

# “Treat us like individual human beings”: 2018 qualitative interviews with Washington State syringe exchange participants

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## Key Findings

- Syringe exchange program participants appreciate the services available through the exchange and are interested in expanded services at these locations.

*“I think it’s an amazing and pertinent resource for this community. If we’re gonna engage in this activity, might as well be clean about it, you know.”*

- Participants reported that they used methamphetamine because it was very available and to increase energy, cope with mental health issues, lessen physical pain, and handle symptoms of opioid withdrawal. Participants reported they used heroin primarily to avoid opioid withdrawal, “numb” their emotions, and manage physical pain.
- Lack of housing and the consequences of drug use were top concerns for interviewees who also identified a range of services that would be helpful to improve their overall quality of life.

*“I’d feel like a person. To wake up in a bed, I can’t even tell you the way that it feels, and a door that locked. Yeah, it would definitely help me.”*

*“If there was a methadone clinic or something like that where you could go in, get that done, then you’d be able to go and look for a job or get up and go to work afterwards or something like that instead of spending your whole day having to try and find heroin.”*

- Despite these concerns, many participants expressed satisfaction with areas of their life, and in particular with relationships with friends, family, or a significant other.
- Interviews clearly documented respondents’ humanity and their desire, and often their ability, to continue to function in important areas of their lives.

*“I just enjoy being around my kids all the time.”*

- At the same time a notable proportion of participants said they were “not satisfied” with anything in their lives.

*“I’m completely unsatisfied right now, like I’m not happy at all. I’m very depressed.”*

- Many people had previous experience with medications for opioid use disorder and had faced barriers in accessing or staying in a treatment program so they could stay on medications.

## Introduction

Since 2015, the University of Washington's Alcohol & Drug Abuse Institute (ADAI) has coordinated and helped conduct biennial surveys of participants of syringe exchange programs (SEP) across the state to assess drug use patterns and health needs of people who inject drugs (PWID). In 2018, we did qualitative interviews to complement the brief surveys for the first time. The qualitative interview topics were inspired by the previous year's survey findings. The 2017 WA State Syringe Exchange Health Survey<sup>1</sup>, involving 1,079 participants from 18 SEPs, produced several notable results:

- Methamphetamine use is common and may be increasing. The percentage of survey participants who reported using any methamphetamine in the last three months increased from 69% in 2015 to 82% in 2017; the cross-sectional survey approach does not allow for formal testing of trends.<sup>2</sup> Among those who identified heroin as their main drug, 78% said they had also used methamphetamine at least once in the last three months, up from 60% in 2015.
- Lack of housing was a primary concern. Approximately two-thirds (69%, n=745) of survey respondents reported having temporary or unstable housing or none at all. Twelve percent of respondents outside of King County<sup>3</sup> identified homelessness as their primary concern about their health.
- Most individuals wanted to reduce or stop their primary drug use. 78% of people whose main drug was heroin and 47% of people whose main drug was methamphetamine said they had some interest in reducing or stopping their use of those drugs. Participants mentioned a wide range of preferred services to help them do so such as mental health counseling or medications, drug treatment, and medications to help reduce their stimulant use.
- PWID have a wide range of unmet healthcare and support needs beyond drug use. Over half of respondents outside of King County (59%) said they had not sought medical care they needed within the last 12 months, most often because of stigma or negative judgement from medical providers. Other services needed included housing and mental health care.

To get a richer and more contextual understanding of these issues, ADAI conducted in-person qualitative interviews with syringe exchange participants to explore the following questions:

- How, with what frequency, and why are SEP participants using methamphetamine, and what is driving the apparent increase in concurrent methamphetamine use among people who primarily use heroin?
- Beyond health, what other life concerns or challenges do SEP participants have, and conversely, what are they most satisfied with in life?
- What services or resources would help participants address their needs and would they want these services located at their syringe exchange?

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<sup>1</sup> <http://adai.uw.edu/pubs/pdf/2017syringeexchangehealthsurvey.pdf>

<sup>2</sup> The cross-sectional (not within person longitudinal) survey approach does not allow for formal testing of trends.

<sup>3</sup> The questions in the survey administered by Public Health-Seattle & King County in King County varied somewhat from those in the statewide survey. The King County survey did not ask about primary health concern.

## Methods

A five-question, semi-structured interview guide was developed using a grounded theory approach and modified after pilot testing with five SEP participants. IRB approval was obtained from the University of Washington Institutional Review Board.

Alison Newman, MPH and Connor Henry, an MPH student at the time, conducted the interviews in August and September 2018 at three syringe exchange programs selected for geographic variability: Dave Purchase Project (formerly the Point Defiance AIDS Projects) in Tacoma, Blue Mountain Heart to Heart in Walla Walla and Pasco, and Whatcom County Public Health in Bellingham.

Potential interviewees were recruited by syringe exchange staff and the two interviewers by convenience sampling of program participants who came into the syringe exchange during regular operating hours. Potential participants were asked if they wanted to participate in a qualitative interview that would take about 30 minutes. For one location, the interviewers sat in the waiting area and recruited participants after they had exchanged syringes. At the other sites, the program staff referred participants to the interviewers.

Prior to giving verbal consent to participate, individuals were told about the goals of the interviews; that interviews would be anonymous, voluntary, and confidential; and that participants would receive a \$25 gift card to a local grocery store. Because of the need for transcribed interviews, participants were asked to consent to audio recording and not to provide any personally identifiable information about themselves or others.

The interviews were conducted in a private setting in or near the syringe exchange program, such as a gazebo or van for the outdoor exchanges, and lasted 15-30 minutes. Recordings of the interviews were transcribed and then uploaded for analysis into Dedoose, an online qualitative research program.

## Analysis

A priori codes were developed based on interview questions, reviewed for clarity, and entered into a final codebook that was tested using the Dedoose training center until sufficient between-coder agreement (74%) was reached.

## Results

Twenty-four individuals participated, including both men and women ranging in age from 25 to 69 years old. (Table 1)

Table 1. Location and demographics of participants, n=24

Location			Gender			Race/Ethnicity		
Tacoma	9	38%	Male	15	63%	White	22	92%
Pasco	7	29%	Female	9	38%	Black	1	4%
Bellingham	6	25%	<b>Age (range 25-69)</b>			Latino	1	4%
Walla Walla	2	8%	25-30	3	13%	<b>Housing Status</b>		
<b>Primary drug</b>			31-40	8	33%	Homeless	14	58%
Heroin	20	83%	41-50	7	29%	Temporary	2	8%
Methamphetamine	3	13%	51-5	4	17%	Permanent	6	25%
Alcohol	1	4%	60-69	2	8%	Unknown	2	8%

Very few of the participants had regular employment and over half (n=16) were homeless or had unstable housing, including two people who lived in their cars and two others who were "couch-surfing."

## 1. Heroin and Methamphetamine Use

### **Patterns of use**

The majority of the 24 participants (n=20) identified heroin as their primary drug, of whom 75% (n=15) had also used methamphetamine in the last three months; these proportions were similar to that seen in the 2017 survey. Three participants reported methamphetamine as their main drug with no concurrent heroin use in the last three months. One participant reported alcohol as their main drug but had also used both methamphetamine and heroin in the last three months.

All participants reported injecting some drug. While almost half of participants (46%, n=11) reported that they use drugs by injection only, slightly more (54%, n=13) reported that they also smoked drugs in addition to injecting. One reported alternating between injecting and smoking as a way to protect his veins. Many participants who used both heroin and methamphetamine reported that they typically inject heroin and smoke methamphetamine, and that this was common among their peers.

*"Well most people, I would say it's like 50/50 for smoking and shooting heroin. But most people smoke meth, the people that I know anyway."*

*"Ninety percent shoot heroin and smoke meth and it's just because of that need you feel to get better when you're sick on heroin, like I said, you literally think you could die and just smoking or snorting [heroin] is not going to cut it . . . I don't have that physical need [to inject] with meth . . . I would say a lot of people won't risk missing a vein and not having veins or trying to find a vein with meth."*

### **Motivations for heroin use**

The primary driver of heroin use appeared to be avoidance of withdrawal. Many participants talked about having to use opioids, usually daily, to avoid withdrawal, or to return to "feeling normal." Participants also talked about using heroin to cope with negative experiences like past traumas or as an emotional anesthetic; three participants explicitly used the word "numb" when talking about their reason for using heroin.

*"That's why I get high, so you don't have to think about it. It numbs. It puts it away . . . It's probably—in a way, heroin saved my life."*

*"I went through some traumatic events when I was young that I truly believe I use drugs to repress and cope with . . . I don't have counseling available to me. I don't trust anybody I talk to on a day to day basis to open up to. You know, so it's almost like I'm in a revolving circle, you know. And as soon as those feelings or emotions start coming up, then I use drugs to numb them and run away from them."*

Four participants talked about their heroin use as a *response* to being homeless:

*"I think I'm not homeless because I'm using. I'm using because I'm homeless . . . You don't have to think about it . . . It just makes it go away . . . But then a whole day goes by. Sh\*t, the next day you're in the same predicament."*

## **Motivations for methamphetamine use**

In addition to using it for the high, participants regarded methamphetamine as a tool for productivity. This was particularly true for those who also used heroin. Many participants spoke of how common methamphetamine use is now among people who use heroin, primarily as a way to feel more “functional” while using heroin. Use is facilitated by methamphetamine’s low price and easy availability:

*“They’ve kind of gone hand-in-hand. Everyone that’s doing heroin is doing meth. So you’ve got your meth and dealing and also to be able to keep up so you can get your next fix and not go to sleep until you’re dope sick.”*

*“Well, right now meth is like really cheap and it’s just everywhere . . . And if people get a little too high on heroin they have to freaking try and wake themselves up a little bit so they can get done what they need to get done.”*

*“Just like a cup of coffee in the morning, make sure I get up and get active and get some sh\*t done.”*

Among people who used heroin, methamphetamine often played another functional role in helping to manage opioid withdrawal symptoms:

*“If you do meth and you’re sick from heroin, it usually takes care of the pain.”*

*“Nobody wants to—okay in my personal experience, none of my friends or people I know are around . . . they don’t want to do meth. They do it because it’s there and it keeps them going until they can obtain heroin.”*

Methamphetamine was also used by many as a functional aid for sex, staying awake and alert while homeless, and to manage pain. One person had a heart condition and felt methamphetamine helped improve it. Another person said:

*“Meth just gives me the energy to basically function. I don’t really even get that high anymore. I mean it—otherwise I’m in a lot of pain . . . I have a lot of joint problems in the first place and just have a lot of pain when I don’t use.”*

People also discussed using methamphetamine to manage attention deficit disorder (ADD) or depression.

*“I had ADD and I’m just kind of—it’s really hard to make me maintain attention to things I really don’t care about. So I do meth and it makes me pay a lot more attention.”*

Two women talked about how their drug use was related to sex work and the need to dull emotions or be awake.

*“I’m not going to be able to do what I do for money when I’m sober. You know what I mean?”*

*“I was selling myself on the street and a guy would rather have me standing up than like this,” she said as she slumped down.*

## 2. Life Challenges and Satisfaction

Interview participants were asked “If there were one thing you could change in your life, what would it be?” The majority of respondents (75%, n=14) cited their drug use, of whom four specifically stated they wish they had never started using drugs. Other top concerns were relationships with family or friends, health issues, housing, a lack of stability in their lives, and grief.

Participants were also asked “What are you most satisfied with?” About half (n=10) of respondents said they were most satisfied with their relationships with friends or family. Several people talked about their relationships with their children as a primary source of satisfaction or happiness in their lives. Many felt their social relationships provided stability or support, even when those relationships were challenging.

*“I just enjoy being around my kids all the time. They’re always needing me for something. And so just being around them is helpful and even my adult kids need me all the time and to help them with stuff so it just makes you good to be around your family.”*

*“I’m in a lot better relationship now than I used to be . . . he actually wants to get clean and wants the same things . . . It’s a lot easier to have someone that’s on the same page, someone that you’re not having to fight with and someone that’s actually helping you and you don’t have to do everything yourself.”*

While many participants could easily identify positives in their lives, one-third (n=8) said they were not satisfied with anything in their lives:

*“There isn’t a single aspect in my current situation that I call my life that I’m content with, that I’m happy with. You know, I’m not happy with my relationships, I’m not happy with the girl I’m with, I’m not happy with anything I do on a day to day basis, because it’s all unhealthy.”*

*“I’m completely unsatisfied right now, like I’m not happy at all. I’m very depressed. I haven’t been this depressed in years and it just keeps getting worse and worse and I’m not really sure where to make a change or how to change—cause I can’t—it’s just hopeless . . . It’s just too much. It’s way too much. I’m tired of these people. I’m tired of the way they are and I miss—I don’t know. I miss what I used to be.”*

## 3. Interest in Reducing or Stopping Drug Use

Although not specifically asked about it, the topic of reducing drug use and/or drug treatment arose frequently in these interviews. Almost half the respondents (42%, n=10) mentioned previous experience with drug treatment involving either a residential or outpatient program and/or using different medications for opioid use disorder (OUD). (The actual proportion is likely higher as the topic was not part of the interviewer guide.) About a third of interviewees (n=8) expressed some interest in starting or resuming treatment for their drug use through a variety of options such as residential treatment, drug counseling, support groups, detox, and OUD medications.

A recurring theme throughout the interviews was the high personal costs of drug use and its cascade of negative consequences such as relationship challenges, compromised values, difficulty finding or maintaining employment, and stigma.

*"It takes over everything, your relationships with friends, family, I mean everybody. Yourself. I mean, you know, you lose your morals. People start doing things that they never thought they would ever do. So yeah, I mean it takes up your entire life for sure."*

*". . . heroin destroyed my life. My life was already bad and it [heroin] just made it worse."*

*"I'm still lucky to even be alive and I don't know how many more times I can hit the reset button and actually be here."*

Several people talked about the way their drug use limits their time and personal freedom. When asked how his life would be different if he were able to stop using heroin, one participant said:

*"I'd be able to do stuff and not be restrained on time. I'd be able to go to my work and not be worried whether or not I'm gonna be able to take a break so I'm not sick or not and I wouldn't have to worry about when I'm with my family, leaving early on family barbecues and stuff like that . . . I'd be able to do what I want when I want it. I don't have to be worried about whether or not I'm gonna be sick or not."*

## 4. Help or Services Needed

### **Housing**

Nearly half the participants (n=11) said the help they needed the most was housing, and housing, in general, emerged as a prominent theme throughout the interviews. Five participants discussed barriers to finding housing such as cost and the complicated process of applying for and obtaining housing. When asked how housing would help, one respondent said:

*"I'd feel like a person. To wake up in a bed, I can't even tell you the way that it feels, and a door that locked. Yeah, it would definitely help me."*

Some participants discussed the need to have housing before they could reduce or stop their drug use.

*"I'm not sure that I could [stop using drugs]. I could try I guess, but I meant I have to get housed first and I have to get an ID. I have so many other problems that are bigger than that [quitting drugs] right now it seems like that's just secondary to everything almost."*

### **Drug treatment**<sup>4</sup>

About a third (n=8) of participants mentioned they wanted help with drug treatment, with preferences ranging from inpatient and outpatient programs, to counseling, to medications for OUD:

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<sup>4</sup> For his thesis Connor Henry conducted a thorough analysis of these interviews on the theme of medications for opioid use disorder "Qualitative Analysis of Treatment Barriers for Syringe Exchange." Once a link to this document is available it will be included here.

*"If there was a methadone clinic or something like that where you could go in, get that done, then you'd be able to go and look for a job or get up and go to work afterwards or something like that instead of spending your whole day having to try and find heroin."*

Participants often expressed a preference for a particular OUD medication influenced by a range of factors including availability and access, how they physically felt on the medication, and how well it worked for them in the past. Eighteen interviewees mentioned buprenorphine (though always by the brand name Suboxone) and 14 mentioned methadone; no one mentioned naltrexone.<sup>5</sup> Some people described experiences obtaining buprenorphine on the street, rather than in a medical or drug treatment setting.

Eight people discussed specific barriers to starting or staying on buprenorphine or methadone treatment, including lack of transportation, the long distance to treatment, and a lack of available treatment in the area. A few people mentioned that some of the requirements of their previous treatment program (e.g., intensive counseling, abstinence from all substances) were not personally helpful or were too difficult to manage:

*"I didn't go to the classes. I went to a few classes and then I got on Suboxone, and then got a few of the Suboxone. But it was like, I don't know, I just didn't-couldn't keep going to the classes. I didn't like sitting in groups. I'm not a group person."*

*"I mean they do work with you a lot, but it's kind of a hassle to get in there and get on the program. And then they snap on you for certain things, like say the Xanax. You have any Xanax or anything like benzos in your system, they will kick you out of the program and now you're stuck with your habit and you're trying to get clean and no way to get your prescription, you know. So that's rough."*

*"The UA [urinalysis] is a big barrier 'cause it scares me from being able to go in there and pass it."*

## **Other services**

Beyond housing and drug treatment, several interviewees (n=6) expressed that more services in general would be helpful; the most frequently mentioned services included transportation, counseling, medical care, food stamps, and help navigating housing and employment programs.

*"[Having easier transportation] would do a lot for me. I could get a lot more done in a day. I need to go to the doctor's appointment and then I needed to take a shower. Everything is all over. They don't have one place that we can go and do everything. I need to go down there and take a shower. For the life of me, I need to go take a shower."*

Other desired services that were mentioned less often (by 3 or fewer people) included safe drug consumption spaces, alternatives to incarceration, debt consolidation, and women-specific shelters.

Although not a service or program, several (n=5) mentioned how less stigma about addiction and better community understanding around OUD would be helpful overall:

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<sup>5</sup> Naltrexone is a long-acting opioid-blocking medication given as an injection.

*"My kids are clueless and I hope they stay that way actually. I want them to not understand addiction. But it would be nice if they understood a little bit of where I was coming from and what was going on with me, if there's some way to get that information to people like that."*

## 5. Role of Syringe Exchange in Providing Services

Overall, participants valued their syringe exchange and its services; seven participants specifically mentioned their SEP's critical role in preventing the spread of disease:

*"I mean, I think they're doing a great job. I'm very, very grateful to have their help."*

*"I think it's amazing and pertinent resource for this community. If we're gonna engage in this activity, might as well be clean about it, you know."*

*"I think it's awesome you guys give out needles instead of everybody using [just] one. I see people use the same over and over. It keeps you from getting disease and stuff."*

Participants also expressed positive feelings towards the location and privacy of the exchange, as well as being able to learn about and obtain naloxone, a medication that can reverse an opioid overdose.

Most participants (n=13) were generally supportive of additional services at syringe exchange programs. The reasons for this included ease of centralized services, they already go to the syringe exchange to obtain syringes, they appreciate the staff and environment, and it was easy to travel to the location. A few participants said that they would not be interested in additional services because they use the exchange as a place to obtain and dispose of syringes only.

Potential changes to the exchange that were suggested were: longer operating hours, case managers to assist exchange participants, more information about vein health, and providing pipes or foil so that people could safely smoke heroin or methamphetamine.

Participants were then asked about their interest in receiving specific services at their syringe exchange: "What do you think about the syringe exchange as a place to get different services, such as drug treatment, counseling, or medical care?"

Most answered how they would feel about each service specifically, while a few replied that they were generally supportive of more services, but did not specifically address each type of service.

### **Medical care**

Sixteen of the 20 respondents who spoke specifically about medical services thought it was a good idea to provide medical care at the syringe exchange. Only one person expressed a negative opinion, and three expressed ambivalence. Participants indicated that they would like the syringe exchange as a place to get medical care because of the privacy and comfortable atmosphere of the exchange and because of stigma faced in other settings:

*"There's lots of us that, like, have abscesses, get abscesses and we don't necessarily go and have them treated because of the privacy. I walked into [the local hospital] one day and I had nothing to do with an abscess or anything like that and the gal that's with me, at the top of her lungs said, 'So you shoot drugs then?' so everyone could hear. The first thing she said to me . . . Their attitudes are different. It seems like they don't spend as much time. They really don't want to deal with you."*

## **Counseling**

Half of participants (50%, n=12) felt that having counseling available through the exchange would be a benefit to provide support for a wide range of mental health issues, including issues beyond drug use.

*"Not everybody has mental health issues, but I mean everyone has some kind of issues or even just somebody to talk to is always good for people."*

*"I'm sure counseling would help. Someone you could talk to. Someone you could actually get into a relationship with. Somebody you can trust, you feel comfortable with. And that helps a lot, talking does help a lot."*

## **Peer education about OUD medications**

Survey participants were also asked how they would feel about peer education programs to help educate exchange participants about treatments for opioid use disorder. The majority of survey participants had a positive perception of using peer educators to help people learn about "new ways to stop or reduce their opioid use" with only a few expressing a negative perception. In general, peers were valued for their life experience, understanding, and compassion. Some participants felt that it was important that a peer educator be in recovery, while others felt that the most important criteria was knowing factual information on medications to treat OUD.

Some participants (n=11) mentioned that they were interested in actually becoming peer educators themselves because of the enjoyment or satisfaction they feel when helping others. Some were already acting as informal educators on other topics such as proper injection, hygiene, and overdose prevention.

*"I learned that I could get naloxone from the exchange . . . found out how and came down and did it and Bang! I'm still teaching others about it. I also taught a guy . . . about the Good Samaritan Law. Like if someone's overdosing, don't be afraid to call 911 . . . He's like 'Really?' I'm like 'Yeah, really.' I guess he had a friend who died because everyone at the party was too afraid to call the police. So, I try to push the facts."*

## **Implications for Services for Syringe Exchange Participants**

The syringe exchange participants we spoke with had complicated and often difficult lives. They had a high level of self-awareness about the reasons they used drugs, as well as the potential negative consequences of their drug use for themselves and those around them.

### **Addressing methamphetamine and heroin use**

Many people who used heroin said they also used methamphetamine to manage opioid withdrawal symptoms and to regain a sense of personal productivity that had been eroded by their daily heroin use.

In some cases, helping individuals access medications for opioid use disorder may help them, indirectly, also reduce their use of methamphetamine or other drugs. However, for some, other substances may play a beneficial role in dealing with social or mental health issues, and use may not decrease unless those factors are also addressed. Providers who work with people with OUD should be aware of the high level of concurrent use of heroin and methamphetamine (and/or benzodiazepines or other drugs and alcohol) and initiate open conversations with individuals to explore and understand any potential motivations for continuing, decreasing, or ceasing other substance use.

While most exchange participants identified their drug use as the main thing they would change, the supports they most wanted were diverse and not limited to drug treatment such as housing, transportation, medical care, and improved relationships with friends and family. For these individuals, drug treatment (medications and/or counseling) alone, without additional supportive services, may not be enough to reduce or cease drug use. Assistance in accessing and navigating systems for housing, mental health counseling, employment, and other services that can help address social determinants of health is essential to provide holistic and sufficient support to individuals trying to build lives beyond drug use.

It is also important to note how individuals perceive and react to the word “treatment.” Two individuals, for example, mentioned using buprenorphine but did not equate that with “drug treatment.” Another participant talked about a previous experience being prescribed buprenorphine, but when asked about barriers to accessing treatment, he replied “I’ve never been to treatment.” This may reveal several important underlying beliefs: that treatment is a “place” rather than an activity or process, that medication is not drug treatment, or that treatment is undesirable due to negative perceptions. Interventions and messages to engage individuals in behavior change may be more successful if they avoid the generic use of the word “treatment” and instead focus on an individual’s motivational level for change. These factors underlie the wording of the question in the Washington statewide survey, “How interested are you in reducing or stopping your use?”

Exchange participants expressed interest in learning from or educating their peers. Many SEP participants already educate their peers about naloxone and overdose, so there is potential to harness these social networks to help diffuse accurate information about opioid treatment medications within communities. ADAI has developed a brochure entitled “Medications for Opioid Use Disorder” that can be used as part of a patient-centered treatment decision making process; the brochure and other materials are available online at [www.learnabouttreatment.org](http://www.learnabouttreatment.org).

### **Expanding services at syringe exchange programs**

Interest in expanded services at SEPs highlights the strong positive relationship between these programs and the participants they serve. Enhanced services at syringe exchanges like care navigation or case management could help exchange participants access a wider range of services. Same day access to buprenorphine at SEPs has the potential to help make medications more accessible, and to increase the likelihood that many more people who are interested will start medications. Preliminary [results from the Buprenorphine Pathways program](#) that began January 2017 have been published and indicate that a largely homeless, poly-substance using population can be engaged in care and significantly reduces illicit opioid use. Other similar programs are increasing in Washington State and a [multi-site study](#) is currently underway to study the impacts of same day buprenorphine starts at community programs such as syringe exchanges combined with care navigation.

Despite a strong interest by SEPs to provide or house these services, many SEPs face significant challenges in their ability to do so. Hours and staffing at many SEPs are quite restricted by funding levels, so expanding services would require a significant increase in resources. Additionally, many exchanges are mobile and operate out of a van or in a semi-public setting in which some services (e.g., counseling) may not be possible. The capacity of many SEPs to expand services is also limited by the uncertainty if they will even remain open under increasing political and/or public scrutiny. In fact, not long after interviews were conducted, one of the interview sites was forced to close and move to another town due to local pressure.

### **Limitations**

The perspectives shared in these interviews are a small subset of the overall population who inject drugs and may not be representative of the larger population of PWID or people using heroin or methamphetamine. People who use syringe exchange services primarily inject their drugs and their views may be different than those of people who smoke or use drugs by other routes of administration. The survey participants showed a fairly high degree of self-

awareness and self-reflection, and people who agreed to participate in surveys maybe more likely to be interested in an array of services and to serve as peer educators.

The \$25 gift card may have been more appealing to people who did not have much or any income, and our participants may have been more likely to be homeless or jobless than the overall population at SEPs. Each interview took approximately 30 minutes, and some participants had to wait to be interviewed. People who had jobs or other responsibilities may have been less likely to agree to the interview based on their availability.

Almost all (92%, n=22) of the individuals interviewed were white, and their experiences may not reflect those of individuals of other races; respondents to the [2017 Statewide Syringe Exchange Survey](#) were 83% white. The two interviewers were both white, which may have influenced who was willing to be a participant, as well as what they are willing to share. Some respondents may also have been more or less comfortable discussing specific topics based on the gender of the interviewer (one female, one male).

Additionally, interviewer bias may have played a role in what topics people discussed, as each interviewer may have asked more follow up questions or shown more interest in certain topics. This may also have played a role in analysis and what themes were identified. The two interviewers were public health professionals focused on drug use and health, so their interest in this topic may have influenced responses.

## Conclusion

Overall, qualitative interviews with 24 individuals accessing SEP services showed that there is no single or simple solution to improving the lives of SEP participants. Individuals need multiple types of services that are readily available and easy to access in terms of time, cost, and effort. One way to do this is by locating additional services within a single site, such as a SEP, where trust and engagement are established. Based on the interviews, a holistic approach that addresses social determinants of health such as housing, transportation, access to employment, social relationships and stigma is critical.

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