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# Exploring the role of peers in addressing the toxic drug crisis in emergency departments

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## Abstract

**Introduction:** Health systems across Canada are facing high numbers of patients who use drugs (PWUD), have a diagnosed substance use disorder, or are experiencing a toxic drug poisoning event, necessitating innovative approaches to care. With high instances of toxic drug poisoning events, emergency department staff are facing increasing burnout and moral distress (Van Hout & O'Reilly, 2020). A quality improvement pilot-project was conducted with the aim of incorporating individuals with lived experience using unregulated drugs (i.e., peers) into emergency department teams to improve patient outcomes and enhance staff supports, in response to the significant impact of the toxic drug crisis on healthcare systems.

**Methods:** The project used an overarching Plan-Do-Study-Act (PDSA) quality improvement framework, and a mixed-methods, utilization-focused evaluation to assess the impacts of embedding peers into the emergency department. A mixed methods design was used to collect data from intake forms, patient/staff experience surveys, and a semi-structured focus group of peer support staff.

**Results:** The most common reasons for peer encounters (N = 764) were emotional support, harm reduction, referrals, witnessed consumption, and requests for basic necessities. The patient survey (N = 51) results demonstrated how the peers helped the majority of patients feel safe and more supported while accessing emergency care. ED staff (N = 22) shared positive experiences in the survey about the new peer program, highlighting improvements in patient support, increased access to harm reduction services, and the development of a more trusting healthcare system. During focus groups, peers (N = 2) outlined the importance of having this role embedded into emergency departments to ensure patients are receiving the care they need in a high-stress environment that, historically, has had the potential to cause significant harm through stigma and biases to PWUD.

**Conclusion:** Integrating peers in the ED during the toxic drug crisis improved support for both patients and staff. This approach also has the potential to boost staff morale, reduce workload stress, decrease stigma toward PWUD, and enhance patient care. Overall, the hope is that integrating peers optimizes resources and strengthens both patient and provider experiences.

*Keywords:* emergency department, drug use, toxic drug crisis, peer support workers, lived experience

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## Introduction

In 2023, toxic drug poisoning was the cause of death for at least 2,511 people in British Columbia (BC), Canada, equating to about 6.9 deaths per day (British Columbia Coroner's Service, 2024). Fraser Health Authority (FHA) Emergency Departments (EDs) are continuing to see high numbers of patients presenting with toxic drug poisonings, often referred to as overdoses (Fraser Health, 2023). Research indicates that substance use within hospitals is a documented issue in BC, often linked to increased risks of overdose (Health Canada, 2021). A study on hospitalizations for opioid-related poisonings revealed that these incidents sometimes result in severe outcomes, such as brain injuries from delayed intervention. In hospitals, the absence of supervised consumption services can exacerbate these risks, as patients might use substances discreetly, leading to potential delays in life-saving care (Health Canada, 2021). FHA is also home to many Indigenous & Aboriginal peoples who are disproportionately affected by the toxic drug crisis with data showing that Indigenous people are nearly five times as likely to die of a drug poisoning event than non-Indigenous BC residents (Auger & Local Journalism Initiative Reporter, 2023).

In this article, the term drug refers to unregulated or illicit substances including, but not limited to fentanyl, methamphetamine and heroin. The increasing number of patients presenting to the ED with drug use or toxic drug poisonings, compounded with gaps in support and resources for patients who use drugs (PWUD), has led to increased workloads, burnout, and compassion fatigue among ED staff and added stress on patients (Van Hout & O'Reilly, 2020). In addition, stigma toward PWUD from both the public and healthcare providers, often leads to a distrust in the healthcare system and a desire to conceal drug use, further exacerbating the negative consequences of toxic drug use by encouraging using alone and discouraging visits to healthcare settings (Chan Caursone et al., 2019; Kennedy et al., 2019).

This article explores a pilot project in BC where peer support workers (PSWs) are integrated into the ED at one community hospital that has seen an increase in unregulated drug deaths and overdose response calls (BC Emergency Health Services, 2023; BC Coroners Service, 2024). The framework for the pilot project was inspired by two similar projects in which people with lived experience supported patients in navigating treatment and improving their quality of life (Coll et al., n.d.; The Neighbourhood Group, n.d.). Though one project implemented peers for people with HIV in Vancouver and the other for PWUD in Toronto, the patient-focused support provided by a non-medical professional was a structure seen in both projects, and this aligned with the desired foundations of the FHA PSW pilot project. The goal of this type of service is to mitigate downstream complications.

Specifically, the PSW pilot aims to address the toxic drug crisis in one lower mainland ED by enhancing patient outcomes and providing advocacy for PWUD; this is hypothesized to improve staff satisfaction, reduce workload, and prevent burnout. This project has also contributed to the development of a standardized engagement guide for peers.

Peer workers are individuals with lived experience of a topic (in this case, unregulated drug use) who are hired to apply their experiences and expertise to become effective patient navigators in health systems (Scow et al., 2023; Richardson & Rosenberg, 2018). Benefits of peer integration include a reduction in the burden and workload for healthcare professionals, reduction in stigma, increased quality of care, and rapport building, all understood to impact long term benefits for both patients and staff (Pauly et al., 2021; Smith et al., 2020). Peers can also assist with emotional support, patient advocacy, resource navigation, witnessed consumption, and connecting with low-visibility patients who have a relationship with drugs (Piatkowski et al., 2024).

## Methods

### Setting

FHA is the most densely populated health authority in BC serving more than 2 million people and provides health services to more than 20 diverse communities (Fraser Health, n.d.). The PSW pilot project was implemented in the ED at the Chilliwack General Hospital, a community hospital serving approximately 107,000 residents (Statistics Canada, 2023).

This project was reviewed by the FHA Research Ethics Board and given an exemption as per Tri-Council Policy Statement 2: Ethical conduct for Research Involving Human, Article 2.5. While an exemption was provided due to the quality improve-ment nature of the project focused on improving the health sys-tem, confidentiality of all patient information was maintained in compliance with organizational data privacy policies. As such, patients and staff who participated in any part of the project were not provided any honorarium.

### Program Description

The pilot project incorporated a patient-centred approach by integrating PSWs into the ED team. Peers were responsible for offering support related to drug use, including facilitating wit-nessed consumption, resource navigation, and providing educa-tion on harm reduction approaches (Table 1). The pilot project currently employs four PSWs, who provide ED coverage 7 days a week from 8:00 am to 10:30 pm. PSWs report directly to the ED manager, while funding and some additional support is pro-vided by the regional FHA Toxic Drug Response team. Beyond supporting patients in the ED, PSWs also conduct preliminary walks on the hospital's outdoor premises, to identify and offer support to people who may benefit from outreach services.

### Implementation

The pilot project was developed by a multidisciplinary working group comprised of representatives from Chilliwack General Hospital ED and regional emergency and toxic drug programs. Implementation was conducted in a phased approach, empha-sizing the importance of change management and a gradual roll-out to address any potential ingrained stigma. The Consolidated Framework for Implementation Research (CFIR) outlines five domains that influence successful implementation: interven-tion characteristics, outer setting, inner setting, characteristics of individuals, and process. While this project did not adopt a structured CFIR approach, it did take each of these domains into account and used quality improvement methodology to trial various components (Cullen et. al, 2023).

**Table 1**

*Peer Support Worker Job Description*

**Key Objectives:**

1. Provide one-to-one support to PWUD to ensure they are feeling valued and cared for
2. Reduce stigma towards PWUD and assist with resource navigation
3. Prevent and mitigate toxic drug poisonings by providing witnessed consumption, drug checking, harm reduction supplies and allyship
4. Support ED staff in caring for PWUD to help alleviate burnout, moral distress and compassion fatigue

**Key Activities:**

**1. Create a safe environment for patients**: Prioritize building connections, debriefing, and fostering allyship
**2. Support PWUD**: Facilitate drug checking, witness consumption and distribution of harm reduction supplies
**3. Engage in in-depth conversations**: Discuss overdose risk, drug-use planning and safety options
**4. Conduct teaching sessions**: Educate patients and their support network on harm reduction practices and available resources
**5. Assist with de-escalation**: Implement techniques to ensure patients feel heard and valued
**6. Prepare and maintain accurate documentation**
**7. Support connections between patients and care teams**: Facilitate interactions with site resources and community services
**8. Provide education and support to frontline ED staff**: Offer training on harm reduction, trauma-informed practice, anti-stigma, and various substance use topics

*Note*. PSW = peer support worker; PWUD = people who use drugs; ED = emergency department.

Prior to the PSWs starting, ED staff, including nurses, unit clerks and healthcare aids, were invited to participate in a two-hour training session covering the history of drug criminalization, stigma, and the importance of harm reduction. Fifty-four staff members attended more than eight sessions that were facilitated by a harm reduction lead, a site ED Patient Care Coordinator, and the regional ED Clinical Nurse Educator. This training session also served as pre-assessment for implementation for the team to understand any potential barriers; more importantly, however, it provided an opportunity for ED staff to ask questions, discuss concerns, and understand the rationale behind the new role. Notes from the session were recorded by the facilitators and brought back to the multidisciplinary working group to make any necessary implementation changes.

Barriers to achieving buy-in from ED staff included comments on 'site-culture', perceived 'characteristics of individuals', and 'knowledge and beliefs'. Concerns also were brought forward about trust and fear and how PSWs may lead to greater harms toward patients. To address identified barriers and any underlying stigma, significant efforts were put into socializing and identifying ED champions to help with educating and engaging staff about the program's purpose and objectives through unit huddles, staff meetings, newsletters, and posters, for several months before program launch.

For the PSWs, to help facilitate integration into the ED, they participated in orientation courses, engaged in mentorship with the charge nurse and educators, and collaborated with interdisciplinary teams, to become familiar with the ED and site/community resources. The ED manager regularly checked in with staff for feedback and provided ongoing support, debriefing and education through meetings with PSWs. A Peer Community of Practice was also established by the regional Toxic Drug Response team to connect peers from different FHA programs, providing opportunity for collaboration and shared learning.

**Evaluation and Quality Improvement**

The evaluation of the project followed the utilization and outcome-based methodologies of Laursen et al.'s (2017) "Four approaches to project evaluation" (Appendix 1). Main data sources included program utilization data (number of clients, number of referrals, number of witnessed consumptions, etc.), feedback from patients, feedback from staff, and administrative data. The adopted methodology utilizes measures of outcome-based success of the program using specific success criteria. The evaluation of the project aimed to describe the different users and services of the PSW program, including its barriers and strengths. See Appendix 2 for the logic model.

The overarching quality improvement approach was guided by the Plan-Do-Study-Act (PDSA) framework to ensure effective integration within the ED and to collect valuable information on the program's impact (Coury et al., 2017; Johnson & Reterink, 2009). The methodology included iterative cycles, ranging from larger changes (e.g., onboarding and harm reduction service implementation – how referrals are conducted, communication between staff members, service delivery, etc.) to smaller ones (e.g., location of data collection tools), with each cycle informing the next. Each cycle included outlining the goals and logistics (plan), implementing the change (do), assessing feedback through various data collection methods (study), and adopting, adapting, or abandoning the change (act).

**Data Collection and Analysis**

A mixed-methods approach was used in data collection. After being trialled with staff to ensure best collection practices, intake forms were developed by program leadership and filled out by the peers to collect patient information, including demographic information and the reason for their visit to the ED. Given the impact of toxic drug poisoning within Indigenous communities in BC, the program included an optional opportunity for patients to self-identify as Indigenous. This allowed for culturally safe and appropriate support to be offered through a trained Indigenous Health Liaison (IHL). While the program was designed to serve the general population, understanding its influence on the engagement of Indigenous communities with health services was a key consideration, ensuring that the program respected and addressed the unique needs of these communities.

An anonymized patient survey was offered by the PSWs via a

QR code to patients, which consisted of nominal single choice questions regarding their experience with the service as well as a free text option for any further feedback. A similar staff experience survey was used to collect staff feedback regarding the program. One hour-long PSW focus group was conducted in person, approximately 6 months after program initiation, to obtain open-ended feedback, including perceived barriers and opportunities, from the PSWs; two out of four peers attended to share their learnings. The session was not recorded and, though it was guided by a set of five questions, was more conversational than formal, which allowed the peers a safe environment to share freely without fear of consequences or judgment.

Microsoft Excel and Stata IC v15.1 were used for descriptive statistic analysis. Chi-square tests, ANOVA, and t-tests were performed as appropriate, with a significance level set at 0.05. PSWs completed intake forms during their initial contact with patients, using information from the patient's chart and details voluntarily provided by the patient; as a result, some information was occasionally missing. Patients were referred to a PSW by ED nurses or physicians based on patient request, presenting complaints (e.g., toxic drug poisoning), or self-identification as a PWUD. In accordance with FHA's universal screening practices, all ED patients are to be asked about unregulated drug use in a trauma-informed and culturally safe manner. Referrals to PSWs are made through an online Meditech order-entry system.

Available case analysis was used to address missing data on the intake forms, and for each variable analyzed, only the available data for that specific variable was used. Data from both staff and patient surveys were collated by question and displayed tabularly. Free-text responses and focus group feedback were thematically organized into broad categories. These themes were determined after a thematic content analysis of the free text in the surveys and the notes taken by the evaluator during the focus group, who organized the feedback into relevant categories for the purposes of the evaluation (Braun et. al, 2014). Reporting followed the Standards for Quality Improvement Reporting Excellence (SQUIRE 2.0) guidelines (problem description, what was done to address problem, what were the findings, and what does it mean; Ogrinc et al., 2015).

## Results

The PSW in ED pilot project was launched in August 2023 and is currently ongoing. From inception until June 2024, 1,055 patient encounters (defined as when a peer engaged with a patient in a manner resulting in the completion of an intake form and further relevant support) occurred. The volume of patient intakes quickly exceeded the capacity of manual entry; therefore, only data using Microsoft Forms was used for this analysis (N = 764). Tables 2 and 3 outline patient characteristics and types of peer engagement that took place. The full evaluation report is available upon request.

### Patient Feedback

An adapted version of the already-established anonymous regional patient experience survey was created to understand the experience of patients specifically accessing support from the PSWs in the ED. The survey was adapted to include questions specifically in reference to the PSW program, rather than with patient experience during their acute visit overall. This survey was anonymous, not mandatory, nor was it incentivized with an honorarium. 51 patient surveys were received, and most feedback was overwhelmingly positive (Table 4).

**Patient quotes:**

1. I enjoyed the check-in and the support.
2. It was really cool to be offered harm reduction tools in a place I normally feel embarrassed.
3. I worked with a PSW and [they] taught me how to use safely and provided tools. It was a good experience and [PSW] helped me without judgement.
4. Accessed witnessed consumption and it was really great for me. It kept me here longer, thank you [PSW].
5. Witnessed consumption was helpful for me and my girlfriend. I felt safe and looked after.

### Staff Feedback

A total of 22 responses were received after sending it out to 142 staff members. All staff surveyed indicated they were aware of

**Table 2**

*Patient Characteristics*

| Responses | Total | Male | Female | Not specified | *p* value |
|---|---|---|---|---|---|
| Total *n*, (%) | 764, (100) | 547, (87.4) | 205, (32.7) | 12, (1.9) | n.a. |
| Age, Number of responses *n*, (%) | 626 | | | | |
| Years, Mean (SD) | 43 (15) | 43 (16) | 38 (15) | 38 (22) | < 0.05 |
| Years, Median (IQR) | 41 (8–85) | 41 (13–85) | 39 (8–75) | 36 (18–62) | - |
| Self-identified as Indigenous *n*, (%) | 226 (30) | 154 (28) | 70 (34) | 2 (17) | 0.170 |
| Asked to be referred to Indigenous Health Liaison *n*, (%) | 53 (7) | 29 (5) | 23 (11) | 1 (8) | < 0.05 |
| Registered for hospital care *n*, (%) | 652 (85) | 480 (88) | 167 (81) | 5 (42) | < 0.05 |
| Revisits *n*, (%) | 437 (57) | 347 (63) | 82 (40) | 8 (67) | < 0.05 |

*Note*. SD = standard deviation; IQR = interquartile range.

**Table 3**

*Peer Engagement with Patients*

| Engagement activity | Episodes, *n* (%) |
|---|---|
| Support type requested | |
| Total requests | 737 (100) |
| 1:1 support | 695 (94) |
| Basic necessities (food, clothing, etc.) | 172 (23) |
| Referral(s) | 104 (14) |
| Witnessed consumption | 55 (7) |
| Other | 63 (9) |
| Harm reduction supplies given | |
| Total supplies given | 219 (100) |
| Inhalation tool | 173 (79) |
| Naloxone kit | 135 (62) |
| Safe injection kit | 37 (17) |
| Safe sex supplies | 37 (17) |
| Other | 39 (18) |

**Table 4**

*Patient Feedback on PSW Program*

| Survey responses | |
|---|---|
| **Survey question** | **Response, *n* (%)** |
| I felt invited to make decisions about my care in collaboration with the PSW | |
| Strongly agree | 19 (44%) |
| Agree | 18 (42%) |
| Neutral | 6 (14%) |
| Disagree | 0 (0%) |
| Strongly disagree | 0 (0%) |
| Missing data | 8 (18%) |
| The PSW assisted me in feeling safe while in the emergency department | |
| Strongly agree | 21 (49%) |
| Agree | 19 (44%) |
| Neutral | 3 (7%) |
| Disagree | 0 (0%) |
| Strongly disagree | 0 (0%) |
| Missing data | 5 (10%) |
| The PSW was available during my time in the emergency department | |
| Strongly agree | 13 (31%) |
| Agree | 19 (45%) |
| Neutral | 8 (19%) |
| Disagree | 2 (5%) |
| Strongly disagree | 0 (0%) |
| Missing data | 5 (10%) |
| Total responses | 51 (100) |

*Note*. PSW = peer support worker.

**Table 5**

*Staff Survey Results*

| Survey questions | Response, *n* (%) |
|---|---|
| Total surveys received | 22 (100) |
| Have you heard of the Peer Support Worker Program? | 22 (100) |
| I believe the PSW could positively impact patient outcomes in the following ways: | |
| Improve quality of life | 20 (91) |
| Improve access to harm reduction resources | 21 (95) |
| Creating a support system | 20 (91) |
| Partnership with community | 19 (86) |
| Building trust with patients | 20 (91) |
| Other (please specify): providing safe space, avenues for witnessed consumption, aid with patient's self-identified outcomes/ needs | 3 (14) |

*Note*. PSW = peer support worker.

the PSW program, and most respondents believed that positive outcomes could be achieved with the PSW program in place (Table 5).

Although there were concerns brought forward during the ED staff training sessions that were held prior to the PSWs starting, as the project progressed, there was a noticeable shift in ED staff attitudes. As the survey results show, most ED staff noted they believe the PSWs created a support system for patients that led to building better partnerships and trust. The feedback from ED staff highlights that the PSW role has greatly improved patient care, reduced staff workload, enhanced emotional well-being of patients, and contributed to better overall outcomes in the emergency department, with staff expressing strong support and a desire for expanded availability.

**Staff quotes**

1. As a physician at Chilliwack General Hospital ER I have come to value the PSW role. PSWs fill a real gap in personal connection and compassion as well as a bridge to services. they make us all better.
2. The PSW pilot program has been an amazing addition to the Chilliwack General Hospital emergency department. Their knowledge is invaluable and the ability to build connections has drastically improved the overall emotional wellbeing of the population they assist. My workload in that aspect has decreased thanks to them. I just wish they were available 24/7.
3. PSW has been an incredible resource for us at Chilliwack General Hospital. It has helped with staff workload and improved patient experiences tremendously.

4. I have noticed a significant decrease in the code whites we have and a significant improvement in patient satisfaction since our peer support workers started.
5. Huge fan of the PSW role. Valuable for patients. Saves a lot of emotional burden for direct medical staff. Would be hard to transition back to working without the PSW.
6. The money spent hiring PSWs should have been put toward creating more treatment centres.

**Peer Support Worker Feedback**

The analysis of the focus group with two PSWs highlighted their dedication to their roles, driven by a desire to share their lived experiences and assist those with whom they empathize. The session was not recorded for the peers' comfort and, therefore, there are limited direct quotes for analysis. The PSWs reported feeling well-supported by site management and fully integrated into the ED team, which is crucial to the program's success. They described feeling fulfilled by witnessing patients progress and having a "tangible place to manage their own discomfort with the system" in the form of advocacy. Furthermore, they outlined the importance of having PSWs embedded into the ED to ensure patients are receiving the care they need in a fast-pace and often stressful environment. Peers also outlined feelings of burnout and moral distress caused by witnessing systemic injustices, biases among staff, wage inequality, and lack of community resources. Overall, the peers were overwhelmingly supportive of the program and shared a desire for it to continue.

## Discussion

The PSW ED pilot project demonstrated that peers can be effectively integrated into complex health systems, enhancing both patient and staff experiences, when a multidisciplinary approach, comprehensive planning, and iterative quality improvement methods through PDSA cycles are employed. PSWs not only provided important care to PWUD, but also helped to reduce stigma among staff. Embedding PSWs into the ED team fostered trust, respect, and collaboration, as reflected in the feedback, and has the potential to contribute to a more compassionate and empathetic work environment.

ED nurses reported in the survey that having PSWs present reduced their workload and improved overall job satisfaction. PSWs facilitated access to basic necessities, witnessed consumption, referrals to community resources, and provided 1:1 support—tasks that were often previously handled by ED nurses, which allowed nurses to focus more on their clinical duties. While no pre-survey data on workload was collected, staff comments highlighted that the PSW role effectively filled a service gap, alleviating workload pressures. Studies have shown that increased workload pressures in EDs have led to staff experiencing moral distress, burnout, and decreased retention (Boulton & Farquharson, 2023). Therefore, reducing staff workload through the involvement of PSWs has the potential to mitigate moral distress and burnout by addressing the system-level challenges associated with caring for complex patients. These benefits may also help address broader issues within the Canadian healthcare system, such as staff retention challenges, high turnover rates, and the increasing strain on emergency departments, while ensuring sustainable, high-quality care delivery (Boulton & Farquharson, 2023). It is recommended that future projects measure staff burnout and workload pressures using standardized tools iteratively throughout the project to statistically demonstrate any changes after the initiation of PSWs.

Before implementing any such program however, it is crucial to thoroughly understand the existing landscape, including the potential challenges and barriers of integrating staff with lived experience of drug use. Meaningful collaboration and socialization are imperative to uncover and mitigate any preconceived biases that may exist among ED staff. Although most staff saw benefits to having peers embedded into the ED, two comments appeared to denote possible stigma, which further highlights the need for this program's continuing education and de-stigmatization work. This project demonstrated how peers, equipped with drug use expertise, can also assist with de-escalation, resource navigation, and education, further supporting patients and staff. ED staff noted, through open-ended feedback in the survey, a noticeable decrease in code whites after the implementation of PSW role, but code white data was not collected prior to the initiation of the role, so it is difficult to determine if there was a decrease of statistical significance.

Beyond practical aid, PSWs seemed to offer invaluable allyship to patients amidst the demanding healthcare setting. While PSWs are a part of the healthcare team and work collaboratively with clinical teams to support patients in their care-continuum, it was done so with a patient-first model. The patients are seen as the experts of their own health and if they desired referrals to detox, treatment, or any additional supports beyond acute care, PSWs would help navigate the health system along with the patient and healthcare team. This harm reduction approach aligns with the recent shift in medical management toward shared decision-making (Fairman & Tariman, 2019). Furthermore, our patient experience survey showed that 80% of patients reported that PSWs helped create a safe and trusting environment, which may help encourage individuals who might otherwise hesitate to seek medical care to engage with healthcare services. One of the benefits outlined by patients and staff alike was that PSWs provided avenues for witnessed consumption. While outside of the scope of this project, evidence suggests safe consumption services can offer multiple benefits, and as abstinence may not be the preferred goal for all patients, programs that offer supervised consumption can provide an avenue for safer use and connection (Dow-Fleisner et al., 2022). Future projects may find benefit from incorporating a more robust family of measures including iterative data throughout the project on toxic drug poisoning events, mortality, standardized staff workload/burnout questionnaires, number of readmissions, and number of patients with a history of using drugs.

It is well documented that Indigenous peoples are disproportionately represented in toxic drug poisoning deaths due to complex intersections of systemic barriers rooted in stigma, oppression, and intergenerational trauma (First Nations Health Authority, 2022; Jongbloed et al., 2017). While completing the intake forms, PSWs asked every patient if they identified as Indigenous. If the patient answered 'yes,' the patient received an explanation of the IHL program and were offered a referral. IHLs help support patients in the hospital who identify as Indigenous through cultural support, advocacy, community referrals, and

navigation through the health care system. While 8% of the population served by CGH identifies as Indigenous, 30% self-identified as Indigenous to PSWs, while completing the intake form and only 23% of those who identified as Indigenous asked to be connected to an IHL (Statistics Canada, 2023). Though not explored further during this project, this low referral rate could be because the patient is already connected with the IHL team as the resource is also offered at hospital registration, the patient was not wanting additional supports at the moment, or was not feeling safe to ask for help. This learning highlights the need for additional conversations with Indigenous partners to ensure patients are receiving the supports they desire.

To ensure the sustainability of embedding peers into the ED, it is essential to provide regular support as the role can lead to burnout and moral injury (Mamdani et al., 2021), as highlighted in the peer focus group. Programs that have incorporated peers into other settings, such as in-community have also outlined increased burnout felt by peers – a common occurrence in environments that involve working with PWUD (Olding et al., 2021). Based on PSW feedback, future planning for programs of this nature should incorporate regular check-ins, mental health and wellness supports specifically tailored to peers, a competitive wage, a sustainable schedule and ongoing destigmatizing work with ED staff (Greer et al., 2019). These considerations are equally essential during initial budgetary allocations to building a sustainable and resilient program, thereby reducing peer burnout. Additionally, it is imperative when integrating a peer program that opportunities for their feedback to be received are implemented meaningfully to ensure their voices are valued (Bardwell et al., 2018). Such safe spaces create opportunities to share thoughts both verbally and through writing, consultation when changes or decisions are being considered, and representation at presentations or discussions of the project with leadership or stakeholders (Brown et al., 2019).

A distinctive aspect of this pilot project is the employment supervision and support structure of the PSW program. The PSWs report directly to the ED manager to facilitate hands-on support, role accountability, and team building. They are hired under the Hospital Employee Union, ensuring the peers are receiving healthcare and vacation benefits. The PSWs attended ED staff meetings, education sessions, morning huddles, and had direct role accountability to ED leadership, allowing for rapport and respect to form between PSWs and other ED staff, demonstrating true integration into the ED team. This may have had an impact on preconceived biases, as ED staff were now privy to information and learnings from individuals with lived experience working alongside them, which has the potential to offer new perspectives on issues like substance use. Program materials were updated regularly based on feedback provided by the peer staff in collaboration with the project's interdisciplinary working group.

In addition, the regional Toxic Drug Response team was heavily involved in the development of the program to provide expertise, support, and to ensure a harm reduction lens was used throughout. Although this reporting structure has many benefits, there were some instances in which role clarification was needed to understand the reporting matrix. In the future, further understanding of how other similar roles may be implemented across the region and clearly defining how reporting structures will work using quality improvement (QI) resources, such as a Responsible-Accountable-Consulted-Informed matrix, may help alleviate challenges (Brower et al., 2021; Scheeres, 2015).

Incorporating quality improvement and evaluation methodologies was important in navigating challenges and assessing the project's impact. For example, in the initial weeks following the program launch, it became evident that PSWs were supporting patients outside through witness consumption. This observation prompted the team to explore the feasibility of establishing a fixed on-site supervised consumption area. However, logistical constraints rendered this approach impractical, necessitating the development of alternative strategies. As a result, the team pivoted to strengthen strategies to ensure safety of the PSWs and patients while outside, such as partnering with security and using 2-way radios connected to an ED staff member. Over the course of the project, approximately 20 PDSA cycles were conducted, each contributing valuable insights to the iterative refinement of the program. As the program matured, formal documentation of the PDSA cycles became less structured. However, the methodology remained a cornerstone of the decision-making process. The robustness of our measurements was limited by the competing priorities faced by ED staff. Additionally, our real-time data collection efforts lacked a denominator to account for the number of potential patients who may have been missed. Consequently, future teams seeking to implement similar programs should engage with relevant data teams early in the process to ensure that appropriate data pathways are established from the outset. Similarly, careful consideration should be given to the operational aspects of program planning, including clear reporting structures, defined roles, and task boundaries for peers, especially in fast-paced environments like the ED. Addressing task clarity, a sustainability plan for peer payment, and the scope of practice for peers is essential to ensure proper support for patients, peers, and staff during the complexities of implementation. The lessons learned from this pilot can inform the development of related peer programs in other healthcare settings, potentially transforming patient care across Canada.

**Limitations**

The electronic forms relied on voluntary information provided by patients, which could introduce bias despite our efforts to accurately link multiple encounters. Patient/staff experience surveys were anonymous, raising the possibility of multiple responses from the same individual. Additionally, the analysis included data from when the program was more established; therefore, experience might have been different if assessed at inception. The survey for staff did not define "quality of life," and therefore, respondents may have very different perceptions of what that means and how the peers may have an effect on it for their clients. Out of four PSWs, only two were able to attend the focus group. Finally, our analysis did not include a comparator, access to health system data to assess trends over time, or any pre-implementation surveys. Despite the team's expertise in analysis, evaluation, and quality improvement, competing regional priorities and challenges in accessing critical data limited the depth

of engagement and the scope of impact analysis. Future projects with enhanced methodological and statistical rigour, including the integration of more robust monitoring systems for additional variables like code whites, may reveal additional insights. As there is little preexisting literature of a project of this nature, the evaluation of this project informs changes that are implemented on an as-needed basis, and thus informs new funding cycles and further recommendations for future projects.

## Conclusion

The implementation of the PSW pilot project has proven invaluable amidst the strain of the toxic drug crisis in one lower mainland emergency department and is a promising role that should be replicated elsewhere. Based on feedback received, the role appeared to support both patients and staff, potentially fostering quality healthcare experiences for patients and offering a pathway for early identification of substance use needs and resource allocation of respective care. Patients shared that the peers allowed patients to feel genuinely heard, respected, and valued as they navigated their healthcare decisions. PSWs played a pivotal role in promoting safer drug use practices through supervised consumption, distribution of harm reduction supplies, allyship, and harm reduction educational initiatives.

Staff feedback indicated that the program boosted morale, improved workload stress, and reduced substance use stigma, all resulting in the potential of improved patient care and decreased burnout felt among staff in the ED. Integrating peers into the ED can support PWUD meaningfully, while empowering staff to deliver more compassionate, comprehensive, and empathetic care.

## Implications for Emergency Nursing Practice

1. Implementing the role of peers provides necessary support to ED staff in managing cases involving drug use, thereby alleviating workload pressures and reducing burnout among healthcare providers.
2. Through regular consultation and focus groups, peers offer valuable perspectives and may help mitigate both conscious and unconscious biases with ED staff, supporting a trauma-informed approach to care.
3. Collaboration between the peers and ED staff may improve patient care outcomes through engagement of harm reduction practices.
4. Multi-disciplinary collaboration with bidirectional leadership engagement from multiple levels within the health authority is necessary for creating sustainable improvements that directly impact emergency practice.

## About the Authors

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## Conflicts of Interest

*Authors are employed for the health authority that conducted the pilot project.*

## CRediT Statement

***Janelle Tarnow:*** *writing- original draft, writing- review & editing, conceptualization, validation, resources, supervision, project administration.* ***Rita Metwally:*** *conceptualization, methodology, validation, formal analysis, resources, data curation, writing original draft, visualization.* ***Aven Sidhu:*** *conceptualization, methodology, validation, formal analysis, data curation, writing-original draft, visualization.* ***Mary Van Osch:*** *writing- review and editing, conceptualization, supervision.* ***Tracy Stoneson****:*

*writing- original draft, supervision, writing- review & editing.* ***Jade Black****: conceptualization, validation, resources, writing- reviewing and editing.* ***Kim Wood****: validation, visualization, writing- review & editing.* ***Kassaundra Benoit:*** *validation, visualization, writing- review & editing.*


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