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Socio-spatial stigmatization and the contested space of addiction treatment: Remapping strategies of opposition to the disorder of drugs

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Abstract

In recent years, the Not-In-My-Back-Yard (NIMBY) phenomenon has become increasingly prevalent with regard to harm reduction sites, addiction treatment facilities and their clients. Drawing from a case study of community conflict generated by the relocation of a methadone clinic into a rapidly gentrifying neighbourhood in downtown Toronto, Canada, this article offers a unique analysis of oppositional strategies regarding the perceived (socio-spatial) 'disorder of drugs'. Based on interviews with local residents and business owners this article suggests the existence of three interrelated oppositional strategies, shifting from a recourse to urban planning policy, to a critique of methadone maintenance treatment (MMT) practice, to explicit forms of socio-spatial stigmatization that posited the body of the (methadone) 'addict' as abject agent of infection and the clinic as a site of contagion. Exploring the dialectical, socio-spatial interplay between the body of the addict and the social body of the city, this article demonstrates the unique aspects of opposition to the physically, ideologically and discursively contested space of addiction treatment. Representations of the methadone clinic, its clients and the larger space of the neighbourhood, this paper suggests, served to situate addiction as a 'pathology (out) of place' and recast the city itself as a site of safe/supervised consumption.

Keywords

Canada; Addiction treatment; Socio-spatial stigmatization; NIMBY; Drug policy; Urban planning; Place; The body; Methadone clinic

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> When the methadone clinic first opened its doors in the Corktown district the first few days saw the nastier side of an inner-city neighbourhood wanting desperately to dress up its down-and-out image with a new facade. A cosmetic touch here, a cosmetic touch there, and it all added up to better curb appeal […] better aesthetics and better property values. A methadone clinic in the backyard, however, especially in Corktown's backyard, was not what these new urban cosmeticians had in mind when it came to neighbourhood enhancement. (Whitestone, 2007, p. M4).

Introduction: Corktown and the contested space of addiction treatment

Following deindustrialization, the landscape of east central downtown Toronto witnessed significant disinvestment and residential desertion, leading to the area being considered a 'void' or 'wasteland' throughout the second half of the twentieth century (Wintrob, 2006). Owing to its low residential density and relative distance from the central business district, this area became the site of a high concentration of social services, including homeless shelters and drug treatment facilities, leading to perceptions of the area as a social service

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'dumping ground' (Takahashi, 1997) and 'service-dependent ghetto' (Dear & Wolch, 1987). At the turn of the 21st century, increasing real estate pressures, coupled with the widespread adoption of 'creative class' planning ideologies, spurred a massive wave of reinvestment throughout Toronto's east central downtown.

Central to this uneven, patchwork landscape of competing class and social interests is the neighbourhood of Corktown, situated between the Distillery District, adaptively redeveloped according to Toronto's competitive re-branding as a 'creative city' (Blackwell, 2006; City of Toronto, 2003; Florida, 2002), and Regent Park, the first and largest public housing project in Canadian history. Originally home to the area's industrial working class, middle class resettlement in Corktown began in the late 1990s, leading to strategic representations of the neighbourhood as a space of history and heritage, arts and upper-class amenities, bringing together big city sophistication with 'urban village' charm (Barnes, Wiatt, Gill, & Gibson, 2006; Short, 1999; Sibley, 1995). Intermingling discourses of place promotion and spatial purification, strategies advanced by the *Corktown Residents' and Business Association* (CRBA) served to situate the neighbourhood on the cusp of Toronto's 'redevelopment frontier' (Smith, 1996). Above and beyond its central mandate to promote the neighbourhood, the CRBA also acted as the primary institutional body through which residents and businesspeople engaged in organized forms of community policing (Fischer & Poland, 1998).

In early 2006, CRBA opposition to the relocation of a methadone clinic into Corktown served to generate significant public attention and mobilize fear among the larger community. Closely following a media-fuelled moral panic regarding methadone maintenance treatment (MMT) policy and practice in Ontario (Donovan & Leeder, 2006), the conflict surrounding the Corktown methadone clinic culminated in the establishment of a provincial Methadone Task Force by the Ontario Minister of Health. Charged with conducting an assessment of treatment services, the Task Force was mandated to investigate five specific areas of MMT practice, notably including the question of 'community engagement' (Ontario Ministry of Health and Long-Term Care, 2007).

Driven by the CRBA, the campaign of opposition against the methadone clinic contained several clear, though interrelated themes. Not unlike the media scandals concerning MMT that preceded the conflict in Corktown, these oppositional strategies contained an implicit, underlying critique of the private, for profit, group practice treatment model that emerged with the 1996 shift from federal to provincial control of MMT in Canada. Pre-1996, under federal regulation, the vast majority of MMT services were provided in specialized addiction clinics that offered a broad range of integrated, comprehensive treatment services (Fischer, 2000). Post-1996, by contrast, in an effort to increase the availability of opiate treatment services, guidelines established by the College of Physicians and Surgeons of Ontario (CPSO) enabled (and arguably encouraged) the emergence of a new and yet significantly more limited model for MMT.

With the loosening of training requirements and the abolishment of patient caps for physicians, along with the relaxing of admission requirements for clients, private, for profit, group practice treatment centres proliferated across the province, resulting in an exponential increase in the MMT client population (Brands, Blake, & Marsh, 2002; Fischer, 2000). In Canada, methadone is administered orally, in liquid form, generally mixed with the commercial drink 'Tang'. Referred to as '*juice bars*' by critics owing to the highly limited range of treatment services, the private, for profit model serves to segregate addiction treatment clients from other health care populations (Strike, Urbanoski, Fischer, Marsh, & Millson, 2005). In this model, MMT is therefore conceived as little more than the

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"dispensing and consumption" of 'medication' ('juice') (Lilly, Quirk, Rhodes, & Stimson, 2000, p. 167).

In the case of the Corktown conflict, community opponents advanced three distinct, though inherently interrelated strategies, and as these strategies changed, the perceived 'enemy' in the conflict shifted from municipal politicians, to clinic staff, and finally to MMT clients. Rooted in planning discourse, the first strategy portrayed Corktown as victim of a careless municipal government that used the neighbourhood as a social service 'dumping ground' (Takahashi, 1997). Demonstrating how oppositional discourse served to invoke Corktown's position in relation to the social body of the city (Toronto), this strategy suggested a direct relationship between revanchist gentrification and opposition premised on urban planning policy, delineating the 'moral geography' of the neighbourhood (Ruddick, 2002).

Involving a policy critique of MMT practice, the second strategy worked to posit clients as victims of a flawed treatment system. Here, an economic critique of the methadone 'industry' was conflated with a critique of drug treatment policy and the MMT 'system', all of which contained an underlying condemnation of the private, for profit treatment model. Characterized by forms of stigmatization that positioned the body of the (methadone) addict as agent of infection and the clinic as site of contagion, the third strategy was based on the clinic's perceived impact on the Corktown community. Here, oppositional discourse shifted from critical concern to explicit forms of stigmatization based on the notion of abjection. In this case, opponents effectively positioned the methadone clinic and its clients as threats to the social body of Corktown, situating addiction as a 'pathology (out) of place' in the transitional, gentrifying neighbourhood (Cresswell, 1996; Sommers & Blomley, 2002). Drawing from an ethnographic case study analysis of the Corktown conflict, this paper explores socio-spatial stigmatization regarding the contested space of addiction treatment in the case of MMT, specifically focusing on the private, for profit, 'juice bar' treatment model.

Literature review: NIMBYism, socio-spatial stigmatization and the place of drugs in the city

Sibley (1995) and others have argued that a critical consideration of abjection is central to understanding processes of socio-spatial exclusion (for examples related to drug users and other abject urban outcasts, see Bergschmidt, 2004; Butler, 1990; Fitzgerald & Threadgold, 2004; Sommers, 1998). The desire to exclude the abject, which commonly manifests in the enforcement of socio-spatial borders—distinctions, both in built form and social practice between "clean and dirty, ordered and disordered, 'us' and 'them'"—is endemic in the history of Western culture, creating a sense of acute anxiety because such separations can never be complete (Sibley, 1995, p. 8).

Louis Takahashi (1997) explores NIMBYism through the production of socio-spatial stigmatization, where representations of 'spoiled identities' and 'tainted'/'outcast' spaces are woven together in discourses of socio-spatial infection, contagion and purification (Goffman, 1963; Purdy, 2005; Woolford, 2001). Focusing specifically on services for people who are homeless and people with HIV/AIDS (PWA), Takahashi (1997) suggests that non-productivity, dangerousness and personal culpability are three characteristics central to strategies of socio-spatial stigmatization. Due to lack of economic productivity, specific client groups are (de)valued and stigmatized based on their relative (in)abilities to 'contribute' to society (Strike, Meyers, & Millson, 2004; Takahashi, 1997). In a related trajectory, perceived criminality and deviance serves to cast certain client populations as 'dangerous'. In the case of homelessness, lack of participation in the paid labour market often equates to the perception that survival is dependent on the informal economy and other

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illegal/quasi-legal income generating strategies (Takahashi, 1997). In the case of PWA, by contrast, danger has been associated with the threat of (physical) infection and (moral) contagion (Takahashi, 1997; Woolford, 2001). Personal culpability is a distinctly moral form of stigmatization that absolves structural responsibility for social 'diseases' and shifts responsibility to the agency of those afflicted (Takahashi, 1997). Perceived as criminally 'dangerous', morally and criminally 'deviant', and 'diseased' individuals who are responsible not only for their own condition, but also for various forms of moral and physical contagion, drug users elicit the highest degree of community opposition (Dear, 1992; Strike et al., 2004).

Socio-spatial stigmatization is a process whereby stigma attached to people both *extends from* and *extends to* the stigma associated with places (Takahashi, 1997). Arguing that the stigma attached to 'disorderly' client groups becomes embodied in the physical space of service facilities, Takahashi suggests that social service sites and their immediate surroundings also become associated with the perceived characteristics of non-productivity and dangerousness (Takahashi, 1997). Due to the 'mutually constitutive' process of socio-spatial stigmatization, in areas where such facilities are concentrated, "the identity and widespread understanding of specific communities may become intertwined with stigmatized identities" (Takahashi, 1997, p. 911). The opprobrium attached to clients therefore results in perceptions of neighbourhood decline and devaluation, and heightened efforts by opposed factions to enforce socio-spatial boundaries between the 'pure' and 'polluted' (Sibley, 1995). Casting the subject of addiction treatment as dirty, diseased, deviant, and dangerous, oppositional discourse framed by the 'disorder of drugs' serves to position the addict as abject agent of physical contagion and moral infection. Extending from this social stigma, opponents argue that needle exchange program (NEP) sites in Ontario directly result in the congregation of clients who are 'drawn into the community', attracting drug dealing and 'public disorder' (Strike et al., 2004). Opposition to the contested space of addiction treatment is therefore distinguished by concern for explicitly *spatial* forms of infection and pathology.

Fuelled by the shifting ideologies of fear and domination that characterize the 'new urban frontier', revanchist gentrification inherently produces a heightened climate of conflict that serves to perpetuate socio-spatial stigmatization (Colon & Marston, 1999; Smith, 1996; Strike et al., 2004; Takahashi, 1997). As a rapidly gentrifying neighbourhood, Corktown was itself a contested space, and the conflict surrounding the clinic drew from larger 'regimes of representation' involved in the strategic re-branding and redevelopment of the community resulting from various forms of urban boosterism—the (inter/intra-)urban practice of promoting a given city or region that has become a central aspect of "the civic culture of contemporary capitalism" (Short, 1999, p. 37). In this sense, the deployment of 'urban village' and 'creative class' strategies can be seen as a response to the social 'problems' perceived to be effecting the area, where intra-urban boosterist strategies of place promotion intermingled with strategies of spatial purification (Barnes et al., 2006; Short, 1999; Sibley, 1995).

In recent years, the 'Not-In-My-Back-Yard' or NIMBY phenomenon has become increasingly prevalent with regard to harm reduction/addiction treatment facilities and their clients (Strike et al., 2004). Despite the growing incidence of community opposition to the perceived 'disorder of drugs', the space and subject of addiction treatment have received little more than passing references in scholarly debates. While there is a large body of literature that examines the NIMBY phenomenon in relation to homeless shelters (Dear, 1992; Henig, 1994; Lyon-Callo, 2001; Takahashi, 1997) and HIV/AIDS service facilities (Colon & Marston, 1999; Takahashi, 1997), people who use drugs have been neglected in academic literature regarding socio-spatial exclusion and stigmatization.

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This article extends Takahashi's (1997) insights regarding socio-spatial stigmatization to suggest that NIMBY-based opposition to the 'disorder of drugs' is always already spatialized. Through a case study analysis of the conflict surrounding the Corktown methadone clinic, a critical reading of oppositional discourse premised on the socio-spatial 'disorder of drugs' provides evidence of a dialectical relationship between the body of the addict and the social body of the city. Invoking notions of infection and contagion that bled between social and spatial dimensions, interweaving metaphors of pathology and place, these oppositional strategies simultaneously served to posit 'addiction' as a *pathology (out) of place* and situate the city itself as a *site of 'safe'/'supervised' consumption* (Cresswell, 1996; Douglas, 1966; Sibley, 1995).

Methodology: from junky to NARC and back again

Based on six months of ethnographic fieldwork during the height of the conflict surrounding the Corktown methadone clinic (June–November 2006), this article draws from qualitative interviews with local opponents, public documents produced by the Corktown Residents' and Business Association (CRBA) and other mediated forms of community self-representation. While other areas of the larger project from which this work was drawn are devoted to examining the voices of addiction treatment clients, this paper focuses attention on the question of community opposition to the contested space of addiction treatment. Semi-formal, open-ended, tape-recorded interviews were carried out with 20 members of the Corktown community. Given the snowballing recruitment method, the majority of participants were strongly opposed to the clinic, with a handful of more moderate voices; emphasis was placed on community opponents in order to specifically interrogate strategies employed in response to the perceived (socio-spatial) disorder of drugs.

Both residents and businesspeople were equally involved in the oppositional campaign. Among this group, eight individuals were residents who had no business interest in the local community, seven individuals either worked or owned businesses in the immediate area, and five individuals both lived and worked or operated businesses in Corktown. Additionally, many of the community interview participants represented in this sample were actively involved in the Corktown Residents' and Business Association (CRBA), which was largely responsible for organizing and mobilizing opposition among the larger community. In order to protect the anonymity and confidentiality of the actors involved in the conflict, pseudonyms were used for all interview participants, and community opponents are identified only by their status as residents, business owners, or CRBA activists. This research was conducted with ethics approval from York University (Toronto, Canada). All interviews were transcribed, coded and analyzed to identify key themes. In addition to interviews, this article draws from public documents produced by the CRBA that were derived from the Association's website (www.corktown.ca), along with a *CRBA Community Impact Statement* presented during a public meeting of the Methadone Taskforce convened in Corktown (January, 2007).

Owing to the fact that I started my research in the context of the clinic, visibly interacting with clients, suspicion and wariness regarding 'whose side' I was on (Becker, 1967) came to characterize my initial contact with the local community. Due to my previous familiarity with the methadone clinic, I arguably occupied the position of 'insider' in this context, and by extension, the position of 'outsider' in relation to the larger community. Given that I moved near Corktown shortly before starting my research, as well as the fact that I was not a methadone client, however, the distinctions between 'insider' and 'outsider' were not stable or immutable; instead, they blurred and shifted throughout the course of my research. In this sense, not only did members of the community question my motives and alliances, in several cases accusing me of being a 'junky' or employee of the clinic, but methadone clients also

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expressed moments of doubt and suspicion, and periodically circulated rumours that I was a 'NARC' or undercover cop. During my field research I was therefore necessarily forced to adopt and shift between several distinctly different forms of self-representation. Moving between 'insider' and 'outsider', or from 'junky' to 'NARC' and back again, in the contested space of Corktown my own research position was itself therefore the subject of contestation and conflict.

Research findings: remapping strategies of opposition to the disorder of drugs

Through intra-urban boosterism strategies that shifted seamlessly between discourses of place promotion and spatial purification, Corktown was distinguished as a space of rapid socio-spatial transformation, a symbolically purified space tainted by the arrival of the methadone clinic (Short, 1999). Driven by the CRBA, community opponents employed three interrelated strategies against the methadone clinic, each based on emphasizing a different relational configuration between the body of the (methadone) addict and the social body of the city. In the first strategy, oppositional discourse served to reiterate the relationship between the space of Corktown and the wider social body of Toronto through direct recourse to urban planning discourse. The second and third strategies, by contrast, involved forms of discourse that situated MMT clients in relation to the moral geography of Corktown, taking contradictory lines of attack that positioned the body of the (methadone) addict as first victim, then villain.

"A cure for the neighbourhood": Corktown and the social body of the city

The immediate recourse to planning policy by Corktown opponents reveals how solutions to social 'problems' such as addiction are increasingly posed in the terms of urban planning and redesign (Barnes et al., 2006; Cusick & Kimber, 2007; Fischer, Turnbull, Poland, & Hayden, 2004). Opposition based on a critique of municipal planning policy focused first and foremost on zoning by-laws regarding addiction treatment services. "It became rapidly apparent that Toronto did not have by-laws dictating where these specialized clinics/ dispensaries could be located", read the CRBA *Community Impact Statement*.

> There is no clear line of responsibility by any level of government related to the placement of a methadone clinic/dispensary […] or the monitoring of its short or long term effects … As long as you have a license to prescribe methadone, you can buy a building with commercial zoning […] anywhere in the city, open your very lucrative business with no community consultation process, and the residents have no recourse. (2007, p. 3–4)

In their efforts to oppose the clinic on the basis of planning policy, the CRBA appealed to all levels of government, circulated petitions, and attempted to take legal action in order to establish interim zoning by-laws, strategies common to NIMBY conflicts (Dear, 1992). Insinuating that the city used Corktown as a social service 'dumping ground' (Takahashi, 1997), the CRBA then began drawing attention to the unequal distribution of social services by making references to the space of Corktown in relation to traditionally affluent, upper-class Toronto neighbourhoods.

> If this clinic was opened in Rosedale, what do you think the people in Rosedale would be saying? Do you thing they'd be saying, 'I'm paying $150,000 a year in taxes, and it's okay to have *those people* loitering outside my door'? (***Sandy*, resident, business owner, member of CRBA**)

In this line of attack, community opponents drew attention to the acute polarization of the municipal ward in which Corktown was situated. As the perceived 'enemy' in the 'battle'

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shifted from politicians to service providers to clients, therefore, oppositional arguments based on the 'place' of Corktown worked to challenge the socio-economic positioning of both city politicians and methadone clinic staff.

> All the stuff in this neighbourhood is not our problem, it's the city's problem. But I can guarantee you every one of those councillors in city hall will not put a methadone clinic in their neighbourhood. (***Siobhan*, resident)**

Community opponents repeatedly emphasized the belief that the local concentration of social services was responsible for drawing undesirable individuals into the neighbourhood. In response to arguments that social services should be located in areas of demonstrated need, community opponents claimed 'if you build it, they will come' (***Patricia,* resident, former member of CRBA**). Moreover, the clinic was seen as catalyst to a larger wave of social services that threatened to contaminate the area's reputation. One resident remarked: "There is a rumour that the safe injection site is going to go into the nearby housing development: this methadone clinic is just a start" (***Alan***). Beneath this discourse lies the implicit notion of a 'cure', remedy, antidote or solution to the question of addiction, a subtext that was rendered stark by one Corktown resident in both social and spatial terms:

> I'd like to see, for all this stuff, a cure; this whole neighbourhood, there's no cure at the end of the tunnel. (***Siobhan***)

"The home-depotization of methadone": oppositional critiques of MMT 'system'/'industry'

Following the deployment of oppositional strategies focused on the social subtext of planning policy, members of the Corktown community turned to critique the socio-*spatial* implications of drug policy, implicitly focusing on the private, for profit MMT model. Conflating an economic critique of the lucrative financial implications of the methadone 'industry' with a critique of the policies in place to regulate the methadone 'system', this line of opposition served to frame methadone clients as victims of a flawed treatment system, amounting to "NIMBY with a caring face" (Dear, 1992, p. 290).

Drawing attention to the high financial stakes for MMT service providers, community opponents described the Corktown clinic as a 'big box' 'factory' that equated to the 'Home-Depot–ization' of methadone treatment (***Mary*, business owner, former member of CRBA**). Here, *Home Depot* stands in as the quintessential big box retail phenomenon, likened to the perceived unregulated growth of private, for profit MMT clinics in Ontario. Focusing on the large volume of clients, recurrent references to the clinic as a 'big box' 'factory' served as a descriptive metaphor that vividly encapsulated a critique of the private, for profit treatment context.

> They should be brought in smaller volumes so that it's not a factory. They've created a situation where the physician is making a tremendous amount of money and since we're paying for their 'rehabilitation', then I would love these people to be rehabilitated. I want the addicts to get the best possible treatment they can, but I think we're locking them into a certain way of life which isn't good for them, and isn't good for the community. (***Alexander*, resident and business owner)**

Shifting focus from economic to policy dimensions of MMT, opponents implicitly advocated for the *(re-)medicalization* of methadone treatment (Rosenbaum, 1995). "I'm not a NIMBY, but I feel methadone should be in a controlled environment, perhaps in a clinical situation" remarked one resident and former member of the CRBA (***Patricia***). Insisting that treatment services should be integrated within multi-purpose medical centres that limited the number of MMT clients, the notion of integration was rooted in *re-institutionalization*. Here, a critique of the 'demedicalization of MMT' (Rosenbaum, 1995) became manifest as an implicit attack on the private, for profit, 'juice bar' treatment model, where patients became

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'clients' and physicians were reduced to 'prescribers'. Further, oppositional strategies consciously worked to present clients as victims of an exploitive treatment system that demonstrated little regard for the interests of the larger community. "There was no thought given to the large number of addicted people, many of whom are incapable of controlling their behavior, who would now be coming daily to a heritage community," read the CRBA *Community Impact Statement*, invoking the 'urban village' and 'heritage' strategies employed in the re-branding of the neighbourhood.

> Nothing could have prepared us for the sheer volume of patients and the appalling physical condition of so many of these unfortunate people. Initially our concern was for the community but now we feel just as strongly about the rights of methadone patients and the quality of care they are receiving in this type of treatment program … (2007, p. 4)

In another highly sophisticated line of critique, opponents invoked notions of 'segregation' and 'integration'. "I think it's horrific for people to be brought in such huge volumes to the same location which is segregated," remarked one local resident and business owner:

> The clients are not being integrated back into society, and there's no social program, so it's simply a function of giving them their dosage for the day. It seems that the program should be structured such that people are integrated within society, because they're fortifying the ghettoization on a sociological level. (***Alexander*)**

'Integration' was invoked by community opponents not only in socio-spatial terms that served to problematize the segregation of addiction treatment clients and call into question the 'ghettoization of addiction' produced by private, 'big box', 'juice bar' methadone treatment. Perhaps more importantly, this notion of integration was informed by an underlying abstinence-based critique of the 'maintenance model' for opiate dependency treatment, a critique that further blurred the distinctions between *client-as-victim* and *client-as-villain*. "What is the final goal?", one local business owner queried. "Is it simply to be able to keep these people off heroin, or is it to reintegrate them into society without the methadone?" (***Winston,* resident**). In yet another attack trajectory, the notion of (re-)integration was expressed as a pointed critique of the limited spectrum of services offered in the private, for profit treatment context:

> I believe very firmly in holistic based health care, and it makes me so mad that clients are being given what is effectively a liquid noose around their neck … These people are given a very expensive treatment, but for the province of Ontario it's a cheap fix … [T]his should be holistic care, where they are in a hospital setting, not a big-box business. (***Patricia,* resident, former member of CRBA**)

Framing critiques of MMT practice as concern for the best interests of clients, strategies employed by Corktown opponents involved both a morally-informed interrogation of addiction treatment, and a more complex evaluation of the socio-spatial implications of the 'juice bar' model for MMT. Descriptions of the impact of the clinic and its clients, however, contained a constant tension between compassion and condemnation, sympathy and stigmatization. Starting from a discourse of care that worked to situate clients as victims, oppositional strategies turned to explicit forms of socio-spatial stigmatization, positing the clinic as a site of infection and its clients as 'villains', agents of contagion that threatened to sow the 'disorder of drugs' throughout the neighbourhood. In this sense, the abject body of the methadone addict was positioned as 'out of place' in relation to the 'transitional' space of Corktown, a process contingent on the invocation of socio-spatial boundaries and borders, blurring distinctions between bodies real and imagined.

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“A garbage dump of people”: the abject body of the methadone addict

Underlying oppositional discourse premised on the ‘client-as-victim’ framework lay a series of value judgments that served to portray MMT clients as ‘abject other’. Following Sibley, I argue that the notion of abjection—“that unattainable desire to expel those things which threaten the boundary”—is central to understanding socio-spatial exclusion relating to marginalized inner-city populations, particularly drug users (1995, p. 18). Kristeva’s (1982) work suggests that abjection designates a boundary between self and other, the pure and the polluted, thus serving to preserve the identity of those engaged in the practice of exclusion. The abject therefore provides “the constitutive outside, the outcast whose presence is indispensable for the construction of those categories of subjectivity from which its abjection is defined because it, in turn, marks the boundaries of their identities” (Sommers, 1998, p. 289). In dialogue with Douglas’s (1966) work on the ‘boundaries of the body’ and ‘matter out of place’, Butler asserts that abjection delineates a border, where divisions between the “‘inner’ and ‘outer’ worlds of the subject” correlate to questions of “social regulation and control” (1990: 133).

Constructions of the abject body contain an explicit emphasis on bodily fluids (Bataille, 1999; Butler, 1990; Kristeva, 1982). Sibley suggests that the desire to expel or exclude the abject is invoked in the “boundary between the inner (pure) self and the outer (defiled) self”, a boundary that becomes manifest in relation to bodily fluids before taking on wider socio-spatial significance (1995, p. 7). In Corktown, oppositional discourse based on the stigmatization of clients as dirty, diseased, dangerous, deviant and disorderly attests to how local community members perceived the clinic’s impact in the terms of abjection, registering an acute sense of nervousness, discomfort and anxiety regarding bodies and behaviours deemed ‘out of place’ (Cresswell, 1996).

Socio-spatial stigmatization regarding the contested space of addiction treatment contains an inherent, in-built, explicitly spatial dimension, characterized by invocations of the ‘disorder of drugs’, where the abject body of the addict is cast as an agent of infection that threatens to sow disorder, deviance and disease throughout the social body of the city. Describing its impact on the local community, Corktown residents and business owners positioned the clinic as a catalyst responsible for attracting other abject bodies traditionally seen as threats to the social body of the city, drawing explicit attention to the residual traces of bodies and behaviours ‘out of place’.

> People in the neighbourhood have been photographing because they’re so concerned with people who are throwing up, pooping, peeing … Hooker clothes have been found throughout the area and they have been seen and documented walking up the street, so it’s having a major impact on my neighbourhood. (***Sandy*, resident, business owner, member of CRBA)**

Described in terms that dialectically transpose disorderly people and disordered landscapes, opposition to the disorder of drugs is premised on the projection of ‘social pathologies’ on to physical places, posing spatial purification as an antidote to perceived social problems, with an explicit emphasis on the public realm. Here, not only the presence of bodies and behaviours out of place, but also their residual traces revealed explicit attention to the abject, as boundaries, borders and bodies blurred together in a discourse based on notions of purification that were simultaneously social and spatial. Detailing “just a few of the incidents witnessed by community members” following the arrival of the methadone clinic, the CRBA *Community Impact Statement* contained a list of transgressions that seamlessly shifted between social and spatial dimensions, bleeding together people, pathology and place:

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> People who are vomiting on the street and projectile vomiting on surrounding buildings … People who use our parks to urinate into bottles and then sell this fresh urine to others … People who are so high on drugs that they force their way into neighbouring restaurants to use their bathrooms leaving their crack kits behind…. People who use our children's wading pool in the park for a bathtub and wash their underwear in our drinking fountain … People loitering on the streets and in the parks around the clinic, intimidating pedestrians … People who wander into adjacent streets, threatening residents … People who leave used crack kits and needles in our parks and behind buildings. (2007, p. 4–5)

Sometimes the mere public presence of bodies out of place was portrayed as 'intimidating', while in other cases, the transgression of the public/private distinction was deemed the source of 'threat'. And beneath all this, the visible residual traces of abject bodies, in the form of garbage and discarded harm reduction equipment, tainted by the implication of contact with the diseased and dirty. Calling back to Richard Sennett's (1970) work on the 'myth of a purified community', Strike et al. suggest that in cases of community opposition to NEPs, "the primary concern of residents appears to be the maintenance (or creation) of the purity of their communities by excluding [drug users] and the artefacts of their presence" (2004, p. 266). As Kristeva writes, it is "not lack of cleanliness or health that causes abjection but what disturbs identity, system, order […] [w]hat does not respect borders, positions, rules" (1982, p. 4).

Gesturing towards a direct relationship between the abject body of the addict and the social body of the city, some investigations of community opposition have focused on affect. As Fitzgerald and Threadgold suggest, confrontations with the *body-becoming-city*—"when the body of the drug user becomes part of the furniture of the city"—and the *city-becoming-body*—"when the city becomes bits of the drug users' body"—signals the inherent socio-spatial dimensions of the disorder of drugs (2007, p. 408–410).

> I don't want to have to post a letter in my only mailbox down there beside the methadone clinic. I mean, why do we have to go by and have people loitering and swearing at us? And why do we have to walk around people—bodies on the street —that are sitting there, you know? **(*Mary*, business owner and former member of CRBA)**

In the contested neighbourhood of Corktown, where socio-spatial boundaries between the 'pure' and the 'polluted' were still being cemented, attention to the abject was particularly acute in relation to the community's central, symbolic public space, Sackville Park. Here, through the transgression of normative social rules and spatial boundaries, the behaviours and visible traces associated with abject bodies were posited as a threat to the fragile sense of order and homogeneity that represented the re-branded vision of Corktown.

> I don't like the impact the clinic is having—the loitering of people, the garbage. I've noticed a lot more garbage, and where are the people from? They're directly from the methadone clinic. I can't spend the day in my doctor's office because I have nowhere else to go, so why are they spending the day there? Or in the park? **(*Sandy*, resident, business owner, member of CRBA)**

Opposition to the disorder of drugs stakes strategic power in both the rigid enforcement and effective blurring of socio-spatial boundaries, bodies and identities. Here, literal references to the presence of garbage morphed into metaphorical references to socially produced forms of waste—wasted time, wasted space, wasted lives—with the streets becoming a "garbage dump of [disorderly] people", drawn in to the community by the methadone clinic (***Mary*, business owner and former member of CRBA**). In this sense, perceptions of non-productive people signal the inherent threat of place itself becoming non-productive, the

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mere presence of out of place ‘bodies on the street’ loitering and littering in public space producing discursive projections of decline and urban decay.

If discursive opposition to the disorder of drugs contains an explicit spatial subtext, the ‘social disease’ of addiction then signals a ‘pathology (out) of place’ that serves to immediately situate and localize the abject body of the addict in relation to the social body of the city. Metaphors of pathology, however, not unlike those of ‘war’, implicitly serve to simplify an issue or conflict deemed to be complex, irrational, or outside the possibility of immediate human engagement; a situation ‘beyond our control’ (Woolford, 2001). Yet in these disordered encounters, a constant underlying sense of *desire*: the desire for revenge, for intervention, for solution or ‘cure’. Articulating the simultaneous sense of desire produced in encounters with the abject, Kristeva writes “The fascinated start that leads me towards and separates me from them … I abject *myself* within the same motion through which ‘I’ claim to establish *myself*” (1982, p. 3).

In the disorder of drugs, therefore, we are forced to encounter not only the body of the addict, but also the social body of the city in the terms of abjection. In this discourse, references to dirt, deviance, decay, disorder and disease shift seamlessly between people and places, tracing a relationship between “the body politic and the body of the individual member” (Derrida, 2003, p. 32). Simultaneously constituting a pathology ‘out of place’, and a pathology ‘of place’ the disorder of drugs is perceived and positioned as a threat to the productive potential of transitional, gentrifying spaces as both symptom and cause of socio-spatial infection.

Conclusion: MMT, ‘social productivity’ and the disorder of drugs

Inverting normative capitalist notions of ‘consumption’ and ‘control’, the disorder of drugs signals a *pathology (out) of place*, beneath which lies a critique constructed on conceptions of ‘social productivity’. Resonating closely with Takahashi’s (1997) description of socio-spatial stigmatization based on the perception of non-productivity, Derrida’s (2003) discussion of the discursive logic of prohibitionism points back to processes of production and consumption. Here, while ‘irresponsibility’, ‘nonwork’ and ‘unproductivity’ are posited as representing a loss of control and the destruction of the “‘natural’ normality” of both “the body politic and the body of the individual member”, the disorder of drugs also curiously connotes a form of liberation from “the reactive forces that constrict originary forces of desire” (Derrida, 2003, p. 32). Implicated in deviant forms of consumptive behavior, the disorder of drugs—measured in terms of the visible presence and traces of abject, ‘out of place’ bodies and behaviours—conjures the transgression of socio-spatial boundaries and borders, signalling the need for social control through spatial (re-)development (Butler, 1990).

Throughout the discursive strategies employed against the Corktown methadone clinic, opponents repeatedly drew attention to the visible presence of (out of place) ‘loitering’ ‘bodies on the street’, in essence implicating the private, for profit MMT model in the social *stagnation* of addicted bodies, with an underlying emphasis on waste. From the residual traces of abject bodies drawn into the neighbourhood by the clinic, to the mere presence of ‘out of place’ bodies and behaviours that threatened normative socio-spatial boundaries, literal and metaphorical references to ‘garbage’ served to delineate the border represented by abjection. In an effort to define and distinguish the social body of Corktown as a ‘transitional’, gentrifying neighbourhood, oppositional strategies therefore contained an underlying critique of the clinic and its clients as ‘unproductive’—wasted lives, simultaneously ‘trashed’ and trash itself.

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Dole and Nyswander's (1967) first published accounts of the success of the 'maintenance' model hailed MMT for its dramatic transformative potential with respect to 'social productivity'.

> Approximately 70% of the patients who have been in the program for six months or longer are employed or in school; the remaining patients, although not yet socially productive, have at least ended heroin usage and related antisocial behavior. The dramatic improvements in social status of patients on this program have exceeded expectations. (p. 20)

Engaging morally-informed debates regarding the nature of addiction, Dole and Nyswander's work served to question the goals of treatment, equating social productivity with 'cure' (1967, p. 22). The role of MMT in radically transforming social productivity has been taken up and advanced in subsequent debates regarding the bio-medical cost/benefit analysis of methadone treatment. Here, MMT is positioned as a 'harm reduction' intervention that dramatically reduces the 'social costs' of addiction, as illustrated in the CAMH *Community Planning Guide*, a manual that Corktown opponents referred to as a "step-by-step guide on how to indoctrinate a community" (***Patricia,*** **resident, former member of CRBA**). MMT, the guide suggests, "reduces the criminal behavior associated with illegal drug use, promotes health, and improves social productivity, all of which serve to reduce the societal costs of drug addiction" (2000, p. 8)

In spite of their awareness of this literature, Corktown opponents shifted between discourses that posited the client as both victim and villain, underscored by the perceived negative impacts of the segregation of addiction treatment clients produced by the private, for profit model for methadone treatment. Advocating for the re-medicalization and re-institutionalization of MMT, community critiques suggested that 'social productivity' could only be achieved through de-segregation and notions of '(re-) integration' that bled between moral, social and spatial concerns.

Caught between the shifting, fluid forms of bio-political control reflected in the private, for profit, 'big box', 'juice bar' model for MMT, and the specific symptoms of socio-spatial stigmatization produced by community opposition to the 'disorder of drugs', this analysis suggests that the body of the (methadone) addict is always already framed in relation to the social body of the city. Based on the creation and maintenance of symbolic boundaries between real and imagined, literal and metaphorical bodies, the simultaneous forces of attraction and repulsion, desire and disgust implied in the notion of abjection serve to denote a sense of intrigue in the act of navigating 'imperative' acts of exclusion. This process therefore involves a dialectical experience of the disorder of drugs.

The first force, a 'fear of sense' (Fitzgerald & Threadgold, 2004), propagated by the 'myth of a purified community' (Sennett, 1970), perceives the body-becoming-city/city-becoming-body in abject terms: a visible threat foreshadowing socio-spatial infection that posits addiction as a *pathology (out) of place*. It is in this vision that I argue the city itself is being redeveloped into a site of safe/supervised consumption. The second force we might call a *users' guide to the city*. Here, through spatial tactics that worked to assert users' 'right to the city' (Lefebvre, 1996), the subject of addiction/treatment narrates the lived experience of the late-capitalist cityscape in terms of the myriad configurations between shifting forms of consumption and control. Ambiguously empowered as autonomous 'consumers' of harm reduction and addiction treatment services, users therefore confront the diffuse and decentralized control mechanisms that make up the new landscape of the city as site of supervised consumption, composing, in the process, a *users' guide to urban space*.

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