Finding the treasure: everyday moments of becoming well in a semi-rural place
5th Contemporary Drug Problems, Prato Italy, September 2019 Rethinking 'Change': New Theories, New Topics, New Questions, New Methods

I am a social worker and here to share with you some insights from my PhD project exploring the production of health in a semi-rural place and how I am beginning to apply assemblage thinking in my practice as an alcohol and other drug counsellor. I will present a vignette from one of the interviews in my research and then briefly reflect how assemblage thinking may be used to potentially provide new and creative ways to disrupt patterns and promote health.

This is a work in progress and, as I am still grappling with complex ideas, I am looking forward to feedback from you. I would like to thank the many people (some of whom are at this conference), who have inspired my thinking, having not only changed the course of my study but also the way I am beginning to approach my counselling practice.

Much of the work within the critical drug field considers issues relating to consumption while there is a smaller body of work exploring harm reduction and the production of health (e.g., Dennis, 2019; Dilkes-Frayne, Fraser, Pienaar and Kokanovic, 2017; Fomiatti, Moore & Fraser, 2017; Moore, Pienaar, Dilkes-Frayne et al., 2017; Duff, 2014). To my knowledge, none of this emerging body of work focusses specifically on semi-rural places, places that are unique within the geographic, political and social landscape. I developed an interest in the process of change in these areas through my work in two small semi-rural towns in the Yarra Valley, Victoria, one of which is also my home.

Semi-rural places are contested spaces deemed by government legislation as neither rural nor urban (Fisher, 2017). In Melbourne, these areas are home to significant population growth, yet their contested nature sees them receive less government funding than wholly rural or urban areas, creating inequity in infrastructure and services available to constituents (Interface Councils, 2009). Services exist in urban hubs where the possibility of access does not always translate into 'actual' or 'real' access. From a social work perspective, it is crucial to develop greater understanding of the development of health in these areas to advocate for accessible and suitable services.

In the Yarra Valley, alcohol is within the counselling space more than any other substance, overtly present in rooms that I work in as well as in the physical and social space of these towns and broader cultural milieu. I am curious about how people change their relationship with alcohol in these small-town places, replete with social intimacies and cultural expectations. In thinking about change and the process of recovery I turn to Cameron Duff's (2017) Assemblages

of Health where recovery is seen as ‘an emergent capacity to manipulate the affects, signs, spaces and events of a body’s ‘becoming well’ (p. 59).

Utilising Deleuze’s distinction between *real* and *possible* recovery, Duff moves beyond considering generic recovery practices and broad rehabilitation goals to capture how recovery ‘advances and retreats’ (p. 59) in an assemblage of forces, always unfinished but working towards a joint enhanced capacity where material and non-material forces affect each other. In this sense recovery happens when small, incidental moments come together and do so repeatedly over time, thus producing an assemblage of health. For example, the small moment of being able to walk to the supermarket or shower daily are different to big goals such as become (and stay) employed. Thus, the assemblage of health constitutes the collective body of elements that come together to create moments of embodied wellness. According to Duff (2014), in this sense, health is a process of 'affective and relational becoming in which quality of life is advanced in the provision of new affective sensitivities and new relational capacities' (p. 136).

Ella Dilkes-Frayne and Cameron Duff’s (2017) notions of tendencies and trajectories help me consider how events and encounters work to produce emergent and enduring subjectivities within assemblages of health. Building upon the ideas of Deleuze and Delanda, Dilkes-Frayne and Duff (2017) explore the idea of tendencies, or inclinations, that hold unrealized states or ‘virtual capacities’ (p. 958) that may or may not be actualised depending on the particular configuration of an event. Tendencies are seen as ‘habitual inclinations’ (p. 958) that do not hold a pre-determined outcome but are open to novel expressions with each new encounter or event. Change is seen to occur when tendencies manifest in different ways that may, over time, become stable and enduring.

The concept of trajectories illustrates how tendencies *act* within an event. Trajectories map the direction or ‘lines of futurity’ (p. 959) of tendencies, where, while a lived past is drawn into the present, there is the possibility of the trajectory, or line, being interrupted because of current circumstances. Disruptions to a line alter the event and can change the course of a trajectory. In thinking about harm reduction, rather than attributing blame (and thus responsibility) for dangerous consumptions on the individual or substance, Dilkes-Frayne and Duff (2017) call for a consideration of how events of consumption may be modified to re-direct tendencies and trajectories and in doing so reduce the ‘actualisation of harmful potentialities’ (p. 964). `

In my exploration, I am applying Duff's (2014) theory of assemblages of health and Dilkes-Frayne and Duff's (2017) tendencies and trajectories to address the following research questions:

1. What are the assemblages of forces relating to the disruption of alcohol and other drug consumption patterns for people who live in a semi-rural place?
2. In what ways do everyday moments contribute to the production of health?

To date, I have interviewed twenty-two people who live in the Yarra Valley and I will now share some of my thoughts about a case study from this research. In the following vignette, Mick foregrounds alcohol as the most agential element in the change process, feeling that it is alcohol that needs to be removed to actualise 'health'. I am using situational analysis (Clarke, 2005) to consider other elements that are also at work in this space.

Mick attends the interview held in a sparse white room with a large window in the small town where we both live. He appears nervous, sitting on the edge of the chair, legs twitching, hands wringing, eyes cast downwards, but his voice is strong and clear. Sitting with me is producing observable anxiety and tension in his body, an intensity flowing from him into the room.

Before I have asked the first question, Mick's opening words place him in a certain set of circumstances, cultural and normative ideas influencing his account of who he feels he is:

> *I am the second eldest and one of six boys. My father's Italian, my mother's Irish. I'm from an immigrant background. Childhood of divorce, domestic violence, alcoholism in the family. I am a recovering alcoholic. I am fifteen months sober. My sober date is 1st January 2017. Fifteen months*.

This account hangs in the room, shaping the way he presents an event that to him, was the primary catalyst for change, an incident at a family barbeque where he was arrested for assaulting his brother and subsequently placed on a community corrections order. Mick articulates that this event encapsulated common features in his life:

> *Being in trouble with the police was definitely a theme for me, lots of alcohol related incidents. Alcoholism, gambling, a lot of assaults.*

Mick foregrounds alcohol as having the most agency in past events of violence, relegating to the background other elements such as his childhood experiences of family violence, his cultural heritage and the ways he learnt to manage conflict. He recounts that it has been his responsibility to change his relationship with alcohol and that the absence of this substance has improved his situation

> *I've taken a lot of ownership. I've seen the benefits in change. My life has significantly increased. I've gotten better for the decision I've made to stop drinking*.

In his words, he had been living a *'nefarious lifestyle of alcohol-fueled violence*', reiterating a popular narrative that is embodied in dominant discourses within popular media, enacted in liquor licensing regulations, courtrooms, child protection services, anger management courses and AOD treatment agencies. This narrative of masculinity-alcohol-violence and individual responsibility is one I am familiar with as it permeates the treatment services and counselling rooms that I work within. In the process of becoming-researcher and my growing curiosity about the production of health within a physical and relational space, I am challenged by how to decenter Mick and alcohol as the primary units of analysis.

As Mick problematises alcohol and accepts responsibility for changing his relationship with it, I try to see the kaleidoscope of relations, actions and materialities also at work. As his story drops into the space between us, I am transported to this BBQ: I see, alongside alcohol, a plethora of other non-human objects such as food, music, rooms and furniture and the garden space where bodies gather. Other human bodies are present, enmeshed with sociocultural elements such as his Italian/Irish heritage, normative ideas of masculinity and violence and the role of alcohol in Australian culture. Within this milieu is the family story of divorce and violence, mental illness, collective poor emotional regulation, trauma, grief and loss, and the judicial consequences of an act of retribution enacted by Mick on the person who killed his brother some years earlier.

Mick shifts in his seat, seeking comfort in the hard vinyl clad chair. His voice wavers with emotion as his words take me to another time and place, his bedroom in a share house on New Year's Eve 2016. His voice has dropped. Quiet, heavy words convey a sense of sadness and pain for cumulative events that have led him to this moment of what he calls desperation.

> *So, I was sitting in my bedroom, December 31st, New Year's Eve, 2016. I was drunk and I had run out of alcohol and I remember saying to myself, "I have no money, I have no friends, maybe I can give it [sobriety] a go"*

On this night, the trajectory that Mick had been on is disrupted by the entanglement of certain current events, affects and material circumstances but also past situations that have been carried forward into the present. The trajectory of other tendencies have already been disrupted by decisions that were enacted some six months prior, shifting when he rented a room in this town away from the suburbs, a physical move that interrupted his tendency to sleep in his car or couch surf with peers that he had come to see as a 'hindrance'

> *They weren't encouraging me to be the best version of myself, you could say that.*

When he settled in this town he reached out to a gambling counsellor, thus altering his tendency to keep his worries to himself, an act that gave him a positive experience of asking for help and learning to trust another person

> *I did trust her and she's more than a counsellor to me. She really is. She's like my Aunty or my mother, you know? Someone I never had in my life.*

Positive experiences such as these create capacity in the moment but also build virtual capacities that may lie latent until activated by certain conditions. On this night, these tendencies continue to flow forwards, coalescing with other personal and family circumstances as well as normative ideas of violence and alcohol, feelings of shame and stigma, an ache of loneliness and intoxication. Through these a desire forms that endures through the coming days until he can see a doctor and pharmacist to purchase medication to aid withdrawal. This action forges a pathway, a trajectory that stretches and twists, connecting with other bodies, human and non-human. Mick feels that for him, help is easy to access: the consideration of his housemate, the medical industry with standardised tests and risk protocols, employment with leave provisions and shiftwork structure, and a desire for more in his life, all join to support his decision. Mick's self-imposed isolation within the town is helpful in this process because he is anonymous here, having no prior history nor the weight of expectation of others in this place to be a certain way.

This moment of reaching out and the positive affect it produces flows into other areas of Mick's life. Over the next few months, his bedroom shifts from having been a place where he had enacted the tendency to drink alone, to become a sanctuary from where, through the Internet, he reaches out to the world of sobriety. His computer and technologies within hold particular agency, the virtual space a place where he can safely '*be sober*'. Mick creates an Instagram page about his sobriety, and from his room, he beams himself across the world as a sober person:

> *Being sober, I had lost my identity. I lost my confidence. I'd lost everything. I had to find that again. Fifteen months into it sometimes I still feel like a fucking idiot, you know, but in the beginning, the Internet was all I had. It was a start.*

The tendency to enact 'sobriety' within the physical space of his room as well as within the virtual space of the Internet augments his capacity to do so in different physical spaces within the community such as the local gym and yoga studio. New tendencies develop, evidenced in repeated activities and interactions that, while being socially sanctioned and individualised methods of creating health, foster a sense of increasing capacity, of becoming-well. New tendencies such as going to the gym, attending yoga class or going to AA fold in on themselves, embodying 'real' rather than 'possible' recovery, forging a trajectory that endures through time and space and opening Mick's world to new relational capacities and possibilities for living.

As I hope the analysis of Mick's case illustrates, assemblage thinking can be productively employed to analyse how different forces can influence change. For me, the research-assemblage continues to form as new knowledges weave their way into different areas of my life. The cadence of my counselling changes as the research-assemblage flows into rooms and offices, new ideas taking shape as words are heard and exchanged. Counselling rooms become alive with possibilities as materialities are invited into conversations. Habits lose their rigidity as they are transformed into tendencies, the word itself embodying the possibility of movement and with this the actualisation of different events and moments that may work together to reduce harm.

As my practice changes, I recognise what Aaron Hart (2018) identifies as the ordering of clinical realities. Hart (2018) distinguishes between aggregated and humanistic modes of ordering clinical phenomena where, albeit via different pathways, AOD use is foregrounded as 'the problem' in a person's life. I see this ordering enacted through the use of artefacts such as standardised assessment forms, compulsory data collection, the application of 'evidence-based' treatment protocols and government funding that allocates a specific number of hours per episode of care; I feel it in my restricted capacity to address broader issues within the assemblage of people's lives. Hart (2018) explains that these modes of ordering fail to recognise the co-production of difficult life circumstances where AOD use is only part of the assemblage, limiting the capacity of clinicians to develop novel treatment approaches that foster client empowerment rather than resistance. As a clinician, I am frustrated by these limitations daily.

Despite this, in the words of Fay Dennis (2019), I can enact 'harm reduction and *more*' (p. 152) by welcoming materialities, moments and tendencies into the counselling space; I can consider and explore the forces within assemblages, particularly in relation to semi-rural places, and I can continue to trouble dominant perspectives of AOD consumption and change, working to produce healthier bodies, defined by the freedom or power to act (Dennis, 2019), regardless of the status of consumption. The genie is out of the bottle and cannot go back: I cannot help but think of health in terms of life well lived and it is my hope that I can bring these ideas into the counselling space by increasingly 'becoming-with' (Dennis, 2019, p. 198) the bodies I care for.

Beyond this, I am curious about how these ideas might influence clinical practice and research more broadly. How might a conversation about materialities and tendencies influence the focus or trajectory of treatment? How might it influence the way we identify strengths and opportunities that lie latent, awaiting activation? Could such a conversation inform governments that have a tendency to fund short-term office-based counselling rather than practical care or community development? Might it put words to tensions that clinicians feel as they push against aggregated modes of ordering that force them to tick boxes relating to data

gathering and output rather than enabling them to provide situated care that is relevant to those who reach out for help?

In closing, I'd like to thank Monash University for funds received through the Vice-Chancellors International Inter-Campus Travel Grant enabling me to travel to Prato, my participants, my supervisors Emeritus Professor Chris Trotter and Dr Michael Savic for keeping it real and thank you for your attention this morning.

References

Clarke, A. E. (2005). *Situational analysis: grounded theory after the postmodern turn*. Thousand Oaks: CA: Sage Publications.

Dennis, F., & Taylor & Francis. (2019). Injecting bodies in more-than-human worlds: Mediating drug-body-world relations (Routledge studies in the sociology of health and illness).

Dilkes-Frayne, E., & Duff, C. (2017). Tendencies and trajectories: The production of subjectivity in an event of drug consumption. *Environment and Planning D: Society and Space, 35*(5), 951-967.

Dilkes-Frayne, E., Fraser, S., Pienaar, K., & Kokanov, R. (2017). Iterating 'addiction': Residential relocation and the spatio-temporal production of alcohol and other drug consumption patterns. *International Journal of Drug Policy, 44*, 164-173.

Duff, C. (2014). *Assemblages of Health: Deleuze's Empiricism and the Ethology of Life.* Dordretcht: Springer

Fisher, V. (2017). *How to categorise local areas in Australia*. Retrieved 13 September 2018 from https://blog.id.com.au/2017/location-analysis/how-to-categorise-local-areas-in-australia/

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

Hart, A. (2018). Ordering clinical realities: Controversy and multiplicity in alcohol and other drug treatment for young adults. *International Journal of Drug Policy, 52*, 79-86.

Interface Councils. (2018). *Interface Councils Liveability Policy June 2018.* Retrieved 10th February 2018 from https://docs.wixstatic.com/ugd/e90bcb_7c13554a14174a69bc85965696e0c29b.pdf

Moore, D., Pienaar, K., Dilkes-Frayne, E., & Fraser, S. (2017). Challenging the addiction/health binary with assemblage thinking: An analysis of consumer accounts. *The International Journal on Drug Policy, 44*, 155-163.

Yarra Ranges Council. (2017b), *Yarra Ranges Health & Wellbeing Profile 2017*. Retrieved 18th November 2017 from https://www.yarraranges.vic.gov.au/files/assets/public/webdocuments/corporate-services/governance/policies-strategies-governance/hwb_health_profile_2012-13.pdf