Salutogenesis: Contextualising place and space in the policies and politics of recovery from drug dependence (UK)

Place, Space and Substance Use

The sentiment underlying Harvey's (1996, 316) observation that 'places are constructed and experienced as material ecological artefacts and intricate networks of social relations' has been increasingly recognised throughout the social sciences during the last two decades (see Fitzpatrick and LaGory 2000). This recognition is particularly notable within a large body of, mainly qualitative, research that focuses upon the relationship between places and spaces associated with various forms of (illicit and licit) drug consumption. Studies of this nature have typically sought to consider the *social construction* of drug use *within* specific drug-using *environments* in attempts to identify socio-cultural and socio-spatial practice that may be, in turn, used to generate debate regarding a particular health-place nexus. For example, studies of youth-oriented 'recreational' drug scenes (Measham et al 2000, Parker et al 1998, Sandberg and Pedersen 2011, Thornton 1997, Williams 2013) have identified assorted socio-cultural affiliations within informal/formal economies that connect social networks, specific drugs of choice (including patterns of use) within places of consumption (such as music-venues, nightclubs, dance events, street-based settings). These studies have generally noted that consumption of specific *drugs* in specific *locations* may be (in part) regarded as the physical manifestation of *cultural* consumption as it is representative of active participation and membership of the relevant milieu.

In contrast, other research has focused more upon the spatial settings that shape and determine practice associated with injecting drug use and/or associated dependence (especially heroin and/or cocaine). Examples of this particular research include assorted ethnographic studies that demonstrate the ways in which people who inject drugs (PWID) are physically-, socially-, culturally- and environmentally-situated within transitory and/or fixed environments (Bourgois and Schonberg 2009, Briggs 2011, Carlson 2000, McKeganey and Barnard 1992, Taylor 1993). In such locations, (homeless encampments, squats, street-based settings, residential accommodation, so-called 'shooting galleries' / 'crackhouses' and settings associated with sex-work), places of drug-using episodes typically provide temporary sanctuary (privacy, safety, accommodation, social networks), access to resources (injecting paraphernalia, drugs, information, cash) that is outwith the gaze of the general public and figures of authority (police, security guards, surveillance equipment). Consensus amongst these studies of more entrenched drug use is that (despite the *spatial capital* provided) the overall effect of place upon the *health* of those concerned is typically detrimental due to the co-presence of various place-related hazards that house social action (Parkin 2013, 2014).

Sociological Theory and Places of Substance Use

Other researchers (Bourgois and Schonberg 2009, Neale 2002, Rhodes 2002) have considered the spatial qualities (including associated capital) of drug-using environments from theoretical positions that prioritise the dialectic of 'structure' *and* 'agency' (the two way

relationship between individual action and structural influences). Similarly, Parkin (2013, 2014) presents an empirical assessment of Pierre Bourdieu's theories concerning *habitus* in the context of street-based injecting environments. More accurately, this latter work provides an applied account of Bourdieu's (1984, 101) structuration formula for explaining injecting-related harm as experienced within street-based settings of several UK cities. Namely:

$$(habitus) + (capital) + field = practice$$

In brief, habitus refers to individual learned and acquired responses to structural conditions within the immediate cultural setting; capital relates to a variety of individual resources (social, economic, cultural and symbolic) that permit participation in the field; field concerns the social arenas shaped by structural forces (e.g. laws, rules, expectations, organisations etc.). Together these constituent components interact to produce social action - or *practice* - at an individual, collective and societal level. In the context of drug-using environments however, underlying all aspects of this formulaic approach to understanding social behaviour is the ever-present, yet often understated, constant of place and space (Parkin 2013).

Accordingly, the social construction of drug-using environments throughout relevant cultural milieux may be regarded as illustrative of a symbiotic relationship; places provide environmental opportunities for networks to consume substances and are, in turn, consolidated via socio-cultural attendance/association. In this regard, the socially-produced environment is intrinsically bound to geographic setting, communal belonging and a shared social identity (see de Certeau 1984, Harvey 1996, Lefebvre 1991). As such the social, symbolic, physical and emotional relations attached to particular 'place and space' shape individual and collective identity that in turn establish the constituent characteristics of the activities taking place within. Perhaps more simply, drug-using environments provide opportunities at an individual/collective level ('agency') to identify with 'like-minded' others and provide the necessary settings for negotiating relationships (and facilitating consumption) within *places* that are typically removed from (and closed to) wider society. Experiences and accounts within 'shooting galleries' and/or 'crack-houses' provide a quintessential illustration of such socially-orientated place-making within environments that may be 'closed' to wider membership/participation (*ibid*). In short, places of substance use typically provide opportunities for *street-level capital* to be generated and exchanged amongst those accessing such settings (Bourgois and Schonberg 2009, Parkin and Coomber 2009, Sandberg and Pedersen 2011).

The Emergence of Capital in UK Drug Policy

It is currently *en vogue* for politicians and policy-makers (on a global scale) to respond to issues of drug dependence with terms of sociological-grounding such as 'recovery capital'[1].

For example, interest in this particular ideal is made explicit throughout the UK Government's most recent Drug Strategy document (HM Government 2010) in which the Home Secretary explains:

[1] A term that appears to have originated in the United States by Granfield and Cloud (1999)

> A fundamental difference between this strategy and those that have gone before is that instead of focusing primarily on reducing the harms caused by drug misuse, our approach will be to go much further and offer every support for people to *choose recovery* as an achievable way out of dependency. … The solutions need to be holistic and centred around each individual, *with the expectation that full recovery is possible and desirable*. (HM Government, 2010, 2 *emphases added*)

Whereas the UK's initial Drug Strategy (1985-1995) formalised harm reduction as a public health response to HIV/AIDS, successive strategies prioritised a 'crime-treatment' nexus to the policies and politics of substance use. Stimson (2000) refers to the period 1995-2008 of UK drug policy as the 'crime phase' of strategic planning, in which government attempted to correlate the 'treatment' of drug users with a reduction in 'crime' throughout British society. The subsequent introduction of a more abstinence-orientated Drug Strategy (HM Government 2008) perhaps initiated the 'recovery phase' of the present day. Monaghan (2012) notes that during the early stages of this phase, the State offered short-term commitment to on-going treatment programmes (such as Opiate Substitution Therapy[2] [OST] involving maintenance/reduction prescriptions of methadone) with the expectation that these initiatives would eventually focus upon the more long-term goal of drug-free lifestyles. Indeed, this goal is made explicit in the title of the current (2010) Drug Strategy in which central government makes a commitment to supporting services 'work with individuals to draw on (social, physical, human and cultural) capital in their recovery journey' (HM Government 2010, 18-19); in order to maximise their 'recovery capital' (*ibid*).

Recovery capital has been defined as 'the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from severe alcohol and other drug problems' (White and Cloud, 2008, 1). It is also an ideal that appears to have been internationally embraced by policy despite its ongoing controversy in the field of substance use policy/research (Ashton 2008, Berridge 2012, Duke et al 2013, Neale et al 2014). Similarly, recovery capital comprises of the aforementioned variations of capital that (in theory) aim to synergise physical recovery from drug dependence in ways that are difficult to measure and quantify.

Nevertheless, levels of ownership of the various forms of capital will vary amongst populations *per se*; amongst people who use drugs and especially amongst those accessing 'treatment' services for drug dependence. Indeed, the latter view has informed recognition that drug treatment services typically comprise a client-base consisting of different dependence/capital categories. This view is premised upon Mueser et als (2008) 'quadrant model' and provides a categorical framework for allocating service-users into appropriate models of need, care and intervention. White and Cloud (2008) further suggest that relevant service-user populations may be categorised into one of four treatment categories that each reflect levels of drug dependence (severity) and levels of capital owned (whereby low capital

[2] Current debate about this term further highlights a semantic divide, in which *some* researchers and physicians prefer the term Opioid Agonist Treatment (OAT) as a less stigmatising term of reference. Further details of this discussion may be found at http://www.eurekalert.org/pub_releases/2015-04/bumc-lpr041515.php (*Accessed 14 July 2015)*

equals minimal resources that may problematise recovery; high capital equals increased resources to facilitate recovery). The model, (and its classification of service-users' dependence/capital), provides an *indicator* of 'recovery potential' at an *individual* level and is summarised in Box 1 below:

< BOX 1 HERE>

White and Cloud's algorithm (Box 1) possibly provides a useful framework for identifying the most appropriate service provision for addressing varying degrees of drug dependence. However, several aspects of this model are perhaps noteworthy, particularly in the context of this Commentary that prioritises 'place and space' in the politics and policies of recovery.

First, comparisons with the Bourdieu's formulaic approach to agency ('practice') may be noted in the above schema. Indeed, the notion of 'severity' + 'capital' = 'treatment design' has clear parallels with 'habitus' + 'capital' = 'practice'. However, whereas Bourdieu's formula represents a schematic and dialectic relationship *between* structure and agency, White and Cloud's formulae seek to inform structural intervention (treatment service choice) *upon* agency.

Second, White and Cloud's emphasis upon the *spatial locations* of appropriate treatment design for particular population groups is also evident. These places provide an emphasis upon structural settings of clinical intervention (detoxification unit, residential rehabilitation). As such, they make implicit the *centrality* of access and membership of exclusive place and space dedicated to achieving and/or sustaining recovery goals via the physical removal of agency from social (drug-using) networks[3].

Third, as perhaps indicated by White and Cloud's (2008) classification system, individuals reporting 'high drug severity' may not achieve recovery without prolonged, high intensity support. Similarly, individuals within this category typically originate from disempowered, disenfranchised and deindustrialised communities whose life trajectories have been characterised by social and economic exclusion, vulnerability, ill-health and lifestyles entrenched by substance use. Indeed, ethnographic studies throughout the UK (Briggs 2011, Parkin 2013, Taylor et al 2004) have noted that the place and spaces most frequented by

[3] Detoxification and residential rehabilitation units may be interpreted as *structural* models of *transitory* salutogenesis due to the commitment by *agency* to become 'well' again whilst within (see Neale et al 2013). However, as noted by many studies (Callahan and Cunningham 2002, Conahan and MacIntyre 2012, Hanne et al 2013, Linton et al 2014, McKeganey et al 2004) these geographically-liminal places do not necessarily prevent future relapse. This is typically because these exclusive and excluding settings do not appear to have any *spatial impact* upon any agency re-engagement with (drug-centred) places, spaces and social networks within such service users' communities. As noted by Wilkinson et al (2008) such environments are unable to fully address 'what happens *before* and *after* residential rehabilitation'(emphasis added) and that admission/discharge procedures need to adopt a 'a comprehensive holistic approach to client needs, including childcare, housing, training and education, employment, family and relationship concerns' (2008, 404). For these reasons, detoxification and residential rehabilitation units cannot be fully recognised as salutogenic environments (and may be better regarded as *enabling* environments).

those of this population possess capital that has been socially, culturally, economically and symbolically shaped by drugs, drug use and other drug users for periods of many years. Accordingly, recovery from long-term dependence for this population typically requires intervention that prioritises high-intensity and long-duration OST (White and Cloud 2008). Similarly, there is equal recognition that individuals with former drug-centred lifestyles may require treatment periods of 5-7 years at a minimum (Best et al 2010, 12) whilst simultaneously experience a wide range of ongoing 'collateral damage' (Advisory Council on the Misuse of Drugs [ACMD] 2013, 16) including ill health, poverty, crime and imprisonment. In short, the acquisition of 'recovery capital' by service users of this nature may be hindered by sustained and continued attentiveness to *street-level capital* (relating to the people and places of continued drug use).

Fourth, when viewed through the lens of sociological critique – and particularly from a Bourdieusian perspective – the *complete absence* of 'field' (or its equivalent) from the severity/recovery matrix is somewhat problematic (from applied *and* academic perspectives). Indeed, the absence of 'field' from any emulation of Bourdieu's formula fails to acknowledge all *structural* influences underlying *agency* decisions (such as poverty, unemployment, homelessness etc.) relating to drug use (or other). In addition, the absence of 'field' does not fully acknowledge the concomitant socio-cultural, socio-spatial attachments and identity associated with various forms of street-level capital at an agency level.

Places of Recovery and Productivity?

Various conditions attached to the treatment of drug dependence (such as high intensity, long duration and interruption) have raised divisive opinions relating to the overall efficacy of OST, especially for 'high severity' populations, throughout the UK (see McKeganey 2011). Indeed, polarised discussions *at an applied level* has perhaps characterised policy-related debate of this topic in the UK for over a decade (ibid). Similarly, theoretically-grounded critiques (Bourgois 2000, Fraser 2006, O'Malley 1999) of services similar to *Prolonged High Intensity Service Intervention* reflect Harvey's (1996; 312) view that 'place here functions as a closed terrain of social control that becomes extremely hard to break (or break out of) once it achieves its particular permanence'. For example, the 'methadone clinic' (as an exemplar of 'high intensity intervention service') establishes a 'zone of control that produce(s) docile bodies totally enclosed and imprisoned in the repressive mechanisms of disciplinary powers' (*ibid*) and may provide situated circumstances that replicate opportunities to acquire street-level capital through ongoing contact with other service-users (*cf.* Fraser 2006, Neale et al 2013).

Perhaps more significantly is the State's emphasis upon the way in which 'recovery systems' (i.e. 'places' of treatment) aim to increase the *productivity* of individuals so that 'individuals will … successfully contribute towards society' (HM Government 2010, 18). In this regard, Harvey's (1996, 314) critique of the reconstruction (via transformation and interlinking) of people and place towards a 'capitalist-inspired regime of social relations, institutions and political-economic practices' appears to be validated, particularly in an age of (global) economic austerity. This may also be further confirmed in the provision of various

opportunities and programmes by/within treatment settings that are designed specifically to increase the 'recovery capital' of service-users. For example, these may include a variety of education/training programmes that seek to develop existing vocational skills and qualifications (and thus prospects and productivity). However, the *environmental and social settings* of such treatment programmes are not necessarily conducive to individual needs - or the desired recovery agenda. Indeed, this oppositional dialectic (between structure and agency) is made explicit in various studies of drug treatment services (e.g. Fraser 2006, Radcliffe and Stevens 2008). In one study, the researchers emphasise that day programmes associated with treatment services:

> are seen by some drug users as replicating the *social* setting which reinforces a commitment to drug use … (in which) the *social* world of the day programme, inhabited as it is by *acquaintances* from the local drug market, can exclude people who have reason to fear or distrust these acquaintances
>
> (Radcliffe and Stevens 2008, 1072).

Findings such as this remind us of the historic tension noted throughout the discipline of sociology between structure and agency but here in the context (*and places*) of drug treatment services. In short, the underlying assumption is that (*structurally-formed*) 'recovery-focused' environments may collide with the (*agency-informed*) social and physical associations attached to drug-using environments. As such, the socio-cultural components of the latter may impact upon the former to the detriment of a treatment agenda. To further emphasise this point, the above extract infers that *place-based associations* (relating to the social construction of drug-using places) appear to influence an individual's 'recovery potential' when re-situated within structurally-produced settings.

This is a significant and noteworthy tension due to the prominence given to the development of 'recovery potential' by the UK government and its Advisory Council on the Misuse of Drugs (ACMD). According to the latter body (ACMD 2013), recovery potential may be assisted by positive experiences within 13 specific domains including families; criminal justice; education/training; employment/volunteering; housing; recovery communities; local communities and treatment services. Notably, almost all domains are typically situated within *physical* environments at an agency level. Perhaps more significantly, *all 13 of the ACMD domains that maximise recovery potential may be considered as the aforementioned missing 'field' from White and Cloud's (Box 1) formulaic approach to recovery from dependence.*

Salutogenesis: A Synthesis of Place, Capital and Public Health Politics?

Thus far this commentary has highlighted the centrality of place relating to drug-using environments and the way in which place facilitates substance use *and* the production of street-level capital. In addition, an overview of the way in which drug policy has attempted to engage sociological approaches to drug treatment and recovery from dependence has highlighted the *applied value* of theory (relating to capital). A third highlight relates to structural attempts to reproduce an alternative form of capital that facilitates recovery from dependence in *places* that may not be fully conducive to this goal. Fourth, the author has

noted a theoretical 'field' (relating to the spatial settings of agency) that has remained understated in the relevant (political and academic) debate surrounding recovery (potential/capital). The final section of this commentary seeks to amalgamate these disparate – but related – connections in drawing attention to a theoretical construct known as 'salutogenesis' (Antonovsky 1979, 1987, 1996). More accurately, this model is introduced to the readership and discussed as a *potential* framework for *complementary intervention* alongside existing (international) drug treatment services.

Salutogenesis is a conceptual framework of health care and health promotion developed in the field of medical sociology by Aaron Antonovsky (*ibid*). Whereas public health, clinical intervention and epidemiology each attempt to identify the underlying causation of illness and ill health, salutogenesis seeks to identify the factors and mechanisms that foster good health and the principles of 'keeping well' *at an agency level*. Although the framework is essentially conceptual, Antonovsky argues that it provides a heuristic device for understanding how some stay healthy and others do not[4]. Similarly, it is a model that is considered appropriate for any field of health care and promotion (and would therefore appear fitting in the present discussion of recovery from drug dependence).

Salutogenesis is premised upon the core principles of Generalised Resistance Resources (GRR) and Sense of Coherence (SOC). GRR is defined as 'any characteristic of the person, group or the *environment* that can facilitate effective tension management'[5] (Antonovsky 1979, 99 *emphasis added*). Examples of GRR may include access to money, knowledge, experience, social networks and self-esteem; qualities that may be compared to those known as social / cultural capital. Collectively, GRR contribute to an individual Sense of Coherence (SOC) which provides 'a generalized orientation toward the world which perceives it, on a continuum, as *comprehensible, manageable and meaningful*' (Antonovsky, 1996, 15, *emphasis added*). Accordingly, within a salutogenic framework, those reporting greater GRR will report greater SOC and be more motivated to manage ill health; recognise the challenge(s) underlying illness and believe that resources are available to improve health.

Whilst the above is a necessarily succinct account of a complex framework, immediate comparisons with the 'recovery capital' ideal may be evident. However, divergence from the latter may be noted in its potential for shaping and constructing 'salutogenic environments' of health care and health promotion. More accurately, *environments* that are specifically constructed and shaped (even manipulated) to increase GRR should, in theory, develop greater SOC from the generation and growth of *spatial capital*. Perhaps the most widely-discussed (salutogenic) environments are those relating to 'green spaces' in urban centres and how such places are perceived to foster well-being and promote good health (Ferres and Townshend 2012, Lee and Maheswaran 2011, Thompson 2010). Similarly, research concerning spatial arrangements within the settings of healthcare provision often make *implicit* acknowledgement to the salutogenic impact of smarter/better design (Ulrich 2000, Wang et al 2011). For example, the 'designed environment exerts significant effects on

[4] As a historical footnote, Antonovsky developed this model following qualitative work with female survivors of Nazi concentration camps (Lindstrom and Erikkson 2006)

[5] Tension here relates to coping strategies to facilitate survival and longevity

clinical outcomes for patients' (Rubin et al 1998) and include influences such as ventilation (air quality), lighting (natural and artificial), furniture arrangement, noise levels, public/private/personal space as well as features that establish the overall 'ambience' of the setting (music, art, nature). Positive environments for healthcare typically prioritise the aforementioned issues in addition to social support (conversation, empathy, care) and positive 'distractions' (television, internet, reading space, refreshment areas). Furthermore, the principle designs underlying positive intervention appear premised upon *patient privacy* and *patient control*. Whereas privacy relates to confidentiality (and anonymity), control refers to 'an individual's real or perceived ability to influence their situations and determine what others do to them' (Ulrich 2000, 54). Furthermore, patient control may be undermined by environments characterised by an inappropriate and unsupportive ambience (unfriendly, lacking privacy, poor lighting, poor air quality, unacceptable noise levels) that may impact upon treatment outcomes and overall well-being. In short, when considered collectively, salutogenic environments appear to prioritise the needs of *agency* within *structural* settings (hospitals, care homes etc.).

In the context of substance use, Parkin's (2013, 2014) ethnographic work of injecting drug use describes an 'inverted salutogenic environment' found within some street-based settings. Such locations provide temporary shelters for addressing withdrawal symptoms associated with opiate dependence and offer spatial capital amongst those who may be homeless / roofless (2013; 176). Indeed, as Parkin (*ibid*) demonstrates, the spatial capital normally provided within international, state-sanctioned, Safer Injecting Facilities[6] may be interpreted as the structural re-production of long-established street-based activity.

Whilst the latter illustrations may be regarded as an unorthodox interpretation of salutogenesis one may better recognise aspects of the concept within the places of *grassroots* peer support and 'recovery advocacy' (White and Graham 2011) - also from the field of substance use. Initiatives of this design are developing in tandem with a 'recovery advocacy movement' throughout the UK and typically provide alternative *enabling environments* for those seeking recovery. Examples of such grassroots (user-led) activism include so-called *Recovery Cafés* that provide a wide range of structured, informal activities (with little or no emphasis upon 'drugs') within supportive environments that facilitate extending social networks and developing vocational skills that are often *led* by people in recovery[7]. Social activities may focus upon 'performance' (theatre), musicianship and participation in outdoor events that promote social well-being[8]. Such initiatives (that prioritise the role of agency) however are typically located in third sector environments, have restricted access /

[6] Also known as Drug Consumption Rooms. These are places of harm reduction in which drugs may be prepared and ingested whilst under supervision by medically-trained personnel. Such facilities exist throughout Australia, North America and mainland Europe but have never been available in the UK (at the time of writing in 2015).

[7] For an example of (and guidance on establishing) social hubs of this nature, see http://www.comas.org.uk/resources/Guide%20to%20Developing%20Recovery%20Cafes.pdf *Accessed 14 July 2015*

[8] For an example involving the role of bee-keeping in developing recovery capital see http://www.disc-vol.org.uk/news/2015/7/13/calderdale-in-recovery-creates-a-buzz *Accessed 14 July 2015*

availability, receive limited (if any) financial input *and appear to play only limited roles in complementing 'mainstream' drug treatment services (in the UK).*

As with recovery capital there appears to be a lack of empirical evidence to support the impact of salutogenesis (and salutogenic environments) *per se*. Nevertheless, the theoretical implications attached to such models appear equally optimistic. For example, *Recovery Cafés* may demonstrate that such intervention can be founded upon *individual agency* (at 'grassroots' level) in which participation is not necessarily a formalised component of 'treatment' (as individuals 'control their situations and determine what others do to them'). Similarly, salutogenic environments of this design appear appropriate for maximising individual resources (including recovery potential and capital) via participation in *re-created* places and spaces (i.e. 'spatial capital').

Similarly, such environmental design would appear to focus (implicitly) upon the three inter-related aspects of salutogenesis. Namely, (and as summarised by Lindstrom and Erikkson 2006) (i) a specific focus upon problem solving/finding solutions to health-related issues, in which (ii) the identification of individually relevant capital (GRR) aims to generate positive outcome. Finally, (iii) such a salutogenic approach seeks to establish an overall sense of coherence in which individuals/collectives aim to control / manage health-related stress (such as dependency) in a meaningful and confident manner using a variety of resources, skills and abilities (capital).

In theoretical terms, the synthesis of (grassroots-generated) agency-led salutogenic environments within formalised (structural) responses to drug dependence on a sustained (daily) basis would aim to establish a *constructive* dialectic relationship *between* structure and agency, in which the accumulation of spatial capital further facilitates recovery potential[9]. Similarly, a salutogenic approach to maximising recovery potential in this way establishes re-constituted settings that *reproduce* the socio-cultural capital previously obtained within/from places formerly associated with drug use. It is therefore within these *salutogenic enabling environments* in which 'recovery capital' may be naturalistically consolidated via activities that are led by the agency of those involved. This theoretical model may be simplified using the aforementioned formulaic approach to social action. Namely:

Salutogenic Environments (Place + Spatial Capital) + Field-based Recovery Potential = Increased Recovery Capital

Despite a lack of empirical evidence relating to the impact of salutogenic environments *per se*, the above formula provides a framework that hypothetically seeks to synthesise areas of commonality surrounding the policies, politics and practice of substance use. These being public health intervention, the maximisation of individual capital and the fostering of enabling environments that replicate the socio-cultural importance of *place*. It is also a model that seeks to reconcile the tensions and collisions surrounding structure and agency that have been noted throughout. Whilst a hypothesis such as this needs to be empirically assessed with further research, the model may (in the very least) facilitate discussion of

[9] From the 13 domains identified by the Advisory Council on the Misuse of Drugs

… a need to look for long-term sustainable strategies … for healthy public policies. As evidence is collected and analysed, the salutogenic framework could be a guiding principle in such interventions.

(Lindstrom and Erikkson 2006; 243)

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(to add following review and favourable Editorial Decision)

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