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Commentary

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

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ABSTRACT

This commentary seeks to make a contribution to applied and academic debates concerning recovery from drug dependence. This involves a discussion of various commonalities relating to the places and spaces of substance use/treatment; the identification of various tensions relating to 'structure and agency' in current service provision and the way in which environmentally disparate settings may be synthesised to establish enabling environments of recovery. At the centre of this discussion is Aaron Antonovsky's (1984) model of 'salutogenesis' (and 'salutogenic environments') and how this conceptual framework may be considered and/or applied in the field of recovery from dependent substance use.

Whereas public health, clinical intervention and epidemiology each attempt to identify the underlying causation of illness and ill health, salutogenesis is an agency-led concept that seeks to identify the factors and mechanisms that foster good health and the principles of 'keeping well'. It is suggested that a salutogenic approach to recovery options would draw upon the guiding principles of the framework towards advancing, individual level, recovery capital. These principles being (i) the development of social/cultural capital within socially-constructed environments; in which (ii) individual action (or agency) seeks to (iii) manage ill health; recognise the challenges underlying illness and identify the resources that are available to improve health. The author suggests that opportunities for a more 'salutogenic approach' to recovery may be noted within a grassroots model burgeoning throughout parts of the UK (and known as Recovery Cafés). This design is in stark contrast to the State's more structurally-focused treatment options that may not fully appreciate the influence of agency (and the role of place) in attempts to garner recovery capital.

In order to demonstrate the academic and applied value of the proposed salutogenic framework to the issue of recovery from dependence (including the centrality of space and place in debate surrounding substance use/treatment), the author draws upon empirical research as well as theoretical and hypothetical frameworks from the discipline of sociology to illustrate throughout.

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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 & 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, Aldridge, & Parker, 2000; Parker, Aldridge, & Measham, 1998; Sandberg & Pedersen, 2011; Thornton, 1995; 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.

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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 & Schonberg, 2009; Briggs, 2011; Carlson, 2000; McKeganey & Barnard, 1992; Taylor, 1993). In such locations, (homeless encampments, squats, street-based settings, residential accommodation, so-called 'shooting galleries'/'crack-houses' 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 & 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:

$$(\text{habitus}) + (\text{capital}) + \text{field} = \text{practice}$$

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 & Schonberg, 2009; Parkin & Coomber, 2009; Sandberg & 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:

> 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' (HM Government, 2010).

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 & 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, Herring, Thickett, & Thom, 2013; Neale, Nettleton, &

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

[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).

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