Connections built and broken: the ontologies of relapse

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Introduction

Deleuzo-Guattarian methodologies and systems of thought have contributed to the unfolding of drug-related realities and practices as not fixed, but fluid and emergent (Bøhling 2014, 2015, 2017, Dennis 2016, Dilkes-Frayne 2014, Dilkes-Frayne and Duff 2017, Duff 2014a, Duff 2014b, Farrugia 2015, Fitzgerald 1998, 2010, Malins 2004, 2017). The deployment of the writings of Deleuze by researchers of AOD has informed our thinking with context (Bøhling 2014, Duff 2014a, Duff 2014b), the understanding of desire and pleasure as affect (Bøhling 2017, Fitzgerald 1998, 2010, Malins 2017), the transformations and striations of the drug assemblage (Malins 2004), and the exploration of drug use as an event (Dennis 2016, Dilkes-Frayne 2014). Deleuzian thinking has also attracted the interest of critical psychology (Annual Review of Critical Psychology 2018, issue 14) and the sociology of health and illness, especially in the exploration of recovery from mental illness (Duff 2014a, McLeod 2017). Little attention has been paid though (Oksanen 2013) in the ways that the Deleuzo-Guattarian thought can expand our empirical research of recovery from AOD. In what follows I explore this field by rethinking relapse as the outcome of connections built and broken, emerging within the time and space of recovery from AOD.

There is not one way to define 'recovery', the services that provide it and the practices associated with it. Recovery has been deployed to account for various different relations between a person and a substance. People on opioid prescriptions, those in detoxification clinics and residential rehabilitation centres, as well as former users abstaining from illicit and prescribed drugs for specified or unspecified periods of time, are talked about as recovering subjects (Frank 2018, Nettleton, Neale and Pickering 2013). Furthermore, several research studies have contributed to the understanding of how the recovery subject is produced through its engagement with treatment services (Dahl 2015, Fomiatti, Moore and Fraser 2019, Hughes

2007, McIntosh and McKeganey 2000). I am interested in the becoming of the recovering subject *with* treatment services and practices.

Studies on the ontopolitics of AOD have empirically argued that substances are not singular objects with a stable essence but produced in practice and entangled with site-specific implementation practices (Rhodes et al. 2019). Bodies consuming drugs are in a constant state of flux, always in the process of becoming in drug-body-world relations (Dennis 2019). Drawing on this body of research, I shift my attention from the substance to the service, to situate relapse in relation to site-specific treatment contexts. By moving from the ontologies of drugs to ontological practices of care emerging within spaces of recovery, my aim is to imagine recovery as a force that resists the regulation of drug using bodies, and fights instead for the enhancement of their capacity to act.

The focus of this paper is on the *process of recovery*, a process initiated when a body's desire is either blocked or not addressed through their encounters with substances. Engagement with treatment services signifies the beginning of a novel connection that enables the renegotiation of the relationship between a body and a substance. Drawing on the Deleuzo-Guattarian concept of the assemblage (Deleuze and Guattari 2004, DeLanda 2016), and on its deployment by posthumanist analyses of health and illness (Andrews and Duff 2019, Duff 2014a, McLeod 2017), I mobilise the term *recovering assemblage* in order to make a distinction between recovery as a time-limited and specific encounter with a service, and recovery as a state of becoming. The *recovering assemblage* entails all the encounters of a body before, during and after its engagement with a specific recovery service. These might include experiences of harm reduction practices, short periods of voluntary or involuntary abstinence from substances, short-lived encounters with recovery services, rejection of or interest in their practices, re-engagement with the same recovery services and engagement with other services. In other words, the recovering assemblage entails different temporalities: the harm reduction time, the recovery time, as well as the relapse time. Drawing on Deleuze's philosophy of temporality (1994), recovery is conceived not 'as a distinct process in and of

itself but rather a series of processes that come to generate different modalities of time' (Bristow 2018: 75). Bringing together the narratives of people in recovery with Deleuze's (1994) syntheses of time, 'relapse time' is addressed as an intrinsic part of the recovering assemblage, a constitutive element of the modifications, differences and repetitions (Deleuze 1994) that render new connections desirable and possible. I then move on to focus on space and repetition. Drawing on Garcia's analysis of the entanglement between historico-political spaces and chronicity, relapse is discussed as the outcome of the interrupted relationship between a subject and a recovery space. Finally, policy-making practices are addressed as forces that have the power to interrupt or enhance the connections produced within the recovering assemblage.

Building connections between contexts

The data discussed in this paper were produced through my collaboration with two drug and alcohol recovery services: the Liverpool-based Genie in the Gutter[1] and the Athens-based 18 ano[2]. In what follows I briefly discuss the policy contexts of Greece and the UK, and the methods deployed in my engagement with the two fieldsites.

In Greece, the 'problem' of drug use was abruptly produced by the press as 'a major social issue' in the middle of the 1980's (Tsili 1995). Since then, the birth and evolution of treatment services has been defined by: a) the very low rate of HIV positive drug users up until 2012 (Nikolopoulos et al. 2015), leaving harm reduction practices unexplored until the middle of the 2000's, and b) the lack of governmental interventions on the treatment and recovery models applied (Fotopoulou and Parkes, 2017, Kokkevi et al. 2000). Despite the state's punitive approach to drug use and possession, the provision of drug treatment has never been heavily regulated (Tragakes and Polyzos 1998), leaving space for the main public drug recovery

[1] Genie from now on

[2] Both Genie and 18 ano consented to be named, and were keen on their recovery practices being widely communicated.

programmes, still active today, to develop their own therapeutic approaches, while maintaining their public funding.

This lack however of direct political intervention to the way drug treatment is provided does not automatically signify the absence of any sort of regulation. With the Ministry of Health being either the main or the only source of funding, public recovery programmes are administratively dependent on the state and constantly under the threat of financial drought. It is through bureaucratic mechanisms and administrative processes that the control of drug services is achieved. Liberty to develop therapeutic practices on the one hand, and lack of financial flexibility and bureaucratisation on the other, traverse the history of the drug recovery centre 18 ano. The service was born as part of, and administratively still belongs to, the Psychiatric Hospital of Attica. In 1972 it was relocated to the upper floor of the building 18 of the hospital, where the name of 18 ano comes from ('ano' [άνω] in Greek means 'upper'). The recovery principles of the programme, as they still stand today, were set in 1987, when its employees decided to render treatment voluntary, and stopped accepting mandatory admissions following court orders. Since then psychotherapy and art therapy constitute the programme's primary treatment approaches.

Conversely, central drug policies have played a pivotal role in the evolution of the provision of drug treatment in the UK. Although both recovery and harm reduction practices were originally developed as grassroots initiatives (see for example Yates 1992 for the first years of the Lifeline project and McDermott 2005 for the birth of harm reduction in Merseyside), long-term funding would only be secured through the adaptation of their practices to the demands of official drug policies. Genie belongs to this category of services that developed as a response to un-met needs of the drug using population. Established in 2008, its focus was on the provision of holistic support to people taking their first steps in the recovery process. The service's original aim was to break the polarisation between recovering and active drug users. This initiative was supported by the Liverpool Council through the provision of stable funding for 8 years. However, following directions coming from the central government, Genie, along

with other small-scale providers in the wider area of Merseyside, lost its public funding in 2016. Inevitably this signified changes in the daily operation of the service, including the range of the support offered to service-users, the inability of the service to keep maintaining the same number of paid members of staff, and a shift in the responsibilities of those that kept working in the service. Following three years of applications to various funders, in August 2019, having exhausted all potential sources of funding, Genie had to close its doors.

18 ano and Genie are two recovery services becoming in fundamentally different policy contexts. Although they both constitute grassroots initiatives, the drug users' needs they have attempted to meet, and the policy structures they have been called to navigate differ significantly. This differentiation is reflected on the production and organisation of time and space through the structure and treatment practices of the two services.

18 ano is a two-year long recovery programme structured in three stages. During the first stage service-users are supported in their attempt to maintain abstinence from drugs and alcohol. Once this has been achieved, they move on to the second stage which is residential and lasts for seven months. One to one and group psychotherapy, as well as art groups are the main activities they engage with. The last stage is called 'social reintegration' and lasts for approximately one year, supporting service-users to develop connections with the community.

Genie was a drug and alcohol recovery-focused daily service, located in Liverpool city centre. The service-users were not expected to maintain abstinence but to present in a state that they were able to participate in group discussions, and to show a certain level of commitment towards recovery – meaning that they were expected to manage and/or gradually reduce their drug and alcohol intake. The programme did not have a specific duration and service-users could remain involved with the service for as long as they felt the need to.

The differences between the two services extend to the treatment approaches they practise. 18 ano is based on discursive psychotherapy, and the aim of the programme is to accompany service-users in the exploration of the roots and causes behind their drug use. Genie was

primarily focused on the ‘here and now’ of its service-users’ needs. The emphasis was on supporting them to build coping mechanisms to deal with triggers, and to provide for them a safe and welcoming environment where they could spend their day away from drugs and alcohol, while socialising and developing new skills.

Through my empirical engagement with these two recovery services my aim has been to produce space-specific research by taking the particularities of each site into consideration, and simultaneously to establish connections between the filedsites that go beyond specific territorialities. My initial connection with both services was established through volunteering for a period of four months. Unlike ethnographic research, where involvement with services is primarily a way into participants’ lives (Garcia 2010, Zigon 2011), in empirical sociological studies the engagement with treatment providers as a paid or unpaid member of staff complicates the researcher’s positionality. Switching between volunteer’s and researcher’s role includes different responsibilities (Dennis 2019: 44-45), and the knowledge produced is an amalgam of the connections that the researcher builds through multiple attributions (Knight 2015). Building connections through research practices works towards the creation of an ‘*assemblage of relations*, drawing together diverse experiences of space and spatialisation; embodiments and becoming; conduct and social practices (Duff 2007: 504, emphasis in original). Following this line of thought, *the context of fieldwork* refers to the researcher’s experience of space, embodiment and practice (Duff 2007: 507) becoming with, and as part of the assemblage of recovery. Such an understanding of context, and the positioning of the researcher in it, renders the ‘matter and space [of research] continuously evolving and becoming’ (Duff, 2014a: 129), affective to and affected by the connections in place, and the ones becoming with the research assemblage. In what follows I account for the interview event becoming in each fieldsite, and for the connections established between these space-specific practices, through a Deleuzo-Guattarian reading of the data produced.

In Athens, I interviewed in total 15 service-users, 6 women and 9 men, from the ages of 25 to 45 who had been using drugs for 7 to 35 years. With the exception of one participant whose

drug of choice was benzodiazepines, all others reported heroin as the primary substance of use. Apart from heroin being their preferable substance, the majority of the participants considered themselves poly-drug users of various substances including cocaine, sisa[3], cannabis, benzodiazepines, and alcohol. Interviews took place *outside* the participants' structured recovery daily programme. As attendance to psychotherapeutic and art groups taking place at various locations in the city is compulsory for service-users, interviews were conducted at times that did not coincide with any therapeutic activities. Although I would always make the effort to arrange interviews at times and places primarily convenient for interviewees, the time spent for the interview was part of their *personal* rather than their *recovery time*. The space thus created for the interview event was somewhere in-between the recovery and the personal space, leading to the production of connections different to the ones service-users and myself had built through structured recovery activities.

In Genie, I interviewed in total 11 service-users, 8 men and 3 women, from the ages of 31 to 71 who had been using substances for 2 to 49 years. For most of them the substances of choice were alcohol, cocaine and cannabis. Only two participants named heroin and other opioids as their drug of choice. Apart from the participants identifying as alcoholics (6), the others reported poly-drug use. The connections created with service users of Genie differed significantly from the ones built with the service-users of 18 ano. Genie was a day centre with specific opening days and times. The service-users were welcome to spend the whole day there (9am-5pm) even if they were not willing to attend all activities and groups taking place throughout the day. As a result, my interviews with participants were scheduled to take place on week days between 9am and 5pm, *within* the recovery space and time. In that sense, the commitment required from their part – in terms of the structure of their day, not in relation to their emotional commitment to the project – was not additional, but part of their commitment

[3] Sisa is a psychoactive drug from Greece, also known as the 'austerity drug' as it first appeared during the years of the financial crisis and is cheaper than any other illicit drug. Its main ingredient is crystal methamphetamine filled with battery acid or engine oil (https://www.talkingdrugs.org/sisa-the-drug-of-the-poor).

to attend the service at a specific day. Therefore, unlike my experience at 18 ano where the interview space created, shifted the nature of my connection with the participants, at Genie the interview space would be better described as an extension of the recovery space.

Besides the differences of the spatial and temporal realities produced in the two recovery spaces discussed above, there are meaningful connections emerging through the stories told, and it is by following a Deleuzo-Guattarian way of thinking that I attempt to render these connections visible. Although the participants' experiences of recovery between the two fieldsites as well as within each service vary, the desire of becoming-other and expanding life possibilities traverses all accounts. In both fieldsites, there are forces – like policy-making practices and restrictive social environments – blocking desire from flowing beyond the recovery assemblage. By following the flows of desire through service-users' accounts, it is not comparable experiences, but shared struggles transcending specific temporalities and territorialities, positioned at the centre of attention. The aim is not the production of homogenising, all-encompassing narratives to be applied to all recovery spaces, but the establishment of relations between heterogeneous parts (DeLanda 2016: 2), bringing and holding the recovery assemblage together. While maintaining the participants' lived experiences as the main source of knowledge production, deploying a Deleuzo-Guattarian methodology has enabled me to follow the non-linear, complex threads of their desires. The stories emerging through the interview event are not treated as narratives of individual lives but as shared experiences of the transformations of the using and recovering body, when connected with other bodies, objects and spaces (Duff 2007: 515).

Relapse and the desire for connection

'Lapses, parapraxes and symptoms are like birds that strike their beaks against the window. It is not a question of interpreting them. It is a question instead of identifying their trajectory to see if they can serve as indicators of new universes or reference capable of acquiring a consistency sufficient for turning a situation upside down' (Guattari quoted in Deleuze 1997: 63-64).

In *Difference and Repetition*, Deleuze (1994) produces an ontology of time and memory through three interrelated and interactive syntheses of time. The first one is the passive synthesis of the living present, where 'through contraction, past events and future possibilities become actualised in the present moment' (Bristow 2018: 75). The past, present and future are conceptualised through *repetition*, the experience of expectancy produced by things that happened 'before', leading to expectations about the processes of the future (ibid.). The second synthesis, the passive synthesis of the pure past, accords to *memory* and how it informs present temporal processes, while the last one, the static synthesis of the future, is able to create a *difference*, 'to impact upon the present and the past by remaining open' (ibid: 76-77). By following accounts of people in recovery with Deleuze's conceptualisation of time, I explore how the connections built in the recovery space allow for an understanding of the repetition of relapse and its memory as a process that renders *different becomings* possible, 'offering practical insights into the [recovering] subject's emergence' (Duff and Price-Robertson 2018: 98).

The accounts of recovery discussed in this paper demonstrate the impossibility of the production of a linear disposition from drug using to recovery time. The participants' responses to questions about their initial engagement with recovery-services reflect the simultaneous existence of various syntheses of time. The repetition of drug use is interrupted by encounters with recovery-services, and in turn engagements with recovery are interrupted by the memory of drug use. The repetition of drug use re-emerges but the memory of recovery shifts the way drugs are used in the present. This complex interrelation between temporalities reflects the complexity of desire; as explained by one of the participants the desire for drugs and the desire to become without drugs coexist and shape the experience of drug use *and* recovery:

'I've come to realise that all the years that I've been using [drugs], I've also been trying to quit'. (Athens)

The statement of the service-user above challenges systems of thought that simplify subjectivities by imagining a direct link between a body's desires and actions. Conversely, it

is indicative of the conflicts, contradictions and complexities that traverse a body's flows of desire. It also paves the way for the understanding of the recovering body not only as the one engaging with a specific service, but as a body that carries the desire of recovering, whether this is acted upon or not. Acknowledging the complexity of the recovering assemblage and the conflicting desires and temporalities that it entails, is fundamental if we are committed to shifting away from discourses of blame to the understanding of the recovering body as a modification (Deleuze 1994: 70), affective and affected by the assemblages that it encounters. In Deleuze's thinking with Hume, repetition does not block but enhances modification; it '*changes nothing in the object repeated, but does change something in the mind which contemplates it* (1994: 70, emphasis in original). Modifications are not outcomes of changes happening elsewhere. Service-users, in their accounts of engagement with recovery services, of the interruption of this engagement through relapse and their subsequent return to the same service, are not concerned with what the service does differently, but with how difference becomes possible through repetition:

'I didn't take their help straight away. Nor did I trust them straightaway. It was very hard for me, hence I came for a second time. I had lots of issues. One time was not enough'. (Athens)

This is a reflection of the body as a modification, an account of a first experience of the recovery encounter, discussed while re-engaging with the same service. The affective relations produced through a body's encounter with a recovery service differ, following its becomings. So while the service remains the same, repetition changes 'something in the mind that contemplates it' (Deleuze 1994: 70), enabling the becoming of affective relations that were not made possible through the first encounter. Time in this narrative is entangled with the production of difference. *One time was not enough*, says the service-user, rendering repetition essential for the becoming of a different contemplation of recovery. The fact that she *had lots of issues* does not come with an expectation from the service to address them all at once, but as an affirmation that it is through repetition that difference is produced.

Reading re-presentation as a failure of the users does not address the complexity of their desire of becoming other. Accordingly, blaming a service for not instantly producing 'recovered' bodies does not enable a closer look at the small gestures, the minor modifications that eventually rendered the second encounter – and potentially long lasting one – possible. It should thus be acknowledged that *all encounters between the service and the user matter*, and constitute components of an ongoing turning point that gradually enables connections between the using body and the recovering assemblage, opening up the way for a future deterritorialisation.

These connections are not always visible or straightforward and in many cases the service-users emphasised that they could not have talked 'back then' the way they talk 'now'. Staying with the difference becoming possible through repetition, in the following quote the service-user talks about her first, her 'back then' encounter with recovery while standing in the present, the 'here and now' of her second experience with the same service:

'When I called the first time I hadn't understood what they do. It was like, since I couldn't escape from the whole thing [referring to personal problems] through using [drugs] then I'd go there [to the recovery service]. And that's why I didn't stay. I freaked out. I was 22…This had to do with me, the situation I was in. I didn't go to quit [drugs]. [I wanted to] find another way to leave from what was going on at home, because the way I'd found [drug use] was killing me'. (Athens)

The interview takes place at a present time where the past and the future are dimensions of this present (Deleuze 1994: 76). While being in the present, the service-user recalls how the same space where she stands at the time of the interview '*freaked [her] out. [She] was 22, and that's why [she] didn't stay'*. The future is also a dimension of her present account, as the desire now is not to leave, but to stay and complete the programme. She recalls that her engagement with the service was not an outcome of her desire to stop using drugs, but the outcome of drugs failing to give her a *'way to leave from what was going on at home'*. Her first encounter with recovery is a story of her being wounded and trying to escape. Her subsequent

engagement with the service is about the contemplation of her scars, while standing inside the recovering assemblage. A scar is the sign not of a past wound but of ''the present fact of having been wounded'': we can say that it is the contemplation of the wound, that it contracts all the instants which separate us from it into a living present' (Deleuze 1994: 77). In the accounts shared in this empirical study, the participants contemplate the fact of having been wounded and imagine a future, while becoming with the recovering assemblage. They are not subjects emerging 'before time, or even contemporaneous with it, rather the subject is in and of time; a form of unfolding time and its divergent syntheses' (Duff and Price-Robertson 2018: 102). Interestingly, service-users do not understand the recovery spaces they engaged with as the providers of solutions to all problems. Recovery might be unable to provide the refuge that the wounded user is looking for, while occasionally '*one time is not enough'* in order to address all issues and heal all scars. The time of recovery constitutes a prolonged present where the contemplation of the past renders difference possible in the future.

Following this line of thought, the primary aim of recovery is not the provision of 'relapse prevention' and 'coping' tools, but the enhancement of the connections that render the contemplation of wounds possible, and the desire of becoming other stronger. By positioning the focus on the connections that become possible within the recovery space, healing becomes a socio-political rather than an individual process, 'accomplished less through personal therapeutics and processing of painful memories than through a small-scale, tentative restoration of ties of trust and support' (Biehl and Locke 2010: 334). It is thus in the recovering assemblage that a body's capacity to act (Deleuze 1988, Fox 2002) is both enhanced and protected, creating space and time for the contemplation of the past and an imagination of the future. It is this present becoming that renders possible the contemplation of past encounters and how these matter, either with the same service, as discussed earlier, or with different services, as talked about in what follows:

'But the thing with it was, it did help me, because it did actually put me on the rung to like, you know, the right path if you like, but there wasn't enough going on for me, I still had far too

much time, which you know for me was an absolute killer, the isolation, I needed to be involved. And I put this to him [keyworker] one day, and he suggested a few other organisations' (Liverpool)

'That was better, there was a lady there that, she was, she understood some of it, she'd had you know similar experiences, and she was actually from Norway, which is where my eldest daughter's from, and we engaged because we had contacts with, through Norway and that was something where you know her life and mine actually touched. So yeah, that was a little more personal and I was more interested in that, but I eventually slipped back into drink. After two, two and a half months or so' (Liverpool)

'I'd tried many times [to engage with recovery] but I wasn't ready, I didn't want to get into this when I was younger. Maybe in the back of my head I did but with every failed attempt I'd see I'm not ready…at the age of 35 I realised that I had to do something, that I was in danger and I would either live or die' (Athens)

In the accounts above, the service-users reflect on the encounters that slowly enabled their *present* connection with a service; they reflect on their experience of the recovering assemblage. These encounters take all kinds of different shapes and forms. They might have put someone on '*the right path'*, when *'right*' here stands for the support provided to the service-user to identify his needs and move on to another service ('*I needed to be involved. And I put this to him [keyworker] one day, and he suggested a few other organisations')*. For another service-user it was his encounter and connection with another person that enabled his first recovery experience ('*there was a lady there that, she was, she understood some of it, she'd had you know similar experiences')*, while in the third account, the service-user talks about the desire of recovery being somewhere at the back of her head, leading to 'failed' attempts until she felt ready to establish a longstanding connection with a service. Overall, the service-users share their experiences of 'testing the waters' of recovery, until the desire of becoming a service-user prevails over the desire of becoming a user. In their narratives the emphasis is on *time*, and encounters that get blocked or render other connections possible.

Thinking of re-presentation and engagement with various services as articulations of different encounters within the recovering assemblage, challenges discourses of blame. The body that re-presents at a service is always becoming, never the same as the one that approached the service for the first time. It is between these repetitions that difference lies (Deleuze 1994: 76) and recovery becomes possible.

Engaging with different services and experimenting with various ways of connecting until the encounter that unblocks a body's flow of desire is mobilised, is an essential component of the recovering assemblage. This was stressed out by all service-workers I interviewed, both in Athens and Liverpool. Although both services are recovery-focused, and thus their members of staff would be 'categorised' as advocates of recovery and abstinence, they all emphasised that all possible treatment approaches should be available to service-users, from purely harm reduction services to all different types of recovery. Accordingly, those categorised as harm reduction 'advocates' share the same views, as discussed during an interview with one of the members of the team that operated the first harm reduction service in Liverpool:

'*a lot of it is about making the person happier and safer as an individual so they can actually cope with either staying on methadone long term or coming off it eventually for reduction. So I think all harm reductionists believe that a range of options to come off should be available…it's highly complex and everybody is different so I think really it's flexibility and the ability of approaches that's important giving to people if you can afford it, a lot of different options for staying on methadone or harm reduction approach or coming off in different ways*'

The belief that all types of services and approaches should be available, expressed by all the workers that I encountered and who follow the (recovering) users' everyday realities, positions the question of temporality in the focus of attention: there is using time, harm reduction time, recovery time, and accordingly relapse time, all of them part of the recovering assemblage. These temporalities are not produced in isolation and do not linearly succeed one another. They are interrelated and interactive, and bring to the front the 'messiness' of recovery with its multiple and discontinuous temporalities. As accounted for by a service-user earlier in this

paper (*I've come to realise that all the years that I've been using [drugs], I've also been trying to quit')*, using time is not uninterrupted. It is traversed by complex desires, sometimes flowing and other times being blocked through drugs ('*[I wanted to] find another way to leave from what was going on at home, because the way I'd found [drug use] was killing me').* Harm reduction practices, and specifically the presence of harm reduction practitioners in drug using environments, further complicate drug using time by enabling connections that do not always involve substances:

'*You know what, I was feeling really nice when I was seeing them [harm reduction practitioners]…I think they had an influence on me. Seeing people standing on their feet, addressing the difficulties without becoming one with them, and they just ask you to try and they treat you like nobody has treated you before…It was also through them that I learned about 18 [ano], I can't remember exactly when but it stayed in my mind, and years later I called [at 18 ano]' (Athens)*

In this account harm reduction time disrupts drug use time through the production of connections that do not position the substance at the centre of attention. Recovery time is also present, not as a life-changing transition that abruptly interrupts the connection with a substance, but as a possibility, emerging through the influence that recovery practitioners had on the narrator, and leading to a phone call years later. While having this discussion, the service-user stands within recovery, accounting for how recovery time came to dominate her present. Her account is not linear, there is no clear transition from one temporality to another. Harm reduction time mingles with drug using time, producing recovery time as a possibility. It is through this complex coexistence of temporalities and the connections they enable that relapse time can be accounted for. In the same manner that the possibility of recovery is present in drug using time, recovery time is equally penetrated by the possibility of drug use. When thinking with time, relapse is not produced as a failure of the individual, but as an expression of the interrelation and conflict between temporalities.

Following this line of thought emphasises the necessity of existence of practices of care throughout all these different timings, and directly challenges the need for 'central drug policies' that attempt to control the using and recovering time, by prioritising certain treatment approaches over others. Focusing on the ontological practices of care collaboratively created, rather than the regulation of the way harm reduction and recovery is done, renders possible the enablement of potential turning points throughout one's encounter with a substance, encouraging a meaningful engagement with services that do not attempt to control using and recovering bodies, but to enhance their capacity to act.

Relapse and broken connections

Relapse and re-presentation to services has been addressed as a component of the recovering assemblage, when through the accounts of service-users it is discussed as part of a body's modification through its shifting encounters with one or various services. Following Deleuze's conceptualisation of temporality, 'relapse time' has been discussed as one of the temporalities of the recovering process. In what follows I argue that for relapse to be addressed in all its complexity, accounting for the connections produced is not enough; we also need to account for the connections broken. I do so by shifting my attention from time to space, drawing on Garcia's (2010) analysis of the entanglement between historico-political spaces and chronicity.

In her ethnography *The Pastoral Clinic: Addiction and Dispossession along the Rio Grande*, Garcia (2010) explores how New Mexico's landscape and addiction are shaped together, narrating a shared story of mourning and loss. Through this entanglement, 'institutional structures and claims are absorbed by the addict, exacerbating a sense of personal failure that contributes to a collective sense of hopelessness and, in turn, the regional heroin problem itself' (Garcia 2010: 8-9), unfolding the problem of 'chronicity' not as a medical one, but as a socio-political issue. Addressing Deleuze's question on the causality of drug use (2007) and whether its transformation from a vital experimentation into deadly dependence is inevitable, Garcia focuses on the context within which repetition is produced; the historico-political space

of Rio Grande where the outcome of repetition always remains the same and difference is always blocked from becoming. Garcia's subject is not unitary; it emerges in the flux of time, affects and relations (Duff and Price-Robertson 2018: 98). While in the accounts discussed earlier this emergence was becoming through modifications and novel connections that open up new possibilities for difference, in Rio Grande the (addicted) subject is trapped in repetition and broken connections, constituted by feelings of loss and mourning (Vitellone 2015: 383-384).

Rio Grande's historico-political space drives Garcia's analysis of the detoxification space where her participants' attempts to 'go clean' are trapped in repetition. Drawing on Garcia's emphasis on space, in what follows I return to relapse and the empirical accounts of service-users form Liverpool and Athens to discuss how the symbolic space of policy affects the connections built in the actual space of recovery. In the empirical accounts that follow it is policy that blocks the possibility of difference, by breaking the connections produced in the recovering assemblage. For Liverpool's service-users, relapse is the outcome of policy and systemic failures, deriving from the domination of a medical apparatus opting for short-lived and fragmentary interventions. Participants from Athens discuss relapse as a risk associated with the disengagement from the recovery space and the reengagement with a social reality in crisis. In both fieldsites participants reflect each other's' accounts through the association of relapse with socio-political contexts, rather than lack of individual determination.

Unlike the accounts discussed earlier, where the desire for connections was emerging, the following quotes highlight how the ontology of the recovering subjectivity is affected when the connections enabled through the recovering assemblage break, the body's becoming other is interrupted, and the desire of becoming a user re-emerges:

'I was only really being seen for a couple of weeks or something and then the support went. And then there was a couple of times I had breakdowns and the first time they ran tests in the hospital and stuff but again, I was discharged after a short while, I didn't you know stay in hospital at all. And then I went to the doctors with, again anxiety, depression kind of issues,

and I did the cognitive behavioural therapy, the talking therapy, but again that only lasted a couple of weeks. So there was nothing really long-term, structured or disciplined or anything like that until I got referred to [name of service]'. (Liverpool)

'I started engaging with services probably about twenty years ago and I was engaged with one and I didn't find it useful or the funding stopped or they closed down'. (Liverpool)

'At first, when I first started drinking, I was around twenty one, and that went on till like I was about twenty two, so it was about a year, and then I tried this rehab place…and I ended up doing that for eight months, a residential rehab. And then once I completed that, I came back to Liverpool and I, you know stayed like sober for a couple of months but because I'd made all like my connections there, I come back to Liverpool and then you know, I had no like friends or connections, so I picked up again and went out there for like another eight years on and off'. (Liverpool)

The first account discusses the engagement with different institutions for short periods of time, until '*the support went'*. It follows medical encounters at the hospital and with one's GP, and psychological encounters through CBT and talking therapy. All these encounters were interrupted ('*nothing really long-term, structured or disciplined'*), breaking the connections that would have potentially led to a different investment of the service-user's desire. This resonates with Gomart's criticism of specialists' apparatuses that, instead of acknowledging that the problem lies with them for failing to acknowledge relapse as a phenomenon in which they are supposed to intervene, they instead attribute relapse to the patient's difficulty to commit to a human relation with the therapist (2004: 91). The 'patient's' difficulty though discussed through this account is entangled with the way the medical space is produced. Following short medical and psychological interventions the 'patient' is discharged, considered recovered and his connection with a potentially recovering space is interrupted, blocking possibilities of difference.

Accordingly, in the second account, both ways of talking about relapse are addressed. Occasionally services were not found useful, but in other cases, *'the funding stopped or they closed down'*. Once more, the connections made possible appear to be unexpectedly interrupted, leaving the desire of becoming other un-addressed. The third account discusses the lack of after-care in the community, following the completion of a residential rehabilitation programme. Although the service-user managed to successfully attend and complete the programme, the connections created were interrupted when that ended, leaving him in isolation.

This interruption of connections is not only addressed by service-users but also by workers, and traverses different types of support services. In an interview with a social worker that manages a residential service for young people in London, the process of making connections that are interrupted due to the fact that residents are expected to 'move on' when they turn 18, was talked about as potentially responsible for young people's isolation in the community:

'*There are kids that stay with us [at the service] and have significant mental health or addiction issues, or comorbidity and if they could stay with us until the age of 20, with the relationship that we'd have developed with them and with the work being done, because an adolescent does not connect easily, at the age of 19-20 [they] might be able to connect with therapy, but when at the age of 18 this provision is cut and they tell them go live in a flat on your own and make your own connections with the services and the community because we have to save money, there you see that it is the financial management that defines the case management'*.

The experience of the social worker above demonstrates that although the desire for the development of encounters that can enhance a body's capacity to act is present from both workers and service-users, it is eventually blocked by the space of policy, through decisions that derive from financial imperatives, not taking into consideration the lived experiences of those that work at, and those that benefit from the specific service. The connection built between the worker and the service-user is interrupted when the latter turns 18 and has to 'move on', meaning to leave behind the connections enabled within a recovery space. 'Moving

on' from recovery to other spaces is also problematised by 18 ano's service-users.

In Garcia's (2010) ethnography, relapse is accounted for through the collective sense of hopelessness traversing the socio-political history of Rio Grande. In Greece, collective consciousness has been defined by the inability to find its place between the traditions that draw from the East, and the call for modernisation coming from the West (Triandafyllidou, Gropas and Kouki 2013). This ambiguity has generated a chronic distrust towards the state, public services and institutions, a distrust that reached its peak during the last decade's financial and social crisis. This social space of austerity and restricted options clashes with the protective space of recovery, producing an 'inside' and 'outside' regarded by some service-users as problematic:

'*If you want my opinion, one thing that I don't like about 18 [ano] is that it doesn't present realistically the 'outside'. The fact that in 18 [ano] we all love each other, we're all next to each other, when leaving [you realise that] it's an illusion and that's a shock to the system…It's not the same. There's solidarity and comradeship but only for as long as you're in 18 [ano]*' (Athens).

The problems associated with the disengagement from the recovery space and time are not unknown to the workers of services. The risk however of relapse and the return to drug using time extends beyond spaces of recovery. It is potentially not through shifting recovery practices, but through a problematisation of the spatial and temporal realities service-users have to reintegrate in, that the question of relapse should be explored:

'[service-users] finish the programme and they say fine, I'm recovered alright, is this how my life is going to be? So essentially they confront again the same problems, the same reasons they started using at first place'

In the statement above a therapist of 18 ano discusses chronicity as an entrapment in a vicious circle between drug using and recovering times. He addresses the lack of a temporality that follows recovery and differs from drug using time. There is therefore a shift of responsibility

from recovery services to social apparatuses. Unlike systems of thought that position the blame of relapse with services and their users, empirical accounts from Liverpool and Athens demonstrate how it is policies and social structures that fail to maintain and enhance the connections built in the recovery space. For UK-based service-users, policy-making time clashes with recovery time through the prioritisation of short-term recovery interventions. Accordingly, in Greece, service-users are expected to re-integrate in a crisis-stricken social reality defined by restrictions and relationships of exploitation. In both cases, the connections built within recovering assemblages are broken by a system defined by everyday practices of speed and intensity. 'Liberated' from their relationship with substances, the bodies considered 'recovered' are expected to become part of this system, even if, more than the substance, it is the speed of the world that makes them ill.

Conclusion

The opening quote to this paper challenges the production of relapse as an 'indicator of a pathological determination by a memorializing unconscious' (Biehl and Locke 2010: 332). Following a Deleuzo-Guattarian methodology, I have addressed it instead, through the accounts of people in recovery and service-workers, as an indicator of new universes capable of turning a situation upside down. Drawing on these words of Guattari, and following his image of lapses, parapraxes and symptoms as birds striking their beaks against the window, relapse is unfolded as an urgency for connections, a potentiality of new becomings (Biehl and Locke 2010: 332). I have followed this desire for connections and new becomings as they are enhanced and blocked inside and beyond the recovering assemblage.

Thinking relapse with Deleuze's (1994) syntheses of time contributes to the ontopolitical thinking of drugs, and specifically to the body of literature committed to the empirical de-pathologisation of drug using bodies and practices. Drawing on these studies, I shifted my empirical gaze from the connections produced between bodies and substances, to those enhanced in spaces of recovery. The aim has been to account for the different analytical routes that drug using and treatment temporalities open up, as these are explored from *within*

the recovery assemblage. The empirical accounts discussed in this paper are service-users' reflections on the fact of having been wounded in the past, while becoming with the recovery assemblage in the present. This reflection on scars, rather than open wounds, the distance between the time that one was wounded and the time that one talks about the fact of having been wounded, provides a novel understanding of the ruptures that accompany the recovery process. The coexistence of multiple temporalities in the service-users' accounts renders visible the connections, ruptures and repetitions that produce difference and expand life possibilities. The constitution of recovery as a 'success' or 'failure', based on the production of 'recovered' bodies is challenged through accounts that focus on how their becoming with recovery has been made possible *through* the ruptures and repetitions in their engagement with treatment services. Relapse is talked about as one such rupture; an expression of the ongoing coexistence and conflict between drug using time and recovery time.

Thinking of relapse as entangled with the recovering process, part of its temporality and an act of repetition that renders difference possible, challenges its pathologisation. Conversely, it is a testimony of the fact that all the recovering encounters matter, as they carry a desire for wellbeing, where wellbeing does not stand for a stable state of being, a final goal to be achieved, but a non-linear, complex process of becoming, entangled with illbeing and destratifications (McLeod 2017). Challenging narratives of recovery where the 'recovered' subject emerges as stable and fixed, I have demonstrated that it is small gestures, occasionally interrupted by relapses and re-negotiations with one's desire of becoming a service-user that establish long term, meaningful connections that enhance a body's capacity to act.

Relapse though has also been explored as the outcome of policy's failure to enable the longevity of the connections made possible in the recovering assemblage. When financial management is prioritised over case management, connections are broken and service-users are left in isolation, dislocated from the spaces of recovery where difference is becoming. In Liverpool it is through the forced interruption of services, and in Athens through a hostile social

environment that connections break. In both cases the recovery time is disrupted by forces external to the recovery space, and people are trapped in repetitions with similar outcomes. The space of policy is thus exposed as *disconnected* from the recovering realities of the subjects it is called to care for.

The need that arises is the re-connection of policy practices with the lived experiences of recovery, the practice of policy as a force focused on strengthening rather than blocking the connections built within the recovering space, a force that increases the possibilities of difference, emerging through repetition. Thinking relapse with ontology has demonstrated the need to closely explore how the interruption of connections affects the realities of people in recovery. This need is reflected in the present analysis of the recovering assemblage, and has also been observed and criticised by empirical studies on harm reduction that have focused on how bad connections or the lack of them cost lives (Dennis 2019: 135). Therefore, thinking with time does not only expand our understanding of the practice of recovery, but of all the temporalities that constitute the recovering assemblage.

In the introduction of this paper I defined the recovering assemblage as the amalgam of the encounters that contribute to a body's engagement with spaces of recovery. Following this line of thought, drug using time, harm reduction time, as well as relapse time are temporalities where the presence of caring practices increases the potentiality of difference and enhances life possibilities. Exploring the connections and interactions between the divergent temporalities of drug use and treatment constitutes a step towards the problematisation of the production of recovery and harm reduction as two conflicting approaches to drug treatment. Thinking with time opens the way for a holistic understanding of treatment encounters as practices that position the desires of service-users in the focus of attention, and resist the regulation of bodies according to predefined systems of thought.

Relapse troubles recovery, and my aim in this paper has been to stay with this trouble (Haraway 1988). In doing so I have unpacked relapse as one of the components that contribute to the wider question of how we can do recovery differently; how can we understand

recovery as a desire for connections, and what is the role of policy in enhancing and enabling this flow of desire. Thinking with the Deleuzo-Guattarian assemblage unfolds the practice of recovery as a series of processes caring not for the production of 'recovered' individuals, but for the enablement of new becomings and desires. Finally, as the ontopolitical turn in the research of drug use has come to demonstrate, the empirical matters. By following the accounts and lived experiences of people in recovery, my attempt has been to explore how relapse is made in practice and in policy, and most importantly how it can be made differently, how can we enable the striking beaks against the window to be better heard and attended.

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