"It's Gonna be a Lifeline": Findings From Focus Group Research to Investigate What People Who Use Opioids Want From Peer-Based Postoverdose Interventions in the Emergency Department

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Study objective: Postoverdose interventions that deploy peer recovery support specialists to emergency departments (EDs) are a promising response to opioid overdoses among patients presenting in EDs. The objective of this study was to elicit patients' perspectives regarding the feasibility and acceptability of such an intervention and to ensure that their perspectives are represented in intervention design, implementation, and evaluation.

Method: In 2019 the study investigators conducted focus groups with people who use opioids to elicit perspectives about a postoverdose intervention delivered in the ED by using a semistructured interview guide that asked about feasibility, acceptability, perceived benefits, and concerns. Focus groups were digitally recorded, transcribed, and analyzed for emerging themes.

Results: Nine focus groups with 30 people who use opioids were conducted. Key findings that could improve feasibility and acceptability of the intervention include the following: the importance of balancing the urgency of seeing patients quickly with a need to accommodate the experience of precipitated withdrawal symptoms; the need to address privacy concerns; and the need to address concerns related to cost, insurance coverage, and sustainability. Perceived benefits of the intervention included the ability of the peer recovery support specialist to provide advocacy and support, serve as a model of hope and encouragement for behavior change, and fill key service gaps.

Conclusion: Postoverdose interventions in the ED provide the opportunity to integrate harm reduction–based interventions into traditional biomedical care facilities. These interventions can fill gaps in services and provide additional care and comfort for people who use opioids, but design, implementation, and evaluation should be informed by a patient-centered care perspective. [Ann Emerg Med. 2020;■:1-11.]

Please see page XX for the Editor's Capsule Summary of this article.

0196-0644/$-see front matter

https://doi.org/10.1016/j.annemergmed.2020.06.003

INTRODUCTION

Background

The United States is approaching 2 decades of escalating unintentional opioid overdose deaths.[1] Emergency department (ED)–based postoverdose interventions involving peer recovery support specialists have been implemented in various forms in recent years.[2] The goal is to conduct a brief intervention immediately after a nonfatal opioid overdose; this intervention may involve behavioral health assessment or screening, brief negotiated or motivational interviewing, naloxone distribution, and referrals or warm handoffs to treatment, including medications for opioid use disorder (ie, buprenorphine/naloxone, or methadone) or harm reduction or social services.[2] This form of intervention may be particularly critical in communities where initiating medications for opioid use disorder in the ED is not possible, and it may provide critical support for patients who are not ready or willing to initiate treatment.

Importance

The rationale for locating such an intervention in the ED is 3-fold. First, some investigators hypothesize that the moments after an unintentional overdose could represent a powerful "teachable moment," in which people who use opioids are amenable to considering behavior change.[3,4]

Editor's Capsule Summary

What is already known on this topic

Deaths from opiate overdose continue to rise nationally. Although evidence suggests potential efficacy of peer-based interventions to connect survivors of opiate overdose to recovery in other settings, data are limited regarding emergency department (ED)–based interventions.

What question this study addressed

This qualitative study assessed perspectives of people who use opiates regarding the feasibility and acceptability of a postoverdose intervention that deploys peer recovery support specialists in the ED.

What this study adds to our knowledge

Postoverdose interventions with ED-based peer recovery support specialists are acceptable, although they must be carefully designed to address patients' priorities including acute care needs as well as privacy and financial concerns.

How this is relevant to clinical practice

This study provides recommendations of important considerations for designing an ED-based postoverdose intervention program for persons who use opiates.

Second, ED care for an overdose may represent a "reachable moment,"[5] in which people who use opioids who may not otherwise have access to routine health care, behavioral health, or social services become visible to the health care system, thus providing an opportunity for support, connection, and engagement in services. Third, survivors of opioid overdose are at elevated risk of death from a subsequent overdose,[6] and many could benefit from additional harm reduction and treatment services after medical stabilization.[7] Despite this rationale for an ED-based intervention, and some evidence that peer-based interventions are effective in other settings,[8,9] less evidence exists regarding their feasibility, acceptability, or ultimate effectiveness in supporting patients with opioid use disorder in the ED.[10]

Goals of This Investigation

In the current study, we report findings from focus group research conducted with people who use opioids during the early implementation of an ED-based postoverdose intervention program. Our goal was to elicit patients' perspectives regarding the feasibility and acceptability of the program, to ensure that their perspectives are represented in the design, implementation, and evaluation of these programs. We used a patient-centered care perspective, which suggests that centering patients' subjective experiences of illness, suffering, and medical care is critical to improving the delivery of high-quality health care services.[11] According to Gerteis et al,[11] "what patients experience, and what they think of that experience" should matter in the planning, delivery, and evaluation of health care services.

MATERIALS AND METHODS

Study Design and Setting

In 2017, Mobile Recovery Outreach Teams were established in Nevada to provide interventions for patients presenting to EDs with opioid overdose or a primary or secondary opioid use disorder diagnosis. The teams are funded through the Substance Abuse and Mental Health Services Administration State Targeted Response to the Opioid Crisis and State Opioid Response grants, and they are housed within community-based organizations in northern and southern Nevada. Peer recovery support specialists are trained and certified through a standardized online training offered by the University of Nevada, Reno, Center for the Application of Substance Abuse Technologies. In 2019, Mobile Recovery Outreach Teams began operating continually in participating hospitals. ED staff members in those hospitals call a centralized telephone number when a potentially eligible patient presents to the ED, and Mobile Recovery Outreach Team staff (typically 1 peer recovery support specialist and 1 drug and alcohol counselor) drive to the hospital to meet with the patient. The intervention is a single meeting in the ED that includes assessment, a brief negotiated interview, naloxone distribution, and referral or warm handoff to services according to the patient's needs and wishes. Peers may follow up with patients, if requested. At the time of data collection, Mobile Recovery Outreach Teams were operating in 4 hospitals throughout the state.

Selection of Participants

Our goal was to recruit 30 people who use opioids (6 focus groups of 5 people each) who could encounter the Mobile Recovery Outreach Team in an ED setting, evenly distributed between northern and southern Nevada. Eligible participants self-identified as people who use opioids and were 18 years old or older. We did not restrict eligibility to people who use opioids with recent experiences of overdose or ED care because most people

who use opioids could have the potential to engage with the Mobile Recovery Outreach Teams in the future. Eligibility was evaluated using a short screening questionnaire.

We used convenience sampling to recruit participants through flyers placed in pharmacies, opioid use disorder treatment centers, and other agencies, by using online advertisements, and by word of mouth. Recruitment for the first 6 focus groups resulted in a sample dominated by people who injected drugs, so to ensure conceptual saturation we targeted recruitment efforts toward people who used prescription opioids for an additional 3 focus groups. We ended sampling when the focus group facilitators and principal investigator agreed that no new information was emerging. All study procedures were approved by the University of Nevada, Reno, Institutional Review Board. We also obtained a Federal Certificate of Confidentiality from the National Institutes of Health.

Data Collection

Focus groups lasted approximately 90 minutes and were conducted in a nondescript university-leased research field site (northern Nevada) and in the offices of a community-based organization providing services for people who use opioids (southern Nevada). The purpose of the study was explained to the participants before conducting the informed consent process. The Institutional Review Board granted a waiver of documentation of consent because the only piece of identifying information linking people to the study would have been their signature on a consent form.

After providing verbal informed consent, participants completed a brief anonymous survey that collected demographic information, drug use behavior, and substance use disorder treatment and overdose history. Each group was moderated by 2 of 4 research assistants using a semistructured interview guide that began with a scripted description of the program (Appendix E1, available online at http://www.annemergmed.com). Development of the focus group guide was informed by our formative research, which included interviews with ED clinicians, meetings with Mobile Recovery Outreach Team and ED staff, and participant observation in the EDs. Through this work we identified 2 key decision points that could affect program acceptability: (1) when and (2) how the Mobile Recovery Outreach Teams are introduced to patients. We asked about these issues specifically in the focus groups. We also asked about perceived benefits and concerns about the program and recommendations for increasing its potential for success.

Discussions were digitally recorded and transcribed verbatim. Transcripts were reviewed by project staff to ensure accuracy and complete redaction of identifying information. Focus group facilitators also took notes during the sessions. Participants received up to $50 cash to offset their time and travel expenses immediately after providing informed consent, and they were offered resources, naloxone, and referrals to services at the conclusion of the focus groups.

Primary Data Analysis

Analysis was conducted from October to December 2019 using procedures for thematic analysis,[12] using ATLAS.ti software version 8.4.2 (ATLAS.ti, Berlin, Germany) for data management and coding. Transcripts were stored and analyzed on a university-hosted remote desktop server accessible only to project staff through secure login. Two analysts (KDW and MLM) independently read the transcripts, developed codes that were based on the a priori categories, and identified emerging themes within each category. For example, "introduction" formed a parent code for the a priori category representing how participants wanted the teams to be introduced to them. Then, within that parent code, subcodes identified emerging themes (eg, concerns related to timing of the introduction, physical withdrawal symptoms, or desire for support within the hospital). Next, we conducted axial coding to combine subcodes and generate higher-order inference. Both analysts recorded impressions in memos that also identified connections between codes. The analysts then met to develop consensus on the coding structure. Finally, the first author (KDW) reread the transcripts and ensured that the coding conformed to the consensus-based analysis plan. Representative quotes are presented with (I) to indicate the interviewer and (R) to indicate respondents. The focus group identifier is provided in parentheses after each excerpt. We used the Consolidated Criteria for Reporting Qualitative Research checklist[13] to guide reporting of this focus group study.

We took several steps to enhance trustworthiness of the data collection and analytic process.[14] A single focus group guide and protocol were used across all groups. Transcripts were subjected to a quality assurance protocol before analysis to ensure accuracy. Memos and coded material were prepared independently by both analysts, who then met to discuss their independent impressions, cross-check codes and code definitions, and arrive at a consensus on themes and coding structure. Finally, findings were shared with the broader authorship team to evaluate accuracy and face validity.

Research Characteristics and Reflexivity

Because this research draws from a constructivist or interpretivist paradigm that acknowledges the co-constructed nature of social phenomena and the study thereof, here we describe the research team and broader study context. The study was funded separately from the Mobile Recovery Outreach Team intervention and was designed to evaluate its feasibility, acceptability, and outcomes. The study was conceived of and implemented in close collaboration with the state and community-based agencies who direct the Mobile Recovery Outreach Teams. Study staff met frequently with program and hospital staff to provide feedback from research findings and conduct ongoing evaluation of the Mobile Recovery Outreach Team program.

Focus group facilitators worked in teams of 2 (female-female or male-female pairs) to facilitate the groups. Facilitators were professional research staff with on-the-job training in qualitative research methods who had been conducting research with or providing services for people who use opioids for 2 to 10 years. The analysts were doctoral-level researchers with 20 and 10 years of experience, respectively, conducting qualitative and mixed methods research and providing services and clinical care for people who use opioids. One of the analysts was unaffiliated with the Mobile Recovery Outreach Team program and the community-based agencies that manage the Mobile Recovery Outreach Teams, thereby providing a more independent perspective. Study locations were known to people who use opioids as locations for research or services, a feature that increased familiarity with the research team and facilitated formation of rapport.

RESULTS

We conducted 9 focus groups with 30 people who use opioids between April and November 2019 (5 groups in southern Nevada; 4 groups in northern Nevada). Focus groups had a range of 1 to 7 participants per group (median 2). Because of the difficult-to-reach nature of the study population, for the 1 group in which only 1 person participated, we decided not to reschedule and instead conducted the session as a 1-on-1 interview. No one dropped out of the study after enrollment. Participants (N=30) were 50% female (Table 1). Seventeen percent identified as Latinx ethnicity; 87% reported their race as white, 3% identified as multiracial, and 6% did not report their race. The median age was 31 years (range 22 to 72 years). All but 2 participants (n=28 of 30) reported current (past 6-month) opioid use, with most reporting use of heroin, prescription opioids, methamphetamine, or benzodiazepines, typically in combination. Two participants (7%) reported methamphetamine use alone in the past 6 months. One fourth reported being currently

Table 1. Participant demographics (n=30).

Characteristics	No.	% (or IQR)
Female	15	50
Latinx ethnicity	5	17
Race		
White	26	87
Black	1	3
Multiracial	1	3
Missing or refused	2	6
Median age, y	31	(IQR 12.25; range 22–72)
Substance use in the past 6 mo		
Heroin alone	2	7
Heroin in combination with other drugs	22	73
Prescription opioids alone	0	0
Prescription opioids in combination with other drugs*	4	13
Methamphetamine alone	2	7
Currently enrolled in a substance use disorder treatment program	8	27
Currently participating in peer-to-peer support group (eg, AA, NA)	5	17
Experienced at least one overdose past 12 mo	10	33 (range 1–6)
Services accessed in the past 6 mo (not mutually exclusive)		
Syringe access program	16	30
Emergency department	10	19
Primary care doctor	7	13
Social services or case management	6	11
Urgent care	4	8
Other	2	4
None	6	11

IQR, Interquartile range; *AA*, Alcoholics Anonymous; *NA*, Narcotics Anonymous.
*To deal with any potential overlap, participants who reported prescription opioids in combination with heroin are reported in the "Heroin in combination with other drugs" category.

enrolled in a substance use disorder treatment program, which included outpatient care, medications for opioid use disorder, and sober living environments. Thirty-three percent had experienced at least 1 opioid overdose within the past year (range 1 to 6, among those who reported at least 1). Nineteen percent had accessed care in an ED in the past 6 months, 13% had seen a primary care doctor, and 8% had accessed an urgent care clinic (not mutually exclusive). One fourth had heard of the Mobile Recovery Outreach Team program before it was explained to them, although only 1 participant reported having encountered the Mobile Recovery Outreach Team in the ED.

Qualitative findings are organized into 3 a priori categories determined by the structure of the interview guide: opinions about when and how the Mobile Recovery Outreach Team program should be introduced to patients, perceived benefits, and concerns about the program. Within each category we present emerging themes derived from the thematic analysis. A summary of findings and recommendations is presented in Table 2.

Introducing the Mobile Recovery Outreach Team Program

Participants provided a variety of recommendations about how the Mobile Recovery Outreach Team should be introduced to the patient, arranged into 2 themes labeled "timing" and "content."

Timing: Participants highlighted 2 competing concerns related to timing: the urgency of contacting a patient immediately, before they leave the hospital versus the need to account for physical discomfort. Some emphasized that immediately having a face-to-face encounter with a peer could facilitate assistance with urgent needs and could ensure that the relationship is established before the patient leaves the hospital. In the following excerpt, a couple (R2 and R1) responds to the interviewer's (I) query by

Table 2. Themes related to people who use opioids' perspectives of an emergency department–based postoverdose intervention.

Category 1: Introduction of the Mobile Recovery Outreach Team Program to the Patient	
Findings	**Recommendations**
Timing: Balance need for urgency with attention to withdrawal symptoms	Provide out-of-hospital and ED-based interventions that minimize and treat withdrawal symptoms Provide ED-initiated medication for opioid use disorder
Content: privacy and law enforcement concerns	Ensure that relationship between hospital staff and interventionist is clearly delineated, limitations of confidentiality are explicitly communicated
Content: low pressure, voluntary, patient-led	Facilitate shared decision making, patient autonomy, patient choice
Content: cost and insurance	Identify sustained sources of funding for continued care
Category 2: Perceived Benefits of the Mobile Recovery Outreach Team Program	
Findings	**Recommendations**
Value of peer with lived experience	Ensure peers with lived experience of substance use and recovery are identified as such to patients when possible Ensure training and development of uniform competencies for peers
Advocacy in the hospital	Empower and collaborate with peer recovery support specialists as patient advocates
Social support	Provide nonjudgmental support for patients that extends beyond the ED encounter
Fill service gaps	Ensure that peers provide naloxone take-home kits, wound care kits, and referral or linkage to services including, but not limited to, substance use disorder treatment
Encouragement and hope	Value peer recovery support specialists' expertise and highlight their ability to serve as role models
Category 3: Concerns or Worries About the Mobile Recovery Outreach Team Program	
Findings	**Recommendations**
Sustainability	Identify sustained sources of funding for continued care Provide workplace support, training, and clinical supervision for peer recovery support specialists
Privacy and confidentiality	Ensure that relationship between hospital staff and interventionist is clearly delineated, limitations of confidentiality are explicitly communicated

discussing how a recent overdose experience informed their thinking about the issue of timing:

I1: So, in the event that you were in that situation again, how would you prefer that the mobile team members approach you about this and talk to you?

R2: Honestly, I feel like right away because she was really out of it when she first went in and it was really hard for them. They didn't want to prescribe her methadone or nothing.

R1: And I was in pain.

R2: Like it's a life or death situation. You're playing with a life. She's either going to figure out how to get something in here, because she can't just be sick like that.

R1: And in pain. (FG 2-1)

As seen in this encounter, another consideration was the experience of precipitated opioid withdrawal after an overdose reversal with naloxone. This discomfort may also be aggravated by chest discomfort caused by compressions from cardiopulmonary resuscitation (CPR) maneuvers, as described later. Some patients believed that under these conditions, they would be less receptive to engaging with Mobile Recovery Outreach Team immediately and would prefer a delayed introduction:

R5: When I overdosed and the EMTs [Emergency Medical Technicians], or whatever, they gave me Narcan, or whatever, and I'd never had it before, but they had to give me CPR too and it hurt [to] breathe and like, when you get Narcan'd it's like when you get woken up by anesthesia but like times a million. So, you're foggy and it's just weird. It's like you're in another dimension. So, I personally didn't want to…I was like, "can you call my mom?" Then I was like, "No! Don't call my mom!" [laughter]. So yeah, I didn't want to talk to anyone when I went to the hospital. I think—

R2: Waiting till you're stable [cross talk]. (FG 1-1)

Content: To help them decide whether to engage with the intervention, participants wanted to know the nature of the relationship between the Mobile Recovery Outreach Team and other entities (eg, law enforcement, hospital) and the extent of patient privacy protections, the fact that participation is voluntary, and any cost for the services and insurance coverage options. Finally, nearly all participants emphasized that the initial encounter should elicit the patient's needs, rather than automatically prioritizing a conversation about opioid use disorder treatment.

Participants were adamant about their desire to understand the nature of the Mobile Recovery Outreach Team's relationship with other entities, specifically any affiliation with law enforcement. They saw this as a way of creating a safe space that would facilitate a constructive patient-provider relationship, without the threat of criminal justice or other sanctions.

R2: I think that it would be…just letting them you're not there to like…that your stuff isn't going on record with you guys, like it's confidential. That's there's a HIPAA [Health Insurance Portability and Accountability Act] form, you know? Letting them know that you guys are just not part of the law, in any way, shape or form. You're not there to get them in trouble or…you know what I mean? (FG 2-1)

Many participants also wanted a clear delineation of the relationship between the Mobile Recovery Outreach Team peers and the hospital. Some suggested that badges or uniforms could help distinguish Mobile Recovery Outreach Team peers from hospital personnel and could also increase trust in the team as a legitimate program. Others wanted an explanation about the nature of that relationship. Some concerns were motivated by past negative experiences in hospitals, and respondents would therefore "be more open to what somebody has to say, who is not from the hospital." (FG 3-2)

Participants also emphasized that a low-pressure introduction that highlights the voluntary nature of the program is key to building rapport:

R2: Come on gently. I'm really in the scene of using opioids and if I'm really, really full-blown out of it, I want you to come gently. Gently get to know me. (FG 5-2)

Nearly universally, respondents emphasized that the peer should allow patients to identify their own needs and not push the topic of opioid use disorder treatment. For example, 1 respondent suggested that the peer should offer naloxone first, as a way to build rapport:

R1: Uh, I think definitely the naloxone. Offering that, that would be…right off the bat…I mean, not so much pushing the treatment thing right off the bat, because a lot of the time maybe they might get the wrong idea. Like, they're not trying to stop. Obviously in that situation it might be a little bit different because they're probably scared shitless and they might want to stop, so then…you know…so

obviously that is great to have but, I'm just saying, maybe not so much pushing that issue. (FG 1-2)

Respondents in another group recommended having an "open mindset" and letting the patient lead:

R2: You're there to help.

R1: Yeah. We're here to try to make you comfortable and we understand that, you know, a lot of nurses and doctors, no matter what, are going to have their mind set on drug addicts, you know? But we are here—

R2: To educate you.

R1: And to try to make it, you know, as comfortable as a transition for you. You know, we're not here to push or force anything upon you. Just kind of…like, let them kind of go…I don't know…let them kind of just go on their own way…like let them fall into it instead of feeling pressured into it, I guess, is what I would say.

I1: OK.

R1: Because the pressure is what kind of—

R2: Pushes people away.

R1: Yeah, puts fear into people. (FG 2-1)

One respondent also highlighted the need to ensure that Spanish-speaking peers were available, if needed.

Finally, although not as common as the content discussed thus far, some participants also raised the issue of cost and insurance coverage. Some wanted to know up front whether the service would generate a bill, whereas others wanted to ensure that any bills would be covered by insurance or Medicaid.

Benefits of the Mobile Recovery Outreach Teams Program

Participants discussed multiple perceived benefits of the Mobile Recovery Outreach Teams program, including the value of lived experience of substance use, advocacy in the hospital, social support, filling gaps in existing services, encouragement that one can change their behavior, and assistance for friends or family of the patient.

Value of lived experience of substance use: Most respondents saw value in the role of the peer as someone with lived experience of substance use. They believed this shared experience was key to establishing an empathetic relationship that could create a safe space to discuss patients' concerns:

R2: I like that, you said that one of them has lived the life of us.

I1: The Peer Support Specialist?

R2: Yeah, it automatically catches my attention when someone has been there, done that…kind of thing, you know?

Having an advocate: One of the most frequently cited benefits was that the Mobile Recovery Outreach Team peer could serve as an advocate in the hospital, separate from the hospital clinicians:

R2: If you're in that situation, where you're overdosing, of course you want to have someone, one of your friends there, or whatever, but a lot of the times…on the other hand, a lot of people do get scared, so they'll drop them off at the hospital and they'll dip. They'll take off. So, to have this team there, or whatever it is, waiting there for you would be great. Yeah, not just…not like the doctors are against you or…but I can see how they would put you off or give the bare minimum, you know what I'm saying? I think it's a pretty good idea. (FG 1-2)

The rationale for this benefit stemmed from participants' extensive history of interacting with the health care system. Although some positive experiences were noted, most were described in negative terms. Those experiences, whether faced personally, witnessed, or discussed among members of a social network, created negative attitudes toward seeking care for overdose or other conditions associated with substance use (eg, soft tissue infections). The peer was seen as an advocate who could buffer such experiences:

R1: So, just one person to be there for these people, just to help, you know? Just to be a voice and, you know, a doctor might not listen to you as the patient but if someone more professional comes in, they might listen to them like, "OK, you're not a drug addict. You know what's going on, so I'm actually going to listen to you because you're educated. I'm not going to listen to this person." So, just a voice I think would help a lot. (FG 2-1)

Providing social support: Another benefit was that the peer was seen as someone who could provide social support to patients during their hospitalization and after discharge. When asked what they thought the Mobile Recovery Outreach Team program should provide, respondents agreed that "someone who's more willing to listen… like a friend type deal" (FG 1-2) was needed. Later in the same group, the conversation returned to the issue of social support and a willingness to listen:

R3: Yeah, just as they are sobering up, I guess. But the team is there for their support more than anything, you know what I'm saying? Don't so much push the

ideas of treatment and all that stuff on them so much, 'cause then they get the impression—

R1: Just like she said, "what do you need?" Be willing to listen to what they need and just have an open ear, and then at the end, once you've got their trust a little bit—

R3: Yeah.

R1: Find out who they are, where they come from, then maybe say they offer this too, you know? (FG1-2)

Filling service gaps: Respondents perceived that the Mobile Recovery Outreach Teams program could provide services that were difficult to access (eg, take-home naloxone), as well as ensuring greater continuity of care. In part, this stemmed from previous experiences in which respondents faced challenges accessing services after their hospitalization for an overdose. Respondents identified several other services that would help fill gaps in the existing service landscape, including distribution of wound care kits, help with Medicaid applications, help with housing, providing nicotine replacement therapy, and addressing other health care needs (eg, cellulitis, endocarditis).

A critical component of the Mobile Recovery Outreach Teams program for respondents was that the peer would be someone who was knowledgeable about all the different treatment options (including both medications for opioid use disorder and abstinence-based treatment), including whether programs accept the patient's insurance, and could help ensure successful transition into treatment.

Encouragement: Another perceived benefit of the Mobile Recovery Outreach Teams was its potential to provide encouragement, hope, and a vision of a path forward for those seeking to change their substance use behavior:

R6: A lot of people want to get out, so maybe just tell them that they can provide a way for you to get out of this lifestyle. That gives people hope 'cause that's what they want anyway.

R1: Yeah, that's always the main…the end goal.

R6: And they can provide that pathway.

(FG1-1)

For others, however, the prospect of changing their behavior raised fears. When asked about any potential worries about the program, one respondent said:

R2: Just the fact that if I start the program me quitting because, I can't lie, I like to get high. Weed, coke, pills heroin, whatever it is. 'Cause I got a lot of psychological problems, as is, and…you know what I mean? That problem on top of being homeless and this and that. It's like fuck it, get high and numb the pain. And, you know, our families totally just booted us out. So, quitting would be my only worry. (FG 3-2)

This issue highlights the importance of working closely with patients to examine both the benefits and consequences of proposed behavior change, and the need to address co-occurring mental health concerns and other social determinants of health such as homelessness and trauma.

Only one participant had interacted with the Mobile Recovery Outreach Teams in the ED, for a non-overdose complaint. She emphasized many of the same benefits perceived by those who had not yet encountered the team, including providing support for family, serving as an advocate in the hospital, facilitating access to naloxone and filling other service gaps, and providing hope and encouragement. Another respondent in the same focus group lamented that the service had not been available years ago when he was experiencing major health concerns related to his substance use:

R1: I'm getting emotional because I think had this been in place…earlier…um…[voice cracking]…I'd be a lot closer to living a lot longer.

R2: What do you think you would have done?

R1: Oh, with the help? Instead of, "There's a bus that's going to be here in twenty minutes. We're gonna discharge ya [sic] and no, we can't prescribe you what you need to stay healthy?"

I1: Having somebody there to be on your side and an ally for you when you can't—

R1: The years have literally just rolled by. Little too little, little too late, but it's gonna benefit someone else. You know, someone's gonna…it's gonna be a lifeline…so, it's…yeah. (FG 4-1)

Concerns and Worries About the Mobile Recovery Outreach Team Program

In addition to fears related to behavior change, respondents identified other concerns that must be addressed to ensure successful implementation. These can be understood in 2 broad categories: sustainability and privacy or confidentiality protections.

Sustainability: Respondents saw a potential for disappointment by the program on the basis of 2 different mechanisms: discontinuation of grant funding and relapse or disappearance of the peer. Respondents were aware of the grant-funded nature of the program and were worried about whether services would continue after the grant ended. In the following exchange, participants describe their concern that they could be disappointed by the peer:

R1: If I was to get…like if I was to get attached to somebody that…you know how you get a sponsor from like AA? If it was like that person that came into my hospital room and I got attached to that person and they just dipped out or something.
R5: Relapse.
R1: Yeah. Or if they were to disappoint me in anyway…like that would be really bad…'cause that would be the person I would look up to for my sobriety and stuff.
R1: That's the only thing I would think about 'cause that would keep me from getting attached in the first place. That's probably why I wouldn't want to talk to anybody in the first place. Like nah, they'll just disappoint me like everybody else does, so I'll deal with it myself [nervous laughter]. I got my own back. (FG 1-1)

Privacy and confidentiality: As described earlier, respondents were very concerned about the potential for exposure to criminal justice sanctions related to participating in the Mobile Recovery Outreach Team program, and they desired a clear explanation about the extent to which participation could put them at risk:

R1: Definitely if the person had kids, like you said with the CPS [Child Protective Services] thing. Definitely that route, because if they are…obviously it's different if you're in the medical field and, as a parent, you don't want to get into treatment because then CPS is going to get involved and things like that. So, that's one worry I would think, you know?
R2: Or if it was a government run agency and they were reporting your stuff to...
(FG 1-2)

Respondents also voiced worries about whether discussing their substance use with hospital staff to access the intervention would exacerbate negative encounters with health care providers.

LIMITATIONS

Our findings should be interpreted in light of some limitations. Although postoverdose interventions are designed for anyone with an opioid use disorder who is receiving treatment in an ED, all but 2 of the opioid-using participants reported use of other illicit and licit substances in addition to opioids, and although all identified as opioid users on enrollment, 2 reported using only methamphetamine in the past 6 months. In addition, only one fourth had visited an ED in the past 6 months, even though 33% had experienced at least 1 overdose in the past year, and all had experienced or witnessed overdoses in their lifetime. As such, the findings reported here may not generalize to other populations of opioid users or people who overdose more frequently. However, as discussed later, our findings reflect those of research conducted in other settings, thereby enhancing transferability of our conclusions. Nonetheless, these findings should be interpreted with caution given the small number of respondents and the limited geographic setting. Focus groups tend to elicit normative responses; therefore, participants with dissenting opinions in the groups may have been less forthcoming, and socially desirable accounts may be overrepresented. Finally, few of the respondents in these focus groups had encountered the Mobile Recovery Outreach Team program, and opinions may change once patients have a chance to interact with Mobile Recovery Outreach Team peers.

DISCUSSION

We conducted 9 focus groups with people who use opioids to elicit their perspectives on how an ED-based postoverdose intervention should be delivered. Key findings that could improve feasibility and acceptability of the intervention include the following: the importance of balancing the urgency of seeing patients quickly with a need to accommodate the experience of precipitated withdrawal symptoms; the need to ensure that privacy concerns are addressed; and the need to address concerns related to cost, insurance coverage, and sustainability of the program. Perceived benefits of the intervention included the ability of the peer recovery support specialist to provide advocacy and support, serve as a model of hope and encouragement for behavior change, and fill key service gaps.

A primary concern expressed by participants was that being treated for an overdose can be stressful and upsetting, an experience driven both by the physical sequelae of the overdose and the fear or history of negative encounters in hospitals.[15–17] Participants perceived that the symptoms of naloxone-precipitated opioid withdrawal could affect the acceptability of the Mobile Recovery Outreach Team intervention by making it difficult for them to engage in the moments immediately after the overdose. Although the presence of a peer recovery support specialist who can provide empathy during that moment was identified as a key benefit of the intervention, there are also opportunities for emergency medicine professionals to provide treatments in the out-of-hospital and ED settings that can minimize patient discomfort and improve the overall patient experience. These include prioritizing supportive oxygen

rather than naloxone administration (if indicated),[18] using lower bolus doses of naloxone or administering naloxone in a low-dose infusion and gradually titrating it,[19] or administering other medications such as sedatives or partial or full opioid agonists, rather than naloxone.[20]

Respondents identified other issues that must be addressed to help develop rapport between patients and peers, including assurances of voluntary participation, privacy protections, separation from criminal justice agencies, and an orientation that centers on a concern for patients' needs, rather than an a priori emphasis on treatment or referrals. These findings reflect those reported in a study of an acute care–based addiction medicine consultation team in Canada that identified compassion, support for patient autonomy, shared decision making, and attention to patient needs and preferences as key facilitators of program success.[17]

Concerns about insurance coverage and program sustainability must also be addressed, by ensuring that peer recovery support is a reimbursable service and that there is a long-term, public, and fully funded commitment to providing comprehensive and ongoing care for people who use opioids. Given concerns about the potential for disappointment by a peer, findings suggest that peers could be best constructed as part of a broader network of support that extends beyond a single peer support specialist, and that peers should be provided with clinical supervision and workplace support to ensure their wellness.

Our findings highlight the value of peers with lived experience of substance use and recovery as critical components of the intervention and suggest that they should be considered essential professional positions, and that their lived experience of substance use should be described to patients if and when possible and appropriate. Ongoing guidance for training and development of uniform competencies for peer recovery support specialists will be required to advance the professional development of peer recovery support specialists. These include cultivating the ability to form a genuinely empathetic connection with people who use opioids and foster a sense of hope; ensuring accuracy in the communication of evidence-based messaging about medications for opioid use disorder, resources, and connections to care; and training peers to facilitate shared decisionmaking and patient empowerment when making decisions about opioid use disorder treatment or other services.

Another perceived benefit of the intervention was its ability to fill service gaps by providing services such as take-home naloxone, wound care kits, and linkage to services. The peer-based intervention could also increase motivation to engage with treatment, which could also enhance the success of ED-initiated medications for opioid use disorder. However, in circumstances where there is no opportunity to initiate medications for opioid use disorder in the ED, or when the patient is unable or unwilling to do so, the value of the intervention may stand alone and facilitate more positive health care experiences for people who use opioids.

Our findings support the notion that the ED is fertile ground for the explicit integration of harm reduction principles into the delivery of care for people who use opioids.[7,21] Harm reduction approaches share the common characteristics of treating people who use drugs with dignity, maximizing intervention options, and prioritizing achievable goals.[22] A hallmark of the approach is that harm reduction efforts seek to "meet people where they are," in terms of their willingness to change their substance use behavior, and provide services in a way that demonstrates respect for self-determination.[23] Respondents in our study emphasized the need for the intervention to meet patients where they are, both physically (ie, in the ED before patients leave and when they need the most support) and in terms of addressing their immediate needs first, rather than prioritizing opioid use disorder treatment. This is also consistent with a patient-centered approach that works collaboratively with patients to improve quality health care delivery for people who use opioids.[24,25]

In summary, ED-based postoverdose interventions can play an important role in the emergency medicine continuum of care by meeting patients "where they are" and providing patient-centered, harm reduction–oriented services after clinical stabilization that focus on alleviating physical discomfort, providing empathetic and supportive resources, and linking patients to the resources they need. Our findings suggest that rather than focusing on opioid overdose as a "teachable moment" because of its potential for increasing perceptions of personal risk or redefining self-concept,[3] overdoses may be better constructed as a "reachable moment,"[5] in which people who use opioids present in a particularly vulnerable state, and require empathy, support, and an opportunity for connection. Interventions should be developed with the input of people who use opioids to ensure that they are responsive to patient concerns and delivered in a manner that optimizes the potential for successful outcomes.

The authors would like to thank the respondents for their time and willingness to share their experiences for this research. The research team would also like to acknowledge Chelsi Cheatom, Lisa Lee, Krista Hales, Michelle Berry, and Minggen Lu for their contributions to the broader project.

Supervising editor: Kristin L. Rising, MD, MS. Specific detailed information about possible conflict of interest for individual editors is available at https://www.annemergmed.com/editors.

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Author contributions: KDW conceived of the study and served as principal investigator and lead analyst. MLM contributed to the qualitative analysis and interpretation and reporting of findings. RWH, KPS, and ADD conducted the data collection and contributed to interpretation and reporting of findings. XW conducted the quantitative analysis. SW, NAR, and RFO contributed to the overall conceptualization of the research, acquisition of funding, and interpretation and reporting of findings. KDW takes responsibility for the paper as a whole.

All authors attest to meeting the four ICMJE.org authorship criteria: (1) Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; AND (2) Drafting the work or revising it critically for important intellectual content; AND (3) Final approval of the version to be published; AND (4) Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Funding and support: By *Annals* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see www.icmje.org). The authors have stated that no such relationships exist. This research was supported by a grant from Arnold Ventures. The views in this paper do not necessarily represent the views of the funders. KDW, KPS, RWH, and NAR have received funding to assist with the implementation of the Substance Abuse and Mental Health Services Administration Opioid State Targeted Response grant, which funded the intervention activities described in this report. MLM is supported by National Institute of Drug Abuse grant 3R01DA040648-02S1. SW is the state administrator responsible for the overall implementation of the intervention activities described in this report.

Publication dates: Received for publication January 2, 2020. Revisions received March 23, 2020, and May 18, 2020. Accepted for publication June 3, 2020.

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