More-than-harm reduction: Engaging with alternative ontologies of 'movement' in UK drug services

Abstract

Over the last ten years, UK drug policy has moved towards making abstinence-based recovery rather than harm reduction its primary focus. Drawing on ethnographic fieldwork involving participant observations and interviews in two drug services in London, we explore how this shift towards recovery is materialised through the practices of drug service delivery as an 'evidence-making intervention'. We understand recovery's making in terms of 'movement'. Where previous policies performed harm reduction through 'getting people into treatment' and 'keeping them safe in treatment', new policies were said to be about 'moving people through treatment'. Approaching movement as a sociomaterial process, we observe how movement gets enacted in both narrow ways, towards abstinence from drugs, and more open ways, in what we call 'more-than-harm reduction'. The latter is a speculative practice of doing or 'tinkering with' recovery to afford a care for clients not bound to abstinence-based outcomes. We describe observed modes of tinkering and consider how they operate as a form of care. This is important given the limits associated with a recovery-orientated policy impetus. By engaging with alternative ontologies of movement, we highlight an approach to intervening that both subverts and adheres to perceptions of recovery, embracing its movement, while remaining critical to its vision of abstinence.

Introduction

Carrying out fieldwork in 2014 at a central London drug service, the first author was often confronted with bemused looks as she talked to workers about her interest in exploring drug injecting practices to inform harm reduction strategies. Harm reduction 'refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption' (IHRA, 2010: 1). It was not the study's aim to better understand drug

experiences that surprised people, but perhaps more curiously – given the continued health harms experienced by people who use drugs, such as HIV, hepatitis C and skin and soft tissue infections, and the remit of harm reduction to reduce these harms – the attention it gave to harm reduction. Indeed, one worker said how 'old fashioned' the term sounded. We can understand this in relation to a policy shift whereby recovery – often signified by the requirement to abstain from illicit drugs and even opiate substitution treatment (OST) – has become the outcome marker of drug treatment services.

Looking back, we are interested to explore how the shift in UK drug policy towards recovery was materialised through the practices of drug service delivery. We feel this data has ongoing relevance due to the sector's continued focus on recovery. And, with the benefit of hindsight, we contend that we can appreciate the multiplicity of recovery and the dangers of its absolutist manifestations, especially as drug-related deaths continue to rise year-on-year (ONS, 2019). To do so, this article extends thinking on some previously published data (Dennis, 2019) by asking how recovery is mobilised as an 'evidence-making intervention' (Rhodes and Lancaster, 2019), particularly in relation to how it affords 'movement'. We seek to trace how recovery is enacted in terms of movement, witnessed in service provider's accounts of 'moving people *through* treatment', against a previous harm reduction logic which privileged 'getting people *into* treatment' and 'keeping them *safe*'. Yet, rather than thinking about movement as a recovery metaphor or construct in opposition to harm reduction, we consider how staff worked *with* service users and technologies to negotiate and navigate movement in practicing what one worker called 'harm reduction and *more*'. Our approach therefore follows a turn to ontology within critical studies of drug use and policy (e.g. Duff, 2013; Seear and Moore, 2014; Fraser, 2020) and, more specifically, investigates how the object of treatment itself becomes embedded in an ontological politics (Dwyer and Moore, 2013; Hart, 2018; Rhodes et al., 2019; Fraser, 2020; Rhodes and Lancaster, 2020). By attending to drug treatment as a reality situated in material practices, we can not only notice how drug treatment realities are 'made multiple' but also speculate on how they might be made 'otherwise' (Mol, 1999; 2002).

We take then, an 'evidence-making intervention' approach to recovery as an effect of its material implementations (Rhodes et al, 2016; Rhodes and Lancaster, 2019). Such an approach emphasises how drug treatment interventions emerge differently and multiply according to their local sites of knowledge-making, and are thus best treated as 'fluid interventions' always in a process of becoming (Rhodes, 2018; Gomart, 2002; de Laet and Mol, 2000). We take this up here to explore how recovery gets 'done', and what recovery 'does', in

two UK drug services. We consider how this shift in UK drug policy enacts these emergent modes of recovery as movement, and explore how these are re-worked in the drug service delivery in ways that are both enabling and disenabling of people's capacities to move. First, though, we attend to how the policy focus of recovery has come to dominate over harm reduction.

Policy environment

Once a defining feature of national drug policies designed to address the public health concern of HIV during the late 1980s and 1990s (Stimson, 2007), and even before (Berridge, 1993), the term harm reduction goes unmentioned in the 2010 and 2017 UK national drug strategies (HM Government, 2010; Home Office, 2017). Instead, the 2010 Drug Strategy marks an acute turn towards recovery (HM Government, 2010). Although this turn can be traced to the beginning of the century (Stimson, 2000), for the first time, the term was ratified in the Strategy's title: 'Reducing Demand, Restricting Supply, Building *Recovery*: Supporting People to Live a *Drug Free Life'* (our emphasis). Furthermore, the Strategy articulated recovery as an individually-focused and abstinence-based recovery, and invents 'full recovery' as a target for drug service delivery. Underpinned by metrics governing the performance (and thus funding) of drug services in relation to this target, full recovery constitutes an abstinence from all substances, including legally prescribed substitution medications (HM Government, 2010; Home Office, 2012; National Health Service, 2012).

Outlining ways to apply this vision, the Home Office (2012) put forward their 'roadmap': 'Putting Full Recovery First'. This offers a guide for re-structuring drug services in line with these abstinence goals (as realised in the findings below), with the explicit intention to 'shake up the maintenance oriented status quo of heroin addiction' (2012: n.p.). Moreover, in the National Health Service (2012) report, 'Medications in Recovery: Re-orienting Drug Dependence Treatment', opiate substitution treatment (OST) – a long heralded harm reduction strategy for reducing illicit drug use, health harms and crime (e.g. see ACMD, 2016) – was specifically redefined as a recovery technology. Political lobbying group, the Centre for Social Justice (CSJ), directed by Conservative MP Iain Duncan Smith, also released several documents criticising the use of OST for its perceived obstruction to 'recovery' (CSJ, 2013; 2014, see also Dawson, 2012; Holehouse, 2014; BBC 2012, 2014). These documents popularised terms such as 'parked' on methadone and 'stuck' in treatment. Such imagery does

important work when understanding how OST-based treatments have been positioned as restricting movement and therefore, as a remedial, how a focus on recovery operates to combat this perceived stasis.

The current Drug Strategy continues this focus on 'full recovery' (Wincup, 2017). In the highlighted statement of the policy, reiterated in the Home Secretary's foreword, it states:

> By working together, we can achieve a society that works for everyone and in which every *individual* is supported to live a life *free from drugs*, fulfil their potential and enjoy a brighter future for themselves and their families. (our emphasis)

Interestingly, the Strategy also claims to take a more 'balanced approach' and acknowledges a need to 'prevent escalation to more harmful use, as well as providing evidence-based treatment options […] to provide people with the best chance of recovery' (Home Office, 2017: 5). A generous interpretation is that this reflects a response to the widespread criticism of recovery-orientated drug policy that has been seen to prioritise ideology over evidence-based treatment and the human rights of people who use drugs (e.g. Release, 2017), especially because this policy shift coincided with a rapid loss of life (ONS, 2016).

We draw here then on qualitative data generated during a time (in 2014) when the policy rhetoric of recovery was just starting to take effect in service implementation, at the same time that drug-related deaths were rising dramatically (doubling between 2012-2015, ONS, 2016), possibly as collateral (ACMD, 2016; Boyt, 2014; Stevens, 2019). While this data may be limited in understanding the specificity of current drug service practices in a fast-moving sector, we feel it is relevant for understanding an enduring focus on recovery in a context where drug-related deaths are continuing to rise (ONS, 2019). Rather than relying on old dichotomies to criticise recovery discourses, we explore how recovery is materialised through local practices of drug treatment to highlight how the ontologies of movement opened up by recovery can, through a process of tinkering, act to generate new kinds of care beyond harm reduction *or* recovery.

Approach: 'navigating movements', 'working together'

> I like the notion of 'walking as controlled falling' – the ability to move forward and to transit through life, isn't necessarily about escaping from constraints. (Massumi, 2015: 12)

In an interview with Mary Zournazi entitled 'navigating movements', philosopher of affect, Brain Massumi proposes a politics of movement based on 'where we might be able to go and what we might be able to do' (2015: 3). From this approach, movement is an embodied process of changing affective potential, whereby, as bodies connect with other bodies and technologies, they change, creating new bodies in their relation to space and time. This contrasts with a commonly understood 'punctural system' of space and time as measures external to us. Rather than an ontology of 'being' (as given), this politics follows a Deleuzian ontology of 'becoming' where 'becoming is the movement by which the line frees itself from the point, and renders points indiscernible' (Deleuze and Guattari, 1987: 294). Time and space, once defining measurements of movement, no longer 'serve as coordinates for a point or as localizable connections for two points, running from one point to another', but emerge as 'lines' in relation to bodies brought into being in this process (Deleuze and Guattari, 1987: 295).

Bodies, as assemblages of human and nonhuman processes, do not move through space and time, but rather co-construct one another, and hence, are always in motion, becoming-other. In thinking about movement and moving bodies in this way, as emergent and dynamic space-time-bodies, active work is needed to produce them. Movement is not an abstract measurement of before and after, that just happens, but has to be worked at. And it is from this position that we wish to rethink the 2017 Drug Strategy's defining statement on 'working together'. Where the Strategy lays out a utopian vision of 'working together' to achieve 'lives free from drugs' (based on an individual autonomy), we want to think critically with this in terms of how movement is actively navigated.

Here we also draw on Isabelle Stengers' (2000) conceptualisation of 'working together' that, unlike the Drug Strategy's aim of autonomous drug-free lives, thinks with both human and nonhuman actors in relation to an 'ecology of practices' (Stengers, 2010). As opposed to a humanist cosmopolitics, which restricts agency to individual and collective human bodies (the 'society' in the mentioned policy statement), this is an ecology which allows for a collective-becoming or 'working together' of humans and nonhumans. We contend this enhances an understanding of the work both drugs and drug service technologies do in 'moving people through treatment'.

Stengers' imperative of working together is rooted in the natural sciences, stemming from the idea that there is no all-knowing subject and known object, but rather they 'work together' in producing scientific knowledge. This means that data also makes itself known, and

it is necessary for the researcher to be open to this dynamism, thus putting the researcher and her epistemologies 'at risk'. This resonates here. That is, while acutely aware of the way drug services and their technologies were often separated into binary responses of either harm reduction *or* recovery, we fostered an openness that allowed for these poles to become blurred as our research subjects and objects made themselves known in different ways. For example, where recovery has been widely criticised for its moralism (e.g. Stevens, 2019), service providers, in this study, expressed a surprising appreciation for its optimism in terms of *moving* service users on and the 'things' that helped produce this movement. Stengers' work explicitly allows for this openness to *know* these things – people, objects, forces – in different ways: 'to understand means to create a language that opens up the possibility of "encountering" different sensible forms' (Stengers, 2000: 157).

Movement then, rather than simply being a popular metaphor or trope, is analysed here as an ontological concern: the way human and nonhuman processes work together to create new formations of space-time-bodies, based on an understanding of 'how things are interrelating and how a perturbation, a little shove or a tweak, might change that' (Massumi, 2015: 44). Drawing from Spinoza, Massumi states: what a body is, 'is what it can do as it goes along' (2015: 4). Bodies are defined by their capacity to affect and be affected in relation to others 'step to step' (Massumi, 2015: 4). Rather than bodies simply moving, as a matter of course, this is a much more agentic and topological form of 'passing', which involves human and nonhuman others (see, in drug studies, Gomart and Hennion, 1999). In this paper, we try to tune into these processes, for example, the way outcome measures and opiate substitution plans work to restrict movement, but also the ways that technologies, sometimes the same technologies, help to propel new kinds of movement, for service users 'to grow' as one worker put it.

Where movement becomes blocked, the ultimate blockage is death, which tragically strikes a chord here as people who use drugs continue to die in greater numbers than ever before. With this in mind, we take up Annemarie Mol's 'logic of care' and notion of 'tinkering' to understand how research subjects and objects work together in navigating movement away from such harms (Mol, 2008, 2010). Therefore, rather than simply dismissing the recovery agenda as antithetical to the work of harm reduction, we are interested in how recovery emerges in practice as, as one participant put it, harm reduction and *more*.

Methods

We draw on qualitative data generated from the first author's doctoral project, which took place in London, UK, between March and October 2014. While this data is now dated, having been collected over five years ago, we believe it offers a useful and even timely tool to think with as the drug sector continues to both privilege recovery and see drug-related deaths increase, with policy divides becoming even more acute (e.g. Stevens, 2019). By bearing witness to these early manifestations of this 'new' recovery (see also Fomiatti et al, 2019), we are able to appreciate recovery as multiple and therefore offer a way forward in negotiating a present with recovery that does not have to rely on such divisive modes.

Among its aims, the study sought to explore how ideas of recovery, promoted in recovery-focused policies, were being implemented in practice. These data were generated through: in-depth interviews with ten drug service providers from two services in different parts of the city, anonymised here as the Dunswell and Eastford service; participant observations over six months at the Dunswell service; and in-depth interviews with thirty-two people who inject drugs (predominantly heroin and/or crack cocaine). Here, we draw specifically on the interviews with the service providers and the service observations.

Among the service providers formally interviewed were three 'recovery workers' (notably, in the year prior to the study, all drug workers at the services had been renamed recovery workers), managers of each service, a project leader of the Dunswell service, a doctor and a community care coordinator (who assesses people for residential detoxification and rehabilitation) at the Eastford service, a regional manager of the Dunswell service and a borough-wide drug service commissioner (for more details on the participants, please see Author, 2019). The participants were recruited following purposive sampling, with the data from each interview informing who we wanted to speak to next. The interviews took place in the employing services, with one taking place at the authors' university, and lasted between 1.5 and 2 hours. Observations were undertaken by the first author for one day a week over a six-month period at the Dunswell service where she carried out shadowing and key-working tasks. The authors met regularly throughout this period to discuss the findings and their interpretations.

The analysis techniques employed in this article draw on Gilles Deleuze and Félix Guattari's geophilosophy and, in particular, their figure of 'the rhizome'. Unlike a conventional coding frame:

> [the rhizome is defined by] principles of connection and heterogeneity: any point of a rhizome can be connected to anything other, and must be. This is very different from the tree or root, which plots a point, fixes and orders. (Deleuze and Guattari, 1987: 7)

Analysing rhizomatically allows an appreciation for the relationality of the research subjects and objects and the multiple ontologies at play. Rather than coding data which can pin phenomena down arborescently, as branches of the same root, mapping rhizomatically allows things to exist/be known in many ways and move more easily between and beyond current knowledge frames (MacLure, 2013). We employed pictorial techniques to map research events, depicting the human and nonhuman processes involved, including bodies, technologies, knowledges and immaterial forces. These maps attempted to capture the 'mess' (Law, 2004) indicative of our social scientific realities. According to Ringrose and Coleman, 'geophilosophy', based on mapping relations, offers 'a methodology of looking differently at connections, and, possibly, a methodology of tracing how these connections might be made differently' (2013: 125). It is this potential for 'invention' (Lury and Wakeford, 2012), to connect thinking to mapping, and representation to world-making, that connections between seemingly disconnected phenomena can be made (e.g. policy documents, licit/illicit substances, measurement technologies). It is through this mapping that we come to understand how movement *works* – how movement was created through relations of bodies, space and time, made and remade in both narrow and open ways. In our analysis below, we attend first to how movement becomes established as a defining feature of recovery, before then exploring some of its effects, and how such movement is worked-with in practice.

Recovery: 'Now it's all about the movement'

Service providers describe a policy impetus towards movement, in 'getting people *through* treatment', as opposed to 'keeping them safe' *in* treatment – both through the language they employed in their accounts and in explicit reference to shifts in policy. For some, a shift towards 'moving people on' was felt to be a good thing. Simone, a project leader at the Dunswell service, notes:

> The idea that clients can *move forward rapidly*… it's like from, you know, from the onset you're looking at a client and saying how do you want to plan your recovery? How long? So that's a good thing...

Here, movement was framed as a life-affirming departure from reducing the harms associated with drug use. Importantly, we see how a notion of rapid movement ('move forward rapidly') is employed. It is expedient, perhaps, to talk in these terms given changes to the way drug services are funded. Although 'payment by results' (where services are solely paid on outcomes) had not been implemented in either of the services, participants talked about 'payment by results in kind', which meant payment was based on 'successful completions', enacting a specific understanding of change and movement. Eva, a recovery worker, comments:

> However, there's funding things because I know that in terms of the recovery agenda and payment by results and things like that, people are pushing for drug-free completion rates, you have to be drug-free, so people aren't getting paid for people *in treatment,* you're getting paid for people *leaving treatment.*

Although this push towards moving people through treatment was generally welcomed by the service providers in the study, it was often felt that there were not the resources to implement it:

> But, you know, along that [recovery] journey where the resources need to be […], that's where, because of *the resources being tied and the constraint on it*, that's slightly a bit difficult to be able to provide that. So, there's a lot of pressure on different agencies in terms of clients and how quickly they want clients to complete treatment and all that. (Simone)

Eva also highlights the tension between 'successful completion' – 'now it's about the movement, the through-puts' – and what is needed to achieve it:

> Well there was a lot of money put into getting people in treatment and none were moving so now *it's about the movement*, the *through-puts* or whatever, of people coming through the system and out the other side. But, I think, people really need, they really need counselling, they really need housing, they need some support with relationships, they need support with their health, you know, there's a lot of things that have to happen for a person to be able to 'recover' […] It's not an easy, it's not an easy process.

What seems apparent here is the uneasy relationship between the imagined recovery focus of 'moving people on' and the actualisations of financial, political and institutional restraints that mean there are not always the resources, protocol or knowledge-base (Eva later on in the interview talks about a de-skilling of the work force) to do so. So, although the recovery agenda was often thought to be a 'good idea', it brought about more issues in practice.

Furthermore, an emphasis on movement without the means to support it seemed to produce a unique set of exclusions. Taking a relational approach to bodies as movement, where bodies are moved in relation to other bodies, things and forces, we can understand how these exclusions might take place. Bodies in their make-up – for example, in relation to policy documents, static imagery, financial restraints and de-skilled workers, to name a few infolded entities – can become constrained.

Movement as abstinence

The movement enacted in the treatment service in relation to tightened resources and payment linked outcome measures was linear, long-term and abstinence-based. Treatment 'success', for example, was measured in terms of the months (six required) people stayed out of treatment after discharge. This vision of success did not accord with the aspirations of all service users. Little support was available, for example, for people who wanted to continue or reduce but not end their illicit drug use. That is to say, those space-time-bodies *moving* in different ways, in perhaps smaller ways – for example, where people were reducing their illicit use but not fully abstaining – were not allowed to exist (access services in a meaningful way) in the same way as those who were able to move (as we have seen, often rapidly) towards long-term abstinence, with some literally disappearing as they 'dropped out' (discharged themselves or stopped attending) or were invited to leave due to non-compliance. In considering the role of space and time in making bodies (as movement), and together constituting service users' agency, we look here at how movement gains its potential, or lack of, in relation to technologies, such as outcome measures, payment-by-results schemes, policies, opiate-substitution treatment (OST) medications and illicit substances. And, as such, how movement is more than a problematic metaphor in a newly invigorated recovery-oriented sector but encapsulates in some cases the very apparatus used to restrict or 'block' certain service users from living in their own way.

Simone, introduced above, explains how clients could not be discharged as a 'successful completion' if they continued to use heroin or crack cocaine (the most common substances used by people at the service):

> We've had situations where some people say […] 'I've stopped heroin, but I still want to use crack once a week'. And we can't close them in a planned way, because they're still using crack once a week.

Abstinence from heroin and crack cocaine was a specified treatment goal. But notably, opiate substitution medications, such as methadone, were also being included as part of this. For example, an interim manager of the Dunswell service, Callum, reduces OST to the status of a drug rather than a medicine in saying: 'so I think services will be given less money to provide drugs to drug users'. Along similar lines, a commissioner of community drug services says: 'you're just giving them another thing that ensnares and traps them in addiction'. As such, OST provision was sometimes seen as a form of 'collusion' (a term frequently used by drug workers when they felt they were enabling 'an addict' in terms of their 'addictive traits') rather than treatment.

'Maintaining' people on OST, which was once an acceptable mode of treatment, or even goal (DoH, 2007), was now being reversed. Dr Green, a borough-wide lead on substance misuse, comments on this situation:

> I think, when you sort of seem to challenge people in authority about that [whether maintenance is an option] they say 'oh no, no, no, of course, if it's appropriate and they need it, maintenance is still an option', but it feels a bit like, a) that's a bit of a treatment failure and b) you shouldn't really be doing it for many people.

Despite official lines, space in the service for those pursuing maintenance was closing in. Indeed, the interim manager, Callum, had just finished restructuring a neighbouring service in line with the recovery agenda as laid out by the government's 'roadmap' (aforementioned) in which he notes that *everybody* is now on a reduction plan: 'Incidentally everybody in [that service] is on a reducing script. There isn't anybody who's on a maintenance script'. When asked if maintenance is no longer an option, he clarifies: 'It is in reality but everybody has a reduction plan, whether they stick to it or not is another matter'.

This narrow and singular understanding of movement as a movement towards abstinence (from specific substances, and for more than six months) often put the recovery agenda at odds with 'safety' and, with this, drug treatment services at odds with health professionals. Speaking in relation to the re-structured service, Callum says:

> The doctors in [that service] are locums who are brought in by the [service] and, as long as they feel they're not being asked to do something that is clinically unsafe, they will basically do what the service asks them to do. And the service asked them to support a process whereby we're always looking for a reduction [from opiate substitution], and that's what they do. Whereas the natural position of a doctor or clinical consultant seems to me from my limited

experience is 'is this safe?'. So, if you start from 'is this safe' then you'll never reduce [OST], because it's always safe not to reduce.

Callum here refers to his 'limited experience', but nonetheless detects and reproduces recovery as a kind of movement that excludes not only illicit drugs but also those medications used as substitutes. This means that simply reducing one's consumption or employing strategies to make it safer were insufficient steps or kinds of movement. Consequently, people who were using drugs in ways that were less able to become free from heroin, crack cocaine and/or OST often felt marginalised.

As the treatment services became more dependent on 'successful completions', people who use heroin and/or crack, as well as those already receiving or seeking OST maintenance, were becoming a less attractive group to treat. Callum again candidly comments on this: 'So, one of the things I'm trying to do here now is offer services to a wider range of drug users because *I know that I'll get better completions for those drug users'*. Dr Green, in talking about how the definition of a 'successful completion' includes a strict time frame in which those who return to treatment within six months no longer count as 'successful', is concerned that this might disproportionately affect people who use heroin, prone to relapse and in need of opiate substitution. This is further exacerbated by the approach promoted by the 2017 Drug Strategy which introduces an even longer time frame of a year, thus cancelling payments for those service users returning to treatment within that period. This can perpetuate a practice of 'cherry picking': 'I think if you miss out on harm reduction you end up *cherry picking* who you work with, because people are in different places in recovery and their drug use' (Nyundo, Eastford manager). Thus, not only was abstinence (from opiates, crack cocaine and OST) central to this kind of movement, but it also had to be sustained (for more than six, and now twelve months), creating modes of treatment less conducive to certain service users, in particular, as we have seen, those who have been using OST for a long time and those who use heroin or/and crack.

Alter-ontologies of movement

It's having that thought that everyone has the potential to flourish and grow and develop. (Angela, recovery worker)

Although an ontology of movement (as abstinence) was getting enacted in restrictive (failing to register slower, smaller kinds of movement), and restricting ('blocking' certain service users

from treatment) ways, there were also competing ontologies or movements, which were more inclusive, loosely based on making a difference, whether this included drugs or not.

Angela, a recovery worker, reflects above on how the recovery agenda made a positive change to her practice, in that she now has more faith in people's ability to change. For Angela, a key component of this shift was the strengths-based assessment tool used to gather information on new (mostly self-referred) service users' treatment needs. Where the previous assessment form started with a question on 'reasons for drug use', the new strengths-based form avoided specific questions on drug and alcohol use. She says it's about: 'not being *stuck* in the reasons of using', and 'rather than working with you *are* a drug user […], let's think about that to try and unfold stuff, so that it doesn't continually repeat itself'. Angela's language unintentionally speaks to an idea of infolded time and space, and outer and inner worlds, in which drug use is 'repeated', and space-time-bodies become 'stuck' or 'territorialised', to use Deleuze and Guattari's (1987) term. In this broader approach to movement and recovery, it is about more than the drug. For Angela, treatment is less about whether people use illicit or licit (such as OST) drugs, but more about their potential for 'growth', or what Deleuze and Guattari (1987) might call 'lines of flight'. For Angela, attention shifts from the drug to a wider appreciation of the relations that make people up. She says that regardless of whether service users continue to use heroin or methadone, she will continue to see them and 'encourage the kind of things [they] want out of life':

> There's a balance of not putting too much pressure on people and kind of allowing people to really *go at their own rate*. Like, what I would say in a session is 'I'm here to see you whether you are on methadone, not on methadone, whether you smoke heroin, whether you don't smoke heroin, that's not my choice, I will see you each week, every fortnight, regardless, but what I am here to do is to kind of help to encourage the kind of things you want out of life'.

For Angela, treatment is less about whether people use licit or illicit drugs, but more about their potential to get new things 'out of life' and become other. In this more fluid notion of movement, there is now less emphasis on having to reduce or stop OST. There is also a slower pace to this movement, in contrast to the rapidity seen in Simone's statement (above).

Similarly, Dr Green highlights the contradictions in what constitutes movement in drug service provision by comparing it to other patient groups. He says that where his diabetic patients are allowed to take long-term medication alongside making lifestyle changes, people

who use drugs are not, despite the fact that they 'function well and work on a maintenance prescription'.

> I see, personally, no problem, if somebody is doing well on maintenance, why that's a problem any more than somebody being on medication for diabetes say. You still want a diabetic to lose weight and do exercise and eat healthy, but it's not to say you're pressuring the diabetic to stop taking medication, whereas, using that analogy with substance misuse, it sort of feels like, ok, now you should *move on* [to become OST-free].

Although there were increasing difficulties to practicing in the ways Dr Green and Angela promoted, their resistance to a singular enactment of movement as abstinence is testimony to recovery's making in local practice as a *negotiation* which generates alternative ontologies of movement, which crucially can include OST and even illicit drugs.

Angela and Dr Green are engaging with an ontology of movement that is relative ('at their own rate'), specific ('some people…'), situated ('what you want out of life') and slow ('not putting too much pressure on'; 'not pressurising'). Angela and others, like Eva (in her earlier quote), talk about the importance of family, friends, housing and employment in producing movement. Embracing this movement away from the drug per se, towards wider connections or networks, a manager of the Eastford service, Nyundo, even set out to create *more than a drug service* in opening a 'recovery café to 'break down the walls to treatment and *open up a bigger experience* for people so they can have a bit more *life*, a bit more activities that are *not just treatment'*.

To register (and thereby also bring about) these alternative ways of moving, the otherwise rigid measurement tools were regularly negotiated or 'fiddled with'. Karolina expressed frustration with quick interventions (promoted in the recovery agenda, for example, Home Office, 2012) and their inadequacy for those needing longer-term treatment. Karolina now had to deliver group work rather than individual work and in a strict twelve-week programme, which she felt failed to acknowledge the different kinds of work and time people needed.

> It should always be in twelve weeks, but that's like the theory, that never worked for me. I was one of those worse offenders of *keeping people in treatment* for a very long time [...] I almost feel guilt for *holding people* in treatment, like, *intuitively* you know that you can't discharge this person because they need support, then you've got your manager saying, you know, […] if you have this client, you can't see somebody else.

She refers to 'keeping people in treatment' and 'holding people in treatment' as an offence, reflecting perhaps what MacGregor (2017) calls a crisis of public expenditure and those images of the 'stuck' and 'parked' drug user. In resisting this perceived stasis, that is, in supporting alter-ontologies of movement (space-time-bodies) that are not so easily conducive to abstinence, Karolina helps to enact a more situated and necessarily complicated movement, which involved 'fiddling *with*' those fixed measurements.

> It's really, really complicated. It should be twelve weeks. But most of the time it is not, you will have people that drop out and you will have people that only want counselling […] There are people that have been on the case load for a long period of time and then you kind of *fiddle with it*, we do it, and [another drug service] do it as well, I know that one of the workers was sitting in a review meeting with social services and she said I have to close the case now but I'll re-open it next week. So, you have to be so *creative*.

Karolina explains how she had to be creative and 'fiddle with' the ways movement was getting measured in order to respond to different service-using bodies in their relation to treatment technologies and techniques (such as counselling). With this, she took a relative approach to time, where treatment duration could not be standardised at twelve-weeks, seen to be too long for some and not long enough for others. Karolina's collaborative and 'intuitive' practice disrupts fixed outcome measures, producing a situated ontology of movement that allowed for differences in how bodies affect and are affected by services: some people drop out, some stay for long periods, some only want counselling. She had to be creative in navigating these absolute measures of success/failure in order to continue working with people in the way they needed.

Karolina's account is similar to Simone's story (quoted in the previous section), in which she explains how she had to ignore the fact that a service user continued to use crack cocaine in order to allow her to leave in 'a planned way'. Simone spoke about how there had been a change to the outcome measures or 'data sets' which meant there were only two ways to record a 'successful completion', either service users had to be 'drug-free' or an 'occasional user' but the measures, she says, specified 'no heroin or crack'. 'You could grade people in so many different ways, but then they took all those options away'. She says how she has now learnt to ignore people when they say they wish to continue using crack cocaine or heroin in a reduced or controlled way, in order to recognise these client-defined successes, which would otherwise be recorded as treatment failures. Even though the measures only recognised movement in these absolute ways, workers in collaboration with service users, and the

measures themselves, made them more flexible, allowing for and getting involved in these other kinds of movement.

Discussion: less than recovery, more than harm reduction

Rather than setting up an oppositional dynamic between recovery and harm reduction treatment models, we have worked with qualitative data generated at two UK drug services to consider the multiple ways movement, as a defining feature of recovery, is enacted in practice. While drug service providers understood the recovery agenda as an implementation of movement, this movement was enacted in modes that were both narrow and absolute, and open and flexible. Narrow recovery, for instance, was enacted through practices of 'rapid' treatment defined (and measured) by making people free of heroin, crack cocaine and opiate substitutes, as well as drug service provision for at least six months. Open and more flexible versions of recovery were enacted through practices that were less determined by time, having to stop drug use, or exit treatment as a measure of success. As such, we observe these networks, respectively, working to block and extend bodies in their connections with other actants such as policy documents, images (of being 'stuck'/'parked'), service outcome measures, workers, illicit substances and opiate substitution therapy (OST) medication. We argue that recovery's making in practice is a recovery worked-with and thus a recovery made multiple (Mol, 2002). We therefore consider how best to promote certain recovery practices and the bodies they produce as a situated matter, rather than something that can be governed by fixed and external measures of success.

We tend to agree with Brian Massumi's politics of movement (aforementioned) where he notes that 'focusing on the next experimental step rather than the big utopian picture isn't really settling for less' (2015: 3). Where, in UK drug services, the utopian picture is one of 'full-recovery' and 'lives free of drugs', workers speak to practices of less-than recovery but more-than harm reduction. They were keen to embrace the productivity of recovery, the sense that people could 'move on', while not dictating the terms of achieving this. They commonly embraced a fluid and affective approach to movement through small changes and at a slower pace. Following Isabelle Stengers (2005), we see this slowing down of the move towards absolutist and rapid recovery as a form of 'ontological disturbance', in which different versions of the making of recovery are invited to exist. That is, by generating space for indeterminacy and difference against the taken-for-granted and stable recovery, new modes of knowing and

caring can emerge. 'The idea is precisely to slow down the construction of this common world, to create a space for hesitation regarding what it means to say "good"' (Stengers, 2005: 995). For example, we saw how for Nyundo this was about experimenting with the drug service itself, trying to widen 'the experience' and people's relationships 'with the world', in being open and available to what might emerge.

Tinkering

Opposing a policy of recovery outright may not be a practical option given how drug services are funded, configured, measured, and thus made to exist on this basis. Instead, we observe how workers worked-with recovery in various ways. For example, with recovery's potential of optimism and its sense of affording changes for the better. Yet this was a recovery of a local and embodied making, a recovery-in-use, and a recovery-in-action, distinct from the propositional recovery of policy or of national strategy and targets. Crucially, this recovery in practice was constituted as a provision of care framed and actioned by service users, even if this meant 'fiddling with' outcome measures to either recognise clients' successes or keep them in treatment for longer than their designated slot. As Massumi says: 'luckily people didn't wait around. They jumped right in and started experimenting and networking, step by step. As a result, new connections have been made' (2015: 16). Here we see recovery's local making as a practice of more-than-harm reduction (Dennis, 2019). These practices accentuate the sense of movement evoked in the recovery model while refusing to prescribe what it should look like, or paint out the bigger picture, to use Massumi's phrase (above). We attend here to the ways this negotiation took place in allowing bodies to move in these different, smaller ways by disrupting autonomy and external treatment measures in caring for and within collectives.

This more flexible form of navigating movement is reminiscent of what science studies scholars have called 'tinkering' (Law, 2011; Mol, 2008; Moriera, 2010). For Annemarie Mol and colleagues (2010), tinkering is a mode of care which takes the technological, social and natural together:

> For rather than insisting on cognitive operations, they involve embodied practices. Rather than requiring impartial judgements and firm decisions, they demand attuned attentiveness and adaptive tinkering. (2010: 15)

This is about not judging, or using objective measures, but adapting to what Stengers (2010) would call an 'ecology of practices'. Like Karolina said, rather than trying to gain control of the complexity ('it's very, very complicated'), she worked in negotiation with these relations.

These relations are similar to what Moriera (2010) observes in a dementia care-home as 'life collectives' for making things *work*. From this position, 'good care' is about 'persistent tinkering in a world full of complex ambivalence and shifting tensions' (Mol et al., 2010: 14). In this situated relationality, to draw on Latimer and Puig de la Bellacasa's (2011) discussion of 'ethics in the making', 'things are not yet decided as good or bad', and thus must be worked out in practice, in the moment. This 'work' involves nonhuman as well as human actors, as Dr Green argues in his comparison of diabetic patients and patients who use drugs. While the former are allowed insulin, patients who use drugs are not allowed OST medications. He actively refutes this and practices *with* OST medications, a practice that the interim manager perhaps wished he would not in complying to his perception of the risk averse, safety-oriented doctor, at odds with the perceived risk needed for recovery.

Caring

These care practices embody and enact a more intimate approach, or ethicopolitics, as workers *feel* their way in determining what is best rather than following pre-prescribed goals. What recovery *is* has been debated for some time, with 'person-centred' approaches being favoured by some over more absolute measures (Best, 2012). However, what we are observing here in workers' practices are more than a pursuit of individually defined goals but an active working together towards new ways of being. There are no predefined measures. Instead, there is a sense of growth or moving on, not necessarily away from drugs, but towards increased capacities to affect and be affected – 'to grow' – to move in different ways, in which those who are 'cared for' are also part of the process. Akin to Mol's 'logic of care', unlike the 'logic of choice' seen in individually defined recovery goals, this process of care does not separate value from fact, ethics from politics. Thus, we saw in this study, 'being a drug user', according to Angela, was as much about the history, stigma and context ('the reasons') as the addiction or dependency. Drugs and drug-using identities lose their foundation – their essence as bad – as the context is privileged, and, as such, being drug-free is no longer the focus.

What constitutes 'successful' treatment cannot be decided before and must be negotiated in practice. Recovery becomes known through its multiple implementations in practice as an 'evidence-making intervention' (Co-author, 2018). Recovery's effects become known through the practices of care that are enabled in the connections between workers, patients, technologies, policies, funding, target measures, and so on. Discussing target blood sugar levels for diabetic patients, Mol says: 'Within the logic of care, identifying a suitable

target value is not a condition for, but a part of, treatment. Instead of establishing it before you engage in action, you keep on searching for it while you act' (2008: 53). Here, this meant 'holding' some people in treatment longer than others, accepting some people 'functioned well' on maintenance and that some people wanted to continue using some drugs while stopping others. Therefore, to register the successes that this less-than-recovery demands, a new kind of speculative treatment governance is needed. That is, following Mol, we believe that 'in the process of care it is not possible to put the facts on the table first, to then add the values, so as to finally decide what to do' (2008: 45). Workers tinkered within modes of care, disrupting dichotomies between harm reduction and recovery, and what is targeted and measured as best policy and practice, to foster different kinds of moving with/in treatment. These findings have ongoing relevance in a sector that is arguably becoming increasingly divided (see Stevens, 2019) by a policy environment that continues to privilege a narrow understanding of recovery.

Concluding

People who use heroin and long-term OST recipients are seen to be particularly at risk, where their becoming-with substances is actively discredited and worked against in recovery-based policy documents, resulting in people feeling unwelcome or even excluded from treatment. In these blocked connections, new connections could be made: to the illegal drug market, to the street (homelessness), unemployment (losing one's job), ill health and so on. Unfortunately, these are some of the very connections thought to be responsible for rising death rates among people who use opioids in the UK. For example, the latest statistics show how, over the last five years, while the number of people in treatment has been reducing, deaths have been soaring (PHE, 2018). Further research is needed to see what difference the new Drug Strategy may make, and specifically, what the 'balanced approach' 'does' in practice. However, with extended time periods of absence from treatment required for the original treatment episode to be considered successful (from six months to twelve), more treatment services set to be paid 'by results', and reduced funds for OST provision (HO, 2017), the movement engendered is looking to be even more constrained and constraining than before.

Notes

Ethical approval for the study was granted by [removed for review]

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