FIELDWORKS

A Regulation-First Scottish Framework for Substance-Use Treatment Fit

Practice-facing version

Function, Polysubstance Regulation, Medication Ecology, Conduct Discipline, and Practical Freedom

Status	Public practice-facing version
Purpose	To make the framework usable across the recovery field: people using services, families, workers, peer supporters, prescribers, managers, and local services.
Important note	This is a working framework for discussion and practical use. It is not clinical guidance, formal endorsement, or organisational approval.
Use route	Whole-field reflection, supervision, worker discussion, lived-experience discussion, local adaptation, and further clinical or prescriber review where appropriate.

Core question: *What changes when treatment systems assess the conditions a person is living within, rather than only whether something was completed or not completed?*

Contents

1. Purpose of this version

FIELDWORKS is a practice-informed conceptual framework for understanding substance use, recovery, and treatment fit under real conditions, with particular attention to Scotland's polysubstance recovery context.

The purpose of this practice-facing version is not to ask for agreement with every part of the framework. It is to ask whether the argument is grounded enough to be useful, careful enough to be safe, and fair enough to workers as well as people using services.

The central question is:

> *What changes when treatment systems assess the conditions a person is living within, rather than only whether something was completed or not completed?*

In substance-use treatment, a person may attend or not attend, comply or not comply, disclose or not disclose, reduce use or not reduce use. But those outcomes do not explain the conditions that made the outcome more or less possible.

FIELDWORKS tries to make those conditions visible.

2. Core position

FIELDWORKS begins from a simple correction:

> *Substance use should be understood first by function, not verdict.*

This does not mean substance use is safe. It does not minimise harm. It does not argue against medication-assisted treatment, clinical care, harm reduction, abstinence pathways, recovery communities, safeguarding, or professional judgement.

It asks a prior question:

> *What is the use doing?*

In Scotland's polysubstance context, that question has to go further:

> *What is each substance doing inside the person's actual recovery field?*

A substance may function as intoxication, pain relief, withdrawal avoidance, crisis regulation, sleep management, shame relief, social participation, boredom interruption, emotional escape, stimulation, confidence, oblivion, or life-tolerability.

The same substance may serve different functions at different times. Different substances may also serve different functions inside the same life.

This matters because treatment may be technically available while still being practically unusable.

3. Scotland as the field

FIELDWORKS is specifically attentive to Scotland's substance-use reality.

This matters because Scotland's recovery field is often not cleanly single-substance. A person may have one baseline substance while other substances gather around it for different functions.

For example, a person may be alcohol-dependent as their baseline pattern, smoke crack or use cocaine socially or impulsively with others, use heroin or another opioid to calm down, take diazepam to sleep, and use pregabalin for pain, anxiety, or bodily discomfort.

The point is not the exact combination. The point is that the substance-use pattern may operate as an informal regulation system.

Different substances may be doing different jobs:

- one may maintain the baseline;
- one may provide stimulation;
- one may provide social access;
- one may soften shame;
- one may calm the body;
- one may reduce pain;
- one may make sleep possible;
- one may interrupt boredom;
- one may help the person tolerate exposure, loneliness, pressure, or ordinary bleakness.

This is why FIELDWORKS cannot treat substance use as if each substance has one stable meaning. Nor can it assume that the 'main problem substance' explains the whole pattern.

A single label such as 'alcohol problem', 'crack use', 'benzodiazepine misuse', 'opioid dependence', or 'polydrug use' may be technically accurate and still functionally incomplete.

4. Cocaine as a recovery-field condition

Cocaine needs to be named directly in the Scottish context.

In FIELDWORKS, cocaine is not treated as a side issue. In many Scottish recovery fields, cocaine is socially available, socially normalised, and often treated as less serious than opioids, benzodiazepines, or alcohol because it may sit inside ordinary social behaviour rather than obvious dependency identity.

That makes it especially important.

Cocaine may operate as stimulation, confidence, social access, boredom interruption, emotional escape, status performance, sexual confidence, or a way to keep participating in a field the person is trying not to lose.

It may also become the bridge back into other substances:

- alcohol into cocaine;
- cocaine into opioids or benzodiazepines;
- stimulants into sedatives;
- social use into private dysregulation.

For recovery, this means cocaine cannot be treated as peripheral simply because the person's main recorded problem is alcohol, opioids, benzodiazepines, prescribed medication, or another substance.

A person's recovery field may be destabilised not only by the substance they are dependent on, but by the substances that remain socially acceptable around them.

The question is not only:

> *What is your main substance?*

It is also:

> *What substances remain socially close enough to keep reorganising your recovery?*

5. Treatment availability is not treatment usability

A central distinction in FIELDWORKS is the difference between treatment being available and treatment being usable.

A service may exist. A prescription may exist. An appointment may exist. A pathway may exist. A professional may be available. A standard may be met.

But the person may still be unable to use the treatment honestly, safely, consistently, or without destabilising consequences.

Treatment usability depends on more than access. It depends on:

- timing;
- dose pattern;
- trust;
- shame exposure;
- professional conduct;
- transport;
- physical health;
- pain;
- cognition;
- childcare;
- court or social-work pressure;
- housing stability;
- pharmacy environment;
- local drug field;
- cocaine-normalised social contact;
- alcohol culture;
- fear of judgement;
- fear of record consequences;
- whether the person can describe what is actually happening.

A person may appear non-compliant when the treatment is actually poorly fitted.

That does not mean every refusal is justified. It means refusal, dropout, partial engagement, or self-management should be investigated before being judged.

The key principle is:

> *Treatment did not become usable because the person finally became compliant. Treatment became usable when the sequence began to fit the person's regulation reality.*

6. Medication routines as recovery ecology

Medication-assisted treatment is central and should not be dismissed. But medication is not only pharmacological. It is also social, environmental, temporal, and practical.

A medication routine may support recovery, or it may place the person back into the field they are trying to leave.

> *A dose is not only a dose. It is a demand placed on a body, a routine, a day, and a recovery field.*

A prescription is not only a clinical decision. It creates timing, exposure, bodily effect, pharmacy contact, possible shame, possible dignity, and the state a person is left in after treatment has technically been delivered.

This means treatment delivery can reduce one risk while increasing another.

For example, a medication routine may reduce withdrawal risk while also leaving the person sedated, frustrated, exposed, ashamed, overmedicated, under-regulated, or less able to function. If that state increases the chance of taking something else later, then the medication routine has to be understood as part of relapse vulnerability, not only compliance.

The question is not only:

> *Does the dose cover withdrawal?*

It is also:

> *What kind of day does the dose make possible after it enters the body?*

Relevant questions include:

- Does the dose pattern support regulation across the day?
- Does once-daily administration match the person's lived regulation pattern?
- Does supervised consumption create shame?
- Does pharmacy attendance expose the person to people they are trying to avoid?
- Does collection timing disrupt ordinary life?
- Does the routine support work, parenting, appointments, sleep, food, and daily functioning?
- Does the routine increase or reduce contact with the local drug field?
- Does the person feel able to be honest about how the medication is working?
- Does the treatment plan respond when the person says the fit is poor?

Medication standardisation should not be mistaken for treatment fit.

This does not mean supervision is wrong. Sometimes supervision protects life. Sometimes structure supports recovery. Sometimes difficult treatment is necessary.

FIELDWORKS does not remove clinical judgement. It asks that clinical judgement include the field.

7. Conduct before treatment

FIELDWORKS depends on Fieldethics.

The short version is:

> *Conduct before treatment.*

But conduct does not simply mean being nice, friendly, or well-intentioned.

Conduct means taking the time to think through what your decision actually creates in the person's life.

A professional signature, instruction, record, expectation, or treatment plan is not just an administrative act. It becomes part of the person's field.

It may create:

- safety;
- dignity;
- shame;
- exposure;
- confusion;
- trust;
- pressure;

- guardedness;
- relapse vulnerability;
- better disclosure;
- worse disclosure;
- a more usable day;
- a less usable day.

This is why FIELDWORKS argues for standardised conduct before standardised treatment.

Treatment should be person-specific. Conduct should be system-standard.

That does not mean workers should become identical, scripted, cold, or robotic. It means service users should not have to gamble on whether the worker they meet that day will listen accurately, interpret fairly, record carefully, and respond proportionately.

FIELDWORKS is not anti-worker. It is anti-randomness.

A person's treatment fit should not depend on whether they encounter the right personality on the right day.

8. Disciplined kindness, not domination

A further Fieldethics principle is:

> *Disciplined kindness, not domination.*

Kindness without discipline can become rescue, avoidance, indulgence, confusion, or emotional performance.

Discipline without kindness can become control, punishment, coldness, compliance management, or professional domination.

The task is not to direct the professional's will into the person. The task is to direct professional responsibility toward the conditions around the person.

For adults with capacity, care becomes ethically dangerous when it tries to convert the helper's will into the person's movement. That can become domination disguised as care, concern, risk management, or ethical restraint.

The test is:

> *Ethical restraint limits the helper's will. Domination limits the person's agency.*

This distinction is important in recovery work.

Care is not ethical because it names itself care.

Care becomes ethical when it disciplines the will of the helper before directing the life of the person.

9. Professional training and lived sequence

This framework is not an argument against academic knowledge, professional training, prescribing, policy, evidence, or clinical judgement. Those things matter.

The concern is what can happen when trained knowledge assumes authority over lived sequence before it has properly listened.

A professional may know the medication. The person may know the day that medication creates.

A professional may know the policy. The person may know the pharmacy queue, the shame exposure, the walk home, the dishes still needing done, the body-state after the dose, and the substances that become easier to take when regulation drops.

Treatment fit begins when both forms of knowledge are held seriously.

The question is not only:

> *Is this treatment indicated?*

It is also:

> *What is this intervention offering the person inside the life they actually have to live?*

Humility in recovery work is not optional softness. It is part of treatment safety.

Training should increase responsibility, not entitlement to impose meaning.

10. Life-tolerability use

FIELDWORKS introduces the concept of life-tolerability use.

This sits between crisis regulation and getting high. It describes substance use that is not primarily about acute crisis and not simply about intoxication, but about making ordinary life feel less bleak, flat, boring, painful, humiliating, tense, or unrewarding while the person continues living it.

Some substance use is not about escaping life completely. It is about making life feel more bearable while remaining inside it.

The person may still be attending appointments. They may still be cooking, cleaning, parenting where allowed, working, volunteering, appearing responsible, or trying to maintain ordinary routines.

From the outside, they may look functional enough. But functioning is not the same as living.

If ordinary life feels cold, flat, ashamed, exposed, unrewarding, and without future, then substance use may become a private technology of tolerability.

In a polysubstance field, life-tolerability may be distributed. Alcohol may make the evening begin. Cocaine may make social contact possible. An opioid may soften the return. A benzodiazepine may force sleep. Pregabalin may reduce pain, agitation, or bodily discomfort.

The pattern may be dangerous and chaotic, but it may still be organised around making life bearable enough to continue.

This does not make it safe. It makes it understandable. And what becomes understandable can be worked with more honestly.

Services should therefore ask not only:

> *What are you trying to escape?*

But also:

> *What does this help you stay inside?*

11. Missing language and patient reporting

Substance-use care depends heavily on what people can report about themselves and what systems believe those reports mean. But patient reporting is not simple.

People often do not have exact language for their internal states, especially under stress, shame, withdrawal, pain, fear, stigma, or professional scrutiny.

A person may say:

- I'm fine.
- I'm depressed.
- I'm raging.
- I'm bored.
- I'm done.
- I need something.
- I just wanted to use.

These may be true, but incomplete.

The underlying state may involve:

- bodily agitation;
- shame;
- overload;
- withdrawal fear;
- pain;
- loneliness;
- social exposure;
- life-tolerability collapse;
- loss of regulation capacity;
- lack of future horizon;
- fear that honesty will be used against them.

This is not dishonesty. It is often missing language.

The problem becomes more serious when services impose meaning too early.

'I wanted to use' may be recorded as craving, ambivalence, poor motivation, relapse risk, non-compliance, or lack of insight. Sometimes those interpretations may be partly right. But they may also miss the real function.

FIELDWORKS therefore separates:

- signal;
- state;

- substance;
- sequence;
- function;
- feeling;
- interpretation;
- judgement;
- action;
- record.

That sequence matters.

If the signal is collapsed too early, the record may become inaccurate. If the record becomes inaccurate, future decisions may be built on poor knowledge. If decisions are built on poor knowledge, trust declines. If trust declines, future disclosure becomes less safe and less accurate.

The system may then mistake guardedness for evidence against the person.

12. Feedback depends on sequence

A system receives the kind of feedback its sequence makes possible.

If the sequence is pressure-first, feedback will often be guarded. If the sequence is shame-heavy, feedback will often be partial. If the sequence is punitive, feedback will often become strategic. If the sequence collapses complexity, feedback will become simplified. If the sequence records too quickly, feedback may become defensive. If the sequence is safe, disciplined, and clear, feedback can become more accurate.

This means feedback is not just a property of the person. It is a property of the field.

When a service says a person is not being honest, not engaging, not disclosing, or not showing insight, FIELDWORKS asks:

- What sequence did the service create?
- Did the person have reason to trust that honesty would be handled safely?
- Was there a real distinction between disclosure and consequence?
- Were they given enough language to describe the function of use?
- Were they given enough safety to describe polysubstance reality?
- Did the professional separate concern from judgement?
- Was the person's account recorded accurately?
- Did previous honesty improve care or increase punishment?

These questions do not remove the need for risk assessment, boundaries, safeguarding, or professional judgement.

They prevent systems from treating poor feedback as if it emerged from the person alone.

Feedback quality is co-produced by conduct.

13. Epistemic reliability and records

A report is not automatically reliable because it has entered a record.

This is especially important in substance-use care, where information travels through addiction services, GP records, mental health, pharmacy, justice, housing, social work, child protection, tribunals, reviews, risk assessments, and multidisciplinary meetings.

If the original report was shaped by shame, fear, poor sequencing, missing language, or premature interpretation, then what travels may not be the person accurately understood. It may be the system's imposed meaning.

The risk is not simply that a service misunderstands a moment. The risk is that a system builds decisions around a version of the person that was produced by poor sequence.

This is particularly serious in polysubstance contexts. A record may correctly name several substances and still fail to describe their sequence, function, or field. 'Polydrug use' can become a shorthand for chaos when it may also contain important treatment-fit information.

Records should distinguish:

- what the person said;
- what was directly observed;
- what substances were named;
- what sequence was described;
- what function was reported;
- what the professional inferred;

- what remains uncertain;
- what context shaped the disclosure;
- what action is required now;
- what should not be over-interpreted.

Good records preserve proportion, uncertainty, sequence, and context so that future decisions are better informed.

14. Practical freedom under real conditions

FIELDWORKS also distinguishes formal choice from practical freedom.

Modern systems often treat freedom as increased choice: more options, more services, more flexibility, more independence, more personal responsibility.

But under real conditions - tiredness, illness, loneliness, poverty, stress, recovery, disability, system pressure, or emotional strain - more choice can become another burden.

Choice can become noise. Choice can become pressure. Choice can become another demand placed on the nervous system.

The FIELDWORKS line is:

> *Freedom is not more choice. It is knowing what sustains you.*

This applies directly to recovery.

A person may technically have many choices while lacking the money, safety, energy, clarity, trust, regulation, or self-knowledge needed to choose what sustains them.

Independence is not proved by doing everything alone.

Sometimes independence is knowing when to stop forcing, when to accept support, when to choose the familiar thing, when to rest, when to eat properly, when to avoid novelty, and when to reduce the field of choice because regulation is needed now.

Recovery systems should be careful about treating 'choice' as automatically liberating.

A person is not always freer because more options are placed in front of them. Sometimes freedom begins when they can recognise the one choice that will sustain them.

15. Treatment-fit sequence

FIELDWORKS proposes the following treatment-fit sequence:

1. Stabilise the field of conduct

Before asking for disclosure, create conditions where disclosure is less likely to become punishment, shame, or misrecorded certainty.

2. Identify the baseline and wider substance ecology

Do not assume the named substance explains the whole pattern. Ask what substance is baseline, what substances gather around it, and what sequence links them.

3. Identify the function of each substance

Ask what each substance is doing before deciding what it means.

4. Distinguish the type of use

Is this withdrawal avoidance, intoxication, crisis regulation, pain management, social participation, life-tolerability, oblivion, or something else?

5. Identify socially close substances

Ask what substances remain normalised in the person's social field, including cocaine, alcohol, sedatives, or other substances that may not be named as the main problem.

6. Identify what would become intolerable without the pattern

Do not remove the function without understanding what the person may lose.

7. Assess treatment usability

Is treatment technically available but practically unusable? If so, why?

8. Examine medication ecology

Does the medication routine support recovery across the person's actual day and actual field?

9. Examine exposure

Is the person being returned to the same people, places, routines, pressures, or shame fields that sustain use?

10. Restore practical freedom

Help the person recognise and choose what sustains them under real conditions, not ideal conditions.

11. Record with discipline

Separate what was said, what was observed, what was inferred, what remains uncertain, and what action is needed.

12. Review feedback quality

If disclosure becomes more honest over time, the sequence is improving. If disclosure becomes more guarded, the sequence needs examined.

This is not a rigid model. It is a discipline for thinking.

16. Limits and ethical cautions

FIELDWORKS is not a validated clinical model. It is a lived-experience and practice-facing framework for improving treatment-fit thinking.

It should not be used to replace clinical judgement, safeguarding duties, emergency intervention, medication standards, harm-reduction practice, legal duties, or professional supervision.

It should not be used to excuse harmful conduct. It should not be used to romanticise substance use. It should not be used to encourage self-management outside treatment. It should not be used to argue that all treatment discomfort means treatment is wrong.

Some treatment will be difficult. Some boundaries are necessary. Some risks require action. Some disclosures require immediate safeguarding or medical response.

FIELDWORKS does not soften those duties.

It asks that they be carried out with better sequence, better conduct, better interpretation, and better record discipline.

The ethical risk of FIELDWORKS is that services could adopt its language without adopting its discipline.

For that reason, FIELDWORKS must remain tied to Fieldethics.

Without Fieldethics, FIELDWORKS could become another assessment vocabulary imposed on people. With Fieldethics, it becomes a way of making treatment more honest, usable, and safe.

17. Practice reflection questions

General accuracy

- Does this framework feel recognisable from substance-use treatment practice?
- Does the distinction between treatment being available and treatment being usable make sense?
- Is the framework fair to workers as well as people using services?
- Does anything feel too strong, too vague, or likely to be misunderstood?

Scottish polysubstance context

- Does the Scottish polysubstance section feel accurate?
- Is it useful to distinguish a baseline substance from substances that gather around it for different functions?
- Does the cocaine section feel realistic and fair?
- Is cocaine being framed carefully enough as a recovery-field condition rather than as a moral judgement?

Medication and treatment fit

- Does the medication routine section feel clinically fair?
- Is it reasonable to say that a dose routine may reduce one risk while increasing another?
- Is the phrase 'what kind of day does the dose make possible?' useful, or does it need reworded?
- Does the framework avoid sounding anti-medication or anti-supervision?

Conduct and Fieldethics

- Does 'conduct before treatment' make sense in practice?
- Is 'disciplined kindness, not domination' useful language?
- Does the section on professional training and lived sequence feel fair, or does it need softened?
- Is there anything in the conduct section that could be read as unfair to staff?

Safety and next steps

- Is anything unsafe to share more widely?
- Is anything missing that would make the framework more responsible?
- Would this be worth a doctor or prescriber reading in your setting?
- What would make this more useful for actual practice?

18. Closing position

FIELDWORKS begins from the reality that substance use happens in fields.

People do not use, recover, relapse, disclose, trust, or disengage in isolation.

They do so inside bodies, rooms, streets, services, routines, relationships, records, pharmacies, housing placements, memories, pressures, hopes, fears, and futures.

In Scotland, they often do so inside polysubstance fields where one substance cannot explain the whole pattern.

The pattern may be dangerous, chaotic, and harmful. It may also contain treatment intelligence.

If treatment does not understand the field, it may misread the person. If it misreads the person, it may misfit the treatment. If it misfits the treatment, it may produce guarded feedback. If feedback becomes guarded, knowledge becomes unreliable. If knowledge becomes unreliable, decisions become less safe.

FIELDWORKS offers a different sequence.

Ask what each substance is doing. Ask what would become intolerable without the pattern. Ask whether treatment is available or truly usable. Ask whether medication routines support the person's actual recovery ecology. Ask whether cocaine, alcohol, or other socially close substances are reorganising the recovery field. Ask whether the field has changed enough for recovery to survive. Ask whether the person has enough language to describe their own state. Ask whether professional conduct makes honesty safer. Ask whether records preserve reality or impose meaning.

And finally, ask what freedom means under real conditions.

> *Freedom is not more choice. It is knowing what sustains you.*

For recovery, that may be one of the most practical questions of all.

Not only:

> *What options exist?*

But:

> *What keeps this person well enough to live, and how do we help them recognise, protect, and build from that?*

That is the work of FIELDWORKS.