A Student-Driven Advocacy Project to Address the Opioid Crisis in Canada: Implications for Developing Competency in Health Advocacy During Medical Training

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In Canada, health advocacy is one of the six essential competencies that physicians must attain in their training. As health advocates, physicians are to work “with those they serve to determine and understand needs, speak on behalf of others when required, and support the mobilization of resources to effect change” [1]. As such, it is crucial for medical students to engage in health advocacy activities to achieve a core competency of their training and improve the health of the communities they serve. Notably, health advocacy is a valuable competency to address public mental health issues as illustrated in this project, and highly beneficial to medical trainees with professional interest in psychiatry. In 2019, a group of medical students at a large Canadian medical school engaged in an advocacy project to lobby for solutions to the opioid crisis in their city. This paper presents a report on the project to model medical students’ involvement as health advocates. The subsections in the report include (a) an overview of the opioid crisis, (b) description of the advocacy project, and (c) recommendations to promote competency-driven learning on health advocacy among medical students.

Overview of the Opioid Crisis

The opioid crisis remains a major public health issue of concern, with serious socio-economic medical, and mental health consequences in Canada. In 2018, there were 4460 apparent opioid-related deaths reported in Canada, corresponding to a rate of 12.0 deaths per 100,000 people [2]. One

of the main factors attributed to the rise in the opioid crisis is the increasing prevalence of synthetic opioids (e.g., fentanyl) in street drugs [3], accounting for 70% of all opioid-related deaths reported in Canada [2]. On a general scale, opioid use disorder (OUD) has corresponded with increased opioid-related hospital admissions, infectious diseases, and mental health comorbidities [2, 4, 5]. The healthcare cost of OUD in Canadian dollars includes \$0.31 billion for opioid use, \$1.83 billion for lost productivity, \$1.11 billion for criminal justice, and \$0.23 billion for other direct costs [6].

The large Canadian city in this report has been disproportionately impacted by the opioid crisis in comparison to other cities within the province and across Canada [7]. To illustrate, this city ranked fourth in the number of opioid poisoning hospitalizations in a metropolitan area within Canada, and had a higher cumulative rate of opioid-related deaths than the provincial average [6].

Opioid use disorder is a treatable mental health problem [8–13]. For instance, injectable opioid agonist therapy (iOAT) is a high-intensity effective treatment involving prescribing specific injectable doses of hydromorphone or diacetylmorphine for individuals with OUD who have not benefited from other treatments, including opioid agonist therapy (such as methadone and buprenorphine/naloxone) [8, 9]. Evidence have demonstrated that iOAT as an integral component along the continuum of care decreases exposure to illegal opioids [8] and improves functioning in patients with long-term, treatment-refractory OUD [10, 11]. In managed opioid programs (MOPs), iOAT and other supportive services are provided for case management [12]. Hydromorphone was estimated to provide individuals with more than three additional years of life, on average, compared to methadone alone [13]. Additionally, the economic analysis indicated that over a lifetime, the provision of hydromorphone could save society approximately \$140,000 (2015 Canadian dollars) per individual [13].

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Outline of the Advocacy Project

This advocacy project aimed for medical students to meet with city councilors to inform them about the opioid crisis and convince them to support our asks pertaining to the implementation of MOPs and iOAT in their city. Asks are specific requests to the legislator on the topic of an advocacy initiative.

Diacetylmorphine was previously only available in very limited amounts in Canada. In 2019, diacetylmorphine was added to the list of drugs for an Urgent Public Health Need by the Government of Canada, allowing provinces and territories to import diacetylmorphine for treatment of OUD [14]. The only licensed manufacturer through which Canada imports diacetylmorphine is in Switzerland. However, hydromorphone does not pose the same regulatory barriers and was demonstrated to have similar outcomes to diacetylmorphine, which is conducive to the expansion of MOPs [13].

The provincial Drug Benefit Formulary containing prescription drugs that are covered by the Ministry of Health and Long-Term Care (MoHLTC) [15] listed only methadone and suboxone as medications used in opioid-agonist treatment [15]. Furthermore, the concentrations of injectable hydromorphone required as treatment in iOAT for OUD (50 mg/ml and 100 mg/ml) were not listed on the formulary, resulting in a significant barrier to treatment access [8].

First, we asked that the City Council publicly support the implementation of MOPs in the city and throughout the province given the urgency of the opioid poisoning crisis and as part of the continuum of care for OUD. Secondly, we asked that the City Council write a letter to the provincial Minister of Health for the MoHLTC, in support of the following items:

1. Adding iOAT medications at their required concentrations (50 mg/ml and 100 mg/ml hydromorphone) to the provincial Drug Benefit Formulary for the treatment of OUD and ensure the accessibility of these medications to individuals with opioid use disorder;
2. Seeking authority from Health Canada to import diacetylmorphine (pharmaceutical heroin) for use as a managed opioid program medication in the province; and
3. Ensuring that managed opioid medications are universally accessible to all individuals in the province who could benefit from these kinds of programs, and that cost is not a barrier.

Strategies Implemented in the Project

Planning Overview

The planning for the advocacy initiative began in June 2019 after receiving a transition report from the previous

Municipal Day of Action team, an entirely student-driven effort. Our team was initiated by a medical student on the medical school student council, who subsequently recruited a planning team through an application process, consisting of the Day of Action lead (oversaw entire planning process), backgrounder leads (oversaw the research and preparation of the backgrounder and one-page summary, and delegate training), personnel leads (spearheaded community consultations, social media communications, and the scheduling of meetings with city councilors), and logistics leads (managed finances, recruitment of delegates, and organization of the training day). The coordination of activities among the groups was facilitated through monthly progress meetings and group messaging. While no formal administrative sponsorship was sought from our medical school, our medical school permitted our use of their name in branding our advocacy initiative, and we received consultation on our backgrounder and asks from relevant faculty.

Problem Definition and Stakeholder Consultation to Inform and Support Advocacy Asks

The planning team chose the focus of our advocacy project to be the opioid crisis, given its huge municipal impact and intensive federal media coverage. During community consultation in September 2019 with experts in the field of harm reduction, including the local public health unit and community advocacy groups, we discussed potential asks, including lobbying for naloxone kits in municipal public buildings, building another Consumption and Treatment Service (CTS), or the implementation of MOPs. Given the research conducted by the City Council and public health unit on MOPs, and abundance of evidence on best practices, we selected the implementation of MOPs as our main ask [16].

Education and Recruitment of Medical Students

The planning team recruited medical student delegates to meet with city councilors through an online application. Delegates were selected based on a qualitative assessment of their responses to the following questions:

1. Why are you interested in becoming a Municipal Lobby Day Delegate?
2. Describe one time when you have successfully advocated for others.
3. What skills and experiences do you possess that will make you an effective Municipal Lobby Day Delegate?

The application was delivered via Google Forms, and shared on the medical school class of 2021 and 2022 Facebook groups. Overall, there were sixteen applications. Twelve delegates, in addition to the seven members of the

planning team, were recruited. Delegates were required to provide their availability to attend a city councilor meeting and attend the delegate training weekend (see Table 1 for project timeline). The majority of our recruited delegates acknowledged that health advocacy responsibilities align with their future career as physicians, and identified the need for further experience in political advocacy in medicine to help underserved populations. Many applicants expressed interest in harm reduction and addressing the local impact of the opioid crisis. The majority of applicants described their skills in written and verbal communication as assets to aid their participation. Most applicants did not have previous advocacy experience.

The training weekend consisted of teaching on the backgrounder and asks, a presentation by a community advocacy group on lived experience with OUD, and an advocacy workshop facilitated by a provincial Medical Association board member to develop and practice advocacy skills. Funding for the training weekend and printed materials was provided by the medical school student council and the provincial Medical Association.

Project Outcomes

City Councilor Meetings

Overall, our team met with seven councilors out of the 15 members of the City Council in groups of 3–4 medical students. Following the meetings, each group was required to report the overall outcome of the meeting and plan for follow-up. Our delegates were encouraged to post about their meeting on Twitter, and many councilors posted about our meetings on social media. Four out of the seven meetings were rescheduled due to changes in councilors' availabilities. Overall, the meetings were successful and well-received by the councilors. Typical items for follow-up involved councilors requesting emailed copies of our backgrounder. After all the meetings were conducted, we were invited by a city councilor, who was also vice-chair of the Board of Health (BoH), to present our advocacy project to the BoH.

Board of Health Meeting

The BoH is composed of the mayor and the City Council and meets monthly. Three members of the team attended the November 2019 meeting to present our asks. We prepared a PowerPoint presentation outlining our background information and asks. We accepted questions from the BoH that pertained mostly to the evidence regarding the efficacy and cost-effectiveness of iOAT. Earlier in this meeting, one councilor put forth the motion to declare an opioid crisis in the city. Following our presentation, the councilor addended

their motion to include our asks, and the motion successfully was passed by the BoH through a vote [17].

Draft Letter to the Ministry of Health and Long-Term Care

Following the passing of the motion, the BoH requested that we prepare a draft letter to the MoHLTC advocating for the implementation of MOPs in the province. A draft letter was prepared by our team and submitted to the BoH. Shortly afterwards, the SARS-CoV-2 pandemic emerged and the BoH's and MoHLTC's work concerning MOPs was overshadowed.

Promoting Competence in Health Advocacy During Medical Training

Reflection on Competency-Enabling Skills Needed for Health Advocacy

Multiple skills were learned throughout our advocacy project, lending themselves to developing important competencies that would allow medical students to become effective health advocates. In Canada, there is currently little guidance outlining competencies that encapsulate the role of health advocates [18]. Reflecting on our experiences during this project, we devised seven "competency-enabling skills" (CES) (see Figure 1) that are necessary for effective health advocacy, and mapped them with appropriate "competency-enabling tasks" (CET) that were exercised (see Table 1). We hope that these skills and tasks can be better operationalized and developed into structured curricular schema or elements for health advocacy in medical education.

Formal Curricular Support for Health Advocacy

Better engagement and competency in health advocacy will allow medical trainees to be knowledgeable about the effective strategies to address health inequities. This is particularly important for trainees interested in mental health, where sustained advocacy is crucial to address inequities in mental health services, and marginalization of people with mental disorders. Our advocacy initiative underscores the potential benefits of developing an overarching curricular framework for medical trainees to garner competencies in health advocacy, addressing mental-health-social issues in the community.

Our experience demonstrates that trainees can effectively engage in political health advocacy to address major public mental health issues. Importantly, we received great support from legislators towards achieving the goals of our health advocacy work. In Canada, many medical schools

Table 1 Project overview, timeline, strategies, and competency-enabling activities conducted by students

Timeline (2019)	Activities (A) Competency-enabling tasks (CET)	Strategy	Deliverables	Competency-enabling skills
June	A: Topic selection CET: Literature review, community stakeholder consultation, individuals with lived experience consultation, development of asks	1. Brief initial consultation with local harm reduction advocacy group and individuals with lived experience of OUD ¹ 2. Review of previous years' backgrounder 3. Team discussion on most feasible lobbying objectives to become our asks	1. Selected opioid crisis as advocacy topic 2. Developed asks pertaining to implementing naloxone kits in public spaces	1. Health literacy 2. Scientific inquiry/critical thinking 3. Relational engagement 4. Sociocultural sensitivity
July	A: Backgrounder research CET: Literature review, community stakeholder consultations, individuals with lived experience consultation, written and oral scientific dissemination, delegation of tasks	1. Research tasks delegated to members of planning team: opioid crisis epidemiology, history of opioid crisis, opioid poisoning crisis, governmental response to opioid crisis, evidence for naloxone kit usage 2. Attended community meetings for implementation of safe consumption site, and community support groups for individuals with lived experience of OUD	1. Completed literature review on opioid crisis and evidence for naloxone kit use 2. Received perspectives on the opioid crisis and previous work done by advocacy groups	1. Health literacy 2. Scientific inquiry/critical thinking 3. Relational engagement 4. Sociocultural sensitivity 5. Communication 6. Teamwork/communication
August	A: Preparation of backgrounder CET: Written and oral scientific dissemination, literature review, delegation of tasks	1. Findings from literature review and community consultations compiled into written backgrounder document 2. Editing and revision tasks delegated to members of planning team	1. Backgrounder draft completed and ready to receive feedback from community stakeholders	1. Communication 2. Health literacy 3. Scientific inquiry/critical thinking 4. Teamwork/collaboration
September	A: Backgrounder completion, delegate recruitment, city councilor meeting scheduling CET: Community stakeholder consultation, literature review, written and oral scientific dissemination, development of asks, delegation of task, delegate recruitment, interaction with politicians, administrative tasks	1. Revision of backgrounder delegated to 2 members of planning team to change literature review and asks 2. Delegate application administered through Google Forms and recruited via class Facebook groups 3. Liaising administrative assistants of city councilors to determine meeting times	1. Finalized backgrounder to focus on iOAT ² and MOPs ³ , with asks targeting implementation of MOPs 2. Feedback received from harm reduction advocacy groups, physicians, and public health officials 3. Scheduled 7 city councilor meetings 4. Recruited 12 delegates through online application	1. Health literacy 2. Communication 3. Scientific inquiry/critical thinking 4. Relational engagement 5. Project management 6. Teamwork
October	A: Delegate training, city councilor meetings CET: written and oral scientific dissemination, public speaking, delegate training, individuals with lived experience consultation, interaction with politicians	1. Provided delegate packages including printed copies of backgrounder, one-pager, pens, and folders 2. Breakfast and lunch catering, honoraria for speakers 3. Created delegate training power-point 4. Applied for OMA ⁴ and medical student society funding to cover costs of training day 5. Rescheduling of 4 meetings based on availability changes	1. Delegate training day consisting of backgrounder training, OMA advocacy training workshop, presentation by individual with lived experience 2. Delegates attended seven city councilor meetings	1. Communication 2. Health literacy 3. Project management 4. Sociocultural sensitivity 5. Relational engagement 6. Teamwork/collaboration

Table 1 (continued)

Timeline (2019)	Activities (A) Competency-enabling tasks (CET)	Strategy	Deliverables	Competency-enabling skills
November	A: Follow-up on city councilor meetings CET: Interaction with politicians, Twitter posts, delegation of tasks	1. Emailed backrounders to city councilors, social media posts on Twitter tagging councilors 2. BoH ⁵ presentation delegated to planning team members with most involvement in preparation of backgrounder	1. Invited to present at BoH meeting by city councilor/BoH vice-chair 2. Creation of slides on asks and presentation	1. Digital technology/ social media use 2. Relational engagement 3. Teamwork/collaboration
December	A: BoH meeting CET: Written and oral scientific dissemination, public speaking, interaction with politicians	1. BoH requested letter addressed to MoHLTC ⁶ , prepared by synthesizing information from backgrounder 2. Presentation at BoH meeting by three members of DoA ⁷ planning committee	1. Asks addended to a motion and passed by BoH 2. Draft letter prepared for City Council to review	1. Communication 2. Health literacy 3. Relational engagement 4. Teamwork/collaboration

¹Opioid use disorder; ²Injectable opioid-agonist treatment; ³Managed opioid programs; ⁴Ontario Medical Association; ⁵Board of Health; ⁶Ministry of Health and Long-Term Care; ⁷Day of action

Competency-enabling skills (CES) mapped with competency-enabling tasks (CET) conducted by students

- A. Communication: written and oral scientific dissemination, public speaking, delegate training
- B. Digital technology/social media use: Twitter posts
- C. Health literacy: literature review, delegate training, interaction with politicians
- D. Project management: delegate recruitment, delegate training, administrative tasks
- E. Scientific inquiry/critical thinking: literature review, development of asks, community stakeholder consultation
- F. Relational engagement: interaction with politicians, community stakeholder consultations
- G. Sociocultural sensitivity: individuals with lived experience consultations
- H. Teamwork/collaboration: interaction with politicians, literature review, delegate training, development of asks, delegation of tasks

Figure 1 Competency-enabling skills identified by medical trainees involved in health advocacy

do not have a formal curricular element on health advocacy despite health advocacy being a core competency prescribed by professional medical bodies [1, 18]. Most health advocacy initiatives executed by trainees are conducted as extra-curricular activities. Hence, greater support from medical schools to promote engagement in health advocacy among medical learners is needed. For instance, mentorship-based activities on health advocacy, involving faculty or mentors with cognate experience, can galvanize interest among trainees. The development of a structured protocol to define and guide specific curricular elements for health advocacy can enhance the standardization of competency-based training and assessment on health advocacy, and allow future comparative analysis across different training programs.

General Principles for Engaging in Physician Health Advocacy

The conceptualization of physician health advocacy within a larger, collective effort as opposed to an individualistic approach is gaining traction to effect change [19]. Our advocacy project was conducted in collaboration with a team of local stakeholders, and ensured that our asks aligned with local needs and existing efforts addressing the opioid crisis. Notwithstanding the variations in context or public mental health issue, physicians and medical educators need to be abreast with the general tenets of effective mental health advocacy [20].

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Declarations

Disclosures On behalf of all authors, the corresponding author states that there is no conflict of interest.

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