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# Syringe Exchange Clients' Perceptions of Medications for Opioid Use Disorder

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Abstract

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*Background:* Methadone and buprenorphine are effective interventions for reducing opioid use and associated harms. Given the changing nature of illicit opioids and new medication treatment models and access points, current information is needed regarding user perceptions of these medications in order to improve enrollment and adherence.

*Methods:* We performed qualitative semi-structured interviews (N=24) with syringe exchange program (SEP) clients in four Washington State counties. The majority of participants ( 87.5%) alluded to medications for opioid use disorder (MOUD) without prompting. We coded interviews for MOUD (any excerpts mentioning buprenorphine or methadone) and analyzed responses using an inductive approach until finalized themes were adjudicated by the study team.

*Results:* Highly interdependent themes emerged from the data including; access, preference, addictiveness, stability and timing. *Access* was characterized by the need for available preferred treatments in practical proximity of SEP clients. *Preference* included a distinction between buprenorphine and methadone treatment when choosing a MOUD option. *Timing* included thoughts on both when to start MOUD and the preferred duration of treatment. The theme of

*Addictiveness* was characterized by the perceived likelihood of physical dependency. Lastly, MOUD was seen as a means to gain *stability* in the lives of interviewees.

*Conclusions:* Opioid users accessing services at WA state Syringe Exchanges offered strong opinions regarding MOUD, even when not explicitly asked. Participant preferences may benefit MOUD treatment uptake and retention.

## **Background**

Opioid Use Disorder (OUD) is a public health epidemic resulting in numerous personal, social and economic consequences. According to the Centers for Disease Control (CDC), opioids comprised 67.8% of fatal overdoses with 47,600 total deaths in 2017 (Rudd et al. 2016).

Temporally, the opioid crisis can be thought of as occurring in three phases; overuse of prescription opioids, a subsequent rise in heroin use, and an increase in synthetic opioids such as Fentanyl (Kolodny et al. 2015, Rudd et al. 2016). The scope of the problem has required multifaceted interventions on both the state and federal level, including the utilization of medications. Washington state, for example, has implemented a varied strategy to combat the crisis including prescription monitoring, new clinical guidelines and overdose prevention efforts (Franklin et al., 2015).

Medications for Opioid Use Disorder (MOUD) include buprenorphine, commonly referred to by its brand name “Suboxone,” and methadone. These treatments demonstrate effectiveness in reducing illicit opioid use, blood borne infections, morbidity, and mortality (Langendam, Van Brussel, Coutinho, & Van Ameijden, 2001; Mattick, Breen, Kimber, & Davoli, 2014; Pinto et al., 2010). Further, these medications have been proven more effective than psychotherapy alone in reducing mortality, promoting their consideration by many experts as the “gold standard” of care (Banta-Green & Coffin, 2016; Carroll & Weiss, 2016). Yet, despite this demonstrated clinical utility, MOUD uptake is lacking; only 20% of persons with opioid use disorder were receiving MOUD treatment in 2017 (Center for Behavioral Health Statistics and Quality, 2017).

An important strategy for improving MOUD uptake and adherence is careful assessment of personal perceptions of these medications and their impact on lifestyle. Syringe exchanges programs (SEPs) offer an idealized setting for this work. Washington state currently has at least 25 SEPs operating in 18 counties implemented via multiple public and private entities (Banta-Greet et al. 2017). Surveys at these exchanges have indicated that the majority of clients (77%) are interested in obtaining help to reduce or stop their use (Frost, Williams, Kingston, & Banta-Green, 2018).

Previous qualitative work on perceptions of MOUD suggests thematic commonalities. A large qualitative study (N=283) by Yarborough et al. (2016) found that prior experience with MOUD, associated MOUD stigma, fear of MOUD addictiveness, and treatment education all contributes to MOUD initiation and sustained treatment. Stigma (a negative judgement or appraisal) was mainly associated with methadone use and its association with street heroin use. Similarly, methadone was perceived as more physically addictive than buprenorphine with participants often failing to draw a distinction between physical dependence and OUD, a known phenomenon of use in spite of consequences. Other work has also underscored the stigma associated with Methadone treatment. Unlike Buprenorphine which can be prescribed monthly in an outpatient setting, persons receiving Methadone treatment are required to frequent clinics multiple times weekly which is sometimes seen as demeaning and paternalistic (Bishop et al 2019, O’Byrne & Pearson 2018). Further, patients often report that Methadone has more sedating effects than Buprenorphine, adding to the perception of some in society and people who inject drugs (PWID) that Methadone is simply a legal way to continue or substitute use (Bishop et al. 2019, O’Byrne & Pearson 2018).

While these qualitative studies are informative, more information is needed especially across different populations of those with OUD.

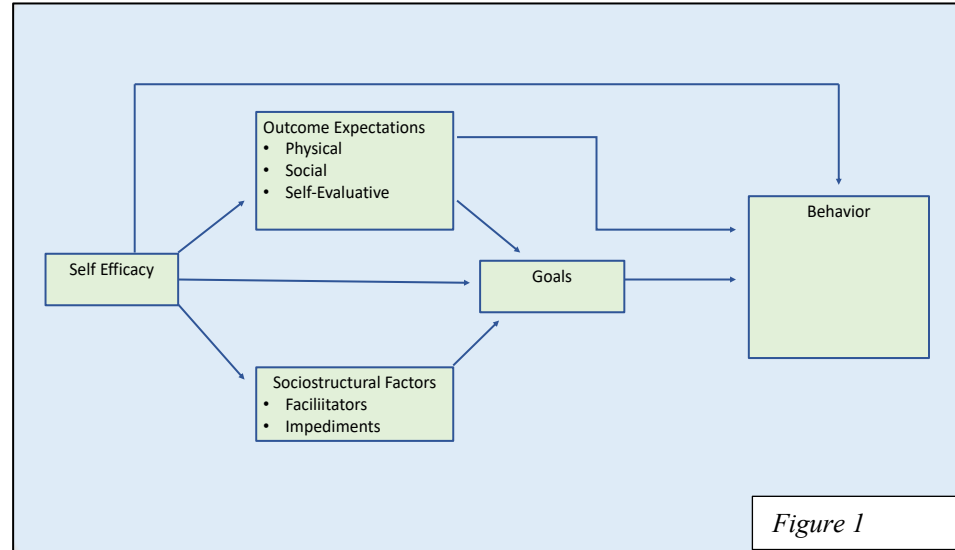


Figure 1

SEPs have been identified as practical locations to target treatment uptake, and lend themselves well as study locations (Kidorf, King, Gandotra, Kolodner, & Brooner, 2012). A modified Social Cognitive Model (Bandura, A. 2004, figure 1) provides a useful conceptual framework to this end. Health behavior change, according to this model, relies heavily on in interplay between self-efficacy, expected outcomes, goal-setting and structural factors that either inhibit or promote behavior. Within this model the greater self-efficacy one has, the greater goals they set. The more sociostructural and individual barriers impeding outcome expectation and goal setting, the less a desired behavior will occur and the more individualized support is necessary to facilitate change.

Within this framework individual perceptions of facilitators and barriers can provide useful leverage points for actionable items for clinicians and public health professionals alike. Thus, this study aims to provide a descriptive qualitative analysis of perceptions of MOUD in clients of WA state SEPs in hopes of better identifying mechanisms for MOUD uptake.

## **Methods**

Semistructured interviews were conducted with (N=24) SEP clients at four sites across four WA state counties. Two interviewers, one male and one female, conducted the interviews. IRB approval was obtained from the University of Washington.

### *Participants & Setting*

A convenience sample of SE clients accessing services were approached to participate in interviews after first consulting SEP staff to confirm permission and to inform interview logistics. Inclusion criteria included active heroin and/or methamphetamine use and age  $\geq 18$  years old. For those who wished to participate, interviews were conducted in a separate private area. Informed verbal consent was obtained from participants emphasizing confidentiality, potential risks and benefits, and agreement with the interview being audio-recorded. Participants were offered a copy of the unsigned consent form for their record and given a \$25 grocery store gift card to compensate them for their time.

### *Interviews*

Based on previous syringe exchange surveys (REFS), a semi structured interview guide was developed. Team meetings were held to discuss initial questions and subsequent prompts which fell in to three predetermined domains: services utilized at the exchange, general life problems facing SEP clients, and drug use motivations in order to gain insight in to actionable improvement items for SEP administrators. In addition, basic demographic variables were collected including age, gender, race and drug use patterns. Pilot interviews (N=6) were

conducted to test the interview guide and were subsequently included in the final data set. Semi structured interviews (N=24) were conducted at four SEPs in four Washington counties between July and September 2019. The number of interviews was determined by feasibility and agreement that sufficient information would be gained. Interviews ranged from 11 to 33 minutes in length. Two interviewers affiliated with the University of Washington's Alcohol and Drug Abuse Institute (ADAI), one male Masters of Public Health student and one female (MPH), conducted the interviews. Both interviewers had previous education and experience working with people with substance use disorder and some hands-on experience with qualitative interviews. Questions were asked in a semi-structured manner allowing participants to guide the interviewers to topics they felt were important. Probes and follow-up questions were included in the interview guide, which allowed for flexibility while still addressing predetermined domains. All interviews were audio recorded.

## **Analysis**

Interviews were professionally transcribed and uploaded to Dedoose qualitative analysis software. Two members from the study team developed initial codes categorized by the 3 predetermined domains (services at the exchange, general life problems and drug use motivations). An inductive approach was utilized, allowing for codes and themes to emerge through an iterative process via categorical summaries of raw data for relevant themes (Thomas 2006). To arrive at the final themes pertaining to MOUD, the following steps were taken. First, a code book was developed by the study team after initial readings of the transcripts. Common topics were given a "parent code" to capture broader themes. More granular information was subsequently assigned under "child codes" under their respective parent codes. Next, team

meetings were held to discuss parent and child code construction until a finalized code book was developed. Coders used the testing feature in Dedoose to reach a proportion of 72% agreement before analyzing the data independently.

The code “MOUD” was applied for all excerpts pertaining to methadone and buprenorphine. From this subset of data, excerpts (N=56) were again analyzed by a deep reading of the text. Memos were created to summarize thematic elements from these coded excerpts. Finally, team members met to discuss and agree upon a finalized set of themes.

## **Results**

Medications for opioid use disorder were not directly addressed in the interview guide but were spontaneously discussed by 21/24 (87.5%) of participants. Two participants who mentioned MOUD did not report opioid use and were excluded from the final analysis leaving 19/24 (79.2%) of participants in the final data set, with a total of 56 excerpts about MOUD. Most of these clients reported polysubstance use, with 13/19 (61%) reporting at least occasional methamphetamine use in addition to opioids. The majority of respondents were white (89%) with a mean age of 39 years and 52% male.

### *MOUD Preferences*

Treatment preference was a consistent theme across the interviews when MOUD was mentioned (n=12, 63%). Many participants perceived Methadone and Suboxone to have differing effects. Methadone was sometimes purported to do a better job of reducing cravings and providing sedation, which were preferable to some (n=4). Others welcomed the less sedating effects of

buprenorphine, preferring it to the lethargy of methadone (n=6). Salient past experiences, especially negative ones, informed distinct opinions. For example, two participants reported allergic reactions (to Suboxone only), dissuading them from a second attempt at initiation. As one participant explained when asked why people may prefer different options:

*“Yeah, probably just because of the difference in the high or maybe the convenience of it. Some people just don't like suboxone, the way it makes you feel. Because they're all different. Suboxone is not heroin and methadone is not suboxone. You know what I mean?”- 32 year old Male*

At times participants stated a clear preference but didn't give a definitive reason for doing so, as this SEP client explained:

*“Suboxone, I don't know, I just – suboxone I just never cared for it. I was on a suboxone clinic for a short time. I don't know, I just don't like it. Methadone, I feel methadone is a better way to go than suboxone. But I think that knowing about each one of them and what they can do for you is, you know, might as well, the more knowledge you have the better.” -32 year old Male*

In addition to medication type, preferred duration on MOUD was important. Some SEP clients expressed a desire for MOUD as a way to detox. Others preferred the idea of a maintenance period to stabilize before ultimately discontinuing. Lastly, some users expressed a preference to remain on MOUD indefinitely.

*“If they had something here, not a suboxone clinic 'cause that doesn't work. Like a methadone clinic here would help me a lot or something close to that where they can wean you off of*

*H[eroin] and then get you on whatever else and wean you off of that so you're not shooting up all the time so – just getting rid of that and getting away from that and in general it's just a good thing.” -42 year old Male*

Lastly, treatment requirements and associated stigma, defined as a negative view or judgment, influenced MOUD preference as well. While some wanted support, others found that the requirements of some programs stifled their independence dissuading them from continuing treatment, as these clients recalled:

*“– a lot of places, they don't want you near them if you're on methadone. You're using, they consider it, so they don't want you near them or whatever. So if they were more understanding about it and know it's controlled” -47 year old Male*

*“That was all right. Sometimes I didn't like the control they had over me. Got to do what they say or else they cut you off, you know, this and that. But other than that it was sort of a lifesaver. You didn't have to go out and borrow and steal and spend all your money or whatever you got to do. You've got that relief off your mind so, you know” -69 year old Male*

Overall, SEP clients had differing experiences and preferences for medications. Users had strong opinions on which medication they would prefer, based on a number of factors including prior experiences, which included perceived differing effects of the medications. SEP clients also had different preferences for buprenorphine or methadone based on associated treatment requirements and stigma, the latter being associated with methadone treatment.

## **MOUD Access**

A need for greater access and common barriers to receiving treatment were pervasive themes. Although MOUD was desired, distance to preferred treatment options was commonly mentioned as a barrier (n=15, 78%). Many clients suggested that it was not practical to take long and costly bus trips to receive treatments as would be necessary at an opioid treatment program, the only place methadone can be obtained. The theme of “preference” also tied in heavily with access. Often, participants had an option for either Methadone or Suboxone nearby, but not their preferred mode. As this SEP client explained, a barrier such as distance can thwart treatment compliance:

*“I mean, I went down to – I use heroin, so I went down to [City X] for a little while, because they give you Suboxone the next day. But that just seems like it’s too much of a bus ride, ‘cause I just take the bus. So if you have a car it’s probably easy, but I take the bus so it’s an all-day thing. So I did it for a couple of weeks but then it was just too much for me.” -41 year old Female*

Cost was also a consistent concern (n=5) and differed depending on medication type. Suboxone was seen by some as too costly, often requiring private insurance to see the only physician(s) in town able to prescribe. As a result, multiple participants told of a Suboxone street market where those desiring medication obtained it on the street:

*“Interviewer: So, there’s no way for you right now to get it legally?”*

*“Interviewee: No. If I wanted to, I could go somewhere and ask for somebody, “Hey, do you have any Suboxone,” and get it off the street. But I don't want to do it illegally. I'd like to get it legally.”* 47 year old Female

Participants expressed that this need for access was often an impediment to entry and maintenance of MOUD treatment. Unrealistic expectations by programs in terms of travel, program requirements and cost placed a heavy burden on SEP clients who were often frustrated by these barriers.

### MOUD Timing

Users often expressed the importance of timing (n=14, 74%). MOUD was seen as a desirable option, but the timing of preferred initiation and maintenance was ambiguous. Some mentioned that they experienced times when they would be more receptive to MOUD or other treatment, if it were available. This was more likely when participants were unable to procure heroin for whatever reason. The importance of timing was also strongly linked to the themes of “access” and “preference.” As this participant recalls, when they felt the timing was right having ready access to Methadone treatment made initiation easier:

*“I woke up one morning. I was sleeping across the street. That particular morning I don't know what happened but I lost it. I was crying uncontrollably asking God to do something. I couldn't do this anymore. Somebody took me by the hand and marched me into the Methadone clinic. I had an appointment pretty much from that day.”* - 45 year old Female

Since participants were engaged in active use of street opioids at the time of interviews, the theme of timing was inherently past and future oriented. Participants saw MOUD as a viable option, but often something they would undertake in the future (n=8) or would have already done in the past if their preferred option were readily available (n=5).

### Addictiveness of MOUD

A less common but salient reason for avoiding MOUD was a perception of its addictiveness (n=4, 24%). Some saw MOUD as a continuation of their opioid dependence in a more structured manner, failing to make a distinction between a physical dependence on opioids and OUD. For these participants, heroin use was perceived as simply a matter of satisfying a physical need rather than a complicated cycle of problematic use. Further, some expressed the perception that withdrawal syndrome from MOUD was more severe than heroin itself which sometimes dissuaded them from MOUD initiation as these SEP clients explained:

*“So, I never really gave it much of a shot. Methadone, I've heard that it will get me more addicted than the actual heroin. So, I'm kind of leery to try it” - 33 year old Male*

*“So basically you're getting the opioid and spinning your wheels going nowhere. Eventually you gotta fix that problem next. That's harder to kick that than the other street drugs” - 51 year old Male*

At times a distinction between Methadone and Suboxone's addictive potential was noted, with some seeing Methadone as more addictive. Despite the recognition that both drugs still continue physical dependency on opioids, it was sometimes seen as a necessary means to discontinue

street opioid use and associated behaviors. As this participant points out, perceived addictive potential also tied in heavily with the theme of MOUD preference:

*“Getting suboxone because that does help. I'd rather get on that than methadone. Methadone is like getting back on heroin. It's too addicting.” - 47 year old Female*

Interviewees expressed a general recognition that MOUD therapy continues physical dependence. Thus, a subset of participants saw it as a futile effort failing to address the underlying problem, which was often simply perceived as a physical dependency issue rather than a disorder of problem use. Especially when MOUD was seen as more physically addicting than heroin, as was more frequently the case for Methadone, participants expressed hesitancy to engage in treatment if their preferred option (Suboxone) was unavailable.

### Stability

Users generally expressed a desire for stability in their lives and MOUD was often seen as a way to do so (n=10, 53%). Some had previous or current experience with MOUD and recalled the associated stability it provided. Generally, users were dissatisfied with the time, effort and money it took to sustain their street opioid habits. One participant explained the time-consuming cycle of obtaining and using heroin as a job in and of itself, expressing an eagerness to break this routine:

*“You didn't have to get up every morning and worry about where you're gonna get well and then where you're gonna make sure that you have something so you're well again so you can go to sleep and, you know. If you didn't have that – that's a full-time job right there in itself. So if there*

*was like 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.” - 31 year old Female*

Another SEP client succinctly stated that not having to worry about going through withdrawal daily allowed them to function as a member of the community:

*“On a methadone program I can function. I'm not sick. I can get up every day. I can be a contributing member of society. I can – Where on heroin you can't do that” - 53 year old Female*

A general lack of stability was a pervasive theme for participants. For some, MOUD was seen as a tool that could allow for a return to normal daily routines without the cycle of needing to obtain money for and procure street opioids. Employment and a return to relationships along with a sense of community were also often hoped for, with MOUD perceived as a means to do so.

<b>Theme</b>	<b>Definition &amp; Subthemes</b>
MOUD Preference	A desire to engage in one MOUD treatment option (buprenorphine or methadone) over the other.
MOUD Access	The ability to engage in preferred MOUD modality when wanted. Most often tied to distance and cost.
MOUD Addictiveness	The perceived physical dependence potential of MOUD treatment. Methadone treatment was often seen as more physically dependent than buprenorphine or heroin itself.

MOUD Timing	The perceived timing preference to initiate MOUD treatment and desired duration.
Stability	Perception of MOUD as a tool to provide stability, especially regarding worries about withdrawal and behaviors associated with street opioid use.

Table 1

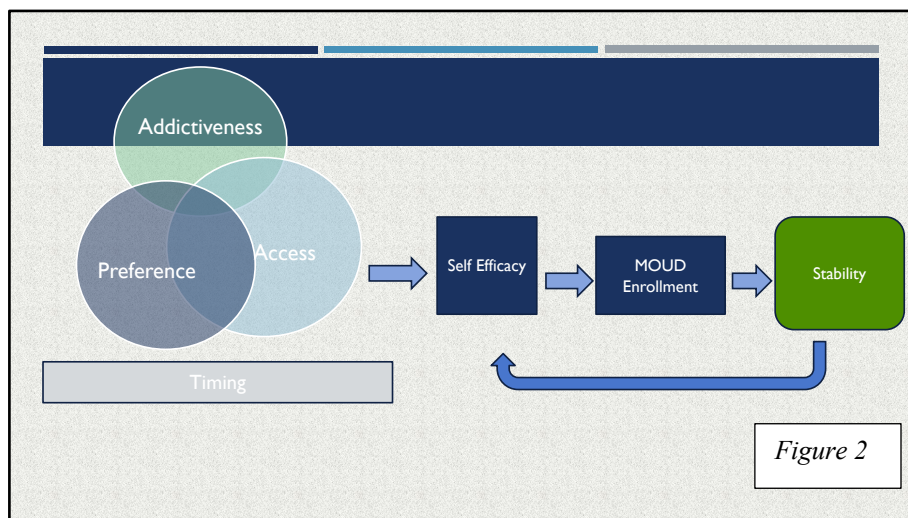
In summary, SEP clients’ largely had distinct *Preferences* as to which medication they would choose if they initiated treatment. This was heavily dependent on past experiences and perceived effects of the medications, as well as associated social desirability. This theme also overlapped substantially with those of *Access* and perceived *Addictiveness* of MOUD. Participants often suggested a willingness to engage in a preferred treatment that was either unavailable, highly burdensome or negatively perceived. Treatment *Timing* again interplayed with these subsequent themes, especially that of *Access*. SEP clients were often open to MOUD, but timing of treatment initiation as well as desired duration were variable for interviewees. Lastly, participants saw MOUD as a means to *Stability* in their lives.

**Discussion**

This qualitative analysis of SEP client perceptions of MOUD adds to previous literature describing distinct opinions of SEP clients towards these treatments. The majority of participants (87.5%) offered unsolicited opinions on MOUD, which we believe underscores its importance in the minds of those with OUD. Our analysis identified several common themes that were highly interdependent and largely consistent with other qualitative work on the subject (Bishop, Gilmour, & Deering, 2019; Yarborough et al., 2016). Namely, a need for access to preferred

treatments at appropriate times emerged as essential facilitators to treatment uptake. Unique to our study, however, was the advantage of interviewing SEP clients with OUD before being engaged in treatment, lending a unique perspective relative to much of the qualitative work on the subject. These results highlight potentially useful leverage points for those utilizing SEPs within a sociocognitive model by utilizing patient choice to optimize self-efficacy and improve health behaviors (Figure 2). This work also highlights policy measures to improve buprenorphine access outlined by Haffajee et al. 2018 which provides practical suggestions for improving sociostructural factors currently impeding access, including improved MOUD care coordination, reimbursement models and provider training.

SEPs are a practical location to increase MOUD treatment in those with OUD, providing a centralized location to disseminate treatment



information and options. Often associated with health agencies and staffed by knowledgeable health professionals, SEPs provide a unique opportunity to reach those with OUD in an environment that is familiar and comfortable. Our results point to the importance of empowering patients to be involved in treatment decisions, both in regard to preferred MOUD modality and duration. Emphasizing autonomous treatment decisions in those with OUD is the practical way to increase self-efficacy in contrast to a paternalistic approach that may increase maladaptive responses of learned helplessness (Shaghaghy, Saffarinia, Iranpoor, & Soltanynejad, 2011).

Indeed, our results suggest that a “one size fits all” approach to prescribing and treatment for those with OUD will not prove effective. Instead, a “no wrong door” approach encouraging MOUD initiation through collaborative low-barrier methods should be emphasized (King County Heroin and Prescription Opioid Task Force, 2016 Kourounis et al. 2016, Dr. Robert Bree Report 2017). Imperative to this aim is acknowledging past experiences and existing knowledge of those with OUD when deciding to initiate and maintain treatment.

### **Limitations**

While results from this study show several key themes consistent with prior literature, limitations exist. Foremost, the data provided by SEP clients may not be representative those with OUD as a whole and therefore may not be generalizable to other populations with OUD.

There are also a number of factors that could compromise the validity of the data. The fact that MOUD was first asserted by clients, and not interviewers, may have reduced the breadth of the information obtained. On the other hand, this approach offers unique and potentially less biased insight into these preferences. Further, although interviewers were impressed by the depth and emotionality of information offered, it is possible that participants reported information they believe would be looked upon favorably resulting in a social desirability bias. Lastly, while a qualitative approach provided unique perspectives essential for characterizing SEP clients’ perceptions of MOUD, this methodology is limited for drawing causal connections. More research is needed to characterize perceptions of MOUD in those with OUD, especially as they relate to treatment induction, maintenance and long-term outcomes.

## **Conclusions**

MOUD is the most effective treatment option available to those with OUD and is vastly underutilized. Our results show key thematic perspectives from WA state SEP clients not engaged in treatment, providing a unique perspective that may be utilized by public health professionals and clinicians in order to improve MOUD uptake. Namely, participants stressed a desire and intention to engage in MOUD treatment when the time was right in hopes of gaining stability in their lives. Detrimental to this achievement was a lack of access, especially to preferred MOUD medications. Developing low barrier MOUD options based on these factors may benefit future treatment uptake and retention.

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## Appendix

### I. Semi-Structured Interview Guide:

**Introduction (after consent process is done):** The purpose of this interview is to help us better understand syringe exchange clients and what types of help and support they need. It is an opportunity for you to share your thoughts on this topic. This information will help us provide recommendations about what programs syringe exchange clients would benefit from. These interviews are a follow up to a survey we conducted last summer of exchange clients.

In this interview I will ask you about preferences for different types of services, your quality of life, and what drugs you use. The only potential harm to you from this interview is that it could be upsetting to talk about some of these issues.

#### **START Recording:**

**Interviewer name:**

**Interview location:**

**Interview date and time:**

#### **Participant demographics:**

Gender:

Race/ethnicity:

Age:

#### **Specific services**

What do you think about the syringe exchange as a place to get different services, such as drug treatment, counseling, or medical care?

PROMPT: What would be good about it? What would be bad?

Some exchanges are thinking about peer educator programs to help exchange clients learn about new treatments for heroin and opioid addiction. In these programs exchange clients would learn about

treatments, and then educate their peers. If there was a program like that at this exchange how likely would you be to participate?

PROMPT: Why did you give the answer you did? What would make you more or less likely to participate?

## **General Life**

Next I'm going to ask you some more personal questions about you. Your answers will help us understand what's important to you, and what might help you.

- If you could change one thing in your life what would it be?
  - PROMPT: What would your best friend or your family say?
- What would you need to make that change?

*Keep asking probing questions until it's clear that there isn't more to elucidate.*

## **Drug use motivations:**

*Explore a little about how the interviewee uses drugs.*

- In a typical week what drugs do you use?
  - *If someone asks "what is typical" you can reply "whatever it means to you."*
  - *Follow up prompts: Do you have a main drug? How do you use those drugs? (Ask questions to learn about route of ingestion, form of drug, where do you use, what social settings)*

*Learn more about if and how they use meth and heroin together.*

- We'd like to learn more about why people use meth and heroin at the same. Do you know anyone who uses heroin and meth? What does that look like? Why do you think people use both?
  - *Follow up prompts: Are people mixing heroin and meth together? Do people use heroin and then meth or vice versa? What are the benefits of using heroin and meth? Do people*

inject both, smoke both, whatever is available? *Ask questions until you have a good understanding of how people use and some of why.*

### ***Conclusion***

- What part of your life are you most satisfied with?
- Is there anything else I should know about you, or services we should offer?

Thank you for taking the time to speak with me. I appreciate you sharing your experiences. If you have any questions that come up, here is my contact information. *Give them a card with the [info@stopoverdose.org](mailto:info@stopoverdose.org) email address.*

## **II. Consent**

### **UNIVERSITY OF WASHINGTON CONSENT FORM Qualitative Interviews of Syringe Exchange Participants**

#### **Researchers**

*Principal Investigator:* Caleb Banta-Green, PhD, MSW, MPH  
*Continuing Education Specialist:* Allison Newman

Alcohol and Drug Abuse Institute: 206-685-0937

**24-hour emergency telephone number:** Caleb Banta-Green 206-543-0937

#### **Researchers' statement**

We are asking you to be in a research study. The purpose of this consent form is to give you the information you will need to help you decide whether to be in the study or not. Please read the form carefully. You may ask questions about the purpose of the research, what we would ask you to do, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When we have answered all your questions, you can decide if you want to be in the study or not. This process is called "informed consent." We will give you a copy of this form for your records.

## **PURPOSE OF THE STUDY**

We want to know more about people using syringe exchange programs. We want to ask people who use these services about drug use, services they may need and other aspects in their life. We want to use results from this study to improve syringe exchange programs, conduct further research and to make recommendations to policy makers.

## **STUDY PROCEDURES**

You will be asked to participate in an interview about drug use, your life in general and health services you may use or want to use. For example, we will ask about the primary drug you use, general problems you may be experiencing and health services you may want to use.

An interviewer will ask to talk with you for about 1 hour in a private location near the syringe exchange. We will ask to audio record the interview so we can accurately use information from the interview later. You may refuse to answer any questions you do not wish to answer. You may also refuse to be recorded, but we will not be able to continue with the interview if you choose not to do so. We ask that you not identify yourself or others by name during the interview, or refer to situations (such as employment) that could make yourself or others easily identifiable.

## **RISKS, STRESS, OR DISCOMFORT**

You will be asked sensitive questions about drug use and problems you may be experiencing in your life. These questions may make you uncomfortable. You may refuse to answer any questions you do not wish to answer. While we make every effort to keep your information confidential, it is possible someone may find out you participated in the study.

The interview will be audio recorded. Only members of the research team will have access to these recordings. The recordings themselves will not be published. Instead, we will choose themes from the interviews to use in written research publications. We ask you not to identify yourself or others by name during the interview.

You may ask for parts of the recording to be erased during the interview. After the interview is over you may later contact the researchers and ask for the entire interview to be erased. This does not apply to information that has already been used from the recording.

## **ALTERNATIVES TO TAKING PART IN THIS STUDY**

This study does not provide treatment. The alternative to taking part in this study is to not participate.

## **BENEFITS OF THE STUDY**

There is no direct benefit to you for participating in this study. We hope that information from this study will benefit other people who use drugs in the future.

## **SOURCE OF FUNDING**

The study team is receiving financial support from the Washington State Division of Behavioral Health and Recovery to conduct this study.

## **CONFIDENTIALITY OF RESEARCH INFORMATION**

All of the information you provide will be confidential. However, if we learn that you intend to harm yourself, we must report that to county mental health providers. If we learn of any child abuse or elder abuse, or that you intend to harm others, we must report that to local police.

All recordings will be anonymous with no links to identify you. The research data will be destroyed after the records retention period required by state and/or federal law. Data recordings will be kept on secure computers at the UW Alcohol and Drug Abuse Institute until they are transcribed in to written format. Once the recordings are transcribed they will be destroyed.

Government or university staff sometimes review studies such as this one to make sure they are being done safely and legally. If a review of this study takes place, your records may be examined. The reviewers will protect your privacy. The study records will not be used to put you at legal risk of harm.

Qualitative Interview of Syringe Exchange Participants 2 of 3

## **OTHER INFORMATION**

You may refuse to participate and you are free to withdraw from this study at any time without penalty or loss of benefits to which you are otherwise entitled.

You will be given a \$25 gift card to Safeway or Kroger after the interview is completed.

## **RESEARCH-RELATED INJURY**

If you think you have been harmed from being in this research, have questions, complaints or concerns about the study, contact Caleb Banta-Green: 206-543-0937

The UW does not normally provide compensation for harm except through its discretionary program for medical injury. However, the law may allow you to seek other compensation if the harm is the fault of the researchers. You do not waive any right to seek payment by signing this consent form.

### **Subject's statement**

This study has been explained to me. I volunteer to take part in this research. I have had a chance to ask questions. If I have questions later about the research, or if I have been harmed by participating in this study, I can contact one of the researchers listed on the first page of this consent form. If I have questions about my rights as a research subject, I can call the Human

Subjects Division at (206) 543-0098 or call collect at (206) 221-5940 I will receive a copy of this consent form.

Copies to: Researcher Subject