Submission to the Strategic Priorities and Policy Committee
City of London

Re: Item 4.6 – Advocacy Request – For-Profit Addiction Treatment in Ontario

Submitted by: Blair Henry, London Resident

Dear Committee Members,

I am writing in strong support of this motion.

Let's be honest about what's happening.

We are asking community-based, publicly accountable organizations to deliver complex, relationship-based, long-term addiction care… while funding them at levels that are structurally incapable of sustaining that work. Then we act surprised when gaps appear—and those gaps get filled by high-volume, for-profit models that were never designed to carry the full weight of care in the first place.

That's not a system failure by accident. That's a system designed to fail.

This issue is not about whether treatment should exist—it's about how it is delivered, and whether the system is actually set up to support recovery. Right now, too often, it isn't.

We are seeing a model where prescribing, dispensing, and ongoing care are fragmented. Where relationships are thin. Where wraparound supports—mental health care, housing, aftercare, and community connection—are treated as optional rather than essential. And when those supports aren't there, people don't stabilize—they cycle.

At the same time, we are underfunding the very organizations that know how to do this work properly. Community Health Centres, frontline nonprofits, and integrated care providers are expected to deliver outcomes without the resources required to build and sustain real continuity of care. Meanwhile, a system that rewards volume and throughput continues to expand.

There is a fundamental misalignment.

A system built on patient volume and ongoing utilization sits in direct tension with the goal of recovery—where success should mean people need less support over time, not more . If we are serious about recovery, we need to fund models that are designed for it.

We also need to acknowledge the structural disconnect. Municipalities are left managing the downstream impacts of systems they do not control—through policing, by-law enforcement, and strained community services—while decisions about care models and funding are made elsewhere . That disconnect is not theoretical. It is visible in our neighbourhoods, and it is felt by residents, businesses, and people trying to access care.

If we want different outcomes, we have to build a different system.

That means properly funding integrated, publicly accountable models of care. It means investing in the full continuum—access, detoxification where needed, treatment, aftercare, housing, and long-term supports. It means resourcing the organizations already doing this work, rather than underfunding them and expecting them to carry an impossible load.

Access alone is not care. Volume is not success. And underfunding a system while expecting it to solve one of the most complex public health challenges we face is not just ineffective—it is irresponsible.

This motion represents an important step toward a more coherent, accountable, and effective approach—one that aligns funding, care delivery, and outcomes in a way that actually supports recovery.

We can do better than this. We just have to choose to build it—and fund it—properly.

Yours in Service

Blair Henry