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

Function of Use, Life-Tolerability, Conduct Reliability, and Recovery Sequencing in Scotland's Polysubstance Context

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Publication Position

Fieldworks is not submitted or published as a request for institutional validation. It is being developed as a public lived-experience framework through fieldnotes.scot. Any future journal submission should be understood as a route for reach, scrutiny, refinement, and faster access to relevant practitioners, researchers, services, and policy audiences.

Journal publication would not make Fieldworks real. It would make the argument easier to find, examine, challenge, and potentially use in settings where the questions are already urgent.

Fieldworks is offered as a sequence-corrective, conduct-reliability, and treatment-fit lens for Scotland's polysubstance recovery context. It does not claim to be an empirically validated treatment model. It does not replace medication-assisted treatment, harm reduction, psychological care, abstinence-based goals, safeguarding duties, or clinical judgement. Its purpose is to ask whether existing interventions are being introduced through conduct, language, sequencing, and decision-making conditions that make them usable from the person's lived position.

Abstract

Scotland's drug-related harm remains severe and is strongly shaped by deprivation, polysubstance use, contaminated supply, and social conditions that cannot be fully understood through generic addiction-treatment models alone. Existing treatment systems increasingly recognise trauma, complexity, harm reduction, and medication-assisted treatment, yet people may still be asked to pursue abstinence, insight, compliance, or behavioural change before treatment has fully understood what substance use is doing within their lived recovery field.

This paper introduces Fieldworks as a regulation-first Scottish lived-experience framework for substance-use treatment fit. Fieldworks proposes that, in a subset of cases, substance use functions not only as intoxication, dependence, or reward-seeking, but as informal regulation infrastructure: a way of mediating distress, bodily agitation, pain, frustration, shame, boredom, social exposure, withdrawal risk, or narrowed future horizons.

The paper also introduces the concept of life-tolerability use: a function of substance use that sits between crisis regulation and intoxication-seeking. In this form, substances may be used not because

the person is in immediate crisis, and not simply to “get high,” but to make ordinary life feel less bleak, flat, painful, humiliating, boring, tense, or unrewarding while the person continues living it.

Fieldworks is grounded in a wider sequence architecture. Horizon Theory provides the developmental order through which regulation, safety, honesty, capacity, responsibility, and outcomes become possible. The Missing Language of Development, hereafter referred to as Missing Language, provides the distinction set needed to separate signal, state, feeling, interpretation, judgement, action, and record. Fieldethics provides the system principle that a system receives the kind of feedback its sequence makes possible. Fieldworks applies these principles to substance-use care.

The paper argues that Scotland’s drug problem does not need standardised treatment first. It needs standardised conduct. Treatment must remain responsive to the person, but conduct should be dependable across the field. If professional conduct is inconsistent, reactive, shaming, poorly sequenced, or dependent on individual worker style, then patient knowledge becomes unreliable, decisions become inconsistent, trust weakens, and future disclosure becomes less accurate.

Where services remove, restrict, or morally interpret the function of use before restoring regulation capacity and practical alternatives, relapse and disengagement may be misread as poor motivation rather than failed sequencing or poor treatment fit. Fieldworks therefore proposes a treatment-fit sequence: understand the person’s field, hold conduct discipline, identify the function of use, improve language, assess reliability, restore regulation capacity, make treatment usable, then support choice, responsibility, and recovery outcomes.

Fieldworks does not reject medication, harm reduction, psychological care, abstinence-based goals, or clinical judgement. It asks what conditions must be present for these interventions to become usable from the person’s lived position. Its contribution is a sequence-corrective, conduct-reliability, and treatment-fit lens for Scotland’s polysubstance recovery context, with wider relevance to high-harm settings where treatment is available but not always usable.

Keywords: substance use; Scotland; treatment sequencing; regulation capacity; life-tolerability; medication-assisted treatment; lived experience; epistemic reliability; standardised conduct; treatment fit; Fieldethics

1. Introduction

Scotland’s drug-related harm cannot be understood only through generic models of addiction treatment. The harms are not only pharmacological, behavioural, or diagnostic. They are lived through deprivation, shame, boredom, pain, polysubstance availability, social exposure, contaminated supply, constrained horizons, and treatment systems that may be present without always being usable.

Official statistics show the severity of the Scottish context. In 2024, Scotland registered 1,017 drug misuse deaths. The age-standardised rate remained 3.6 times as high as when the series began in 2000. People in the most deprived areas were 12 times as likely to have a drug misuse death as those in the least deprived areas. More than one drug was implicated in 80% of drug misuse deaths. Opiates and opioids, benzodiazepines, cocaine, and gabapentin or pregabalin were among the most common substances implicated (National Records of Scotland, 2025).

These figures matter because they show that Scotland’s treatment field is not a simple single-substance or single-mechanism environment. It is a polysubstance recovery context in which people may be

managing overlapping withdrawal states, pain, prescribed medication, street medication, stimulant use, sedative use, alcohol use, shame, social pressure, and daily survival demands at the same time.

Scotland's unregulated supply also intensifies the problem. Nitazene-type synthetic opioids are now a major public-health concern in Scotland and have been identified as unexpected contaminants in drugs sold as heroin and other substances (Public Health Scotland, 2025). This means that people who are already attempting to manage unstable recovery conditions outside a usable treatment pathway may be exposed to a supply that is far more potent, unpredictable, and dangerous than they intend or anticipate.

Fieldworks begins from this lived Scottish field. It asks what treatment changes when substance use is understood first as function, not verdict.

In some cases, substances are not used only to "get high." They may be used to settle the body, reduce agitation, interrupt shame, mediate pain, escape frustration, participate socially, manage boredom, preserve routine, avoid withdrawal, or produce a temporary sense of control. These functions may be harmful, unstable, or dangerous. Fieldworks does not romanticise them. The point is narrower: where use has become part of a person's regulation system, treatment must understand what the use is doing before it can safely and effectively ask the person to stop, reduce, substitute, or change it.

There is also a major middle function that is often missed. Some use is not crisis regulation and not simple intoxication-seeking. It is life-tolerability use: substance use that makes ordinary life feel less bleak, flat, boring, painful, humiliating, tense, or unrewarding while the person continues living it. This may be especially important in Scottish environments where deprivation, limited opportunity, stigma, social pressure, chronic stress, and narrowed expectations of the future shape daily life. A person may be technically stable, housed, medicated, and attending appointments, while still experiencing life as grey, unrewarding, or difficult to inhabit.

A treatment pathway can be evidence-based and still poorly sequenced from the person's lived position. A service can be available and still unusable. Medication can be clinically appropriate while its administration routine creates shame, exposure, or destabilising contact. Psychological intervention can be valid while arriving too early for someone who does not yet have enough regulation capacity to use it. Abstinence can be a legitimate goal while becoming unsafe or unrealistic if demanded before the person has enough stability to tolerate the loss of their main regulator.

Fieldworks is proposed as a response to this sequencing problem.

It is not a new treatment modality. It is not a rejection of medication-assisted treatment, harm reduction, psychotherapy, peer support, or abstinence-based recovery. It is a framework for asking whether these interventions are being introduced through conduct, language, sequencing, and relational conditions that allow them to work.

The central claim is simple: regulation capacity is not merely a later recovery outcome. In some cases, it is the ground from which recovery work can begin.

2. Theoretical Position: Horizon Theory, Missing Language, Fieldethics, and Fieldworks

Fieldworks should not be read as a standalone addiction-treatment theory. It is the substance-use application of a wider sequence architecture developed through Horizon Theory, The Missing Language of Development, and Fieldethics.

Horizon Theory provides the underlying developmental order. Regulation, safety, honesty, capacity, responsibility, and outcomes cannot be treated as interchangeable demands. Where systems ask for later-stage behaviour before earlier-stage conditions exist, they may misread failure as unwillingness, resistance, poor insight, or poor motivation.

In substance-use care, this matters because a person may be asked to pursue abstinence, insight, compliance, or recovery identity before they have enough regulation capacity, safety, trust, or life-tolerability to make those demands usable.

The Missing Language of Development, hereafter Missing Language, provides the distinction set required to understand regulation capacity. It separates signal, state, feeling, interpretation, judgement, action, and record. Without these distinctions, internal states may be collapsed into inaccurate treatment meanings. Frustration may be misread as low mood. Overload may be misread as hopelessness. Shame may be misread as avoidance. Life-tolerability collapse may be misread as pleasure-seeking. Continued use may be misread as unwillingness to recover.

Fieldethics provides the system principle:

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

This principle is central to Fieldworks. People do not disclose the function of substance use in a neutral field. They disclose inside systems shaped by risk assessment, shame, supervision, child protection fear, medication control, criminal justice pressure, stigma, and previous experiences of being misread. If a treatment system begins with compliance, abstinence, or behavioural correction, it may receive guarded, partial, defensive, or performative feedback. If the system asks first what the use is doing, what it makes bearable, what it prevents, what it provides, and what would become intolerable without it, it may receive information that is more useful for treatment.

Fieldworks therefore applies Horizon Theory, Missing Language, and Fieldethics to Scotland’s polysubstance recovery context. It asks whether treatment is being introduced in a sequence that makes honesty, regulation, responsibility, and reliable decision-making possible.

It does not reject treatment. It asks whether treatment has been made usable.

The core Fieldworks question is not only: why is this person still using?

It is: what kind of system sequence would make the truthful answer safe enough, precise enough, and useful enough to hear?

3. Feedback Depends on Sequence

Fieldworks is grounded in the wider Fieldethics principle that a system receives the kind of feedback its sequence makes possible.

This matters in substance-use care because people do not disclose function in a vacuum. They disclose within a sequence of questions, expectations, risks, assumptions, and consequences. If a service begins with compliance, abstinence, risk, or behavioural correction, it may receive guarded, partial, performative, or minimised feedback. If the person expects judgement, loss of trust, increased supervision, child protection consequences, shame, or withdrawal of support, the system may not hear what substance use is actually doing.

This does not mean people are always consciously withholding truth. It means the structure of the encounter shapes what can safely be said.

A treatment system that asks “why did you use?” after relapse may receive a different answer from one that first asks “what did the use make bearable, prevent, interrupt, or provide?” A system that treats use only as failure may receive defensive explanation. A system that asks about function may receive treatment-relevant information.

Fieldworks therefore applies the Fieldethics principle directly to substance-use care: if services want more accurate feedback, they must build sequences in which accurate feedback is safer to give. Function of use, life-tolerability, shame, exposure, medication fit, and relapse risk all become more visible when the system asks in an order that makes honesty possible.

The question is not only whether the person is ready to be honest. It is whether the treatment sequence makes honesty usable.

4. Fieldethics Conduct Discipline and Accountable Presence

Epistemic reliability depends not only on the questions a system asks, but on the conduct of the professional receiving the answer. In substance-use care, patient knowledge is produced through interaction. The quality of that knowledge is shaped by the professional’s presence, regulation, assumptions, language, timing, and record discipline.

Fieldethics therefore requires a conduct discipline from the professional. A community psychiatric nurse, addiction worker, doctor, social worker, pharmacist, justice worker, or other practitioner must be mindful not to allow personal reaction to enter the record as if it were patient fact. Irritation, fear, frustration, disappointment, moral discomfort, urgency, sympathy, suspicion, or fatigue may all arise in professional encounters. These reactions are human, but they are not neutral evidence.

Where a professional reaction is not recognised and held with discipline, it may become imposed meaning. A patient may be described as “difficult,” “guarded,” “chaotic,” “drug-seeking,” “avoidant,” “low motivation,” or “non-compliant” when the record may partly reflect the professional’s unmanaged response to distress, risk, frustration, ambiguity, or challenge. Once recorded, that interpretation can travel as knowledge about the patient.

This is why Fieldworks requires accountable presence. Accountable presence means remaining sufficiently regulated, attentive, and self-aware to separate what the patient has said, what has been observed, what has been inferred, and what the professional has felt in response. It does not require

emotional neutrality. It requires disciplined honesty about the difference between observation and reaction.

A Fieldethics record should therefore ask:

What was directly observed?
What did the person actually say?
What is being inferred?
What meaning has been added?
What uncertainty remains?
What might my own reaction be contributing?
What would be fair to carry forward into another system?

This discipline is not only ethical. It is epistemic. If professional reaction enters the record unnoticed, patient knowledge becomes less reliable. If patient knowledge becomes less reliable, later decisions may become less fair. If decisions feel unfair or misrecognising, patient trust may reduce. If trust reduces, future disclosure may become less safe and less accurate.

Fieldworks therefore treats accountable professional presence as part of the stabilising feedback loop. Better conduct produces cleaner knowledge. Cleaner knowledge supports more reliable decisions. More reliable decisions support trust. Trust supports safer disclosure. Safer disclosure supports better treatment fit.

The professional's task is not only to listen. It is to listen without turning their own unmanaged reaction into the patient's recorded identity.

5. Standardised Conduct Before Standardised Treatment

Scotland's drug problem does not need standardised treatment first. It needs standardised conduct.

This does not mean rejecting clinical standards, medication-assisted treatment, prescribing guidance, harm reduction, psychological care, or evidence-based intervention. It means recognising that no treatment model can remain reliable if the conduct through which it is delivered is inconsistent, reactive, shaming, dismissive, or poorly sequenced.

Treatment should be responsive to the person. Conduct should be dependable across the system.

Fieldworks therefore distinguishes between treatment standardisation and conduct standardisation. Treatment may need to vary according to the person's substance use, function of use, regulation capacity, medication needs, trauma history, housing situation, social exposure, life-tolerability, and recovery goals. But the conduct of the system should not vary according to worker mood, moral reaction, stigma, fatigue, personal preference, or local culture.

Standardised conduct means that every person should be met with disciplined presence, accurate language, careful interpretation, proportionate curiosity, and accountable recording. It means professionals should separate observation from inference, patient report from professional reaction, risk from judgement, and uncertainty from certainty. It means the system should not allow personal discomfort, frustration, suspicion, or disappointment to become recorded identity.

This is the basis of epistemic reliability. If conduct is inconsistent, the knowledge produced about patients will also be inconsistent. If knowledge is inconsistent, decisions become less reliable. If decisions are unreliable, trust weakens. If trust weakens, disclosure becomes less safe. If disclosure becomes less safe, services receive poorer feedback and may mistake that poorer feedback for evidence about the person rather than evidence about the sequence.

Fieldworks therefore argues that Scotland's substance-use response must treat conduct as infrastructure. Medication matters. Harm reduction matters. Therapy matters. Housing matters. But without standardised conduct, each of these can be delivered in ways that either stabilise or destabilise the person.

The core conduct standard is simple:

Receive the person accurately.
Do not impose meaning too early.
Do not let personal reaction enter the record as patient fact.
Ask what the use is doing before deciding what the use means.
Hold uncertainty honestly.
Make the next honest disclosure safer where possible.
Record in a way that is fair to the person and useful to the next professional.

Only then can treatment become reliably usable.

6. Standardised Conduct Is Not the Removal of Worker Freedom

Fieldworks does not remove individual worker freedom. It does not ask professionals to become identical, scripted, emotionally flat, or unable to use judgement. Good treatment depends on human presence, relational skill, local knowledge, humour, warmth, flexibility, and professional discernment.

The point is different.

Fieldworks asks workers to hold the same standard across the field when they enter the door in the morning.

A practitioner may have their own style, voice, strengths, methods, and relational approach. But the person seeking support should not have to gamble on whether that worker's personal style will produce accurate listening, fair interpretation, proportionate recording, and usable treatment. Conduct cannot depend entirely on individual temperament.

Standardised conduct means a shared baseline:

Receive the person accurately.
Separate observation from inference.
Do not let personal reaction enter the record as patient fact.
Ask what substance use is doing before deciding what it means.
Hold uncertainty honestly.
Make the next disclosure safer where possible.
Record in a way that is fair to the person and useful to the next professional.

This is not bureaucracy. It is field discipline.

Treatment may need to flex around the person. Professional style may remain human and varied. But the ethical standard of conduct should be dependable. When conduct varies too widely, patient knowledge becomes unreliable, decisions become inconsistent, and trust becomes fragile.

Fieldworks therefore protects professional freedom by locating it inside accountable presence. Freedom is not the right to practise through unmanaged reaction, stigma, habit, mood, or personal preference. Freedom is the ability to respond skilfully while still meeting the same ethical standard as everyone else in the field.

Treatment should be person-specific.

Conduct should be system-standard.

7. Policy Change Without Conduct Change

Scotland does not only need another recovery policy. It needs a recovery system capable of changing the conduct through which policy becomes practice.

A national strategy can set aims, standards, routes, and language. But if the conduct of the system remains inconsistent, reactive, shaming, poorly sequenced, or dependent on individual worker style, the same problems may continue under updated terminology. People may still be misread. Patient knowledge may still be unreliable. Records may still carry imposed meaning. Treatment may still be available but unusable. Relapse may still be interpreted before its function is understood.

The question is therefore not only what policy Scotland adopts.

The question is whether Scotland wants a national recovery strategy, or another policy change that allows people to keep perpetuating the same problems with better language.

Fieldworks argues that policy must be joined to conduct discipline. Treatment can remain person-specific, but conduct must become system-standard. Without standardised conduct, any recovery strategy risks becoming another layer of aspiration placed over unstable practice.

A recovery system is not built by changing what services say they intend to do. It is built by changing what people can reliably expect to happen when they enter the room, disclose risk, describe use, relapse, ask for help, or become difficult to understand.

Policy sets the promise.

Conduct decides whether the promise reaches the person.

8. Missing Language, Regulation Capacity, and Patient Reporting

Fieldworks is connected directly to Missing Language because substance-use care depends heavily on what people can report about themselves, and what systems believe those reports mean.

A person may not initially be able to describe their internal state with precision. They may say they are “fine,” “depressed,” “raging,” “bored,” “done,” “needing something,” or “wanting to use,” while the underlying state may involve bodily agitation, shame, overload, withdrawal fear, pain, social exposure,

life-tolerability collapse, or loss of regulation capacity. The words available to the person may not yet separate signal from feeling, feeling from interpretation, interpretation from judgement, or judgement from action.

This is not dishonesty. It is often missing language.

The system can then add a second problem: imposed meaning. If a service hears “I wanted to use” and records this only as craving, poor motivation, ambivalence, non-compliance, or relapse risk, it may collapse several distinct states into one treatment meaning. A person’s report may be clinically important, but it may not yet be clinically precise. Fieldworks therefore asks services to treat patient reporting as signal requiring careful interpretation, not as raw material for immediate judgement.

Collapsed language can distort treatment. Boredom may hide life-tolerability failure. Anger may hide overload. Low mood may hide frustration. Non-attendance may hide shame, exposure, or poor treatment fit. Relapse may hide the loss of the only available regulator. “I just wanted to get high” may hide a more complex function: to feel warmer, less flat, less humiliated, less alone, less physically wrong, or briefly more able to remain inside life.

Missing Language therefore supports Fieldworks by making regulation capacity more legible. It helps services ask more accurate questions before imposing meaning:

What is the signal?
What is the state?
What is the feeling?
What is the interpretation?
What judgement has already been added?
What function did the substance serve?
What would have become intolerable without it?
What treatment condition would make a more accurate report possible next time?

This connects directly to the Fieldethics principle that a system receives the kind of feedback its sequence makes possible. If the system asks collapsed questions, it receives collapsed answers. If the system imposes meaning too early, it may train the person to conceal, simplify, perform, or translate their experience into language the service already expects.

Fieldworks therefore treats patient reporting as relational and sequenced. The question is not only whether the person can tell the truth. It is whether the system has created the language, safety, timing, and interpretive discipline required for the truth to become sayable, hearable, and useful.

9. Epistemic Reliability and Travelling Patient Knowledge

The effects of collapsed language and imposed meaning do not remain confined to a single appointment. Once a person’s report has been interpreted, summarised, recorded, or shared, it may become part of the system’s working knowledge about that person. This creates an epistemic reliability problem.

In substance-use care, knowledge about the patient often travels. A description formed in one setting may be carried into another through referral letters, clinical notes, risk assessments, pharmacy communication, justice reports, housing records, child protection processes, mental health reviews, or 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's state accurately understood. It may be the system's imposed meaning.

This matters because later professionals may treat inherited descriptions as reliable context. "Non-compliant," "ambivalent," "chaotic," "drug-seeking," "low motivation," "poor insight," "failed to engage," or "relapsed" may appear to describe the person, when they may partly describe the limitations of the sequence through which the person was first understood.

Fieldworks therefore treats patient knowledge as something that must be ethically produced, not merely collected. A report is not automatically reliable because it has entered a record. Its reliability depends on the conditions under which it was generated: the questions asked, the language available, the level of safety present, the person's regulation capacity, the consequences attached to disclosure, and the interpretive discipline of the system receiving it.

If the sequence makes honesty unsafe, feedback may become guarded. If the language is collapsed, feedback may become imprecise. If meaning is imposed too early, feedback may become distorted. If that distorted feedback is then recorded and circulated, the person may become known across systems through unreliable knowledge.

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.

For Fieldworks, this has practical consequences. Before relapse, non-attendance, continued use, medication concerns, or treatment disengagement are recorded as evidence of motivation, risk, or character, services should ask whether the account is epistemically reliable. Has the function of use been explored? Has regulation capacity been assessed? Has life-tolerability been considered? Has the person had enough safety and language to report accurately? Has the system separated signal, state, feeling, interpretation, judgement, and action? Has professional conduct been held to a standard that prevents personal reaction from becoming recorded identity?

If not, the record may need caution rather than certainty.

Fieldworks therefore asks services to improve not only treatment sequencing, but knowledge sequencing and conduct discipline. Better conduct supports better sequencing. Better sequencing produces better feedback. Better feedback produces more reliable records. More reliable records support fairer decisions.

10. Reliable Decisions and the Stabilising Feedback Loop

Reliable patient knowledge matters because it affects the decisions that follow. Where services produce more accurate accounts of a person's state, function of use, regulation capacity, and treatment fit, they are more likely to make decisions that feel proportionate, recognisable, and fair from the patient's lived position.

This is where the stabilising feedback loop begins.

If a person recognises that a service has understood them accurately, trust may increase. If trust increases, disclosure may become safer. If disclosure becomes safer, feedback may become more precise. If feedback becomes more precise, decisions may become more reliable. If decisions become

more reliable, the person may experience the system as less threatening, less shaming, and more usable.

In this way, reliable decisions do not only improve care planning. They support regulation. A person who expects to be misread may conceal, simplify, perform, withdraw, or escalate. A person who experiences accurate understanding may become more able to report early warning signs, name function honestly, discuss medication fit, disclose relapse risk, and ask for help before crisis.

Fieldworks therefore treats trust not as a soft extra, but as part of the treatment mechanism. Trust is not produced by reassurance alone. It is produced when the system's decisions repeatedly show that the person's feedback has been heard accurately and used responsibly.

The stabilising feedback loop can be described as:

Standardised conduct.
Better sequence.
Better feedback.
More reliable knowledge.
More reliable decisions.
Greater patient trust.
Safer disclosure.
Better treatment fit.
Greater regulation capacity.

When the loop works, treatment becomes more usable. When it fails, the opposite loop may form: inconsistent conduct produces poor sequence; poor sequence produces guarded feedback; guarded feedback produces unreliable knowledge; unreliable knowledge produces poor decisions; poor decisions reduce trust; reduced trust makes future feedback less accurate; and the system then mistakes the resulting disengagement for further evidence against the person.

Fieldworks therefore asks services to consider not only whether they are making decisions about the patient, but whether their conduct and decisions are producing the conditions for more reliable feedback in the future.

A decision is not only an outcome of knowledge. It shapes the next knowledge the system will be able to receive.

11. Positionality and Lived-Experience Development

Fieldworks was developed from Scottish lived experience of polysubstance use, treatment disengagement, frustration escape, life-tolerability use, exposure to contaminated supply, self-sequencing, and later treatment re-engagement. This positionality is not offered as empirical proof. It is offered as the practice-ground from which the method became visible.

Central to this lived-experience development was the recognition that treatment does not only depend on what services offer. It depends on the reliability of the knowledge that services produce about the person, the conduct through which that knowledge is produced, and whether the person can trust that knowledge to be used fairly.

Where a person is repeatedly misunderstood, or where their reports are collapsed into imposed meanings such as low motivation, non-compliance, poor insight, ambivalence, or risk, the treatment relationship may become less safe. The person may then conceal, minimise, perform, disengage, or translate their experience into what the system appears able to hear. This does not make the person dishonest in any simple sense. It shows how poor sequencing and inconsistent conduct can make accurate feedback harder to give.

The development of Fieldworks came from recognising this feedback problem from the inside. When system decisions are based on unreliable or prematurely interpreted knowledge, trust is weakened. When trust is weakened, disclosure becomes less safe. When disclosure becomes less safe, future feedback becomes less accurate. The system may then treat the resulting guardedness or disengagement as further evidence against the person, completing a destabilising loop.

The reverse is also possible. When a service produces decisions that feel accurate, proportionate, and recognisable from the person's lived position, trust may increase. When trust increases, disclosure becomes safer. When disclosure becomes safer, feedback becomes more precise. More precise feedback can then support more reliable decisions. In this way, reliable decision-making can begin to stabilise the treatment field itself.

This understanding is central to the lived-experience development of Fieldworks. The framework did not emerge only from reflection on substance use. It emerged from living through the relationship between conduct, sequence, feedback, record, decision, trust, disclosure, regulation, and treatment usability.

Fieldworks therefore asks services to consider not only what they decide about a person, but what their conduct and decisions make possible next.

12. Treatment Fit, Self-Sequencing, and Contaminated Supply

A further lived-experience insight in the development of Fieldworks is that formal treatment can be present while still being unusable from the person's lived position. This does not make treatment unnecessary. It shows that the sequence, form, dose, timing, conduct, and relational conditions of treatment matter.

In the lived-development case behind Fieldworks, long-term opioid substitution treatment had become poorly fitted to the actual regulation problem. The difficulty was not only opioid dependence. It involved regulation capacity, perceptual disturbance, daily functioning, child-contact demands, trust, and the need to remain stable without returning fully to chaotic use.

When formal treatment was not fitted to these conditions, the person began to self-sequence care outside the formal pathway. This should not be romanticised. Self-sequencing may appear rational from inside a poorly fitted treatment field, but it carries serious risks, especially where the unregulated supply is contaminated, unpredictable, or far more potent than expected.

In this lived-development case, a small amount of illicit opioid use later became part of a self-managed attempt to prevent destabilisation and preserve functioning. The use was not functioning simply as intoxication-seeking. It was being used within a wider attempt to maintain enough stability for daily responsibilities and child-contact demands. This does not make the pattern safe. It makes its function important to understand.

The pattern was then severely disrupted by nitazene contamination in the local heroin supply. In this instance, contamination was confirmed by a positive field test. This individual experience sits within a wider Scottish public-health concern: nitazene-type synthetic opioids have been detected across Scotland and may appear as unexpected contaminants in drugs sold as heroin and other substances.

This matters for Fieldworks because it shows the danger of leaving people to self-sequence care in an unsafe supply environment. A person may be attempting to manage dose, function, and stability carefully, but the drug supply itself can override that care. Where heroin contains nitazenes or other potent synthetic opioids, overdose risk may increase sharply, tolerance may be destabilised, and later treatment re-entry may become more complex.

Poor treatment fit therefore becomes more dangerous in a contaminated supply context. If people cannot use formal treatment safely, flexibly, or honestly, they may be pushed toward self-management in an environment where the supply is increasingly toxic and unpredictable. The issue is not only individual risk behaviour. It is the relationship between treatment usability and supply risk.

A later treatment turning point came when the person was able to re-enter formal care through a medication pattern that better matched the already observed regulation reality. This again points to treatment fit rather than treatment rejection. Treatment became usable when medical practice began to listen to the working regulation pattern instead of imposing a standard sequence that did not fit.

This is not presented as a model for others to copy. It is evidence of a Fieldworks principle: 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.

13. The Scottish Recovery Field

Scotland’s substance-use context is not adequately captured by individualised accounts of motivation, pathology, or poor decision-making alone. In many communities and social environments, drug and alcohol use may sit within a wider field of deprivation, constrained opportunity, boredom, physical and emotional pain, informal economies, social pressure, housing instability, criminal justice contact, stigma, and narrowed expectations of the future.

This does not mean substance use is safe, inevitable, or culturally fixed. It means treatment must account for the field in which substance use has become functional.

In this field, substances may serve several overlapping functions: relief from bodily agitation; escape from frustration or pressure; management of pain; temporary emotional shutdown; social participation; interruption of shame; boredom relief; identity maintenance; reward after stress; preservation of routine; temporary control; avoidance of withdrawal; confidence support; life-tolerability; making ordinary life feel inhabitable; intoxication; or oblivion.

These functions are not excuses. They are treatment information.

If a person’s use is doing several of these things at once, then removing or restricting use without replacing its function may increase instability. Relapse may then be interpreted as poor motivation, when the more accurate explanation may be that treatment has removed the person’s regulator, reward, relief, or tolerability support before building another one.

Fieldworks therefore asks services to begin with a different question: what would become intolerable, unavailable, or destabilised if this use stopped tomorrow?

That question does not lower expectations. It improves accuracy. It helps treatment identify what must be supported before behaviour change can become sustainable.

14. Life-Tolerability Use

Earlier versions of Fieldworks distinguished substance use as regulation rather than recreation. That distinction remains important, but it is not sufficient. There is a major middle layer between managing acute distress and getting high.

Fieldworks calls this life-tolerability use.

Life-tolerability use refers to substance use that functions to improve the felt quality of ordinary life under constrained conditions. It is not simply crisis regulation, and it is not simply intoxication-seeking. It is the use of substances to make life feel more bearable, warmer, less flat, less humiliating, less boring, less tense, or less unrewarding while the person continues to live it.

This distinction matters because services may misread life-tolerability use as pleasure-seeking, denial, poor motivation, or unwillingness to change. Yet from the person's lived position, the function may be closer to making the day inhabitable than pursuing a high. The substance does not simply produce intoxication. It changes the felt quality of being alive under constrained conditions.

In Scotland's high-harm recovery context, this may be especially important where deprivation, shame, boredom, limited opportunity, social pressure, pain, stigma, and narrowed horizons shape daily life. A person may be housed, medicated, attending appointments, and not in visible crisis, while still experiencing ordinary life as grey, unrewarding, or difficult to inhabit. In such cases, substance use may persist because it provides not only relief from distress, but a temporary restoration of warmth, appetite, humour, confidence, interest, or felt possibility.

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

This changes the treatment question. Services should ask not only what substance use helps the person escape from, but what it helps them stay inside. Does it make housing tolerable? Does it make boredom tolerable? Does it make loneliness tolerable? Does it make pain, shame, low status, or lack of future orientation tolerable? Does it provide the only reliable sense of reward in an otherwise unrewarding day?

Where this function is not recognised, treatment may assume that the person is choosing intoxication over recovery. Fieldworks suggests a more precise interpretation may sometimes be required: the person may be choosing a temporary improvement in the felt quality of life because ordinary life has not yet become sufficiently liveable without the substance.

This does not make continued use safe. It makes its function clinically and socially relevant.

15. Function of Use Before Verdict

Fieldworks proposes that substance use should be understood first as function, not verdict.

The question is not only: what is the person using?

It is also: what is this use doing for them?

A single substance may serve different functions at different times. Cocaine may be used for social confidence, boredom relief, work-like energy, emotional armour, reward after pressure, or temporary restoration of status. Benzodiazepines may be used for anxiety reduction, sleep, emotional shutdown, withdrawal management, or escape from intrusive thought. Alcohol may be used for social participation, grief, shame interruption, sleep, confidence, or routine. Opioids may be used for pain, withdrawal avoidance, emotional quiet, bodily regulation, or protection from despair.

This functional complexity matters in a polysubstance setting. If services treat all use episodes as the same kind of failure, they may miss what each use episode is doing. A relapse after shame may require a different response from a relapse after boredom, pain, social pressure, confidence inflation, or pharmacy exposure. A use episode driven by life-tolerability may require a different response from one driven by withdrawal avoidance or acute dysregulation.

Fieldworks therefore asks services to distinguish at least five broad functions:

1. Withdrawal avoidance: use that prevents sickness, panic, pain, or physical collapse.
2. Crisis regulation: use that prevents escalation, shutdown, rage, despair, or immediate destabilisation.
3. Life-tolerability: use that makes ordinary life feel less bleak, flat, painful, boring, humiliating, or unrewarding.
4. Social participation: use that supports belonging, confidence, shared rhythm, or avoidance of exclusion.
5. Intoxication or oblivion: use that seeks euphoria, escape, disappearance, sleep, or numbing.

These categories are not fixed diagnostic boxes. They are prompts for better interpretation. Their purpose is to prevent treatment from collapsing all substance use into one moral or clinical meaning.

16. Regulation Capacity

Regulation capacity refers to the ability to remain present, tolerate internal discomfort, manage bodily escalation, slow impulses, complete ordinary tasks, recover from interruption, and move through the day without immediate reliance on escape behaviours.

In earlier Fieldworks versions, regulation capacity was positioned before understanding, choice, support alignment, and medication where indicated. That remains the core sequence. The revised Scottish version extends this by asking what the person’s field requires them to regulate against.

It is one thing to ask someone to regulate in a therapy room. It is another to ask them to regulate inside a life shaped by deprivation, stigma, unstable housing, peer pressure, pharmacy visibility, community exposure, child protection fear, criminal justice requirements, chronic pain, boredom, and lack of future horizon.

Regulation capacity should therefore not be treated as a purely internal skill. It is relational and environmental. A person may appear poorly regulated not because they lack insight, but because the field they are living inside repeatedly exceeds their current capacity.

Fieldworks does not lower expectations. It sequences them.

Responsibility is still necessary. Behaviour still matters. Harm still matters. But responsibility becomes more realistic when the person has enough regulation capacity to exercise choice without constant suppression, panic, shame, or escape pressure.

17. Treatment Usability

Treatment can be available and still unusable.

This is one of the central claims of the revised Fieldworks framework.

A service may exist. A prescription may be clinically correct. A psychological intervention may be evidence-based. A recovery group may be well-intentioned. A relapse plan may be properly documented. Yet from the person's lived position, the pathway may still be unusable if it is poorly timed, socially exposing, shame-producing, cognitively inaccessible, or misaligned with regulation capacity.

Treatment usability asks whether the person can actually use what is being offered.

This includes practical questions:

Can the person attend without destabilising their day?
Does the appointment time fit their regulation pattern?
Does the pharmacy routine expose them to people or pressures they are trying to avoid?
Does the treatment setting increase shame or visibility?
Is the person being asked to reflect before they can remain regulated?
Is medication being standardised in a way that undermines daily functioning?
Are abstinence demands being made before alternative regulation exists?
Is relapse being interpreted before its function is understood?
Does the person trust the worker enough for honesty to be safe?
Does the treatment plan make ordinary life more liveable, or only more monitored?

Fieldworks defines treatment fit as the relationship between intervention, timing, person, conduct, and field. A treatment is not fitted simply because it is clinically recognised. It is fitted when the person can use it without being unnecessarily destabilised by the very conditions through which it is delivered.

18. Medication Routines as Recovery Ecology

Medication-assisted treatment is central to Scotland's response to opioid-related harm. Fieldworks supports medication-assisted treatment and does not frame medication as secondary, suspect, or opposed to recovery. Its concern is treatment fit.

Medication administration is not only a pharmacological matter. It is also a social and environmental exposure point.

Where a person is required to attend the same pharmacy, at the same time, under visible supervision, or alongside people connected to active use, past use, stigma, or pressure, the medication routine may create recovery risk even while the medication itself is clinically appropriate.

For some people, shame, unwanted recognition, temptation, and contact with destabilising networks are not peripheral issues. They are part of treatment fit.

This is especially important where people are required to consume a full dose at once, attend frequently, or collect medication in settings where others are doing the same. Even where a dosing arrangement is pharmacologically legitimate, it may not be functionally suitable for the person's day. A 24-hour half-life does not automatically mean that once-daily administration supports 24-hour lived regulation.

Medication standardisation should not be mistaken for treatment fit.

Fieldworks therefore asks not only whether medication prevents withdrawal, but whether the administration pattern supports regulation across the day and protects the person's recovery field. Does it help the person build an ordinary day? Does it reduce shame? Does it support distance from destabilising contacts? Does it reduce exposure to pressure? Does it allow the person to recover socially, not only pharmacologically?

A medication routine can either support recovery-compatible life or repeatedly place the person back into the field they are trying to leave.

19. Prison Release, Housing Placement, and Recovery Field Exposure

Recovery is not only individual. A person may leave prison, hospital, residential care, or another controlled setting with reduced use, improved stability, or genuine intention to continue recovery, but be placed into an environment that immediately reactivates the conditions associated with use.

This is especially relevant where people are discharged or released into homelessness services, temporary accommodation, unstable housing, or areas where cocaine, street benzodiazepines, heroin, alcohol, and other substances are readily available. In such settings, relapse may not be adequately explained by craving or weak motivation. It may reflect field exposure: the person has been placed back into a social and environmental context that makes use highly available, socially pressured, emotionally rewarding, or difficult to avoid.

The Scottish recovery field includes these transitions. Prison release without stable housing, treatment continuity, social protection, and life-tolerability support may return a person to the exact conditions they were trying to escape. A person may have changed, but the field has not.

Fieldworks therefore asks services and systems to consider whether recovery plans protect the person's field. The question is not only whether the person has been advised, prescribed, referred, or discharged. It is whether the next environment makes recovery more possible or less possible.

A recovery plan that ignores exposure is not a recovery plan. It is a hope placed into a hostile field.

20. Journal Route, Public Route, and Urgency

Fieldworks is public-grounded before it is journal-grounded.

If the framework is submitted to a journal, that submission should not be understood as a request for validation. It should be understood as an attempt to make an urgent matter more likely to reach the right people sooner. Scotland's substance-use context is not waiting for perfect theory. People working in addiction services, recovery communities, justice, housing, social care, public health, and peer support already face the practical question Fieldworks raises: what is the person's use doing, and is treatment usable from their lived position?

The journal route may help the framework reach practitioners, researchers, services, and policymakers who are more likely to encounter work through peer-reviewed channels. It may also invite appropriate scrutiny, challenge, refinement, and future empirical testing. These are useful functions. They are not the source of the framework's legitimacy.

If Fieldworks is made public, its primary public home should be fieldnotes.scot. This allows the framework to be presented with the correct context, boundaries, updates, plain-language versions, practice questions, and ethical cautions. Public access through Fieldnotes is not a substitute for evidence. It is a way of making a lived-experience framework available for reflection, discussion, and careful use while empirical development remains future work.

A journal can help carry the argument. It does not create the argument.

21. The Fieldworks Treatment-Fit Sequence

Fieldworks proposes the following sequence for Scotland's polysubstance recovery context:

1. Understand the field

Before interpreting behaviour, services should ask what conditions the person is living inside. This includes housing, income, pain, shame, boredom, social contact, family stress, criminal justice pressure, community exposure, pharmacy routines, prison release, housing placement, and the local availability of substances.

2. Hold conduct discipline

Professionals should enter the encounter with accountable presence. This means separating observation from inference, patient report from professional reaction, and uncertainty from certainty before meaning is imposed or recorded.

3. Identify the function of use

Substance use should be understood first as function, not verdict. The question is not only what the person is using, but what the use is doing for them.

4. Improve language before imposing meaning

Services should separate signal, state, feeling, interpretation, judgement, action, and record before assigning treatment meaning. Patient reporting may be truthful but still imprecise if the person does not yet have the language, safety, or regulation capacity to describe their state accurately.

5. Assess epistemic reliability

Before inherited descriptions are treated as stable knowledge about the person, services should ask how that knowledge was produced. Was the person safe enough to be honest? Was function explored? Was meaning imposed too early? Did the record distinguish state from judgement? Was professional reaction kept out of patient identity?

6. Assess regulation capacity

Services should ask whether the person can remain present, tolerate discomfort, manage bodily escalation, slow impulses, complete ordinary tasks, and recover from interruption without immediate escape.

7. Identify life-tolerability gaps

Services should ask whether the person's ordinary life has enough warmth, rhythm, connection, appetite, purpose, humour, reward, and future orientation to be liveable without the substance. If not, continued use may reflect not only dependence or poor motivation, but the absence of tolerable alternatives.

8. Assess supply and exposure risk

Services should consider whether the person is being pushed toward an unregulated supply, high-risk peer field, unsafe housing placement, or pharmacy routine that increases exposure to pressure, shame, or contaminated substances. Treatment fit must include the risks of the field into which the person is being sent.

9. Make treatment usable

Treatment should be adapted so the person can actually use it. This may involve timing, location, relationship, pacing, medication arrangements, psychological readiness, advocacy, practical support, or reducing unnecessary exposure to destabilising environments.

10. Support choice

Choice becomes more meaningful when the person has enough regulation capacity and practical stability to experience alternatives as real.

11. Make reliable decisions

Decisions should be based on accurate, sequenced, function-aware knowledge. Reliable decisions can increase trust, make future disclosure safer, and strengthen the stabilising feedback loop.

12. Expect responsibility

Fieldworks does not remove accountability. It sequences accountability after capacity. The aim is restored agency, not lowered expectation.

13. Pursue outcomes

Abstinence, reduction, safer use, improved health, parenting stability, housing stability, work, study, or community participation may all become more achievable once treatment is fitted to regulation capacity and lived field conditions.

22. Practice Questions

Fieldworks can be used as a reflective lens within existing services. It does not require a service to adopt a new model before asking better questions.

Useful practice questions include:

1. What is this substance use doing for the person?
2. Is the use regulating crisis, improving life-tolerability, enabling social participation, avoiding withdrawal, seeking intoxication, or producing oblivion?
3. What would become intolerable or destabilised if this use stopped tomorrow?
4. Is the person being asked to change behaviour before enough regulation capacity exists?
5. Is treatment available but not usable?
6. Does the medication routine support recovery, or repeatedly expose the person to shame, pressure, or destabilising contact?
7. Is relapse being interpreted as poor motivation when it may reflect failed sequencing?
8. Does the person's ordinary life contain enough warmth, reward, rhythm, connection, and possibility to make recovery feel inhabitable?
9. Has the system separated signal, state, feeling, interpretation, judgement, action, and record?
10. Is the patient knowledge being used in this decision epistemically reliable?
11. Has professional reaction entered the record as patient fact?
12. What decision would make future honest feedback safer?
13. Is the person being pushed toward an unregulated or contaminated supply because formal treatment is not usable?
14. Does the person's housing, placement, pharmacy routine, or release plan protect recovery or expose it?
15. What is the smallest regulatory or practical support that would make the next step possible?
16. What expectation becomes fair once capacity has been restored?

23. Limits and Ethical Considerations

Fieldworks is not presented as an empirically validated intervention. It is a practice-informed conceptual and service framework that requires empirical evaluation. Its claims should be treated as testable propositions rather than settled clinical conclusions.

The framework is not universally applicable. Not all substance use functions as regulation or life-tolerability. Some use is chaotic, escalating, compulsive, socially driven, or directly intoxication-seeking. Some patterns require urgent clinical, safeguarding, or emergency intervention. Fieldworks should not be used to delay necessary action where risk is immediate.

Fieldworks also does not claim that all self-managed substance or medication patterns should be preserved. The point is narrower. In some cases, a person may already be using a pattern to preserve function, reduce destabilisation, or prevent escalation. Where that appears to be the case, services should first understand the regulatory or tolerability function of the pattern, assess risk carefully, and then work toward safer sequencing rather than imposing standardisation before the person has enough capacity to tolerate it.

Self-sequencing outside formal treatment carries serious risks and should not be romanticised. This is especially true in Scotland's current unregulated supply context, where nitazene contamination and other unpredictable substances can make illicit opioid use far more dangerous than the person intends or anticipates. Fieldworks does not present self-management outside care as a preferred route. It presents it as evidence of what can happen when formal care becomes unusable.

Regulation-focused approaches must not substitute for psychological care, pharmacological treatment, harm reduction, safeguarding duties, or clinical judgement. The framework is intended to improve treatment fit, not to create a new orthodoxy.

The conduct discipline component should not become another punitive standard imposed on workers without support. Accountable presence requires training, supervision, reflective space, manageable workload, and organisational responsibility. Fieldworks does not blame individual workers for system conditions that make good conduct harder to sustain. It asks systems to make reliable conduct possible and expected.

The Missing Language component should also be used carefully. It should not become another way for professionals to overrule the person's own account. The purpose is not to say "the patient does not understand themselves." The purpose is to ask whether the person and the service have enough shared language, safety, and sequence to understand the report accurately together.

The epistemic reliability argument should not be used to dismiss patient reporting. It should be used to improve the conditions under which patient reporting is heard, interpreted, recorded, and carried across systems.

Ethically, Fieldworks reframes relapse and disengagement without removing responsibility. Its aim is restored agency, not lowered expectation. It asks services to align expectations with capacity so that responsibility becomes more real, not less.

24. Conclusion

Fieldworks proposes a regulation-first Scottish framework for substance-use treatment fit. It begins from the reality that Scotland's high-harm recovery context is shaped not only by substances, but by deprivation, polysubstance availability, contaminated supply, shame, social exposure, boredom, pain, stigma, pharmacy routines, prison release, housing placement, narrowed horizons, and treatment systems that may be present without always being usable.

In a subset of cases, substance use may function as informal regulation infrastructure. It may settle the body, interrupt shame, mediate pain, support social participation, avoid withdrawal, or escape frustration. Fieldworks also identifies life-tolerability use as a major under-recognised function: substance use that makes ordinary life feel less bleak, flat, humiliating, boring, or unrewarding while the person continues living it.

This distinction matters. If treatment interprets all use as intoxication-seeking, non-compliance, or poor motivation, it may miss what the use is doing. If treatment removes or restricts the function before restoring regulation capacity and practical alternatives, relapse may become more likely and more easily misread.

Fieldworks also argues that substance-use care depends on the reliability of professional conduct and the knowledge systems produce about patients. Collapsed language, imposed meaning, unsafe disclosure conditions, premature judgement, and unmanaged professional reaction can produce unreliable patient knowledge. Once recorded, that knowledge can travel across services and shape decisions. Poor sequence and inconsistent conduct can therefore affect not only treatment engagement, but the reliability of decisions made about the person.

The reverse is also possible. Standardised conduct can support better sequence. Better sequence can produce better feedback. Better feedback can produce more reliable knowledge. More reliable knowledge can support more reliable decisions. Reliable decisions can increase patient trust. Greater trust can make future disclosure safer. Safer disclosure can improve treatment fit and strengthen regulation capacity.

This is the stabilising feedback loop at the centre of Fieldworks.

Fieldworks does not ask Scotland’s treatment systems to care less about outcomes. It asks them to stop demanding outcomes before the person has enough regulation, trust, language, and usable support to reach them. It also asks systems to stop relying on policy change alone when the conduct through which policy becomes practice remains unstable.

Policy sets the promise. Conduct decides whether the promise reaches the person.

The core sequence is:

Understand the field.
Hold conduct discipline.
Identify the function.
Improve language.
Assess reliability.
Restore regulation.
Assess exposure and supply risk.
Make treatment usable.
Make reliable decisions.
Support choice.
Expect responsibility.
Then pursue outcomes.

Fieldworks does not reject treatment. It asks what conditions must be present for treatment to become usable.

The public ground for this work is fieldnotes.scot. A journal may help the argument travel, but it does not decide whether the problem is real.

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