

Peer Support Workers as a Bridge: A Qualitative Study Exploring the Role of Peer Support Workers in the Care of People Who Use Drugs During and After Hospitalization

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Abstract

Background: To describe the key qualities and unique roles of peer support workers in the care of people who inject drugs during and after hospitalization.

Methods: We conducted a qualitative study. Key stakeholders were recruited including: people who use drugs who had been hospitalized, healthcare team members, peer support workers, and employers of peer support workers. Data was collected from 2019-2020 using semi-structured interviews that were audio-recorded, transcribed, and analyzed thematically.

Results: Fourteen participants were interviewed: 6 people who use drugs who had been hospitalized, 5 healthcare team members, 2 peer support workers, and 1 employer of peer support workers. At the core of the data was the notion of peer workers acting as a bridge to overcome systemic barriers. We found two themes that related to functions of this bridge: advocacy and navigating transitions within the healthcare system. We found two themes for building a strong bridge and making the role of a peer support worker function effectively (training and mentorship, and establishing boundaries). We found three themes involving characteristics of an effective peer worker (intrinsic qualities, contributions of shared experiences, and personal stability). When the bridge works well it ultimately serves to rebuild trust between healthcare providers and people who use drugs.

Conclusions: Peer support workers are highly valued by both people who use drugs and members of the healthcare team. Peer support workers act as a bridge between patients and healthcare providers, and are critical in establishing trust, easing transitions in care, and providing unique supports to people who use drugs during and after hospitalization.

Background

People who use drugs (PWUD) present to the emergency department and are hospitalized more often than the general population [1-3]. Hospitals have been identified as a “risk environment” for PWUD, who experience significant barriers to accessing health services [4,5]. The stigma experienced by PWUD in hospital can result in delayed presentation to care, lack of trust in healthcare providers, higher rates of patient-initiated discharge, and hesitance to access acute care when needed [4-7].

Healthcare providers (HCPs) have also expressed feeling ill-prepared and reluctant to provide care for PWUD [8,9]. This reluctance can manifest as avoidance and lack of engagement, often interpreted by PWUD as neglect and mistreatment [4,5,9,10]. Many studies have shown that HCPs hold negative attitudes towards PWUD which can reinforce the stigma experienced by PWUD when accessing healthcare [9]. Thus, despite frequent interactions between PWUD and HCPs in acute care settings, significant barriers exist that impair the formation of a strong therapeutic alliance and adversely impact the hospital experiences of PWUD [10].

Integrating people with lived experience of drug use as partners in clinical care delivery in hospitals has been proposed as a potential de-stigmatizing intervention [7]. Peer support workers are individuals with lived experience who may take on formal or informal roles in the care of the clients they serve. The use of peer workers in community-based care models for PWUD has been shown to have favourable outcomes: reduced substance use, better retention in treatment, and improved relationships with treatment providers [11-13].

However, literature on the role of peer support workers in supporting PWUD while hospitalized is sparse. To our knowledge, two studies have been published that specifically examine the role of peer workers for PWUD while in hospital [8,11]. Both studies arose from the integration of “peer mentors” into an inpatient addiction consultation team (IMPACT) in Portland, Oregon [8,11]. One study highlighted strategies to successfully integrate peer mentors into the healthcare team and identified that clear role definition, structured hiring and retention process, and ongoing training were critical [11]. The second study evaluated the role of peer mentors and found that they were considered valuable additions to the healthcare team, assisted in engaging patients, and acted as cultural brokers between patients and HCPs [8].

Despite the well-established challenges faced by PWUD when hospitalized and the limitations of traditional HCPs to provide care to this patient population, there remains a paucity of literature on the use of peer support workers with lived experience of drug use to support PWUD in acute care settings. This study aimed to explore: (1) qualities that make a good peer support worker for PWUD during and after hospitalization for acute illness and (2) the essential functions of a peer support worker for hospitalized PWUD within the context of overall care.

Methods

Study design

This was a qualitative study. One-on-one semi-structured interviews were conducted.

Participants

Fourteen participants were interviewed: 6 hospitalized PWUD, 5 members of the healthcare team (two family physicians, general internist, infectious diseases specialist, cardiologist), two peer support workers, and one employer of peer support workers.

Research team

The research team was composed of three individuals. The first author is a family physician with expertise in addiction medicine. She coded 100% of the transcripts. The second author was a research associate with over 10 years of research experience and 5 years of healthcare research. They also have experience with qualitative research designs and interviewing participants. They conducted and coded 100% of the interviews. The third author is an infectious disease specialist with expertise in addiction

medicine and low-barrier care for PWUD. He helped with the contextualization of the results, and challenged the thematic map. All authors believe in a harm reduction and person-centred approach to providing care to PWUD.

Interview guide

The first and second authors developed the interview guide. The first interview (that was with a patient) was treated as a pilot interview. It was deemed successful based on the depth of information gathered and no changes to the interview guide were made.

Procedure

Participants were recruited using purposive sampling and snowball sampling procedures to gather in-depth information specific to our research questions [14,15]. We recruited patients, HCPs, peer support worker employers, and peer support workers. After the 14th interview it was decided that the richness of the meaning was sufficient to answer our research questions and recruitment was ended [16].

Data analysis

A professional transcription company was used to transcribe audio recordings verbatim. We used (reflexive) thematic analysis [17] to identify, analyze, and report patterns or themes in the interview data. We inductively coded the data and followed the six phases of thematic analysis outlined by Braun and Clarke [17]. We took an interpretivist approach. Analysis was primarily grounded in a pragmatic framework [18].

We followed Lincoln and Guba's (1986) [19] and Tracy's (2010) [20] recommendations for ensuring the trustworthiness, authenticity, and credibility of the data. For credibility, we used purposive sampling - participants who could speak to the topic intimately, providing rich information to answer our research questions. For authenticity, direct quotations were used in the results. Credibility was fostered by having two people code and analyze the data independently. The first and second authors met to discuss interpretations and initial theme development after the first five interviews, and again after all the interviews. In each meeting the coders discussed discrepancies until consensus was reached. These meetings also involved refinement of the thematic map.

Results

Participants had interacted with peer support workers to different extents, but most had some past experience with peer workers that informed their responses. All participants identified the role of peer workers as being unique and valuable in the care of PWUD during and after hospitalization. All six PWUD interviewed said that they would welcome involvement of peer workers in their care.

Thematic map overview

As demonstrated by the thematic map (figure 1), at the core of the data was the notion of the peer worker acting as a **bridge to overcome system barriers**. We found two themes that related to functions of this bridge: **advocacy** and **navigating transitions within the healthcare system**. We found two themes for building a strong bridge and making the role of a peer worker function effectively (**training and mentorship** and **establishing boundaries**). We also found three themes involving characteristics of an effective peer worker (**intrinsic qualities, contributions of shared experience, and personal stability**). When the bridge works well it ultimately serves to **rebuild trust** between HCPs and PWUD.

The Core: Peer support workers as a bridge to overcome system barriers

Central to the data was the concept of peer support workers as a “bridge,” and served as an anchor in our analysis. The word “bridge” was mentioned in various ways by HCPs, peer support workers, and employers of peer support workers within the study to illustrate their importance. For example, “bridge” was used to describe how a peer worker could facilitate a discharge plan (P9, HCP), or serve as a connection between the patient and the healthcare team, or with community resources (P10, P11, P12, HCPs), or to bridge gaps in communication and information (P11, HCP).

The notion of “bridge” illustrated the potential for peer workers to help overcome systemic barriers faced by PWUD in hospitals, such as system trauma, stigma and inflexibility. Participants used this analogy explicitly; “I [the peer worker] was also able to connect with people and be that bridge that bridged the gap between the academics, the medical people and the people who are using... That’s kind of the job of a peer support worker. We want to bridge the gap between these two because people have a lot of fear of hospitals and the medical industry, the medical scene” (P13, peer worker).

This theme took shape as participants paired the acknowledgement of these system barriers that PWUD have experienced with the notion that peer workers have a unique lens that may help overcome these challenges, as they may have experienced similar barriers themselves. For example, P6 noted that “they [peer support workers] see that there’s a value in connecting with the system, but they also recognize that it isn’t easy, and that it can be very stigmatizing...So, I think that’s where the value comes in; it’s that bridge and that buffer between a system that can actually do harm in some ways and also benefit” (peer support worker employer). Having peer workers representing the community of PWUD within the healthcare team was noted to put patients at ease, and begin to restore a sense of safety within healthcare spaces.

“[peer support workers] did a lot in terms of building trust for people to get in the door. Because I think what we realized really early was that people actually don’t feel really reassured by a doctor or nurse being around, but they feel really reassured by someone from their community being there and telling [them] that it’s a safe place.” (P8, HCP)

Participants described acute care as a highly structured and inflexible environment that can cause tension between PWUD and HCPs, and one in which peer workers could assist in overcoming system rigidity. One patient described a conflict that arose with her nurse because she was not allowed to leave

the ward to go outside for a cigarette: “nobody will compromise with me and I am lashing out because of it.” (P4) She went on to reflect that if there was a peer support worker involved in her care, they may have been able to work together differently:

“To get on the same page. And, you know, it’s something that the nurses and like people like me can’t do, to be honest; and something that a peer support worker and I probably could do, and we could compromise like that. (P4, patient)”

Both PWUD and HCPs felt that peer support workers could use their unique lens to be creative about solutions to overcome inflexibility, and could work with both patients and HCPs to make these changes work:

“let’s figure out a different way. If one way is not working, figure something else out... you know, a different solution.” (P4, patient)”

“all of our physicians are willing to think outside the box, but sometimes...we need some help coming up with the different ideas (P12, HCP).”

Functions of the bridge

Closely tied to the core concept of peer workers as a bridge were themes relating to the functions of peer workers for PWUD in hospital and after discharge: advocacy and navigating transitions within the healthcare system.

Advocacy

Many PWUD felt disempowered within the hospital system, and thought that a peer worker would be able to advocate for their needs both in hospital and after discharge. One participant recounted her experience presenting to hospital:

“Like I don’t know if that whole—the first hospital I went to up in [city] was just horrid; like it’s almost like they didn’t believe me that I was having pain. Like I was having a lot of pain in my leg, that was because my body was full of infection and because I had a heart infection...it’s like they almost didn’t believe me and thought I was just there wanting drugs or something.” (P7, patient)

She went on to express that she would have felt better if someone like a peer worker was with her at the time who could “speak up for [her]” (P7, patient) and help advocate for her needs. All other PWUD reaffirmed this sentiment and described peer support workers as someone who could “push for you” (P5, patient) or “be my voice” (P4, patient).

Navigating transitions within the healthcare system

A salient theme was the role of peer workers in bridging transitions from hospital to outpatient care. All HCPs felt that the immediate post-discharge period was the highest risk for adverse patient outcomes,

often due to patients facing structural barriers (lack of housing, lack of transport, limited social supports) in their home environments that interfered with their ongoing engagement in care. PWUD also felt that upon leaving hospital, they would have limited awareness of the resources available to them and that a peer worker would be helpful: “They know more about what's in the neighborhood or your community.... I really don't know anything when I'm leaving here.” (P5, patient) Similarly, HCPs felt that once the patient left the hospital, they had limited ability to maintain contact and ensure good continuity of care.

In transitioning from hospital-based to community-based care, participants envisioned peer support workers acting as a “touch point” (P10, HCP) and providing continuity between settings. This navigation could be bidirectional: “...both the patient getting back in the healthcare system, if needed, and the healthcare system getting in touch with the patient.” (P9, HCP)

If given flexibility in their role and the opportunity to connect with patients in both hospital and community settings, peer workers could position themselves as “being a main bridge between those two times [hospital and community-based care] (P11).”

Building a strong bridge: Making the role of peer support worker function effectively

Ongoing training and peer mentorship

Participants emphasized the importance of adequate training for peer support workers to allow them to function effectively. Having lived experience is essential and informative, but without training on how to channel that lived experience to serve the needs of clients, peer support workers felt poorly resourced to fulfill their role:

“I wasn't saying the right things even through my lived experience... I was like, I don't know what to do in this situation, I don't know how to help someone else, I don't know what to say, you know, and how to keep them safe, and what is crossing boundaries and what isn't.” (P13, peer worker)

In particular, participants highlighted the need for specific training about mental health and suicide prevention, especially when serving clients with complex mental health needs. Harm reduction training and guidance on boundary setting was also noted to be essential for peers working with PWUD.

Participants also emphasized the need for ongoing support and mentorship of peer support workers over the course of their employment. This can be achieved through “continual coaching” (P6, peer support worker employer) or the use of a designated peer mentor to provide ongoing guidance. This ongoing mentorship was noted to be helpful as challenges unique to the peer worker role arise, such as boundary concerns and ethical issues.

Establishing boundaries

Many participants emphasized the critical role of establishing boundaries in peer support work. These boundaries are rooted in clearly defined expectations of the role. When describing what went wrong with

a past initiative involving peer support workers, P6 said “you do have to be very clear about what your expectations are from the beginning...I don’t think there were clear expectations as to what was okay and what wasn’t okay [regarding the past initiative], and so then when things started happening that weren’t okay, people were confused, right, because that hadn’t been communicated that that wasn’t okay.” These predetermined expectations help set boundaries, which served a dual purpose: allowing the peer support worker to function effectively in their professional role, and mitigating the risk of social distress and burnout.

Especially if working within a community that they have lived in or have strong relationships with, peer support workers can encounter situations where maintaining professional boundaries is challenging:

“We’re going to have to be careful... about overlap between maybe social circles or communities from where the person with lived experience or the peer support worker comes from and the individuals that they’re helping to support because it’s important that they come with some shared perspective, but you don’t want it to feel not safe to either of them because there’s too much overlap between their original communities.” (P12, HCP)

The overlap between professional and personal communities was a challenge that peer workers recounted from past experiences; “I had to figure out my boundaries... it’s a unique situation for a peer support worker. You know, a lot of these people that are coming in... you know them.” (P13) Even if previous relationships did not exist, peer support workers articulated that the unique therapeutic relationship formed between peer support workers and their clients could lead to blurring of professional boundaries:

“There’s a certain inherent sort of trust between people that gets built, and it becomes a type of a friendship; but you have to be really careful to keep people that you’re working with professionally. It’s difficult, but you need to be able to keep that professional.” (P14)

If professional boundaries were not upheld, or if peer support workers were not given guidance on how to set these boundaries, they can be at risk for burnout. As per one peer support worker; “... it ended up becoming a problem for me because I had no space for myself, and I was getting overtired. Because like my job would never kind of end.” (P13)

It was acknowledged that for peer support workers to have sustainability in their role, they needed to be able to set and maintain professional boundaries to prevent the burnout and distress unique to their position. Participants felt an ideal peer worker should be “a careful balance between somebody that can really be there with the individuals while they’re with them but doesn’t take it home with them too much, because we don’t want those individuals to burn out either” (P12, HCP). Maintaining boundaries was noted to be an essential component of self-care and sustainability for peer support workers; “Boundaries ties us in with self-care... if I can’t take care of myself, I cannot do my job. I can’t help people.” (P13, peer worker)

Characteristics of an effective peer support worker

Intrinsic qualities

Participants listed many intrinsic qualities that a good peer support worker should possess. Desirable qualities included being reliable, open-minded, respectful, adaptable, and empathetic. Participants voiced a need for the peer support worker to be highly sociable, be able to form strong social connections, and to read people well: “you have got to be able to mirror the person that you’re talking to” (P14, peer worker). A consensus formed among participants that the peer support worker must be an exceptional communicator, and more importantly – an excellent listener: “someone who listens, that takes time to listen... who genuinely cares” (P7, patient).

In terms of characteristics to avoid, being judgmental and closed-minded were noted as highly undesirable qualities: “not being able to understand the other side of the coin (P2, patient).”

Contribution of shared experiences

Patients clearly articulated the unique benefits of having a peer with lived experience involved in their care. Having a shared understanding of the challenges of substance use made PWUD feel more comfortable opening up to peer workers, and made peer workers more relatable members of the healthcare team.

“...if they have been there and done it themselves, they understand more than anybody else... it’s easier to talk to somebody who understands and has been through it themselves, than somebody who has just read it out of a textbook.” (P3, patient)

Healthcare providers also recognized the benefits of this shared understanding. One provider commented, “I think it would be powerful to have somebody that can really be there with them and understand it in a different way than the rest of our care team can” (P12, HCP).

An additional benefit of integrating peer support workers with the traditional healthcare team was their unique lens in identifying potential triggering aspects of acute care for PWUD.

“I think somebody with lived experience, a peer support worker, might be able to understand how bothersome it might be when people are poking your arm or whatever again for bloodwork or having, you know, constant IV access as potentially a trigger for you for ongoing injection drug use.” (P12, HCP)

When asked about the importance of the peer worker’s lived experience mirroring their own, most PWUD felt that it was unnecessary for the peer worker to have used the same substances or have a shared substance use pattern as they did. As long as the peer worker had lived experience, the specifics of their substance use were less important, “It doesn’t matter because it’s all the same; it’s an addiction.” (P5, patient)

Personal stability

When asked about whether peer workers being active or in remission from their substance use should be a consideration for the role, there was no consensus among participants. Rather, many participants brought up the concept of “stability” as being most important for a successful peer worker. Stability was conceptualized as the sum of many factors including: an individual’s substance use pattern, mental health support, housing stability, and access to social supports.

“I think in this role, if you’re there as a support person for someone else, you just have to have at least enough stability, whatever that means for you, to be able to be reliable and show up [for] someone else.” (P8, HCP)

Many participants felt that the role of peer worker is diverse and depending on the setting they were working in, the level of personal stability required may differ. As one peer support worker said: “I think that there’s a place for everybody in peer support work.” (P13, peer worker)

In highly structured settings such as acute care, one participant felt that unstable substance use could potentially impact the peer worker; “in terms of their ability to fulfill their role on a regular basis” (P10, HCP).

Many participants felt that as long as the peer worker was “strong and stable enough that they can support other people,” (P9, HCP) there were no specific requirements as to where that individual should be in their personal arc of substance use. Instead, the most important requirement was that they be able to perform the duties of their role reliably. In determining this stability, one participant felt that the best gauge of readiness for the role would be peer worker self-assessment: “they’re the ones that should be able to tell us where they are in their journey” (P11, HCP).

When the bridge works well: restoring trust between HCPs and PWUD

Participants identified that “there is a distrust between... the community that we’re dealing with and the medical system” (P10, HCP) and that when integrated effectively, peer support workers could act “as the bridge between the two” (P10, HCP).

“all sorts of different kind of longstanding historical pieces that I think have really contributed to the culture of making it a really unpleasant experience when people who use substances come into hospital. There’s a significant lack of trust for a lot of those reasons as well.”

Participants expressed that the lack of trust could impede the provision of adequate care, and that for PWUD to feel comfortable discussing their substance use with the healthcare team, trust is essential.

“to help your patient, to get them to open up [...] so you can give them proper care they have to be able to trust to talk to you, and especially about something so vital in their life” (P4, patient)

Peer support workers identified rebuilding trust between patients and HCPs as being a key component of their role.

“... to build trust between doctors and people that [...] may have had extremely bad experiences” (P13, peer worker)

The unique position of peer support workers as being part of the healthcare team and also having shared experiences with PWUD was identified as helpful by both HCPs and PWUD in lending them credibility. From the perspective of one PWUD:

“my credibility and maybe a peer support worker's credibility are two different things. Like, they could also be a voice, right. Because a lot of times the nurse is not willing to listen...there could be somebody there who has got a bit more credibility and can, you know, relate to them as well.” (P4, patient)

One physician similarly felt that the peer worker could lend credibility to their role by being “...someone who is part of the community, who is fairly known within the community who can kind of vouch for me.” (P10, HCP)

Discussion

Our study supports the analogy of peer support workers serving a bridge. This is consistent with the limited studies available on peer workers in hospitals [8,11]. As a bridge, peer workers can ease transitions in care between hospital and community, and can facilitate stronger therapeutic alliances between PWUD and their healthcare teams.

Particularly around the high-risk period after hospital discharge, our findings suggest that peer workers could act as a bridge from hospital to community, and back again if needed. Peer workers could use their unique perspective to aid in effective discharge planning, which is consistent with literature suggesting that “peer-facilitated care planning” is more inclusive of patient-identified needs, such as housing and employment [21].

PWUD valued peer workers acting as their advocate and assisting them in engaging and communicating with their healthcare teams, particularly around their substance use and unique needs in hospital. When encountering hospital policies and rules that are restrictive, PWUD identified peer workers as a resource to come up with creative, flexible solutions to overcome these barriers. These findings support the notion that integrating peer workers can be a destigmatizing intervention used to improve the hospital experiences of PWUD [7].

For HCPs, the potential benefits of having peer support workers integrated with the traditional healthcare team were clearly articulated. HCPs felt peer workers could assist them in building a stronger therapeutic alliance with PWUD by facilitating communication and identifying areas of clinical care that could be triggering or distressing to PWUD. This is aligned with existing literature highlighting peer workers' ability to reframe and contextualize the patient experience to enhance HCPs' understanding [8]. Given the abundance of literature describing the historically challenging relationships between HCPs and PWUD, the potential for peer workers to assist in bridging this divide was a positive finding.

The intensity of the hospital environment and working with acutely ill clients has been identified as a potential challenge for peer workers who may not have much experience in acute care settings [11]. Our findings confirmed that without supportive measures in place, peer workers are at risk of social distress and burnout. Potentially protective factors identified included adequate training and mentorship, the ability to maintain professional boundaries, and supporting self-care practices. These protective practices are consistent with those suggested by Englander et al. based on their experience integrating peers into hospital-based addiction consultation service [11]. In our study, the employer of peer support workers also highlighted the potential role of “peer mentors” - someone who has previous experience in the peer role and who could act in a supervisory capacity to provide ongoing guidance to peer workers. This layered approach to integrating peers has not yet been explored in the hospital setting, but could be helpful in assisting peer workers in navigating the challenges unique to their role.

A common query in selecting peer support workers is whether or not there should be a requirement for remission from substance use prior to engaging in peer support work. In the only other published work addressing this in hospital-based peer workers, Englander et al. suggested that peer workers should be stable in their recovery, or have two years of continuous remission from substance use [11]. In our study, there was no consensus suggesting that peer workers must be in remission from substance use. Rather, a consensus formed suggesting that peer workers should have enough personal stability to allow them to reliably fulfill their role requirements. Stability was conceptualized as encompassing more than an individual’s substance use pattern, including factors such as secure housing, mental health stability, and robust social support.

Our study adds to the growing evidence for the integration of peer support workers within acute care. Specifically, our findings highlight that integration of peer support workers at the hospital level may not only offer tangible supports to PWUD while in hospital and after discharge (i.e., address service gaps), but also help to dismantling existing system barriers. As such, the integration of peer support workers within healthcare teams could be an innovative strategy to rebuild trust between PWUD and the healthcare system.

Limitations

Despite our study’s contributions, some limitations should be noted. First, patients were interviewed during their hospitalization; thus, impressions of discharge were not based on their actual experience being discharged from hospital. Second, we used purposive sampling to gather in-depth information, however, other stakeholders, such as nurses, administrative staff, policy makers, may offer different (or peripheral) perspectives. Finally, our study was within the context of the publicly-funded Canadian healthcare system. The peer support worker role may operate differently in other health systems and funding models.

Conclusion

Hospitalization can be a critical moment in a patient's healthcare journey, and one that is particularly challenging for PWUD who face system barriers and distrust when accessing health services [4,5]. Our findings suggest that integrating peer support workers into hospital teams is a potential intervention that could combat these barriers for PWUD [7] and help to rebuild trust in the healthcare system. Guidance on how to successfully integrate peers within hospital care teams is sparse [11]. Our findings highlight the need for programs to ensure adequate training and mentorship, boundary setting, and the use of self-care practices to protect peer workers against distress. Our findings add to the growing support for the use of peer support workers for PWUD in hospital as a novel concept.

List Of Abbreviations

PWID: people who inject drugs

PWUD: people who use drugs

HCPs: healthcare providers

Declarations

Ethics approval and consent to participate

This study was undertaken with ethics approval from the Hamilton Integrated Research Ethics Board (Study ID # 5877). All participants provided written consent and received a \$20 honorarium.

Consent for Publication

Not applicable

Availability of data and materials

Data sharing not applicable to this article as no datasets were generated or analyzed during the current study.

Competing interests

The authors declare that they have no competing interests.

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Author's Contributions

LL completed semi-structured interviews with participants. LL and RL contributed to protocol development and data analysis. All authors contributed to manuscript preparation.

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Figures

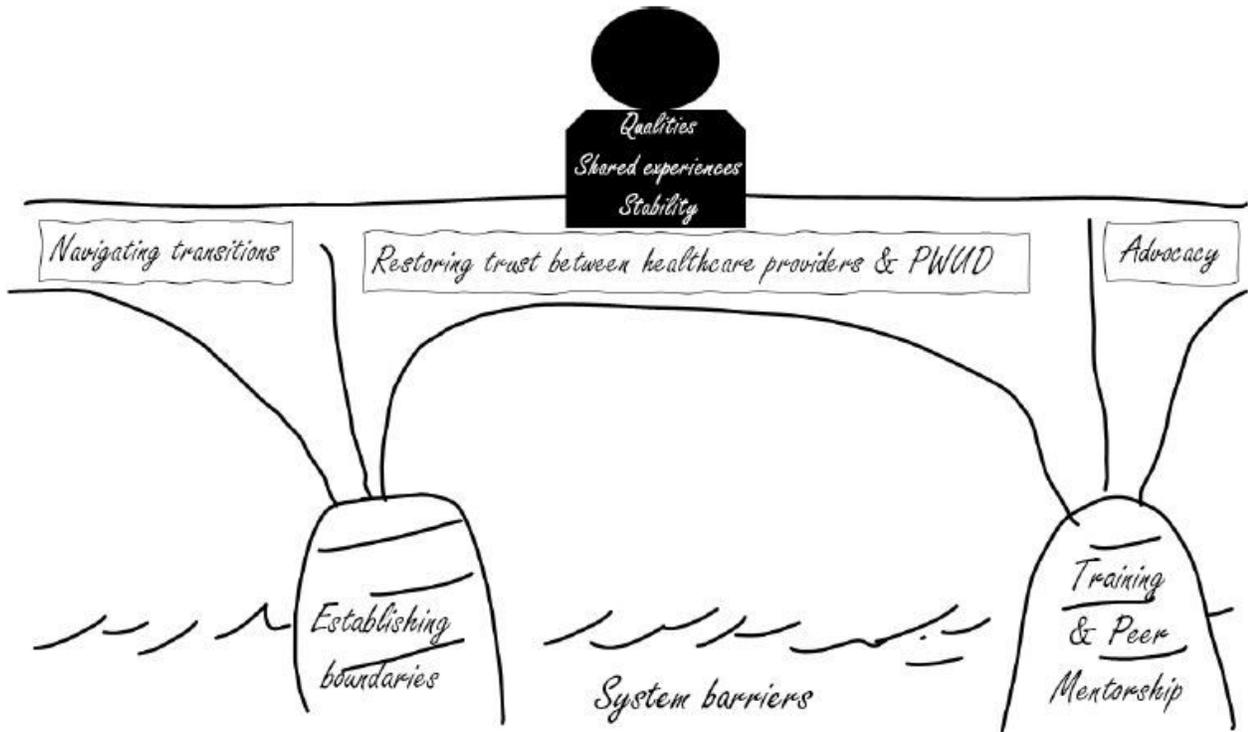


Figure 1

Thematic Map