvable strips or dissolvable pills once or twice daily. Patients can pick up buprenorphine from regular pharmacies. Buprenorphine can also be given from a doctor's office as a once-a-month injection at a doctor's office.
Naltrexone is an opioid blocker. Patients on naltrexone do not feel the effects of opioids. It can be given as a pill taken once daily and prescribed to regular pharmacies. It can also be given from a doctor's office as a once-a-month shot.

1. What do you think about transitioning to other medications like buprenorphine, aka Suboxone or naltrexone, aka Vivitrol?
2. There are versions of these medications that are given as a once-a-month shot. What do you think about this as an option?