REAL POLICY COMES FROM REAL LIVES

A Lived-Experience Challenge to CURRENT Addiction Strategy

This paper examines how recovery can be strengthened through community, faith, and lived experience. It offers practical recommendations for shaping addiction policy that supports not just treatment—but transformation.

Stuart Patterson
July 2025
Partnership Coordinator, Street Connect
Pastor, Easterhouse Community Church

Table of Contents

Real Policy Comes from Real Lives

Toward a Community-Rooted, Hope-Centred Approach to Addiction Recovery in Scotland and the UK

Executive Summary

Addiction policy across the UK and in Scotland remains predominantly anchored in a medicalised model, with Medication-Assisted Treatment (MAT) at its centre. While MAT has a legitimate role in harm reduction, its dominance risks reducing recovery to chemical management—keeping individuals alive, but not necessarily helping them live.

This paper argues for a paradigm shift: away from systems that frame addiction as a lifelong medical condition, and toward frameworks that empower individuals to grasp life beyond addiction. Grounded in lived experience, supported by academic literature, and informed by real-world data, it calls for bold investment in community-rooted, identity-forming, hope-sustaining recovery models.

Core Premise

Recovery is not simply about stabilisation or abstinence. It is about transformation—of self, story, and surroundings. It begins when individuals are helped to:

- **See** a future beyond addiction
- **Grasp** that future through meaningful support
- **Grow** into new roles and restored identities

Systems that fail to facilitate this journey risk maintaining dependency under another name.

Section 1: Where Policy Fails to Reach

There are tens of thousands of individuals in the UK living with addiction who are not engaged with any form of support.

According to *National Records of Scotland* (2023), 1,197 people died from drug misuse in 2022. Meanwhile, *Public Health Scotland* (2023) estimates that only 60% of those with opioid use disorder are in contact with services. That leaves a vast silent majority—unseen, unreached, and often untreated.

These are not just gaps in provision. They are blind spots in our collective moral vision.

We cannot fix what we refuse to face—and the uncomfortable truth is that many people in addiction never cross the door of any service. Not because they don't care. Not because they've given up. But because what we call "help" often feels more like monitoring, medicalisation, or moral scrutiny.

Many of us who eventually found recovery didn't do so because a referral letter arrived. We were reached—in alleyways, drop-ins, bus stops, church halls—by people who looked like us, sounded like us, and *stayed* with us.

Why Many Never Engage

People avoid services for complex reasons:

- **Fear** of being judged, sectioned, or separated from their children
- **Shame** so deeply ingrained that asking for help feels like admitting defeat
- **Cultural mismatch**—clinical language and forms that don't reflect lived experience
- **Geographic barriers**—especially in rural or marginalised urban areas
- **Distrust of systems**—often shaped by years of institutional harm or trauma

Engagement begins not with "access points," but with encounter—when someone meets you not as a case, but as a person.

Who *Is* Reaching Them?

The irony is that **there are people already doing this work**. Recovery communities, peer-led outreach teams, faith-based missions, small churches, cafés, and lived-experience leaders embedded in their local context.

These are the people who:

- Go looking for the lost—not waiting for them to walk through an office door
- Offer warmth before paperwork
- Bring credibility not from credentials, but from *having been there*

And yet, despite their effectiveness, these grassroots actors remain underfunded, marginalised, and structurally excluded from the tables where strategy is set.

Policy often assumes that professional qualifications equal professional reach. But many of us know firsthand: it was the volunteer who changed our life, not the form we filled out.

The Cost of Ignoring the Frontline

When we fail to fund and platform those closest to the chaos, we lose more than effectiveness—we lose *trust*. Systems become echo chambers. Services become warehouses. And people die—**not for lack of treatment slots, but for lack of human connection**.

Policy cannot simply invest in models that work on paper. It must begin listening to the ones that work on pavements.

Policy Recommendations

- Fund and formalise peer-led, faith-based, and community-rooted outreach as core pathways—not adjuncts—to national provision
- Create "first engagement" funding for micro-initiatives operating outside of statutory frameworks but with proven relational reach
- Measure reach not by sign-ups, but by contact with the unreached—including presence in prisons, streets, hostels, and homes

- Invite lived-experience practitioners to co-create engagement strategy, especially for “hard-to-reach” populations

Section 2: The Limits of MAT: Stabilisation Is Not the Destination

Medication-Assisted Treatment (MAT) has saved thousands of lives across the UK and globally. It reduces overdose risk, helps regulate chaotic use, and offers a medical safety net to those spiralling in crisis. But MAT alone is not recovery. At best, it provides a holding pattern; at worst, it can reinforce the belief that true freedom is impossible.

A 2019 toolkit by Change Grow Live found that over 50% of service users continued to use illicit opioids while in MAT programmes. A European study (Novak et al., 2014) reported 30–80% of MAT participants continued to use heroin or cocaine. 27% misused their own prescriptions, with 16.8% misusing methadone and 12.5% buprenorphine. These are not marginal outliers—they are systemic patterns.

The data highlights what many with lived experience already know: chemical dependence alone is not the problem. Trauma, disconnection, shame, emotional immaturity, and despair often drive substance use long after dosing has begun.

MAT and the Myth of Maintenance

The dominant clinical narrative frames addiction as a "chronic relapsing condition." Within this model, long-term chemical dependency under state supervision becomes an acceptable outcome. But this framework risks collapsing hope—suggesting that "safe addiction" is the best one can hope for.

There is an unspoken message embedded in many MAT-centred systems:

"You'll never be free, but we can manage you more safely."

This is dignified despair.

Case Insight: My Recovery Didn't Begin with a Dose

I entered Teen Challenge in May 1997 while still focused on getting my next fix. I didn't arrive with hope—I arrived with desperation. What changed wasn't a prescription. It was a community of faith that believed in something beyond my addiction before I could.

The Teen Challenge programme didn't pathologize me. It discipled me—slowly, patiently, through real-life application and structure. The "Group Studies for New Christians" and "Personal Studies" weren't psychological excavations—they were tools of rehumanisation. They gave me purpose before I knew how to handle pain. And as scars surfaced, they were met—not clinically, but pastorally.

I wasn't detoxed I was invited into a new way of life. That's what policy still misses.

Emotional Impasse, Not Just Chemical Dependency

Clinical MAT strategies often stabilise the brain but leave the emotional body untouched. People who begin using substances in early adolescence are often trapped at that developmental age. When crises come, the MAT script offers no relational tools, no inner language, no vision.

A weekly appointment and urine test cannot:

- Teach how to handle grief.
- Rebuild trust in relationships.

- Replace shame with worth.

That's why MAT should be seen as a starting line, not the finish. Until policy funds and values what comes after stabilisation, it cannot call itself a recovery strategy.

The Cycle of Low Expectation

When people on MAT are told—implicitly or explicitly—that full freedom is impossible, many stop reaching for it. Dependency becomes a tolerated identity. Even those who want more are rarely offered the wraparound support—emotional, spiritual, vocational—to pursue it.

Yet in faith-based and community-rooted models, we find the opposite. Participants are encouraged to envision life beyond addiction, equipped to handle setbacks, and called to more than maintenance.

Policy must learn from these models—not marginalise them.

Policy Implications

- MAT must be repositioned as harm reduction, not identity reconstruction.
- Treatment programmes must fund and embed community-based, lived-experience-led pathways that offer vision and emotional literacy.
- Individuals must be allowed to define recovery not by the absence of relapse—but by the presence of purpose.

Many individuals who found real recovery did not begin with clinical scripts, but with community, vision, and dignity. Faith-based environments like Teen Challenge, for example, offer structured discipleship, emotional growth, and a strong sense of purpose. Group Studies for New Christians and Personal Studies for New Christians were developed not to excavate trauma prematurely but to help participants process it as it surfaced—within a scaffolded environment of hope and identity.

This approach may not suit everyone, but its long-term success in producing drug-free, purpose-filled lives must be included in the national recovery conversation.

Policy Implications

- MAT must be clearly positioned as harm reduction, not the default definition of recovery.
- Outcomes must include emotional development, reconnection, and purpose—not just retention and dosage.
- Community-based pathways must be funded and integrated—not sidelined.

Section 3: The Developmental Cost of Early Addiction and the Unseen Majority

A significant number of people who enter addiction began using substances in their early teens—many even before puberty. The earlier the onset, the more profound the developmental arrest. Emotional responses often remain tethered to the age at which substance use began. Many in recovery face adult problems with pre-adolescent coping mechanisms.

Addiction, in such cases, is not just a health issue but a developmental crisis. Healing requires not only detox, but a form of emotional re-parenting—learning to feel, trust, grieve, and hope, often for the first time.

Mainstream services rarely account for this. Therapeutic language dominates, but without developmental awareness, interventions risk being misapplied. Trauma-informed systems must also be growth-informed—capable of supporting the emotional education that addiction often interrupts.

The Unseen Majority: Addiction Outside the System

Much of addiction policy—especially in Scotland and the UK—is built around those already known to services. Yet a staggering number of individuals remain outside formal systems. They are unseen, uncounted, and unengaged. And if policy is built only for those already in the room, it will fail to reach those still in the darkness.

Who Are the Unseen?

Scotland has an estimated 70,000 people with opioid dependence (Public Health Scotland, 2024), yet only around 40% are in treatment at any one time. That leaves roughly 42,000 people navigating addiction with no structured support. That figure doesn't even include individuals with alcohol dependency, crack cocaine use, benzodiazepine misuse, or poly-drug patterns. Across the UK, the disparity is even more pronounced: the Office for National Statistics (2023) reports thousands of drug-related deaths annually, many of which involve individuals never engaged in services.

Globally, the UNODC (2019) states that only 1 in 7 people with substance use disorders receive treatment. And the longer someone remains disengaged, the harder re-entry becomes—due to stigma, hopelessness, system fatigue, or fear of failure.

Why People Don't Engage

These individuals are not unwilling. They are often:

- Disillusioned from past failed attempts or judgmental experiences.
- Unaware of services that exist outside of punishment or shame.
- Distrustful of clinical models that feel cold or overly medicalised.
- Disconnected—spiritually, relationally, emotionally—from any recovery community.
- Or they're simply too broken to ask.

Many don't walk through the door because they believe there is no door for them.

Case Insight: I Almost Didn't Walk Through the Door

When I entered Teen Challenge, I wasn't looking for recovery. I was looking for a way to score in a new town. The idea of "treatment" never appealed to me—not because I was proud, but because I was broken. I thought the system would want to manage me, not know me.

It was only when someone outside the system—a man named Ken Persaud—spoke to me like I was still worth saving, that I even considered it.

What if I hadn't made that call? What if his number hadn't been on that small business card I'd forgotten in my pocket?

For every person like me who walks through the door, there are hundreds who don't. We need to go where they are—not wait for them to arrive.

Who's Really at Risk?

Many of the unengaged are:

- Sleeping rough
- In active trauma cycles
- Parenting while dependent
- Newly released from prison
- Living in emotionally numb dependency

They're not "non-compliant." They're exhausted, ashamed, often emotionally and spiritually paralysed.

And they're precisely who Jesus sought out. If recovery policy doesn't include them, it's not just ineffective—it's unjust.

Policy Must Change its Approach

Most current strategies aim to make services more accessible. But we must go further:

We need to move from "come to us" to "we'll come to you."

This includes:

- Street-level outreach with trained peer mentors.
- Community-based intake through faith groups, food banks, or GPs.
- Non-clinical entry points: barber chairs, drop-ins, bus stops, housing visits.
- Pre-treatment engagement: where conversation, not compliance, is the starting point.

People don't need a "treatment slot." They need someone who believes there's life beyond the mess—and will walk beside them until they believe it too.

Policy Recommendations

- Fund embedded outreach workers in areas of highest drug-related deaths—not to signpost, but to accompany.

- Mandate all ADP strategies to include lived-experience-led visibility initiatives—including storytelling, mentoring, and trauma-safe engagement.
- Support faith and peer-based organisations as equal partners in first-contact addiction work.
- Invest in small-scale community pilots that demonstrate relational-first, clinical-later models.

Section 4: From Clinical Metrics to Human Outcomes

At the heart of sustainable recovery is the reconstruction of identity. Recovery cannot be reduced to habit management; it is a narrative and relational task. People must discover not only what they are recovering *from*, but what they are recovering *for*.

Current addiction policy across the UK and Scotland is dominated by clinical metrics—appointment attendance, dosage stability, reduction in offending. These data points may track service use, but they do not capture personal recovery. Recovery is not merely the absence of chaos; it is the presence of connection, growth, and purpose.

Clinical outcomes tell us who is surviving. Human outcomes tell us who is becoming.

The Identity Gap in Policy

Faith-based communities, peer mentors, and recovery leaders are often effective because they speak directly to the identity question. They don't just ask, "What went wrong?" They proclaim, "Here's who you can become."

But a system that never moves beyond pathology will fail to form purpose. Policies must create space for narrative change, vocational reintegration, family restoration, and spiritual growth—however defined by the individual.

The Metrics We Fund

Public services tend to fund what they can count: MAT retention rates, urine test results, number of interventions delivered. But human transformation is hard to quantify. How do you measure trust rebuilt? Shame lifted? The ability to respond to pain without relapse?

In focusing on what's measurable, policy often sidelines what's meaningful. People become data points, not stories.

What Gets Missed

People can be fully compliant with clinical targets and still be spiritually broken, relationally isolated, and emotionally numb. They are 'in recovery' on paper, but not in purpose.

Conversely, individuals in community-rooted models may show inconsistent service engagement, but display dramatic gains in self-worth, stability, and contribution. These stories rarely make it into policy rooms, because they don't fit the spreadsheet.

Case Insight: Becoming a Dad, Not Just Drug-Free

Recovery for me didn't begin with a negative test—it began with a positive vision. I stopped chasing drugs because I started dreaming about becoming a husband, a dad, a community leader. That vision did more to hold me in recovery than any prescription ever could.

I wasn't just surviving—I was becoming someone.

Toward Holistic Recovery Indicators

We must broaden what counts as evidence. Emerging models in other sectors—such as community health and mental wellbeing—track indicators like social connectedness, personal agency, hopefulness, and purpose. These can and should be adapted to recovery contexts.

Imagine a system where:

- Peer trust is an indicator.
- Reconnection with children is valued.
- Service users define success in their own words.

Policy Recommendations

- Reframe national outcomes frameworks to include relational, vocational, emotional, and spiritual wellbeing.
- Embed lived-experience co-design in measurement tools to reflect what recovery actually feels like.
- Allocate funding not just to services that retain people—but to those that release them into meaningful lives.

Section 5. Deprivation as Root Cause and Reinforcer

Addiction does not emerge in a vacuum. It takes root in very specific environments—homes strained by unspoken trauma, communities marked by cumulative disadvantage, and systems where silence often replaces support. In Scotland, addiction is not simply a personal health issue—it is a symptom of social fracture.

According to Audit Scotland (2022), individuals living in the most deprived communities are 18 times more likely to die from drug-related causes than those in the least deprived areas. Public Health Scotland's RADAR report (2023) confirms that drug-related harms remain highest in areas of multiple deprivation, with concentrated rates of non-fatal overdoses, benzodiazepine misuse, and treatment disengagement.

In these communities, addiction is rarely about thrill-seeking. It is often about surviving with the tools available. As the Scottish Drug Deaths Taskforce noted in its final report, deprivation is both "a precondition and a perpetuator" of harmful substance use (Scottish Government, 2021).

More Than Poverty—A Culture of Pressure

In many schemes and inner-city neighbourhoods, the root issue is not just economic poverty, but emotional pressure and social conditioning. These environments often demand:

- Strength over vulnerability
- Silence over expression
- Performance over pain
- Self-reliance over help-seeking

In such settings, the first use of heroin, street valium, or alcohol is often not about rebellion. It's about relief. It's about emotional escape in a world where few other exits exist.

As one service user put it during consultation:

"I wasn't trying to get high—I was trying to get out of my own head."

Services That Misread the Signs

Mainstream addiction services often misinterpret this dynamic. They document "non-engagement" or "lack of motivation" without understanding that many individuals have never experienced a safe or trusting system. Shame is often their mother tongue. Bureaucracy feels like another form of rejection.

Those who need help most are often the least likely to walk through a clinic door—not because they don't want recovery, but because they don't believe it's available on their terms.

What Policy Must Grasp

If drug-related deaths are highest in the poorest areas, then deprivation must be treated not as a background factor but as a central determinant of addiction risk. The metrics are clear, but the response is often cosmetic—token funding, short pilots, or partnerships without power-sharing.

Instead, policy must:

- **Design services that begin in the scheme, not in the clinic**
- **Embed first-contact access in trusted spaces**: churches, peer drop-ins, foodbanks, barber shops
- **Support trauma- and dignity-informed outreach** that recognises the **intergenerational layering of pain**
- **Fund place-based strategies long enough to gain trust and show fruit**

As the National Records of Scotland (2023) report reveals, the majority of those lost to drug deaths were never in treatment. This is not a failure of individual will—it is a failure of national imagination.

From Surviving to Reimagining

In deprived communities, the pathway to recovery rarely starts with paperwork. It begins when someone is seen, named, and believed in. That doesn't happen in a waiting room. It happens on the walk home from the chemist, in a peer mentor's living room, or during a chance conversation outside a community café.

These are the moments that policy rarely measures—but they are where recovery begins.

If we want people to stop disappearing, we must build systems that make them visible—and valuable.

Section 6: Systems That Expect People to Fail

Despite decades of reform, addiction policy in the UK still operates on a deficit model—one that quietly assumes failure is inevitable and designs services accordingly. Official frameworks speak the language of harm reduction, compliance, and relapse prevention, but rarely articulate a compelling vision of transformation.

Services may measure dropout rates, medication adherence, and engagement, but they seldom ask *why* people disengage. Many individuals drop out not from denial or defiance, but because the system offers no credible alternative. When survival becomes the only outcome, people stop believing in anything beyond it.

As one recovery leader put it:

"If the system never shows you what a better life looks like, you'll just return to what you already know."

The Tyranny of Low Expectations

The dominant model frames addiction as a "chronic, relapsing brain disease" (NIDA, 2020). While this has reduced stigma in some sectors, it has also reduced aspiration. In many settings, relapse is expected, dependency is managed, and flourishing is unmeasured. Words like *growth*, *calling*, or *purpose* are conspicuously absent.

When success is defined as maintenance—rather than movement—the system communicates:

- "You are expected to relapse."
- "We will always need to supervise you."
- "You will always be dependent."

This isn't trauma-informed care. It's trauma-resigned care. It trains workers to manage, not mentor. And it subtly teaches people in addiction that true freedom is for someone else.

A review by the Scottish Drugs Forum (2022) found many individuals had been engaged in services for five years or more **with no discharge plan**. Few had been asked what they wanted life to look like beyond addiction. Recovery becomes something to be endured—not something to be pursued.

Case Insight: A System Without a Vision

No one ever told me I'd be on methadone for life. But in hindsight, no one ever told me I could be anything else either. I was stabilised, not envisioned. When I tapered down from 80ml to 2ml, I wasn't celebrated—I was simply processed. I never "relapsed," because I'd never truly recovered. I just changed drugs again—back to heroin.

This wasn't a personal failure. It was a system that had no language for life beyond the script.

From Risk Management to Growth Culture

If we want recovery to mean more than maintenance, we must build systems that expect more than survival. We must create cultures that speak a different gospel:

- "You can get well."
- "You can become someone your kids are proud of."
- "You belong here—even before you're clean."

This is not idealism. It is the only model that has ever worked long-term. As Best and Laudet (2010) argue, recovery capital is relationally activated. Change is sustained when people are *believed in* and *called higher*, not merely stabilised and supervised.

Faith-based and peer-led communities already operate with these assumptions. They offer not just detox, but discipleship—not just maintenance, but meaning. That posture should not be the exception. It should be the model.

Policy Recommendations

To replace the culture of managed suffering with a culture of expectation and growth, policy must:

- **Reframe national outcomes** to include identity formation, purpose, and reintegration—not just retention or dosage metrics.
- **Fund recovery roles** that foster character, vision, and leadership—not just harm mitigation.
- **Invest in community-rooted initiatives**—churches, peer hubs, family outreach—that expect transformation, not just compliance.
- **Track real-world flourishing**: employment, relationships, emotional maturity, and spiritual engagement.

Until we build systems that call people to life, they will return to the only survival that ever worked for them.

And when they do, it won't be failure.
It will be policy working *exactly as it was built*.

Section 7: Helping People See and Grasp Life Beyond Addiction

Much of the UK's addiction policy remains focused on reducing harm, managing relapse, and improving engagement with treatment services. These are necessary goals—but they are not sufficient. Without helping people in addiction *see* a life beyond addiction and *grasp* the tools to build it, we are not offering recovery. We are simply reorganising despair.

Seeing the Possibility: Making Hope Visible

Hope is not a vague feeling. In recovery, hope is a cognitive, relational, and spiritual awakening—a dawning belief that life beyond substance use is possible and desirable.

Yet many people in addiction cannot picture any alternative. After years of trauma, exclusion, and failure, chaos becomes identity and survival becomes the only goal. In such environments, even glimpsing a better future requires more than encouragement—it requires *embodied examples*.

Studies have shown that hope is a key predictive factor in long-term recovery outcomes (Best et al., 2022). Recovery capital—the internal and external resources needed to sustain recovery—is significantly influenced by hope, purpose, and identity (Cloud & Granfield, 2008).

This means policy must invest in environments that model transformation, including:

- Peer mentors who have walked the road themselves
- Community-rooted spaces—churches, peer-led hubs, women's circles, cafés
- Stories of identity renewal, not just "clean time"
- Faith-informed settings that rekindle purpose

As Lippard and Burnside (2021) argue, transformational recovery settings create new "identity scripts"—narratives in which individuals can see themselves not merely as abstinent, but as renewed.

Grasping Empowerment: Making the Future Achievable

To glimpse a better life is one thing. To believe you can live it is another.

Long-term recovery requires more than clinical engagement. It demands *identity reclamation*—the rebuilding of emotional, relational, spiritual, and vocational capacity.

Effective policy must therefore fund:

- Scaffolded environments for guided emotional growth
- Practical skills training—emotional regulation, communication, literacy, budgeting
- Relationship repair through trust-based, community-rooted models
- Opportunities for contribution—apprenticeships, volunteering, mentoring

A longitudinal study by Hibbert and Best (2021) found that individuals given visible roles of contribution within their recovery communities were significantly more likely to maintain abstinence and report greater life satisfaction.

Recovery is not sustained by safety alone. It is sustained by meaning.

Embodied Hope: Borrowed Until Believed

Hope is not always self-generated. Often, it's borrowed.

Peer-led and lived-experience communities don't thrive because they're clinically advanced. They thrive because they're emotionally *credible*. Hope becomes believable when it's *flesh and blood* across the room.

Embodied hope looks like:

- A volunteer who's been clean five years making tea at a drop-in
- A pastor who remembers your name when no one else does
- A peer mentor walking beside you, not ahead

Hope cannot be prescribed. But it can be carried.

"When I arrived at Teen Challenge, I didn't believe in a better future. But others did. And I borrowed their hope until I could hold my own."

Case Insight: From Survival to Discipleship

When I entered a residential programme in 1997, I wasn't looking for purpose. I was looking for pain relief. But I encountered more than detox—I encountered discipleship.

There were no deep therapy sessions on day one. Instead, there was structure and scripture, accountability and prayer, relationships and responsibility. In that space, hope became habit. Over time, life beyond addiction didn't just seem possible—it became real.

This is not anecdote. It's *proof of principle*. People don't recover because they are told to stop. They recover because someone *hands them a future*.

Policy Recommendations

To create environments where people can *see* and *grasp* life beyond addiction, policymakers should:

- **Fund vision-casting roles**: embed peer recovery mentors, spiritual workers, and lived-experience advocates within statutory services
- **Track recovery capital**, including purpose, identity, and belonging—not just attendance or dosage
- **Invest in projects that offer embodied hope**: community-rooted initiatives where transformation is visible and relational

- **Adopt national wellbeing metrics** for recovery: employment, family stability, relational healing, and spiritual meaning

Until people are shown something worth building, relapse will remain the most rational option they were offered.

Building With, Not For

Policy often nods toward lived experience through panels and testimonial videos. But *true recovery strategy must be co-designed*.

People with lived experience must hold paid, empowered roles in shaping strategy, allocating funding, and evaluating outcomes. Without this, policy will always misfire.

The difference is simple—but decisive:

Are we building systems *for* people in recovery, or *with* them?

Section 8: Community as Core Infrastructure

Recovery doesn't happen in the abstract. It happens in places. In faces. In the everyday ordinariness of human connection, structured belonging, and mutual responsibility.

Yet policy still treats "community" as an accessory rather than a foundation. Despite decades of evidence, addiction strategy continues to prioritise clinical provision over communal restoration—as if healing can be administered but not lived.

Recovery Is Relational Before It's Clinical

Numerous studies confirm that relational connection is one of the strongest predictors of sustained recovery (Best et al., 2016). People are more likely to remain abstinent, find purpose, and contribute to society when they are rooted in networks of support, responsibility, and belief.

Churches, recovery cafés, peer homes, men's walks, women's circles, family support groups—these are not "soft supports." They are the recovery infrastructure. They offer:

- **Proximity**—walking with people in the thick of life
- **Visibility**—modelling that change is not only possible, but happening now
- **Belonging**—inviting people into family-like structures of care
- **Meaning**—through roles, service, and spiritual renewal

In contrast, service-led approaches—however well-intentioned—can inadvertently reinforce passivity and dependency when they fail to include people in building their own recovery environments.

The False Divide: Professional vs Community Support

Some critics draw a line between "evidence-based" interventions and community or faith-based responses. But this is a false binary. Evidence supports both.
In fact, a major review by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA, 2018) found that community-based recovery models—especially those involving peer leadership—led to significant improvements in abstinence rates, housing stability, and employment outcomes, as well as reduced rates of reoffending and hospitalisation. These outcomes were strongest where relational support, social participation, and a sense of belonging were central to the recovery process.

Churches and grassroots organisations in Scotland have long embodied this model. They operate in places professionals often can't reach. They provide hope where services have been exhausted. Yet they are often underfunded, treated as fringe contributors, or required to conform to clinical frameworks in order to be recognised.

Case Insight: We Built a Church Before We Built a Service

In Easterhouse, long before there was a funded recovery plan, we planted a local church that welcomed people in addiction without judgement. There were no referral forms. No formal assessments. Just shared meals, gospel hope, and stubborn presence.

Men and women who would never cross the door of a clinic came to worship, to volunteer, to eat, to cry. Some found sobriety. Others found community. Many found both.

That church—alongside others across Glasgow and beyond—is not a "bolt-on." It's a lifeline. A lived space of grace. And a template for what policy might look like if it took community seriously.

Why Community Must Be Funded as Infrastructure

Treating community support as optional is no longer sustainable. Community **is** the context where recovery happens. As Best and Laudet (2010) argue, recovery capital is relationally activated. It requires investment in:

- Long-term spaces of belonging (not just short-term interventions)
- Local ownership of recovery initiatives
- Faith-informed and peer-led leadership structures
- Flexible funding that allows community projects to develop organically, not just deliver predefined outcomes

Policy Recommendations

- Reclassify churches, peer hubs, and local community groups as core recovery infrastructure, not adjunct providers
- Develop community recovery commissioning frameworks that value story, belonging, and contribution—not just throughput or clinical data
- Fund sustainable spaces of transformation, including church-based outreach, recovery cafés, peer homes, and spiritual retreats
- Empower community-based leaders to shape strategy and distribute resources—not just receive them

Until recovery policy sees community as the place where change happens, we will keep designing systems people can't live in. And we will keep losing them—quietly, tragically—outside the doors of well-resourced buildings.

Section 9: Conclusion—From Survival Management to Transformation Policy

Current policy structures too often produce what might be called well-managed despair: individuals stabilised but stuck, retained but unreleased. Systems track compliance, not change. They define success in terms of risk reduction, not restored lives.

This is not a rejection of harm reduction—it is a refusal to let it become the ceiling. When harm reduction becomes the destination instead of the starting point, recovery is no longer a journey but a holding pattern.

The Test of Policy: Not What It Prevents, But What It Makes Possible

Real recovery begins when people are:

- Helped to see a future worth living for
- Equipped to grasp that future with relational, emotional, and spiritual tools
- Enabled to grow into a new identity beyond their addiction

These are not poetic ideals. They are evidence-based needs. Research confirms that sustainable recovery is driven by access to recovery capital—internal and external resources like hope, purpose, community, and identity (Cloud & Granfield, 2008; Best et al., 2016).

What the System Offered Me—and What It Didn't

I wasn't told I'd be on methadone for life. But I was placed on it—twice.

The second time, I responsibly reduced from 80ml to 2ml. I followed the plan. But no one ever asked what life I wanted beyond the dosage. No tools for vision. No community to belong to. No framework for becoming more than "compliant."

When I stopped taking methadone, I didn't relapse—I simply resumed heroin. Because I'd never been given anything else.

That's not failure. It's inevitability in a system that defines success as survival—not transformation.

The Missing Pillars: Faith, Belonging, and Becoming

True recovery isn't just about subtracting substances—it's about adding back everything addiction stole: dignity, direction, relationships, purpose, and belief in a better self.

Faith-based and community-rooted environments succeed not because they moralise, but because they humanise. They provide:

- Meaning where the system offers monitoring
- Identity where the clinic measures intake
- Belonging where bureaucracy offers appointments

These spaces are not sentimental—they are strategic. As the Advisory Council on the Misuse of Drugs (ACMD, 2021) notes, social reintegration is essential to recovery. Yet the very structures

that support this—churches, peer networks, spiritual homes—are often underfunded, excluded, or required to conform to clinical models in order to be recognised.

From Containment to Change: Final Policy Directions

To build a framework that does more than manage symptoms, we must:

- **Reframe outcomes**: Prioritise growth-based metrics such as restored relationships, vocational contribution, emotional stability, and spiritual wellbeing—not just "engagement" or dosage
- **Fund community-rooted transformation**: Support the spaces where real change happens—faith hubs, peer mentorships, recovery cafés, and local initiatives with embedded relationships
- **Elevate lived experience to leadership**: Co-design policy with those who have walked the path—not as figureheads, but as strategic decision-makers
- **Expect change, not containment**: Design systems that believe in growth, not just maintenance

Final Reflection: Stop Managing Pain. Start Funding Futures.

Addiction may begin in despair. But recovery begins in vision.

Until policy recognises that recovery is about becoming someone, not just ceasing something, we will continue to recycle people through stabilisation—never offering them transformation.

The real test of a system is not how well it manages brokenness, but how boldly it imagines wholeness.

Let us build recovery policy that doesn't just ask, "What went wrong?"—but dares to ask:

"What could be rebuilt?"

References

Advisory Council on the Misuse of Drugs (2021). *Drug misuse prevention review*. London: Home Office.

Audit Scotland (2022). *Drug and Alcohol Services in Scotland*. Available at: https://www.audit-scotland.gov.uk

Best, D., Irving, J., & Albertson, K. (2016). Recovery and desistance: What the emerging recovery movement in the alcohol and drug area can learn from models of desistance from offending. *Addiction Research & Theory*, 24(1), pp.1–10.

Best, D., & Laudet, A. (2010). *The potential of recovery capital*. London: RSA.

Best, D., Musgrove, A., & Hall, L. (2022). Hope, agency, and belonging: pathways to recovery in community settings. *Journal of Substance Use and Recovery*, 27(1), pp.12–24.

Change Grow Live (2019). *Opioid Substitution Treatment: Evidence Toolkit*. London: CGL.

Cloud, W., & Granfield, R. (2008). Conceptualising recovery capital: expansion of a theoretical construct. *Substance Use & Misuse*, 43(12–13), pp.1971–1986.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2018). *Recovery models and drug services in Europe: A literature review*. Luxembourg: Publications Office of the European Union.

Hibbert, L., & Best, D. (2021). Recovery roles and wellbeing: longitudinal evidence from peer-led communities. *Drugs: Education, Prevention and Policy*, 28(4), pp.295–307.

Lippard, K., & Burnside, J. (2021). Narratives of change: The role of story and script in addiction recovery. *Addiction Research & Theory*, 29(6), pp.493–503.

McLellan, A.T., Lewis, D.C., O'Brien, C.P., & Kleber, H.D. (2000). Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. *JAMA*, 284(13), pp.1689–1695.

National Institute on Drug Abuse (NIDA) (2020). *Drugs, brains, and behavior: The science of addiction*. U.S. Department of Health and Human Services. Available at: https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/preface (Accessed: 1 July 2025).

National Records of Scotland (2023). *Drug-related deaths in Scotland in 2022*. Available at: https://www.nrscotland.gov.uk

Novak, S.P., Bluthenthal, R., Wenger, L., et al. (2014). Initiation of and retention in medication-assisted treatment among opioid-dependent adults. *Journal of Substance Abuse Treatment*, 47(4), pp.367–372.

Public Health Scotland (2023). *Substance Use and Drugs: National Statistics*. Available at: https://publichealthscotland.scot

Public Health Scotland (2023). *RADAR Quarterly Report – Q4 2023*. Available at: https://www.publichealthscotland.scot

Scottish Drugs Forum (SDF) (2022). *Making Recovery Real: Treatment Retention, Expectations and Outcomes*. Glasgow: Scottish Drugs Forum.

Scottish Government (2021). *Drug Deaths Taskforce: Final Report – Changing Lives*. Available at: https://www.gov.scot