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COMMUNITY EMPOWERMENT, ADULT EDUCATION AND SOCIAL MEDIA APPROACHES TO THE OPIOID CRISIS IN VANCOUVER

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Abstract

This study focuses on how public health workers, as adult educators, and people with lived experience of drug use in Vancouver's Downtown Eastside create supportive environments and educational programs that foster harm reduction and community empowerment to address the Opioid Crisis. The study uses community empowerment theory as its conceptual framework, and an interpretive case study sensitized by appreciative inquiry as its methodology. Findings show how adult education by public health workers, community members, allies, and activist users of drugs promotes community empowerment. Findings further detail the role of social media in these efforts, and the barriers and limits to social media's adoption for public health education among marginalized adults. The study highlights the importance of addressing systemic oppression in adult education programming and building relationships with marginalized people with lived experiences, valuing their knowledge and integrating their voices into the design and running of adult education programs for community empowerment.

Résumé

Cette étude porte sur les façons dont les travailleurs en santé publique, les éducateurs d'adultes et les personnes ayant de l'expérience en consommation de drogues dans le centre-ville est de Vancouver créent des milieux de soutien et des programmes éducatifs favorisant la réduction des risques et l'autonomisation communautaire pour confronter la crise des opiacés. La théorie d'autonomisation communautaire sert de cadre conceptuel; on utilise une étude de cas éclairée par l'enquête appréciative comme méthodologie. Les conclusions montrent que l'éducation des adultes par des travailleurs de santé publique, des membres de la communauté et des alliés promeuvent l'autonomisation communautaire. Elles expliquent aussi le rôle des médias sociaux dans ces efforts ainsi que les obstacles et les limites à leur adoption pour l'éducation en santé publique chez les adultes marginalisés. L'étude montre

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l'importance de confronter l'oppression systémique dans les programmes d'éducation des adultes et de développer des relations avec les personnes marginalisées ayant des expériences vécues afin d'apprécier leurs connaissances et d'incorporer leurs contributions dans la conception et l'offre des programmes d'éducation des adultes visant l'autonomisation communautaire.

Keywords

adult education, harm reduction, community empowerment, social media

Mots clés

éducation des adultes, réduction des risques, autonomisation communautaire, médias sociaux

Throughout my fourteen-year career as an educator, I (the main researcher) have worked with young adults struggling with drug addiction and feelings of isolation. In an effort to offer holistic educational and family support, I have in times past taken a community-based approach to fostering bonds within school communities and the wider community to facilitate positive social change. I see public health workers as adult educators, imparting knowledge and enabling people to have more control over their health and the health of their communities, with the understanding that public health needs to be addressed as a collective concern (Mayfield-Johnson, 2011). My own lived experience of trauma, related to observing a beloved relative and others battle drug addiction, contributed significantly to my interest in how adult educators working on the ground support harm reduction for drug users.

The issues related to opioid addiction in the Downtown Eastside (DTES)—loss of lives, impacts on families and communities, a lack of public awareness—are enormous but strikingly similar to those in many communities globally. I was raised in a single-parent home in the inner city of Kingston, Jamaica, where neighbours, friends, and even a close family member became drug addicts. This has impacted how, as an educator and researcher, I have navigated life and professional practice. I grew up exposed to illicit drug activities and, like many of my peers, was liable to become a victim of drugs in one way or another. During those formative years, I heard my playmate's mom being called a "drug mule," I witnessed drug-related crimes, and I saw some of the young men I grew up with change before my eyes. Some became loud and aggressive, seemingly very dangerous, as they were always talking to themselves or threatening to attack other people, while others became withdrawn, afraid, and frail, shadows of themselves. Some were murdered, some died by overdose, and some were unable to recover from their addiction. In my late teens, my cousin's marijuana was laced with powerful drugs by someone at a house party he hosted. Due to this, he was later diagnosed with schizophrenia, which severely impacted the entire family. The reality that mental illness through drug consumption was not selective hit us hard. This was not supposed to happen to our family.

The devasting realities of the drug trade became even more apparent when I left my island's shores to become an educator on a neighbouring Caribbean island. There, I learned that cellphones and social media played a significant role in marketing drugs. After seeing what happened to my cousin and others, my resolve to effect positive social change grew. I accomplished this by working with community groups and as a school-based

educator and mentor to young men from "broken" or impoverished homes and communities. I collaborated with guidance counsellors and drama teachers to host workshops with "troubled youths" to identify innovative, co-operative measures to build self-confidence and self-esteem. While my efforts as an educator had some impact, I often wondered what collective effort could be employed to further impact positive change.

It was not until I moved to Vancouver in 2018 to complete an MA in adult education that I started to understand the harsh realities of the opioid crisis in North America. A television newscast revealed the grim statistics on the number of people who had already died due to drug overdoses only halfway through the year. Later that year, on my first trip to Vancouver's DTES, I saw many homeless people and also drug users, jaywalking or crouched on street corners, dazed or begging. In the same space, people went about their usual business, seemingly unperturbed by the devastating human impacts of the Opioid Crisis in their community, as if substance abuse and overdose were exclusive to homeless and impoverished people. I immediately had flashbacks to the communities where my cousin, friends, and former students resided, and to the lack of collective support that contributed to their demise. This led me to explore ways in which the public could develop greater concern for the lives of others and possibly join forces with public health workers to increase harm reduction efforts. And in our world of Internet and cellphone use, I wondered where social media could fit into these efforts.

Study Rationale

According to Philpott (2020), opioid-related overdoses are Canada's "most significant public health threat since 1919, when 55,000 people died from the Spanish flu" (p. 17). She further noted that an estimated one million Canadians are at risk of being exposed to toxic opioid products. In Vancouver, out of some 8,000 injection drug users, approximately 4,700 live in the DTES, a community more than any other in Canada likely to have high levels of HIV and hepatitis C infection and overdose deaths (Jozaghi, 2012). In 2013, in British Columbia, there were already 20,000 injection drug users marked by extreme poverty, mental illness, and homelessness (Jozaghi & Andresen, 2013, p. 1). This Opioid Crisis is oppressive, not only for those who are drug users but also for communities that are inundated by people addicted to opioids, and by the realization that the next victim could very well be one of their own. As noted by Freire (1968/1970), "oppression—overwhelming control—is necrophilic; it is nourished by love of death, not life" (p. 77).

The Canadian Mental Health Association (2018) argued that "there is strong evidence to suggest that a public health approach to managing problematic substance use is much more effective than policies that punish and criminalise people who use drugs, as failed anti-drug and 'war on drugs' policies have shown" (p. 3). Because community is seen as "the engine of health promotion, the vehicle of empowerment," it takes a community effort to properly address this issue (Labonte, 1994, p. 260). Several harm reduction policies and initiatives related to drug abuse have been implemented over the years in Vancouver, including the opening of a medically supervised safe injection facility in 2003, driven by the desire to "save" lives (Wood et al., 2006). Still, efforts to meet the demands of this crisis have faced the ongoing challenge of an inability of "targeted groups to access programs designed for their benefit" (Kerr et al., 2017), along with resistance from policymakers, and the public's fear that services provided may attract more substance abusers and contribute to a spike in crime (Wood et al., 2006). Numerous documents on public

health approaches to the Crisis, including the BC Centre for Disease Control's (BCCDC) *BC Harm Reduction Strategies and Services Policy Indicators Report* (BCCDC, 2020) and the city of Vancouver's Four Pillars drug strategy (vancouver.ca/people-programs/four-pillars-drug-strategy.aspx), highlighted the importance of grassroots community education for harm reduction but offered little comment on the uses of social media.

In Vancouver, health educators have long been adept at this approach to "collective action for social change" (Israel et al., 1994, p. 150). Such an approach is two-way, with health educators serving as resources and, more importantly, engaging as partners (Wallerstein & Bernstein, 1994). Together with community members, they co-design programs to address community needs and generate a high degree of success in developing strategies that work (Persily & Hildebrandt, 2008). In the Opioid Crisis, Jozaghi (2014) highlighted the fact that in 1998, the Vancouver Area Network of Drug Users (VANDU) became "the first public health supported organisation of current and former drug users in North America" (p. 215), which significantly contributed to the opening of North America's first sanctioned supervised injection facility. Moreover, the BC Ministry of Health (2005) has developed face-to-face outreach programs that "deliver information, resources and services to hard-to-reach populations of drug users and establish links between isolated drug users and critical health services" (p. 7). Outreach includes HIV and hepatitis C risk-reduction programs that "promote teaching and modelling of risk reduction by leaders of drug user networks, distribute condoms and bleach kits, make referrals to services, provide counselling and support community development" (p. 7). According to Jozaghi (2014), of all initiatives in place, peer support groups seem to be most far-reaching and effective in addressing "many of the micro-environmental factors that drive sharing behaviour or overdose risk and enhance individual ability to employ overdose prevention practices" (p. 216).

Various modes of social media are also being employed by public health workers to address the Opioid Crisis in Vancouver's DTES. However, not all DTES residents have access to these technologies, so not all social media efforts for health education using cellphones or computers are necessarily effective. The purpose of this study is to examine what community-based harm reduction strategies are currently in place in the DTES and to understand how public health workers are using or could potentially use social media to foster community adult education for empowerment in combating the Opioid Crisis. The study has three research questions:

1. What are the community empowerment approaches to public health education employed by health workers and community advocates to promote harm reduction in the DTES?
2. How do health workers use social media for public education and harm reduction in the DTES?
3. What are the challenges associated with the use of social media as a community support strategy?

Literature Review

In this section, we briefly elaborate on the meaning of adult education for community empowerment related to public health and on the role of social media in public education and advocacy for social action.

Community Empowerment

The World Health Organization (WHO) (2009) defined community empowerment as enabling communities to regain or increase control over their lives. This is the transformative power of the collective that Freire believed in, where community members, through participatory education, develop a "sense of identification with a group" (Israel et al., 1994, p. 153), becoming "actors in history, able to name their problems and their solutions to transform themselves in the process of changing oppressive circumstances" (Wallerstein & Bernstein, 1994, p. 142). Also beneficial to the community is the ability to partner with stakeholders and, in so doing, to remove inequalities that were inadvertently introduced in collaborations (Royal Society of Edinburgh, 2014) and ultimately revolutionize public health practice. An empowered community is one "which is confident, resilient, independent and energetic, which has the capacity to identify problems and design solutions at the local level, and which is inclusive and voluntary" (p. 8). Community members both recognize problems and identify ways in which they may be able to influence change or contribute to the design and implementation of services that lead to collective support in addressing the issue. Empowerment then becomes a process that promotes "self-reliance, participation in decision-making, dignity and respect, belonging and contributing to community" (WHO, 2010, p. 1). Hence, it is liberatory, as individuals become confident in their abilities to activate positive social change and, along with stakeholders, apply their skills and resources collectively to influence decisions and changes in the social system (Israel et al., 1994).

Community empowerment encapsulates the idea of community education and lifelong learning through various outreach initiatives, educational programs, and forms of media, where public health workers act as adult educators who communicate knowledge and help community members retrieve power. It "enables community people to increase their knowledge and health care decision-making capabilities" (Persily & Hildebrandt, 2008, p. 131). A community is where public health problems emerge and continuously evolve. To properly address a problem, it has to become a community concern. Through the process of reflection and action (praxis), the community and stakeholders act to effect positive social change, and public health workers then conceive of power as "an expanding commodity" (Israel et al., 1994, pp. 153–154).

Research on community-based adult education programs shows them to be effective at promoting individual and collective empowerment. This includes those programs with a focus on health care. Coady (2013), for example, showed how a community-based cardiovascular health program in rural Nova Scotia facilitated transformative learning and better health for participants. A study by Mayfield-Johnson et al. (2014) detailed the role of community health advisors in Mississippi and Alabama and their effectiveness in bringing health care to marginalized communities, as well as their own transformative learning and empowerment as community members. Other recent research in adult education shows more generally how adult education, community organizing, and social justice are critical to community empowerment (Edwards et al., 2021; Zhang & Perkins, 2023).

For this study, we adopt the Royal Society of Edinburgh's (2014) definition of community empowerment, quoted above, which described an empowered community as one that "is confident, resilient, independent and energetic," with "the capacity to identify problems and design solutions at the local level" while remaining "inclusive and voluntary"

(p. 8). This definition conveys the essence of how an empowered society functions. It supports the belief that those people within a community who are determined to initiate practices for positive changes embody characteristics such as determination, innovation, openness to learning new methods/models for growth, and willingness to form partnerships and embrace an integrative approach to learning (p. 8). Community empowerment facilitates the mutual exchange of learning and growth by creating the "conditions for professionals and communities to engage in empowering practice together" (Wallerstein & Bernstein, 1994, p. 142). Reciprocity is experienced as public health professionals and community members work together, sharing and respecting each other's inputs to create positive results (Persily & Hildebrandt, 2008). Public health workers continuously liaise with those on the ground to extend their reach, forging relationships and networks that enhance community empowerment. Social media contributes to these efforts.

Education through Social Media

Careless (2015b) emphasized the fact that "the rapid pace of technological evolution in society has dramatically altered the way most people live, work, socialise, and learn" (p. 51). In the last two decades, social media platforms have increasingly been used professionally and personally for educational purposes, knowledge sharing, networking, and coordination (Li et al., 2019). Social media has "exploded as a sociocultural practice of communicating with others and sharing knowledge" (Careless, 2015b, p. 51). Social media tools such as Facebook, Twitter, YouTube, and WhatsApp allow for video calling, instant messaging, and quick access to videos and presentations, enabling users to engage in social networking. These collaborative tools are "free, ubiquitous, and nonhierarchical" (p. 50); they are also effective at building community, promoting relationships between individuals and among groups, and facilitating community discourse (Careless, 2015a; Li et al., 2019; Warburton, 2013). Ventola (2014) argued that health care workers "can use social media to potentially improve health outcomes, develop a professional network, increase personal awareness of news and discoveries, motivate patients, and provide health information to the community" (p. 491). Careless (2015b) further noted that social media tools can be employed to "identify and address the needs of adult learners through customisation, personalisation, collaboration, and networking" (p. 51).

As adult educators who develop a critical understanding of social media tools, public health workers can use these tools to challenge the banking form of education (Freire, 1968/1970) with more active social learning (Careless, 2015b). Though social media has its drawbacks—it is not accessible to everyone and may offer poor quality or unreliable information, breach personal privacy, involve licensing and legal issues, and facilitate identity theft—it is also true that public health workers can apply ethical guidelines to help overcome these problems (NCSBN, 2011). Social networks are gradually becoming more significant in building community and mobilizing community organizing and social action (Niven, 2011). Careless (2015b) argued that "social media are undeniably a rich site of learning in contemporary society—free, unlimited access to global discourse and knowledge" (p. 52), and further emphasized the accountability and honouring of varying perspectives. If designed with proper guidelines to prevent risk, and used by the public health department with a community empowerment approach (Ventola, 2014), social media may contribute to social reformation and transformation for those with access to it.

Methodology

This is an interpretive case study informed by appreciative inquiry (AI). A case study methodology allowed "the study of elements of our social fabric through comprehensive description and analysis of a single situation or case" (O'Leary 2017, p. 143), and the interpretation of data "by developing conceptual categories, supporting or challenging the assumptions made regarding them" (Chetty, 2013, p. 42). AI allowed us to highlight the strengths of the community we engaged and acknowledge its limitations (Creswell, 2012). AI moved us away from a commonly held "deficit perspective" of Vancouver's DTES as an impoverished, resource-poor community and of homeless people and users of drugs as "deficient" and lacking agency. Instead it gave us an appreciative perspective that humanized the residents and understood them as knowledgeable, wise, and dedicated community activists for change. AI further allowed us to help support research informants to recognize "successful past practices, identify personal and group strengths, and identify foundational values" (Calabrese & Cohen, 2013, p. 6). As a result, we were better able to understand the lives and perspectives of DTES community members, their working relationships with others, and aspects of community culture and public education—including social media—that were proving effective in addressing the Opioid Crisis in the DTES.

Data for the study were collected through a review of local media, reports, studies, and interviews with four academic experts on the Opioid Crisis in Vancouver. AI interview questions for the experts sought to uncover or identify community strengths through stories about the community or lived experiences of the respondents (Cooperrider & Whitney, 2005, p. 277). A four-stage AI model framed participant interviews—namely, Discovery (What gives life?), Dream (What might be?), Design (How can it be?), and Destiny (What will be?) (Creswell, 2012).

Our original aim was to visit DTES public health outreach programs, interview program coordinators and members of harm reduction and other community-based organizations, and observe public health programs addressing the Opioid Crisis. However, research began in the early stages of the COVID-19 pandemic, and with new public health concerns and restrictions in place, the original plan was aborted. Instead, we recruited academic experts who research and participate in projects or work as medical professionals in the DTES and interviewed them via Zoom and telephone. Using the "expert" directories of three major public universities in Vancouver, we identified 21 prospective participants and emailed letters of invitation to participate in the study. Of the 21 persons contacted, ten did not respond, and seven responded that they were not qualified to speak about social media for harm reduction. The remaining four responded favourably. Of the four key research informants, three were professors in the Department of Public Health in their institutions (one practised as a public health nurse in the DTES for a few years), and the fourth was a professor in the Department of Medicine, focusing on social medicine. The wealth of experience and knowledge these experts possessed, having worked intimately in various capacities in the DTES with persons with lived experiences, was immense. All four are widely recognized for their research and have implemented programs and partnerships to promote harm reduction policies, public health education (including social media platforms), and public health advocacy in the Opioid Crisis.

Interviews were semi-structured (Creswell, 2012), approximately 60 minutes, with six open-ended questions posed. Each interview was recorded and transcribed verbatim by the main researcher. For the sake of anonymity, the research respondents were assigned

pseudonyms. Recurring themes in the transcripts were identified, and tentative mutually exclusive categories were developed and tested against transcript data to become study findings. Data from secondary sources (newspaper articles, surveys, and reports) were used to strengthen the findings' reliability and validity (Creswell, 2014). Documents such as the BCCDC's 2019 and 2021 Harm Reduction surveys, and the BC Coroners Service 2018 report, proved helpful in providing background information and supporting details.

Findings

The study generated insights into the nature of community empowerment through adult education (RQ1), the use of social media (RQ2), and the barriers and limits to the adoption of social media in public health education for harm reduction in the DTES (RQ3).

Community Empowerment Approaches to Public Health Education

- RQ1: What are the community empowerment approaches to public health education employed by health workers and community advocates to promote harm reduction in the DTES?

According to study participants, community empowerment approaches to public health education for harm reduction in the DTES rely, above all, on the relationships of public health workers, service agencies, and researchers with community members. Peer-to-peer leadership and advocacy by community activists, various forms of community adult education co-developed with stakeholders, and partnerships with journalists promoting public education are also essential.

The importance of community relationships was identified by all four key informants as the core factor in community empowerment. They described these relationships as "giving life" to the DTES. All highlighted the importance of caring, committed community workers and organizations; strong, trusting relationships with DTES community members; and the critical role of local activists who also use or used drugs. Candice lauded these DTES community members as being "the first ones to start everything"; they "understand tremendous, painful, beautiful stories" and are "working day in, day out" to change the deficit narrative of drug users. The other three key informants echoed Candice's thoughts. Karen, for example, highlighted the importance of local activists in harm-reduction efforts:

> That's why we are very famous in a lot of ways for our harm reduction infrastructure. That's really because of the efforts of people who use drugs to organize and demand change and demand a safe injection site. So, I think that at the heart of those services is the activism of people who use drugs themselves.

Candice further explained that

> it's not just people with lived experience, but also some of the service providers as well, who are committed to making a difference and often with lots of barriers: it's that commitment, that passion, and to really just keep trying. I mean, when you see so many people, so many deaths, so many tragedies . . . it's really important to really just listen to people and identify what we can do to help.

Many of the successes of the DTES community have come from its peer-to-peer social movement, led by active drug users who have played an integral role in humanizing the issue of addiction (Lupic, 2017). The most notable participant in this role is VANDU (https://vandu.org). Coupled with this peer-to-peer activism is a combination of outreach strategies employed by public health personnel like street nurses, who work on the ground to implement public education strategies and support peer-led overdose prevention training. High levels of reciprocal learning and active peer-led adult education programs by people with lived experiences using drugs were vital to community harm reduction as well. Drug users were seen as having strong intrinsic motivation, collegiality, and a wealth of shared knowledge coupled with a rich and open exchange of ideas between them, health professionals, and public health researchers.

Collaborative, sustainable educational approaches to harm reduction involving several stakeholders are also being planned and implemented. Candice noted the importance of face-to-face educational programs put on by institutions such as Vancouver Coastal Health and the BC Campus project. These were based on an exchange of knowledge between different stakeholders, where "they work together to try and identify who's the best to do what and then make sure it happens." She further stated that public health education should support long-term change: "There's a lot of education that goes on that is . . . one-offs and very reliant on individual people—and what we're aiming for is trying to have something that is more sustainable, [with] resources that people can [continue to] use." One example of this form of co-created sustainable education was anti-stigma workshop modules (https://toward the heart.com/reducing-stigma). These come with a facilitator's guide and other community resource materials. Community-produced videos were another example. Candice, for instance, helped DTES community members create a video as an educational resource. The video was about people with lived experience of drug use who are trying to prevent overdoses, and to change the narrative surrounding drug addiction. Karen, likewise, has integrated anti-stigma and awareness videos, narrated by young people who use drugs, into harm reduction activities she has promoted. She hopes that posting these videos on social media will "generate discussion [and] build empathy among the public and greater understanding." She sees the videos as collaborative ventures and as building community since they are a "shared exercise in telling stories together."

Karen noted that because many young people who use drugs have dropped out of school, "they really are being educated" through non-formal education and informal learning gained by sharing with peers and researchers, and "the public health workers working with them are really their educators." Candice saw these forms of adult education as central to a bottom-up, empowered approach to social change, where community members are essential in decision making and confident in their contributions to make change. To this end, Karen highlighted the importance of face-to-face meetings as an informal, empowering educational space:

> We get together in a space where everybody feels really comfortable and share a meal and we just make it a really nourishing experience all around . . . people are really acknowledged, not just as people who use drugs, as research participants or even as co-researchers—[these are places] where people are acknowledged as people.

Candice saw the meetings as critical in extending education to other members of the DTES community:

> If I wanted to reach a large number of folks who use substances, just going down to VANDU and one of their meetings helps because you have a huge amount of people there who will listen and respond and give feedback and take the message out. And that works. It excites me to see [this] education and how people with lived and living experience are running sessions with their colleagues. There is a lot of hands-on education that is led by people with lived experience for people with living experience.

Much reciprocal learning occurs during these meetings, activism and advocacy are birthed, and non-formal peer-led trainings are developed and implemented. Overdose-prevention training exercises in the use of naloxone (for opioid overdose reversal), clean needle and syringe distribution, social activism, advocacy for marginalized members of the community, and the establishment of safe consumption sites are just a few initiatives that have been spread through these community meetings.

Partnering with journalists and traditional media was another critical, empowering relationship for the DTES community. Chloe endorsed this and shared further insight when she said, "I think folks in the Downtown Eastside have really developed some very strong relationships with those reporters." She went on to acknowledge in particular the work of Jen St. Denis, a reporter for the BC news magazine *The Tyee*, as well as reporter Andrea Woo, the *Globe and Mail*'s public health reporter. Karen highlighted the work of Travis Lupic from the *Georgia Straight* and the importance of his book *Fighting for Space: How a Group of Drug Users Transformed One City's Struggle with Addiction* (Lupic, 2017). Sarah explained that these journalists "understand how [media] moves, they understand the power of images, they understand the power of words, they know how to say two or three things with few words. We need to partner with them." However, with regards to a more inclusive approach to public education and harm reduction, much more is needed.

Public Health Education through Social Media

- RQ2: How do health workers use social media for public education and harm reduction in the DTES?

Key informants saw the integration of social media into public health programming as a critical means of expanding community networking and relationships, promoting harm reduction education, and developing collective support and advocacy for DTES users of drugs. They mentioned how social media platforms like Twitter (now X) and Facebook, podcasts, and life-saving drug apps have been effectively used by public health personnel, journalists, and users of drugs in public education and harm reduction efforts.

Candice identified Facebook and Twitter as invaluable platforms to promote public education, especially among youth. Karen noted that Facebook is mainly used by "people who are edging up towards thirty" and that Twitter is "a fantastic venue for political debate and for connecting with like-minded individuals and for, you know, generating support and activism" when used by public health workers. Two other participants highlighted the importance of the DTES-based podcast series Crackdown (crackdownpod.com),

produced in partnership with UBC and Yale University academics, and edited by drug user activists from VANDU, the BC Association of People on Opioid Maintenance, and the Western Aboriginal Harm Reduction Society. Crackdown offers "first person" perspectives of people who use drugs. According to the Crackdown website, the podcast, as a form of community education, "seeks to make research knowledge about the war on drugs more accessible to drug users, students and the general public" by using storytelling as a "medium for building connections, demystifying esoteric concepts, and seeking social change."

Chloe believed that social media is an effective educational tool because "it gives you control over how you tell your story and what you're asking . . . and then you can control the narrative, and this is also one strategy in organising that is very important." Karen agreed that social media like Twitter seems to be "a good space for reaching government, activists and people who are already politically engaged." As Chloe put it, Twitter is a "speaking to power tool" that can be used to reach wider audiences with power:

> Twitter remains a place where it's possible to connect with journalists, with, you know, investigative reporters, with lawyers, with politicians, and for me, it continues to be the one that I keep because it gives you access to people who would not otherwise be accessible in that way and you can really present ideas and have a really fast, big, impact.

Life-saving social media apps like RADAR, Lifeguard, and Brave are also effective overdose prevention tools for DTES residents, immediately connecting drug users to a community of support. RADAR (Real-time Drug Alert & Response) is activated by sending a text to 253787 (ALERTS) to receive real-time toxic drug alerts and to report possibly contaminated drugs to health authorities. Lifeguard connects users to mental health and drug use resources and allows them to set a timer to alert paramedics if they become unresponsive when using drugs. Candice described a third app, Brave (www.brave.coop), which serves as a peer-supported site for virtually "observed substance use," where people using drugs do not have to go to supervised consumption sites but instead have the option of connecting with someone on the phone. In the event something happens, there is somebody "who knows where you are and [will] alert services if need be."

Key informants also identified partnerships with journalists and traditional media as a critical aspect of public education around harm reduction. Sarah noted that journalists "handle social media better than anybody else right now." As Karen explained,

> There are some reporters who we work with quite often, who do a fantastic job of covering the issues fairly, and who are really interested in understanding what young people are thinking about the overdose crisis and about substance abuse and about harm reduction and are interested in getting out those kind of things in the media.

Karen argued that more work needs to be done in public health partnerships with local media to change the dominant narrative of a "broken community in need of rescuing." She then shared a story of how building a trusting relationship with DTES harm reduction staff led her to write op-ed pieces for local press, such as the *Georgia Straight* newspaper, which then triggered attention on social media, which in turn contributed to

"provincial-wide meetings in Vancouver with all the big nursing organizations because of the pieces that I had written."

Limits and Barriers to Social Media Use

- RQ3: What are the challenges associated with the use of social media as a community support strategy?

While key informants saw the use of social media and phone apps as speaking to the strengths of a community, they also pointed to several limitations of these technologies. Despite the efforts of public health personnel and people who use drugs to co-develop innovative social media–based adult education programs for harm reduction, there have been major challenges. Candice, for example, argued that "it's all very well saying we've got these apps, . . . but how you reach people [is] . . . not always through social media, it's word of mouth—it's so important in this community." Karen concurred: "We still need to make sure we're doing the old-fashioned work, sitting together in rooms, you know, advocating and talking about these issues, speaking about how we can come together to create these changes." Chloe noted that "there are limits to people [using social media] depending on the type of employment they have." As a former DTES nurse, she said, "My reality is that every single nurse I know out there cannot really be vocal on social media because their employer can come back and, you know, discipline them." Public health workers who are "publicly identifiable" on social media without authorization or who say "something that might be seen as not professional" may risk getting fired.

Karen highlighted access to technology as another challenge to social media use. While some DTES residents have access to computers or the Internet at libraries or in some businesses, "people who use drugs are kicked out of a lot of spaces that have free Wi-Fi." She noted:

> We need to be careful about assuming that social media, being this inclusive space, is always going to draw everyone together because I think social media and the Internet do function like that for a lot of us if you've got access to, you know, an Internet connection and a laptop or smartphone, but people who are living in entrenched poverty in the city don't necessarily have access to those things.

Candice added,

> We found in our survey, which was in 2018 and again in 2019, only about 50% of people have a phone and those that do have a phone may . . . only have it at the beginning of the month when they get their social assistance payment, and they sell it again later on in the month.

Karen further explained that people who use drugs would not necessarily be drawn to social media because they might struggle with the idea of "how to present yourself online." She further noted that social media at times does not feel like an inclusive space, and as a "democratic" space it also poses too many risks. Sarah echoed this sentiment and added that even though people have beautiful stories to share, social media is not for everyone. For some, the power to construct a counter-narrative can also prove problematic. Sarah explained that on social media there are some "aggressive people that will say whatever,"

who do so without getting the facts or "double-checking . . . they just do it and there is no consequence." Karen was also of the opinion that social media, while "potentially important for some people," may not prove beneficial for everybody, as many DTES residents are already facing multiple life challenges with little room left for the demands of social media:

> Social media will not come across as an engaging or inclusive space because they are navigating the constant everyday emergencies of poverty, unstable housing, addiction in terms of substance use. So, it's very, very hard to be involved in political organizing when you're absolutely exhausted from the day in day out process of, you know, staying alive.

While social media has the potential to positively reinforce harm reduction efforts by public health workers and others on the ground, key informants believe that these variables ought to be considered.

Discussion

Study findings show high levels of reciprocal adult learning and education in the community: peer to peer, healthcare worker to patients, and vice versa. This learning is a significant component of DTES vitality and community empowerment (Persily & Hildebrandt, 2008). In the DTES, a participatory learning process, often catalyzed during face-to-face meetings, stimulates conscientization, generative themes, and action (Freire, 1968/1970) to develop community harm reduction initiatives, challenge stigmatizing deficit perspectives, and promote collective community identity and empowerment for social change (Israel et al., 1994; WHO, 2009, 2010) among people who use drugs. The community learning process is both peer-led and led by public health workers, allowing a union of lived experience and professional training that fosters community empowerment (Royal Society of Edinburgh, 2014), and also reinforcing a strengths-based approach to change (Cooperrider & Whitney, 2005).

Findings also point to the importance and promise of social media in adult education programming for harm reduction and community empowerment. Platforms such as Facebook and Twitter help to promote public education and amplify the media publications of allied journalists and health workers. Community-generated podcasts such as Crackdown are critical sites of empowerment for both the drug users who create them and the wider DTES community, above all in "listening parties" organized at various DTES sites. Life-saving apps like RADAR, Lifeguard, and Brave likewise prevent immediate harm to drug users and foster a supportive, educative community of practice with peers and public health professionals. However, the fact that almost 50% of people who use drugs do not own a cellphone or do not have reliable access to free Wi-Fi challenges assumptions about the universality of social media and limits its effectiveness as a form of harm reduction education, especially among older adults. The "democratic" space of social media also means that any individual can promote their views on harm reduction, meaning loud, sometimes ill-informed voices may undermine community-based harm reduction efforts. The many burdens of poverty, ill health, and drug addiction may also leave little capacity for drug users to help develop and use social media. Finally, for frontline public health

workers, publishing community-supportive views on social media may pose risks to their careers and practice as health professionals.

The challenges and limitations of social media are reflective of more considerable pedagogical and programmatic challenges in adult education for community empowerment of marginalized people like drug users on the DTES. To help address such challenges, key informants identified the need for educational programming for health workers and others on DTES history and the systemic forms of oppression experienced by its residents (racism, colonialism, poverty, inequality). In essence, they proposed educational programs that foster community empowerment, educate the public, promote positive policy initiatives, and, ultimately, help enact broader social change.

Conclusion

This study has important implications for the work of community health professionals, educational programming for harm reduction, and understandings of the vitality, humanity, and leadership capacities of marginalized people who use drugs. First, it offers insights on how public education, program planning, and social media can foster community empowerment and ultimately lead to positive change. This includes ensuring relationships are built with people with lived experience, valuing their inputs and integrating their voices into structured programs where they can participate and share with others (peers, public health personnel, police officers, etc.). As Karen said: "What your project [the present study] is getting at, . . . the step that we could take which is one step further, is to educate the people about how to be activists, to really work within the system, to change the system." Second, it highlights the limitations of social media use in the DTES. Finally, it offers an opportunity to improve public health education approaches by ensuring that health professionals are trained in the skills that will allow them to see and appreciate the knowledge base of people in communities like the DTES so that they can offer the best support to help those people function optimally.

During this research project, I (the main researcher) was reminded that people who use drugs have been exposed to personal traumas and systemic issues like poverty, colonialism, racism, inequitable access to education, and a myriad of challenges that contribute to their resorting to drug use. I have many times paused and reflected on my cousin, whose mom left him with relatives when he was a teenager and went in search of a better life in the United States. I now better understand how the absence of his mother led to his dependence on alcohol and other drugs. I further reflected on my own life in Jamaica, where I grew up exposed to drugs, guns, and violence, and other social determinants of health. I am now able to credit the progress made in public health awareness initiatives to those from within the inner-city communities, those who took a grassroots approach to educating their peers. My earliest recollection is of growing up in East Kingston during the HIV/AIDS epidemic, where, in an effort to foster awareness and community empowerment, community members developed numerous public health initiatives similar to those in the DTES of Vancouver. Workshops on safe sex practices and condom distribution programs—that is, harm reduction programs—remain in practice to this day. Each effort helped to reduce the fear of contracting HIV/AIDS and the feelings of hopelessness brought on by poverty. Now, as an aspiring academic, I am more determined to shed light on community-based initiatives in marginalized communities that bring hope, and to

advocate for those struggling to overcome social stratifications and social constructs that keep them from living full lives.

In completing this study, I also reflected on the resilience, strength, and dedication of the users of drugs in the DTES community in sharing their stories, co-developing educational programs for harm reduction, and contributing to public education. They are writing, recording, and sharing their stories on the Crackdown podcast, in a local street newspaper called *Megaphone*, and in interviews with journalists and researchers. They offer a wealth of knowledge and skills to the community, which, if supported, can positively contribute to supporting harm reduction while reducing existing inequities. This research has helped to highlight that those in positions of power need to address the social determinants of health, including not only systemic oppression but also practice-based issues like access to cellphones and Internet technology and fostering increased communication, community relations, and support. Finally, our hope is that the findings of this study contribute to new, appreciative perspectives on adult education for marginalized people, specifically in public health education. In Vancouver, adult education in the form of liberatory, Freirian pedagogy could help to demystify the systemic issues surrounding the Opioid Crisis and empower members of the DTES. Community-led initiatives such as naloxone distribution kits and overdose first aid training are critical, but long-term systemic change requires community-based health education to empower marginalized adults.

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