300 Dufferin Avenue
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February 25, 2026

The Honourable Sylvia Jones
Minister of Health
Ministry of Health
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Email: Sylvia.Jones@ontario.ca

To the Honourable Sylvia Jones, Minister of Health:

I am writing in my capacity as a City Councillor representing downtown London, Ontario, to request regulatory review of prescribing and dispensing practices associated with New Dawn Medical Clinic and related pharmacy operations in London, including Medpoint (248 Dundas Street), London Medical Pharmacy–Downtown (528 Dundas Street), and Chapman's Pharmacy (650 Dundas Street). I also note that New Dawn Medical Clinic lists additional London locations at 740 Dundas Street and 1920 Dundas Street East on its website: https://newdawnmed.com/locations/.

I am bringing forward concerns raised to my office by residents, local businesses, and other stakeholders regarding visible disorder and safety incidents in the immediate area, concerns about possible diversion of prescribed medications, and the resulting impacts on both patient wellbeing and the surrounding community.

To be clear, this is not an argument against harm reduction, opioid agonist treatment, or prescribed alternatives. Prescribed alternatives to the toxic street supply can be an important component of addiction care and can be life-saving when delivered with strong clinical oversight, consistent monitoring, and integrated supports. My concern is about how care is being administered in practice, including whether current prescribing and dispensing models are providing the level of clinical monitoring, continuity, and wraparound care required for a high-risk population.
The concerns raised to my office relate to what appears to be a high-volume model in which prescribing may occur virtually, physicians may not be consistently present in the local

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community, and pharmacies may become the main point of ongoing contact. Even where this may be technically compliant with current rules, the structure itself can create gaps in assessment, continuity, monitoring, and accountability across the full care pathway. I have also heard concerns, including from those with health systems and health economics perspectives, that heavy reliance on virtual care in this context can contribute to rapid patient turnover and reduce continuity of therapeutic engagement.

Over the past period, business owners, residents, and patrons have reported escalating impacts near operations associated with New Dawn Medical Clinic, particularly at 248 Dundas Street, 528 Dundas Street, and 650 Dundas Street. Stakeholders describe recurring concerns affecting staff safety, customer access, daily operations, and residential use of the area. Reported issues include congregating near entrances, visible impairment, barriers to access, repeated requests for police or foot patrol attendance, disruptive behaviour, property damage, and recurring sanitation and security concerns. Businesses have also reported reduced hours, staffing challenges tied to safety concerns, and declining confidence among long-standing operators. Many stakeholders report that these impacts appeared soon after clinic or pharmacy operations opened or relocated.

At a broader neighbourhood level, there are five locations associated with the New Dawn Medical Clinic network along Dundas Street in London, with four located within close walking distance of one another. This concentration raises concerns about cumulative impacts on the corridor, surrounding businesses, nearby residents, public spaces, and the patients receiving services.
It is also important to note the limited tools available to municipalities in this area. Municipalities do not license or regulate medical prescribing practices carried out by regulated health professionals, and cannot impose clinical operating conditions on these models. The City does not have the authority to close a health clinic that is operating within provincial law. Municipal responses are therefore limited to secondary impacts through by-law enforcement, policing, and public realm maintenance. This increases the importance of provincial regulators reviewing system-level risks when visible community impacts are persistent.

This also reflects a broader structural issue. In practice, municipalities are often left managing downstream impacts while decisions about addiction service delivery models, funding, and accountability structures are set elsewhere. In some cases, this can result in credible and accountable community health centres being constrained from operating or expanding life-saving

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addiction programs, while private clinic models fill the gap. Even where a private clinic is acting in good faith, it will not typically have the same integrated service model, governance, or community accountability structure as a community health centre. This is a structural problem that requires provincial attention and support.

Another concern raised by stakeholders is the increasing role of private, high-volume clinic and pharmacy business models in a part of the health system that requires sustained, relationship-based, multidisciplinary care. Opioid dependence and substance use treatment are not well suited to throughput-driven models that may prioritize volume, speed, or prescribing activity over continuity, integrated supports, and long-term stabilization. Where private equity or investor-driven ownership structures are influencing service delivery, there is a risk that financial incentives may not align with the clinical needs of patients or the broader public interest. In my view, this type of care should be delivered, wherever possible, within more publicly accountable and community-integrated health care settings, and the current balance between private delivery and public oversight warrants review. This is not a request to reduce access to care, but a request to strengthen how care is delivered by prioritizing models with transparent governance, multidisciplinary teams, and accountability to both patients and the communities where services operate.

I would also note that similar concerns related to New Dawn Medical Clinic operations have been raised in other Ontario communities, including public complaints from nearby residents and businesses and public statements by local elected officials referencing concerns about clinical oversight and formal complaints to the College of Physicians and Surgeons of Ontario (CPSO). More broadly, comparable concerns have also been raised in relation to other private clinic and pharmacy operations working in this same area of care. This suggests the risks may not be limited to one location or one operator, but may reflect broader vulnerabilities in the service model and oversight framework currently permitted under provincial regulation.

For that reason, I respectfully submit that the issues being raised in London may not be isolated and may warrant broader regulatory review of high-volume prescribing and dispensing models, particularly where care is delivered through a combination of virtual prescribing, pharmacy-based dispensing, and limited integrated wraparound supports.

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A key concern raised by stakeholders is the apparent separation between prescribing and ongoing in-person care. In particular, concerns have been raised about:

- limited continuity with the prescribing clinician
- inconsistent or unclear follow-up practices
- uncertainty about how diversion risk is assessed and managed
- limited visible wraparound supports, aftercare, or integrated social and health supports near the dispensing environment

New Dawn Medical Clinic and similar providers may point to physician relationships as evidence of ongoing care. However, many of the original prescribed alternatives and safer supply programs were designed with a broader wraparound model, including allied health staff, mental health supports, outreach workers, and community-based care teams. A pharmacy, even when functioning as an important dispensing and contact point, is not able on its own to provide the same scope of integrated care.

This concern is consistent with the direction of the Canadian guidance I reviewed. The Centre for Addiction and Mental Health (CAMH) synthesis of Canadian guidelines on opioid agonist therapy emphasizes that harm reduction and prescribed alternatives should be paired with safety measures, that urine drug testing should be used therapeutically rather than punitively, and that care should include integrated supports, trauma-informed care, and appropriate monitoring. The same document also notes that emerging harm reduction approaches should not be treated as a standard of care without appropriate safeguards and ongoing clinical judgment (Centre for Addiction and Mental Health, *Opioid Agonist Therapy: A Synthesis of Canadian Guidelines for Treating Opioid Use Disorder*, 2021).

The College of Physicians and Surgeons of Ontario (CPSO) *Advice to the Profession: Prescribing Drugs* (last updated December 2025) is also directly relevant. The CPSO states that opioid agonist treatment is a first-line, evidence-based treatment and that physicians must prescribe in accordance with the Prescribing Drugs policy and relevant opioid use disorder guidance. The CPSO also states that safer supply prescribing must be carried out in a manner that minimizes harm and unintended consequences to individual patients and to the broader public, including diversion, and highlights the importance of careful documentation and consultation where appropriate. The CPSO further

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reminds prescribers to take reasonable steps to review prescription histories, including through the Digital Health Drug Repository and related provincial clinical viewers.

My concern is not that access to care should be restricted. It is that prescribing and dispensing of high-risk medications should occur within a model that includes stronger supervision, clearer monitoring standards, and better integration with care and support services, including consideration of witnessed consumption or other strengthened safeguards where clinically appropriate.

For these reasons, I respectfully request that the College of Physicians and Surgeons of Ontario and the Ontario College of Pharmacists, within your respective mandates, undertake a coordinated review and also communicate these concerns to the Ontario Ministry of Health for broader system and policy action. I further request that the Ontario Ministry of Health work with expert clinicians across the substance use treatment spectrum, including frontline clinicians, public health experts, allied health professionals, researchers, and people with lived experience, to develop robust guidelines addressing:

- clinical assessment and reassessment practices
- prescribing patterns and prescribing governance
- documentation standards and continuity of care
- dispensing practices and supervision protocols
- monitoring and follow-up practices, including responses to suspected diversion risk
- integration with addiction medicine, primary care, mental health, and psychosocial supports
- safeguards in virtual prescribing and pharmacy-led care models
- any system-level issues related to high-volume or geographically clustered operations
- opportunities to strengthen best-practice standards to reduce harm to patients and the broader public

While robust and comprehensive guidelines are needed to ensure vulnerable patients receive excellent clinical substance use care, those guidelines will only be effective if the Province and the Ministry of Health also commit adequate supports and financial resources. Investment is needed in multiple areas, and I am requesting your consideration of the following:

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- investment in all levels of housing: transitional, supportive, highly supportive, and community housing needs to be rapidly expanded and committed to beyond one-time funding or pilot project initiatives
- investment in strong community-led health organizations such as Community Health Centres (CHCs). CHCs and similar models are uniquely positioned to deliver the comprehensive, full-scope primary and substance use care that is required for vulnerable people addicted to the toxic drug supply
- investment in tertiary-level hospital resources focused on the full spectrum of substance use care: stabilization, harm reduction, medication supports, long-term psychosocial interventions, and strong aftercare programs for people who use substances
- investment in strong linkages between community organizations and hospital-based care to ensure that current gaps created during transitions in care no longer allow patients to fall through the cracks
- investment in community-based organizations that save lives before people are able to access long-term supports: supervised consumption, supervised inhalation facilities, and public health initiatives that support the prevention of blood-borne disease through the provision of medically indicated harm reduction supplies

Beyond investment of financial resources, I respectfully request that the Province and the Ministry of Health recognize the significant expertise available in Ontario from clinicians, researchers, and people with lived experience. Development of a model that will save the lives of Ontarians and improve the communities they live in requires a commitment to evidence-based interventions supported by rigorous scientific research, with implementation free from political interference. Additionally, I respectfully request consideration of a provincial science advisory table that includes experts in substance use care to help guide the Ontario government's response to the toxic drug crisis, save lives, and mitigate the downstream effects of the current system.

My office continues to hear from residents and businesses about ongoing impacts in the Dundas Street corridor, and I remain concerned that vulnerable patients may be receiving care in a model that does not consistently provide the level of support needed for stabilization and longer-term health outcomes. This issue warrants careful regulatory review grounded in evidence, patient safety, and public safety.

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Thank you for your attention to this matter.

Respectfully submitted,

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