

REVIEW ARTICLE

Diversity, Equity and Inclusion

Peer support for patients with opioid use disorder in the emergency department: A narrative review

Helen E. Jack MD¹  | Shaheer A. Arif BA²  | Michael A. Moore MSN, NP-C¹  |
 Elenore P. Bhatraju MD, MPH¹ | Jennifer L. Thompson MD³ | Maureen T. Stewart PhD⁴ |
 Kathryn F. Hawk MD, MHS⁵ | Emily Bartlett MD, MS³

¹Division of General Internal Medicine, Department of Medicine, University of Washington School of Medicine, Seattle, Washington, USA

²College of Arts and Sciences, University of Washington, Seattle, Washington, USA

³Department of Emergency Medicine, University of New Mexico, Albuquerque, New Mexico, USA

⁴Institute for Behavioral Health, The Heller School for Social Policy and Management, Brandeis University, Waltham, Massachusetts, USA

⁵Department of Emergency Medicine, Yale University School of Medicine, New Haven, Connecticut, USA

Correspondence

Helen E. Jack, Division of General Internal Medicine, Department of Medicine, University of Washington School of Medicine, Seattle, WA, USA.

Email: hjack@uw.edu

Funding information

National Institute of Mental Health, Grant/Award Number: K23MH129420; National Institute on Drug Abuse, Grant/Award Number: P30DA035772

Abstract

Faced with a growing opioid overdose crisis, emergency departments (EDs) are increasingly hiring peers—people with lived experiences of addiction and recovery—to work with patients in the ED who have opioid use disorders (OUDs) or who have experienced an opioid overdose. Despite a clear need for more support for patients with OUD and rapid expansion in grant funding for peer programs, there are limited data on how these programs affect clinical outcomes and how they are best implemented within the ED. In this narrative review, we synthesize the existing evidence on how to develop and implement peer programs for OUD in the ED setting. We describe the key activities peers can undertake in the ED, outline requirements of the peer role and best practices for peer supervision and hiring, detail how ED administrators have built financial and political support for peer programs, and summarize the limited evidence on clinical and care linkage outcomes of peer programs. We highlight key resources that ED clinicians and administrators can use to develop peer programs and key areas where additional research is needed.

1 | INTRODUCTION

Between 2015 and 2020, the number of deaths from opioid overdose in the United States more than doubled.¹ Peers—people with lived experience of addiction and recovery—are a growing part of emergency care in the United States for patients with opioid use disorder

(OUD),^{2–4} often in combination with initiation of medication for opioid use disorder (MOUD). In 2022, the Biden-Harris White House committed \$1.5 billion toward fighting the opioid epidemic, specifically calling for investment in peers in emergency departments (EDs).⁵ In response to funding to combat the opioid overdose epidemic, EDs are rapidly developing peer programs, although data on these programs are limited.^{6,7}

Supervising Editor: Carlos Roldan, MD

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Peer providers for people with OUD build on a long history of professionalized peer support for people with severe mental illness^{8,9} and mutual help within substance use treatment.¹⁰ Peers have recently become part of substance use care in medical and community-based settings.^{11,12} Peers play a different role in settings other than the ED.^{11,12} In EDs, they disproportionately see people who have just experienced an overdose, work with care teams with little formal training in addiction medicine,¹³ and may engage patients with negative prior ED experiences or who did not present seeking OUD treatment.^{14–16}

Peer programs are heterogeneous, with wide variation in the activities peers perform, which patients are connected to peers, duration of peer contact with patients, and how peers are trained, hired, and supervised.^{4,17,18} As there is no consensus on how to design and implement an ED-based peer program, clinicians and administrators are often left to make these decisions. While several reviews have been published on peers,^{11,12,19,20} none specifically focus on peers in the ED or other acute care settings. Reviews of OUD care in the ED discuss peers,^{13,21–23} but their focus is much broader, and they do not cover the specifics of peer programs.

In this narrative review, we provide an overview of peer support for patients with OUD in the ED. Our objective is to support administrators and practitioners who are currently designing and implementing peer-delivered programs in the ED.

1.1 | Search strategy

We conducted a PubMed search using terms related to peers and navigators (including synonyms such as “community health worker” or “health advocate”), substance use, and acute care settings (including both the inpatient hospital and ED). We did not limit by date of publication. We also searched gray literature to identify publicly available toolkits and resources. We closely reviewed more than 60 relevant manuscripts that described the development and implementation of peer programs, which informed this review. We included several studies on roles that do not necessarily have lived experience but may play a role similar to that of peers (eg, patient navigators and community health workers).

2 | FINDINGS

2.1 | What is a peer?

This review utilizes the term “peer,” but many terms can be used to describe this role. Other terms include peer support workers,^{24–28} peer navigators,²⁹ patient navigator (specifically referring to navigators with a history of substance use, although this term is also used to refer to people without a history of substance use),³⁰ peer recovery specialists,^{31,32} and peer recovery coaches,^{33,34} all of which required individuals to have lived experience of addiction and recovery. In some instances, individuals with a family member with a lived history of SUD have been considered peers, even if they have not lived the experience themselves.^{3,4} Other terms that do not require a shared history

of substance use, but permit a shared history of substance use include substance use navigators, health promotion advocates, and linkage managers.^{35,36}

2.2 | Role of peers in the ED

2.2.1 | Activities

The peer role typically centered around meeting at bedside while the patient was in the ED.^{3,29,31,33,37} The content and degree of structure of that encounter varied, with some programs encouraging peers to focus on counseling or education, others having a greater emphasis on service navigation, and some combining both. Of those that included counseling or education, they involved motivational interviewing^{2,38}; education on overdose prevention, naloxone, and/or MOUD^{2,27}; or more informal counseling or sharing of lived experiences.^{39,40} Those that focused on service navigation frequently had peers facilitate linkage to MOUD and other addiction treatment^{26,27,34,37} or arrange transportation, primarily to addiction treatment providers.²⁶ In some programs, peers had contact with patients after the initial ED visit either in person, over the phone, or both.^{3,28} Some health systems deployed peers in roles previously filled by people with more specialized training but without lived experience, such as drug treatment counselors.^{13,35,36}

2.2.2 | Intensity of intervention

Intensity of peer-delivered interventions can be measured by the length of each peer–patient interaction and the duration of longitudinal engagement. One study of peer support for individuals after an opioid overdose in 20 New Jersey EDs found that peer bedside encounters lasted 25–60 min.³ The duration of peer support interventions varied from a single encounter in the ED, an encounter in the ED with follow-up in the 24–48 h after ED discharge, or weeks to months of ongoing contact following an ED visit.^{28,33,34,38} The majority of longitudinal interventions included contact with patients within a few days of the ED visit and had more frequent contacts in the initial week, followed by decreasing contact. For instance, two higher intensity peer-delivered interventions, one in New Jersey EDs and the other in Rhode Island EDs, involved an initial bedside visit from a peer in the ED, contact within 24 h of ED visit, and at least weekly contact for 2–3 months.^{3,32} In the randomized controlled trial (RCT) comparing peer-delivered care to social worker-delivered care in Rhode Island EDs, researchers found that peers were able to reach 85% of patients within 10 days of their ED visit,³² although this follow-up may not be generalizable to people who did not choose to enroll in a trial.

2.2.3 | Patient population

Peer programs used varying criteria to select people with OUD to receive peer services in the ED. In some programs, peers saw only

those who were post-overdose^{31,33,37} or those initiating MOUD,^{30,41} whereas in others peers saw patients with any substance use disorder (SUD) diagnosis.² Few studies have specified criteria for the patient's clinical stability at the time of peer visit in the ED, although one raised the question of whether patients seeing a peer needed not only to be clinically stable but also not intoxicated or in withdrawal.⁴² Little has been reported on whether other patient characteristics, such as incarceration, pregnancy, preferred language, hospital admission, or hospital transfer, were used to exclude patients.^{2,17,43,44}

2.2.4 | Integration into ED workflow and care team

Existing programs used a variety of mechanisms to identify appropriate patients for peer consultation: direct referral by emergency medical services (EMS) after an overdose regardless of whether the patient went to the ED³⁸; ED clinician consultation, including a consultation feature within the electronic health record (EHR)³⁴; or peers identifying patients either by screening patients who presented to the ED for SUD^{30,45} or reviewing records.⁴⁶

How peers work with other members of the ED care team is typically not specified, beyond studies stating that an ED clinician would refer patients to the peer.³⁴ Some EDs in New Jersey operate a program in which state- and Medicaid-funded peers and patient navigators work together, playing complementary roles in caring for patients after an opioid overdose. The peers provided non-clinical support, counseling, and referral to a navigator, while the navigators worked on referrals to treatment or other services.^{3,31} Several programs allow peers to view and/or document in the EHR, potentially facilitating communication with other care team members.^{30,47} When an ED at an urban safety net hospital in Indiana developed an intervention, including peer support, for patients who had experienced an opioid overdose, they created office space for the peers in the ED,³⁷ potentially facilitating better collaboration with ED clinicians and the social work staff who were also involved in the intervention. Conversely, a peer support program that operated across 20 EDs in New Jersey described that peers were based both at larger hospitals and a regional hub from which they could be sent to smaller hospitals.³ A single qualitative study in an urban, academic hospital in Oregon indicated that peers, who met patients while they were hospitalized, helped communicate provider recommendations to patients, and helped clinicians understand patient needs.⁴⁸

2.3 | Hiring and support

2.3.1 | Hiring and training

There is little evidence and few program descriptions to guide peer hiring. During the hiring process for peers working in a program in the inpatient hospital, program leadership recommended that peer candidates have opportunities to shadow hospital staff and discuss challenging cases.⁴⁹ Given the fast-paced nature of the ED, a similar

approach could be useful in an ED setting.⁵⁰ A peer's history of recovery from substance use may create barriers in the hiring process,^{49–51} although it is an important part of their lived experience. Possible mechanisms that hospitals and clinics used to address this include contracting with a community-based organization that hired the peers, meeting with hospital leadership prior to initiating the program to build support from the outset, and providing explanations to the hospital system about issues that arose in a peer's background check, such as a history of justice system involvement.⁵¹

Many states have a formal peer support certification, which often requires at least 2–4 years of SUD recovery and some didactic education.^{32,51} Certification may be a requirement of employment or included as part of job training.^{2–4,17,28,31,33} Additional site-specific training may be needed, including EHR documentation, ED policies and procedures, ethics, referral processes, and working in the ED setting.^{30,50} Qualitative interviews with people who had experience working with peers in the ED or doing clinical management in EDs in New Mexico revealed that making the whole ED team, including the peer, aware of the peer's role and scope was essential.⁵⁰ There was little discussion in the ED-based literature about how an individual peer's experience of recovery affected their work. This tension may particularly emerge if a peer did not utilize MOUD³⁹ and is supporting patients on MOUD,^{52,53} as stigma toward MOUD as lack of abstinence remains in some recovery communities,^{7,54} highlighting an important need for training.

2.3.2 | Supervision and support

Having ongoing support and/or clinical supervision for peers is important.^{20,51} Supervision can involve observation and feedback,³⁰ fidelity checks,³⁰ coaching from ED staff members,² support over the phone,³⁰ or clinical case conferences.^{55,56} Supervision may not directly take place in the ED but could come from a program supervisor elsewhere in the hospital³⁰ or a community-based organization through which the peer was hired.^{34,50} There are a variety of approaches to providing peers with guidance on self-care and boundaries,^{25,30,49–51} including overdose death debriefing³¹ and talking circles to share challenges and celebrate successes.⁵⁷ We identified no formal evaluation of how supervision and support methods affect outcomes, including peer job satisfaction, retention, and psychological distress.

2.4 | Program development and administration

2.4.1 | General administrative and regulatory considerations

Several peer programs in the ED or inpatient hospital used a collaborative approach to program development and documented this approach using qualitative research methods.^{49,58} This included engaging all stakeholders (peers, ED clinicians and staff, hospital administrators) in planning or working with teams at different sites to learn from

TABLE 1 Gray literature toolkits and other resources for developing peer programs.

Source	Topic	Focus/setting
Substance Abuse and Mental Health Services Administration ⁷²	Describes core competencies of peers and recommendations on supervision.	Not specific to the ED setting
City of Philadelphia Department of Behavioral Health and Intellectual Disability Services and Achara Consulting ⁴⁰	Provides a history of the incorporation of peer providers in behavioral health. Emphasizes need for organizations to be clear regarding the functions they are hiring peer staff to perform. Also, emphasizes need for support for peer providers and recommends hiring at least two providers within an organization. Includes summary of actions needed to prepare for the integration of peer support staff.	Written for outpatient behavioral health organizations
Southern Plains Tribal Health Board ⁷³	Describes core roles and responsibilities for peers. Describes ethical conduct for those in peer specialist roles. Provides a program planning checklist and lists elements of a recommended core curriculum for training a peer.	Addresses cultural components of providing care to American Indian/Alaskan Native populations. Is focused on Oklahoma/Southern Plains region. Not specific to ED setting.
ACMHA: The College for Behavioral Health Leadership and Optum ⁷⁴	Provides history of peer support in behavioral health services. Provides description of peer provider roles. Provides an overview of different peer support job definitions and designations as well as qualifications to be a peer specialist. Describes possible benefits of having peer-run organizations that contract with healthcare and other agencies. Provides recommendations on peer supervision.	Mentions possibility of expanding peer services to ED settings; however, toolkit is primarily written from the lens of community-based peer recovery organizations.
California Bridge ⁷⁵	Includes sections on: Getting started (defining role, integrating into the hospital, patient privacy and confidentiality, ethics and professional conduct) Understanding substance use disorder and MOUD Starting treatment Connecting patients to ongoing care Leading change in hospital culture Patients with co-occurring substance use and mental health disorders Strengthening community connections Improving and sustaining your program	Materials are intended for substance use navigators as audience, not specifically peer providers. Includes link for a template navigator job description.

Abbreviation: ED, emergency department.

each other. Other common themes in program development included developing a clear role and job description for the peer, paying peers competitively to recruit and retain them, and finding appropriate workspace for the peers.^{3,46,50} One study, based on qualitative interviews with people involved with peer-delivered services or ED management in New Mexico, identified obstacles to peer services in EDs and used those to develop a checklist of individual, hospital, and system-level needs to start a peer program in the ED.⁵⁰ Some teams took a health-system approach that included the development of an outpatient “bridge” clinic, where patients get short-term follow-up after ED discharge, including MOUD prescriptions.^{2,17,59,60} In Table 1, we summarized gray literature toolkits geared for implementers.

A small number of papers raised patient privacy protections, including the 42 Code of Federal Regulations (CFR) Part 2, as a barrier to coordination of post-discharge care.⁵¹ The 42 CFR Part 2 goes beyond the privacy safeguards provided by the Health Insurance Portability and Accountability Act to protect medical records related to substance use care if that care is delivered by certain federally funded

programs. This regulation is intended to protect patient privacy and make patients more comfortable seeking care. ED-based programs for patients with SUDs are delivered as part of general medical care and therefore do not fall under 42 CFR Part 2. There are, however, concerns that this regulation may inhibit communication and information sharing for ongoing care beyond ED discharge.^{61–63} This may be addressed by asking patients to sign a release of information form granting permission to share clinical information or follow-up on successful treatment linkage.

2.4.2 | Scheduling

While some programs sustained 24-h ED peer coverage,^{3,31} others had more limited hours.⁵¹ Programs without 24/7 coverage often prioritized weekend or overnight hours. For instance, one community ED in Ohio had peers available from 7 am to 3 am.⁵¹ As previously described, in some ED-based peer programs, peers actively followed

up with patients via phone or text message for days to weeks after the patient's initial ED visit, and patients could call the peer for ongoing support.^{3,30} There were few details, however, about when peers were expected to do these tasks (i.e., during their hours on duty in the ED or at other times) or be on-call to take patient calls.³⁴

2.4.3 | Funding and payment structures

Several papers described launching peer programs with grant funding from federal and state sources^{3,28,64} or direct funding from the hospital system,³⁵ with some later transitioning to more sustainable funding through Medicaid.³ States are increasingly using specific Medicaid funding options to cover peer services by requesting permission from Centers for Medicare and Medicaid Services (CMS) to include them in the state Medicaid plan or through Medicaid waivers or demonstration projects.⁶⁵ In a 2022 survey of state Medicaid programs, 40 states reported covering peer services.⁶⁶ Three of these states required copayments for peer services, and 16 states placed limits on this coverage.⁶⁶ Medicaid-managed care plans, however, may have different benefit policies from state Medicaid programs.

In 2021, CMS established a billing code for initiation of MOUD in the ED, which includes payment for post-discharge care coordination, a service peers could provide.⁶⁷ There is also a Healthcare Common Procedure Coding System billing code for peer services for both Medicaid and private insurance: H0038. Peers can also be supported within a bundled rate for OUD treatment.⁵³ Opioid settlement funds, distributed on a state level, are a likely future source for funding of peers. Given the changing landscape of funding for peer services, individual state health departments often provide up-to-date information on funding and billing for peer services.

2.5 | Clinical outcomes

Linkage to OUD treatment after the index ED visit was the most common primary outcome in the studies identified (Table 2). There was less focus on direct clinical outcomes, such as mortality, overdose, hospital readmission, or substance-free days. Clinical and linkage results were not consistent across studies, making it challenging to draw broad conclusions about the effect of peer programs.

In the two more rigorous RCTs, peer programs did not clearly have better primary clinical outcomes than usual care. One randomized patients with OUD in the ED to meet with a peer for up to 3 months versus a social worker once in the ED. That RCT found that there was no difference in their primary outcome of receipt of MOUD prescription or enrollment in inpatient substance use treatment within 30 days of ED visit. About 30% of patients in each group linked,³² speaking to the potential for peers to perform equivalently to staff members with more formal training. A cluster RCT compared an intervention consisting of peer coaching in the ED, assistance with transportation to follow-up care, and ongoing phone contact with a peer to usual care for patients with OUD in the ED. The investigators found no dif-

ference in re-presentation to the ED with opioid overdose (primary outcome).⁶⁸

A single cohort study with a comparison group assessed MOUD linkage in patients who did versus did not receive a peer-delivered intervention in the ED after an opioid overdose. They found that 28.5% of patients linked to MOUD within the year after ED visit, with no difference between groups.³⁴ On the other hand, two prospective cohort studies without comparison groups found that over 70% of patients were linked to OUD care after receiving a peer-delivered intervention in the ED.^{30,41} The high incidence of linkage in these studies may be because they included only patients who initiated buprenorphine in the ED,^{30,41} which has been shown to increase linkage to care.⁶⁹ Other investigators did not limit their sample to only those receiving buprenorphine.

Given the relatively limited evidence on the effectiveness of peer programs in the ED and the focus of existing effectiveness studies on MOUD linkage outcomes, further clinical outcome assessment is needed. Clinical outcomes may include proximal outcomes, including engagement with harm reduction services or substance-free days during a specific interval after ED discharge.^{2,17,33,38,70,71} Assessment could also focus on more distal outcomes, including hospital or ED readmission, overdose, or mortality in the month to year following peer contact.^{37,55} These could be measured at the patient or population level, using individual or public health data.³⁴ More patient-centered outcomes may include social determinants of health, such as employment and housing, quality of life, or connection to community or family.^{19,71} Describing intensity of the peer-delivered intervention and the population eligible for contact with a peer is important to facilitate comparison of outcomes across studies.²¹

3 | DISCUSSION

Our narrative review highlights pragmatic considerations in the implementation and management of ED peer support programs. We also highlight key research gaps in the implementation and effectiveness of peer programs. This review is particularly timely, as there are increasing resources, often from state or federal grants, to establish peer programs, and these programs may be an important tool for addressing the opioid overdose crisis.

We need not only larger RCTs examining clinical outcomes of different types of peer interventions but also smaller pragmatic studies that focus on the complexities of implementation of such programs in real-world settings, including in rural, critical access, and other non-academic sites. As evidence begins to emerge on the effectiveness of peer-delivered interventions, we must continue to recognize the heterogeneity of peer programs. Included studies vary in the duration and content of peer interventions, making it challenging to make global assessments of the effectiveness of programs. Future research should specifically focus on determining the value of ongoing engagement versus one-time contact, assessing how having a peer versus a navigator without lived experience affects clinical outcomes, and evaluating different reimbursement policies for peer-delivered services.

TABLE 2 Clinical and linkage to care outcomes of peer or navigator-delivered interventions for opioid use disorder.

Citation	Study design	Population	Intervention	Outcomes	Setting
ED-based studies					
Treitler et al. 2024 ^{7,6}	Retrospective cohort study	Adult Medicaid enrollees in New Jersey who were treated for non-fatal opioid overdose.	OORP services delivered by peers who conducted an intervention immediately following an opioid overdose. This was followed by non-clinical recovery support for 8 weeks and patient navigation services to facilitate service linkage.	Primary outcome was probability of 60-day MOUD initiation. In the first 6 months after implementation, OORP was associated with a 3.4 percentage point increase in the primary outcome, which represents a 45% increase compared to the pre-implementation period.	Seventy acute care hospitals in New Jersey. Intervention was delivered at the bedside in the ED. Some OORP programs embedded peers within EDs, and others dispatched peers to the ED as needed.
Watson et al. 2024 ^{4,8}	Cluster randomized controlled trial	Adult patients with possible OUD based on admitting diagnosis on the electronic health record ED tracking board. Patients were required to be medically stable prior to peer-delivered intervention.	Peer-conducted brief assessment of the patient's high-risk drug use behaviors, harm reduction coaching, naloxone, linkage to recovery supports, and referral to treatment. After initial contact, peer arranged transportation assistance as needed and continued phone-based support. Contact attempts were continued until patient was linked to MOUD, requested service discontinuation, or follow-up attempts had been unsuccessful for 2 weeks.	Primary outcome was overdose-related ED re-presentation. The primary outcomes was 3% in both the intervention and control groups. The secondary outcome of MOUD linkage was 36% in the intervention group and 14% in the control group (p -value 0.22).	Two EDs in a university health system in Indiana.
Anderson et al. 2023 ²	Retrospective cohort study	Patients in the ED with cocaine, methamphetamine, alcohol, and opioid use-related diagnoses.	SUN intervention included motivational interviewing, stigma reduction, and provision of harm reduction education and resources. SUNs were community health workers with training in behavioral health; they were not required to have a history of substance use. Comparison group: patients who received standard care when SUNs were not available. MOUD available for both groups.	Primary outcome was linkage to treatment within 30 days of ED visit. A higher proportion of patients in the SUN intervention group were engaged in outpatient treatment within 30 days of ED discharge (50.4% vs. 15.9% for comparison group).	Three EDs: one urban teaching hospital, one urban, community hospital, and one suburban community hospital. Health system has a low-threshold addiction medicine clinic.

(Continues)

TABLE 2 (Continued)

Citation	Study design	Population	Intervention	Outcomes	Setting
Beaudoin et al. 2022 ³²	Randomized controlled trial	Patients in the ED for an opioid overdose, received treatment related to an OUD, or had an opioid overdose within the previous 12 months.	Intervention group: behavioral intervention from a certified peer recovery specialist in the ED with continued contact with participants for up to 90 days. Certified peer recovery specialist defined as someone with at least 2 years of recovery who completed a 45-h training program and had 500 h of supervised work experience. Comparison: standard intervention delivered by a hospital-employed licensed clinical social worker, delivered as a one-time intervention after ED discharge. MOUD available for both groups.	Primary outcome was receipt of MOUD or admission to an SUD treatment program within 30 days of ED visit. Receipt of SUD treatment occurred in 32% of the intervention group and 30% of the comparison group within 30 days of ED visit (not a statistically significant difference). Treatment outcomes were similar for those in the ED after an overdose and those who were there for other reasons.	Two EDs in Rhode Island: one academic tertiary care hospital and one high-volume community hospital. Patients primarily seen in the ED, but patients could elect to remain in contact with the peer for up to 3 months after ED visit.
Jennings et al. 2021 ⁴¹	Prospective cohort study	Patients in the ED with OUD, including those with polysubstance use, who initiated buprenorphine. Patients identified at triage using NIDA Quick Screen.	On-site peer recovery specialist conducted SBIRT. Buprenorphine initiated in ED and patients referred to community clinics for next day follow-up. Prescription for buprenorphine not provided at time of ED discharge. No comparison group.	Primary outcomes were attendance at first MOUD appointment, retention in treatment at 30 days, and length of time in addiction treatment. 77% of patients attended first referral appointment, 43.1% were retained in treatment at 30 days, and mean time in treatment was 158 days.	Five EDs including an academic medical center and community and regional medical centers in both rural and urban areas.
Watson et al. 2021 ³⁷	Difference-in-difference analysis	Patients in an ED after non-fatal opioid overdose.	Intervention delivered by ED and social work staff as well as peer recovery coaches. Peers helped facilitate MOUD linkage and naloxone distribution for patients after opioid overdose. Intervention group: patients admitted to the ED when a project staff member was working; control group: patients admitted to the ED when no project staff member was working. MOUD available to both groups.	Primary outcomes were MOUD prescriptions dispensed (buprenorphine or injectable naltrexone), non-MOUD opioid prescriptions dispensed, naloxone access, and subsequent hospital admission for drug poisoning. Intervention is associated with an increase in MOUD prescriptions (ME 1.53), increase in non-MOUD opioid prescriptions dispensed (ME 1.00), and naloxone access (ME 2.35). No significant difference in subsequent drug poisoning-related hospital admissions.	One community ED in Indiana. Peers met patient at bedside in ED.

(Continues)

TABLE 2 (Continued)

Citation	Study design	Population	Intervention	Outcomes	Setting
Bogan et al. 2020 ³⁰	Prospective cohort study	Patients in the ED with OUD, including patients with polysubstance use, who received buprenorphine. Patients identified at triage using NIDA Quick Screen and AUDIT-C tool.	Patient navigators completed SBIRT in ED. All but one navigator were in recovery from a substance use disorder. Three years' sustained recovery and education at least at the level of a GED were required. Dose of buprenorphine provided in the ED referral to outpatient treatment within 24 h. No prescription for buprenorphine provided at time of ED discharge.	Primary outcome not specified. 76.6% of patients attended next-day appointment, 59.9% of patients were retained in treatment at 30 days.	Three EDs in South Carolina: one academic site, one large private hospital, and one small community hospital.
Samuels et al. 2018 ⁷⁷	Retrospective cohort study	Patients discharged from an ED after a non-fatal opioid overdose.	Three interventions utilized: usual care, take-home naloxone, or a recovery coach with take-home naloxone. Interventions were selected based on provider and patient discretion. Recovery coaches were required to have been in addition treatment for at least 2 years and received 36 h of peer recovery coach training. MOUD not included in interventions.	Primary outcomes were initiation of MOUD, additional ED visit for overdose, or mortality in the year after ED visit. No statistically significant difference between groups in initiation of MOUD (28.5% across groups), additional ED visit for overdose, or mortality.	Two EDs: one urban academic medical center and one suburban academic hospital.
Gryczynski et al. 2021 ⁵⁵	Randomized controlled trial	Hospitalized patients with substance use disorder (opioid, cocaine, or alcohol).	Intervention group: patients received counseling, substance use treatment navigation, linkage with social services, and frequent phone check-ins. Patients first met with a navigator in the hospital, and navigators remained in frequent contact for 3 months post-release. Patient navigators were master's level social workers who were not required to have a history of substance use. Control: patients received usual care from their medical team and the addiction consultation service. MOUD available to both groups.	Primary outcomes were hospital readmission within 12 months. Intervention group had fewer readmissions (hazard ratio 0.74; 95% CI 0.58–0.96), fewer ED visits (hazard ratio 0.66; 95% CI 0.49–0.89).	One urban academic hospital in Baltimore, Maryland. Intervention was initiated in the inpatient hospital setting.

(Continues)

TABLE 2 (Continued)

Citation	Study design	Population	Intervention	Outcomes	Setting
Langabeer et al. 2021 ¹⁷	Prospective cohort study	Patients with opioid use disorder, including patients with polysubstance use and postpartum patients.	Visit with an advanced nurse practitioner and emergency physician for a buprenorphine prescription followed by a counseling session with a licensed chemical dependency counselor within 2 weeks, and daily contact with a peer via in-person groups or one-on-one telemedicine sessions. Peers were individuals with lived experience with SUD with at least 2 years of sustained recovery and who had achieved statewide certification. No comparison group.	Primary outcomes were (1) adherence to program components in the first 30 days (receiving MOUD prescriptions for 30 days, received at least one behavioral health counseling session, met with peers weekly) and (2) linkage to community-based MOUD care after initial program. 90.43% treatment program adherence at 30 days, and 62.65% successful linkage to ongoing MOUD in the community.	Intervention delivered by combination of telemedicine and in-person settings in medical clinics or community-based organizations. Patients referred to the program from EDs, EMS, law enforcement, and community organizations.
Scott et al. 2020 ³⁸	Randomized controlled trial	Patients who had an opioid overdose reversal with naloxone administered by EMS within the past 30 days.	Intervention group: patients assigned to linkage managers who followed-up with participants 2–3 times per week for 4 weeks. Linkage managers were required to have a bachelor's degree and to be certified in motivational interviewing. Linkage manager not required to have a shared history of substance use. Control group: received an informational brochure with local resources. Both groups referred to MOUD treatment programs available in the community.	Primary outcomes were receipt of OUD treatment, number of days of OUD treatment, receipt of MOUD, and number of days of MOUD received. Intervention group had higher odds of initiating any kind of treatment for OUD (OR 7.94; 95% CI 1.60–39.42), initiating MOUD (OR 20.22; 95% CI 3.45–118.65), and had received more days MOUD and more days of other OUD treatment (Cohen's effect size ≥ 1.00 for both outcomes).	Conducted in an urban setting (Chicago, Illinois), Pre-hospital setting only.

Abbreviations: CI, confidence interval; ED, emergency department; EMS, emergency medical services; GED, general education development; MOUD, medication for opioid use disorder; NIDA, National Institute on Drug Abuse; OORP, Opioid Overdose Recovery Program; OR, odds ratio; OUD, opioid use disorder; SBIRT, screening, brief intervention, and referral to treatment; SUN, substance use navigator; SUD, substance use disorder.

As EDs innovate in their development of peer programs, we must also continue to include peers in program design, management, and evaluation. In contrast to the traditional hierarchical medical model, in which years of education often dictates status, peers bring expertise through lived experience. This lived experience may not only be useful in informing how the peer engages with a patient but also in shaping how a peer program is developed and informing how EDs develop an environment that improves experience in care for individuals with OUD.

AUTHOR CONTRIBUTIONS

Helen E. Jack and Emily Bartlett conceived the study. Helen E. Jack, Michael A. Moore, Emily Bartlett, Jennifer L. Thompson, and Elenore P. Bhatraju conducted literature review and evidence synthesis and drafted the initial manuscript. Helen E. Jack, Emily Bartlett, Maureen T. Stewart, Kathryn Hawk, and Shaheer Arif contributed substantially to manuscript revision. All the authors meet the ICJME authorship standards.

ACKNOWLEDGMENTS

We would like to thank peer support specialists Kesha Johnson-Jedlicka and Liza Neumann for reviewing a draft of this manuscript. Dr. Jack is supported by the National Institute of Mental Health under award number K23MH129420. Dr. Stewart is supported by the National Institute on Drug Abuse under award P30DA035772. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

CONFLICT OF INTEREST STATEMENT

The authors declare they have no conflicts of interest.

ORCID

Helen E. Jack MD  <https://orcid.org/0000-0003-2815-4725>

Shaheer A. Arif BA  <https://orcid.org/0000-0002-7678-2200>

Michael A. Moore MSN, NP-C  <https://orcid.org/0000-0002-9669-3045>

REFERENCES

- Centers for Disease Control and Prevention. *Overdose Death Rates Involving Opioids, by Type, United States, 1999–2020* Accessed July 21, 2023. <https://www.cdc.gov/drugoverdose/data/OD-death-data.html>
- Anderson ES, Rusoja E, Luftig J, et al. Effectiveness of substance use navigation for emergency department patients with substance use disorders: an implementation study. *Ann Emerg Med.* 2023;81(3):297–308. doi:10.1016/j.annemergmed.2022.09.025
- Liebling EJ, Perez JJS, Litterer MM, Greene C. Implementing hospital-based peer recovery support services for substance use disorder. *Am J Drug Alcohol Abuse.* 2021;47(2):229–237. doi:10.1080/00952990.2020.1841218
- McGuire AB, Powell KG, Treitler PC, et al. Emergency department-based peer support for opioid use disorder: emergent functions and forms. *J Subst Abuse Treat.* 2020;108:82–87. doi:10.1016/j.jsat.2019.06.013
- Fact Sheet: Biden-Harris Administration Announces New Actions and Funding to Address the Overdose Epidemic and Support Recovery. The White House; September 23, 2022. Accessed July 21, 2023. <https://www.whitehouse.gov/briefing-room/statements-releases/2022/09/23/fact-sheet-biden-harris-administration-announces-new-actions-and-funding-to-address-the-overdose-epidemic-and-support-recovery/>
- Hawk K, D'Onofrio G. Emergency department screening and interventions for substance use disorders. *Addict Sci Clin Pract.* 2018;13(1):18. doi:10.1186/s13722-018-0117-1
- Cowan E, Perrone J, Bernstein SL, et al. National Institute on Drug Abuse clinical trials network meeting report: advancing emergency department initiation of buprenorphine for opioid use disorder. *Ann Emerg Med.* 2023;82(3):326–335. doi:10.1016/j.annemergmed.2023.03.025
- Myrick K, Del Vecchio P. Peer support services in the behavioral healthcare workforce: state of the field. *Psychiatr Rehabil J.* 2016;39(3):197–203. doi:10.1037/prj0000188
- Davidson L, Chinman M, Kloos B, Weingarten R, Stayner D, Tebes JK. Peer support among individuals with severe mental illness: a review of the evidence. *Clin Psychol Sci Pract.* 1999;6(2):165–187. doi:10.1093/clipsy.6.2.165
- Kelly JF, Greene MC, Bergman BG. Recovery benefits of the “therapeutic alliance” among 12-step mutual-help organization attendees and their sponsors. *Drug Alcohol Depend.* 2016;162:64–71. doi:10.1016/j.drugalcdep.2016.02.028
- Bassuk EL, Hanson J, Greene RN, Richard M, Laudet A. Peer-delivered recovery support services for addictions in the United States: a systematic review. *J Subst Abuse Treat.* 2016;63:1–9. doi:10.1016/j.jsat.2016.01.003
- Eddie D, Hoffman L, Vilsaint C, et al. Lived experience in new models of care for substance use disorder: a systematic review of peer recovery support services and recovery coaching. *Front Psychol.* 2019;10:1052. doi:10.3389/fpsyg.2019.01052
- Martin A, Butler K, Chavez T, et al. Beyond buprenorphine: models of follow-up care for opioid use disorder in the emergency department. *West J Emerg Med.* 2020;21(6):257–263. doi:10.5811/westjem.2020.7.46079
- Sokol R, Tammara E, Kim JY, Stopka TJ. Linking matters: barriers and facilitators to implementing emergency department-initiated buprenorphine-naloxone in patients with opioid use disorder and linkage to long-term care. *Subst Use Misuse.* 2021;56(7):1045–1053. doi:10.1080/10826084.2021.1906280
- Hawk K, McCormack R, Edelman EJ, et al. Perspectives about emergency department care encounters among adults with opioid use disorder. *JAMA Netw Open.* 2022;5(1):e2144955. doi:10.1001/jamanetworkopen.2021.44955
- Collins AB, Baird J, Nimaja E, Ashenafi Y, Clark MA, Beaudoin FL. Experiences of patients at high risk of opioid overdose accessing emergency department and behavioral health interventions: a qualitative analysis in an urban emergency department. *BMC Health Serv Res.* 2023;23(1):370. doi:10.1186/s12913-023-09387-7
- Langabeer JR, Champagne-Langabeer T, Yatsco AJ, et al. Feasibility and outcomes from an integrated bridge treatment program for opioid use disorder. *J Am Coll Emerg Physicians Open.* 2021;2(2):e12417. doi:10.1002/emp2.12417
- Hawk K, Glick R, Jey A, et al. Emergency medicine research priorities for early intervention for substance use disorders. *West J Emerg Med.* 2019;20(2):386–392. doi:10.5811/westjem.2019.1.39261
- Stanojlović M, Davidson L. Targeting the barriers in the substance use disorder continuum of care with peer recovery support. *Subst Abuse Res Treat.* 2021;15:117822182097698. doi:10.1177/1178221820976988
- Stack E, Hildebran C, Leichtling G, et al. Peer recovery support services across the continuum: in community, hospital, corrections, and treatment and recovery agency settings—a narrative review. *J Addict Med.* 2022;16(1):93–100. doi:10.1097/ADM.0000000000000810

21. Stewart MT, Coulibaly N, Schwartz D, Dey J, Thomas CP. Emergency department-based efforts to offer medication treatment for opioid use disorder: what can we learn from current approaches? *J Subst Abuse Treat*. 2021;129:108479. doi:10.1016/j.jsat.2021.108479
22. Duber HC, Barata IA, Cioè-Peña E, et al. Identification, management, and transition of care for patients with opioid use disorder in the emergency department. *Ann Emerg Med*. 2018;72(4):420-431. doi:10.1016/j.annemergmed.2018.04.007
23. Macias-Konstantopoulos W, Heins A, Sachs CJ, Whiteman PJ, Wingkun NJG, Riviello RJ. Between emergency department visits: the role of harm reduction programs in mitigating the harms associated with injection drug use. *Ann Emerg Med*. 2021;77(5):479-492. doi:10.1016/j.annemergmed.2020.11.008
24. Francia L, Berg A, Lam T, Morgan K, Nielsen S. "The peer workers, they get it"—how lived experience expertise strengthens therapeutic alliances and alcohol and other drug treatment-seeking in the hospital setting. *Addict Res Theory*. 2023;31(2):106-113. doi:10.1080/16066359.2022.2124245
25. Lennox R, Lamarche L, O'Shea T. Peer support workers as a bridge: a qualitative study exploring the role of peer support workers in the care of people who use drugs during and after hospitalization. *Harm Reduct J*. 2021;18(1):19. doi:10.1186/s12954-021-00467-7
26. Bilello LA, Bull KL, Gautam S, Pomm R. Project save lives: rapid treatment protocol using peer recovery specialists in the emergency department. *J Addict Med Ther Sci*. 2020;6(1):052-057. doi:10.17352/2455-3484.000038
27. Welch AE, Jeffers A, Allen B, Paone D, Kunins HV. Relay: a peer-delivered emergency department-based response to nonfatal opioid overdose. *Am J Public Health*. 2019;109(10):1392-1395. doi:10.2105/AJPH.2019.305202
28. Waye KM, Goyer J, Dettor D, et al. Implementing peer recovery services for overdose prevention in Rhode Island: an examination of two outreach-based approaches. *Addict Behav*. 2019;89:85-91. doi:10.1016/j.addbeh.2018.09.027
29. Walter LA, Li L, Rodgers JB, et al. Development of an emergency department-based intervention to expand access to medications for opioid use disorder in a Medicaid nonexpansion setting: protocol for engagement and community collaboration. *JMIR Res Protoc*. 2021;10(4):e18734. doi:10.2196/18734
30. Bogan C, Jennings L, Haynes L, et al. Implementation of emergency department-initiated buprenorphine for opioid use disorder in a rural southern state. *J Subst Abuse Treat*. 2020;112:73-78. doi:10.1016/j.jsat.2020.02.007
31. Powell KG, Treitler P, Peterson NA, Borys S, Hallcom D. Promoting opioid overdose prevention and recovery: an exploratory study of an innovative intervention model to address opioid abuse. *Int J Drug Policy*. 2019;64:21-29. doi:10.1016/j.drugpo.2018.12.004
32. Beaudoin FL, Jacka BP, Li Y, et al. Effect of a peer-led behavioral intervention for emergency department patients at high risk of fatal opioid overdose: a randomized clinical trial. *JAMA Netw Open*. 2022;5(8):e2225582. doi:10.1001/jamanetworkopen.2022.25582
33. Dahlem CHG, Scalera M, Anderson G, et al. Recovery opioid overdose team (ROOT) pilot program evaluation: a community-wide post-overdose response strategy. *Subst Abuse*. 2021;42(4):423-427. doi:10.1080/08897077.2020.1847239
34. Samuels EA, Baird J, Yang E, Mello MJ. Adoption and utilization of an emergency department naloxone distribution and peer recovery coach consultation program. *Acad Emerg Med*. 2018;26(2):160-173. doi:10.1111/acem.13545
35. D'Onofrio G, Degutis LC. Integrating project ASSERT: a screening, intervention, and referral to treatment program for unhealthy alcohol and drug use into an urban emergency department. *Acad Emerg Med*. 2010;17(8):903-911. doi:10.1111/j.1553-2712.2010.00824.x
36. Bernstein E, Bernstein J, Levenson S. Project ASSERT: an ed-based intervention to increase access to primary care, preventive services, and the substance abuse treatment system. *Ann Emerg Med*. 1997;30(2):181-189. doi:10.1016/S0196-0644(97)70140-9
37. Watson DP, Weathers T, McGuire A, et al. Evaluation of an emergency department-based opioid overdose survivor intervention: difference-in-difference analysis of electronic health record data to assess key outcomes. *Drug Alcohol Depend*. 2021;221:108595. doi:10.1016/j.drugalcdep.2021.108595
38. Scott CK, Dennis ML, Grella CE, et al. Findings from the recovery initiation and management after overdose (RIMO) pilot study experiment. *J Subst Abuse Treat*. 2020;108:65-74. doi:10.1016/j.jsat.2019.08.004
39. Blondell RD, Behrens T, Smith SJ, Greene BJ, Servoss TJ. Peer support during inpatient detoxification and aftercare outcomes. *Addict Disord Their Treat*. 2008;7(2):77-86. doi:10.1097/ADT.0b013e31804eff1b
40. Philadelphia Department of Behavioral Health and Intellectual Disabilities Services and Achara Consulting Inc. *Peer Support Toolkit*. 2017. https://dbhids.org/wp-content/uploads/1970/01/PCCI_Peer-Support-Toolkit.pdf
41. Jennings LK, Lane S, McCauley J, et al. Retention in treatment after emergency department-initiated buprenorphine. *J Emerg Med*. 2021;61(3):211-221. doi:10.1016/j.jemermed.2021.04.007
42. Wagner KD, Oman RF, Smith KP, et al. "Another tool for the tool box? I'll take it!": feasibility and acceptability of mobile recovery outreach teams (MROT) for opioid overdose patients in the emergency room. *J Subst Abuse Treat*. 2020;108:95-103. doi:10.1016/j.jsat.2019.04.011
43. Byrne KA, Roth PJ, Merchant K, et al. Inpatient link to peer recovery coaching: results from a pilot randomized control trial. *Drug Alcohol Depend*. 2020;215:108234. doi:10.1016/j.drugalcdep.2020.108234
44. Cupp JA, Byrne KA, Herbert K, Roth PJ. Acute care utilization after recovery coaching linkage during substance-related inpatient admission: results of two randomized controlled trials. *J Gen Intern Med*. 2022;37(11):2768-2776. doi:10.1007/s11606-021-07360-w
45. Gertner AK, Roberts KE, Bowen G, Pearson BL, Jordan R. Universal screening for substance use by peer support specialists in the emergency department is a pathway to buprenorphine treatment. *Addict Behav Rep*. 2021;14:100378. doi:10.1016/j.abrep.2021.100378
46. Watson DP, Staton MD, Gastala N. Identifying unique barriers to implementing rural emergency department-based peer services for opioid use disorder through qualitative comparison with urban sites. *Addict Sci Clin Pract*. 2022;17(1):41. doi:10.1186/s13722-022-00324-3
47. *Epic Dot Phrases for Substance Use Navigators*. Bridge to Treatment. Accessed July 21, 2023. <https://bridgetotreatment.org/resource/epic-dot-phrases-suns/>
48. Collins D, Alla J, Nicolaidis C, et al. "If it wasn't for him, I wouldn't have talked to them": Qualitative study of addiction peer mentorship in the hospital. *J Gen Intern Med*. 2019. doi:10.1007/s11606-019-05311-0
49. Englander H, Gregg J, Gullickson J, et al. Recommendations for integrating peer mentors in hospital-based addiction care. *Subst Abuse*. 2020;41(4):419-424. doi:10.1080/08897077.2019.1635968
50. Crisanti AS, Earheart J, Deissinger M, Lowerre K, Salvador JG. Implementation challenges and recommendations for employing peer support workers in emergency departments to support patients presenting after an opioid-related overdose. *Int J Environ Res Public Health*. 2022;19(9):5276. doi:10.3390/ijerph19095276
51. Kauffman E, Qiu Y, Frey JA, Bischof JJ. Barriers and facilitators to peer support services for patients with opioid use disorder in the emergency department. *Cureus*. 2022;14(3):e23145. doi:10.7759/cureus.23145
52. Whiteside LK, D'Onofrio G, Fiellin DA, et al. Models for implementing emergency department-initiated buprenorphine with referral for ongoing medication treatment at emergency department discharge in diverse academic centers. *Ann Emerg Med*. 2022;80(5):410-419. doi:10.1016/j.annemergmed.2022.05.010
53. Thomas CP, Stewart MT, Tschampel C, Sennaar K, Schwartz D, Dey J. Emergency department interventions for opioid use disorder:

- a synthesis of emerging models. *J Subst Abuse Treat*. 2022;141:108837. doi:10.1016/j.jsat.2022.108837
54. Bergman BG, Ashford RD, Kelly JF. Attitudes toward opioid use disorder medications: results from a U.S. national study of individuals who resolved a substance use problem. *Exp Clin Psychopharmacol*. 2020;28(4):449-461. doi:10.1037/pha0000325
 55. Gryczynski J, Nordeck CD, Welsh C, Mitchell SG, O'Grady KE, Schwartz RP. Preventing hospital readmission for patients with comorbid substance use disorder: a randomized trial. *Ann Intern Med*. 2021;174(7):899-909. doi:10.7326/M20-5475
 56. Wakeman SE, Rigotti NA, Herman GE, et al. The effectiveness of post-discharge navigation added to an inpatient addiction consultation for patients with substance use disorder; a randomized controlled trial. *Subst Abuse*. 2021;42(4):646-653. doi:10.1080/08897077.2020.1809608
 57. *Peer Recovery—Talking Circle*. Indian Country ECHO. Accessed July 21, 2023. <https://www.indiancountryecho.org/event/peer-recovery-4th-wednesday-2022-06-22/2023-05-24/>
 58. Staton MD, Watson DP, Thorpe D. Implementation of peer recovery coach services for opioid overdose patients in emergency departments in Indiana: findings from an informal learning collaborative of stakeholders. *Transl Behav Med*. 2021;11(10):1803-1813. doi:10.1093/tbm/ibab031
 59. Incze MA, Sehgal SL, Hansen A, Garcia L, Stolebarger L. Evaluation of a primary care-based multidisciplinary transition clinic for patients newly initiated on buprenorphine in the emergency department. *Subst Abuse*. 2023;44(3):220-225. doi:10.1177/08897077231188592
 60. Snyder H, Kalmin MM, Moulin A, et al. Rapid adoption of low-threshold buprenorphine treatment at California emergency departments participating in the CA bridge program. *Ann Emerg Med*. 2021;78(6):759-772. doi:10.1016/j.annemergmed.2021.05.024
 61. McCarty D, Rieckmann T, Baker RL, McConnell KJ. The perceived impact of 42 CFR Part 2 on coordination and integration of care: a qualitative analysis. *Psychiatr Serv*. 2017;68(3):245-249. doi:10.1176/appi.ps.201600138
 62. *Fact Sheet: SAMHSA 42 CFR Part 2 Revised Rule*. July 13, 2020. Accessed February 27, 2024. <https://www.samhsa.gov/newsroom/press-announcements/202007131330>
 63. *Substance Use Navigator Frequently Asked Questions*. Bridge to Treatment. Accessed February 27, 2024. <https://bridgetotreatment.org/resource/substance-use-navigator-frequently-asked-questions/>
 64. Kennedy S, Sheets L. *Medicaid Delivery System Reforms to Combat the Opioid Crisis*. March 2021. https://academyhealth.org/sites/default/files/publication/%5Bfield_date%3Acustom%3AY%5D-%5Bfield_date%3Acustom%3Am%5D/mmf_innovative-delivery_brief_7.pdf
 65. US Government. *Substance Use Disorder: Medicaid Coverage of Peer Support Services for Adults*. August 2020. <https://www.gao.gov/assets/gao-20-616.pdf>
 66. *Medicaid Behavioral Health Services: Peer Support Services*. KFF. Accessed August 28, 2023. <https://www.kff.org/other/state-indicator/medicaid-behavioral-health-services-peer-support-services/>
 67. Davis J. *The New Medicare Add-on Code for Medication-Assisted Treatment in the Emergency Department—Got Questions? ACEP's Got Answers*. February 11, 2021. Accessed February 27, 2024. <https://www.acep.org/federal-advocacy/federal-advocacy-overview/regs--eggs/regs--eggs-articles/regs--eggs-february-11-2021>
 68. Watson DP, Tillson M, Taylor L, et al. Results from the POINT pragmatic randomized trial: an emergency department-based peer support specialist intervention to increase opioid use disorder treatment linkage and reduce recurrent overdose. *Subst Use Amp Addict J*. 2024;45(3):378-389. doi:10.1177/29767342231221054
 69. Herring AA, Rosen AD, Samuels EA, et al. Emergency department access to buprenorphine for opioid use disorder. *JAMA Netw Open*. 2024;7(1):e2353771. doi:10.1001/jamanetworkopen.2023.53771
 70. Webb CP, Huecker M, Shreffler J, McKinley BS, Khan AM, Shaw I. Racial disparities in linkage to care among patients with substance use disorders. *J Subst Abuse Treat*. 2022;137:108691. doi:10.1016/j.jsat.2021.108691
 71. Kelley A, Bingham D, Brown E, Pepion L. Assessing the impact of American Indian peer recovery support on substance use and health. *J Groups Addict Recovery*. 2017;12(4):296-308. doi:10.1080/1556035X.2017.1337531
 72. *Peer Support Workers for those in Recovery*. Substance Abuse and Mental Health Services Administration. Accessed July 21, 2023. <https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers>
 73. Southern Plains Tribal Health Board. *Peer Support Toolkit*. October 15, 2020. Accessed July 21, 2023. https://issuu.com/spthb/docs/peer_support_toolkit_booklet
 74. Hendry P, Hill T, Rosenthal H. *Peer Services Toolkit: A Guide to Advancing and Implementing Peer-run Behavioral Health Services*. December 31, 2014. https://mhanational.org/sites/default/files/Peer_Services_Toolkit%204-2015.pdf
 75. *Substance Use Navigation Toolkit*. September 2022. Accessed July 21, 2023. <https://1k48f5.p3cdn1.secureserver.net/wp-content/uploads/CA-BRIDGE-TOOLKIT-CA-Bridge-Navigation-Toolkit-December-2022.pdf>
 76. Treitler P, Crystal S, Cantor J, et al. Emergency department peer support program and patient outcomes after opioid overdose. *JAMA Netw Open*. 2024;7(3):e243614. doi:10.1001/jamanetworkopen.2024.3614
 77. Samuels EA, Bernstein SL, Marshall BDL, Krieger M, Baird J, Mello MJ. Peer navigation and take-home naloxone for opioid overdose emergency department patients: preliminary patient outcomes. *J Subst Abuse Treat*. 2018;94:29-34. doi:10.1016/j.jsat.2018.07.013

How to cite this article: Jack HE, Arif S, Moore MA, et al. Peer support for patients with opioid use disorder in the emergency department: A narrative review. *JACEP Open*. 2024;e13253. <https://doi.org/10.1002/emp2.13253>