Abstract

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Harm Reduction Workforce, Behavioral Health, and Service Delivery : A Cross-Sectional Study

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Background

Harm reduction is an evidence-based, community-driven, highly effective public health response to reducing rates of infectious diseases, overdoses, and mortality among individuals who use drugs. Despite recent federal fiscal and policy supports to advance harm reduction-related interventions, little is known about the workforce delivering these services. This study sought to understand the composition of this workforce and who provides behavioral health services in these settings.

Methods

A Qualtrics survey was distributed to harm reduction organizations identified through a publicly available website of syringe service programs (SSPs) across the U.S. Participant consent was granted upon initiating the survey (IRB# 22-3035). Descriptive statistics from survey data were run in Stata and two multivariate binary logistic regression models were used to examine the associations between (a) the odds of referral processes within harm reduction organizations and (b) the provision of behavioral health services and distinct types of staff. Analysis of qualitative data used a hybrid approach of inductive and thematic analysis.

Results

The survey yielded a 48% response rate (n = 168) and included primarily leaders/directors (76%) of SSPs across 41 states and Washington D.C. Respondents had an average of 9 years' experience in the field, and seven years' experience within their current organization. More than two-thirds of the organizations offered harm reduction services in multiple locations, with mobile units (51%) and pop-up sites (33%) being the most common. On average, organizations served 350 unique participants per month. Harm reduction teams primarily consisted of community health and peer specialists (87%), medical and nursing staff (55%), behavioral health workers (49%), and others (34%). Less than half of organizations identified having behavioral health staff, yet

almost 75% (n = 127) reported offering behavioral health services. SSPs were found to be 5.06 (95% CI = [1.91, 13.38]) times more likely to have referral processes and 6.11 (95% CI = [1.74, 21.52]) times more likely to have follow-up referral processes when they had embedded behavioral health services. Organizations were 2.20 (95% CI = [1.09, 4.46]) times more likely to have referral processes and 2.36 (95% CI = [1.11, 5.0]) times more likely to have follow-up processes when behavioral health providers were included.

Conclusions

Workforce considerations within harm reduction organizations are increasingly important as these services play an essential role in addressing the U.S. opioid epidemic. Having behavioral health providers as part of harm reduction organizations facilitates significantly more referrals to community, social, and health support compared to other groups of workers (e.g., medical staff and peer/ community outreach workers). Understanding the types of services offered and the workforce delivering them can help harm reduction organizations meet the needs of those accessing SSPs.