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Policy Brief

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

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Background

Harm reduction (HR) 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.[1,2,3] HR includes prevention, treatment, and recovery services that help individuals access healthcare, behavioral health services, social supports, and recovery resources.[4-7] Nationwide, HR programs have substantially increased alongside mounting support that HR is integral to addressing the opioid epidemic.[3,8-10] Despite recent federal fiscal and policy supports to advance HR-related interventions,[3] little is known about the workforce delivering these services. This study sought to understand the composition of the HR workforce and who provides behavioral health services in these settings.

Research Questions

This study addressed three research questions: (1) Who constitutes the community-based HR workforce? (2) Who provides behavioral health services at HR organizations? (3) Do referrals differ by the type of HR?

Methods

An electronic Qualtrics survey was distributed to HR organizations identified through a publicly available website of syringe service programs (SSPs) across the U.S.[11] The 46-item survey was open for six weeks and included (1) organizational characteristics (e.g., size, staff composition); (2) services and mode of delivery (e.g., behavioral health treatment, referral processes); (3) staffing challenges; and (4) respondent demographics. Participant consent was granted upon initiating the survey. 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 HR 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.[12]

Key Findings

Organizational Characteristics. The survey yielded a 48% response rate (n = 168) and included primarily leaders/directors (76%) of SSPs across 41 states and Washington D.C. On average, respondents had 9 years' experience in the field, and seven years' experience within their current organization. More than two-thirds of the organizations offered HR 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.

Team Composition. HR teams primarily consisted of four workforce types: 1) community health and peer specialists (87%), 2) medical and nursing staff (55%), 3) behavioral health workers (49%), and others (34%; i.e., grant managers, administrative staff). Less than half of the organizations had behavioral health staff and of those, 50% offered specialty mental health services. The behavioral health workforce varied: 26% included licensed marriage and family therapists (LMFTs), 26% were addiction counselors, 23% were clinical supervisors, and less than 12% included licensed clinical social workers. However, no education or profession type is discernable within the 'addiction counselors' or 'clinical supervisors' response options.

Behavioral Health Services. Less than half of organizations identified having behavioral health staff, yet almost 75% (n = 127) reported offering behavioral health services: case management (69%), peer recovery supports (61%), counseling (27%), and crisis counseling (20%). About 43% of the organizations had formal referral processes and among these, 32% had formalized follow-up processes. There was also heavy reliance on the peer workforce.

Association Between Behavioral Health Providers and Referral Patterns. Unadjusted results from the first multivariate logistic regression model indicated that HR organizations are 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 have embedded behavioral health services. HR organizations are 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 are included. In both models, neither community/peers nor medical staff were significantly associated with providing higher rates of referrals or follow-up protocols.

Policy Implications

This study confirms that the composition of the HR workforce, particularly those in behavioral health roles, significantly increases the likelihood of organization's ability to offer referrals and follow-up protocols. The following considerations are necessary for the advancement of the behavioral health workforce:

1. *Behavioral Health Workforce Integral to HR Services.* Funding to support behavioral health workers across the spectrum of lived experiences and formal education may be an effective way to support delivery of comprehensive HR services. Workers' roles and tasks should be clearly articulated and evaluated to ensure effective service delivery. Increasing this workforce within the HR field may increase provision of specialty mental healthcare (i.e., evidence-based interventions) to meet people within their community.

2. *Paying for Behavioral Health Services.* A diverse workforce may increase the number of participants who receive access to needed support. However, variation in scope of practice, training, and skills vary by workforce along with payment mechanisms that reimburse differently,[13] if at all. Because not all behavioral health workers can provide specialty mental health interventions, organizations must consider what services are offered, by whom, and what funding can be accessed to expand services.

3. *Importance of Peer Behavioral Health Support.* Peers and community outreach specialists were the most common type of providers identified within this study (87%) and provided the most frequently offered behavioral health service. Future work should explore how peers are supported clinically (i.e., supervision, clinical training). Efforts to support this workforce will be necessary for workforce planning and projections to prevent burnout and increase retention.

Conclusions

Workforce considerations within HR organizations are increasingly important as HR services continue to be essential to address the opioid epidemic in the U.S. Having behavioral health providers as part of HR 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 HR organizations meet the needs of those accessing SSPs.

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Table 1. Respondent Characteristics

Variable (Total responses)	Frequency	Percentage	Mean	SD
Respondent age			42.82	11.42
Role (168)				
Executive leadership	128	76.19		
Participant services staff	21	12.50		
Program coordinator	19	11.31		
Respondent gender identity (147)				
Female/Woman	94	63.95		
Male/Man	37	25.17		
Transgender, genderqueer, gender non-conforming, or non-binary	15	10.20		
Prefer not to disclose	1	.68		
Respondent ethnicity (153)				
Non-Hispanic or Latino	137	81.55		
Hispanic or Latino	16	9.52		
Respondent race (154)				
White	129	76.79		
Black or African American	10	5.95		
Other*	15	8.92		
Respondent educational attainment (152)		152		
Master's degree or Doctorate/PhD, MD, or JD	42	25.0		
4-year degree	61	36.31		
Some college	27	16.07		
2-year associate degree/vocational degree	12	7.89		
Up to a high school degree or GED	10	5.95		

Table 1. Respondent Characteristics (continued)

Variable (total responses)	Frequency	Percentage	Mean	SD
Has the respondent completed a certificate program related to harm reduction services? (153)				
No	90	53.57		
Yes	63	37.50		
Years worked in harm reduction (152)			8.86	7.86
Years respondents has worked in their harm reduction organization (149)			7.51	7.28

* To ensure data are deidentified, the racial category "Other" was created to include Asian, American Indian, or Alaskan Native, and Pacific Islander/Hawaiian individuals.

Table 2. Organization Characteristics

Variable (total responses)	Frequency	Percentage	Mean (SD)
Syringe Services Program (SSP) has multiple sites (168)			
Yes	111	66.97	7.08 (9.80)
No	57	33.93	
Physical setting of the organization			
Primary location (168)	132	78.57	
Mobile unit (168)	86	51.19	
Pop-up sites (168)	56	33.33	
Tele-services (168)	23	13.70	
Number of unique participants served per month			350 (607.32)
Organization affiliation			
Non-profit (168)	111	66.07	
Health department (168)	53	31.55	
Faith-based (168)	11	6.55	
Other (i.e., for-profit, tribal affiliation) (168)	7	4.17	
Behavioral health services offered	127	75.60	
Case management (127)	88	69.29	
Peer recovery (127)	78	61.41	
Counseling (127)	34	26.77	
Crisis counseling (127)	26	20.47	
Other (127)	37	29.13	
Types of providers/staff at organization			
Behavioral health (168)	82	48.80	
Community outreach (168)	146	87.0	
Medical (168)	92	54.76	
Other (168)	57	34.0	

Table 2. Organization Characteristics (continued)

Variable (total responses)	Frequency	Percentage	Mean (SD)
Is there a formal referral process? (168)			
No	95	56.55	
Yes	73	43.45	
Is there a follow-up process for referrals? (168)			
No	114	67.86	
Yes	54	32.14	
Are there specialty mental health services? (159)			
No	80	50.31	
Yes	79	49.70	

Table 3. Harm Reduction Workforce—Four Primary Types

Variable (each type of provider out of 168)	Frequency	Percentage
Behavioral health providers		
Clinical supervisors	46	27.38
Marriage and family therapists	43	25.60
Addiction counselors	38	22.62
Clinical social workers	19	11.31
Mental health/professional counselors	13	7.73
Psychiatric mental health nurse practitioners	13	7.73
Psychologists	9	5.35
Community outreach providers		
Community outreach specialists	114	67.86
Peer support specialists	99	58.93
Social workers	62	36.90
Advocates	32	19.05
Housing specialists	27	16.07
Insurance specialists	20	11.90
Translators	17	10.12
Case Managers	16	9.52
Job trainers	13	7.74
Promotoras	6	3.57
Medical providers		
Physicians	40	25.0
Nurse practitioners	42	23.81
Pharmacists	16	9.52
Paramedics	8	4.76
Dentists	8	4.76
Other types of providers		
Grant writers	50	29.76
Researchers	14	8.33
Lawyers	12	7.14

Table 4. Logistic Regression Models Assessing the Odds of Referral Supports within Harm Reduction Organizations

Variable	*OR*	95% CI	*p*-value
Formal referral process			
Behavioral health services	5.06	[1.91, 13.38]	<.001
Behavioral health providers	2.20	[1.09, 4.46]	.029
Community outreach providers	1.17	[0.65, 2.14]	.592
Medical providers	1.14	[0.90, 1.44]	.281
Follow-up referral process			
Behavioral health services	6.11	[1.74, 21.52]	.005
Behavioral health providers	2.36	[1.11, 5.0]	.025
Community outreach providers	1.67	[0.86, 1.42]	.209
Medical providers	1.10	[0.86, 1.42]	.430