The Continuum Nobody Funds Whole

"A child may inherit none of the events but all of the settings." — *Civilizations Fatal Addiction: War as a Neural and Social Compulsion*

A Shared Starting Point

People are dying. Systems built to stop that are failing to keep pace. Everyone close to this work, whatever camp they sit in, is tired of an argument that keeps circling back to the same unresolved question: which half of the response actually works. That question has consumed a decade of policy attention on both sides of the Atlantic. It may be the wrong question.

A different one is available. Not which model is correct, but what happens, structurally, when a continuum of care, harm reduction at one end, recovery support at the other, with everything connecting them in between, is cut into competing halves instead of funded as a whole.

Two Directions, One Structural Error

Two governments have taken opposite ideological paths toward the same mistake. Alberta has spent the past several years defunding harm reduction while investing in recovery-oriented care. Oregon decriminalised drug possession in 2020 without building the treatment infrastructure that decriminalisation was supposed to lead people toward.

Alberta has closed supervised consumption and overdose prevention sites across the province; Edmonton's site has already closed, and Calgary's last remaining site is scheduled for closure in 2026 — the same city, the same year, as the Recovery Capital Conference. Red Deer's overdose prevention site had its contract stripped in 2023, with remaining harm reduction services in the area defunded by roughly 80 percent by 2025, ending 37 years of harm reduction provision in that community. Oregon's own data on Measure 110 found that fewer than 0.85 percent of people who received citations were ever referred into treatment — decriminalisation copied without the investment infrastructure Portugal built alongside its own version.

One caution is worth stating plainly, because the temptation to reach for it is real and the evidence does not yet support it. A 2026 linked cohort study in Addiction, comparing Red Deer's overdose prevention site users against a Lethbridge comparison group after Red Deer's closure, found no statistically significant increase in deaths, emergency department visits, or EMS events. That finding should not be read as settled either way: two formal responses in the same journal, including a critical appraisal from the Ontario Drug Policy Research Network, have raised substantial concerns about the comparability of the two sites, Lethbridge's own service was itself a reduced replacement, lacking inhalation rooms and the comprehensiveness of what Red Deer offered before closure, and the study did not examine opioid-related mortality specifically. The honest position is that Alberta's own mortality data does not yet support a causal claim in either direction. Leaning on it would be exactly the kind of unverified amplification this campaign has already argued against.

The Mechanism That Does Not Need Alberta's Data to Stand

The stronger, better-evidenced case does not depend on what Alberta's own numbers eventually show. It rests on a well-documented behavioural mechanism: losing legal, low-barrier access to a supervised site does not produce recovery. It produces displacement into isolated, higher-risk use.

Sarah Brayne's concept of system avoidance, developed from national survey data, found that people with criminal justice contact become systematically less likely to engage with surveilling institutions generally, including medical ones, regardless of their actual need for care (Brayne, 2014). Applied to overdose response, the same mechanism has been documented repeatedly: fear of arrest produces rushed injection, reluctance to carry sterile equipment, and reluctance to call emergency services, patterns recorded across Appalachia, Denver, Rhode Island, and Maryland. Even where Good Samaritan laws exist on paper, a 911 call for an overdose still typically brings police alongside paramedics — which continues to deter the call. The loss of naloxone access at the exact point of highest-risk use is the most direct link in the chain, and it does not need the wider displacement argument to stand on its own.

Alberta is not a data point whose outcome is still unknown. It is the next instance of an already global, well-documented pattern. The more interesting question is not whether the data will eventually show harm. It is how long a jurisdiction can dismantle its own capacity to observe what is happening before the absence of data gets mistaken for the absence of harm.

Scotland: The Harder Lesson, Because It Has Already Run

Scotland offers a version of this story with a decade of hindsight attached. In 2015, responsibility for drug policy moved from Justice to Health and Sport, coinciding with a £14 million cut to Alcohol and Drug Partnership funding; NHS Boards were expected to offset the gap and did not. By 2016–17, funding had fallen to £57.3 million, a 22 percent single-year reduction. Scotland's drug death rate per 100,000 people rose from 9.0 in 2010 to 13.4 in 2015, then accelerated to 25.6 alongside the cuts, peaking at 1,339 deaths in 2020. Catriona Matheson, former Chair of the Scottish Drug Deaths Taskforce, told the Social Market Foundation there is “no doubt one of the problems that caused drug deaths to increase was funding cuts to ADPs in 2015” (Shepherd et al., 2026). Academic analysis from Iain McPhee and Barry Sheridan at the University of the West of Scotland reached the same conclusion independently: post-2009 budget decisions “resulted in widening inequalities and increased drug-related deaths” in Scottish communities (McPhee & Sheridan, 2020).

The 2021 National Mission on Drugs, backed by £250 million through 2026, drove real improvement. Total alcohol and drug spending reached £157 million in 2024–25, 66 percent higher in real terms than five years before, and 2024 deaths fell 13 percent to 1,017 — the lowest figure since 2017, a 24 percent fall from the 2020 peak. That improvement was front-loaded: naloxone rollout, medication-assisted treatment expansion, and the most treatment-ready cohort were reached first, and those are the fastest gains to secure. The structural pressures underneath move more slowly — an ageing cohort (the average age at death has risen from the early thirties to the mid-forties since 2000), a deprivation gradient in which people in the most deprived areas are twelve to eighteen times more likely to die, and a volatile drug supply, with nitazene-related deaths rising from 23 in 2023 to 76 in 2024, and provisional figures already recording 244 nitazene-related deaths to June 2025, 14 percent of all drug deaths that quarter. Provisional Police Scotland data recorded 1,146 deaths in 2025, an 8 percent rise (81 deaths) on 2024's 1,065, figures not yet confirmed by National Records of Scotland. This reads less as a new crisis beginning than as the curve meeting its harder floor once the fastest, easiest gains had been exhausted.

Naloxone distribution and needle exchange are among the most robustly evidenced harm reduction interventions in the field, described by the Social Market Foundation's review as “highly cost-effective and potentially cost-saving” (Shepherd et al., 2026). They are not resolving the underlying structural pressure, deprivation, an ageing cohort, market toxicity. They are the buffer standing between that pressure and a materially higher death toll. That buffer is not secure. Scottish Government letters to Alcohol and Drug Partnerships, consistent in language across 2023/24, 2024/25, and 2025/26, state that

underspends cannot be rolled forward and that reserves not flagged as legally committed must be spent before new funding is drawn down; the 2025/26 letter specifically notes a "significant accumulation of reserves" and states future allocations will account for confirmed reserve levels "to ensure we continue to allocate funding based on need and avoid a build-up being carried forward." The practical effect is that an underspend, caused by staff vacancies, commissioning delays, or service disruption, is read as reduced need and triggers a smaller subsequent baseline, a perverse incentive that operates independently of the size of the overall block grant. ADP commissioning allocation fell from £106.5 million in 2021/22 to £89.3 million in 2022/23, a single-year cut of roughly £19 million. This is worth separating clearly from the Barnett formula: the block grant itself was rising through this same window, from £45.5 billion in 2024/25 to £47.6 billion in 2025/26 in cash terms, with the largest real-terms settlement since devolution announced for 2026–29. Austerity is the right explanation for the 2015–2020 lag story. It is not the right explanation for 2025's uptick, the no-rollforward mechanism is what survives the objection that the budget went up. And the National Mission's own £250 million funding commitment is due to end in 2026.

Scotland shows what a buffer looks like while it is still standing. Calgary is closing its last one, the same week it hosts a conference built on the idea that abstinence, not access, was the missing piece all along.

Portugal: The Control Case

Portugal's 2001 decriminalisation succeeded alongside, not instead of, major investment: treatment and harm reduction spending rose 210 percent between 2000 and 2021, and its share of the health budget grew from 1.2 to 5.8 percent. The continuum was funded as a whole, not managed as competing claims on a shrinking pot.

Oregon copied the decriminalisation without the investment , fewer than 0.85 percent of people cited under Measure 110 were ever referred to treatment. Oregon's later reversal is evidence against decriminalisation attempted without investment. It is not evidence against Portugal's actual model, and the two should not be conflated. Portugal itself saw a partial policy reversal in 2024, following a rise in overdose deaths; reporting on that reversal has attributed it substantially to the arrival of fentanyl in the country's drug supply and disruption from the COVID-19 pandemic, rather than to a failure of the underlying policy (France 24, 2025). That context is worth stating honestly rather than omitting, in either direction.

The Frame Versus the Finding

Systems don't fail because they chose the wrong half. They fail because they were only ever resourced to defend a half.

Worth asking, if you're in a room this week built entirely around one half of that continuum: who is funding the other half, and who is still counting the people who don't show up in either column.

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