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Emergency department-based peer support for opioid use disorder: Emergent functions and forms

Alan B. McGuire^{a,b,*}, Kristen Gilmore Powell^c, Peter C. Treitler^d, Karla D. Wagner^e, Krysti P. Smith^e, Nina Cooperman^f, Lisa Robinson^g, Jessica Carter^{a,b}, Bradley Ray^h, Dennis P. Watson^g

^a Richard L. Roudebush VAMC, 1481 W. 10th St. (11H) Rm. C8108, Indianapolis, IN, 46202 United States

^b IUPUI Dept. of Psychology, Indianapolis, IN, United States

^c Center for Prevention Science, Northeast & Caribbean Prevention Technology Transfer Center, School of Social Work, Rutgers University, New Brunswick, NJ, United States

^d Center for Prevention Science, School of Social Work, Rutgers University, New Brunswick, NJ, United States

^e School of Community Health Sciences, University of Nevada, Reno, 1664 N. Virginia St. MC 0274, Reno, NV 89557, United States

^f Division of Addiction Psychiatry, Robert Wood Johnson Medical School, 317 George Street, Suite 105, New Brunswick, NJ 08502, United States

^g Center for Dissemination and Implementation Science, Department of Medicine, College of Medicine, University of Illinois at Chicago, 818 S. Wolcott, Chicago, IL 60612, United States

^h Center for Health and Justice Research, Public Policy Institute, School of Public and Environmental Affairs, Indiana University-Purdue University Indianapolis, 334 N. Senate Ave, Indianapolis, IN 46204, United States

ABSTRACT

Emergency department (ED)-based peer support programs aimed at linking persons with opioid use disorder (OUD) to medication for addiction treatment and other recovery services are a promising approach to addressing the opioid crisis. This brief report draws on experiences from three states' experience with such programs funded by the SAMHSA Opioid State Targeted Repose (STR) grants. Core functions of such programs include: Integration of peer supports in EDs; Alerting peers of eligible patients and making the patient aware of peer services; and connecting patients with recovery services. Qualitative data were analyzed using a general inductive approach conducted in 3 steps in order to identify forms utilized to fulfill these functions. Peer integration differed in terms of peer's physical location and who hired and supervised peers. Peers often depend on ED staff to alert them to potential patients while people other than the peers often first introduce potential patients to programming. Programs generally schedule initial appointments for recovery services for patients, but some programs provide a range of other services aimed at supporting participation in recovery services. Future effectiveness evaluations of ED-based peer support programs for OUD should consistently report on forms used to fulfill core functions.

1. Introduction

Authorized as part of the 21st Century Cures Act to combat the opioid epidemic, State Targeted Response (STR) funds in six states are supporting the integration of peer support services within emergency departments (EDs), with peers in this context referring to persons who have lived experience in substance use disorder recovery. The adoption of ED-based peer services is a phenomenon that is happening beyond the context of STR funding and precedes evidence of effectiveness or model clarity (i.e., what works) for such approaches. However, there is rationale for ED-based programs for opioid use disorders (OUD)—e.g., the experience of non-fatal opioid overdose substantially elevates risk for overdose-related death (Stoove, Dietze, & Jolley, 2009) and the ED may represent a rare encounter with the healthcare system for a population who are irregular users of primary care. Moreover, there is

rationale for the use of peers to engage people with opioid use disorder (PWOUD). Peers more effectively engage persons with severe mental illness (Wright-Berryman, McGuire, & Salyers, 2011) and previous research has linked peer-provided supports with positive outcomes such as reduced hospitalization and criminal recidivism and increased adherence to treatment (Injecting, Australian, and Illicit Drug User League, 2003; Souleymanov et al., 2016; White & Kurtz, 2009).

Given the above rationale, ED-based peer recovery supports for OUD can be considered a promising practice. Nonetheless, existing literature on such programs has focused primarily on feasibility, determinants of implementation, or early-stage service outcomes (Dwyer et al., 2015; Powell, Treitler, Peterson, Borys, & Hallcom, 2019; Richardson & Rosenburg, 2019; Samuels et al., 2018; Samuels, Baird, Yang, & Mello, 2018; Waye et al., 2019). From what can be gathered from these articles, there is wide variation of scope among programs, ranging from

* Corresponding author at: Richard L. Roudebush VAMC, 1481 W. 10th St. (11H) Rm. C8108, Indianapolis, IN, 46202 United States
E-mail address: Alan.McGuire@va.gov (A.B. McGuire).

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simple naloxone distribution and education to intensive follow-up by peers to connect patients to long-term treatment. If the literature on ED-based peers continues in this manner, conclusions from disparate program models may be inaccurately combined under one heading.

However, while a cautious, linear approach based in a research-to-practice paradigm might seem prudent, it fails to match the realities in the field. The rate of opioid-related overdose deaths in the United States has grown exponentially in recent years (Jalal et al., 2018). Accordingly, the Government has spent significant amounts of funding to support programming (Centers for Disease Control and Prevention, Prevention for States, 2017; HHS, SAMHSA to Maintain Funding, 2017; State Targeted Response to the Opioid Crisis Grants, 2017). Given the urgency of the opioid crisis and availability of funding to support program implementation, it is unrealistic to expect localities will wait for more rigorous research before implementing promising practices. Instead, proactive efforts to describe program models, including key differences among programs of this type, may better organize and direct knowledge acquisition and use.

Model clarification is one of many putative factors that might affect dissemination and implementation of promising practices (Damschroder et al., 2009). Differences regarding which specific elements of a model are used across programs can affect the degree to which outcomes can be compared and may be used to explain variation in observed outcomes (Bond, Evans, Salyers, Williams, & Kim, 2000). Jolles, Lengnick-Hall, and Mittman (2019) demonstrated a pioneering way to organize and understand knowledge pertinent to complex interventions that focuses first on clarifying *core functions* of a program and then enumerating specific *forms*- activities or strategies- that can be tailored to local settings. They suggest such an approach is appropriate for a “flexible multicomponent model implemented within heterogeneous and dynamic settings that continuously reshape the intervention before and during implementation” (Jolles et al., 2019, Page 2).

Consistent with Jolles and colleagues' approach (Jolles et al., 2019), our team sought to identify core functions of ED-based peer programs for OUD and provide real-life examples of forms taken in settings implementing such programs. To this end, we convened researchers studying STR-funded ED-based peer services for OUD from three states. These teams provide a valuable perspective as they have close access to a wide variety of ED-based peer recovery support programs. Additionally, each team was engaged in some form of data collection regarding the programs in their states and while the lack of uniformity may preclude drawing conclusions about the prevalence or effectiveness of particular model types, these data could be combined to provide a broad picture of the various ways programs are attempting to fulfill their core functions. Analogous to Jolles and colleagues “top-down” approach (Jolles et al., 2019), this work developed from conversations among three of the authors (KW, NAC, and DPW), as they engaged in discussions regarding research they were conducting that aimed to leverage opportunities to conduct rigorous research on linkage to evidence-based treatment through opportunities made available by STR funding. These researchers' projects aimed to assess effectiveness of STR-funded ED-based peer recovery support programs in the states of Nevada, New Jersey, and Indiana, respectively. Early in these discussions, the researchers identified key overlaps and divergences in implementation occurring in each state, which generated an interest in explicitly clarifying the scope of programs subsumed within “ED-based peer recovery support” programs. Accordant with Jolles and colleagues' “bottom-up” approach (Jolles et al., 2019), they then invited additional researchers to the table who were working on the Substance Abuse and Mental Health Services Administration (SAMHSA)-funded evaluations of STR activities within their states. This larger group used program-level data to chart key programmatic elements (forms). These two approaches converged on the following key functions of ED-based peer recovery support programs: 1) Integration of peers into EDs; 2) Identifying and linking PWOUDs with peer recovery support; and 3) Connecting PWOUDs to recovery services. In the current paper we describe

the diversity of forms used by programs within participating states to accomplish these core functions.

2. Methods

2.1. Settings

Our data reflect 22 separate programs from three states—New Jersey ($n = 10$ programs), Nevada ($n = 2$ programs), and Indiana ($n = 10$ programs)—funded to implement ED-based peer recovery support programs as part of their state's STR activities. Programs serve rural ($n = 4$; 18.2%), urban/suburban ($n = 11$; 50.0%), and a mix of rural and urban/suburban ($n = 7$; 31.8%) communities. Each program is composed of one or multiple hospital EDs, with the number of EDs that are served by a given program ranging from 1 to 17 (mean = 2.9; std. dev. = 3.6). Each state differed in the specific mandate guiding program implementation, as described briefly below.

2.1.1. Indiana

The Indiana Recovery Coach and Peer Support Initiative (RCS) was started with STR funding. It was based on an Indianapolis hospital's quality improvement initiative/pilot that was employing peers to help link overdose patients to treatment, as well as literature describing the early efforts an ED-based peer program in Rhode Island (Waye et al., 2019). Patients were targeted for services if they were admitted to the ED and were identified as having an opioid-related issue by ED staff. To qualify as a peer, persons had to either be a state certified peer recovery coach with: 1) lived experience in substance use disorder recovery or 2) be a family member of someone with a substance use disorder (SUD).

2.1.2. Nevada

A large component of Nevada's STR response was to create Integrated Opioid Treatment and Recovery Centers based on the hub and spoke model. In addition to having a brick and mortar property, the recovery centers were required to provide mobile recovery units to conduct services such as outreach and engagement. The goals of the mobile teams included increased rates of identification, initiation, and engagement in treatment, reduction in opioid related overdose deaths, reduced utilization of emergency departments through improved access to continuum care service, and fewer hospital readmissions where readmission is preventable and medically inappropriate. Patients targeted for services included those presenting in the ED with opioid overdose and anyone presenting with a primary or secondary diagnosis of opioid use disorder. All peers have lived experience in recovery from substance use; each recovery center has internal requirements for the peers to receive certification through Foundation for Recovery or the International Certification & Reciprocity Consortium.

2.1.3. New Jersey

New Jersey's initiative was first implemented in NJ in 2016 to address the gap between naloxone administration and OUD treatment admissions, after the state found that very few individuals with OUD were admitted to treatment within 30 days of naloxone administration. The OORP existed in 11 NJ counties prior to Opioid-STR but was expanded to the remaining 10 counties using Opioid-STR funding. Patients targeted for services were individuals who overdosed on an opioid, were administered naloxone, and were then transported to the ED. Peers have at least two years of either 1) lived experience in recovery or 2) experience with a family member or loved one in recovery. The educational requirement is to have a high school diploma or equivalency, with an associate's degree preferred. Peers are required to attend 18 h (3 days) of ethics training which includes peer role functions, competencies, responsibilities and orientation to other statewide treatment initiatives.

2.2. Procedures

Qualitative data were collected by researchers in each state: these data were collected between February 2018 and January 2019. New Jersey data included field notes; 15 semi-structured interviews with patient navigators, program directors, and clinic directors (ED, behavioral health); and focus groups with peer recovery specialists. Data were collected as part of an evaluation of a state-funded program, which was later expanded under STR funding. Indiana data ($n = 10$ semi-structured interviews with program administrators and champions) were collected as part of STR evaluation activities. Nevada's data (field notes from one year of observations) were collected as part of externally-funded pilot research aligned with STR activities. Data collection activities in each state were led by a doctoral-level researcher with assistance from trained graduate-level research assistants. Each state was in a different phase of implementation at the time data were collected. In New Jersey several programs were in full operation, while in Indiana and Nevada programs were piloting and planning implementation.

2.3. Analyses

Data were analyzed using a general inductive approach conducted in 3 steps (Thomas, 2006). The first step in this process involved the summarization of each state's data using a template developed by the First Author (AM) to collect information reflecting program components we had identified as important due to either (a) emphasis placed on them in discussion with STR-funded entities engaged in the evaluation or (b) notable variations in implementation across programs. While we were unaware at the time, the creation of the matrix based on the ongoing conversations outlined above roughly parallels Jolles et al. (2019) "top-down" process in identifying general functions. Second, we established a clear link between the data and objectives by entering the site summary information into a data matrix organized by our guiding questions. Third, we identified and solidified themes/patterns in the data as they pertained to each of the functions, thus identifying multiple forms (similar to Jolles et al. (2019) "bottom-up" process. This was accomplished through a conference call in which individual group members reflected on the information in the matrix, including critical differences across sites, emerging themes, and outstanding questions. Preliminary results were then triangulated by searching individual states' primary data for support and counter-examples.

3. Results

Below, we report on observed programmatic forms aimed at fulfilling each core function (Table A).

3.1. Core function 1: integration of peers into the ED

The means by which programs integrated peers into EDs differed along two, inter-related axes: (Bond et al., 2000) where peers are physically based and (Centers for Disease Control and Prevention, Prevention for States, 2017) where they were administratively housed (i.e., what department and/or organization hires and supervises peers). In terms of where peers are *physically based*, in rare cases they sat in the ED. For instance, in one New Jersey program peers occupied an office in the ED which was already reserved for the behavioral health team; peers were alerted before an overdose patient arrived and have the opportunity to respond immediately [Site 203]. For some programs, peers were located in the target hospital, but not in the ED. In still other programs peers are located off site. For instance, in one New Jersey program [Site 308] peers maintained their offices at a nearby treatment agency where they engaged in other recovery-based activities (e.g., the program's drop-in center) and traveled to the ED when they were notified an eligible patient had been admitted to the ED. Some programs

employed peers on a per diem basis; therefore, they had no physical office but were called/paged when a person with an opioid overdose was admitted to the ED and responded from wherever they were situated. Finally, one program in Indiana employed a telehealth model, where peers were situated in a centralized hub and communicated with patients via videoconference.

A similarity across all programs is that no peer programs were *administratively housed* within the ED. Instead, peers were either administratively positioned (a) in another department of the target hospital or (b) within a community agency outside of the hospital. When peers were administratively overseen in the hospital, the most typical hospital department providing oversight was behavioral health. When peers were administratively overseen outside the hospital, community entities (e.g., outpatient opioid recovery programs, community mental health centers, or other social service agencies) directly employed or contracted with the peers, and provided their services to the EDs as part of STR-funded activities. For instance, NV had two teams of peers housed in two community-based opioid treatment centers who responded to calls from six hospitals. The arrangements between the peers and the treatment centers also differed – in one case, peers were employed directly by the treatment center. In the other, the peers were employed by a non-profit agency and were contracted by the treatment agency to provide the ED-based services.

3.2. Core function 2: identifying and linking PWOUD with peer recovery support

The means by which this core function was accomplished by programs differed in two main ways: (Bond et al., 2000) how the peer was notified when a potentially eligible patient is admitted to the ED and (Centers for Disease Control and Prevention, Prevention for States, 2017) who made the patient aware of the availability of peer's services.

Our data reflect a wide range of mechanisms hospitals used to make peers *aware of an eligible patient's ED arrival*. In particular, sites differed as to whether peers are directly privy to admissions or someone else was required to make peers aware of a potential patient. Most programs required a referral, meaning an ED staff member notified the peer of a potential patient. ED staff members notified the peer through a pager, hotline number, global text message system, or direct phone call. In some cases, the notice-giver was a designated staff person occupying a specific ED role (e.g., charge nurse, social worker, or receptionist/clerk), in other cases any ED staff person was able to make the referral. For example, one New Jersey site alerted peers via a phone call from ED staff or the psychiatric emergency worker [Site 305]. To augment this referral process, hospitals in New Jersey implemented or planned to implement alerts in their electronic health record (EHR) that either automatically contact the peers or prompt the ED staff to make the referral when certain keywords are detected. In other cases, peers employed by the hospital were able to observe admissions directly through the EHR system without an intermediary referral.

As to how the *patient was first introduced to the availability of peer services*, in only a few programs were the peers the first person to introduce their services to patients. For instance, in one Indiana program peers scanned ED admissions for patients who might be eligible for their services [Site 203]. Notably, in this program, even though peers may have become aware of a potential patient before they receive an ED referral, the program still required an official doctor's order for the peer to enroll the patient into the program. In some Indiana EDs with a telehealth program, ED staff wheeled videoconferencing equipment into the patient's room as standard care regardless of patient interest; therefore, the telehealth peer was the first to introduce the program to the patient. However, in most programs, an ED staff member talked to the patient about peer services prior to contacting the peer. These programs often did not refer patients who declined and/or who the ED staff did not think were appropriate. Some programs have implemented standardized scripts for ED staff in order to provide consistent and

Table A

Core functions and forms of ED-based peer support programs for OUD.

Core Function 1: Integration of peers into the ED

Where are peers physically based?

- ED
- Target Hospital (Not ED)
- Community Agency
- No Office
- Telehealth

Where are peers administratively housed?

- Within another department of the hospital
- Within a community agency outside of the hospital

Core Function 2: identifying and linking PWODs with peer recovery support

How is the peer notified when a potentially eligible patient is admitted to the ED?

- Through a referral
- Designated staff person notifies peer
- Any ED staff person notifies peer
- EHR alerts peer
- ED staff are alerted by EHR to refer peer
- Admissions are directly observed through EHR

Who makes the patient aware of the availability of peer services?

- Peer
- Other (e.g., ED staff member)

Core Function 3: connecting PWODs to MAT and other recovery services

What approaches are taken to make the initial referral?

- Scheduling an initial appointment with a MAT provider
- Peers have relationship with MAT provider
- Peers are employed by same program as MAT provider
- MAT provider has walk in hours
- ED-initiated buprenorphine

What strategies are used to ensure patient engagement in treatment after the initial referral?

- Short-term communication to identify and reduce barriers to MAT engagement
- Assertive outreach
- Meet with patients in the community
- Offer/support transportation to appointments

Programs integrate peers into the ED. This integration may be facilitated by:

- physical integration** - where peers office/desk space resides and
- administrative integration**- what department/organization hires and supervises the peer.

Program identifies PWODs presenting to the ED, alerts the peer (if necessary), and makes the patient aware of peer support services.

The program connects the PWOD to OUD treatment of his choice and provides services aimed at reducing barriers to the PWOD engaging in treatment.

accurate program information.

3.3. Core function 3: connecting PWODs to MAT and other recovery services

A key goal of the STR-funded peer services in all three states was engaging patients with medication for addiction treatment (MAT) or other recovery services, per patient choice. Programs varied in terms of strategies for recovery service engagement, including (Bond et al., 2000) the approaches taken to make the initial referral and (Centers for Disease Control and Prevention, Prevention for States, 2017) strategies to ensure the patient's engagement in treatment after the initial referral.

The initial MAT referral was accomplished in different ways. In several programs, the peer or another member of the peer program was tasked with scheduling an initial appointment with a MAT provider. This referral was facilitated in some cases; for instance, some peers maintained a special relationship with MAT providers and/or were employed by the same program as the MAT provider. One MAT provider facilitated referrals through walk-in hours for program participants. Four programs in New Jersey [Site 301, Site 302, Site 306, Site 308] and one in Indiana [Site 205] had access to ED-initiated buprenorphine (i.e., a limited amount of buprenorphine prescribed before the patient leaves the hospital that is intended to last the patient until they can meet with another MAT provider). Some programs were planning to or had discussed providing a time-limited buprenorphine prescription (to provide relief from detoxification until an intake appointment with a MAT provider could be scheduled) before the patient left the ED, whether provided directly within the ED or by a different department within the hospital.

Programs also employed a variety of strategies to ensure the patient engaged in treatment after the referral was made, though all of them included some form of short-term communication to identify and

reduce barriers to MAT engagement. Such services may be provided by the peer or by another member of the program team. For some teams, peers or an associated patient navigator conducted assertive outreach, allowing the programs to maintain contact with patients for a period of time to ensure continued engagement with services. One program even met patients in the community, including in patients' homes, in order to maintain this contact and engagement. A large portion of programs also offered, or at least supported, transportation to appointments, using a program-owned vehicle, transportation vouchers, or a dedicated ride (via shuttle, ride-share, cab, etc.) to the initial MAT appointment. Other programs were going further by providing rides to any needed appointment or from the ED to transitional housing. Some programs provided case management and connected patients with a wide range of services to support their recovery, including housing, employment, insurance assistance, and mental healthcare.

4. Discussion

This report identifies three core functions of ED-based peer support programs for OUD and enumerates observed forms extant programs have utilized to fulfill these functions. Future research should report how target programs fulfill these core functions and the presence or absence of the particular forms enumerated here. Such work will facilitate empirically establishing the impact of these particular elements on implementation and effectiveness. Prior work in numerous areas has demonstrated the link between implementation fidelity and patient outcomes (Ehde, Dillworth, & Turner, 2014; Schoenwald, Chapman, Sheidow, & Carter, 2009; Stewart et al., 2015). The operationalization of critical elements is a first step in model definition, which in turn supports fidelity monitoring (Bond et al., 2000). Importantly, researchers should take care when comparing outcomes from trials using certain elements (e.g., direct peer referrals, embedded peers) to other

trials using ED-based peer programs without these elements.

Anecdotal evidence accrued by our team point toward factors that may influence the selection of particular programmatic forms and how this may impact workflow and effectiveness. The volume of patients presenting to an ED with OUD seemed to impact the programmatic form. For hospitals where the volume of overdose patients was high, locating peers in the ED made sense as a way to ensure response times were quick and few calls were missed. In some higher-volume hospitals, peers employed by outside behavioral health or substance abuse treatment organizations were given space within the EDs and/or were provided volunteer or other hospital credentials to facilitate access. However, for hospitals where the volume of overdose patients was low but the number of hospitals needing coverage and/or the physical distance between them was high, locating peers outside the hospital in a centralized location (and bolstering their coverage with telehealth) was a more viable solution. Hospital volume was also relevant in terms of administrative oversight. In hospitals where the frequency of overdose was relatively low, it was cost prohibitive for hospitals to employ peers directly and peers were more frequently employed by outside agencies.

The integration of peers into the ED subsequently affected the burden on ED staff in linking patients with peers. Many programs require active measures by ED staff to connect potential patients with peer recovery support providers. This may hamper enrollment (and, indeed, several programs reported revising initial models due to low enrollment). Prior research highlights the importance of a new program's fit within a setting's existing workflow and processes (Damschroder et al., 2009; May & Finch, 2009). Programs that require multiple, active steps provide additional opportunities for referrals to be missed or lost and for longer delays between the patient presenting and being seen by a peer. Additional duties may be particularly unfeasible for busy ED staff. Finally, placing others between peers and patients obviates a central justification for utilizing peers—peers' potential advantage in engaging patients with opioid use disorder. Peers have been theorized to be uniquely positioned to engage hard-to-reach populations based on their shared experience; to this end, prior research in intensive case management demonstrated patient engagement as the key advantage of the inclusion of peer providers on case management teams (Wright-Berryman et al., 2011).

The effectiveness of ED-based peer support programs for OUD may ultimately be limited by the availability of effective OUD treatments, particularly MAT. Indeed, in our sample, MAT availability varied. In one case, there were no MAT providers in the county. Additionally, while naltrexone was more readily available, methadone and buprenorphine were often unavailable locally. This is consistent with prior research documenting limited availability of MAT (Jones, Campopiano, Baldwin, & McCance-Katz, 2015; Sharma et al., 2017), and is problematic considering prior research has shown most patients are not interested in naltrexone as an option (likely due to the need to go through detox before it is administered) (Di Paola et al., 2014; Lee et al., 2018). Finally, despite promising research (D'Onofrio et al., 2015), very few EDs served by our sample programs provided ED-initiated buprenorphine.

The current study is a preliminary report and its limitations should be recognized. First, data regarding these elements were not systematically collected for each program and varied within programs; therefore, no conclusions should be drawn regarding the overall prevalence of each program element. Moreover, although we chose to focus on three core functions and their associated forms, experience with these models in future settings may provide other important insights. While the programs examined present a broad swath of extant programs, they are not all of the ED-based programs functioning in the targeted states, let alone the nation.

Future research should remain open to describing and examining additional elements of ED-based peer support programs for opioid overdose survivors. As noted above, future work aimed at assessing ED-

based peer program's effectiveness should systematically track program elements so the association between element presence and outcomes can be examined. Such research will necessitate clear and consistent measurement of the implementation of such elements. Moreover, research should examine peer-level interactions in order to understand behaviors associated with better patient outcomes and define peer practice and competence. Finally, research should focus on the impact inner and outer context have on implementation of similar programs (Damschroder et al., 2009; Watson et al., 2018).

Declaration of Competing Interest

None to declare.

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