Health & Place 30 (2014) 107–115

Contents lists available at ScienceDirect

Health & Place

journal homepage: www.elsevier.com/locate/healthplace

# A healthy island blue space: From space of detention to site of sanctuary

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ARTICLE INFO

*Article history:*
Received 27 February 2014
Received in revised form
27 June 2014
Accepted 18 August 2014

*Keywords:*
Islands
Blue space
Wellbeing
Alcohol
New Zealand

ABSTRACT

Island blue spaces are associated with restorative potential, but few studies examine this proposition when an island's use has changed over time. We examine Rotoroa Island (near Auckland, New Zealand) where, for almost a century, the Salvation Army ran an alcohol treatment facility. The island's relative isolation was central to its mixed therapeutic and carceral roles. Following change in treatment ideologies, the facility closed in 2005. It subsequently re-opened as a reserve for recreation, remembrance and environmental restoration. Our analysis focuses on the enabling resources at Rotoroa across these two eras, in the context of different constructions of healthy island blue space.



## 1. Introduction

Belief in the ability of coastal environments to restore mental and physical wellbeing is long-standing, but few studies trace how this understanding has been acted upon in particular places, or how such places have changed over time. In this paper, we examine the case of Rotoroa Island – located in the Hauraki Gulf to the east of Auckland, New Zealand. The Salvation Army operated an alcohol treatment facility on this small (82 ha) and relatively isolated island (32 km by boat from downtown Auckland) for over nine decades. Established under the *Habitual Drunkards Act 1906*, the facility opened in 1911 and over subsequent years admitted almost 12,000 men and women, both voluntarily and by court order. As treatment ideologies and the role of the third sector changed in the late 20th century, so too did the functions of the facility. A move away from isolated and carceral institutional forms of treatment for alcoholism led to the facility's eventual closure by the Salvation Army in 2005. Rotoroa was then re-envisioned as a site for active recreation, historic remembrance and environmental restoration, opening to the public in 2011.

Our focus here is the changing role of blue space on Rotoroa Island as it has operated (variously) as a site of detention, treatment, sanctuary and healthful activity. We follow Völker and Kistemann's (2011) call to understand water not merely as a common feature of therapeutic landscapes, but also as a potentially salutogenic environmental element in its own right. This potential stems from water's capacity to be experienced as an activity space with social and symbolic dimensions. From this vantage point, the health-enhancing qualities of blue space are a relational outcome, emerging from the intersection of human agency, social relations, and built and natural environments (see also Conradson (2005a)). In this paper we apply the term blue space to a maritime environment that encompasses islands as well as sea water (and the littoral interfaces between these features); here blue space exists in relation rather than opposition to terrestrial space.

To examine Rotoroa's associations with health, we draw on Cameron Duff's (2011) concept of 'enabling places'. This notion captures a range of ideas related to "the role specific places play in generating or enabling the conditions necessary for the experience of health and wellbeing" (Duff, 2011, p. 149). It focuses on the diverse actor-networks that generate enabling resources in place, which in turn enable some places to promote health. In developing this idea, Duff identifies three categories of enabling resources: social (centred on intimacy, trust and reciprocity), affective (centred on feelings, disposition and action-potential) and material (centred on access to goods, services and the physical environment). In what follows, we consider the enabling resources created and experienced at Rotoroa both by patients and staff during its time as a site of detention/treatment, and more recently by recreational visitors.

This approach emphasises that the therapeutic and restorative benefits of place are not only or primarily a function of the setting itself but rather are continually made, or created, through the

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http://dx.doi.org/10.1016/j.healthplace.2014.08.005
1353-8292/

interactions and practices of diverse actors. Drawing on Latour (2005), Duff (2011, p152) notes that actors of relevance "include not only humans but also objects, tools, instruments, plans, logics and so on." It follows that health-related resources are generated in place through the exercise of complex forms of agency – including people 'acting into' and 'receiving from' place – and are not static or inherent qualities. We deploy this theoretical lens to examine Rotoroa as both a site of prior institutional treatment as well as a contemporary place of recreation and contemplation. Specifically, we identify and explore the social, affective and material resources that have made Rotoroa an enabling place across these two eras. In examining the transformation of the island in this way, we contribute to knowledge of spaces of alcohol treatment (Wilton and Moreno, 2012), as well as to emerging theorisations of blue space.

We drew upon a broad range of sources to develop our perspective on the island's resources: archival records (available via web-based repositories and a substantial collection presented at the on-site exhibition centre), a recently-published history of the Salvation Army's role in addiction treatment in New Zealand (Hutson and Hutson, 2013), and a semi-structured interview with a senior Salvation Army officer who had a long-standing involvement in the management of Rotoroa. We also undertook first-hand landscape analysis on the island, and a survey of media reports and publicity materials. Information from these diverse sources was organised into two time periods (1911–2005 and 2008–present), and then analysed with respect to how particular configurations of resources enabled wellbeing on the island. Before turning to Rotoroa, we first consider the literature on sites established to treat those with alcohol-related problems.

## 2. Inebriety, institutions and place

Place is deeply implicated in the history of alcohol use, in terms of sites of consumption as well as restoration (Jayne et al., 2010). In this section, we review the role of place in the treatment of inebriety, a notion linked to the increasing medicalisation of the problem in the second half of the 19th century. Specifically, an emerging understanding of drunkenness as a physical and hereditary disease gave rise to the possibility of treatment and cure (Thom and Berridge, 1995). However, such views were challenged by the "deeply entrenched" view of drunkenness as a moral failing and sin, not a sickness (Brown, 1985, p. 91). From the latter perspective, grounded in religious and temperance-based understandings, the drunkard required reform rather than cure (Baumohl, 1990). These conflicting viewpoints gave rise to different modalities of place-based care.

Mid-19th century physicians specialising in inebriety combined the emerging disease concept of drunkenness with a high regard for the curative power of asylum-based treatment. Specifically, they contended that the cure for chronic drunkenness lay in imposed abstinence via involuntary treatment in institutions modelled after the psychiatric or 'insane' asylum (Baumohl, 1990; Brown, 1985). Herein lay the possibility of a spatial solution to the problematic drunk: "[p]lacing an inebriate in such an asylum would remove him from the alcoholic poison that was the exciting cause of his malady" (Brown, 1985, p. 520). Parallels with the insane asylum included a complex built form, with "elaborate systems of wards to segregate patients by social and diagnostic criteria and voluntary or involuntary status," and a preference for isolated rural settings (Baumohl, 1990, p. 1189). In such settings, recovering inebriates could engage in productive farm work that was intended to be therapeutic, but which also helped to offset institutional running costs through the provision of food (Clark, 2012) – another practice borrowed from the classical asylum (Moon et al., 2006). Remote locations also served to distance patients from the 'poison' responsible for their disease. Indeed, in Montreal it was proposed that an inebriate asylum be built on a small island in the St. Lawrence River, so as to complicate both escape and access to alcohol (Baumohl, 1990). This identification of an island site within reach of, but set apart from, a metropolitan centre parallels aspects of the Rotoroa case study presented in this paper.

The first inebriate asylum opened in New York State in 1864, but such institutions never became widespread, as highlighted by studies from North America (Baumohl, 1990; Brown, 1985), the UK (Thom and Berridge, 1995) and Australia (Clark, 2012). The limited acceptance of this treatment model reflected a range of factors, including enduring debates over whether drunkenness constituted a disease or moral failing, concerns over the coercion involved in court-ordered committal, and rising acceptance of voluntary treatment for inebriety. Voluntary treatment could occur not only in large asylums, of which relatively few were ever built, but also in a plethora of smaller reformatory homes and retreats in urban areas. The latter facilities were typically operated by charitable religious and temperance groups, and emphasised mutual assistance and self-control as key to reforming the inebriate (Baumohl, 1990).

In principle, these places of alcohol addiction treatment differed starkly: inebriate asylums were total institutions characterised by isolation and medical control; the smaller reformatory homes were 'community-based' and operated with a philosophy of non-restraint (Baumohl, 1990). For medical critics of urban home- and retreat-based treatment, the absence of restraint combined with the location imperilled both patients and the community, as "they could not ensure isolation from environmental hazards, notably the taverns" (Baumohl, 1990, p. 1192). This concern echoes contemporary observations regarding the stresses of the service-dependent ghetto for the deinstitutionalised mentally-ill and other vulnerable groups (DeVerteuil and Evans, 2009). However, institutional treatment was also criticised, particularly for the uncertain efficacy of its 'cures'. This problem, combined with cost concerns, saw most of these facilities closed – or converted to other public uses (such as insane asylums) – by the early 20th century (Baumohl, 1990; Clark, 2012).

In practice, differences between asylum-type facilities and reformatory homes were often more subtle than their contrasting philosophies suggested. As already noted, although asylums were initially predicated on involuntary admission, they came to accept voluntary patients in large numbers: "as early as 1883 … one inebriety specialist noted that 94% of all patients treated in American inebriate asylums were treated voluntarily" (Brown, 1985, pp. 55-56). Conversely, many urban homes and retreats ultimately admitted involuntary patients, who were committed to them by the courts (Baumohl, 1990). They could also adopt medical models of treatment. A study by Clark (2012) found that facilities catering to inebriates in Victoria, Australia from 1870 to 1930 ranged from a public asylum on an extensive rural site to small facilities in urban centres, but that all offered medical interventions. This included a city-based facility run by the Salvation Army, which combined physical, psychological and pharmacological treatments with an emphasis on religious redemption and "uplifting moral support" from staff (Clark, 2012, p. 1762). Like the asylum, it was subject to government oversight, accepted patients admitted involuntarily under relevant legislation, and received public funds to treat patients.

The involvement of the Salvation Army in place-based alcohol treatment is long-standing and widespread (Thom and Berridge, 1995; Baumohl, 1990). Established in mid-late 19th century London – a time and place in which the temperance movement was very influential – the Salvation Army adopted abstinence from