

Ep.2-Harm-Reduction-Approaches-to-Opioid-Use.mp3

[music]

Rhonda Lovell [preview]:

You know, what if I went to nursing school? Public health nursing was where my heart was. I wanted to be on that preventative end of things. And what's interesting to me now, though, is to look back over the, you know, the last 15 years of my career in public health and go, as much as I was so excited to come into public health, I actually didn't have a clue. I thought I knew what public health nursing was all about. And it *is* that but so much more.

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Susan Blue:

Hi, I'm Susan Blue.

Maureen Cava:

And I'm Maureen Cava.

Susan Blue:

This is *Stories From The Field: Public Health Nursing in Ontario*. Today we're meeting Rhonda Lovell. She's been a public health nurse in the Kingston area for 15 years.

Rhonda Lovell:

My name is Rhonda Lovell. I'm a public health nurse here at KFL&A Public Health. What I have been working on for the last three years or so is the harm reduction portfolio specific to opioids.

Maureen Cava:

So what is harm reduction? It involves supporting individuals to minimize health risk in their day-to-day lives. Examples include: wearing a bike helmet, or wearing a seatbelt when driving a car.

So, Susan, how does that apply when talking about substance use?

Susan Blue:

Well, it's providing a person who is using substances with a supportive environment where they may be able to taper off—not necessarily quit, but to be supported in a non-judgmental, caring, and kind way to deal with their substance or addiction use in a way that helps them be safer.

Maureen Cava:

So what it sounds like is that it really is trying to meet people where they're at. And it's my understanding that there's been a dramatic rise in opioid deaths during COVID-19. Some are calling it "a pandemic within a pandemic." In Ontario, there's been a

staggering 60 per cent increase in opioid-related deaths from 2019 to 2020, and sadly 73 per cent of those deaths occurred when no one was present to intervene.

Susan Blue:

So it's clear that harm reduction is more important now than ever. These rising and concerning stats certainly set the stage for learning more about Rhonda's work.

Maureen Cava:

But first, we'd like to acknowledge and thank both the Lawrence S. Bloomberg Faculty of Nursing and the University of Toronto. Funding from the Verna Huffman Splane Endowment Fund enabled us to produce the podcast series. A public health nurse who lived to be 100, Verna's legacy donation supports education to promote public health nursing.

Susan Blue:

Can you tell us, ah, why you chose public health nursing as a career?

Rhonda Lovell:

Public health nursing actually came on my radar as a new, young, single mum. And it was my interactions with a few public health nurses, during that period of time, that just really flagged it for me as a potential career opportunity. And those interactions were the catalyst for major changes in my life. I don't think I had any sort of a vision of what my life could like, and then suddenly I saw these women doing these phenomenal roles, that I thought, "Gee, you know, this is really valuable work to do." It was a side of nursing that I didn't have a clue existed.

So, I had actually moved back from B.C.—when I (laughing), me with my very large belly at the time—back to Newfoundland. And we actually had a public health nurse who was in our community; just I babysat her children, I think. And so she actually turned out to be the woman who was running the prenatal program.

And, quite frankly, I was a (laughing) very begrudging participant, initially. Because I thought, "You know, what it is that makes anybody think that just because I'm pregnant, or that I'm just going to naturally groove with all these other women, and this is going to suddenly have this major impact on my life?" I really had little resources at my disposal. My mum was strongly encouraging me to participate in this program. She saw not only the benefit of me getting that prenatal information but the program offered really practical supports as well. So we would get seven litres of milk, a dozen eggs, and a dozen oranges a week—and just like really, really practical things. And also get connected to other mums—not necessarily all of whom were new or young—that might have some wisdom to share with me as well, in addition to that role from the nurse.

Now granted, this was in Newfoundland, very small town, they were very much generalists. But the type of care that they provided for me was just really inspiring. And so that kind of piqued my interest. And then I actually took on a role as a peer facilitator for a prenatal program, as I think "Resource Mother" was the actual title of it. But it got

me to work really closely with the public health nurse around prenatal classes, and postnatal care, all kinds of things.

And I kept coming up against barriers. It was the same prenatal program that I had been enrolled in as a low-income mum at that time. And yeah, I just kept finding that there were things that I wanted to change, things that I wanted to see happen, things that I wanted to impact in the lives of these women that in the role that I was in, I was limited. And I thought, “You know, what if I went to nursing school? You know, what if I took this a step further?”

Susan Blue:

Wow. So this is from the ground, up. Like you really got introduced to public health nursing because you were involved in a program facilitated by actually a woman you knew, because you babysat her children, and then she brought you along, begrudging. But it sounds like over time that grudging attitude maybe dissipated to, ah, being a little bit more open.

Rhonda Lovell:

Absolutely. And I think a big part of it for me was seeing that she genuinely *cared*. Even looking back, I don't think it was just because, you know, she had known me as a person outside of her role as a public health nurse. I think she maintained those professional boundaries exceptionally well, which again wasn't something I was aware that needed to happen, you know, back then prior to, you know, taking on the nursing role myself.

But I look back, and I see how she managed those boundaries extraordinarily well but still managed to go above-and-beyond in connecting me. Like I—housing was a major issue for me at the time. And that woman advocated for me like... like nobody has in... in my life. Sorry, I'm getting a little emotional just thinking about it. No, it's, ah, it's interesting. Because I talk to—there's a gal who does prenatal and postnatal care, and every now and again I hear her on the phone. And we've actually had chats about that, where I've said to her, I'm just like, “Please know how valuable your work is.” Like you have no idea—like no pressure (laughing) but—you have idea the impact that could potentially have on somebody's life. You could completely change the direction, change the course of their life and the life of their child.

So I really went into nursing specifically because of my interest in public health nursing. It was what I wanted. You know, I kind of went through the—all the rest of it. And sure it was interesting and exciting—all the different types of experiences throughout the course of my degree. But it was really public health nursing was where my heart was. I wanted to be on that preventative end of things.

And what's interesting to me now, though, is to look back over the, you know, the last 15 years of my career in public health and go, as much as I was so excited to come into public health, I actually didn't have a clue. I thought I knew what public health nursing was all about, and it *is* that but so much more.

And that was the other thing that I think I've really enjoyed throughout the course of my career was the potential for those lateral moves within the agency. So I'm still a public health nurse, but the work that I'm doing now is so drastically different than what I was doing two years ago, let alone ten years ago. But all of the skills that I've gained, just they transfer across every portfolio, and just serve to just really, I think—I hope (laughs)—improve my practice and just.... Yeah, it just kind of continues to light my fire, I guess. Keeps the relationship fresh (laughs).

[music]

Susan Blue:

After graduating, Rhonda spent nine years working in the area of injury prevention—specifically, growing programs to support the decrease of falls in adults over 65. Rhonda described it as a phenomenal job, however, as the years passed, she began to feel a little stale in the role. So she talked with her manager about needing a change to broaden her skills and take on new challenges.

Can you actually tell us what led to your interest in harm reduction work?

Rhonda Lovell:

Yeah. So it was sort of a collision of factors. So I had been working, actually, in fall prevention for about nine years. And I had grown that portfolio from it had been very sort of ground-level work, sort of direct programming with the community. And you know, the longer I was in it, I started to see all the system-level factors that really needed to change. And so it moved to, you know, sort of more regional-level work, provincial-level work. We set up a community of practice, provincially. That then started to expand nationally. It was just a phenomenal job. But I started to feel as though I was growing a little stale in the role. And I was sort of hitting some walls in terms of my capacity and, you know, what I thought I had to continue to offer.

Around about the same time, you know, I was recognizing that I had some people in my personal life that were at risk for opioid overdose. My awareness around that issue started to grow. I started to see a little more in the news. You know, there were some higher-profile overdose cases that were happening in sort of the Ottawa region, just north of here.

This is important work. Like I said, with that personal connection, I... it just really hit home, ah, for me. I had just started to learn about naloxone. As you know, Susan, that's the drug that can reverse an opioid overdose. And so I was just starting to get an idea of what that was all about.

Susan Blue:

Opioid overdoses were increasing. And Rhonda accepted a newly created assignment: a position which included working to develop a local community drug-prevention strategy.

Rhonda Lovell:

It was an interesting, eye-opening experience to walk into a brand new, blank slate portfolio on a topic that was massive, and had that personal tinge as well. You know, I was stepping into something that this drug strategy was already kind of starting. So for me it was trying to better understand who was who at the table. I think I've said this to you before, Susan. Relationship building is absolutely at the heart of, I think, every portfolio that I've ever been in, in my 15 years—or however many years (laughing) it's been now—in public health.

And, ah, you know, so for me, it was really assessing who is—who's at the table already? You know, who's engaged? Why are they here? Because there's that assumption that we're all there for the same reasons. And, ah, that's absolutely not always the case. We don't always have the same idea of what the problem is, let alone, you know, what we hope to achieve or what we think that we have to offer.

So, really that assessment of the key players, and also the gaps. You know, who else needs to be at the table? That was one of, probably, the most beautiful things that I saw, over the last few years, was how that group really evolved. So, it was a lot of very senior-level people in their organizations. You know, we had even so far as the Chief of Police at the table, and continues to be at that table. But over time, they really started to realize, you know, that what we really needed was that frontline expertise. The most critical piece was having people with lived experience as part of that group.

And we tend to think of ourselves as experts—sometimes without realizing it—and maybe there's some content expertise there but I think we have to really look at, you know, moving from just a content expert to a *context* expert. I think that that's vital when you're doing any kind of community-level work. Because community engagement can be like a very unidirectional like "I'm the content expert, and I am going to tell you the things, and then you're going to do things with the things."

And even something as seemingly simple as asking questions of the community—you know, do not ask questions that you don't actually want the answers for, that you don't have any intention of doing them with.

[music]

Maureen Cava:

A large focus of Rhonda's community drug-prevention strategy was to create a safe environment, so that community members and agencies could come together and talk about their perceptions of harm reduction. For Rhonda, that included being aware of semantics and using language with a softer approach.

Rhonda Lovell:

You know, when we initially started, there was all this talk about harm reduction. We were almost being told to not necessarily use that language because it had a certain

connotation that wasn't very palatable to the broader community or to certain groups. And so it was often the, ah, the euphemism of "community safety": safe needle dropboxes or, you know, needle exchange programs, that kind of thing. You know, if you put these dropboxes in the areas, maybe in a playground, then you're going to have the needles in the bin versus on the ground. And so if you talk about it from a community safety standpoint.

The hope, the desire as a nurse is always that, you know, you're going to move people to that next level of awareness of acceptance that harm reduction is really just the place where evidence and reality meet. Let's talk about reality, please.

Susan Blue:

And do you think that's made some, from the community safety sort of softened approach, to a more honest, and direct, and, ah, clear approach in labeling harm reduction what it is, do you think there's been some progress there?

Rhonda Lovell:

I really do. I really do. Because I've done so many different trainings. So, the naloxone training and distribution program resulted in a lot of fear-based interest in naloxone and in the opioid overdose epidemic, in general. You know, we had lots of organizations that wanted to get training around naloxone, but it wasn't because they necessarily were fully understanding of the issues. It wasn't that they were necessarily thinking that they were going to maybe have to use this drug on a client; it was more that they were concerned for themselves.

So say, for example, if you were an organization that part of your work took you into the homes of vulnerable people who maybe had issues with drug use, or just that drug use was happening, period, people were like, "You know, if I go into that home and, you know, they have fentanyl there, like am I going to like keel over and die?" Basically. And it's like, "Well, if there's a bowl of pills on the table, don't eat them!"

But honestly, the level of fear at the outset of this portfolio—the fear that I heard from the community, it was all very rooted in misinformation and misunderstanding. And a lot of it very much harkened back to, you know, the AIDS crisis of the '80s where, you know, there was just so much misinformation that people were like, "Stay away from me. You know, don't come near me. I don't want to get this."

And it was the same thing with fentanyl. You know, I had people say, "Well, you know, we go into prisons and the prison person said, you know, if you've got to sign stuff, like don't touch that guy's pen because, you know, you're going to get fentanyl on your hands and then you're going to croak." It's like, "Mm, okay. So let's backtrack a little bit, and let's talk a little bit about opioids and how they act on our body. Let's talk about the likelihood that you're going to encounter pure fentanyl in the line of your role."

And so we were able to just take that back to just a really practical sense and ground it in facts. Not every organization then suddenly came onboard and became distribution

sites. You know, we've got maybe 10 or 12 solid distribution sites in the area now. And you know, as far as I'm concerned, we have the major players onboard. And I think for some of them, it may have been just that soft sell initially of going from a fear-based perspective to going, "Okay. All right. This is what the level of risk actually is for my staff. Here's how we can adjust things so that we can actually get kits into the hands of people who need that drug."

[music]

Susan Blue:

I talked to Rhonda about being aware of bias, as a nurse, and how reflection helps to minimize these biases.

Rhonda Lovell:

As nurses—with any profession related to health but nurses in particular—I think we have to really be careful in terms of our own biases. The things that we hold onto, I think that reflective practice is so critical. Because, you know, we're not always aware of the things that may be holding back work that are actually coming from within ourselves.

This will sound like a silly analogy (laughs). Yeah, I remember my mum, a number of years back, before she had surgery for carpal tunnel, back before she really realized that there was a problem going on, she's at her doctor's office and for something entirely unrelated. And he just kind of out of the blue asks her to tell him about the pain in her hands. And she's like, "Well, how did you know about the pain in my hands?" And he's like, "Well, pretty much the entire appointment, you've been sitting and just kind of nursing your hands, like rubbing your hands. And so tell me (laughing), tell me about it." You know, and so she was unaware. You know, when you have that chronic pain, you know, you're unaware of maybe some of the ways that you're responding to it, and the way that that can show up to others, and the ways that that can show up in your life.

And just like sort of those long held biases, for me, you know, I was born in 1976. You know, I grew up in a time when there were a lot of judgments and a lot of biases around drugs and people who used drugs. I grew up in the time of the "Just Say No" campaigns that, you know, really just served to criminalize people who used drugs—to criminalize a health issue.

And so, you know, really taking the time to invest in that self-reflection to see, you know, what are my long-standing beliefs that I'm not even aware are there? You know, what are the ways that's holding me back in my work? What are the ways that that's holding back movement in the work in the community?

So, yeah, I think we have to always be on the eye out for how we can adapt internally, so that the work can adapt as well.

Susan Blue:

When you reflect on, ah, your work in—specifically in harm reduction, what are the principles that guide your practice?

Rhonda Lovell:

I think harm reduction work is very much rooted in meeting people where they're at. I think it's rooted in, you know, ensuring dignity for all, and ensuring respect is there. Making sure that access to health isn't conditional somehow. And so, you know, or that, you know, we require people to behave in a certain way, or listen to what we think is right, in order for them to access services. Because we certainly see that quite a bit in, you know, policies that are very against—you know, very much work against the principles of harm reduction, in terms of dignity, autonomy, respect.

You know, so just making sure that the person is—and their reality, all parts of their reality are at the centre of everything we do, and that we're not just coming at it from a perspective that's just going to add oppression to people that are already quite vulnerable and quite marginalized.

Susan Blue:

When I hear you talk about your work, I hear so many roles being identified. I hear: advocate, community mobilizer, educator, innovator, leader, community capacity builder, health promoter. There are so many roles that you've taken on in the important work that you're doing. Is there anything else you would add to that list?

Rhonda Lovell:

I remember as a student going through, you know, and you learn all the theory, you learn all about the behind-the-scenes things, the models, that eventually you get to the point—like I am, I guess, in my career—where you've integrated it all. It's very overt when you're first doing it; because you have to pay attention, because you don't really know exactly what you're doing, you're learning.

You know, the reality of public health nursing is quite different than what it sounds like in a book. Coming to this role, respecting the power that we actually have in this role—you know, and I could talk for days about the dynamics of power—but also coming at it from a place of ultimate humility of knowing that by no means is what I say (laughing), you know, going to be the bottom line. You know, it's got to be that collaborative experience. We've got to come together.

Susan Blue:

So to bring things to a close, I'd like you to tell us, though, about what you are most proud of in what you've accomplished, to date, in your work.

Rhonda Lovell:

Oh, gosh. What am I most proud of? The fact that I have persisted (laughing). Honestly, it's true. I think, you know, the growth that I've experienced, I'm proud that I've allowed myself to grow as much as I have. And again that comes back to that balance of power

and humility of understanding what our role is but, you know, knowing that we have to grow and change.

But yeah, I think it's persistence. Because the public health nurse role, it is about the long game. I think you and I talked about this, maybe when we first met, Susan. You know, and I said, "I came out of nursing school, as many, you know, brand new nurses do, wanting bonfires." You know, even though I knew I was going into public health, you know, you still come out of it with that striking enthusiasm of like, "I wanna get stuff *done*." You know, like, "I'm here to work. Let's do this thing."

And you know, that's great. And obviously COVID-19 has taught us that, you know, public health has its bonfires, too. You know, there's definitely times where you're going to bring that full-bore energy. But really, the bulk of public health work, in my experience anyway, has been, you know, at the level of the embers. It's that slow, slow—that warm burn that we've just got to keep going.

I talk to students in the Masters of Public Health program here at Queen's, a few times, around community engagement. And what we always wind up talking about, "Let's talk about the reality of public health." You know, if you're coming into this, you know, self-care is key, and also balancing that passion with the understanding that this is long-term work. We need nurses that are committed to the long haul, because that's where we're going to ultimately see the change happen.

And you're not always going to see the full change happen, even over the course of your own career. Anthoni Gaudi didn't see the Sagrada Familia, you know, finished in the course of his lifetime. But he *built* the pieces. You know, he built those 3-D models for the people that would come after him to continue building this massive cathedral that's still not finished, you know, after whatever over 100 years.

It's the same thing with public health nursing. It's—we're not in this for the glory. We *are* going to see wins over the course of our career. There's always going to be low-hanging fruit to go after. That's the stuff that helps hook in community partners. But for those real big, long-term outcomes, you've got to have that long-term gain in mind and pace yourself.

Plan for the future; and plan for the fact that, you know, you might be passing the torch to another nurse at some point.

[music]

Susan Blue:

What keeps your passion? You have brought so much energy and excitement, and—and just passion to our discussion today. What keeps that alive for you, Rhonda?

Rhonda Lovell:

Remembering why I did this. You know, remembering why I came into this role. Because I actually genuinely care. I want to see a difference. You know, and I do believe that the role of the public health nurse is absolutely vital in terms of community well-being.

So when we get those little wins, you know, celebrating them. It doesn't have to be like some big overt party. We're not allowed to have parties now. Just acknowledging those wins when they happen. And just, again, going back to remembering the basics of "Why did I take this on? Why do I want to do this?" And it's because it matters.

[music]

Susan Blue:

Thank you for listening to *Stories From The Field*, hosted by me, Susan Blue...

Maureen Cava:

... and me, Maureen Cava.

Susan Blue:

This series is produced by Katie Jensen and Sabrina Brathwaite of Vocal Fry Studios.

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