

Peer Support Workers in Emergency Departments: Engaging Individuals Surviving Opioid Overdoses – Qualitative Assessment

Overview

The Centers for Disease Control and Prevention (CDC) reports that from 1999 to 2015, the amount of prescription opioids dispensed in the U.S. nearly quadrupled, and the number of drug overdose deaths has never been higher. The majority of these deaths – more than 60% in 2016 – have involved opioids.ⁱ The current opioid epidemic has awakened communities and stakeholders, calling for innovative approaches to address substance use, misuse, and addiction.ⁱⁱ

Despite the need for prevention, treatment, and recovery services, nearly 80% of individuals with an opioid use disorder do not receive treatment of any type,ⁱⁱⁱ and only 41.2% of addiction treatment providers offer some type of FDA-approved medication to treat opioid use disorder (OUD).^{iv} Further, prevention and recovery services are often hard to access or nonexistent.

Emergency departments (EDs) have presented an opportunity to increase the provision of addiction-related services, particularly for individuals who have received overdose reversal treatment through the administration of naloxone. Hospitals and EDs are an ideal location to intervene with an individual who has just been revived from an opioid overdose, and immediately connect them with appropriate services and support, including medication-assisted treatment (MAT). Despite this, many EDs do not have the necessary workforce, expertise, or experience to effectively engage with the overdose survivor. Consequently, many individuals are released from care with little or no intervention or leave against medical advice. These instances present numerous missed opportunities, often resulting in a “revolving door,” in which the same individual returns to the ED for repeated overdose reversal treatments. This creates a cycle in which the individual leaves the hospital, returns to use, eventually overdoses, and often dies.

To address this gap, several recovery community organizations and programs are employing peer support workers* in emergency department settings to engage individuals surviving opioid overdoses. A growing body of evidence suggests that peer support workers can efficiently connect individuals suffering from opioid use disorder with proper treatment and recovery interventions, often to greater effect than primary care or clinical behavioral health staff.^v However, despite the growing evidence, little research or analysis has been conducted that codifies the best-practices for a peer support worker in an ED setting.

**For this issue brief, we will use the term peer support worker to refer to a provider with lived experiences that support the recovery and wellbeing of an individual. Other terms for this workforce include: peer recovery coach, peer recovery specialist, and peer support specialist.*

Evidence for Peer Interventions in ED Setting

There is a growing foundation of research that indicates the effectiveness of peer support services in improving a myriad of health and wellbeing outcomes.^{vi vii} A systematic review evaluating the use of peer support workers reported significant decreases in substance use and improved recovery capital (e.g., housing stability, self-care, independence, and health management) for individuals who used peer support services.^{viii} Research also points to an increased likelihood of abstinence among those exposed to peer support workers.^{ix} Further, studies examining effects of recovery coaching on recidivism rates in ex-offenders living with OUD show that those who work closely with a peer support worker are less likely to become repeat offenders compared to those who do not receive such services.^{x xi}

A key differentiating factor in the peer support worker role from other behavioral health positions is that the peer support worker operates from their own lived experience and experiential knowledge, supported by training and a mastering of competencies.^{xii} Peer support workers operate in the context of recovery, frequently utilizing language based upon common experience rather than clinical terminology, and person-centered relationships that foster strength-based recovery.^{xiii} These advantages that peer support workers bring to their work have been shown to have a range of favorable results for building trusting relationships.^{xiv xv xvi} Information provided in a peer-to-peer context may be viewed as more credible than that provided by mental health professionals.^{xvii} Additionally, when peers are part of hospital-based care, the results indicate shortened lengths of stays, decreased frequency of admissions, and a subsequent reduction in overall treatment costs for patients presenting with behavioral health issues.^{xviii} Other studies also suggest that the use of peer support can help reduce the overall need and use for behavioral health services over time.^{xix xx xxi}

While there is extensive evidence to support the efficacy of peer support services to improve recovery outcomes, because of the newness of peer support workers within emergency department settings, only moderate research exists that specifically identifies the effectiveness. Further, little evaluation has been conducted to indicate the most effective way to integrate and operationalize peer support workers within an emergency department setting. Despite this, the need for novel recovery engagement strategies in the wake of the current opioid epidemic has inspired many hospital systems into creating and embedding peer support programs of their own within their ED.

Qualitative Assessment

This issue brief highlights current and promising practices used to integrate peer support workers into ED settings. To understand the current practices and efforts underway to involve peer support workers in emergency department settings, the National Council conducted a cursory qualitative assessment involving an environmental scan and semi-structured interviews with pertinent stakeholders. The emphasis of this work is to understand the placement, role, and promising practices of peer support workers in ED settings that assist individuals who have been revived from an opioid overdose.

Structure of Analysis

Information gathered as part of the environmental scan was collected primarily utilizing online searches with a collection of key words such as: peer support workers, emergency department, emergency room, opioid overdose, recovery, and medication assisted treatment. Information was primarily gathered from grey literature sources. Along with information gathered as part of the environmental scan, individual and group interviews were conducted to ascertain information on program examples, promising practices, and common themes across programs.

The following individuals were interviewed

- ✚ Dr. Craig Allen, Chief of Psychiatry Midstate Medical Center/Medical Director Rushford/A Hartford Healthcare Partner (Connecticut)
- ✚ Kristen Aja, Project Director; Sarah Munro, Executive Director; Vermont Recovery Network
- ✚ Deb Dettor, Director, Anchor Recovery Community Center/Providence Center; George O’Toole, ED Manager, Anchor Recovery Community Center/Providence Center (Rhode Island)
- ✚ Michael Santillo, Executive Director; John Brooks Recovery Center (New Jersey)
- ✚ Eric McIntire, Lead Recovery Specialist, RWJ Barnabas Institute for Prevention (New Jersey)
- ✚ Dr. Terry Horton, Chief, Division of Addiction Medicine, Medical Director, Project Engage; Christiana Care Health Services (Delaware)
- ✚ Jennifer Chadukiewicz, Recovery Coach Program Manager, Connecticut Community for Addiction Recovery (CCAR)
- ✚ Todd Whitmore, Associate Professor, Co-Director, Department of Theology, University of Notre Dame (Indiana)
- ✚ Kimberly Miller, Mental Health America Indiana; Rebekah Gorrell, Mental Health America Indiana; Melissa Reyes, Eskenazi Health; Dennis Watson, Indiana University; Amy Brinkley, Indiana Family and Social Services Administration
- ✚ Tony Sanchez, Director, Office of Recovery Transformation, Georgia Department of Behavioral Health; Neil Campbell, Executive Director, Georgia Council on Substance Abuse; Owen Dougherty, Deputy Executive Director, Georgia Council on Substance Abuse

Prominent Interview Themes

Based on environmental scan research and interviews, the following themes have been identified as a sampling of promising practices:

Relationship Between Hospital and Recovery Community Organization

While some hospitals employ peer support workers directly, in most cases embedding peer support workers in the ER involves a collaboration between the hospital and a Recovery Community Organization (RCO) that employs, trains, organizes, and deploys the workers. A strong relationship and clear communication between the hospital and the RCO are critical elements to program success.

Often, a pre-existing relationship will exist between leadership at an RCO and a hospital, although the relationship may stem from members at any level of the organizations. This relationship – often informal – can be the basis and eventual conduit for establishing the peer support program. It can also serve to strengthen buy-in from other key stakeholders at both the RCO and hospital. In our interviews, several organizations highlighted this relationship as an instrumental component for the creation and eventual success of their program.

Following significant buy-in from leadership at both the RCO and hospital, the relationship becomes more formalized, involving of a memorandum of understanding (MOU) or contract, outlining the details of the peer support program. These details may specify such things as articulating a scope of work and expectations of peer providers, as well as which party is responsible for, training, establishing clearance requirements, employing and paying, and supervising for the peer support workers.

Case example: Opioid Overdose Recovery Program (OORP), New Jersey

The purpose of OORP is to respond to individuals reversed from opioid overdoses and treated at hospital emergency departments because of the reversal. OORP utilizes specially trained, part-time peer support workers to engage individuals reversed from an opioid overdose by providing non-clinical assistance, recovery supports, and appropriate referrals for assessment and treatment. OORP services are currently provided in 11 counties, with plans to expand to all 21 counties in New Jersey.

Each OORP in New Jersey is either led by a hospital, or an RCO that has an MOU with a hospital. Establishing an MOU between an RCO and a hospital can be difficult, particularly if a pre-existing relationship between these two organizations does not exist. Bureaucratic, legal barriers, and differing practices may inhibit the relationship. For example, one hospital required that all staff pass a criminal background check. This presented a potential barrier, as the RCO did not have this requirement for peer employment. Further, many peers have a criminal background that would exclude them from working in the ER. Support from administrators and organization leaders allowed the hospital and RCO to come to an agreement around hiring practices and amend their MOU.

ED Staff Understand the Value and Scope of Peer Support Services

Interviews with RCOs and hospitals revealed that training for ED staff was a major component of early implementation of the peer support program and was seen as a primary factor for overall program success and sustainability. It was underscored that ED staff, as well as all hospital staff, need to understand the role, scope, and value of the peer support worker. This can be an important component for encouraging teamwork, empowering ED staff to properly leverage the impact of peers to improve patient outcomes, and to mitigate potential bias and discrimination that ED staff may hold towards individuals with addiction.

Formal trainings and resources for ED staff can disseminate pertinent details about peer support workers and serve to empower both the peer worker as well as the ED staff. In-person trainings, research, articles, workflow structures, and group discussions can help ED staff understand the exact role and scope of peer workers, as well as the value that peers bring to patient care. This educational component can ensure that peer support workers are not asked to perform any duties that are outside of their scope or role (sometimes referred to as “cooptation”). Trainings and resources should be provided on a continual basis, particularly in the early stages of program development, to ensure that all staff across all ED shifts are given access to this information.

Training can also reinforce the realities of addiction as a chronic disorder and the possibility that recovery can happen for everyone. Many ED staff have encountered, even provided opioid overdose-reversing medication to, the same individual on multiple occasions. Because of this, they may have become and even disparaging towards people with addiction, with fault them for being “frequent flyers” and a drain on the system. RCOs, hospitals, EDs and peers themselves should support ED staff in helping them understand and contextualize preconceived notions, stigma, or biases that may be present within the ED setting and amongst staff.

A successful way to encourage staff buy-in and promote the value-add of peer workers has been to include peer support workers as part of daily/shift huddles. This has been helpful with ED staff to accept that peer workers as “part of the team,” encouraging ED staff to engage with peer workers on a personal and professional level. Additionally, peer support workers should be encouraged to report-out positive patient outcomes following discharges from the hospital, to help ED staff understand the peer role in achieving positive outcomes for patients

Case example: Georgia Council on Substance Abuse and Northeast Georgia Medical Center

In partnership with Northeast Georgia Medical Center (NGMC) and Georgia’s Department of Behavioral Health and Developmental Disabilities (DBHDD), Georgia Council on Substance Abuse (GCSA) provides peer support to individuals having experienced an opioid overdose or any substance use disorder related incident in NGMC’s three campus emergency departments in Gainesville, Braselton, and Winder. Since its inception this program, entitled CARES in the Emergency Department (CARES stands for Certified Addiction Recovery Empowerment Specialists), has also spread to Neonatal Intensive Care Units (NICUs) in NGMC’s hospitals located in Gainesville and Braselton.

After establishing formal relationships with both the state and NGMC, the Georgia Council on Substance Abuse focused on gaining ED staff buy-in, particularly amongst the nursing staff. GCSA hosted four listening sessions with nursing staff at the Northeast Georgia Medical Center, to present the program concept and solicit design feedback. Nurses were asked what kinds of support they needed when addressing addiction and overdose within the ED, and to identify what would help peer workers be successful in an ED setting. The Georgia Council on Substance Abuse also engaged with the medical center’s manager for behavioral health intake, who allowed GCSA staff to sit-in on nursing meetings. GCSA estimates that they have a very strong relationship with 75-80% of the medical center’s nurse managers, who utilize the peer support services.

Hiring Processes and Employment Requirements for Peer Support Workers

Employment requirements and hiring processes for peer support workers differ greatly due to a number of factors, such as state or county regulations, hospital rules and codes, and unique community factors. However, interviews with RCOs and hospitals revealed several hiring and employment decisions to be considered.

Employment requirements for peer support workers include specific training and certification requirements. State or local regulations often dictate which trainings/certifications are required (many states have their own certification) – in general, most trainings/certifications will include topics such as peer ethics, science of addiction, motivational interviewing, multiple pathways to recovery. Organizations looking to employ peer support workers should ensure that they are abiding by any state or local requirements for employment, particularly if peer support services are reimbursable by specific payers.

Another consideration for employment requirements is the criminal history of applicants. Individuals in recovery may have had previous interactions with criminal justice systems – for some, these interactions may have helped shape their recovery process. In most cases, applicants with criminal backgrounds are seen as assets in peer support programs, because the specificity of their lived experience is useful in engagement and relationship building. Organizations employing or hosting peer workers need to consider the impact that criminal background disqualification employment rules have on a potential peer support worker. Creative hiring structures, such as contracting with peer support workers for their services, may assist organizations that have strict rules in this regard.

Length of time in recovery is another factor that is often under consideration during the hiring process. Interviews with RCOs and hospitals revealed variation in recovery time requirements, from several months to four years (most required a minimum of two years). Most organizations decided upon such requirements after soliciting feedback for current peer support workers and members of the recovery community. Besides recovery time requirements, the interviews revealed other tips to consider in the hiring process, including: screening applicants to ensure “right fit” in the ED setting, having ED staff participate in the interview process, and the use of shadowing/on-the-job training prior to official start date.

Case example: Project POINT, Indiana

Project POINT, a partnership between Indianapolis Emergency Medical Services, Eskenazi Hospital’s emergency department, and Midtown Mental Health, provides peer recovery services to individuals who have experienced an opioid overdose. Project POINT has developed a hiring process to determine the most appropriate peer support workers for the job.

The process begins with a phone screening interview, followed by several in-person interviews, which are led by Project POINT staff. Then, applicants shadow a peer support worker to familiarize them with job requirements and work conditions. The shadowing process helps to predetermine a good fit, as work at Eskenazi can be chaotic, stressful, and trauma-activating.

Self-care is an important aspect for peer support workers and each hire is required to have their own wellness plan. Project POINT emphasizes recovery maintenance for their staff and offers additional supports, as needed.

Peer Support Workers in the Emergency Department: Workflows and Processes

Integrating peers into workflows and procedures vary considerably across workplace settings, depending on the size, scope, and demographics of the emergency department and surrounding community. Other factors, such as the structural settings under which peer workers are employed (e.g., full-time, per diem, on-call) and contractual requirements of a peer worker program (e.g., data-reporting requirements) can also dictate how peer workers are integrated into workflows and procedures.

Many of the interviews with RCOs and hospitals revealed that the precipitating event that initiates the involvement of a peer worker is most often an opioid overdose reversal using naloxone. However, there are other factors that initiate peer involvement, such as when a patient self-discloses use of substances or and has a positive blood screening. In many of the interviews, patient agreement and stabilization were discussed as workflow variables. As a patient-centered intervention, peer recovery support is never initiated until the patient explicitly agrees to meet with a peer support worker. In a similar fashion, peer recovery support should not begin until the patient has been physically stabilized. The simple fact that an individual has been brought into the ED means that they are in some form of crisis. A minimum of level of stabilization should be met before a peer support worker can safely and effectively engage with the patient.

This may be particularly true for individuals who have just been revived from an overdose as such individuals may be confused, embarrassed, frustrated, angry, or feeling unwell.

Also, many of the interviews emphasized the end goal and final workflow step of peer support within the ED, which may take a variety of forms. Some patients may choose to enter detox or treatment (medication or otherwise), while others may decline clinical help but agree to continue engagement with the peer or the RCO. It is important that peer workers, ED staff, the RCO and the hospital understand that the end goal is not *solely* to support patients into entering treatment. Much of peer services are rooted in the stages of change,^{xxii} and as such, are dictated by the patient’s readiness to begin, consider, or become more knowledgeable about a recovery pathway. In the spirit of meeting people where they are, the primary goal of any peer interaction is to establish a relationship with the patient and foster ongoing engagement, so that if and when that individual is ready to begin their chosen pathway to recovery, there is support and guidance available.

Case example: Project Engage and Christiana Care Health System, Delaware

Project Engage began in 2008 at Wilmington Hospital, and has since expanded to Christiana Hospital in 2011 and to the Emergency Departments at Christiana and Wilmington hospitals in 2013. Project Engage promotes early intervention and referral to substance use disorder treatment program, designed to help hospital patients who may be struggling with alcohol or drug use. The program integrates peer support workers (Engagement Specialists) into hospital settings. Meeting with patients at their bedside, Engagement Specialists inquire about their substance use, learn about the patient’s goals, and coordinate treatment options – when warranted – that support the patient’s needs. Project Engage at Christiana Hospital has distinct workflow components for engaging individuals in recovery support services:

Project Engage Pathway in the Emergency Room

Due to workforce constraints, ED staff often have limited opportunities for patient engagement than staff who work in an inpatient setting. Engagement Specialists are a vital part of the ED staff. Part of their role is to help identify patients that may have issues with substance use and engage accordingly. Engagement Specialists are available to assist the team within their scope of practice; in addition to waiting for case referrals, they can utilize the hospital’s electronic health record (EHR) to assist in identifying individuals who may be misusing substances.

Opioid Withdrawal and Pharmacologic Treatment Pathway

Patients that are identified as possibly having an opioid use disorder may be screened using the Opioid Withdrawal Risk Assessment (OWRA) and Clinical Opioid Withdrawal Scale (COWS). If clinically appropriate, patients can initiate treatment with Suboxone within the emergency room. Engagement Specialists may assist patients in making an informed decision about the use of MAT in their treatment and recovery. For patients that initiate MAT within Christiana Hospital, or are interested in engaging in Medication-Assisted Recovery (MAR) following discharge, Engagement Specialists are well equipped to connect patients with community partners.

Medication Assisted Treatment (MAT) and Recovery (MAR)

Medications used to treat opioid use disorder and support recovery are key elements in assisting many individuals in overcoming their addiction. Since emergency departments are currently experiencing a high rate of patients for opioid overdose reversal, they are proving to be a opportune places for these patients to initiate medication-assisted treatment. Additionally, a hospital setting presents a suitable environment in which to initiate patients to medications for treating OUD (a process that requires medical screening and oversight).

Peer support workers in ED settings should feel comfortable discussing the use of medications to treat addiction and support recovery. This is true regardless of whether or not the peer support worker has used medications to support their own recovery. Peer support workers should offer medications, while also discussing other alternative or additional supports. Most importantly, all approved medications to treat OUD should be discussed as an option with the patient – regardless of whether the medication is provided by the hospital or by another provider.

While it is ideal for hospitals to be able to offer MAT onsite, and within a reasonable time limit, some organizations interviewed mentioned that they did not offer MAT or were not able to do so in a reasonable time limit. With these potential limitations in mind, hospital staff, including peer support workers, should have strong relationships with community providers that do offer MAT and MAR supports. The nature of these relationships, and the ensuing referrals made to these providers, is critical. For instance, referrals should only be made to community providers that can see patients and provide medication in a timely manner. In lieu of this, the peer support worker should work with the patient to develop a plan of how they will access the services when they are available, and what supports are needed in the interim.

Case example: Hartford HealthCare, Connecticut

Hartford HealthCare employs peer support workers in several of their hospital emergency departments. Called recovery coaches, they are employed by the Connecticut Community for Addiction Recovery (CCAR), meet with patients within two hours of agreeing to peer support services.

For patients that are interested in beginning MAT/MAR, and are medically cleared to do so, many providers within Hartford HealthCare EDs are eligible to provide one or two of the approved medications (buprenorphine, which requires federal certification to prescribe, and naltrexone, which can be prescribed by any provider authorized to prescribe medications). Initiating patients to medication within the ED setting aligns with recent research that ED-initiated treatment for OUD results in increased engagement in treatment services after discharge. ^{xxiii xxiv}

For patients that initiate medication within the ED, and/or those that are interested in beginning treatment outside of the ED, the peer support workers play an important role in facilitating the continuation of treatment and recovery within the community. Peer support workers may be responsible for calling the patient to remind them of their treatment or recovery support appointments and, in some cases, are able to drive the individual to their appointments. This warm support is in-line with contractual obligations for the peer support workers – for patients that meet with a recovery coach while in the ED, the recovery coach is asked to connect with the individual at least ten times over the first two weeks following discharge.

Discussion for Replication and Expansion

The themes discussed above represent only some of the promising practices that RCOs and hospitals are utilizing to deploy peer support workers in ED settings. Other factors, such as funding and sustainability of peer support programs in EDs, will be highly contextualized to the unique community and organizations. It is recommended that any community interested in integrating peer support workers within emergency department settings should first begin a community scan and analysis to identify current infrastructure that prevents, treats, and supports recovery from addiction. The success of a peer support program in the ED setting may be dependent on availability of treatment and recovery capital in the community.

Communities and providers should also consider the current climate in healthcare – notably, the high levels of funding available to address the opioid epidemic and the emphasis on outcomes-based reimbursement. Many communities have leveraged federal and state grant and contract funding to establish and build out an ED-based peer support program. With the understanding that these funding sources may not be available in the future, states should consider other means of financial sustainability such as Medicaid 1115 waivers and State Plan Amendments. Additionally, as healthcare continues towards outcome-based reimbursement models, organizations should be mindful of the limited yet strong research that highlights many outcomes-based improvements that peer support programs offer.

Additionally, organizations and communities should consider the other domains of primary care in which peer support workers may assist in addressing issues related to addiction. For example, hospital inpatient units are a setting in which peer support workers can leverage their skillset and experience to assist individuals who are struggling with addiction but who may not have presented at the hospital due to an overdose. Project Engage and Christiana Health Care System have implemented such a program, in which patients that present with primary care concerns which may be indicative of substance misuse or addiction (e.g., endocarditis, cirrhosis of the liver) in the inpatient setting are linked to peer support workers.

Future of Peer Support Workers in Emergency Department

As communities continue to look for effective interventions to address the opioid epidemic, it is vital that systems are designed to include peer support services. To effectively engage individuals surviving an opioid overdose, the following should be considered:

1. Develop a set of best practices for the delivery of peer support services in emergency department settings to build the foundation of an evidence-base. This includes best practice of peer support delivery, hiring peer support workers, and implementing peer support programs.
2. Collect data on validated metrics that indicate the effectiveness of peer support workers across a number of domains, such as increasing client engagement in recovery services and community, reducing hospital recidivism, and increasing utilization of treatment services.
3. Create more efficient pathways between peer engagement and access to MAT. This includes reduction of wait-time for MAT providers and ideally the initiation of MAT within emergency department settings.

Special Thanks

A special thanks to the leaders and organizations that provided their time and insight as part of this issue brief.

For more information about the organizations interviewed in this issue brief:

[Anchor Recovery Community Center](#)

[Connecticut Community for Addiction Recovery \(CCAR\)](#)

[Georgia Council on Substance Abuse](#)

[Growth Works](#)

[Hartford HealthCare](#)

[Opioid Overdose Recovery Program \(OORP\), New Jersey](#)

[Opioid Overdose Recovery Program \(OORP\), RWJ Barnabus](#)

Project Point, Indiana – [Link 1](#), [Link 2](#), [Link 3](#)

[Project Engage, Christiana Care Health System](#)

[Vermont Recovery Network](#)

Endnotes

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Funding for this initiative was made possible (in part) by grant no. 5U79TI026556-03 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.