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A Users' Guide to 'Juice Bars' and 'Liquid Handcuffs': Fluid Negotiations of Subjectivity, Space and the Substance of Methadone Treatment

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Abstract

The contested *space* of addiction treatment is a space of intersections and inscriptions, a space where the biopolitics of treatment practice meets strategies of sociospatial stigmatization projected by the surrounding community. Drawing from a case study of community conflict surrounding the relocation of a methadone clinic into Corktown, a rapidly gentrifying neighborhood on the peripheries of downtown Toronto, this article explores the sociospatial dimensions of addiction treatment through a theoretical and ethnographic investigation of client impressions regarding the space of the methadone clinic, before and after its relocation into Corktown. Examining clients' engagement with the space of the clinic as a series of body-space "assemblages" and "folds," this analysis reveals the clinic as an inherently social space, where clients negotiate both the fluid strategies of biopolitical control implicated in treatment practice, and strategies of sociospatial stigmatization in order to assert and articulate their "right to the city."

Keywords

methadone; sociospatial stigmatization; addiction treatment; the body; biopolitics

When the methadone clinic first opened its doors in the Corktown district last summer [...] the first few days saw the nastier side of an inner-city neighborhood [...] with recovering opiate addicts being welcomed to their new clinic by a handful of local residents and business owners standing across the street taking their photographs, and shouting taunts and obscenities.

—Bonokoski (2007)

We fill pre-existing forms and when we fill them we change them and are changed.

—Bidart (1997/2003)

Introduction

The space of addiction treatment is a physically, ideologically, and discursively contested space implicated in the social and spatial regulation of addicted bodies. Here, at sites such as methadone maintenance treatment (MMT) clinics, policy, discourse, and the lived experience of the city come together to participate in the mutual production of bodies and

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space. Arguing that the socially and spatially segregated phenomenon of the methadone clinic as it has become manifest in North America represents a complex network of control relations fundamentally related to the question of space, this article draws from a case study of community conflict surrounding the relocation of a methadone clinic into a gentrifying neighborhood in Toronto, Canada to examine how the subjects or users of addiction treatment services—variously reconstructed under neoliberalism as “clients” or “consumers”¹—in turn negotiate the contested space of the clinic. Through an analysis of the competing forces of control that serve to contest the subjects of treatment both from within and from without, this article suggests that the space of the methadone clinic functions as a site that is implicated in both the inscription of biopolitical regulation, and sociospatial stigmatization projected by the local community, responsible for perpetuating conflict and contestation regarding the “place” of addiction treatment more generally (Bourgois, 2000; Des Jarlais, Paone, Friedman, Peyser, & Newman, 1995; Fischer, 2000; Fraser, 2006; Keane, 2009; Strike, Meyers, & Millson, 2004).

In recent years, the “Not-In-My-Back-Yard” or NIMBY phenomenon has become increasingly prevalent with regard to harm reduction sites, addiction treatment facilities, and their users (Des Jarlais et al., 1995; Smith, 2010; Strike et al., 2004; Tempalski, Friedman, Keem, Cooper, & Friedman, 2007). Despite the growing incidence of conflicts regarding the *space* of addiction treatment, there is a lack of qualitative literature that examines the nexus between space and treatment through the perspectives of treatment users. Similarly, few qualitative investigations exist regarding user perceptions and experiences of MMT treatment. Although the majority of research regarding drug use, addiction, and treatment is overwhelmingly characterized by quantitative epidemiological approaches that lack an engaged, ethnographic dimension (Bourgois, 2002; Bourgois & Bruneau, 2000), this article contributes to an interdisciplinary sociospatial analysis of addiction treatment through a theoretical and ethnographic case study of MMT user experiences in Toronto, Canada during a period of heightened community opposition.

In early 2006, the province of Ontario witnessed a media-fuelled moral panic regarding MMT. Conflating an economic critique of the lucrative financial implications of the methadone “industry” with a policy-based critique of the MMT “system,” the early stages of this moral panic centered on a chain of group-practice methadone clinics accused of both exploiting Ontario’s publicly funded health care system and endangering the lives of users (Donovan & Leeder, 2006). Following on the heels of these scandals, community opposition to the relocation of a methadone clinic into Corktown, a gentrifying neighborhood on the peripheries of downtown Toronto, served to bring MMT back into the public spotlight: “When a methadone clinic moved into the historic area east of downtown last year, the locals didn’t exactly roll out the Welcome Wagon. Residents don’t feel safe. Patients report intimidation” (Whetstone, 2007). Situated within the larger moral panic regarding MMT, the conflict surrounding the methadone clinic culminated in the establishment of a provincial Methadone Task Force by the Ontario Minister of Health, charged with investigating “community engagement” among other areas of MMT practice (Ontario Ministry of Health, 2006).

With an explicit focus on the interrelationship between the spatial context of the clinic/community and the social dimensions of MMT, this article explores the “culture of the clinic” (Bourgois 2000) through user narratives of encounters and altercations with the built environment, treatment policy, and members of the local community, demonstrating how the

¹The author recognizes that the subject of drugs and “addiction” is a delicate and unsteady discursive terrain. Eschewing the stigmatizing connotations of conventional discourse, this article uses the term *user* in reference to the subjects of addiction treatment services.

space of the clinic serves as a point of intersection and contact between the body of the (methadone) “addict” and the social body of the city. Navigating between inscriptions of disciplinary/regulatory biopower and the experience of sociospatial stigmatization, user narratives reveal how “prescriptions, power and politics” (Fischer, 2000) become manifest in the social and spatial dimensions of the methadone clinic. Considering the clinic as an inherently social space, the article concludes with a series of critical suggestions regarding desegregating and destigmatizing the space of addiction treatment, pointing to a direct relationship between the sociospatial context for MMT and user experiences of sociospatial segregation, stigmatization, marginalization, and exclusion.

Literature Review: Bodies and Space, Biopower, and Sociospatial Stigmatization

Investigations into the biopolitical dimensions of MMT have pointed to the various ways that treatment practice contribute to user experiences of MMT in punitive, disciplinary terms (Bourgois, 2000; Keane, 2009; Smith, 2008). Foucault (1978) broadly defines biopower as “technologies of power that take life as their objective” (p. 152). Describing the forces that “brought life and its mechanisms into the realm of explicit calculations and made knowledge-power an agent of transformation of human life” (p. 143), Foucault suggests that biopower emerged with the rapid proliferation of techniques designed to subjugate individual bodies and control large populations, and was thus fundamental to the development of capitalism. Considering that one of the primary institutional justifications for MMT lies in its ability to transform “addicts” into functional, socially productive, contributing members of the workforce (Dole & Nyswander, 1967), the relationship between MMT, biopower, and capitalism is rendered stark.

Dosing policies, urine screening, and methadone “take-home” privileges have all been cited as examples of disciplinary biopower in MMT (Bourgois, 2000; Fraser, 2006; Keane, 2009; Smith, 2008). In the case of dosing, for example, Bourgois (2000) notes how dosage increase or decrease because of users’ noncompliance (such as ancillary drug use detected through urine screening) is often employed as a punitive, disciplinary measure, determined by “a struggle over pleasure, pain, and compliant social control” (p. 182). Bourgois has also explored how the inherent properties of methadone can be seen in biopolitical terms, where to supplement or intensify its “latent or frustrating euphorogenic qualities” (p. 179), users often turn to ancillary drug use in the form of crack/ cocaine or benzodiazepines such as Xanax.

Strict regulations often require MMT users to travel to the clinic and pharmacy for daily dosing of liquid methadone and regular appointments to see physicians and submit urine samples. Daily attendance at the methadone clinic/pharmacy has been noted as a source of resentment among users (Bourgois, 2000; Fraser, 2006; Rhoades, Creson, Elk, Schmitz, & Grabowski, 1998), giving rise to the descriptive metaphor of “liquid handcuffs” employed by methadone users in Canada and the United States (Smith, 2008). Beyond user descriptions of being “chained to the clinic,” disciplinary biopower has also been analyzed from the perspective of the spatial design of treatment sites (Bourgois, 2000; Fraser, 2006; Smith, 2008). Here, Fraser (2006) has explored not only how the spatiotemporal phenomena of “queuing” contributes to stigma, conflict, and confidentiality concerns among MMT users in Australia but also how the physical design of methadone clinics is based on a spatial distancing between staff and users. As Bourgois (2000) writes, “the complicated micrologistics for overseeing the consumption of methadone in order to prevent illegal methadone ingestion and to discourage ongoing poly-substance abuse by recovering addicts has given birth to a culture of the methadone clinic.” (p. 179).

Above and beyond the various ways that control becomes manifest in the physical space of the clinic, users are also often forced to navigate the forces of sociospatial stigmatization projected by local community opponents. In addition to the social application of stigma, which creates “a definition of acceptable and non-acceptable individuals and groups,” stigma also operates in spatial dimensions, creating “a powerful cognitive map of acceptable and non-acceptable places” (Takahashi, 1997, p. 904). Drawing on Goffman (1963), Takahashi (1997) writes that *sociospatial stigmatization* represents “a mutually constitutive process, whereby places inherit the stigma of persons, but persons also become stigmatized through their association with places” (p. 910).

Nonproductivity, dangerousness, and personal culpability are three specific dimensions that have characterized sociospatial stigmatization relating to homelessness and HIV/AIDS, all of which closely correspond to contemporary oppositional discourses regarding the space and subject of addiction/treatment (Dear, 1992; Smith, 2010; Takahashi, 1997). Building on Takahashi’s work regarding homelessness and HIV/AIDS, scholars have addressed how sociospatial stigmatization relates to the siting and operation of harm reduction services such as needle exchange programs, perceived as contributing to the loitering and congregation of users who are drawn into the community, attracting drug dealing and exacerbating public disorder/order issues (Des Jarlais et al., 1995; Strike et al., 2004; Tempalski et al., 2007).

In the case of the conflict surrounding the Corktown methadone clinic, stigmatization took both social and spatial forms, serving to simultaneously frame MMT users as abject agents of contagion and cast the clinic as a site of infection that threatened to sow the sociospatial “disorder of drugs” throughout the community, in the form of disease, danger, deviance, and disorder (Smith, 2010). In the oppositional strategies employed, local residents and business owners made repeated reference to the fact that because of the clinic’s location, any individuals entering or exiting the building were automatically assumed to be users. Ostensibly expressed as a concern for user privacy, these strategies point to how bodies become stigmatized through their association with place. Conversely, because of their perceived associations with deviance, danger, dirtiness, disorder, and disease, the stigma attached to MMT users was transposed on to—and embodied in—the space of the methadone clinic itself, leading to perceptions of neighborhood decline, decay, and disinvestment (Sibley, 1995; Smith, 2010; Takahashi, 1997).

In reconsidering the relationship between bodies and space in the context of the methadone clinic, Lefebvre’s commentary concerning the social production of space is a useful point of departure. Lefebvre (1974/1991) positions the social production of space as a process involving three competing forces, which he terms the *perceived-conceived-lived* triad. In the *conceived* realm (representations of space), the city is seen as the predominant/dominant domain of technocratic planners, equating to a science of the city that produces a planned, ordered, and controlled urban landscape (Mitchell, 1995). In the *lived* realm, “dominated and hence passively experienced” representational spaces invite and allow social actors to “change and appropriate” space through acts of imagination and creativity that recode the conceived use of space through “systems of non-verbal symbols and signs” (Lefebvre, 1974/1991, p. 39). Finally, the *perceived* realm of spatial practice mediates between the planned, controlled, ordered nature of representations of space, and the sense of resistance implied in *representational spaces*, ensuring “continuity and some degree of cohesion” between these competing forces (p. 33). Building on the work of Lefebvre (1967/1996), scholars have pointed to the inherently political, contested nature of urban public space, exploring how marginal groups such as the homeless attempt to assert and articulate their “right to the city” (Davis, 1990; Mitchell, 1995; Zukin, 1995).

The work of Deleuze and Guattari (1987) provides a synthesis that points to both Foucault's insights into the biopolitical production of bodies and Lefebvre's insights into the social production of space. These concepts also provide tools for understanding how bodies and space interact in the contested space of the methadone clinic and surrounding environment, positing the clinic as a site of encounter and negotiation implicated in the mutual production of bodies and space. Using Deleuze and Guattari's concepts to extend Lefebvre's analysis of the dialectical interrelationship between built form and spatial practices, critics have argued that space can be thought of as an "assemblage" of built form and social order (Fitzgerald & Threadgold, 2004, p. 409).

Here, space is seen to be constituted out of a host of competing factors and forces, attributable to no one single dimension of production. Representing a movement between inside and outside, interiorities and exteriorities, space—not unlike the body and human consciousness²—is the product of physical/material factors, along with "machinic" forces that are mobilized to form "assemblages" of desire (Fitzgerald & Threadgold, 2004, p. 408). In this way, we can speak of body-space assemblages as an interdependent, mutually constituting relationship between bodies and space that is transitory and fleeting, involving various forms of movement and potentiality through fluid and fixed states (Malins, 2004).

The distinction between "smooth" and "striated" spaces articulated by Deleuze and Guattari (1987) offers further critical insight that can be applied to our analysis of how users engage with the space of the clinic and navigate the surrounding spatial environment. In contrast to the strict and stringent associations with striated space, the notion of smooth space implies "slipperiness and movement, where one slides seamlessly from one site (place, meaning, image, identity) to another" (Dovey, Fitzgerald, & Choi, 2001, p. 328). In this sense, "smooth" spaces are sites composed of continual variation that invite and encourage transformations by opening the body up to creative movements of "becoming" (Malins, 2004, p. 486).

As a space of resistance that "utilizes the potential of camouflage and guerrilla action within the striations of authority which serve it as masks" (Dovey et al., 2001, p. 328), the notion of smooth space resonates with Lefebvre's discussion of *representational spaces*, where the planned, ordered, and controlled nature of *spaces of representation* is challenged, contested, and appropriated by the imaginative powers and lived use of social actors. Correspondingly, Deleuze and Guattari's (1987) notion of striated space shares a number of similarities with Lefebvre's (1974/1991, p. 38) discussion of *representational spaces*: "conceptualized space, the space of scientists, planners, urbanists, technocratic subdividers and social engineers," characterized by rigid inscriptions of control. In spite of the sharp distinctions between smooth and striated spaces, it is important to recognize that all space is composed of a mixture or combination of these two forces, which exist "in a mutual relation where they are constantly 'enfolded' into one another" (Dovey et al., 2001, p. 328).

Deleuze's (1988) discussion of "folds" extends on Foucault's early work to emphasize the material and spatial dimensions of subjectification (Dovey et al., 2001). Suggesting that the subject is produced not only through social and ideological forces but also through a series of folds, Deleuze (1995), posits four different kinds of folding evident in Foucault's work: "the folding of our body [...] the folding of a force impinging on itself rather than other forces, truth enfolded in relation to us, and finally the ultimate folding of the line outside"

²Buck-Morss (1992) argues that the physical environment is an inherent part of the human nervous system, acting as "the source for stimuli and the arena for motor response" (p. 12). In this sense, the brain can thus be seen as an *assemblage*: "not an isolable anatomical body, but part of a system that passes through the person and her or his (culturally specific, historically transient) environment" (p. 12).

(pp. 112–113). Constituting “the acting or material cause of subjectivity and interiority as a relation to oneself,” Deleuze (1988) argues that these folds are “eminently variable,” having “different rhythms whose variations constitute irreducible modes of subjectification” (pp. 104–105). Here, “against a concept of discourse as something which acts directly and deterministically upon the body,” the concept of *folding* enables an appreciation of discourse as an embedded phenomenon that can be used as a tool for the body to narrate and negotiate surrounding sociospatial relations (Malins, Fitzgerald, & Threadgold, 2006, p. 512).

The first type of fold, the *folding of the body*, concerns the body’s relationship to the physical/ material space of the world, where one is seen to fold into the other, blurring the boundaries and borders between the body and space (Malins, 2004). Here, Massumi (2002, pp.184–185) uses the example of a Möbius strip to describe how mind and body (the “inside”) becomes intimately entwined with discourse, knowledge, and spatial built form (the “outside”) through the process of body–space folding, resulting in the fact that bodies and spaces can no longer be conceived as separate, distinct entities.

The second type of fold, the *folding of force*, relates to the body’s ability to absorb, avoid, and deflect force, allowing forms of self-regulation and self-governance to emerge through a negotiation of the forces acting on the body. Related to the folding of force, the third fold, *truth in relation to the self*, involves an appreciation of the ways that knowledge and discourse fold and become embedded and inscribed in the body, with enfolded discourse becoming a tool for the body to narrate its relations with other physical and social bodies and spaces. While the folding of force enables bodies to (re)produce themselves through forms of self-regulation in the spatial environment, the folding of truth in relation to the self involves the ability of the body to unfold and refold discourse that has become embedded in space and the body to imaginatively reinvent subjectivity (Malins et al., 2006).

Building on Foucault (1978), feminist theorists have explored the social construction of categories of gender and sexuality as a process of “bodily inscriptions” (Butler, 1990). Here, scholars have suggested that the development of medicolegal discourses led to the taxonomic transformation of acts into identities in the case of both the “homosexual” and the “addict” (Sedgwick, 1992)—figures that share a close historical association as typologies of deviance (Bergschmidt, 2004; Brodie & Redfield, 2002; Butler, 1990). Pointing to the ways that Foucault’s interpretation of subjectivation reduces the body to a passive, bounded, taken-for-granted site that is produced in subordination to power (Bergschmidt, 2004), Butler (1990) turns to Douglas’s (1966/2001) work that questions cultural assumptions about the boundaries and borders of the body. From this perspective it is important to understand the body not as a passive site of inscription formed in subordination to power but as an entity possessed of agency and autonomous forces that has the potential to “fold” into various forms of sociospatial control (Malins, 2004). Here, power is both internalized and doubled back on itself, reproduced, and at the same time radically transformed.

Scholars have usefully applied many of these concepts to analyze the relationship between bodies and space among street-level injecting heroin users in Australia (Fitzgerald & Threadgold, 2004; Malins, 2004; Malins et al., 2006). In particular, Malins’s (2004) notion of body–space folds provides invaluable inspiration for this article. Shifting focus to the space of methadone treatment in Toronto, Canada, this article places theoretical and ethnographic emphasis on how MMT users negotiate strategies of biopolitical control and sociospatial stigmatization inscribed and embedded in the methadone clinic, using a series of tactical body–space folds and assemblages to rewrite a users’ guide to urban space.

Methodology: Fieldwork in Contested Urban Spaces and Methodological Positionality in Conflict

Based on 6 months participant observation fieldwork at the methadone clinic and throughout the Corktown neighborhood during the height of community opposition (June–November 2006), this article draws from qualitative interviews with MMT users and ethnographic field notes collected by the author. While other areas of the larger project in which this work was conducted explored the discourse of community opponents (see Smith, 2010), this article explores the contested space of the clinic through the voices and perspectives of treatment users. Confidential semiformal, open-ended, tape-recorded interviews were conducted with 34 MMT users (14 males and 20 females), and fieldwork began 1 week prior to the clinic's relocation into Corktown. The initial process of recruiting interview participants was mediated by clinic staff, although more informal recruitment strategies were employed as comfort with both staff and users grew. Often, recruitment took place during casual interactions in the clinic waiting room.

Among the 34 interview participants, 27 identified as Caucasian, 3 as Middle Eastern, 2 as Caribbean, and 2 as Southeast Asian. The age of participants ranged from 21 to 72 years, with a median age of 39. More than one third of the interview sample ($n = 12$) lived in subsidized housing and more than 50% ($n = 18$) stated social security as their primary source of income. Nearly one third of the interview participants ($n = 10$) lived in relative proximity to the methadone clinic, whereas another third ($n = 11$) lived in adjacent neighborhoods, with some even traveling from satellite cities outside Toronto ($n = 3$). During daily field visits to the methadone clinic during its open hours (8:00 a.m.–1:00 p.m.), the author developed relationships with staff and users, many of whom posed questions such as “Are you writing a book?” and “Are you studying to become a doctor?” during the initial stages of the research. Conducted with ethics approval from York University (Toronto, Canada), informed consent was collected from all research participants and pseudonyms were used in all cases to protect anonymity. Fieldwork was not confined to the singular, bounded space of the methadone clinic, but also took place throughout the Corktown community, where the author observed and took part in interactions with users, residents, and business owners in the streets, parks, public spaces, restaurants, and coffee shops throughout the neighborhood. All interviews and field notes were transcribed, coded, and analyzed by the author.

Because the research began in the context of the clinic, involving visible interactions with users, and subsequently moved outward to involve interviews with community opponents, suspicion and wariness regarding “whose side” the researcher was on (Becker, 1967) in some cases came to characterize perceptions of his methodological positioning in the larger contested space of Corktown. As both a resident just outside the formal neighborhood boundaries of Corktown, and someone with previous familiarity with methadone treatment, the researcher occupied a liminal space between “insider” and “outsider,” forcing him to navigate his methodological positioning through occasional moments of crisis and conflict. While in one instance community opponents evidenced doubt and suspicion regarding the alliances and motives of the researcher, levying accusations that he was a “junky” or employee of the clinic, in another case an MMT user circulated rumors that he was a “NARC” or undercover cop. In this sense, fieldwork in the contested space of the clinic, situated within the larger contested space of the neighborhood, led to the author's methodological positioning at times becoming the subject of contestation itself.

Research Findings: The Methadone Clinic as Site of Inscription and Intersection

The research findings from this investigation are divided into four sections, corresponding to key themes that emerged from user interviews. The first section provides a description of the clinic and surrounding environment before and after relocation through analysis of user narratives concerning each respective site. The second section hones in on user experiences of the biopolitical dimensions of MMT, exploring how strategies of biopolitical control are inscribed in both treatment policy and the physical space of the clinic. The third section then moves on to examine user narratives concerning interactions, encounters, and altercations with the space of the neighborhood and members of the surrounding community. Based on this analysis, the conclusion considers the clinic as a social space, exploring user narratives regarding the social dimensions of MMT in the socially and spatially segregated “juice bar” context.

Owing to both the segregation of methadone users and the limited spectrum of treatment services, high-volume, group-practice methadone clinics are often referred to by critics as “juice bars” in Canada, where methadone is mixed with orange juice and generally administered orally (Smith, 2010). Concluding this analysis, the article argues that current MMT policy, responsible for enabling and encouraging the emergence of the “juice bar” model for MMT, effectively forces users to negotiate between competing strategies of control. Through a critique of the sociospatial stigmatization, segregation, and confinement that is actively produced by the “juice bar” model for MMT, the article concludes by suggesting a direct relationship between “juice bar” methadone treatment and user descriptions of MMT treatment practice as a punitive, disciplinary form of “liquid handcuffs” (Smith, 2008).

“Here You Gotta Stay in the Bullpen”: Situating the Space of the Clinic

Located in a busy and commercially thriving, mixed-use area on the peripheries of Toronto’s downtown core, in close proximity to a community college and a large market area oriented toward tourists, prior to relocation, the Corktown methadone clinic was situated in a small commercial space built into the ground floor of a high-rise condominium. The adjacent unit was occupied by a pharmacy designed with a separate entrance exclusively for methadone provision. Illustrative of increasing sociospatial polarization, the surrounding area contained a large number of upscale hotels and commercial establishments, along with a high concentration of social services.

Situated on a quiet side street in between two major arterial roads, the clinic did not have a sign advertising its presence and existed virtually unnoticed, in spite of—or perhaps owing to—the high volume of local foot traffic. When queried about the absence of a sign at the former location, MMT users illustrated a range of responses relating to the stigma attached to the space of the clinic:

Brent: I don’t think the pharmacist and the doctors want to attract attention from the local residents, and once they have a focus, a target—once they see “methadone clinic”—then they have something to lobby against. This way it’s sort of vague, right?

William: I think they want all the junkies out of here, you know, because P... Street is very beautiful, and I don’t want junkies around. Like, I’m a junkie, but I don’t want my friends doing what I did. I don’t look up to people around [the clinic], I look up to [community residents] because they’re trying to make a difference.

Stigma surrounding the space of the clinic was negotiated by MMT users through the folding of force and the folding of truth in relation to the self (Deleuze, 1988, 1995). In contrast to Foucault's contention that discourse acts (and is thus inscribed) on the body through direct and deterministic forces of power located in major sites and institutions of confinement, the concept of enfolded truths allows for an understanding of how embedded discourse has the potential to be used as an instrument of mediation and resistance (Malins, 2004). In this sense, user sympathy for local community residents who are "trying to make a difference" points to forms of self-governance produced by the folding of oppositional discourses into the body, illustrating the body's ability to performatively act on (and self-govern/regulate) itself.

User narratives concerning the rationale behind the clinic's relocation yield further insights into the folding of force and discourse, bodies and space. Here, MMT users made repeated reference to the relationship between behavior around the clinic and the mounting opposition of neighborhood residents, pointing to how the (social) stigma associated with methadone users effectively served to perpetuate (spatial) stigma regarding the methadone clinic itself:

Gerard: I think they're moving because of the guys upstairs in the condo.... They're moving near [the public housing project]. And then just beyond that is the [local] jail, you know? It's like, "who give a fuck, it's just a bunch of crazy junkies shooting themselves." That's what they think.

Liz: I think they got moved because of the area they were in—[the clinic] had so many problems with that condo that was connected to them, so people sort of got sick of it. I even heard there was a wire set up recording [users].

Describing the former clinic as a space that was used as a "drop-in" for people to "hang-out and do [illegal] business," with a lack of concern and "respect" for their immediate environment (Mike), some MMT users saw the negative behavior of their peers as a factor that justified the resentment of local community members, illustrative of the folding of truth in relation to the self (Deleuze, 1995). Here we see evidence of users internalizing and enfolded the hostility projected at the clinic by community residents sharing the same proximate space, where the immediate visible urban landscape makes even self-identified addicts "feel uncomfortable" and "wish it wasn't the way it was" (Calvin).

In sharp contrast to its former location, the clinic was relocated to the corner of a main street in the heart of Corktown, described by community residents as a "transitional," "upwardly mobile" "heritage" community with a "small town" feel (Smith, 2010). Situated in a small commercial strip in a largely residential area, the new clinic was positioned immediately across from one of the oldest churches in Toronto, one block away from the local police headquarters. Although it moved less than 1 kilometer from its former location, the new clinic existed in a different municipal ward that was undergoing an intensive wave of reinvestment, redevelopment, and revanchist gentrification (Smith, 2010).

Unlike the former location on a quiet side street with a high degree of pedestrian traffic, where MMT users could make tactical use of space to blend in with the surrounding environment, the lower levels of pedestrian traffic and spatial context of the clinic's Corktown location resulted in users standing out and being significantly more visible to the surrounding community. Local residents and business owners repeatedly referred to the neighborhood as having a "small town" feel, thus situating the methadone clinic as a tainted, outcast space in the center of Corktown's "main drag" (Smith, 2010; Woolford, 2001). Additionally, whereas the former location existed in close proximity to several high-traffic public spaces such as parks and coffee shops where users could congregate without drawing attention, the public spaces in Corktown were fewer in number, received less pedestrian

traffic, and were more intensively policed by members of the local community (Fischer & Poland, 1998).

User narratives regarding the space of the clinic and surrounding environment before and after relocation yield important insights into the production of space and the “smooth” and “striated” tendencies of each respective site:

Liz: In this neighborhood [i.e., Corktown] there's not much around us and if there's a bunch of people standing around the clinic and the cops drive by, well it's easy to tell what's going on at this place. The old location was in a neighborhood that was kind of blended, you know? Like I could walk down and people wouldn't know that I was going to the pharmacy. But here people know right away. At the old clinic there were a lot more places to kind of blend in, like in a situation where you were stuck waiting for the doctor you had somewhere you could piss off to. Like I'd go to the market and come back. Now I have to sit around for two hours and wait for the doctor to show up with nothing to do, and nowhere to go. I think the old clinic was better—there were more spaces to kind of spread out, like you could go to the coffee shop, you could go to the park, you know what I mean? It wasn't so confined.

Nikita: I liked it better at the old clinic; here it seems like you're being watched. I've heard about all this picture-taking, and it seems so different here—it seems like we're not liked very much. It was a lot quieter at the other clinic, even though a lot of people told me there were problems.

Here, the exposed and highly surveilled space of Corktown was portrayed as a striated space of confinement, in sharp contrast to the relatively discrete and disguised smooth space of the clinic's former location, where users were able to “blend in” through tactical utilization of representational public spaces where they could “spread out,” unnoticed by the surrounding hum of pedestrian traffic and commercial activity. In the Australian context, researchers examining the relationship between gender, urban space, and the bodies of injecting drug users have noted how female injecting drug users tactically harness “the smoothing potential of retail space” to “re-create themselves—at least temporarily—as “shopping bodies” and thereby fold themselves smoothly out into the city's spaces of consumption” (Malins, 2004, p. 488). In a similar manner, the high-traffic, mixed-use, smooth qualities of the clinic's former location afforded users the ability to blend in among the shopping, tourist, and student bodies that peopled the streets.

Comparative analysis of user impressions regarding the interior space of the clinic provides additional evidence to suggest that the spatial dimensions of MMT treatment practice contribute to the experience of stigma:

Giles: It's like a dungeon, it's pretty dingy down here [at the clinic's former location]. Just because we have addictions doesn't mean we should be treated like scum, you know? We should have the right to sit in a nice clinic, with nice chairs, and be able to go to the bathroom without everybody knowing that you're going to the bathroom, or walk outside without everybody knowing who's coming in, who's coming out.

Markus: [The former location] was ugly and run down and stuff. I didn't like that, because it gave us the feeling like, “you're just addicts, you don't deserve anything better.” You go into the pharmacy and it's all nice with a nice entrance, and you go to the other door to drink your methadone and it's this ugly room with a little jail window where they pass you your medication.

User descriptions of the interior space of the former clinic—as an “ugly,” “dingy,” “run-down,” “skuzzy,” and “unpleasant” “hole in the wall” (Bentley)—contrasted starkly with commentary concerning the new location. Described by users as “brighter,” “cleaner,” and bearing a closer resemblance to “a place engaging in the provision of medical services” (Brent), following relocation, clinic staff consciously attempted to create a more traditional institutional, medical feel, causing users to remark that it was “just like a *real* doctors’ office” (Tara). In comparing the waiting room and other interior elements of the clinic at each location, users identified how social relations both inform and are informed by spatial context, rendering stark the sociospatial dialectic (Soja, 1989) in the case of addiction treatment, where processes of body–space folding complicate distinctions between the smooth and striated:

Bentley: I feel that people often tend to live up to their surroundings, so if the [new clinic] is nicer, and appears more friendly and conducive, then people will behave that way. So we may find one of two things: either the behaviour around the clinic might get better, or the clinic might deteriorate to match the behaviour.

Owing to what one local resident referred to as the “visual impact” of the clinic following its relocation into Corktown (Stephen), several explicit modifications were made to the exterior of the building. The most significant alteration was the addition of an 8-foot, enclosed wooden fence surrounding one side of the building, designed as an area for users to congregate and smoke cigarettes out of view from the community. “Bulpen” is a prison slang reference to the common area where inmates are held prior to being assigned individual cells. Immediately after it was erected, users began to refer to the smoking enclosure as either the “bullpen” or the “penalty box,” conjuring vivid images of discipline, confinement, and incarceration. Because of the height of the fence and the distance between the vertical boards used in its construction, the bullpen made it difficult for anyone standing inside to have a clear view outward. Seen from outside, however, the structure allowed passersby to visibly scan the enclosure for the presence of bodies. In this sense, monitored by a closed-circuit television surveillance camera, the spatial arrangement and surveillance of the smoking enclosure closely resembled that of the panopticon, a model for prison architecture that induces “a state of constant and permanent visibility that assures the automatic functioning of power” (Foucault, 1977, p. 205). “It reminds me of the bullpen,” one user remarked, “where you can’t see anything going on outside and you’re just waiting to get jumped by the [prison] guards” (Gerard).

The example of the bullpen yields subsequent insights into how users engaged in tactical body/ space relations and gestures to negotiate the highly striated qualities of the clinic environment. Owing to the angle and positioning of the camera, only half of the enclosure was visible to the gaze of closed-circuit television surveillance, and clinic staff arranged chairs such that users were directly in the field of visibility. Following the erection of the bullpen users repeatedly rearranged the chairs outside the camera’s view to buy, sell, or consume drugs. Creating a space that lay outside the gaze of both clinic authorities and the surrounding community, such acts demonstrate the blurred, relational quality of smooth and striated spaces, where even a highly striated space such as the bullpen could be shifted and subverted through tactical (re)appropriation by users.

Creatively reconceived and reappropriated by the lived use of social actors, representational public spaces such as parks and coffee shops offer users “smooth” alternatives both outside and within the confining, controlling nature of spaces of representation, pointing to the potential to recreate and reconfigure rigidly striated sites of restriction and regulation (Dovey et al., 2001; Mitchell, 1995). Planned, ordered, and controlled spaces of representation are highly striated, based on visual surveillance; in the case of the clinic, the space itself can be seen as being (re) produced and (re)inscribed by the strategic forces of

disciplinary and regulatory biopower, dictated by explicit concerns of monitoring and control:

Katie: The old clinic just seemed a little bit more hidden, you know. Here you're not allowed to hang around out front, but there everybody was hanging out at the clinic even if they didn't have to be there, just to sell drugs or whatever. Here it just seems like it's a lot more strict. Here you gotta stay in the bullpen to smoke, you know what I mean?

“Somehow You're Trapped”: Negotiating the Biopolitics of MMT

The sometimes self-critical discursive subtext that appears in MMT user narratives regarding behavior such as drug use, dealing, and loitering points to an internalized, enfolded sense of conflict concerning the various forms of control implicated in the biopolitics of MMT treatment practice. Although some users viewed drug dealing and use as a naturalized aspect of the culture of the clinic attributable to methadone pharmacology, others saw such acts as negating the treatment program's abstinence-oriented aims and directly contributing to community opposition. These references also point to the ambiguous social dimensions of MMT centered around the space of the clinic, which has come to replace the lost community of active opiate addiction (Bourgois, 2000; Bourgois & Schonberg, 2009).

As Bourgois (2000) writes, “by strategically varying, supplementing, or destabilizing the effects of their dose with poly-drug consumption, methadone addicts can augment the otherwise marginal or only ambiguous pleasurable effects of methadone” (p. 180). From this perspective, ancillary drug use can be seen as a tactic employed to counter the controlling biopolitical properties inherent in methadone pharmacology, or in other words an effort to resist and perhaps temporarily escape the grip of the “liquid handcuffs” (Fischer et al., 2006):

Matthew: When I'm on methadone I don't crave heroin anymore, but for some reason I still like doing coke. It seems that when I'm bored or have nothing to do, I go to score. So that's my craving.

Bleeding from the controlling aspects of methadone pharmacology into rigid regulations regarding dose, “take-home” privileges, and urine drug screening, MMT user narratives depicting treatment practice as a form of “liquid handcuffs” are particularly revealing of biopolitics at work in the “juice bar” clinic context:

Giles: It's like liquid handcuffs. You can't go anywhere without it. You need to get your [methadone] every day and it does restrict you, mostly traveling. It's like having a ball with a chain attached to your leg, or, like I said, liquid handcuffs.

Markus: I felt myself totally being trapped into something that yes, is beneficial to me, but at the same time is putting up so many barriers. That's what I hate about methadone: there are so many barriers. Somehow you're trapped—you're chained to the doctor, and you're chained to the pharmacy.

By the time users reach a stable dose of methadone, they no longer experience any euphoric effects from the drug, yet remain “addicted” in the sense that methadone produces a higher degree of physiological dependence than opiates such as morphine or heroin. Whereas many pre-1996 MMT programs in Canada responded with dose reductions (Fischer, 2000), in contemporary practice dose *increase* is often used as a punitive response to evidence of continued use of illicit substances (Bourgois, 2000). During the course of field research some MMT users engaged in polysubstance abuse because of refused requests for dosage increase, whereas in other cases users who wished to decrease their dose were actively

dissuaded by physicians, who insisted that they were “not yet ready,” or “not stable enough”:

Tara: The doctor always explains “well Tara, if you were a diabetic....” He always gives me that, because I always want to get off. A couple times I’ve almost hurt myself because I’ve come in saying “take me down.”

Matthew: I just wanted to get off—I hated being controlled like that. So from 100 I went down 10 mls a week, and when I got to 30 I went nuts because I couldn’t sleep. I was sweating all the time—you know, all the withdrawal symptoms.

According to Deleuze (1995) the disciplinary society described by Foucault was characterized by “long-term, infinite, and discontinuous” forms of power that operated by “organizing major sites of confinement ... each with its own laws” (p. 177). Reaching their height in the early 20th century, Foucault (1977) himself glimpsed the end of disciplinary societies based on confinement, pointing to the ways that the panoptical machinery of power had begun to bleed “from the penal institution to the entire social body” (p. 298), through the fluid continuity of interlinked disciplinary institutions. Extending Foucault’s insights into the operation of power, Deleuze (1995) argued that “control” has come to name the fluid, unbounded, and continuous nature of power in contemporary capitalist societies, which “no longer operate by confining people, but through continuous control and instant communication” (p. 174).

In this sense, we might begin to think of users’ experience of “liquid handcuffs” as a direct product of the shifting, amorphous nature of control represented by the socially and spatially segregated “juice bar” model for MMT. Although “liquid” can be seen as a literal reference to the dispensing and consumption of methadone in the form of a syrup (hence “juice”), it also lends itself to a reading of *fluidity* in terms of the discipline and control implied in “handcuffs.” To be a user of the “juice bar,” then, means to be engaged (or, more popularly, *trapped, stuck, and chained*) in a series of fluid, continuous, seamless, and unbounded matrices of control relations (Deleuze, 1995).

Although mediated by the “prescriber” and the very nature of the “prescription” itself, this control is not bound or confined to the site/space of the clinic but instead bleeds throughout everyday forms of sociospatial inscription.

“Until the Druggies Clean up Their Act, Why Shouldn’t the Police Watch Them?”: Negotiating Sociospatial Stigmatization

A manifestation of broader, regulatory biopolitical forces, the multiple forms of segregation produced by the “juice bar” clinic context directly inform the process and experience of sociospatial stigmatization. Here, MMT user narratives of encounters and altercations with members of the local community following the clinic’s relocation into Corktown begin to depict the tangled web of intersecting control forces that are inscribed in and by the space of the clinic.

Anticipating fierce community opposition, clinic staff attempted to impose tighter restrictions on user conduct around the clinic immediately following relocation:

Katie: [Clinic staff] are not letting us hang around. They’ve made a point to say, “smoke in the bullpen, don’t hang around out front, get your methadone, see your doctor, and get the fuck out of here” so we’re not all hanging out smoking rock [i.e., crack] or whatever, you know what I mean?

Owing to the highly visible location of the clinic, the striated qualities of the immediate environment, and the aggressive community policing strategies employed by local residents,

the space of the Corktown clinic had less “smooth” potential for users to un-fold and en-fold in order to create more discrete or disguised body-space assemblages (Malins, 2004). A few days after the clinic first opened in Corktown, for example, several users were involved in an altercation with two local business owners who appeared from an office across the street brandishing a digital camera. “We’re recording,” one of the men shouted as the other held the camera aloft, “We love recording methadone addicts—so long for your privacy.”

Without the “smoothing” potential of proximate mixed-use commercial and public space (Malins, 2004) users were significantly more exposed to various forms of surveillance and monitoring, and in the immediate period following relocation the clinic was under close scrutiny by both community opponents and local police. Owing to both the moral panic surrounding MMT that took place in the 6 months preceding the conflict, along with the community’s successful campaign to mobilize fear and oppositional support, merely being seen as an “outsider” in proximity to the clinic in this climate of heightened tension served to signal the danger of bodies and behaviors deemed to be “out of place” (Cresswell, 1996; Smith, 2010):

Calvin: This morning I was standing outside and this lady comes by on a bike, and I said “good morning,” and she didn’t say a word back. And then she just pulled out a camera and started taking pictures. And we didn’t say nothing to her at all after she started taking the pictures, and then a minute later, a police cruiser pulls up, stops, looks at us and gives us the evil eye, like, “yeah, I got my eye on you fellas.” The police have gone by every 20 minutes since I’ve been here this morning, you can almost set your watch by it. They’re making themselves noticed, you know?

Following relocation, in spite of increased attempts by clinic staff to monitor and regulate congregation and behavior in the area immediately surrounding the clinic, community residents consistently cited the high volume of user traffic and “loitering” among their chief concerns (Mary). The ostensible justification for the clinic’s relocation circulated by clinic staff concerned the inadequacy of the physical space and the inability of the former site to accommodate the growing clinic population. During the first month of operation in Corktown, however, the waiting room contained only a limited number of chairs. Some MMT users remarked that clinic policies such as the lack of scheduled appointment times (often resulting in long waits), coupled with the crowded waiting room, encouraged user congregation:

Gerard: One lady asked me “do you always have to hang around here?” and I’m like, “yeah, kind of,” because look at how big the waiting room is, and I’m the last guy to show up, and I’m outside having a cigarette, and meanwhile everybody before me is already out there having a cigarette.

In navigating the physically, ideologically, and discursively contested space of treatment, MMT users encounter intersecting forces of control, negotiating subjectivity through a multiplicity of folds and assemblages between space and self. While the folding of force allowed some users to deflect and redirect the force of stigma by attributing community conflict to regulations associated with MMT in the “juice bar” clinic context, in other cases, the experience of sociospatial stigmatization became internalized or “enfolded” in the body through the folding of truth in relation to the self (Deleuze, 1988, 1995). Here, the force of community hostility is bent back and applied against the body to produce forms of self-governance that allow the body to express its relationship to the world through embedded discourses (Malins, 2004; Malins et al., 2006):

William: Yeah, sometimes the cops watch here, but no big deal, why shouldn’t they? There’s a lot of druggies here and until the druggies clean up their act, why

shouldn't the police watch them? I don't want my kid walking by here and getting asked to buy drugs, you know what I mean?

As illustrated in the preceding narrative, the folding of force allows some users to (re)construct and (re)present themselves as "responsible" subjects who are conforming to the objectives of the MMT program by "cleaning up their act," in contrast to the "junkies" and "druggies" whose behavior creates negative community perceptions of the clinic.

Conclusion: "Almost Like a Community"

The culture of the clinic (Bourgois, 2000) is produced not only by the biopolitical control implicated in treatment practice and the "smooth" and "striated" tendencies of the clinic and surrounding environment but also importantly through the interrelationship of these factors with the social dimensions of the segregated "juice bar" model for MMT. Throughout the preceding discussion, user narratives worked to position the clinic as an inherently social space. Through tactics that allowed users to shift and reverse the spatial qualities of the clinic from "striated" to "smooth," subverting the planned, ordered, and controlled representation of space, the clinic was effectively re-visioned and reappropriated as a representational space, giving rise to articulations of identity that subtly conveyed users' right to the city (Lefebvre, 1974/1991/1967/1996).

Although in some cases the fluid, smooth nature of the spatial environment surrounding the clinic's former location was valued by users because of their ability to make tactical use of representational public spaces such as the nearby coffee shop to buy and consume illicit/licit substances in an attempt to temporarily escape and counteract the pleasureless pharmacological properties of methadone, in other cases, user congregation was cited as a negative factor that acted as a trigger for relapse. Here, the folding of force reveals a degree of critical self-reflection on (and resistance to) the social dimensions of a treatment model that is in and of itself perceived to be a "drug scene":

Christie: At the old clinic there was the coffee shop just up the street, where you could walk in and get whatever you want, you know what I mean. Like, if you wanted to get some crack or some Valium, you could walk into the coffee shop and look in and see who was there, and they'd all be sitting there most of the time.

Dave: At one time I thought coming to the clinic was a bad influence because I'd run into people who might have drugs. I'm sure [MMT] is better than [injecting] dope into your arm, but you're still involved in a drug scene, and you're still surrounded by drug people of one sort or another, so it's less bad maybe, but it's tricky, it's borderline.

Characterized by sensationalist accounts of loitering and illegal, disorderly conduct, oppositional discourse leading up to the relocation of the Corktown methadone clinic received considerable news coverage in Toronto (Bonokoski, 2007; Whetstone, 2007). As Deleuze (1988) suggests, the "folding of truth in relation to the self" involves the process of knowledge folding into the body in the sense that discourse "constitutes a relation of truth to our being" (p. 104). Seeing discourse not as a unidirectional force that acts directly and deterministically on the body, the concept of "enfolded truths" allows for an understanding of discourse as an embedded phenomenon that can be employed as a tool to negotiate and articulate the body's relations with other (social and individual) bodies (Malins et al., 2006):

Mike: I read in the news about methadone patients hanging around and doing [illegal] business in front of the clinic, and that's why people have made complaints. If people just see their doctors and get their [methadone] and then go home, okay, but people hanging out here is not good. Why are people hanging out here so much? I think this is the only place they can see each other, almost like a

community. They go for coffee, smoke cigarettes, but this is only 50% of the clinic's population.

User narratives demonstrate how experiential engagement with the social space of the clinic enables a critical perspective that points to a systemic critique of MMT policy and practice. In the juice bar clinic context, as users remarked, "all you get is a script" (Matthew), and "you're still surrounded by drug people of one sort or another" (Dave), in a program that "doesn't do such a great job at dealing with any of the reasons why you were using in the first place" (Bentley). Against a reductionist conception of MMT based solely on the "dispensing and consumption" of "medication" ("juice"), Lilly, Quirk, Rhodes, and Stimson (2000) argue that MMT is an inherently social process, concluding that successful outcomes can only be achieved by balancing "both the 'medical' and 'social' components of 'treatment'" (p. 167).

Analyzing the sociospatial dimensions of MMT through the voices of users, this investigation demonstrates how users negotiate strategies of biopolitical control and sociospatial stigmatization through a complex series of relations between bodies and space. This analysis of the culture of the clinic pointed to a relationship between the "juice bar" clinic context and MMT user experiences of treatment practice as a controlling from of "liquid handcuffs," suggesting two key factors that might serve to desegregate and destigmatize MMT.

First, the social and spatial segregation produced by concentrating MMT users at high-volume, limited-service, "juice bar" clinics directly serves to exacerbate users' sense of marginalization, exclusion, and dislocation, structuring the experience of sociospatial stigma. As one user interview participant stated, "you get a bunch of drug addicts around a bunch of drug addicts, what are they going to talk about, what are they going to do, right?" (Liz). Not only can socially reintegrating addiction treatment service users with other health care populations serve to reduce the (social) stigma associated with segregation but spatial reintegration of methadone treatment services can also play a role in reducing stigmatization by the surrounding community. Here, situating treatment services in areas such as multipurpose medical centers with access to proximate smooth, representational spaces that allow users to "blend in," "spread out," and avoid "standing out" (Liz) is a critical consideration.

Second, methadone treatment delivery needs to be reconceived as an inherently social process that has important spatial implications, consisting of more than the simple dispensing and consumption of medication ("juice"; Lilly et al., 2000). Without a comprehensive service model, the "juice bar" can be seen as a literal application of the hegemonic pathology paradigm for understanding addiction, positing pharmacological substitution as a panacea or "technocratic magic bullet" (Bourgeois, 2000, p. 173), without consideration for the diverse structural factors underlying the phenomena of drug dependence (Alexander, 2000, 2008; Granfield, 2004). Segregated from other health care populations, the larger health care system, and also from the wider community, MMT user narratives pointed to a correlation between the sociospatial dynamics of the "juice bar" and stigmatization projected by the local opponents:

Gerard: This place freaks people out. I think people have a prerequisite notion, you know what I mean? There's like an image that goes, "oh, that's badness." No offence, but look, they've got this thing they call the penalty box right here. It's kind of closed in, you know, and they try to hide the fact that we're sitting outside having cigarettes. So they put us in a little box—again, putting us in a little box.

Vividly encapsulated by user descriptions of MMT as a form of "liquid handcuffs," this article suggests that the controlling aspects of MMT are a direct manifestation of the various

forms of segregation involved in the “juice bar” clinic context. Here, the question of mobility is paramount, as “liquid handcuffs” denotes a decentralized, inherently fluid landscape of control that shifts seamlessly between the controlling properties of the drug itself, the biopolitics of treatment practice, and sociospatial stigmatization projected by the surrounding community. As a space of inscription and intersecting forces of control that is inextricably implicated in the commingling production of bodies and space, the space of the clinic is a literal bridge or point of connection between the body of the (methadone) user and the social body of the city. In both their real and imagined, physical and figurative forms, these bodies constitute lived fictions that people the capitalist cityscape in the interplay between prescribed spaces and social prescriptions, scripted performances of identity and the spatial scripting of stigma, inscriptions of control in and through physical built form, and reinscriptions of subjectivity in the ever shifting forms of (body-space) “folds” and “assemblages.” Caught between competing forces of control, users negotiate the contested space of addiction treatment, in the process narrating a users’ guide to urban space. “Users’ guide” conjures up the notion of manual, while the reference to “city” invokes guidebooks designed to help orient the foreign tourist. *Using space, using words, using “illicit” substances, and using spatial tactics* to navigate, negotiate, and narrate identity and belonging in the shifting late-capitalist urban landscape, this users’ guide to the city points to how users themselves assert and articulate their “right to the city” (Lefebvre, 1967/1996).

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Biography

Christopher B.R. Smith currently holds a SSHRC (Social Science and Humanities Research Council of Canada) postdoctoral fellowship at the University of Pennsylvania. Christopher’s present research resituates the voices and experiences of clients and service providers in the contested (physical, ideological, and discursive) space of addiction treatment by critically analyzing the rapidly shifting policy landscape on both sides of the Canada–U.S. border, with an explicit emphasis on the frontlines of treatment practice.