# "I think one enhances the other": Use of harm reduction and drug treatment among participants of syringe services programs

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## Key Findings

- Interviews were conducted with 27 participants of three syringe services programs (SSPs) in WA State; all had recent experience with substance use disorder (SUD) treatment.
- Participants had used both SSPs and SUD treatment, sometimes concurrently. SSPs were often important access points for harm reduction services before, during, and/or after SUD treatment.
- The positive aspects of SSPs for participants included their easy access, friendly staff, and availability of supplies to meet basic needs and reduce health risks of drug use.
- The benefits of SUD treatment for participants included reduced drug use, better coping skills, and improved quality of life. However, participants also reported challenges in accessing or staying in treatment or finding programs that were a good fit.
- Most interviewees valued access to both harm reduction and SUD treatment concurrently, though some reported challenges using these services simultaneously.
- More than half the participants were interested in receiving treatment at an SSP due to the easy access and supportive staff.

## Background

People who use drugs access different types of services to manage their health and substance use. These can include medical and mental health care, substance use disorder (SUD) treatment, and harm reduction services, most often provided by syringe services programs[1] (SSPs). SUD treatment can include detox services, inpatient/outpatient treatment, medications prescribed for opioid use disorder (e.g., methadone, buprenorphine, naltrexone) or recovery support groups.

SSPs provide education, materials, and services to reduce risks of illicit drug use (e.g., sterile syringes and/or smoking equipment, naloxone, wound care supplies); address other health needs (e.g., nicotine replacement therapy, contraception, condoms); or fill basic needs (e.g., tents, food, clothing). Services and supplies vary by program, but all SSPs offer referrals to local services and SUD treatment. Learn more about WA State SSPs here.

[1] "Syringe services programs" (formerly known as "needle exchanges") provide education, materials, and services to support safer use of illicit drugs. From their inception, these programs have focused on injection drug use. But many now also provide supplies for safer smoking of drugs to engage people who do not or have never injected drugs. Because of this broader reach, some SSPs prefer to call themselves "harm reduction programs" or "harm reduction centers." For consistency, this report uses the term *syringe services programs*.

Traditionally, the realms of harm reduction and drug treatment have often been seen (by providers and individuals) as siloed and mutually exclusive, given their different roles and orientations on abstinence. For many people who use drugs, however, these two worlds are often less distinct and may even overlap at times. This study aimed to understand the range of SSP participant perspectives about their use of harm reduction services and SUD treatment.

## Methods

This descriptive study used qualitative interviews to understand experiences and perspectives of participants using both harm reduction services (at SSPs) and SUD treatment. Approval for this study was obtained from the University of Washington Human Subjects Division. Project partners included three SSPs in WA State that were selected for geographic variability and because they had not previously been involved in qualitative interviews with our team (Table 1).

Table 1. Location and description of participating SSPs

| Name | City | Operating hours | Description |
|---|---|---|---|
| Willapa Behavioral Health | Aberdeen, WA | several hours once a week | van parked next to an opioid treatment program |
| Mason County Public Health and Human Services | Shelton, WA | several hours twice a week | RV in a parking lot |
| SHARE | Vancouver, WA | several hours twice a week | van in downtown area |
| *Each SSP provides safer drug use equipment, naloxone, and survival supplies. SHARE also provides community drug checking services. While these SSPs do not have onsite drug treatment services, such as low-barrier access to buprenorphine or SUD counseling, staff at each SSP actively provide referrals to treatment and other services.* | | | |

Interviews were conducted during regular SSP hours in Fall 2024. SSP participants were eligible if they:

- had accessed SUD treatment[2] in the last two years.
- had used non-prescribed opioids or stimulants in the past week.
- were at least 18 years old.
- spoke English.

Semi-structured interviews were completed after verbal informed consent was obtained. Interviews were recorded and transcribed by a HIPAA-compliant transcription service. Rapid qualitative analysis was conducted using transcript summaries and team-based thematic analysis (Hamilton, 2013; Hamilton et al., 2019). MaxQDA software (Verbisoftware 2022) supported the initial summary process. Data visualization was conducted in the R Language and Environment for Statistical Computing (R Core Team 2025) with the ggplot2 package (Hadley Wickham).

[2] SUD treatment was defined as any use of detox, inpatient or outpatient treatment, medication prescribed for opioid use disorder (i.e., methadone, buprenorphine, naltrexone) or recovery support/12-step groups.

# Results

## Demographics

Twenty-seven interviews were conducted (Aberdeen: 15, Shelton: 5, Vancouver: 7). The majority of respondents were white (70%), with some participants identifying as Black, Latino, Native American, or Pacific Islander. Slightly over half of participants (52%) were unhoused, and about a third lived in a temporary housing situation. The gender of participants was evenly split between men and women. The average age was 42, with an age range of 20-64 years old (Table 2).

Table 2. Participant demographics, n=27

| **Gender** | | | **Race/ethnicity** | | |
|---|---|---|---|---|---|
| Woman | 14 | 52% | White | 19 | 70% |
| Man | 13 | 48% | Latino/Hispanic | 2 | 7% |
| **Age** | | | Native American | 2 | 7% |
| Mean | 42 years | | Black | 1 | 4% |
| Range | 20-64 years | | White + Latino | 1 | 4% |
| **Housing status** | | | White + Pacific Islander | 1 | 4% |
| Unhoused | 14 | 52% | White + Native American | 1 | 4% |
| Temporary housing | 8 | 30% | **Transportation barriers*** | | |
| Stable housing | 5 | 19% | Lack of transportation impacted daily living | 16 | 59% |

** Response to the question: In the past 12 months, has a lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?*

## Drug use

All participants reported using methamphetamine in the past week, and two thirds reported using fentanyl in the past week (Table 3). Some had used heroin in the past week but said this was less frequent than fentanyl because heroin was less available. A few had used benzodiazepines or cocaine.

Table 3. Drug use patterns, n=27

| **Drugs used in the past week** | | | **Main drug** (as defined by the participant) | | |
|---|---|---|---|---|---|
| Methamphetamine | 27 | 100% | Methamphetamine | 11 | 41% |
| Fentanyl | 17 | 63% | Fentanyl | 9 | 33% |
| Heroin | 6 | 22% | Fentanyl and methamphetamine | 3 | 11% |
| Benzodiazepines | 2 | 7% | Heroin | 2 | 7% |
| Cocaine | 2 | 7% | Cannabis | 1 | 4% |
| **Route of ingestion** | | | Fentanyl and methadone* | 1 | 4% |
| Smoke | 17 | 63% | Methamphetamine and heroin | 1 | 4% |
| Smoke and inject | 7 | 26% | ** One person said methadone from their opioid treatment program had replaced fentanyl as their "main" drug, but they still used fentanyl.* | | |
| Inject | 3 | 11% | | | |

A third of participants reported using only methamphetamine, and no other drugs, in the past week. Conversely, all of those who had used fentanyl in the past week also reported using methamphetamine. Participants primarily identified methamphetamine (41%) or fentanyl (33%) as their "main drug," while 11% considered both as their main drugs. The majority of people currently smoked their drugs as their only route of administration. Fewer people also injected (or only injected) drugs currently.

## Use of SSPs and SUD treatment

Participants were asked to describe a timeline of when they first used a stimulant or opioid, first tried an SSP, and first tried SUD treatment. Figure 1 shows that the timing and sequencing of these first-time events varied across participants. Some people had engaged in harm reduction or treatment services early in their use; others had substantial gaps from when they started to use drugs until they first accessed an SSP or treatment program. Although all participants had used SUD treatment in the past two years (an eligibility criterium), 19% (n=5) of participants reported being currently in treatment, and 26% (n=7) reported using some form of SUD treatment within the calendar year.

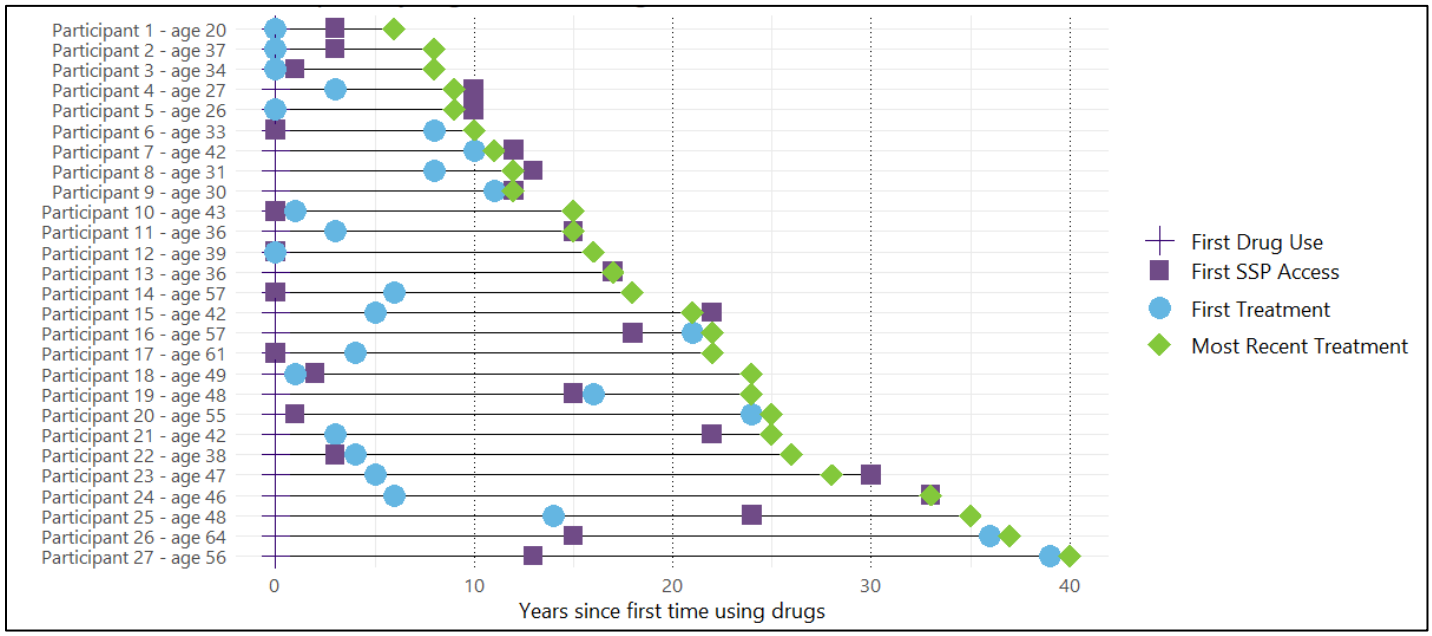


*Figure 1. Use of SSPs and SUD treatment over time*

Ten participants (37%) had used an SSP prior to SUD treatment; three (11%) had started to use an SSP and SUD in the same year; and 14 (52%) had tried SUD treatment prior to using an SSP.

## Perspectives on use of syringe services programs

### Benefits of using an SSP

Many participants reported using services at their current SSP for years or decades, although some began accessing services as recently as 2024.

Overall, participants viewed their SSP favorably as a unique and significant service that had a positive impact on their lives and the community. Participants described multiple benefits from services at SSPs which fell into four general domains: drug use risk reduction, first aid/medical, basic needs, and positive social interactions (Table 4).

Table 4. Beneficial domains of syringe services programs

| Service Domain | Examples |
|---|---|
| Drug use risk reduction | Syringes, smoking equipment, naloxone, drug checking services |
| First aid/medical | Wound care, disease testing/prevention, medicine |
| Basic needs | Hygiene supplies, food, clothing, tents, sleeping bags |
| Positive social interactions | Positive regard, absence of judgment and stigma |

Regarding wound care, participants noted that medical supplies (e.g., bandages, gauze, antibiotic ointments) were expensive and hard to get. Therefore, access to these wound care supplies at SSPs was hugely beneficial, and in some cases, even life-saving:

> *"I'm pretty sure that if it wasn't for this exchange [SSP] right here doing what they're doing, I would either be dead or I would not have legs because they keep me in my medical supplies so I can keep my wounds clean. I'm sure I would have been dead because this has killed me twice already … this exchange has been really wonderful."*

Participants appreciated receiving food, water, clothing, hygiene kits, and outdoor supplies (e.g., sleeping bags, tents) and noted these supplies were of great value to their quality of life and well-being. They also identified positive, judgment-free interpersonal interactions as one of the most valuable aspects of using the SSP and often different from interactions with the public or in healthcare.

> *"The workers are always really nice and helpful, and they're always there with a smile on their face and there to help us out and give us our supplies when we need them. It's nice to have people like that because there's not a lot of people around here that are like that, that are giving and kind."*
>
> *"Just that I guess I get some positive interaction with somebody, where people aren't demeaning or put off a way that they're judgmental or—just positive human contact … it's one of the greatest things about dealing with the people, here."*

Many participants reported that they would continue to engage with harm reduction services in the future, and for some, even if they stop using drugs.

### Suggestions for improvement

Some participants suggested improvements and additional services for SSPs such as:

- Expanded hours of operation
- Flexible service models (e.g., home delivery, mail order)
- Easier to access location
- Additional hygiene services
- Safer smoking supplies (at programs that did not already provide them)
- Relapse prevention supports
- Access to bus passes, gift cards, and other supplies to help cope with homelessness

## Perspectives on use of substance use disorder treatment

People reported using several forms of SUD treatment since they started using drugs, particularly in the last two years. These included:

- Detox services
- Outpatient and/or inpatient treatment
- Medications for opioid use disorder (MOUD)
- 12-step/recovery support groups

Two-thirds of participants reported trying MOUD at least once. Several people discussed having tried SUD treatment (outpatient or inpatient) multiple times in the past, including having tried the same type of treatment more than once. One young person described having tried SUD treatment seven times in the past two years. While some people said they were able to achieve long periods with no or reduced drug use, others reported that they continued some level of substance use even while in SUD treatment (most often while on MOUD).

### Motivations for SUD Treatment

Participants were motivated to try SUD treatment to stop or control their drug use, often in order to improve quality of life. Motivations included: not wanting to die/concerns about overdose; to improve or save their health; to stay out of jail; or to be there for family or regain custody of their children.

> *"I'm 20. I have so much time in my life that I don't want to waste out here. I don't know. It's not worth it, chasing something that's never going to satisfy you. So I'm just tired of this lifestyle. I'm tired of these people. And I'm either going to end up in the grave or behind bars, and I'm not really trying to go to jail, and I don't want to die, so."*

A few people reported they started SUD treatment to primarily satisfy drug court or housing program requirements, rather than from a personal desire to stop using.

### Benefits of SUD treatment

Several people spoke about positive experiences with SUD treatment staff, describing them as supportive, welcoming, or helpful. Other positives described were easy access due to location or

transportation support. Others described the benefits of group counseling or accountability. A few people felt their health improved after a break from drug use, or that stopping drug use was essential to staying alive. Participants' positive experiences with MOUD varied, but there was wide support for MOUD as a treatment that "worked well" to help decrease drug use and increase other positive elements of their lives.

> *"I just needed to-- well, I mean, I wanted to change my internal dialogue. I have this small voice in my head telling me these things that I thought were…then I went to treatment, and everything that I was speaking was confirmed by somebody really smart."*

Negative experiences with SUD treatment often reflected challenges with rigid treatment environments or rules:

> *"They're like, 'You get a dirty UA you're getting kicked out.' and I'm like, 'Shit'… It was terrifying."*

Most participants identified some barriers to starting or continuing SUD treatment, including: fear of withdrawal or stopping drugs, life challenges, self-motivation, health insurance, transportation, and program requirements, such as requiring counseling sessions with methadone dosing or completing detox first. Other barriers were medical issues or being sent to jail or prison.

> *"I had to start out going every week, and I was doing two and a half Suboxone [strips] daily. And then when I was so far along, then I just had to go every month. But then once I started-- I think I was at every three months. Then I started slacking, and then I just relapsed. I had to go to ____. So then my car broke down and then lost transportation. Had to take the bus. So then I just stopped going."*

### Suggestions for improvement

Participants shared various recommendations for how to improve their treatment experience. These included more flexible options for treatment, both in types of services offered, as well as modes of access, such as lower-barrier or virtual. Others spoke about wanting a "one-stop-shop." A few people spoke about the importance of connection and support after leaving SUD treatment.

## Using harm reduction and SUD treatment at the same time

Participants were asked *if* and *how* harm reduction and SUD treatment should intersect based on their experiences. Half of participants believed using harm reduction and treatment at the same time would be beneficial. Some participants offered that getting these services at the same time "made sense" and that these sources of support went "hand-in-hand" and complemented one another. Some described the challenges of drug use and felt grateful to access both harm reduction and treatment services to help them manage the "chaos of their addiction."

> *"I think it would be pretty helpful [to use both at the same time]. Having services to keep myself a cleaner version [with harm reduction services] and going to treatment to learn all the coping skills and what not to do with cross addiction and stuff like that would help a lot."*

Several people acknowledged that starting treatment did not necessarily mean someone was ready to stop using drugs entirely and that harm reduction services were essential to support health.

> *"I think one enhances the other. The treatment … I feel like it was really hard to quit. But with needle exchange it's like slowly wean yourself down, and they can work with you on like [decreasing use] stuff like that."*
>
> *"I think it'd be good. Yeah. Because, like I said before, it helps people with having access to clean rigs and stuff like that, keep some away from the diseases and everything. So if they're still using it, it's still a possibility."*

A few participants thought they would benefit from maintaining positive connections with harm reduction staff even while they were engaged in treatment:

> *"You need people to check in with. They care. They make you feel like they do, anyways. You know what I mean? They do care."*
>
> *"… if I needed help with anything, I would definitely come here because, like I said, I do trust and like these ladies way more than anybody even at treatment. [laughter] And I trust them more."*

Some participants raised concerns, however, about using harm reduction and SUD treatment at the same time. This group of participants agreed that staying in treatment would be more difficult if someone were also accessing harm reduction services. Being around familiar drug use supplies and social connections make it "hard to stop using".

> *"I don't know. To me, that doesn't mix. You can't still be using it and doing-- you either commit to it [treatment] and you actually take the steps to do it, or you're just contemplating it. I mean, that's where that lies. And so I don't think that that is a (good) mix."*

The phrase "one or the other, not both" came up several times from different participants, along with the idea that accessing harm reduction while engaged in treatment was like "cheating."

> *"… well, you got to pick. You got to pick one or the other."*
>
> *"So no, because when I'm in treatment, I don't want nobody to know [that I'm at the SSP]. I could see my counselor across the street, and he might know what this is. And he sees me here, and I'm in treatment. 'What are you doing there?' That's like being caught."*

## Information sharing

Participants were asked if SUD treatment programs should offer more information about harm reduction and SSPs and if SSPs should offer more information about SUD treatment. Many participants

thought treatment programs should provide more information about harm reduction services to help people who are still using drugs while in treatment or if people started to use again after treatment.

> *"Absolutely, because 90% of people relapse. Yeah. You got to be realistic. Yeah, I think they should. I think that there should be information more available, period."*

Some felt their SSPs already provide good information about SUD treatment and that it is helpful to have more information about treatment options, such as local availability, different treatment approaches, or requirements.

> *"I mean, they always ask if we need referrals for treatment. And I think probably most people that use know what treatment is, through other systems they've probably been involved in."*
>
> *"I think, all the information that a person can get, maybe a person might not know. And they come and use this program (SSP) and they see it. Hey, information is power. Definitely."*

Some participants acknowledged the potential tension between treatment and harm reduction and that offering information about treatment too aggressively could convey judgement about drug use or even push people away from the SSP:

> *"No, you shouldn't push anything on anybody."*
>
> *"No. I mean, I guess, to me, if somebody wants it-- and I don't want it pushed on me and especially people that are deep in using because then they'll stop coming. I don't want somebody who's constantly, 'Well, are you sure you want to talk about this? Do you want to see this?'"*

### Interest in receiving treatment at the SSP

More than half of participants thought offering treatment services, including MOUD, at the SSP could provide several benefits including easier care access, a more casual environment, and kind, understanding staff who have personal experience with drug use and treatment.

> *"That would probably be helpful to a lot of people because some people just don't like to go into the (treatment) offices and talk to people that don't seem like they're very helpful. Some of the people that are provided (in treatment settings) never used before, some people have. And then so that is an issue amongst some addicts. But I think it'd be helpful. I don't know, a one-stop shop."*
>
> *"I would probably be more likely to engage with that than going into a treatment facility like I had before. It would be easier to do here…the relationship that we have with the people that run the program and the ease to which-- I mean, I feel at ease here and don't feel as judged… it's a less clinical setting."*

## Conclusion

- Participants appreciated easy access to SSPs, positive interactions with non-judgmental and caring staff, and the availability of essential resources that were hard to get otherwise.
- Benefits of SUD treatment included help to reduce or stop drug use, better coping skills, and reconnection with children/family. Many felt buprenorphine or methadone provided stability.
- Although harm reduction and SUD treatment have different approaches and intentions, the majority of participants felt these programs could be complementary; using both harm reduction and SUD treatment programs had substantial benefits.
- Participants expressed broad support for the cross-pollination of SUD treatment and harm reduction services. This included support for providing both types of services in the same location and for providing education about both types of services in different programs.
- People expressed interest in obtaining treatment and other services at the SSP because of the lower-barrier access.
- People endorsed expanding access to low-barrier and flexible programs where supportive staff could provide holistic care and offer supplies to meet basic needs.

## Limitations

The majority of people we spoke with were unhoused, and their perspectives may not be representative of everyone who uses drugs. Our interviews did not ask about other services such as medical care, housing, legal aid, or other supports, although those issues arose frequently. Interviews were conducted only at vehicle-based SSPs where cohoused SUD services are not available. Perspectives may be different among participants of SSPs that do have onsite SUD treatment services.

The interviews collected for this study were gathered using purposive, non-random sampling and as such are limited in terms of their generalizability. We talked exclusively to people who were currently using SSP services, so the possibility of documenting negative experiences with SSPs, including discontinuation of SSP use, was limited by design. In addition, alternative perspectives from people currently in SUD treatment about their experiences using harm reduction services/SSPs was not a part of this study. Further research on these additional perspectives could contribute meaningfully to this area.

## Acknowledgments

Thank you to the syringe services program participants who shared their time, expertise, and experiences with us. Your insights and knowledge are essential to guide the work to reduce improve the health of people who drugs.

Thank you to the syringe services programs who partnered with us on this project: Mason County Public Health and Human Services, SHARE Vancouver, and Willapa Behavioral Health. These interviews were possible thanks to the trust and positive relationships you have with your participants. We appreciate the work you do to keep people alive.

WA Health Care Authority funded this project and had no editorial role.

## References

Bittinger, K. Angelo, F., Campbell, K., & Felver, B. (2025). Current State Assessment, Report 2: Variations in Behavioral Health Treatment Rates SFY 2020–SFY 2022. WA State DSHSH Research and Data Analysis Division. https://www.dshs.wa.gov/sites/default/files/rda/reports/research-9-130a.pdf

Gleacher, A. A., Olin, S. S., Nadeem, E., Pollock, M., Iachan, R., Prosser, L., Douglas, S., & Hoagwood, K. (2016). Implementing a measurement feedback system in community mental health clinics: A case study of multilevel barriers and facilitators. *Administration and Policy in Mental Health*, 43(3), 426-440. https://doi.org/10.1007/s10488-015-0642-0

Hamilton, A. B., & Finley, E. P. (2019). Qualitative methods in implementation research: An introduction. *Psychiatry Research*, 280, 112516. https://doi.org/10.1016/j.psychres.2019.112516

Hamilton, A. (2013). *Qualitative methods in rapid turn-around health services research* [Presentation]. Veterans Affairs Health Services Research & Development CyberSeminar.

Kingston S, Newman A, Banta-Green C, Glick S. Results from the 2023 WA State Syringe Services Program Health Survey. Seattle, WA: Addictions, Drug & Alcohol Institute, Department of Psychiatry & Behavioral Sciences, School of Medicine, University of Washington, April 2024. URL: https://adai.uw.edu/download/9208/

O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for reporting qualitative research: A synthesis of recommendations. *Academic Medicine*, 89(9), 1245-1251. https://doi.org/10.1097/ACM.0000000000000388

Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., Griffey, R., & Hensley, M. (2011). Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. *Administration and Policy in Mental Health*, 38(2), 65-76. https://doi.org/10.1007/s10488-010-0319-7

VerbiSoftware. (2022).

**Citation**: Newman A, Winstead T, Layman L. "I think one enhances the other": Use of harm reduction and drug treatment among participants of syringe services programs. Seattle, WA: Addictions, Drug & Alcohol Institute, Department of Psychiatry & Behavioral Sciences, School of Medicine, University of Washington, June 2025. URL: https://adai.uw.edu/download/11678/