

Oxy to Oxy 2

Impacts and Recommendations Community Forum



Second Informal Summary Report
June 11, 2012

Oxy To Oxy 2:

Impacts and Recommendations Community Forum

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Executive Summary

The United States made OxyContin available in 1995 and was the first country in North America to experience the negative impacts, which along the way gained the moniker “hillbilly heroin.” In 2010, the U.S. replaced OxyContin with a reformulated Purdue product. Reformulation reduced the illicit demand for the new medicine and drove up demand for other narcotics¹, primarily heroin and fentanyl².

In February 2012, Ontario announced that a reformulated OxyContin called OxyNeo would be added to the Ontario Drug Benefit Plan along with changes in prescribing and benefit guidelines³.

Responding to concerns that the Ontario decisions may have significant and potentially fatal impacts on area citizens and services,, between March 5th 2012 and March 8th 2012, the Wellington Guelph Drug Strategy and the Waterloo Region Crime Prevention Council convened both a survey of service providers as well as a community forum. Survey results, forum proceedings and recommendations from participants are found in the first Oxy to Oxy report.⁴

In June 2012, participants met again to discuss the landscape three months after the Ministry decision, to note any changes and to make recommendations. It was thought then that the full impact of the decision was yet to be realized.

Three key recommendations were made by participants in June:

1. An Enhanced Addiction Treatment System

- Immediate action is needed to address persistently long waiting lists for addiction treatment.
- Immediate strategies and added capacity is needed to support individuals during the transitions between assessment and referral, community based treatment, withdrawal management and longer-term treatment options.
- Short-term and long-term supportive housing should be made available at every stage of treatment continuum to ensure maximum success.

2. The Development of a Local Naloxone Distribution Program

- Accidental overdoses have been a leading cause of death for several years. Naloxone has been the treatment of choice for primary care professionals for decades though is not widely dispensed locally. Participants reiterated an urgent need to implement a local naloxone-based overdose prevention program.
- Multiple physicians should be encouraged to prescribe and/or write medical directives to ensure low threshold availability.

3. Increased Capacity within the Primary Care Sector

- Increased addictions training for family physicians and primary care staff, students, hospital emergency room staff and frontline health care workers;
- Establish a mobile medical-health program in order to provide primary care and outreach acute care services to vulnerable and isolated populations.

On behalf of the citizens and service providers without whom this informal report would not exist, we are pleased to submit this second report for consideration by community, funders, policy and programming bodies.

Part One: Since February 2012

Since its introduction in 1996, OxyContin, produced by Purdue Pharma, has had many benefits in managing pain, due in large part to its time-release properties. Opioid-based pain management has been an accepted tool for many years; among the varieties of opioids and opiates available legally and illegally are Morphine, Percocet, Tylenol 3 and codeine, Fentanyl and Dilaudid. Heroin, introduced to North America by Bayer Pharmaceuticals in the 19th century, has not been widely prescribed since the early 1900s and its presence in North America is a result of a black market that has existed since prescribing ceased.

The negative impacts resulting from the introduction and surge in OxyContin prescribing include a variety of fiscal, health and social costs borne by citizens, neighbourhoods, service providers, governments and others. These consequences are in part because opioids are inherently addictive, an increase in dispensing, an increase in dosage, and the existence of a robust black market. For example, between 1991-2007 oxycondone prescribing in Ontario rose by 850%. Moreover, the addition of oxycondone to the Ontario Drug Benefit plan was associated with a five-fold increase in oxycondone mortality (of which 24% were deemed to be intentional); more than half of the victims had seen a physician and a pharmacist within the month preceding their death⁵ (Dhalla et al., 2009a). The societal burden has been described as substantial⁶ (Dhalla et al., 2009b).

On February 17, 2012 the Ontario Ministry of Health and Long Term Care announced that OxyContin would no longer be covered under the Ontario Drug Benefit Plan, and that new prescriptions would cease, to be replaced by Purdue Pharma's patented replacement called OxyNeo, effective March 1, 2012⁷. The patent for OxyContin expires November 2012.

It was an announcement that most heard about through the media and were unprepared for. In what appeared to be the absence of a funded mitigating provincial plan, and the prospect of potentially grave consequences locally, the Wellington Guelph Drug Strategy and the Waterloo Region Crime Prevention Council collaborated to create and distribute a survey of service providers across the Waterloo Wellington Local Health Integration Network (WWLHIN) area (see Appendix B for a geographic description). Within a week, survey results were made available, a community forum was held, and an informal summary report was released. The report- Oxy To Oxy: Impact and Recommendations - was distributed in March to participants, the Ontario Ministry of Health and Long Term Care, the WWLHIN, area health units and community members.

Since the Oxy to Oxy Report's release, a number of events related to the OxyContin decision have occurred. Among them:

- On March 1, 2012, the Ontario Ministry of Health and Long Term Care announced the formation of an Expert Working Group on Narcotic Addiction to provide advice to the Minister on the short, medium and long-term unintended health and social impacts of addiction withdrawal with immediate attention to the situation created by the removal of OxyContin from the Drug Formulary, and develop recommendations on how to mitigate these impacts.

The draft Terms of Reference suggested the following objectives and deliverables:

Identification of major issues	March 9, 2012
List of short-term recommendations	March 16, 2012
List of medium- and long- term recommendations	April 13, 2012

On October 15, the "[Report to the Minister of Health and Long-Term Care from the Expert Working Group on Narcotic Addiction](#)" was released to the public.

- On March 5, the Chief Medical Officer of Health for Ontario, Public Health Division, requested that information be collected regarding the activity within local harm reduction programs led or supported by public health units across the province. To date it is not known what the monitoring has revealed in any detail.
- On March 12, the Ministry of Health and Long Term Care (MOHLTC), the Ministry of Children and Youth Services and the Ministry of Aboriginal Affairs announced that they would monitor the impact of the removal of OxyContin from the Canadian market and expand access to addiction services in Ontario.
- Local Health Integration Units (LHINs), the local funding bodies of the Ontario Ministry of Health and Long Term Care, were directed to implement a weekly monitoring effort amongst LHIN-funded health care providers and others in local communities.

It is not known what local monitoring has revealed in any detail, however we were privileged to have a WWLHIN representative at the second Oxy To Oxy forum to provide a broad overview of the information collected to date.

- Public Health Ontario advised that inquiries related to OxyContin should be directed to the Ontario Emergency Management Branch of the Ontario Ministry of Health and Long Term Care. Between March 5, 2012 and April 18, 2012, several requests for information related to opioid withdrawal management suitable for persons addicted to OxyContin were placed but with no response. A search of the MOHLTC and Health Canada websites yielded no health and safety guidance for persons withdrawing from, or persons wishing to support someone withdrawing from, opioids.
- At the end of April 2012, the Ministry of Health and Long Term Care released a series of advisories for professionals, including advice related to tapering of opioids, supporting intoxicated clients and the treatment of individuals experiencing withdrawal. It was indicated that similar plain language advisories would be developed and distributed for community members, though to date these have not been released,
- Preventing Overdose Waterloo Wellington (POWW), a training group unique in Canada, saw a surge in requests for overdose prevention and intervention training from communities across Southern Ontario. Additionally, POWW participated in a province-wide webinar at the end of March 2012, together with Toronto Public Health and Toronto Public Health The Works. This webinar training was coordinated and funded by the Ontario Harm Reduction Distribution Program.
- On April 4, 2012 with support from the Ministry of Children and Youth Services, the Ministry indicated that additional resources were made available for:

Telemedicine: The Ontario Telemedicine Network has purchased equipment to expand access to addiction treatment and consultation. The Ministry is working with its partners, including the LHINs and Health Canada, to determine priority areas for distribution.

Overdose Kit Training and Supplies: The Ontario Harm Reduction Distribution Program has purchased naloxone for use in overdose kits intended for distribution to harm reduction programs throughout the province. Last week (March 2012) front-line workers in harm reduction programs were trained via Webinar on the use of naloxone overdose kits; and

Surveillance: Implementation of real-time surveillance of opiate overdose and withdrawal in 73 emergency departments across Ontario.

- The Ontario Harm Reduction Distribution Program (OHRDP) purchased naloxone, and kits are now available free of cost in Ontario. However, distribution of naloxone has been limited both locally and across Ontario, as very few no physicians are prescribing and/or writing Medical Directives. Community distribution programs appear to be limited to Toronto and Ottawa.
- The Ontario Harm Reduction Distribution Program (OHRDP) produced a 210 page guidance document called “Community-Based Naloxone Distribution” that provides detailed information on implementing naloxone-based overdose prevention programs in Ontario.
- Inquiries were made to the WWLHIN and to the Ontario Ministry of Health and Long Term Care to acquire data from the ‘real-time monitoring’ (to collect and provide up to date overdose data) taking place in hospitals and other sites indicated in the Minister’s Statement of April 4, 2012. The methodology is unknown and this data has not been made available to the public.
- With Purdue’s patent on OxyContin set to expire in November, concerns about generic versions being made available have been expressed by the Ontario Minister of Health and Long Term Care to Health Canada.
- On October 15, the “Report to the Minister of Health and Long-Term Care from the Expert Working Group on Narcotic Addiction” was released to the public. Entitled [“The Way Forward: Stewardship for Prescription Narcotics in Ontario”](#), the report outlines immediate and short (within 3 months), medium (within 6 months) and long-term (six months and beyond) recommendations.

Part Two: Oxy to Oxy Impact and Recommendations

The discussion and recommendations from our community survey and the first community forum were highlighted in the report *Oxy to Oxy: Impacts and Recommendations* (March 14, 2012). The Recommendations are found in Appendix A.

A second forum was held in June 2012, with one of the objectives being to determine the degree to which recommendations made from participants were being realized and further, if impacts that were predicted by the community in March were in fact occurring. Email invitations were sent to all participants who attended the first forum, and an e-flyer was also broadly distributed throughout community and social networks.

On June 11, 2012, over 40 participants from the following 12 groups/sectors were present:

- Waterloo Wellington LHIN
- The Addiction & Mental Health Network
- Addiction & Mental Health Treatment Providers
- Health Care Service Providers
- Housing Providers
- Outreach Services
- Youth Service Providers
- People in Active Substance Use
- People in Recovery from Substance Addiction
- Police Services
- Social Workers
- Students

Participants had an opportunity to participate in overdose prevention training, provided in a morning session. The increased risk of accidental overdose was a key concern raised by Oxy participants in March.

Preventing Overdose Waterloo Wellington (POWW) provided free overdose prevention and intervention training. Unique in Canada, POWW's training offers an overview of substance use, risk factors for accidental overdose, and training to help recognize the signs and symptoms. Strategies for responding effectively to an overdose are also highlighted. Core training components include:

- Overview of the influence of depressant, stimulants and hallucinogens
- Overview of factors influencing the use of drugs and the patterns of drug use.
- Overview of harm reduction strategies
- Preventing overdoses and reducing the risk factors
- Signs and symptoms of overdose relating to depressants and stimulants.
- Step-by-step guide to responding to an overdose.
- Debriefing and Self-Care

Waterloo Wellington Local Health Integration Network Presentation

Following lunch, participants heard a presentation from Patricia Syms-Sutherland, Senior Manager with the Waterloo Wellington LHIN. Patricia shared that since March 2012, the Ministry of Health has been monitoring the Oxy changes through a number of different mechanisms, including:

- Report submissions from Public Health Units;
- Emergency department data collection;
- Connex/Drug and Alcohol Help Line contacts;
- Tracking clients' who access methadone maintenance programs;
- LHIN data collection obtained from local Health Service Providers

Patricia shared that with respect to the local data, weekly surveys are being submitted to the LHIN by adult and youth addiction and mental health providers, hospitals and Community Health Centres; some non-LHIN funded service providers have also submitted reports.

It was indicated that while many providers have not observed any changes in service demands or the types of services being requested, other providers have reported the following:

- a) Increases in request for information about the Oxy changes, and inquiries about available treatment options;
- b) That addiction treatment providers at capacity, and are observing a further growth in waitlists;
- c) That there are limited intensive support options for individuals while they await longer-term treatment options;
- d) Limited capacity of methadone maintenance services;
- e) Limited access to primary care for complex clients needing support;
- f) Reports of individuals switching to other drugs, both observed among those accessing withdrawal management services, as well as in the general population of people using drugs.

Patricia noted that many service providers have been proactive in their approach to the issue, engaging in staff training, implementing a flexible service model to support clients with more complex needs, and supporting clients to integrate harm reduction approaches and practices.

Oxy to Oxy: The Local Context, Impact and Recommendations

Following the LHIN presentation, a summary of the concerns and recommendations from the March 2012 forum was presented to the group. Participants were then divided into small groups and asked to respond to the following four questions:

1. What changes, if any, have you observed in the community since the discontinuation of OxyContin and the introduction of OxyNeo? Are these changes new or are they existing issues that have perhaps intensified because of the Oxy changes?
2. Are you aware of any local or provincial responses that may have mitigated, alleviated or addressed any of the issues that you may have observed?
3. Using existing resources (no new funding) what could organizations and/or our community as a whole be doing to reduce the impacts?

4. As a group, review the list of short, medium and long-term recommendations made at the first Oxy Forum. What recommendations should be prioritized at this time? Are there additional recommendations that you feel should be added?

The following is a summary of the response collected from the group:

1. ***What changes, if any, have you observed in the community since the discontinuation of OxyContin and the introduction of OxyNeo? Are these changes new or are they existing issues that have perhaps intensified because of the Oxy changes?***

Media Coverage

The discontinuation of OxyContin by Purdue Pharma has been a popular subject within the news since the announcement was made, and participants felt that this coverage has increased awareness amongst the general population of the potential impact this drug has on individuals and families.

Supply & Demand

The announcements by Purdue Pharma and the Ministry produced a sense of panic regarding the supply and availability of OxyContin, which was reported to have resulted in stockpiling and hoarding of existing prescriptions. As expected, decreased supply has corresponded with an increase in cost of the drug on the black market, with some participants reporting that the price of Oxy has now tripled. It was speculated that until the supply has completely dissipated, there will continue to be those who use this drug despite its expense.

Switching from OxyContin to OxyNeo

With OxyContin diminishing from the market, some individuals have switched to its replacement. Called OxyNeo, this new version has been designed with the intent of being harder to manipulate for injection use, and therefore presumed to minimize illicit prescription drug use. Participants shared that a perilous trial and error process of experimentation has emerged. It was shared that street health service providers are observing an increase in the incidence of abscesses, as well as in the demand for abscess kits that are distributed through local needle exchange providers. It was indicated that few seek treatment for fear of stigma, as well as the risk that their prescriptions will be discontinued.

Switching from OxyContin/OxyNeo to Other Drugs/Opioids

Participants shared that many individuals who use Oxy have taken either proactive or reactive measures to avoid withdrawal. Some have opted to switch from their drug of choice to another opioid; in particular, attendees noted that heroin (opiate) is making a remarkable comeback. Participants also shared that the availability of crystal methamphetamine has also surged community and that Fentanyl (a high potency opioid) is also becoming more popular, particularly amongst youth and in correctional facilities. What is most significant about this shift is the coinciding increased risk in health risks, most notably the risk of an accidental overdose.

Seeking Treatment

It was reported that the discontinuation of OxyContin has been the catalyst for some individuals to seek treatment. However, it was also shared that as a result of both capacity and distance issues experienced with withdrawal management services, because of the absence of intensive community based treatment for addictions, and due to extensive waitlists for residential treatment, the availability of these supports is often being ill-timed to meet needs of those who need the help.

Conflict & Tension

With the supply of OxyContin ebbing daily, it was reported that there is increased conflict and tension within the drug-using community.

Participants indicated that while some of these concerns are new to the community, several are existing pressures that have pre-existed with the addiction or health care system which have subsequently been amplified by the Oxy changes.

2. Are you aware of any local or provincial responses that may have mitigated, alleviated or addressed any of the issues that you may have observed?

Participants noted that they were indeed aware of some local responses that have attempted to mitigate, alleviate or address some of the issues they had either observed or encountered, but were less aware of provincial responses.

Locally, participants were aware of:

- a) Preventing Overdose Waterloo-Wellington (POWW) expanding their training base to include both increased local delivery, as well as presentations at several sites across the province;
- b) The Wellington Guelph Drug Strategy and Waterloo Region Crime Prevention Council's earlier forum and survey efforts, and subsequent *Oxy to Oxy Report* which was distributed widely;
- c) The WWLHIN's data collection efforts to track changes;
- d) Addiction treatment centres, outreach workers and street nurses promoting methadone treatment as an option available to clients.
- e) Increased discussion regarding naloxone distribution opportunities taking place within our communities, as well as the use of Subloxone as a treatment option for withdrawal. However there was a noted concern about physicians' reluctance to prescribe either of these options.

Provincially, participants were aware of:

- a) A provincially funded webinar event that profiled the Toronto Public Health's naloxone Program as well as POWW's Overdose Prevention Training, launched in late March of this year
- b) The creation of an Provincial Expert Working Group to act as an advisory to the Ministry of Health and Long Term Care.
- c) Guidelines to support health service providers working with individuals experiencing withdrawal management symptoms have been released by CAMH. Guidelines to support individuals, family members and community service providers have yet to be released.

3. Using existing resources (no new funding) what could organizations and/or our community as a whole be doing to reduce the impacts?

When asked about what existing resources, organizations and our community as a whole could be doing to reduce the impacts of the situation, participants of the forum clearly advised that the swiftest action would be a community-based response. With this in mind, the following community-based suggestions were made:

- a) Providing up to date, easily accessible information, including resources for harm reduction and treatment services individuals, families and professionals. Participants felt that promoting *available* services was vital to reducing the impacts facing our community be reduced.
- b) Using media outlets and online resources as vehicles for educating the public. Additionally, the use of social media such as Facebook or Twitter as a space for individuals to share

their personal stories through posts, blogs, etc. Media and social media was also indicated as an important mechanism for sharing information regarding bad drugs.

- c) Participants also felt that primary care providers needed to be involved and that they should be prescribing the opioid antagonist naloxone (also known as Narcan).

Ideally, participants wanted to see more funding and resources directed to the issue to support more substantial efforts such as housing and mental health needs.

4. What recommendations should be prioritized at this time? Are there additional recommendations that you feel should be added?

1. An Enhanced Addiction Treatment System

- Immediate action is needed to address persistently long waiting lists for addiction treatment.
- Immediate strategies and added capacity is needed to support individuals during the transitions between assessment and referral, community based treatment, withdrawal management and longer-term treatment options.
- Short-term and long-term supportive housing should be made available at every stage of treatment continuum to ensure maximum success.

2. The Development of a Local Naloxone Distribution Program

- Accidental overdoses have been a leading cause of death for several years. Naloxone has been the treatment of choice for primary care professionals for decades though is not widely dispensed locally. Participants reiterated an urgent need to implement a local Naloxone-based overdose prevention program.
- Multiple physicians should be encouraged to prescribe and/or write medical directives to ensure low threshold availability.

3. Increased Capacity within the Primary Care Sector

- Increased addictions training for family physicians and primary care staff, students, hospital emergency room staff and frontline health care workers;
- Establish a mobile medical-health program in order to provide primary care and outreach acute care services to vulnerable and isolated populations.

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4. Wellington Guelph Drug Strategy and the Waterloo Region Crime Prevention Council (2012). *Oxy to Oxy: Impact and Recommendations Informal Report, March 14 2012*. Find it at: <http://wgdrugstrategy.ca> and <http://www.preventingcrime.ca>
5. Dhalla, I.A., Mamdani, M.M. Sivilotti, M., Kopp, A., Qureshi, O. & Juurlink, D. (2009). Prescribing of opioid analgesics and related mortality before and after the introduction of long-acting oxycodone. *CMAJ*, 181(12), pp. 891-896.

Appendix 1: Community Recommendations (March 2012)

Based on the multiple and varied concerns that community members discussed, a list of recommendations were brought forth to better manage what participants described as the most serious and negative impacts of OxyContin's discontinuation. It is important to note that there is little or no capacity to take on additional responsibilities amongst providers. The participants at the community forum indicated that client/patient-centred care is paramount, and both regulatory support and new/re-allocated resources from the Province are required to mitigate impacts.

The most common concern identified at the Community Forum was overdose deaths and injuries.

The community recommends:

General

- i. Participants encourage the Ministry of Health and Long Term Care (The Ministry) to view the OxyContin policy change as an opportunity to break the cycle of addiction, intergenerational abuse, and neglect. Further, participants encourage the Ministry to take immediate action that prevents further fatalities and injury and allows people to transition into healthier life circumstances;
- ii. Participants also view the policy change as an opportunity to educate and train about issues of substance use, addiction and mental health - to increase awareness that addiction is also a health issue, and to decrease stigma and discrimination about related issues.

Immediate (0-4 weeks)

- i. The Ministry should rapidly establish the mechanisms to allow for the immediate low-threshold distribution of naloxone (Narcan) and associated training.
- ii. Increase the availability of overdose prevention training for all impacted service providers, people at risk of overdose and persons who may be in a position to administer life-saving overdose techniques to an overdose victim.
- iii. Implement mobile withdrawal management and medical services across the Waterloo Wellington LHIN area.
- iv. Increase support for parents in withdrawal and children's safety by including other family members in the process (other protective adults to wraparound children).
- v. Increase awareness about, and the availability of, medications and techniques that support clients in the withdrawal process.
- vi. Institute a process to alert affected citizens and service providers when dangerous substances are present in drugs available through the black market.
- vii. Promote DART and Connex, which are telephone services that provide callers with comprehensive information about drug treatment options and availability; 211 may need to be alerted.
- viii. Enhance capacity and knowledge of existing distress lines to support people dependent on substances, their caregivers, families and friends regarding withdrawal, addiction, overdose prevention, referral supports etc.
- ix. Increase promotion and marketing of the available addiction support, for example, treatment programs that accept clients using methadone or residential programs for parents with children.

- x. Increase communication within the Waterloo Wellington network regarding the local impacts and mitigating measures, including pharmacists and primary care providers in discussion; non-WWLHIN funded providers and citizens should also be included in this network.
- xi. The Ministry should start deploying health information related to Opioids (e.g. withdrawal).

Medium-term (3-8 weeks)

- i. Initiate mobile health care and include withdrawal and related substance use information and referrals, primary care, harm reduction supplies (e.g. withdrawal supplies, Narcan); proposal to this effect was submitted to the WWLHIN in 2009.
- ii. Make HIV and Hep C testing more accessible.
- iii. In addition to existing treatment services, increase support for pregnant women who are using substances through additional nursing care and outreach efforts.
- iv. Increase treatment opportunities for couples and single parent options with childcare;
- v. Increase the availability of street nurses who are able to treat abscesses.
- vi. Address the waiting gap between Withdrawal Management Centre and treatment services, which can be up to 2 years in the WWLHIN area. This could be met through funding to support intensive case management and coordination for individuals with addictions.

Long-term

- i. Increase capacity of Primary Care system (physicians, nurse practitioners) and improve training in addictions within medical schools and amongst practitioners.
- ii. Institute incentives for pharmacists dispensing Methadone.
- iii. Ensure the availability of a greater range of treatment options such as in-home, residential and outpatient.
- iv. Provide increased housing options.
- v. Increase or reallocate funding for treatment spaces (i.e. residential treatment beds).
- vi. Improve and increase pain management options, including better training for health care professionals.
- vii. Review emergency response protocols to determine if overdose witnesses in the WWLHIN area are reluctant to call 9-1-1 and if so, what policy changes are necessary to improve calls for service (a province-wide "Good Samaritan" law, similar to those being passed by States in the U.S.A., was suggested at the forum).
- viii. In the future, consult and develop a plan well in advance of major policy changes affecting the addictions-health system, and the people served by those and related systems.

Appendix 2: Geographic Area of the Waterloo Wellington Local Health Integration Network



Waterloo Region, Guelph and Wellington County are within the boundaries of the Ontario Ministry of Health's Waterloo Wellington Local Health Integration Network (WWLHIN), the major health funder in our communities. The entire WWLHIN area is located in southwestern Ontario, spans 4,800 square kilometers and includes approximately 730,000 people.

The WWLHIN area stretches from Proton Station in the north to Ayr in the south, Clifford at its most westerly point and Erin to the east. The WWLHIN area incorporates four major urban centres: Waterloo, Kitchener, Cambridge and Guelph, as well as a vast rural area with many smaller communities. 90% of the WWLHIN's geographic area is rural.



WELLINGTON GUELPH DRUG STRATEGY

The Wellington Guelph Drug Strategy (WGDS) is a coalition of over 30 partner agencies and members of the lived experience community, who are working to implement a 4-Pillar drug strategy in the municipalities of Wellington County and the City of Guelph. The 4-Pillars include Prevention, Treatment, Enforcement and Harm Reduction, with a 4-Pillars strategy recognizing that no one sector can effectively respond to substance misuse in isolation. Our cross-sectoral partnerships acknowledge the integral role that each pillar plays, and in many instances, weave the pillars together in our strategies and responses. In doing so, we have made many successful strides towards our goal of reducing the impacts of substance misuse in our communities.

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The Waterloo Region Crime Prevention Council works collaboratively to close the gaps between services and identify new directions for reducing and preventing crime, victimization and fear of crime by bringing together individuals, neighbourhoods, organizations, agencies and all levels of government. Established in 1995, it is an advisory committee to the Region of Waterloo and consists of 34 members representing many sectors including the community-at-large, social services, education, health, planning, justice, police, and community agencies among others. The Waterloo Region Crime Prevention Council has been upheld across Canada as an effective model for municipally-based crime prevention.

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