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Hope, Choice and the Improvable Self:

A Critical Analysis of 'New Recovery' in Australia

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Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made. This thesis contains no material which has been accepted for the award of any other degree of diploma in any university.

Signature: 

Date: 11/12/17

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Publications from this research

Some of the data and analysis presented in this thesis have been published. The following article is a shorter version of Chapter 7.

Fomiatti, R., Moore, D., & Fraser, S. (2017). Interpellating recovery: The politics of 'identity' in recovery-focused treatment. *International Journal of Drug Policy*, *44*, 174-182.

Abstract

While notions of recovery have long been a fixture of alcohol and other drug discourse, policy, advocacy and treatment, over the last decade a 'new' form has gained prominence in the United Kingdom, Australia and elsewhere. The 'new recovery' paradigm is built upon a critique of the acute-care model that new recovery researchers and advocates argue is characteristic of existing addiction treatment. The new recovery movement promises transformative change in addiction treatment and in the lives of recovering persons. It promises a more hopeful and optimistic future for people who use drugs by promoting freedom, choice, care and new 'revolutionary' aspirations. Despite these claims, the meanings of this new iteration of recovery are ambiguous, and the continuities and differences that endure from older forms have yet to be explored in the critical sociological literature on drugs.

My research examines both new recovery's claims to newness and its ability to fulfil the liberatory and transformative functions its proponents claim for it. It questions: what kind of liberation is posited when the only frontier is the improvable self? Three main research questions inform my analysis. First, how is this new iteration of recovery enacted in drug policy, research and treatment in Australia, and what assumptions and claims about drug use and people who use drugs are made along the way? Second, how do people who use drugs adopt, accommodate, resist or otherwise engage with new recovery in treatment and in their everyday lives? Finally, what are the political effects of these new recovery enactments?

Answering these questions requires an approach sensitive to processes of enactment, continuity and difference, and politics. To this end, I draw on three central concepts from recent work in science and technology studies – enactment, multiplicity and ontological politics – as well as on several cognate posthumanist interpretive tools. I use these tools to

trace and analyse several spheres of activity, all of which are significantly implicated in the production and mobilisation of new recovery: policy development, psychological science and professional practices. Further, by collecting and analysing in-depth qualitative interviews with 25 people who inject or have injected drugs, and 11 health professionals, I also explore the constitution of new recovery in and through treatment and everyday practices. I trace the ways in which people who use drugs, professionals and treatment practices adopt this new iteration, while continuing to accommodate older, enduring forms and practices of recovery, and produce local and hybridised enactments.

My analysis demonstrates that new recovery in authoritative sites of enactment can be termed new insofar as it expands upon and intensifies many of the individualising and stigmatising assumptions about drug use, people who use drugs and their social relationships that have operated more subtly in previous Australian drug policy and psychological research. I make visible the kind of political universe drug-using subjects are asked to embrace in their adoption of new recovery. Built into different enactments of new recovery are different forms of stigma that cast drug-using subjects as failed citizens, as pathological and disordered, and as socially deviant. These processes of stigmatisation and exclusion simultaneously buttress a regulatory myth of ideal neoliberal subjecthood. Achieving citizenship, health and community membership is almost solely defined in terms of individualised effort, self-improvement and self-enterprise, rather than as intimately bound up with political, social and economic forces and arrangements. This limits the kind of political claims drug-using subject can make, and the development of more socially and politically oriented responses to drug harms, poverty and marginalisation.

While the ambiguity and opacity of new recovery has contributed to its prominence and conceptual utility, its insufficient novelty and lack of innovation means that it has not succeeded in dislodging older forms of recovery. In my analysis of professional accounts, I

demonstrate how professionals and professional narrative practices coordinate recovery enactments into a common therapeutic entity, and manage the various contradictions. I make visible how professional forms of coordination make local and hybridised enactments of recovery that encompass new associations with progress and citizenship *and* older elements that reproduce normative goals around abstinence and the recovery 'journey'. Similarly, recovery-focused treatment tends to be organised around the treatment of a particular type of addicted drug-using identity. The notion of recovery is enacted and elicited in ways consistent with older and pathological notions of addiction, while reproducing the contemporary focus on suspect social relationships and sociality, and practices of responsibilisation. I also explore how participant accounts emphasise a 12-step model and associated practices of recovery, which play out through intense practices of self-work and self-management. These accounts also critique the universalising gaze of addiction, recovery and health, and feature dynamic practices of resistance, strategic accommodation and incorporation. Individuals provide accounts of health, citizenship, life and their social relationships in terms that disrupt the normative images and binaries of citizenship and health, and the political universe, constituted in new recovery.

My research contributes to critical sociological literature on new recovery by analysing how drug use, people who use drugs and their social relationships are constituted in and through multiple domains of practice associated with new recovery. I draw attention to the stigmatising and marginalising ontological politics of new recovery, which are reflected and reproduced in everyday practices, enact a range of abject subject positions and contend with older recovery forms, to help determine the available narratives through which people account for their lives and may conceive and enact their futures.

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List of Abbreviations and Acronyms

AA	Alcoholics Anonymous
AIVL	Australian Injecting & Illicit Drug Users League
ANCD	Australian National Council on Drugs
AOD	alcohol and other drug/s
ARC	Assessment of Recovery Capital
MCDS	Ministerial Council on Drug Strategy
MMT	methadone maintenance treatment
NA	Narcotics Anonymous
NDRI	National Drug Research Institute
PROM	patient reported outcome measure
RCSP	Recovery Community Support Program
SEM	structural equation modelling
SIMOR	Social Identity Model of Recovery
STS	science and technology studies
UK	United Kingdom
UKDPC	United Kingdom Drug Policy Commission
US	United States
VAGO	Victorian Auditor-General's Office
WPR	What's the problem represented to be?

Chapter 1

Introduction

In the United Kingdom (UK), Australia and elsewhere, 'new recovery' has become an increasingly prominent feature of debates in alcohol and other drug policy, advocacy and service delivery. My research maps the social and scientific constitution of 'new recovery' in Australia and examines both its claims to newness and its ability to fulfil the liberatory and transformative functions claimed by its proponents. The term 'new recovery' is used throughout this thesis to distinguish the most recent wave of recovery policy, research and debate from the historically longstanding interest in addiction recovery in self-help discourses (Keane, 2002) and 12-step fellowships (e.g. the programs and practices espoused in Alcoholics Anonymous) (Frank, 2011; Kitchin, 2002; Miller & Kurtz, 1992; Valverde & White-Mair, 1999). Also referred to as the 'new recovery advocacy movement', new recovery emerged in the 1990s in the United States through the growth in addiction recovery advocacy organisations, recovery events and support institutions (e.g. community organisations, recovery homes, recovery schools). It also developed in and through policy shifts (that I describe below) in which we have seen a reorientation towards recovery in national health care policy and treatment systems in places such as Connecticut and Philadelphia (Achara-Abrahams, Evans, & King, 2011; Anex, 2012; Laudet & Humphreys, 2013; White, 2008).

The new recovery paradigm is built upon a critique of the 'acute-care' and 'pathology and intervention paradigms' that new recovery researchers and advocates argue is characteristic of existing addiction treatment (Kelly & White, 2011; Laudet, 2007; White, 2008; White, Kelly, & Roth, 2011). Proponents of new recovery argue that treatment should be based upon

a conceptualisation of addiction as a chronic disorder as opposed to 'isolated, episodic treatment that focuses on symptom reduction and/or stabilisation' (Achara-Abrahams et al., 2011, p. 203). This conceptualisation of addiction as chronic would mean that addiction (like the other chronic health disorders it is frequently likened to in the recovery literature, such as type 2 diabetes and asthma) requires ongoing and long-term support and self-management in the community. In the new 'solution-focused recovery paradigm', treatment should be based on a continuing care model of 'recovery management' within larger recovery-oriented systems of care (White et al., 2011, p. 298). In theory, recovery-oriented systems of care include but are not limited to professional treatment. They also include 'networks of indigenous and professional support designed to initiate, sustain, and enhance the quality of *long-term* addiction recovery' (White & Kelly, 2011, p. 3, emphasis in original). Non-professional or 'indigenous' support consists of peer-led advocacy organisations, 12-step groups and fellowships, mutual aid societies and new independent recovery community organisations and institutions (Achara-Abrahams et al., 2011, p. 188).

Influenced by these changes in American health policy and treatment, and the accompanying research agenda, new recovery has also been adopted as the overarching principle of UK alcohol and other drug policy over the last decade.[1] Australian alcohol and other drug professionals, sector peak bodies and drug user advocacy groups scrutinised developments in the UK (Australian Injecting & Illicit Drug Users League (AIVL), 2012; Anex, 2012). Mirroring the critical response from some in the alcohol and other drug sector to the adoption of new recovery in the UK, concerns were expressed that recovery would undermine Australia's reliance on evidence-based policy and its well-regarded commitment to harm

[1] As I explain later in this chapter, the UK context was also shaped by particular concerns about the effects of methadone maintenance treatment and about the role of drug treatment more broadly.

reduction. Despite widespread apprehension, the emergence of new recovery in the UK and its popularity in the mental health sector meant that debates about new recovery in the Australian alcohol and other drug sector became unavoidable (Lancaster et al., 2015). Linked to these international developments, in 2011 UK recovery researcher and advocate David Best was appointed as Head of Research and Workforce Development at one of Australia's leading alcohol and other drug research and treatment institutions, Victoria's Turning Point Alcohol and Drug Centre. His appointment was associated with the organisation of the '1st Recovery Roundtable' in Canberra, an emerging recovery research agenda in Australia, the creation of the Recovery Academy of Australia and recovery-focused treatment system reform in Victoria. In spite of this flurry of political and research activity, however, it was still possible in 2015 to observe, as did Lancaster, Duke and Ritter, that 'the meaning of "recovery" and how it could be realised in policy and practice is still being negotiated' (2015, p. 624).

Although new recovery is now a common feature of drug policy abroad and remains topical in Australia, the meaning of the term is still very much 'under construction' culturally and politically (Fraser & Seear, 2011, p. 2). It remains the source of some confusion and is subject to ongoing processes of debate and contestation. Researchers have repeatedly observed that 'recovery' is a notoriously elusive concept that defies definition and the achievement of consensus among policymakers, researchers and professional practitioners (e.g. Best, Groshkova, Sadler, Day, & White, 2011; Kelly & White, 2011; Laudet, 2007; Neale et al., 2014; White, 2007). Nevertheless, considerable effort and activity is being expended in promoting it as the way forward for policy and practice. New recovery advocate William White claims that 'recovery is a revolutionary concept' (2008, p. 1987). Other new recovery advocates and researchers argue that it represents a significant change in focus for the delivery of drug treatment, with the potential to offer more person-centred, strengths-

based and individualised care (Best et al., 2010). In contrast to the alleged pathology focus of professionalised acute care models, new recovery and recovery-oriented care promise 'hope, choice, freedom and aspiration' (Best & Laudet, 2010):

> What is clear, however, is that the essence of recovery is a lived experience of improved life quality and a sense of empowerment; that the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the rarefied atmosphere of clinical settings. Recovery is a process rather than an end state, with the goal being an ongoing quest for a better life. (p. 2)

Influential and well-regarded definitions of recovery often centre on the promise of new claims to empowered forms of citizenship, freedom and improved personal health for people who use drugs (Her Majesty's Government, 2010; The Betty Ford Institute Consensus Panel, 2007; Scottish Government, 2008). As will become evident later, understandings of new recovery also speak to the reclamation of self and identity (Best, Haslam et al., 2016; Laudet, 2007). Considering the ongoing political and scientific uncertainty surrounding new recovery and the claims to novelty and liberation made by its proponents, there exists a need for critical analysis. How 'new' is the new recovery? Does it fulfil the liberatory function claimed by its proponents? And what kind of liberation, in what kind of political universe, is being posited?

The central argument of this thesis is that new recovery, as it has been mobilised in Australian policy, science and treatment, is not a singular, stable phenomenon. Rather, new recovery is made differently through multiple practices and processes of constitution in different sites. As such, its effects are neither given nor fixed but made in practice (Fraser, 2010). As I go on to explore, new recovery is characterised by multiplicity, hybridity,

contradiction and continuity. Existing sociological research into new recovery has yet to fully explore its multiplicity or its specificities (in relation to older existing forms of recovery). I adopt a conceptual approach well suited to the analysis of complexity and multiplicity, drawing on contemporary social theory associated with the recent 'ontological turn' (Fraser, 2017; Mol & Law, 2002; Mol, 2002). I return to this theoretical development in more detail in the literature review conducted in the follow chapter. Briefly, the term captures a conceptual shift in the social sciences wherein the ontology of objects, subjects and other phenomena is understood to be made and re-made in practices. Objects, subjects and other phenomena do not exist in the world anterior to our attempts to grasp them. The conceptual and analytic tools that have emerged from this 'turn' allow me to conceptualise new recovery as constituted *multiply* in and through a variety of knowledge and research practices. This thesis traces several such activities and practices, all of which are significantly implicated in the production and mobilisation of new recovery: policy development, psychological science, professional practices, treatment and individuals' everyday practices. Not only do I examine the particular ways in which these practices are active in new recovery's constitution, I argue that these practices are political: they contribute to a particular politics of new recovery. In that new recovery discursive practices take as their concern the restoration of drug-using subjects to ideal forms of subjecthood and health, they also actively theorise and contribute to the production of contemporary citizenship. As such, the constitution of new recovery is also thoroughly political: it involves political choices and engenders significant political effects, particularly for those drug-using subjects who seek to claim legitimacy through the adoption of new recovery. The sense in which I use the term 'politics' will become clearer in Chapter 3, which explores the theory-methodology used in my study. However, it is employed here to capture a range of forces and processes beyond those of government or public affairs usually considered 'political'. This is therefore a broad study of the politics of new recovery, as it is

being actively made in specific practices, and with particular associations and material effects.

In the remainder of this introductory chapter, I examine in detail the central debates that have accompanied the emergence of new recovery internationally and in Australia, focusing on the recent emergence of new recovery in the UK, and its subsequent move into Australian public discourse and policy. This material provides important background to the critical analysis of new recovery that follows. Other sites for the constitution of new recovery are detailed and explored in later chapters (e.g. psychological research on new recovery). I then briefly sketch my theoretical framework, foreshadowing the fuller discussion in Chapter 3, and conclude with an outline of the thesis chapters and their contribution to my overall argument.

The international rise of new recovery

Although new recovery continues to provoke a high degree of uncertainty and scepticism, recovery *per se* is not a new concept in alcohol and other drug discourses (Berridge, 2012). It can be traced to the long history of recovery in mutual aid groups and the development of professional addiction treatment in America. Alcoholic mutual help movements (e.g. the Washingtonians) formed in response to the temperance movement in the late 19th century (Room, 1998; White, 2008). Modern conceptions of 12-step recovery programs can be traced to the emergence of 12-step fellowships, in particular, Alcoholics Anonymous (AA). AA was founded in 1935 following the ostensible defeat of the temperance movement's moral reform program and the repeal of Prohibition (Room, 1998; Valverde & White-Mair, 1999, White, 2008; Yates & Malloch, 2010). White (2005) argues that the founding of AA 'marked the re-emergence of *recovery* as a word and concept centrally linked to the resolution of alcoholism' (p. 6, emphasis in original). Since the founding of AA, and of Narcotics Anonymous (NA) shortly afterwards in 1953, a variety of other secular and religious alternatives to 12-step

fellowships have developed (e.g. Women for Sobriety, Rational Recovery, SMART recovery) (White et al., 2012). At the same time that recovery support developed in and through mutual aid societies, a multi-branched treatment movement of religiously operated inebriate homes and addiction asylums developed in the late 19th-century United States (US) (White, 2000). White argues that 'these early institutions saw themselves providing treatment that would "cure" the "disease of inebriety"' (White, 2008, p. 1990). Like early mutual aid groups, many of these collapsed as a result of Prohibition, to be replaced by criminal justice and psychiatric institutional management, for example, inebriate penal colonies and the 'foul wards' of public hospitals (White et al., 2012). Following sustained advocacy and legislation in the mid-20th century, modern addiction treatment developed as a specialised form of health care.

Proponents of the new recovery advocacy movement claim that these parallel developments in mutual aid and professional treatment 'created a void of unmet need in the larger community for a broader spectrum of recovery support services' (White et al., 2012, p. 303). The new recovery paradigm in the US can be traced to the growth of new recovery support institutions, advocacy and policy change, and the transformation of treatment systems in the late 1990s. Government agencies began to adopt the language of recovery and develop recovery-focused funding programs (Laudet, 2008). In 1998 The Center for Substance Abuse Treatment, part of the federal Substance Abuse and Mental Health Services Administration, initiated the Recovery Community Support Program (RCSP). The RCSP provided seed money for grassroots recovery support services to launch anti-stigma campaigns, run recovery education programs and recovery celebration events, and conduct advocacy for pro-recovery policy and programs (Laudet, 2008; White, 2008; White et al., 2012). White (2009) argues that in 2002 changes in policy resulted in a shift in focus from advocacy to peer-based recovery support services – turning these grassroots organisations into recovery support specialists. In 2003 The White House developed an Access to Recovery program, which also

provided grants to states and tribal organisations for peer and other recovery support services (White et al., 2012, p. 303). These changes at the level of federal policy were associated with the further proliferation of grassroots recovery community organisations and large scale service system transformation to recovery-oriented systems of care in Connecticut and Philadelphia (Anex, 2012; Kelly & White, 2011). These changes were also accompanied and supported by a discourse advocating for the development of a larger 'culture of recovery' – comprising personal identification, community development and political change – that transcended treatment or recovery mutual aid societies (White et al., 2012, p. 307).

Although 'new recovery' emanates from the expansion and diversification of mutual aid groups in the US, the notion of recovery is well established in mental health policy and treatment approaches in the US and elsewhere. Even so, its definition in the mental health sector remains contested, with multiple definitions and conceptual approaches reflecting its historical formation in different social movements, including the physical disability, independent living and psychiatric survivor movements (Davidson & Roe, 2007; Pilgrim, 2008; Ramon, Healy, & Renouf, 2007; Smith & Sturdy, 2013). Mental health researchers identified several important tensions over its definition that foreshadow contemporary debates in alcohol and other drug research, policy and practice. For example, they debated whether one recovers *from* mental illness and becomes symptom free or recovers *in and with* mental illness and lives with a chronic mental health condition (Davidson & Roe, 2001). These questions highlight how different formulations of recovery necessarily invite different ontological understandings of illness (Pilgrim, 2009). Pilgrim, for example, argues that biomedical psychiatrists treat mental illness as a 'stable reality of pathological states' (2009, p. 300), thus eliciting medicalised forms of treatment and a focus on symptom reduction. Social psychiatrists focus on long-term psychosocial rehabilitation, wherein mental illness is understood as an impairment arising from a range of biopsychosocial factors. In contrast,

mental health service users who identify with the psychiatric survivors' movement appropriate a recovery identity as an expression of 'survival' in the face of professional and medicalised authority (2009, p. 297). Evident in these debates is that different understandings and uses of the concept of 'recovery' produce different problematisations of disorder and disease. In turn, these understandings of the 'problem' requiring treatment serve to legitimise specific treatment modalities that have far-reaching political consequences for those diagnosed with the 'problem'.

Although several new recovery researchers working in the alcohol and other field have acknowledged the tensions inherent in attempting to generate an evidence base for a phenomenon that is so poorly defined (Best et al. 2012; Best, De Alwis, & Burdett, 2017; Laudet, 2008; Pillay, Best, & Lubman, 2014), this has not hampered the development of a burgeoning field of recovery-focused research. Recent scientific research on new recovery, mainly in social psychology, has studied a diverse range of themes including peer relations, social networks, social identity, the recovery experience, quality of life, abstinence, spirituality, protective resources and desistance factors (e.g. Best, Ghufran, Day, Ray, & Loaring, 2008; Best, Irving, & Albertson, 2017; Best, McKitterick, Beswick, & Savic, 2015; Best et al. 2013; Best et al. 2014; Kelly & White, 2011; Maffina, Deane, Lyons, Crowe & Kelly, 2013; Mawson, Best, Beckwith, Dingle, & Lubman, 2015). Much of this work has framed recovery through the lens and language of social psychology, and conceptualised it within a 'biopsychosocial' treatment model of illness or disease. Qualitative and quantitative psychological research has focused mainly on developing the 'evidence base' necessary to gain support for recovery as a viable policy response to drug-related harm. The political imperative to create an evidence base has been acknowledged by leading new recovery researchers such as David Best, William White and Alexandre Laudet, whose research often

has an explicit focus on raising political awareness of and support for recovery as a guiding principle in treatment policy (e.g. Best & Ball, 2011; Laudet, 2008; White, 2012a).

Influenced by the emerging new recovery agenda, drugs policy and the alcohol and other drug sector in the UK has embraced recovery-oriented drug treatment over the last decade (Duke, 2012; Duke, Herring, Thickett, & Thom, 2013; Neale et al., 2015). The shift to recovery in UK policy was driven most significantly by the reframing of opioid substitution treatment as an approach that perpetuates addiction and entrenches people who use drugs in criminal activities and unemployment (Ashton, 2007; Duke et al., 2013; Duke & Thom, 2014). Several scholars of UK drug policy have documented the complex processes that led to this reframing, with particular attention paid to how conservative stakeholders used particular kinds of evidence to criticise harm reduction and methadone prescribing in particular (Ashton, 2007; Duke & Thom, 2014; Thom et al., 2013; Wardle, 2012). For example, the Centre for Social Justice, a conservative UK think tank, published two reports that were highly critical of the expansion of MMT, arguing that it was implicated in the 'entrenchment' of addiction (Centre for Social Justice, 2007; Duke, 2012; Lancaster et al., 2015). Following an influential media report from BBC reporter Mark Easton, numerous media outlets also reported National Agency Treatment statistics that suggested that only 3% of service users exited treatment drug free. Stakeholders and the media debated whether there should be a greater emphasis on abstinence and on ensuring that people left treatment drug free (Ashton, 2007; Duke, 2013; Lancaster et al., 2015). As Duke (2012) argues, 'the drugs "problem" was increasingly redefined and framed as a harm reduction and methadone problem with too many users stuck in the "methadone parking lot"' (p. 47). Alongside the media focus on the importance of exiting treatment 'drug free', several influential stakeholders, including Scottish new recovery advocate David Best (prior to his relocation to Australia), Mark Gilman of the National Treatment Agency, Kathy Gyngell from the Centre

for Policy Studies and Neil McKeganey from the Centre for Drug Misuse Research, published influential research on the topic and gave public presentations criticising the ethics of methadone treatment (Ashton, 2007; Wardle, 2012). This period has been described by some commentators as signalling the 'fall from grace' of harm reduction (e.g. McKeganey, 2012).

In addition, during the lead-up to the UK general election in May 2010, stakeholders debated about the proper purpose of treatment and how 'recovery' should be defined. The form and content of these debates were influenced by the Betty Ford Institute Consensus Panel, which convened in the US in 2007 in order 'to develop a consensus definition that might serve as a starting point for open communication' (The Betty Ford Institute Consensus Panel, 2007, p. 222). The panel included influential researchers, clinicians, policymakers and community members in recovery, along with recovery advocate William White and Dr Thomas McLellan, the former Deputy Director of the White House Office of National Drug Control Policy (Duke & Thom, 2014). The panel defined recovery from 'substance dependence' as 'a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship' (The Betty Ford Institute Consensus Panel, 2007, p. 222). Following on from the consensus panel, the United Kingdom Drug Policy Commission (UKDPC) convened meetings of stakeholders to 'identity the common-ground and develop a clearer understanding of recovery' (UKDPC, 2008, p. 2). The UKDPC defined recovery as 'voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society' (UKDPC, 2008, p. 6). The UKDPC's adoption of a more harm reduction-oriented approach, which also included 'medically maintained abstinence', did not satisfy those stakeholders who supported complete abstinence (Duke, 2012; Duke et al., 2013). In 2008 the Scottish Government published its new drug strategy, *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem*. Although

heavily influenced by the recovery debate in mental health, this strategy positioned recovery as a process leading to the development of a 'drug-free life' and of becoming 'an active and contributing member of society' (Scottish Government, 2008, p. vi). Influenced by these developments, and following the 2010 election, the newly formed British Conservative-Liberal Democrat coalition government published a new drug strategy focused on supporting drug users to become 'drug free' and enter into 'recovery' (Duke, 2012). Since the publication of this strategy, new recovery has 'been endorsed at multiple levels [in the UK] including government strategies, publications by think tanks, speeches by politicians, substantial grassroots activity, changes to commissioning practices and service delivery and altered funding structures' (Neale, Panebianco et al., 2016, p. 31). Although the uptake of new recovery in drugs policy and in the alcohol and other drug sector in the UK has been substantial, this approach has met with a different reception in the Australian context, for reasons I explore below.

The making of new recovery in Australia

In Australian alcohol and other drug policy and practice there has been a growing emphasis on 'evidence-based' or 'evidence-informed' policy (Lancaster, 2016; valentine, 2009). As Lancaster argued recently, '"evidence-based policy" has become the catch-cry of the drug policy field' (2014, p. 949). Yet, despite the increased focus on the production of 'gold-star' evidence and policy-relevant research (Lancaster, 2014), new recovery emerged in Australian policy discourse and service delivery in the absence of empirical research identifying a local need for recovery-oriented policy responses. As I explore later, however, new recovery is constituted differently in different contexts. Its emergence in Australia has been tempered and modified by the strong harm reductionist ethic characterising alcohol and other drug policy and treatment, and, as I explore in later chapters, the tenacity and continuing influence of 12-step models of recovery in everyday lives and practices.

Since the late 1980s, harm minimisation, broadly defined as policies, programs and interventions that encompass harm reduction, supply reduction and demand reduction strategies, has been the primary organising framework and philosophical approach underpinning alcohol and other drugs policy and treatment in Australia. Although scholars have continued to analyse and debate the principles, values and regulatory effects of harm reduction (e.g. Lenton & Single, 1998; Moore & Fraser, 2006; O'Malley, 1999; Rhodes, 2002), it is widely accepted that harm reduction policies and principles 'promote rationality, pragmatism and utilitarianism in the development of drug interventions' (Keane, 2003, p. 228). Moreover, harm reduction policy and practice is supported by a significant body of sociological and epidemiological research, and illicit drug policy analysis, which has highlighted the effectiveness of harm reduction interventions and practice in Australia (e.g. Hawks & Lenton, 1995; Ritter & Cameron, 2005; Single & Rohl, 1997; Stimson, 1998; Wodak & Lurie, 1997).

Australian critics have argued that to embrace a new recovery approach may herald a return to abstinence-based policy wherein deterministic notions of drug harms and addiction may undermine the autonomy, agency and health of people who use drugs (AIVL, 2012; Anex, 2012). Following the circulation of documentation arising from the UK drug policy experience, opposition to new recovery initially came from harm reduction-focused peak bodies in the alcohol and other drug sector (Lancaster et al., 2015). For example, in their responses to new recovery, AIVL (2012) and Anex (2012) (now the Penington Institute) harnessed emerging international criticisms concerning the potential of recovery-focused treatment to undermine harm reduction policy and reduce spending on harm reduction programs (Ashton, 2007; Watson, 2012). These alcohol and other drug sector peak bodies were not persuaded by arguments that new recovery is compatible with harm reduction philosophy and practice. In these 'recovery as harm reduction' arguments, new recovery is

conceptualised as a long-term process leading to improved quality of life and which incorporates a wide range of interventions (Best & Ball, 2011; Best et al., 2010; White, 2012a). However, new recovery discourse has also emphasised a drug-using trajectory that predominantly ends in abstinence and which focuses on sustained abstinence as a central measure of success (e.g. Best et al., 2011; Laudet & Stanick, 2010; White, 2007). In response to the preference for abstinence-based outcomes, AIVL (2012) has argued that 'harm reduction is about ***active drug use***. Harm reduction ***is*** the goal' (p. 6, emphasis in original). This restatement of the longstanding harm reduction commitment to reducing harm rather than reducing drug use *per se* highlights the underlying assumptions about the undesirability of drug use in new recovery discourse (AIVL, 2012; Duke, 2012; Keane, 2000).

In its response to the emerging new recovery agenda, AIVL also questioned whether abstinence-based treatment discourse may exclude and further stigmatise long-term pharmacotherapy consumers. Earlier iterations of new recovery emphasised 'full recovery' (Best & Ball, 2011; Her Majesty's Government, 2010; White, 2007) and distinguished between 'active use' and 'people in recovery' (Boyle, Loveland, & George, 2011; Laudet, 2007; van Melick, McCartney, & Best, 2013). In later chapters I explore these important issues in greater detail, particularly the way in which such demarcations are reflected and reproduced in contemporary psychological research and treatment practices. The distinction potentially excludes pharmacotherapy users from the category of those in 'full recovery' and implies that drug users who 'actively' use drugs are disordered or ill and therefore in need of treatment or restorative interventions. Likewise, in its position paper, Anex (2012) noted that even though recent developments in recovery policy have attempted to accommodate pharmacotherapy clients, abstinence remains the primary goal of recovery-focused treatment in the US and UK (Best et al., 2010; White, 2007). Furthermore, there was a general lack of

discussion about the significant issues of HIV prevention and hepatitis management within new recovery literature (Anex, 2012, p. 12).

In June 2012, in an effort to resolve some of the tensions within the Australian alcohol and other drug sector, the Australian National Council on Drugs[2] (ANCD) convened the '1st Recovery Roundtable' in Canberra to discuss the meaning of the recovery concept and its implications for the Australian treatment sector (Lancaster et al., 2015). This roundtable was widely attended by those working in professional organisations, advocacy groups, peak bodies, research departments and treatment services. Although it provided a legitimate forum for stakeholders to air their concerns, no consensus on the status of new recovery was reached (p. 622). Unlike the British context in which the merits of recovery were debated, in the Australian context, 'recovery itself was constituted as problematic' (p. 620). In this sense, Australian debates around new recovery were 'in many ways contingent upon the problematisations [already] produced in "recovery" discourse in the British context' (p. 623) – that is, the problematisation of methadone (and more broadly of harm reduction) as entrenching addiction. Although no consensus was reached on the status of new recovery, some of the claims made at the recovery roundtable constituted a 'vigorous defence of the existing treatment system' (p. 623). In this respect, the recovery roundtable did reach a consensus on the need to retain harm minimisation as the guiding principle of the National Drug Strategy. In contrast to these debates at the national level, the emergence of new recovery took a very different course in the state of Victoria.

[2] At the time, the ANCD was the principal advisory body to the Australian Government on drug policy.

Recovery-focused treatment in Victoria, Australia

In Australia, recovery-focused treatment approaches have a long unofficial history in residential services and therapeutic communities (AIVL, 2012; Ritter, Lancaster, Grech, & Reuter, 2011), with the latter placing great emphasis on recovery-oriented interventions (Yates, 2011). In these settings 'peer community' is used to facilitate individual social and psychological change (De Leon, 2000). The daily routine and structure of these communities is marked by rigidity, pressure, hierarchy and the strict deployment of rules (Yates, 2011). These rules are thought to provide healthy behavioural cues and motivate positive identity change among residents (Best, Haslam et al., 2016; Yates, 2011). The recovery discourses and practices also operate in other residential treatment settings, withdrawal services, counselling and self-help groups. As I noted earlier in the chapter, this specific notion of recovery has also long been central to peer-based and self-help support services such as AA and NA (Alcoholics Anonymous, 2006). In contrast to these older and broader ideas of recovery, new recovery, the specific focus of this thesis, emerged in Victorian policy and practice through the recommissioning and reform of the delivery of alcohol and other drug treatment services undertaken in 2013–2014. While several studies have focused on clinicians' attitudes to new recovery in Victoria (Best, Savic, Mugavin, Manning, & Lubman, 2016; Maffina et al., 2013; Pillay et al., 2016), to date no sociological research has examined how those enrolled in treatment in Australia view and experience recovery.

Prior to the recommissioning and reform of Victorian alcohol and other drug treatment services in 2013-14, a review of the effectiveness of alcohol and other drug prevention and treatment services had been undertaken in 2011 (Victorian Auditor-General's Office (VAGO), 2011). The VAGO report identified several problems related to funding and service delivery in the existing Victorian treatment system, which, since 1994–95, had been based on a payment model characterised by 'episodes of care'. An episode of care was defined as 'a

completed course of treatment undertaken by a client under the care of an alcohol and drug worker which achieves significant treatment goals' (Department of Human Services, 2003, p. 90). The VAGO report argued that this system measured 'output over outcomes', allocated inadequate resources to 'complex clients' and encouraged the deliberate opening and closing of episodes in order to extend the length of treatment and boost the perceived level of service activity (Moore & Fraser, 2013; VAGO, 2011). In response to the issues identified in the VAGO review (and in addition to a longstanding interest in sector reform), the state government instituted a reform of the treatment system and services in 2013–2014.

Alongside the growing impetus for treatment system reform, David Best's appointment to Victoria's Turning Point Alcohol and Drug Centre in 2011 helped new recovery to gain local policy traction. During his tenure, recovery became a significant issue in drug policy and research. Best generated considerable recovery research activity in Victoria, including the development of a research agenda on recovery and social identity (explored in Chapter 5), and new research collaborations with Victorian treatment providers (Mackenzie, Best, Savic, Hunter, & Bailey, 2015). He also set up a new Master of Addictive Behaviours degree with a specialised 'recovery principles' unit at a major Victorian university, and founded the Victorian arm of the Recovery Academy of Australia. He also generated considerable policy activity, including contributing to the previously mentioned 'recovery roundtable', the shift towards recovery-focused policy and system planning, and the subsequent recovery-focused reform of the treatment system.

Following the release of the VAGO (2011) report, the Victorian Government conducted an intensive period of alcohol and other drug system planning. This involved the publication of several major reform-oriented policy documents and the establishment of a whole-of-government Expert Advisory Group, which operated for 12 months, as well as alcohol and other drug practice-oriented advisory groups (Berends & Ritter, 2014). The Expert Advisory

Group was established to provide an evidence-based assessment of the strengths and weaknesses of the existing system and to identify potential areas for reform (p. 17). The Victorian Alcohol and Drug Association, the peak body representing alcohol and other drug services, also undertook community consultation to inform strategy development during 2012 (Berends & Ritter, 2014). Although these community consultations took place, their significance in the final design of the redeveloped treatment system is unclear (Berends & Ritter, 2014).

In 2012, the new Victorian strategy was released, which had an overarching focus on 'care, treatment and recovery' (Department of Health, 2012a). Previous Victorian drug strategies, and indeed all the previous national strategies, had made no such claim. These earlier strategies had focused primarily on reducing individual risk behaviour and drug-related harm (e.g. Commonwealth Department of Health, 1985; Department of Human Services, 2008; Ministerial Council on Drug Strategy (MCDS), 1993, 1998, 2004). Although the Australian national strategy (MCDS, 2011) included a new recovery focus as part of its commitment to demand reduction, it retained its overarching commitment to harm minimisation. The Victorian strategy was therefore out of step with the national strategy; it had shifted from the national 'harm minimisation approach' (p. 9) to a 15-point plan that focused on strategies to address 'the safe, healthy and responsible use of alcohol, tackle the misuse of pharmaceutical drugs, reduce illegal drug use, and assist the care, treatment and recovery of people with drinking and drug problems' (Department of Health, 2012a, p. 3). In June 2012, the Victorian Government published *New Directions for Alcohol and Drug Treatment: A Roadmap*, which charted the course for treatment reform: 'We want to reorient alcohol and drug treatment to build a stronger focus on a person's individual, social and economic recovery' (2012b, p. 2). It also presented an explicit 'roadmap' to redevelop a 'recovery-oriented alcohol and drug treatment system' (p. 18). During this period several ministerial communiques and reform

documents were also published that outlined the emerging new recovery approach (Department of Health, 2013a; 2012c).

Although the extent to which new recovery has been adopted in the newly reformed Victorian system remains unclear, it is evident that new recovery ideas were significant in the earlier stages of the reform. This was particularly the case in regards to policy development and recommissioning, which had flow-on effects and political implications. For example, in late 2013, the Victorian Department of Health began recommissioning adult, community-based (non-residential) alcohol and other drug treatment. Prospective service providers were required to prepare extensive submissions detailing their capacity to provide the redeveloped treatment types in a particular catchment area. A document released by the Department of Health (2013c) informing service providers about the service specifications required in order to be eligible to submit a tender was prefaced by a newly developed statement of Victorian alcohol and other drug treatment principles. In the reform specifications document, the Department of Health (2013c) stated 'the principles have as their foundation a philosophy of harm minimisation and a recovery orientation' and that they 'should underpin all practice approaches, models of care, treatment modalities, policies and procedures, planning, performance, supervision, training and quality activities' (p. 4). The principles reflect much of the language of new recovery, including that treatment must be 'person-centred', involving people 'who are significant to the consumer', provide 'for continuity of care' and be 'oriented towards people's recovery' (pp. 4-5). Without wishing to overstate the importance of these principles, the inclusion of new recovery language and practices in the tendering process presumably influenced prospective service providers or consortia to incorporate recovery discourse in their submissions in order to improve their chances of success.

The recommissioning process resulted in the consolidation of 20 separately funded treatment types delivered through 105 providers into 27 organisations or consortia delivering a mixture

of treatment types across 16 catchment areas (Berends & Ritter, 2014). The existing treatment types were consolidated into five new treatment activity streams: intake and assessment, care and recovery coordination, counselling, non-residential withdrawal and catchment-based planning. Whereas funding was previously allocated on the basis of the 'episode-of-care' model, funding under the new system was based on 'Drug Treatment Activity Units'. The episode of care was 'the fundamental unit for aiming to measure or guide service activity, service outcomes/quality and service funding' in the previous system (Department of Human Services, 2003, p.1). In activity-based funding, the unit of activity, rather than the entire episode, became the fundamental unit used to determine funding and monitor accountability. O'Reilly et al. argue that the 'main rationale for moving to activity-based funding is the establishment of a transparent link between funding and activity' (2012, p. 74). In other words, governments are more easily able to track where the money is being spent. Prior to the reforms, advocacy groups had expressed concern about the possible adoption of a 'payment by results' system of funding similar to that being trialled in the UK (AIVL, 2012). Although payment by results is indeed a type of activity-based funding, the Victorian model falls short of incentivising outcomes and instead retains the 'block' payments system of the episode of care model. However, instead of funding episodes, cases or outcomes, it funds particular activities that have a fixed price.

Despite the emphasis on developing a recovery-oriented system of care in the policy and reform documents, councelling received the largest amount of statewide funding in the reformed system ($17.3 million), followed by intake and assessment ($13.7 million), care and recovery coordination ($5.4 million), non-residential withdrawal ($3.5 million) and catchment based planning ($768,000) (VAADA, 2013). Considering the funding allocation, it is unsurprising that the most significant change was the development of a centralised intake and assessment service, whereby a single service provider in each catchment area (nine metro

and seven rural) delivers statewide screening and referral. For example, the intake and assessment function for the Inner North Melbourne catchment (comprising the local government areas of Moreland, Moonee Valley, Melbourne and Yarra within the city of Melbourne, the capital of the state of Victoria) is now provided by Uniting Care ReGen, a non-government organisation. Whereas previously, service users could access multiple points of entry for direct intake or referral to specific services, they were now directed to a central intake point in each location or were advised to contact DirectLine, a new statewide telephone and online portal, to complete an assessment. Although there has been little research evaluating the impacts and effects of the reform (Berends & Ritter, 2014), anecdotal reports suggest that the centralised intake and assessment points have required service users to travel further to access treatment and that pre-existing relationships with local service providers and supports have been disrupted.

At the centralised intake and assessment point in each catchment area, service users are assessed for treatment through a new standardised screening and assessment tool that was developed, piloted and evaluated by Turning Point Alcohol and Drug Centre (Department of Health, 2013a; Department of Health, 2013b). The screening tool records information about the service user, including demographics, substance use information, mental health and wellbeing, living arrangements and employment/training status. This information is used to allocate clients to five tiers of alcohol and other drug problem severity and life complexity. The allocation to a particular tier determines the treatment that service users are eligible to receive. For example, service users whose score places them within tier 1 or 2 receive brief interventions such as telephone counselling, psychosocial education, information and advice. Service users whose score falls within tier 3, 4 or 5 are entitled to a face-to-face comprehensive assessment. Service users who fall under tier 5 and are assessed as more complex might be recommended for ‘care and recovery coordination’. In theory, care and

recovery coordination was introduced to assess, monitor and coordinate the progress of all treatment clients. However, in Victoria, only clients assessed as 'complex' on the screening and assessment tool (i.e. those defined as having an alcohol or other drug dependence and behavioural, legal, physical health and/or mental health issues) received this recovery-focused treatment coordination (funding for which is capped at 15 hours per 'episode of care' over 12 months). Limited in reach and funding, care and recovery coordination has been criticised as ineffectual and lacking detail and clarity (Berends & Ritter, 2014).

The above account suggests that despite the attenuation of new recovery discourse in the reformed treatment system, new recovery has gained considerable traction in Australian and Victorian research, policy and practice. Having provided this background on debates over the emergence of new recovery in US, UK, Australian and Victorian drug policy, I now provide a brief overview of my theoretical approach to the constitution of new recovery.

Making recovery anew

This research examines the making of new recovery and its effects across multiple sites. My analysis is informed by recent scholarship and concepts drawn mainly from science and technology studies (STS). This approach is broadly interested in the performativity of material–discursive practices and the constitution of realities in a broad array of practices including policy, science, institutions and discourse. Where appropriate, I also draw on feminist poststructuralist scholars Judith Butler and Carol Bacchi, whose work has either influenced or been influenced by STS, to further explore the relationship between the making of new recovery and the making of material realities and subjectivities.

I explore the key STS concepts used in this thesis in more detail in Chapter 3. Here I provide a brief outline of recent relevant work in STS and how these insights inform the scope and focus of my thesis. In particular, I draw on three concepts which pose a radical challenge to

the realist orientation of much sociological and scientific research (i.e. recovery exists in the world and the challenge is for researchers to intelligently explore and explain its underlying mechanisms and attributes). The first concept is that of *enactment*, which emphasises that all entities and phenomena are forged and sustained through continuing networks of practices (Law, 2004). It holds that objects and realities do not exist independently 'out there' in the world but are instead made in practice. A focus on enactment reframes my object of inquiry from new recovery as it 'exists' in the world to the multiple and related knowledge, political, professional, institutional and technical practices engaged in its making, and to the relations between these practices that preserve new recovery's authoritative and empowering character. The concept of enactment foregrounds the relational and entangled character of realities and reality-making. At stake in any given enactment of new recovery are other phenomena and realities too; for example, of central importance to my study are enactments of addiction, identity and citizenship. Each enactment of recovery makes different iterations of these entities – different 'collateral realities' – 'along the way' (Law, 2013). The ontological approach here is one of performativity, with the focus being the continual practices of enactment and crafting that sustain specific realities of recovery. The second concept that informs my theoretical orientation is *multiplicity*. If we accept that new recovery exists only in its enactment (and re-enactment) through networks of practice, recovery can no longer be thought of as a coherent independent entity (e.g. residing in individual identities and behaviour) but as multiple (Mol, 2002). This observation about ontological multiplicity is significant because it must follow that no specific reality is given in nature. Instead objects and realities are forged through practices and processes that materialise and bear traces of preferences, forms of inclusion and exclusion, and politics more broadly (Mol, 1999). In light of this ontological indeterminacy, the practices that constitute new recovery can be understood as engaging in *ontological politics*, which is the third concept informing my

theoretical orientation. ‘Ontological politics’ is the recognition that because realities are made in ongoing practices, they can always be made otherwise (Law, 2004; Mol, 1999). I analyse the ontological politics of new recovery by examining multiple sites of enactment and the relations between these enactments of recovery. As one might imagine, the ontological politics of recovery is complex and comprises and extends into a vast array of practices, knowledges, associations and politics.

Drawing on an STS approach allows me to ask three research questions in my analysis of new recovery:

1. ***How is this new iteration of recovery enacted in drug policy, research and treatment in Australia, and what assumptions and claims about drug use and people who use drugs are made along the way?***
2. ***How do people who use drugs adopt, accommodate, resist or otherwise engage with recovery in treatment and their everyday lives?***
3. ***What are the political effects of these recovery enactments?***

To answer these questions and conduct my analysis, I first analyse a corpus of Australian alcohol and other drug policy documents and psychological scientific texts in order to identify how new recovery is enacted and the different kinds of assumptions that are mobilised about drug use and drug-using subjects. I then analyse interviews conducted with 11 alcohol and other drug professionals, including service providers, policy stakeholders and researchers, and 26 people who currently inject drugs or who have done so in the past. I look closely at professional narrative accounts of recovery and treatment practices to examine how new recovery takes shape in and through treatment practices and discourse, and how new recovery is organised as a coherent therapeutic entity through professional practices. In order to explore the political effects and ramifications of new recovery, I closely examine the

recovery in and through treatment and everyday practices. These accounts reveal the multiplicity of practices and knowledges that shape recovery and the competing tensions that shape peoples' lives and agency. They also foreground the persistence of older, largely 12-step-informed, recovery ideals and practices in everyday realities. To this end, I speculate as to whether the failure of new recovery to greatly influence treatment or everyday practices of recovery might be due to its inability to offer anything genuinely new. Instead, I argue that new recovery recapitulates neoliberal logics of self-management and responsibilisation and fails to build on more recent socially-oriented approaches and responses to drug harms (Faulkner-Gurstein, 2017; Fraser, 2017). It intensifies normative understandings of health, self-responsibility and citizenship, actively reproducing a reality that is harmful, stigmatising and politically disempowering for many individuals who use drugs.

Thesis outline

In the following chapter I review the literature on new recovery and note the limitations of existing research. Qualitative literature on new recovery is most fully developed in relation to UK policy discourse. Reflecting the now entrenched nature of new recovery in UK politics, much of this research has endeavoured to refine its central concepts and concerns in order to make recovery more sensitive to service users' experiences. I also review three critical studies that suggest the need for an analysis of new recovery that examines its underlying assumptions about drugs and the people who use them, as well as the kinds of political claims new recovery makes possible (and forecloses). Thus far, the question of what new recovery offers beyond previous iterations has yet to be explored. In part, this is because the existing research has not fully explored its relationship to older, broader versions of recovery. Therefore in the second part of the literature review, I examine key sociological analyses of earlier forms of 'recovery'. These explore recovery by focusing on identity, governmentality and treatment practices. These studies offer useful starting points, in different and various

ways, for my analysis of new recovery and highlight continuities between these older forms of recovery and its new iteration.

In Chapter 3, I describe the theory–methodology conceptual framework that I sketched briefly above. This chapter introduces the main theoretical concepts used to analyse the constitution of recovery: enactment, multiplicity and ontological politics. I show how these concepts have been used in recent work in STS and how they provide the means to produce an account of new recovery that emphasises emergence, relationality and politics. Although the theory-methodology I use is generally informed by the STS concepts of enactment, multiplicity and ontological politics, I also employ more specific interpretive tools derived from, or cognate with, STS in each chapter in order to showcase the utility of posthumanist approaches. In the second half of Chapter 3, I outline a 'case' approach (also informed by STS), which allows me to focus on practices of enactment and tension in each empirical site, and describe how my data were gathered and analysed.

Chapter 4 is the first of five empirical chapters. I draw on poststructuralist policy analyst Carol Bacchi's 'What's the problem represented to be?' approach. Bacchi's work is influenced by Foucault and STS, and I use it to examine new recovery discourse in Australian and Victorian alcohol and other drug policy. This approach to policy analysis draws attention to the implicit and explicit problem representations that policy proposals purport to address. These problem representations, Bacchi argues, have discursive, subjectification and lived effects. I consider policy claims that new recovery represents a shift from a pathologising to a strengths-based approach. I identify three problematisations and dynamics which trouble this claim. First, I argue that new recovery intensifies the pathologisation of individual drug use; second, the increased focus on treatment in new recovery in Victoria more concretely enjoins specific obligations by which drug-using subjects must operate; third, the expanded focus on community solutions poses the risk of potentially marginalising drug-using subjects from

civic life, thereby contributing to the social exclusion it hopes to address. I argue that new recovery is usefully viewed as a contemporary citizenship regime that intensifies and expands upon neoliberal commitments that have operated more subtly in previous Australian drug policy.

Building upon my analysis of new recovery in policy, Chapter 5 presents another authoritative site through which to explore enactments of new recovery: psychological science. In this case, I explore how the science of new recovery distils and reproduces broader obligations and expectations around responsibility and citizenship through a psychological lexicon. I draw on Law's (2011) account of 'simplification practices' (p. 162) – that is, those of selection, juxtaposition, deletion, ranking and framing – to illuminate practices of inscription, inclusion and exclusion that enact scientific accounts of new recovery. In particular, I draw attention to new recovery's binary logic between the individual and the social environment, and consider the subjective and political effects of this simplification. The social worlds of people who use drugs are enacted primarily as consisting of manageable 'resources' and interpersonal social relationships, with little attention given to entrenched and enduring socioeconomic and political forces. This simplification forms the basis for a sustained responsibilisation in which individuals are enjoined to take control of the social environment in order to change their behaviour and 'recover'. I argue that the ontological politics of new recovery science enacts a depoliticised account of the social, wherein drug-using subjects are figured as entirely responsible for their own recovery. Moreover, new recovery ignores recent innovations in harm reduction, which cast the social relationships of people who use drugs as valuable resources for health (Farrugia, Fraser, & Dwyer, 2017; Faulkner-Gurstein, 2017; McLean, 2016), by framing the control and divestment of these relationships as central to recovery and health.

New recovery is also enacted in professional narratives and practices of treatment, which I explore in Chapter 6. I use Mol's work on 'coordination strategies' as a way of drawing attention to the kind of work being done in professional accounts. These accounts draw together different recover*ies* into a serviceable clinical entity and render 'recovery' sensitive to the complex and contradictory ways in which people pursue health and change through treatment. However, in trying to make 'recovery' cohere as a singular entity, they also highlight the multiplicity of different recovery enactments currently in operation in treatment services in Australia. In these coordinating practices, professional enact their own local and hybrid variants of recovery, which, at times, accommodate elements of new recovery but which also often mobilise longstanding enactments of recovery.

In Chapter 7 I move from professional practices to treatment practices. I examine how the social and material practices of alcohol and other drug treatment are themselves active in the constitution of the 'recovering addict' identity that is the object of so many previous enactments of recovery. I use Law's 'modes of ordering' and his reworking of Butler's interpellation to examine the accounts of treatment experiences and practices provided in interviews with people who inject or have previously injected drugs. This chapter troubles the coherent 'recovering addict' identity that is central to the psychological accounts I examine in Chapter 5. I argue that the 'recovering addict' is a socially produced category, and I trace the instantiation and adoption of this identity in relation to three dynamics identified in the data: 1) the tendency to materialise treatment subjects as both disordered *and* as 'in control' of these disorders; 2) the production of treatment subjects as enmeshed in suspect social relationships and therefore requiring surveillance as well as social support; and 3) treatment's particular enactment of social context such that it erases stigmatisation and marginalisation and paradoxically performs subjects as entirely individually responsible for relinquishing drug use. These dynamics invite identification with a 'recovering addict' identity, and support

the professional approaches examined in Chapter 6. They also gesture towards the ongoing multiplicity and hybridisation of 'recovery' in practice. Older notions of addiction and the 'recovering addict' identity are reproduced in residential treatment environments, and are buttressed by the recent concern with social relationships and citizenship in this new iteration of recovery.

In Chapter 8, the final empirical chapter, I examine everyday life as the location where the multiple orderings and enactments of new recovery produced in authoritative sites meet. Although noticeably absent in the authoritative accounts of new recovery analysed in earlier chapters, 12-step understandings and practices of recovery remain influential in the lives of people who use drugs. Many people engage and perform recovery via an ethics of self-work, which requires constant self-scrutiny. I explore how individuals, in remaking themselves as recovering subjects, are interpellated by reparative, responsiblising and normalising logics. Paradoxically, the identification with addicted subjectivity and the practices of hyper-vigilance and self-improvement demanded by recovery produced some undesired and uncomfortable effects. In this chapter, I also explore other ways of engaging with recovery: resistance to the authoritative enactments of recovery, particularly the narrow and deterministic understandings of addiction and health; the strategic adoption of recovery concepts and practices for purposive aims; and the (partial) incorporation of 12-step discourses and practices. These accounts suggest much more complex engagements with recovery than have been acknowledged in the literature thus far. The strategic accommodation and incorporation of recovery by other participants in everyday life also point to alternative conceptions of recovery that exceed the category of identity.

In the concluding chapter, I draw together my conclusions as to how new recovery is enacted across authoritative sites and the assumptions it makes about drug use and people who use drugs. I argue that new recovery is enacted multiply, with continuity, overlap and

hybridisation with other longer-standing forms of recovery. I explore the ontological politics of new recovery, arguing that it is constituted through various problematisations, simplifications and erasures. These repeatedly, and in different ways, pathologise drug-using subjects, ignore important social, political and material forces that are constitutive of drug harm, and frequently stigmatise their social relationships. These have political effects that surface in everyday practices and constitute a range of abject subject positions that help determine the narratives on which people draw to make sense of their lives, and foreclose other kinds of more socially-oriented political claims.

Chapter 2

Locating new recovery

In this chapter, I first review recent scholarly work on new recovery. I then review earlier sociological literature on previous discourses of recovery in order to identify some of the commitments carried over from this earlier research into the more recent literature. I argue that tracing these threads of continuity raises questions about the claimed originality of new recovery.

Of the recent qualitative work, critical policy research has most forcefully problematised new recovery. These scholars, mostly from the UK, have drawn attention to several tensions relating to ongoing difficulties in defining recovery, the potential for new recovery concepts to be absorbed and appropriated in neoliberal alcohol and other drug policies, and the challenge it has posed (in the UK) to harm reduction policies and practices. Responding to the emergence of new recovery in UK policy, sociologists have sought to refine the recovery agenda through critical scrutiny of its key concepts and assumptions. This research has sought to develop more sensitive measures of recovery that incorporate the experiences and concerns of people who use drugs. Although this research has yielded important insights, it has also helped to authorise and consolidate new recovery's position in drug policy. I then review three pieces of scholarship that focus on the politics of new recovery, forerunners of the direction I take in this study. This section highlights how the normalising and profoundly subjectifying effects of new recovery shape our understandings of drug use, people who use drugs, and drug treatment. It also emphasises the importance of examining people's accounts of their everyday lives in order to illuminate the avenues and political claims new recovery makes available for achieving healthy subjecthood and citizenship.

In the second half of this chapter, I review earlier sociological work on previous versions of recovery. I highlight the key contributions of this work and explore its significance for this study. I identify themes and commitments in this earlier work that continue to shape understandings of and research on new recovery. I first argue that symbolic–interactionist accounts of recovery as a process of individual identity change remain influential (I return to this theme in Chapter 5). Although recent poststructuralist accounts explain recovery-as-identity-change as shaped by discourse, gender and treatment, they tend to reinforce and reify a monolithic notion of recovery as a process of identity change. I then review poststructuralist analyses that have explored the connections between addiction discourses and the constitution and regulation of healthy neoliberal citizenship. This work consistently highlights the significance of addiction recovery discourses in reflecting and reproducing contemporary norms and values around subjecthood, health and citizenship. I argue that research on new recovery has yet to fully interrogate the kind of political universe its subjects are being asked to embrace. Finally, I explore the critical literature on recovery-focused treatment that highlights the powerfully subjectifying effects of treatment practices. Importantly, while several studies have examined new recovery in Australian alcohol and other drug policy (Lancaster, 2016; Lancaster et al., 2015), no work has yet been undertaken on how new recovery has influenced alcohol and other drug treatment in Australia. Similarly, while critical policy scholarship on new recovery has begun to use conceptual resources related to the ontological turn (Frank, 2017; Lancaster et al., 2015), the utility of posthumanist approaches for understanding new recovery has yet to be fully explored. To date, there has not been a detailed critical exploration of new recovery across multiple sites. There is a need for an analysis that engages the multiplicity of new recovery in professional and treatment practices, and the extent to which new recovery has informed professional practices, treatment and people's everyday lives.

Qualitative research on new recovery

The following section examines qualitative literature on new recovery. As I explore first, qualitative literature on new recovery is most fully developed in relation to UK policy discourse. Responding to the rise of new recovery in UK policy and practice, the second body of research I examine endeavours to make the concept of recovery more sensitive to service users' experiences so as to improve treatment experiences and outcomes. I argue that although this research is politically important, it does not fully engage with the ontological and ethical assumptions of new recovery, or the performativity of knowledge practices. I then review three critical studies that suggest the need for an analysis of new recovery that interrogates its underlying assumptions, as well as the kinds of political claims new recovery engenders.

Problematising new recovery

The qualitative literature on new recovery overwhelmingly takes a critical perspective on new recovery's aims and political effects. This work has been conducted primarily in the UK and has emerged in response to changes in national policy and in treatment delivery brought about by the adoption of new recovery as a governing principle. Critical policy studies is one area in which criticisms of new recovery have been most fully articulated. Although some new recovery researchers have argued that the definition of new recovery is left intentionally broad so as to encompass individual and diverse experiences (Laudet, 2007; White, 2007), critical policy scholars have suggested that its definitional ambiguity is central to new recovery's political attractiveness (Duke, 2012; Duke et al., 2013). Exactly how new recovery differs from older articulations that focus on 'cure' and 'rehabilitation' depends on the changing political contexts 'within which the new language operates' and the political and professional interests invested in its meanings (Berridge, 2012, p. 23). New recovery-focused

policy in the UK represents significant changes from the past but it also carries over threads from Labour's previous policy frameworks, which, like new recovery, sought to mobilise volunteering, participation and community responsibility (Duke, 2012; Monaghan, 2012). With its focus on exiting treatment, responsibility and self-management, the new recovery agenda aligns well with neoliberal reforms in health policy in which health becomes the active responsibility of individuals rather than governments (Lancaster et al., 2015). Because it is so open to interpretation, recovery can be framed in different ways depending on the policy context and the interests of relevant stakeholders (Duke, 2012). As Duke (2012) argued, the new recovery agenda, which emphasises freedom, self-management and independence via largely non-governmental support structures, aligns well with neoliberal policy agendas.

Researchers have also expressed concerns about the potentially harmful effects of new recovery on the organisation and focus of drug treatment services (Duke et al., 2013; Monaghan, 2012). These concerns have mainly centred on new recovery's implications for the funding and resourcing of harm reduction services and interventions. McKeganey (2012) has argued, for example, that the challenge for harm reduction services is how they might accommodate a recovery orientation within service delivery to avoid the situation 'in which individuals slip back into a previous pattern of chaotic drug use' (p. 282). More broadly, he suggests that the harm reduction movement in the UK needs to redefine its agenda so that is more compatible with the recovery focus in UK drug treatment policy.

Other scholars have taken a different approach. Although the new recovery movement claims to eschew the 'pathology' focus of 'acute' interventions, many scholars have identified the ways in which the recovery agenda has the potential to stigmatise people who use drugs. Through its focus on chronic models of addiction and disorder (Lancaster et al., 2015), treatment and abstinence have progressively been valorised as the desired means for drug-

using individuals to become healthy, productive and 'legitimate' citizens (Duke, 2012; Duke et al., 2013; Wardle, 2012). Neale, Nettleton, and Pickering (2013) argued that individuals' expectations of treatment have been shaped by the recovery agenda and the focus on abstinence in treatment. The participants in their study expressed an increased desire for rapid detoxification and abstinence in order 'to become "normal", "productive" [and] "recovered" members of society as quickly as possible' (p. 168). Scholars have also warned against the wholesale adoption of this particular conception of citizenship. Through its attendant focus on economic productivity and participation, it configures people who use drugs as unproductive and untrustworthy (Smith & Riach, 2014). It also presents a similarly narrow and stigmatising view of the relationship between drug consumption and employment. When abstinence is privileged as the only legitimate goal of treatment, there is the potential to lose sight of other worthwhile achievements such as improved relationships, engaging in meaningful and pleasurable activities, acquiring material possessions and resources, and achieving better mental and physical health (Neale, Nettleton, & Pickering, 2011a).

Further, several scholars have raised concerns about the implications of emphasising recovery at a policy level for those people who continue to use illicit drugs and enter opioid substitution therapy (Monaghan, 2012). Ashton (2007) argued that equating full recovery with achieving abstinence excludes individuals who use drugs from qualifying as healthy, productive and worthwhile citizens. Scholars have also raised serious concerns that enjoining people to reduce their methadone dose without adequately resourcing anti-relapse programs 'is a very good way to help them kill themselves' (Ashton, 2007, p. 3). A recent report from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA, 2017) stated that in 2014 the UK had a record number of drug-induced deaths, and that the figure was likely to keep rising. While this increase cannot be solely attributed to the new recovery policy

framework, the emphasis on self-help and community support has been associated with reduced central spending on treatment services in the UK (Best, De Alwis, & Burdett, 2017).

The only substantive policy analysis of new recovery in Australia to date was conducted by Lancaster et al. (2015), who undertook a comparative analysis of reports published by the UK Drug Policy Commission Recovery Consensus Group (2008) and the ANCD (2012). These reports (which I discussed in the introductory chapter) were published following stakeholder discussions on the meanings and significance of new recovery for alcohol and other drug policy in the UK and Australia. Lancaster et al. (2015) identify in these reports similarities in terms of the way individual problematic and/or dependent drug *use* is emphasised as a problem, which can be ameliorated by recovery. However, they also identify the importance of 'national imaginaries' (see Moore, Fraser, Törrönen, & Tinghög, 2015) in shaping distinct figurations of the 'responsibilised' drug-using subject (UK) or the 'patientised' drug-using subject (Australia). These problematisations rely on different discourses of responsibilisation and medicalisation that produce different emphases on self-management and control. They also identify the various political implications of these problematisations, noting in particular the way in which recovery discourse ties drug use, productivity and recovery to the attainment of citizenship and citizenship rights.

My analysis extends this work in several significant ways. Whereas Lancaster et al. analysed reports by government advisory bodies, in Chapter 4 I focus on official national and state policy documents. I also trace how problematisations differ and emerge not only across place but across time. Such an approach allows me to consider whether the claims that new recovery-focused policy heralds a 'paradigm shift' in thinking about alcohol and other drug problems and their resolution (e.g. Best, Irving, & Albertson, 2017; White, 2008) are justified. Furthermore, I am able to elaborate on the *local* dimensions of the encounter

between the conventions and logics of Australian alcohol and other drug policy and the specificities and associations brought to bear by this contemporary articulation of recovery.

Improving new recovery

Despite criticism of new recovery, its uptake in the UK has been apparent in policy development, advocacy, service delivery and funding (Neale, Nettleton, & Pickering, 2014; Neale, Panebianco et al., 2016; Wincup, 2016). As Neale, Panebianco et al. (2016) argue, 'without due reference to aspirations of recovery, services in the UK struggle to be funded and drug and alcohol users can find it difficult to access support' (p. 32). For these reasons, they argue scholars are ethically obliged to 'to find a way of conceptualizing recovery such that it is deployed positively to optimise treatment, minimize harm, and best support those who want and need services' (Neale, Panebianco et al. 2016, p. 32).

Qualitative research in the UK has therefore sought to refine the central ideas and concerns underpinning new recovery. This research has greatly improved understandings of what new recovery can mean and its effects on the lives of people who use drugs. Sociologists Neale, Nettleton and Pickering have published several influential articles drawn from the Everyday Lives Study, a qualitative project involving in-depth interviews with 40 'recovering' heroin users (Neale, Nettleton, & Pickering, 2011a, 2011b, 2012, 2013, 2014; Nettleton, Neale, & Pickering, 2011a, 2011b, 2013).[3] This research has demonstrated the value of interrogating the basic assumptions of new recovery. One of the most significant papers from this study problematised a key finding from an influential quantitative paper co-authored by Neale (McKeganey, Morris, Neale, & Robertson, 2004): that drug users preferred abstinence over

[3] In the Everyday Lives Study, 'recovery' was broadly defined in order to include a diverse sample of participants. These included people who used methadone or Subutex, were in detoxification from illicit or prescribed opioids, were in residential rehabilitation services, and were abstinent (Neale et al., 2011a).

harm reduction when entering treatment. This finding was 'deployed by those who seek "evidence" that abstinence is the bedrock of recovery and harm reduction is no longer needed' (Neale et al., 2011a, p. 190). Neale et al. highlighted that although some interview participants may express a desire to achieve abstinence in treatment, this was reflective of differences in how abstinence was itself understood by participants; that is, participants used the term 'abstinence' to describe qualitatively different goals. Researchers have also argued for more gender-sensitive accounts of the constructs used to explain new recovery (Neale & Stevenson, 2014; Wincup, 2016) and of the experience of recovery itself (Neale, Nettleton, & Pickering, 2014). Perhaps because the field is dominated by quantitative psychology, research into new recovery has not adequately addressed gender, or men's and women's different needs and experience of harms in different and disproportionate ways. Most recently, qualitative research has been used to inform the development of a patient reported outcome measure (PROM) (Neale, Finch et al., 2014; Neale & Strang, 2015, 2015a; Neale et al., 2015). Such measures 'assess health status and health-related quality of life from the patient/service user perspective' (Neale, Vitoratou et al., 2016, p. 159). One reason for developing a PROM for recovery from alcohol and other drug dependence is to identify indicators that reflect the experiences and knowledge of both service users and alcohol and other drug professionals. Until the development of the PROM, existing measures of new recovery were based upon hypotheses developed in quantitative research (Elison, Davies, & Ward, 2016, Groshkova, Best, & White, 2013). Prompted by concerns that existing measures of recovery did not reflect the goals and aspirations of service users, Neale et al. (2015) used participatory methods to develop the measure. As Neale and Strang (2015) argue, 'PROMs, particularly those involving early and meaningful engagement with purposively-selected groups of patients and service users, can certainly enhance our understanding of how people feel about their health' (p. 123). In addition, ensuring the involvement of people who use

drugs is politically significant because they have traditionally been sidelined from the development of drug policy and treatment interventions (Lancaster, Ritter, & Stafford, 2013; Lancaster, Sutherland, & Ritter, 2014; Neale et al., 2015).

However, there are limitations to this work too. Neale and Strang, two of the creators of the recovery PROM, observe that the translation of complex personal feelings into numeric scores is inherently flawed: 'PROMs tend to gloss over human diversity and the day-to-day, moment-by-moment, fluctuations in how people perceive their health and health status' (2016, p. 123). Also, like all forms of measurement, PROMs assume that different people understand a construct in similar ways. In their explicit acknowledgment of these limitations, Neale and Strang argue that PROMs are 'perhaps best viewed within the philosophical tradition of pragmatism' (p. 124). Put differently, PROMs are most useful 'when we eschew endless debates about methodology and the meaning of knowledge, concepts or reality, and instead focus on their practical application' (Neale & Strang, 2015a, p. 124).

Although this pragmatism is understandable in light of the influence of new recovery in the UK, there is no easy distinction between abstract theoretical knowledges, methodology and 'practical application'. Although the development of PROMs is based on a user-sensitive and inclusive methodology, their political effects must still be interrogated (Dwyer & Fraser, 2015). For example, the processes of validation at work in psychometrics function to legitimise screening and assessment tools as scientific and objective measures of new recovery. However, such tools are shaped by normative and social assumptions that have political effects. Further, as Dwyer and Fraser (2015) have highlighted, these tools can have 'looping effects' wherein their distribution and implementation can help shape ideas of 'normal' behaviour and subjectivity. For these reasons, a binary opposition between 'practical application' and 'theoretical knowledge/methodological debate' becomes hard to sustain and risks reinforcing the status quo. If we fall back on 'commonsense' understandings

and methodologies for practical reasons, we are less able to adequately illuminate how the 'pragmatic' is also inherently political.

This body of research has contributed to developing more sensitive and nuanced understandings of recovery that incorporate the complexity and diversity of lived experiences and accounts. This work is also frequently reflexive and explicitly acknowledges that all research negotiates 'questions of meaning, definition and value and knowledge' (Neale et al., 2011a, p. 189). It is politically significant in that it aims to improve the experiences of service users and provides more complex understandings of issues that are routinely simplified in public health discourse. Importantly, because this research is often geared towards improving the empirical robustness and utility of the recovery concept for public health purposes (Moore, 2004; Nettleton, 2013), it implicitly establishes a distinction between research practices and a reality of new recovery. This bifurcation attributes to research practices a kind of neutral objectivity and stabilises an anterior reality that may be identified and explained through improved research practices. In this respect, it leaves the ontological and ethical assumptions of new recovery unexamined. In contrast, attempting to map the performativity of recovery research and other knowledge practices, including my own, is one of the main tasks of my research. In the section below, I consider in detail the sociological work (some of it by the same authors) that has begun to question the politics of new recovery, and the way it enacts drug use and people who use drugs. These analyses move beyond the task of making recovery more sensitive and serviceable for policy and treatment. They challenge the ethics of new recovery with regard to the kinds of individualising and normalising politics it harnesses and the opportunities for social and political change that are inevitably lost.

Rethinking new recovery

Nettleton et al.'s (2013) empirical analysis of recovery in the UK, '"I just want to be normal": An analysis of discourses of normality among recovering heroin users', is the first piece of sociological research I explore in detail. Specific to new recovery, Nettleton et al. explicitly engage with a central tension in recovery discourse between the privileging and desire to 'be normal' and the ways in which achieving normality is constrained by the pathologisation of drug-using identity. Drawing on qualitative data, they analyse recovery discourses and practices as a form of governmentality that takes the regulation and normalisation of drug-using subjects as its focus. Importantly, they draw out the various meanings of 'normality' emerging in participants' accounts. They illustrate the ways in which discourses of normality can include aspirations to cultivate 'typical' everyday practices and normative embodied functioning, as well as critiques of 'boring' normal life and the myth of 'normal' life. They also highlight how comparisons between 'using and non-using' hinge on notions of normality. Comparisons between past experiences of drug use and current experiences of recovery operate along an abnormal/normal binary, wherein using drugs is posited as abnormal. Second, comparisons between recovering and 'normal' people mark out the recovering identity as a damaged identity operating in 'a socially undesirable space' (Nettleton et al., 2013, p. 185). The authors argue that even though normality may be an imagined state, these understandings lead to the stigmatisation of people who use drugs and their labelling as socially deviant. Their analysis of the way in which discourses of normality function in contemporary discourses of new recovery is pertinent. They note the political function of such discourses, enjoining drug-using subjects to adopt normative practices and to engage in regular self-monitoring. They argue that while the desire for normality is a commonly shared aspiration among the wider population, 'for recovering heroin users the boundaries of normality are constrained' (p. 187). Moreover, the adoption of a narrow set of

norms by recovering heroin users is often subject to the scrutiny of authorities who monitor recovery progress. Thus, this work illuminates the regulatory functions of new recovery, and its relationship to contemporary ideals and practices of normality. This research flags how discourses of new recovery centre on the regulation and upholding of specific kinds of 'normal' lifestyles and narrow forms of 'healthy' subjecthood. Discourses of new recovery pay little heed to the regulatory functions of these exemplars of life and personhood, or to their attainability, particularly for marginalised groups, such as people who inject heroin.

In Lancaster's (2017) commentary on McKay's (2017) paper, 'Making the hard work of recovery more attractive for those with substance use disorders', she argues that instead of incentivising recovery, 'the assumptions and conceptual premises which lodge within the concept of "recovery"' (p. 758) need to be interrogated to fully understand their implications for drug-using subjects. Lacking the space to properly interrogate these assumptions and premises in a short commentary, Lancaster instead sets out an agenda for research on new recovery. She argues that underpinning new recovery are 'neoliberal assumptions about work, productivity, and what it means to live a "contributing life"' (p. 758), which are premised on the denial of full citizenship to drug-using subjects. Using Bacchi's poststructuralist approach, Lancaster argues that researchers need to consider the 'productive and constitutive effects' of such discourses, policies and practices, which may work to elicit the very problems and disordered forms of subjectivity they aim to address (p. 758).

The task of considering new recovery's 'productive and constitutive effects' was taken up in a recent paper by American scholar David Frank (2017). In his analysis of US methadone maintenance treatment (MMT) in the context of new recovery, he highlights the nebulous effects of new recovery on people enrolled in MMT. He argues that in the US recovery framework, many argue that MMT has been restored to its 'rightful position as medically-based treatment for addiction' (p. 1). This position, Frank argues, obscures the diversity of

people's desires, the different purposes that drug use, including pharmacotherapy, serves, and the different treatment goals people may hold. Furthermore, he argues that 'positioning MMT as being "about recovery" has significant implications for the ways that drug use, drug treatment, and drug control are understood' (p. 1). Frank's analysis of individual accounts of MMT mounts several significant critiques of recovery. In the US model of 'recovery oriented methadone maintenance', addiction is constituted as a medical problem, which can be treated with methadone and an array of psycho-social-spiritual interventions. Yet, Frank's participants framed their drug use difficulties as emanating from the 'structural-legal context of prohibition/criminalisation', citing problems such as acquiring drugs safely and reliably (p. 5). Further, participants offered accounts of addiction that were critical of simplistic disease explanations and some rejected their characterisation as pathologically addicted. Consistent with Neale et al.'s (2011a) observation that a focus on abstinence obscures a broader range of treatment goals, Frank's participants' accounts suggest that the new recovery-oriented reframing of MMT increased scrutiny of their non-opioid drug use and delegitimised other goals, such as achieving 'stability' with MMT or other changes in their lifestyles. Finally, Frank argues that the incorporation of MMT into a recovery narrative pressured people into viewing their positive treatment outcomes as a result of medical interventions. Frank argues that the focus and concerns of new recovery in the US preclude the development of political critiques of criminalisation and other structural issues.

The critical analyses of Nettleton, Neale and Pickering, Lancaster and Frank highlight issues of regulation, normalisation and subjectification that warrant further investigation. They also demonstrate that the particular contexts in which new recovery emerges produce different effects and associations. In particular, Frank's consideration of the kinds of political claims new recovery forecloses are of particular significance to my research. Such analyses, I argue, aided specifically by theoretical tools that concern themselves with the politics of new

recovery, are very much needed. I next turn to the sociological literature concerned with earlier forms of recovery in order to identify continuities between these older forms of recovery and its new iteration.

Unsettling claims to novelty: Earlier sociological work on 'recovery'

The origin of the word 'recovery' can be traced to the mid-14th century Anglo-Norman term *recoverie* (*Oxford English Dictionary*; accessed online 10th November, 2017). In the 16th and 17th century, this etymology began to reference the restoration of a person, or consciousness, to a healthy or normal condition and also the 'cure' or 'healing' of an illness. As might already be evident, these older meanings of recovery endure and have significant implications in contemporary discourses of recovery. Although new recovery has emerged as a topic of considerable interest in sociology over the last decade, longer-standing discourses of recovery have been the object of sociological research for some time. In the following section, I examine how the phenomenon of addiction recovery has been understood in sociology through the analytic categories of identity, governmentality and treatment. This review of the literature builds on the critiques of new recovery I explored earlier in two ways. First, I identify several insightful and significant examinations of the phenomenon of recovery, which I argue are pertinent to the critique of new recovery that I offer in this thesis. Second, in undertaking this review, I also identify some enduring commitments and practices that continue to be reflected and reproduced in new recovery (albeit via slightly different articulations and associations). In both these ways, my analysis of these continuities unsettles and challenges new recovery's claims to novelty. How new is new recovery? What previous forms has recovery taken? What is the critical impulse and value of new recovery if it harnesses that which has gone before?

(Re)assembling identity

The concept of identity has been (and continues to be) extremely generative in research on recovery. Much sociological research on the phenomenon of recovery has been located within the symbolic interactionist tradition and focused on identity change (Nettleton et al., 2011a). New recovery explicitly builds on an earlier body of research on 'natural recovery' – drug use cessation without participation in formal treatment (e.g. Biernacki, 1986; Cloud & Granfield, 2001; Klingemann, 1991; Waldorf & Biernacki, 1981; Winick, 1962). This research was influential in establishing a particular trajectory of 'recovery' from addiction, one in which the process of individual identity change followed a now familiar narrative arc: motivated by 'rock bottom' experiences, individuals come to reject their drug-using lifestyles and gradually develop 'non-addict' identities through participation in 'normal' social relationships, practices and responsibilities (Dahl, 2015; Nettleton et al., 2011a). Drawing on Winick (1962) and Robins (1973), Biernacki's (1986) oft-cited *Pathways from Heroin Addiction: Recovery Without Treatment* is premised on a claim that recovery offers a radical alternative to the conventional wisdom that opiate addiction is chronic and untreatable. His study of 101 former heroin users suggested that upon recognition and acceptance of their 'damaged' identity, recovering addicts fashioned new identities through the cultivation of conventional social relationships. More recently, McIntosh and McKeganey (2002), in their influential monograph *Beating the Dragon: The Recovery from Dependent Drug Use*, argued that a 'spoiled identity' and identity restoration is central to the process of recovery from addiction. For McIntosh and McKeganey, rejecting a drug-using identity is a necessary condition of the recovery process (Nettleton et al., 2011a). In this narrative, addicts' decisions to stop using drugs and to restore their 'damaged sense of self' follow from the 'realisation' that they exhibit 'characteristics that are unacceptable both to themselves and to significant others' (p. 51).

The notion of spoiled or damaged identity has continued to be influential in shaping many of the core assumptions underlying understandings of new recovery (e.g. Best et al., 2011; White, 2007; White et al., 2012). However, the usefulness of much of this research is limited by dated sociological notions of drug use as intrinsically 'deviant'. An effect of this framing is that drugs (unlike other consumables, habits and social influences), and the social relationships of people who use drugs, are attributed exaggerated agency and force in shaping identity. As several scholars have noted, this approach conflates actions with a 'master' identity, such that the 'recovering addict' identity is assumed to define individuals and explain their behaviour (Dahl, 2015; Keane, 2002). As Dahl (2015) argues, 'this tradition, in which recovery is seen as the management of a spoiled identity, makes a strong connection between people's actions and their identity. Doing drugs and being a drug user are depicted as reciprocally dependent' (p. 176). Moreover, the focus on identity in sociological research on natural recovery has produced an enduring focus on the rational, cognitive and narrative dimensions of people's experience, which has the potential to overlook the material, embodied and practical agencies that animate social life (Nettleton et al., 2011a).

More recently, several scholars have drawn on the work of Erving Goffman and Michel Foucault in order to identify some of the social and practical relations that enjoin and shape 'recovery' identities (e.g. Andersen, 2015; Copes, 2016; Dahl, 2015; Gibson, Acquah, & Robinson, 2004, Hill & Leeming, 2014; Hughes, 2007; Mackintosh & Knight, 2012; Martin, 2011; Radcliffe, 2011; Rodriguez & Smith, 2014). Some of this research has identified gender as a key dimension in processes of recovery and identity transition. A particular focus has been the way in which the identity category of 'motherhood', in relation to treatment discourses and practices, produces strong incentives for women to disengage from drug use and to remake themselves as healthy, normal and unremarkable mothers (Martin, 2011; Radcliffe, 2011). This research attributes to people who use drugs a more active and

purposeful role in the management of identity practices and the presentation of self (Martin, 2011; Radcliffe, 2011). Here, identity is flexible, mediated and shaped by social processes and practices that exceed individual control.

Although this recent sociological work has provided a more complex understanding of the social contexts of drug use, thinking about the phenomenon of recovery in terms of identity processes has several limitations that this research seeks to move past. Although this recent literature does not assume identity is innate or solely an individual attribute, it tends to reproduce the notion that 'drug-taking practices and relationships are in and of themselves constitutive of particular identities' (Martin, 2011, p. 354). As I mentioned earlier, conflating consumption, such as drug use, with identity has the potential to stigmatise and pathologise people who use drugs.

More significantly, the sociological work on identity has tended to reproduce the assumptions of earlier sociological work on natural recovery, albeit in slightly more complex and nuanced ways. Gibson et al. (2004), for example, argue that recovery is a process of disentangling one's identity from drug-using practices and habits – largely through biographical reconstruction. Hughes (2007) takes a similar approach to Gibson et al. but argues for a focus on everyday practices and social relations, along with the 'expert narrative management' (p. 677) practices that drug-using subjects employ to build non-using and recovering identities. This research has illuminated recovery as a complex process of identity work (Radcliffe, 2011), 'migration' (Hughes, 2007), 'disentangling' (Gibson et al., 2004; Hughes, 2007) or re/construction (Dahl, 2015; Hill & Leeming, 2014; Mackintosh & Knight, 2012). Through the focus on identity, this research runs the risk of reinforcing a monolithic understanding of recovery. It has not yet fully considered the specificity of particular constitutions of recovery, some of which overlap, are partially connected and are contradictory. This research aims to engage with the social and political features of new recovery as it is being made multiply

across different sites. Drawing attention to the multiplicity of recovery, and the resonances between different enactments, requires theoretical and methodological innovations of the kind developed in STS and posthumanist studies more broadly. Although sociological analyses of recovery identities have been useful, in this research (described specifically in Chapter 7), I use interpretive tools developed through STS to question the politics of the category of identity. I examine the way in which identity underpins and authorises the organisation of recovery-focused residential treatment, and in doing so trace the epistemological contradictions and disorder it disguises.

Governing obligations

Poststructuralist alcohol and other drug research challenges some of the unexamined foundations of new recovery research. Influenced by the work of Foucault and feminist critical engagement with notions of power, governmentality and subjectivity, this work illuminates the ways in which subjectivity and experiences of health, illness and disease are inevitably political. In this work, the concept of identity has, for example, been overtaken by an interest in the discursive production of subjectivity (e.g. Fraser & valentine, 2008; Keane, 2002; Moore & Fraser, 2006; Sedgwick, 1993; Valverde, 1997). Sedgwick (1993), for example, links the development of addicted subjectivity to 20th-century late capitalism. In her influential piece, she investigates the dualism of free will and compulsion central to notions of addiction in consumer culture (Fraser & valentine, 2008). According to Sedgwick, this binary underpins the influential disease concept of addiction, which routinely casts into doubt the legitimacy of those attributed with addiction. Figured as pathological, compulsive and un-free, addicted subjects are defined in opposition to highly valorised qualities such as rationality, autonomy and responsibility. It is through the 'addicting' of particular activities and subjects that contemporary ideas of citizenship and health are being made and reproduced (Fraser, Moore, & Keane, 2014).

Drawing on Sedgwick's work, Keane (2000, 2002) provides a detailed study of the proliferation of contemporary discourses of addiction, arguing that these and the resulting variety of addicted subjectivities are necessary foils to the constitution of the ideal modern subject: autonomous, rational and healthy. Keane (2000) argues that 'the regimes of the self established by therapeutic authority were framed as ways to achieve freedom, conceived as the production of an autonomous, progressively realising self' (p. 327). Recovery discourse, she argues, is part of a broader category of regimes of freedom produced in therapeutic self-help knowledges and practices. Through this lens, she examines practices of recovery in self-help texts as 'technologies of the self', that is, practices aimed at transforming drug-using subjects through the cultivation of autonomous and free selfhood. In her astute analysis, she draws attention to several paradoxical elements within recovery discourse, including:

> [T]he simultaneously physiological and spiritual nature of the disease; the difference and identity which marks the relationship between the addicted and recovering self; the operation of freedom as a regulatory norm; the production of the authentic inner self through training; the accessibility and intelligibility of the interior self; and the simultaneous promotion of individuality and homogeneity. (Keane, 2000, p. 340)

Keane's work remains one the most detailed analyses of self-help recovery discourses, eloquently exploring the binaries and contradictions that make the recovery concept so pervasive and compelling, yet ultimately circular in logic and impossible to achieve.

Foucauldian empirical studies of health promotion and alcohol and other drug treatment and interventions, influenced in large part by the work of Nikolas Rose (1996, 1999, 2000, 2007), have identified how drug-using subjects are governed in neoliberalism through particular modes of subjectification. Central to this literature is the Foucauldian notion of 'governmentality', which seeks to draw out the means by which power acts upon and through

subjects beyond traditional understandings of the sovereign nation-state. As has been well documented, this is a conception of power that is not solely repressive, universal or possessed by any one individual or institution; rather, power exists in relation when it is put into action (Procacci, 2004). Foucault (1982) argued that power is 'always a way of acting upon an acting subject or acting subjects by virtue of their acting or being capable of action' (p. 789). The concept of governmentality speaks to those practices that engineer conduct and delineate the possible fields of action for particular subjects. Governmentality-inspired scholarship has mounted sustained criticisms of how alcohol and other drug policy and health promotion strategies govern drug-using subjects to be risk-averse, autonomous and rational health citizens, despite often being poorly resourced to counter 'risk' or marginalisation (Moore & Fraser, 2006; Rhodes, 2009). This research has also critiqued simple binaries of domination and subordination in relation to treatment and expert knowledge practices, and has highlighted the association between alcohol and other drug treatment and normalisation (Duff & Moore, 2015; Nettleton et al., 2013), the politics of responsibilisation in harm reduction and health promotion (Fraser, 2004; Moore & Fraser, 2006; Nettleton & Bunton, 1995), the centrality of risk and medical frameworks to the governance of drug users (Alaszewski, 2011; Fraser, 2010; Race, 2012) and the production of new forms of active citizenship that simultaneously empower and disenfranchise people who use drugs (Moore & Fraser, 2006).

The research literature on the governing obligations operating in and through older discourses of recovery and help-promotion discourses and practices in contemporary liberal and neo-liberal societies is important to my argument. Following Sedgwick's attention to the way in which addiction and recovery speak to the constitution of contemporary citizenship (Seear & Fraser, 2010), a question I address in this thesis is: what kind of political universe does new recovery constitute? Moreover, I extend Keane's analysis of the binary underpinnings of self-help discourse to new recovery, and ask how these binaries bear upon subjecthood,

citizenship, health and the agency of drug-using subjects, and what more nuanced understandings of drug use and the experience of recovery do they miss? Finally, I draw on the critical governmentality literature to analyse the governing logics that enjoin neoliberal citizens to conduct themselves in particular and specific ways in order to recover. In the next section, I consider these dynamics in relation to research on recovery-focused treatment.

Subjectification in treatment

To date, there has been no sociological research on recovery-focused treatment in Australia. However, there exists a detailed international literature which, inspired by Foucault, has emphasised the complex power dynamics and negotiations characterising different treatment environments (e.g. Carr, 2011; Friedman & Alicea, 2001; Ning, 2005; Weinberg, 1996, 2000; Wilton & DeVertuil, 2006). This literature focuses on the regulatory and normalising effects of recovery-focused therapeutic discourse. For example, in Weinberg's (2000) ethnographic examination of residential treatment discourse, he traces a conceptual logic that assists clients in reconciling a pathological disease notion of addiction with a rationale of recovery based on participation in self-help groups. Analysing treatment clients' accounts of recovery, he argues that they recursively engage a distinction between the cleanliness, healthful and medicinal worlds of the recovery program 'in-here' (inside the treatment program) and the 'doleful' world of addiction 'out-there', which is 'fraught with myriad emotional and physical hazards' (p. 614). Weinberg (2000) argues that this distinctive organisational logic of treatment discourse provides participants with compelling reasons to stay in treatment. It suggests that the forces that might rekindle addiction are ecologically located outside of treatment. Weinberg observes that this binary is also key to the construction of 'relapse' which is often 'routinely cast as movement from one ecological space to another' (p. 610).

Treatment discourses are also central to Ning's (2005) ethnographic examination of a Canadian methadone clinic that prioritised recovery as an outcome. Providing a different perspective to Weinberg on the function of clients' engagement in treatment discourses, Ning's analysis suggests the adoption of treatment discourses does not necessarily mean conformity to treatment ideals. Ning traces how staff determined 'truthful' recovery and 'good' clients in accordance with a notion of compliance, which broadly equated to the pursuit of abstinence. Ning argues that clients engaged in various tactics – such as 'ratting off', 'gossip' and changing 'dress codes' – in order to achieve their desired treatment goals. However, central to Ning's analysis is that the binary between conformity and resistance to regulatory practices is muddled in everyday practices and experiences. For example, when a particular client who had recently relapsed reported on others about illicit activities, he was able to resist his marginal space at the clinic (as a chronic relapser or 'bad' client). However, at the same time he also rendered himself more open to the control of professionals and their desire that he abstain from drug use. A significant point to take from Ning's Foucauldian analysis is that resistance 'is never in a position of exteriority in relation to power' (p. 364). In addition to exploring the dual effects of recovery logics and individuals' engagements with recovery, I aim to move beyond this binary by demonstrating new recovery's multiplicity across several authoritative sites.

Sociological scholarship on recovery-oriented treatment is of significance for my research because it points to the importance of treatment practices in shaping addicted subjectivity. Aston (2009), for example, shows how authoritative medical and treatment discourses intersect with gender to shape women's accommodation to and performance of 'recovering addict' identities (see also Friedman & Alicea, 2001). To be clear, Aston (2009) takes a different approach to identity to the one identified earlier, arguing instead that 'the identity of "addict" is seen simultaneously as a social and ideological subject position' (p. 613).

Recovery as an institutional and political discourse is framed around the notion of an addicted identity that women are enjoined to adopt in treatment. Similarly, Carr's (2011) insightful ethnography of 'Fresh Beginnings', a US addiction service for homeless women, is another important contribution to research on recovery-focused treatment. Like Weinberg (2000), Ning (2005) and Aston (2009), Carr foregrounds the politics of therapeutic talk in her analysis of addiction recovery. Specifically, she conducts a detailed linguistic analysis of therapeutic exchanges between counsellors and clients. She demonstrates how professionals enjoin clients to adopt particular linguistic cues to describe their experiences. Through the therapeutic encounter and clinical practices, clients are instructed in how to describe themselves through a model of addicted subjectivity. Therapists introduce clients to a particular topographical model of addiction that explains the innermost authentic self as hidden beneath layers of denial, anger and shame. Through counselling, clients are taught the language of 'inner reference' that consistently reproduces a highly individualised and self-referential model of addiction. As treatment clients become versed in the language of self-reference and addiction, they are judged to be recovering via their adherence to honest, open and willing recovery narratives. When clients produced alternative narratives to the topographical script of addiction or were ambivalent or critical of particular interventions or regulations, this resistance was cast as pathological proof of the denial at the heart of their addiction. Importantly, like Frank (2017), Carr highlights how this model of addiction works to preclude critiques of broader cultural and institutional arrangements. As Fraser, Moore and Keane (2014) observe about Carr's analysis, treatment seemed to be 'primarily about reconfiguring the clients' relationship to language and training them in a particular way of speaking about the self' (p. 6). Drawing on posthumanist approaches that illuminate the agency of non-human forces, my research explores the kinds of political rationales and

relations that the politics of 'inner reference' (and by extension the individualised binary of addiction and recovery) obscure.

The research on recovery-focused treatment highlights the significance of encounters between treatment practitioners and service users, and of treatment discourses in shaping clients' experiences and expressions of addiction and recovery. My analysis builds on this literature to examine further dynamics in treatment. I follow Aston (2005) to examine the specific ways in which people learn about addicted subjectivity in treatment. However, whereas this literature is largely focused on language, I also attend to other socio-material dynamics in treatment. These include professional narratives and practices in preserving the coherence of recovery as a therapeutic object. I also analyse the institutional organisation of treatment, which I argue reproduces individualising and stigmatising assumptions about the social relationships of people who use drugs and the social contexts in which they are embedded.

As I explain in the following chapter, I conduct my study of new recovery with a range of conceptual resources drawn primarily from the 'ontological turn' in social sciences and its reflection in recent sociological research on drug use and addiction (Fraser, 2017; Moore, 2017). This turn has involved a (re)turn to matter, to socio-material practices, as a constitutive force in the making of realities. As Fraser (2017) argues, it is 'a turn towards the idea that the ontology of things (the nature of their being) is *constituted* in practice – in the ways those things are understood, responded to and even researched' (p. 130, emphasis in original). This conception of ontology as emergent and ongoing is able to attend to notions of agency that exceed the action of the individual drug-using subject (Dennis, 2017). These insights have been taken up to great effect in critical drugs scholarship to destabilise notions of rational individual agency and deterministic understandings of drug effects (e.g. Demant, 2009; Dilkes-Frayne, 2014; Duff, 2014; Dwyer & Moore, 2013; Fraser, Moore, & Keane,

2014; Fraser et al., 2017; Fraser & Seear, 2011; Fraser & valentine, 2008; Pienaar et al., 2016; Poulsen, 2015; Savic & Fomiatti, 2016; Seear, 2014; Seear & Fraser, 2016). On this view, new recovery is not a monolithic experience that can be objectively registered through good research practices. Applied to this thesis and my research aims, this scholarship inspires my analysis of the politics of new recovery across several different sites of enactment: policy, scientific research, professional practices, treatment practices and everyday lives. How is recovery enacted in these sites? What practices make these enactments possible? How might attention to practices, enactment and multiplicity generate a more generous and nuanced account of drug use and people's lives than is currently enacted in new recovery? I consider these questions in detail in the following chapter.

Conclusion

This literature review has located new recovery in a specific historical and social context, and in a particular lineage of sociological work on earlier forms of recovery. I have done this to distinguish the specific object of my study and thereby avoid the opacity that is sometime characteristic of sociological research on recovery. In reviewing the existing qualitative research on new recovery, I argued that it has been most fully explored in UK critical and poststructuralist policy studies. In reviewing this literature I identified key debates that have given shape to new recovery in alcohol and other drug policy. These debates have to do with the capaciousness of the term 'recovery', and its capacity to be co-opted by conservative policymakers and put to work for a variety of purposes that may pathologise or further disenfranchise drug-using individuals. Scholars have also expressed concern about the political implications of new recovery for the legitimacy and funding of harm reduction programs and policies. Responding to these concerns, researchers have also aimed to improve the recovery agenda in order to minimise its harmful effects on service users and people who use drugs. I argued that although this research is important, its characterisation as 'pragmatic'

subtly reinscribes the supposed objectivity of researchers and the bifurcation between research practices and an anterior reality. This is a distinction I seek to challenge.

I finished the first section by reviewing qualitative literature on new recovery that argued for a sustained critique of its underlying assumption and practices, the ways in which it has the potential to shape individual lives and the kinds of agency new recovery makes available. I then moved on to review sociological work on earlier discourses of recovery, arguing that this literature develops useful lines of inquiry for my analysis of new recovery and reveals continuities across different recoveries. The concern with identity has endured across different articulations of recovery and runs the risk of treating recovery as monolithic and ahistorical. In contrast, critical poststructuralist research has identified how addiction recovery discourses engender obligations to pursue and achieve autonomous, healthy and rational citizenship. This critical impulse informed Nettleton et al.'s (2011) article on normality talk in recovery discourse but can also be used to explore a range of other phenomena and associations in new recovery. For example, one of my aims is to interrogate the political effects of new recovery enactments, and a central interest is the kind of political universe that new recovery enacts. Research on recovery-focused treatment highlights its profoundly subjectifying nature. Scholarship of this kind has yet to be undertaken in Australia in relation to new recovery and treatment. Moreover, this kind of analysis can be made of other influential sites, the kind which I explore in this thesis. Finally, I argued that there exists a need for an analysis to engage the multiplicity of new recovery. In order to engage fully with this multiplicity and afford new possibilities for how new recovery might be made, I use several posthumanist theoretical and methodological tools. If, as Mol (2002) argues, 'methods are not a way of opening a window on the world, but a way of interfering with it', then it is useful to utilise several interpretative methodological tools in order to engage with

the various entities that produce new recovery (p. 155). In the next chapter, I outline the posthumanist theoretical and methodological tools I use to advance such an analysis.

Chapter 3

Crafting a theory–methodology

Three central research questions are addressed in this thesis:

1. How is the new iteration of recovery enacted in drug policy, research and treatment in Australia, and what assumptions and claims about drug use and people who use drugs are made along the way?
2. How do people who use drugs adopt, accommodate, resist or otherwise engage with recovery in treatment and their everyday lives?
3. What are the political effects of these recovery enactments?

Answering these questions requires an approach that is able to account for the interrelationships between practices, concepts and bodies in the making of new recovery. The particular focus on the specificity of new recovery also necessitates an approach that can bring to light the multiplicity of specific phenomena and the partial connections between different enactments and experiences. To guide this account of new recovery as multiple, relational and emergent, I draw on a theoretical-methodological framework informed by recent work in STS. Although theory and methodology are often treated separately, I consider them together here through the compound term 'theory–methodology' because to do so is consistent with the STS insistence on the performativity of knowledge practices. Recent STS work seeks to problematise the taken-for-granted distinction between representation/reality, discourse/matter and theory/practice. As John Law (a key STS theorist whose work is discussed below) has argued, to speak of methodological practices traditionally connotes a particular version of 'rigour' (2009, p. 9). In this context, 'rigour' suggests that it is possible to establish an accurate representation of reality with clear, precise and scientific methods.

Underpinning this idea of methodological practice is the assumption that reality pre-exists in a particular form and is awaiting discovery and representation. In contrast to such realist views of method, the intellectual aim of recent work in STS is to subvert this representationalist orientation. STS scholars argue that methods and methodological choices participate in the making of realities and therefore in politics (Law, 2004). They bear upon the world in particular ways and carry specific epistemological and ontological assumptions about the nature of reality. The epistemological orientation of a specific method determines what kind of account is produced and what kind of reality we understand to have authorised particular accounts. In this sense, what might be conventionally be considered 'theory' and/or 'methodology' actually entail one another and are most productively explored and considered together in order to retain a keen watch on the ways in which I produce an account of new recovery (Pienaar, 2013).

I first provide a detailed explanation of the overarching conceptual framework underpinning my analysis. This framework draws primarily on recent work in STS developed by scholars Annemarie Mol (1999, 2002; Mol & Law, 2002) and John Law (2004, 2009, 2013). The onto-epistemological provocations developed in and through the work of Mol and Law have been put to good use in the study of alcohol and other drugs (Dennis, 2017; Duff, 2014; Farrugia, 2017; Fraser, 2010; Fraser & Seear, 2011; Seear, 2014). This scholarship has been concerned with the way in which knowledge practices *produce* material realities, and the complex epistemological and ontological ramifications of this claim. If reality cannot be said to pre-exist our efforts to know it, how then do we study the 'real' (Mol, 1999)? If the nature of the real is produced through various practices, how might we characterise 'this process of shaping' and the suggestion of ontological malleability (Law, 2004; Mol, 1999)? If reality is multiple, how do they relate (Mol & Law, 2002)? And crucially, what methodological and

epistemological innovations and caveats might be required in order to explore reality as multiple (Mol, 2002)?

I begin by introducing three key concepts informing my study of recovery: 'enactment', 'multiplicity' and 'ontological politics'. The concept of *enactment* draws attention to the idea that the 'ontology of things (the nature of their being)' is forged in and through specific networks of practices (Fraser, 2017, p. 130). In this approach, the nature of particular entities, objects and realities is not 'fixed' or 'given' prior to their constitution in and through specific and continuing practices. Therefore, a focus on enactment emphasises that reality is socially and materially produced rather than stable, anterior and given in nature. A central implication that emerges from a performative theory of enactment is that of ontological *multiplicity*. For example, if new recovery is made in and through different networks of practice, and ontology is always only ever 'ontology-in-practice', it can no longer be thought of as a coherent singular entity but as multiple entities (Mol, 2002, p. 143). This observation is important because an expanding array of material–discursive practices are rendered politically and ethically significant in the making of new recovery. From here, I discuss the political implications of the emphasis on enactment and multiplicity through a discussion of the concept of *ontological politics*. If specific entities are multiple and made in practice, it follows that the 'conditions of possibility are not given' (Mol, 1999, p. 75); rather the character of reality is relatively open, contingent, contested and political. An understanding of ontological multiplicity also troubles simple determinations of the 'nature of the good' or 'the just' because different orderings of recovery entail and forge different subject positions, objects, relations, simplifications and associations, and produce different material effects (Mol & Law, 2002, p. 8).

A theoretical interest in performativity directly informs the methodological considerations shaping and organising my analysis of new recovery. In the second half of the chapter, I

describe this methodology through a discussion of Mol and Law's notion of 'cases'. Unlike examples, cases do not aim to be representative of an anterior or universal object; instead, they sensitise us to events, tensions and contradictions that may have been relegated to the background in more simplified orders of representation. I outline five cases that generate insights into the making of new recovery: alcohol and other drug policy; psychological science on new recovery; professional accounts of recovery; recovery-focused treatment; and the everyday practices of people who use, or have used, drugs. I introduce each case separately and explain how I generated and analysed my textual and interview data. I turn now to discuss the concept of enactment, which is one of the central theoretical concepts in the theory-methodological framework used in this thesis.

Practices all the way down

The approach adopted in recent work in STS is one of enactment, in which realities are understood as constantly being made in and through continuous practices of crafting. The concept of enactment seeks to go beyond what Law (2004) refers to as 'Euro-American common sense' understandings of reality (p. 31). Research underpinned by 'common sense realism' largely presupposes that the world is anterior and independent of our actions, and definite and singular in form (pp. 24–26). This epistemological presupposition, which has shaped much traditional sociological inquiry, generates research methods and practices that aim to faithfully represent the 'true' reality of a given social problem. The concept of enactment subverts this representationalist orientation by blurring the distinction between representational practices and the object being represented. The emphasis in the notion of enactment is the way in which practices perform and produce their object of inquiry. As Law (2013) observes, 'there is no escape from practice. It is practices all the way down, contested or otherwise' (p. 172). The concept of enactment disrupts the notion that new recovery pre-

exists in the world, awaiting scientific study, and foregrounds the political nature of knowledge and research practices in producing new recovery.

John Law is perhaps most widely known for his book *After Method* (2004). Along with Annemarie Mol's *The Body Multiple* (2002), Law's text forms the main conceptual resource for my research. It pulls together several important works and arguments on the performativity of scientific practices (e.g. Latour & Woolgar, 1979; Mol, 2002) to argue for the relevance of their conclusions for the social sciences. Law explores these arguments to subvert traditional notions of method and meaning making. He argues that scientific and social science practices do more than simply uncover facts that are given in nature. By way of a discussion of Latour and Woolgar's (1979) ethnography of a scientific laboratory, Law argues that scientific practices function to identify particular relations, objects and entities, and assemble them into specific realities. These practices work as 'inscription devices', which are 'set[s] of arrangements for *converting relations from non-trace-like to trace-like form*' (Law, 2004, p. 28, emphasis in original). By this he means to suggest that scientific practices produce material traces (e.g. notes on paper, extracts in test tubes, graphs, fractions and statements) that purport to directly correspond and represent a putative reality. These scientific practices entail particular framings and therefore have a discrete and limited purview. That is, they can only ever be sensitive to some forms and relations while necessarily excluding other entities at the same time. In this sense, scientific practices do not just describe a corresponding reality, they craft and assemble specific relations, objects and entities into a particular and necessarily partial reality. As Law (2004) argues:

> To talk of enactment, then, is to attend to the continuing practice of crafting. Enactment and crafting never stop, and realities depend upon their continued crafting – and perhaps by people, but more often (as Latour and Woolgar imply) in a

> combination of people, techniques, texts, architectural arrangements and natural phenomena (which are themselves enacted and re-enacted). (p. 56)

It is also evident that through the concept of enactment Law is arguing for a relational understanding of reality-making, in which realities are produced through and contingent on complex arrangements of practices, people, techniques and material phenomena. As well as being relational, the focus on enactment also suggests that reality-making is made and remade through 'continuing practices of crafting'. In this way, realities can only be said to exist in relation to the practices engaged in their specific enactment.

A clear example of enactment can be found in Annemarie Mol's (2002) ethnography *The Body Multiple.* Following different scenes of medical diagnosis and treatment in a Dutch hospital, Mol traces the enactment of the leg disease atherosclerosis in and through situated medical practices of diagnosis and treatment. Mol recounts an encounter with a pathology resident who informed her that he had an amputated atherosclerotic leg for her to view. As Mol explains, 'we sat down with the microscope on the table between us [… and] with an inbuilt pointer he taught me what to see' (p. 30). The resident indicates the artery, points to the calcification and the visible traces that were left from the surgeon's cutting, the lumen (the space inside the artery) and the blood cells. Finally he remarks, 'Look. Now there's your atherosclerosis. That's it. A thickening of the intima. That's really what it is' (p. 30). Mol continues, 'then he adds, after a little pause: "Under a microscope"' (p. 30). For Mol, the addition of 'under the microscope' was an illuminating distinction. She argues that this enactment of atherosclerosis as a thickened intima (the innermost layer of an artery or vein) is contingent on the microscope. In addition to the microscope, this enactment of atherosclerosis also depends on the technician, the tweezers, the knives and dyes, and of course the amputated leg. Through these practices, Mol argues, a particular enactment of atherosclerosis is being 'done', being performed in and through practices. A commonsense realist approach

might suggest that an underlying and singular reality of disease resides inside the body and precedes scientific and clinical practices of the kind she describes. However, as Mol explores in her book, atherosclerosis is not always enacted as a thickened intima. The atherosclerosis she encounters in the hospital changes depending on the network of practices producing it. That is, atherosclerosis is enacted multiply across the different sites of the hospital and its attendant practices.

More than one and less than many

By attending to the practicalities of enacting disease, Mol (2002) argues that 'ontology is no longer a monist whole. Ontology-in-practice is multiple' (p. 157). Over the course of her ethnography, Mol shifts sites and moves around the hospital exploring this ontological multiplicity through practices of diagnosis, surgical intervention and treatment. She observes how different practices within the hospital enact different versions of the disease. For example, in the consulting room of the outpatient clinic, vascular surgeons ask questions about pain, look at the colour and texture of the skin, and try to feel the arterial pulse by placing their hands on the patient's leg (p. 29). The clinical enactment of atherosclerosis through the assessment of an arterial pulse and pain is different from the pathological enactment that is contingent on an amputated leg and a microscope. A poor arterial pulse cannot be determined if the leg has been severed and vice versa – a thickening layer alongside the arterial wall cannot be determined without severing the leg. As Mol argues, these practices of 'enacting clinical atherosclerosis and pathological atherosclerosis *exclude* one another' (p. 35, emphasis in original). Therefore, Mol's ethnographic account of multiple atherosclerotic entities is not a 'perspectival' account of disease. She is not suggesting that the different sites and practices of the hospital provide particular vantage points from which to view different 'aspects' or 'dimensions' of a singular entity. Rather, she argues that atherosclerosis is ontologically multiple, it is 'more than one – but less than many', enacted

in multiple processes of constitution (p. 55). Importantly, this ontological reconfiguration does not suggest that reality is fragmented or takes an indefinite number of different and disconnected forms. Although reality is multiple, it also 'hangs together' and is related in complex ways through various forms of coordination (p. 55). (I return to Mol's concept of coordination in more detail in my analysis of alcohol and other drug professionals' organising relations in Chapter 6.) Similarly, in summarising Law's (2004) notion of the 'hinterland' of pre-existing social and material practices and realities, Dwyer and Moore (2013) argue that realities always connect and interfere because they are embedded in pre-existing 'networks of relations between statements, practices, skills, objects and actors' (p. 204). The hinterland shapes the conditions of possibility for any given reality because an emergent reality has to fit with the existing hinterland. In this way, the hinterland tends to constrain and facilitate realities that appear and are thought to be 'more or less stable' (Law, 2004, p. 32). However, caution should be exercised here around attributing an essential or unchanging quality to the hinterland. Hinterlands are emergent and fluid; they emerge in relation and are ascribed to objects and subjects in 'acts of ontological politics' (Fraser, Moore, & Keane, 2014, p. 239).

This ontological reconfiguration marks a departure from poststructuralist accounts of reality in terms of the empirical scope that determines the conditions of possibility for any given reality (Law, 2004). For Foucault, realities, objects and subject positions are constructed within a set of strategies produced within a single modern network or rationale (episteme). The episteme governs what can be thought and said within a particular time period. Mol and Law (2002) argue that 'the discovery of multiplicity suggests that we are no longer living in the modern world, located within a single *epistème*' (p. 8, emphasis in original). Multiple modes of ordering, logics, styles and practices enact different realities, often at the same time. In their co-authored introduction to the edited collection *Complexities: Social Studies of Knowledge Practices*, Mol and Law (2002) contemplate how the notion of complexity (and

social scientific inquiry) changes with the shift from a single order to multiple orders of reality. They argue that the 'trope of the single order that reduces complexity (or that is bound to fail in its attempts to do so) starts to lose its power when order is multiplied, when order turns into orders' (p. 7). That is, multiple orderings and enactments disrupt narrowly conceived binaries between simple and complex or good and bad. This is because multiple orderings of reality relate in complex ways. As Mol (2002) argues:

> Ontology-in-practice is multiple. Objects that are enacted cannot be aligned from small to big, from simple to complex. Their relations are the intricate ones that we find between practices. (p. 157)

If ontology-in-practice is multiple, it follows that the various orderings and enactments of reality 'do not always reinforce the same simplicities or impose the same silences' (Mol & Law, 2002, p. 7). As I discuss below, Mol and Law are not arguing that we can 'choose' the better option. As Fraser notes, choosing between alternatives cannot be resolved rationally but must be 'negotiated socially' (2010, p. 237). If, as Mol and Law suggest, there are multiple coexistences present at a single moment, we need to develop methods of analysis that can attend to ontological multiplicity.

Fraser and Seear's (2011) analysis of hepatitis C is a useful demonstration of what an engagement with multiplicity might offer. Drawing on the same conceptual tools, Fraser and Seear aim to do away with the notion that hepatitis C has a fixed, pre-existing material form with stable attributes and properties. For example, in an analysis of self-help books, they examine the social constitution of hepatitis C, particularly through its associations with HIV, injecting practices and iatrogenic (medically caused) transmission. They argue that through specific associations with sexual practices and blood, hepatitis C is often conflated with HIV, and enacted as having stable and fixed attributes. This constitution ignores the particular

political contexts, operation of stigma and governing regulations that shape the scale and speed of transmission. Through other associations with injecting drug use, these texts also function to assign feelings of anger or guilt (depending on the route of transmission) and to enact people who inject drugs as responsible for contracting the hepatitis C virus and its transmission (thus foreclosing other regulations and agents that shape transmission). In addition, the self-help literature often conflates injection with transmission, which functions to further stigmatise injecting practices (and people who inject drugs) and delimit other viable measures that might curb infection. Fraser and Seear's argument is not limited to remarks about the discursive construction of disease; their argument is a political one. Although these enactments of hepatitis C are often contradictory and flawed, they have material effects: they contribute to stigmatisation, to the scale and shape of transmission, to disease prevention responses and measures, and to the treatment of people who inject drugs. Fraser and Seear's analysis draws out how different enactments of hepatitis C, produced according to different knowledges, practices and conventions, produce different and significant material and lived effects. The benefits of their analysis, which highlights the multiplicity of hepatitis C, and the partial connections between these enactments, is that they can draw attention to ways of engaging and remaking hepatitis C in less stigmatising and individualising ways.

Ontological politics

The conceptual scheme I have so far been sketching out in this chapter has to do with what Mol (1999) terms 'ontological politics'. The concept of ontological politics works to underline the fact that the conditions of possibility that shape the real are not self-evidently given in a natural order of things. Instead, realities are 'historically, culturally and materially located' (p. 75). As Mol (1999) argues:

> Reality does not precede the mundane practices in which we interact with it, but is rather shaped within these practices. So the term politics works to underline this active mode, this process of shaping, and the fact that its character is both open and contested. (p. 75)

The realities in play at any given time are only ever temporary, contingent versions of the variety of realities potentially available, and must be continually re-enacted to remain stable. The work involved in fashioning them and holding them stable inevitably involves political choices that centre on dynamics of inclusion and exclusion. The implication of the concept of ontological politics is that if realities are made in practice, there exist opportunities to remake the world in alternative ways. As Law (2004) argues, 'truth is no longer the only arbiter and reality is no longer destiny' (p. 152). Instead, the world and the entities that animate it can be made otherwise via engagement with ontological politics. In light of this radical ontological instability, Mol (1999) suggests four questions that are important to consider in an ontological politics approach:

> 1. *Where* are the options?
>
> 2. *What* is at stake?
>
> 3. *Are* there really options?
>
> 4. *How* should we choose? (p. 79, emphasis in original)

Implicit in these questions is an investigation of what it means to conduct research in light of open-endedness and ontological multiplicity. First, Mol (1999) warns against an uncritical adoption of the notion of 'choice', as if we could, she argues, detect 'decisive moments' in the determination of ontologies and choose the 'good' or 'best' one (p. 79). As I have already sketched out, realities are held in place by hinterlands of practices, knowledges, concepts and associations. For example, as I explained above, Fraser and Seaar (2011) demonstrated how

hepatitis C is enacted via its association with HIV and injecting drug use, which delimits the shapes and trajectories that particular enactments of hepatitis C might take. Mol argues that that an examination of ontology-in-practice reveals that options are embedded everywhere, across diffuse networks of interrelated practices. Therefore, if it were possible to 'choose' between options, it is not just one reality that is at stake. Because realities are never singular, isolated or discrete but rather imbricated and entailed in other realities, objects and practices, the reality effects for an unquantifiable number of realities are also at stake. Third, considering that entities have relational ontologies, it is difficult to suggest that there exist 'options' when the various enactments of recovery are not simply opposed, but often collaborate with one another (I examine this empirically in professional accounts of recovery in Chapter 6 and individual practices of individuals who use or have used drugs in Chapter 7). Fourth, the question is no longer how to 'choose' between the options but what choices are represented and what are the effects of these choices. Such provocations are intensely productive in the context of new recovery. In the following chapters, I investigate the ontological politics of new recovery. My analysis examines the significant networks of practices and relations – alcohol and other drug policy and psychological research – that are ascribed to new recovery to authorise and evidence it. I examine how these hinterlands and their constitutive discourses, practices and conventions enact and circumscribe recovery and the assumptions they produce about drug use and people who use drugs. I also question how the ontological politics of new recovery shapes the conditions of possibility for drug use and related subject positions. To this end, I consider the extent to which the claims made in alcohol and other drug policy and psychological research about new recovery *are* remaking recovery by examining people's experiences of treatment and everyday life.

While the concepts I have assembled here from recent work in STS (enactment, multiplicity and ontological politics) are the main theoretical influences that shape my research, I also

draw on other work at specific points later in the thesis. In Chapter 4, I engage Carol Bacchi's poststructuralist method for policy analysis to examine the ways in which recovery is forged via problematisations in alcohol and other drug policy. In Chapters 5 and 6, I focus in more detail on the techniques Law and Mol outline in their work to attune my analysis to processes of enactment. Chapter 5, on the science of new recovery, is inspired by Law's work on the simplification practices implicated in enacting realities. In Chapter 6, I take up Mol's (2002) notion of organising relations to draw attention to the partial connections being forged between different enactments of recovery, which allows recovery to 'hang together' as a therapeutic entity (p. 5). I also draw on Law's adaptation of Judith Butler's concept of interpellation in and through 'modes of ordering' to examine how subject positions are forged and enacted through social, institutional and treatment in Chapters 7 and 8. These approaches resonate with the broader conceptual framework I have sketched out in that they engage with practices of enactment and illuminate the ontological politics of recovery. By using multiple, yet complementary, theoretical tools inspired by STS, I am able to attend to the specific practices of enactment across various sites as well as the specificities of the various sources of data I analyse. In engaging the complexity of new recovery, I can draw attention to the specificities of the multiple associations and relations that sustain its opacity and vagueness, and thus its conceptual utility.

So far, I have argued that the concepts propounded in recent work in STS scholarship provide a novel conceptual framework for an analysis of new recovery, which can address and examine its enactment across multiple sites. The concept of enactment presented here moves beyond the singular focus on policy discourses that have characterised much previous research on new recovery. It points to the significance of a wider array of sites and practices in the production of the forms new recovery takes. It also problematises the well-meaning but limited agenda of improving new recovery through more sensitive measurement tools. In the

ontological politics approach I have set out here, such tools emerge as a key site of enactment. Although they can be used to improve the ontological politics of new recovery (as Neale and colleagues have demonstrated), they stop short of destabilising the arguably unethical and stigmatising politics that new recovery reflects and reproduces.

The approach adopted in this thesis opens up ways of destabilising the authority of new recovery by researching and enacting it as unstable (yet held together), made in practice and open to change. This approach to reality as neither given nor fixed, but as contingent and actively shaped in and through practice, emphasises the ontological politics of research and reality-making. That is, processes of enactment are necessarily political because they are forged through processes of inclusion and exclusion that bring some realities into existence and foreclose others. This understanding of the performativity and politics of research practices has explicitly influenced what might traditionally be characterised as methodological concerns.

A 'case' approach

The theoretical framework set out above raises questions about how complex phenomena might be handled in knowledge practices without exerting simplified and singular orders of meaning or, alternatively, generating ever more complexity and chaos (Mol & Law, 2002). Mol and Law (2002) argue that we need to find methods and 'modes of relating that allow the simple to coexist with the complex, of aligning elements without necessarily turning them into a comprehensive system or a complete overview' (p. 16). In his book *Aircraft Stories*, Law (2002) argues that social scientific accounts have tended to simplify the complexity of social realities, so that:

> Events follow other events. Things are made to follow other things. This practice conforms to a tradition of continuity, or narrative, of telling how things arose,

> developed. And a powerful tradition it is, this tradition of ordering, of consistent explanation, of foundations, of origins. (p. 188)

The challenge, then, is to generate methodological practices that are sensitive to reality as enacted multiply. To be clear, this thesis does not aim to provide a comprehensive account of new recovery, even if that were possible. There are many more sites for analysis I could have included in this study, including, for example, new recovery support institutions or advocacy groups and practices. Similarly, I have not examined *all* scientific theories about recovery, choosing instead to focus on those that appear to be gaining traction in the design and organisation of Australian treatment practices. I also do not consider all aspects of participants' treatment experiences or their experiences of living in recovery. Instead, in line with an STS approach to the performativity of scientific and knowledge practices, my analysis will inevitably perform a partial (and political) account of recovery. This assumption has informed the selection of methodological practices and the organisation of the thesis, emphasising again the inseparability of theory from methodology. Recovery is treated as an emergent phenomenon constituted in and through various domains of practice. In the remainder of this chapter, I sketch the methodological practices involved in data generation and analysis.

Mol and Law also propose that we need to be self-conscious about the methodologies we use to relate to the object of inquiry. They propose three modes of relating that do not necessarily exert simple, single orders: lists, cases and walks. This thesis works specifically with the notion of 'cases', yet, as Mol and Law argue, all three modes suggest how knowledge practices and empirical inquiries might approach ontological multiplicity and complexity so as to allow for open-endedness, contingency and change. The 'case' is put forward as an alternative to an 'example'. Examples, Mol and Law argue, serve a representative function. They aim to illustrate specificities through recourse to an assumed larger order or whole. In

contrast, they argue that a case does not aim to be representative and can be used to study the specificity of phenomena, 'each [case] differing slightly in some (unexpected) way from all the others [… yet] still instructive beyond its specific site and situation' (Mol & Law, 2002, p. 15). Summarising Mol and Law's explanation of the utility of approaching phenomena as cases, Fraser and Seear (2011) make the following observations about cases:

1. They sensitise us to otherwise unrecognised events and situations;
2. Offer potentially 'translatable' ideas and insights;
3. In disrupting assumptions they can 'destabilise expectations';
4. They can be used as allegory, to speak indirectly about other things. (p. 14)

In each of the following substantive chapters, I conceive of the various new recovery enactments and sites that produce these enactments as *cases*; not as 'examples' of recovery, but as recovery enactments in the making, in their own right. In each chapter I aim to identify how drug use, the people who use drugs and other key phenomena are constituted in new recovery enactments. A case approach also leads me to 'ask questions about difference and similarity, about what alters in moving from one place to another' (Mol & Law, 2002, p. 16) without having to characterise these tensions through recourse to a larger, coherent whole. Significantly, a case approach highlights modes of relating, alignment and co-existence between different recovery enactments without suggesting a definitive, singular reality of new recovery that is common to all.

The cases I examine are:

- problematisations in alcohol and other drug policy;
- simplifications in psychological science on new recovery;
- organising relations in professional accounts of recovery;

- modes of ordering and interpellation in recovery-focused treatment; and
- modes of ordering and interpellation in the everyday practices of people who use, or have used, drugs.

These cases emerged in response to the research questions I introduced in Chapter 1: How is this new iteration of recovery enacted in drug policy, research and treatment in Australia, and what assumptions and claims about drug use and people who use drugs are made along the way? How do people who use drugs adopt, accommodate, resist or otherwise engage with recovery in treatment and their everyday lives? What are the political effects of these recovery enactments? In the following sections, I explain how the selected cases shed light on these questions and provide further details about their parameters. I discuss the first three cases individually as they are each concerned with different datasets: alcohol and other drug policy texts, psychological scientific research, and interviews with alcohol and other drug professionals. The last two cases I discuss together as they draw on the same dataset – interviews with people who use, or have used, drugs.

What's the problem represented to be in new recovery-focused policy?

In the following chapter, I examine the policy enactment of new recovery in a selection of Australian and Victorian policy documents. National drug policies are an important site for analysis. Smith et al. (2009) argue that 'public policy statements are a distinctive kind of text which frame the nature of policy problems, shape the boundaries of possible responses and act as points of reference for a wide variety of actors to justify subsequent actions' (p. 219). National strategies have the potential to set and generate tone, values, ideas and interests, and in this way, are important in the framing of state policy agendas (Lancaster & Ritter, 2014). State policy strategies and papers do similar work but produce local variants of the 'policy problem' and the strategies designed to ameliorate it. State policy documents are also useful

to examine in order to assess the extent to which national priorities and agendas are taken up at the state level. I adopt Victoria as a case for several reasons. First, as I noted in Chapter 1, David Best, a prominent researcher and recovery advocate, was head of clinical research at Turning Point Alcohol and Drug Centre in Victoria from 2013 to 2015. During his tenure, there was an increase in Australian research and advocacy on new recovery (e.g. Beckwith, Best, Dingle, Perryman, & Lubman, 2015; Best, Beckwith et al., 2016; Best & Lubman, 2012; Best et al., 2013). The second reason for choosing Victoria as a case is that, during this time, the Victorian treatment system underwent major reform. As I noted in the Introduction and explain in more detail in Chapter 7, developing a focus on 'treatment and recovery' was a central aim of this reform. The third reason for selecting Victoria is that it was the location of the interviews I undertook with people who inject drugs, service providers and policy stakeholders. Although I do not mean to suggest that people's attitudes to recovery align directly with or simply emerge from policy, authoritative enactments form part of the hinterland that sets possibilities and limits for expressing subjecthood, agency and legitimate forms of citizenship. Therefore, critically examining the central assumptions and presuppositions of Victorian alcohol and other drug policy is useful for elucidating the way these ideas are reflected and reproduced in the accounts provided by people who inject drugs and by alcohol and other drug professionals. Taking note of the concentration of new recovery ideas and stakeholders in Victoria, and the location of the people I interviewed, new recovery and its associated phenomena are more comprehensively explored in the Victorian policy documents and alcohol and other drug reform papers than in those produced elsewhere in Australia.

My analysis focuses on key policy documents published by the federal and Victorian governments (see Table 1, Appendix A). The Australian Government published *The National Drug Strategy 2010–2015: A Framework for Action on Alcohol, Tobacco and Other Drugs*

(hereafter referred to as the *National Drug Strategy)* in 2011. The Victorian policy documents are authored by the Victorian Department of Health. *New Directions for Alcohol and Drug Treatment Services: A Roadmap* (hereafter referred to as *New Directions: A Roadmap)* was published in the first half of 2012 and sets out the framework for the reform of the alcohol and other drug treatment sector in Victoria. It contains the most detailed descriptions of new recovery and it retains much of the aspirational and optimistic language used in the UK policy framework. The Victorian alcohol and other drug policy, *Reducing the Alcohol and Drug Toll: Victoria's Plan 2013-2017* (hereafter referred to as *Reducing the Alcohol and Other Drug Toll*) was released six months later, towards the end of 2012, and *New Directions for Alcohol and Drug Treatment Services: A Framework for Reform* (hereafter referred to as *A Framework for Reform)* was published in 2013.

In addition to these formal alcohol and other drug strategy texts, I also draw on a secondary corpus of supporting policy literature including the Victorian strategic directions, implementation plan and reform frameworks. Because the recovery focus in formal alcohol and other drug policy is relatively recent, the time span of the publications is limited to 2008–2013. All drug policy documents were publicly available and downloaded from the Victorian Government's Department of Health website or the Australian National Council on Drugs database.

Simplifications in psychological science on new recovery

The second case (presented in Chapter 5) examines how new recovery is enacted in psychological science. In 2013, I used Google Scholar and the databases ProQuest, ScienceDirect, Medline and Informit to search for relevant literature. I used combinations of the terms 'new recovery', 'recovery', 'addiction', 'drug and alcohol' and 'Australia'. This initial search yielded thousands of research articles and opinion pieces in Australian

newspapers and popular publications like *Health and Medicine Week* and *Australian Family Physician.* I disregarded the opinion pieces because recovery was invariably either peripheral to their focus or the term was used in a broader sense to capture a more general and less defined sense of recovery than that connoted by 'new recovery'.

I narrowed my scope to psychological scientific articles for several reasons. Most research on new recovery emerges from within quantitative psychology. This body of research is substantial and includes, for example, attempts to develop a consensual definition; elucidations of the experience of 'recovery', including its 'stages'; examining correlations between recovery and other phenomena (e.g. abstinence, mental health, quality of life and spirituality); examinations of the efficacy of peer recovery and broader recovery support services; recovery management and recovery-oriented systems of care; post-treatment monitoring; and participation in social networks and social group membership. From within this broad range, I narrowed my focus to psychological scientific research on 'recovery capital' and 'social identity change'. These topics were chosen because, as my PhD candidature progressed, they became central to Victorian policy and treatment, and to Australian research on new recovery.

Following David Best's appointment at Turning Point Alcohol and Drug Centre, Victorian research activity on new recovery increased. For example, Best adapted the US Life in Recovery Survey designed by Alexandre Laudet and colleagues on behalf of Face and Voices of Recovery (Laudet, 2014) to develop an 'Australian Life in Recovery Survey' (Best, 2015). This was disseminated in Victoria and New South Wales. A total of 573 surveys were completed and analysed by a research team at Turning Point Alcohol and Drug Centre. The research received extensive media attention. Its aim was to demonstrate the size of the recovery community and the positive impact of recovery on people's lives, particularly 'given the opposition to the idea of recovery from a number of prominent clinical and policy

figures' (Best, 2015, p. 4). The survey was a relevant tool from which to advocate for and inform policy.

In addition, researchers from Monash University (Victoria), with which Turning Point Alcohol and Drug Centre is affiliated, in collaboration with researchers from the University of Queensland and Deakin University (Victoria), received an Australian Research Council Grant to examine the role of social networks and group membership on recovery from drug dependence (Best, Haslam et al. 2016). This longitudinal investigation of social identity change within therapeutic community settings examined whether individuals who 'successfully recover undergo a social identity transformation' (Australian Research Council, 2014, p. 245). This study spawned numerous publications (e.g. Beckwith et al., 2015; Best, Lubman et al. 2014; Best, Beckwith et al., 2016; Dingle, Stark, Cruwys, & Best, 2015; Mawson et al., 2015) and its data was used in a related PhD project aiming to develop a social identity model of recovery (Best, Beckwith et al., 2016).

Importantly, in addition to the increasing focus on social identity change in Australian research, Best's advocacy work and collaboration with Victorian treatment providers in the lead-up to the Victorian treatment system reform resulted in a new focus on 'recovery capital' in Australian research and treatment delivery. For example, Turning Point Alcohol and Drug Centre adapted a measure of 'recovery capital' (Groshkova et al., 2013) and included it as an optional, yet routine assessment undertaken by professionals when screening and assessing service users entering treatment (Department of Health, 2013d). Furthermore, 'recovery capital' and 'social identity change' are often studied together, and are often treated as related and overlapping. For example, the Australian Research Council-funded study of social networks and recovery included the assessment of recovery capital in the interviews that formed the basis of the project. An aim of the study was to test the impact of identity change on recovery capital (see, e.g., Best et al., 2014; Best, Haslam et al., 2016). Conversely,

identity change is also conceptualised as a form of recovery capital (see, e.g., Department of Health, 2013d). My analysis in Chapter 5 considers them together in order to offer insights into how their mutual constitution shapes the way in which new recovery is enacted in this research.

In sum, my selection of scientific texts was informed by an iterative logic that involved repeated cycles of reading and writing, along with close scrutiny of unfolding developments in Australian and Victorian policy, research and treatment. In order to examine how recovery capital is enacted in psychological science, I focus on two quantitative articles, authored by prominent recovery advocates and researchers, which develop the construct of recovery capital (Laudet, Morgen, & White, 2006; Laudet & White, 2008). I also analyse the more recent development of an empirical measure of 'recovery capital' and the resulting scale (Groshkova et al., 2013; Department of Health, 2013d):

1. Laudet, A. B., Morgen, K., & White, W. L. (2006). The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug problems. *Alcoholism Treatment Quarterly, 24*(1-2), 33-73.
2. Laudet, A. B., & White, W. L. (2008). Recovery capital as prospective predictor of sustained recovery, life satisfaction, and stress among former poly-substance users. *Substance Use & Misuse, 43*(1), 27-54.
3. Groshkova, T., Best, D., & White, W. (2013). The assessment of recovery capital: Properties and psychometrics of a measure of addiction recovery strengths. *Drug and Alcohol Review, 32*(2), 187-194.
4. Department of Health. (2013d). Optional module 8: Assessment of recovery capital. Melbourne: Victorian Government.

These articles are significant because they represent the first attempts to define recovery capital empirically and inform contemporary research (e.g. Best et al., 2012; Best et al., 2013; Best et al., 2015). Further, the related assessment of recovery capital has been used to validate other measures of recovery (Neale, Vitoratou et al., 2016). As previously mentioned, this assessment is also currently an optional (but routinely used) component of screening and assessment in the Victorian alcohol and other drug sector (Department of Health, 2013d), and therefore potentially influences service users' experiences of treatment.

Research on recovery as a form of social identity change, which is being led by Australian researchers, is an emerging and influential area – particularly in regards to the organisation and focus on residential treatment in Australia. In order to examine how social identity change is enacted in psychological science, I focus on the recently published Social Identity Model of Recovery (SIMOR) (Best, Beckwith et al., 2016). I focus on Best and colleagues' (2016) SIMOR article because it brings together the work of key figures in the field of social identity change and addiction recovery, and is the first conceptual framework, to my knowledge, that attempts to identify and explain the 'underlying mechanism' of new recovery. Drawing on several prior studies on social identity, most of which have been conducted in treatment settings (Beckwith et al., 2015; Buckingham, Frings & Albery, 2013; Dingle, Cruwys & Frings, 2015; Mawson et al., 2015), SIMOR is the result of an international collaboration between recovery advocate and researcher David Best (now based in the UK), leading researchers in Social Identity Theory, Alexander and Catherine Haslam at The University of Queensland, and Victorian researchers at Turning Point Alcohol and Drug Centre.

Organising relations in the narrative practices of professionals

The next case (presented in Chapter 6) is an examination of the professional practices and accounts of alcohol and other drug professionals. This professional site is significant because it is here that earlier notions of recovery seemingly endure and are made stable even as they are co-opted by 'new recovery'. Briefly, this chapter is concerned with the narrative and treatment forms of coordination (Mol, 2002) that operationalise recovery in a hybridised form – bringing together various enactments of recovery into a coherent therapeutic discourse and treatment experience. These professional narratives are understood as a 'set of signs' that generate specific meanings (Squire et al., 2014, p. 5).

This case draws on interviews conducted with 11 professionals, including senior managers, service providers, policymakers and researchers between October 2014 and April 2015. This number of interviews provided sufficient variation in terms of the roles and types of service in which participants were employed (see Table 2, Appendix B). Ethics approval for collecting these interviews was granted by the Curtin University Human Research Ethics Committee (HR 165/2013). A targeted approach was used to recruit service providers, researchers and policy stakeholders. Given the Victorian treatment system reform was underway at the time of recruitment, I focused in particular on those organisations commissioned to provide residential services, and care and recovery coordination. In addition, following discussions with my thesis supervisor, I developed a short list of researchers in Australia with relevant expertise who would be able to contribute insights about developments in recovery-focused policy and treatment. All three researchers on the list agreed to participate. The composition of the interview sample took into account a range of issues (e.g. professional background, treatment modality and levels of client engagement). The identified service providers, researchers and policy stakeholders were then approached by email and provided with a plain language statement. This explained the purpose of the

project, the interview length, topics of interest, how the information would be used and stored, and procedures for ensuring confidentiality. Participants were drawn from state health and social welfare government departments, non-government organisations delivering advocacy and policy advice and prevention programs, treatment organisations, primary health care centres, therapeutic communities, residential rehabilitation, harm reduction organisations, universities and research institutes. Participants included an ex-senior government policymaker, senior researchers in policy and treatment systems, managers at harm reduction services, therapeutic communities and residential rehabilitation centres, and a 'care and recovery coordinator'.

Interviews were usually held at the National Drug Research Institute (NDRI) office in Melbourne or at the interviewee's workplace. Interviews lasted between 45 and 90 minutes. Interview questions and topics varied according to the type of alcohol and other drug professional being interviewed. Broadly, the interviews focused on the key concepts informing new recovery-focused policy and treatment, recovery-focused treatment practices, treatment goals and outcomes, program delivery, therapeutic language and interventions and organisational philosophies. Interviews with treatment service providers delved more deeply into the intersection between new recovery discourse and harm reduction principles, the day-to-day delivery of 'recovery-oriented' treatment practices and tensions emerging from the Victorian alcohol and other drug reform. Interviews with researchers and policymakers focused more explicitly on the development of policy, the role of evidence in recovery-oriented policy development, the ethics of recovery discourse and its political effects on service users.

Given the recruitment frame, the politicised domain of policy research and the small number of recovery-focused services in Victoria, I exclude descriptive and potentially identifying data (such as gender, role and organisational affiliation) when introducing participant

quotations in order to maintain confidentiality. Instead I use anonymised pseudonyms (e.g. 'Professional 1'). I also use the broad term 'residential rehabilitation' to refer to different types of therapeutic residential treatment and exclude the names of particular treatment practices which might be recognised by other professionals and service users.

Recovery in treatment and everyday practices

The case presented in Chapter 7 concerns how the notion of the drug-using identity is reflected and reproduced in treatment. In Chapter 8, the focus is the experiences of people who use or have used drugs and their engagements with recovery in everyday life. In both chapters, I draw on in-depth interviews with people who inject, or have injected, drugs. Chapter 6 also includes material from the professional interviews described above. Therefore, although Chapters 7 and 8 present two different cases of recovery, I examine them together as they rely on the same data-generating techniques and similar analytical techniques. These interviews were also covered by the ethics approval noted above.

Recruitment

I interviewed 26 people (see Table 3, Appendix B) who had past or current experience of injecting drugs (one interviewee withdrew from the study and is therefore excluded from the analysis) between August 2014 and April 2015. The criteria for inclusion in the interviews were being at least 18 years old and having injected a drug within the last three years. I recruited people who inject drugs because they are the most pathologised and stigmatised of all drug users and therefore seen as most in need of treatment, normalisation and recovery (AIVL, 2012; Fraser & Seear, 2011; Lancaster, Santana, Madden, & Ritter, 2014; Lloyd, 2013; Simmonds & Coomber, 2009). I recruited participants from inner-city treatment services in Melbourne including detoxification and withdrawal facilities, local drop-in centres that offered alcohol and other drug services and material assistance, and outer-suburban

residential rehabilitation services. I approached six services via email and provided a brief explanation of the research and requested permission to display an information sheet advertising the research in public reception areas. All of the sites I approached agreed to my request, and displayed an abridged version of the plain language statement with my contact details attached. The information sheet included a carefully worded explanation of the project, information regarding the length and potential content of the interviews, details of reimbursement and an assurance of client anonymity and confidentiality. I recruited and interviewed seven participants from the six services.

Recruitment also relied on the pre-existing professional and personal contacts established during my previous employment in the Victorian alcohol and other drug and homelessness sectors. These contacts generated referrals and assisted in locating participants who were not enrolled in treatment at the time of interviewing. During July and September of 2014, I also sent out a brief email to past colleagues and professional contacts with a short description of the research and the information sheet attached. I encouraged people to forward my contact details to relevant people and to encourage past or present clients to contact me if they thought they were eligible to be interviewed. As a result, I recruited and interviewed four people from a forensic alcohol and other drug program, an intensive long-term case management program for homeless drug users, and a needle and syringe service. These recruitment methods allowed access to participants engaged in treatment but not those who had not undergone treatment or been out of treatment for some time.

Snowballing proved to be the most productive avenue of recruitment. After I began the research in early 2013, I continued to work casually in the adult alcohol and other drug sector for another six months. As a result, I was in close contact with people who injected drugs or had ceased to inject drugs within the last few years when recruitment began. I explained to several people that I was conducting interviews for my PhD project and asked if they would

consider being interviewed. At the end of three of the interviews, I asked interviewees whether they would consider forwarding my contact details to their peers. From these interviews, and through subsequent word of mouth referral, I recruited and interviewed 11 participants.

When people contacted me, I scheduled interview dates and times and negotiated a suitable location. Interviews were conducted in locations convenient to participants. Private interview and counselling rooms in service provision settings were offered when interviewees made contact. When participants preferred to meet in non-clinical settings, every attempt was made to ensure privacy and confidentiality when conducting interviews in public settings such as parks, cafes and street locations. Prior to each interview, following the agreed university ethics and fieldwork protocols, I sent my supervisor a text message informing him of the location of the interview, the starting time and the expected finishing time. Following the interview, I confirmed via text that the interview had finished.

When I met participants, I introduced myself and gave a brief informal summary of the research project. All research participants provided informed consent before participating in the study. They were provided with a plain language information sheet and consent form outlining the research objectives; procedures for data generation, storage, analysis and publication; and measures for protecting respondent anonymity and confidentiality. I also read aloud and explained the consent form to interviewees and then recorded their verbal consent.

Interviews were digitally recorded on a mobile phone, then copied to a secure NDRI computer and deleted from the phone. Interviews were semi-structured and kept intentionally broad so as to explore participants' accounts of drug use, treatment, social relationships, stigma and recovery. They covered drug use history, where participants had learnt about

recovery, extent of identification with ‘recovery’, understandings of recovery, experiences of recovery in treatment, and relationships with family and friends. Participants were reimbursed AUD40 (approx. USD37 in mid-2013) for their time, expertise and travel costs in accordance with accepted practice in Australia (National Health and Medical Research Council, Australian Research Council, & Australian Vice-Chancellors’ Committee, 2007).

Data generation

When recruitment began I developed a plain language statement for individuals with experience of injecting drugs, which described the project as a ‘study of how “recovery” is understood and experienced by people who inject drugs’. I deliberately avoided including recovery in the inclusion criteria as I wanted to assemble a diverse range of experiences and accounts. I did not distinguish between ‘recovery’ and ‘new recovery’ as I thought this would be confusing for individuals and service users (as it still is for policymakers and professionals). Further, one purpose of my research was to determine the extent, and in which ways, new recovery ideas and practices have been engaged by people who use drugs. This is evident through a careful analysis of how individuals’ accounts reflect and reproduce authoritative discourses.

After beginning the interviews, I modified the eligibility criteria by extending the time frame in which people had ceased injecting drugs from 12 months to 7 years. It emerged over several interviews that many people considered recovery to be an ongoing process not delimited by a specific number of years ‘in recovery’. For this reason, I also included people with longer experiences of recovery to examine how concepts and practices of recovery might have changed over time.

During the period in which I conducted interviews, I kept a spreadsheet recording demographic information (for example, gender, age, ethnicity and suburb of residence). I also recorded participants’ injecting status at the time of the interview, time since last use, past

and present involvement in treatment, and the different treatment types (including opioid substitution treatment) in which participants had been or were involved. This allowed me to adjust the sample throughout the recruitment process and purposively recruit people who had a diverse range of treatment experiences and potential engagements with recovery.

Participants ranged from 20 to 61 years of age. Of the 25 participants, 15 were men, a gender ratio that reflects rates of illicit drug use in the Australian population (Australian Institute of Health and Welfare, 2017). At the time of the interview, seven of the men were not engaged in any forms of treatment although most had accessed multiple treatment modalities in the past. The other eight male participants were engaged in residential rehabilitation, case management, opioid substitution treatment, NA or counselling. Of the 10 female participants, five were engaged in a range of treatment services, including day programs, counselling, NA and opioid substitution treatment. The other five women were not formally involved in treatment at the time of the interview, although all had accessed withdrawal and rehabilitation services in the past. Most participants identified themselves as Anglo-Australian, with the remainder identifying with a wide range of ethnic backgrounds. Approximately half of the participants were employed, with several working casually in hospitality, information technology, the arts and sex work, and three participants were studying.

While I was primarily interested in understandings of new recovery, I also wanted to avoid leading the interviewees by introducing the term too early in the interview. In order to allow participants to articulate their experiences in their own words, I often refrained from using the term ‘recovery’ until a participant introduced the term. Yet, on several occasions, participants appeared to reframe their experience within a discourse of recovery once I had introduced the term. For example, Jess, a 31-year-old woman, described her recent experience of drug cessation and how she now felt ‘in control’. Midway through the interview, I asked if she considered herself to be ‘in recovery’. She responded by assuring me that she was indeed in

recovery. Similarly, Ryan, a 37-year-old man, told me he was 'in recovery' but when I asked him if he would have used this phrase prior to the interview or usually thought about his drug use in these terms, he responded 'I wouldn't have said that'. After further discussion and reflection, he said that he might not use the word 'recovery' because he 'didn't get enough education around [drug] using'. He also flagged reluctance to use the term because 'it's kind of letting somebody know … I'm a drug addict or an alcoholic'. Moreover, the positive valence ascribed to recovery and its association with abstinence meant that some of the participants who knew me prior to the interview explicitly expressed shame about their current injecting drug use. It is impossible to discern whether this would have been the case with a different interviewer. However, these subtle negotiations over language and identification were instructive in highlighting the performativity of the interview encounter in reinscribing power relations between interviewer and interviewee. These encounters may also be explained by the pre-existing relationship I had with some participants as 'clients' when I was a 'worker'. These subject positions may have been reiterated through the power dynamics of the interview encounter and the loaded associations with injecting drug use and recovery. The complex negotiations speak to the notion of enactment I introduced earlier in this chapter. The dynamics of the interview practice do not exist independently or objectively of the realities being produced (Law, 2004). Rather, the power relationships, subject positions, concepts and practices that constitute the interview encounter also enact the kind of recovery realities being produced and foreclose other realities.

A second issue that emerged during interviews related to my prior employment in the alcohol and other drug sector. In many ways my practical experience and familiarity with the Victorian alcohol and other drug terrain served me well during the recruitment and interviews. As I described above, I had many pre-existing contacts to draw on who were very generous in providing informal character references for me to other potential participants. In

a sense, being ‘recommended’ to other people as trustworthy and ‘in the know’ aided recruitment and possibly engendered a sense of intimacy and informality in the interview process. For example, it was not uncommon to continue chatting with people and swapping stories after the interviews had finished, to share cigarettes or to swap news about people or particular treatment services with which we were familiar. I was also familiar with marginalised accounts of drug consumption, which were often entangled with demoralising and traumatic experiences of poverty, homelessness and violence. However, as I describe below, my familiarity with the narrative accounts of ‘addiction’, ‘trauma’ and ‘recovery’ that circulate widely in treatment settings also produced some difficulties. For quite some time, I was unable to analyse the interview accounts in such a way as to generate novel insights that might disrupt the dominant and often stigmatising accounts of addiction. In my previous position as a ‘worker’, I had been acculturated in the discourses and practices of recovery-focused residential treatment. I was very familiar with addiction recovery stories and had come to regard these narratives as expressing an anterior and stable reality of addiction and recovery. I found it very difficult to adopt an analytical approach in which these interviews were treated as accounts rather than facts. (By the term ‘account’, I mean my understanding of the interview data.) I had to learn that participants’ narratives were not transparent expressions of a ‘true’ reality. In addition, they give a sense of the discourses, practices and governmentalities that shape people’s experiences. In this way, participants’ accounts reflect and reproduce the socio-material arrangements that shape people’s lives.

Risk of harm to interview participants

Interviews with marginalised people, such as people who inject drugs, often prompt reflection on heavily stigmatised practices and experiences. Asking people to recount these experiences has the potential to elicit distress. As part of obtaining ethics approval, I had established a set of procedures for dealing with such situations if they arose during interviews, including the

provision of harm reduction information and contact details for counselling services. I also drew on my professional experience in facilitating therapeutic groups in a residential alcohol and other drug rehabilitation service. During my interviews, there were several instances where I was required to draw on these procedures. For example, during an interview with Tessa, a 20-year-old woman who appeared visibly drug affected, I stopped the interview because she was having trouble answering questions and kept falling asleep. She became visibly distressed and started crying and apologised for wasting my time. To the best of my ability, I assured her she had not 'wasted my time' but that I needed to stop the interview. I paid her the $40 dollars reimbursement. After we had talked for some time and she appeared less upset, I gave her the contact details for a harm reduction-focused youth alcohol and other drug service. On another occasion, Rosa, a 43-year-old woman, became visibly distressed recounting her experiences of a 'rapid detox' that necessitated an abortion. Recounting this particularly horrific experience, she started crying and apologising to me. I asked if she would like to stop the interview but she declined. Instead we had a gentle conversation about her experiences. Following this conversation, Rosa was much less distressed and we carried on with the interview. More broadly, interviews often finished with participants apologising to me about the interview not being useful. On all occasions, I strongly affirmed how valuable the interview had been and how much I appreciated them sharing their experiences and expertise with me.

Once completed, interview recordings were sent to a professional transcriber (who had signed a contract that included a confidentiality clause) and transcribed verbatim. Interview transcripts were entered into the NVivo10 data management and coding software. Participants who injected drugs were allocated a pseudonym, which was stored separately from the data and kept in a locked cabinet accessible only to me. As I noted above, the professional participants were given anonymised labels to maintain confidentiality.

Identifying information regarding participants and individual organisations is not used in the thesis, and has not and will not be used in conference presentations and publications based on the study.

Data analysis: 'Plugging in' to the data

Data analysis is informed by Jackson and Mezzei's (2011) concept of 'plugging in' to the data. In their book *Thinking with Theory in Qualitative Research*, they propose this concept (which they adapt from Deleuze and Guattari) to capture an alternative way of thinking *with* theory and data sets. 'Plugging in' is a way of 'reading-the-data-while-thinking-the-theory' (Jackson & Mezzei, 2011, p. 4). That is, Jackson and Mezzei argue that theory and data co-constitute one another. They go on to argue that plugging in requires three manoeuvres, which I reproduce below:

1) putting philosophical concepts to work via disrupting the theory/practice binary by decentering each and instead showing how they *constitute or make one another*;

2) being deliberate and transparent in what analytical questions are made possible by a specific theoretical concept (deconstruction, marginality, power/knowledge, performativity, desire, intra-activity) and how the questions that are used to think with *emerged in the middle* of plugging in; and

3) working the same data chunks repeatedly to 'deform (them), to make (them) groan and protest' with an overabundance of meaning, which in turn not only creates new knowledge but also shows the *suppleness of each when plugged in*.

(Jackson & Mezzei, 2011, p. 5)

The authors explore the process of plugging in by examining interview accounts with women professors who are first-generation college graduates. In each chapter of their book, they plug

in to the same interview accounts by thinking and engaging them through different theoretical concepts (derived from the work of Derrida, Spivak, Foucault, Butler, Deleuze and Barad). In doing so, they demonstrate how the specific analytical questions they ask of data are shaped according to the specific conceptual concerns. At the same time, it is not just the questions that change in relation to key theoretical concepts. What emerges in their account is that data is co-constituted by the theory, researcher and research question. We can also characterise this process through the lens of ontological politics in that different research practices (and their constitutive theory–methodologies) enact and afford different insights, possibilities and realities (Mol & Law, 2002).

In attempting to identify the realities enacted by new recovery, I began to 'think' the different data I had gathered through Mol and Law's concepts of practices, enactment and ontological politics (Dilkes-Frayne, Fraser, Pienaar, & Kokanovic, 2017). This generated a renewed focus on the different kinds of knowledge practices that enact new recovery across different sites. I then engaged a 'specific concept from the theorists who made up part of the assemblage' (e.g. Mol and Law) to address my research aims and to think/produce data that could address the ontological politics of new recovery (Jackson & Mezzei, 2011, p. 5).

In chapter 4, I begin my analysis by analysing how new recovery is enacted in national and Victorian alcohol and other drug policy. I draw on the poststructuralist policy method outlined in Carol Bacchi's (2009) 'What's the problem represented to be?' (WPR) approach. Bacchi's approach, which I explore in more detail in the following chapter, prompts scrutiny of the implicit problematisations lodged in policies that authorise and legitimise particular kinds of solutions. My analysis followed an iterative, inductive logic and focused on identifying specific problem representations particular to new recovery; the presuppositions and assumptions underpinning specific problem representations; potential oversights and silences in these representations; and alternative ways in which these representations might

be framed. This iterative process of reading, reflection and writing allowed me to consider the political effects of specific problem representations. My analysis of these policy texts was also shaped by the interview data I was concurrently generating, which allowed me to counterpoise the problematisations I identified in policy texts with lived accounts of recovery. In many respects, my analysis of policy problematisations continued alongside my analyses of other processes of enactment as the broader interpretive framework of my thesis began to take shape.

In Chapter 5, I drew on Mol's (2002) analysis of scientific practices in the hospital and on Law's (2013) detailed breakdown of the way in which simplification practices '*do* realities' (Law, 2013, p. 157). I explain these practices in more detail in Chapter 5, but briefly, Law directs attention to specific practices of selection, framing, juxtaposition, ranking and deletion. In line with the concept of enactment, these simplification practices perform and achieve inclusion and exclusion, and contribute to the performance of the real. Thinking with these five concepts of simplification shifted my focus to the practices of scientific inscription and quantification that enact new recovery in particular and political ways. The articles and assessment of recovery capital were analysed using an iterative inductive approach in which I read and reread the articles thinking through Law's typology. I made detailed notes on how new recovery was being constituted through these simplifications. This allowed me to identify the key binaries in operation in new recovery, and the specific political terrain recovering subjects are obliged to manage and uphold.

Chapter 6 draws on professional accounts of new recovery and the way in which ideas of recovery circulate through professional knowledges and practices. I began reading and re-reading the interview accounts, coding them into recurring themes. I developed a large corpus of codes concerning how professional practices constituted recovery differently, professional and therapeutic knowledges about addiction and recovery, specific new recovery practices

and broader treatment practices, and criticisms of new recovery. This case allowed me to understand how authoritative enactments of new recovery are distilled in and through professional practices. My initial coding also demonstrated that older notions of recovery endure in professional practices, existing alongside and being appropriated by new recovery. This multiplicity and overlap inspired me to use Mol's work on multiplicity, particularly her analysis of the organising relations that operate in institutional settings (e.g. hospitals) to coordinate various enactments of disease into a serviceable and treatable entity. I drew on the thematic codes related to treatment practices to read them through Mol's concepts of 'coordination' and 'distribution'. Through detailed note-taking, writing, re-reading and re-writing, I began to identity the kinds of organising relations that operate in professional knowledges and practices concerned with recovery. As I argue in this chapter, some ideas and concepts associated with new recovery were operating in professional practices, but my analysis also identified older and hybridised forms of recovery too.

The cases presented in Chapters 7 and 8 draw predominantly on the interview accounts of people who inject or have injected drugs. I began reading and re-reading the interview accounts, coding them into recurring themes. I developed a large corpus of codes concerning how people understood recovery, injecting practices, different recovery discourses, treatment practices and experiences of treatment, goals and aspirations, everyday practices, social relationships and stigma. During my research, residential treatment was emerging as an important area through which people learnt about and practised new recovery. My research aim was also to explore how people engaged with recovery in their everyday lives. This twin focus led me to write separate chapters on recovery in treatment and in everyday practices. My early reading and analysis of the thematic codes relating to treatment and everyday practices indicated that treatment settings had their own complex institutional logics and obligations that were not always consistent or coherent. Similarly, participants' accounts of

their everyday lives revealed differing discourses and practices that reproduced various older ideas of recovery – particularly those informed by 12-step discourses and practices. Mol and Law's work on modes of ordering and interpellation has to do with identifying the different patterns and strategies in specific sites that enact reality multiply. Therefore, in Chapters 7 and 8 I generated the cases through Mol and Law's concept of 'modes of ordering', and Law's reworking of Butler's notion of interpellation, to explain how different subject positions are enjoined and enacted. Like the other concepts I use to plug in to the data, I explain these concepts in greater detail in the relevant chapter. However, briefly, both concepts provide a means of understanding the enactment of new recovery in multiple ways in treatment and individual practices, and its constitutive effects for subjectivity. Thinking with these concepts, I began to take note of the variety of institutional and therapeutic ordering practices in recovery-focused treatment settings. Similarly, I began to look for everyday patterns and practices that reflected or reproduced new recovery, or the lack thereof. In both cases, I made detailed notes about the ways in which people were enjoined to view themselves according to these different orderings in order to address my second research question. These concerns and the methodological choices I have made for analysing this last of my four datasets are shaped by assumptions about the relational and ontological multiplicity of recovery.

Conclusion

In this chapter, I have outlined a theory–methodology that can account for the partial and multiple co-production of new recovery across several significant sites. By speaking of method and theory together, my thesis aims to trouble the epistemological and ontological distinction between representation and reality that underpins much of the extant literature on recovery. These accounts tend to locate recovery as anterior to social practices and awaiting research attention. In contrast, the performative conceptual framework I have sketched here

exceeds this representationalist ontology by locating my research, and the methods I selected, among the many processes of constitution engaged in the enactment of new recovery.

Drawing on recent work in STS, I introduced the concept of enactment as a way of capturing the productive activity through which particular entities are forged and brought into being. Critical to the notion of enactment is a reframing of social inquiry away from the entity itself to the practices that inscribe and perform it. Mol (2002) suggests that there is no prior ontological referent – the ontology of a specific reality is only ever ontology-in-practice; or, as Law (2013) argues, 'there is *no escape from practice.* It is practices all the way down, contested or otherwise' (p. 172). This thesis directly engages with tracing and exploring recovery enactments in policy and psychological scientific practices, and the narrative accounts of treatment providers and people who inject, or have injected, drugs. In this sense, the case approach I employ also responds to the notion of multiplicity I introduced earlier. That is, these different networks of practices forge and sustain different realities of recovery. In this sense, these practices are engaged in the ontological politics of new recovery, actively shaping its character and identity in partial and political ways.

As well as tracing the ontological politics of new recovery across various sites, I explained my own research practices as actively contributing to this same politics. In the second half of this chapter, I described the interpretive tools developed by Bacchi, Mol and Law that I used to analyse cases of recovery. I also outlined how I analysed my different data sources by plugging in to the data through these concepts. As I have emphasised, none of these cases is representative but each allows me to make claims about the nature of new recovery as it is being actively constituted. This approach also allows me to explore whether new recovery's claims to being new are warranted, because I can track its development and continuity with older ideas across different sites. In the following chapters, my aim is to explore the multiple

constitution of new recovery, and to help remake it in ways that are more generous to those subjects enjoined to ‘recover’.

The next chapter is the first of five empirical chapters. In it, I examine how new recovery is enacted in Australian national and state alcohol and other drug policies. Policy strategies have been an important site of enactment of new recovery in Australia and internationally. I argue that specific policy problematisations of drugs and of the people who use them have significant political consequences in terms of the granting or withholding of citizenship.

Chapter 4

‘A solution in search of a problem’:

Rethinking recovery in alcohol and other drug policy

The quotation in the above title is taken from an interview I conducted with an alcohol and other drug professional (Professional 7). The description of new recovery-focused policy as a ‘solution in search of a problem’ succinctly expresses a widely held concern about the paucity of evidence supporting such a focus in Australia policy. The quotation speaks to a central argument flowing through this thesis: that knowledge practices do not simply respond to pre-defined, concrete and fixed problems ‘out there’ (Law, 2004) in the world but actively participate in their making. To this end, the particular kinds of problems identified and enacted by new recovery are politically significant. They shape how people are governed as citizens (or less-than-full citizens), have subjective and material implications for people who use drugs, and restrict the development of alternative ways of conceptualising and responding to the troubles associated with drug use (Bacchi, 2009).

Advocates of new recovery often argue that alcohol and other drug policy focused on recovery and recovery-oriented systems of care represents a shift from a pathologising, acute-care model of treatment to a strengths-based, person-centred and solution-focused approach (see Best & Ball, 2011; Best et al., 2010; Laudet & White, 2010; White, 2008; White et al., 2012). In this chapter I consider these claims in relation to enactments of new recovery in Australian and Victorian alcohol and other drug policy, and the specific problematisations reflected in these policy proposals. Using Bacchi’s (2009) methodological approach, I aim to clarify the contribution of new recovery to the development of Australian alcohol and other drug policy. In my analysis, I trace three specific dynamics, which emerge in the encounter

between the familiar ideas and terms (e.g. medicalisation, treatment, community) that animate Australian alcohol and other drug policy and the introduction of new recovery discourse. First, the focus on new recovery crystallises the existing policy focus on reducing individual drug *use* via an increased emphasis on medicalised notions of dependence, mental illness and addiction. Second, the new recovery focus strengthens the existing emphasis on increasing access to treatment and the quality of treatment. In providing a more detailed description of treatment aims and desired outcomes, the analysed policy documents more concretely elicit a typical treatment client and enjoin a set of obligations that must be fulfilled in order for drug-using individuals to be considered healthy citizens. In addition to the focus on treatment, new recovery discourse intensifies the focus on 'community' as a curative and rehabilitative site. Although, at a surface level, community participation sounds empowering, it is premised on the problematisation of drug-using subjects as peripheral or marginal to civic life. Further, this obligation to recover through community reintegration sits in tension with the simultaneous problematisation of drug use and drug-using subjects as a source of harm to the community.

I argue that these problematisations intensify neoliberal logics of pathologisation, individualisation and marginalisation that have long been central to Australian alcohol and other drug responses. However, the new recovery focus expands upon ideas that have to date operated less visibly within the abstinence-based strategies that have long been part of the objectives of harm minimisation. New recovery explicitly (rather than implicitly) links the control of drug use and the 'rehabilitation' of the drug user to wider citizenship goals such as improved health, active citizenship and economic productivity. Procacci (2004) argues that citizenship is usefully conceptualised 'as concrete practices of government, as specific requirements and expectations, rights and duties, involving public action and subjectivity' (p. 346). In this sense, recovery as a policy solution is usefully viewed as *another* articulation of

a contemporary citizenship regime (Procacci, 2004). On this view, new recovery reflects and reproduces the political rationality informing contemporary practices of citizenship. It contributes to a particular neoliberal view of the world in which issues of responsibilisation and self-management trump political, social and economic relations in explanations for the production and entrenchment of drug harms. The problematisations and proposals underpinning new recovery do not represent a novel break from the pathologising logics and concepts that have long underpinned policy approaches to alcohol and other drug use. Rather, new recovery intensifies them by continuing to position the individual drug-using subject as the proper target of concern.

'Evidence', problematisations and policy

The inclusion of new recovery discourse in national and state policy in the absence of extensive or localised Australian research reminds us that the forces motivating policy change often have little to do with evidence and are complex, contested and political (Colebatch, 2010; Kingdon, 2003; Lancaster, 2014, 2016; Lancaster & Ritter, 2014; Lancaster, Treloar, & Ritter, 2015; Sabatier, 2007; valentine, 2009). These forces include political and ideological conflict, media representations of drug-related problems, public perceptions, and financial considerations and constraints (Ritter, 2009). Indeed, the notion that scientific evidence and evidence-based policy function as objective resources mobilised by governments in policy development has long been criticised in a wide range of policy areas (Bacchi, 2009; Harrison & Checkland, 2009; Pawson & Tilley, 1997; Schorr, 2003; Steib, 2004; Williams & Glasby, 2010). The rhetoric of 'evidence-based policy' has come under scrutiny in the drug policy field in recent years for several reasons. The mechanisms for incorporating research into policy-making processes have been shown to be informal and unclear (Colebatch, 2010; Fischer, 2003; Fraser & Moore, 2011; Lancaster, 2016; Lancaster et al., 2017; Ritter, 2009). Moreover, researchers have argued that a paradigmatic commitment to scientific evidence

obscures the ways in which particular types of evidence (such as randomised controlled trials, epidemiological analyses and 'modelling' studies) are accorded greater authority within the policymaking process and valued over other forms of research evidence (Duke & Thom, 2014; Lancaster, 2014; Ritter & Lancaster, 2013; Williams & Glasby, 2010; valentine, 2009). Valentine (2009), for example, argues that the emphasis on evidence-based policy paradigms limits scholarly critique by restricting policy analysis to evaluations of policy and practice effectiveness. This restriction obscures the overarching contextual issues of political power, control of knowledge, ideology and marginalisation that characterise the policymaking process. Pointing to a new focus for future scholarship on drug treatment policy, she argues for a 'value critique of social policy' that is:

> [D]esigned to confront technicist and too-narrow criteria of 'evidence', the difficulties of applying clinical frameworks to social domains, and the imperative to address ethics and values within the context of power. (valentine, 2009, p. 450)

However, valentine also warns against proposing 'values' as a simple counter to evidence because such a move maintains a false dichotomy: it treats some knowledges as solely political or social and others as objectively scientific. Informed by recent feminist scholarship, valentine (2009) argues for an alternative mode of analysis in which we consider 'science, evidence, values and politics as mutually constitutive, or as folding together' (p. 459). More recently, Lancaster and colleagues have taken up some of the issues raised by valentine in relation to alcohol and other drugs policy. They argue that the notion of evidence is performatively constituted in and through policy, delimiting what kinds of knowledge can be constituted as relevant and authoritative (e.g. randomised controlled trials), and what kinds of people (e.g. 'experts') are permitted to speak (Lancaster, 2014; Lancaster, 2016; Lancaster, Ritter & Colebatch, 2014; Lancaster et al., 2017). Several scholars have expanded the analytical gaze beyond effectiveness and evidence to consider the 'problematising' activities

of policymaking and policy practices. Largely influenced by Bacchi's WPR approach, these analyses have opened up taken-for-granted policy 'problems' to critical scrutiny.

What's the problem represented to be?

Bacchi's WPR approach is particularly useful for the analysis of my first research question: How is new recovery enacted in drug policy, research and treatment in Australia, and what assumptions and claims about drug use and people who use drugs are made along the way? It also addresses the third question – what are the political effects of these recovery enactments? – by drawing attention to the discursive, subjectification and lived effects of these policy discourses (Bacchi, 2009).

Bacchi's approach is informed by Foucault's (1977) work on power and problematisations. She examines the operation of power and its regulative effects on conduct and practices through policy problematisations. Like Mol and Law, Bacchi does not understand social problems as existing 'out there' in the world waiting to be addressed by policies. Instead, 'policies *give shape* to "problems"' and the ways in which we might think about social life and solutions (Bacchi, 2009, p. x, emphasis in original). Bacchi's approach builds on Foucault's concept of 'problematisation' as 'the set of discursive and non-discursive practices that makes something enter into the play of the true and the false and constitutes it as an object for thought' (1988, cited in Bacchi, 2012, p. 4). The WPR approach understands problematisation as the governing practices that produce particular entities and relationships as problems. In the WPR approach, 'these problematised phenomena become *problematisations*, the foci for study' (Bacchi, 2012, p. 1). In the sense that problematisations are performative – they *enact* particular kinds of social problems and solutions – Bacchi is interested in the ontological politics of policy practices. In her most recent work with Susan Goodwin (Bacchi & Goodwin, 2016), she makes this link explicit, drawing on Mol and other

STS theorists to argue that the knowledges produced in policy practices are critical to governing practices and the making of reality. She argues that 'the term "ontological politics" captures how lived realities are created by, rather than reflected in, social practices, including policy and research practices' (Bacchi & Goodwin, 2016, p. 6).

As tools for critical analysis in the WPR approach, Bacchi (2009) outlines a series of key methodological questions that have guided my analysis of policy documents:

1. What is the problem represented to be?
2. What presuppositions or assumptions underlie the representation of this problem?
3. How has this representation of the problem come about?
4. What is left unproblematic in the problem representation? Where are the silences?
5. What effects are produced by this representation of the problem?
6. How/where has this representation of the 'problem' been produced, disseminated and defended? How could it be questioned, disrupted and replaced? (p. 2)

Her first question identifies 'a place to begin the analysis' (Bacchi & Goodwin, 2016, p. 20). Bacchi observes that policy proposals rarely explicitly outline the specific problem to be addressed; rather, through various policy directives and changes, the 'problem' is implied. It is necessary to adopt a sceptical approach in order to identify 'problems' that have been naturalised or taken for granted over time. One needs to work backwards by analysing the kinds of objects, subjects and relations that are constituted as problematic in particular policy proposals. The second question in the WPR method draws attention to the knowledges and assumptions embedded in the framing of the problem representation that make it possible and culturally intelligible. In their 2016 work, Bacchi and Goodwin argue that this question has several other significant goals, including the identification of important concepts and binaries

that constitute the 'problem', and the operation of political governmental rationalities (p. 22). It considers the way in which specific problematisations reflect and reproduce specific political rationalities that seek to work on subjects as citizens in particular ways. Although I do not address Bacchi's third question in this chapter, the purpose of asking how a representation has come about is to identify and map the practices over time that produce problem representations. This genealogical approach is important for tracking the particular history of a problem representation. It is also useful insofar as it enables the identification of how alternative problematisations might have emerged under different circumstances. Bacchi's fourth question encourages 'a critical practice of thinking otherwise' (Bacchi & Goodwin, 2016, p. 22). That is, this question directs attention to unproblematised elements of the issue under investigation or to aspects that have been relegated to the background, marginalised or obscured. The aim of question five is to think critically about how problem representations engender political effects that distribute agency and power unequally. Bacchi argues that this question can be used to identify three main effects of problem representation: discursive, subjectification and lived effects. Lancaster, Seear, and Treloar (2015) succinctly explain these effects as: 1) 'the ways in which problem representations delimit what can be thought or said'; 2) 'the ways in which particular kinds of political subjects and subject positions are discursively produced' and 3) 'the real, material repercussions in people's lives' (pp. 1199–1200). Finally, question six directs our focus to the different, co-existing sites of representation in order to examine the 'practices and processes that allow certain problem representations to dominate' (2004, p. 19).

This heuristic method for policy analysis is useful in light of the ontological politics approach guiding my overarching analysis. Bacchi and Goodwin (2016) argue that policy analysis that engages in critical practices of interrogation is a form of political work that intervenes in and makes worlds. The questions in the WPR approach provide the basis for an analysis of new

recovery enactments in alcohol and other drug policy that eschews traditional notions of evaluation and evidence, and also simple assertions of 'good' or 'bad' policy. The WPR approach understands public policy as performative and reality as being made and remade through policy activity. Thus, in using the novel questions laid out in the WPR approach, my aim is not to represent a reality of recovery but to draw together the associations, techniques and strategies that produce new recovery as an appropriate solution to a specific social 'problem'.

These questions have been used productively to explore a range of alcohol and other drug policy problematisations (e.g. Fraser & Moore, 2011; Lancaster, Duke, & Ritter, 2015; Lancaster, Hughes, Chalmers, & Ritter, 2012; Lancaster, Seear, & Treloar, 2015; Lancaster & Ritter, 2014; Lancaster et al., 2017). For example, studies have highlighted the ways in which policy on methamphetamine use and harms enacts simplistic accounts of harm and drug effects which are based on unexamined notions of 'causation' and 'evidence' (Fraser & Moore, 2011; Lancaster, Ritter, & Colebatch, 2014; Moore & Fraser, 2015). Others have highlighted the problematisation of 'alcohol-related violence' in public and policy debate (Lancaster et al., 2012; Moore, Fraser, Keane, Seear & Valentine, in press), 'addiction' in Victorian drug policy treatment and practice (Moore & Fraser, 2013), and alcohol and other drug 'problems' in South African alcohol and other drug policy (Pienaar & Savic, 2015). Increasingly, a 'problematising' approach is also being used to examine the cultural assumptions and 'problem' objects and subjects enacted in legislature and legal debates (Lancaster, Seear, & Treloar, 2015; Seear & Fraser, 2014; Spivakovsky & Seear, 2017). A recurrent theme in these studies is that many contemporary alcohol and other drug policy problematisations are premised upon the individualisation of risk, harm and 'problem behaviours'. These rationales are linked to neoliberal governance that takes the individual subject, their health 'choices' and their conduct as the object of regulation. Several scholars

have further noted that the individualisation of risk is a likely factor influencing the emergence of new recovery as a policy idea (Lancaster & Ritter, 2014; Moore et al., 2015).

In the remainder of the chapter, I respond to four of Bacchi's six questions: 1) 'What's the problem represented to be' in recovery-focused policy?; 2) What presuppositions or assumptions underlie this representation of the "problem"?; 4) What is left unproblematic in this problem representation?; and 5) What effects (discursive, subjectification, lived) are produced by this representation of the problem? A genealogical analysis (question three) and an analysis of other sites where these problematisations have been produced (question six) are beyond the scope of this chapter. In so doing, I make visible the problematisations that render new recovery an attractive and intelligible policy proposal for the amelioration of harms associated with drugs. I begin by examining how new recovery discourse continues to pathologise the 'problem' of drug use through medical categories of addiction and dependence, and through its association with mental illness, before considering the significant consequences of these problematisations in terms of the organisation of treatment and valorisation of community life.

(Re)pathologising drug use

The new recovery paradigm purports to provide a novel way forward for drug policy and treatment, partly based upon the premise that it eschews pathologisation. In the following section, I trace the ways in new recovery discourse expands upon an existing tendency in Australian drug policy to pathologise individual drug use by medicalising dependence and addiction, and by associating drug use with mental illness. To this end, I suggest that new recovery does not represent a decisive break from the objectives of conventional alcohol and other drug policy approaches and is instead consistent with a neoliberal philosophy of health and responsibility that underpins much existing alcohol and other drug policy, including harm

reduction (Fraser & Moore, 2006). In each of the sections of this chapter, I begin my analysis with the National Drug Strategy 2010–2015 (MCDS, 2011) before moving to recent Victorian alcohol and other drug policy and policy documents.[4]

The National Drug Strategies have provided the overarching national framework for alcohol, tobacco and other drugs policy in Australia since their inception in 1985. Prior to the 2011 strategy, none of the National Drug Strategies used the specific term 'recovery'. Previous definitions of 'demand reduction' emphasised abstinence-oriented strategies and treatment to reduce drug use. For example, the strategy released in 2004 defined demand reduction as 'strategies to prevent the uptake of harmful drug use, including abstinence oriented strategies and treatment to reduce drug use' (MCDS, 2004, p. 2). The 1998 national strategy used a similar definition but did not include the explicit focus on treatment: 'Demand-reduction strategies designed to prevent the uptake of harmful drug use, including abstinence-oriented strategies to reduce drug use' (MCDS, 1998, p. 1). The focus of demand reduction in the current strategy has moved beyond emphasising abstinence to support people to 'recover' from dependence. The 2011 strategy introduced the term 'recovery' as part of its harm minimisation framework, an approach that has historically comprised three pillars: demand reduction, supply reduction and harm reduction. The term 'recovery' first appears in the 2011 strategy in the Executive Summary on the second page as a new addition to demand reduction. Five pages of the 26-page strategy are dedicated to describing the Government's approach to demand reduction. This approach consists of several objectives related to prevention, use reduction, recovery and community reconnection, and social inclusion and resilience (MCDS, 2011, p. ii). Demand reduction is defined as strategies that:

[4] The release of the 2016–2025 national drug strategy (25 July 2017) came too late for it to be included in my analysis.

> Prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community. (MCDS, 2011, p. ii)

Broadly, this new definition of demand reduction features a heightened concern with individual drug consumption and, specifically, harmful practices of consumption (i.e. misuse and dependence). The first prevention-focused strategy in the quotation replaces the term 'harmful drug use', present in both the 1998 and 2004 strategies, with 'use', thus expanding the focus of concern to any use of drugs. This has the effect of treating *all* drug use as potentially harmful and problematic. By contrast, the second aim – to 'reduce the misuse' of drugs – suggests that drugs have the potential to be used without an unacceptable level of harm, and only their 'misuse' should be of particular concern. The final strategy in this extract identifies a third risk: that individuals may develop 'dependence', a condition that requires professional support and community interventions in order to recover. The different kinds of distinctions made here between use, misuse and dependence operate as 'dividing practices', which Bacchi and Goodwin (2016) define as 'dynamic practices of differentiation and subordination' (p. 51). Dividing practices are 'vital government mechanisms' (p. 51). In this case, they identify and enact different categories of drug use, and by extension, different categories of people, which require different government interventions. For example, the enactment of a group of people experiencing 'dependence' is associated with harms that are purported to exceed the capacity of preventative or use reduction measures. This problematisation and these associations justify the need for a specific intervention – recovery – that differs from strategies to prevent 'use' or reduce 'misuse'.

Although both ‘abstinence-oriented strategies’ and ‘recovery’ rely upon the premise that the ‘problem’ of drugs is one of individual drug use, the concept of recovery has markedly different meanings to purely reducing or abstaining from drug use. How does this shift in concepts from ‘abstinence-oriented strategies to reduce drug use’ to ‘support people to recover from dependence’ alter the nature of the problem that is represented (Bacchi, 2009, p. 8)? In contrast to the 2004 National Drug Strategy, which included a glossary in which ‘drug dependence’ was defined, the 2011 strategy is silent about what constitutes ‘dependence’. By extension, although the medical term ‘dependence’ has been the subject of extensive scholarly criticism (e.g. Fraser, 2016; Fraser & Moore, 2011; Moore & Fraser, 2013), it is represented here as ‘fixed, known and incontrovertible’ (Lancaster et al., 2015, p. 620). Later in the same drug strategy, ‘recovering from drug dependence’ is explained as ‘a long-term process in which individuals need support and empowerment to achieve independence, healthy self-esteem and a meaningful life in the community’ (MCDS, 2011, p. 11). Therefore, although ‘dependence’ is not explicitly defined in the strategy document, it is underpinned by the presupposition that it is a particular kind of unliveable and intractable problem that requires recovery. It robs people of their ‘independence’ and ‘self-esteem’ and their chance for a ‘meaningful life in the community’. Compared to the previous policy focus on abstinence-oriented strategies as a means to reduce drug use, the new recovery problematisation of ‘drug dependence’ enacts the rehabilitation of the drug user as the central way to address the drug ‘problem’.

Importantly, this problematisation of dependence has ‘subjectification effects’ (Bacchi, 2009): it produces the category of the dependent drug user. As Sedgwick (1993) argued in relation to the discursive construction of addiction, ‘in the taxonomic reframing of a drug user as an addict, what changes are the most basic terms about her’ (p. 129). Similarly, the new policy focus on ‘dependence’ enacts a particular *kind* of person who can be wholly

understood through this term – as constrained, as having low self-esteem and as socially maladjusted. This stigmatising problematisation is also contingent upon the presupposition that there exist, 'out there' (Law, 2004) in the world, suitably 'free' people who live independent, healthy and meaningful lives. In this sense, the binary characterisations of dependence/recovery buttress the figure of the neoliberal citizen which functions as the exemplar model that drug-using subjects are enjoined to adopt. The risk here is that the strategy may shape how people view themselves and therefore produce the low self-esteem it supposedly aims to counter.

Over time the national drug strategies have increasingly framed the 'problem' as one of drug 'use' rather than 'drug-related harms' (Lancaster & Ritter, 2014). Continuous with these shifts, the new focus on recovery in the 2011 strategy, through its focus on dependence, emphasises the drug-using individual as a pathological subject in need of support and curative intervention. Responding to Bacchi's fourth question, which promotes a 'critical practice of thinking otherwise', there are important limitations and inadequacies in the way new recovery discourse emphasises dependence and the needs of people categorised as such. The medicalised binary of dependence/recovery simplifies the diversity of drug-using experiences and constrains a fuller of understanding of the complexity of people's experiences using drugs. For example, people engage in the kinds of regular drug use that might attract a diagnosis of dependence while also engaging in activities deemed productive and meaningful, such as paid employment, volunteer work and social relationships (Pienaar et al., 2016). That is, even when people use alcohol and other drugs regularly, and sometimes heavily, experiences of drug consumption are diverse and may enhance health and wellbeing rather than foreclosing it (Moore, Pienaar, Dilkes-Frayne, & Fraser, 2017; Pienaar et al., 2016). Importantly, this individualising binary also obscures other social and political ways of thinking about the causes of drug use difficulties. By addressing the problem of

dependence, the solution of recovery is only ever able to address the individual subject and individual behaviour, primarily through interventions that support people to control their drug use. This kind of 'liberation' might produce improved health outcomes, and is likely to be experienced as empowering when one considers the political and social value attached to notions of autonomy and self-control. However, it is unable to address material practices and processes such as marginalisation, laws and legislatures, and stigmatisation, which deserve equal consideration in the production of drug harms and effects. On this view, new recovery, as it is enacted in the national strategy, is underpinned by individualising problematisations that enact similar understandings of drug use and responsibility to those evident in previous national drug policies.

New recovery discourse in Victorian alcohol and other drug policy enacts the 'problem' of drugs in ways that differ from the 2011 national strategy. A vaguely defined use of the term 'recovery' was evident as far back as the 2008 Victorian Labour Government's document on treatment system reform, *A New Blueprint For Alcohol and other Drug Treatment Services 2009–2013* (Department of Human Services, 2008). In this document recovery remains a peripheral term, appearing a handful of times in relation to the proposed treatment reform (which did not eventuate until 2014) and in the Minister's foreword. The Victorian Government's 2012 plan for treatment system reform, *New Directions: A Roadmap* (Department of Health, 2012b), was released ahead of the official strategy (the first whole-of-government strategy in Victoria to be developed). It contains the most detailed and extensive discussion of new recovery in any of the policies examined here, in which it outlines how the reform would deliver a 'person-centred, family-inclusive, recovery-oriented' approach to treatment. I further explore the treatment model proposed in the strategy and interrogate the assumptions underpinning it in the next section. But first, I consider how the definition of

recovery put forward in *New Directions: A Roadmap* shapes how drug use is conceptualised and might be thought about:

> Recovery is about building a meaningful and satisfying life as defined by the person, whether or not they experience any ongoing or recurring symptoms or difficulties. Recovery is a personal journey, unique to each individual. A person's recovery is informed by their strengths, preferences, needs, experiences, values and cultural background. (Department of Health, 2012b, p. 19)

Compared to the national policy focus on recovery from 'dependence', this definition of recovery (and the document as a whole) avoids treating drug consumption as the problem to address. Although the language is ambiguous, it suggests that the problem is not drug use *per se* but the quality of people's lives (Lancaster et al., 2015). Indeed, *New Directions: A Roadmap* explicitly suggests that recovery is *not* defined in relation to 'ongoing or recurring symptoms or difficulties' but 'is about building a meaningful and satisfying life'. Like the 2011 national strategy, the assumption underpinning this definition is that regular drug users lead unsatisfying and meaningless lives and do not therefore uphold the responsibilities of healthy and productive citizenship. However, in contrast to the national strategy, *New Directions: A Roadmap* explicitly avoids mentioning any particular kind of problematic drug consumption (thereby avoiding debates about the definition of recovery and whether it includes abstinence). It suggests instead that recovery is a self-defined 'journey' irrespective of 'ongoing or recurring symptoms or difficulties'. These terms are central to definitions of 'personal recovery' in mental health policy and service provision, where recovery from mental illness is considered possible even in the presence of ongoing clinical symptoms (Slade, 2009, pp. 35-37). One effect of the adoption of this language in alcohol and other drug policy is an implied association between drug use and mental illness (AIVL, 2012). This discourse of new recovery likens ongoing drug use to a 'symptom' of a prior disorder or

condition, foreclosing the possibility that drug-using subjects may express agency. The question then becomes: To what extent can this notion of new recovery be considered novel, de-pathologising or emphasising strengths when drug consumption is rhetorically merged with mental illness? Rather than representing a novel way forward, the co-option of mental health concepts in this articulation of new recovery can be seen as an extension of pathologising, disease-based understandings of drug use as a kind of illness. Such an approach continues to erase other ways of understanding and approaching drug use as an expression of agency. Furthermore, as AIVL (2012) argues in its response to the 'new recovery' paradigm, the conflation of drug dependency and mental health issues ignores the complexity and specificity of these distinct experiences, the diverse needs of the individuals concerned and the different treatment responses required (p. 12)

Despite the explicit focus on recovery-oriented treatment in *New Directions: A Roadmap*, the official strategy, *Reducing the alcohol and drug toll: Victoria's plan 2013–2017* (Department of Health, 2012a), released later in the same year, articulates an attenuated version of new recovery. Unlike the roadmap, the strategy does not define 'recovery' and mostly divests itself of the aspirational tone adopted in the earlier document. Described as a '15-point plan' to 'promote the safe, healthy and responsible use of alcohol, tackle the misuse of pharmaceutical drugs, reduce illegal drug use, and assist the care, treatment and recovery of people with drinking and drug problems' (p. 3), the policy is organised into five action areas: alcohol (points 1–5); pharmaceutical drugs (points 6–7); illegal drugs (points 8–10); care, treatment and recovery (points 11–14) and leadership (point 15). The enactment of new recovery in this strategy contains a more conventional preoccupation with forms of drug consumption considered problematic, such as 'addiction, dependence or other forms of substance-use disorder':

> For some people, the misuse of alcohol and the use of illegal drugs can lead to addiction, dependence or other forms of substance-use disorder. Addiction is characterised by chronic and/or persistent behaviour, despite harmful consequences. But it is possible to gain control and recover from addiction. […] Caring for a person with a severe addiction can be complex and challenging. (Department of Health, 2012a, p. 42)

Like the 2011 national strategy, the 2012 Victorian strategy makes distinctions between the harms that might emerge from drug use. Although the strategy represents some forms of disordered consumption (e.g. 'dependence', 'misuse' and 'substance-use disorder') as so self-evident that they do not require definition, 'addiction' is (briefly) defined as 'chronic and/or persistent behaviour, despite harmful consequences'. Its co-listing with 'dependence', which is not defined, is especially confusing. The reference to 'other forms' of 'disordered' alcohol and other drug consumption suggests a diversity of drug-using experiences. However, the absence of definitions (with the exception of 'addiction') and interchangeable use of the different terms underlines the pervasiveness of the 'drug problem' and justifies the need for professional and medical responses.

Further, the extract from the Victorian strategy demonstrates the subjectification effects of new recovery discourse. The imperative to 'gain control and recover from addiction' is underpinned by the specific and pejorative characterisations of addicted persons. Despite the suggestion that it is 'possible' to recover from addiction, the term 'possible' inadvertently functions to indicate the tenacious character of addiction. Persons with a 'severe addiction' (how this differs from other forms of 'addiction' is not spelled out) are also implicitly characterised negatively as being 'complex' and 'challenging' to care for. These subject positions form the basis from which people make sense of the social word and their selves (Bacchi, 2009). Again, it is unclear how new recovery, enacted in and through these

problematisations of addiction and addicted subjectivity, heralds a significant change from policies that have historically understood drug use and addiction as problems of chronicity, compulsivity and harm.

In this section I have examined how discourses of new recovery are articulated in national and Victorian alcohol and other drug policy documents. As we have seen, the various articulations of new recovery *reproduce* rather than disrupt pathologising accounts of drug use as dependence or addiction, and re-enact associations between drug use and mental illness. In these ways, the problematisations underpinning new recovery do not appear to offer a 'significant paradigm shift' (Best, Irving, & Albertson, 2017, p. 1) from a 'pathology and intervention paradigms' to 'a solution-focused recovery paradigm' (White et al., 2012, p. 298). Rather, pathological notions of drug use continue to authorise responses to drug harms that centre on individual support, care and treatment. To this end, new recovery continues to emphasise the individual as the proper subject of treatment and policy. I turn next to consider the implications of the focus on treatment.

Bringing the subject of treatment into focus

The pathologisation of individual drug use (and by extension drug users) in new recovery discourse is associated with more detailed explanations of the role of treatment and service providers in facilitating recovery. This focus on the benefits of treatment gives more detailed expression to a 'typical' treatment client. It also makes explicit the particular expectations and responsibilities that drug-using subjects must meet and adopt in order to qualify as recovering. I argue that this process of problematising drug-using subjects through injunctions to seek care, recovery and treatment is implicated in the further stigmatisation of drug-using subjects and simultaneous (re)production of legitimate forms of subjecthood and citizenship (Fraser et al., 2017).

As I noted earlier, the term ‘recovery’ first appeared at a national level in the 2011 National Drug Strategy. Building on the objectives to increase access to treatment and the quality of treatment articulated in previous national strategies (Ministerial Council on Drugs Strategy, 1998, 2004), the new recovery focus produces more explicit injunctions for drug-using subjects to enter treatment and provides more detailed information about the role of treatment and outcomes of interest. Although the strategy suggests that ‘different people will have different routes to recovery’, treatment is envisioned as having a central role in supporting recovery:

> While different people will have different routes to recovery, support for recovery is most effective when the individual’s needs are placed at the centre of their care and treatment. Treatment service providers can help individuals recover from drug dependence, help the individual access the internal resources they need (such as resilience, coping skills and physical health) and ensure referral and links to a range of external services and support (such as stable accommodation, education, vocational and employment support and social connections). (MCDS, 2011, p. 11)

This new focus on ‘care and treatment’ centres on the needs of the individual treatment client rather than the more abstract problem of ‘drug use’ that was characteristic of previous national strategies. Whereas the 2004 national strategy included broadly framed objectives, such as to ‘reduce the use’ of illicit drugs and associated ‘risk behaviours’, the 2011 national strategy personifies the drug ‘problem’ through a new focus on how recovery-focused treatment can address the ‘needs’ of individual service users. To this end, treatment service providers are enjoined to ‘help individuals recover from drug dependence’ and to ‘help the individual access the internal resources they need’. The treatment client is enacted as needing ‘help’ to access their own ‘internal resources’: ‘resilience, coping skills and physical health’ (as we saw earlier by becoming independent and building satisfying and meaningful lives).

This understanding of the role of the treatment is based upon a typical kind of treatment client who either lacks these capacities or is unwilling to mobilise them. The latter assumption implies that these capacities reside within the inner selves of drug-using subjects, who need professional 'help' in order to access them. This problematisation obscures other, arguably more balanced, ways of thinking about capacities such as resilience, coping skills and health. For example, the language of 'resilience' is used simplistically here to suggest that merely saying 'no' to drugs characterises individuals as resilient. Yet the definition of resilience as 'the quality or fact of being able to recover quickly or easily from, or resist being affected by, a misfortune, shock, illness' (*Oxford English Dictionary*; accessed online 1st April 2017) is an apt description of the many accounts of coping with stigma and discrimination that emerged in my interviews with people who use drugs. The notion of 'resilience' might also characterise the skills and abilities displayed by some drug-using subjects when they adapt to homelessness or transient living arrangements, unemployment and limited access to storage and facilities to wash or prepare food. This approach to use reduction and recovery sits in direct contrast to the 2004 national strategy, which took a broad public health approach centred on public education campaigns and improving access to treatment through treatment-system level interventions (e.g. developing partnerships and workforce development). In this way, we can see how the new emphasis on recovery-focused treatment intensifies the responsibilisation of individuals, at the same time as they are 'patientised' (Lancaster et al., 2015), and foregrounds a focus on their capacities and behaviours in policy interventions.

At the same time that the focus on treatment in the national strategy outlines a typical kind of treatment client, the Victorian policy documents give expression to particular expectations and responsibilities that drug-using subjects must meet and adopt to recover. The Victorian policy documents similarly identify the individual drug-using subject as the most important target of treatment. However, the new recovery focus also foregrounds an ideal treatment

trajectory that establishes a normative and preferred outcome. Although this trajectory is outlined most explicitly in the policy documents published in the lead-up to the reform of the Victorian treatment system, a preferred treatment trajectory was evident as far back as the 2008 Victorian reform framework, *A New Blueprint For Alcohol and other Drug Treatment Services 2009–2013* (Department of Human Services, 2008). In this earlier document, the concept of 'recovery' is used loosely to describe a range of objectives and treatment practices. For example, recovery refers to both a treatment modality and a life goal:

> The blueprint promotes an integrated service system that delivers prevention, early intervention, treatment, harm reduction and recovery responses. It recognises that individual pathways through the service system are not necessarily linear and that a range of interventions may be required at different stages of a person's journey towards and beyond recovery. (Department of Human Services, 2008, p. 8)

This earlier document does not define 'recovery responses' or provide further detail. Although the 2008 strategy explicitly states that treatment pathways are 'not necessarily linear', the metaphor that a person is on a 'journey towards and beyond recovery' promotes a successful treatment trajectory as one that concludes with recovery. Although little else is said in this document about what form recovery 'and beyond' takes, 'recovery' is presented as the normal and self-evident outcome of treatment. I examine the work that metaphors do in more detail in professional practices in detail in Chapter 6. For the time being, it is enough to highlight how metaphors, such as the 'journey', attribute to recovery a satisfying logic of growth and empowerment, while revealing little substantive or situated content about the intense practices of self-work and scrutiny that such 'journeys' require.

What exactly constitutes a successful treatment trajectory or outcome in new recovery-focused treatment is not made explicit until the publication of *New Directions: A Roadmap*

(Department of Health, 2012b). The roadmap adopts an empowering and encouraging tone to describe the purpose and goals of recovery-focused treatment:

> A recovery-oriented approach to alcohol and drug treatment supports people to build and maintain a meaningful and satisfying life regardless of where they are on the continuum. For some people, it can take repeated attempts over a number of years before they can overcom**e** substance misuse. Other people will never access a treatment program but will decide for themselves to stop or reduce their harmful use of a substance. Some people may give up alcohol or drugs entirely, while others may find they can successfully reduce their use of alcohol or drugs to a level where it no longer impacts negatively on their lives. Some people are able to care for their children, work at their jobs, and generally do the best they can to lead healthy and happy lives… The fact remains that many people recover and have periods of extended health and wellbeing when they participate effectively in society. (Department of Health, 2012b, p. 20)

Although the strategy emphasises that the recovery journey is 'personal' and 'unique', this trajectory or 'continuum' is underpinned by a narrow and normalising imperative that drug-using subjects must change, actively work on themselves and seek out 'meaningful and satisfying' lives by monitoring and managing their drug use. This injunction to cultivate better lives enacts a homogenous and stigmatising understanding of the needs of treatment clients and also circumscribes the conditions of possibility for a meaningful and satisfying life. As others have argued, managing one's drug use is framed in new recovery discourse as a problem of the self: 'recovery inextricably links drug using behaviour with the worthiness of the lives of people who use [drugs]' (Lancaster et al., 2015, p. 621). Thus, the control and management of one's drug use is represented as the central (and perhaps only) means by which people who use drugs can cultivate health, wellbeing and satisfaction. This logic is

underpinned by the injunctions in this extract, which urge drug-using subjects to make 'repeated attempts' to 'overcome' substance use, 'decide for themselves to stop or reduce their harmful use' or just 'do they best they can' to lead healthy and happy lives. These narrow injunctions obscure the many complex and varied practices through which people cultivate meaning, for example, through the pursuit and cultivation of passions, intimacies, knowledge and travel. Instead, recovery discourse prioritises the management and control of one's drug use, and by extension one's whole self and life, as the central means by which drug-using subjects might pursue health and citizenship.

Furthermore, the emphasis on treatment in the official Victorian strategy (2012a) also frames the 'problem' of drugs and drug users as an economic problem that adversely affects the broader community and economy:

> There is abundant evidence that substance-use disorders are under-treated in the community. Yet, every day thousands of Victorians receive dedicated care and support for their alcohol and drug problems from doctors, psychologists, counsellors, allied health workers, specialist alcohol and drug workers, carers, families and their friends. […] Providing access to effective support and treatment, centred on recovery, provides benefits through reduced health care costs, reduced crime, safer communities and improved participation in work and education. (Department of Health, 2012a, p. 42)

'Substance-use disorders' are framed through medicalised discourse, in which they emerge as a particular kind of disorder that requires careful and 'specialist' monitoring and treatment. However, the 'benefits' of 'effective support and treatment, centred on recovery' are framed in terms of improved public safety, reduced health-care costs and improved participation in the labour market. These benefits tend to reiterate stigmatising notions that people who use

drugs are a burden on the health care and welfare system, are criminals and pose a risk to community safety. According to this problematisation of drug use, it is necessary that addicted persons recover from addiction in order to be contributing, productive and healthy members of society. In this way, enrolment in treatment and recovery is seen as necessary to the production of healthy, risk-averse and participatory neoliberal citizens and integral to the social and economic health of the nation.

In this section I have argued that the focus on treatment, evident in earlier national and state policy, has intensified with the advent of new recovery discourse, identifying the drug-using subject and their presupposed needs in more detailed terms. Prioritising treatment and recovery silences the social and political dimensions of drug use and related harms, and continues to erase the diversity of drug-using experiences that do not fit neatly into an addiction/recovery binary. I have also argued that in new recovery discourse, treatment works in service of wider citizenship demands and practices, necessarily reinstating normative judgements about the abject and marginalised character of drug-using lifestyles. I explore this theme in more detail in the following section on the mobilisation of 'community' in new recovery discourse.

Community and citizenship

A large body of critical scholarship has argued that alcohol and other drugs policy (Duke, 2012; Fraser, 2004; Moore, 2004; Moore & Fraser, 2006), and public health more broadly (Beeson & Firth, 1998; Greco, 2009; Peterson & Lupton, 1996), has focused on individual responsibility in matters of health, consumption and illness. The individualisation of risk has been associated with the decentralisation and devolution of powers and responsibility from central governments to community health and welfare organisations (Duke, 2012; Joseph, 2002). This shift has been associated with New Labour's 'Third Way' (Giddens, 1991)

politics in the UK (Fremeaux, 2005; Rose, 2000), a variant of neoliberalism centred on the principle of social inclusion. A central focus of the Third Way was its emphasis on refashioning the relationship between the state, market and individual via the construct of 'community'. The politics of the Third Way gained currency in the Australian Labour party in the 1990s – particularly in the writings of Mark Latham and Lindsey Tanner (Romano, 2006). Broadly, in the economic programs put forward in the Third Way, community is enacted as a 'key institutional site for responding to welfare demands' (McDonald & Marston, 2002, p. 383). The provision of welfare in this model is predicated upon rationalities, obligations and practices of active citizenship, community participation, empowerment and capacity building (Summerville, Adkins, & Kendall, 2008).

As might already have become evident, these themes are echoed and intensified through the aims and rhetoric of new recovery discourse and policy. In Duke's (2012) analysis of changes in UK drugs policy discourse and the emergence of 'recovery', she argues that the '"community" is increasingly expected to fill the gaps left by cuts to public sector funding' and that community organisations are increasingly responsible for addressing social problems and providing treatment (p. 49). Duke also argues that in a time of increasing budget austerity for social services and punitive welfare reform, the emerging 'recovery' agenda in alcohol and other drug policy conveniently locates resources for the responsibility and treatment of social problems in the 'community'. Building on my analyses of the problematisation of drugs, the drug-using subject and the ideal treatment trajectory, I identify a close relationship between these problematisations and the development of community discourses in recovery-focused policy. In addition to intensifying the pathologisation of drug use and the need for professional treatment, new recovery discourse also promotes another kind of 'solution' – that of adopting and embracing healthy citizenship through community involvement. On this view, the focus on community practices can be understand as a central element of the

citizenship regime forged in and through new recovery policies and practices. Although the concept of community has been the subject of critique in research on social policy and public health (Everingham, 2001; Fremeaux, 2005; Makuwira, 2007; McDonald & Marston, 2002; Rose, 2000), it has received less attention in analyses of alcohol and other drug policy. Considering the extent to which new recovery is co-constituted through a discourse of community in the Australian setting, this discourse and the wider citizenship practices it entails warrant critical scrutiny. In this section, I examine enactments of community as a 'dividing practice' (Bacchi, 2009; Bacchi & Goodwin, 2016). That is, how does 'community' function as a particular kind of practice that produces oppositions, differentiations and subordination? When we speak of 'community', who is included and who is excluded? On whose behalf is the language of 'community' mobilised and to what effect? What social problems or problem subjects are articulated when we offer up community development, empowerment, safety and social inclusion as the solution?

The Australian National Drug Strategies have long mobilised discourses of community in the development of alcohol and other drug policy. Improving community understanding and education regarding drug-related harms has been a key objective in the previous two national strategies (MCDS, 1998, 2004) and continue to be dominant themes in the 2011 strategy. However, 'community' takes on a particular valence in light of the new focus on recovery in the 2011 strategy (MCDS, 2011). For example, consider objective 4 in the strategy's section on demand reduction, which aims to bolster 'social inclusion' in order to promote 'resilient individual, families and communities':

> Resilient and inclusive communities are characterised by strong social networks and work together to support individuals who need assistance. They also promote safe and healthy lifestyles. Supportive and informed families and communities can prevent the uptake of drug use, identify drug use in its early stages and help individuals access

> and maintain treatment. A resilient community will support people to avoid relapse and help them reconnect with the community. (MCDS, 2011, p. 13)

Despite the assertion that communities are 'inclusive', the enactment of the 'community' as a benevolent entity comprising 'strong social networks' of citizens and 'supportive and informed families' who support vulnerable 'individuals' has the discursive effect of constituting drug-using subjects as distinct from the community. In this sense, 'community' works as a rhetorical 'dividing practice' differentiating between desirable and undesirable behaviour, and by extension, desirable and undesirable subjects too. This division is underpinned by the assumption that drug-using lifestyles are dangerous and unhealthy and thus drug-using individuals are produced as 'governable subjects' (Bacchi & Goodwin, 2016, p. 23) subject to the promotion of 'safe and healthy lifestyles'. Whereas previous strategies aimed to increase community understanding of drug-related harms (MCDS, 1998, 2004), new recovery discourse constitutes 'community' as having a transformative capacity: it can abate people's need for drug use and transform the lives of those who use drugs via the transmission of moral codes and conduct, healthy norms and safe lifestyles. It is through the adoption of these moral behaviours and values that drug users *recover* and 'regain the individual capacities and qualities befitting a resilient liberal subject' (Moore et al., 2015, p. 423).

Notions of 'community reconnection' and 'community reintegration' are used interchangeably in the 2011 national strategy. On page two, the phrase 'support people to recover from dependence and reintegrate with the community' is used in the new definition of demand reduction. In comparison, a later statement suggests that the policy aims to support people to 'recover from dependence and reconnect with the community' (MCDS, 2011, p. 11). It is unclear whether increased community participation or social inclusion furnishes recovery or whether it is through recovery that people are able to 'reconnect' with the

community. In other words, the *means* by which the community functions to assist in 'recovery' is ambiguous. Duff (2014) has written about this ambiguity in relation to policy regarding recovery in mental health. He argues that 'most policy statements seem to endorse the notionally therapeutic role of the *community itself* in supporting and promoting recovery' but 'avoid explicit statements regarding the *means* by *which* community participation and increased social inclusion actually facilitate recovery' (p. 98). In addition, the differences between the two directives – reintegration and reconnection – are not acknowledged or explained. Moore et al. (2015) argue that the subtle difference in the connotations of the terms is important. The notion of community 'reconnection' implies that drug users 'remain different but tolerated' whereas community 'reintegration' suggests that drug users are to be 'restored to sameness' (p. 424). Despite these different connotations, the notion of social inclusion, of inviting *inside* people assumed to be *outside* the societal boundary, reasserts these hierarchies of difference and legitimacy, and stabilises the unequal distribution of agency at the centre of drug policy (Moore et al., 2015).

The limits to the notion of the socially inclusive community as a resource to be mobilised in new recovery discourse are exposed by comparing it to a second discourse evident in the 2011 national strategy: the community at risk of harm from illegal drugs, drug use and drug trafficking. For example, the stated purpose of harm reduction in the strategy is 'to reduce the adverse health, social and economic impacts of drug use on communities, families and individuals' (MCDS, 2011, p. 16). In this example, drug use has clear adverse effects that can be categorised in relation to the pre-defined categories of health, the social and the economy. Second, drug use is constituted as an isolated individual practice that again occurs outside of 'community'. Positioned as external to the 'community', drug use and people who use drugs are constructed as threatening the cohesion and health of communities, families and individuals.

Similar notions of ‘risk’ and ‘safety’ circulate in the Victorian strategy (2012a) to authorise increased law and order regulations and interventions. These include recommendations to ‘maintain and strengthen laws protecting the community from harms caused by illegal drugs’, ‘constant monitoring and adjustment of drug regulations to ensure that the community continues to be protected from the risk of drugs’ and ‘continual attention to our laws and policing strategies … to ensure that they are effective in keeping the community safe’ (Department of Health, 2012a, p. 32). In comparison to the image of the socially inclusive community promulgated elsewhere, here the ‘community’ is produced as a vulnerable set of individuals at risk. In these recommendations, drug use, and by extension drug users, are represented as criminal, risky, threatening and harmful.

The notion of risk is also used to police boundaries between people who inject drugs and the broader community at risk of ‘transmissible infections’ (Department of Health, 2012a, p. 37). People who inject drugs are no longer exclusively located outside the community but constituted as a particular subset of the community that has particularly risky health practices and diseases. However, the ‘community’ is also increasingly expected to assume responsibility for the health and social welfare of people who use drugs:

> Recovery does not depend on treatment alone. It is helped by the informal social support of families, friends and community members of the person seeking recovery. Everyone in the community can play a part in recovery by helping to reduce stigma and improve understandings of addiction. Myths about addiction, alcohol and drug problems and recovery need to be challenged, and the voices of people who misuse alcohol and drugs need to be heard. (Department of Health, 2012a, p. 40)

In this sense, the Victorian strategy is similar to the national strategy. The ‘community’ is again galvanised as a coherent and consensual assembly of people that can be brought

together in order to execute awareness-raising and participatory activities. The community is urged to assume responsibility for improving their own understandings about 'recovery' and addiction, reducing stigma and making space for the voices of people who 'misuse' drugs. It is mobilised in such a way as to evoke notions of benevolence, compassion and neighbourly consideration. This representation assumes that the 'community' will assume responsibility for supporting individual people entering treatment and delivering post-treatment care. Yet, as we have seen, the same policy represents people who use drugs as non-citizens and as capable of damaging the health and cohesiveness of this same community. It seems optimistic to expect that communities 'at risk' will assume responsibility for people who have been positioned as likely sources of danger. Strategies for addressing stigma will surely struggle to have the desired effects, especially when the policies that purport to address these harms repeatedly assert the illegitimacy of drug users.

Like the focus on individual drug use and treatment analysed earlier in the chapter, notions of 'community' occupy a central place in new recovery discourse in the Victorian strategies and 2011 national strategy. They are mobilised in recovery policy as a social entity that can temper the urge to use drugs and the deviance thought to be associated with drug-using 'lifestyles'. Yet, at the same time, they are used to differentiate people who use drugs as non-citizens and figures of threat and harm. Such imperatives of reconnection and reintegration ultimately work to reassert hierarchies of citizenship, in which offers of inclusion are provisional and dependent on the adoption of normative codes of health and moral conduct.

Conclusion

In this chapter, I explored the way in which the new iteration of recovery is enacted in alcohol and other drug policy in Australia, the implicit and explicit assumptions about drug use and people who use drugs that this enactment relies on and reproduces, and the political

effects of this enactment. I argued that recovery is indeed a 'solution searching for a problem'. Although new recovery discourse claims to develop an approach 'based on strengths and positive aspirations and expectations' (Best & Ball, 2011, p. 17), it reflects and reproduces conventional problematisations that have long underscored alcohol and other drug policy. However, while seeking to emphasis this continuity, I also sought to draw out some of the associations and political implications specific to the policy encounter with new recovery. First, I argued that new recovery intensifies the pathologisation of drug use, by reinforcing medicalised notions of dependence and addiction and revisiting older medicalised associations between drug use and mental illness. Second, new recovery is enacted in drug policy via an increased focus on treatment, which in turn elucidates a typical treatment client and the 'needs' of the individual drug-using subject. These are largely centred on attributes, characteristics and resources that drug-using individuals are assumed to lack. The focus on treatment also instantiates a preferred way of acting, in that drug-using subjects are required to actively manage their drug use in order to be acknowledged as citizens. I argued that the other option for citizenship is presented through the notion of community participation, but this is further complicated by tensions underpinning the notion of 'community' in which the drug-using subject is rendered marginal, peripheral to the healthy community and potentially harmful.

Returning to Procacci's (2008) notion of citizenship which I introduced earlier, new recovery as a governmental policy proposal is perhaps most usefully viewed as another contemporary articulation of a citizenship regime.[5] It functions to identify problematic attributes and practices and transform these qualities through 'recovery'. When the language of recovery is

[5] Earlier articulations of citizenship regimes include methadone maintenance treatment (Fraser & valentine, 2008) and hepatitis C prevention (Fraser, 2004).

used in the context of alcohol and other drug policy, it unequivocally implies the rehabilitation or advancement of a 'normal' citizen–subject. This conceptual logic intrinsically characterises drug-using subjects as unfree, risky and marginal. At the same time, however, drug-using subjects are charged with a potentiality for recovery that might be animated through the adoption of particular ways of acting. The adoption of legitimate forms of behaviour, in particular taking control and charge of one's health by relinquishing illicit drug use, community participation and finding employment, are presented as specific requirements for acquiring citizenship status and social respect. Through their recovery into a normative citizenship regime, drug-using subjects are offered a provisional form of citizenship, which is contingent on individual change, self-management and responsibilisation. In these ways, the notion of recovery contributes to the subtle and stigmatising processes of exclusion that foreclose belonging and the extension of citizenship to people who use drugs, particularly marginalised people. The individualisation of drug problems is not limited to recovery-oriented policy and should be located in a broader shift in the way public health conceptualises and puts into practice 'active citizenship' in neoliberalism. However, in this chapter I argued that we should be exceedingly wary of the aspirational and empowering rhetoric of new recovery discourse. It functions to strengthen a policy focus on individual change at the expense of more ethical policy developments that locate harms, and responsibility for mitigating these harms, in broader social and economic forces and arrangements. Having focused in this chapter on the first of five cases in which recovery is being enacted, I now turn to a second authoritative site of enactment, that of psychological scientific research.

Chapter 5

Framing responsibility:

Psychological science, simplifications and the improvable self

Like alcohol and other drug policy, scientific research is a key site shaping the ontological politics of new recovery. In 2007, prominent US new recovery researchers Alexandre Laudet, Keith Morgen and William White wrote, 'to maximise its usefulness, research on recovery must use state of the art methodology including large representative samples, quantitative methods and sophisticated statistical techniques that help elucidate the critical processes at work' (p. 35). Over the last decade, psychological scientific research has increasingly sought to 'elucidate' the recovery process through the extension of new theorisations of recovery and the processes underpinning it. In this chapter, I draw on Law's (2013) typology of simplification practices. This interpretive tool is effective in illustrating the different framing devices through which realities of new recovery are inscribed and enacted. I analyse prominent and influential scientific accounts of two of the 'processes at work' in new recovery: the accumulation of 'recovery capital' and the process of 'social identity change'. My analysis addresses the way in which the new iteration of recovery is enacted in select psychological scientific research and the political effects of these enactments.

I argue that the psychological theories being mobilised in current research on new recovery evince continuities with existing popular understandings of recovery and contemporary neoliberal currents in health and drugs policy. The science of new recovery rationalises 'common sense' (Law, 2004) ideas about recovery and healthy subjecthood through the psychological lexicon and practices of scientific measurement and inscription. Along the way, political ideas about normality, citizenship and deviance are reiterated, with the

exemplar of successful recovery enacted as the successful adoption of autonomous, enterprising and self-determining subjecthood. Self-interest, intense self-scrutiny, enterprise and the management of one's social relationships are presented as the only legitimate means of pursing change. This obligation to change one's self is sustained – paradoxically – by a renewed interest in the 'social' contexts of recovery. Of the many social entities that might usefully be enacted as bearing upon alcohol and other drug consumption and wellbeing, human relationships are the sole type included in new recovery research. In this way, rather than making new recovery innovative or emancipatory, or drawing on recent harm reduction initiatives that cast the social relationships of people who use drugs as important and valuable resources, the science of new recovery frames the divestment of these relationships as central to the achievement of recovery and health. Despite the attachment by researchers to a political imaginary that envisions new recovery as progressive and empowering, contemporary psychological scientific research continues to constitute drug use as a form of deviance that one must recover from through the adoption of narrow, conservative expressions of social life and normality.

I begin the chapter by returning to the work of John Law and demonstrating the relevance of his typology of simplification practices for my analysis of psychological scientific practices. This is followed by a brief overview of the development of recovery capital and social identity theory in the science of new recovery and their significance to Australian approaches to drug treatment. Following this, the first section of my analysis argues that new recovery research enacts the social as a governable resource for individuals in recovery. It *frames* social life through static and rational metaphors that give the impression it can be readily controlled, *selects* only human relationships as constituting the social, and *deletes* arguably more important socio-material forces that may constrain 'recovery'. In the second section of the analysis, I examine the ways in which this simplification forms the basis of injunctions

that individuals must attend to and carefully manage their social environments in order to recover. The successful accumulation of recovery capital involves the adoption of an enterprising and neoliberal form of subjectivity, in which taking responsibility for one's behaviour is paramount. In the model of social identity central to new recovery, drug-using subjects are enjoined to transform their identities by carefully monitoring and managing their friendships and relationships. I conclude by considering the ontological politics of new recovery as it is enacted in psychological science. I argue that the science of new recovery is always already political, inaugurating normativities and political goals that serve to further delegitimise people who use drugs, and in particular their social relationships.

Scientific inscription and simplification practices

Scientific research into health problems and illness implies within its logics and methods theories about causation and cure (Fraser & Moore, 2011; Seear, 2014). An ontological politics approach invites us to see scientific knowledge as contingent upon specific sets of practices, concepts and relations. In this approach, scientific knowledge can only ever be partial (and thus political) rather than objective and true. It also invites us to scrutinise not only the reliability of scientific claims (Dwyer & Fraser, 2016) but the framing of particular entities (and accompanying practices of inclusion and exclusion) in the making of any phenomenon. What parts of the world become visible in a particular set of practices? Which objects are foregrounded, and which are relegated to 'context', pushed to the periphery or made entirely absent? Which actors have agency, and who or what is denied? In order to address these questions, we must become attuned to how scientific practices frame and elevate particular problems over others, shape particular entities and pull patterns of relations together into one shape or another (Mol, 2002). Following Mol, my critique needs be attuned to the ontological politics of psychological science and its enactment(s) of new recovery. To do this, I briefly revisit some of the key insights from STS discussed in Chapter 3 as well as

introduce Law's typology of simplification practices that illuminate the performative work of reality-making and enactment.

In order to think about ontological politics, we need first to stress the technical practicalities of enacting objects. Annemarie Mol (2002) argues that we need to stubbornly take note of the techniques, machines, practices and knowledges that '[make] things visible, audible, tangible, knowable' (p. 33). John Law (2004) calls these practicalities 'inscription devices' (p. 18): the human and non-human practices, technologies and instruments that convert complex social phenomena into labelled, bounded and often quantifiable traces (e.g. numbers, statements and objects). The argument here is that realities are inscribed into being. This is not a faithful case of translation, of perfectly capturing an anterior reality; rather, particular entities are elevated into being through inscription devices and practices. They acquire various degrees of realness via their continued re-enactment in elaborate networks of people, objects, texts, techniques and knowledges. Therefore, this chapter attends to the practicalities and politics of enacting recovery in psychological science and how it might be made otherwise. What scientific practices are employed in this enactment of recovery? What techniques of measurement are employed, and *who* or *what* is being measured? What are the political effects of these practices?

Analysing scientific work and inscription also requires a sensitivity to simplification and exclusion. Inscription and enactment necessarily involve arranging, shifting and cutting phenomena into specific shapes and schemes so as to make possible ordered and meaningful statements about reality. These classifications rely upon processes of simplification that simultaneously expel or erase complexities or less viable realities that do not fit easily within established scientific schemas. John Law outlines five simplification practices that perform realities: *selection, framing, juxtaposition, ranking* and *deletion.* Selection refers to questions of inclusion: What socio-material entities and agencies are included in the study of any given

phenomenon? The particular character of included phenomena is dependent on acts of *framing*, which attribute to phenomena contexts and boundaries. For example, acts of framing are evident in the inscription of the individual via the category of 'identity', which frames the individual as a psychological subject with particular qualities, capacities, enduring tendencies and relations. Framing also relies upon *juxtaposition*, which refers to the process by which selected entities are made to stand in relation to each other. The juxtaposition of particular entities through binary logic, oppositions and hierarchies is crucial in establishing particular relationships of power, agency and causation. Selection, framing and juxtaposition also imply that scientific practices participate in *ranking* particular entities in terms of importance. Those socio-material entities considered too hard to measure or pin down are invariably excluded or *deleted* from how any given reality comes to matter. Importantly, that which is deleted is not necessarily repressed or excluded in a finite way. Objects, subjects and realities that are relegated to the margin remain productive in that they bear upon and constitute the outside or Other to any given phenomenon. In this way, marginalised phenomena mark the boundaries and forcibly produce the domains of legitimate social life. Paying critical attention to these practices, as a means of cultivating sensitivity to the performativity of psychological science and the ontological politics of new recovery, is one way in which to denaturalise commonsense notions of recovery as pre-existing and awaiting scientific elucidation. One consequence of this approach is that we start to appreciate that the object of inquiry is enacted in and through practices that are specific and political. Such an approach is important to properly assess claims as to whether new recovery brings about novel effects and politics, and to open recovery up to different ways of being done. Before beginning my analysis, I briefly consider the advent of theories of recovery capital and social identity change in research on new recovery and examine the political implications of the ensuing accounts for Australian research and treatment.

The science of new recovery: 'Recovery capital' and social identity change

In Chapter 3, I argued that the psychological theories of recovery capital and of recovery as a form of social identity change are particularly significant in Australian treatment and research. Research into the social identity model of recovery is being led by Australian researchers working with Victorian and Queensland treatment organisations, and an assessment of recovery capital has become a routine part of treatment entry protocols in Victoria. Although these constructs have been developed independently by different sets of researchers, they have also tended to overlap and bolster one another. For example, in the recent edited collection *Addiction, Behavioural Change and Social Identity* (Buckingham & Best, 2016), several chapters draw connections between social identity change and recovery capital, suggesting that the transition to a recovery identity is more likely when associated with higher recovery capital and that the social networks underpinning this transition provide recovery capital (or alternatively, an increased risk of relapse). A measure of social identity is also embedded in the tools used to measure recovery capital (Groshkova et al., 2013). Despite the increasing association and overlap between these two constructs, they have distinct theoretical traditions.

'Recovery capital' first emerged in US sociological research on 'natural recovery' conducted by Cloud and Granfield (2001, 2008). The quantitative psychological research I analyse later in this chapter builds on this earlier work. Cloud and Granfield (2001) analysed qualitative interviews with 46 'formerly substance dependent persons who overcame their dependences without treatment or participation in self-help groups' (p. 85). In recruiting their participants, Cloud and Granfield used the following criteria: participants had to have been dependent on alcohol or other drugs for at least one year, had to have 'resolved' their dependencies for a period of one continuous year, and had to have achieved 'natural recovery' without treatment, including participation in 12-step groups. Cloud and Granfield draw on sociological accounts

of social capital (Bourdieu, 1988; Coleman, 1998; Putnam, 1995) in order to better understand the social contexts that facilitated the personal attributes required for successful cessation. They introduce the concept of 'recovery capital' as 'a way to capture the embeddedness of these natural recovery strategies within a unique structural context' (Cloud & Granfield, 2001, p. 85). Although many of their respondents spoke about overcoming dependency in individualised terms, Cloud and Granfield argued that recovery was achieved via the conferral of social and material 'capital' to individuals via the particular relationships in which they were embedded. The concept of 'recovery capital' was later defined as 'the sum total of one's resources that can be brought to bear on the initiation and maintenance of substance misuse cessation' (2008, p. 1972). Recovery capital could be further divided into the following categories: social capital (e.g. emotional support, friendships, social expectations and obligations), physical capital (e.g. income, savings, property and financial assets), human capital (e.g. knowledge, skills and educational credentials) and cultural capital (e.g. values, beliefs and dispositions). Cloud and Granfield's concept of recovery capital is frequently used in contemporary research on new recovery and has been used most recently to analyse gender differences in experiences of recovery (Neale et al., 2014), neighbourhood safety (Evans, Li, Buoncristiani, & Hser, 2014), participation in social networks (Mawson et al., 2015; Best et al., 2015), processes of individual change (Skogens & von Greiff, 2014), social networks and homelessness (Neale & Stevenson, 2015), and the impact of new technologies on recovery (Neale & Stevenson, 2014). It has also appears in policy and treatment discourse in the UK and Australia (Department of Health, 2012a; Neale & Stevenson, 2014; UnitingCare ReGen, 2012).

Recently, the relationship between social capital, social networks and identity has become a focus of new recovery research. Recovery is increasingly being understood as a process of social identity change. As Buckingham and Best (2016) argue, 'overall, social identify theory

provides us with a series of hypotheses about behaviour and behaviour change' (p. 5). While the extension of social identity to recovery is new, the concept of social identity is not. The social identity approach has been used widely in research on improving physical and mental health related outcomes and behaviours, wellbeing, ageing and recovery from injury (Jetten, Haslam, & Haslam, 2012). It was originally developed in the work of social psychologists Tajfel and Turner (1979), who attempted to explain how participation in social groups informs a sense of identity based on group membership (social identity theory) and also how processes of self-categorisation (in terms of identification with an in-group and out-group) function to influence and structure identity. The social identity model of recovery aims to provide a broader understanding of the factors informing the process of identity change that has long been thought to underpin recovery. As such, it has sought to emphasise the 'social' dynamics of identity formation and the multiple identities available to people through their participation in different social groups (Best, Beckwith et al., 2016). It aims to consider the various 'identities that the person may hold' and 'the wider social context of groups they may belong to' (p. 113).

In sum, new recovery is increasingly subject to scientific knowledges and explanations. Scientific knowledges function to establish a specific object of inquiry as 'real' and 'true' and attribute to it a degree of certainty and stability. The epistemological commitments of psychological scientific approaches hold that its methods and knowledges are neutral and objective, faithfully transposing the 'critical processes at work' in recovery as it exists in the world. The increasing 'scientisation' (Fraser & Seear, 2011, p. 91) of recovery is in part driven by the rhetoric of evidence-based alcohol and other drug policy discussed in the previous chapter. As noted, this rhetoric validates and legitimates particular knowledges. In the case of new recovery, the proliferation of scientific research is a central means by which recovery has been legitimised as an object of psychological scientific research. In turn, this

legitimacy has significantly influenced its uptake in treatment delivery and outcome measurement in Victoria.

As I noted in Chapter 2, to my knowledge, the science of new recovery has not been subject to sociological critique. This contrasts sharply with recent critical attention to addiction science (Dwyer & Fraser, 2015; Dwyer & Fraser, 2016; Fraser, Moore, & Keane, 2014), alcohol epidemiology (Hart & Moore, 2014) and research on methamphetamine (Dwyer & Moore, 2013; Thomson & Moore, 2014). The following analysis is the first to analyse the scientific practices and knowledges that contribute to the ontological politics of new recovery.

Limiting social context(s)

The psychological science of new recovery relies upon a series of binary oppositions, the most central being that between the individual and their social context. Other binaries include internal/external, identity/groups, responsible/irresponsible, control/compulsion and order/disorder. Within the individual/social context binary the individual is privileged as self-determining, autonomous and independent, and the social context is rendered as a resource to be harnessed during individual change. In the following section I examine how the theory of recovery capital accumulation and the social identity model of recovery enact the 'social' so as that it might be considered a governable resource for recovery. I detail the erasure of other significant socio-material forces and contingencies and consider the implications of this move.

Assembling social 'resources'

My analysis focuses on quantitative research on recovery capital and, in particular, on one of the earliest quantitative models of recovery capital (Laudet et al., 2006; Laudet & White, 2008) and on a more recent scale – the Assessment of Recovery Capital scale – that measures

personal and social recovery capital (Department of Health, 2013d; Groshkova et al., 2013). I selected the articles by Laudet et al. (2006) and Laudet and White (2008) for analysis because they were among the first empirical studies to employ and quantify the model of recovery capital originally offered by Granfield and Cloud in 1999 (see Hennessy, 2017). In addition, the model they propose was developed on the basis of research with people who use illicit drugs (earlier research on recovery tended to focus on alcohol), which is the focus of my research. As well as being among the first studies to quantify recovery capital, both have become influential in the field. According to a recent search in Google Scholar, they are among the most highly cited articles included in a recent systematic review of the literature on recovery capital (Hennessy, 2017). I focus on the Assessment of Recovery Capital scale (Department of Health, 2013d) because, of the three scales of recovery capital developed so far, it has had the most significant impact. It has been used in several other studies of recovery capital (Best et al. 2014; Best et al. 2015; Mawson et al. 2015; van Melick et al. 2013) and in validating new recovery measures (Neale, Vitoratou et al., 2016). In addition, as noted earlier, this scale has been adopted in screening and assessment in the Victorian alcohol and other drug sector.

Earlier empirical research on recovery capital did not make explicit claims about the ontology of recovery. In the main, it treated the meaning of recovery as self-evident and accepted the lack of consensus in the field as unproblematic. Laudet et al. (2006) published the first attempt to operationalise a model of recovery capital, in which they argue that there was 'a critical need for knowledge about the process of addiction recovery' (p. 35). Drawing on Granfield and Cloud (1999), they define recovery capital as 'the amount and quality of internal and external resources that one can bring to bear to initiate and sustain recovery from addiction' (Laudet et al., 2006, p. 59). However, the meaning of recovery only becomes apparent in the methods section, where it is narrowly defined as a measure of 'clean time'

(Laudet et al., 2006, p. 47). Unlike the 'personal' and 'unique' nature of recovery suggested by the definitions operating in some of the alcohol and other drug policies analysed in the previous chapter, 'recovery' is narrowly equated with periods of abstinence. This inscription (and the deletion of other potential markers of recovery) suggests that this model of recovery capital is framed by an imperative to identify the factors contributing to and promoting abstinence.

In selecting 'internal' and 'external' resources that were important enough to qualify as 'recovery capital', Laudet et al. (2006) necessarily engage in ranking and deleting other socio-material relations that may also contribute to recovery. The aim of the 2006 study was to examine whether 'recovery capital' buffers stress and enhances 'quality of life satisfaction' among recovering persons. The authors select 'social supports', 'spirituality', 'religiousness', 'life meaning', and '12-step affiliation' as recovery capital resources. Their hypothesised model of recovery capital appears in Figure 1.

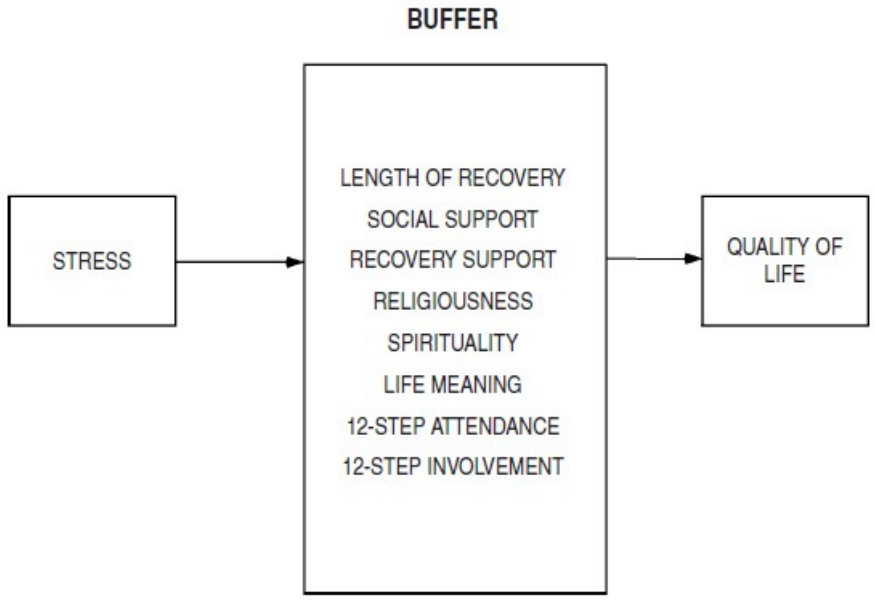

Figure 1: Hypothesised model: Supports, spirituality/religiousness and 12-step affiliation that buffer quality of life satisfaction from stress (reproduced from Laudet et al., 2006, p. 49)

In this model of recovery capital, spirituality and religious faith are constituted as internal resources, while social supports and 12-step affiliation are framed as the key external resources. The authors justify their selection of these resources through a literature review. They argue that each of these recovery capital resources was of interest because of their role in enhancing health and quality of life and buffering the impact of stress. The circularity of scientific research methods are evident here. The authors' selection of these specific resources from the many that might improve health and decrease stress assumes the relationships it seeks to examine. The elevation and ranking of these resources as significant components of recovery capital 'establishes what there is to explain' (Rose, 2007, p. 12). It also deletes from the research other resources that might be important in recovery. Furthermore, the binary between internal/external resources suggests that some of these resources are social in character; yet, the enactment of 'external' resources as 'social supports and 12-step affiliation' narrows social relations and dynamics to those involving personal relationships and participation in 12-step meetings and activities. Notably, some of the significant social and material forces identified as agential in earlier sociological iterations of recovery capital, such as education, employment, housing and financial capital (Cloud & Granfield, 2008), are deleted in this enactment of recovery capital.

The assumption that recovery capital consists of 'resources that one can bring to bear to initiate and sustain recovery from addiction' (Laudet et al., 2006, p. 59) relies on complex processes of simplification and inscription that convert theoretical constructs and complex phenomena into 'singular, settled and uncontroversial "variables", "factors" or "influences"' (Fraser, Moore, & Keane, 2014, p. 146). Building on Laudet et al. (2006), Laudet and White (2008) tested the hypothesis that higher levels of recovery capital predict sustained recovery, higher quality of life and lower stress one year later. The authors use the same resources to define recovery capital and inscribe them through multi-question Likert scales (e.g. 1 =

strongly disagree to 4 = strongly agree). Likert-type scales work by producing a common metric that can be quantitatively compared and ranked (Espeland & Stevens, 1998). For example, the 23-item Social Support Appraisal Scale (Vaux et al., 1986), which Laudet, Morgen and White use in both articles to establish 'social supports', consists of a list of statements about people's perceptions of their relationships with family and friends. Items focus on the extent to which people feel respected, cared for, important to others, well liked, admired, valued and connected. Such measures work to simplify fluid, complex and subjective feelings into one of four evaluations ranging from 'strongly agree' to 'strongly disagree'. The responses to these items are assigned numerical values, with positive self-assessments of support scoring higher than negative self-assessments. Responses are then summed to produce an overall score, with lower scores being read as indicative of an individual's social disengagement and deficit. These types of translation – from unruly phenomena into ordered data in the form of scores – are modelled on the assumption that, like physical attributes (such as velocity, temperature and length), psychological and social attributes have 'a distinctive kind of internal structure' (Michell, 1997, p. 367). For example, social support is the same and replicable across different contexts and for different people. In this sense, these scales function to organise complex and contingent social relationships into 'discrete categories of meaning and constancy' (Malins, 2004, p. 86) that can then be quantified and ranked to affirm a particular hypothesis. Crucially, simplifying social relations into the discrete category of 'resources' gives the impression that reality is made up of uniform entities that can be used and mastered productively.

The inscription of social life into manageable resources is further reinforced through an additional quantitative inscription device, structural equation modelling (SEM), which is a dominant scientific practice in the methodological hinterland of quantitative psychological research. It refers to a collection of statistical techniques that allow a set of relationships

between one or more variables to be established (Ullman, 2006). SEM establishes associations and quantifies the *types* of associations between objects. Put differently, SEM allows for the juxtaposition of different entities. Laudet, Morgen and White use SEM to test models of correlation between the different resources. For example, the 2006 article establishes the validity of the construct of 'recovery capital' and its positive effect on the stress and quality of life satisfaction of recovering persons. The 2008 article uses the now-validated construct of recovery capital as if settled and uncontroversial. The authors test whether higher levels of recovery capital predict sustained recovery (measured as abstinence) and influence subsequent quality of life and stress levels. Although SEM is increasingly popular because of its claimed ability to incorporate multiple variables, it retains the same limitations as the statistical technique of factor analysis from which it derives. SEM is unable to account for more complex, relational forces that are less easily distilled into a singular resource, such as processes of marginalisation and stigmatisation. Moreover, despite claims to independence, objectivity and 'validity', factor analysis (like the preliminary selection of 'factors') is inherently subjective (Dwyer & Fraser, 2015). While its statistical calculations can show correlations between items and the clustering of groups of items, explanations of these 'factors' always relies on interpretation (Fitch, 1984). In this respect, despite claims to the contrary, subjective interpretation is intrinsic to the method and is needed to confer a single reality of 'recovery capital' across abstract mathematical associations.

Evident in the various processes of enactment I have traced thus far is the framing of recovery capital in relation to abstinence, the selection of particular entities (and the deletion of others) and their framing as 'resources', and their subsequent juxtaposition through SEM. Also evident is a circular logic in which these research practices and logics presuppose entities and their effects in order to confirm them (Dwyer & Fraser, 2015). Researchers hypothesise a construct, a real 'thing' that exists in the world and is amenable to

measurement. They then design questions that are thought to reflect and operationalise the hypothesised construct (e.g. through Likert-type scales). They then note clustering of some of these items – 'factors' – and interpret these factors as confirmation of the real thing, although these factors are hypotheses and remain in need of confirmation. In this sense, the statistical techniques that underscore psychological science have built into them normative values and assumptions, in the form of subjective selection and interpretation. One of the significant political effects of this process is that social life is shaped in human-centred, rational and simplified ways, so as to sustain the neoliberal logic that individuals' lives are entirely the result of good choices, behaviour and self-management. The point of this analysis is to suggest that although a model of recovery capital might be able to 'predict' that social supports, religiousness, 12-step affiliation and life meaning influence a person's ability to cultivate abstinence, this conclusion is not surprising. These constructs and the emergence of this correlation reflect a pre-existing psychological interest in drug cessation and the continual curtailing and deletion of other constructs, forces and relations that either do not fit the hinterland of scientific method or might complicate this conclusion.

Inscribing groups

Like the work on recovery capital, research on the social identity model of recovery also works to simplify and order social life into stable and discrete categories. However, in contrast to research on recovery capital, social identify-focused research partitions and segments sociality into stable 'groups' of drug users and non-drug users. These simplifications form the basis of a stigmatising logic that suggests that people who use drugs need to divest themselves of their existing social connections in order to develop a new identity and 'recover'. Within research on the social identity model of recovery there is a tendency to assume homogeneity within drug-using or non-drug using 'groups'. This homogeneity is built on two questionable premises: first, that all members of 'groups' share

similar norms and values, and second, that the 'positive' or 'negative' effects of group participation can be determined by the group's drug-using status. In comparison to the research on recovery capital, the social identity approach is explicitly concerned with theorising the 'mechanisms of change' (Best, Beckwith et al., 2016, p. 111). As I noted in Chapter 3, the social identity model of recovery (SIMOR) was developed on the basis of several studies on social identity change, conducted mainly in treatment settings (e.g. Beckwith et al., 2015; Best, Beckwith et al., 2016; Buckingham et al., 2013; Dingle, Cruwys, & Frings, 2015; Mawson et al., 2015). In the following extract, Best, Beckwith et al. (2016) explain how recovery occurs via a process of social identity change:

> [I]n which a person's most salient identity shifts from being defined by a membership of a group whose norms and values revolve around substance abuse to being defined by membership of a group whose norms and values encourage recovery. This emerging sense of self is shared with others in recovery, thus strengthening the individual's sense of belongingness within recovery-oriented groups. This emerging social identity is gradually internalised, so that the individual comes to embody the norms, values, beliefs and language of recovery-oriented groups. This, in turn, helps the individual shape and makes sense of changes in substance-related behaviour, and reinforces the new social identity. (p. 113)

Although the SIMOR suggests that a broad range of social groups can strengthen a recovery-focused identity, Best, Beckwith et al. (2016) use AA participation as the empirical foundation for the SIMOR model. Perhaps within the structure of an AA meeting or treatment facility, the presumption of sameness is reasonable. As I argue in Chapter 7, the highly regulated and repetitive structure of recovery-focused treatment environments invites identification with narrow models of addiction and addicted subjectivity. Viewed through this lens, the presumption of shared norms within treatment environments and mutual aid

societies has some basis. However, even within the normative constraints of recovery-focused environments, multiple and heterogeneous enactments of addiction are forged through various treatment practices and institutional arrangements (Aston, 2007; Hughes, 2007; Karasaki, Fraser, Moore, & Dietze, 2013). Moreover, it is well established in the literature on new recovery, and on older forms, that people have diverse treatment needs (Neale et al., 2011a), are motivated by different concerns (Nettleton et al., 2013) and engage with treatment in different ways (Fraser & valentine, 2008; Holt, 2007; Moore, 2009; Ning, 2005; Lancaster, Santana et al., 2015). Thus, the assumption of sameness, or of shared 'norms' and 'values' via participation in a recovery-focused group, is at best tenuous.

In addition to the taken-for-granted assumption of sameness, the SIMOR assumes that social groups are inherently stable, that using and recovery groups can be treated as discrete entities, and that social groups have a fixed character – as either supporting or undermining recovery. Take, for example, this schematic representation of the SIMOR (Figure 2):

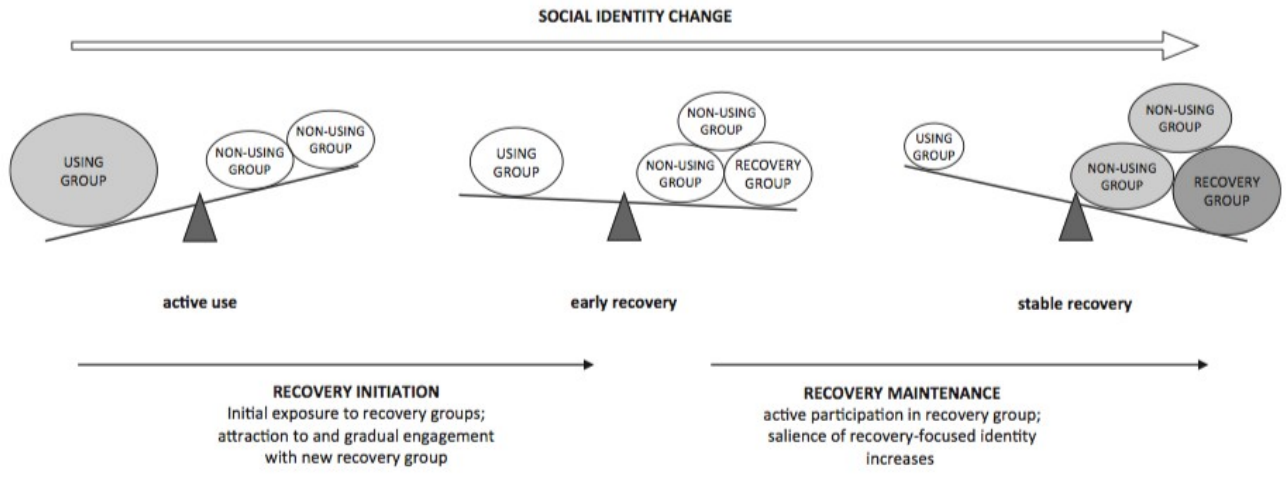

Figure 2. Model of Social Identity Change (reproduced from Best, Beckwith et al., 2016). Copyright 2016 *http://www.tandfonline.com*.

This visual juxtaposition of ‘using groups’, ‘non-using groups’ and ‘recovery groups’ is located on a linear recovery trajectory, from ‘active use’ through ‘early recovery’ to ‘stable recovery’. These binaries between using/non-using groups and active use/recovery simplify the often contingent nature of intimate relationships and the complexity of drug use and drug cessation. Set on a linear seesaw, active use and recovery initiation are aligned with a large and coherent ‘using group’. As the person goes through early recovery, and later stable recovery, the person’s social networks are progressively populated by non-using and recovery groups. These groups are depicted by smooth, definite, uniform borders. There are clear problems with this diagram and with the general treatment of groups in the SIMOR approach. In an AA meeting, in which abstinence and verbal declarations of sobriety are almost mandatory, the boundaries between using and non-using, or using and recovery, are easier to identify and police. However, outside such highly ritualised environments, the distinction between using and recovery-oriented groups is porous and much harder to maintain. How does one determine whether a group is a ‘using’ group or a ‘non-using’ group, or supportive of recovery? As we saw in the previous chapter on policy, people are encouraged to participate in community groups, to volunteer and to take up employment as part of their recovery. In this light, a sports team would likely be considered a non-using or recovery-focused group. However, in practice, the sporting ‘group’ might participate in a range of other social practices. For example, considering the prevalence of heavy drinking in Australian sporting culture and clubs (Hart, 2016), it is highly likely that participation in a sports group would involve social occasions during which heavy drinking is encouraged or, at the very least, settings in which alcohol and other drugs are consumed. In this sense, the sports team is a using group and a non-using group at the same time. The group takes on different forms, functions and membership depending on location, space and time. Consumption status is not an inherent quality of the group itself.

Furthermore, determining the 'positive' or 'negative' character of a group in advance of the group's formation is an equally difficult task. Although taking part in a group might indeed provide friendship and bolster 'health promoting' behaviours, it might also involve competition, frustration, rejection, new risks and challenges, and insecurity. Moreover, as is often the case with social dynamics, these 'positive' and 'negative' effects might, and most probably will, occur at the same time in more complex, emergent forms than allowed for in this binary. Without an account sensitive to the situated social dynamics and embodied complexities of specific group formation and feeling, it is difficult to determine in advance whether participation in a recovery-focused group will engender 'positive' or 'negative' effects, integration or isolation, improved health or injury. The binarised depiction of using groups as having *a priori* negative effects on identity erases the ways in which people who use drugs are important sources of 'lay' harm reduction and knowledge exchange. For example, Faulkner-Gurstein (2017) argues persuasively that naloxone provision builds upon the social relationships and local knowledges developed through opioid consumption, thus producing novel forms of responsibility and citizenship. In addition to facilitating education and harm reduction, research has shown how shared drug-using practices can promote novel forms of intimacy and care (Farrugia, 2015; Fraser, Treloar, Bryant, & Rhodes, 2013; Manton, Pennay, & Savic, 2013; Poulsen, 2015). The simplified enactment of 'using' and 'non-using' groups (as discrete, dichotomous and positive/negative) does not hold up to critical scrutiny. Further, this scientific model of new recovery reproduces traditional conceptualisations of drug use as abnormal and people who use drugs as dangerous and deviant. In this sense, the scientific enactment of the sociality of people who use drugs is not only normative and limiting, but stigmatising too, deleting experience, expertise, care and pleasure.

Thus far I have traced the ways in which social life and forces emerge in psychological scientific research on recovery capital and the social identity model of recovery. Both accounts enact the social environment as contained, constant and orderly, and the individual as capable of managing and curating their social environment. I have highlighted several political implications of the simplifications of social life in psychological scientific research on new recovery. First, the particular kinds of simplifications produced in psychological research on new recovery almost entirely conflate social life with other human relationships. This has the effect of deleting material, economic and political relations, which shape people's capacity to pursue health and wellbeing. Second, in pursuing this logic, these scientific practices also erase the contingency of sociality and its emergent character. Third, these enactments of the social worlds of drug use and people who use drugs have the potential to be extremely stigmatising. Not only are drug-using subjects responsibilised to recover, but they must necessarily renounce their social networks in order to do so. In these ways, this binary logic works to reinforce and naturalise the individual drug-using subject as exclusively in control and as therefore responsible for recovery.

Responsibilising the individual

Psychological scientific research on new recovery locates drug-using subjects in socio-material circumstances but limits these to interpersonal relationships and social participation. This framing excludes the political, economic, legal and cultural forces and elements that shape people's lives. In addition, the theory of recovery capital and the SIMOR enact the social lives and sociality of people who use drugs as manageable problems that can be carefully monitored, managed and changed in order to recover. This enactment of the social instates a hierarchy in which the individual subject is obliged to manage their social environments through enterprise and activity in order to recover. In the following section I analyse how the Assessment of Recovery Capital (ARC) scale (Department of Health, 2013d)

reproduces a 'normal' and 'healthy' recovering subject according to a neoliberal political rationality: one who is entirely in control of her future, autonomous and self-determining. Service users are elicited to adopt this kind of self through self-assessments of their recovery capital. In contrast, the SIMOR enacts the individual's 'social identity' as the locus of change and the mechanism of recovery. Drug-using subjects are ascribed a compromised form of agency in the model of social identity, passively subject to unconscious group dynamics and intra-psychic dynamics, while simultaneously responsible for divesting themselves of deviant social relationships. The continued scientific focus on individual recovery capital and identity processes and practices buttress neoliberal policy logics and treatment approaches that see the individual as the cause of harm and proper target of treatment.

Eliciting a model citizen

The ARC scale (Department of Health, 2013d; Groshkova et al., 2013) is an especially significant text for analysis because, as noted earlier, it is embedded in treatment screening and assessment in Victoria.[6] The stated aim of the tool is to 'identify internal and external resources and strengths that individuals can draw upon to help them meet their recovery and treatment goals' (Department of Health, 2013d, p. 15). The ARC is used in practice with people who engage in treatment to motivate individual change and 'progress' in the form of 'recovery'. Whereas the model of recovery capital analysed in the previous section aimed to theorise recovery capital, the ARC was motivated by the desire to measure people's levels of recovery capital and help 'direct individuals towards appropriate forms of intervention' (p. 193). As such, in addressing my overarching research aims, the following analysis traces the political, subjective and ethical effects of this scale. Specifically, what kinds of capital are

[6] The ARC module was added to screening and assessment protocols after the pilot evaluation of the screening and assessment package. At the time of writing, there is no available data on how widely it is used in practice.

privileged here and what forms of progress are defined as appropriate? What assumptions about ideal forms of health, social life and citizenship are incorporated and reproduced in the ARC? What kind of political rationality underpins these criteria and objectives? How does the scale work to enrol service users into specific forms of responsibility? And what other avenues for subjecthood, care and change are erased as a result?

According to its creators (Groshkova et al., 2013), the ARC scale was based on discussions with treatment providers and service user groups, and with reference to current research describing addiction recovery (the 2013 article does not detail which research). On the basis of these discussions, which identified key areas of recovery, domains and questions were developed and tested in focus groups and individual interviews with people in various stages of recovery. The initial version of the scale was piloted with clients attending a community rehabilitation service in Scotland, followed by field-testing of the revised scale in further community rehabilitation services and recovery groups and communities across England. The scale consists of 50 items organised into 10 domains with each domain comprising five items assessing recovery strengths (Groshkova et al., 2013). The domains are: substance use and sobriety; global psychological health; global physical health; citizenship and community involvement; social support; meaningful activities; housing and safety; risk taking; coping and life functioning; and recovery experience. Participants are asked to answer yes or no to the 50 questions across these 10 domains, with each section scored out of five, with a higher score indicating higher recovery capital. The authors demonstrated moderate ARC scale test reliability and good concurrent validity with the World Health Organization's quality of life assessment instrument (WHOQOL-BREF) (Arndt, Sahker, & Hedden, 2017).

As noted above, the ARC scale is designed to be used in clinical settings to assist service users to meet their recovery and treatment goals (Department of Health, 2013d). In this sense, one of the functions of the assessment is to facilitate critical self-reflection and, where

relevant, assist people to identify areas of change. As Dwyer and Fraser (2016) argue, addiction screening and diagnostic tools commonly treat self-assessments 'as reflections of fact' (p. 12), when instead they promulgate norms, feelings and experiences that are social in character. This assessment of recovery capital professes to capture objective and 'real' facts about people's resources and strengths, but upon closer inspection can be seen to promulgate very specific political and ethical norms and expectations. For example, consider the first three sections of the scale concerning people's relationships with their substance use, psychological health and physical health (Figure 3):

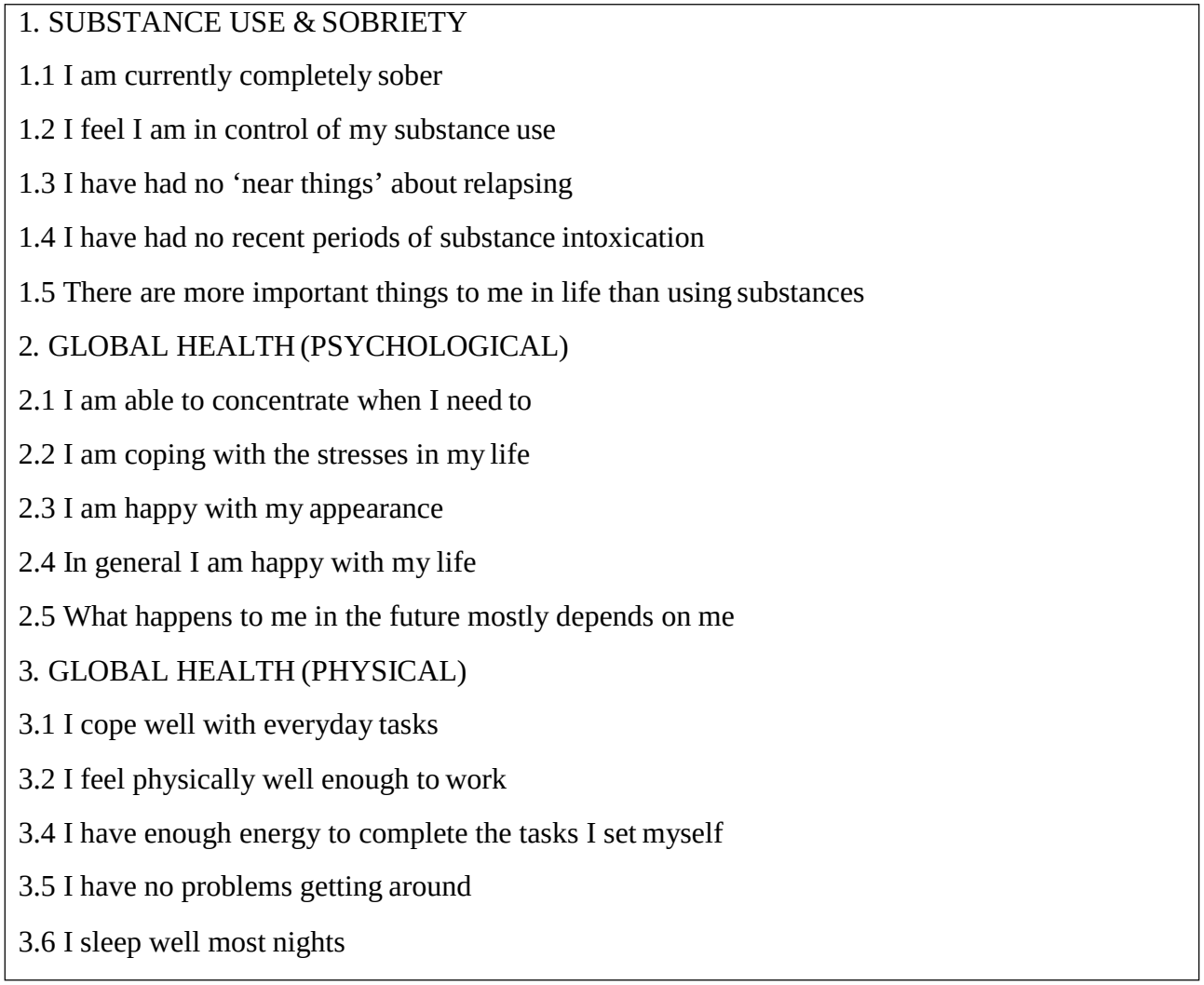
1. SUBSTANCE USE & SOBRIETY
1.1 I am currently completely sober
1.2 I feel I am in control of my substance use
1.3 I have had no 'near things' about relapsing
1.4 I have had no recent periods of substance intoxication
1.5 There are more important things to me in life than using substances
2. GLOBAL HEALTH (PSYCHOLOGICAL)
2.1 I am able to concentrate when I need to
2.2 I am coping with the stresses in my life
2.3 I am happy with my appearance
2.4 In general I am happy with my life
2.5 What happens to me in the future mostly depends on me
3. GLOBAL HEALTH (PHYSICAL)
3.1 I cope well with everyday tasks
3.2 I feel physically well enough to work
3.4 I have enough energy to complete the tasks I set myself
3.5 I have no problems getting around
3.6 I sleep well most nights

Figure 3: Optional Module 8: Assessment of Recovery Capital, questions 1–3 (reproduced from Department of Health, 2013d)

The scale elicits from service users subjective summations of personal competencies ranging from sobriety (and strength thereof) to capacity to concentrate and cope with stress. Through this process of screening and assessment, service users are educated in the proficiencies and qualities that constitute healthy and normal subjecthood in neoliberal societies. In addition, the questions on the scale detail the terrain of healthy subjecthood in such a way as to suggest the very techniques and strategies through which drug-using and 'addicted' subjects can remake themselves as healthy neoliberal citizens. For example, controlling substance use, pursuing happiness and self-reliance, and cultivating 'energy' and good sleep hygiene are all framed as tactics that produce a higher score. However, the criteria for accruing recovery capital advanced in the ARC and in recovery more broadly are, in many cases, patently unattainable and thereby stigmatising when used with marginalised people, who are often significantly economically and materially disadvantaged. For people in recovery, complete sobriety and tightly held 'control' of their substance use is instated as the desirable norm. This is despite the fact that for many people not in recovery, regular use of alcohol and other drugs is part of their everyday lives and produces pleasure, stress relief and sociality. It seems particularly unfair to suggest to people who may already be experiencing difficulty in moderating their alcohol and/or other drug consumption, as well as likely being socially marginalised, that their recovery hinges on complete sobriety, without any 'near' relapses.

The pressure to reach unattainable standards is also evident in the normative and insensitive framings of health instated by these criteria. The ability to concentrate and cope with stress, happiness with one's appearance and life, taking responsibility for the 'future', feeling physically well, having energy and mobility, and sleeping well are presented as exemplars of psychological and physical health. However, these exemplars instate as desirable norms capacities and attitudes that are difficult for most people to meet. Body image, for example, is

a complex gendered and socio-economic phenomenon, with approximately 28% of Australian men and 35% of Australian women aged 11–24 years stating that they are dissatisfied with their appearance (National Eating Disorders Collaboration, 2010). Similarly, four out of 10 Australians suffer from inadequate sleep to such an extent that a 'sleepiness epidemic' has been declared (Deloitte Access Economics, 2017). Stress and tiredness are almost taken-for-granted facts of contemporary society. Yet, recovering people are encouraged to understand these competencies not only as desirable but as *normal*. Through the enactment and intensification of these norms, the ARC enacts a fantastical model of contemporary subjecthood. Out of reach for most people, these competencies and attributes are even less accessible to vulnerable and marginalised people, who are less able to accrue the financial and material resources with which to moderate contemporary stresses and strains. In this sense, the ARC is at risk of both contributing to the stress and 'future' failures it apparently aims to address. In reinforcing this myth of ideal neoliberal subjecthood, the tool also potentially reinforces the sense of an enormous gulf between one's present situation and what it would take to become normal.

In addition to eliciting a normative model of health, the ARC scale enacts a particular model of individualised enterprise and social citizenship as principal markers of successful recovery. Sections four, five and six present questions on citizenship and community contribution, social relationships and participation in meaningful activities (Figure 4). Many of these questions present 'active' participation in society as necessary to cultivating recovery and becoming a 'normal' subject. Participation, however, is enacted as a one-sided affair, wholly contingent on enterprise and effort and fettered by little else. The questions selected to indicate citizenship and community involvement focus exclusively on individual enterprise to the neglect of other forces.

4. CITIZENSHIP /COMMUNITY INVOLVEMENT

4.1 I am proud of the community I live in and feel part of it – sense of belonging

4.2 It is important for me to contribute to society and or be involved in activities that contribute to my community

4.3 It is important for me to do what I can to help other people

4.4 It is important for me that I make a contribution to society

4.5 My personal identity does not revolve around drug use or drinking

5. SOCIAL SUPPORT

5.1 I am happy with my personal life

5.2 I am satisfied with my involvement with my family

5.3 I get lots of support from friends

5.4 I get the emotional help and support I need from my family

5.5 I have a special person that I can share my joys and sorrows with

6. MEANINGFUL ACTIVITIES

6.1 I am actively involved in leisure and sport activities

6.2 I am actively engaged in efforts to improve myself (training, education and /or self awareness)

6.3 I engage in activities that I find enjoyable and fulfilling

6.4 I have access to opportunities for career development (job opportunities, volunteering or apprenticeships)

6.5 I regard my life as challenging and fulfilling without the need for using drugs or alcohol

Figure 4. Optional Module 8: Assessment of Recovery Capital, questions 4–6 (reproduced from Department of Health, 2013d)

For example, higher recovery capital rests on ‘contributing to society’, becoming involved in activities that contribute to community and helping other people. Other significant forces shaping participation could include local governance, cultural and ethnic background, community resourcing, socio-economic determinants and existing attitudes within society that limit the participation of people who use drugs in all manner of activities and

responsibilities. Instead, healthy citizenship is narrowly circumscribed as the *responsibilities* and *obligations* of drug-using subjects, with little attention paid to their *rights* and *needs*. Turning to domain six, a similar one-sided obligation for drug-using subjects to be enterprising underpins the enactment of meaningful activities. Aside from the question asking service users to reflect on their 'opportunities for career development', leisure and sports activities, training and education, and recreational activities are framed as abundant and available by virtue of 'active' enterprise and effort. Notably, across all three domains, the questions are framed through eliciting subjective assessments of how happy, proud and satisfied the individual feels. This framing further shores up practices of citizenship, social support and participation as matters of personal effort and enterprise, as opposed to contingent effects of politics, and social and economic policy.

As might already be evident, the particular enactment of enterprising citizenship that underlines successful recovery resonates with the political enactment of new recovery in the National Drug Strategy (MCDS, 2011) I analysed in the previous chapter. However, perhaps because of the quantity and individualised nature of the questions, the ARC scale presents an even more conservative citizenship ideal. Many questions on the scale enjoin service users to redefine forms of socioeconomic inequality (for example, homelessness and a lack of financial and material resources) as effects of failures of self-determination, resilience and independence. Consider, for example, the questions in the three sections on 'housing and safety', 'risk taking' and 'coping and life functioning' (Figure 5). Here, the framing of the questions makes assumptions about what is within the realm of individual control and responsibility. To what extent are these questions about having adequate housing and safety – framed as matters of personal pride and individual freedom – usefully directed towards individuals in recovery? Presumably, service users have little power to make affordable and safe housing more available or to reform the taxation laws regarding negative gearing, an

investment practice widely considered to be a key factor in housing unaffordability in Australia (Blunden, 2016; Eslake, 2013).

7. HOUSING AND SAFETY
7.1 I am proud of my home
7.2 I am free of threat or harm when I am at home
7.3 I feel safe and protected where I live
7.4 I feel that I am free to shape my own destiny
7.5 My living space has helped to drive my recovery journey
8. RISK TAKING
8.1 I am free from worries about money
8.2 I have the personal resources I need to make decisions about my future
8.3 I have the privacy I need
8.4 I make sure I do nothing that hurts or damages other people
8.5 I take full responsibility for my actions
9. COPING AND LIFE FUNCTIONING
9.1 I am happy dealing with a range of professional people
9.2 I do not let other people down
9.3 I eat regularly and have a balanced diet
9.4 I look after my health and wellbeing
9.5 I meet all of my obligations promptly

Figure 5: Optional Module 8: Assessment of Recovery Capital, questions 7–9 (reproduced from Department of Health, 2013d)

Similar questions can be asked about the peculiar enactment of ‘risk taking’. One can question the selection of these particular risks and the extent to which concerns about money, having the resources to make decisions about one’s future, privacy and self-responsibility constitute ‘risk taking’ at all. In the privileging of these specific risks, the individual subject is placed at the centre of risk prevention, thus ignoring the multiple and heterogeneous forces that constitute ‘risk’ in contemporary neoliberal societies (Fraser, 2004). The final domain,

‘coping and life functioning’, follows a similar course, suggesting that ‘health and wellbeing’ and a ‘balanced diet’ are within the realm of exclusive individual control. Again, the questions about being ‘happy dealing with a range of professional people’, ‘not [letting] other people down’ and ‘[meeting] all of my obligations promptly’ promote an ethical standard which is both impractical and difficult to achieve. The rank promotion of neoliberal political subjectivity within this tool risks further stigmatising drug-using subjects as the sole cause of their problems. Although neoliberal rationalities and values have long underpinned alcohol and other drug treatment, the ARC scale is particularly striking in its reflection and reproduction of participatory obligations, impossible standards of conduct and highly individualised avenues for self-realisation. As such, new recovery discourse and practices enact an exceedingly narrow version of subjecthood and health. Any deviation from this singular figure is constituted as a risk to recovery. Although this model of subjecthood shares similarities and continuities with wider neoliberal changes in alcohol and other drug policy and health promotion, ‘new recovery’ departs from the ‘highly technical and rationalist framework’ underpinning harm reduction (Race, 2009, p. 142) to focus exclusively on individual change and cessation.

Enacting identity as a ‘mechanism of change’

So far, I have considered one way in which responsibilisation figures in psychological scientific research: via the ARC scale’s embodiment of the enterprising citizen as the normative model of subjecthood. The SIMOR incites responsibilisation differently through a model of recovery that emphasises the changing social identity of the drug-using subject. Psychology has traditionally understood identity as a core feature of the self, ‘our deepest, most profound reality’ and the ‘repository of our familial heritage and our particular experience as individuals, which animate[s] our thoughts, attitudes, beliefs, and values’ (Rose, 1996, pp. 3–4). As I mentioned earlier, in comparison to the research on recovery

capital examined above, the social identity approach is explicitly concerned with theorising the 'mechanisms of change' that produce recovery (Best, Beckwith et al., 2016, p. 111).

The SIMOR enacts the 'underlying mechanism' of recovery as a process of identity change in which a 'person's most salient identity shifts from being defined by a membership of a group whose norms and values revolve around substance abuse' to 'membership of a group whose norms and values encourage recovery' (Best, Beckwith et al., 2016, p. 113). Although the SIMOR understands identity as multiple (i.e. people have different identities shaped by different social groups), it is underpinned by the assumption that 'addiction' and participation in 'substance-using social networks' (p. 113) result in a salient drug-using or 'addict' identity. While the SIMOR acknowledges that people hold many social identities, it does not explain why a drug-using identity should be considered more salient than other identities (e.g. mother, child or researcher). Or to borrow the language of the research itself, it does not explain why the 'accessibility' or 'fit' of a drug-using identity should be considered greater than any other identity. Instead, it tends to rely on the idea that participation in 'deviant norms and activities', along with social exclusion and stigmatising attitudes, provide the dynamics for the production of a drug-using identity (Best, Beckwith et al. 2016, p. 114). While this may well be the case, this authors presume in advance a central building block of their argument, one that requires further consideration and confirmation.

Further, these social identity categories address the inner depths of a person – the authentic 'sense of self' that someone holds – but they reveal little about the richness, ambivalence and contingency that characterises an individual's relationship to self, others and consumption. In this sense, identity reproduces a 'totalised and unified view of the self, in which one truth explains every aspect of a person's existence' (Keane, 1999, p. 72). Ironically, although identity is often framed in terms of truth and authenticity, it is mobilised here to make the drug-using subject submissive to a singular psychological narrative of change and recovery.

Therefore, although the social identity approach reaches towards an understanding of identity as multiple, it continues to conflate drug use and 'deviant' social behaviour with identity. In these ways, it relies upon and reinscribes a static model of identity as homogenous and unified. Although the salient identity might be supplanted, possibilities for entanglement, dispersed agency, intersectionality and ambivalence are excluded.

Like the injunctions for self-improvement and determination underpinning the ARC scale, the salience of a recovery-focused social identity is dependent on the active engagement of individuals in recovery-focused groups and disengagement from substance-using groups. However, although the emerging recovery identity is a result of participation and belonging, recovering subjects are also characterised by passivity and lack of agency:

> The transition to a maintained state of stable recovery [see Figure 2] involves ongoing involvement with recovery-oriented groups whose mechanisms of impact include social learning and social control thereby shaping social identity. Here, the salience and stability of a recovery-focused identity will grow as the individual becomes actively engaged in recovery groups. Moreover, as this identity becomes internalised the influence of using group values and norms significantly diminishes. In response, the recovery-focused identity becomes the more accessible and meaningful social identity, thus supporting recovery maintenance. (Best, Beckwith et al., 2016, p. 116)

Here, social identities are framed as subject to external social dynamics and abstract psychological mechanisms. Elsewhere, the individual is framed as at risk of exposure to the norms and values of various social groups and the 'influence of using group values and norms' (Best, Beckwith et al., 2016, p. 166). More broadly, the model of social identity change is figured as an unconscious and somewhat involuntary intra-psychic process shaped

by ‘norms’, ‘values’, ‘transitions’, ‘attraction’ and processes of ‘assertive linkage’. Earlier in the article, the authors argue that the social identity of groups:

> [S]tructure (and restructure) a person’s perception and behaviour – their values, norms and goals; their orientations, relationships and interactions, what they think, what they do, and what they want to achieve. (Best, Beckwith et al., 2016, p. 113)

Compared to the neoliberal subject instated via the ARC scale, the SIMOR is evocative of a 20th-century psychological theory of identity ‘as a passive responder to external events’ (Ogden, 1995, p. 409). Yet at the same time that drug-using subjects are figured as having ‘vulnerable’ identities, they are also responsibilised to actively engage in recovery groups. This tension between compromised agency and masterful competence and control is a key theme reiterated in and through treatment practices. As I explore in Chapter 7, these tensions are a source of considerable anxiety for service users.

Although the social identity approach claims to provide opportunities for thinking through the complex dynamics of social change and agency, the deployment of discrete identities based on consumption delimits the scope and nature of change. Many of the people I interviewed for whom the concept of recovery was significant spoke about recovery as complex, multiple, unstable and fragmentary. For people who desire and practice recovery, it rarely follows a linear, coherent trajectory with a new sense of self emerging at its conclusion. Indeed, many participants spoke about repetition and relapse, and their frustration at needing to re-learn the same lessons many times over. Even for people who identified as having been in recovery for many years, the ‘fit’ of a recovery identity was not characterised by a linear transition but by daily self-work and repetition. Even more so, many participants’ accounts of recovery suggest that recovery is shaped by treatment settings and an array of contingent and non-rational forces too: luck, timing, space, concepts, drugs and habit. The deployment of a using

or recovery identity as the ontological basis of recovery reinforces the longstanding interest in individual change and ignores developments in social research on drug use and health.

Conclusion

In this chapter I critically examined the enactment of new recovery in research relating to two significant and contemporary psychological theories. I also drew out several significant political implications that emerge out of the framing of citizenship, agency and responsibility advanced in psychological scientific work. Foremost, I identified a prevailing taken-for-granted binary logic of individual/social that sustains the extremely individualising thrust of contemporary research into new recovery. People who use drugs continue to be subject to prohibitionist obligations to change themselves and to remove themselves from their existing relationships with people who use drugs and spaces of drug use.

Drawing on Law's taxonomy of simplification practices, I considered the inscription and juxtaposition of the individual/social binary in work on recovery capital and the social identify model of recovery. Drawing on this interpretive tool, I was able to perform a sensitive and detailed analysis of the assumptions and practices enacting new recovery, which are usually overlooked or taken-for-granted in the psychological lexicon. First, I argued that despite claims to the contrary, the social continues to be narrowly rendered in psychological scientific research on new recovery. Researchers selected specific 'resources' in relation to a pre-existing interest in abstinence. These resources were framed narrowly as human relationships and 12-step participation. Similarly, the 'group' was framed as a rational, discrete and bounded entity and ranked as the most important determinant of identity. Both psychological theories frame the social in such a way as to delete political, economic and other social forces and relations that shape health and wellbeing. They also continue to stigmatise the social relationships of people who use drugs and the sociality of drug use as

singularly deviant. This enactment of the social as discrete and governable also functions to persuade people who use drugs that their social lives can be managed and mastered in order to cultivate recovery. In this sense, people who use drugs are doubly responsibilised for their own behaviour and for the surrounding environment.

In the second section, I examined the other constitutive force in this binary – the enactment of individual agency. The recently developed ARC scale elicits a self-determining, autonomous and highly independent subject as the exemplary recovering figure. I argued that the selection of questions in the ARC and their framing had the potential to stunt 'recovery' and efforts to improve health. It presents a fantastical model of subjecthood that, even for those who are most materially and economically resourced, would be difficult to inhabit. The injunction to manage and master one's social life is also present in the enactment of identity as the locus of change. But the particular inscription of identity also raises complex dynamics wherein the recovering subject is figured as a passive recipient of external dynamics.

In highlighting these simplifications I mean to draw attention to their participation in the politics that make new recovery. As I have just argued, psychological science routinely deletes socio-material entities from the frame of analysis. In doing so it privileges an understanding of the individual as autonomous and entirely responsible for their own health. In addition, this binary logic simplifies human agency and conceals the relational nature of social problems. These scientific practices are not inconsequential and I consider them central to the processes by which an individualising account of new recovery has come to be constituted. An implication of this analysis is that although scientific research presents and may continue to develop 'new' theories of the underlying mechanism of recovery, the 'options' (Mol, 1999) between the various enactments are indeed limited because they share the same ontological foundations. Psychological accounts of both recovery capital and social identity work to reinscribe the same binary logic and distribute agency unequally. As Mol's

approach might suggest, the ‘options’ relevant to the shaping of the ontological politics of new recovery do not yield simple ‘choices’. Indeed, current psychological enactments of recovery buttress dominant ways of thinking about recovery in relation to responsibilisation and active citizenship, and pejorative assumptions about people who use drugs in general.

Chapter 6

Putting new recovery into practice:

Coordination and contradiction in professional accounts

So far, I have examined two cases in my analysis of the contemporary enactment of new recovery: Australian alcohol and other drug policy and psychological scientific research. In keeping with a case approach, and my desire to showcase the utility of posthumanist approaches, I analysed these specific cases of new recovery using different theoretical and methodological tools while retaining my overall focus on enactment, multiplicity and ontological politics. Applying Bacchi's approach to Australian alcohol and other drug policy in Chapter 4, I showed how new recovery discourse revitalises older pathological notions of drug use, heightens the focus on the individual drug-using subject as the rightful object of treatment, and emphasises a conception of 'community' that has the potential to produce the very harms it aims to resolve, such as marginalisation and stigmatisation. Those advocating new recovery make sweeping claims about its capacity to inspire hope and empower change, but its enactment in Australian alcohol and other drug policy suggests continuities with neoliberal health policy framings of drug-using subjects as failed citizens who are ultimately responsible for their troubles. In Chapter 5, I showed how the psychological science of new recovery, which is framed as independent and objective, further bolsters these neoliberal trends in health and social policy. I drew on STS scholar John Law, and in particular his attention to simplification practices and inscription. I argued that psychological scientific theories of new recovery reproduce a narrow binary simplification of social context and individual agency that underpins a sustained responsibilisation in which individuals are enjoined to take control of their social environments to recover. Excluded from this logic are

potentially more creative and affirming approaches to addressing the harms associated with drug use.

In this third of five empirical chapters, I continue my examination of the ways in which new recovery is enacted in Australia, how people who use drugs adopt or otherwise engage with new recovery, and the political effects of new recovery. Here I am primarily concerned with enactments of new recovery in professional practices. Inspired by Mol's analysis of the way medical and professional practices make different enactments of atherosclerosis 'hang together' into a coherent disease entity, I mobilise her interpretative notion of 'organising relations'. The potential of this conceptual tool to more sensitively foreground the professional relations and practices that make multiple enactments of 'recovery' cohere in clinical and treatment practices is yet to be explored. Professional practices play a crucial role in coordinating different recovery enactments into a common entity, and in managing its contradictions, so that it might be mobilised in the provision of therapeutic treatment. I argue that embedded in professional and clinical practices are several strategies and relations that work to make 'recovery' cohere and to render it sensitive to the complex and contradictory ways in which people pursue health and change through treatment. I use Mol's concepts of coordination and distribution to show how different enactments of recovery are assembled and made serviceable for treatment purposes. Although professionals are often attuned and sympathetic to the complexity of clients' troubles and material circumstances, clinical knowledges, techniques and practices materialise recovery in ways that reproduce normative goals and values (e.g. taking responsibility for one's self, self-management, freedom and autonomy), and privilege the individual as the legitimate object of treatment. Further, in enacting their own local and hybrid variant of recovery, professional accounts combine elements of new recovery alongside longer-standing enactments of recovery. The methods used to generate these data were presented in Chapter 3. To recap, I interviewed 11

professionals working in policy, treatment provision and/or research. The interviews explored the nature of participants' work, their reflections on the recent reform of the Victorian treatment sector on recovery-focused treatment practices, and their understandings of key concepts underlying treatment and recovery.

The chapter is organised into five sections. First, I begin by discussing Mol's (2002) analysis of organising strategies in the treatment of atherosclerosis, specifically her concepts of 'coordination' and 'distribution'. Second, I analyse one such coordination strategy – that of 'addition' – in professional accounts. I argue that the addition of multiple enactments of addiction contributes to the formation of a singular and serviceable problem, and preserves the therapeutic authority of new recovery as a meaningful 'psycho-social' response. Third, I analyse a second coordination strategy in professional practices – that of 'translation'. Metaphors are central to professional narratives and work to translate authoritative logics and obligations into a therapeutic enactment of new recovery. Fourth, I examine how incompatible enactments of new recovery are kept apart through 'distribution'. Finally, I examine these organising strategies in order to illuminate the kind of work being done by professional knowledges and discourses, and to further map the ontological politics of new recovery.

Making new recovery 'hang together'

My analysis of professional accounts of new recovery is inspired by Mol's (2002) tracing of how various enactments of atherosclerosis come to be treated and understood as a single disease. Of particular relevance is Mol's exploration of the complex organising relations in practice in the hospital she studied, which coordinate the various versions of atherosclerosis and thereby manage potential contradiction and incompatibilities. I draw on her concept of 'coordination' and explore two of the three forms of coordination she presents, *addition* and

translation. I also draw on her concept of *distribution*, another organising relation that works to preserve the coherence of recovery.

Coordination refers to those relations and strategies that make the object of inquiry 'hang together' as a seemingly singular entity (Mol, 2002). As the term suggests, addition refers to the process of 'adding up' several enactments to make a coherent whole. The addition of multiple and divergent enactments produces capacious disease concepts that can incorporate multiple enactments while simultaneously obscuring ontological differences and contradictions. Mol outlines two modes of addition in her study of atherosclerosis. The first involves the addition of multiple diagnostic and treatment enactments that 'project a common object' behind them, for example, the body. She traces the diagnosis of atherosclerosis across the patient's account of their medical history, a physical examination, pressure measurements and an ultrasound. The ultrasound that visualises the flow of blood in the artery functions to 'back up a single diagnosis. This patient, they say, has a stenosis in the common femoral artery of his left leg' (Mol, 2002, p. 57). The second form of addition does not rely upon a common object. Rather the various enactments of the entity-to-be-treated are added together to form a composite reality. As Mol (2002) writes, 'Don't try to explain how they hang together inside the body. Forget about the body. Just add up your findings' (p. 68). However, when differences between enactments become visible, they need to be made comparable through acts and practices of *translation*. For example, although the ultrasound and the angiography 'present different data', in that the 'angiographic image shows the vessel lumen, and [the ultrasound] tells about blood velocity' (p. 75), the two entities are made comparable via quantification in which the outcomes of the ultrasound are translated into a percentage of lumen loss. That is, the ultrasound 'is made to speak about the same object as angiography' (p. 78). By turning one enactment into another, the coherence of atherosclerosis as a disease is maintained.

At other times, however, achieving coherence is not the goal. Instead, the different and potentially conflicting enactments of atherosclerosis are spatially and temporally *distributed.* Although atherosclerosis might be defined as both pain upon walking in diagnosis and a clogged artery in treatment, these divergent enactments are distributed across different sites and thus never pose a challenge to the coherence ascribed to the disease object. Although, the distribution concept proposes a different kind of relation to that of addition and translation, as Mol suggests, by separating out 'what might otherwise clash', distribution helps manage the various tensions and assembles atherosclerosis.

Mol's analysis illuminates how the ontological certainty and self-evident nature of a disease object is a product of specific relations that emerge from within scientific and professional knowledges and technical practices. These relations enact the realities of disease and other objects of inquiry as stable and consistent across different locations and, in turn, shore up the authority of scientific and medical knowledge. In light of my concerns in this thesis, Mol's approach is helpful because it denaturalises the ontological claims made by new recovery-focused research and treatment. Moreover, by emphasising professional organising relations, I am able to draw out the kinds of work professionals engage in through accounts of treatment and through treatment practices. These organising relations are productive in that they work to strengthen and sustain the professional authority of residential and therapeutic treatment by legitimising its focus on the individual client. I turn now to the first theme – the addition of addiction entities into a composite and complex psycho-social object that can be addressed through recovery-focused treatment.

'What does [new] recovery mean?': Adding enactments together

Professional accounts of new recovery are often located in explanations of the 'disease-to-be-treated' (Mol, 2002, p. 72). That is, recovery-oriented discourses and concepts are commonly

intertwined with a narrative of 'addiction' or its subtle variations. Perhaps more than in any of the other authoritative sites we have encountered so far, Australian alcohol and other drug clinicians are attuned to working with the complexity and contradictions of 'addiction' and broader drug-using experiences (Fraser, 2016; Hart, 2016). Fraser has noted how many Australian alcohol and other drug treatment providers reject narrowly essentialist accounts of addiction and try to account for complex and divergent experiences by enacting addiction as a '"bio-psycho-social problem" or a "multifactorial" one' (Fraser, 2016, p. 10). Managing this tension between understanding addiction as multiple and complex on the one hand, yet mobilising it as a singular problem that might be resolved via 'recovery' on the other, is explored in the following section via Mol's addition concept. I also return to the question of the extent to which the recovery that 'hangs together' in professional practices should be considered 'new', and whether it offers a novel engagement with issues associated with drug consumption and health more broadly.

One way in which alcohol and other drug practitioners rationalise recovery-focused treatment is through the addition of different addiction enactments into a single and thereby *treatable* 'psycho-social' condition. Although the following account of addiction is comprised of spatially and physically separated (distributed) entities, the addition of these enactments into a 'psycho-social' concern makes 'addiction' appear a coherent object of treatment. Professional 4 (service management) was a member of the management team at an organisation delivering a broad range of services, including recovery-oriented residential rehabilitation programs. Earlier in the interview, he had described the agency's residential treatment programs as based on recovery, peer support and professional expertise. Here, he explains the organisation's approach in more detail:

> It absolutely goes to the heart of how you understand addiction. I guess we take a fairly eclectic approach that acknowledges that there is often a genetic or a biological

> basis to addiction. We all have a different physical make-up, our capacity to control our behaviours or our impulses are different, and our personality styles and traits are different. Fundamentally, all of those things mean that we don't have equal choices, in that some people will need higher levels of sensation seeking to have the same sort of biological experiences and effects as other people. We kind of assume there's a biological basis there, but [that] fundamentally people have to take some responsibility for how they manage within their own makeup and the choices that they make. Those choices are completely different [for] different people here and for different people across [the] community, but those are skills and choices. [… If] they take responsibility for seeking help around those – not being responsible for the traumas and things [that] they've experienced in the past, and not necessarily for their individual differences – but just how they manage and work within those […]. So the emphasis on our programs here becomes psycho-social. Skills based. There's a lot of behavioural stuff, because we acknowledge that many people come here with cognitive impairments. […] So a lot of it is teaching the basics of a work ethic of structure and routine and benefit. In some ways, taking away choices in your life by following a routine can actually free you up to live a life close to your goals if you maintain a focus on the goals and you put in a structure and a routine. (Professional 4, service management)

Here, Professional 4 mobilises a psycho-social discourse of addiction, which services the 'skills based' approach underpinning treatment in this particular residential treatment service. This is an expansive account of addiction that includes a 'genetic' or 'biological' predisposition, plus experiences of trauma and the presumed resulting impairments in impulse control and behaviour. In this treatment facility, the effects of addiction are most visibly demonstrated in the client's inability to uphold a normative work ethic, routine and

structure, which become the focus of treatment. This capacious definition of addiction adds biological, trauma-informed, behavioural and social enactments of addiction together. It does not attempt to explain the underlying associations or relationships assumed to exist between these enactments. It is enough to add these entities together into a composite 'psycho-social' addiction-to-be-treated through the provision of psycho-social skills.

The deployment of a 'single narrative' (Mol, 2002) of addiction (for example, as 'psycho-social', as complex, as multifaceted and as requiring an 'eclectic' approach) works to align these divergent entities into a stable and serviceable therapeutic object. As Fraser and Seear (2011) show in relation to hepatitis C, the narrative of a singular disease is strengthened by the inclusion of facts and examples related to the variability of the disease, its unpredictability, and its diverse and inconsistent symptoms. As they argue, and as is the case here with addiction, these allusions to complexity, which might hint at the multiplicity of disease, are instead understood as examples of a singular disorder. Variations in the presentation of the disease are made comprehensible through the idea of a scale of experience and deviation from the norm or normal experience (Fraser & Seear, 2011, p. 48). That is, it is not the presence of multiple and perhaps unrelated entities and objects, but versions of the same disease in different guises and potencies.

Furthermore, in the extract above, the depiction of the treatment approach as 'eclectic' or 'psycho-social' – one that is purportedly broad and straddles the numerous sites of the disease-to-be-treated – stabilises the purported coherence of the addiction concept, aligning potentially unrelated entities and erasing its multiplicity. One political implication arising from this multifactorial, 'psycho-social' characterisation of addiction is that failures to 'recover' are largely treated as the result of the complex nature of the addiction object itself. Addiction is posited as a wily, chronic and resistant disorder. This enactment and its reproduction through professional knowledges and treatment suppresses more difficult

questions concerning the appropriateness of clinical science and the individualised concept of 'recovery' for addressing complex social and political phenomena, such as abuse, unemployment and housing. Importantly, although addiction is spoken of as a 'meaningful independent entity', by criticising essentialist accounts of addiction and taking up more complex heterogeneous narratives, alcohol and other drug professionals destabilise addiction at the same time as they reify it (Fraser, 2016, p. 12). Close scrutiny of professional and treatment practices (which is the subject of the following chapter) suggests that the composite object does not hold together so well.

While addiction entities are made to cohere into a coherent 'psycho-social' concern, a hierarchy privileging psychological over social enactments of addiction is institutionalised through the provision of individualised 'skills based' treatment. Although professionals handle addiction as a problem that has at least a partly social character, the provision of treatment privileges and stabilises an individualised psycho-behavioural enactment of addiction. Responding to a question about how the Victorian treatment system reform, underpinned by new recovery principles, had changed his organisation's service delivery, Professional 4 explained:

> I don't think recovery was particularly well articulated. So I don't think our practice has changed significantly. I think we're just allowed to speak about it a bit more and put it into a bit more of a clear framework for staff so that they understand where the activities that they'd been doing sit and fit.

For Professional 4 then, the equivocal nature of new recovery discourse meant that it did not substantively change the way in which the organisation delivered recovery-focused treatment. However, new recovery discourse did function to provide a clearer framework for the organisation's existing treatment approach. A recovery approach, in this treatment setting,

ostensibly meant helping people make better choices and teaching them how to 'manage within their own makeup'. Like the ARC scale analysed in the previous chapter, 'recovery' positions people as responsible for managing their own lives, constrained only by the limits instated by pre-existing personal capacities and character. Again, this neoliberal-liberal vision of people who use drugs as ultimately rational and responsible for resolving their addiction is not specific to new recovery. Indeed, the extent to which concepts of new recovery blended so easily with treatment practices that were already operating under the broader banner of recovery again calls into question its originality or novel contribution.

At the same time that addiction enactments are brought together as a single stable entity, other professional accounts of recovery have no such investment in a common object. Unlike the clinician who needs frequently to decide 'what to do?' (Mol, 2002, p. 69), and therefore is enjoined to treat a common object, non-clinical alcohol and other drug professionals, such as researchers, advocates and policymakers, may handle and express different entities at the same time. For example, consider the following explanation of recovery:

> I'd start by saying I decreasingly think of recovery as something that happens in somebody's head or somebody's body. I see it as an interpersonal phenomenon […] as basically a social identity. You know, it does stand for something that's about a social movement for change… and it's something that has very powerful community origins and roots… and what does recovery mean? Well it's a kind of... it's a journey and a process that involves connectedness, hope, self-determination, empowerment, positive identity, a positive sense of meaning. (Professional 3, research)

Clearly, this researcher adopts some of the central concepts of new recovery examined in previous chapters, such as 'social identity', 'social movement' and 'community'. Unlike the first composite enactment of addiction, these enactments of new recovery do not rely on the

projected existence of a single body or disease object. Here, 'recovery' is characterised by several dimensions (Mol, 2002; Mol & Law, 2002) that include identity change and transformation, the social reclamation of identity from medicalised notions of addiction-as-disease, and the emergence of new communities of hope and health. While researchers have sought to develop a stable definition of recovery and have insisted on recovery as a meaningful independent entity, these practices simultaneously enact recovery multiply via the proliferation of 'equally' valid hypotheses. This 'insistence on singularity is productive' (Law, 2004, p. 67) in more ways than one. For example, other policymakers and researchers respond to these multiple 'dimensions' by developing new research agendas, new hypotheses and various psycho-social theories of recovery. In the words of one participant:

> The recovery literature is very thin, so trying to find the connections between what works and [what] doesn't in recovery terms for people with alcohol and drug [problems]… this is how come I know about desistance theory. It's one of the things and I followed the path. I followed the trail of 'what does desistance theory tells us about alcohol and drug treatment and why'? I followed the path of emergency management and why you'd intervene and change the trajectory around trauma, so that notion of trauma-informed [practice] and why. People started using trauma – we are all trauma informed – but I don't think many people knew what it was. You know, there is a wealth of literature available, it's a question of gathering it all together and having the time and resources to go through it in detail, to distil. (Professional 1, policy)

Here we can see how 'gathering it all together' – that is, the addition of different theoretical approaches, such as desistance theory, emergency management and trauma-informed practice – powerfully work to reinforce a singular object – 'recovery' – awaiting definition and explanation. As I noted in the previous chapter, scientific accounts of new recovery posit

particular theories as holding the key to unlocking the *real* mechanisms of disease and the underlying causes. Here, this professional's narrative account reproduces clinical science as progressive and authoritative. The implication is that bringing together the right mix of scientific theories and clinical practices 'in recovery terms' illuminates the complexity of 'alcohol and drug problems'. Like the previous example, in which addiction was constituted as a composite object, recovery-focused treatment is being made by Professional 1 as a composite that coheres around a central and predetermined 'problem'.

What is also evident in these accounts is the hybridisation of recovery. Different enactments of recovery are drawn together, thereby contributing to its opacity and vagueness. As I explore further in the following chapter, is it reasonable to oblige people who use drugs, and those who engage with services, to decipher and manage this opacity and vagueness, when the careful adoption of new recovery is sometimes offered as the only means of retrieving a valuable, rational and healthy identity.

New recovery metaphors and translation

Professional accounts of recovery, both of earlier forms and its most recent iteration, rely heavily on metaphor in order to express what 'kind of thing' recovery is (Keane, 2002, p. 10). In this section, I highlight the politics of metaphor in making recovery 'hang together' in light of Mol's take on translation: her recognition that coherent entities are sometimes achieved by translating one enactment into another. How might the notion of metaphor align with Mol's concept of translation? In considering this question, I turn first to Fraser and valentine's (2008) work on the metaphorical figuration of methadone, which draws on the work of feminist scholar Meryl Altman. I reproduce Altman's (1990) definition of 'metaphor' in full here:

> A certain class of utterance that is literally neither true or false, that uses substitution and/or catachresis to establish a kind of ontological third space or free zone. Metaphors are things which feel or sound true, which you can get people to agree are true, but which make no literal sense when dissected by a sceptic: i.e. 'my love is a little white lamb' doesn't imply that the speaker engages in bestiality. Metaphors, in other words, have truth effects without having actual truth value narrowly defined. What interests me is not the distinction between a metaphor and a simile, but rather the way this distinction in practice always becomes blurred: what begins as an interesting analogy spills over into a proposition about how something 'is'. This blurring is the source of a tremendous discursive power. (p. 496)

Altman's definition opens up the concept of metaphor to Mol's notion of translation. Altman suggests that metaphor establishes 'a kind of ontological third space' where the claim of what something 'is' produces truth effects despite having no literal truth to it. To rephrase this sentiment in the language of enactment, 'the material world makes metaphor, but its materiality is also formed in and through metaphor' (Moore et al., 2015, p. 421). Or, as Fraser and valentine (2008) observe in their study of MMT (drawing on Karen Barad), 'metaphor is always already produced through the process of observation (such as through our reading of it), and through its relationship to other concepts such as the "literal"' (p. 43). They use this approach to metaphor to analyse media representations of methadone, and argue that it is enacted through its symbolic alignment with inauthenticity ('substitution'/not heroin), constraint and battle, and the feminine. These representations, they argue, are inseparable from the materialisation of methadone as substance, especially in relation to issues of withdrawal, treatment and subjectivity. Keane's (2002) work also examines the politics of metaphor in addiction discourses. For her, metaphor is at the centre of 'struggles over the identity of addiction':

> Is addiction like diabetes or high blood pressure (a chronic disease)? Is it like hunger or thirst (a visceral drive)? Is it like enjoying opera (an acquired taste incomprehensible to non-enthusiasts)? Is it like watching TV in the evening (a routine habit)? Is it like falling in love (an irrational attachment)? (Keane, 2002, p. 10)

As Keane goes on to argue, each metaphor works to enact a particular object of inquiry and 'particular problematics of desire and consumption' (p. 10). In all these ways, metaphor acts to translate complex phenomena – such as addiction – into different and specific entities – a chronic disease, a visceral drive, a taste, a routine, an everyday habit and an irrational attachment. Metaphor, and its entanglement with other metaphors and rationalities, co-constitutes the particular contours of addiction and produces far-reaching political implications in terms of ontology, lived experiences and claims to agency.

The use of metaphor by alcohol and other drug professionals enacts recovery by translating specific obligations and practices into recovery enactments and elaborating new associations. I argue here that metaphor is a central means by which injunctions to change and adopt more valorised forms of citizenship are remade as 'recovery'. As well as doing 'translation' work, I also argue metaphor functions in professional discourse and practices by suggesting strategies for achieving recovery, which invariably centre on self-work, determined effort and the adoption of responsible practices. Many of these themes overlap with new recovery enactments produced in policy discourse and the psychological scientific research. In this sense, professional narrative practices can also be understood as translating and activating these authoritative enactments of recovery, as well as extending them, in clinical practice and treatment. These metaphors have remained largely unexplored (see Keane, 2000 for an exception), both in terms of the functions they serve and their congruence with lived experiences of 'recovery' (which I explore in later chapters). Because recovery discourses refer to these entities as though they are known or self-evident, the need to interrogate them is

disguised. Here, I attempt to denaturalise these metaphors by examining how they work in professional narratives to translate particular, and political, expectations into 'recovery'.

Journeys, positive movement and growth

In her analysis of earlier recovery discourses in self-help texts, Keane (2002) argues that the 'images and metaphors found in recovery discourse compare recovery to a natural process of growth: a butterfly emerging from a chrysalis, the opening of a flower' (p. 163). Fortunately, the images and metaphors of new recovery that surface and circulate in contemporary Australian clinical practice and professionals' narratives are (mostly) more restrained. However, these earlier themes of transformation, emergence, authenticity and growth are commonplace in contemporary enactments of recovery in professional practices. Indeed, the most common metaphor used in professional accounts of new recovery is that of the 'journey'. For example, one professional explained that 'as they [treatment clients] start to become more independent and stable in their journeys, they may go back to school or they may go back into part-time work' (Professional 11, service management). Another professional suggested that it was important to recognise that 'people's journey in recovery or towards recovery is up and down' (Professional 1, research) and to design services accordingly. In comparison, another professional explained that the underlying ethos of their program was about 'people sharing a journey of recovery together and learning from each other and challenging each other along that journey' (Professional 4, service management). In these examples, 'journey', like recovery itself, functions as a 'worn out' metaphor in that it is 'regularly referenced as if it were widely understood' (Fraser & valentine, 2008, p. 44) and ontologically real.

The origin of the word 'journey' relates to the 12th-century Old French *journée*, meaning a day's travel (*Oxford English Dictionary*; accessed online 10th November 2017). It is defined

currently in the *Oxford English Dictionary* in two ways. The first defines journey as 'an act of travelling from one place to another', and the second as 'a long and often difficult process of personal change and development' (*Oxford English Dictionary*; accessed online, 23rd September 2017), a definition that resonates more strongly with its use in new recovery discourse. In relation to addiction recovery, the journey metaphor is familiar and commonplace, but it is worth considering how it enacts drug use and people who use drugs, as well as the political effects of this enactment. Consider the following extract from a manager of a large alcohol and other drug organisation that delivers primarily 'recovery-focused' support, including residential and non-residential services:

> We say that recovery is a journey, not an end result. It is self-defined by people, but generally, it always has the principle of positive movement. When we talk about helping our people get an idea of what their own recovery might look like – there does need to be some momentum in that journey, you know, for them. That they identify what they want to change in their life. We don't see it as recovery to a particular space, we see it as recovery of opportunity. Recovery of opportunity to make choices. (Professional 11, service management)

Here, the journey metaphor translates normative public health and policy expectations that autonomous citizens in neoliberal societies will actively seek health and autonomy into the therapeutic rationality of recovery. As Keane (2002) observed of earlier forms of recovery over a decade ago, the journey metaphor constitutes recovery as a 'satisfying and meaningful trajectory of progress and development' (p. 160). The metaphor of the journey continues to be central in enactments of new recovery, which again raises questions about its claimed novelty. Compared to the recovery journey Keane analysed, rooted as it was in notions of spirituality and authenticity, this more recent iteration produces stronger links to the practices and obligations of citizenship. As the service provider explains, recovery is 'not an end

result' but is the 'recovery of opportunity to make choices'. This statement is reminiscent of Nikolas Rose's (1996) well-known argument that contemporary forms of freedom are bound:

> [T]o a regime of subjectification in which subjects are not merely 'free to choose', but obliged to be free, to understand and enact their lives in terms of choice under conditions that systematically limit the capacities of so many to shape their own destiny. (p. 18)

In this sense, although the service provider insists that the journey of recovery is 'self-defined', the obligations to journey, to identify areas of change, to be autonomous and to recover 'choice' are not so negotiable. In contrast, acquiring or regaining these capacities through a 'journey' of recovery is presented as fundamentally necessary to the realisation of a 'free' and autonomous self. As Rose (1999) highlights, however, access to the freedoms on offer – the 'freedom to choose' – is limited (p. 103). These limitations include, for example, the pervasive and stigmatising discourse of addiction that enacts addicted persons as always already unfree. They also include the treatment context, which provides opportunities for addicted persons to identify 'what they want to change in their life' but is rarely able to provide the resources that form the horizon of change – housing, education, respectful social relationships, and social and economic opportunity. In these ways, the journey metaphor neatly condenses and translates by now familiar obligations to change, to take responsibility for oneself, and to be free into an individualised enactment of recovery.

Notably, the meaning of the journey metaphor is not made in isolation. It gathers its meaning through association with other metaphors, such as the frequent allusions to movement. In the previous extract the professional describes the recovery journey as always having the 'principle of positive moment' and 'momentum'. In this example, references to movement translate specific expectations about change into recovery. The way in which movement

translates the obligation to change is made clearer later in the interview when the same participant contrasts recovery with harm reduction:

> So I think that what we've done is we've extended out a visibility for people to see an opportunity beyond just maintaining reduction of harm. That's all it was ever about. It's not saying it's for everybody. It's just saying that actually some people do choose to go into a momentum of working towards positive change and there are plenty of people who feel that there is a possibility to do that. (Professional 11, service management)

Here, the metaphor of momentum translates a citizenship and clinical expectation that people will work towards positive change into recovery, and also implies that harm reduction cannot promote these desired forms of change. 'Maintaining [the] reduction of harm' is represented as a form of stasis or upholding the status quo, while recovery is by extension represented as positive, optimistic and radical.

The interview accounts also suggest that professionals' narratives make use of 'extended metaphors' (Fraser & valentine, 2008, p. 50) around transformation in order to translate enactments of authentic subjecthood into a recovering subject position. A 'care and recovery coordinator' explained in detail how the concept of recovery informed the kind of work he did with clients:

> So recovery for me has a lot to do with emotional development and maturity and growing as a person. [… It means] taking responsibility for the choices that you make in life and being able to live with the consequences of those decisions. Moving away from the kind of egocentric, emotionally volatile, over-dependent adult child, which a lot of my clients are – and there are reasons for that you know, I don't bag [criticise] my clients for being like that, there are good reasons that they remain like that, usually around

> pain and internal hurt and fear of actually feeling a journey – to becoming aware of these egocentricities and actions and how they actually keep people in a state of suffering. And gently making them aware of that, bringing them into an awareness of that and allowing them to grow and be a more authentic version of themselves. (Professional 2, service provision)

The metaphors of transformation in circulation here – development, growth, movement, awareness and journey – have long been evident in recovery discourse. Keane's (2002) earlier work analysed similar formations in which the recovery journey, produced in tandem with humanist and social psychology, and new age spirituality, offers a vision in which the addict finds freedom and becomes a 'whole' person. In the example above, the professional participant suggests that by cultivating mindfulness and self-awareness, his clients can harness (and by extension resolve) their egocentricities, pain, and internal hurt and fear, to recover and become 'more authentic version[s] of themselves'. Although Professional 2 is careful to highlight that many clients have 'good reasons' for being 'egocentric', 'emotionally volatile' and 'over-dependent', he also reproduces familiar understandings of the addict as emotionally selfish and volatile and as having limited agency. The transformation narrative also reproduces a central tenet of addiction treatment discourse: when addicted persons are helped to become 'aware' of their limitations, they may become more authentic human beings (Carr, 2011). These metaphors around transformation produce a particularly individualised treatment response:

> [Recovery] kind of moves away from the relapse prevention, harm minimisation model and moves into a deeper internal process and describing what that process is. That's recovery for me, it's coming out and [… looking at] the journey of recovery. It's recovery from our own selfishness and our own egocentricity. It's recovery from being totally focused on the self to a movement to starting to focus on the other and

> how counter-intuitively, happiness is achieved when one focuses on the other rather than the self […] I think that this kind of idea of a holistic treatment where you look at different areas of your life and move, you know not just the drug and alcohol [use], but looking at all these other areas. I think that's recovery as well, because what it's providing people is the ability to come into insight about 'Oh yeah, I should really deal with that issue around this or that'. (Professional 2, service provision)

When recovery is enacted through metaphors of individual transformation, recovery-focused treatment is imagined and designed to work in service of these metaphors. As is evident in this extract, treatment becomes 'holistic' and is directed towards a 'deeper internal process' and helping people to 'come into insight' so that they might develop a more harmonious relationship with the self. Although this participant was employed in a newly created 'care and recovery coordination' role that emerged from the recovery-oriented reform, the style or local variant of recovery that was practised and elicited tended to draw on much broader ideals and metaphors of recovery, of the kind that Keane highlighted in her analysis over a decade ago. This speaks to the heterogeneity of recovery practices and discourses in Australian settings, and that hybrid models of recovery may be emerging. Earlier discourses of recovery seem to be alive and well but are practised and funded under new names.

In this section I have discussed two ways in which translation takes place via metaphor so that new recovery 'hangs together' in clinical practices. First, metaphors of change, movement and transformation in clinical settings work to translate the political obligations and expectations of 'healthy' citizenship into recovery. Second, metaphor translates and signifies familiar authoritative and popular enactments of recovery into clinical practice and therapeutic discourse. These metaphors turn things that are elsewhere subtle and implicit – such as the obligations of citizenship or the need to change – into a therapeutic variant of recovery in professional discourse and clinical settings.

A new recovery 'itinerary': Drugs and distribution

At the same time that addiction entities are added together in recovery-focused treatment and recovery is enacted through metaphorical acts of translation, other potentially incompatible enactments of recovery are kept apart. In other words, one of the ways in which 'recovery' is made as a coherent therapeutic discourse is through the spatial and temporal distribution of incompatible enactments. Mol uses the metaphor 'distribution' to allude to the process by which sites, or localities, of enactment are sometimes kept apart. For example, she argues that atherosclerosis is distributed over different sites, departments and locations within the hospital building in which she conducted her research. In the following account, Professional 9 (service management) explains the strengths of their residential program by emphasising the 'very vast array' of treatment types and modalities:

> We've got an amazing naturopathy clinic. We've got access to addiction medicines specialists. We've got a unique sort of experiential therapy staff. We also have clinical psychologists. We have a very vast array of practitioners that we've got ready access to in a multitude of modalities. So when anyone arrives now, part of the [Victorian treatment sector] reform that was part of what we wanted to do internally, which sort of all happened at the same time, was we developed [an] interdisciplinary team. So every person that gets referred to us, gets uniquely assessed by this team that's inclusive of clinical psychologists, addiction specialists, [an] assessment nurse, which is a psych[iatric] nurse. We have a naturopath on that team. We have a care and recovery coordinator on that team. There's a role called 'service coordinator' and her focus is on family violence and issues with children. So anyone that would have children that are with DHS [Department of Human Services] or even just children that they've been separated from [their parents] in some way, that's her complete focus.

> So up front, we do a lot of 'what does this person need, like what have they told us they need?' (Professional 9, service management)

Here, the participant describes multiple treatment interventions including naturopathy, addiction medicine, psychology, psychiatric nursing, care and recovery coordination, and service coordination. Reflecting upon this extract, what exactly does recovery *mean* when it includes all kinds of non-specialist health services? Furthermore, what does recovery-focused treatment aim to treat? In Mol's (2002) terms, within this one treatment service there are multiple treatment practices, and each enacts a different addiction reality. As therapeutic interventions, they do not 'primarily yield facts' (as compared to the scientific enactments of new recovery I examined in the previous chapter): 'they are supposed to change the object with which they interact… They enact an object by altering it' (Mol, 2002, p. 89). As such, through the therapeutic use of nutrition and herbal supplements, the naturopathic clinic enacts addiction as an imbalance in the immune system or physiological condition; through counselling, addiction is a cognitive and behavioural maladaptation or an effect of trauma; and through clinical assessment, addiction is a composite object of accommodation, employment, family circumstances, mental health problems, and alcohol and other drug use.

Here, then, there are incompatibilities. The addiction object diagnosed by the assessment nurse is not the same addiction object treated by the counsellor. Although these enactments of addiction are divergent, the disorder of 'addiction' is still treated as a unified matter-real condition (and may be put back together as a 'composite' object by the interdisciplinary team assessment). This coordination is achieved, in part, by the spatial and temporal distribution of recovery-focused treatment that separates contradictory or incongruent enactments of addiction across different locations in residential treatment. The naturopathic site has a local variant of addiction, as does the counselling clinic. The spatial separation means that these various enactments do not necessarily clash or pose a problem. Instead through the 'care and

recovery coordinator' or other case managers or clinical practices, the patient is located on an 'itinerary' (Mol, 2002, p. 116) – moving from one site, one local variant, one situation, to another. In this way there is no imperative for different addiction objects to cohere. However, this is not to suggest that at times different treatment modalities do not clash or produce tensions that need to be resolved. As I explore in the following chapter on treatment, when addiction entities clash, they provoke confusion and tensions that usually require resolution through treatment subjects' admissions of failure and disorder.

In addition to spatial distribution, accounts of treatment practices – particularly those relating to the regulation of drug use – suggest that recovery is also coordinated into a common entity via the distribution of different recovery enactments across clients. This is perhaps most clearly demonstrated when I consider how recovery-focused treatment can be constituted through abstinence, methadone maintenance and even recreational alcohol and other drug use. Aside from opioid substitution therapy, most forms of residential treatment require clients to be 'drug free'. Prior to entering therapeutic treatment, clients usually undertake a period of withdrawal from alcohol and other drugs at a separate detoxification facility. The requirement of abstinence in order to begin residential forms of treatment enacts drug use not as the problem to treat but as something that must be removed as a necessary precondition to providing treatment. In this sense, this requirement enacts the treatment problem as the 'underlying' behavioural or emotional 'problems' that 'cause' addiction. However, abstinence is not always a prerequisite to treatment. As I mentioned earlier, some clients are enrolled in residential treatment to reduce or withdraw from methadone maintenance. The same professional explained how methadone reduction relates to recovery:

> I mean we've got people [in treatment] that want to come off methadone. We're funded to reduce methadone. Not all of them come off the methadone, like all the way off. If they think they're in some sort of recovery process, then good on them. I think

> if the person that's down at the therapeutic community to be abstinent, thinks they're in a recovery process, then good on them as well. (Professional 9, service management)

Here, different enactments of recovery are distributed across different treatment clients. For example, the treatment provider notes that some people access treatment to reduce their methadone dose and 'if they think they're in some sort of recovery process, then good on them'. Methadone-assisted recovery is constituted through the regulated ingestion of methadone. Not only this, but recovery is enacted via the methadone because of its purported capacity to 'hold' or 'stabilise' a reduction in the client's desire for other opiates. Therefore, this also involves an act of translation in that methadone is recast as a therapeutic aid.

Also evident in this enactment of methadone-assisted recovery is recovery as a process – a temporal phenomenon – a process of reduction and recovery that occurs over time. This enactment sits in contrast to other enactments of recovery as abstinence, which also emerge in scientific, professional and treatment practices. Clearly, recovery enacted as abstinence is constituted through the absence of drugs. Although these enactments of recovery mutually exclude each other, in that recovery constituted through abstinence cannot include methadone, and methadone-assisted recovery cannot include abstinence, these realities do not appear contradictory or incongruent because they are distributed over different clients. Another example of distribution became apparent in an interview with another service manager. I mentioned that I had heard reports that although this particular treatment facility was abstinence-based, some participants resumed moderate alcohol and other drug use following treatment. The service manager responded with the following explanation:

> There's a whole lot of recreational drug use out there. We don't have a black and white view around drugs per se. Drugs are just drugs and most drugs have some

> potential for medication and there's going to be a whole lot of new medications that come out of cannabis. It's how people use them, the frequency of the dose, what they're being used for, all the underlying people problems that are the problems, not so much the drugs. When you address those, people's drug use suddenly gets completely changed […] We have a lot of people that have absolutely incorporated alcohol use into their lives in various ways, very successfully and in no way, shape or form do they or anyone else here see that as a lapse or them not having been in recovery. (Professional 4, treatment provider)

Although the residential treatment facility was abstinence-based (the program rules included no alcohol or other drugs), it was not uncommon for people to reintroduce alcohol and other drugs into their lives after treatment. As the treatment provider explains, this reintroduction is not defined as a 'lapse'; instead these people, too, are enacted as 'in recovery'. Here, drugs are abstained from during treatment in order to enact recovery but later, when treatment finishes and people are once again living in the 'community', drugs may be reintroduced 'recreationally' as part of a healthy recovery. The spatial and temporal distribution of recovery enactments (abstinence and recreational drug use) is dependent on a temporal notion of progress and change. To this end, common to most professional accounts was the notion that recovery was an ongoing and lifelong journey rather than a finite process.

Indication criteria: Addiction severity and individual capacity

Different enactments of recovery and the course of therapeutic treatment are distributed across different people by way of 'indication criteria'. As Mol argues, the different realities of atherosclerosis determine the chosen treatment modality, for example, as something to be 'circumvented', something to 'scrape away' or something to 'push aside'. These different atherosclerosis and treatments are distributed over different clients by means of 'indication

criteria'. These distributive tools 'link patient characteristics to one of the available treatment strategies' by describing and establishing the characteristics and severity of a disease object (Mol, 2002, p. 101). To illustrate her point, Mol uses the example of the length of the narrowing in a blood vessel (stenosis), which determines which treatment modality will be employed. In contrast to the physical specificity of atherosclerosis, 'recovery' has not yet been attributed to authoritative physical sites in the body (although the field of neuroscience is increasingly claiming recovery via theories of neuroplasticity) (Blum et al., 2013; Erickson & White, 2009; Galanter, 2014). Despite this aetiological ambiguity, different interventions and enactments of recovery – as abstinence, as methadone-assisted and as recreational use – are still distributed across different treatment clients. This is achieved through indication criteria. In treatment, the main calculus that determines the distribution of treatment is, as Mol observes, heterogeneous. It contains both the clinician's assessment of the 'primary problematic drug' and the client's 'capacity' for recovery, along with the client's treatment preferences.

Later in the interview, the service manager who had discussed the reintroduction of alcohol and other drug use following treatment explained how decisions about particular kinds of treatment are made:

> If you've come in here after twenty years, where alcohol has been your primary problematic drug, then it's highly likely that even if you wanted to institute controlled drinking after a program like this, you're probably not going to ever choose that. The staff would probably never support you one hundred per cent to go down that path because a lot has probably shown you that that's not going to work for you around alcohol […] However, if heroin or amphetamine or cocaine or cannabis has been your primary drug of choice, and you've done a whole lot of work on the behaviours that led you to use particular drugs in particular ways, and you've got stable housing and

> you've got a new job, and you want to go out on any night of the week or at home and have a drink and you're crystal clear that that's not a trigger for you to relapse [...] Many people haven't had great experiences of using any drugs in a sort of moderate way. There are some skills to learn around that, but again as I said, our goal is to help get people to a point around expectations that the general community has and the majority of drug use in the general community is a glass of wine with a meal, a few extra drinks at a party or a wedding or whatever. (Professional 4, treatment provider)

This account suggests that a heterogeneous set of indication criteria determines how recovery comes to be enacted in treatment. First, there is the assessment of the client's 'primary problematic drug'. In a clinical context, the enactment of a primary problematic drug tends to ascribe to a particular drug a pre-determined form of malign agency (Hart, 2016). Drug use is centralised in the client's life narrative as the most powerful agent producing harms. In this way, other social forces that might be implicated in the problems experienced by clients are disregarded or relegated to a lesser status. In this account, the enactment of alcohol as the primary problematic drug underscores an informal assessment as to which therapeutic treatments are most appropriate for clients. For example, the service manager suggests that if alcohol had been the primary problematic drug, then it would be highly unlikely for a client to institute 'controlled drinking'. The service manager also provides another example. He suggests that 'if heroin or amphetamine or cocaine or cannabis ha[d] been [the treatment client's] primary drug of choice' and they were in secure housing and employment, a 'drink' or 'moderate use' might be an option. In these examples, the particular assessment of the primary problematic drug – that is, whether it is alcohol and or an illicit drug – determines whether to support the client to 'go down that path' of controlled use or to recommend abstinence. However, it is unclear whether the treatment provider is suggesting that moderate or recreational use of alcohol is appropriate because the particular primary problematic drug

is *not* alcohol or whether moderate alcohol consumption is more in line with the general expectations of the community. Notwithstanding this ambiguity, the establishment of a primary problematic drug functions in a clinical context to determine the types of treatment modalities considered most appropriate for a client.

The indication criteria also include the clinician's assessment of the capacity of individual clients to manage their drug use through abstinence or controlled use. The assessment of a client's capacity for control is informed not only by the determination of the primary problematic drug but also by the length of problematic use and an informal assessment of how much therapeutic work a client had already done to address the underlying 'behaviours that led [the client] to use particular drugs in particular ways'. As the treatment provider suggests, part of the therapeutic work of treatment is to acquire detailed self-knowledge about one's 'triggers' and the necessary 'skills' to use alcohol and other drugs 'moderately' in line with 'community expectations'. The assessment of the client's capacity to control their drug use also includes an assessment of their housing and employment status. In this respect, a professional assessment as to whether a client has accumulated enough knowledge, skills and resources to be able to control their drug use in line with community expectations functions to facilitate different therapeutic treatments and professional interventions or to warn against others. It is perhaps unsurprising that both indication criteria – the assessment of addiction severity and individual capacity – shore up professional knowledge as authoritative and knowledgeable. As I demonstrate in the following chapter, similar power relationships structure treatment practices and the therapeutic encounter, enacting the treatment subject in similarly unsophisticated and problematic ways.

Conclusion

In this chapter I continued my examination of enactments of new recovery, their assumptions about drug use and about people who use drugs, and their political effects. My analysis here mapped the organising relations operating in and through professional practices. Following Mol (2002), I argued that these relations – addiction, translation and distribution – coordinate different recovery enactments into a relatively coherent entity for therapeutic and treatment purposes. Although new recovery is routinely referred to in the scientific and advocacy literature as difficult to define and as exceeding simple definition, institutional requirements compel professionals to make recovery a stable and serviceable concept. Not only do alcohol and other drug practitioners need to address clients' clinical requirements, but in Victoria they are held accountable through activity and performance monitoring of treatment targets that demonstrate progress and a recovery-oriented approach (Department of Health, 2013a). This chapter presented several forms of organisation that help new recovery to 'hang together'. First, I analysed how professional knowledge of recovery adds various addiction and recovery entities together to form a coherent psycho-social object. Second, I examined how metaphor functions as a form of translation in professional accounts, neatly condensing obligations around citizenship, progress and change into a therapeutic rationality of recovery. Third, I traced how order is maintained in clinical knowledge and treatment through the distribution of potentially incompatible enactments of recovery across different spaces and bodies. This was aided by the use of particular kinds of indication criteria, which ultimately reproduced professional judgement as authoritative.

Although I have foregrounded how professional socio-material practices enact and elevate a singular and independent reality of recovery, it has not been my intention to suggest that alcohol and other drug professionals knowingly employ organising strategies to deceive clients. Rather coordination responds to political rationales, scientific knowledges and the

organisation of treatment, which aim to service and treat a singular disorder of 'addiction'. Organising relations emerge at the point when alcohol and other drug professionals must decide what action to take and, shaped by specific medical and scientific knowledges and practices, what treatment to provide.

In this sense, professional accounts of recovery reflect and reproduce the complex ontological politics of new recovery that I have tracked so far. In tracing the organising relations that make recovery 'hang together', I have also gestured towards the multiplicity and hybridisation of the realities reproduced and inaugurated in professional practices and knowledges. Currently, professional accounts and practices enact recovery in normative and familiar ways, in accordance with both the rationales laid out in new recovery and older existing notions of recovery. Addiction is routinely enacted as the 'problem' to be treated in a guise familiar to new recovery and to older forms, in that it commonly fails to adequately account for social and political forces. In a familiar move, the drug-using subject is enacted as the primary target of treatment and framed as wholly agential. Recovery is enacted as a form of social identity change, a journey of self-development and growth, the development of an authentic self, the practice of healthy citizenship, abstinence, and maintained or controlled recreational use. It is evident that at the same time that elements of new recovery are reproduced in professional practices, they continue to rely on existing, more diffuse discourses of recovery.

The multiplicity evident in professional knowledges and practices again raises questions about what new recovery means, and what it might offer above and beyond the 'recovery' already made popular and influential by 12-step fellowships, self-help books, spiritual discourses and some residential forms of alcohol and other drug treatment. As Professional 4 said, new recovery is so vague and malleable that it has not required substantive change in practice. This statement offers some explanation as to why, perhaps, new recovery was

influential in Victoria, in that recovery was so open to interpretation that it could be used to describe most things and to justify a wide range of existing and available responses. However, if new recovery is this broad and open-ended, if it does not substantively change existing practices and if it is not dissimilar to that which has come before, then what of its claims to uniqueness and its effectiveness in treatment? I address this question in the following chapter by examining recovery-focused treatment and therapeutic practices. I ask, how does this multiplicity play out in the lives of clients, how do people engage with recovery in treatment and what exactly does recovery-focused treatment demand of them?

Chapter 7

Interpellating new recovery:

The politics of 'identity' in recovery-focused treatment

In the previous chapter I examined professional accounts of new recovery, arguing that the practices of addition, translation and distribution that work to make recovery a stable and serviceable concept also contribute to its multiplicity and instability. Furthermore, when 'recovery' cohered, it emerged as a composite concept, reproducing older discourses and metaphors, contemporary maxims, and scientific and popular associations. These hybridised enactments of recovery were different from the recovery enactments I tracked in Chapters 4 and 5, yet they too were marked by continuity and disarray. Policy enactments of recovery were rooted in familiar pathologisations of drug use and people who use drugs, with increasing responsibility for recovery assigned to an illusory concept of 'community'. Psychological scientific research on new recovery reflected and reproduced normative judgements about the constituents of a meaningful life and of proper conduct. Although recent research has increasingly focused on groups and social resources, individuals and their behaviour remain the focus of research while the social conditions and entrenched political relations that shape opportunity and people's lives continue to be erased.

In this chapter, I explore similar vacillations between singularity and multiplicity and between continuity and change in the enactment of new recovery within recovery-focused treatment settings. I also begin to address my second research question about how people who use drugs experience and accommodate new recovery in treatment. As might have been suggested by the focus of professional practices and discourses in the previous chapter, recovery-focused treatment tends to cohere around the treatment of a particular type of

addicted drug-using identity in need of recovery from 'addiction'. This rationale has political effects insofar as it constitutes a limited range of abject subject positions that delimit the narratives available to people through which they can account for their troubles and hopes for change. In this chapter, I examine how the social and material practices of recovery-focused alcohol and other drug treatment are themselves active in the constitution of this 'recovering addict' identity. Using Judith Butler's theorisation of interpellation and its recent mobilisation in STS, I examine the accounts of treatment experiences and practices provided in interviews with people who inject drugs. I argue that the 'recovering addict' is not a coherent psychological identity but rather a socially produced category. I consider the production of this category in relation to three dynamics identified in the data: 1) the tendency in therapeutic models of addiction to materialise treatment subjects as both disordered (because of unresolved trauma, unmanageable emotions or disease) and as 'in control' of these disorders; 2) the production of treatment subjects as enmeshed in suspect social relationships and therefore requiring surveillance as well as social support; and 3) treatment's particular enactment of social context such that it erases stigmatisation and marginalisation and paradoxically performs individuals as entirely responsible for relinquishing drug use. As I will argue, these dynamics produce capacities and attributes often ascribed to identity but which are better understood as articulations of epistemological disorder in the state of knowledge about addiction, and its expression in treatment. Like my observations about the hybridisation of recovery via professional practices, treatment practices enact recovery in ways consistent with older notions of addiction and the 'addict' identity (Aston, 2009; Carr, 2011; Weinberg, 2000) as well as producing the rationales of suspect social relationships and sociality, and of responsibilisation, associated with new recovery. By way of conclusion, I question the utility of 'recovery identity', conventionally defined, in providing a rationale for treatment.

In developing this critique of the 'recovering addict' identity, I draw on participants' accounts of their experiences of recovery-focused treatment in Victoria. To ensure my analysis was of recovery-focused treatment, I drew specifically on participants' accounts of residential treatment and time spent in therapeutic communities. These accounts are drawn from interviews with 14 participants with experience of residential treatment. The residential treatment programs were characterised by a focus on helping clients to develop intimate self-knowledge about their consumption patterns and former behaviour. The therapeutic settings, treatment programs and length of treatment differed but the organisational structures of group work, individual counselling, community participation and daily routines were similar. Broadly, the drug treatment programs in Victoria were characterised by a focus on individual change, wellness and recovery, which although not explicitly centred on abstinence, required abstinence from illicit drugs and alcohol as a prerequisite and condition of ongoing treatment. These interviews were semi-structured and explored participants' experiences of drug use, treatment and social relationships, and their experiences and understandings of recovery.

The hybridisation of recovery that I have so far identified and tracked across three different sites makes it difficult to distinguish between older modalities of recovery-focused treatment and contemporary treatment modalities and approaches that might be representative of new recovery. In examining the social and material dynamics of treatment, my analysis picks up on this ambiguity. While new recovery might gain traction in policy and psychological science, residential recovery-focused treatment performs its subjects in familiar and outmoded ways that challenge many of the empowering and transformative claims of new recovery made across the sites I have examined thus far.

Recovery-focused treatment

As I noted in the Introduction, the reform of the Victorian treatment system attenuated the version of new recovery that was proposed in the Victorian reform documents and subsequent alcohol and other drug policy that I analysed in Chapter 4. However, despite the diminution of new recovery ideals and practices in the reformed treatment system, the analysis I undertake in this chapter suggests that concepts of recovery (in ambiguous, hybridised and contradictory forms) have shaped and continue to shape the lives of many people who seek residential, therapeutic-community and self-help treatment. Therapeutic communities have historically placed great emphasis on recovery-oriented interventions (Yates, 2011). In these settings 'peer community' is used to facilitate social and psychological change in individuals (De Leon, 1994). The daily routine and structure of these communities is marked by rigidity, pressure, hierarchy and the strict deployment of rules (Yates, 2011). These rules are thought to provide healthy behavioural cues and motivate positive identity change among residents (Best, Haslam et al., 2016; Yates, 2011). Recovery-focused ideals and practices are also found in other residential treatment settings, withdrawal services, counselling and self-help groups. While few studies have been conducted on clinicians' attitudes to 12-step recovery in Australia (Best, Savic et al., 2016) and the developing model of recovery-oriented care in Victoria (Pillay et al., 2016), to my knowledge, no sociological research has examined how those enrolled in treatment in Australia view and experience new recovery or recovery more broadly.

The chapter begins to address this absence by examining experiences of recovery-focused treatment. I contend that treatment is an active site of knowledge production about addiction and recovery as well as a key resource for the cultivation of drug-using and recovery identities. In the analysis to follow I draw out the multiplicity of addiction knowledges, models and treatment practices in operation, examining and mapping the particular socio-

material sites and practices constituting recovery-focused treatment. In doing so I ask the following questions: How does recovery-focused treatment interpellate those in its purview and what kinds of subjects are inaugurated in this process of interpellation? What modes of ordering addiction are mobilised in 'successful' treatment? And what unintended consequences emerge from the contradictions between and within the modes of ordering with which the drug-using subject must engage, and from which must arise new subjects? The authoritative modes of ordering new recovery in policy, science and professional practices produce drug-using subjects as pathological and less-than-full citizens, yet also as rational, responsible and capable of transformation and entirely in control of their social environments and lives. The account of recovery-focused treatment I offer in this chapter points to the ways in which the organisation of treatment and treatment practices reproduces these stereotypes and normative enactments of the 'recovering addict', undermining the treatment demand that clients recover and the ability of treatment subjects to do so.

The politics of the subject

In this chapter I draw on Butler's theorisation of interpellation and its recent reworking in STS attention to modes of ordering. This conceptual approach is useful because it privileges the action of socio-material practices in the enactment of subjectivity, thereby decentring the agency or 'identity' of individual subjects. STS approaches to subjectivity have developed in tandem with feminist and poststructuralist thinking around agency and the subject (Fraser & Seear, 2011; Law, 2004, 2011; Seear, 2014). One of the key contributions of this work to the social sciences is its dismantling of the standard Enlightenment subject: the universal, unified and rational subject seen to underpin socio-material relations, practices and discourse (Fraser & Seear, 2011; Seear, 2014). For theorist Judith Butler, subjects are produced through iterative socio-material practices, and these are characterised by dynamics of inclusion and exclusion. As Butler (1993) explains, it is only through the identification, production and

exclusion of a range of abjected Others, who 'circumscribe the domain of the subject' (p. 3), that the legitimate and intelligible subject comes to be formed. This abjected Other haunts the domain of legitimate subjectivity. As Fraser and Seear (2011) argue, 'The abject is a "site of dreaded identification" for the subject, thus the abject exists in counterpoise to the subject, against whom it is produced through forces of exclusion' (p. 118). These processes of mutual constitution can be drawn on to illuminate the issues under scrutiny in this thesis: the role and function of new recovery discourse and practices in shaping our understandings of drug use and the agency of people who use drugs. They remind us that the 'the addict' and the subject of recovery are thoroughly entwined, remaking each other across the cultural and symbolic poles of virtue and vice, health and sickness, legality and deviance, freedom and coercion, self and other.

Exactly how are subjects made in these processes? Butler makes use of Louis Althusser's (1971) term 'interpellation' to describe the way in which subjects are inaugurated into discourse. According to Althusser, subjects come to recognise themselves through the ubiquitous process of being 'hailed' (as when a policeman calls out 'Hey, you there!' and we automatically turn in response – that is, we recognise ourselves as the objects of regulatory discourse). As Butler (1997) explains, however, 'the interpellative name may arrive without a speaker – on bureaucratic forms, the census, adoption papers, employment applications' (p. 34). Here, interpellation is not a single performative act but rather a socio-material 'circuit of recognition' (Jackson & Mezzei, 2011, p. 74) in which the subject is materialised via repetitive and interrelated acts of hailing, many of which are abstracted and bureaucratic in nature.

STS scholars such as Law (2000, 2004), Mol (2002) and Moser (2005, 2006) also work with (and adapt) interpellation, relating it to 'modes of ordering'. For Law, interpellation needs to be disarticulated from Althusser's notion of 'false consciousness', that is, from his belief in

the distinction between science and ideology, and in the idea that oppressed subjects can be freed of false beliefs through science's ability to tell us, finally, the truth of our social and political conditions. According to Law, interpellation relates to particular modes of knowing, none of which are true as opposed to false. Instead, all are 'arrangements that run through and perform material relations, arrangements with a pattern and their own logic' (Law, 2000, p. 23). Law reframes these socio-material arrangements as 'modes of ordering' that generate complex patterns of interpellation that perform multiple, and often contradictory, subject positions (and of course, objects and other phenomena too). Ingunn Moser has been particularly instructive in relation to subjectivity because of her detailed research into the enactment of disabled subjectivities in everyday life. Moser's (2006) starting place for (disabled) subjectivities is that 'disabled is not something one is but something one becomes, and, further, that disability is enacted and ordered in situated and quite specific ways' (p. 373). Of particular interest for Moser is how people slip and move between multiple modes of ordering disabled subjectivity. She looks to everyday life 'as the location where these ordering practices meet and enact their normativities, more or less together' (Moser, 2005, p. 671). In this approach, one mode of ordering does not cancel out the other; they co-exist but also interfere with one another. Reorienting research using these ideas brings into view how social and political arrangements 'recursively perform themselves through different materials – speech, subjectivities, organizations, technical artifacts' (Law, 2000, p. 23), or, in Moser's example, how disabled subjectivities are animated and ordered through accommodation to, and/or rejection of, new technologies, devices and instruments. Here, it is important to note that modes of ordering do not necessarily solidify and become unassailable or preclude dissent or resistance. According to Butler (1993), the recursive process that maintains social and political arrangements – 'iteration' – always 'produce[s] a set of consequences that exceed and confound what appears to be the disciplining intention' (p. 82).

The spaces between repetitions, she argues, can allow error, disarticulation and novel formations (Butler, 1993).

These insights underlie my examination of the socio–material practices that govern, regulate and order the lives of people who inject drugs. In particular, it allows me to trouble one of the key regulatory assumptions underlying alcohol and other drug policy, treatment and research: that a singular anterior reality of addiction resides within the disordered identities of alcohol and other drug clients, and authorises the need for recovery.

Modes of ordering addiction

This chapter addresses the second aim of my thesis, which is to consider how people who use drugs adopt, accommodate, resist or otherwise engage with new recovery in and through treatment. I begin my analysis by considering how modes of ordering addiction materialise treatment subjects as both disordered and as 'in control'. In the next section I consider the interpellative logics of social connection, the injunctions they produce and the 'insecure' and 'hyper-vigilant' subject positions they engender. Finally I examine how the simplistic mode of ordering 'social context' in treatment interpellates a responsibilised subject as entirely responsible for avoiding and managing threats to recovery. I briefly examine some accounts of 'triggers' and 'relapse' to counterpoise these enactments.

Disorder and control

As I suggested above, modes of ordering addiction interpellate consumers of alcohol and other drugs as 'disordered' in various ways (e.g. as compulsive, chaotic, isolated, deviant, traumatised or diseased) and mobilise treatment as a way of reinstating 'order' (e.g. as leading to stability, recovery and productive citizenship) (Fox & Ward, 2009; Fraser & Moore, 2008; Seear & Fraser, 2010). This interpellative logic is evident in the therapeutic technologies that order treatment group work and counselling. One participant, George (male,

47, consumer, residential rehabilitation),[7] described being interpellated into a particular view of his drug use during a three-month stay at a residential rehabilitation service. Here he learned about the 'cycle of addiction' in a 'relapse prevention' group:

> To be shown the cycle of addiction put on a board in front of you … you can actually really understand how the cycle works and if you've been through that cycle enough times, you can actually picture the stages that you've been in. So that's a good way to recognise what stage you are in your cycle at the time […] Why would they have – what's it called – 'Relapse Prevention' if it wasn't a relapsing condition?

In this passage, George describes taking part in structured group work, a common, sometimes daily, practice in recovery-focused residential treatment (Yates, 2011). The focus and purpose of the group are unclear in George's interview, but therapeutic groups commonly focus on learning how to regulate emotions (such as anger), prevent relapse, develop life skills, build relationships and communicate effectively. According to George, this particular group teaches him about the mechanisms of addiction and how they relate to his thoughts and behaviour. Given the many models of addiction currently deployed in policy, research and practice (Karasaki et al., 2013; Moore & Fraser, 2013), it is difficult to know which model of addiction was at work in this group. Several widely used therapeutic models represent addiction as a 'cycle' of 'stages' involving emotional triggers, uncontrollable or overwhelming feelings of craving or compulsion, relapse into ritualised or repetitive drug use, and feelings of guilt and shame. It is possible that George encountered the common 'stages of change' model of drug use (Prochaska & DiClemente, 1986), which posits five stages: pre-contemplation, contemplation, preparation, action and maintenance, and

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[7] In Chapter 6, I avoided specifying age and agency type when presenting alcohol and other drug professionals in order to preserve anonymity. Here, I return to a more conventional format when presenting the demographic characteristics of people who consume alcohol and other drugs.

‘classif[ies] people according to […] their readiness for change’ (Thomson, 2014, p. 180). Whichever model is in operation here, the key point is that the therapeutic encounter interpellates George to order his past (and future) behaviour and self in the terms provided by a ‘relapsing’ model of addiction.

However, interpellation and the kinds of subjects it inaugurates are not established forever by single events but unfold in repetitive and interrelated acts of hailing and iteration (Aston, 2007). Thus, moments after George describes the group work, he goes on to describe a different treatment modality operating within the same residential setting – ‘counselling’. He explains that he came into contact with the idea of recovery through counselling and learnt ‘why [he] drank and ways to deal with [his] anxiety’:

> I didn’t even know what anxiety was until five years ago […] I learnt what it was. I thought the feelings that I was having when I was lying in bed, I didn’t even know it was anxiety […] Once I got the anxiety, I would use [alcohol] to stop the anxiety, because I’d rather be drunk than deal with the anxiety, but only now, in the last couple of years, I’ve found out that [drinking] brings on the anxiety so much worse.

While the therapeutic group George encountered in residential rehabilitation treatment rendered addiction as a broad ‘relapsing condition’, his clinical counselling experience offered a distinctly psychological mode of ordering addiction. Here he was taught how to link his drinking to unmanageable feelings, and through this formulation, ‘found out’ that his drinking further compounded these feelings. Both treatment modes perform versions of a disordered subject: individual behaviour (a relapsing condition) and emotions (anxiety) are the primary causes of addiction and the primary objects of treatment.

George also described encountering a different disease concept of addiction in NA and AA. Proponents of new recovery call for ‘assertive linkage’ procedures between addiction

treatment programs and recovery-focused mutual aid groups (White et al., 2013). While self-help programs are not a central component of publicly funded alcohol and other drug treatment in Australia (Ritter et al., 2011), many participants had attended self-help programs such as NA, AA and to a lesser extent SMART (Self Management and Recovery Training) Recovery. For George, it was in the 'AA and NA rooms' that he 'really did learn that addiction was a disease':

> **George**: Well, I didn't really think it was worth giving it [recovery] a really hard shot, until I really did learn that addiction was a disease. So I think if you've got the disease, it can be treated or managed and maybe you can get rid of the disease, do you know what I mean? So once I came to believe, or [was] brainwashed into believing it was a disease, then it gave me, in my mind, [the idea that] 'right, this can be fought against'.
>
> *Renae: You said you believe it's a disease but you just said then 'brainwashed' into believing it was a disease. What do you mean?*
>
> **George**: Because I've heard more about it being a disease in the [AA and NA] rooms than I have from clinical doctors or counsellors [...] I wouldn't say I was brainwashed into it, but if I was, good, because now I believe it's a disease and it can be treated.
>
> *Renae: So knowing it's a disease allows you to think that there's a kind of possibility to treat it?*
>
> **George**: One hundred per cent [correct]. Before that I had given up on thinking it was.
>
> *Renae: Right, because beforehand what did you think?*

> **George**: I'm just screwed. Yeah, just screwed, pretty much, and I'm going to die like that, and I was quite willing to, yeah, quite willing to for sure.

In this excerpt, George expresses a complicated relationship to the multiple and contradictory modes of ordering addiction to which he had been exposed in treatment. Prior to attending NA or AA, George thought he was 'just screwed'. This is perhaps unsurprising given the subject positions made available to him were chronic relapser or anxious drinker. Both modes of ordering rely on circular interpellative logics that foreclose the types of change, choice and 'positive movement' to which new and older forms of recovery aspire. Thus, in order for George to feel he could recover, he first needed to recognise himself as diseased (a hailing central to older recovery discourses). In order to make addiction treatable – or, as George says, something that can 'be fought against' – he needed first to make addiction a treatable object. To do this, he privileged the disease concept of addiction over other concepts to which he had been exposed (invoking in passing a notion of 'brainwashing' very close to the Althusserian 'false consciousness' Law rejects). Here, the interferences between co-existing modes of ordering addiction are momentarily settled through George's acceptance of the terms of addiction laid out in 12-step fellowships – that he has a 'disease'. Through his identification with a diseased addict identity, George manages the various tensions and subjectivities they inaugurate. His options are limited, however, in that all of the available interpellative logics of addiction downplay his agency and produce him as disordered.

Most significantly, my analysis suggests that the disorder and contradiction so readily located in addiction and those defined as addicted emerge just as forcefully or more so between and within professional modes of ordering in the contradictions, incoherencies, uncertainties and interferences they enact. This has significant implications for how we understand the agency of drug-using subjects. As has been identified in other contexts (e.g. Fraser & Seear, 2011; Seear, 2014), medical and scientific knowledge tends to assume that any apparent disorder,

incoherence and instability in an object of study arises from that object of study. Framing uncertainty in this way obscures the limitations of medical and scientific knowledge and, indeed, authorises the ongoing need for new theories to establish the 'truth' of any given object of concern. One way coherence is achieved in treatment modes is through the interpellation and performance of damaged subjecthood. Unlike the rhetorical devices lodged in medical strategies that function to legitimise the 'heroic' and scientific character of medicine (Fraser & Seear, 2011), George's description of himself as brainwashed reconciles scientific and professional differences via a self-characterisation that hints at many of the assumptions so closely aligned with addiction – that he is coerced, without free will and not fully in control – a disordered subject. In treatment, it is not researchers and scientists who must manage the ambiguities and contradictions of modes of ordering addiction, but service providers and the already devalued and stigmatised drug-using subject.

Although these contradictory modes of ordering addiction are characteristic of broader long-standing accounts of addiction recovery, other treatment modes of ordering reflect and reproduce dynamics more readily associated with new recovery. I turn to these now.

Suspect social relationships and surveillance

So far, I have examined how existing modes of ordering addiction interpellate an unstable, emotional or diseased treatment subject, and how those enrolled in treatment must manage the interferences between these modes. I now turn to a second dynamic in recovery-focused treatment. As I highlighted through my analysis of social identity in Chapter 5, the social relationships of drug users, like those of other marginalised and stigmatised groups, continue to be considered deviant, and therefore ripe for governmental and public health intervention (Lancaster, Santana et al., 2015). Concerns about the suspect sociality of those who consume drugs acquire a particular valence in new recovery discourse given policy's attentiveness to

social connections and to community reconnection and reintegration following treatment (MCDS, 2011; Department of Health, 2012a). This attentiveness is reproduced in formal expectations that those enrolled in treatment will develop 'non-drug using' social relationships and 'supports'. One service provider explained how developing 'social connections' was a key topic of discussion in the planning groups convened to assist people with 'their reintegration back into the community':

> In their planning groups [… clients were always] having to demonstrate the levels of supports that they had, demonstrate the plans that they had in place to strengthen some of the relationships, including families, and what steps they were making towards developing new ones, as well as all those fundamental skills that we thought were critical to people being able to build good social connections. (Professional 4, service provider)

This account offers important insights into how a new recovery-focused treatment mode of ordering materialises 'recovering addict' subjects and their social relationships. The emphasis on strengthening non-drug-using social relationships as an aid to recovery reflects and reproduces the focus on recovery-oriented groups in the social identity model of recovery. In this sense, it has the potential to reproduce the social relationships of drug users as suspect and as a target of therapeutic concern and rehabilitation (Yates, 2011). Through the interpellation to continually demonstrate evidence of recovery-focused social relationships, and the 'steps they were making toward developing new ones', treatment clients are performed as marginalised from civic life (Lancaster, Santana et al., 2015) and embedded in dubious social relationships. The treatment subject must recognise and accept the need to develop 'good social connections' as a key step in recovery.

Within this mode of ordering, self-knowledge, forward planning and the development of skills are considered to be important elements of treatment retention and the achievement of wellbeing and recovery. However, the widespread stigmatisation of people who use drugs is perhaps even more significant in shaping people's access to social support and improved health outcomes (Fraser & Treloar, 2006; Lloyd, 2013). People who use drugs are highly stigmatised by the general public and professionals alike. This has the potential to lower self-esteem and to hinder the achievement of recovery-focused goals and norms evident in policy and science, such as participating in the community and securing stable employment (Lancaster, Santana et al., 2014; Lloyd, 2013). Yet, the interpellative logic underlying the injunction that individuals must cultivate social support obscures the social and political forces that make the creation of these 'social connections' challenging. Although treatment interventions designed to encourage increased social support might be intended to ameliorate the isolation felt by many people after leaving treatment, they also downplay the stigma associated with drug use and treatment. Like the psychological scientific enactment of new recovery, structural dynamics and patterns of inequality and opportunity are ignored.

In addition to problematising the social relationships of people who use drugs, the treatment focus on developing social connections sometimes engenders feelings of anxiety and a propensity for self-surveillance among those enrolled in treatment. For example, Calev (male, 31, consumer, NA) began to question whether his relationships with people were 'good enough':

> [Treatment staff] kind of drill it into us that we have to be talking about our feelings and have these emotional[ly] close bonds and make real friends. It was almost like you couldn't just muck around with people and have fun […] Every time I was speaking to people, I was really analysing [the communication] because I wanted to be close with people and I wanted to have good friendships […] I was just constantly

> having these deep conversations [and] I was always thinking 'this relationship's not good enough, because we are just talking about random stuff'.

Here, Calev reports feeling intense pressure and increasing insecurity about the authenticity of his social relationships. As he explained, the heightened practices of self-surveillance engendered an anxiety that his relationships were 'not good enough'.

Like Calev, Matt (male, 25, consumer, residential rehabilitation) also described treatment demands to cultivate appropriate social relationships. However, unlike Calev, who emphasises the emotional and intimate elements of social relationships, Matt explains that communication in treatment is central to holding people 'accountable' to the aims and objectives of recovery:

> **Matt:** Everyone goes in there [residential treatment] in a really negative head space and all you can really [do to] connect with one another is to talk about what you used to do and how you used to score and use drugs and [commit] crime […] You know, people like to connect and be able to relate to one another and I guess when you first go in there, that's all you've really got. So it's all about holding one another accountable and trying to talk about good, positive things to look forward to in the future. Because if you sit around talking about all that [past] stuff, it can cause people to leave and want to use. [If] you talk negative, you're going to be negative.
>
> *Renae: And when you say 'it's about holding people accountable', what does that mean in practice?*
>
> **Matt**: Well, you know, if I see a peer flirting with a girl or [who] just does nothing but wants to talk about jail or talk about how much they used to use, it's all irrelevant, you know. We're all there to kickstart a new life. So to sit around and talk about our old life, we're still in it.

Matt's account offers important clues about the logics operating in treatment modes of ordering. One of the central tenets of recovery-focused treatment is to improve social connection, a particular and partial version of connection as 'positive', forward-oriented and recovery-focused. Matt's description shares much with conventional understandings of drug users as disordered. In this sense, Matt reproduces the conventional notion that people enter treatment in a 'really negative head space' and with narrow interests such as buying drugs and committing crime. In offering this account he enacts himself as responsible for monitoring social relationships in relation to key issues for treatment progress: gendered moral codes and visions of a positive future. His account, and that of Calev, suggest a tension around sociality: social connection is enacted as normal and desirable, yet the social relationships between people who use drugs are suspect and in need of ongoing monitoring and surveillance. As I have outlined here, one consequence of the focus on social connection in treatment is that, in 'doing recovery', clients can become acutely concerned about the quality of their relationships and in turn increase their surveillance of themselves and others. Thus, insecurity and concern are standard, possibly even deemed appropriate or necessary, effects of treatment modes of ordering addiction recovery.

The treatment provider quoted above (Professional 4) makes this point especially clearly in suggesting that if people 'choose to drink' (after residential treatment), they should be 'asking themselves a series of questions' focused on their social context and relationships:

> Who am I with? Where am I? Is this connected to a particular mood or feeling? Am I using this to avoid? Am I using it just to want to be a part of a fit-in or am I just drinking because [I am] in this particular context, I'm feeling good, I'm with people I trust [and] love. So yeah, there are discussions and strategies around that.

Clearly, participants' insecurity and concern about the emotional authenticity of their relationships, along with close surveillance of their health-promoting capacities, are mobilised as successful strategies to ensure recovery in treatment and beyond.

The politics of responsibilisation

Thus far, I have addressed two of the ways in which recovery-focused treatment interpellates clients in different ways according to particular modes of ordering: in the assignment of agency to treatment subjects constituted as simultaneously 'disordered' and 'in control', and in the enactment of treatment subjects as needing to develop 'good [non-drug] relationships', thus rendering them insecure and hyper-vigilant. These hybridised recovery interpellations are consistent with the normative goals and obligations that have underpinned earlier discourses of recovery aimed at the cessation of drug use and resolution of individual disorder. The focus on monitoring social relationships and sociality also accommodates and reproduces concerns that are central to new recovery. The final theme in my analysis of treatment interpellation and modes of ordering in residential treatment settings picks up on a central issue identified in Chapter 5 on the science of new recovery: depoliticised enactments of social context. Consistent with my previous observations, this has significant implications for the constitution and distribution of responsibility for drug consumption and drug-related harm.

One of the most routine yet rarely mentioned features of residential treatment (but see Weinberg, 2000, for an exception) is the physical separation of people from the social contexts of drug use. Although the 'closed' environment is a taken-for-granted element of the spatiotemporal organisation of residential treatment, it deserves consideration as a practice that participates in, rather than precedes, the production of a recovery identity. This is

because it enacts a controlled and disciplined social context. As Aidan (male, 31, consumer, residential rehabilitation) explains:

> You come in with no responsibility, you know. Basically it's just about getting yourself acquainted with the place and getting yourself comfortable and getting up on time, you know, doing the chores and all that sort of stuff […] When you first get there, you do the house run and you go around, tick everybody's name off, and account for everyone every two hours. You do the phone desk, which is the reception job; do vehicle checks, making sure all vehicles are locked; and there is night work where you vacuum all the rooms when everybody else is in bed. So, yeah, there's those responsibilities. [… Later in the program], you get more serious responsibilities like taking people to court for their [… appointments].

As is evident in Aidan's opening comment, 'You come in with no responsibility', he understands the organisation of treatment to be related to responsibilisation. The authoritarian and regulatory technologies of pre-established wake-up times, roll call, chores and work constitute a highly regimented social environment. Within this environment, treatment subjects are interpellated as orderly, disciplined and (increasingly) responsible.

In the next extract from his interview, Aidan explicitly takes up the enactment of responsibility in his account of scenarios involving new residents and those who have been in the residential program longer (and have been allocated more responsibility):

> Basically [you] have to memorise a piece of paper with, say, that much [holds fingers approximately 10 cm apart] text on it and then you give [other residents] three […scenarios], where, say, one of the responsibilities [is, for example,] 'A [… new] resident finds a bag of contraband in one of the vehicles. What do you do?' And then the [… more experienced] person has to go to you and tell you what you got to do.

> You gotta ‘Stop, don’t touch, have a peer have your back, get the [… new resident] to return, follow the [new resident] back to vehicle, get them to place the contraband exactly where they found it, close the vehicle, lock the vehicle’.

Seemingly, these exercises are designed to teach clients how to identify ‘contraband’ objects and how to respond to them safely and ‘responsibly’. However, there are evident problems with this approach. First, as I have already noted, these tests posit a disordered subject: one who is deviant and chaotic. More importantly, the hypothetical enactments of proscribed objects and responsibility rely upon a specific ordering of the individual, the environment and the encounter. First, the threat to recovery addressed here is simple and obvious in that it relates to ‘contraband’; substances clearly defined by their illegality and proscribed status. In this sense, the threat is easily identifiable and patently undesirable. In turn, the instructions for acting responsibly take the form of rote learning of simple, manageable steps. Here, identifying and responding to objects or situations that threaten recovery require none of the skills and agency demanded of people operating in the complex social contexts of drug use. Furthermore, this enactment of social context performs abstinence from drug use as simply a matter of responsible decision-making and identifying and avoiding threats. As already noted in relation to the injunction to develop social connections, learning to be ‘responsible’ does not address the politics of stigmatisation nor the complex and unpredictable challenges of social life outside residential treatment settings. The shortcomings of a focus on responsibilisation are clearly demonstrated in Rachael’s (female, 33, consumer, NA) account of repeatedly ‘relapsing’ after treatment:

> So I remember doing little plans with them. I’d been there for three weeks and I’d be like, ‘oh cool, when I leave, I’m going to do tai chi’ […But] I would walk out the door and half an hour later, I’d have the fit [needle] in my arm and there goes my tai chi. And I did that over and over and over again.

Another participant, Adam (male, 40, consumer, counselling), identified how the feelings associated with particular cities 'triggered' his heroin use:

> I find that Melbourne is a massive trigger for me […] It's so in your face here […] I moved to Perth for nearly five years, didn't have a problem in Perth at all. Only when I came back to Melbourne for my one or two-week holiday from work, I'd blow out for two weeks and spend a couple of thousand dollars and then I'd go back and be straight for six months. In Queensland, when I'm around good people that are doing the right thing, it's sort of OK.

Rachael and Adam's accounts trouble the simplistic enactment of social context in treatment, and highlight its poor correspondence with the competing demands and emergent desires of life outside treatment settings. Noticeably, in both accounts, the capacity to identify and respond to threats to recovery is limited because these threats are complex, emergent and rarely manageable through recourse to the skills acquired in treatment. For Adam, the rhythms and textures of the city itself were loaded with temptations and 'triggers' (Dennis, 2016). For Rachael, opportunities to use drugs emerged quickly after leaving treatment; within half an hour she was injecting heroin again. Although a highly regulated treatment environment could interpellate her as someone who does tai chi, this interpellation was quickly superseded by another in the complex and dynamic social environment she re-entered after treatment. The speed at which this occurs for Rachael suggests that notions of rational decision-making and responsibilisation are a poor fit for understanding the textures, desires and forces of her everyday life.

The failure of recovery-focused treatment to enact useful and relevant social contexts of drug use is troubling. It is also reflects and reproduces the individualising and depoliticised ontological politics of new recovery that I have tracked so far across several authoritative

sites. As has been noted many times in the literature on drug use, the rhythms of everyday life are shaped by dynamic social and material configurations – including politics, knowledges, bodies, technologies and emotions – that are not always readily amenable to the individualised management of risk or 'responsible' behaviour (Fraser, 2004; Moore & Fraser, 2006; Race, 2012). This is particularly the case for those people who use drugs entangled in configurations of poverty, homelessness, trauma, inequality, stigmatisation and gendered violence. Despite a now lengthy history of critical research highlighting these issues, harm reduction and recovery-focused treatment routinely emphasises individual responsibilisation at the expense of other concerns. As others have highlighted (Fraser, 2004, 2013; Moore, 2009; Moore & Fraser, 2006; Race, 2012), the politics of responsibilisation are produced and reproduced across many material–discursive sites. The existence of publicly funded alcohol and other drug treatment suggests there is a degree of recognition that responsibility for addressing problems associated with alcohol and other drugs is, in part, a public one. However, recovery-focused treatment, in line with most contemporary forms of alcohol and other drug treatment in neoliberal policy contexts, produces subjects as entirely responsible for managing complex social concerns.

Conclusion

This chapter has critically examined participants' perceptions and experiences of the ontological politics of and rationale for recovery-focused research and treatment. Drawing on feminist theory and STS scholarship, I have identified three key dynamics at work in the ontological politics of recovery-oriented addiction treatment. First, I have drawn on participants' accounts to show how addiction treatment modes of ordering have the potential to enact disordered subject positions, while simultaneously interpellating these devalued and stigmatised subjects as responsible for managing the many interferences between modes. Second, I have traced how the familiar new recovery interpellative logics of social connection

produce the social relationships of people who use drugs as suspect and render them insecure, anxious and hyper-vigilant about the quality of their relationships. Third, participants' accounts highlight how the simplistic enactments of social context in new recovery research and treatment interpellate a responsibilised subject easily able to identify and respond to threats to recovery. In sum, these accounts of treatment suggest that the drug-using subject is enacted in recovery-focused treatment as disordered, enmeshed in suspect relationships, and potentially irresponsible. Recovery identities are built here through the cultivation of order, healthy relationships and responsible management of threats.

As I argued at the beginning of this chapter, the hybridisation of recovery in professional and treatment practices, and the enduring commitments to the addicted individual that have been carried over from older forms of recovery into this new iteration, make it difficult to assess the influence of new recovery on treatment. These hybridisations and continuities contribute to the opacity and ambiguity of new recovery and make it difficult to define and identify. They also make new recovery highly malleable, politically attractive and conceptually useful. At this same time, this disorder and confusion limits the capacity of new recovery to displace older recovery ideas, such as the 'recovering addict' identity I have traced in this chapter. Of course, in some respects recovery approaches overlap with the normalising and responsibilising rationale that is indicative of other approaches to alcohol and other drug associated problems, such as harm reduction. However, the broad and hybridised recovery approach in operation in Victorian treatment can be distinguished from the main alternatives by its prescriptive focus on individual change via participation in 'normal' (i.e. non-drug) social relationships, practices and responsibilities. As such the stakes for those interpellated through recovery might be said to be higher: in its prescriptiveness lies the potential to reproduce stigmatising ideas about people who consume drugs and, many have argued, an implicit normative commitment to abstinence.

My findings raise some important questions regarding how the organisation of treatment can more adequately account for drug-using experiences above and beyond the arguably individualising and stigmatising lens of identity. To this end, I question the utility and ethics of the concept of identity as it is conventionally mobilised in research on new recovery and treatment. If recovery-focused treatment currently relies on a 'recovering addict' identity in which the drug-using subject is poorly placed to articulate agency and which eclipses the political, economic and social challenges of life outside the treatment setting, what are the alternatives? To begin, we need to rethink the development of alcohol and other drug policy, and its expression in service provision, to consider how addiction concepts and treatments can incorporate issues of poverty, family violence, historical dispossession and homelessness (Fraser, 2016, p. 13; see also Weinberg, 2000). These issues were prominent across the interview accounts but were routinely disregarded or downplayed in the organisation of residential treatment and in treatment practices – likely because of treatment funding arrangements or system goal setting that focuses on alcohol and other drug use (Moore & Fraser, 2013). In keeping with the aims of this thesis to critically analyse enactments of new recovery and their political effects, it can be argued that so long as addiction is treated as something subjects have and must recover from, the pathologising category of identity, and specific, limiting, identity interpellations, will likely be deployed to authorise and secure this recovery.

Chapter 8

Doormats, derelicts and addicts:

Resisting, accommodating and incorporating new recovery in everyday lives

In this chapter I expand my analysis by addressing how people who use drugs engage with new recovery in their everyday lives. In Chapters 4 and 5, I traced authoritative enactments of new recovery in policy, science and professional practices. The new form of recovery is perhaps most forcefully enacted in alcohol and other drug policy and psychological science, yet many of its central ideas display continuities with older forms of recovery. Differences between new recovery and longstanding forms of recovery are most visible in its intensification of neoliberal discourses of personal responsibility. Further, unlike more recent socially-oriented responses and approaches to drug harms, such as the provision of take-home naloxone (Farrugia, Fraser, & Dwyer, 2017; Faulkner-Gurstein, 2017; McLean, 2016), new recovery policy and practice registers the social relationships of drug-using subjects as sources of deviance and harm. New recovery also contributes to a longstanding tendency to erase the political and legal regulations that shape people's lives and the difficulties they experience. As I explored in Chapters 6 and 7, more hybridised forms of recovery in professional and treatment practices continue to cohere around the treatment of failed individual subjects. In this sense, clinical knowledge about new recovery and recovery-focused treatment practices reproduce the same neoliberal vision of the recovering subject inaugurated in policy and science: as rational, autonomous, self-managing and enterprising. The previous two chapters also demonstrated how the organising and ordering practices that

aim to enact recovery in a stable and singular fashion (by extension, buttressing professional and clinical knowledges) also worked to constitute its multiplicity and undermine its stability.

This chapter continues tracking these authoritative enactments of recovery to examine how, and to what extent, new recovery plays out in individuals' everyday lives and practices. These accounts are drawn from interviews with all 25 participants about their understandings of recovery and recovery practices, their social relationships, and their drug use. As I have argued in previous chapters, drug-using subjects are regularly enjoined to change, adopt responsible behaviour and take control of their social relationships. Yet, these injunctions can be difficult to manage and take complex and contradictory forms. For example, drug-using subjects are encouraged to actively participate in the community and to make new social relationships but are also frequently represented as figures of harm and enjoined to view their own relationships with suspicion. Psychological science has tended to support the view that drug-using subjects need to take responsibility and control of their lives while frequently positioning them as pathologically unable to exert self-control, disordered and deviant, and in need of expert care and identity transformation. Recovery-oriented clinical encounters and residential treatment enjoin self-management, personal transformation and 'recovery' but through its individualising focus denies drug-using subjects many of the integral social and material resources which might furnish these changes. In light of these multiple and contradictory modes of ordering and interpellations across authoritative sites, it is politically important to carefully analyse how they are adopted and experienced in the everyday practices where ordering practices meet (Moser, 2005).

In pursuing this line of inquiry, I draw again on Mol and Law's 'modes of ordering' (2002) and their reworking of interpellation to explore the ways in which recovery is enacted and recovering subject positions are interpellated and resisted. Foremost, I argue that participants' accounts continue to emphasise 12-step models and practices of recovery rather than those

evident in new recovery. Participants overwhelmingly associated recovery with 12-step fellowships, and practised (and resisted) recovery in relation to 12-step knowledges and modes of ordering. The prevalence of the 12-step model of addiction recovery suggests that there has been minimal uptake of new recovery on the part of people who use drugs. Perhaps because it has not provided sufficient novelty and innovation, and perhaps because of the opacity and ambiguity that characterises it (tracked across earlier cases), new recovery appears to have failed to dislodge older forms of recovery.

In the first half of this chapter, I look closely at the accounts of three participants for whom the idea of recovery was important. Although their accounts differ, the constitution of oneself as a responsible and 'normal' subject was crucial. To the extent that older and new forms of recovery are repeatedly made synonymous with the performance of healthy and productive citizenship, this familiar interpellation is unsurprising. I explore the primary means through which this enactment and interpellation is achieved, namely, through a permanent project of intense self-management and self-work. I examine the way in which practices of self-work, and their articulation in and through different modes of ordering addiction recovery, surface in drug-using subjects' accounts of everyday life, as well as the various ways self-work relates to understandings of the self, addiction, reparation, authenticity, responsibility and citizenship. One of the most consistent findings to emerge is that despite new recovery's patent disavowal of the language and practices of 12-step recovery, these principles and practices were present for almost everyone I interviewed.

In the second half of this chapter, I adopt Moore's (2009) work on 'resistance', 'strategic accommodation' and 'incorporation' to analyse encounters between service providers and people who inject drugs, in order to more closely illuminate the dynamics of subversion that are also produced via interpellations. In their everyday lives, drug-using subjects resist authoritative enactments of recovery by resisting processes of interpellation, disrupting

binary accounts of addiction/recovery and addiction/health, and critiquing the normative images of citizenship promulgated in new recovery discourse. People also purposefully adopt some enactments of recovery for strategic purposes – such as reclaiming status and caring for the self. Finally, people also incorporate therapeutic discourses but resist other associated interpellations. I explore this specifically in relation to 12-step knowledge and practices. These dynamic engagements and partial iterations highlight the various ways in which drug-using subjects disrupt the universalising gaze of recovery, which seeks to define them. The negligible uptake of recognisably new recovery concepts, principles or practices raises questions, which I explore in relation to new recovery's claims of both novelty and innovation.

In the next section, I explore the way in which drug-using subjects mobilise and put recovery into practice through an exploration of practices of self-management and self-work. I examine what these practices entail and how they work, particularly in relation to responsibilisation, normalisation and citizenship.

Self-work, normality and recovery

Bojana

At the time of our interview, Bojana was 37 and lived with her young son in a privately rented flat in the outer east of Melbourne. When we spoke, she told me that her last methadone dose had been 'eight months and three weeks ago' and she had her last 'shot' of heroin 'about a year ago'. Prior to her current period of abstinence from alcohol and other drugs, she had been injecting heroin for around 20 years. She explained that following a diagnosis of hepatitis C in 1997 she had attempted 'getting clean' but had continued to oscillate between periods of using heroin and abstinence for many years. In 2009 she became pregnant with her son and enrolled in methadone maintenance treatment. She continued to

use heroin intermittently. However, following the birth of her son and incarceration of her partner, Bojana reduced her methadone dose and began to abstain from heroin, motivated by a strong sense that she was 'doing the wrong thing' as a mother. She explained that she 'really tried a lot of things to be clean' including attending six 'rehabs', therapy and studying Gestalt therapy, none of which she found useful at the time. Like other people I interviewed, Bojana explained that she found the institutional components of residential treatment restrictive and rigid. She mentioned feeling 'trapped by the programs', 'the structure' and the 'time limit' of many of the treatment programs she entered. At the time of our interview Bojana was engaged in private psychodynamic therapy but, as was common with many of the people I interviewed, she primarily drew on the recovery-focused discourse and practices of NA.

Over the last year, Bojana had become proactively involved with the NA community. Instead of 'being a doormat', she explained that recovery was about learning from past 'injustice' and using her experiences productively to help other people recover. With their focus on moral self-inventory, restitution, spirituality, confession, identity and service, 12-step fellowships provide a fertile forum for these kinds of altruistic worldly engagements and work on the self (Keane, 2000; Miller & Kurtz, 1992). 12-step modes of ordering addiction recovery share, with popular narratives of recovery, a focus on reparation (Andersen, 2015; Keane, 2000; Kleinig, 2008; Smith & Riach, 2014). 'Addicts' are figured as forever needing to perform acts of restitution in order to make amends but also to continuously manage the resentment and denial at the heart of addiction (Alcoholics Anonymous, 2001). Addiction is figured as a bio-medical disease but one which is 'nourished by a profound existential malaise; the addict is possessed of a disordered or diseased self' (Keane, 2000, p. 324). Upon closer inspection, the techniques and practices of self-work that embody the promise of redemption and

transformation from addiction are ironically the very practices that foreclose the possibility of freedom from the addicted self.

Bojana attended regular NA meetings, undertook step work with her sponsor and talked to her daily, and participated in regular service. Service included setting up for meetings, welcoming 'newcomers' to the fellowship by checking on their wellbeing and transporting them to meetings. Bojana describes the sense of connection and parity she feels when she engages in 12-step practices:

> What I find is that on a continuous basis, when I got to meetings and I work the steps and I reach out to new people in the fellowship and give of myself and when I do service and again give of myself, like when I spread myself around and I'm able to share myself, I feel connected. I don't feel so different anymore.

Here, Bojana suggests that when she regularly attends meetings, 'works' the 12-steps, reaches out to other people and does 'service' she is able to feel 'connected' and akin to other people. Although this account bears some resemblance to the theory of social identity change I examined in Chapter 5, it performs a much more complex and nuanced account of the kind of work involved in recovery. The verbs Bojana employs to describe the work she is doing in recovery – 'reach out', 'give off', 'do service', 'spread' and 'share' – speak to the kinds of labour elicited by recovery ideals and practices. Bojana's account of recovery goes beyond the passive account of identity change enacted in the social identity model of recovery in expressing the view that it is through self-sacrifice, selflessness and active service that she can achieve change and connection.

However, although these practices and work on the self are enacted as necessary to the cultivation of healthy subjecthood in recovery, such conscious engagement with making

reparation foreclose the necessary unselfconscious distance and change desired in recovery. When I asked Bojana later in the interview 'where is this work taking you?' she responded:

> **Bojana:** It just takes me away from the way that I think and it takes me away from the way that I'm most likely to behave you know, and then brings me back into being really present. It is like a ritual … it's like a structure you know like I treat myself with it because when I don't do it […] I start going a little bit loopy. I start thinking a bit too much and I start being a bit nastier to myself and I get a little bit more unavailable […] and look, I've got that thing. I've got that thing of like 'fuck! I'm fucking going to do this forever', you know, but like for now, I'm been doing it and for now I'm okay with it. […] I mean it feels like fucking hard work.
>
> *Renae: What does?*
>
> **Bojana**: Being me.
>
> *Renae: Being you?*
>
> **Bojana**: Yeah. I get fucking totally exhausted from just being myself.

Here, Bojana describes the feelings of exhaustion associated with the recovery program she is engaged in, summarising that 'it feels like fucking hard work'. Although this might seem like an obvious point to draw out, it is worth noting that such challenges and discomforts are rarely referred to in the authoritative cases of new recovery I have explored thus far. Bojana goes so far as to suggest that the self-work and recovery program she engages in has the potential to overshadow any sense of recovery. She mentions later 'maybe I don't feel like I'm recovering at the moment […]. I'm working on the parts of myself that I fucking hate and I'm sitting with it clean and at the end of the day, that's what it is for me'. Bojana's description highlights how 12-step modes of ordering addiction recovery interpellate a hyper-vigilant subject position (reflective of the subject position interpellated in treatment), which

precludes the 'spiritual' peace and freedom it promises. Instead, in recovery, a magnified attention to one's imperfections, flaws and 'defects' has the potential to limit the goals of recovery, such as change, transformation and empowerment.

However, ironically, the self-monitoring and discipline promulgated in 12-step recovery only serves to strengthen notions of freedom, salvation and redemption (Keane, 2002). In the last moments of our interview, Bojana outlined her 'fantasy' of what an ideal life in recovery might look like:

> Well, the way that I see it, one of my fantasies is that I wake up in the mornings and I'm able to get myself out of the way. So I don't think about myself anymore. I wake up with an empty mind, a still mind and I'm able to really forgive myself you know like on a daily basis… to have a laugh about it or to go, 'well, I'll do better next time', that sort of self-acceptance, which is like harder in nature. It's not so fucking heavy and like you know, this fucking – this coming to get my soul for it, so I'm able to finally surround myself with people that – like that things are good enough for me. That things are good enough for me… All I want to be is just, I want to be a fucking ordinary person and I'd like to have an extraordinary experience here and there.

Bojana's final wistful remarks hint at the potential harms associated with the myth of normative neoliberal subjecthood that I have tracked across previous chapters – of a fantastical figure who is simultaneously proactive, enterprising and empowered, yet also peaceful, mindful and accepting. Bojana desires to 'get [her]self out of the way' and to 'forgive' and accept herself. Evidently, although 'ordinariness' and normalcy (supplemented by the occasional 'extraordinary experience') are valorised as the norm, the citational practices interpellated in 12-step modes of ordering evoke a 'heavy' sense of self-condemnation and recrimination. Echoing Eve Sedgwick's (1994) observations, it can be

argued that for Bojana, an ethics of recovery requires never-ending assertions of being 'utterly compelled' (p. 133) and thus requires constant vigilance and maintenance against relapse. Bojana's account troubles the simplistic and somewhat hollow enactment of recovery as a smooth 'journey'. It also highlights how anxieties around punishment and moral retribution – evident in Bojana's fear that someone or something might be 'coming to get [her] soul for it' – underpin the imperative of self-work and reparation.

In this first account, I have explored the continuing influence of 12-step modes of ordering recovery to individuals' lives. As I have noted, and will continue to explore below, 12-step knowledges and practices continue to be significant in many participants' accounts of recovery. Evident in NA modes of ordering is an interpellative logic of reparation that enrols 'addicts' into intense practices of self-work and service. The nature of these practices are characterised by a logic of 'interiority' (Keane, 2000) or 'inner reference' (Carr, 2011) in which the inner, disordered self is routinely monitored, judged and worked upon, foreclosing the desired goals of transformation and freedom (Miller & Kurtz, 1994). It is also evident how injunctions to certain kinds of self-work in 12-step modes of ordering sustain the popular fallacy of healthy, normative and 'ordinary' subjecthood that has been reproduced time and again across the different authoritative sites of new recovery. In this sense, the resilience of 12-step fellowships attests to how these discourses can accommodate and sustain contemporary enactments of subjecthood, health and citizenship (Frank, 2011), while drawing on older moralised discourses of addiction and reparation.

Gary

Gary was 51 at the time of our interview. Unlike Bojana, he did not currently attend NA (although between the ages of 28 and 31 he had attended countless meetings), nor was he currently enrolled in therapeutic treatment. Gary had been on MMT for the last two years and

injected heroin a few times per month, usually on the day he received his Centrelink benefits. He had been to a 'few rehabs' in the past, the first when he was 16 years old. He had been injecting heroin since the age of 14 and had also frequently used cannabis, amphetamines, barbiturates and benzodiazepines. Gary had grown up in state care and experienced physical, psychological and sexual abuse, which resulted in diagnoses of depression and complex post-traumatic stress disorder as an adult. In the past year he had secured permanent housing through a homelessness service and subsequently began attending an abstinence-based community day program (which was being defunded at the time of interviewing), which he found enjoyable and useful. During the first half of our interview, Gary reflected on the nature of his drug use and made several comments suggesting that the troubles he experienced were caused by his drug use. As he explained:

> I've suffered a lot because of my drug use. I ended up a derelict two years ago. […] I was homeless. I was very scattered. There was no direction or order in every aspect of my life. As much as I like to have a shower every morning, I wasn't able to have a shower or put clean clothes on a daily basis, you know, didn't know where my next meal was coming from. Used to do shoplifting solely to get another drug. Yeah. […] Well it's all drug-related, you know, not paying my rent. You know, drugs came first and everything else was secondary. My responsibility towards myself and society was secondary.

This account reflects and reproduces the simplistic interpellations generated in the problematisations of drug use and the drug-using subject found in alcohol and other drug policy (Chapter 4). These injunctions towards responsibilisation, and normal and healthy citizenship, have been central across the different sites and modes of ordering recovery that I have examined thus far. Drug-using subjects are interpellated by these logics in complex and contradictory ways – as capable of becoming legitimate and responsible citizens while also

enacted as selfish, immature, deviant and risky. Gary's account is consistent with this narrative, explaining that previously 'drugs came first' and his 'responsibility' towards [him]self and society was secondary. As I explore below, the adoption of this individualising narrative has political implications for the ways in which people can address their health and pursue change.

Although Gary had not used the language of recovery during the first half of his interview, he expressed a strong desire for a 'functional, proactive life'; a life that was not 'socially unacceptable'. When I asked Gary whether he considered himself to be 'in recovery' he said 'yes' and explained what recovery meant for him:

> Facing up to it and trying to deal with the issues, to be responsible for myself and deal with any of the issues that cause me disease inside and just deal with it the best way that I possibly can and facing up to it rather than just […] having the thought or a feeling and just switching off thinking about things. To be mindful of them and to deal with it.

The account of recovery offered by Gary is consistent with clinical, treatment and 12-step hybridised enactments of the disease model of addiction recovery, in which 'facing up to' the underlying issues and accepting responsibility for one's behaviour are the keys to recovery (Carr, 2011). However, Gary's broader experiences of sexual abuse, physical assault, homelessness, relationship breakdowns and entrenched social isolation suggests that the forces and relationships in operation in his life are complex and exceed simplistic solutions – such as taking responsibility, 'switching off' his thinking or being 'mindful' – made available to him through the interpellative logic of recovery. In short, this interpellative logic cannot accommodate the wide array of entities that might potentially be considered as shaping Gary's experiences. How does one take responsibility for childhood neglect and sexual

assault within a society that has been shown to comprehensively defend and favour perpetrators (Commonwealth of Australia, 2017)? How is homelessness addressed through becoming mindful? In a related move, the accommodation of this logic forecloses innovative and novel political responses to social problems and alcohol and other drug practices that move beyond individual responsibilisation. In this sense, Gary's account offers powerful and important insights into what kinds of erasures are necessary to sustain this authoritative constitution of drug use and people who use drugs as solely responsible for their problems and as needing to develop the responsibility required to overcome them.

Furthermore, in light of this logic, what meaningful options does Gary have to pursue recovery? Keen to impress upon me that his life now was marked by order, responsibility, routine, good health and self-care, Gary explained:

> Look, I make fresh fruit salad for breakfast, I have salads for lunch, and I have a fridge. Like, you know I go home, I cook a meal and you know, the other night, I had some schnitzel and had an avocado salad and I cooked up half a dozen vegetables on the side of that […] My rent's paid every week and my bills, my gas and electricity bills are paid. Whereas I used to jump the train… I'll put two weekly tickets on my myki[8] you know.

Critical scholarship has argued that the injunction to pursue good health is not value-free nor its achievement the natural counterpart to ill health (Peterson & Lupton, 1996; Nettleton, 2013). In contemporary society 'health is an opportunity and participation is voluntary but both are precisely predefined and monitored' (Singleton, 2005, p. 775). Although many social practices might be considered meaningful to or to contribute to improved health, Gary takes

[8] Myki is the name for the reusable travel card for trains, trams and buses in Melbourne and regional Victorian centres.

pride in arguably narrow enactments of health concerned with eating fresh fruit, salads, schnitzel, avocados and vegetables. In addition, he emphasises that he now pays his bills and rent on time, and organises his budget in advance. Certainly, these are all worthwhile achievements but what are the costs of responsibilising individuals through narrowly focused trajectories of recovery regardless of their prior circumstances, difficulties and resources (Fraser 2004; Moore & Fraser, 2006)? What other changes might be disregarded in the relentless pursuit to responsibilise individuals for a range of forces outside of their control? In their 2006 article on harm reduction discourse, Moore and Fraser argue that the approximation of neoliberal subjectivity might be experienced as empowering, in that individuals are positioned as having agency, autonomy and responsibility, all traits highly valued in neoliberal societies. Yet the adoption of neoliberal subjectivity cannot address other forms of subjectivity, nor the socio-economic contexts that undermine these very processes of responsibilisation. Therefore, although Gary is now able to eat well, care for himself and budget, the interpellative logic of recovery does not and cannot address the structural causes of suffering and impoverishment. Indeed, it bolsters and sustains these inequitable relations.

James

At the time of our interview, James was 39 years old and lived with his girlfriend in her flat in an inner-city suburb. I first met James several years before, when I worked as a community development officer at a residential rehabilitation service, and we had kept in touch. When I interviewed James, he explained that he had developed a particularly large heroin habit, largely due to the fact that he had quick and easy access to relatively large sums of money. James had an unofficial job driving sex workers to client appointments. In exchange for providing a car and informal security, James received a portion of the earnings and as a result he was spending $500 to $600 per day on heroin. He expressed a deep longing, however, to

be ‘in recovery’ again. Although James had been using heroin for 20 years, in the last few years, he had regularly frequented residential treatment facilities and AA meetings, and maintained long stretches of abstinence. However, his periods of ‘recovery’ were followed by periods of intense heroin use and homelessness. James understood addiction to have changed his thinking –‘re-wired’ his brain – in contrast to how a ‘normal person’ would think:

> **James**: I believe I do suffer from a disease that a normal person doesn’t have. Yeah, a disease of like, alcoholism which is a disease within my thinking or my thoughts. You know, I believe that a normal person doesn’t have that, yeah… and since I’ve used for so long, my brain’s been re-wired [… from] how I think […] from the normal person, and my thinking is broken.
>
> *Renae: When you say your thinking is ‘broken’, what do you mean?*
>
> **James**: It’s exactly that, you know my thinking’s broken because I have used for so long and I’ve done a lot of damage. If I’m in recovery, I really need to do the opposite of what I think because everything I think leads me down the wrong path. […] I’m never free of this disease. It’s always there in the back of my mind.

James’ account of the disease model of addiction is striking. Notably, the same mobilisation of disease that led George (in Chapter 7) to suggest that he could overcome the disease of addiction because it ‘could be treated’, interpellates James to constitute himself as broken, damaged and pathologically ‘re-wired’. This example suggests the ‘diseasing’ of addiction (Fraser et al., 2017) is highly productive. Addiction’s status as a pathological, compulsive and chronic disease buttresses the impossibility of recovery and achieving normal subjecthood. Yet at the same time, the concept and practices of 12-step recovery suggest that change, transformation and ‘normal life’ are possible, through self-control, willpower and responsible behaviour. This binary is productive, the effects of which are evident in the

practices of self-work I have been exploring throughout this chapter. Furthermore, as evident in the excerpt above, it is essential to note that although addiction and recovery are commonly represented as antithetical – indeed as mutually exclusive – they are propelled by the same imperative: the mutual constitution, regulation and interpellation of normality and 'normal' citizens (Fraser et al., 2017; Nettleton et al., 2013; Seear & Fraser, 2010). Narratives of addiction function as cautionary tales that name and shame the many ways in which drug-using subjects have strayed from the norm. Simultaneously, older and new recovery narratives suggest the techniques, practices and kinds of conduct which will bring people back into normality (Keane, 2000; Nettleton et al., 2013). This 'addicting' (and, perhaps, 'recovering') of contemporary society is one of the multiple processes constituting the conditions under which legitimate 'normal' subjects emerge (Fraser, Moore & Keane, 2014).

Importantly, what exactly do these enactments of normality in accounts of addiction recovery suggest about the contemporary constitution of citizenship and subjecthood? James described regular heroin use as involving whole days centred on the procurement of heroin – 'getting money, scoring and then getting money and scoring… it's the whole day just fooling around'. In his assessment, this way of living is 'not good. It takes up my whole day and withdraws me from my family and friends'. In contrast, James explains that 'before then', when he was 'in recovery', he was 'just doing 12-step meetings and I was actually working and playing sport and you know… doing the normal thing'. James described a typical day in recovery in the following way:

> I'd usually probably get up, go to work until say, four, come home, get something to eat, go to the gym […]. I was working in [Melbourne suburb] for a while when I was clean last time […], that was a proper legit job in a factory […]. And then I'd, you know, go to the gym for maybe an hour and a half after work, come home, get something to eat, then I'd go to an AA twelve-step meeting till about nine-thirty, then

> come and cook up [something to eat] and then go to bed at ten-thirty and go to sleep and do that Monday to Friday. That was my routine. On weekends […] I'd also go to the gym and catch up with friends or family, still do the twelve-step meetings and just relax and clean up the house a bit, you know what I mean. Yeah, maybe socialise a bit on the weekend and you know hopefully I've got something on, you know, for Saturday night […] It's totally the opposite to when I'm using and when I'm in recovery.

Like Gary's, James' account suggests the ways in which drug-using subjects incorporate authoritative injunctions to recover through subscribing to work, exercise, good nutrition and normative understandings of relaxation and socialisation on the weekend. It also speaks to the work individuals do to sustain a 'normal' existence. James explains that addiction and recovery are 'totally opposite', yet both accounts are centred on repetition and routine. Although I do not wish to offer a naïve reading of James' experience, it is important to examine why, when both addiction and recovery constitute norms for James, it is only the experience of recovery that might possibly be legitimised as 'normal'. One argument that can be made is that the intense stigmatisation surrounding drug use and drug-using lifestyles, works to consistently disqualify people who use drugs from the realm of normal life. As Fraser et al. (2017) argue, it is precisely this entrenchment of stigma that enacts drug-using subjects as 'not competent to "speak back" against this rendering' (p. 199). That is, when drug-using subjects are enacted across authoritative sites as so thoroughly abnormal, there is no way in which drug-using subjects, like James, can describe their experiences in normative terms. In order to become legitimate and intelligible subjects, they *must* recover.

Through the interpellation and performance of normal subjecthood in recovery, James explained that he slowly got his 'self-esteem' and 'confidence' back. Yet, other parts of

James' account intimate that adopting normal subjecthood was also productive of the kinds of marginalisation that might cause low self-esteem in the first place:

> **James**: It's good being a part of the community and doing the right thing, you know, instead of just stealing and doing all this stuff to support your habit. Yeah, it's just a far better quality of life and you just… you know, you feel better within yourself that you don't have to do the things you used to do to make money.
>
> *Renae: Did you feel like you were in a community when you were in recovery?*
>
> **James**: I was still far on the outside, but… I just felt in the outside part of the community because it's hard to fit in when you've been using… So I kind of like felt on the outside of the community but at least I was having a go and trying, you know what I mean?
>
> *Renae: And what type of community are you talking about?*
>
> **James**: Just community in general, you know what I mean? […] Just like the whole community, you pass on the street, like you know, just normal everyday life, you know everyday people, like in your suburb in the State of Victoria you know, just you know, just fitting in and just doing what normal people do.

The ambivalence James feels towards his status as a member of normal society can be understood as an effect of the complex patterns of interpellative interferences between the 'recovering addict' identity and that of 'normal citizen' evident in 12-step and new recovery enactments. The focus on community reintegration in authoritative recovery policy discourses and the emphasis on doing service in AA interpellate James to 'fit in' and 'do what normal people do'. However, even when James imagines himself to be performing the markers of healthy citizenship correctly, he explains that, in everyday practice, community reintegration or 'fitting in' is much more provisional and tenuous. When James alludes to

being ‘far on the outside’ of normal society, he expresses an acute awareness that he still occupies what might be termed a partial and marginal form of citizenship. Performing the subject position of ‘recovering addict’ is contingent on his acceptance of the disordered addict identity, which precludes the ‘unselfconscious normality of the non-addicted’ (Keane, 2002, p. 161). In this sense, James’ account evokes a sense of being among the community, of being witness to it, but ultimately being different from the normal people ‘you pass on the street’. Although James may almost be the same as ‘normal’ community members, *almost* the same does not appear to produce the empowered agency that is central to policy enactments of new recovery and 12-step practices.

Read together, the recovery accounts I have analysed in the first half of this chapter speak to the complex and contradictory patterns of interpellation at work in modes of ordering addiction, drug-using subjects and citizenship. The majority of participants spoke in recognisably 12-step ways and the 12-step form of recovery continues to be powerful and informative in people’s everyday practices. For Bojana, the interpellative logic of reparation moved her to engage in intense practices of self-work and service that made her feel ‘heavy’ and, at times, like something was ‘coming to get [her] soul’ for past wrongdoings. The interpellative logic of responsibilisation I explored through Gary’s account foreclosed a more politicised and nuanced reading of his drug use that would include his impoverishment, sexual abuse, mental health and homelessness. His interpellation into this individualising purview meant that he was poorly placed to challenge the status quo in terms of these popular understandings of how drug ‘problems’ emerge. In James’ account, I sought to draw out multiplicity and interferences, showing how the mutual interpellation of an addict identity and a ‘normal’ recovering subject produced tensions in his daily life. His sense of himself as always an addict problematised the simplistic enactments of community reintegration produced in enactments of new recovery in Chapter 4. Although there are differences

between Bojana, Gary and James' accounts, all three speak to the allure of the legitimacy offered by recovery to those who use drugs. These accounts also speak to how the practices required of drug-using subjects (e.g. intense self-work, abstinence, service, volunteer work, counselling) in order to qualify for inclusion in neoliberal citizenship are hard to sustain. They tend to be emotionally exhausting, resource heavy and time consuming and, ironically, tend to reinscribe the disordered, broken and addicted identity interpellations from which people are struggling to escape. In this way, they condemn people to a permanent project of intense self-management, largely precluding criticism of social conditions. This is an obligation also familiar to 'new' enactments of recovery, as was evident in the ARC scale analysed in Chapter 5, which intensifies individualising logics of responsibilisation to the neglect of other more politically and socially-oriented interventions.

In the following section, I proceed thematically rather than by individual accounts. I extend my analysis of several of the significant themes I have addressed above through a more detailed examination of the ways in which individuals who use drugs respond to and subvert these reparative, responsibilising and normalising interpellative logics. These responses are inspired by Moore's ethnographic analysis of the ways in which people who inject drugs accommodate, incorporate and resist authoritative discourses and professional encounters.

Resistance, strategic accommodation and incorporation

In his ethnographic analysis of the power dynamics that operate in encounters between service providers and people who inject drugs, Moore (2009) draws on Scott's (1985) work to offer alternative accounts of the tactics adopted by drug-using subjects when engaging with alcohol and other drug services. The first element Moore observes in these encounters is resistance. This takes the form of 'everyday tactics' that 'undermine, exploit or explicitly challenge the way in which they, and their needs, are defined by service frameworks'

(Moore, 2009, p. 1162). The second distinction Moore makes is that of 'strategic accommodation', which refers to encounters in which participants purposively adopt and use authoritative discourses in order to achieve desired goals. Strategic accommodation can take several forms: adopting therapeutic discourse in order to gain access to much-needed resources, entry into services or to gain respect from service providers. In this sense, strategic accommodation can be hard to distinguish from the final mode – incorporation. Moore argues that 'incorporation' comprises participants' 'adoption of service-provider discourse' (p. 1166). This dynamic was evident in the accounts above, and I explore this with specific reference to 12-step principles and practices below. Importantly, as Moore's analysis makes evident, these characterisations are useful heuristics but less definite in everyday practices. As I discussed in the previous section, people are subject to multiple modes of ordering and interpellations, which interfere and enact complex subject positions. In this sense, resistance, strategic accommodation and critical incorporation are not always easy to distinguish and are better thought of as overlapping rather than as discrete modes of engagement.

On resistance

For individuals who had never attended residential rehabilitation, clinical treatment or 12-step meetings, the language and practices of recovery (whether of earlier forms or of the more recent iteration) were less familiar. For example, when I asked Murray (male, 61, not in treatment) if he had heard of recovery, he responded that 'no, [I've] never heard of it'. Murray had never been enrolled in treatment and subsequently had not been exposed to older or new recovery discourses and practices. Aside from these responses, which might be termed indifferent (and which were rare), many people I interviewed actively resisted the various interpellations enacted through authoritative modes of ordering new recovery. Ryan (male, 37, residential rehabilitation), for example, objected to the stigma associated with recovery:

> But I just never use that word [recovery] … . It's kind of letting somebody know, you know, if I don't know them and I say, 'I'm in recovery' you know, 'I'm a drug addict or an alcoholic or was' do you know what I mean? […] It's kind of hard to tell people you don't know that you've been a drug user and an alcoholic or whatever, yeah.

Here, Ryan's account critiques scientific enactments of new recovery as a potentially empowering social identity. Indeed, he suggests the very opposite: that a recovery identity is unappealing because it makes visible his status as a 'drug addict or an an alcoholic'. In this way, Ryan's account draws attention to the inseparability of the categories of addiction and recovery, and the stigma that might emerge from this binary. His account suggests that it is potentially not worth the risk of identifying publicly with recovery because of the potential that he may incite negative attitudes or responses. Instead of identifying with recovery, Ryan went on to explain that 14 months had passed since he had last used drugs and he did not 'really think about it [drug use] anymore'. He still drank but was 'mindful of [his] alcohol use'. His health had improved, he did not feel 'so depressed', he had more money, his children now spoke to him and he was 'able to make better decisions'.

Other people rejected the specific ontology of addiction as a compulsive and out-of-control disorder that many older and new recovery enactments rely upon. Robert (male, 37, not in treatment), for example, described himself as being 'pretty stable' in his 'addiction' to heroin, which he had started using for pain management following a car accident over a decade ago. By 'stable', he explained that he had not 'needed any opiate treatment programs or drug referral programs', or been in a state of withdrawal, at any time during the previous 14 years. However, to be clear, Robert did consider himself 'addicted' to heroin:

> Oh yeah, yeah. Oh every day. I know I'm addicted to it. It's something that I've come to deal with. […] I've accepted that this is pretty much my lifestyle if I want to maintain some mobility.

However, he resisted an interpellation of addiction that would enrol him into an identity marked by disordered consumption and little else. Instead, he stated that 'you've got control of anything in your life; it's about how you approach it'. Robert went on to explain that 'addiction' was shaped by how 'you maintain your environment and who you expose yourself to in that environment as well.' For example, Robert organised his heroin use most days around the care of his son. For Robert, the obligation to care for his son enjoined him to 'mobilise' himself:

> Yeah. I have a bit of heroin and I can mobilise myself, I can get out with my son and do physical things, whereas when I'm not medicated, I'm pretty painful, [a] sorry, sore mess. That's without withdrawal. With withdrawal on top of it, I can't function.

Here, Robert explicitly resists orderings of addiction as unproductive and non-functioning. He argues instead that using heroin allows him to be normal, to 'mobilise' himself, to 'do physical things' and to 'get out with [his] son'. Robert's account of heroin addiction disrupts many of the familiar binaries through which older forms and this new iteration of recovery are constituted. For example, he has rationed his heroin use over 14 years, which suggests that the negative decline and inevitable 'rock-bottom' experiences (Keane, 2000) associated with addiction are not inevitable consequences of drug use. Furthermore, after using heroin, Robert explained that he could 'mobilise' himself to become physically active and care for his son. In contrast to many pejorative enactments of drug users as lazy, irresponsible and isolated, Robert's account highlights how his regular heroin use facilitates particular forms of agency, health and responsibility (Moore et al., 2017). Robert's experience of heroin use

allowed him to maintain health and wellbeing and ostensibly cultivate and maintain a 'normal' existence.

In the following account, Emma and Peter also resist many of the pejorative assumptions made about drug use and people who use drugs in new recovery. They are also sceptical of the promises of freedom and improved choice in new recovery discourse. I was originally scheduled to meet Emma (female, 33, not in treatment) at a café in the western suburbs of Melbourne. However, Emma contacted me to say she was still waiting to purchase heroin so she would not feel unwell during our interview. Emma was using heroin daily at the time, and occasionally injected methamphetamine. She eventually suggested that we meet at her house to conduct the interview. On arrival, her boyfriend Peter (male, 37, not in treatment), who had previously been in a relationship with a man (who had worked in the alcohol and other drug sector), made us cups of tea and then made himself scarce for the interview. However, later he decided he'd like to take part in the interview. After Emma agreed to this and I'd obtained Peter's informed consent, he began by saying:

> **Peter**: I can't even imagine saying 'I'm in recovery'.
>
> *Renae: Why not?*
>
> **Peter:** I don't know. Recovery, I think, means abstinence from all drugs. You know, in the classic sense […] I've always wanted to be able to use smack [heroin] as I choose, when I want […] I think if you're in recovery, I'm not allowed to do these things you know like it's – I wouldn't be in recovery if I was allowed to go off and use, that's how I see it.

Peter objects to what he sees as the more coercive elements of recovery discourse, such as the necessity of 'abstinence from all drugs', which has largely endured in the new iteration of recovery. The idea that he would not be 'allowed' to use 'smack' when he likes is a source of

frustration because he values being able to use heroin on his own terms. Peter's interpellation as a free, independent and autonomous neoliberal citizen – a subject who values choice and freedom – interferes with his ability to adopt recovery, which he suggests undermines his autonomy. This is an interesting interference as policy modes of ordering new recovery aim to empower people to become citizens, but overlook the more coercive, regulative and paternalistic aspects of recovery that undermine this same enactment of citizenship.

In addition to mandated abstinence, Peter objected to the chastising tone of recovery-focused therapeutic discourse and its framing of drug use as arising from trauma:

> **Peter**: How would I [see recovery]? Okay… like if I wanted to get off drugs and I went to some place that helps you know, I would see therapy, I would see a bunch of language you don't really like hearing.
>
> *Renae: Why don't you like hearing it?*
>
> **Peter**: Oh I don't know, could be linked to rehab. I just hated the language, I don't know. […] It's sort of, crikey what's the word – I'm not very good, hang on. It's kind of a bit –
>
> **Emma**: It's kind of chastising?
>
> **Peter**: I don't know, it's fake in a way is – there is a better word, but I just can't come up with [it]. I don't believe it and when people talk to me using this language to try and get something out of me […]. I would say 'therapy language' okay, and my ex-boyfriend and I… I had an issue with him. He was in this sector [the alcohol and other drug sector] you know and he'd gone through treatment and if we broke into an argument, he would sort of say 'oh you're not bloody – '

Renae: 'You're making me feel like you're not respecting my boundaries in this' - something like that?"

Peter: Thank you! Exactly. Thank you, thank you, yeah and so yeah, I first come across that in rehab and then I came across it more with my ex, so I hate that aspect of it – of recovery and treatment and seeking help. I think they think that I've had some terrible experience in my life and they're going back and trying to sort of nut out this issue.

Here, Peter is explicitly resistant to the treatment mode of ordering recovery I examined in the previous chapter and to his interpellation as a traumatised and problematic client. In particular, he rejects the 'therapy language' used by his ex-boyfriend that was also characteristic of his treatment experiences. In Peter's account, 'therapy language', or therapeutic discourse, operates as a form of mobilising power through empty authoritative rhetoric. He rejects the assertion that his drug use is caused by trauma or other issues in his childhood, which is potentially why he does not see recovery as fitting with his needs. He argues, 'I need something to stop opiate withdrawals when I'm not using and that's really what I'm after. I'm not after recovery of my whole mind and body or whatever'. In contrast to professional and treatment modes of ordering recovery, which interpellate clients to look inward and confront 'the cause' of their addiction, Peter does not desire to transform himself or develop a more authentic self. If there is a 'problem' to be solved, Peter suggests it is opiate withdrawal, which he later explains is mainly influenced by the price of heroin and his finances.

Furthermore, both Peter and Emma were critical of the alleged benefits of community reintegration and sceptical of their interpellation into the subject position of 'healthy good

society members'. Contrary to the aims of new recovery-focused policy, they reported minimal aspirations to 'reintegrate into the community':

> **Peter**: I'm not in a healthy society.
>
> *Renae: […] Why's that?*
>
> **Emma**: Well we thieve, we use drugs.
>
> **Peter**: We need to steal food from the supermarket sometimes, because we don't have money […]. I don't think we are seen as healthy good society members by the greater society you know. [However] if we look at ourselves… I don't think I'm a bad person.
>
> **Emma**: Well I've never really considered myself a healthy society member, because society's not really something I wanted to fit into anyway. So I guess I sort of prided myself, being a little punk and you know, being a little anarchist, I never really wanted to fit into society, so I've always sort of rejected anyway kind of thing being a healthy society member.

Like James earlier, Peter and Emma are aware that their drug-using practices are defined as unhealthy and that their practices marginalise them from 'healthy society'. However, as Emma suggests, she does not aspire to being part of 'healthy society'. Perhaps this resistance can be connected to the everyday stigmatisation that people who use drugs experience. As I argued earlier, the problematisation of people who use drugs as sources of danger and risk makes it unlikely that the 'community' will 'take responsibility' for their recovery. Similarly, it is equally problematic to expect that people who are subject to marginalisation and stigmatisation will necessarily strive for membership of the 'healthy society'. Moreover, as Emma intimates, 'healthy society' does not appeal to her as a desirable concept. Her anarchist

political orientation meant that she neither desired to 'fit' into society, nor did she think that the normative conception of society could meet her ethical or political needs.

Further, another participant, Claire (female, 38, counselling), questioned the reality of the myth of a wholesome society populated by normal people who do not suffer from the pain and confusion experienced by 'addicts'. Claire was in her third year of a university science degree at the time of the interview. She had been abstinent from heroin for the previous four years but continued to drink and occasionally used other drugs socially with friends. She also continued to see a psychiatrist regularly, as well as a psychologist, but was not engaged in any other treatment or 12-step groups. Although Claire explained that prior to the interview she would not necessarily describe her experience as one of recovery, she referred to recovery often throughout the interview as 'learning life again', as a 'process' and as a 'journey'. However, for her, the narrative of recovery as an extraordinary state or transformation was questionable:

> **Claire**: It was a long process I think… of lots of stuff and it still is. I'm sort of realising what life is and whether that's addiction or whether that's everything, that's just life, I'm not sure.
>
> *Renae: What do you mean?*
>
> **Claire**: Okay, I've had two deaths really close to me in the last couple of years, one of them being my boyfriend. So that process is all kind of… grief is kind of intertwined with my recovery I would say, if I had to think about it, because it's like, is this… you know, life I'm dealing with? You know, they're all sort of things that I hadn't had to... Did that make sense? Yeah, no, that recovery's hard and I'm not sure if…
>
> *Renae: If recovery's hard or if it's just…*
>
> **Claire**: Or if it's just life's hard.

Claire's account resists the linear transformative characterisation of many enactments of older and new recovery. As she insightfully observes, her experience of 'recovery' over the last few years was entangled with and inseparable from the grief she experienced in relation to her boyfriend's death. Far from being an 'empowering' journey, her everyday life encompassed the cessation of injecting heroin, unforeseen tragedy and grief. On this note, Claire was unsure whether addiction and recovery were hard or if it was 'just life' that was hard. She explains further:

> I think … you're always sort of in a state of recovery from something really. I think everyone has trauma in their life at some point and especially once you get to sort of late thirties, even younger people obviously. Everyone's got something that they recover from, so I really view life as a journey of… I mean it's not a journey of recovery. That sounds really depressive. But […] I think recovery is always engrained in life really.

Expanding upon her earlier comments, Claire suggests that everyone is 'in a state of recovery from something'. She explains that 'everyone has trauma' and has 'got something that they recover from'. In her view, there are similarities in the difficulties, struggles and events that characterise people's experience, whether they are 'addicted' or not. This account can be read as resistant to the new recovery discourse that would posit addicted people as pathological and other people as normal and mostly untouched by miserable events, systematic discrimination and disadvantage. It can also be understood as a political claim about the nature of life and society. Life is marked by inequity, injustice and abuse, and we all inexpertly cope with life and events as best we can, and some mistakes are more visible and condemned than others.

The accounts I have explored in this section expand upon the tensions and contradictions that surface through the recovery interpellations that I explored in the previous section. I have illuminated practices and discourses of resistance, which work in several different ways. First, these lived accounts of recovery can provide nuance and contextualise authoritative accounts of recovery, as did Ryan's experiential knowledge about the stigma associated with identifying with recovery. Second, as Robert's account illustrated, accounts of drug use and 'addiction' can disrupt binary accounts of addiction/health and show us the multiple ways in which drugs may act in ways that enhance agency (Moore et al., 2017). Third, as is evident in my interview with Peter and Emma, and in Claire's critique of recovery, people interpellated into stigmatised subject positions can perhaps most astutely critique the normative fantasies of healthy society and citizenship that work to enact stigmatisation and exclusion. However, other participants resist authoritative interpellations through more subtle and contradictory ways. I consider some of these accounts next.

On strategic accommodation

Participants sometimes engaged strategically with recovery discourses and practices in order to achieve desired ends, for example, to gain and preserve access to services or to comply with institutional requirements. One subtle example of strategic accommodation is provided by the adoption of a recovering subject position in the interview encounter. Chien (male, 51, counselling), for example, momentarily adopted the term 'recovery' once I had introduced it into the interview:

> *Renae: I'm just really interested, do you consider yourself in recovery?*
>
> **Chien**: Yeah.
>
> *Renae: You do?*
>
> **Chien**: Yeah.

Renae: […] Before we ever had this conversation, would you [have] conceptualise[d] your life now as in recovery?

Chien: Yeah.

Renae: You would?

Chien: Yeah.

Renae: Have you used that language before with people?

Chien: No […] No, I never talk [about it] with [them] before.

Although this might appear to be a relatively banal example, Chien's initial response to define himself as 'in recovery' might be understood as a prudent decision considering the socio-political context of the interview. Like other sites of knowledge production, it can be understood as a discursive and political encounter (Radcliffe, 2011). Chien's initial response to my question can be understood as strategic because he knew the focus of our interview was recovery and by adopting recovery he could perform himself as a 'useful' interview subject and responsible drug user (Neal & McLaughlin, 2009; Ostrander, 1993; Radcliffe, 2011).

Embracing the interpellation of a recovery subject position can also be a strategic means to gain access to a more socially desirable form of subjecthood. This is evident in the way Melissa (female, 42, not in treatment) adopts a recovery identity in order to differentiate herself from other stigmatised people:

> I'm not a thief and not a working girl. I have no other means to get the money to do it, so I have all of those reasons to go, 'yeah, I'm in recovery' because I'm not making myself a working girl, I'm not making myself a shoplifter, I'm not making myself any of these things.

Here, Melissa purposefully adopts a recovery identity in order to differentiate herself from 'thieves' and 'working girls' and to 'make' herself a valued citizen who is 'in recovery'. Melissa's account implicitly reflects and reproduces the 'dividing practices' underpinning the policy enactment of new recovery analysed in Chapter 4. Roseanne's (female, 46, not in treatment) account of the social meanings associated with recovery also highlights how the concept attributes legitimacy to those who adopt it:

> It [recovery] sounds better than sobriety. […] Sobriety just sounds like just putting down a drink. [… Recovery] sounds like a combination of things, like getting on with your life, taking it day by day, you know, just functioning again.

In contrast to sobriety, which Roseanne defines as 'just putting down a drink', recovery 'sounds […] like getting on with your life' and 'functioning'. These examples from Chien, Roseanne and Melissa highlight the ways in which they are attuned to the productive political effects of language, specifically in relation to how recovery discourses can improve one's status and legitimacy. Read together, these accounts suggest that engagements with recovery can be an explicitly political exercise in managing the identities others impose on them.

However, the motivations for participants' accommodation of new recovery discourses and practices were not always so clear. In the previous chapter, I examined how Matt (male, 25, residential rehabilitation) stringently adopted the norms of accountability and surveillance that operated in the residential program in which he was enrolled. However, during the interview, I noted his reticence to use the language of recovery or to identify as being in recovery. This was surprising as Matt had disclosed he was living in a share house with two other residents he had met at the residential program. They continued to uphold and reproduce some of the treatment practices from the residential rehabilitation service in their living arrangements. For example, they had formal written methods for communicating

concerns to each other about each person's recovery. Just prior to the interview, Matt explained that his housemates had adopted this method of communication and subsequently 'sat [him] down and said, "look, you're doing so much. You're boxing, you're at [the] gym. You need to slow down, mate"'. However, after probing Matt several times during the interview to clarify if he understood the practices he engaged in as constituting 'recovery', he eventually responded by saying:

> **Matt**: I don't like that word 'recovery' […] I guess for me, it's just like [go to] work, get fit [and] have good people in my life, which I guess I need all that. Everyone needs that. But I don't think I'm still 'in recovery' […] I don't like to say that.
>
> *Renae: Yeah, why? What is it about the word or the idea, which doesn't sit easily with you?*
>
> **Matt**: Oh shit. I don't know. I guess maybe the self-judgment […] Like I don't like to… like I've been there, I've done it […] I've done treatment […] I don't know about the whole – I feel like I guess I am recovered. There are still things I've got to keep in check and you know, see my psychologist every week and unload a heap of emotional stuff, but you know I'm on the right track. I don't want to I guess sit in that pit of 'fuck I'm still in recovery. I'm in recovery for the rest of my life'. I just want to get on with it. I want to get on with it. I want to work and save money and watch the bank account grow and save for a house and meet a nice girl and play sport and get my family back in my life and be a good uncle to my niece and nephew. You know, do travel, get on with it. It's done.

Matt's account provides an insight into the overlap between strategic accommodation and resistance. He explains that he lives with people who have also gone through treatment and they support each other by monitoring each other's wellbeing and offering support 'when

something is wrong'. He also sees his psychologist every week, in addition to attending an NA meeting once a week. He was also passionate about regularly attending the gym, boxing and staying 'connect[ed] to good, healthy people'. By adopting the practices he learned in residential treatment, and living with people who upheld similar norms, Matt was able to keep 'in check' some of the difficulties or tensions which informed his decision to access treatment in the first place. However, like Claire in the previous section, he explicitly resists the appropriation of 'normal' behaviour and practices by 'recovery' and the identity politics attached to it.

Through strategic accommodation, many participants display the active, enterprising and self-managing qualities that constitute the much-lauded and desired outcomes of new recovery. At the same time as they are being interpellated into neoliberal subjecthood by authoritative enactments of recovery, they subvert those elements they find problematic.

On critical incorporation: Amending the 12-step program

In this final section, I attend more closely to the ways in which people incorporate 12-step therapeutic discourses. As I examined in the first half of this chapter, longstanding 12-step notions of recovery were one of the most influential modes of ordering addiction in participants' accounts. In this section, I explore the inconsistent and partial incorporation of 12-step therapeutic discourses of recovery by participants who also offer up criticisms. For example, I asked Aidan (male, 31, residential rehabilitation) whether his understanding of recovery was the same as that offered in NA meetings, which he was attending at the time of the interview. He replied:

> Similar but not the same, no. I've taken little bits of ideas from different areas. Similar, but I don't totally adhere to their doctrine, which is very specific […] Like I

> disagree with some things that NA teaches but most of my, most of my belief in recovery, my views on recovery do come from NA I find.

Aidan went on to explain that he disagreed with NA's focus on spirituality, specifically the understanding that 'addiction destroys you spiritually' and the belief in a 'higher power'. However, he found NA 'a lot easier going' than the previous residential program he had attended and that this was 'one of the things that drew [him] back'. In contrast, James (male, 37, not in treatment), whose accounts of AA and normality I examined in detail in the previous section, appreciated the rigidity of the 12-step program. He explained that 'to full on be in recovery' he would need to be entirely abstinent. However, even James had deviated from this principle whereby on several occasions he had used methadone 'to start off with' in the early stages of recovery, before gradually decreasing his dose until he was abstinent. In this way, James accepted the ultimate necessity of abstinence to achieve 'full recovery', but temporarily suspended this principle by including MMT as part of his early recovery practices to assist with withdrawal and 'hanging out [cravings]'.

Although the US term 'medication-assisted' recovery (White, 2012b) has recently been used to bring patients on methadone and other opioid substitution treatment under the framework of new recovery (Frank, 2017), opioid substitution treatment has always had a long and ambivalent relationship with recovery. At 12-step fellowships, members are required to identify themselves at the beginning of every meeting if they are enrolled in substitution treatment. Further, there exists a provision that members may not begin working the 12 steps until they have concluded such treatment. These distinctions speak to the emphasis on abstinence in the framing of 'proper recovery', and its association with authenticity, honesty and willingness to get well (Carr, 2011). These accounts of critical incorporation point to the tenacity and enduring influence of the 12-step model of recovery. It can accommodate new technologies and discourses and withstand epistemological shifts (Frank, 2017), while

simultaneously doubling down on its message of addiction-as-disease and recovery as spiritual growth.

Other participants were sceptical of the 'arbitrary' nature of some 12-step practices, while tending to engage with those practices they understood as worthwhile. Although Calev (male, 31) had attended NA regularly for the last three years, he was still 'sceptical' about the evidence base for many 12-step practices and the rationales provided by senior NA members:

> **Calev**: Like, I'm a bit kind of sceptical on a lot of the stuff in NA, but they do suggest doing a gratitude list and I agree with that, because I've read studies about how good it is and the benefits of it.
>
> *Renae: What sort of things are you sceptical about?*
>
> **Calev**: [I'm] sceptical about a lot of the arbitrary things that they say like […], 'you have to do ninety meetings in ninety days'. They have these little rules like 'you can't be in a relationship for the first year' and then the steps, the twelve steps and I pretty much agree with all the things on the steps – that they are good things to do and they might help with recovery – but I don't think that the step themselves are like some magical answer. Because you know, people do the steps and they don't get clean and the success rates in NA are no better than the success rates in any other kind of recovery program and people in NA try to say, 'that's because the people who do the steps properly, they are hundred per cent guaranteed to stay clean' and I just think it's all kind of bad science.

At the time of our interview, Calev identified as 'in recovery' although he did ponder whether 'that's just the term that has kind of been drilled into me from NA'. Calev's use of the term 'drilled' is notable and perhaps reflects the 'zealous' and ritualised practices commonly associated with 12-step and other self-help groups (Galanter, 1990; Valverde & White-Mair,

1999). He did, however, think that it was important not to underestimate the risk of relapse and to focus on 'doing stuff to make sure you are happy and enjoying life and not stressed and stuff like that'. For these reasons, Calev adopts some 12-step practices, such as doing the gratitude list, attending meetings and engaging a sponsor. However, he is also critical of other aspects that he thinks are 'arbitrary' and not based on evidence, such as having to attend 90 meetings in 90 days, not being able to pursue a romantic relationship for the first year and the 'magical' power he sees some people attributing to the 12-steps. Similarly, despite having been abstinent and heavily involved with NA for over seven years, Rachael (female, 33, not in treatment) also engaged critically with the language and practices of 12-step models:

> I definitely have my criticisms of it. […]. There's a lot of focus on people's clean time and if someone relapses… the relapse [becomes the focus] rather than their overall care or 'how do we work with this person' and they're not interested.

Later, Rachael also criticises the 'Christian' undertones that inform doing 'inventory',[9] suggesting that it has 'overtones of penance and being wrong and being punished'. Despite having problems with the interpellative logic of reparation I examined earlier, Rachael still adopts many of these practices because she finds 'the actual process of it' like 'nothing else'.

Moore (2009) poses a question of the tactic of critical incorporation, which is relevant in thinking through the significance of these accounts. In sum, he asks should drug-using subjects have to accept service-provider definitions (or therapeutic discourses), which largely define them in disordered and pathological ways, 'in order to transform their lives' (Moore, 2009, p. 1167)? Moore highlights one potential effect: enrolment in professionalised

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[9] In *Alcoholics Anonymous* (Alcoholics Anonymous World Services, 2001), the fourth step in the recovery program is making a 'searching and fearless moral inventory' of oneself (p. 59), and 'inventory' is described as a 'fact-finding and fact-facing process' (p. 64). The inventory focuses on an individual's resentments, their perceived cause and their effects. Reviewing one's own conduct through inventory is thought to make people more aware of their character flaws and helps them to create more honest relationships with other people.

discourses robs drug-using subjects of the necessary resources to counter marginalisation and deal with services more effectively. In the examples I have explored, we could ask to what extent the rigid adoption of principles that characterise the NA program, such as attendance, spirituality and the rejection of opioid substitution treatment, conflict with the demand that recovering subjects also be autonomous, rational and economically productive? Is it reasonable that Rachael should recite Christian practices and traditions when she finds the notions of punishment and reparation old-fashioned and undesirable? Although critical incorporation engenders a more nuanced incorporation of therapeutic discourses it is not able to fully bring to light the 'outside of legitimacy' (Fraser et al., 2017, p. 195) which makes these practices culturally and politically legitimate.

Conclusion

In this chapter, I have shown how 'recovery' can, at certain times and for some people, be experienced as a positive force, whereas for others at other times it is less compelling for a range of reasons. I continued my analysis of modes of ordering and interpellation by addressing the second aim of this thesis – exploring how people who use drugs engage with recovery in their everyday lives. 12-step logics, embodied and enacted through continual practices of self-improvement, continue to be an important mode of ordering in the everyday lives of drug-using subjects who engage with recovery. The continued prominence of 12-step models and practices in the ordering and regulation of addiction raises questions about new recovery's ability to dislodge, and offer something more than, these older forms. However, its prominence also attests to the capaciousness and malleability of recovery ideals, as they have been practised in 12-step fellowships, buttressing notions of authenticity, reparation and amends while appropriating new associations with health, citizenship and responsibilisation. On this view, the enactments of 'recovery' I have analysed in this chapter are perhaps best viewed as 'hanging' together in hybridised forms (Mol, 2002).

In the first half of the chapter, I analysed the practices of self-work that people perform in response to a range of authoritative injunctions that they must recover in order to be healthy and productive citizens. As Bojana, Gary and James' accounts suggest, working on one's self provided opportunities to rebuild relationships with family, develop positively-regarded routines and order in their domestic lives, and cultivate healthier eating and exercise practices. Their accounts also suggest the productive sense of empowerment, self-worth, responsibility and normality that is associated with their interpellation into these practices and associated subject positions. On the other hand, however, these accounts suggest that recovery interpellates drug-using subjects into narratives of reparation, responsibilisation and normalisation that enjoin continuous practices of self-work and self-scrutiny. Underpinning these projects of self-realisation are the flawed political assumptions that 1) individuals really are autonomous and have control over their lives and 2) that the idealistic enactments of productivity, resource accumulation and perfect health that underpin 'normality' in recovery are real and achievable, despite participants' experiences of unfortunate events, systematic discrimination, stigma and disadvantage.

In the second half of this chapter, I explored alternative ways in which individuals engage with these interpellations. That is, in my explorations of resistance, strategic accommodation and critical incorporation, I demonstrated the ways in which authoritative modes of ordering drug use – whether those found in older forms or those evident in the new iteration – are challenged by those who use drugs. Participants resisted the recovery identity interpellation, which is so central to authoritative enactments of new recovery. Their accounts also provided useful counters to the polarised binaries of addiction and health, which continue to sustain the explanatory power of recovery. Perhaps most importantly, these accounts were able to illuminate and disrupt the normative fantasy of the recovering subject position. Instead, they made political claims for a more nuanced vision of subjecthood and social life predicated

upon sameness, rather than a binary understanding of the differences between drug-using subjects and 'normal' people.

Significantly, I noted the explicit prevalence of 12-step understandings of addiction recovery, which maintain historical associations with the addiction-as-disease concept, spirituality, moral reform, and reparation. Yet, evidently, 12-step modes of ordering are also capable of refashioning these understandings and aims through contemporary associations with citizenship, normality, good health and responsibilisation. The fact that 12-step knowledges and practices featured so heavily in participants' accounts is significant, and speaks to the tenacity and capaciousness of addiction-as-disease models. In support of the critique I have developed across the previous chapters, which has fundamentally questioned new recovery's claim to newness, this chapter also raises questions about the usefulness of investing resources in new recovery. First, this study suggests that it has failed to gain traction in the lives of those it targets. More importantly, my analysis of the onerous obligations, self-scrutiny, and self-recrimination required of drug-using subjects via the interpellation of 12-step recovery suggest that new recovery is bound to enact similar forms of harm: principally the inability to address political forms of inequality and social suffering, while further responsibilising already marginalised and stigmatised people.

Chapter 9

Conclusion

My research critically explored multiple enactments of ‘new recovery’, which has become an increasingly prominent feature of recent debates in alcohol and other drug policy, advocacy and service delivery in the UK, Australia and elsewhere. My analysis was guided by three questions:

1. How is this new iteration of recovery enacted in drug policy, research and treatment in Australia, and what assumptions and claims about drug use and people who use drugs are made along the way?
2. How do people who use drugs adopt, accommodate, resist or otherwise engage with new recovery in treatment and their everyday lives?
3. What are the political effects of these new recovery enactments?

In particular, I have sought to map the social and scientific constitution of ‘new recovery’ in Australia and to scrutinise its claims to novelty and liberation. How ‘new’ is the new recovery? Does it fulfil the liberatory function claimed by its proponents? And what kind of liberation, in what kind of political universe, is being posited?

To build my argument, I mobilised posthumanist interpretive tools to analyse five cases of the enactment of new recovery: alcohol and other drug policy, psychological science, professional accounts, treatment and the lived experiences of those interpellated by ‘recovery’. By mobilising these tools, my account foregrounded politics, multiplicity, contestation and negotiation, and eschewed conventional approaches that seek to define, quantify or evaluate recovery as an anterior, singular and independent object. The analysis has drawn on recent scholarship in STS, notably Law’s (2004) concept of ‘enactment’, which

understands realities as *effects* of diverse and varied practices. That is, realities emerge in and through specific networks of socio-material practices. Building on Law's critique of reality as prior, anterior and singular, I analysed how knowledge and political practices enact recovery in each of the five cases. Critically engaging with the proposition that realities are ontologically inseparable from practices, and that different networks of practices produce different realities, meant recognising the ontological multiplicity of specific realities. Following Mol (2002) and Law's (2004) work on multiplicity, I traced the various enactments of new recovery (e.g. as a citizenship regime, as the accrual of recovery capital, as social identity change, as a therapeutic journey), and sought to draw out their continuities with older iterations, and the tensions, contradictions and forms of coordination that sustain them. In undertaking these analyses, I analysed the ontological politics (Mol, 1999) of these iterations of new recovery, drawing attention to the implicit and explicit practices and processes that produce multiple new recover*ies*. In adopting this approach, I sought to show how the realities of these recoveries are contingent upon and entail 'politics', that is negotiations, absences, inclusions, erasures and normativities. In addition to the overarching theoretical interest in enactment, multiplicity and ontological politics, I drew on a range of other interpretative tools in relevant chapters. These tools are consistent with the STS focus on performativity and emergence, and their use is intended to showcase the utility of posthumanist approaches.

In order to pursue my argument, I adopted a 'case' method (Mol & Law, 2002). This method allowed me to draw out the ontological politics of the different recovery enactments produced across different sites, without trying to make larger claims about the 'real' nature of recovery or assumptions about a singular, stable object of study. Instead, I employed Mol and Law's (2002) argument that cases should be understood as 'sensitising' mechanisms (p. 15). By accentuating 'relations of a variety of different kinds', cases incite questions 'about

difference and similarity, about what alters in moving from one place to another' (pp. 15-16). I focused on five significant sites: new recovery problematisations in alcohol and other drug policy, scientific simplifications in psychological science on new recovery, organising relations in the narrative practices of professionals, the production of addicted subjectivities in recovery-focused treatment, and accounts of the everyday practices and realities of recovery. Although, as Mol and Law (2002) argue, these cases are not representative of some larger, coherent recovery reality, they remain instructive beyond their specific sites. Therefore, without trying to assemble the meanings generated in each case into a singular mode of ordering, my research makes several key sociological contributions to the analysis of new recovery and related concepts.

My analysis has shown that recovery is still very much 'under construction' (Fraser & Seear, 2011, p. 2), shaped by ontological multiplicity, ongoing negotiation and contestation, processes of legitimation and coordination, and practices of inclusion and exclusion. Although I sought to preserve these tensions and explore their social and political effects, I also attempted to draw attention to continuities, which form the basis for several key concluding observations about recovery. Most significantly, I argued that, across the cases, enactments of new recovery rely on the continuous simplification and stigmatisation of drug use, of people who use drugs and of their social relationships. Built into the very ontology of new recovery are different forms of stigma (e.g. failed citizens, damaged identities, suspect social relationships) that establish the legitimacy of recovering subjects (and by extension free and autonomous subjecthood) through the exclusion of drug-using subjects (Fraser et al., 2017). These processes raise serious doubts about the claims that new recovery is not intrinsically pathologising and stigmatising.

In addition to the recursive operation of stigma in producing and reproducing recovery realities, I sought to show the complex work that must go into making recovery 'hang

together' (Mol, 2002) as a coherent and singular phenomenon. This includes not only the professional organising relations I traced in Chapter 6, but the interpellation of disordered subjects through treatment and everyday practices, the valorisation of individualised explanations for life circumstances, and the inculcation of practices of responsibilisation and self-work. Therefore, rather than seeking to establish the 'real' nature of recovery, I traced (in its ontological variability and multiplicity) the ways in which agency, responsibilisation and subjectivity are central to the politics of recovery. I also argued that enactments of new recovery actively take part in theorising the nature of reality in that they posit the existence of a 'normal life' somehow free of struggle. In Chapter 8 I explored participants' resistance to the rigid images of healthy subjecthood, society and normal life mobilised in new recovery discourse. Their nuanced and situated accounts highlighted the limitations of the binary between addiction and health, which operates so forcefully to sustain contemporary enactments of citizenship, and the need for recovery, in authoritative sites. These accounts also highlighted the mythic character of 'normal' and 'healthy' society, illuminating longstanding experiences of social stigmatisation, and emphasising the shared nature of inequity, injustice and abuse that characterises all people's experiences, not just those labelled as addicted. In the rest of this chapter, I review the major arguments of the thesis and explain how they correspond with the three questions guiding the thesis. I then discuss how the thesis relates to the existing literature, reflecting on the implications of my analysis for understandings of recovery and of drug-using subjects, before concluding by summarising the main contributions of the thesis to this literature.

Enacting new recovery and drug-using subjects

In Chapters 4 and 5, I explored authoritative discourses of new recovery, tracing how this most recent iteration of recovery is enacted in drug policy and research practices. I argued that the focus on new recovery in national and Victorian alcohol and other drug policy

documents intensifies the pathologisation of individual drug use, by reinforcing medicalised notions of dependence and addiction, and by revisiting older medicalised associations between drug use and mental illness. These enactments of drug use trouble claims made by researchers and advocates that new recovery represents a shift away from a pathologising approach to drug use. They also underpin and legitimise an amplified focus on treatment. This expanded focus on treatment more explicitly outlines a 'typical' kind of treatment client and a successful treatment trajectory that require drug-using subjects to actively manage their drug use in order to qualify as 'healthy' citizens. The promotion of more active citizenship practices also occurs through the focus on community participation, which is simultaneously troubled by the enactment of drug-using subjects as marginal and as potential sources of risk and harm. Understood as a contemporary citizenship regime (Procacci, 2008), new recovery reflects and reproduces political claims about the nature of life and society. That is, new recovery reproduces a neoliberal formulation of the subject as self-managing and responsible and ignores the political, social and economic forces and arrangements deeply implicated in the production and entrenchments of drug-related harms. Drug-using subjects continue to be excluded from the category of 'normal' citizens and citizenship practices, while increasingly required to adhere to the standards that mark these categories in order to achieve 'recovery'.

Notions of change, responsibilisation and citizenship were also central to scientific enactments of new recovery. Psychological science enacts recovery as a process of change, centrally achieved by individuals accepting responsibility for social inequality and their own disadvantage and working to manage their social environment. This enactment of recovery relies upon a narrowly inscribed individual/social binary that erases significant socio-material relations and forces, such as marginalisation, poverty and homelessness. The psychological science of new recovery centres on the social relationships of people who use drugs as the most significant entities influencing a person's recovery. Subsequently, the divestment of

these friendships and social connections are framed as paramount to the restoration of health, wellbeing and citizenship. This binary reinforces individualised conceptions of self-management, responsibility and agency, and conceals the fluid and contingent nature of sociality and agency. The enactment of new recovery in psychological science also draws on familiar forms of stigmatisation that cast people who use drugs and their social relationships as deviant.

In Chapters 6 and 7, I examined some of the dynamics operating in and through professional practices and treatment settings. Professional practitioners routinely distil, translate and coordinate vague and disparate enactments of recovery into a coherent therapeutic rationale. These organising relations emerge at the point when alcohol and other drug professionals must decide what therapeutic action to pursue in order to assist their clients. Professional accounts produce capacious theoretical constructs that add and align different enactments of addiction into a composite, singular disorder amenable to recovery. I also argued that metaphor plays a crucial function in professional accounts and clinical settings by translating citizenship and identity obligations into clinical practices and therapeutic discourses. Recovery is also made coherent by distributing and holding apart potentially conflicting enactments of recovery, such as recovery as abstinence, recovery as MMT and recovery as the capacity to engage in recreational alcohol and other drug use. Professional coordination practices reflect and reproduce the complex ontological politics of new recovery explored in previous chapters, in which a focus on pathology, identity change and responsibilisation is central. However, professional accounts also enact recovery via older associations (e.g. the recovery journey and abstinence), producing contradictory and hybridised enactments of recovery.

My analysis of treatment practices and dynamics in Chapter 7 also demonstrated the ways in which recovery is ‘held together’ (Mol, 2002). The interpellation of ‘recovering addict’

identities inaugurates drug-using subjects with the capacities and attributes often ascribed to identity (disordered, enmeshed in suspect social relationships and potentially irresponsible) but which are better understood as contradictions and tensions emerging in and through the state of knowledge about addiction and its expression in treatment.

In the final empirical chapter (Chapter 8), I analysed how these authoritative enactments, modes of ordering and interpellations are adopted and experienced in the everyday practices of people who use drugs. Even for those who willingly adopted recovery beliefs and practices, the recursive interpellation of reparation, responsiblisation and normalisation in authoritative and 12-step recovery practices meant that the attributes and alleged benefits of citizenship, identity change and transformation promised elsewhere did not always materialise. These accounts highlighted the enduring significance of 12-step recovery practices and beliefs, which are largely excluded from the policy, psychological scientific research and treatment practices analysed earlier. The continued prominence of 12-step models and practices suggests that new recovery has not proven to be sufficiently novel or strong enough to displace older forms of recovery, which continue to inform everyday recovery practices for those who use drugs. Drawing on Moore's (2009) work, I further examined some of the dynamics characterising participants' engagement with the various enactments of recovery including the ways in which they resist, strategically accommodate and partially incorporate authoritative enactments. Some participants resisted authoritative modes of ordering addiction, in particular the ordering of addiction as compulsive and irrational, and the regulative aspects of recovery, which emphasise rigid notions of health, including abstinence. The exploration of strategic accommodation showed how participants can adopt recovery in purposive ways in order to claim status and access to more valorised subject positions. In addition, participants incorporated recovery beliefs and practices at some times (e.g. when enrolled in treatment) and not at others, illustrating the inadequacy of

models in which recovery is constituted as an essential identity. This exploration of the orderings, interferences and resistances pursued in everyday life drew attention to drug-using subjects' management of the complexities of recovery practices. The tensions around subjecthood, sociality and agency in recovery discourse and practices, found here and in the experience of treatment (Chapter 7), impact primarily on, and must be resolved by, drug-using subjects.

The ontological politics of new recovery

In summarising my research, three central arguments emerge that respond to the three guiding questions with which I opened this thesis. First, eschewing a concern with defining recovery or improving recovery outcomes, I have instead focused on the multiple enactments of new recovery and the assumptions they make about drugs and the people who use them. As I argued in Chapter 4, new recovery-focused discourse in alcohol and other drug policy generates problematisations of drugs and drug-using subjects that legitimise the need for recovery-focused policy. Although recovery discourse appears focused on empowerment and the creation of opportunities for meaningful participation, it is also highly stigmatising in that drug-using subjects are permanently denied the attributes of rational, autonomous citizens and thus limited in the ways in which they might express agency or make political claims. Building on the problematisations of drugs and drug-using subjects in policy, Chapter 5 attends to a different, but no less important, underlying assumption about the nature of agency and change. Psychological research enacts recovery through a binary opposition between the individual and the social. This simplistic binary posits a simplified and governable social environment, narrowly circumscribed as social relationships, on the one hand, and a wholly agential drug-using subject (as self-managing and enterprising) on the other. In both the theory of recovery capital and the social identity model of recovery, drug-using subjects are enjoined to change by taking control of their social relationships. Thus

whereas the regulative framework of alcohol and other drug policy produces drug-using subjects as variously disordered, compulsive, vulnerable yet threatening, outside the community but reliant on its support, and marginal, scientific research produces drug-using subjects as enterprising, as the locus of change and as entirely in control of their social environments. Professional practices and discourses must manage these tensions alongside those emanating from the earlier, longstanding discourses of recovery found in self-help organisations. Chapter 6 drew attention to the varied ways in which professional practices function to preserve the singularity of recovery by assembling it into a coherent therapeutic object. However, through these organising relations – namely addition, translation, and distribution – professional accounts highlight the multiplicity, overlap and hybridisation of new recovery with other iterations. Their practices highlighted the multiplicity of recovery and the seeming failure of new recovery to stake a claim in professional knowledges or practices in Australia.

Given these multiple authoritative enactments of recovery, and the forms of contradiction and stigmatisation they produce, how do those addressed by 'recovery' respond? In order to pursue this second of my three overarching questions, I examined the ways in which people engage with the ontological multiplicity of recovery. Chapters 7 and 8 explored the ways in which people who inject drugs (the most marginalised and stigmatised of all drug users) engaged with the ontological multiplicity of addiction and recovery in their experiences of treatment and in everyday life. The conflicting and inconsistent enactments of addiction, agency and responsibility produced across authoritative sites, and the limited subject positions they make available, have major implications for those interpellated by recovery. In Chapter 7 I explored how the social and material practices of recovery-focused treatment demand that treatment subjects resolve complex epistemological and institutional tensions by adopting a disordered 'recovering addict' subject position. Modes of ordering addiction in

residential treatment interpellated treatment subjects as both disordered and as 'in control'. The interpellative logics of social connection, and the particular obligations they enact, produce insecure and hyper-vigilant subject positions. I also argued that treatment practices enact social context in simplistic and rational ways that obscure the contingency of social settings and events. Like psychological scientific research, treatment practices interpellate a responsibilised subject as entirely responsible for recovery.

In Chapter 8, I explored how recovery is enacted and recovering subject positions are interpellated in the everyday practices of people who inject drugs. I argued that individuals responding to authoritative enactments to recover and change engage in intensive practices of self-work in order to manage the addicted self. These practices change and take on different meanings in relation to different modes of ordering recovery, and different interpellative logics, including reparation, responsibilisation and normalisation. Despite the backgrounding of the language and practices of 12-step recovery in authoritative sites, these principles and practices were central to understandings and enactments of recovery in everyday life. These accounts spoke to the limitations of new recovery and, in particular, to its inability to dislodge older forms. However, in the second half of the chapter, I explored how individuals resisted these interpellations, used them strategically for specific purposes and critically incorporated 12-step ideas. Participants spoke of the limitations of common understandings of addiction, arguing that the association of addiction with compulsion, lack of control and trauma were not their experiences. These accounts demonstrated the creativity of participants who could leverage new recovery to claim legitimate identities for themselves. They also suggest that interpellation and incorporation are always partial and changing, as evident in some individuals' careful adoption of specific 12-step ideas and rejection of others.

Finally, what are the political effects of recovery enactments? I argued that the enactment of new recovery in policy reproduces stigma by problematising drug use as pathological and

‘dependent’ drug users as failed citizens. I also drew attention to the ways in which these same processes of stigmatisation make the extension of citizenship to drug-using subjects contingent on the acceptance and adoption of normative health and community expectations and practices. Yet those who are the targets of recovery have been afforded few opportunities to participate in the definition of what counts as ‘normal’. Further, these policies reflect and reproduce depoliticising myths about ordinary life and what it means to be a contemporary citizen. First, new recovery implicitly suggests that ‘ordinary’ and ‘normal’ life exists in some kind of pristine and harmonious form. Second, it offers direction about how this kind of life can be achieved through sustained enterprise, empowerment, choice and change. In this way, it limits more socially and politically oriented responses to drug harms, poverty and marginalisation and severely limits the kinds of political claims drug-using subjects can make.

Related to this, I have also shown how psychological science is involved in scientific simplifications that privilege individual control and responsibility as the primary determinants of recovery. These simplifications actively erase a host of other agential socio-material forces implicated in contemporary citizenship practices, health, wellbeing and social life. The political effects of these simplifications are perhaps most clearly demonstrated in everyday accounts of recovery, in which people struggled to incorporate more relational and political understandings of the relationships between drug use and broader socio-material forces. Some participants adopted narratives of drug use as a pathological moral failing. This kind of narrative attributes to the drug and the drug user moral responsibility and cannot account for other experiences that may be implicated in people’s difficulties, such as abuse, poverty, mental illness, criminalisation and homelessness. Furthermore, if participants adopt these logics of enterprise and change, played out through self-work, they continually reiterate their own sense of disorder and failure. In this sense, the erasure of socio-material forces

evident across policy, science and treatment has the potential to further pathologise drug use and people who use drugs, and to restrict potential responses for those concerned with managing their consumption.

The circumscription of subjecthood and agency has even greater political effects for those people unable or unwilling to engage with or maintain recovery. Many people expressed regret that they were currently injecting heroin and a desire to be in recovery again. The associations between recovery and citizenship produce a powerful incentive to recover. However, the socio-material circumstances of people's lives did not always support these kinds of recovery, even if desired, and the kinds of change recovery requires. In these cases, individuals made sense of 'relapse', or their failure to recover, through individualising accounts emphasising failure, lack of self-control and effort, disorder and disease. People who continued to consume drugs and resisted the interpellations of recovery were frustrated with what they perceived to be simplistic political and professional understandings of drug use. Is it not possible to be 'addicted' *and* healthy, orderly and responsible? Should 'recovery' be the primary goal or is finding safer ways to use drugs a more suitable course of action? Can recovery ever be over? These critical accounts highlight some of the ways in which people resisted the neoliberal normativity at the centre of new recovery and recovery-focused treatment. In doing so, these participants assert the kind of agential, choosing and rational subjecthood routinely enjoined in new recovery discourse and practices. These findings, along with those concerning people's strategic accommodation of recovery discourse and practices, suggest that both pathologising and identity-driven accounts of drug use are inadequate in attending to the complexity of drug-using practices and the different kinds of agency expressed by drug-using subjects. They also place an undue, perhaps intolerable, burden on those interpellated by recovery.

Contributing to a critical sociology of 'new recovery'

Qualitative literature on new recovery has been most fully developed in the field of critical policy studies. Responding to the uptake of new recovery ideas in UK policy and treatment, qualitative sociological researchers in the UK have sought to refine the central concepts and concerns of new recovery, in order to make 'recovery' more reflective of the experiences of people who use drugs. Building on three critical studies that have argued for a greater engagement with the central problematisations and assumptions underpinning new recovery, the main contribution of my research are its critical analysis of the problematisations and assumptions underpinning new recovery across several multiple sites. In engaging the specificity of this new iteration of recovery, and examining whether new recovery's liberatory claims are borne out in the accounts offered by individuals who use drugs, I sought to distinguish it from older versions. To take up such questions, my study took a different approach to the research I identified in Chapter 2, which aimed to improve new recovery's sensitive and utility. I instead scrutinised how new recovery is produced and the political effects of this production. This thesis focuses specifically on the practices engaged in making new recovery. While much of the previous literature has, in various ways, tended to support the view of recovery as fundamentally singular and consistent, I drew on STS theory and on STS-informed critical drug studies to argue that new recovery is made multiply in different practices. By conceiving of new recovery in this way, I was able to explore different enactments and understandings of recovery across the different sites. Mine is the first study to critically analyse the emergence of new recovery in Australia above and beyond critical policy studies.

By exploring these multiple enactments of recovery, I was able to not only track how new recovery was being made differently, but explore the extent to which authoritative enactments of recovery inform individuals' lives. I was also able to address the question of

the novelty of new recovery, by arguing that there exist important threads of continuity and intensification, most notably, in the neoliberal politics of responsibilisation, the erasure of socio-political forces, and the continuing stigmatisation of people who use drugs and their social relationships. In my analysis of professional practices, treatment and everyday practices, I also argued that there exists considerable overlap and hybridisation between different recovery enactments. That is, broader, longer-standing, more diffuse notions of recovery are used alongside, and sometimes with, the changing terminology of new recovery, and the specific rituals of 12-step recovery. This overlap and hybridisation speaks to the tenacity of 'recovery', new or otherwise, and the way it is being achieved and maintained, even as it changes and constitutes new realities. Although psychological scientific enactments of recovery capital and social identity have been moving slowly into the purview of treatment via screening and assessment tools and select research studies, these new approaches to treating addiction have been taken up inconsistently by service providers, service users and people who use drugs, at least in Australia. One reason for this might be that, as my analysis revealed, the underpinnings of these 'new' scientific constructs for recovery continue to pathologise drug use and to ignore socio-material forces and arrangements, thus failing to offer people who use drugs genuinely fresh solutions. As I have argued throughout this thesis, the liberatory and empowering claims of new recovery fail to materialise when the 'new' approach remains so focused on individual addiction and pathology, deviant sociality, responsibilisation and self-management.

Another contribution of this thesis is its thorough interrogation of the category of identity, which has been used so productively across older and new iterations of recovery. Symbolic interactionist analyses of earlier iterations of recovery tended to reinforce and reify the notion of recovery as a process of 'identity change' (Biernacki, 1986; McIntosh & McKeganey, 2002). More recent sociological work also explored a broader notion of recovery through the

category of identity (Martin, 2011; Radcliffe, 2011; Dahl, 2015). Further, as I explored in Chapter 5, identity has endured as the basis of the social identity model of new recovery (Best, Beckwith et al., 2016). In drawing on recent work in STS, which has been productively applied in analyses of alcohol and other drug issues (Dwyer & Moore, 2013; Dwyer & Fraser, 2015; Hart & Moore, 2014; Fraser, Moore, & Keane, 2014; Fraser & Seear, 2011; Moore et al., 2017; Seear, 2014; Seear & Fraser, 2014), my research, in part, aimed to decentre the epistemological and ontological credibility of identity and to trace how the enactment and interpellation of identity is central to the politics of recovery. The reliance on identity in earlier sociological work pathologises addiction and recovery, constitutes recovery as an individual process of change, and routinely erases socio-material forces and relations. In later sociological work, the category of identity tends to buttress an individualised understanding of drug harms and subjecthood, and forecloses novel explorations of the social and political enactment of 'recovery' of the kind described in this thesis. To rethink identity and its potentially stigmatising effects as central to the ontological politics of recovery (as opposed to a fixed attribute of recovery) means that we must be attentive to the many sites and practices where taken-for-granted notions of identity are articulated.

I understand my research as intimately engaged in the making of new recovery, and to this end I sought to stress the multiplicity of recovery enactments as well as consider the implications of multiple forms of stigmatisation for people who use drugs. By drawing attention to the instability and contingency that characterise enactments of new recovery, I argued that these enactments (and those of addiction and of drug-using subjects) are deeply political. My research was an (inevitably partial) attempt to trace the ontological politics of recovery in order to identify the kinds of realities and possibilities these enactments produce for drug-using subjects.

Conclusion

Recovery is always already political, reproducing assumptions, binaries and logics that are rarely subject to critical scrutiny. I drew attention to the multiple practices that constitute recovery – the problematisations, simplifications, overlaps, erasures and hybridisation – that have to this point received little scrutiny. These include but are not limited to the positioning of drug-using subjects as marginal to the community and as potential sources of harm; the erasure of socio-material forces in the enactment of recovery as fundamentally a process of individual change; and the interpellation of disordered identity and suspect sociality. The political effects of such authoritative enactments for marginalised groups are significant. As I showed, they extend to the attribution and circumscription of stigmatised forms of agency, citizenship, identity and responsibility, which in turn have ongoing material, lived effects. As the accounts of participants made very clear, the stigmatising and marginalising ontological politics of new recovery, which figure in everyday practices, constitute a range of abject subject positions and contend with older recovery forms, to help determine the available narratives through which people can account for their lives and conceive and enact their futures.

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Appendix A: Policy documents

Table 1: Analysed policy documents

Publication date	Title	Pages	Author
2008	*A New Blueprint for Alcohol and Other Drug Treatment Services 2009–2013*	55	Department of Human Services
2011	*The National Drug Strategy 2012–2015: A Framework for Action on Alcohol, Tobacco and Other Drugs*	26	Ministerial Council on Drug Strategy, Commonwealth of Australia
2012a	*Reducing the Alcohol and Drug Toll: Victoria's Plan 2013–2017*	58	Department of Health, State of Victoria
2012b	*New Directions for Alcohol and Drug Treatment Services: A Roadmap*	32	Department of Health, State of Victoria
2012c	*Victoria's Alcohol and Drug Workforce Framework: Strategic Directions 2012–22*	30	Department of Health, State of Victoria
2013a	*New Directions for Alcohol and Drug Treatment Services: A Framework for Reform*	30	Department of Health, State of Victoria

Appendix B: Participant characteristics

Table 2: Characteristics of participating alcohol and other drug professionals (N=11)

Gender	**Number**
Men	5
Women	6
Occupation	
Research	3
Alcohol and other drug service provision	3
Alcohol and other drug service management	4
Policy	1
State	
Victoria	10
NSW	1

Table 3: Characteristics of participating people who inject drugs (N=25)

Gender	**Number**
Men	15
Women	10
Main preferred drug[10]	
Alcohol	1
Stimulants	1
Opiates	23
Age	
18-29	2
30-39	12
40-49	7
50+	4
Cultural and ethnic background[11]	
Australian	20
Australian Aboriginal	1
Southern and Eastern European	3
South-East Asian	1
Current treatment status[12]	
Opioid substitution treatment	4
Residential rehabilitation	1
Case management/counselling	5
Attended 12-step meetings	4
Not in treatment	11
Most recent drug injecting	
0-4 weeks	13
1-6 months	2
6 months-1 year	2
1-3 years	5
3 years +	2
Unspecified	1
Employment status	
Working/studying	11
Not working/studying	14

[10] Some participants described consuming only one drug, while others talked about two or more. The table lists the drug that participants identified as their primary preferred drug. The emphasis on heroin use reflects the first author's research focus on injecting drug use.

[11] Reporting of cultural and ethnic background follows the Australian Standard Classification of Cultural and Ethnic Groups, developed by the Australian Bureau of Statistics. Cultural and ethnic background was classified according to a combination of self-reported group identification with particular cultural or ethnic groups, the participant's birthplace and their parents' birthplaces.

[12] Most participants accessed multiple treatment modalities at the time of the interview and had done so in the past. The table lists the treatment type that participants were most intensively engaged with at the time of the interview. However, almost half of the participants had previous treatment episodes in residential rehabilitation prior to being interviewed.

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