

REAL POLICY COMES FROM REAL LIVES

ONE YEAR ON

From stabilisation to growth

Early addiction, interrupted development
and the support needed to build a life beyond addiction

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A policy follow-up to Real Policy Comes From Real Lives, July 2025

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A companion paper to the July 2025 analysis

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Executive Summary

In July 2025 I published *Real Policy Comes From Real Lives*. Its central argument was that recovery policy must do more than manage risk and stabilise substance use. It must help people see a future beyond addiction, grasp the support and opportunities needed to pursue it, and grow into a life that can sustain change. [1]

That argument was rooted in my own addiction and recovery, and in work alongside people in active and post addiction. Early substance use, interrupted emotional development, low expectations, deprivation, identity and belonging were connected parts of the argument. Community was important because it could provide somewhere to learn how to live, rather than somewhere simply to stop using.

This follow-up develops that argument against Scotland's 2026 policy framework. It places developmental support at the centre of recovery, updates the evidence and sets out practical tests of delivery. Its focus is how national commitments translate into support, opportunity and influence in people's lives.

The Scottish Government and COSLA published *Preventing Harm, Promoting Recovery* in March 2026. The plan acknowledges a gap between existing policy and implementation. [2] However, recovery communities, personal aspirations and participation were already part of *Rights, Respect and Recovery* in 2018. [3] The question is not whether Scotland has finally discovered recovery. It is why ambitions expressed over several years are still not reliably recognisable in people's lives.

Early addiction can interrupt the development of emotional, relational and practical capacities. Development may become uneven: some capacities grow through survival, while others receive little opportunity to develop. Longitudinal research identifies links between adolescent substance use, later coping patterns and adult substance use disorders. [4] Recovery policy must address these developmental pathways through individual assessment and sustained support. Arrested development describes interrupted capacities; it does not assign everyone a fixed emotional age.

This has practical consequences. A recovery pathway should help people develop emotional literacy, trust, communication, practical skills and meaningful responsibility where these are needed. Trauma-informed care should also be growth-informed. Recognising what happened to someone must lead to consideration of what they now need to learn, practise and become.

MAT can protect life, but it cannot define the destination of addiction policy. Across alcohol and other drugs as well as opioids, people need credible routes beyond dependence and sustained care as they build a life in recovery. For those taking opioid agonist medication, that includes a supported route towards reducing or ending it when they can, followed by continuing care. Some individuals will need medication for longer. The existence of that exception must not turn maintenance into the default ambition for everyone. [5, 6, 17]

Churches and Christian recovery organisations belong within this account of recovery infrastructure. Their contribution can include outreach, practical support, pastoral care, discipleship and enduring community. Policy should recognise that contribution in pathways, partnership and commissioning, with funding and accountability appropriate to the work undertaken.

The recommendations are therefore to fund sustained developmental and relational support; strengthen outreach and continuity; measure personal growth alongside clinical outcomes; invest in community infrastructure; and make influence over commissioning visible. Delivery should be

evaluated through sustained outcomes and the experiences of people receiving support.

The test of recovery policy cannot stop at what it prevents. It must also examine what it makes possible.

Core Premise

Recovery is not simply stabilisation or abstinence. It involves changes in self, story and surroundings. People need help to:

See a future beyond addiction.

Grasp that future through meaningful support.

Grow into new roles, relationships and identities.

For some, that includes recovering capacities and opportunities lost during addiction. For others, it includes developing things they never had a safe opportunity to learn. The distinction matters. We should not assume that everyone has a secure, capable earlier self to return to.

Dingle, Cruwys and Frings' qualitative study of 21 adults in a therapeutic community identified a related distinction. Some participants sought to restore valued identities lost during addiction; others aspired to build new identities through study, work or family roles. [21] This supports examining what a person is trying to recover or develop, rather than assuming a single pathway. It does not establish the causes of interrupted development.

C.S. Lewis's Meditation in a Toolshed distinguishes looking at a beam of light from looking along it. Neither view is inherently truer; each must be examined on its merits. [18] Addiction policy needs both ways of looking. Mortality and treatment data show patterns and risks. Accounts from people within addiction and recovery can reveal what a pathway made possible, or left untouched. A personal account cannot establish prevalence, and a retention figure cannot establish that someone has learned to live beyond addiction.

I write as pastor of Easterhouse Community Church, Head of Outreach at The Haven and a PhD researcher in theology through creative practice. My place within Scotland's recovery movement is shaped by Christian faith, my own recovery and work alongside people in active and post addiction. The questions in this paper arise within that work: how people are reached, what helps them change, and who stays alongside them as they build a different life.

This paper brings personal experience into dialogue with research and national policy. It examines what support people can access, what they are helped to develop and how commissioning sustains that work. National commitments provide the framework; local delivery and sustained outcomes provide the test.

01 Where Policy Still Fails to Reach

Recovery systems must reach people who are outside meaningful support. Access should not depend on someone already being ready, confident and able to navigate services. The 2025 paper placed outreach at the centre of that challenge; the current evidence adds urgency to continuity after contact. [1]

The latest PHS modelling provides the current basis for assessing opioid dependence and treatment reach, replacing the estimates used in the 2025 paper. It estimates 43,600 people aged 15–69 in 2023/24, with a 95% credible interval of 42,000 to 45,400. PHS estimates that

65% received opioid agonist therapy at least once during that year. These are modelled estimates; PHS cautions that they are not comparable with earlier reports. [7]

Neither the remainder nor the prescription figure tells us how many people had no support of any kind. Receiving a prescription at least once is also different from sustained treatment. Coverage reporting must distinguish initial contact, sustained treatment and access to wider support.

Known to Services and Still at Risk

PHS's report published in March 2026 covers deaths registered in 2021 and 2022. Its headline findings describe 2022: 65% had contact in the preceding six months with a service that had an opportunity to address drug use or reduce harm. This includes drug treatment, custody and hospital discharge. Forty-one per cent were prescribed opioid substitution therapy at death, and 60% lived alone all the time. [8]

These findings concern people who died. They cannot establish service coverage among everyone affected by addiction. Nor does contact with custody or hospital establish receipt of adequate addiction care. They do demonstrate that opportunities for intervention can exist before death.

Outreach and continuity must operate together: reaching people outside support and following through when somebody has already been encountered. Being recorded, being treated, being supported and being connected are different things.

From Access to Accompaniment

Fear, shame, geography, previous experiences and competing pressures can make engagement difficult. These possibilities must be explored with people, rather than attributed to every person who misses an appointment. Sometimes practical barriers explain more than lack of motivation.

The 2026 National Specification includes assertive outreach and initiatives to attract engagement. [9] Those commitments should be tested through what happens after the first conversation. Is there someone who helps make the connection, notices a missed handover and stays involved while trust develops?

In the first paper I described Ken Persaud's role in my own route into recovery. That encounter matters because I did not arrive with a fully formed recovery plan. Someone addressed me as a person worth helping before I could imagine a different life. That experience illustrates the practical value of accompaniment before someone can navigate a recovery pathway independently. [1]

Policy recommendations

1.1 Commission engagement and accompaniment before formal treatment begins, as well as support during treatment.

1.2 Agree named responsibility for transitions from custody, hospital and residential care into community support.

1.3 Record referral completion and continuity, rather than assuming that issuing a referral creates a pathway.

1.4 Examine barriers with people who disengage and preserve accessible routes back into support.

02 The Limits of MAT and the Meaning of Progression

Scotland's MAT standards chiefly address medication-based drug treatment, with opioid agonist treatment prominent in their implementation. This paper addresses addiction across substances, including alcohol and cocaine. The central policy ambition is a life beyond addiction, supported by relationships, emotional development and real opportunity. Opioid agonist medication may provide vital stability on that journey. It should not become the assumed destination simply because the system can measure prescriptions and retention more easily than growth.

Methadone and buprenorphine are evidence-based treatments. Sordo and colleagues' systematic review of 19 cohorts found lower all-cause and overdose mortality during treatment than outside it. The periods following treatment cessation carry particular risk. [5] Reduction or cessation therefore needs individual clinical planning, with care continuing afterwards. NICE calls for continued treatment, support and monitoring after opioid detoxification. [17] A risk at transition is an argument for better support through it.

Evidence that treatment reduces mortality does not answer every question about the life somebody is being supported to build. Retention is a measure of treatment, not a complete account of recovery. Services should ask whether a person has a real opportunity to move beyond dependence, develop relationships and purpose, and receive support after formal treatment ends.

The Standards Are Broader Than the Prescription

Scotland's MAT standards recognise psychological and social support alongside prescribing. Standard 6 includes psychological support and developing social networks. Other standards cover advocacy, social needs, mental health and trauma-informed care. [6]

The implementation challenge is whether the full standards translate into sustained opportunities for personal development, participation and recovery. What support is available alongside medication, through a planned reduction where appropriate, and after opioid agonist treatment ends? Can people access it, and does it address the goals they identify?

PHS's 2025/26 benchmarking summary reports 23 of 30 ADPs green or blue for standards 1, 2, 3 and 5, and 14 green or blue across standards 6–10. Revised criteria mean several scores are not directly comparable with earlier years. [10] These are implementation assessments, not direct measurements of personal transformation.

My Experience Beyond the Dosage

I was prescribed methadone twice. The second time I reduced from 80ml to 2ml. I followed the plan, but I was processed rather than helped to imagine and build a life beyond the prescription. I returned to heroin. The 2025 paper told that part of my story because a falling dose, on its own, was never the transformation I needed. [1]

Reducing my dose addressed one part of the problem. It did not provide the relationships, structure, emotional learning and purpose needed to live beyond addiction. That is why care must continue after prescribing ends.

I know people whose methadone treatment began in the 1990s and continues today. Some individuals may not be able to stop safely or may need treatment for the long term. That must be assessed with them. It should not become a reason to withhold a credible route beyond

medication from others, or to stop asking what progress and freedom might mean for each person.

Policy recommendations

2.1 Make a clinically supported route to reducing and ending opioid agonist medication available to people who can pursue it.

2.2 Fund care after medication ends, including relationships, emotional development, community and practical opportunity.

2.3 Examine whether the psychological and social elements of MAT are available in practice and connect people to support beyond treatment.

2.4 Provide continuing medication and wider support where reduction or cessation is not clinically appropriate for an individual.

03 The Developmental Cost of Early Addiction

Early addiction presents a developmental challenge with consequences across adult life. Substance use can become established during years in which a person is learning to manage feelings, sustain relationships and take increasing responsibility. The 2025 paper identified these interrupted opportunities as central to recovery; this follow-up develops their implications for assessment, support and commissioning. [1]

The practical concern is familiar in recovery work: an adult faces grief, conflict, rejection, disappointment or responsibility without a reliable repertoire of responses. Substance use may have become the response they know best. Removing or stabilising it does not automatically provide the missing alternatives.

There is a difference between telling someone what they should do and helping them develop the capacity to do it when life becomes difficult.

Arrested Development and Uneven Capacities

Arrested development describes emotional, relational or practical capacities whose development has been interrupted or constrained. Its policy significance lies in the support a person needs to develop those capacities. The age at which substance use began provides part of a developmental history; it cannot determine a person's present abilities or assign a single emotional age.

Development can be uneven. Somebody may have learned remarkable resourcefulness through surviving addiction while having limited experience of safe disagreement, trusting relationships or ordinary routines. Describing those needs should not erase their strengths or treat them as a child.

Assessment should identify the capacities a person has developed, those they want to strengthen and the circumstances in which supported learning can take place.

There is also no simple causal story. Difficulties can predate substance use; family circumstances, trauma, deprivation and education may shape both use and development. Substance use can begin through enjoyment, curiosity and belonging as well as relief. Not every first use is a disguised trauma response, and not every early user develops dependence.

What the Evidence Supports

Elam and colleagues followed 792 adolescents into adulthood. Their study examined substance use at ages 16–17, coping at later assessments and disorders at ages 26–27. It identified associations between adolescent polysubstance use, later aggressive, reactive and substance-based coping, and adult alcohol or substance use disorders. [4]

This longitudinal evidence supports examining coping as part of a developmental pathway. The associations do not establish a single cause or a uniform intervention. Applying the findings to Scottish recovery provision requires local evaluation.

The policy implication is clear: developmental needs should be assessed and addressed alongside immediate substance-related risk. Services need the capacity to support learning over time and to evaluate which approaches work for whom.

Learning to Live Without the Familiar Response

Emotional re-parenting, discussed in the 2025 paper, describes patient relational support with learning, trust and responsibility. In adult recovery, this work must rest on consent, respect, reliable boundaries and growing autonomy. The purpose is to strengthen a person's capacity to direct their own life. [1]

Someone may need help identifying a feeling before they can explain it. Someone else may need to practise remaining in a difficult conversation, asking for support, managing money or accepting correction without experiencing it as complete rejection. Support should respond to the needs identified with the person.

A programme can explain these skills. A supportive environment gives opportunities to practise them, encounter difficulty and try again. That is why ordinary life within recovery matters: shared tasks, keeping commitments, resolving disagreements, learning a routine and gradually taking responsibility.

The learning should continue alongside necessary treatment. People should not have to become abstinent before being offered support with development, nor should everyone be directed into residential care.

The Adult Consequences of an Early Beginning

Scotland's standards for young people, published in December 2025, explicitly cover people aged 25 and under. [11] Their existence matters. But developmental needs arising earlier do not necessarily disappear when someone enters an adult service.

A person in their forties may still need support with capacities they had limited opportunity to develop. The relevant questions are what they can do now, what they want to do, what gets in the way and where supported learning can occur. Chronological age alone cannot answer those questions.

Policy recommendations

3.1 Include developmental history, existing strengths and present learning needs in collaborative assessments.

3.2 Fund support with emotional literacy, communication, coping and practical life skills where needed.

3.3 Provide repeated opportunities to practise skills, rather than relying on information alone.

3.4 Maintain continuity across age-based service transitions and into adult recovery support.

3.5 Evaluate developmental approaches before claiming particular programmes produce particular outcomes.

04 From Clinical Metrics to Human Outcomes

Recovery involves the reconstruction of identity, a central argument of the 2025 paper. [1] Policy must ask what someone is recovering for, as well as what they are recovering from. The developmental argument makes this question practical: a new role can provide a reason to learn and somewhere to practise.

Becoming a parent, worker, student, neighbour or volunteer can change the demands a person faces and the support they need. Those roles are not rewards reserved for an ideal recovery story. They can be part of building one, at a pace appropriate to the person.

When I first entered The Haven, I was told, ‘You’re not an addict, you’re a student.’ I remember the force of being addressed as someone capable of learning. The words did not do the work of recovery on their own; the structure, relationships and responsibilities that followed mattered. But they opened a role beyond the one that had defined me. Best and colleagues describe recovery identity as socially negotiated through networks and meaningful activity. Their model helps interpret this experience without treating one person’s account as proof of an intervention’s effect. [19]

Best, Irving and Albertson’s conceptual paper links recovery and desistance through relational identity change and reintegration into communities. [12] This framework helps explain how relationships and community participation can contribute to identity change; the effectiveness of particular interventions requires evaluation.

What Gets Counted and What Gets Missed

Attendance, treatment retention and reduced risk matter. They should remain visible. But an appointment record cannot tell us whether someone is better able to manage conflict, has developed a trustworthy relationship or can imagine a worthwhile future.

Equally, a moving testimony cannot establish lasting outcomes or substitute for safe clinical care. Outcome assessment must capture both clinical protection and the wider changes people seek. We need information about protection, experience and change, with enough follow-up to avoid mistaking a promising moment for a sustained result.

The National Specification includes individual care plans and recovery goals alongside clinical and non-clinical support. [9] This creates a basis for asking how goals are reviewed and whether the person recognises them as their own.

Development as an Outcome

I propose that services examine changes in coping, communication, relationships, participation and practical responsibility where these are relevant to the individual. These are proposed domains, not a validated scale. Existing instruments should be reviewed before developing another form.

Bunaciu and colleagues’ systematic review examined 69 studies and identified ten recovery capital questionnaires. These assess the resources and barriers involved in recovery, including aspects of relationships, meaningful activity and everyday functioning. The review also identifies

a need for stronger validation across different populations and settings. [23] Commissioners should select measures appropriate to the people and provision being assessed, alongside discussion of the goals people identify themselves.

The same goal may mean different things. Paid work may be appropriate for one person; rebuilding a daily routine may be a substantial achievement for another. A family relationship may be unsafe to restore. Spiritual wellbeing matters to some people, while others do not want faith included in their support.

Progress must not become a new compliance test. Its purpose is to identify whether support is making a difference and what should change when it is not.

Policy recommendations

4.1 Review person-defined goals alongside clinical outcomes, using appropriate validated measures where available.

4.2 Include changes in capacities and opportunities, not only numbers of interventions delivered.

4.3 Distinguish immediate improvement from sustained change through proportionate follow-up.

4.4 Avoid targets that penalise services for supporting people with greater or longer-term needs.

05 Deprivation as Root Cause and Reinforcer

Deprivation belongs at the centre of addiction policy. The latest evidence strengthens the case for place-based action, while individual assessment remains necessary to understand each person's circumstances.

NRS reported 1,133 drug use deaths registered in 2025, 116 more than in 2024. The age-standardised rate rose from 19.1 to 21.4 per 100,000; NRS reports that this difference was not statistically significant. The most deprived fifth of areas had a rate 15 times that of the least deprived fifth. [13]

These deaths precede publication of the March 2026 strategy and cannot be used as its outcome evaluation. They establish the severity of the situation it must address.

Opportunity Is Unevenly Distributed

Emotional learning is not separate from material conditions. It is difficult to sustain a routine without secure accommodation, attend support without transport or manage money when income is inadequate. A person may be asked to develop new responses while remaining surrounded by the pressures that made change difficult.

Local work should examine how social expectations around toughness, silence and self-reliance affect engagement, alongside the practical barriers people face. Communities carrying substantial harm also contain solidarity, expertise and resources.

Recovery planning should ask what opportunities are actually available locally. Is there somewhere safe to spend time? Can someone learn, contribute and develop relationships outside drug use? What does it cost to reach those opportunities?

A Wider Circle Must Be Reachable

The 2026 strategy places housing, employment and other wider needs within its Wider Circle of Support. [14] The policy test is whether someone receives coordinated help across these areas, rather than a list of separate organisations.

Poverty is not a coping deficit. Housing insecurity is not resolved by improving motivation. A growth-informed approach must support capacities while addressing the conditions in which those capacities are expected to work.

Policy recommendations

5.1 Align recovery provision with housing, income, education and employability support.

5.2 Fund accessible local opportunities in communities carrying greater harm.

5.3 Address transport and practical participation costs within pathway planning.

5.4 Examine both individual change and whether the surrounding environment supports it.

06 Systems That Expect People to Fail

Low expectations can narrow recovery pathways before people have the opportunity to develop. The 2025 paper challenged a culture in which managing risk becomes the organising purpose of support. [1] The practical test is whether services sustain ambition alongside protection and continuity.

The narrowing can begin well before treatment. In my school years, I often felt that my postcode and accent told adults what to expect of me before I had a chance to speak. That is my account, not a claim about every school. Link and Phelan describe stigma as involving labels, stereotypes and status loss in a setting where power is exercised. [20] A recovery system should examine the expectations it places on people as carefully as it examines their risks.

Preparation for relapse is necessary. It should not communicate that a worthwhile life is beyond reach. Long-term support is valuable. It should not imply that a person can only ever be a recipient of care. The difference lies in how support is offered and what opportunities remain open.

The 2018 strategy already placed personal aspirations within recovery. [3] The concern is whether those aspirations shape daily decisions: what staff discuss, what gets funded, what risks are supported and whether disappointment closes a pathway.

Trauma-Informed and Growth-Informed

Trauma-informed care should help staff recognise why trust, safety and choice matter. Care should also be growth-informed: it should consider the capacities someone wants to develop and the support needed to do so.

This does not mean demanding optimism or moving everyone towards the same destination. Someone in crisis may need protection and continuity before taking on further responsibility. The point is to keep development possible, with the person's consent, rather than assume their present circumstances define their future.

Growth-informed support would ask about strengths, goals and learning needs; offer manageable opportunities; support setbacks; and review whether help is increasing autonomy or

unintentionally restricting it. Implementation should include evaluation of people's experiences, increasing autonomy and sustained outcomes.

Responsibility With Support

Recovery settings can go wrong in either direction. Expecting too much too quickly can overwhelm someone. Expecting nothing can deny them opportunities to discover competence. Responsibility should therefore be negotiated, supported and increased with experience.

Volunteering and peer work should not become unpaid substitutes for properly staffed services. Someone in recovery is not obliged to turn their experience into a job, disclose their history or help others as proof of progress. Contribution should expand choice.

Policy recommendations

- 6.1 Examine whether care reviews discuss a desired life as well as immediate risks.
- 6.2 Train and supervise staff in supporting autonomy, learning and realistic aspirations.
- 6.3 Offer supported responsibility with clear boundaries and routes back after setbacks.
- 6.4 Evaluate growth-informed practice through people's experiences and sustained outcomes.

07 Helping People See Grasp and Grow

I have argued for years that we must change the narrative around addiction. The 2025 paper set out a progression from seeing a possible future, to grasping the means to pursue it, to growing into a life able to sustain change. Those are distinct tasks for policy, and all three require visible examples and practical support. [1]

See Making Hope Visible

Some people encounter recovery first through somebody they recognise: a person from a similar place, with a comparable history, now living differently. That encounter may make an alternative imaginable. Visible recovery should be celebrated and made accessible, not hidden on the assumption that it will shame people who are still in addiction.

In my work I encounter senior statutory staff who are wary of saying the wrong thing when recovery is celebrated. The suggestion that celebrating recovery inherently stigmatises people still in addiction confuses visibility with judgement. Scotland's 2026 strategy itself recognises recovery communities as a way to tackle stigma and show that recovery is possible and valued. [16]

Policy should celebrate people who show what changed and fund the routes that helped them. People still in addiction deserve dignity and an invitation into those opportunities. Recovery stories can include difficulties, ongoing learning and the support that helped between crisis and the present.

Visible recovery should not require someone to retell their worst experiences for publicity. In my early rehabilitation I had time to learn within a community before I was invited into outreach. That timing mattered in my case; it is not a timetable to impose on others. People should decide whether, when and how to tell their stories. Celebration can show present relationships, skills and contribution as well as the crisis from which someone came.

Grasp Making the Future Achievable

This is where the developmental argument belongs most visibly. A person needs a route, but may also need help using it. That can include learning to ask for support, communicating difficulties, managing a routine or tolerating a setback without abandoning the whole attempt.

The system should offer practical opportunities alongside those skills: treatment, education, housing, relationships, rehabilitation where chosen, and community participation. Advice about confidence is insufficient when the opportunity itself is missing.

The route should make clear who will help, what can be accessed, how long support can continue and what happens when the first arrangement does not work.

Grow Becoming More Than a Service Recipient

Growth becomes visible when someone has greater choice, develops relationships and takes part in life in ways that matter to them. Their addiction history need not disappear. It need not organise every role they occupy.

The person receiving support today may later help someone else, but that is one possibility among many. Their recovery remains valuable if it takes place quietly, outside public testimony or professional recovery work.

Policy recommendations

- 7.1 Link visible recovery to accessible opportunities, rather than ending with inspiration.
- 7.2 Include supported learning and practical accompaniment within pathways.
- 7.3 Review how opportunities expand over time and where people remain blocked.
- 7.4 Preserve individual choice about disclosure, contribution and the meaning of recovery.

08 Community as Core Infrastructure

Community matters because it can hold recovery within ordinary life. The developmental argument explains part of its value: people need somewhere to practise different ways of relating and taking responsibility, not simply somewhere to receive information about them.

A reliable group, hub, church or peer network can provide repeated contact, shared activity and opportunities to be known. Commissioning should support these relational mechanisms and evaluate the safety, quality and effectiveness of provision.

Laudet and White followed 312 people in recovery in New York over a year. Their measures of recovery capital included social support, life meaning, spirituality and engagement with mutual aid. Greater resources at baseline helped predict subsequent recovery, life satisfaction and stress outcomes. [22] This observational study strengthens the case for assessing support beyond the treatment episode; it does not establish the effectiveness of a particular community programme or funding model.

Faith and My Own Recovery

I entered Teen Challenge in May 1997. Faith was central to what followed. I believe Jesus Christ changed my life. Christian community, discipleship, routine, responsibility and relationships gave substance to a future I had not been able to picture.

The original paper described the Group Studies for New Christians and Personal Studies as part of that process. Their significance in my account was learning through a structured way of life, with pastoral support as difficulties emerged. My experience illustrates how structured learning and sustained relationships became part of building a different life. [1]

Faith-based organisations should remain recognisably themselves, while being accountable for safeguarding, informed choice and respectful practice. People should have appropriate alternatives and should not face coercion to adopt beliefs. Clinical needs still require qualified care.

The Church Within Scotland's Recovery Movement

My concern with the church's role comes from the work I do now as well as the community through which I recovered. At Easterhouse Community Church, our partnership with Street Connect places the church within local outreach and recovery support. My work at The Haven connects Christian recovery provision with churches and community hubs. These are the settings from which I ask what Scotland's recovery pathways make possible.

A church can be somewhere a person is known over years: during active addiction, through treatment and while learning to live differently afterwards. Shared meals, pastoral conversations, practical help, worship, discipleship and opportunities to serve can become part of ordinary life. Someone can arrive needing support and gradually take responsibility within the same community. That continuity gives substance to the developmental argument in this paper.

For a Christian church, this work grows from faith in Jesus Christ and a calling to love our neighbours. In my own recovery, Christian discipleship gave direction to the changes I was learning to make. Churches should be able to explain that conviction honestly when describing their contribution. People approaching support should understand what is offered and have freedom over their participation.

The church's contribution needs to be connected to the wider pathway. Local partnerships should establish how outreach leads to appropriate treatment, how churches and recovery organisations support people during transitions, and where someone can belong after a programme ends. Clear referral arrangements, trained volunteers and communication with qualified services can help make those connections reliable.

I argue that churches and Christian recovery organisations should have a recognised place in Scotland's recovery partnerships, including opportunities to shape local priorities and seek funding for the support they deliver. Their spaces, relationships and volunteer commitment have costs: coordination, training, safeguarding, supervision and sustained access. Those costs should be considered in commissioning alongside the quality and outcomes of the provision.

This is a practical contribution to examine, with each organisation accountable for what it offers. My own story explains why I take faith and church seriously; claims about a particular service's effectiveness require evidence from that service. Recovery partnerships should make room for the contribution while applying clear expectations of safety, informed choice and quality.

Community in the Strategy and in the Budget

The 2026 plan recognises community support and promises multi-year funding for local organisations through a refreshed fund. [15] Delivery must now be made visible through local allocations, funding duration and the capacity sustained.

A published account of ADP spending is needed to assess delivery: allocations, recipients, contract lengths, core-cost coverage and the proportion supporting sustained relational and

developmental work. The scale and sufficiency of investment should be judged against that evidence.

A time-limited grant can fund activities without securing the relationships around them. Where continuity is part of the intervention, commissioning should examine how staff, volunteers and spaces are sustained.

Policy recommendations

8.1 Publish accessible commissioning information, including funding duration and purpose.

8.2 Fund core costs, training, supervision and continuity where community organisations form part of pathways.

8.3 Use proportionate reporting that examines quality and sustained participation alongside reach.

8.4 Support plural routes while applying safeguarding and accountability expectations to all providers.

8.5 Include churches and Christian recovery organisations in local pathway planning and provide transparent opportunities to influence recovery priorities.

8.6 Make funding accessible for their demonstrable recovery work, including coordination, training, safeguarding and continuity, with proportionate outcome evaluation.

09 Consulted but Who Decides

I remain uncomfortable with the phrase lived experience. I use it when discussing official policy because it is the terminology being examined. My concern is what authority people actually hold, not whether the preferred phrase appears in a strategy.

Lewis's distinction has a consequence for who shapes policy. People who have been inside the services under review should be able to challenge what is measured and what counts as success, while their proposals remain open to the same scrutiny as other evidence. [18]

The first paper called for paid, empowered roles in shaping strategy, allocating resources and evaluating outcomes. Consultation is useful, but it does not establish that these responsibilities have been shared. [1]

Tokenisation occurs when an institution wants an account of harm but has little interest in the person's judgement, skills or role in deciding what follows. A recovery story can be valuable when freely offered. It should not be the entry fee for influence. People affected by addiction also bring knowledge from family life, work, community leadership and professional practice; their past experience is one part of what they can contribute.

The Promise Predates This Strategy

The 2018 strategy already discussed handing over power to people with personal experience. [3] The proper test in 2026 is therefore what changed as a result: which decisions, which resources and which accountability arrangements?

People can be invited to speak while having little influence over the priorities already chosen. Conversely, influence can sometimes exist without a formal voting role. We should examine the decision process, rather than assume either tokenism or meaningful power from attendance

alone.

Following the Decisions

Local systems should make it possible to trace how priorities are set, who participates in commissioning, how recommendations are answered and what happens when communities disagree with a proposed direction.

Paid participation recognises expertise and reduces barriers, but payment alone does not confer authority. Decision-making roles also need information, preparation, accessibility and clear responsibilities. Participants must be able to challenge a proposal without fearing loss of support.

There is no single recovery voice. People using medication, pursuing abstinence, living with ongoing difficulties or supporting family members can identify different priorities. Representation should not reward only those whose stories fit the institution's preferred narrative.

Policy recommendations

9.1 Publish how participation changes specific priorities, commissioning decisions and outcome measures.

9.2 Resource meaningful involvement with payment, preparation and accessible information.

9.3 Explain where decision-making authority sits and how community representatives can challenge decisions.

9.4 Report responses to recommendations, including reasons for rejection or amendment.

10 From Survival Management to Transformation Policy

The 2025 paper's central challenge remains: keeping people alive is essential, but policy should also support the lives they want to build. The follow-up strengthens that argument by reconnecting treatment, development, identity, opportunity and community.

The 2026 framework provides a basis for turning established recovery ambitions into accountable delivery. Updated prevalence modelling strengthens the assessment of reach; the developmental analysis identifies support needs beyond stabilisation; and the full MAT standards establish expectations for psychological and social provision. These elements should be brought together in commissioning, care planning and outcome review.

Protection and Progression

The drug environment still demands urgent protection. In 2025, opioids were implicated in 78% of drug use deaths, cocaine in 52% and nitazenes in 22%; categories overlap. NRS warns that changes in nitazene testing limit comparisons over time. [13]

These risks strengthen the need for harm reduction and appropriate treatment. They also make the work of sustaining relationships and credible pathways more urgent. Developmental support should accompany protection, not be postponed indefinitely behind it.

What Delivery Would Look Like

The implementation test should be concrete. A person should be able to identify their support, describe goals they recognise as their own, access opportunities for learning and participation, and experience continuity through transitions.

Commissioners should be able to explain how those opportunities are funded, how outcomes are reviewed and how people affected by addiction influence decisions. The following questions translate the argument into proposed areas for scrutiny.

Policy concern	Question for local delivery
Reach and continuity	Who remains outside support, and who follows through after referral or discharge?
Development	What strengths and learning needs are identified, and where can skills be practised?
Treatment choice	Can people pursue their own goals with appropriate clinical support and alternatives?
Identity and opportunity	What relationships, roles and opportunities become accessible over time?
Community infrastructure	What funding sustains local spaces, people and continuity?
Decision-making power	Which decisions changed through the influence of people affected by addiction?

Final Reflection

When addiction begins early, recovery may involve learning things that others had years to practise. When it continues for decades, the need for growth does not become less important. Across substances, a life beyond addiction must remain a visible and practical possibility. For those leaving opioid agonist treatment, care must continue after the prescription ends.

We need systems that can hold those realities together. Systems that recognise strengths as well as difficulties. Systems that fund patient learning and ordinary opportunity. Systems where community is sustained and people's experience has influence over what happens next.

The language is already there in many places. The task is to make the support, resource and authority correspond to it.

Help people see a different future. Make it possible to grasp. Stay involved while they learn to grow into it.

Real policy still comes from real lives.

Real policy must eventually become real life.

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