

Translation Course

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THE CHALLENGES OF COMMUNITY ENGAGEMENT AMONGST SUBSTANCE USERS IN CANADA

KT Learning Course 2021: Case Study Group 8

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CASE STUDY NAME

DESCRIPTION OF THE CASE (1/2 – 1 PAGE)

WHAT IS THE KTA PROBLEM?

Despite countless efforts to address the opioid crisis, the number of opioid overdose related deaths have increased significantly in the United States (US) and in Canada with 134 000 lives lost in the US and more than 12 000 in Canada between the year 2016 and 2018 (Centers for Disease Control, 2020; Tyndall, 2020). The COVID-19 pandemic has exacerbated the pre-existing opioid overdose situation. Indeed, the opioid overdose is a national public health emergency and many factors have been contributing to the opioid overdose crisis failure among which stigma and discrimination against people who use drugs are very present that are embedded in the political and social arrangement of our world including criminalisation and homelessness (Tyndall, 2020). Moreover, opioid overdose prevention strategies often exclude the socioeconomic factors of the opioid crisis and remain top-down and individually oriented practices without or very little community engagement (CE). Community engagement is broadly defined as: “[...] the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people [...] and it can take many forms with partners from organized groups, agencies, institutions, or individuals. Collaborators may be engaged in health promotion, research, or policy making.” (National Institutes of Health, 2016). Community engagement is important to collective action, empowerment, and co-learning (Ahmed et al., 2010; Lavery et al., 2010). Researchers acknowledge that there is a need for more understanding of: 1) the impact of community engagement as an approach for addressing public health issues like the opioid crisis, and; 2) best practices for engaging communities in the adoption of opioid treatment and prevention initiatives (Glandon et al., 2017; Huang et al., 2018). We acknowledge that the role of community in effective evidence informed policies are neglected in the policy making process and also there is a gap in addressing CE barriers and applying the developed models into practice (Taha et al., 2019; Tyndall, 2020).

Opioid overdose deaths have increased dramatically across North America over the past decade, stemming from a combination of over-prescribing of addictive opioid painkillers and fentanyl contamination in the illicit opioid supply. Canada reported 8.8 opioid overdose deaths per 100,000 in 2016, and increasing to 12.3 per 100,000 in 2018. In total, in Canada, from January 2016 to March 2019, an estimated 12,800 people have died of opioid overdose. The epidemic continues to claim lives despite no official federal declaration of public health emergency, with Canadian policymakers resistant to institutionalized, large-scale harm reduction interventions. The lack of opioid research focused on women has only recently begun to receive broader recognition, and this lack is especially felt in Canada.

WHO DOES IT AFFECT AND HOW?

Various stakeholders are affected by the gaps in the effective community engagement (CE) models and the lack of evidence on the barriers of the community engagements in the prevention of the opioid crisis. First, the most affected population by such gaps are marginalized populations such as women and Indigenous peoples. The term Indigenous peoples is a collective name for the original peoples of North America and their descendants. Canada recognizes three groups of Indigenous peoples this includes the First Nations, Inuit, and Metis. In this crisis, Indigenous people are three times more likely to die from overdose than their non-Indigenous population (Johnston, 2020). Moreover, the COVID-19 pandemic has caused a 135% increase in opioid related deaths in Ontario during its six month period alone and 17 843 years of life were lost due in comparison with the six month prior to the pandemic (Gomes et al., 2021).

In the prevention strategies of the opioid crisis, the top-down CE approaches create further barriers to engagement of the underserved communities and can systematically exclude them from the policy making process (Cyril et al., 2015; Snow et al., 2018). In addition, socioeconomic status of marginalized populations are associated with their lower participation and sustainability throughout the CE process, where stigma and discrimination, as well as implicit biases in societies adds up to such barriers (Snow et al., 2018). Many of these barriers are embedded in a system of power in the engagement process, defining the legitimacy of marginalized groups' participation to inform policy and healthcare decision-makings. Hence, such systems have created a mistrust between the participants and the policy makers as well as healthcare providers that result in poor CE, poor knowledge of opioid overdose interventions and health outcomes. As aforementioned, the crisis has been having a larger burden on the health of Canadians and more specifically women and indigenous communities across the country and opioid overdose has contributed to a lower life expectancy among those with lower socioeconomic status (Snow et al., 2018).

DESCRIBE THE “K”

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WHAT DO WE KNOW AND DON'T KNOW ABOUT IT?

We know that CE is, as defined by many, is a collaborative process of working together with communities to advocate for change and address the needs of the group. This level of community-based collaboration gives voice to the voiceless and narrowing down health inequities, but in practice the CE process involves various barriers that require further needs more evidence. Some of main barriers to CE are overt and bound to systematic racism, as well as colonialistic histories. These factors hamper the use of CE to create meaningful and effective opioid prevention and treatment implementations. There is an urgent call to decolonize community engagement, and for researchers to recognize that all persons know more about their own health and wellness than expert researchers or clinicians do. It is acknowledging that diverse communities have a right to lead research projects in which they choose to participate - to define how research is conducted in their communities and to define the outcomes that guide research priorities.

WHAT ARE THE BIGGEST GAPS?

Although, several CE models have been developed to curate a meaningful engagement of the community, including the Social Ecological model, the Active Community Engagement Continuum, Diffusion of Innovations, and community-based participatory, has been reported the most equitable in addressing power imbalances and improving knowledge exchange; however, they all have implementation barriers for the in engaging meaningful and sustainable CE to improve opioid crisis (Cyril et al., 2015). Therefore, addressing the gaps in the CE process still remain complex and unmet. The need for innovative frameworks based on lived experience of opioid users that improve health inequities of the most disadvantaged through CE in opioid overdose is a national urgency and yet not determined yet. Furthermore, stigma represents a considerable barrier to research, as well as care, recovery and improved well being among people who use substances. Intersection stigma refers to multiple and overlapping types of stigma (racial, gender, sexuality, classism). It may be responsible for contributing to an overall misconceptualization and framing of the epidemic of opioid use as only being among the marginalized, street-entrenched populations, when in fact substance use is indiscriminate. Stigma interferes with help seeking behaviors and knowing more about this and its effects through internalized stigma can be a way forward using CE. A better understanding of intersectional stigmas that underlie substance use-related harms is needed to drive more successful prevention efforts. Therefore, we suggest that the next steps for this framework are to understand the impact of intersectional stigma related to substance use within Canadian health systems is a large gap that needs to be addressed in tandem with the development of innovative CE frameworks for involving marginalized persons in this area of study. Moreover, national and provincial policies in response to opioid have changed throughout the last decade. For instance, British Columbia's provincial government has responded to activism related to increasing overdose deaths with a declaration of a public health emergency and a move towards expanding OPS (BC Centre for Disease Control, 2017; Tait & Woo, 2017). However, the history of OPS is also marked by political interference and barriers. For example, in Ontario, the June 2018 election of a new provincial government has resulted in increased political pushback and stalls in relation to continued operation of existing OPS and the opening of new sites. Currently, although the federal government in Canada are more receptive to harm reduction compared to recent history, this very history shows the impermanence of an enabling policy environment. That is, the National Anti-Drug Strategy created by the former Conservative government removed harm reduction as a key pillar, while the current Liberal government restored this pillar with the recent Canadian Drugs and Substances Strategy (see Health Canada, 2016). As well, an enabling environment at the federal level does not guarantee the same at the provincial and territorial levels of government that have much of the authority to determine the structure of health care and social service systems.

PROMISING PRACTICES

(1 PAGE)

RECOMMENDATIONS

For models to be more successful in improving the engagement of the communities in the prevention of the opioids crisis, we suggest that collaboration must take part at all levels including government, stakeholders, and communities. Meaningful engagement starts with addressing the power dynamics amongst all the participants (Taha et al., 2019). This involves moving beyond tokenism to sharing power and decision-making more equitably to promote empowerment and develop co-produced models of care, in this case to address the opioid crisis. As well as, developing frameworks that promote building trusting relationships between academics/researchers and community members to encourage participation using the CE process to reduce stigma and discrimination towards opioid users. The completion of cultural sensitivity and CE training is advantageous for researchers at all levels of training. The CE approaches should include sex, gender, trauma, and must be contextualized and culturally relevant to reduce socioeconomic inequities to ensure marginalized voices are represented through whole CE process to reduce the barriers to the engagement. Finally, as there is no one size fits into this crisis, meeting the unique needs of different communities, particularly most marginalized contexts can improve CE process and the health outcomes of opioid users (El-Bassel et al., 2021; Taha et al., 2019).

ADAPTATION FOR LOW-RESOURCE SETTINGS

Accounting for low resource settings in CE approaches is vital. Partnering with community-based agencies and advocacy groups will help to connect with individuals who otherwise may not be reachable due to the transient-nature of some substance users. These collaborations can be time intensive, but important to creating trusting researcher-participant relationships and creating meaningful initiatives to address the opioid crisis. Often these voices are absent from policy-driven research for this reason and come to bare some of the most important findings for change practice.

SYNTHESIS

(2-3 PAGES)

Provide brief synthesis/summary or resource review that people can go to if they want to learn more.

The opioid crisis had increased significantly in the United States and Canada since the start of the COVID-19 pandemic; it is in fact exacerbated by many factors such as stigma and discrimination that are embedded in the political and social arrangement of the system (i.e., poverty and health inequities) (Tyndall, 2020). Community engagement refers to “the process of working collaboratively with and through groups of people...to address issues affecting the well-being of those people” (National Institutes of Health, 2016). Community engagement (CE) offers a vehicle for increasing community engagement in research and prevention efforts to inform opioid treatment and prevention initiatives (Glandon et al., 2017; Huang et al., 2018). Community plays a vital role in addressing CE barriers and applying new strategies and learnings into practice (Taha et al., 2019; Tyndall, 2020).

Community engagement and its use provide a voice to the voiceless. It has become pivotal for well-functioning initiatives and moving change forward. Expanding public engagement achieves long-term and sustainable outcomes, processes, relationships, discourse, decision-making, and implementation among diverse communities. It is necessary to give voice to the voiceless and move forward with change as well as address more complex, overt and systematic issues with the system such as racism and colonialist histories that can hamper meaningful change. There is an urgent call from Indigenous groups, in particular, to decolonize the political decision-making structure in this country to acknowledge that all persons have different lived experiences that come to influence their health outcomes. It is important to recognize that diverse communities have a right to lead and contribute to research projects on topics of their choosing directly related to their lived experiences and to define how this work is conducted in their communities.

There is a need for innovative frameworks to inform change among opioid policy and harm reduction to improve the health outcomes of the most disadvantaged through CE. Studies show that stigma represents a considerable barrier to research and care, recovery, and improved well-being among people who use substances. It may be responsible for contributing to an overall misconceptualization and framing of the epidemic of opioid use as only being among the marginalized, street-entrenched populations, when in fact, substance use is indiscriminate. Efforts in addressing the opioid crisis waned at the start of the COVID-19 pandemic but require refocus, and a starting point to change practice is using CE. Further research is needed to understand the intersectional stigmas (i.e., racism, classism) that underlie substance use-related

harms is needed to drive more successful prevention efforts that are meaningful as well as sustainable.

For the initiatives to be more successful in their address of the opioid crisis in Canada and to improve the engagement of the communities in the prevention of the opioids crisis, we suggest that collaborations at all levels including government, key stakeholders, and communities, need to take place to ensure that equitable representation is had in decision-making and the implementation of change practice (Taha et al., 2019). This involves the prevention of tokenism through sharing power and decision-making more equitably to promote empowerment and develop co-produced models of care, in this case, to address the opioid crisis. Further, the completion of cultural sensitivity and CE training is advantageous for researchers at all career levels. There is no one-size-fits-all in addressing this global crisis and meeting the unique needs of different communities, particularly most marginalized contexts, which can improve the CE process and health outcomes of opioid users (El-Bassel et al., 2021; Taha et al., 2019).



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