The Community is the Cure: How African-American Washington, DC Residents Informed Opioid Treatment Engagement

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ABSTRACT

Background: Recent data indicate rising opioid overdose deaths among African-American residents of Washington, DC.

Objectives: We highlight a community-informed approach to assessing attitudes toward opioid use disorder (OUD) treatment among DC residents (February 2019 – March 2020).

Methods: A listening tour with trusted community leaders led to the formation of a Community Advisory Board (CAB). When the COVID-19 pandemic commenced in March 2020, community dialogues became exclusively virtual. The CAB partnered with academic leaders to co-create project mission and values and center the community's concerns related to opioid use and its causes, treatment structure, and facilitators of effective engagement.

Results: Interview guides were created for the engagement of community members, utilizing values highlighted by the CAB. The CAB underscored that in addition to opioid problems, effective engagement must address community experience, collective strengths/resilience, and the role of indigenous leadership.

Conclusions: Engaging community prior to project implementation and maintaining alignment with community values facilitated OUD assessments. Community-informed assessments may be critical to building community trust.

KEYWORDS: Community-Based Participatory Research, Community health partnerships, Power sharing, Substance-Related Disorders, Social Change

BACKGROUND

The opioid overdose epidemic is increasingly affecting urban, predominantly minority populations in the U.S., including Washington, D.C., as indicated by rapidly increasing overdoses clustered in medically underserved, economically disadvantaged, largely African-American areas of the District of Columbia and many of the nation's largest cities (1-3). A major contributor to opioid fatalities nationally is the limited reach or low utilization of medications for opioid use disorder (MOUD), with less than 25% of persons with opioid use disorder (OUD) having received treatment for OUD in the past year (4). The problem is particularly severe for African Americans, who, despite a generally comparable prevalence of OUD, are 47-77% less likely than White Americans to receive OUD treatment (5-9).

Highlighting concerns about low OUD treatment utilization in U.S. cities, Washington, D.C. has experienced one of the fastest increases in opioid-related mortality in the U.S., with rates at least doubling every two years since 2014 (10). African-American residents bear a disproportionate burden of opioid overdose mortality with 73.9 deaths per 100,000 compared to 8.7 per 100,000 among Hispanic residents and 9.1 per 100,000 among White residents (11). The city is divided into eight geopolitical wards. Most recent census data indicate that, combined, DC Wards 7 and 8 make up about 20% of the city's total population age 18 year or older (12). However, these two wards accounted for 46% of the District's opioid overdose deaths in 2020 (13). These wards have predominantly African-American populations (>91%) (12). More than 20% of residents in these wards live below the poverty line (12). Proximity to health care options further compromises these communities (14). Stigma, fears associated with harsh drug laws, institutional mistrust, lack of knowledge and negative attitudes about medication treatments, and lack of recovery resources limit the reach and effectiveness of treatment and compound OUD health care disparities (15, 16). These factors are evidence of the ways in which health inequities are socio-politically determined.

Despite these challenges, these communities also bring significant strengths that can be brought to bear on the problems. Fully leveraging community resources will be essential to stemming the tide of

OUD disparities and the associated morbidity and mortality. These issues and outcomes are embedded in a rich environment of resources and opportunities for enhancing engagement of communities at greatest risk for opioid-related deaths. Potential community-informed solutions may include community-engaged health promotion activities, which have been effective in addressing health disparities among African Americans (17-22) or potentially expanding OUD treatment models to include interventions in non-traditional community settings.

OBJECTIVES

To address the gaps in OUD treatment engagement for African-American residents of Washington, D.C., faculty at Howard University proposed a community-based participatory research (CBPR) process – the Reach, Engage, Retain Project - to engage community stakeholders and assess feasibility and acceptability of integrating evidence-based interventions, such as low-threshold medication treatment, in non-medical community settings (e.g., churches or religious organizations, social services organizations, or neighborhood barber shops or nail/hair salons). Led by a faculty champion, who embraced her role as Director of Community Engagement and New Program Development, Howard faculty and community members envisioned a community-centered process for each phase of the project*: formative phase, community needs assessment, design and implementation, evaluation, and returning results and resources to the community.*

Here, Howard University faculty and Community Advisory Board (CAB) members report on key activities within the formative and needs assessment phases of our work. This includes conducting a listening tour that culminated in the seating of CAB members and co-creation of the project's mission and values. Mutually agreed upon engagement principles helped shape approaches to building community trust through design of interview templates for use with community members, to gain knowledge about barriers and facilitators of engagement in OUD treatment and recovery services. Creating an interview

approach for discussing opioid problems through community-academic partnership yielded lessons that may be applicable in other contexts.

All study procedures, including project introduction, CAB formation, and interview guide development, were approved by the local Institutional Review Board. CAB members were compensated for their expertise and time.

METHODS

Conducting community listening tour, seating CAB, and co-creating project mission and values

Our community engagement process was designed to clarify the experiences of African-American residents of Wards 7 and 8 and identify community-informed approaches for successfully engaging and retaining persons with opioid use disorder in treatment and recovery services. Initial community conversations were launched by a faculty champion who met with a DC-area faith leader who had pastored for over 40 years and functioned as a community guide and connector. This leader assisted the research team in meeting and conducting individual interviews or small group meetings with other faith leaders, mental health clinicians, and community service providers to gather recommendations on ideal strategies for building trust and communicating project milestones. Six small-group dialogues were held. Engaging community before the project started led to the co-creation of project vision and mission statements and ensured the research process operated from an ecologically valid concept of the project and potential solutions.

As a result of the community listening tour (February 2019 – June 2019), six individuals who were active participants during the introductory community discussions and endorsed by trusted community leaders were invited to the CAB (Table 1). Initially, the CAB was chaired by the Howard University faculty champion who had conducted the community listening tour. However, as the project matured, CAB members were invited to participate as community co-chairs, sharing power with faculty

from Howard University. Later, it was jointly decided that the community co-chair position would be on a rotating basis to provide a leadership opportunity for anyone interested. CAB members possessed a range of lived experiences with opioid use and knowledge of community resources, including a person with OUD and taking buprenorphine; the pastor of one of the largest churches in DC Ward 7 with co-located mental health services; the director of a large DC-based non-profit; an economic developer and community organizer; a person in long-term recovery from substance use and the additional lens of motherhood; and a person in recovery from substance use and criminal justice involvement. All CAB members were either residents of Washington, DC or employed within the District. The original charter of the CAB has been included in the Appendix.

Co-creating community interview guides

During monthly in-person meetings and intermittent virtual conference calls, the CAB provided detailed commentary and revisions to the interview questions suggested by the research team (July 2019 – March 2020). The COVID-19 pandemic and public health emergency resulted in exclusive use of virtual meetings in Spring 2020 and a delay in beginning the community interview process. Meetings were facilitated by a faculty co-chair and community co-chair; included CAB members, a note-taker, and other academic leaders; and were audiotaped. Quotations included in the Results are based on meeting notes or recordings.

Faculty members suggested a four-part interview structure based on their understanding of community players, including 1) community members in treatment, 2) community members not engaged in treatment, 3) community leaders, and 4) friends/neighbors. The CAB completed a thorough, question-by-question review of all guides over 7 in-person or virtual meetings and utilized an online shared document to communicate suggestions to the research team. Table 2 describes the CAB Interview Assessment Process. Guides for individuals in-treatment vs. not-in-treatment were consolidated into a single template, *interview for individuals with lived experience,* following recognition of the common

experiences of individuals with OUD that did not appear to hinge upon their status with a formal treatment program.

RESULTS

Project mission and values. The CAB-derived mission and vision statements placed greater emphasis on structural issues and root causes, than on medication treatment, expanding the research team's initial lens for the project scope. Members noted the importance of recognizing the role of social determinants of addiction (23). One member aptly summarized, "*…because it all played a part in my addiction."* The vision and mission statements reflected these experiences and values: *The vision of the Washington, DC "Reach, Engage, Retain" project is for Wards 7&8 to be a healthy, thriving community where residents experience freedom from problems with substance use and addiction. Our mission is to increase access to effective recovery and treatment services; reduce stigma; and deal with the root causes of unhealthy drug use.*

Values-aligned community assessment. Three interview guides were finalized: *lived experience*, *community leader*, and *family member/neighbor*. Table 3 provides an overview of the CAB's edits and their rationale, for the *lived experience* guide. These changes were reflected across the distinct types of interview guides, along with unique questions for community leaders (summarized in Table 4). The interview questions for family members were largely the same as those in the "lived experience" guide, excepting the removal of questions about drug use and treatment history. Key community values were identified by the CAB and included relationship-focused engagement; community education and empowerment; a strengths-based stance for understanding the community; and project sustainability. Health, social, and economic policy figured prominently into CAB members' conceptualization of the problem of opioid dependence and other addictions. There was consensus that policy solutions needed to be "holistic" representing the multi-faceted nature of addiction. Yet, caution regarding over-reliance on

external players, including policy makers, to solve community problems was expressed. One CAB member remarked,

> *One of the problems is that the issues that we face are long term. Government can't develop long term strategies. That's not...that's not their agenda. So, we're sitting around here waiting for them to come up with solutions, and they're looking at trying to get re- elected in four years. We've got to develop 20- year strategies.*

CAB members clearly and consistently advised that opioid treatment should be considered in the broader context of the community's experience with other social determinants of health. They concluded that the depth, breadth, and history of the problems necessitated structural and social change as part of a path toward long term solutions.

> *If they don't know, from where they sit, what the real problem is, and they only have a perceived notion of the problem, then the solution oftentimes does not include really the voice of those who are suffering with the problem, or suffering with a challenge, or suffering with whatever the issue or challenge may be*.

LESSONS LEARNED

Building trust by communicating participatory values. The CAB acknowledged a community grappling with a history of oppression and exploitation would have justified concerns about authenticity and motives of the research team. CAB members indicated that a level of trust could begin to be established if respondents knew that the interview was created by members of the community, rather than by researchers, *"So the way we build the trust, you know, is simple. People want to know if, you know; you've experienced this before; or how you can relate."* Importantly, the introduction to the community interviews stated that CAB members had lived experience with OUD.

Framing opioid problems within larger community context and concerns. The CAB also recommended that all interviews begin with a frame of *community first*, and they added probes to clarify how individual experiences are shaped in the context of community. This perspective widely differed from the research team's initial suggestion that interviews begin with a respondent's experience with drug use and treatment. Recognizing the varied ways in which people identify themselves and define their community and that addiction, in part, was an indicator of the health of the community, CAB members recommended beginning the interview with a definition of "community" from the respondent's perspective. As the research team reflected upon the significance of this change, a CAB member commented, *"We have to start with community... because I am a product of my community."*

Naming root causes of addiction. The CAB viewed addiction issues as derived from structural causes, and not solely the fruit of personal choices or problems. As reflected in their reasons for participating in the CAB, members indicated that solutions would be derived not just from community knowledge, but community control of the resources to apply that knowledge. Members conveyed the importance of control of resources.

> *A lot more can happen when we control resources, because we know as a community, what the problems are. We have the knowledge, we know what the problem is, we just have not been able to have access and control over the resources to come up with and pay for the solutions that we know . . . work. So, I think that's the new frontier for us.*

As a result, questions were added about necessary changes to structures and policies to adequately address the root causes of addiction. The CAB recommended that the term "rules," instead of policies, would be more familiar for the participant interview.

Acknowledging therapeutic role of community structure. CAB members challenged the research team to think about holistic solutions to addiction problems, and to avoid leading with concerns about "treatment," especially medication-based therapies. The research team, in turn, had to grapple with its

own sense of powerlessness to fully address structural determinants of substance use. This tension was acknowledged and addressed through frank discussions between community members and academic leaders. Community members gave a resounding answer when asked about their concept of treatment: *The community is the therapy*. The university research team realized that the community's experiences with oppressive structures and an ingrained medical bias that placed the highest value on medication-based interventions would require that the project focus on relational concepts of treatment; according to the CAB, the community itself was the cure.

Adopting a strengths-based view of community. The CAB also recommended that the community be discussed from an asset-based stance. The research team was counseled to emphasize community strengths and to assume that existing community resources and indigenous leadership would be helpful in addressing opioid problems. Several members agreed that,

> *We've been defined for a long time to be a community of deficits, you know, our whole existence was measured... based on poverty... That's how money came into the community... That's how we saw ourselves... just a community of deficit. And that has all kind of psychological issues that we see play out. To define yourself really means to, you know, create your own reality.*

In line with operating from a strengths-based stance, the CAB was also quite interested in understanding the scope of current community interventions. They introduced a new interview question for community leaders that specifically addressed how organizations were measuring their community impact.

Integrating education with community assessment. From the CAB's perspective, the interview was also part of the intervention. They noted that many community members did not associate their heroin addiction with the opioid epidemic. They explained that the word "*opioid*" was often associated with prescription pain pills and thus classified as *the white people's problem.* Some community members did not know that heroin was also an opioid. The research team was asked to create supplemental materials for use during interviews, explaining the different types of opioids, including heroin and

fentanyl, and clarifying the current toll on minority communities and especially those living in cities like Washington, DC (10, 24, 25). Additional materials explaining the use, mechanism of action, and availability of medications for treating opioid addiction were integrated into the interview process.

Creating an empowering context. The CAB anticipated that each interview would create opportunities for building relationships, sharing knowledge, and thus strengthening the community.

> *…the interview gives them a chance to be able to speak about things that they probably wouldn't have spoken about to no one else, you know, or it gives them an opportunity to dig deeper to the root causes of some of the problems that they had.... just being conscious of when you create an environment, that you can create an environment that's an empowering environment. You can be conscious of empowering people*

CONCLUSIONS

Building upon examples of community-informed SUD treatment engagement (17, 18, 26), we have described a CBPR approach for developing a substance use intervention within a population that has, historically, not been well-served by health care systems and experienced social and economic marginalization. Our work adds to a growing body of work focused on the development of collaborative or co-located service models (27). There is increasing recognition of the value of strategically including the community's voice – as in the current study – to build SUD treatment capacity from grassroots to systemic levels.

Changes made to the interview guides ensured that participatory values resonate throughout the data collection process, as each respondent contributes to interview feedback and revisions (28). There are envisioned opportunities to expand upon our engagement framework to build community-based substance use interventions in urban contexts. The interview guides, one of the main products of our CAB, provided a starting place for adapting conversations about addiction to other communities, specifically those

dealing with socioeconomic inequality. The present work emphasizes the criticality of language: what questions we ask and *how* we ask questions informs our approach to identifying root causes and framing solutions. Future CBPR projects on SUD engagement may also find aspects of our approach highly replicable, including the use of a CAB to conceive a project vision, to articulate community values and principles, and to advise on qualitative data generation and interpretation.

Limitations of our engagement approach include reliance on a CAB whose members had largely overcome active-phase SUD and had been in treatment or recovery for a substantial amount of time or had no history of an opioid use disorder. Individuals actively using opioids were not invited to the CAB; a person early in recovery was invited, but ultimately declined out of concern for maintaining abstinence. Community activists and leaders were strongly represented on the CAB and were usually the source of conversations that shifted the intervention frame from one of medication treatment to holistic solutions, such as community development. It is unclear if an advisory board with greater representation of active-phase SUD would have similar areas of focus. Certainly, the selection of CAB members must also consider the likelihood of meaningful participation and the presence of psychosocial stability, factors that will be affected by the individual's health and substance use history.

Community members gave a resounding answer when asked about their roles in this process: *"I think what you all did well was allowed space or gave space to the creation of this whole process. It really was community directed, community driven…. I feel like you all really allowed a safe space for the community members to really give voice and to direct the process."* CAB member feedback indicates that community members felt heard and respected as co-creators in a design process. Since March 2020, 74 interviews have been conducted utilizing the CAB-guided assessment approach. Not only were products created to be more attuned to the views and experiences of potential respondents, but the interview guide development process also established a standard for how the collaboration would operate overall.

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Table 1. Howard University CTN CAB and Author Team Roster*

Member Designation	Affiliation	Role
Morgan Medlock, MD, MDiv, MPH	Howard University	Faculty Champion
Richard Schottenfeld, MD	Howard University	Faculty/Principal Investigator
Mustafa Abdul-Salaam, MS	Community Economic Development Partners, LLC	CAB Member and Co-Author
Imani Brown, BS, MPH	University of Maryland	Research Assistant/CAB Scribe
Gloria Thombs-Cain, LMSW, PhD	Howard University	Faculty Co-Chair
Kevin Charles, CPRS	Family and Medical Counseling, Inc.	CAB Member and Co-Author
Ernest Clover, BA, MA	DC Dream Center	CAB Member and Co-Author
Kendrick E. Curry, MDiv, PhD	Pennsylvania Avenue Baptist Church	CAB Member and Co-Author
Lazetta Nelson	Washington, DC Resident	CAB Member and Co-Author
Imani Walker	Washington, DC Resident	CAB Member, Community Co-Chair, and Co-Author
Carla Williams, PhD	Howard University	Community Informed Practice Consultant

*The CAB included representation from three persons in recovery, two community-based organizations, and one faith-based organization.

Table 2. CAB Interview Assessment Process

CAB Feedback	Value / Principle	Refinement of Interview Guide
Emphasize participatory action during the interview process.	Co-creation; doing with rather than doing to	Interview guide language was adjusted to emphasize community members as possessors of expertise and partners in project design and assessment.
Utilize a framework that begins with an understanding of community values and structure before delving into what may be perceived as a community problem.	Community first; acknowledging social determinants of health	Questions about drug use were moved to later in the interview guide, while questions about community values and structure were moved to the beginning of the interview guide.
Relinquish deficit-based models of the community.	Approaching community members from a strengths-based approach with an appreciation for indigenous wisdom	Questions regarding community input to solutions development were added/strengthened. Questions that suggested community deficiency, a lack of resources, or an assumption about rampant drug problems, were removed from the interview guides.
Utilizing community assessment as an additional opportunity to educate and empower community members.	Reframing academic partnership with community as therapeutic not detrimental to community	Educational tools on fentanyl and other deadly substances were added to the assessment process, including a path for helping interviewees access treatment, if desired.

Table 3. Interview Guide – Community Members with Opioid Problems

Interview Section	Theme	Initial Language	Revised Language	Rationale
Preamble	Participatory values should be communicated to research participants. i.e., "Doing With"	Hello, my name is _____ and I am a part of a research team doing research to understand opioid use in Wards 7 and 8 of Washington, DC…	Initial language with this addition: *The interview will include 13-17 questions. The interview questions were developed by a community advisory board made up of DC residents, including those with lived experience and leadership in this area.*	Communicate the role of community members in formulating questions. Respond to concerns about data misuse and emphasize authenticity of project.
PART A. Demographic Questions	Measure social determinants of health. Build Trust. Respect Autonomy. Commit to a community benefit.	Race Ethnicity Gender Religious Preference Neighborhood of residence Ward of residence	Initial language with these additional categories: *Age category* *Income source* *Highest degree or level of school completed*	New categories were added: Age, Income, Education. Emphasize that demographic responses were voluntary. Data were collected for the ultimate benefit of the community.
PART B. Views on Drug Addiction Problems	Have a "community first" stance – (i.e., begin with understanding of community structure before asking about drug problems).	The initial version asked a series of questions about personal history using opioids.	When you hear the word "community" what does it mean to you? In this community what are the top substance issues (i.e., drugs or prescription drugs, alcohol use problems) you see?	Acknowledge that individuals are a product of their community. Drug use does not occur in a vacuum. Questions about personal history using opioids were deferred until later in the interview, after larger issues within the community were discussed.

PART C. Opioids in the Community	Avoid *a priori* assumptions.	Please describe how you see opioid use affecting your community.	How, if at all, does opioid use affect your community? In your experience, how do people talk about or describe people who use opioids? Could you tell us about how <u>you</u> talk/describe those who use opioids?	Revised language does not assume the community has a drug problem.
PART D. Experiences with Opioids and Seeking Treatment	Research participation should educate and empower. Use culturally competent, non-stigmatizing language (lived experience vs in treatment, out of treatment).	*Experiences with opioids* How old were you the first time you used X? ___ How long ago did you start using X habitually/on a regular basis? ____ months / ____ years Tell me about the first time(s) you used? Since Y time ago when you started using X, describe for me how it has affected your life and relationships? *Experiences seeking help* What led you to start treatment when you did? What helped you to start treatment? Describe any problems you encountered when trying to enter treatment. Describe what you think would have been helpful in reaching	Open-ended questions added, focusing on individual experience, rather than factual data or points in time: Have you had any experience with opioids? And if so, do you mind sharing about it? *By opioids, I'm referring to "fent"(fentanyl), "carfent" (carfentanil), heroin, "smack," etc... [Opioid Glossary added]* Have you had any experience seeking help for opioid use? And if so, do you mind sharing about it? Have you ever been able to stop using opioids? How long were you able to stay off drugs? What led you to start treatment when you did? What types of treatment have you received? Was treatment beneficial? If so, how? If there were interruptions in treatment, what caused you to stop treatment in the past?	Questions arranged to facilitate bi-directional learning. Community knowledge about opioids and opioid treatment is supported. The research team learns about how the community talks about opioid use and barriers or facilitators for engaging and continuing care.

		you/getting you in substance use treatment earlier. *Experiences at current clinic (if in treatment)* Describe your experience in your current treatment program. Tell me about what helped you start/maintain treatment/ keep you on track. What do you like about treatment at your current treatment program? What would you change about the care you receive there?	What is your understanding of medications for opioid problems? *After response, the interviewer provided prompts for specific medications... What is your understanding of buprenorphine, of methadone, of Vivitrol? [Opioid Treatment Glossary added, and each medication explained to conclude interview]* Where are you currently receiving treatment for opioid use? What has your experience been like at _____?	
PART E. Recommendations	Adopt a strengths-based approach and avoid deficit models.	What do you feel is missing, if anything, in your community's response to opioid use?	In this section, I'd like to hear more about your ideas for engaging individuals with opioid problems in treatment and/or recovery support. What rules would you change about starting and staying in treatment?	Multiple questions about what is missing from current opioid response were eliminated, thereby minimizing inference of deficiency within the community.
Summary	"Doing with" – each respondent is invited to join a process of bringing change to the community. Research participation	Is there anything else you would like to share with me that we haven't already discussed?	Thank you for your time. The information you provided today helps us understand your experience and the community's experience so that we can work together to bring positive change to the residents of Wards 7 & 8.	The summary includes the anticipated impact of this process on the wider community and reminds of everyone's role in creating change. Education remains a focus to conclude

	should educate and empower.		Before we end, would it be okay if I take a moment to share a few additional facts about the opioid crisis and how it is impacting DC residents?	interview; researcher shares facts about the opioid epidemic in Washington, DC and where to find help, if needed.

Table 4. Additional Questions for Community Leaders

Interview Type	Theme	Sample Questions	Rationale
Community Leader	Strengths-based approach Community development should be an integral part of health and health care. Communities should have access to and derive benefit from research derived.	Does your organization address opioid use in the community? If so, how? How do you measure your impact? *Recommendations Section*: What about any policy changes that might be helpful?	These questions were added out of CAB interest in outcomes/impacts that communities have already attained. This opened a new avenue of understanding outcomes that are of value to the community (which may differ from clinical outcomes).

Appendix: CAB Scope of Work

Howard University Reach, Engage, Retain Project

1. Community Advisory Board

The DC CTN is designed to be guided by the "lived experiences" of people affected by opioid and other drug addictions. We seek input from people affected on a personal level and on a community level. To make sure that these real-world experiences are included in planning and carrying out CTN research, a Community Advisory Board (CAB) has been formed. The CAB has 6 members. Members represent community-based groups, faith communities, peer recovery groups, businesses, and neighborhood organizations. The CAB will be involved in each phase of the DC CTN start-up projects.

2. Community Advisory Board Scope of Work

During the start-up project, the CAB will:

1. Work with DC CTN investigators to find the best ways to talk about these issues with community members
2. Link the research team to people and groups who can give useful input on how to achieve the project's goals
3. Help to plan and implement ways to share new information from the research with the community
4. Advise about ways that the research can contribute to the "big picture" of dealing with the root causes and harmful outcomes of opioid overuse in DC communities

The work will proceed in phases. However, the program has a great level of flexibility to adjust approaches, as needed, to achieve the best results. The expected process is outlined below.

2-1. Formative Phase

The CAB and research team will work together to develop the CAB. Outcomes of the planning phase will include:

- A clear shared vision for the CAB's role in the project
- Operating guidelines for CAB activities
- Documentation of expected roles and responsibilities
- Shared understanding of research methods to be used
- Strong working relationship with the research team
- A timetable of planned activities
- A vision for long-term sustainability of the program and CAB beyond the current grant funding

2-2. Needs Assessment

Based on the planning phase, CAB members and research staff will begin to implement tasks to support the project's needs assessment. Expected tasks may include:

- Advise on development of language for discussing opioid and other drug addictions
- Advise and give feedback on questions to be asked during focus groups and interviews
- Assist with arranging focus group sessions
- Provide introductions to key persons for one-on-one interviews
- Recommend activities to help the research team learn about the issue from community members
- Provide ongoing needs assessment as demographic changes occur in the community

2-3. Design and Implementation

- Give input on ways to improve access to medical treatment for opioid overuse or addiction
- Recommend activities to raise awareness of the project in the community
- Identify people and groups who can join in achieving the project goals
- Recommend ways to assess outcomes of the project activities
- Suggest ways to sustain gains from the project

2-4. Evaluation

- Provide feedback on the quality of engagement with communities
- Evaluate the impact of the research on major outcomes including:
    - Increased use of treatment in primary care settings
    - Increased access to treatment in new types of settings
    - Decreased opioid overdose rates in Wards 7 and 8
- Identify strengths, weaknesses, barriers and facilitators for research and service integration in the community
- Recommend other ways to assess outcomes of the project activities

2.5. Returning Results and Resources to the Community

- Review and approve reports tailored for community audiences
- Help develop resources that will build community capacity
- Assist with planning and promoting meetings or forums to discuss the project with residents and plan future work

3. Budget and Justification

The CAB will meet monthly from June to November 2019, and monthly from January to May 2020. Meetings may be conducted in-person or via phone conferences. CAB members will be compensated for each meeting they attend, at a rate of $250/meeting. This compensation rate includes activities between meetings, such as emails, and individual or small group meetings.

Invoice Period	Justification	# Meetings anticipated	Compensation/ meeting	Compensation/period

06/01/2019 – 12/31/2019	Community Advisory Board consultancy services	6	$250	$1,500
01/01/2020 – 05/31/2020	Community Advisory Board consultancy services	5	$250	$1,250
			Total compensation	**$2,750**

4. Signature

Name: _____ Date:_____

PRINT

Signature: _____