

Unmet Needs, Complex Motivations, and Ideal Care for People Using Fentanyl in Washington State: A Qualitative Study



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Key Findings

- In our interviews (n=30) with people who use fentanyl at four Washington State (WA) syringe services programs (SSPs), participants discussed the rapid change in the drug supply from heroin to fentanyl and how this affected their substance use.
- Almost all interview participants smoked fentanyl, and a few also injected it. Many interview respondents had previously injected heroin and switched to smoking fentanyl due to fentanyl's potency and the perceived lower overdose risk from smoking.
- Participants reported complex motivations for using fentanyl including physical pain, mental health issues, trauma, homelessness, opioid use disorder, and easy availability of fentanyl. The majority of respondents were unhoused and said meeting basic needs like housing, food, and employment was a priority.
- For many respondents, the central benefit of using fentanyl was its ability to control their severe, chronic pain (70% of respondents mentioned pain management). Some participants started using fentanyl after a health care provider terminated an opioid prescription or they used fentanyl to self-medicate pain not otherwise addressed through a health care provider.
- The majority (70%) of participants were interested in reducing or stopping their fentanyl use. However, people expressed many barriers to doing so, including unavailable services, being unaware of what might work, fear of withdrawal, and challenges accessing and staying on medications like buprenorphine or methadone.
- Many respondents were interested in or had previous positive experiences with methadone or buprenorphine for opioid use disorder. However, administrative and other barriers limited access to these medications. The regulations for dispensing methadone and the need for daily dosing were particularly challenging, especially for respondents experiencing housing insecurity.
- When asked about the "ideal place" to receive medical care and/or help with substance use, people described holistic and individualized care that was affordable and easy to access. Specific services of interest included: programs to help meet basic needs, medical care, mental health care, care navigation, and support from people with lived experience of substance use.
- The combination of health care barriers, social determinants of health, the strength and half-life of fentanyl, and individual physical and mental pain produced a significant challenge for care systems to respond to the complex needs of many people who use fentanyl.

Introduction

Opioid overdose deaths in Washington (WA) State continue to rise and are primarily driven by unregulated fentanyl. [From 2019-2022 the opioid overdose death rate in WA State more than doubled from 11.3/100,000 to 24.9/100,000](#), and most of that increase was due to fentanyl. In 2022, fentanyl was involved in 90% of opioid overdose deaths in WA State and 65% of all overdose deaths (ADAI, 2023). The emergence—and now dominance—of fentanyl over heroin as the primary opioid in the illicit drug supply has changed the context of opioid use, increased overdose risk, and intensified the need for social and medical supports.

Understanding the experiences, perspectives, and insights of people who currently use unregulated fentanyl can contribute to more nuanced and holistic responses to this crisis. Such insights are crucial to inform public health policy and interventions as communities work to decrease opioid overdose deaths *and* improve the health and wellbeing of people who use fentanyl.

To contribute to this understanding, staff at the University of Washington Addictions, Drug & Alcohol Institute (ADAI) conducted a qualitative study of people who use fentanyl to explore their experiences and views on the following topics: 1) fentanyl use patterns, 2) previous treatment experiences, 3) benefits and drawbacks of fentanyl use, 4) interest in stopping or reducing fentanyl use, and 5) preferred services and ideal care (including staff, services, location, and atmosphere). This work builds on previous collaborations between ADAI and WA State syringe services programs (SSPs) including the [bi-annual survey of SSP participants](#) (Banta-Green et al., 2020) and [two earlier qualitative interview projects](#) (Teadt & Newman, 2022).

Methods

This exploratory qualitative study utilized in-depth semi-structured interviews to explore the topics related to fentanyl use and access to care mentioned above. Interviews were conducted from September through October 2022, in collaboration with four WA State SSPs at five locations: Clallam County Harm Reduction Health Center in Port Angeles, Tacoma Needle Exchange in Tacoma (two sites), Thurston County Syringe Services Program in Olympia, and Spokane Regional Health District Syringe Services Program in Spokane. University of Washington Human Subjects Division gave approval to conduct this research, determined as exempt from full review, in August 2022.

Study recruitment flyers were sent to SSPs two weeks ahead of the intended dates of interviews. Participants were eligible if they were 18 years or older and if they reported using fentanyl at least three times in the previous week. SSP staff provided basic information about the study purpose and identified SSP participants who were interested in the study. ADAI researchers then provided more information about the study to potential participants and obtained verbal consent to be recorded before each interview began. No identifiers were collected, and interviewees were provided with a \$25 gift card for their participation. Interviews lasted 40 – 60 minutes; these were audio-recorded and transcribed verbatim with a HIPAA-compliant transcription service, after which study staff reviewed and prepared transcripts for analysis. Transcripts were analyzed in MaxQDA 2022 (Verbissoftware, 2021) by the study team with a combined deductive and inductive coding approach (Saldaña, 2021). Coding and analysis were iterative and reflexive, involving ongoing team discussion throughout the research process.

Results

Thirty people participated in the interviews across the four programs: 14 in Tacoma, eight in Olympia, four in Port Angeles, and four in Spokane. Just over half (53%) of participants reported white as their racial and ethnic identity, and 73% were male. The mean age of participants was 37 years old, and only 13% of participants reported having stable housing. The majority (73%) were unhoused, and 13% reported unstable housing. See Table 1 for complete demographics of participants.

Table 1: Participant demographics (n=30)

Race/ethnicity (as reported by participants)		Gender identity	
White	53%	Man	73%
Hispanic	13%	Woman	23%
Native American	10%	Nonbinary	3%
Native American & White	7%	Housing status	
Black	3%	Unhoused	73%
Black/mixed race	3%	Unstable	13%
Black/white/mixed race	3%	Stable	13%
Brown	3%	Employment status	
Native & Black	3%	Unemployed	90%
Age in years		Employed	10%
Mean age = 37 (range: 20-67)			

FENTANYL USE PATTERNS

Over half of respondents (56%) reported fentanyl was their main drug, and most (83%) reported daily fentanyl use (Table 2). The remainder reported using between three to five times per week; the average frequency of fentanyl use was 6.42 days per week. Interviewees reported they had been using fentanyl for about a year (12.9 months), on average.

Table 2: Frequency and duration of fentanyl use (n=30)

7 days/week	83%
5 days/week	3%
4 days/week	7%
3 days/week	7%
Mean days/week of use	6.42 days
Mean duration of use	12.9 months

**Recruitment restricted to those who had used fentanyl at least 3 times in the past week.*

Change in the drug market from heroin to fentanyl

Respondents talked about the rapid shift in the drug market from heroin to fentanyl and how this change affected their substance use. At the time of these interviews, respondents were knowingly and intentionally using fentanyl (rather than using it unknowingly mixed in other drugs). Participants often reflected on the effect this shift to fentanyl had on their opioid use and overdose risk.

"It's a mess. But at the time I thought it was a good idea switching from heroin to that. It wasn't a good idea. I should have just stuck with heroin because I wasn't dying from heroin."

"It just took over my heroin addiction without me even realizing it. All of a sudden, one day, I was just addicted to fentanyl instead of heroin. It was weird. And then I tried heroin again, and it didn't do the same thing it used to do for me."

When asked how long they had been using fentanyl, one person responded:

"Honestly, probably about a year now, not really by choice either. It kind of took over the heroin scene, and you can't even find heroin anymore. It's all fentanyl. Everything's with fentanyl. It's ridiculous. And I kind of got forced into it — not forced, but kind of. Yeah."

How do people use fentanyl? Mostly smoking

When asked about their method of ingestion, most people (82%) said they only smoked fentanyl. People reported that smoking fentanyl (rather than injecting) was widespread.

"I smoke it, like the average, like everybody."

People had complex reasons for preferring smoking over injecting or other methods. These included: control of dosage and experience, overdose risk management, preference, and avoiding health risks of injecting. Respondents reported feeling better able to control the amount they used through smoking, rather than injection, which could help lower their risk of overdose.

"I'm just too scared to shoot it, because there's been a lot of people that had. Even with melting the pills down to shoot it they overdosed off of one pill and died even though they have been on it for years. So, I'm too terrified to do it that way. I'm not looking to die. I'm just looking for some pain relief."

"It usually hurts less than poking your vein, so that."

Almost all participants had started their fentanyl use with smoking and maintained that primary method of use. Some participants reported injecting heroin but had discontinued injection when they started using fentanyl due to fentanyl being easier and more desirable to smoke.

"If I can't get fentanyl ... I'll buy some heroin and shoot it up because I'd rather shoot it rather than smoke it because, with heroin, it's kind of different. When I shoot up the fentanyl, I don't really feel it as much as when I smoke it. It's weird. It's like opposite effect."

"Every one of my friends that started using fentanyl [after heroin] has stopped shooting up, pretty much. We shoot up more rarely now than when you used to—I used to use once a day. I've been using once a day for 15 years. It's a lot easier not having to hit yourself. You just grab a piece of foil when smoking it. It's an easier way to receive whatever."

One participant offered the following detailed account about how smoking fentanyl works better for him compared to injecting heroin, which he explained was hard on his body and produced punishing withdrawal more quickly than smoking fentanyl.

"I had been firing [injecting] heroin for so long that my veins were gone. I mean, I was plagued with misses, big abscesses from where I'd miss [not inject in a vein]. I mean, it was just a freaking mess. And so just sitting down to try to do a shot sometimes would take hours and hours. And I'd go through two or three bags of syringes, and I was just angry and just wasting all the stuff just to try to get a little shot, just trying to get well. And then on top of it, too, is that heroin, when I woke up in the morning, I was sick...It was time to get well, and I needed it now. This stuff now [fentanyl], it's not like that. You wake up, and you don't feel too—it's not you're feeling better or any worse. You know what I mean? I can get up. I mean, I can go through the first four or five hours of the day and take care of stuff before I absolutely better pay attention and get my smoke on. So, I don't poke needles in my arm or anywhere anymore. And I'm not drastically sick in the morning. So that's two benefits to (smoking) it.

Of the small number of participants who were primarily injecting fentanyl, a few explained their preference for fentanyl's effects through injection, compared to the less desirable high they felt when smoking it.

"I started off smoking it because I was always afraid of OD'ing. So I kind of dabbled in it at first. But then once my tolerance started getting higher and higher and higher, I just was like, 'Fuck it. I'm not getting high no more. Let's start shooting it.'"

Other substances

Nearly all respondents reported they were currently using other substances in addition to fentanyl, most commonly methamphetamine (64%) and cannabis (40%). A small group reported having recently used heroin (14%) although heroin was difficult to find. Other substances participants reported using concurrently with fentanyl were tobacco (9%), crack (9%), alcohol (5%), and prescription-type opioid pills (5%).

PREVIOUS TREATMENT EXPERIENCES

Two-thirds (63%, n=20) had previous experience with substance use disorder (SUD) treatment or supports including inpatient, outpatient, and the three FDA-approved medications for opioid use disorder (MOUD): buprenorphine, methadone, and naltrexone (Table 3).

Many participants had used multiple types in the past and some types more than once. One third (33%) had no prior SUD treatment experience.

Table 3: Previous treatment experiences

	%	n
Non-prescribed buprenorphine	57%	17
Methadone from clinic	54%	16
Prescribed buprenorphine	50%	15
12-step	46%	14
Detox	46%	14
Inpatient SUD treatment	43%	13
Outpatient SUD treatment	40%	12
Methadone non-legally	20%	6
Extended-release naltrexone	7%	2
None	33%	10

"Inpatient treatment and then out on the street, outpatient. I've done it all."

"I've been to treatment before. Inpatient, outpatient. And I'm currently looking to go into inpatient again."

Previous experiences with traditional SUD counseling and treatment were diverse in terms of relative treatment experiences and success. Frustration and difficulty accessing inpatient treatment were recurring themes amongst participants who were actively seeking support.

"I tried to go to rehab for two weeks. It takes an act of congress to go to rehab here if you're not in state-sentenced probation. It's an act of congress to go to rehab. It's bullshit. It's not fair. It's not. I tried and tried and tried and tried, and then they finally told me after a week and a half of trying. Oh, I got to wait 2 weeks and do an evaluation. So then after the evaluation, they decide how long it takes for me to go to rehab and how long will I be in rehab. So, it could be a 6-month wait then. I don't need rehab in 6 months. I need rehab today, but they don't want to help me. I have Medicaid of Oregon, and they don't want to help me."

"They said they don't have a bed open, so. Let's see what that goes like."

Experiences with medications for opioid use disorder

More than half of participants (57%) reported using buprenorphine from a friend or another source outside of health care or treatment environments. Half of participants reported past treatment with methadone and/or buprenorphine from medical and/or treatment systems. Only a few participants had tried long-acting naltrexone, and some had experienced positive effects with naltrexone.

More than a third of interviewees (39%, n=12) reported accessing MOUD for fentanyl use disorder (see Table 4 for MOUD experiences to address fentanyl use data).

Table 4: Use of MOUD to specifically address fentanyl use n=30

Buprenorphine	23%	7
Methadone	13%	4
Naltrexone	3%	1

Experience with methadone

Previous experiences with methadone from a treatment program were diverse; several said that it was very helpful in reducing opioid use, including fentanyl, and helped to address pain as well. However, many reported challenges maintaining treatment engagement with methadone due to difficulty with near daily transportation to a methadone clinic. Seven participants reported negative experiences with methadone treatment due to the inflexible constraints and regulations of daily, monitored dispensing. Some participants did not like how methadone made them feel or were concerned about how they would eventually stop using methadone.

"And it works for me as long as I stay on it."

"Yeah. I quit taking it after about a week just because the hassle of having to get on the bus every morning and go across town to get it. And again, because I was doing that and it was just easier here on the street. I preferred just doing meth[amphetamine] here on the street."

"I don't like it. It gets in your bones. I had too many peers with bad experiences and not being able to actually get off of it."

Fentanyl-era methadone experiences

Interviewees who accessed methadone for fentanyl use tended to describe their experiences as positive; methadone reduced craving and withdrawal. However, issues related to the burden of daily access and the inflexibility of opioid treatment programs made it difficult to continue to access methadone.

"Methadone has freed me up to behave like a human. I mean, it's supplying myself with the medication that I need to function."

"Yeah, it [methadone] was working. It made me stop doing the fentanyl, so it worked very well."

"I think the biggest thing was having to go in every day and get it. And if I missed the bus, I was screwed. It was a terrible thing. And then having to go there, it just was always hectic, always something at the window, some mistake they made that gets me held up. And I just didn't—at that stage in my detox or my thing, I don't have any patience for shit. So if any shit comes, I'm gone."

One participant recalled his own negative experience with methadone treatment protocols and urged providers to be compassionate when people using fentanyl ask for help and seek treatment:

"When they do get sick and say they're sick, take pity on them. Don't say come back tomorrow. That's a million miles away. Okay. Do something. Help them get well and tell them that's it. I take the bus to the methadone clinic from Tacoma, and I was 15 minutes late, and she [the provider] wouldn't give me my dose [of methadone]. I thank God though that she didn't give me my dose. I'd rather take drugs."

Experience with buprenorphine (common brand name: Suboxone)

Experiences with prescribed buprenorphine were also mixed. Some reported that it had helped them quit heroin in the past and that it also worked well for their pain.

"Suboxone's how I quit last time."

"I liked it because it seemed like it helped with pain a lot better than methadone does."

Negative experiences were equally represented among those who had tried buprenorphine. Participants described disliking the taste of the medication, finding it less desirable than fentanyl, or having difficulty with consistent access to the medication (e.g., finding a clinic/doctor or the hassle of filling a prescription).

"There's no point. I really don't, after a couple of times I kind of stop using it and just go back to what I was using before, because if you're going to use a substance, you probably want to use the best thing going."

Some participants had been prescribed buprenorphine while incarcerated and reported having difficulty obtaining a prescription after they were released due to cost and finding a provider.

"They put me on it for treatment [in jail]. But when I got out, it was before they had generic, so it was like \$900 a prescription, so I couldn't afford to have it. And my doctor wouldn't prescribe it to me."

Many people had tried *non-prescribed* buprenorphine that they obtained from a friend or other source, often to avoid withdrawal. Of these participants, there was a clear concern about not having a consistent and reliable source for non-prescription buprenorphine.

"Yes...some guy gave me Suboxone, I ate the whole thing and it worked so well, I have Suboxone right now. That stuff's good. It's very good. It makes you feel good and takes away the pain. That should be in the place of methadone, or heroin."

"Just like anything else. It works until it don't work no more. With the Subutex [buprenorphine without naloxone co-formulation], if you crush it up and sniff a line of it, it works a lot better than just eating it. Same with Suboxone. If you kind of square a piece of it off, and dissolve it in some hot water, and sniff it, it works better than letting it sit on your tongue. And then, just like everything else, though, there comes the aftermath. If you don't have it, you're sick, and you got to have it again."

Fentanyl-era buprenorphine experiences

Specific responses about using buprenorphine (i.e., Suboxone or Subutex) as a treatment for fentanyl use were also mixed in terms of participants' experiences, access, and attitudes. Some participants had positive experiences with buprenorphine in the past. Yet many were worried about trying buprenorphine while they had been using fentanyl due to concerns about precipitated withdrawal (withdrawal that can be triggered based on the timing, dose, and form of buprenorphine taken). Concerns about precipitated withdrawal were mentioned as a central reason why participants were hesitant to initiate buprenorphine as a treatment for their fentanyl use.

"I just wanted to cut myself off. So, I had to wait a 24-hour period before—otherwise, Suboxone makes you sick. And I couldn't do it. I couldn't stop smoking fentanyl for that long at all, so. And they said that it'd just be like—it would be like a cold or something like that, a flu or something. But nothing like if you went cold turkey. But I couldn't even imagine going cold turkey."

"I'm kind of scared to take Suboxone just because of the simple fact if I take it too soon, I'd get sicker. And so I never tried it."

Another participant described taking buprenorphine from a friend, which caused precipitated withdrawal so difficult that they said they would never try buprenorphine again:

"It was actually a really bad experience that time and I got really, really sick because I guess I didn't wait enough time. And I don't know what happened, but I got really, really sick, and it was horrible."

Some participants could not find a clinic where buprenorphine treatment was available along with the additional support they needed for their mental health. For example, two participants described successfully completing buprenorphine-mediated detox from fentanyl only to then be transferred to an inpatient program that denied both individuals the anxiety medications that they needed.¹ As a result, both interviewees described returning to fentanyl use as their only choice to prevent withdrawal.

A few other participants felt Subutex worked well for them, but that life circumstances made it difficult to stay on the medication, such as this participant explained:

"I got out of jail and then I didn't want to get back on dope again. So I was on the streets for a week, and then I went to a clinic down there and they put me on Subutex and then I had been doing well on it—then I come here [Washington State]. And they wouldn't send me with any, so I went a week with no (fentanyl) pills, yeah. So I went and got back on [fentanyl] pills for a week. I had no choice. Then as soon as I got back to the clinic, I quit doing the pills, but now, I just have shit going on..." [participant returned to fentanyl use].

He explained why Subutex worked better for him than Suboxone:

¹ Benzodiazepines are an often-used class of anti-anxiety medications. They are sedating and, if combined with opioids, can increase risk of overdose. Federal guidance cautions against withholding buprenorphine for those using benzodiazepines. (FDA, 2017).

“Subutex, you don’t—You can wait, and when you—say, if I started getting sick right now, I could take a Subutex, and it would not send me into precipitated withdrawal. So Subutex is the miracle drug, I feel.”²

Long-acting naltrexone

There were only a few participants who had tried naltrexone, and some did report neutral or positive experiences with it to address their opioid use.

“It felt like it took my urge away to smoke, but it didn’t get me high.”

“Vivitrol would be something that I’ll be interested in the future after I’m over the hump.”

However, access to and the expense of naltrexone made it a problematic treatment option for some interviewees:

“Vivitrol worked for a little while. But when I left the treatment facility...They just gave me a prescription. And it cost like \$400 to pay for it, and so I couldn’t pay for it. And so I went back to using.”

MOTIVATIONS FOR USING FENTANYL: BENEFITS AND DRAWBACKS

Motivations for fentanyl use: “Can you talk a little about why you use fentanyl?”

Participants were asked to discuss why they used fentanyl: “Talk a little about why you use fentanyl. What is good and bad about using fentanyl? What are the benefits? Is there anything that is not good about fentanyl?”

Interviewees described many reasons for why they use fentanyl, which were often overlapping and inter-related. Importantly, the reasons reflected a complex interplay of themes related to physical pain management, mental health and trauma, and housing and economic insecurity. Finally, participants talked about the role both drug supply changes and overdose risk play in their current fentanyl use and efforts to take care of themselves.

Pain management

Physical pain reduction emerged as a major reason respondents reported using fentanyl, with 70% of respondents mentioning pain management. Many respondents described having **significant and chronic pain issues** (e.g., osteoarthritis, diabetes-related pain, traumatic injuries from car crashes or work-related

² Research suggests that some people absorb sufficient naloxone from the combination buprenorphine-naloxone product to cause withdrawal symptoms. (Grande, 2022; Strickland et al., 2018).

accidents) and explained the central benefit of their fentanyl use was its ability to control their severe chronic pain.

"If it wasn't for the pain, I wouldn't be doing fentanyl at all."

"It's not just because withdrawal I'm dealing with. I'm dealing with these pain issues that I have to do or else I can't even get out of my car and go pick up the kids, or go play with the grandkids, or whatever. I just can't do these things if I'm in pain. And fentanyl definitely takes care of the pain."

Some participants said they used fentanyl after a health care provider terminated a prior opioid prescription or to manage pain that was not otherwise addressed through a health care provider. Despite its role in reducing or managing pain, however, many respondents expressed negative aspects of fentanyl such as drowsiness and other issues with drug use.

"It's just to get rid of the chest pain. I don't like how it makes you nod out. It makes you sleepy and drowsy. I like the part where it makes my chest pain go away so I can do what I need to do."

"Between some of the positives and negatives that we've discussed, it's hard to really think of a way to—it seems like a problem that's intractable in a lot of ways with the pain and suffering on one hand, and on the other hand, all the problems that come with the drug use."

Some participants identified the way that their efforts to decrease their fentanyl use, manage their pain, and avoid withdrawal interacted with the challenges of their immediate life circumstances. One participant struggled with what she described as extreme pain from cellulitis in her feet and the difficulty she has had in getting supportive medical care for this condition. Another participant noted how fentanyl use created stress on a day-to-day basis.

"I don't care either way other than the fact that I would prefer if I could actually get some pain relief from the doctor without any shit."

"You don't get to really relax when you're a fentanyl user. It's on the go, non-stop. Especially when you're homeless and you're trying to get money, it's just non-stop."

Mental health and trauma

Managing mental health and mood symptoms, negative self-image, previous **trauma**, and difficult life circumstances were reported as motivation for fentanyl use by many participants. Fentanyl was described as

a strategy to create a feeling of **numbness**, or calming, as a way to either block out previous trauma or cope with difficult circumstances.

"I seek it out to numb myself, basically. Because I'm 28 years old, but I've been through more shit than a 56-year-old woman. And it's very complicated because there is certain shit that I'm blocking out that I'm not ready to deal with yet. But if I keep letting it destroy my life like this, I'm going to die within the next week, really. I don't want that to happen, so I called to get into treatment today, so."

"Well, it's just that it just numbs my body, my mind and my body. It makes me feel really, really good. It just shuts you off from the rest of the world."

Specific mention of using fentanyl to help with day-to-day coping with **mental health challenges**, beyond "numbing out" past trauma or difficult circumstances, was also common. For example, participants talked about using fentanyl to decrease **anxiety**, address **depression**, help with **sleep**, and ease mental and physical pain of difficult life circumstances like housing insecurity and poverty.

"One of the positives for me is I believe it makes me feel like I'm invincible like nobody could actually touch me. Nobody could actually make my self-esteem go down because I struggle with self-esteem a lot. And I always care what other people think. But as soon as I take the first hit, it's gone. And I'm able to go out and work without having to worry about whatever they think of me, so."

"I probably have some type of borderline PTSD to ADHD that is—I don't know—not diagnosed or nothing, but I use fentanyl for mental stability or kind of mental security to where I'm not just bouncing off the walls."

"Feel a lot better for yourself—for myself. I feel a lot better. I don't have no bad thoughts like suicidal or things like that. Just the reason is that it gets me in a good mood to just kick it and talk to people, be social for me."

"I can sleep. Because I do meth, so I can sleep. I don't usually sleep before I smoked those blues. I didn't even sleep that much. It would be like every three days I would sleep. But now, I sleep just about every night."

Participants also described the way their life included past and present trauma. In this way, challenges with homelessness, chronic pain, and mental health combined to produce experiences of both physical and emotional trauma. Traumatic life experiences ranged from significant medical events (e.g., back injuries, nerve damage, debilitating osteoarthritis pain, coronary heart disease, seizures, work-related accidents) to

emotional and mental health challenges (e.g., loss of connection from family and children, isolation, loss of loved ones to overdose, feelings of alienation and anxiety).

"It's self-medicating. It's a preferred medication to have for self-medicating myself for the trauma that I've had or whatever else that I'm trying to get rid of."

For example, one participant described using fentanyl to cope with his current situation, saying it helped him be "released from his pain" and made living in his car not feel as punishing. At the time of the interview, he was engaged in methadone treatment and described how desperately he wanted support from his family that he was certain he would not get:

"What we do is, okay, say we're allowed back into the family, but it's scary because they're expecting—I'm even expecting to fail [treatment]. So, it's not going to last, and so we have this mentality it's just not going to last. They're going to change. Well, especially my family. They're not going to do any research, any finding out anything...They will never do it. They're so hardheaded and prideful, and that's scary because I'm so alone. I'm so fucking alone. I hate it."

Causing and coping with homelessness

As with pain control and fentanyl use, connections between **housing** and fentanyl use were complex, as some participants mentioned that fentanyl was the *cause* of their housing insecurity and others talked about fentanyl being a coping strategy in *response to* living on the street.

"My homelessness is definitely due to fentanyl use. I don't work or do anything with myself at all. So pretty much just everything...I couldn't think about going to work because what if I don't have all the dope I needed and I'm not trying to be sick at work."

"I spend more money on fentanyl than I do on getting a car or an apartment."

"The last two years, I've been homeless out here, pretty much because of fentanyl."

"Who'd be fucking sober and live out here?"

Homelessness had a variety of causes, ranging from traumatic events that produced homelessness (e.g., an accident, divorce) to more systemic issues related to challenges accessing basic necessities and services while being unhoused. For example, one participant expressed confusion about how to access services and potential employment without proper identification. Another participant who needed access to stable housing described difficulty applying for social supports that they knew they qualified for, like disability benefits.

Participants also explained that the combination of being homeless and needing fentanyl daily (some reported using more than ten times daily) to avoid withdrawal occupied a large amount of their time. They likened their fentanyl use to a fulltime occupation, leaving little time for other pursuits.

"It's just really just trying to live day to day, have a place to sleep, have clothes to wear, a change of clothes, hygiene products, and those kind of things. It's difficult enough while living on the street and having a fentanyl habit or using fentanyl to the extent that it's used by myself or a lot of people out here."

Withdrawal avoidance

Interviewees indicated the need to avoid withdrawal symptoms was another important reason they used fentanyl; more than a third of respondents said that was the main reason they continued to use fentanyl. People spoke about the higher strength of fentanyl compared to heroin and identified the intensity of withdrawal as a hurdle in their own efforts to stop or reduce their fentanyl use.

"Honestly, I use it because I don't want—so I'm not having the sickness every day. You have to or you're going to feel like shit. So that's pretty much why I use it and have used it for God knows how long. Yeah, pretty much. The fear of sickness is just—it's not fun. It's not something anybody wants to go through."

"...the second reason would just be the dependency or addiction. So, coupled together, it doesn't seem completely realistic to stop using without some sort of replacement, alternative."

"I remember I used to do heroin, and I could do a shot and last half the day. And now I do a shot of fentanyl. Within an hour, I'm ready to do another one. It's just ridiculous."

Some of the responses described a blend of enjoying the feeling they get from fentanyl that was intertwined with withdrawal avoidance:

"For the most part, I mean, I like to do it. But at the same time, I don't want to be sick. I do not—once you start feeling sick, it just does not—and just the most terrible feeling in the world. So you make sure pretty much that you don't go without."

Drawbacks of fentanyl use

Some respondents were unenthusiastic about using fentanyl and mentioned how its **availability** and **convenience** kept them deadlocked in their use.

"Up here in [city] especially, it's cheap."

"I don't know. I mean, I've said, 100 times, I've said I wish this shit [fentanyl] would just go away and heroin, I mean, I never thought I'd ever say that because heroin was just a monkey on my back. But this stuff is so bad, so far gone. So I wish it would—if we could turn back time, yeah, I wish this stuff [fentanyl] would just never have came."

Other negative aspects of fentanyl use included its risk of overdose and negative effects on family and relationships.

Overdose risk

The risk of dying from fentanyl overdose was seen as a strong drawback of fentanyl and was mentioned by several respondents.

"It's killing way too many people, good people who don't deserve to die. And it makes you a prisoner to the drug. And when you try to go without it, it feels like you're dying. And you can't move, you can't get out of bed, it hurts to breathe. It's crazy. And I think that other narcotics were addictive. This is 25 times worse."

"But the high isn't even the same. It's not as euphoric, I guess you could say. Heroin, actually you felt. But this stuff is just—and plus, if you do too much, then you're going to overdose. And the line is really, really small there. With heroin, it wasn't that. You could get away with a lot more than with fentanyl. With fentanyl, there's a very tight—if you do a little bit too much, you're going to overdose. And if you don't have somebody there with you, then sayonara."

Many people discussed that fentanyl's strength was unpredictable. This increased the risk for overdose, which conversely meant that sometimes the substance was too weak to have the desired effect.

"Because the problem is because the pills can vary in strength, whether the mixture, whether it's cut because on purpose or just on accident by how it's stirred together, and people with low tolerances aren't used to it. So when they have it, and they're used to having some pills that are strong and some that are weak, they're going to overdose because they're not use to it being—if it was a set level like where you're getting it from a dispensary where it was professionally done in a set level, and we would know what we were getting, then those people wouldn't have that problem."

Negative impact on other priorities

Many interviewees talked about fentanyl's negative impact on other priorities in their life such as relationships, employment, or housing. Fentanyl also changed how family perceived them.

"Instead of being with my family and doing this and that, doing all these things, I want to have the fentanyl to be okay to go do those things with my family and have them there, which may be a lie that I'm telling myself that I need it to go do those things with my family, but I want that fentanyl first. That's what I want to do and have before I go do anything. It's

more important than food and almost water. That's on how high of a scale it is in my priority list. And I want it, have it, or need to have it, or want to have it."

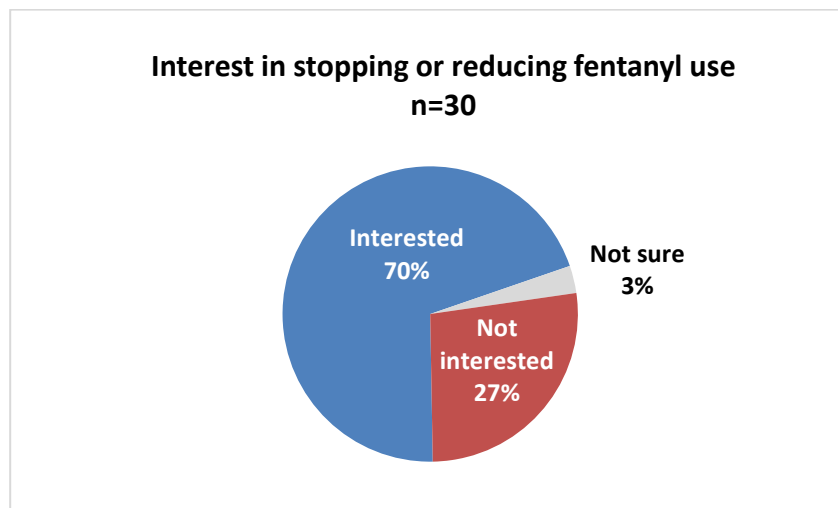
"My family definitely looks at me different because of it. I don't know, they get all scared 'n shit and (excuse my language) but they're all scared of me doing it. But it's like it's—I never expected my life to be like this."

"It's part of who I am. So, fentanyl is a big part of who I am. I was just using it actually before you walked up, had I not been using it, I probably would be a different person I'd probably be more focused on the problems that are out here. And not even talking about this...It's part of who I am so that said, I don't know who I would be if I wasn't on it."

INTEREST IN REDUCING OR STOPPING FENTANYL USE

Respondents were asked "How interested are you in reducing or stopping your fentanyl use?" with a follow up question "Are you interested in reducing or are you interested in stopping?" A majority (70%) of participants indicated an interest in stopping or reducing their use (Figure 1), and many indicated a specific timeframe for that change with reference to wanting their previous life back.

Figure 1: Interest in stopping or reducing fentanyl use



Many of the reasons for reducing or stopping fentanyl use reflected the downsides mentioned in the previous section. Participants often mentioned feeling "stuck" or exhausted from the spiral of chaotic use or wanting to achieve short- and long-term goals:

"I've just been doing this too long, and I don't want to waste the rest of my life."

"I'm tired of it, tired of the lifestyle."

"It's just stopping me from doing the things I need to do to get my life back together."

"I'm not sure because I'm stuck on the street, so I can't get out of here, and I'm not going to be sober being here... I do want to stop—I want a normal life, but I can't get it. I can't get it back again. I want to be going to work, going home, going to work, going home, going to the grocery store. I miss it."

Factors that influence readiness for change

Many expressed that they are ready to return to a non-fentanyl focused life but often don't see a clear path to get there. Interviewees described the very real tension between their desire to reduce or stop their fentanyl use and the many factors that influence their readiness to actually do so.

"It used to be we talked about it [quitting fentanyl] as if it was an eventuality. But now more and more, when we talk about it, it's almost like, "Are you ready yet?" You know what I mean?"

"I mean, everybody's going to be a little different when they're ready to stop. It's just not fun anymore. [laughter] So that's kind of where I'm at with it. And I got forced into it, and it's just not appealing. It's not as appealing—it's not as appealing as it used to be."

"I'm not giving myself a timeframe to stop, either because I want to make sure I do this successfully, my way. And I know there ain't no guarantee it'll work I know it's my best shot. And I don't want to get another drug and be addicted to that drug. I don't want to trade one drug for another. I would like to get back on my pain meds and have it supervised by a doctor the way that it was. And get off this shit once and for all."

An important factor that impacted readiness was the social context of use. Some participants described the challenge and the potential isolation of stopping fentanyl use when important **social relationships** also involved substance use.

"I feel ready, but I feel like it's something that I have to do with my partner if I seriously want to keep the relationship."

"Well, I think, a lot of it, I am waiting for my boyfriend to get on board with me. He says he's ready. But when it comes down to it—some days, we are broke or something, I'm going to be like, "Let's go right now," then he'll be able to think of an excuse of why we shouldn't go...And that's a big part about what's holding me back—I want him to come with me. I don't want to have to leave him behind. So I stay by his side doing it because he's really

about it. ...I get that feeling in my heart where I'm like, "The right thing to do is stop." But soon as I get back around him, that's not even a thought in my head anymore to stop. So, I mean, he has a large part in my decision."

"I've thought about it. I've tried a couple times, but it's just—so hard. A lot of people I hang out with are users. Just, I don't know. It's just kind of the lifestyle of the group that I hang out with. A lot of people I hang out with are very addicted too—I don't know. It would be hard, I think, especially living here, I think."

Barriers to reducing or stopping fentanyl use

Participants identified many barriers to reducing or stopping fentanyl use. These included difficulties accessing supportive medical care to transition from fentanyl to MOUD or manage pain, finding and paying for inpatient or outpatient treatment, or simply needing better life circumstances (e.g., housing, employment, a supportive community).

"To be ready to stop, I would almost be ready to stop if I had a couple of things geared up, like having someone to deal with the pain and to figure out where that is. And that's why I'm looking into getting into a treatment center that's going to be six months up to two years... Because I've done a couple that have been a month, but I want to do something longer. So, I'm looking into something that's going to be a lot longer than that. And I'm hoping they can deal with pain issues, too."

The tension between motivation to change and finding the right supports for successful change illustrates the complexity participants face in trying to stop or reduce their fentanyl use.

Not interested in stopping or reducing fentanyl

Many participants did not want to reduce or stop their fentanyl use because they did not perceive their use to be problematic. For others, the benefits of fentanyl (e.g., pain relief, coping tool) outweighed the drawbacks and the challenges in accessing care, reflecting a deep ambivalence in how some felt about their fentanyl use or ability to stop using.

"Using is no big problem for me. As I said, just here and there use. You know what I'm saying? For myself, and I always kept it like that."

"I don't feel I'm in a situation where it's got that kind of level or anywhere near that kind of power. I like weed way more. It's more of an enjoyment type of thing. It's recreational as far as that like I said I'm not out here in the middle of the night just waiting for one..."

"When I stop being homeless, I'd probably stop using so much drugs, you know. I mean it goes hand in hand just with the environment and stuff, and it helps me where I'm at. So I mean, it might go on for another six months, a year or something. But once I get the idea of what I'm supposed to do to get housing, and then go do it. And then, I'll just quit then. And then, I might need a little bit of help. But I know how to go through detox and do all that..."

"It's kind of hard because I don't want to stop, but in my mind, I know the right thing to do would be to stop. And, my kids, I have two babies. They miss me. So, it's like I want to stop for them, but I guess not enough to actually stop. So no, not really. I don't want to stop."

In addition, a few participants who were not interested in stopping or reducing their use described their strategies for managing their fentanyl use.

"I've tried to be careful about not continuing to increase my usage, so finding a usage level that's kind of sustainable and low."

PREFERRED SERVICES AND "IDEAL" CARE

Services: "What services would you want if they were easy to get?"

Participants were asked "What services would you want if they were easy to get?" and read a list of potential services (see Appendix 1). Respondents described diverse medical, health, and substance use needs and each person had a unique mix of services they felt would help them. The services that received interest from the most participants including services that helped meet basic needs such as housing, cash assistance, and phones. Other services of interest were contingency management, peer support, and harm reduction services and materials such as fentanyl test strips, access to regulated opioids (i.e., "safe supply"), "kick kits" (i.e., medications to manage detox at home), and community drug checking. Eighteen people (60%) were interested in medications for opioid use disorder.

People had the least interest or highest level of ambivalence in substance use disorder counseling and inpatient or outpatient substance use disorder treatment. People also had lower levels of interest in vaccinations and wound care, though the second may be related to the individual respondent's current lack of wounds.

Interest in contingency management

There was a high level of interest in contingency management for fentanyl use, described as "rewards for cutting back or stopping fentanyl use." In other areas of the interview, people highlighted that it would be helpful to be paid to stop using fentanyl.

"Oh, hell, yeah. That would be awesome. That would really help."

"It'd probably work for me because, as long as there's something better on the other side, I'd probably do it."

“Ideal” care

Interview participants were asked to “Describe the ideal place where you’d go to get help with your health and/or substance use.” Follow up questions explored what an ideal facility or care approach might look like, including its values, rules, resources, and general atmosphere or “vibe.” Recurring themes throughout this section of the interview were the importance of accessible and holistic care and the contrast with what care models were currently available.

Atmosphere and values

Many participants mentioned the ideal place for care would have a laidback and **welcoming** environment, offer respect and encouragement, and provide a sense of shared purpose. The space should be accessible, comfortable, and “home-like,” in contrast to sterile or medical settings.

“Just somewhere that’s welcoming, somewhere that feels not like a state building or like—somewhere just stay laidback, be yourself.”

“The ambience that would make you feel comfortable. Even something as simple as offering even some snacks and something and having like a TV where you could watch something on TV as you’re waiting to be served and like that. Anything like that to make a person feel free to be there because that’s really what you want is to have people feel free to be who they are at that moment.”

“That’s not like a facility but not an institution or something, but I don’t know. I would just think a place, should be like a house. You know what I’m saying? So you feel like—you feel like you’re at home.”

A few people spoke about the potential benefits of receiving care in a home setting or with their family.

“It’s just comfortable, and the people that I love and care about me, and they want to help me, and it’s just a good environment, and I could ask them to help me detox if I wanted to. Keep me in the house for ten days if I had to. Yeah. Make sure all my needs are met. That’s what I’m going to do, hopefully, eventually.”

Participants did not want a place with overly punitive or controlling policies. Many described previous negative experiences with controlling, judgmental, or restrictive treatment environments in the past.

“I quit going to all my doctors. Because I don’t want it on my record, because once it’s on my record, they look down on you and they hold that against you, for everything. I don’t like that. We all make bad choices in life. It’s part of growing up, it’s part of learning. It shouldn’t be held over our head for the rest of our lives.”

Ideal spaces allowed for **privacy** and a degree of **autonomy** that contribute to making the space and the approach feel less controlling. Being able to stay in the program, even with a recurrence of use, was also

seen as essential. The atmosphere and rules for the place were often discussed in contrast to previous negative experiences, especially rules that limited continued care.

"To make it where there's an actual way out and not that you're in this permanent, 'I have to live with somebody else in my room.' Under all these strict rules where everything falls apart. You mess up once, and you're just screwed. Even though you're in the treatment and relapsing is supposed to be part of the process, but you're just screwed."

"I mean, relaxed, not so pushy, more towards just trying to help, I guess. Because some of these places, you go in there, and they're trying to push you. Nobody's going to do it unless they really wanted to, so there's no need to be so pushy."

Services and supports

People described wanting holistic care to address and treat complex **medical** and **mental health** concerns, access to medications for opioid use disorder, and care navigation support. Participants emphasized that a successful approach would need to be able to help people meet their **basic needs** for things like housing, transportation, socks, food, toilets, and clean drinking water.

"Definitely housing. Housing is a big one because, again, if you don't change where you're at, nothing's going to change."

"I like the idea—how this year they came out with the information kits and the smokers' kits and stuff like that, and also, the tents. That's brought in a lot more people than they realize, just by saying, 'Hey. You guys cold? You need a blanket?' They might actually know, if they trust me enough to give me a blanket, then I can probably ask them, whether it be a plan B or drug related or just general support."

Accessibility was described as essential for the ideal place for care. Convenient locations, assistance with transportation, and affordability of treatment were mentioned as fundamental components of ideal treatment conditions. On-demand care was also seen as very important. Delays in access to care often meant that people would have difficulty starting a program.

"When they do get sick and say they're sick, take pity on them. Don't say come back tomorrow. That's a million miles away. Okay? Do something. Help them get well and tell them that's it."

Some spoke about the importance of having "something to **work** for," a sense of purpose, or simply having activities to stay busy or provide enjoyment. Offering a range of activities that can help participants build their confidence and engage their interests was suggested by several participants. The possibility of offering on-site work, or community chores, for participants was mentioned often, to build participant accountability and self-efficacy.

"Just a way to give back to the same type of place that was offering you support. So I would imagine it would also have growing food at a place like this so you could contribute to the garden or growing food or offer services or time to that..."

The other **activities** people discussed were varied and included: yoga, mindfulness, basketball, rock climbing, fishing, trips, gardens, and free puppies.

"In terms of mindfulness, yoga, acupuncture, aromatherapy, relaxation rooms, just a place where you can calm your mind and relax and kind of be at peace. I think a lot of times, a lot of people, myself included, cannot be comfortable in the world or in our bodies or experiencing life, so just a place, a reason to be more comfortable with that, with less drug use or dependence on substances, to have that comfort, I guess."

"Activities and sports and stuff you used to do before you started using drugs that you could get back into and remember why you did them in the first place before you got caught up in drugs."

A few participants discussed **safe supply** and overdose prevention sites as important resources to have available.

"In my mind, it would be safe drugs to use and a safe place to use drugs. Also, a safe place to get alternative treatments, and also a safe place to not use drugs, and a good place to detox."

Participants also described wanting practical assistance with the bridge to a **stable life after getting care** related to their fentanyl use. Even after formal treatment ends, interviewees mentioned connections to positive and supportive social networks and help accessing support services as important elements for creating lasting health improvement.

"One other thing I really liked was that our counselors talked to us about programs that now have funding and stuff that we could get into. So just keeping it focused around how to get ourselves in different networks so that we're creating new pathways. That kind of information is really useful. But also I wish they had more talk about our individual plans and what kinds of resources there are even out there now."

"Helping you to understand, just making us aware of some of these options that we have for help where you can go out. So, once we get out of the facility, where do we get the things that they're helping us with inside. So the ability to go to get stuff we're getting inside, outside."

Staffing

There was clear agreement among participants that having competent, nonjudgmental, and compassionate staff was a crucial component of an ideal care environment.

"When people are nice and understanding and they'll never make you feel like—belittle you like they're better than you or something, more people that just understood and really cared and wanted to help you."

When asked about who would work in an ideal setting, people identified these types of staff as key: people with lived experience, medical staff, and social workers or case managers.

"A psychologist, a doctor, the staff members, secretary, and the clinical workers, social workers, providers."

"I think you'd have to start with having caseworkers that would be able to bridge the gap between me and whatever services are available. I have no idea what they are. I don't know how to apply for them. My ADD, it's just so bad that from one day to the next, I can't continue with that. So if I don't have somebody like that to help me stay focused on it and figure out what I'm doing, then nothing gets done."

Having staff with lived experience of substance use was the most frequent attribute that people referenced. Many people mentioned this as important or that it had been beneficial in previous treatment experiences. Lived experience was often linked to more understanding of substance use and in contrast to providers or other treatment staff who were viewed as judgmental.

"Once I was at—one of the very first times I started methadone, my counselor, she hadn't been through nothing. And I didn't want a counselor like that, so I switched."

"To have somebody who has already been through it, to show us that there is light at the end of that dark tunnel."

"Understanding that that person could be your brother, your sister, or your mom, things like that. So yeah, that kind of understanding. Just because you haven't talked to your mom doesn't mean she's doing great or your sister or your brother is not doing great. Understanding of that."

"People that have had experience with this themselves, personally, or have had family. I don't know. Firsthand experience, or secondhand experience. It's easier to empathize and understand somebody you can relate to personally. Or I don't know. I mean, people who

actually care about the people that they're interacting with rather than the substances that they're using."

Interest in medications

Many interview respondents were interested in methadone or buprenorphine as part of their ideal care for opioid use disorder. Of people interested in a medication, the largest number expressed interest in methadone, especially if it was normalized or more accessible.

"I've heard that it's effective [methadone]. You only have to take it once a day or twice a day, and it will last all day. I'm just interested in not being in pain, and that's it, so ... I'd like to get it at the pharmacy. Get a 30-day supply ... Just to have it treated like something else, like some weird thing that you have to go into some specialized place to get every day is weird to me. It doesn't make sense ... As a medication like any other medication, yeah. Have a doctor be able to prescribe it like any other medication, but they can't."

"If they had a methadone clinic closer to my home, I wouldn't have to drive an hour and a half, two hours every day to get to it ... Or if they gave out a week doses at a time that'd be cool."

Many others expressed interested in buprenorphine; one person was interested in naltrexone. Even so, some interviewees expressed concerns about withdrawal from buprenorphine and methadone, which led to a common perception that it was better to stop fentanyl without the use of medications. People were interested in learning more about the medications, and some expressed not being knowledgeable enough to be able to pick a specific medication.

Most who were interested in medications wanted to use the medications and discontinue their use of fentanyl over time. Some said there would likely be a transition period where they continued to use fentanyl while using buprenorphine or methadone.

"Because the key is to not have to use anything else out there. And eventually, maybe not even need to use some of the things that are here, the suboxone and stuff. But that's one step at a time."

Discussion

Fentanyl has exacerbated an already deadly and debilitating overdose epidemic due to its potency and variability. The people we spoke with did not want to die, were taking steps to stay alive and healthy, and most were interested in reducing or stopping their fentanyl use.

Most people reported that they **smoked** fentanyl, while a few combined smoking with injection of fentanyl. This represents a shift from how people had previously used heroin, which was primarily injected. Several people spoke about smoking as preferable to injection and that fentanyl's strength allowed people to switch from injection to smoking. Many people viewed smoking as an overdose risk reduction strategy; they

believed that smoking allowed them to use in smaller, more controlled amounts and manage the variability of fentanyl's strength. While smoking is increasingly preferred and can reduce the risk of injection-related infections, it still carries considerable overdose risk, as shown by recent data from British Columbia where smoking was involved in 56% of illicit drug toxicity deaths in 2021 (BC Coroners Service, 2022).

The prevalence of smoking as the preferred route of administration, as documented in this study, is consistent with other research that shows a shift to smoking versus injecting fentanyl in Western coastal states (Kral et al., 2021; LaForge et al., 2022). Due to this shift, programs to support people who use fentanyl should offer, or continue to offer, safer smoking supplies. In addition, further research should evaluate the efficacy of smoking as an overdose risk reduction strategy and provide related education.

The arrival of fentanyl into the unregulated **drug market** has increased overdose risk and the severity of withdrawal for people who use fentanyl. Access to many support services and effective treatment remains difficult. **Participants reported that continuing to use fentanyl was easier and more accessible than treatment**; barriers to entry are high and options are limited. Education and support for people who use fentanyl should be expanded so people are aware of and able to navigate the available options.

Participants often described the reasons for their fentanyl use in one or more of the following ways: to address physical pain, as a strategy to mitigate withdrawal caused by opioid dependence, and/or as a coping strategy to tolerate difficult life circumstances. People often had multiple motivators for fentanyl use, suggesting that people may need a range of supports and services to address these motivators.

A key **drawback of fentanyl** was the risk of overdose and dying. Unlike in a [previous series of interviews](#) before fentanyl dominated the drug supply, fear and concern about dying from overdose was a recurrent theme. The variable presence and strength of fentanyl contributed to this concern. Most respondents were aware of the variability in strength of fentanyl pills and were taking precautions to prevent fatal overdose. This was cited as a motivation for reducing fentanyl use. For many people, fentanyl use became a priority over other essential activities in life, such as finding housing, employment, and family relationships.

Most respondents had **previous experience with substance use disorder treatment**, and previous treatment attempts were often discussed in negative terms. Participants pointed to restrictive rules and program design that resulted in a discontinuation of care and/or MOUD. Barriers to care included: the challenge of accessing SUD evaluations; finding placement in health care or SUD treatment; program rules that discontinue care (especially in methadone and housing programs); and stigma and punitive controls (e.g., not feeling welcome, rules, or being denied medical care). In addition, participants identified location, insurance, available services, and program hours as barriers to accessing care and services.

Chronic pain, homelessness, and co-occurring mental health conditions intermingle to make low barrier social services, health care, and harm reduction-based treatment access even more important. The severity and complexity of need also make it harder for current programs and facilities to serve vulnerable people like these interviewees whose multiple health and life conditions make many of them ineligible for care currently offered across the state.

Most people (70%) were interested in **reducing or stopping their fentanyl use**. This is similar to previous surveys our team conducted with SSP participants; [in 2019 82% of people whose main drug was heroin were](#)

[interested in reducing or stopping their use](#) (. While fentanyl and heroin are not the same, peoples' motivations for using them or their desire to stop using them are not radically different. If scaled, appropriate and accessible care for people who use fentanyl could have a big impact on improving health and reducing overdose deaths.

The “**ideal care**” that participants described was rich, varied, and individualized. Participants did identify the importance of offering holistic care to include addressing basic needs such as housing and medical care, in addition to substance use disorder supports and mental health. Ideal care, as described by participants, was also accessible in location, hours, and cost. It was also described in contrast to previous care attempts that were difficult to access and where people experienced judgment. The insights of these interviews suggest that care (including health care, substance use services, mental health, etc.) should be available for people when they feel ready to engage in services, rather than when they are ready to stop or decrease their fentanyl use. Rather than only considering abstinence treatment for substance use disorder, we should consider ongoing care for people who use fentanyl and create or expand programs to address these needs in a flexible, accessible setting.

Recommendations

- **Treat fentanyl as a serious public health crisis.** Services and supports to reduce overdose risk and support people who use fentanyl should be expanded immediately to save lives.
- **Ask people who use fentanyl what services and supports would help them.** People who use fentanyl are experts on their lives and can provide key insights into barriers and facilitators for improving their health and expanding life opportunities.
- **Build and support accessible programs that focus on health.** Programs should have accessible locations and hours and be flexible to meet participants' diverse needs. These needs include physical and mental health, and for many people, serious chronic pain. Programs should include harm reduction approaches, services like safer smoking and overdose prevention supplies, and staffing facilities with nonjudgmental staff who understand the challenges of substance use.
- **Meet people's basic needs.** Social determinants of health are drivers and exacerbators of fentanyl use. Programs should address people's basic needs without making it contingent upon their level of interest in stopping their substance use.
- **Provide safer smoking supplies to engage people who use fentanyl.** Most of the people we spoke with smoked fentanyl, and perceived benefits to smoking over injecting. Distribution of safer smoking supplies is a key way to engage people who use fentanyl.
- **Increase accurate information and education about methadone and buprenorphine.** People are interested in these life-saving medications but misconceptions about their efficacy keep people from starting or staying on them.
- **Consider safe supply.** Fentanyl is particularly deadly due to its potency and its variability. The people we spoke with wanted to stay alive, took steps to reduce their risk of overdose, and did not like that fentanyl was highly variable. Providing a source for regulated, quality-consistent opioids (other than MOUD) may be able to help decrease overdose deaths and provide some stability for people who use fentanyl.

Conclusions

Fentanyl use exacerbates and complicates the gap between what people want and need and what is available to **support their health**. For many interview participants, continued fentanyl use was described as a rational response to the combination of their social reality and their practical access to care. Current systems of care around housing, behavioral health, medical services, or first responder services, were not designed with the potency, risk of overdose, and robust withdrawal symptoms of a substance like fentanyl. Right now, **medical treatment for pain and support to address opioid dependence are more difficult to access than unregulated fentanyl**.

Limitations

This study and its findings are subject to a few key limitations. This was a convenience sample that is not representative of all people who use unregulated fentanyl in Washington State. The majority of survey respondents were either unhoused or unstably housed, and their responses may not reflect other groups of people using fentanyl. Most respondents were men, and the results of this may not reflect which services may be needed and desired by women or people of other genders who use fentanyl. Another limitation is that the study was conducted in Washington State, and there may be substantial differences in the drug supply in other parts of the country, such as the timing of the introduction of fentanyl and its form.

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Appendix 1

SERVICES LIST: “WHAT SERVICES WOULD YOU BE INTERESTED IN IF THEY WERE EASY TO GET?”

	Interested	Not interested	Not sure	No response
Housing	27	1	0	1
Rewards for reducing or stopping/Contingency Management	25	1	2	1
Cash assistance	24	2	1	2
Employment support	22	5	1	1
Phones	22	4	1	2
Peer support (someone with lived substance use experience)	22	4	1	2
“Kick kits” (take home detox management)	22	2	1	4
Fentanyl test strips	21	4	1	3
Safe supply	21	4	1	3
Naloxone	21	3	2	3
Drug checking (mass spectrometer)	20	6	1	2
Someone to help navigate services	20	5	0	4
Detox	20	5	1	3
Primary health care	20	5	0	4
Safe injection site/overdose prevention site	20	4	2	3
One-on-one mental health counseling	18	6	2	3
Medications to reduce opioid use (MOUD)	18	5	3	3
Help with legal issues	17	10	0	2
Help with a specific health issue	17	8	1	3
Testing for HIV/STIs/hepatitis C	16	6	4	3
Outpatient SUD treatment	14	8	2	5
Mental health medications	14	7	4	4
Wound care	13	10	3	3
Inpatient SUD treatment	12	9	5	3
Vaccinations	10	10	5	4
One-on-one harm reduction counseling*	9	13	2	5
One-on-one substance use disorder counseling	9	11	6	3

*Most participants were not familiar with the term “harm reduction counseling.”