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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.

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 '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

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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 "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 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