

The Impact of Therapeutic Jurisprudence: A Critical Study of Toronto's Mental

Health Court

by

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For Joan Alice Bain (nee Smith)

1929-2009

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Chapter One: Introduction and Background

There are people spending time in jails who do not belong there (Alexson & Wahl, 1992). Seriously mentally ill offenders make up a disproportionate number of inmates and tend to be in and out of jail frequently often for minor offenses (Wexler & Winick, 1996). Within the criminal justice systems in North America, judges, lawyers, prosecutors, physicians, and social service providers have collaborated to address this problem with the establishment of mental health courts, like 102 Court in Toronto, Canada (Schneider, Bloom & Hereema, 2007). In recognition that this particular population is in trouble with the law not because of criminality but due to illness, poverty, homelessness, and isolation, professionals endeavor to “divert” accused away from jail and towards the services they need (Slinger & Roesch, 2010; Wexler & Winick, 1996). This is a deliberate attempt to reduce rates of recidivism by replacing traditional punitive interventions with therapeutic interventions, based on the legal concept of therapeutic jurisprudence (Wexler, 2011).

This dissertation examined the processes and impact of the Toronto mental health court between January and August 2012. I conducted an ethnography of the court during which I observed the court daily and spoke with judges, lawyers, social workers, accused, and their families. I also conducted a phenomenological analysis during which I interviewed nine accused who had successfully completed the diversion process through 102 Court. 102 Court is a stunning example of Foucauldian bio-power at work and I use this and related concepts and subjectivity to critique the court in the chapters that follow.

Several critical issues emerge from this work. First, for some people who pass through 102 Court its approach, processes and personnel are “life-saving” and the Court is interpreted as a threshold to a new life. Second, despite this potential benefit there are also potential dangers and evidence of egregious racial disparity among the accused. A disproportionately large percentage of black accused appeared in 102 Court compared with the Toronto population and there is evidence that the processes of the court may negatively impact non-English speakers and immigrants more than their Anglophone and Canadian-born peers. Third, the processes of the court may, in some cases, lead to involuntary pharmaceutical treatment after very brief assessment by psychiatrists and may even result in indefinite detention in a psychiatric facility. Finally, benevolent and medicalized discourses mask coercion and de-politicize the processes and outcomes of the court.

Research Aims

Morrow and Jamer (2008) called for new ways to listen to and interpret the experiences of people with mental illness in the current climate of mental health care reform in Canada. Consistent with their call, the aim of this research is to critique the application of therapeutic jurisprudence in 102 Court through the theoretical lens of subjectivity. I will explore the subjectivity of the accused through a phenomenological analysis and assess the processes of subjectivation that shape their experiences through an ethnographic analysis. I will argue in Chapter Four that a particular sort of bio-power (Foucault, 1976) is at play in this system, a pharmaceutical-subjectivity that

controls both individuals and the community of mentally ill accused. The main research question is: What are the experiences of adults with mental illness in contact with the law in Toronto? The secondary research question is: How are subject positions produced by the processes of the TMHC?

In this chapter I provide necessary background information to contextualize the research presented in Chapters Two and Three and the discussion in Chapter Four. To understand the role of specialty courts like 102 Court I first provide a sketch of the evolution of mental health courts from the U.S. drug court model. Then, I describe the demographic characteristics of Toronto's population, sketch the history of the Canadian deinstitutionalization of seriously mentally ill people, discuss 102 Court's position at the medico-legal nexus and the political economy of the pharmaceutical industry in Canada, discuss the theoretical framework I will employ, and elaborate my methods.

Specialized Courts: What problems are being solved?

During the 1990s one of the most important policy concerns to emerge in the U.S. was mental health and substance abuse problems among people entering the criminal justice system (McGaha, Boothroyd, Poythress, Petrila, & Ort, 2002). The nature of these problems results in a "revolving door" effect (Wexler & Winick, 1996), where people cycle in and out of the judicial system regardless of time in jail or charges conferred. Research in the 1990s illustrates the enormity of the problem. For instance, Ditton (1999) estimated that the prevalence of mental health and substance abuse issues may be over 60% among offenders. Accused with mental illnesses were jailed 2-

3 times longer than their counterparts who do not suffer mental illnesses (Alexson & Wahl, 1992). Jails pay for medications for prisoners, must administer those medications, house them safely, and provide supervision in some cases for accused who pose a danger to themselves or others (McGaha et al., 2002). Court dockets (especially in urban centers) can become clogged with these revolving door populations that may take longer to process than other cases (McGaha et al., 2002). Specialized courts developed to address these issues, increase efficiency in the courtroom and jails, and help people in need. Looking upstream, specialized courts evolved to understand and address the underlying issues of addiction and mental health, to help people deal effectively with these problems, and to break the cycle of re-appearance before the courts (Wexler & Winick, 1996).

The first of these specialized courts, a drug court, was spearheaded by then state attorney Janet Reno in Miami, Florida in 1989 (Nolan, 2001). Accused before the court were diverted away from the regular judicial system into court-centered treatment (Schneider et al., 2007; Slinger & Roesch, 2010; Wexler & Winick, 1996). There was the recognition that non-violent drug possession charges and traditional punishment paradigms did not change addictive behaviors. Ongoing addiction results in seeking out drugs when released, leads to more possession charges, and results in a revolving door phenomenon (Wexler & Winick, 1996, p. 4). The Miami drug-treatment court emphasized the rehabilitation of accused and cast the judge as a member of the treatment team (Wexler & Winick, 1996). Those who agreed to plead guilty and have their cases diverted from the regular stream to the drug-treatment court also agreed to: remain

drug-free, periodic drug-testing, treatment recommendations, and they were asked to report to drug-treatment court for supervision (Wexler & Winick, 1996). Assessment of the Miami court began in 1990 and was published in the early 1990s (Goldkamp, 1994). The promising recidivism rates reported sparked tremendous interest in the U.S. and other countries, resulting in over 2,600 drug courts in the U.S. today (National Association of Drug Court Professionals, n.d.).

There has been extensive evaluation of these drug courts in the United States since Goldkamp's study that support and expand his encouraging results. The U.S. Government Accountability Office [U.S. GAO] conducted a large-scale study and concluded that drug courts significantly reduce recidivism rates (U.S. GAO, 2005), conclusions supported by several meta-analyses (Aos, Miller, & Drake, 2006; Lowenkamp, Holsinger, & Latessa, 2005; Wilson, Mitchell, & MacKenzie, 2006). A multi-site National Institute of Justice study of adult drug courts in the U.S. (dubbed MADCE) compared drug court participants from 23 sites with matched comparison offenders from six sites where drug courts were not available and has resulting in several analyses. Published results based on this data concur that drug courts result in significantly reduced recidivism rates among drug court participants compared with matched non-drug court accused (Rempel, Green, & Kralstein, 2012a; Rempel et al., 2012b). Rempel et al. (2012b) reported that in addition to significantly reduced recidivism rates, participants in drug court programs were significantly less likely to report drug and alcohol use than the comparison group, results that were confirmed by oral swab. Green and Rempel (2012) investigated psychosocial outcomes related to drug courts based on

the MADCE data and found modest non-significant improvement across a broad range of variables that fell into four categories: socioeconomic well-being, family relationships, homelessness, and living situation (Green & Rempel, 2012). Funding for drug courts may come from local, state and federal sources. For instance, Florida State drug courts include fines collected from people charged with prostitution and related acts at the local level, state funding through agencies including the Department of Corrections, and federal funding sources including Drug Court Discretionary grants, Operation Weed and Seed funds (designated for high crime areas), Drug Free Communities funding, Housing and Urban Development programs, etc.¹ (Florida State Courts, n.d.).

Accused with addictions are only one of several revolving door populations that bog down legal systems with cycles of release and re-entry². Other populations include sex trade workers, domestic violence cases, people charged with driving while intoxicated, and seriously mentally ill offenders. With the positive recidivism results of the Miami and subsequent drug courts, specialty courts have emerged to address the needs of these and other populations³. The focus of this research is a mental health court, so only this derivation of the drug court model will be discussed in detail.

Mental health courts (MHCs) are a more recent evolution of drug courts, with the first one appearing in Broward County, (Fort Lauderdale) Florida in 1997 (McGaha et al., 2002; Wexler & Winick, 1996). The Broward MHC emerged from the work of a

¹ Some of these grants require partnerships with health care service organizations.

² And increases costs associated with the courts

³ Some specialty courts sub-specialize to women (women's mental health court) or students (campus drug court) or Veterans (Veterans drug court) or Aboriginal persons (Aboriginal drug courts). There are dozens of combinations and permutations of perceived problem and target population.

Mental Health Taskforce that began in 1994 to address community service needs of mentally ill accused and system efficiency problems related to length of stay in jail and the number of jail admissions (McGaha et al., 2002). The Taskforce was comprised of representatives from the public defender's office, the state attorney's office, the Broward County jail, and community service providers, and chaired by a judge (McGaha et al., 2002). The court required the voluntary participation of accused, included people with a diagnosis believed to have contributed to their legal involvement, and expedited release from jail and referral to community services (McGaha et al., 2002). Only people accused of non-violent misdemeanor crimes were eligible for the Broward MHC (McGaha et al., 2002). It was hoped that evaluation of this court would, as it had for Miami's drug-treatment court, be important evidence for policy makers. However, McGaha et al., (2002) reported numerous complications with their evaluation of the Broward MHC including reluctance to randomly assign participants (deemed unethical), the favorable inter-agency working relationship (likely a result of the Taskforce that preceded the MHC), the dynamic environment of the MHC which made evaluation of court processes challenging, the relative complexity of MHC processes compared with other misdemeanor courts, and the informality of the court that is consistent with the philosophical approach of therapeutic jurisprudence (McGaha et al., 2002).

There are some critical differences between MHCs and drug courts that make MHCs more difficult to evaluate and replicate. Drug courts may leverage free and readily available (at least in urban areas) community-based resources like Alcoholics Anonymous and Narcotics Anonymous in support of their clients, whereas no equivalent

support exists for people suffering serious mental health problems. There are tremendous differences in resources available, a large array of services needed indefinitely for many mentally ill accused, and these many interact with one another and the legal system in multiple ways. The processes of the drug court are relatively orderly and easy to follow and evaluate compared with mental health court proceedings (McGaha et al., 2002). As a result, there are logic models for evaluations of drug courts whereas the variability frustrates similar models for MHCs. Drug courts offer an accused a platform for telling his/her story to the judge and courtroom attendees whereas MHC accused do not have a chance to tell their stories in some iterations of the court. It is relatively straightforward to illustrate a recovery rate with respect to drug courts due to the routinized and structured treatment plans, whereas most serious mental health problems may be chronic in nature and highly individualized (Bureau of Justice Assistance, 2008). MHCs are therefore very local in flavor frustrating quantitative researchers who seek replicable results and making qualitative approaches particularly appealing. Most accused enter a drug court facing drug-related charges whereas MHC accused appear before the court for a variety of reasons (Bureau of Justice Assistance, 2008). Drug court participants are easily monitored through urinalysis and other surveillance tests but MHC treatments are not easily monitored (Bureau of Justice Assistance, 2008).

Mental health courts vary considerably from place to place. For instance, the legal definition of “mental health court” may differ by state. Washington state legislature defines MHC as:

“a court that has special calendars or dockets designed to achieve a reduction in recidivism and symptoms of mental illness among nonviolent, felony and nonfelony offenders with mental illnesses and recidivism among nonviolent felony and nonfelony offenders who have developmental disabilities as defined in RCW 71A.10.020 or who have suffered a traumatic brain injury by increasing their likelihood for successful rehabilitation through early, continuous, and intense judicially supervised treatment including drug treatment for persons with co-occurring disorders; mandatory periodic reviews, including drug testing if indicated; and the use of appropriate sanctions and other rehabilitation services” (RCW 2.28. 180).

By comparison, Illinois state law says "Mental health court" means

“a structured judicial intervention process for mental health treatment of eligible defendants that brings together mental health professionals, local social programs, and intensive judicial monitoring” (730 ILCS 168/10).

Washington State law includes persons with developmental disabilities and traumatic brain injury as well as people suffering from mental health problems. This is sometimes the practice in MHCs even without the legislation⁴. The Illinois legislature emphasizes the more therapeutic possibilities of MHCs including reference to interventions and the cooperative medical-legal-social service alliances that drive these courts. These definitional differences hint at some of the possible implementation variability that is widely acknowledged (McGaha et al., 2002; Schneider et al., 2007).

The impact of specialty courts is most frequently examined through recidivism rates, which are considered for many the gold standard of outcome measures associated with the criminal justice system. There have been several studies of

⁴ As was the Case with the Toronto MHC

recidivism rates among participants of specialty courts in the United States with inconsistent results. For instance, Bonta, Law, & Hanson (1998) reviewed 54 studies of recidivism rates among mentally ill offenders that occurred between 1959 and 1995. They concluded that the major factors associated with recidivism rates were criminal history variables (such as juvenile delinquency) and were the same for offenders with and without mental illness. Clinical variables like specific diagnoses and hospital admission and stay data had the lowest effect sizes (Bonta et al., 1998).

A review of the literature pertaining to recidivism rates among mental health court participants revealed seven studies (Christy, Poythress, Boothroyd, Petrila, & Mehra, 2005; Cosden et al., 2010; Dirks-Linhorst & Linhorst, 2010; Herinckx, Swart, Ama, Dolezal, & King, 2005; McNeil & Binder, 2007; Moore & Hiday, 2006; Trupin & Richards, 2003). These studies were based on U.S. mental health courts and varied widely by sample size, analysis method, and court characteristics. Of these, five studies concluded that mental health courts reported lower recidivism rates among diversion participants (Dirks-Linhorst & Linhorst, 2010; Herinckz, Swart, Ama, Dolezal, & King, 2005; McNeil & Binder, 2007; Moore & Hiday, 2006; Trupin & Richards, 2003). However, two found no statistically significant differences between diversion participants and comparison groups (Christy et al., 2005; Cosden et al., 2010). Only Moore and Hiday's (2006) study included factors associated with recidivism and they reported that only prior arrest severity impacted the odds of re-arrest. However, no clinical factors were used in the design. The authors' explanation for higher recidivism rates among those who fail to complete diversion compared with those who graduate in their study

uses a pharmaceutical metaphor; they refer to partial completion as a “partial dose” and graduation as a “full dose” and their research design predicts that success measured by reduced recidivism rates is premised on a full dose of service linkages, medication compliance, and surveillance (Moore & Hiday, 2006, p. 662).

Examination of the most recent study published study is instructive. Dirks-Linhorst and Linhorst (2010) examined factors associated with recidivism rates among accused who passed through a suburban St. Louis, Missouri mental health court over six years. Their study includes all accused eligible for diversion, divided into three study groups: those who graduated from diversion; those who were negatively terminated from diversion; and those who opted for the regular system of law despite being eligible for diversion (Dirks-Linhorst & Linhorst, 2010). The results indicated that 14.5% of diversion graduates, 38% of those who were negatively terminated from diversion, and 25.8% of those who opted for the regular stream were re-arrested within one year of discharge from the diversion program (Dirks-Linhorst & Linhorst, 2010). The authors stress the lower recidivism rates among graduates in comparison to the other study groups. However, it is very interesting (and absent from) the authors’ discussion that recidivism rates were greater among those who did not graduate but attempted diversion compared with those who opted to have their cases resolved through the regular stream. The process of being negatively terminated from diversion often includes a series of violations of the conditions of release. However, the authors only included re-arrests post discharge, so this would not account for the difference. This study stresses the need for qualitative studies and cannot claim to have evidence that

mental health courts “work” because there is a notable lack of connection between the essential elements of mental health courts and recidivism rates.

Certainly, U.S.– based researchers interested in specialty courts are exploring more questions. Notably, data has emerged regarding differential rates of graduation from diversion programs based on race, leading many qualitative researchers to ask why and design studies that attempt to identify barriers with an eye to systems improvement. Some studies explore the implications of mental health courts for social work practice and research (Castellano, 2011; Linhorst et al., 2010; Tyuse & Linhorst, 2005). Qualitative research includes consumer-perspective assessments of specialty court diversion programs (Cosden et al., 2010). There are hundreds of articles related to specialty courts in the U.S., and many of those include data regarding who passes through the court in terms of gender, race/ethnicity, and age (see Gendreau, Little, & Goggin, 1996) as well as other variables like recidivism rates or economic analyses. The consistent attention to demographic variables especially opens up possibilities for consideration based on disparity that can be analyzed along single dimensions like age or race or at the intersection of multiple overlapping categories of difference. Given the known over-diagnosis of schizophrenia among racialized groups in Canada (aboriginal peoples) and the United States (African-Americans, especially men), and the mass incarceration of those groups, it is reasonable to ask questions about disparity in the mental health court milieu.

Specialty Courts in Canada & Toronto Mental Health Court (“102 Court”)

The Toronto mental health court (TMHC) and the Toronto drug treatment court (TDTC) both began in 1998 and were the first specialty courts in the country (Toronto Drug Treatment Court, n.d.). They are both located in the Old City Hall Courthouse⁵ in downtown Toronto and serve overlapping populations. One process inefficiency that accompanies large numbers of seriously mentally ill people in the criminal justice system is the extra time it takes to conduct fitness assessments in regular court⁶ and the Toronto MHC was created in response to a need to streamline these evaluations (Schneider et al., 2007). These courts were modeled on the American courts discussed above and were modified for the Canadian legal and medical context. The TMHC has, in turn, become a model for similar mental health courts across the country including Saint John, New Brunswick, Ottawa, Kitchener, Sudbury, etc. (Slinger & Roesch, 2010). Similarly, drug courts have multiplied in number and specificity across Canada. Although this growth is modest compared with the United States, its impact is spreading and remains largely unevaluated (Slinger & Roesch, 2010). Perhaps due to an absence of formal evaluations, there are no published recidivism rates related to 102 Court in Toronto.

The Toronto MHC has never received federal or provincial money for its operation. It is a mutually beneficial collaboration between the Ontario Ministry of Health and the Ministry of the Attorney General which each have resources sunk into serving the seriously mentally ill accused whether they be in hospital, outpatient care, or jail. It is

⁵ There is also an aboriginal court in operation at Old City Hall.

⁶ Fitness and its assessment will be discussed in detail in Chapter Two.

the structure and process that shapes the court, not extra funding. Justice Schneider, Toronto mental health court's founding justice and long-standing administrative judge recalls the luck of having an unused courtroom in the court house when he and other justices were collaborating with the Centre for Addiction and Mental Health to develop the TMHC. Some drug courts located in smaller Canadian cities operate in a similar manner. London, Ontario is one of a handful of drug courts in Ontario and like many others "scrape by" with resources drawn from about a dozen community service agencies (Richmond, 2013). The Toronto drug court, by contrast receives \$750,000 from the federal government annually and has three full-time case managers/therapists (Richmond, 2013). Toronto is one of several federally funded drug courts that operate in Canada's most populated cities (also Edmonton, Vancouver, Winnipeg, Ottawa, and Regina). Canadian drug court effectiveness has been questioned recently with a review of the federally funded drug courts by the Canadian HIV/AIDS Legal Network, which found the quasi-coercive techniques used in drug courts are in conflict with therapeutic goals, not in service of them (Werb et al., 2007). The authors also question the methodology used to assess effectiveness in drug courts given the low retention rates in many drug courts and lack of longitudinal data (Werb et al., 2007).

As noted in the discussion of U.S. mental health courts, roughly three quarters of people who suffer from serious mental health issues also have substance abuse issues. The prevalence rates of substance dependence or abuse and a mental illness is estimated at 74% among U.S. state prisoners (James & Glaze, 2006). Similarly, among British Columbian prisoners diagnosed with a substance use disorder, more than 75%

were also diagnosed with a non-drug related mental disorder (Canadian Mental Health Association, 2012).

Unfortunately the literature relating to Canadian mental health courts is not deep. Dewa, Trojanowski, Cheng, and Sirotich (2012) identified factors that program developers deemed important for inter-ministerial collaboration in Ontario. Few evaluations of specialized courts have been conducted in Canada; none have been conducted on mental health courts (Slinger & Roesch, 2010). Canadian courts have produced what Slinger and Roesch call “informal reporting of basic statistics”. Thoughtful planning, including collecting appropriately detailed data are often lacking from these informal reports (Slinger & Roesch, 2010, p. 262). Hannah-Moffat and Maurutto (2012) conducted a study of over 2000 cases in four Canadian jurisdictions. They conducted 50 interviews with professionals associated with three kinds of specialty courts (Hannah-Moffat & Maurutto, 2012). Their work, however, excludes mental health courts and the perspective of disordered accused.

Ironically, discussion about Canadian courts relies heavily on U.S. comparisons (Slinger & Roesch, 2010) while admitting that comparisons are frustrated by the local nature of each court. In a parallel irony, calls abound for more “scientific” or “objective” studies of the courts (Schneider et al., 2007; Slinger & Roesch, 2010) which is a proxy for more detailed statistics about outcome measures such as recidivism rates and number of community service connections. Local qualitative studies are dismissed as “insufficient”, “nonrandom”, and “anecdotal” (Schneider et al., 2007; Schneider, personal communication, 2012). While many researchers and workers call for more research,

there is little interest in the voice of the consumer/client. I posit that this is due in part to an attraction to the perceived objectiveness of statistics and partly due to discrimination of people who suffer with serious mental health issues.

Appearance before the TMHC is voluntary, diverts accused from the regular justice stream into treatment and services, requires periodic reporting before the court to monitor treatment compliance, and to have been screened by professionals from the Centre for Addiction and Mental Health for an appropriate serious mental health problem. To be clear, addiction to drugs or alcohol may be present among the accused of 102 Court, but the primary reason they would be considered “properly” before⁷ the court would be a “serious mental health”⁸ problem. It is clear that the Toronto MHC considers serious mental health problems ones that involve psychosis in the majority of cases. The Diagnostic and Statistics Manual IV includes several psychotic disorders: brief psychotic disorder, delusional disorder, schizoaffective disorder, schizophrenia, schizophreniform, and shared psychotic disorder (Heffner Media Group, 2011). This

⁷ In both the U.S. and Canada there are many specialty courts with overlapping populations. For instance, an accused may be aboriginal, suffer from schizophrenia, and be addicted to drugs and alcohol. How do you determine whether their case is best suited to aboriginal court, drug court, mental health court, or the regular stream? Based on my research this may be influenced by their lawyer and his/her connections with Crown attorneys in the courts, previous experience of the accused with one court (positive or negative), how the accused most strongly self-identifies, the preference of the accused, the perceived biggest problem affecting the behavior of the accused, etc.

⁸ Various disorders may be considered “serious mental illnesses”. The U.S. National Alliance on Mental Illness [NAMI] include: “major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD) and borderline personality disorder” (NAMI, 2013). However, in practice, any subset of these disorders may be used. There is widespread inconsistency in defining serious mental illness (see Ruggeri, Leese, Thornicroft, Bisoffi, Tansella, 2000). Alternative terms include severe mental illness, chronic mental illness, persistent mental illness, mental health issues, mental health problems, mental disorders combined in various ways, further muddying precision.

disorder cluster is characterized by psychosis or delusions and hallucinations (Heffner Media Group, 2011). The DSM defines delusions as, “false beliefs that significantly hinder a person's ability to function. For example, believing that people are trying to hurt you when there is no evidence of this, or believing that you are somebody else, such as Jesus Christ or Cleopatra.” Hallucinations are “false perceptions. They can be visual (seeing things that aren't there), auditory (hearing), olfactory (smelling), tactile (feeling sensations on your skin that aren't really there, such as the feeling of bugs crawling on you), or taste” (Heffner Media Group, 2011). I saw two cases that did not include a psychotic element and those diagnoses were PTSD and severe adjustment disorder. All others were either schizophrenia (and its variants) or bipolar disorder⁹ (and its variants including schizo-affective disorder). The focus on psychosis is consistent with conversations with court workers, forensic psychiatrists, and the non-peer reviewed study by Dinshaw (2010) that appears on the TMHC website.

With different mandates and judicial and health care systems, each court represents a local and unique response to the criminalization of the mentally “disordered accused”. The incomparability of the courts and the lack of a generic model frustrate researchers and policy-makers who wish to extrapolate processes from one court to another. Unlike the U.S. state definitions of mental health courts as even a rough guideline that might increase uniformity within a state, Canada has no definition for mental health courts in the Canadian Criminal Code, only a section (672) that directs

⁹ In court, forensic psychiatrists would diagnose accused as having “bipolar disorder with psychotic features”. This correlates with the DSM category of schizoaffective disorder that sometimes includes major depressive, manic or mixed episodes.

any court in its interaction with mentally ill accused. The local nature of these courts is a perceived barrier to the evidentiary basis for expanding such programs. Despite the lack of generalized evidence, specialty courts are growing in number and the special populations targeted are expanding.

Toronto's MHC is a public space where the business of the court and the people who inhabit its spaces are available for public scrutiny and inquiry. But this is a place hidden in plain sight. People are accused of minor, un-sensational crimes¹⁰ like stealing a bottle of water or rum, repeatedly trying to scrape stickers off convenience store windows, kicking someone who refused to spare change at a bus stop. Many accused cycle in and out of the court and become familiar regulars to the court staff. Many may also be found panhandling on neighboring streets and filling downtown shelter beds. The accused of 102 Court suffer greatly from mental illnesses and most are chronically impacted, sometimes suffering so long, friends and family have long disappeared from their lives. They are the ever-present, largely ignored denizens of Toronto, the homeless, the street people, the shelter dwellers, and the grate-sleepers. And for the most part their passage through the criminal justice system is not very different from the rest of their lives. It is mostly unnoticed, a paternalistic brush with gatekeepers who offer them access to a clean record, more permanent housing and other services for the price of compliance and surveillance. The goal of TMHC is to keep them out of prison, out of the court system, and to connect them with psychiatric treatment and social services they are lacking. So if recidivism rates are lowered among this population, the TMHC

¹⁰ There are no misdemeanors in Canadian law.

has, for many observers, succeeded. I seek to offer a critique of this system of care and surveillance that will place the experiences and thoughts of the “disordered accused” in a position of authority. Social justice advocates are present in the TMHC, working within the system as lawyers, judges, and social workers. Their attempts to make systemic changes through individual cases, their passion about clients, and their frustrations with the healthcare system will add another dimension to this argument.

“Disordered Accused”

How to name the people who pass through 102 Court is a fundamental problem and I have no adequate response beyond unpacking terms, being reflexive, and settling on the least worst option. People accused of crimes are ubiquitously called “accused” and the literature about Canadian mental health courts regularly calls them “disordered accused” (see for instance Schneider et al., 2007). While I am inclined to follow social work convention (and the practice of some defense attorneys) and refer to them as “clients”, I think that few professionals conceptualize them as clients beyond the strict code of professional ethics that guides the relationships. I initially considered them “consumers” of the court along with their non-professional support system if they have one (friends and family). Several months into my field research I realized that they were less consumers of the system than being consumed *by* the system. The term “consumer” implies a degree (at least a modest degree) of power and agency that the disorder accused lack. Also, accused presented themselves to me as being in trouble with the law. I was asked occasionally by accused before the court if I was also an

“accused”. So upon reflection, the term accused is the most appropriate term for the people I did research among.

What is Therapeutic Jurisprudence?

Mental health courts are deliberate applications of the principles of therapeutic jurisprudence (TJ)¹¹, which admit that people who are accused of crimes and proceed through the criminal justice system are affected by that interaction. Therapeutic jurisprudence is an interdisciplinary field of inquiry that focuses on the therapeutic and anti-therapeutic consequences of legal rules, processes, and the behavior of legal actors (Wexler, 2011). Wexler and Winick (1996) asked, “How can mental health law maximize therapeutic outcomes?” The administrative judge of Canada’s first mental health court asserts, “the law should be administered in a way that incorporates therapeutic goals” (Schneider et al, 2007, p. 3). These TJ courts operate under the philosophy that traditional punitive responses to criminal behavior among the “mentally disordered accused” are inappropriate and ineffective (Schneider et al., 2007). There is an understanding that the reason for criminal behavior is not individual choice and mental health court is a response to address the root cause (Schneider, 2010; Slinger & Roesch, 2010). Further, it is an admission that poor social conditions may be part of that

¹¹ Whether therapeutic jurisprudence is properly a theory is uncertain. Schneider et al. (2007) uses the term “theory” without debate, but Wexler (2011) prefers the more modest “field of inquiry”. As Wexler is the Director of the International Network on Therapeutic Jurisprudence and one of the seminal authors on the subject, I will follow his lead.

root cause (Winick, 2003) hence provision of social services is a key feature of these courts.

Wexler and Winick (1996) first described the possibilities of therapeutic jurisprudence to address both the emotional needs of accused and psychological impact of the criminal justice proceedings upon accused and they argued for connections between systemic structure, rehabilitative potential, and psychological concerns. The impact of their distinct legal concept on reshaping the delivery of legal services and fashioning a generation of lawyers has been enormous. Stolle calls the impact “nothing short of phenomenal” (Stolle, 2000, p. xv). It is clear that specialty courts are part of a trend of judicial innovation that attempts to humanize and improve outcomes for litigants, victims, defendants, and communities that face chronic problems (Berman & Feinblatt, 2001). Winick and Wexler, in their introduction, tell us that the “law is a social force that may produce therapeutic or anti-therapeutic consequences” (Winick & Wexler, 2003, p. 7). They assert that therapeutic jurisprudence “has insights regarding how courts might be structured so as to maximize their therapeutic potential” (Winick & Wexler, 2003, p. 7). TJ is a quasi-utilitarian approach to practicing law that attempts to integrate therapeutic goals into legal processes (Stolle, 2000).

Much is written about the symbiotic relationship between specialty courts and the concept of therapeutic jurisprudence but formal definitions of TJ are elusive as are guidelines about which features of specialty courts represent these therapeutic ideals. The courtroom has been described as a “laboratory” to uncover the elements of court processes that contribute to therapeutic goals (Winick & Wexler, 2003), although the

evaluations discussed above emphasize the difficulty in doing so. For practitioners of TJ, the judge and sometimes the court itself are sometimes conceptualized as therapeutic agents (Winick & Wexler, 2003).

There are several core concepts that help define therapeutic jurisprudence and are operationalized in mental health courts¹² (Marini, 2003; Schneider et al., 2007; Winick & Wexler, 2003). 1. Medication is framed as “needed” by the accused. Pharmaceutical intervention is the cornerstone of release plans and, for most accused becomes a key component of diversion. Compliance with pharmaceutical regimes is necessary for graduation from diversion and avoiding penalties that include accumulating more criminal charges. Adherence to pharmaceutical treatment is a tangible outcome measure like recidivism rates (Berman & Feinblatt, 2001). 2. The medical system has failed to adequately care for seriously mentally ill people, forcing the legal system, unprepared for an influx of seriously mentally ill people, to action. This is how most analysts frame the historical circumstances that have resulted in so many mentally ill people in contact with the law and will be discussed below. In order to positively impact outcomes, collaboration with mental health professionals and organizations is necessary (Berman & Feinblatt, 2001). 3. The negative psychological outcomes of jail compared with hospitalization are emphasized, where imprisonment is believed to cause or exacerbate decompensation¹³. 4. The adversarial process in court

¹² I have adapted a generalized list of principles. For stance, Winick and Wexler discuss general outcomes and I specify pharmaceutical compliance.

¹³ Decompensation is a common term in mental health care. Episodes of decompensation are defined by the U.S. Social Security Administration as “exacerbations or temporary increases in symptoms or signs accompanied by a loss of

is suspended in favor of a collaborative approach to put mentally ill accused at greater ease (Berman & Feinblatt, 2001). 5. There is an attempt to look upstream, where the criminal behaviors of the accused are envisioned as caused by mental illness making treatment of the illness the most appropriate deterrent to future criminal behavior.

A key process within the applied framework of therapeutic jurisprudence is the *diversion* of people away from the system of mainstream law towards a more appropriate system. For instance, many mentally ill people are charged with minor, non-violent offenses deemed more appropriately addressed through adequate housing, job training, treatment programs, and other social service interventions. However, not all accused who pass through such a court are eligible for diversion, so my ethnography of the court described in Chapter Two will include many accused who are not being diverted.

The definition of therapeutic jurisprudence remains vague, so it is to these core concepts that I will turn in Chapter Four to critique 102 Court based on the processes of subjectivation described in Chapter Two and the lived experiences of 102 Court accused as discussed in Chapter Three.

Serving Toronto, Serving the World

Toronto has a population of approximately 2.5 million people (Statistics Canada, 2006), and is nestled in an urban corridor (the “Golden Horseshoe”) that includes

adaptive functioning, as manifested by difficulties in performing activities of daily living, maintaining social relationships, or maintaining concentration, persistence, or pace” (Social Security Administration, 2013).

approximately 8.76 million people (Statistics Canada, 2006), one-quarter of the total Canadian population. Among Torontonians, 1.2 million people (or 48%) self-identify as immigrants and 1.1 million people (or 44%) self identify as belonging to a “racialized group”¹⁴. Of racialized Torontonians, south Asians are the largest contingent (25.7% of the racialized groups) followed by Chinese (24.3%), Black¹⁵ (17.9%), Filipino (8.8%), and Latin American (5.6%) (Statistics Canada, 2006).

Deinstitutionalization and Criminalization of the Seriously Mentally Ill

Following the deinstitutionalization of mental health across North America in the 1960s, many seriously mentally ill people fell out of systematic care. In some places there was a deliberate policy of shifting people from institutional to community-based care, but no such policy existed in Ontario. In Ontario there was a deliberate plan to reduce the long-stay population of mental hospitals regardless of what happened to people after discharge (Simmons, 1989). The money saved from dismantling institutions was in theory, intended to be diverted to building local, community-based care programs. Community care was, in its most optimistic incarnation, intended to integrate people with mental health issues into the community and provide more cost-effective care. However, most people with severe and persistent mental health issues have not been the consumers of community care services in Canada (Sealy & Whitehead, 2006).

¹⁴ It is important to note that an immigrant may or may not also belong to a racialized group and those who identify as belonging to a racialized group may or may not be an immigrant.

¹⁵ “Black” is the terminology used by Statistics Canada although other designations are geographical.

The actual outcomes of deinstitutionalization were catastrophic, forcing many mentally ill people onto the streets and out of care completely. One outcome was the increasing visibility of the homeless mentally ill on city streets in the 1970s and 1980s. This was exacerbated in Toronto due to the climate. In central and Eastern Canada, Toronto is one of a handful of mild urban centers. Thus, cities and towns in harsher parts of the province and country shift homeless people (via one-way bus tickets) to Toronto, giving them a chance to survive the winters, eliminating or reducing the visibly homeless in other cities, and inflating the numbers of homeless mentally ill in Toronto compared with other central Canadian cities. Estimates of Toronto's homeless population vary widely due to inconsistencies in the definition of "homeless" and methodological issues associated with enumeration. However, most sources agree that deinstitutionalization resulted in many people with mental health problems living on the streets.

A second outcome of deinstitutionalization is the increasing criminalization of the mentally ill (Lamb & Bachrach, 2001; Schneider et al., 2007). The penal system has become a "surrogate" for the mental health institutions of the 1960s and 1970s, with increasing numbers of adults accused of criminal activities diagnosed with mental health issues and enormous populations of mentally ill people languishing in prisons (Canadian Mental Health Association [CMHA], 2012). One recent Canadian study found the rates of serious mental health problems among inmates to be three times that of the general population (Olly, Nicholls, Brink, 2009).

Sealy and Whitehead (2004) assessed deinstitutionalization in Canada over forty years, but limited the institutions considered to psychiatric hospital beds in psychiatric

units, and community health centres, ignoring jails as a potential variable. Due to this limitation (which they do not acknowledge as a limitation per se), they conclude that people with mental illnesses moved from psychiatric hospitals to psychiatric units, and their hospital use began to decline in the 1990s (Sealy & Whitehead, 2004). They report that community care was slow to be funded and imply that adequate expansion of community care resources may have met the needs of the mentally ill by the 1990s when hospital admissions to psychiatric units began to decline. Fewer admissions to psychiatric units may indicate longer stays or more cost-efficient admissions to non-specialty unit beds. More grievously, they fail to recognize the concomitant rise in severe and persistent mentally ill people incarcerated at this time. Schneider et al. (2007) says that people suffering mental health problems have been entering the criminal justice system at an increasing rate, in excess of 10% per year for the 12 years preceding 2007. It is unclear whether this is due to increased rates of the diagnosis of mental health problems among accused, increased interactions with the law, increased interactions with the law resulting in charges, or some combination thereof¹⁶.

There is significant overlap in the problems associated with deinstitutionalization in both Canada and the United States despite the differences in health care approaches. Universal health care in Canada is a public system (Fierlbeck, 2011) not a national one like that of Britain's National Health Service. The Canadian system is funded by public money and coverage varies by province (Fierlbeck, 2011). Type of service varies as well. For instance, 99% of hospital-based interventions are covered for

¹⁶ The authors of such studies do not unpack the various possible reasons for the increase and assume it is increased criminality among the mentally ill.

those eligible (i.e. citizens and permanent residents) (Health Canada, 2010).

Physicians are not hospital employees, but rather independently bill the provincial government for the services they provide (in and out of hospital) on a “fee-for-service” basis.

Mental health care in Canada is not simply a subset of health care, but is a different system of care. Fierlbeck (2011) argued that some of the major health care policy developments in Canada have actually been *detrimental* to mental health care. She argued that the large-scale deterioration of mental asylums needing expensive renovations, discourse of community-based care coming out of the second World War, the American civil rights movement, and the increasing availability and use of pharmaceuticals all informed decisions in Canada to move towards deinstitutionalization (Fierlbeck, 2011).

Two pieces of legislation, the Diagnostic Services Act of 1957 and the Medical Care Act of 1966, would have greater impact on mental health care policy than any mental healthcare initiative has (Fierlbeck, 2011). These acts defined what would be subject to federal-provincial cost-shared funding. Under this paradigm physician visits, whether hospital or community based, would be covered. However, other professionals including psychologists, social workers, occupational therapists, addiction counselors, and psychiatric workers were not covered outside the hospital setting, making the cost of psychiatric treatment incurred by the province half as expensive in hospital compared with the cost of care in the community (Fierlbeck, 2011). Thus, despite the goals of deinstitutionalization, Ontario and other provinces sought to provide as much mental

health care as possible in hospital settings (Fierlbeck, 2011). Also, legislation ensured that prescription drugs were not covered by health insurance if procured outside the hospital. As mental health treatments became increasingly pharmacological, and as people suffering from serious mental health problems often had trouble securing employment to cover the cost of medications, access to pharmacological treatments actually diminished as more and more pharmaceuticals became available (Fierlbeck, 2011). This trend has been reversed recently and will be elaborated below.

Public health insurance in Canada is traced to either 1947 or 1972 (Fierlbeck, 2011). In 1947, Saskatchewan introduced publicly funded universal hospital insurance but a fully Canadian system was not achieved until 1972 (Fierlbeck, 2011). Technically, there are thirteen health care systems which all feature public health insurance (Fierlbeck, 2011). However, during the transition to public health insurance, many physicians were reluctant to support a government-run system effectively making them employees of the state. The current system was only achieved by ceding the regulation of physicians to physicians themselves and allowing them to retain considerable power over provincial health policy (Fierlbeck, 2011). This degree of influence over health policy has resulted in a highly medicalized model of care and has been cited as a barrier to integrative care within the country (Fierlbeck, 2011). Mulvale, Abelson, and Goering write, “physicians learned to protect the Ontario Health Insurance Plan [OHIP] funds by encroachment from other provider groups and to lobby against any reforms that might reduce existing privileges (2007, p. 376).

Mental health care in Canada has been called the “poor cousin” of universal health care despite the large number of Canadians impacted by mental illness. For instance, one in five Canadians will experience mental illness during their lifetime and 3% (~ 1 million) of Canadians live with a severe and persistent mental illness (CMHA, 2003). Mental illness is the second leading cause of hospital admission among people 20-44 years of age (CMHA, 2003). Families of those with mental illness report being stretched to the limit and unable to cope (CMHA, 2003). Critics of Canada’s mental health care system point out that the country has no national action plan for mental health and lags far behind sister G-8 nations in this regard (CMHA, 2003).

The Mental Health Commission of Canada [MHCC] was created in 2005 (with all party support in the House of Commons) to help establish a national strategy for mental illness with the recognition that a coordinated approach across provinces and territories is desirable to reduce systemic fragmentation although service delivery occurs through non-federal mechanisms, much like health care (CMHA, 2012). The Commission was funded in 2007 and produced a framework for a national strategy in 2009 (Mental Health Commission of Canada [MHCC], 2011). The framework is the outcome of consultations across the country with hundreds of stakeholders. It is extensive and speaks to some of the issues of concern to this project. For instance, there is recognition that good mental health is more than absence of mental illness but is a complex synthesis of economic, social, psychological, and biological factors across a lifespan (MHCC, 2011). Concepts like “cultural safety” and “cultural competency” are referenced and acknowledged. Finally, it is acknowledged that cultural difference can sometimes be interpreted as

illness and that crime is associated with mental illness (MHCC, 2011). The effort is commendable but, at this point, has not been translated into mental health care funding or policies. The emphasis is on indigenous culture and healing practices with some acknowledgment of the repressive colonial policies that have contributed to greater burdens of mental health issues among First Nations peoples. Non-indigenous, non-biomedical practices are acknowledged as important among Canada's diverse population (MHCC, 2011). However, in a poly-cultural city like Toronto more is required than a bureaucratic acknowledgement.

Pharmaceutical interventions play an important part in the treatment paradigms for mental health problems in Canada. Canada's relationship with the global pharmaceutical industry is complex¹⁷. Disease control and pharmaceuticalization are increasingly global in nature, but regional and local variations persist (Biehl, Good, & Kleinman, 2007). In some ways Canadian trends in pharmaceutical sales and consumption, marketing, research and development are consistent with other wealthy countries but there are national and provincial policies and legislation that impact the political economy of big pharma in Canada.

Since 1980, the global pharmaceutical industry has exponentially increased sales, reach, and influence. Global pharmaceutical sales were almost \$500 billion in 2003 and approximately half of that was attributed to the United States and Canada

¹⁷ As is my personal relationship Between 1998 and 2002, I worked in neurological clinical trial research as a clinical manager and occasional research coordinator in Toronto. I have an ambivalent relationship with pharmaceutical industry and pharmacological treatments generally. I elected to leave the industry after receiving a job offer from a Contract Research Organization [CRO] (a professional trial management company) and instead, began graduate studies.

(Petryna & Kleinman, 2006). Canada is among the top ten pharmaceutical markets in the world (Association of the British Pharmaceutical Industry [ABPI], 2013 following IMS World Review 2012 Analyst). In 2007, new pharmaceuticals made up 17% of the Canadian pharmaceutical market share¹⁸ (ABPI, 2013, following IMS Health World Review Analyst, 2010). Drugs account for second highest share (15.9%) of health spending in Canada, behind hospitals and ahead of physicians (Canadian Institute for Health Information [CIHI], 2013). Spending on drugs continues to rise in Canada (CIHI, 2013) but at a slower annual rate than previous years (3.3%) that is thought to be due to patent expirations and generic pricing policies (CIHI, 2013). In other words, while spending rates have slowed this is not necessarily indicative of reduced utilization. Pharmaceutical spending accounts for 17.2% of total health spending in Canada compared with 11.9% in the United States (Laugesen & Glied, 2011).

Political Economy of Big Pharma

The solutions operationalized in 102 Court to address serious mental health issues are nested in a political economy of big pharma in Canada and Ontario. The pharmaceutical industry is rife with secrecy and piecing together the politics and economics of the pharmaceutical industry is incomplete but necessary to appreciate the reliance of mental health professionals on “magic bullet” solutions.

There are many aspects of big pharma that have been sharply critiqued. For example, claims by the pharmaceutical industry that high costs to consumers are to

¹⁸ By comparison, in 2007 new pharmaceutical products made up 21% of the U.S. pharmaceutical market (IMS Health World Review Analyst, 2010).

recoup research and development costs have a hollow ring when big pharma spends more than twice on marketing and administration than R&D (Angell, 2005). There has been a proliferation of lifestyle drugs that have come to market that address chronic diseases common to the west while ignoring tropical diseases in poor countries (Petryna & Kleinman, 2006). Dr. Allen Frances, Chair of the DSM-IV Task Force, asserts that psychiatry today is pathologizing normal feelings, behaviors, and habits¹⁹ (Frances, 2013) and the pharmaceutical industry is benefitting from these expanding markets (Frances, 2013; Leonhauser, 2012). Worse, there are accusations that psychiatry has been bought out by big pharma (Moynihan & Cassels, 2005). It is unclear how much the industry knows of its influence on consumers and physicians (Petryna & Kleinman, 2006). But its influence is enormous. The pharmaceutical mergers of the late 1990s created gigantic companies with huge revenue streams and equally influential research agendas (Law, 2006). Big pharma sets the research agenda, recruits the best and brightest young researchers, regularly lies to physicians and consumers (Frances, 2013) but apologizes and continues to engage in misleading activities because it is profitable (Frances, 2013). There have accusations that pharmaceutical literature (both reports to regulatory agencies and sponsored scientific articles) overemphasize positive results, sometimes downplaying even suppressing negative ones (Healy, 2006). Some critics claim that the majority (as much as 75%) of scientific, peer-reviewed journal articles focused on randomized controlled clinical trial are ghost-written by

¹⁹ This aligns well with former Merck CEO, Henry Gadsden whose dream was to sell pharmaceuticals to healthy people (Moynihan & Cassels, 2005).

pharmaceutical companies who append experts names to them to increase credibility (Healy, 2006).

Direct-to-consumer advertising in the United States is often cited as particularly dubious practice and has been said to “recast well-being as a commodity and a distinct personal achievement” (Petryna & Kleinman, 2006, p. 3). Moreover, these advertisements have been described as marketing illnesses (Healy, 2006) and targeting consumers who do not need treatment (Frances, 2013). While these concerns are important, direct-to-consumer marketing is illegal in Canada²⁰, shaping the approach to marketing for pharmaceutical companies and re-casting physicians, pharmacists and (most importantly) third-party payers like provincial governments as *the* consumers in the Canadian market. However, even advertisements in medical journals are regulated differently in Canada and the United States (Chepesiuk, 2005). The Canadian Pharmaceutical Advisory Advertising Board must review and approve advertisements that appear in Canadian journals (Chepesiuk, 2005). As a result, pre-release regulations are more stringent, although even this level of regulation has been critiqued (Cooper & Schriger, 2005).

²⁰ There are many US publications sold in Canada and the Canadian versions of Vogue magazine, Time magazine, etc. must be altered to reflect these laws. Similarly, U.S. television shows are broadcast with a different set of ads. However, there are leaks in this system and some cable packages expose Canadians to some direct-to-consumer advertisements as does frequent exposure to the U.S. and internet access generally. There is also a way to market disorders, even pharmaceuticals, through the media, which might report on new drugs available or promising clinical trial research. After the release of news items related to certain new drugs or technologies, the medical office I worked in would be inundated with calls for appointments to discuss the new therapies.

Much has been made about the lower cost of pharmaceuticals in Canada compared with the United States (Angell, 2005 for instance). The reduced cost is due in part to Canadian national regulatory policy and practices that differ from those of the U.S. (Angell, 2005). Canada became a signatory to the World Trade Organization's [WTO] agreement on Trade-Related Aspects of Intellectual Property Rights [TRIPS] on January 1, 1995 (World Intellectual Property Organization, n.d.). TRIPS obliges countries to provide at least 20 year patent protection in all fields of technology, such as pharmaceuticals (Angell, 2004; Biehl et al., 2007). This works to standardize patent policy globally. However, Canada has national laws that impact how this global regulation is shaped nationally and locally. Canada's Patented Medicine Prices Review Board assesses the market price of patented drugs to ensure they are not deemed "excessive" (Angell, 2005) and the board has legislated transparency (Patented Medicine Prices Review Board, 2011).

Canadian pharmaceutical legislation is constantly being challenged and reformulated. National policy and laws are complicated by power struggles between Ottawa and provinces, particularly when health care is governed provincially. As previously discussed, Canada's provinces and territories each have their own insurance coverage and these health care payers negotiate the product listing agreements with the pharmaceutical manufacturers, which is a list of pharmaceuticals that the provincial government will reimburse when prescribed. If Pharmaceutical manufacturers inflate prices, a province may choose to exclude the patented drug from reimbursement, effectively restricting market share. This is how provinces keep the price of patented

pharmaceuticals low while remaining compliant to global regulatory pressures (Schulstad, 1994). This provincial variation in negotiated listing prices may lead to cost disparities, large administrative costs, and unequal bargaining power within and across provincial and territorial jurisdictions (Morgan, Thomson, Daw, & Friesen, 2013). Recently, Health Canada was accused of favoring pro-big pharma legislation that speeds new pharmaceuticals to the Canadian market at the expense of safety reviews (Vogel, 2011).

Regardless of the patent laws and the regulated length of patent, drugs are manufactured by generic manufacturers once the patent expires. In an attempt to control the competition, pharmaceutical manufacturers in Canada license the production of “pseudo-generics” upon patent expiration to discourage competitors from the necessary investments needed to produce generics (Hollis, 2003). But there are persistent attempts to lower costs wherever possible. For instance, there were recent attempts to lower costs of generic drugs in British Columbia (via the Pharmaceutical Services Act – Bill 35) which proposed reduced transparency of the government’s decision-making processes and allowed researchers access to personal health information stored by the provincial government (Anonymous, 2012).

It is difficult to find statistics about pharmacological utilization in Canada. The Mental Health Commission of Canada recognizes this lack of data and confirms that “there is no single national organization dedicated to gathering or analyzing data nationally or provincially” (MHCC, 2013). Health Canada, the Canadian equivalent of the FDA, has a dataset of approved active and inactive drugs that tells us (for instance) that

there are 718 antipsychotic products approved for use in Canada. This number seems very large but this list separates all strengths available (e.g. 2mg, 5mg, and 10mg tablets of Abilify are counted as three products and drugs that are available in different administration routes are also counted separately). But you cannot search the data for prescriptions filled per product or calculate utilization in any other way.

In 2002, the global sales of antipsychotic drugs rose 19 percent. By 2012, global mental health pharmaceutical sales ranked fifth among therapeutic classes with sales in excess of \$40 billion (USD) (IMS, 2013). In 2008 Canadians were taking more prescription medications than the previous year (The Canadian Press, 2009). Prescriptions filled by Canadians rose by more than seven percent in 2008 compared with 2007. Psychotherapeutics²¹ made up the second most prescribed drug class in Canada in 2008 (The Canadian Press, 2009).

The research I conducted for this dissertation encountered pharmaceuticals and specifically antipsychotic pharmaceuticals ubiquitously. However, data about the specific utilization patterns among accused and prescription patterns by the forensic psychiatrists I witnessed in 102 Court were not collected. Data focused on Toronto generally or by physicians at CAMH are, to my knowledge, not published. But the reliance on pharmaceutical interventions is clear. I will demonstrate that antipsychotic pharmaceutical interventions manage and normalize seriously mentally ill people who frustrate efficiency in the medical and legal institutions.

²¹ I have no data about how this category of psycho-pharmaceuticals is broken down by consumption patterns in Canada. Presumably, Canada consumes anti-depressants in larger quantities than antipsychotics.

Medico-Legal Nexus in 102 Court

The TMHC operates at the medico-legal nexus, intentionally interdisciplinary in accordance with the goals of therapeutic jurisprudence. Certainly the court is part of the provincial court system, operating within a courthouse with many traditional and other specialty courts. The judges, Crown attorneys, duty counselors, clerks, and court officers who work in 102 Court, do not do so exclusively. They rotate in and out of the court, although some appear in 102 Court with greater frequency than others. The court falls under the purview of the Attorney General of Ontario, is part of the provincial criminal justice circuit, and deals primarily with minor offenses such as theft under \$5000.

The court social workers are employed by an agency called the Community Resource Connections of Toronto [CRCT], a provincial Ministry of Health initiative. While in many mental health care settings, social workers provide psychotherapy; the social workers employed at 102 Court describe their role as “brokers”, people who manage community-based case managers. I believe they mean they do not directly arrange services for their clients or perform clinical interventions, but they manage community-based workers who do. However, they do meet with clients every time they come to court, track them down in the community when they do not appear before the court as scheduled, counsel them about court procedures, advocate on their behalf before the judge on occasion, and generally manage their complicated cases. The CRCT offices are adjacent to the courtroom and people flow into and out of the court

when in session. CRCT workers manage the cases of accused participating in diversion. They meet regularly with clients when they are scheduled to appear before the court, help clients make appropriate community connections, find housing, and liaise with clients' case managers in the community.

The TMHC coordinates psychiatric services with the Centre for Addiction and Mental Health [CAMH], a large public mental health hospital located in four sites in Toronto. CAMH is a research, teaching, and clinical facility that dominates the public face of mental health treatment in Toronto. According to its annual report (CAMH, 2012), CAMH served 27,373 individuals during 2011-2012 (CAMH, 2012).

Schizophrenia and other psychotic disorders accounted for 33.4% of the 4,040 (or 1,349 individuals) in-patient admissions for 2011-2012 (CAMH, 2012). It is unclear how many of these patients came to CAMH through 102 Court and other mental health courts in Toronto. Forensic psychiatrists attend 102 Court daily. They usually arrive over lunch and assess anyone the court has found unfit in the morning. They may meet with accused in the cells or the social work offices. There is a schedule for out-of-custody accused to see psychiatrists as well. The assessments vary in length and the psychiatrist will remain available to the court into the afternoon if needed to provide testimony regarding diagnosis and pharmacological treatment options as necessary. While this arrangement seems logical, not all mental health court models employ forensic psychiatrists; British accused access the civil mental health system (Schneider, 2010). This means that accused in Britain become medical subjects while those of 102 Court become forensic subjects, with the legal aspects of their identities securely

adhered to them. I will discuss in Chapters Two and Four how forensic subjects are formed, the enduring legal subjectivity of the accused, and the techniques of surveillance made possible by the processes of subjectivation.

Subjectivity, Bio-power, and Surveillance

A critique of therapeutic jurisprudence ought to include consideration of the ways that subjects are produced and maintained through the processes of 102 Court and how accused experience those processes. Therefore, at the core of this research is an interest in subjectivity. Subjectivity may be defined in many ways and researchers have approached the topic from many angles. Current understandings recognize subjectivity as creative and agentive, one that allows an individual to relate to the world. My ethnography of 102 Court explores how the subject is declared, recognized, disciplined and surveilled in very particular ways. Foucault's work on the subject, bio-power, and surveillance will help shape the discussion and arguments presented in the following chapters.

As way of introduction, Foucault was a French social theorist, who taught and wrote prolifically on the subject, power, discipline, surveillance, madness, and many other topics from a historical perspective. For my purposes, his analysis of the prison (Foucault 1977) and bio-power (Foucault, 1976; Foucault, 2003) are particularly salient. *Discipline and Punish* traces the development of the modern prison and the concomitant development of modern technologies of discipline (Foucault, 1977). Bio-power is a relatively under-developed idea in Foucault's work, appearing briefly in the *History of*

Sexuality (1976) and his lectures at the College de France in 1976 (Foucault 2003).

However, the concept of bio-power has been picked up by many researchers and will be discussed in more detail below and in the following chapters.

Foucault coined the term 'bio-power' and discussed it in only six pages (Foucault, 1976). He proposed a bipolar schematic of power over life that evolved from the ancient power of the sovereign during the 17th and 18th centuries and ushered in what he calls the "era of bio-power" (Foucault, 1976, p. 140) which we are still experiencing. The first pole, anatomo-politics, operates at the anatomical level of the individual body and seeks to produce productive and disciplined bodies. The second pole, bio-politics, operates at the population level and focuses on regulatory controls (Foucault, 1976). Foucault insists that these two poles are not mutually exclusive and that it is around these two superimposed poles that the "organization of power over life was deployed" (Foucault, 1976, p. 139). Anatomo-politics and bio-politics are techniques of power that segregate, hierarchize, and guarantee relations and effects of domination (Foucault, 1976).

Anatomo-politics is targeted at man-as-body (individual level) and deploys disciplinary mechanisms to increase the productivity and docility of individuals (Foucault, 2003). Disciplinary mechanisms include separation, serialization, reports, inspections, training, and surveillance to control and maximize the productivity of individual bodies (Foucault, 2003). Particular institutions including prisons, factories, schools, and hospitals deploy such mechanisms (Foucault, 1977). Bio-politics is targeted at man-as-species (population level) and deploys regulatory mechanisms to address persistent population problems that weaken the population and consequently

waste time and money and decrease productivity (Foucault, 2003). Mechanisms include regulatory processes such as forecasts and statistical estimates that intervene at the general level (eg. Recidivism rates must be lowered) and attempt to establish an equilibrium that protects the population from the internal problem or threat (Foucault, 2003) such as serious mental health impacts. Both anatomo-politics and bio-politics seek to maximize productivity (Foucault, 2003). Taken together, anatomo-politics and bio-politics constitute bio-power. Medicine plays a critical role in Foucault's conceptualization of bio-power because it possesses both disciplinary and regulatory effects (Foucault, 2003). Medicine establishes a link between the scientific knowledge of both the biological processes that operate on populations and organic processes that operate on individuals (Foucault, 2003).

One effect of bio-power is that it distributes the living according to value and utility; it distributes them around a norm. The norm becomes increasingly important as the era of bio-power evolved (Foucault, 1976). Foucault argued that the norm is one element that circulates between the disciplinary and the regulatory, can be applied to both the individual organism and the population, and can control the disciplinary order of the body while insulating the population from internal threat (Foucault, 2003). The following chapters will provide an example of bio-power and will illustrate Foucault's claim that the law operates "as a norm...increasingly incorporated into a continuum of apparatuses (medical, administrative, etc.) whose functions are for the most part regulatory" (Foucault, 1976, p. 144).

Working in a Foucauldian tradition, Rabinow and Rose expand on Foucault's brief discussion of bio-power and argue that the concept is characterized by a minimum of three elements, which will all recur in the upcoming chapters (Rabinow & Rose, 2006). First, bio-power is characterized by one or more truth discourses and authorities (who are considered legitimate to articulate them). Secondly, strategies for intervention aimed at emergent biosocial collectivities, such as the non-violent mentally disorder accused. Finally, their discussion of modes of subjectification²² is worth quoting in its entirety. They write, "Modes of subjectification, through which *individuals are brought to work on themselves*, under certain forms of authority, in relation to truth discourses, by means of practices of the self, in the name of their own life or health, that of their family or some other collectivity, or indeed in the name of the life or health of the population as a whole" (emphasis added) (Rabinow & Rose, 2006, p. 197). This notion of self-governance was part of Foucault's conceptualization of bio-power. He articulated this before he invented the term bio-power when discussing the 19th century psychiatric practices among the mentally ill (Foucault, 1965). He described 19th century therapeutic interventions that called on the madman to recognize his own madness, to work on himself, to exercise self-restraint and that set up a set of relations between those deemed mad and the men of reason who managed the interventions (Foucault, 1965). Later Foucault argued that the disciplinary practices [of anatomo-politics] "regard individuals both as objects and instruments of its exercise" (Foucault 1977, p. 170). The

²² I use the terms subjectification and subjectivation interchangeably. I prefer subjectivation, but Rabinow and Rose (2006) use subjectification which I will retain when discussing their ideas.

disciplinary subject internalizes the requirements imposed on him, so that he governs himself, thus ensuring increased control without increased resources to control, surveill, report, etc.

Research in 102 Court has demonstrated that this court in particular and the notion of therapeutic jurisprudence that underlies it is a strong example of bio-power at work. Anomo-politics and bio-politics became de-coupled during deinstitutionalization, when seriously mentally ill people were left to their own devices, institutional proxies for the asylum failed to materialize, and mentally ill people were freed from the disciplinary routines and controls of the mental institution. They were spatially disbanded as they dispersed into the interstices of the city as a new homeless population. Bio-politically, their regulation morphed into those regulatory practices associated with the homeless or the poor. However, the increasingly recognized problems of the seriously mentally ill in contact with the law has stimulated the emergence of therapeutic jurisprudence and the courts of law associated with it. This re-coupling of anomo-political and bio-political powers is not really new (although marketed that way by early promoters of TJ like Wexler & Winick, 1996). In the chapters that follow I will analyze the bio-power at play in 102 Court as a lens through which to critique the processes and effects of the court.

Although Foucault's work is influential in many disciplines and his range of interests is broad, he considers his work generally to be about the subject (Foucault, 1982). He says there are two meanings to "subject", "subject to someone else by control and tied to his own identity by self-knowledge" (Foucault, 1982, p. 781). Foucault (1982) tells us that there is a form of power that produces a subject, that categorizes the

individual, that ties him to his individuality, and imposes a truth on him that he must recognize. I call this process subjectivation, and it forms the theoretical framework for Chapter Two. The second meaning of subject refers to the inner thoughts and feelings of an individual and are explored in Chapter Three in a phenomenological analysis. The two aspects of subjectivity are not always considered in partnership as I will do in the following pages, but there are precedents. Anthropologist Janis Jenkins (2010), for instance insists that subjectivity is not solely a feature of individual experience but includes objective forces that operate on an institutional level.

Many other anthropologists have carried out research about or related to subjectivity. Biehl (2005) considered the life of Catarina, a woman isolated and discarded as insane. Biehl's work with Catarina compelled him to recognize that subjectivity is a process of experimentation that encompasses familial, inner, medical, political, and conceptual dimensions (Biehl, 2010; also Biehl et al., 2007). For a review of subjectivity in relation to the body and embodiment in anthropological research see Wolputte (2004).

There is a particular set of processes and practices that *create* the legal subject of 102 Court. So the 102 Court experience for accused is shaped by the subjectivation processes and practices of the court as well as the meaning of those experiences in the lives of accused. The dialectic relationship between subjectivation and subjectivity is the theoretical thread that links the chapters of this work. Thus, this research is both an exploration of the subjectivity and subjectivation of the disordered accused of 102 Court.

The dual sides of subjectivity described above calls for a two-pronged methodological approach: one that addresses questions of subjectivation and a second that seeks answers regarding the experiences and especially the meanings of those experiences for the disordered accused of 102 Court. Here, I use *meaning* in a relational sense. I am interested in the impact of the 102 Court experience for accused as a key to assessing the purported therapeutic framework of the court.

Subjectivation will be explored using data collected from the ethnographic observation of 102 Court processes and people over the course of eight months and interviews with professionals who work in the court. *Subjectivity* will be explored using an interpretative phenomenological analysis (Smith, Flowers, & Larkin, 2009).

Phenomenology is literally the study of “phenomena” according to Stanford Encyclopedia of Philosophy (<http://plato.stanford.edu>). It is “the appearance of things, or things as they appear in our experience, or the ways we experience things, thus the meanings things have in our experience. It can be considered either a disciplinary field in philosophy or a movement in the history of philosophy” launched by Edmund Husserl, Martin Heidegger, Jean-Paul Sartre, and others. According to classical Husserlian phenomenology, “our experience is directed toward things only through particular concepts, thoughts, ideas, images, etc. These make up the meaning or content of a given experience, and are distinct from the things they present or mean”. A more detailed discussion of my phenomenological approach will be discussed below and in Chapter Three. For these purposes I am most interested in the ways we experience things and the meaning those experiences have in our lives. Specifically, I am interested

in the ways that the former disordered accused experienced 102 Court and the meaning the court has in their lives.

Phenomenology

Phenomenological studies are those in which human experiences and meanings are examined through the detailed descriptions of the people being studied.

Understanding the "lived experiences" marks phenomenology as a philosophy based on the work of Husserl, Schuler, Sartre and Merleau-Ponty as much as it is a method of research. As a method, phenomenology involves studying a small number of people to develop patterns and relationships of meaning. Ashworth (1997) argued that an important methodological principle of any research based on the attempt to describe the life-world of another person is that the researcher must begin by bracketing, or setting aside prior assumptions about the nature of the experience being studied. With this approach, the findings will not be generalized but will build upon limited research and form a unique interpretation of events (Creswell, 1994). Phenomenology therefore attempts to understand all aspects of a phenomenon in preference to concentrating on one specific concept and therefore has a reverence for caring for the whole person (Robinson, 2000).

To explore subjectivity among the accused of 102 Court, I conducted an interpretive phenomenological analytic (IPA) study (Smith et al., 2009). IPA is a relatively new addition to phenomenological methodologies, first articulated by Smith (1996) in which he argued for a qualitative and experiential approach that could

dialogue with mainstream psychology. IPA gained most of its momentum in qualitative psychology in the U.K. but is expanding across disciplines and geographic locations (Smith et al., 2009). An advanced search of the *ArticlesPlus* database for English-language peer-reviewed journal articles with “interpretative phenomenological analysis” as the subject resulted in 307 hits, of which roughly 62% were published after Smith et al.’s (2009) manual. Disciplinary subjects included research in clinical psychology (66), sociology (46), rehabilitation (44), public, environmental, and occupational health (39), health psychology (27), and psychiatry (25). These articles ranged in subject from pain (29), illness (26), identity (23), depression (22), and cancer (20). To my knowledge one other study has used both interpretative phenomenological analysis and ethnography. Kemp and Sandall (2010) combined these methodologies to examine the birth talk delivered by midwives to expectant mothers at 36 weeks. Although IPA is not part of the considerable anthropological literature dedicated to phenomenology (see Desjarlais & Throop, 2011 for a review), it might be considered alongside trends in critical phenomenology that attend to the political, social, and discursive forces that shape experience in particular settings (Biehl et al., 2007; Good, 1994; Scheper-Hughes, 1993).

IPA has three theoretical axes: phenomenological, hermeneutical, and idiographic (Smith et al., 2009). IPA is fundamentally phenomenological, but there are some core concepts of phenomenology that do not appear with IPA: notable is the absence of an “essence”. Many qualitative methods books will describe phenomenological studies as striving towards the “essence” of an object or

phenomenon (see for example Creswell, 1994). Husserl (certainly based his philosophy on the idea that every object or phenomenon has an “essence” and this was partially why his ideas were labeled “anti-relativist” (Sokolowski, 2000). This extreme reductionism, which suggests that there is a universal truth about 102 Court, allows little space for pragmatic discussion about perspectives or client-based care and is not consonant with my research aim to critique therapeutic jurisprudence. Therefore IPA’s rejection (or perhaps just setting aside of such truth claims) is consistent with my experiences and goals. However, there are other aspects of Husserlian phenomenology that are picked up by IPA including bracketing and tracing themes, which shall be discussed in more detail in Chapter Three. The IPA approach is more theoretically indebted to Heidegger²³. Specifically, Heidegger was interested in how an embodied and intentional actor experiences the world through possible and meaningful options (Smith et al., 2009). This is a person-in-context approach that allows the experiences of individuals to be nested in relationships, institutions, and policies.

IPA is also based on dual interpretations; hence it is “hermeneutical” and explicitly in the tradition of Heidegger’s hermeneutical phenomenology. First the informant interprets their experience during a conversation, and then the researcher interprets their interpretation. Finally IPA is idiographic or related to the individual. It is radically committed to individual experience. Due to this commitment, IPA studies typically aim to recruit very small numbers of people, and as homogenous a sample as possible. For example, Kemp and Sandall (2010) interviewed 15 people, Pestana and

²³ Heidegger’s work is based on Husserl and while there are numerous examples of phenomenological work, Heidegger’s conceptions are central to IPA.

Raghavan (2011) interviewed four adults with mild learning disabilities to explore their life experiences using IPA, and Simpson, Mullin, & Froggatt (2013) interviewed 10 spouses of people with dementia. Therefore, to recruit nine seriously mentally ill accused that have passed through 102 Court within the last four years is an appropriate sample for this method. IPA research is particularly useful for examining experiences of transition, such as diversion through 102 Court. More detailed methodologies will follow in Chapters Two and Three.

Daily Experiences in 102 Court

To understand the processes and roles of 102 Court, I conducted an ethnographic study of the courtroom and its environs. Ethnography is both a method and a product, often characterized by participant observation (Creswell, 1994). Ethnographic methods generally require purposive and convenience sampling. In other words, a researcher must go to places, talk to people, and experience events that will provide data and inform analysis. This is particularly true when doing urban fieldwork in a poly-cultural city like Toronto (Stoller, 1997). Sherry Ortner defines ethnography as “the attempt to understand another life-world using the self – as much as possible – as the instrument of knowing” (Ortner, 1995, p. 173). Sample size is variable but is considered sufficient when talking to people, going to places, and attending events ceases to alter the overall analysis. Consistent with this approach, I attended and observed the court from January to September 2012. Participant observation is “both a humanistic method and a scientific one (that) produces a kind of experiential knowledge

that lets you talk convincingly” (Bernard, 2011, p. 256). Using this method, the researcher becomes an instrument of data collection and analysis as they learn through firsthand experience of participation and direct observation. This research was particularly heavy on the observation side of the participant-observation equation. However, I did become a participant as a defense researcher in one case that left 102 Court for consideration before the Supreme Court of Ontario.

In anthropological tradition, individual data may help elucidate political and social processes (Biehl, 2005, for example) and provide rich, detailed descriptions of people’s lives that help reveal relationships between the local and the global, between liminal experiences and centralized messages and policies. Also, stories, particularly those rich in detail and affect, can challenge stereotypes and stimulate policy discussion about “universal” access to care and social equity, two fundamental values espoused by generations of Canadian policy-makers.

The court and the courthouse are public spaces, and the proceedings of any court in the building including 102 Court are a matter of public record unless a publication ban is specified during a session. In a court like 102, which proceeds through a docket of approximately 10-20 cases in a day, publication bans are rare. On two occasions, the judge announced a publication ban, so I simply stopped taking notes. Otherwise, details revealed in court (including the name of the accused and details of the allegation) may be reproduced as long as the revelation does not impact the resolution of the case. Because the proceedings are open to the public, school classes rotate in and out, take notes, and sometimes speak to a judge or a Crown

attorney. Authorities from other parts of Canada sit in the gallery (benches for observation) to glean information on processes and logistics to help set up mental health courts in their communities. If an accused is facing more sensational charges and is passing through the court due to fitness concerns, reporters may be seen in the gallery, also taking notes. In my many weeks of observation, I noticed reporters on two occasions regarding one person accused of murder. In other words, access to the court was unproblematic as it is a public space.

The TMHC is an example of a zone of exception (Agamben, 1995). It is open and transparent in theory and characterized by a high degree of surveillance on the part of the court over accused, however the space is invisible in to the general public due to lack of interest, a willful blindness that accompanies homeless, mentally ill, and other marginalized people all over the city. Thousands of people occupy the space of the courthouse as employees, community workers, reporters, guards, accused, families, and legal professionals. But very few of these people notice 102 Court or the accused that pass through it.

The TMHC is in session Monday to Friday from 10:00 am until the docket is complete. The daily schedule of session and recession is not predictable, nor is the total daily time in session. Typically court concludes by 3:00 pm, but on occasion runs until 6:00 pm. The routine varies according multiple factors: the number of people on the docket; which lawyers are in attendance; whether accused have been brought to the adjacent prisoners' cells from the main cells; the schedule of the judge; even the medical necessities of clerks can alter the schedule. Recesses are often loudly

announced – “we’ll reconvene in 15 minutes”. However, there are times when there is no discernible announcement or the announced amount of time passes and the door remains locked. For the out-of-custody accused and me, this means that waiting on the benches in the hall outside 102 Court becomes part of the rhythm of the day. To best approach the experiences of the out-of-custody accused, I arrived at the courthouse approximately 30 minutes before court began each day. The hallway is where the court officers are stationed at the rear employees’ entrance. It is from this vantage point that I observed prisoners, sometimes chained together being led to the cells adjacent to 102 Court from the main cells. Lawyers call out the names of clients, meetings are held between defense attorneys and clients, and duty counselors (free legal aid lawyers) troll for people without representation. Judges flow in through the employees’ entrance in street clothes then ebb back to courtrooms in long black robes. But mostly, large numbers of poorly or un-housed, mentally ill people with a wide variety of peculiar behaviors gathered and waited for the door of 102 Court to be opened. Ten each morning was the assigned time to appear before the court for those accused who had been released from jail. I observed and recorded using²⁴ the processes, routines, language, dress, people and relations in the hall and the court.

In the courtroom I was particularly interested in the processes and routinized language of the court, and the roles of professionals in relation to the accused. Following Coombe (1991, p. 14), I considered the court a “dramaturgy of power” and I analyzed it as performance. Ethnographic analysis was ongoing throughout the period

²⁴ Electronic recording devices are forbidden in the courthouse, so I kept notes with pen and paper.

of data collection and slightly altered my original research questions. Specifically, I encountered early difficulty establishing *who* was being processed through the court as an accused. This seemingly straightforward variable ought to have been easily addressed by one or both of the two datasets associated with the court, but was not. Neither the docket dataset nor the social work dataset²⁵ addressed the ethnic or racial identity of the accused. Daily observation led me to inquire specifically about race among the accused of the court due to what seemed like a disproportionately large number of black people appearing as accused. I altered my research questions and methodology to include observations specifically focused on race, gender and court outcomes. My targeted gender and race observations were easily added to my daily note taking in the court and lasted approximately three months.

Between mid-February and the end of April, 2012 I recorded appearances in court by race and gender and whether the accused appeared before the court in custody or were reporting to the court as part of a bail condition. Because many accused appear before the court multiple times, I refined these data collection methods by May to record individuals by surname. For the purposes of this research, the collection of surnames of the accused will not be reproduced for dissemination purposes, but were collected solely to establish the number of individuals passing through the court. Each day, I designed one sheet of paper for women, one for men. I divided each sheet of paper into four sections: white, black, Asian, and other visible

²⁵ The social work dataset is actually a subset of the individuals who pass through 102 Court. This dataset is specifically about accused in diversion.

minority²⁶. For each individual I recorded their surname, whether they appeared in-custody or out-of-custody, and their return date. If a forensic psychiatrist discussed a diagnosis I included that. For appearances that were more complicated or longer or involved the testimony of forensic psychiatrists, I took notes about the case unless a publication ban was specified.

Observation of court proceedings can be challenging. Microphones are strategically placed throughout the room to capture the voices of key players (the accused, the Crown attorney, the defense, and the judge) for the court recorder who produces the official transcript of the proceedings. But these do not serve to amplify voices for observers. This is exacerbated in 102 Court by the relaxation of court protocol. For instance, regular rules of conduct in the Ontario courts include silence and no disruptions. Many courtrooms are prim, quiet places of etiquette observance. To disrupt the proceedings may result in reprimand or expulsion. By contrast, 102 Court is a lively, noisy, chaotic place. This boisterous atmosphere sometimes complicated data collection because it was, at times, difficult to hear the proceedings and the unofficial discourses were as interesting as the official ones.

These observations were rounded out by semi-structured interviews and informal conversations with key personnel within the TMHC. Interviews with court affiliated social workers, attorneys, volunteers, clerks, court officers, and other support staff were conducted (with consent) throughout the eight-month study period. Many interviews

²⁶ Visible minority is defined by Statistics Canada as not aboriginal and not white in skin color (Statistics Canada 2006).

flowed from questions that arose during observation of the court. Interviews were also conducted with nine accused and three parents of accused.

By focusing on the disordered accused in this study, I situate this work in a stream of social justice advocacy and health disparity scholarship. I hope this work will also add to the literature about bio-power. This work raises questions about racial inequality among seriously mentally ill Canadians (i.e. people diagnosed with schizophrenia and bipolar disorder) that are difficult to contextualize due to major gaps in knowledge about who is diagnosed with what in Canada. This, in turn, raises questions about Canada's values and practices regarding disparity and identity.

Organization of the Dissertation

Three chapters will follow this introduction. Chapter Two will be an exploration of the subjectivation processes of 102 Court. The routine processes, power dynamics, and language of the court based on eight months of observations and clarifying interviews with professionals of the court will form the backdrop for this chapter. To explore *who* becomes this particular legal subject, a different tack will be taken. Detailed observations over three months tracked gender, race/ethnicity, custodial status, diagnosis, and outcome. Chapter Three is an exploration of the experiences of the accused, the meaning of those experiences in their lives (i.e. their subjectivity). Here, an interpretive phenomenological analysis of the open-ended interview questions attempts to tease out the inner worlds of the formerly accused in relation to the court processes. In sum, Chapter Two is concerned with outside pressures that create the subject

whereas Chapter Three is concerned with the inner world of those subjects. The final chapter will offer a critique of the court by uniting the subjectivation-subjectivity work of Chapters Two and Three to assess the declared goals of the court and suggest future areas for research and consideration. Chapter Four will present a consideration of bio-power, subjectivity, surveillance and liminality in relation to the findings of Chapters Two and Three.

Chapter Two: Producing Legal Subjects

As usual, I arrive thirty minutes before court begins to sit in the hall outside 102 Court. Robert, a court affiliated social worker stops to chat. His day is off to a rough start. He has received a call that one of his clients is in a community service agency with his pants around his ankles shooting people with a fire extinguisher. He moves into his office next to 102 Court, shaking his head. A dirty, smelly man passing by suddenly leaned over me, his face inches from mine and yelled, "You think you can fucking rob *me?*", then just as quickly kept on walking. He startled me and I spilled some coffee on my shirt. The court officer at a nearby desk moved to intervene but I motioned that it was okay and he sat back down. Rafik is manning the officer's desk today. We have struck up many conversations lately and now he seems to trust my assessment of the verbal aggression. Jeannie recognized me today, after months of seeing one another. She sat down right next to me wearing a parka (despite the warm summer temperatures), carrying two butter tarts and a styrofoam cup filled with coffee. She did not ask me for money or cigarettes as she always does, but the morning is young. After a few minutes she started her usual conversation, but today extended her discussion of "three country robbery" to include the accusation that "cops killed my kid". Her dislike of the police shines through regularly. She took great offense to a Chinese man who tried to sit next to her, physically blocking him by waving her arms. He sat elsewhere and she began hurling/slurring/ranting racial epithets in his direction while pacing the hall. A quiet man sits on the bench beside me. He hoists his bag onto his lap and gently rocks back and forth. We wait. A tall man wearing a long black robe with diagonal red

sash strides confidently down the hall. The man rocking beside me announced softly, “Here’s the judge”. He stood as the judge passed us and we all followed him down the hall. Our motley crew entered the court and scattered along the benches of the gallery waiting for him to officially enter. The Crown attorney and clerks were already in the court as was another court officer. Attorneys come and go. Workers joke, change from street shoes to work shoes, shuffle files, and discuss cases. Everyone waits for the judge to enter the room and when he does, we stand motionless and quiet until he takes his seat. Court is in session but people continue to come and go, more quietly now.

Gordon shuffles into court. He is old, diminutive. He wears wrap-around sunglasses that cover half his face, and enormous clothes once owned by a much larger man. He knows the court staff and calls out, “Good morning Madame Crown Attorney”. She greets him smiling even after he follows up by calling her “dear”. The court staff seem fond of him. Ananda (a.k.a. “the fan”) is sitting in the body of the court again today. As always she has pulled a seat cushion from her bag that she places on the hard wooden bench. She looks as if she’s attending a baseball game: Cap, oversized shorts, sports socks, trainers, and large tee shirt. But today I wonder if she’s decompensating because she is also wearing a hospital mask, gloves, and is rocking back and forth cackling quietly. When the duty counselor calls her name she marches right up to the judge’s bench and complains about her frequent court appointments. Finally accepting her next return date, she backs out of the courtroom yelling, “it’s too much! I have to poop! I have to shower! I have an appointment at Mount Sinai [hospital] at 11!” This is a typical scene in Toronto’s “102 Court”, Canada’s first mental health court.

This chapter will explore the ways that the subjects of 102 Court are constituted. Here, I seek to unpack some of the processes and routine discourses of the court and reflect on the ways that particular subjectivities are defined and produced. Who appears in 102 Court, for what reasons, and the role of 102 Court events on medico-legal outcomes will be explored. The strength of 102 Court as an example of bio-power will be discussed vis-à-vis Rabinow and Rose's critical three elements: truth discourse and authorities considered competent to speak the truth; interventions aimed at an emergent biosocial population in the name of life and health; and forms of subjectification in which individuals work on themselves (Rabinow & Rose, 2006). Techniques of power underlie the processes and effects of 102 Court, so the disciplinary and regulatory features of the court will be stressed.

A dramaturgical metaphor for court observation was useful. However, observing and considering 102 Court as "theater" was less productive than 102 Court as "performance and protest" (after Lazarus-Black & Hirsch, 1994). The relationship between the production of subjectivities and power and resistance was quickly of interest during research and by altering the lens through which I regarded the court; I hope to have captured more of this perspective.

Coombe (1991) states that legal processes are constitutive of subjectivities. Comack and Balfour (2004) argued that despite the basic legal premise of equality before the law, practices, processes, and discourses of the law maintain an order of inequalities, particularly gender, race, and class inequalities. (Coombe, 1991, p. 5). This chapter focuses on the most ubiquitous discourses, the major processes of 102 Court,

the particular subject positions that are produced through these processes, and how these are implicated in an order of inequalities. In this dissertation I argue that the meaning of 102 Court in the lives of people who experience its processes are constituted by both internal states and external constructions of subject (following Jenkins, 2010). This chapter will focus on subjectivation which foregrounds Chapter Three and the exploration of the inner states of disordered accused. Particular attention to *which* social groups appear before the court and the difficulty of contextualizing observations will be discussed. The variations in approach among the decision makers involved with 102 Court impact who becomes a subject and the processes of subjectivation. The professionals who occupy the key positions within 102 Court rotate in and out of the court including the Crown attorney, the judge, the duty counselors, and the defense attorneys. There are observable differences in approach, emphasis, and habits of the various key players and these variations combine in many different combinations to shape the subjectivation of the accused.

Extending the dramaturgical analogy, therapeutic jurisprudence (and its implementation as mental health courts) is the *deus ex machina*, a contrived solution to an apparently insolvable difficulty, at play here. The creation of 102 Court is an attempt to address structural violence²⁷ within the criminal justice system. The concept of therapeutic jurisprudence admits that physical and emotional harm can result in the imprisonment of seriously mentally ill accused *without* the benefit of rehabilitation. The

²⁷ Structural violence is not a term commonly used by the court or the authors who discuss therapeutic jurisprudence. This is my interpretation of the goals of the court, specifically the goal of reducing or eliminating jail time and re-directing accused towards a system of care rather than punishment.

structural violence that is addressed through the existence of 102 Court may originate with deinstitutionalization, lack of community mental health services, criminal justice responses to interaction with mentally ill people, or some combination thereof. However benevolent the intentions of its founders, 102 Court ameliorates some forms of structural violence for some people while producing new forms. It also reflects structural violence at other junctures of the criminal justice system. The production of new subjects, “proper” legal subjects of 102 Court offers openings and opportunities for some accused, but forecloses possibilities for others (Biehl, 2010). Also, being deemed a proper subject of the court is akin to walking along a razor thin mountain pass; fall one way and be met with freedom, services, housing, and support but fall the other way and you face indefinite detention. Paul Farmer argued that the suffering of victims of structural violence is difficult to capture for three reasons; we find it difficult to relate to the suffering of people very different from us; the enormity and extent of suffering is difficult to convey in facts and figures; and the dynamics and distribution of suffering is little understood (Farmer, 1997). He has highlighted the importance of gender and racial axes, describing an intersectional analytic approach without calling it that (Farmer, 1997). Comack and Balfour (2004) argue that the Canadian judicial system reproduces gender, race, and class inequalities and that therefore the law is complicit in perpetuating disparities. If this argument is valid, it seems likely to be apparent, perhaps amplified among seriously mentally ill people. In this chapter, I will attempt to trace the structural violence of the court within a broader critique of court processes with special attention to the axes of gender and race. The gender axis will be discussed but is less

robust than the racial axis for several reasons. Another nearby mental health court is colloquially known as the “women’s court” and many 102 cases are traversed there possibly resulting in lower than expected numbers of women in 102 Court. Also, fewer of my conversations and interviews were with women. Farmer’s axes are important here but others likely impact the experiences of accused and the ways that structural violence is produced and reproduced in this system. For instance, other axes of marginalization such as being accused of a crime, class, social isolation, immigration status, language, and odd behaviors associated with the diagnostic features of psychosis may all intersect to impact the ways that suffering is experienced. It is beyond the scope of this study to explore those intersections comprehensively but may be a productive future approach to capture suffering among this population.

My ethnography of the court and courthouse included the court in session, the drama of the hall outside 102 Court during recesses, and the Old City Hall courthouse generally. Much of the experience of the courthouse for non-professionals is waiting for lawyers, social workers or other professionals, waiting for court to resume, waiting for your docket number to be called, etc. The hallway outside 102 Court, located in the basement of the courthouse is faded architectural glory. The ceilings are high and the corridor is at least 15 feet wide hinting at a grand architectural past. But, glaring fluorescent lights light the space. It is brutally hot in the summer and very cold in the winter, when anyone with a coat keeps it on and buttoned up. The dirty, neglected walls are lined with uncomfortable, mismatched wooden benches that often cause my legs to fall asleep. The toilets are at best private and at worst revolting. Female employees

have a separate toilet, the door locked with a numeric keypad. The public ladies' room has two stalls. The stall that faced the hallway was without a door so anyone using it risked exposure if the hall door opened. Effectively, it was rarely used. The other stall was smaller than usual; to close the door you had to partially straddle the toilet. The patterns of urine and feces that surrounded this toilet became familiar to me as the months wore on because although the cleaning staff's cart was seen regularly outside the bathroom, the stains never changed. Nor did the smell, which was nauseating and suggested the toilet's outflow was pooling somewhere nearby. Homeless women often used the sink to bathe in, leaving water, paper towels, hair and smudged makeup in their wake. Sometimes vomit, used menstrual pads, and dirty diapers littered the corners. The smells from this bathroom often wafted into the hallway making the benches closest to it the last resort for those waiting on court, especially on very hot days.

The people who linger in the hall, waiting for those with more power, are primarily the accused and their families. There is only one other court off the hall and it hears mostly federal drug cases. So the hall is filled with mentally ill people behaving oddly, speaking aloud to no one in particular, trying to sleep on a bench, marching up and down the hall cackling out loud. But there are also gang members and their friends and families, children, and confused parents. There is all manner of dress here, some look like retired librarians, others like sex workers. People wear fedoras, ball caps, hijab, hockey shirts, saris, fishnet stockings, gang insignia, anarchist symbols, tattoos and piercings, old, cheap bags or just recycled plastic grocery bags. I can only identify a

handful of the languages I hear. We rely on the cheap terrible coffee available around the corner of the hall. It is clear that many of the people in the hall are homeless or inadequately housed. Many are very poor. In contrast are the lawyers and other courthouse employees like clerks, social workers, and volunteers who, having places to store their belongings do not carry coats and bags or wear outdoor weather gear. They have better shoes, are in a hurry, and compulsively check PDAs²⁸. This is where many lawyers meet their clients and talk about cases. There is very little privacy for accused and I frequently heard details of cases from 102 and other courts. The lawyers are always in a hurry, often glancing up and down the hall while explaining strategy or next steps, looking for the next client, another lawyer, something else. Video cameras record all activities and a court officer is stationed at the north employees' entrance. Judges enter wearing street clothes and rarely stop to speak to anyone. Eventually, they flow back down the hall wearing robes to take their place on the benches of the courtrooms. Court workers gather in cliques to go to lunch or smoke outside or go to a pub after work. Lawyers openly discuss their cases and their attitudes towards clients and families are easily discernible. Here I could listen for the various approaches among duty counselors. Some actively announce their role and explain what it means and look for families and accused clients. Others never work the hall so transparently, but may quietly approach someone they think might be a client or relative. Names are called aloud, "Anyone here for Jamieson?" Employees come and go at will through the employee exit, partially explaining the uncomfortable temperatures of the hall. But

²⁸ Personal digital assistants

accused or non-professionals like families and researchers can only exit through the door not re-enter. To re-enter the building requires walking around to the front entrance, climbing the stairs, passing through the security checkpoint (empty pockets, place items on conveyer belt for x-ray inspection, pass through a metal detector then a wand wave, if the detector was triggered) then descend the stairs to the basement again.

For me, the hallway was both a place to continue observing the courtroom activities (broadly conceived) and a place to meet people. Many accused approached me in the hall, because they assumed I was waiting for a lawyer and waiting to report. It was inconceivable to many that I would sit for hours voluntarily. Parents of accused also approached me and I got to know several people very well because of the amount of time we spent sitting and waiting in the hall and the court. Some of the accused and parents later took part in interviews that form the basis for Chapter Three.

As a daily observer of the court, I was the most dedicated audience for the performances and protests of 102 Court. I shared a high level of education with some of the court professionals. But I also shared circumstances with the out-of-custody accused: I moved with them into and out of court as sessions began, ended, and began again. I was mostly ignored as accused are. For some professionals it was months into my daily routine before they would speak to me and introduce themselves. Some of the accused said I was “one of them” because I was not studying law, and was more interested in speaking with them than their lawyers or social workers. Many of the accused are story-tellers who rarely have an audience outside of lawyers and doctors. I sat in the “body” of the court with the out-of-custody accused, their friends, families, and

the occasional housing worker. There were rarely other observers. School classes would briefly attend 102 Court as part of a larger courthouse tour. Students would file in, sit in cliques. Some were attentive, others played with electronic devices. No school group remained more than a few minutes, although some would have an audience with a judge during the lunch break. Sometimes a community worker, whose clients included accused from 102 Court, would watch for a half day. Once a representative from another provincial court watched closely and took notes in order to glean information to establish a mental health court in their prairie community. Three journalists appeared one day following an accused facing very serious allegations. The accused was only briefly passing through 102 Court for fitness testing and was promptly transferred to a more appropriate court. So, I was the entire audience on many days. Towards the end of my research, a court clerk admitted they called me the “resident academic” and another clerk noted that I would talk to anyone, even the “crazies” which had made her a little suspicious of me at first. Her observation highlights the social division between accused and professionals in the court. Professionals greet one another and make small-talk as colleagues often do, speaking about their weekends, children, and other personal details as well as discussing cases. They congregate together, borrow pens, and move easily into the business section of the court. Accused move reluctantly into the professional space of the court, they often sit apart from one another, make little eye contact, and have few conversations. There were few observers in 102 Court and I never witnessed any observer interact with an accused they were not bound to by family bond or professional obligation.

If the activity and practices of the court and environs are considered a dramaturgy, what is this role, “the accused”, in 102 Court, who is cast in this role, and what are the possible story endings for them?

The disordered accused are situated at the liminal space of the legal - medical nexus. The point of 102 Court is to redirect these burdensome people from the legal system to the healthcare system. It is the historical deinstitutionalization and the contemporary state of enormous mental health service deficits that exacerbates the contact between the disordered accused and the law. Jails and hospitals are both publicly funded and under increasing pressures for economic efficiencies and streamlining. The complexity of suffering endured by the disordered accused is enormous and defies efficiency forcing these two institutions into a dance of responsibility. The creation of the court first presents as a cooperative venture that improves efficiencies in both institutions, but tensions remain. Sometimes, the courts become frustrated with the lengthy wait times for psychiatric beds and judges order accused into hospital despite no available bed. This triggers the appearance of legal teams from CAMH in 102 Court and sometimes the intercession of a superior court.

“Order” and its antithesis, “disorder”, are of fundamental importance at play in 102 Court. First, there is law and order, which has been disrupted by the alleged criminal behavior that leads to arrest and eventually to court. Maintaining order is a mandate of the Crown attorney and must be considered for each case that comes before her. The social order that non-accused people benefit from must be protected by the decisions taken by any court. If an accused, mentally ill or not, disrupts that order to

the detriment of “innocent” residents, then an appropriate legal response ought to be meted out. But the “disorder” of disordered accused is not that which is created with criminal activity but a particular kind of internal state that is perceived to drive criminal behavior. Depression or the hyper-vigilance of someone suffering PTSD is not the “disordered” described here, despite being disordered in psychiatric nosology. As described in Chapter One, people end up in diversion in 102 Court following a psychiatric assessment that confirms a diagnosis deemed appropriate for the court. So although the accused in 102 Court have diagnosed disorders, it is only those disorders defined by disordered thinking leading to disorderly behaviors that are the disorders on display. Behaviors perceived as psychotic are the focus of 102 Court. Arrigo (2004) argues that although concepts of order and disorder are processes found in all systems, law artificially corrals disorder and expressions of disorganization. Disorder is disciplined in 102 Court; it is identified, labeled, reported, and surveilled in a classic anatomo-political display of power. The production of “good legal subjects” (Arrigo, 2004, p. 206) is the goal. This discourse is steeped in morality where order is associated with “good” legal subjects and disorder with “bad” subjects. The source of the disorder is clearly individual and internal and conceptualized as neuro-psychological. But the disorder of the individual’s brain and any suffering associated with that are really not the object of interest in 102 Court despite discourses of treatment and therapy and the generally benevolent disposition of the court. The neuro-psychological pathology of the disordered accused spreads outside the boundaries of the individual to impact family, friends, work colleagues, teachers, landlords, and

eventually when the disorder spreads too far, to friction with the police and hospitals. It is, therefore, the spread of the disorder like a contagion that is disturbing. The first, second, even the 15th instance of friction with the police may not result in trouble beyond a growing visibility among the police. When arrest finally occurs, the disorder has spread to such a point that “good” legal subjects (i.e. mentally healthy people not in contact with the law) are perceived as direct or indirect victims of the accused’s disorder. “Good” subjects are impacted directly if they are, for instance, the shop owner whose bottle of water was stolen, the victim of a nuisance crime. Indirect impact includes the increased police resources allocated to these nuisance crimes (and therefore unavailable for other police issues). Depending on the behavior under review, the perceived *potential* for future escalation of the behavior or the potential threat to “good” subjects is a point of decision for the Crown attorney. For example, an elderly, homeless woman appeared in 102 Court accused of kicking another woman waiting at a streetcar stop who refused to give her money. The kick was singular and the only reported incident of the kind. The accused did not know the victim. The victim sustained no injuries, not even a bruise, and declined to make a victim impact statement. Yet the accused was compelled to “give” a DNA sample as a condition of her release from jail lest her criminal violence escalate in the future. Her actions may have been “symptomatic”, a result of psychiatric distress, but they might this be a rather response to chronic poverty, homelessness, social isolation, and frustration?

Those who embody this subjective position come to do so through several routes: accused may self-disclose their mental health issues and ask to be referred to

102 Court²⁹; lawyers may approach the 102 Crown and refer clients; or accused may be referred by the police, front-line first-responders who are able through experience and training to recognize mental health issues. By whatever avenues an accused may find his way to 102 Court, it is the Crown attorney who will decide whether the case is eligible for diversion or not; she is the gatekeeper of 102 Court. She relies on the expert opinion of CAMH psychiatric assessments to evaluate the psychiatric component of her decision and is eminently qualified to assess the alleged criminal acts of the accused and the potential risk to the public. She is looking for a causal relationship between the diagnosis and the criminal behavior, effectively restricting the possible mental health issues that might be addressed through 102 Court. The psychiatrist, and by extension, the Crown attorney must be convinced that the accused suffers a mental health problem that was at play during the commission of the alleged crime. This goes a long way to understanding the concentration of psychosis-related diagnoses in 102 Court. The literature acknowledges a small but significant association between schizophrenia and violent criminal acts (see review by Taylor, 2008). Although this study was intended to study only those “properly” before the court³⁰, an ethnography of the court itself includes those not properly before the court³¹ as well as those properly present. Some of the data that follows in this chapter concerns accused observed in 102 Court over the duration of the study. These data include some “malingerers”, some accused well-

²⁹ Many court workers believe that accused in other courts mangle or try to take advantage of the perceived leniency of 102 Court by pretending to suffer from mental health issues. These malingerers, once identified are summarily transferred back to their original, non-mental health courts for processing.

³⁰ People accused of minor, non-violent crimes

³¹ People transferred to 102 Court to have fitness assessed by the “experts” on hand

known to the court, and others just passing through for fitness testing. It is well understood that many accused who pass through 102 Court have mental health issues, sometimes chronic and very debilitating, but due to the absence of psychosis, they are not “properly” before the court and get transferred back to the regular stream of justice.

Suffering in the Court of Invisibility

Comack and Balfour (2004) argue that legal spaces are built on discourses that resonate with wider society despite being presented in legalese. They emphasize the difficulty in tracing the structural violence of courts due in part to the (re)production of inequalities in discretionary spaces rather than the formal rules of the law (Comack & Balfour, 2004). Long-term observation of the court offers insight into practices and discourses that help define discretionary spaces, unofficial relations, and reflect wider social relationships. One of the most disturbing aspects of my fieldwork in 102 Court was the cries, pleas, screams, and accusations of the accused that were systematically ignored by most people. Mental health courts like all Ontario courts are founded on principles of transparency, where accused must be present when forensic psychiatrists testify about their diagnoses and treatment recommendations. Certainly the court exists due to recognition of the injustice experienced by mentally ill accused in the criminal justice system. The court’s foundation and ongoing operation is an organizational and institutional gesture of benevolence and sympathy regardless of unintentionally draconian outcomes in some cases. Most people who work in the court are very sympathetic to the clients. Some defense lawyers work longer hours for less pay to

specialize in helping mentally ill clients. Judges lay aside the strong rules of etiquette to endure slurs, accusations, and chaotic behavior in the courts. It is not unusual for the smell of vomit, urine or feces to waft through the court, caked on an accused.

For all this obvious sympathy and tolerance, when an accused makes accusations of mistreatment or objects to their diagnosis they are routinely ignored. There are the frequent denials of mental health problems while listening to the testimony of forensic psychiatrists. "I am not bipolar!" One young woman was asked about the injections she received to treat her schizophrenia and she replied calmly, "I don't believe I am schizophrenia [sic]". A male accused returned to 102 Court half way through a treatment order during which he was resident in a hospital and he reported that "they [the psychiatric staff] stick needles in my ass and abuse me". More disturbing are the accusations of abuse by police officers, jailers, fellow accused, or court officers and the pleas for help. Of course some of these expressions of suffering are likely due to delusions, perhaps traumatic memories. Some are surely based on "real" events near or distant in time. Some may well be allegations in need of investigation. But suffering is not *really* the central concern. The intense suffering displayed by some people is ignored as part of the disorder, as "histrionics" of women accused, as inappropriate outbursts, misbehavior, and symptoms. Court room cries, screams, pleas, denials, and the pain and suffering revealed by these behaviors are regularly ignored or addressed sternly as court disruptions. My experience in 102 Court suggests that accusations of violence in distant institutions (like jail) are more likely to be believed than those concerning people in the courthouse like court officers or cell-mates.

Court officers are the sharp end of the disciplinary stick in the courthouse. Within the building they have powers similar to police officers. They wear uniforms closely resembling those of the police, carry handcuffs and weapons, and escort prisoners (willingly or not) around the building. They readily acknowledge the need for force in some circumstances, most deploring its use. There are difficult situations faced by officers such as screaming, defecating in cells, and smearing menstrual blood all over cells. I witnessed an accused in custody in 102 Court reach into his pants and smear feces on his face while court was in session. Some accused refused to wear clothing, persistently trying to disrobe; one man smelled so awful it caused another to retch in the court. Court officers have the least enviable jobs; dealing intimately with accused and attempting to maintain professional propriety and sympathy, sometimes amidst appalling work conditions.

Court officers have various relationships with the accused of 102 Court. I met Clem, a court officer, after seeing him many times in the hallway outside 102 Court. Clem had worked as a court officer for eight years. Although technically based from the downtown Toronto courthouse, he liked variety in his work so taught at the police College from time to time. According to Clem, there were 900 court officers in Toronto and they received no special training to deal with mentally ill accused in the system. He described a spectrum of professionalism and empathy among court officers that he said ranged from excellent, through mediocre, to “embarrassing and awful”. He said that officers learned on the job and hoped they would learn from both the good and bad conduct of other officers. He said he always tried to be a good role model and that

sometimes, a bad role model was also helpful. He gave the example of a court officer now in trouble after making faces at an accused in court that was noticed by the crown attorney and the court recorder. Clem said “102ers” were like “deer in the headlights” compared with other prisoners. Clem reported that regular prisoners are often very savvy and work the system, sometimes arranging meetings with other prisoners by requesting specific court dates, knowing they will be transported from the jails to large holding cells at the courthouse and can intermingle. Although the courthouse experimented with different ways to segregate prisoners (by source or rival gangs or geographically), Clem emphasized that 102ers *needed* to be separated from these other prisoners. He offered to show me the cells of 102 Court.

However, it was Catherine, a court clerk, who took me through 102 Court’s cells. On a recess, before I left the courtroom, she approached me and asked if I would like to tour the cells. She explained she could see no harm in it, I seemed interested in every aspect of 102 Court, and they were empty. The crown attorney and other court staff were very curious about me staying. All eyes followed Catherine and me as we walked through the prisoner’s box and she asked the court officer on duty to let us into the cells. I know what a privilege it was for me to tour the cells. Many people who work with accused never enter them, for security reasons they meet clients in a special room. Busy professionals have no reason to tour empty cells. I saw three separate cells adjacent to 102 Court. There was a small single cell, for people who needed to be alone and two cells large enough for multiple accused. The ceiling was very high (like the rest of the courthouse) but the walls, floors, and benches were all covered in steel floor

plates. This metal sheeting has a raised diamond pattern that provides skid resistance. The benches were built in and thoroughly encased in the metal. I labeled one of the cells, the “graffiti room” because of the almost complete coverage of the walls by messages and drawings. The metal was darkened by grime and bodies. The cells were solid and very private with thick heavy doors and small windows. I recalled all the times I heard the banging of metal doors from these cells while sitting in the adjacent court room and reconsidered how much distress and force would be needed to create the clamor. I also recalled how many accused complained in court about the cold cells in the winter. The bodily fluids of accused that Clem spoke about would be more easily cleaned from these metal boxes, so I could appreciate the practicality of metal as a building material, but it was shockingly inhumane and claustrophobic to me.

There is a tension between the visibility and invisibility of the accused at play in 102 Court. Here is a system that by design is “transparent”; where the courtroom is open to the public, key courtroom voices are carefully recorded and transcribed, and the transcripts are available to anyone who orders them³². Ironically, what actually occurs in this space to the people who pass through it as disordered accused is so unremarkable they are rendered almost invisible to the public. The court is open, yet the body of the court remains unoccupied. The accused are so invisible, drug deals occur in the body of the court while it is in session and if anyone notices, they do not stop it. The elderly mother of one accused, dressed in ill-fitting faded clothes, sat in court for days

³² At \$30 per transcript

before anyone noticed she was not an “out-of-custody”³³. Reporters do not record these proceedings, sketch artists do not portray the scene. The accused rarely speak. In the theater of the court the accused are the courtroom equivalent of drama’s “unseen character”, a role critical to the turning of the plot but never actually seen or heard. The unsolicited cries, pleas, screams, and accusations of accused are not on script; they are dismissed as symptoms, and systemically ignored. In a complete contradiction the accused are highly monitored and watched by the court once they are released. Their housing, medication regimes, community appointments, personal relationships, geographical wanderings all fall under intense surveillance which shall be discussed further in Chapter Four. They are at once watched and disregarded, surveilled and dismissed, visible and invisible.

“You can’t talk to those people, they’re totally irrational!”

Irrationality and rationality are strategically ascribed to accused in both formal and informal ways. Formally, the capability of accused before the law is not typically questioned. Their participation in the legal processes of the court is premised on the assumption that they make a rational choice to proceed through the court’s diversion process if they are offered that possibility. They are able to instruct their lawyers and if they are deemed unable to do so, it is their fitness that is called into question. This rational choice to proceed through diversion or return to the regular stream, to plead

³³ i.e. an accused who has been released on bail and reports to the court. This contrasts with an “in-custody”, an accused who is currently in jail and will be brought into the courtroom by court officers.

guilty or not, to recognize and ably communicate that they understand basically where they are, what they are charged with, and what is happening in the court, is foundational to their participation in 102 Court. It is also the rational decision that is invoked when they violate the terms of parole. But, says the judge, you agreed to report to court every morning at 10:00 am and you have failed to do so. They are held accountable to the rational decisions they have taken. For bail conditions to be met, a set of restrictions and conditions must be recalled, agreed to, and adhered to. They must find a way to move about the city to appointments and court and shelters. They need to stay on their medication regimes. However, I was discouraged from interviewing accused several times due to their irrationality. Accused are “irrational” and “hysterical” when they allege violence or impropriety at the hands of jailers or cellmates. Both their irrationality and rationality are reduced to a neuro-chemical imbalance, considered the root cause of their legal, social, and biomedical problems that might be restored with antipsychotic medications. The accused of 102 Court are expected to enter into a contract with the court voluntarily and adhere to that contract through self-governance. They are to keep their appointments, take their medications, and follow the advice of mental health practitioners while immersed in a system of reward and punishment. This recalls Foucault’s historical examination of 19th century psychiatric practices that called for patients to self-regulate, to admit their unreason in exchange for greater corporeal freedom, and to submit to the authority and truth discourses of experts (psychiatrists then, mental health practitioners, often psychiatrists now) (Foucault, 1965). The ambivalence of ascribed (ir)rationality is a critical feature of the bio-power leveraged by

this court. It is the truth discourses of the forensic psychiatrist that authorizes many of the possible outcomes of 102 Court.

Who are the Disordered Accused: Axes of Race and Gender

There were 1,125 appearances by accused in 102 Court over approximately three months of observation between May and August 2012. During the study period, 483 individuals came through the court of which 77% were men and 23% were women (372 men and 111 women). One hundred and fifty-six men appeared in-custody, making the average number of appearances in custody two per individual man. Two hundred and sixty-five men appeared out-of-custody with a range between one report and 13 reporting events. For female accused 47 individuals appeared in-custody 97 times. In-custody female appearances ranged between one and six times whereas female out-of-custody appearances ranged between one and 22 times. Seventy-seven women appeared 199 times out-of-custody.

Twenty-three men were given a diagnosis of schizophrenia³⁴, four were diagnosed with psychosis or psychotic disorder NOS, three were diagnosed with bipolar disorder and two were diagnosed with both schizophrenia and bipolar disorder. One man was given a diagnosis of anxiety and depression, another with severe adjustment disorder. Similarly, six women were diagnosed with schizophrenia, two with bipolar disorder and one with psychosis. Therefore of 43 diagnoses offered in court as

³⁴ These numbers are based on the testimony of forensic psychiatrists, not self-disclosure or diagnosis that follow accused in their case files. Therefore it is a conservative number.

evidence, 41 or 95% were related to psychosis and 31 or 72% were specifically diagnosed with schizophrenia. See Table 1. for a summary of these findings.

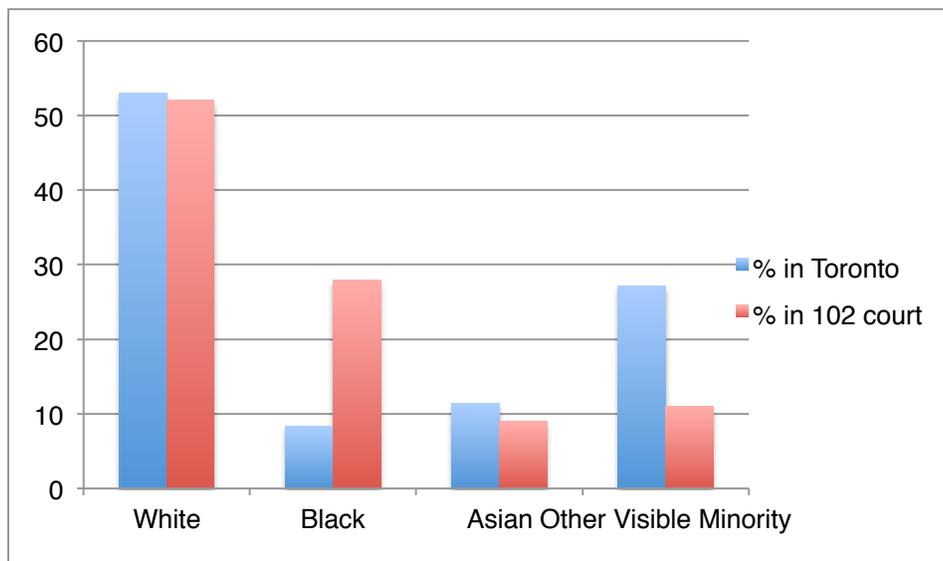
Table 1. Summary of Diagnoses in 102 Court

| | Diagnoses with psychotic features N (%) | Diagnoses without psychotic features N (%) |
|------------------------|--|---|
| Men | 32 | 2 |
| Women | 9 | 0 |
| Total of men and women | 41 (95%) | 2 (5%) |

The first question to be asked is whether the frequency of appearances by men and women in 102 Court was consistent with the general population. According to the 2006 census, 47% of Torontonians self-reported being part of a visible minority (Statistics Canada, 2009) compared with 48% of the men (n=372) and 54% of the women (n=111) I observed and categorized. However, breaking the category of visible minority into three distinct groups namely, black, Asian, and other visible minority is more revealing. Among men, 28% (n=105) of the 372 individuals observed were black, 9% (n=32) were Asian, and 11% (n=42) were other visible minorities. These data may be compared with census data that indicate that 8.4% of Torontonians self-report as

black, 11.4% self report as Asian, and 27.2% as other visible minorities, a significantly different distribution³⁵ (Statistics Canada, 2009) (see Figure 1).

Figure 1. Percentage of Males by Race in Toronto & 102 Court

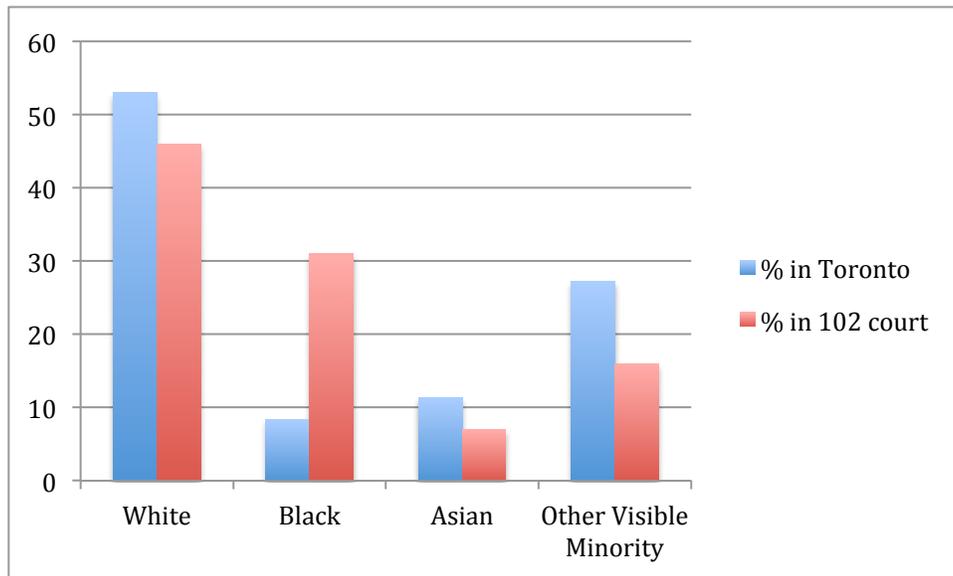


Similarly among women, 31% (n=34) were black, 7% (n=8) were Asian, and 16% (n=18) were other visible minorities, a significantly different distribution than the general population³⁶ (Statistics Canada, 2009) (see Figure 2).

³⁵ χ^2 (3, N=372) = 211.330, p<0.0001

³⁶ χ^2 (3, N=111) = 72.982, p<0.0001

Figure 2. Percentage of Females by Race in Toronto & 102 Court



Testing Fitness, Testing Canadian-ness

Each mental health court emerges from a particular, local political context. The impetus behind the creation of 102 Court was to improve the processing of unfit accused through the criminal justice system. “Fitness” must not be confused with wellness or health. It is concerned specifically with the ability of an accused to understand the proceedings of the court and to instruct his or her defense attorney. While similar to American legal tests of fitness, the Canadian notion places less emphasis on demonstrating rationality to understand the proceedings of the court and more on the ability to communicate with defense attorneys (O’Shaughnessy, 2007). “Unfit to stand trial” is defined in the Canadian Criminal Code as, “Unable on account of mental disorder to conduct a defense at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental

disorder to (a) understand the nature or object of the proceedings, (b) understand the possible consequences of the proceedings, or (c) communicate with counsel” (Government of Canada, 2013). It is a test of the moment, and may change from hour to hour or day to day. The classic test of fitness, called the “Taylor test”, is a series of questions posed by a defense counselor (usually) to an in-custody accused about the court and the roles of people in it. For instance defense might ask, “I am a defense lawyer, your lawyer. What is my job in court? The woman sitting up there [points to judge] wearing the sash is a judge. What is her job? Do you know what you are accused of? In general, not your case, if you are asked for a plea in court, you have two choices. What are your two choices?” The threshold for fitness tests is called “low” in court, meaning that a basic understanding demonstrated without the use of legalese is sufficient to be deemed fit by the judge. However, this test is laden with assumptions.

There is inconsistency with the delivery of the fitness test. For example, the first Taylor test I witnessed was delivered in less than one minute and consisted of four questions, “What is the role of the Crown? What does duty do” – at this point I realized I had no idea what a correct answer might be. The questions continued with, “What does a judge do? “How might you plead to the allegations against you?” The accused answered as I might have, he stumbled through the first two questions and answered the last two questions fairly well. The language used (“Crown” and “duty”) is common in the Canadian legal system. They are short forms of Crown attorney and duty counselor. Crown attorneys are prosecutors under the auspices of the Attorney General of Ontario. Duty counselors are free, legal aid defense attorneys who unlike their private practice

colleagues do not move around from courtroom to courtroom following their clients but remain assigned to a specific courtroom and handle cases of accused who come to court without legal representation. The use of these terms in a fitness test assumes knowledge of the Canadian legal system. This discourse is not general knowledge in Canada, where television and movie depictions of law are often imported from the United States and to a lesser degree the United Kingdom. As a well-educated Canadian citizen, I had no recall of these roles from my school days in Ontario and Quebec. Given a few minutes to think about the answers might have helped with recall, but many of the accused in 102 Court, and many of the residents of Toronto (more than 50 percent) were born outside Canada. Their exposure to this specialized language might be significantly less than many people born and educated in Canada. Further, it assumes a strong grasp of the English language. Of 483 individuals I tracked in 102 Court over three months 7.4% (or 36 people) required the assistance of a court translator to understand the proceedings. There were 25 translators employed during this period who translated between English and French, Tamil, Arabic, Korean, Spanish, Punjabi, Telugu, Urdu, Farsi, Cantonese, Vietnamese, Tibetan, Tagalog, Mandarin, Dinka, Somali, Ethiopian, Indriya, Hungarian, Russian, Polish, American sign language, Croatian, Portuguese, and Hebrew. Of 63 fitness tests I recorded, 52 were performed among people fluent in English and 11 required a translator. The ratio of those deemed fit: unfit³⁷ among the English-speakers was 20:6 compared with a ratio of 5:6 among the non-English-speakers. These accused may or may not be Canadian-born although it is

³⁷ In some cases, numerous fitness tests were performed per individual. In this case, the final finding was employed in this calculation.

perhaps more likely in cases with other than francophone accused. If they were born outside Canada, their length of residency might impact the Taylor test results. Also, given the variation in languages translated and the possible variations of the legal systems in their home countries that might operate very differently from that of Canada, much more than mere word translation is required. It is impossible from these data to ascertain the quality of the translation³⁸, the length of residency of the accused, or the factors that might influence the differential in fitness test outcomes among English-speaking and non-English speaking accused. These findings relate directly to the legal literacy of the accused. The concept of legal literacy is variously defined but here I follow the definition of the Canadian Bar Association which is, “the ability to understand words used in a legal context” (Canadian Bar Association, 1992, p. 23). One court worker described the Taylor test as one of “understanding not knowledge”. By this she meant that textbook definitions of the role of court professionals was not required, but she failed to consider how different kinds of literacy and knowledge were required to pass the Taylor test.

The Taylor test is less a test of ability to meaningfully participate in your own defense than it is a test of Canadian assimilation and the acquisition of highly specialized language. It reflects “how legal thought, logic, imagery, and language symbolically reveal roots of [Canadian] intolerance (Arrigo, 2004, p. 206). Worse still, to fail the Taylor test launches an accused down a narrow path where outcomes become increasingly draconian as I will describe below.

³⁸ Although all court translators are certified to translate in the system.

Released on Bail

Many accused who are found fit are released from jail on bail³⁹. If an accused is not properly before the court, he will be remanded back to another court for processing of bail⁴⁰. But if the accused has a documented mental health issue that falls in the purview of 102 Court, and there is no question of fitness (or they have been found fit), bail is often arranged very quickly (sometimes the same day as their first court appearance) in 102 Court. As discussed, the alleged crimes of these accused are usually very minor, often described as “nuisance crimes”, so risk to the public is minimal. Negotiating bail conditions in 102 Court is collaborative, involving the Crown and defense, and the community contacts of the social workers. The conditions of bail are remarkably formulaic. There are four usual components even though each set of bail conditions is drafted to suit a specific accused and his/her alleged offense. First, a **specification of where the accused will spend nights**. This can range from going home to a shelter bed. For the many homeless clients of 102 Court, the social workers scramble to reserve a shelter bed in the community to facilitate release. This is particularly challenging for women accused because of the scarcity of Toronto community resources for women compared with men. Social workers might arrange one night of shelter then leave it to the accused to find herself ongoing accommodation. For

³⁹ This is often a \$500, no deposit bail meaning no money is needed, nor will the state ever attempt to collect the \$500 should bail conditions not be met. It is symbolic.

⁴⁰ This is the usual procedure, but there are exceptions where the personnel of 102 Court release someone who is not properly before the court. This seems more likely to occur when the accused has been bouncing around the criminal justice system for what seems an exceptional amount of time.

instance, one young woman reporting to the court as an out-of-custody accused was before the court and answering questions about where she was staying. She became agitated with the questions and rhetorically asked the duty counselor where he expected her to sleep. She was homeless, the shelters were unacceptable because the people stole from her, and she no longer qualified for detox because she was clean. Turning away from the judge and lawyers, she suggested that getting high might solve her housing problems, making her eligible for a detox bed. Secondly, bail conditions include a condition to **report back to 102 Court**, which includes meeting with a CRCT social worker. These reporting regimens are what draw so many out-of-custody accused to 102 Court every morning at 10:00 am. Typically, they first check in with their assigned social worker at CRCT, adjacent to the courtroom. Then they sit in the body and wait for their name to be called. They simply rise, greet the judge, collect a yellow reminder slip for their next reporting appointment and leave the court. Generally reporting regimens begin with frequent reporting that lessens as their compliance with reporting regimens and other aspects of bail are demonstrated. Third, **follow the advice of psychiatric practitioners and mental health care workers and sign any releases they require.** Having an psychiatric appointment (or promising to have one soon) is, like housing, a critical component of release. This is the “treatment” cornerstone of diversion, mandating medications and transparency among different kinds of providers. Psychiatrists are provided with court papers and evidence of attendance and adherence from the practitioner’s office will be expected. Not following the advice or refusing medications may become an additional criminal offense, thus obligating practitioners to

report such non-compliance. This fundamentally alters the doctor-patient relationship. Most accused I interviewed were well aware that their doctors were extensions of the law, including those who wanted the medications, tolerated the side effects, and felt better on medication than off. The descriptor “mental health care worker” ranges from the CRCT social workers and community-based social workers to psychiatrists. This accords authority to a group of people with a broad spectrum of education ranging from no university education to specialized medical training who concomitantly differ in autonomy and power. Many people adore their CRCT workers saying, “for some people, these people [CRCT social workers] are all they have” and describing them as “awesome”. However, their positionality as satellites of the law is recognized by accused and by the social workers themselves. If psychiatrists insist they take medications (whether they want to or not) and spend little time with them, the social workers are recognized as people who at least attempt (and often succeed) in securing resources and community connections for them, and this is very appreciated. Yet they remain, despite their good deeds, “court workers” as one man confused about ever meeting a social worker after months of meetings with court social workers told me. Finally, **avoid the context of previous alleged offenses**. Many of the nuisance crimes seen in 102 Court are perseverative, the accused commit the same offense in the same place over and over again. In some cases, if the offense was committed less frequently it would not likely be pursued as an offense. For instance, one woman was accused of calling “9-1-1” over 500 times in several weeks. The woman required a Russian language translator when she appeared in court and she did not seem to understand that dialing “9-1-1” was

not the appropriate route to seeking non-emergency medical attention. A young man repeatedly visited a high-end metro hotel, believing he was interviewing for a job with FIFA. His belief brought him to the hotel lobby multiple times per day, eventually annoying the security staff, leading to police involvement. Another example is the “dash and apologize” escapades of James, a retired British gentleman. By all accounts, James had led a successful and average life until a few years ago. He had been married for decades, was a father to now-grown children, and had retired after a long career in the corporate world. He was energetic, well-spoken, very polite, and friendly. He enjoyed pub lunches with a pint of beer and was well-known in several downtown establishments. However, James’ mental health seemed to deteriorate recently, his wife separated from him, and he began to go for lunch without money. The numerous times I saw James in custody, his story was always the same – he ordered and enjoyed lunch, but had “forgotten his wallet” when the check came. At first, pub managers slapped him on the back and said they would catch up with him next time. But James’ new behavior was very consistent and he would return again and again to the same pubs and restaurants. His wife insisted that he had access to adequate amounts of money; he just did not bring any with him to lunch. James was a favorite among the clerks of 102 Court and one said she wished he would just “dash” after the “dine” instead of apologizing for his forgetfulness to the manager, and avoid the arrest.

The personnel of 102 Court worked proficiently to release people from prison. Even when all these conditions were in place and the accused agreed to them, an “immigration hold” might delay their release. When a person who is the process of

immigration to Canada has a criminal charge leveled at him, immigration officials are notified and must review the file before release occurs.

Ordering “Treatment”: Coercive Pharmaceuticalization

A finding of “unfit” in 102 Court, triggers a series of forms, consultations, and processes with very limited possible outcomes. Sometimes defense lawyers may successfully argue that perhaps more time with their clients (to coach them) would help improve the chances of a subsequent finding of fitness. Because fitness is a test of the moment it may be repeated over and over and individuals may have numerous findings of fitness over the course of one day or over several days. Perhaps part of this patience and persistence on the part of defense attorneys⁴¹ is an understanding of the less-than-optimal consequences of being found unfit.

If an accused is deemed “unfit”, the Crown requests and is typically granted a form 48, the mental health court’s paperwork triggering consultation with a forensic psychiatrist. The judge signs the form and the accused will see the psychiatrist over the lunch break between approximately 1:00 and 2:00 pm. Any accused suspected of being unfit will, if possible, be screened with the Taylor test before the lunch break in order to streamline processing and make good use of the psychiatrist’s time over the lunch break. The accused meets with the psychiatrist for assessment of psychiatric well-being, diagnosis, and fitness. Meetings take place in various locations including (but not

⁴¹ I have witnessed both judges and Crown attorneys who ask whether more time with their defense attorney might render an accused fit to stand trial, effectively prompting defense to request additional time.

limited to) 102's holding cells or the offices of the CRCT staff. By most standards of assessment, these are very brief meetings ranging in duration between five and 15 minutes⁴².

Of the 372 men observed in 102 Court over three months, form 48s were issued in 33 cases (8%). Of these, 8 were white (24%), 15 were black (45%), 5 were Asian (15%), and 5 were other visible minorities (15%). This distribution differs significantly⁴³ from the distribution of ethnicities in Toronto according to census data. The frequencies among women were too low for statistical testing.

During the afternoon court session a fitness hearing is conducted during which the forensic psychiatrist takes the stand and testifies about the results of his meeting with the accused. The court clerk swears the psychiatrist in using either an oath or affirmation based on witness preference. Typically, the Crown begins questioning the psychiatrist about his meeting, his opinion of diagnosis and whether the doctor finds the accused fit or unfit as a result of the assessment. The defense attorney then cross-examines the witness, often asking him about the duration of the meeting and the specific questions asked and how the accused answered those questions. Typically, the opinion of fitness offered by forensic psychiatrists, as experts, is accepted by the judge regardless of defense's exposure of the brevity of the assessment. However, on one occasion during my period of observation, the forensic psychiatrist testified about the details of the questions and answers that formed the basis for her opinion of lack of

⁴² Forensic psychiatrists are sometimes asked about the duration of the meetings and all testimony I witnessed fell between 5 and 15 minutes.

⁴³ $\chi^2 (3, N=33) = 10.385, p<0.05$.

fitness. When presented with the detailed answers provided by the accused the defense submitted that he believed the accused should be found fit and the judge agreed, thus overruling the judgment of the doctor.

If the psychiatrist's testimony is that the accused is fit, the fitness hearing ends and the court will process the case for release from jail. But, if the psychiatrist assesses the accused as unfit, the Crown may (and usually does) opt to apply for a treatment order, which, if granted by the judge orders the accused to undergo mandatory treatment in a psychiatric hospital or the psychiatric unit of a hospital for a period no longer than 60 days. This order is based on the testimony of the forensic psychiatrist that the accused is likely to be rendered fit after the administration of antipsychotic medication.

Here fitness is reduced to a neuro-chemical imbalance, "treatable" with pharmaceuticals. It must be for this system to function. Variables with much more complex mechanisms such as cultural competence, language ability, or even the possibility that behaviors deemed symptomatic of psychosis might be intentional are theoretically recognized but rarely successfully invoked by the defense. For instance, muteness and not meeting the gaze of an assessing psychiatrist may be evidence of distraction due to voice-hearing or they may be intentional acts of non-cooperation by people experienced in poor treatment by those with authority, especially those associated with the criminal justice system. One psychiatrist testified that an accused she had just assessed was wearing a hoodie, which she interpreted as "isolating". This

was accepted though it is common knowledge that the all-metal cells are frigid in the winter.

Treatment orders, where accused are sent either to a psychiatric facility or unit, are laden with the benevolent language of healing and help. They are orders of “treatment” administered by “doctors” in “hospitals”. The psychiatric testimony always includes, sometimes in response to the Crown’s queries, a statement that in their expert opinion the treatment with antipsychotic pharmaceuticals (often named specifically during the testimony) is the “least invasive” method to render the accused fit to stand trial. Voluntariness is suspended here; the cooperation of the accused is irrelevant because if they refuse “treatment”, antipsychotic drugs will be administered by injection, while physically restraining the accused if needed. Ironically, for the loved ones of accused who witness these hearings, many are so relieved to hear their family members will receive “treatment” that they believe this is a benevolent judicial response to their loved one’s suffering. Defense attorneys are openly aware of the coercive and “draconian” nature of this “treatment” and are quick to disabuse client’s relatives that treatment orders are necessarily a good thing. Treatment orders, when first implemented in the court were most often requested by defense attorneys. But increasingly and unsurprisingly, it is the Crown attorney who will request treatment for an accused as it is an operationalization of the court’s bio-power (Foucault 1976) and an avenue towards neuro-chemical restraint and surveillance.

Defense attorneys rarely contest these draconian orders. Some told me that to ensure the best outcomes for their mentally ill clients before the court, it was important

to “play nice”, be cooperative, and follow the well-defined and streamlined processes that see accused move rapidly from a finding of unfit to involuntary treatment. If they did this, Crown attorneys, the gatekeepers of the court, might be more inclined to consider other clients for the court in the future. Other defense attorneys seemed to genuinely believe that treatment orders were exactly what their clients needed. But some attorneys took advantage of opportunities to contest the request for a treatment order although their efforts were seldom successful. It was their belief that by amassing the paperwork of protest could, with enough time, cases, and paperwork change the system.

Women were sent on treatment orders more frequently than men. Of the 483 people observed, 19 men (5%) and 10 women (9%) were sent on treatment orders. While female accused made up 23% of the accused I observed, they account for 53% of the treatment orders executed. Taken together 29 treatment orders were issued or treatment was ordered for 6% of accused.

Dance of Responsibility: The Problem of the Seriously Mentally Ill

Bed shortages are a chronic issue for Ontario hospitals and having a legal obligation to provide a bed for an extended period of time (but no longer than 60 days) has a number of implications. The accused of 102 Court and similar mental health courts in the province must be triaged *faster* than the general public due to court order. Jumping the queue may be a point of criticism, with the recognition that people suffering from mental illness not in trouble with the law have medical attention delayed due to

those who are in trouble with law. Of course, the counter-argument is that trouble with law is not a reflection of character or criminality per se, but a symptom of increased mental health severity, making their faster triage appropriate. Also, some parents of mentally ill adult children leverage this ability to jump the queue to access services faster. This has unintended consequences for families. For example, parents sometimes call the police to come to their homes due to the behavior of their adult children. They do this knowing that when the police are involved, authorities will need to intervene. They are very quick to label their children schizophrenic or bipolar hoping to temper the response by police and fast-track their children to mental health services. However, when a criminal act has occurred at a specific address or is directed at a particular person, say a parent, the conditions of release are very likely to include no contact with the alleged victim and place of the criminal act. This effectively cuts accused off from their family and their parents' home, sometimes rendering an accused homeless.

Friction between the courts and the hospitals can result from the treatment order process. Once a treatment order has been signed, a bed must be located often days or weeks away. Representatives from the Centre for Addiction and Mental Health who specialize in locating and reserving appropriate beds throughout the province come to court daily in order to provide the court with the date and facility name that will be part of the treatment order paperwork. The paperwork and accused will remain in jail until the date specified on the order to transfer them to the named institution for treatment. This delay must be deemed "reasonable" by the judge, but the definition of reasonable is not specified in the criminal code and case law and there is therefore room for various

interpretations of “reasonableness”. I am certain that all judges that preside in 102 Court are well aware and variously sympathetic to bed shortages in the province. But, ruptures in this sympathy are also evident. Some judges, when presented with the dates that beds are available, will find the delay “unreasonable”, triggering events that lead cases to higher courts for resolution. This is the process of 102 Court where the tensions between courts and healthcare providers regarding responsibility is most evident. Schneider et al. (2007) have written that 102 Court is an attempt to ensure that mentally ill accused are directed back towards the appropriate social institution, namely medicine, and away from the criminal justice system, but the Canadian Criminal Code⁴⁴ does not authorize the courts to direct health care institutions to admit people, complicating the dance of responsibility.

Finally, when treatment orders are executed the beds that are available may be local, (in Toronto), but they may also be in various other Ontario cities including Ottawa and North Bay (at distances of 352 kilometers and 292 kilometers, respectively). Timely availability of appropriate beds is the primary concern here, but if an accused has family or other social support in Toronto, the distances to other locations and the many costs of travel (transportation, accommodation, childcare or eldercare, loss of wages, etc.) is often prohibitive for loved ones. Sometimes the communication between lawyers and families is less than optimal⁴⁵, leaving parents⁴⁶ very confused about the system that

⁴⁴ Section 672 pertains to mental health law and the role of the court

⁴⁵ Defense attorneys are under obligation to their clients, of course, and therefore, are not required to speak to family members. Also, it is sometimes the case that an accused may forbid his/her lawyer from speaking with his social supports.

⁴⁶ I interviewed three parents of accused. They were all parents of adult accused.

their son or daughter is being processed through. For instance, I met Vera early on in my court observation. She, like me, spent day after day observing the proceedings, and waiting between sessions in the hall outside 102 Court. Vera, born in Guyana, had immigrated to Canada with her young family decades earlier. She was 77 years old, walked with a cane, and was very worried about her youngest son, whose case was passing through 102 Court. My time in 102 Court overlapped with Vera and her son's only at the end of his court time. He was found NCR (not criminally responsible) and remanded to the ORB (Ontario Review Board) indefinitely. However, Vera who said she faithfully attended all her son's court dates despite her mobility issues and the slippery winter streets was very confused about where he was and what that meant. After many days of sitting next to one another, she leaned over and asked what I was doing in the court every day. I explained my research to her. She paused and asked, "So you're an expert on this court". I denied being an expert, but she was satisfied with her assessment and asked if I knew what "CAMH" meant. She said her son had been "in the CAMH" for months but she did not know what it was, where it was located, or what was happening to him there. I explained that CAMH was the Centre for Addiction and Mental Health, a Toronto hospital. She was happy he was no longer in prison but being "helped" in a hospital by doctors. I knew he had been on a treatment order and did not explain the veiled discipline and coercion of the order to her. After all, the treatment order was over by then. Vera was surprised that CAMH was located so close to her home and that she could have been visiting him for months. She asked if I knew the contact number for CAMH and I promised to call her that evening with a telephone

number. When I called she asked if I might act on her behalf with CAMH staff because she did not know what to ask them. I declined but I did pass her story on to the social service workers of the court-affiliated CRCT. When I described Vera's confusion, their representative became defensive, claiming their door was always open to help families of accused. This may be accurate in many cases and in theory, but it assumes a degree of knowledge of the system, how various professional roles and institutions overlap, and a degree of extroversion or social confidence that Vera did not possess.

I also met Rudy in the body of 102 Court. He was a regular in the court waiting for his son's case to be called. His son had been on a treatment order and was "eligible" for NCR⁴⁷, but was fighting this ruling and wished his case to be returned to the regular stream of justice. As a result of this legal course, the case came regularly before the court and I became friends with Rudy. Rudy was an older man who was born in Guyana and had lived in Canada for 30 years. He was a street preacher who lived roughly 40 km northeast of the city in an outlying suburb. He was always present in 102 Court when his son was on the docket, but it involved hours of travel by bus on two separate bus systems to get to and from the downtown court. Because his job was very flexible he could be in court whenever his son needed him. After a few appearances while in custody, his son was released on a surety bail, with Rudy as his surety. This meant that his son would live with him and he (the son) was instructed to follow Rudy's rules and advice. If the son failed to do so or in any other way violated the rules of his release,

⁴⁷ This is the language of NCR in 102 Court. Being found not criminally responsible may lead to indefinite detention, yet the common language used to frame NCR implies it is a welcome privilege for an accused.

Rudy was obligated to report his son's transgressions to the court. Rudy's failure to do so could result in criminal charges. Rudy accepted these conditions and his son went home with him after spending months in detention in both jails and hospitals. One of the conditions of his release was to continue to take injectable antipsychotic medications⁴⁸. Rudy was dedicated to his son and did not want me, the court personnel, or anyone else to "think badly" of him. For this reason, it took months before Rudy shared with me that he was having a very difficult time with the "house arrest", as he described his role of surety. He desperately wanted the conditions of release changed, to ease the pressure on him and the tensions of living with his son, but the defense attorney was his son's lawyer and did not take direction from Rudy, so another day in court did not result in a request to withdraw surety. He says he is "so tired" of him. His son is having nightmares about being watched even though he is on medication. Rudy says he is behaving as if "he's on something" but has found nothing in the house to support this. He bullies Rudy and Rudy is having trouble controlling his actions. The son wanders off, they argue regularly, and Rudy reluctantly admitted that he was afraid of him.

Into a Zone of Exception: Remand to the Ontario Review Board (ORB)

The most serious outcome if an accused remains unfit to stand trial after they have been on a treatment order is remand to the Ontario Review Board (ORB). Remand (or being ordered) to the ORB indicates that a person will be sent *indefinitely* to a forensic psychiatric unit of a hospital.

⁴⁸ Which was read aloud in court officially as "follow the direction and advice of your psychiatric practitioner".

Each case is reviewed at least once per year to determine if they may be eligible to face their charges⁴⁹, in other words, if they have become fit to stand trial. If the ORB deems them fit to stand trial, they return to 102 Court to re-assess fitness and proceed to bail. However, it is not unusual that the end result is detention in a psychiatric ward for years for alleged offenses as minor as mischief or theft of a bottle of water from a convenience store.

Of the 483 people (men and women) observed over three months, 12 (11 men and one woman) were remanded to the ORB. While this number is too small to reliably test significance, it is disturbing that 8 of the 12 (67%) people remanded to the ORB were visible minorities. This concern was echoed by several defense attorneys who shared concerns about racial and gender biases with ORB procedures. I spoke with a forensic psychiatrist who worked at one of the psychiatric facilities that people from 102 Court were admitted to following a finding of not criminally responsible. He spoke of the racism he witnessed in the facility. He had a patient who had been “detained”⁵⁰ at the hospital under the auspices of the ORB since 1988. The patient was black and accused people in the hospital of racism. The psychiatrist said that he complained so loudly and regularly of discrimination that he was labeled “aggressive and uncooperative”, which perpetuated his detention. A lawyer who regularly attended the ORB hearings about whether to release accused said that she was struck by the number of black women being detained in psychiatric facilities who were denied release because they were

⁴⁹ There were 1,622 accused under the jurisdiction of the ORB in 2010-2011 (Simpson 2011).

⁵⁰ His word

deemed “aggressive”. Further research is warranted concerning racial disparity among people detained under the auspices of the ORB.

What Happens to “Bad” Legal Subjects?

The case of Mark⁵¹, a university student, is an example of the injustices of being a “bad” legal subject before the court. Mark was arrested for mischief and assaulting a police officer⁵² in Spring 2010. He was released from jail, but failed to report to the bail program as required, incurring further charges. He was re-arrested and found his way to 102 Court in custody during the winter of 2012, where I first saw him. He was a trim, young black man. His case was at first unremarkable. He appeared one cold morning in a flurry of in-custodies. He was found unfit, was assessed by a forensic psychiatrist over lunch, who later testified he was unfit. For Mark’s part, he was completely uncommunicative in court. The second day he appeared and remained silent except for a brief outburst in French. The court officers were leading him out of the box and into the cells when he yelled, “Trois cent soixante et un avenue l’Universite” [361 University Avenue]. The judge yelled, “stop” to the court officers. Having just been found unfit to stand trial, he had yelled out the address of the Superior Court of Justice in Toronto. The judge asked rhetorically if being francophone was equivalent to being unfit. The judge was visibly annoyed and spoke briefly in French to the accused. On the third day, a treatment order hearing was held before a different judge without a French translator

⁵¹ To ensure Mark’s anonymity, all identifying features about this case have been changed slightly.

⁵² Assaulting a police officer covers a spectrum of behaviors from attempting to hurt an officer to struggling during an arrest.

despite the previous day's events. He was brought into the prisoner's box and presented very differently than he had before. He looked around the courtroom and he clutched a folded piece of paper in his hands. A second forensic psychiatrist took the stand (the first had testified to his fitness the previous day⁵³) to offer evidence in support of the Crown's request for a treatment order. He testified that he had met with the accused but that he [the accused] had refused to speak with him. He offered that he had been wearing a hoodie, evidence of isolating behavior, and concluded that he was unfit to stand trial⁵⁴. Formulaically, he said that the least invasive treatment to render him fit to stand trial would be injectable antipsychotic medication and anti-side effect medications including anti-Parkinson's medications. But the defense argued that the Crown had not demonstrated that the accused could be made fit within 60 days, and therefore the treatment order should be denied. Once again, the duty counselor asked the accused the Taylor test questions for fitness. This time, Mark spoke but did not answer the questions asked. Instead he asked in English and French for the matter to be returned to Superior court. He named justices (accurately by the reaction of court personnel) who worked at 361 University Avenue. He asked the judge to read him his charges. He said no one had done so yet. The judge complied and began skimming the list. Mark reached his arms through the circular speaking hole in the plexi-glass prisoner's partition and palms up he entreated the judge, "verbatim". He read him all the details of his allegations. Duty argued that because of his accurate recall of judges'

⁵³ Recall that because fitness is a test of the moment, it may be administered over and over and the result may change moment to moment or day to day. The repetition of a fitness test described in this case is common in 102 Court.

⁵⁴ It is not unusual for fitness to be tested repeatedly in a short period of time.

names and his demonstrated knowledge about arraignment practices, that fitness should be re-assessed. Repeated attempts to establish fitness by the duty counselor failed. Duty had a brief (less than five minute) sidebar with his client after which Mark answered the Taylor test questions accurately, quickly, and confidently. The Crown jumped to her feet and demanded to know why Mark had not answered these questions earlier. Even as a spectator the length and circularity of this questioning was frustrating, so her reaction is perhaps understandable but it is inconsistent with the nature of the Taylor test as a test of the moment. Mark seemed to not understand her question. The judge also asked why he had not answered the questions earlier. Looking confused, he asked the court reporter to read back what had just transpired. Mark was found unfit, and angrily accused the judge, whom he addressed by name, of bias based on her previous work with the police as he was being led into the cells. Mark was sent on a treatment order and returned to 102 Court two months later, found fit, and released on bail. But two weeks after that (mid-April), he had failed to report as required by his bail, and was re-arrested with another charge. By this time a June trial date had been set but the Crown attorney was concerned that he would not remain fit until his trial date in the regular stream. Despite her concerns, he was released on his own recognizance and asked to report to 102 Court every Friday. For Mark, between Spring 2010 and September 2012, his problems escalated, his charges increased, he was arrested numerous times, medicated involuntarily, and his legal problems had not yet been resolved. It was unclear if he was more comfortable in English or French, further exacerbating his problems.

Approaches to Defense

In the dance of responsibility evident in the processes of 102 Court, the role of defense attorney stood out as particularly important. Some accused had private attorneys, others were represented by duty counselors, but it seemed that people who had been swirling around the system in the revolving door of 102 Court had found private representation⁵⁵. Defense attorneys may have more power to influence outcomes than is immediately obvious. An informant within the Centre for Addiction and Mental Health explained to me that if a defense attorney seeks a finding of fit or unfit for their client, they schedule their client's appearance on days when specific forensic psychiatrists will appear in 102 Court because there are patterns of psychiatric diagnoses that are more related to the psychiatrist rather than the symptoms of an accused. I got to know several defense attorneys over the course of my ethnographic work. I describe below two of the approaches of private defense attorneys and the variations that may impact outcomes for clients.

One defense attorney, Peter, was very regularly in 102 Court. He was a very likable man and many accused (both interviewees and people I met doing research in the court) mentioned him as a wonderful lawyer. He was one of the first people who asked me about my work in the court and towards the end of my fieldwork he stopped me in the hall to talk. He said he had never seen anyone so dedicated to observing the court and asked me to have lunch with him to hear more about the study. Peter had

⁵⁵ Private attorneys were likely being paid as legal aid lawyers. Law firms must provide a certain percentage of work as legal aid. They may opt to increase that kind of work, but it will earn less money than regularly billable work.

started 20 years earlier as a duty counselor but had quickly gone into private practice. He was, perhaps as one might expect, very well-spoken, with carefully chosen phrases. He described his clients as “indigent, vulnerable, and poor” who he regarded as “more than mentally ill”. He appreciated the intractable and chronic nature of their problems, although it was unclear if he was referring to their mental health problems, their legal problems, problems associated with poverty, or some combination thereof. He said that because his practice consisted of mentally ill accused, it pays much less and takes more time (he often works nights and weekends – the only times when he can focus) but the work is more interesting to him. He confirmed (what other lawyers had told me) that working cases involving the seriously mentally ill often lasted much longer than other lawyer-client relationships⁵⁶. Peter felt that he could have greater impact in his clients’ lives with the extended case period.

Peter, like other attorneys I spoke with, made a distinction between individual cases and the “big picture”. As a young duty counselor, with no trial experience, he did not appreciate the big picture as he does now. He described a grey zone between the letter of the law and normal legal practices, an elaborate chess game that needed to be strategically negotiated in the best interests of clients. For instance, there is a plethora of approaches to following client instructions (and respecting their autonomy) and offering them advice about how best to navigate the system. He cited a fair amount of

⁵⁶ There is a financial disincentive to work with the seriously mentally ill accused because legal aid only pays for a case once it is resolved. So if these cases last longer, lawyers put in more work before being paid for it. More work per case means fewer cases overall, which also negatively impacts revenue. This is in addition to the lower wage they are paid for legal aid work.

paternalism in the system and admitted that as a younger lawyer, he told his clients what to do. Of course, this implies that he also decided what was “best” for them.

He said the spirit of the Canadian criminal code dedicated to mentally ill accused emphasized their autonomy and their choice to access the regular stream of justice, and hence the adversarial stream. In his experience, some accused benefit from the adversarial process, from telling their story and having someone weigh their story equally with the story told by the crown attorney and police. It is ironic that the regular stream of justice, not 102 Court, offers a platform for an accused to tell their story and have it considered equally (at least in theory) as that of the prosecution. The power differentials of 102 Court, and specifically the unquestioned authority of psychiatrists, rendered the story of an accused irrelevant at best and a symptom at worst.

Peter was well aware of critics of mental health courts who complained of the intense surveillance of the accused by the court, but the surveillance was a fair trade for him because he said, many accused would likely “never get bail in the regular stream”.

Peter was one sort of advocate for accused and perhaps the most obviously passionate I encountered during my field work. He looked at accused as *people* and individuals and advocated for them as they navigated the criminal justice system. He actively wrestled with ethical concerns about autonomy and paternalism and iteratively tweaked his practice to reflect what he considered best practices. Peter referenced the “big picture” but there were attorneys who approach best practice from an even more macro lens and with different goals.

Marian, another defense attorney in private practice, seemed to be one of the most competent lawyers I witnessed in 102 Court. So, I was shocked when she sat down next to me in the hall one day and started a conversation by saying she was not always sure what defense counsel was supposed to do. “Was it to help?”, she asked, then quickly answered, “No, it isn’t”. In her opinion, mentally ill accused were as entitled to make poor decisions as other clients. However, she admitted she spent a considerable amount of time trying to talk her clients out of stupid choices. She reminisced about a conversation she had with a psychiatrist in the late 1980s. “Why”, she asked “was the criminal justice system (and the NCR finding) the preferred route to deal with seriously mentally ill people who need ongoing hospitalization compared with the civil commitment route. Her question juxtaposed the forensic and civil commitment processes. This dissertation focuses on the forensic route, but there are other avenues in Ontario through which people come to inhabit psychiatric facilities or wards on a long-term basis. The civil commitment process is governed by the Ontario Mental Health Act. Although the outcomes may be quite similar between these two routes to commitment, the forensic system including 102 Court produces medical-legal subjects (or forensic subjects) who never lose the legal aspect of their identity, whereas the civil commitment route produces medical subjects only. Legal professionals remain part of the power hierarchy that determines outcomes for forensic subjects. For instance, when an accused is considered for release from a psychiatric institution, a hearing is held that is presided over by psychiatrists, crown attorneys, judges, and defense attorneys. This is

the composition of the Ontario Review Board⁵⁷ [ORB] that manages and oversees the disposition of accused detained in psychiatric facilities or wards after they have been found not criminally responsible for their crimes⁵⁸. Marion posed this question about the route to psychiatric detention in the late 1980s to a psychiatrist. The psychiatrist's answer was that the NCR route enabled people to be "treated". Of course this is a recollected conversation from decades earlier, but it impressed her sufficiently to bring it into our brief conversation that day. One of the main differences between these two routes to commitment concerns consent⁵⁹. There are a series of safeguards regarding consent for treatment that are part of the Mental Health Act and may delay the administration of pharmaceuticals compared with the practices possible with a finding of NCR. Marion summed up our conversation with her opinion that the commitment route through a finding of NCR may be considered treatment, but is "coercive".

The agendas, motivations, and approaches of defense attorneys impact outcomes in 102 Court. The attorneys I met who wanted to speak with me knew my interest was understanding 102 Court from the perspective of accused and this may have influenced who chose to get to know me and how they framed discussions with me. But, as I illustrated above, many factors go into what may be a client's best interests, impacting an accused's experience as well as legal and medical outcomes.

⁵⁷Psychologists and public members appointed by Lieutenant Governor in Council are also part of the composition of the Ontario Review Board (Ontario Review Board, 2011).

⁵⁸ In order to be found not criminally responsible for a crime, the accused must plead guilty.

⁵⁹ And may or may not be what the psychiatrist meant by "treated".

Bio-power and Subjectivation in 102 Court

To conclude this chapter I turn to Foucault's concepts of panopticism (Foucault, 1977) and bio-power (Foucault, 1976) and bio-power's expansion by Rabinow and Rose (2006) discussed in Chapter One. First, 102 Court is a strong example of bio-power at work. Recall Rabinow and Rose's three characteristic elements of bio-power which have been discussed above: truth discourses and the authorities who are deemed competent to speak them; strategies for intervention aimed at an emergent biosocial population in the name of health or life; and a form of subjectification in which individuals are called upon to self-govern (Rabinow & Rose, 2006). The truth discourses most clearly in effect in 102 Court involve the diagnoses and testimony of forensic psychiatrists. Their testimony is routinized and often exactly matches the passages of the Canadian criminal code that relates to mental health law. Even when they admit no background information and a brief period of assessment they are able and do make recommendations that might include involuntary pharmaceutical administration or indefinite detention under the auspices of the Ontario Review Board. The emergent biosocial population of concern to 102 Court is the non-violent mentally disordered accused. Foucault's idea of bio-politics includes the identification of problem populations within society and the targeted regulatory techniques that might protect the whole from this internal threat. In some ways, this protection of the social whole from a pathological sub-population is very clear. The crown attorney's job is to weigh the good of the public against the rights of the individual. More subtly, 102 Court regulates the mentally ill accused, streamlining their interactions with state institutions like jails and hospitals to

increase efficiencies that benefit everyone. The subjectivation processes of 102 Court stress that court is envisioned as a therapeutic agent in accordance with the principles of therapeutic jurisprudence. However, in practice 102 Court remains an agent of discipline (as traditional courts are) and *becomes* an agent of regulation that employs neuro-biological authority, pharmaceutical technologies, and rationalizing medical discourses to silence, isolate, and otherwise render the accused invisible to the general public. Foucault tells us that disciplinary mechanisms produce docile bodies and regulatory mechanisms insulate society from risky internal abnormalities. The bio-power of 102 Court insulates the public by rendering the accused docile. It is a suturing of anatomo-political and bio-political powers.

The truth discourses articulated by forensic psychiatrists parrot the Canadian Criminal Code but their authority as therapeutic professionals rationalizes and de-politicizes even the most draconian treatment orders before the court. Rabinow and Rose (2006) discuss the possibility that these truth discourses may not be purely biological. This is seen in the hybridization of forensic psychiatric discourses that present psychotic symptoms as manageable, physiological, while framing the accused as de-contextualized, under-medicated symptom clusters and pharmaceutical interventions as “magic bullet⁶⁰” solutions. The authority of the forensic psychiatrists is shocking. Recall the interpretation by one psychiatrist of isolating behavior by an accused who was wearing a hoodie. Discourses and practices revolve around the merged concerns of risk management (risk of harm to self and society) and its

⁶⁰ The “Magic bullet” model of medicine is basically to discover the cause of a disorder and develop a treatment to counteract it (Whitaker, 2010).

moderation through pharmaceutical technologies of self. Diversion through 102 Court, is, after all, a “voluntary” endeavor, where accused are threatened or punished through criminal sanctions for withdrawing their cooperation if that takes the form of missing court or non-compliance to a medication regimen. This reflects Rabinow and Rose’s (2006) modes of subjectification (Foucault, 1994; Rabinow & Rose, 2006) through which individuals are brought to work on themselves. Accused are encouraged (some might say coerced with promises of stayed or withdrawn charges) to embrace their sick selves and take the medicine that will make them better (citizens). In the next chapter dedicated to the perspective of the accused, Big Al’s experience of 102 Court is exemplary of a person who has embraced these self-governing modes of subjectification.

Chapter Three: Exploring the Experiences of Accused

“the unwanted and scared, the outcast” (Rudy, father of an accused, describing his adult son)

“we’re people too” (Big Al, former accused with schizophrenia)

A critical analysis of 102 Court demands attention to its impact on the lives of accused from their own perspectives. There are several approaches that might accomplish this goal, but I have chosen a phenomenological approach. This chapter is focused on the theoretical background of the method used, an exploration of the experiences of nine accused who have successfully completed diversion in 102 Court, and the meaning of those experiences for them. I followed an established methodological framework (Smith et al., 2009), so the discussion focuses on the philosophical ideas that most informed the method of Interpretative Phenomenological Analysis (IPA). As introduced in the first chapter, IPA has three theoretical axes: phenomenological, hermeneutical, and idiographic and I will focus this discussion more on the phenomenological and hermeneutical axes and less on the idiographic. This approach is theoretically rooted in aspects of phenomenological philosophy first elaborated in the nineteenth century by Husserl and his one-time assistant Heidegger⁶¹ and their intellectual legacies.

⁶¹ Heidegger’s work is based on Husserl and while there are numerous examples of phenomenological work, Heidegger’s conceptions are central to my approach.

Phenomenology in Social Science and Social Work

While most phenomenology can trace its intellectual roots to Husserl and Heidegger, phenomenology has influence beyond the purview of philosophy and is recognized as a major qualitative approach in social science research (see Creswell, 1994). As Zahavi (2008) succinctly puts it, “by presenting a detailed account of human existence, where the subject is understood as an embodied and socially and culturally embedded being-in-the world, phenomenology has provided crucial inputs to a whole range of empirical disciplines including psychiatry, sociology, literary studies, architecture, ethnology, and developmental psychology” (Zahavi, 2008, p. 662).

Both social workers and anthropologists have leveraged this body of work for their own purposes. However, the IPA method of Smith et al. (2009) was first established in the area of health psychology (for a review see Brocki & Wearden, 2006). It is suitable for a range of research approaches and topics including health and illness, psychological distress, and life transitions and identity (Smith et al., 2009). For example, IPA’s idiographic commitment makes it a good choice for in-depth case studies (of one person or a small number of people) common in psychology and health studies. IPA was used in studies that explored the personal experience of various health conditions including chronic fatigue syndrome (Arroll & Senior, 2008), chronic back pain (Smith & Osborn, 2007), and multiple sclerosis (Borkoles, Nicholls, Bell, Butterly, & Polman, 2008). IPA has been used in studies of psychological distress from the perspective of sufferers such as Howes, Benton, and Edwards (2005) study of six women with

traumatic brain injury. Kam and Midgeley (2006) explored the perspectives of five mental health professionals who make decisions about referring children for psychotherapy. IPA has also been adopted for user-led⁶² investigations such as the work by Pitt, Kilbride, Nothard, Welford, and Morrison (2007) who explored the experience of recovery from psychosis. Four in-depth interviews with young people who had experienced homelessness formed the basis for an analysis of identity in a study conducted by Riggs and Coyle (2002).

Phenomenology and subjectivity have long been of interest to anthropologists and can be traced back to the work of Boas and the Boasians in the American tradition. Hallowell (1955) explicitly theorized cultural phenomenology and many followed in this intellectual trajectory. Geertz, for instance, used phenomenology to explore subjectivity in various parts of the world and was dedicated to using phenomenology in his work (see Good 2012). Phenomenological anthropology continues to enjoy favor with some anthropologists. Csordas (1994) has written about experience and embodiment. Corin and Jenkins are anthropologists whose work is in this tradition and whose research interest is in mental illness. Both have done work on the experience of schizophrenia (see for instance Corin, 1998, Jenkins & Carpenter-Song, 2008). Jenkins' interest in the lived experience of voice-hearing remains strong (Jenkins, 2012).

Medical anthropologist and former Geertz student Byron Good has recently written of his frustration with phenomenology as a theory of subjectivity, particularly the inability to explore what is hidden (Good, 2012). He takes cultural phenomenology to

⁶² User-led research refers to studies where service users control all stages of the research process (Rose 2003).

task for failing to deal effectively with complex psychological experiences and political subjectivity, two intellectual threads that recent studies of subjectivity have fostered (Good, 2012). A recent edited volume on subjectivity with contributors primarily working in anthropology rejects phenomenology (and other singular analytic frameworks) as sufficient to account for the inner world and the intersubjective relations that constitute subjectivity (Biehl et al., 2007). There is a tremendous amount of cross-disciplinary phenomenological work with psychiatrists relying on cultural phenomenology in their work and phenomenological anthropologists drawing from various philosophical sources for their theorization.

Social workers have employed phenomenological approaches in both research and clinical interventions. Black and Enos (1981) argued that phenomenology was particularly well suited to operationalize as clinical intervention. They were interested in innovating a self-reflective poetic intervention and used the philosophical underpinnings of phenomenology as their validation for doing so (Black & Enos, 1981). A recent dissertation by Tara Earls Larrison (2009) explored the professional use of self in pedagogy and practices of social work education. A person-in-context approach and a client-centered perspective both implicitly incorporate phenomenological concepts, but are perhaps under theorized in social work. Wherever social work overlaps with thinking in sociology and psychology, where experience is theorized and prioritized one can find phenomenological approaches.

There are only a handful of studies that apply any sort of phenomenological approach to studies of legal processes. Notably among these, is a Swedish study that

employed IPA to explore the experiences of sexually abused children with the legal process (Back, Gustafsson, Larsson, & Bertero, 2011). My rationale for choosing interpretative phenomenological analysis as a method is, in part to leverage the close disciplinary thought between psychology and social work to begin to think about connections between the more theoretical aspects of phenomenology and subjectivity and the practice and research of social work.

Method: Interpretative Phenomenological Analysis (IPA)

The phenomenological branch of this research was designed to utilize Smith et al.'s (2009) interpretative phenomenological method. I selected this method and designed this part of the study accordingly not just because it helps me organize and analyze data but also because it offers some overlap between phenomenological analysis familiar to anthropology and phenomenological methodology increasingly recognized and utilized among health professionals (Smith et al., 2009). Also, by using an established protocol, I have been able to share preliminary results with researchers who share methodological and/or substantive interests and discuss possibilities for future collaborations.

As a method IPA demands studying a small number of people through prolonged engagement to develop patterns and relationships of meaning. Smith et al. (2009) acknowledge the difficulty in determining sample size, which may vary, based on the level of commitment to individual case analysis, the richness of individual accounts, and structural constraints. They recommend a sample size of three for most undergraduate

and Master's studies and more complexity (rather than increased sample size) for the doctoral level researcher (Smith et al., 2009). Following their recommendations, I will present detailed excerpts from four individual interviews, emphasize a comparison between two "success stories" of 102 Court, trace the key similarities and differences among accused, and augment the discussion with data from the other five interviews with accused and courtroom ethnography.

Purposive sampling was used to recruit participants and selection was based on referral from community contacts, opportunities that arose due to the extended period of participant observation in and near 102 Court, and snowballing wherein accused would introduce me to another accused they thought might wish to participate in this study. I used what I came to think of as "passive recruitment" among potential accused I met through opportunity or snowballing. I waited until a person approached me and engaged in a reasonable conversation about the court and my role there. I never mentioned reimbursement during my initial contact with accused, opting to wait until, as a clinically trained social worker, I deemed a person consistent, logical, and appropriate enough to discuss research with. For some accused, voices are so prominent it is very difficult to converse and focus. I was seeking the most successful and stable 102 Court participants, and extreme distraction and an inability to focus were exclusion criteria.

IPA demands a homogenous sample, although the precise interpretation and operationalization of homogeneity varies from study to study (Smith et al., 2009). In this case, all participants were adults who had passed through 102 Court as accused. Nine

accused consented to participate in this study⁶³. The accused had all been diagnosed with a mental health problem that featured psychosis and had been accused of a minor crime within Toronto. The accused had all completed diversion through the mental health court. Of the participants, eight were male and one was female. Six men were white of various ethnic backgrounds, one was of black Caribbean descent, and one was a sub-Saharan African immigrant. The one female accused interviewed was white, originally from Canada's East Coast. The two most common diagnoses among this group are schizophrenia and bipolar disorder (Dinshaw, 2010). This study did not enquire directly about diagnoses and there was no triangulation of diagnostic claims made by participants. Although not everyone who appears before 102 Court is involved in diversion, everyone who participated in the phenomenological arm of the research had been in diversion within four years of participating in the study.

Diversion may occur at the behest of the arresting officer(s), pre-trial, or post-trial. For the purposes of this study, only survivors who have completed the pre-trial and trial processes were considered for participation. This means they were no longer in custody; they had been released and were living independently in the community, and were returning for report (or had completed the reporting process) to 102 Court. Only persons formerly processed through the TMHC who had been released to the community and not classified as prisoners under Canadian law were considered for inclusion.

⁶³ All formal recruitment occurred in May, June, July, and August 2012 after the University of Michigan's board of review approved this study and sufficient time had passed for accused and professionals associated with the court to trust me.

Two men were referred to the study by community social workers that considered them success stories of the court. Relationships with the remaining seven participants developed over the course of my eight-month participant observation of the court. I met these seven people during their reporting phase of diversion, either in the courtroom, in the hall outside 102 Court, in the area around the courthouse, and in the case of one man, along my daily walk from my apartment to the courthouse where I would pass his regular panhandling corner.

Interviews with three of the nine accused occurred in just one sitting. Two of these accused were referrals from community social workers that had long been away from the courthouse. They agreed to participate but with the condition that I did not know their names. I had no means to conduct follow-up interviews and knew that would be the case before the interview began. All interviews were held in public spaces. Adjacent to the Toronto courthouse is a large urban mall, numerous cafes and public squares. They are busy, heavily trafficked areas that are so public they offer a modicum of privacy. Upon consent from participants, one of several locations was selected and interviews occurred in public squares, the mall food court and several nearby coffee shops depending on the interviewees coffee preference (Tim Horton's, Timothy's, or Starbucks). One interview lasted so long (more than four hours) that we walked and talked. While this made note taking more challenging, it put the interviewee at ease. All participants were compensated \$20 for their time⁶⁴ before the interview began. Two of

⁶⁴ All but one participant insisted on buying me coffee with this money despite my protests.

the nine interviews were audiotaped⁶⁵, but one was cut short after approximately one hour when we began walking through a busy, loud mall. I continued to take notes as I walked. Notes were taken during all interviews including those that were electronically recorded. Interviews with accused spanned one to five meetings per person and were roughly 10 minutes to 4+ hours in duration.

Bracketing

Following from Husserl's phenomenological attitude, bracketing, or setting aside our taken-for-grantedness is an ongoing process through IPA. Bracketing is a form of reflexivity about all aspects of the research process from interview questions through interpretation. Heidegger warns specifically about the constant presence of pre-conceptions (which he calls fore-concept, fore-having, fore-sight) that are also a constant threat to interpretation of the experience being examined ("the things themselves"). He says, "an interpretation is never a presuppositionless apprehending of something presented to us" (Heidegger, 1962, p. 191-192). For Heidegger, in interpretation, "...our first, last, and constant task is never to allow our fore-having, fore-sight, and fore-conception to be presented to us by fancies and popular conceptions, but rather.....by working out these fore-structures in terms of the things themselves" (Heidegger, 1962, p. 195). Due to the iterative quality of the bracketing process, some flexibility in interview questions is required and this is easily accommodated by the

⁶⁵ Method of recording interviews was determined by the interviewee. Many of the accused I spoke with had symptoms consistent with schizophrenia, some with paranoid tendencies and therefore the use of an electronic recording device made some uncomfortable.

open-ended interviews of this project. Despite the long history of concerns about preconceptions and the special phenomenological term (borrowed from mathematics) of bracketing, Smith et al. (2009) offer few insights into how to bracket. My response to this dilemma is to disclose the most obvious assumptions that arose for me during the interviews and subsequent interpretation of data.

My second interview was with a young man (Brian) who had graduated that day from diversion. So, he was fresh out of an exit interview with a social worker and had recently completed a rigorous reporting schedule that would have included regular meetings with a social worker every time he reported to court. Further, it was on a recommendation from a social worker regarding his high degree of stability, remarkable recovery, and strong communication skills that we were put into contact with one another. Brian spoke about his lawyer, about the addiction workers he knew, and about psychiatrists, but he never used the words “social worker”. It was notable and I became very aware that he was using other professional titles, could name those professionals by name, understood the system very well, but said nothing about social workers. So I asked him directly about his experiences with social workers, to which he smirked and said, “I have never met a social worker, just court workers”. This exchange brought into relief two assumptions I brought to the project: that social workers were likely to be positive influences in the processes of the court and that they played prominent, key roles in the process. Their physical proximity to the court and their professional alliances with it seemed necessary for efficient and effective practice. However, for Brian (and other accused I met) the overt camaraderie between social workers and court workers,

the easy flow of people between the two privileged spaces of the courtroom and the social workers' offices, even the sharing of file documents between the two groups may have blurred the boundary between those who punish and those who help.

The reflexive and ongoing process of bracketing impacted how I conducted the interviews and the flexibility of open-ended interviews enabled me to slightly alter my questions. I quickly learned that beginning with, "Please tell me about 102 Court" raised eyebrows. It seemed from my first two interviews that people narrated their experience of the court as part of their legal troubles, and these narratives almost always began with arrest. Therefore, I learned to bracket my focus on the court processes in my interview questions and to take a broader approach. I altered my first to, "Please tell me how you got to 102 Court".

Tracing Themes Among the Accused

I transcribed the audio-tapes and written notes, focusing line-by-line on the experiential "claims, concerns, and understandings of each participant" to begin to organize the data and trace themes among participants (after Smith et al., 2009, p. 79). First, I considered each person's experiences individually. Once each person's interview had been analyzed, I compared the narratives for recurring themes. Here I present six themes that peppered the experiences of the accused I interviewed. I go further than Smith et al. (2009) suggest by augmenting the phenomenological data of accused with the experiences and perspectives of parents of accused, professionals associated with the court, and my observations of 102 Court processes and relationships. Also, the

narratives of all participants began with their trouble with the police, usually their arrest and were presented as part of the experience of 102 Court. The themes are not restricted to the courtroom, courthouse or diversion experiences, but include elements of their lives that preceded arrest and subsequent 102 Court appearances or elements of their lives that have remained constant despite 102 Court and diversion. I have arranged the themes in three clusters: experiences before 102 Court, experiences of 102 Court and diversion, and enduring experiences. While I have attempted to balance the voices of the accused that follow, my recording methods made this challenging. The audio-taped interviews offer much more complete quotations. My note-taking skills improved over time, but some of my early interviews were less than ideal. Therefore many of the quotations that follow belong to Big Al, Maria, and Brian (the first two being the audio-taped interviews). I am less comfortable quoting other participants from my notes, so I have paraphrased their experiences and connected them to those of Big Al, Maria, and Brian.

1. Social Isolation

Almost everyone I interviewed spoke about the isolation from their family and their general loneliness. Some were from distant provinces and therefore physically separated; others had extended family in other countries and had not seen them in years. It is likely that the symptoms they suffered caused a fair amount of isolation. For instance Maria described her poor relationship with her mother who lives in Nova Scotia. She had two children aged 10 years and 13 years. She had not spoken with the

elder child, a son, for six and a half years. She was emaciated, doing street drugs, and exchanging sex for money well into her second pregnancy and placed that child, a daughter, for adoption. She could recall the first names and occupations of the adoptive parents, but actively worried about how “they were touching her” now that she was getting older. Maria described her childhood sexual abuse and was very concerned that her daughter might also have those experiences. She described herself as “lonely and scared” and said there were “a lot of people I can’t trust. And I lost people I can trust... but I can’t trust. I want to. I trust people on the surface but I can’t get close enough to any body anymore for it to be real and safe”. Brian described his enduring isolation. He said, “my last girlfriend was always threatening to kill me, my family has nothing to do with me, I’m on my own”. Jack painfully described his estrangement from his father who pressed charges against him. He called the police on Christmas Eve that resulted in a traumatic arrest. He is now homeless because his father’s home (which he had been sharing) is now inaccessible due to his bail conditions. His sister will not speak with him and he cannot stay with her. Perhaps most difficult for him is the death of his mother from cancer a year earlier. His estrangement from his father and sister means he is also cut off from some of the material items that remind him of his mother.

My observation of 102 Court highlighted how difficult it is for local family members who work to support their loved ones through the court process. There is a tremendous amount of waiting around in 102 Court, with the time of appearances of accused largely unpredictable. It is difficult for family to take time away from work, and embarrassing to explain it to employers. Unfortunately some family members are victims

of accused and wish for nothing more from them. Of course, some family members are steadfastly devoted, as were the three parents I interviewed. They were all older, only one, Rudy, still worked, but he was a street preacher who made his own hours. Rudy was a white man of a black son. He had witnessed police discrimination in his predominantly Caribbean neighborhood too many times and did not feel any genuine duty to “rat out” his son when he violated his bail conditions. But, his son’s behaviors and trouble with the law had estranged all other members of the family including his daughter-in-law (and with her, Rudy’s grandson), his son’s mother, and all other extended members of his family making Rudy his sole ally.

Big Al was most eloquent about the bridges he was attempting to rebuild with his mother and sister and the support he had always received from his father.

“I’m in touch with my sister again. Because of all the trouble I was in and all the trouble I caused she didn’t want to talk to me. But my psychiatrist said, do you write her; do you write your mom and your sister or anything? I’ve written notes but they’ve never returned any. Just send a card or something. So I send a couple of blank cards and I wrote in what was going on. Involved in AA no drinking, kinda like going to church you got to make amends and stuff like that. I just gave them a little update. My sister picked up on them. And at the last family party she said we’d email each other. But I have to like you. That’s what she said. You have to like me! Now I got to impress my sister? So we’ve been emailing back and forth. And that, that was my Christmas present. I got a card from her on Christmas. I was sitting at home. I knew I was going to be alone on Christmas Eve again. I always leave it open for my mother and sister. I don’t do anything. Just getting the card was good enough.”

“At one year you get a medallion in AA and you’re no longer alone. Which is awesome. Actually there’s a joke that you’re never alone with a schizophrenic. I thought that was funny. But you’re no longer alone in the sense that there are real people around too, you know. I have friends, I have family, I have people in my life. Dad went through hell and high

water. He was with me the whole time. I mean he was ready to punch me out and send me to jail. He wanted me to punch him out so he'd send me to jail, smarten me up and get me some help. He was at wits end and didn't know what to do. I'm surprised he put up that long. But nowadays we meet for coffee and we just talk. Not too many guys just sit down with your father and have good conversation, you know? Cause there's a lot of resentments."

There are multiple isolations and marginalizations that mark the lives of accused.

They are disconnected from services before diversion, many are homeless, they are usually unemployed and unemployable, they suffer from stigmatized mental health issues that cause behaviors that unnerve and sometimes frighten other people. For those who hear voices, they are perpetually distracted even overwhelmed by their own thoughts. Many are the victims of violence and there are few sources of shelter or comfort. Many accused are turned away at hospitals, deemed problematic at shelters, and are known to police as trouble-makers. Some, due to the protracted experience of marginalization and rejection, hold no hope for a different life.

2. 102 Court as a Threshold

Seven of the nine people I interviewed spoke of the court as a significant threshold in their lives demarcated by a distinct before 102 and after 102 narrative divide. Even informants who relayed a negative experience in the court and/or diversion recognized the potential threshold of the court if only to have charges dropped. One court worker told me there are only three possible outcomes for the accused of 102 Court: "death, jail, and hanging on with some help". But from the perspective of the accused, 102 Court was a defining experience in their lives, a process that allowed

them to move into a different life, transform themselves, find new ways of coping, even repair damaged relationships. 102 Court had a tremendous impact on Big Al's life. He said:

“OK so going through the diversion which I never heard of before in my life. They're just going to let me off [if] I just go to, if I keep going to, keep showing up at court appearances. And stay outa trouble. That, that, I took that. I said for sure. Because I...for years I've been in trouble with the court system because of alcohol and drugs, and schizophrenia and everything. Just acting psychotic andand it was like a chance to start over. And.....I think.....first thing I had to get over was being scared of the court system”

“It helped me so much. It helped.”

“The court helped me. AA helped me. Yeah the diversion worked. The diversion was the best thing because I felt like I could trust them. It wasn't the idea of being let off. There was work involved. I had to stick to what they said, but I learned, I learned to trust them a bit. I learned to trust.”

“I think the courts gave me my life back. I think they did. They helped. Because for years I didn't understand what was going on. I just thought I was hated and was going through a living hell for the rest of my life.”

“After what I've been through, or put myself through, got involved in, just to be here on the other side, to be able to relate, to talk about, to be able to talk about some of it is like, it's a blessing you know. I survived it all. I saw the dark side. I wasn't really aiming for it but I managed to get in there. It found me”.

Brian said, “[102 Court was] kind of a godsend”. He did not understand why he was sent to rehab to get clean and had many issues with court processes. But he leapt at the chance to have his charges stayed or withdrawn and so 102 Court provided an opportunity to do that.

3. Disrupted Therapeutic Relationships

Arranging appointments and fostering therapeutic relationships is a ubiquitous and key process of 102 Court. There are many such relationships that are fostered between accused and psychiatrists, social workers, and other psychiatric practitioners in the community. Inclusion in diversion is premised on a psychiatric diagnosis and the associated therapeutic relationships very often include pharmaceutical interventions and monitoring. The accused have little say in their pharmaceuticalization, although agreement to proceed through diversion is taken as tacit agreement to all forms of interventions directed by the court. Complaints of intolerable side effects may be disregarded, and admissions by the accused that they have changed the dose or discontinued the medication must be reported to the Crown attorney and is grounds for a new criminal offence. Accused are well aware of the reporting responsibilities of their therapeutic practitioners. Often their introductions to practitioners are through the court workers or actually in the court offices or holding cells. Certainly meeting the court social workers at every court appearance and the physical proximity of the CRTC offices with the courtroom links these social workers and court workers like attorneys and judges in the minds of many accused. Relationships can become skewed under these circumstances and seven of the nine accused interviewed expressed these disruptions in various ways. For instance, the Centre for Addiction and Mental Health is the flagship mental health institute in the city, perhaps the country. Many families of mentally ill people wait months for appointments with specialists in the multi-sited institute. They have spent billions on renovating their spaces and updating their public face, with ad

campaigns that attempt to de-stigmatize mental illness. CAMH is a teaching and research facility, linked with the University of Toronto and generally attracts the “best of the best” employees. People suffering with mental illnesses in Toronto face a paucity of resources, so to gain access to the people and services of CAMH would seem an enormous advantage for accused. And yet, there was a great amount of hostility towards the institution generally and psychiatrists more specifically from many accused. Some community social workers were also, surprisingly, skeptical about CAMH’s impact in the lives of the mentally ill. Both accused and community workers called it the “factory”. I asked several accused and a social worker why they called it the “factory” and was told it was because they treated everyone the same way. They felt their care was not individualized, that they were considered symptom clusters not people with their own stories, personalities, and particular problems. My observation of 102 Court revealed many in-custody accused begging for jail rather than treatment at CAMH, which seriously calls into question the stated goal of 102 Court to provide a more therapeutic experience compared with jail. It is possible that the negative attitudes of some social service workers influenced the opinion of the accused, but it is just as likely that the experiences of their clients at CAMH as well as their own professional involvements contributed to the characterization of the hospital as impersonal. As Big Al recalled:

“It was difficult, we talked about things. There wasn’t anything concrete that we could do there. There was a lot of talk. And the psychiatrist he wasn’t too interested – not like the psychiatrist I have now, we talk, he

remembers, he writes everything down and ...um...CAMH was kinda sterile”.

Maria had recently been admitted to CAMH because she was deemed a threat to herself or others. She had been protesting a well-publicized downtown promotion that involved nearly nude models. She knocked a media light over and was arrested and taken to CAMH. This media campaign was one she found “gross” and “disgusting”. She began our interview wanting to discuss it and returned to the topic many times throughout our interview. This struck a chord in her due to her own sexual “violations” on the street and in her childhood. She laughed off her experience in CAMH. It was inconsequential to her because she was neither suicidal nor homicidal and they could not “treat” what was wrong with her in this case.

Of course psychiatrists have a particular role to play in the care of mentally ill accused and that is not necessarily to spend as much time as they would prefer getting to know a patient. That task often falls to social service workers who are in much more frequent contact with accused. The social workers of the CRTC certainly meet with their clients every time they come to court which usually begins very frequently (possibly daily), then tapers as the accused demonstrates his or her compliance with the scheduled court reporting. Also, CRTC social workers set up and monitor community-based social services for clients. However, more than half the accused interviewed described disrupted relationships with social workers. As Brian told me smirking, “I never met with a social worker, just court workers”. Also, the CRTC social workers are involved in the surveillance of medication compliance. They regularly ask clients if they

are taking their medications. It was clear that some accused lie about compliance, well aware that deception threatens their diversion, may precipitate further charges, and may delay their legal troubles. But when side effects are intolerable and those in charge of prescribing medicine override your desire to stop taking it, it forces many to hide the truth from their care providers. As Brian admitted to me, "I don't take the meds....please don't tell them". It might be the case that intolerance to medication *leads* to trouble with the law as a contributing factor along with deinstitutionalization and inadequate mental health care services. If accurate, 102 Court seems an institutionalized mechanism for forcing pharmaceuticals on people who cannot tolerate it; an escalation of deception, isolation, and disconnection from services rather than a solution. While non-pharmaceutical intervention may be proposed and arranged by social workers, they are not alternatives to psychiatric pharmaceutical treatment, and some social workers admit that exposure to 102 Court's population of accused has convinced them of the central role of pharmaceuticals for people's stability. While a positive aspect of care for some, who, if not the social workers, would advocate on behalf of accused that cannot tolerate side effects? Many accused said they had always hated the medications prescribed to them. Hiding their non-compliance from their care teams adds to their social isolation. At best, pharmaceutical interventions were accepted as inadequate but necessary for a better life.

Social workers occupy an ambivalent positionality in this system: they cannot fully build trust with their clients because there is limited confidentiality. They work closely with Crown attorneys, are materially and socially connected to the court workers

(which is clear to anyone attending court, even a casual observer), and they have access to restricted areas of the courthouse like the holding cells. This can be construed as convenient for clients or efficient systemically, but it links care workers and disciplinarians closely. It is not only accused who struggle with these material and symbolic associations, one social worker, in frustration admitted how difficult she found how she was professionally positioned, lamenting that, “I’m not a social worker; I’m a paralegal”. She struggled with the ethics of her professional identity and professional management that did not understand the tension that needed to be navigated regularly due to this ambivalence.

Brian had the most trouble with his prescribed medications, although most people I met objected to them or felt they were of little help. Brian said:

“I’m afraid to tell the doctor what I am really going through. My mind is so clouded. When I take it [medication] at night, it knocks me out, makes me feel stoned. I’m not taking it. Makes me feel uncomfortable in my own skin. I’m on the edge all the time. When I take my meds I feel like shit. Skin crawling, wake up at seven, puke....”

4. Key Supports

All participants listed particular people associated with 102 Court and diversion who were one of the keys to their success. One interviewee was adamant that he was tempted to relapse but did not do so when he thought of the promise he had made to the judge in 102 Court. He simply did not want to disappoint the person who had given him another chance, who believed in him. This was echoed by many accused in the courtroom. Court employees were well aware of the power of their positions. One Crown

attorney said she leveraged this power by looking directly and intently at accused and engaging them to keep their word to her, to see them and treat them as people. She said this tactic worked one day, by chance, and she employed it now and then. She mused that people expect little of accused so it can be powerful to tell them you expect them to follow through. This research indicates that it was not a particular person or professional position that helped accused, but that the presence of someone or a handful of people who were trusted or dedicated or honest was a key factor for the completion of diversion. Big Al credits a rather large support network:

“I’ve had help. I had Bob’s help, I had Susan from Straight Talk. I’m in AA, my family, they don’t judge me. My father was there through the whole thing. I pushed him to the limit because of the illness. It was really bad.”

Big Al saved the highest praise for a lay person, a cellmate who helped him realize his problem with alcohol. He recalled:

“I was at the Don jail, waiting for a bail hearing or something and I was telling this cellmate oh yeah I got drunk last night and I did all this crap. And he handed me the big book which is like the bible of AA. Started reading it. All these people have the same problem as me. I read like a hundred or two hundred pages and then I told my lawyer I was an alcoholic. He told the judge. I can’t remember which one, which time it was that that happened. But then they got the message that it wasn’t just schizophrenia but there are drug and alcohol issues too. I remember his name. His name was James. He was in big trouble. Whenever I’m in a meeting I mention that book. And even though I was behind bars away from society someone had reached out with some help. And it was there. And I got the message”

Social workers, both community-based and those working with the CRTC were sometimes cited as particularly helpful to the diversion process. One man said, “the men in prison are just praying for someone to bail them out and for many people the CRCT folks are their only hope. The stress of the psychiatric hospital is all many can bear; getting better or getting housing is way too much to hope for”. However, Brian was very disillusioned with the social workers he met. I asked him about his experiences with them and he snorted, “what social workers? I never met a social worker. Just court workers”. Maria’s life was not significantly impacted by her experience in 102 Court but she encountered professionals who made a difference to her. She had a legal matter pending that was not eligible for diversion⁶⁶ but one of the duty counselors of 102 Court promised her assistance in transitioning to the regular stream. Despite her struggle to trust people, she was optimistic about the counselor’s involvement with her case. She said, “the guy that’s there is going to advocate for me to get legal aid faster and get the trial over with faster. And be a good girl and not have to be a piece of ass on the street, which is what I’m doing because I am using”.

5. Continuum of Violence

Narratives of all participants included stories of violence, perpetrated both against and by accused. Violence clearly marks the lives of participants and many of the accused I observed in court. The strongest theme and the one most echoed in the courtroom was violence against accused by the police and court officers. There is no

⁶⁶ Possibly due to her refusal/inability to stop taking street drugs which interfere with her ability to obtain prescription medications that would be part of any further diversion.

doubt that court officers are the sharp end of the disciplinary stick in the courthouse. The court officers I interviewed described the challenges of their job and the fine line of empathy and control they walked which seemed especially challenging among an in-custody population that might smear feces or menstrual blood on themselves, or even physically attack them. When a judge orders an accused taken back to the cells and they refuse to move, it is the court officers who must wrangle the person to the cells. Many court workers and accused recognized the difficult role of court officers.

Sid had a particularly difficult time with the court officers. Every time I spoke with him he told me the same story of being beaten badly by court officers⁶⁷. He felt targeted and regularly faced ridicule and physical violence. He explained many of the ways that court officers could “screw with” him and other accused. For instance, in-custody accused will be dressed in street clothes if there is a slight chance of release; otherwise they remain in jail garb, bright orange jumpsuits. If an accused who is disliked by the court officers is at the end of the docket they may legitimately leave the person in the jumpsuit. But if the docket is short and the accused is released, they must make their own way back to the jail to collect their clothes and other belongings wearing only the jumpsuit. This marks them as a prisoner and if they cannot find additional clothing, is inadequate in cold weather.

Certainly the brutality of some court officers was legendary among accused and court workers. Big Al said, “some of them have short fuses so they popped off on some people, some inmates” Sid claimed court cells were more brutal than jail cells. He said,

⁶⁷ In fact, every interview with Sid was about violence perpetrated against him. In some sense his was a trauma narrative.

“Anyone would prefer jail to court cells”. As I described in Chapter Two, I was shown the cells adjacent to 102 Court by a court clerk. Recall that the walls, benches, and floors are made covered in metal. Many in-custody accused complained in court about how cold the cells were.

Police interactions with mentally ill people are cause for some public debate in Toronto, with the police shooting of a runaway psychiatric ward patient making headlines during the course of this research. There is an effort to train police officers to deal with mentally ill people they encounter, but stories about the excessive use of force are ubiquitous. One community social worker recalled how a young mentally ill woman had her leg broken by arresting officers. Many in-custody accused cry out about misuse and targeting by police. Certainly many of the interviewees I spoke with described the violence of their arrests, albeit some thought it was deserved. For instance, Big Al recalls his last arrest:

“...I was out of control. I uh, I heaved a refrigerator off a balcony. I was very psychotic. They sent the ETF⁶⁸. Well they sent, they sent the uh, the building security, then the police then the ETF. When they finally got in the door. And...well... it wasn't pretty. They...they were trying to subdue me but I was already subdued. Well that's alright I deserved it anyways...they brought me out into the hallway. And then the ambulance [guy] said are you alright. I said I'm fine“.

Recalling his last arrest on Christmas Eve at his father's home, Jack says:

⁶⁸ ETF is the Emergency Task Force, the tactical unit of Toronto Police Services. It is mandated to deal with high risk situations like kidnapping or emotionally disturbed people.

“I don’t remember threatening bodily harm. It’s my word versus the cops. I was the one who got the knee to the back, thrown on the ground”

One law clerk passionately explained his view of the Toronto courthouse. Waving his arm over his head to indicate the whole building (or perhaps the criminal justice system) he said, “this whole thing is structural violence”. There are many examples of how this structural violence plays out in the lives of accused. For instance, women have fewer available community resources like shelter beds and women-specific programming, which sometimes causes delays in release planning. There are concerns about the violence of racism and xenophobia among accused, as explored in Chapter Two of this work. Some of the discourse heard in the courthouse reveals how some regard accused as less than people. I heard a lawyer on his phone looking for an in-custody client who had not yet arrived to the courthouse from jail. He said, “I’m trying to locate a body. Where is it? Is it on its way? Is it in transit?” When court is in session it is important to have a “brief and a body” for a case to proceed. This dehumanizing characterization is a glimpse into some forms of structural violence faced by accused.

The gendered axis of violence (both physical and structural) was most prevalent in Maria’s account⁶⁹. Her life is marked by violence. She experienced childhood sexual abuse and she fled her life and family in Nova Scotia to live on the streets of Ontario’s cities. Of her childhood trauma she says, “When I had my first sex ed[ucation] class I found out about molestation and that it was wrong and I said to somebody and my mom kicked the shit out of me cause I told the guidance counselor. I’m still dealing with it”.

⁶⁹ Like Sid’s account Maria’s interview transcript is similar to a trauma narrative.

She has sex in exchange for money when she cannot make ends meet. Describing her life she said:

“I’m homeless. I’m living outside. I still have to live. I have to walk everywhere. I’ve got guys hitting on me, trying to pick me up cause I’ve been on my own forever. And when you’re hungry and you need money or you need companionship, you’re lonely and then you feel guilty and then you run to drugs, right? To cover up the guilt that you feel for having to do that. In this kind of society, in this day and age, why am I going through that?”

She described the challenges of living on the monthly support given her by the Ontario Disability Support Program [ODSP]⁷⁰. But the shortage of money was only part of the problem for Maria. In order to cash the check, she ran a gauntlet of predators waiting for ODSP recipients at downtown check cashing businesses every month. She said,

“I stand there for hours to get in there and get my check and it covers nothing. I go to money mart and I have to worry about the dogs reaching into my pocket and taking it from me. I got to worry about being grabbed and groped. I got to worry about being raped.”

Being a woman addict is very dangerous for Maria. She explained, “When I sleep it’s just like being in a coma (because of drugs) and I get violated.” But there are more subtle ways that Maria’s life is marked by violence. For instance, there are long waits for female-specific programming and many services are clustered in neighborhoods with drug dealers. Maria said,

⁷⁰ ODSP annual income (of \$12, 647) is roughly 68% of the poverty line in Ontario (Poverty Free Ontario, 2013).

“And if you’re hungry, especially in the morning if your hungry, you know and shelters aren’t open in the daytime. Most of the shelters are around drug related [people or places]. Cause it’s the slums. And to get into a program, the wait, the wait is phenomenal.”

The structural and physical violence that marked Maria’s life was overwhelming and beyond the scope of 102 Court to address. Whatever the diagnosis that brought her into the court, there is no provision for accused who may (arguably) be dealing with the sequelae of childhood sexual abuse⁷¹. The scarcity of female-specific resources in Toronto and the vulnerability of street life due to her gender amplify her needs and confounds routinized solutions.

5. Coping Techniques

Many of the participants described their own coping techniques. For some, coping with addiction was the key focus, while for others it was coping with voices or paranoia. Several people believed spirituality was the key to their stability. Big Al believed there was a spiritual aspect to illness:

“I mean who’s to say, I mean maybe they’re sick but maybe they’re spiritually sick too. There’s a spiritual world too. There is”.

Jack was “trying really hard to be healthy”. He rejected the dominance of the pharmaceutical industry in his wellness and was dedicated to healthful eating, doing research about food as medicine, and spreading the word to other similarly diagnosed

⁷¹ Even if these survivors make up a significant proportion of the prison population.

people about herbal combinations and medicinal food alternatives. Rudy, father of an accused and originally from Guyana, believed that his son would be better “in the islands, where there aren’t so many rules, not so much stress. That’s why there’s less mental illness”. Big Al recounted how he used AA meetings to cope with voices:

“I’ve told people If I’m feeling stressed out, anxious, hearing some of the voices, whatever’s happening...if I can get myself to a meeting - within ten minutes of being in the meeting, it [the voices] goes away. I mean I don’t know how to describe it, but it just, it just starts going away. By the end of the meeting, I’ve heard the speaker, I’ve talked to a few people, you know, um, I’m OK, I’m good to go”.

These coping techniques overlap with explanatory models of illness for many people. Sickness of spirit, the ingestion of toxic food combinations, and the social context of fast-paced, stressful, highly medicalized Canadian culture are part of the reason accused do not fit well into society, why doctors and police officers are trying to change and control them, and why they feel so alone.

These explanatory models and the many years of labeling (medically and forensically) coincide with an ambivalent relationship to their diagnoses. For Brian, as with many people I observed in court, the diagnosis has changed over the years. Brian, even after rehab, diversion, and numerous frequent psychiatric appointments, asked me what bipolar meant. He said he understood what schizophrenia was, but this new diagnosis was not something he understood. Big Al was the most biomedically literate participant. He understood his schizophrenia as chronic. He accepted antipsychotic medication and its side-effects and found it helpful:

“And if I feel the voices taking over kinda, I will take one in the day if I need to. So, yeah, I mean I still have the illness. It’s not going away. With the medication, you don’t lose so much, you know, I don’t know how to describe it. I just have to white-knuckle it through sometimes. You know just wait for it to stop. You know my worst bad days nowadays aren’t even close to what it was like before. I just have to hold on”.

He also considered his misuse of alcohol a form of “self-medication” to deal with his voices that stopped working after a while. Then alcohol became an obstacle to coping with the voices:

“Even though I have schizophrenia I can work on the illness now instead of not knowing what’s going on. To abstain from alcohol, like I said, since that last day I drank I’ve had no doings with the police at all...But I still have the illness. I still have it. It won’t go away. It’s manageable. I’m happy with it”.

Sometimes the harsh life of the streets makes other demands on people. To cope with the sexual vulnerability of living on the streets, Maria did drugs to numb the pain and fear of this experience *and* to qualify for a bed in rehab, a safe, if temporary, residence. Once clean, she was ejected back onto the streets and the cycle continues.

It became clear during our many hours together that she was very near-sighted and she often borrowed my glasses to see something. I always carry extra glasses with me on the advice of my specialist, because to lose or damage them, would render me functionally disabled, so I have some appreciation for the limited view Maria had on the world. I was alarmed at her lack of glasses and set about finding the means to get her a

pair. She laughed at my concern and these attempts, reminding me of how little she had to truly see and how being visually impaired was a sort of coping mechanism to soften the edges (literally) of the harshness that defined her life.

The Ambiguity of “Success”

Here I contrast two cases of diversion (Big Al and Brian) through 102 Court in order to stress how very similar accused, professionals, and processes may produce very different outcomes that might both be labeled “successful”. I selected these two cases because there is a high degree of overlap in their experiences, the people they were in contact with throughout their 102 Court experience (lawyers, social workers, etc.), and in numerous other ways. They are both white men, born and raised in the Toronto area, who had graduated from diversion within three years of the interview. They both had been diagnosed with schizophrenia, although Brian had also been diagnosed at various times with bipolar disorder. They both had substance abuse issues and named alcohol as their substance of greatest issue while dabbling in street drugs. Some of the same professionals helped them through 102 Court. They were referred to me by the same social worker who highlighted their stability, improved mental health, and what complete “success stories” of diversion they both represented. I believe she was very proud to have been part of their journey through the system.

Big Al used the language of biomedicine in his recollection of his 102 Court experience, having integrated the truth discourses of sickness that characterize the bio-power at play in 102 Court and discussed the Chapters One and Two (Rabinow & Rose,

2006). Big Al distanced his behaviors and actions from who he was as a person, emphasizing that the illness made him behave in particular ways. This echoes psychiatric discourses about mental illness that dissociates behaviors caused by illness and identity. He accepted antipsychotic medications as necessary, a mode of subjectification, and had a good working relationship with his current psychiatrist. He was well connected with a network of support. Previously, he had been isolated socially, having no friends, estranged from most of his family, and no work colleagues, but was now repairing ties with his family, making new friends, even beginning a new job. Big Al was a model of self-governance. He mimicked the truth discourses of authorities, he had internalized the language and accepted the sickness that lived within him. He could articulate his own irrationality and the consequent behaviors that had brought him into contact with the law. His relative success was in part due to his greater immersion as an anatomo-political subject. Brian, in contrast, was no longer on his medication and had not been compliant for some time. He admitted purposely deceiving the court and social workers regarding his compliance. He did not understand why he had been sent to rehab, felt no one had ever asked for his story, and still felt completely isolated. He was planning to move to a different city, breaking any support ties he had gained through the diversion process.

I wish to stress the huge difference between these two “successes”. What a client reports and what actually occurred can be vastly different and lead to biases about practice impact in people’s lives. The comparison of Big Al and Brian is a cautionary tale for practitioners whose clients are savvy enough to survive the streets, addiction,

isolation, and jail terms and *may view 102 Court* and diversion as another site where survival on their own terms is necessary, even if that means lying to social workers and psychiatrists about compliance, as Brian did. The comparison also offers insight into why exit interviews, particularly performed by agency employees, may not capture an accurate picture of impact among clients.

Summary

Studies of mental health courts like 102 Court in Toronto from the perspective of accused are rare. The accused in this study experienced 102 Court as a threshold imbued with potential. Not everyone agreed that there was anything necessarily therapeutic or healing about the processes of the court, but it was possible, given the right charges, diagnosis, and availability of resources that 102 Court might improve quality of life for those who pass through it as accused. Of particular importance was support from key people. They might be lay people who offered the right advice at the right time, or a particularly helpful attorney or a social worker who saw them through the processes of the court and the local social service system. Also, non-pharmaceutical coping techniques augmented (sometimes dominated) participants' the court-ordered pharmaceutical interventions. Isolation from family, either enduring or before 102 Court, was a strong theme among participants. Many participants also described disrupted therapeutic relationships after years of contact with community and forensic mental health care providers. Violence marked the lives of all accused and ranged from the structural violence of dehumanization and discrimination, the scarcity of resources

available for women, to the sexual vulnerability of living on the streets and the police and court officer inflicted violence that occurs as routine in many arrests and prisoner transfers.

Despite concern from professionals associated with 102 Court that accused could not offer interview answers, asking people to tell their stories had a positive impact on participants. Accused referred to the study were told of the afore-mentioned professional concerns regarding their narrative and cognitive abilities and expressed gratitude for interest in hearing their stories. As one participant said, “we’re people too”.

This research casts light on the difficulty in defining “success” in such a court. Legal scholars and professionals discuss recidivism rates as one of the critical outcome measures for mental health courts. 102 Court relied on exit surveys administered by social workers who worked closely with the accused during the diversion process. Both indicate some degree of success. However, Brian’s narrative, with his admission of non-compliance during diversion and his deception of social workers, psychiatrists, judges, and Crown attorneys throughout the process forces us to reconsider how to define “success”.

There are several limitations that are evident in this work. Only two of the nine interviews presented above were audio-taped. While this was appropriate from an ethical perspective, it limited the consistent in-depth analysis called for in IPA. Transcribing notes, and my note-taking skills were less than ideal. I would prefer any follow-up investigations with this population to require audio-taping even if that meant losing participants.

Big Al was a very articulate interviewee whose narrative style including looping back in his story, reconsidering his words, then rewording his recollections. He was biomedically literate, had an easy-to-follow narrative style, and was one of the participants who agreed to be audio-taped. Therefore, his voice slightly dominates the six themes above. It is possible that the stability enjoyed by some participants may be a function of having completed diversion several years before the interview occurred compared with more recent graduates of diversion. This suggests the need to further compare immediate and longitudinal impact in the lives of diversion graduates. Because of the nature of my chosen population, follow-up interviews were difficult in some cases and it was impossible for me to contact interviewees to go over transcripts to ensure I captured their opinions and stories appropriately. Finally I believe it would be more useful to cluster participants by diagnosis and alleged crime. Most participants revealed their diagnoses voluntarily, but I did not specifically ask them to produce this information. Clustering people by diagnosis and by criminal allegation might further homogenize the sample and strengthen the study.

Chapter Four: Discussion

The aim of this research was to critique the application of therapeutic jurisprudence in 102 Court through the theoretical lens of subjectivity. I have explored the subjectivity of the accused through a phenomenological analysis and assessed the processes of subjectivation that also shape their experiences. In this final chapter I will synthesize evidence presented in the previous chapters and weave the findings through a critical discussion of therapeutic jurisprudence and the bio-power evident in the processes of the court. Four critical issues emerged from this work and will form the basis for the discussion that follows. I will argue that a particular sort of bio-power that produces a pharmaceutical subject is at play in this system. While 102 Court produces openings for some people who pass through it as accused, it forecloses possibilities for others.

Critique of Therapeutic Jurisprudence

Recall that Winick and Wexler describe law as a social force that may produce “therapeutic or anti-therapeutic consequences” (Winick & Wexler, 2003, p. 7). Also, rather vaguely, they suggest court structure may maximize the therapeutic potential (Winick & Wexler, 2003). In a comparison of traditional⁷² and transformed court processes that result when the concept of therapeutic jurisprudence produces a specialized court, legal outcomes are replaced by therapeutic outcomes, rights-based

⁷² By traditional they refer to the regular stream of justice in North American courts, not courts operating in non-Western or small-scale societies.

approaches are replaced with interest- or needs-based approaches, and the adversarial process is replaced with a collaborative process (Winick & Wexler, 2003). Of seriously mentally ill accused, Marini says, “Many of these.....have become homeless. Many refuse to take needed medication in the community, and suffer a reemergence of their symptoms, often requiring re-hospitalization” (Marini, 2003, p. 59). This statement qualifies the medication as “needed”, places the responsibility firmly on the mentally ill person who has refused to take it, and places the responsibility for addressing this problem on health care institutions. “Jail and the criminal court process is inappropriate for most of these individuals, whose problems are due more to their mental illness than to their criminality. As a result, mental health court has been developed to attempt to divert them from the criminal process to the treatment in the community that they need” (Marini, 2003, p. 59).

Recall from Chapter One that there are five core concepts that define therapeutic jurisprudence and are operationalized in 102 Court and other mental health courts (Marini, 2003; Schneider et al., 2007; Winick & Wexler, 2003). Below I discuss each of core concepts in relation to 102 Court.

1. *Medication, framed as “needed”, is the cornerstone of release plans and, for most accused becomes a key component of diversion where compliance is necessary for graduation from diversion.* The processes of 102 Court rely heavily on psychiatric treatment and psychiatrist-patient relationships, medicating accused, and surveilling compliance. The population eligible for diversion through 102 Court, those considered

“properly” before the court, overwhelmingly present with psychotic features, making pharmaceutical treatment possible and preferable in the Canadian evidence-based medical model. Some antipsychotic medications are also conveniently available in injectable formats, making unconsented treatment that may occur during treatment orders much easier to administer. The term “treatment order” belies the coercive and involuntary nature of this legal order. The language of medicine and benevolence saturate court language, where forensic psychiatrists assure the court of the benefits of antipsychotic medicine, where accused are sent to hospital, not jail, but where non-compliance may become a criminal offense.

2. The medical system has failed to adequately care for seriously mentally ill people, forcing the legal system, unprepared for an influx of seriously mentally ill people, to action. This is how most analysts frame the historical circumstances that have resulted in so many mentally ill people in contact with the law. The framing is factual and historical but is not neutral. There is tension between the systems of medicine and law that undergirds the activities of 102 Court, occasionally becoming more visible.

Schneider et al. (2007, p. 2) is fairly direct about the purposes of mental health courts are to shunt people away from the criminal justice system and back to the mental health care system *where they belong*. There is occasional frustration in the court with wait times for hospital beds, which are under the control of the Centre for Addiction and Mental Health [CAMH]. When lower courts like 102 Court attempt to force the medical system to respond more quickly or otherwise disrupts the balance between the two

systems, lawyers from CAMH appear in 102 Court, sometimes leading the legal parties to superior court to have the issue heard before another judge.

3. The negative psychological outcomes of jail compared with hospitalization are emphasized, where imprisonment is believed to cause or exacerbate decompensation.

For example, Marini says, “Subjected to the extreme stress of jail detention, they suffer further decompensation” (Marini, 2003, p. 59). Here he argues that jail itself causes their mental health to suffer, without citing a source. Surely, his statement may be accurate some of the time but evidence gathered in this study has demonstrated that for some, like Big Al, jail and the people he encountered there, were key to his transformation. Confinement in jail can itself be a stressful and violent experience. Certainly the Don Jail, where most male accused of 102 Court would be held until their matter was resolved, is a particularly appalling example of jail in Canada. The Don Jail (a.k.a. “the Don”) has been condemned by many critics as dangerously overcrowded and an embarrassment to the justice system. Justice Schneider, 102 Court’s administrative judge at the time of this research, set Canadian legal precedent when he ruled in *R. v. Smith* [2003] O.J. 1782 that an accused being held at the Don Jail was to be credited three days of “time served” for every day spent in the Don due to the deplorable conditions⁷³. Despite these widely recognized problems with the Don, evidence from both branches of this study challenge the assumption that for all people hospital is less stressful than jail. When an accused is ordered to hospital in lieu of jail, they are

⁷³ A replacement facility, dubbed a “superjail” was under construction in South Toronto, which would replace the Don Jail, at the time this research was conducted.

imprisoned in the building or ward. If they are sent on a treatment order this has a maximum length of stay of 60 days, but if accused are remanded to the Ontario Review Board, their confinement is subject to annual review and may last years, even indefinitely. Observation of 102 Court revealed that some accused *prefer* jail to hospital; some accused beg to be sent to jail rather than return to the hospital. It is important to note that everyone I observed in 102 Court who preferred jail had likely had previous negative experiences in hospital⁷⁴. For some accused, jail time is not a negative experience. In the case of Big Al it was his cellmate, who was “in big trouble” who set him on the path to recovery and played a pivotal role in Big Al’s transformation. It seemed to hold more meaning for Big Al that this help came while he was “away from society”. Finally, one out-of-custody accused of 102 Court purposively broke the law in minor ways when he needed the respite he could find in jail from the hardships of life on the streets. This accused, a well-educated and articulate older man, had been imprisoned in his home country in Africa for many years due to his political beliefs and found Toronto’s Don Jail quite restful by comparison.

4. *The adversarial process in court is suspended in favor of a collaborative approach to put mentally ill accused at greater ease.* There is evidence that the collaboration of the Crown attorney may have been a dramatically different experience for accused who had been before Crown attorneys in regular courts. Families of accused sometimes commented that it was a relief that the Crown did not “throw the book” at their loved

⁷⁴ This was evident from their pleas where they explicitly referenced “the last time” or “not again” or referred to hospital procedures like being held down and injected with drugs.

ones accused in 102 Court. But there were also accused who openly demanded new counsel because their lawyer was not fighting for them. Many accused expect defense attorneys to defend their clients by arguing against the prosecutor. It illustrates a potential problem with the suspension of the adversarial process in 102 Court: it blurs the boundaries between defense and prosecutor. Some defense attorneys silently assented to orders requested by the prosecution like the draconian treatment order without cross-examining the forensic psychiatrist regarding the involuntary administration of antipsychotic medications. By comparison, other defense attorneys resisted treatment orders on every occasion out of principle and to register their objections on the record. For a system that is premised on transparency, the off-the-record negotiations between defense and prosecution⁷⁵ that I could only partially witness and learn about through conversations with attorneys does not reflect the transparency ideals of the criminal justice system especially when the adversarial process is suspended. This lack of transparency about defense-prosecutorial consensus is particularly problematic when the accused is marginalized, without many personal advocates, and less likely to be heard if he alleges misrepresentation.

5. There is an attempt to look upstream, where the criminal behaviors of the accused are envisioned as caused by mental illness making treatment of the illness the most appropriate deterrent to future criminal behavior. The cause of criminal behavior is well outside the scope of this research, but there are two problems of logic associated with

⁷⁵ And likely occurs in all courtroom practices.

this conceptualization. Marini's introduction to mental health courts paints a picture of the release of mentally ill people from institutions into ill-prepared communities. He writes, "The tightening of civil commitment standards and the policy of deinstitutionalization has led to thousands of people with mental illness living in the community" (Marini, 2003, p. 59). This is a rather de-historicized, anachronistic account. Deinstitutionalization occurred primarily in the 1950s and 1960s, when adults were released to the community. Assuming people were released at 18 years of age in 1965, they would be 48 years old in 2013 or older if they were part of the earlier phases of deinstitutionalization. Of course, many people who suffer serious mental illness and live in our communities are significantly younger. His narrative condenses time and links historical policy and events to contemporary social concerns. In his second statement he says that both jail and court processes are inappropriate for these accused because the underlying problem is not criminality but mental illness. Merriam-Webster defines criminality as "the quality or state of being criminal and criminal activity" (Merriam-Webster, 2013). This quality of being criminal cannot be solely defined by criminal behavior or both mentally ill and mentally well accused would possess it. This argument assumes that a mentally ill person could not also possess this quality of criminality. If they did possess both, somehow the mental illness underlies or is more fundamental or more directly responsible for criminal behavior than the quality of criminality. Apparently appropriate responses to crime based on criminality are punitive but responses to crime based on mental illness ought to be therapeutic. Marini's final statement concerns diverting people away from detainment and back to community services. However, in

his narrative community mental health services are where the problems began. I believe as 102 Court has demonstrated that what he really meant to write was that they are diverted away from jail and mandated to adhere to community mental health treatment. If criminality is met by the criminal courts with surveillance and detention, mental illness is met with surveillance and conditional release for some and surveillance and detention for others. It is evident from interviews with accused that many of them had been in community mental health care before entering 102 Court as accused. For instance, Big Al had attended group therapy programs at the Centre for Addiction and Mental Health for concurrent disorders. Sid described himself as a shelter pro saying he had lived in the shelter system for years and felt it part of his responsibility to teach newcomers about the shelter system. Therefore, people passing through 102 Court do not necessarily lack community services. By focusing on illness, the legal system rationally defers the responsibility for mentally disordered accused to the medical system. This produces new forms of subjectivity at the medico-legal nexus that will be expanded later in this chapter.

Despite my attempt to unpack the concept of therapeutic jurisprudence, it remains difficult to assess its impact on people who pass through 102 Court as accused. Let us distill the amalgam of characteristics discussed above to *an attempt to produce more positive mental health effects than negative effects through the processes of the court*. These processes are altered by authorities of the court interested in both efficient and ethical deployment of the law in the best interests of accused. While there is widespread agreement (implicit at least) about the theoretical

possibility of court processes being therapeutic or anti-therapeutic, there is no suggestion that a court designed to deliver therapeutic jurisprudence like 102 Court might, through the very mechanisms intended as therapeutic, inadvertently be anti-therapeutic as the findings of earlier chapters indicate.

As I discussed in Chapter One, the courtroom itself is intended as a therapeutic agent. It becomes the physical center of wide web of connections and relations that are intended to support accused, managed by social service workers and supervised by the Crown attorney and the judge. However, it is also the center of power relations and surveillance. This recalls Foucault's panopticism, which describes the development and deployment of observational technologies to produce disciplined and productive bodies (Foucault, 1977). Foucault draws on an architectural analogy, Bentham's *Panopticon*, a prison system that employs new techniques of surveillance to control prisoners (Foucault, 1977). Prisoners are made highly visible, always scrutinized, or always potentially scrutinized by authorities (Foucault, 1977). Foucault emphasizes the "the capillary functioning of power" that characterizes panopticism, an apt analogy to the disciplinary foci that 102 Court becomes in the lives of accused (Foucault, 1977, p. 198). Recall from Chapter One that Winick and Wexler (2003) described the specialty courtroom as a "laboratory" to uncover the elements of court processes that contribute to therapeutic goals (Winick and Wexler, 2003). Foucault tells us that the *Panopticon* can also be a laboratory, to "alter behavior, to train or correct individuals....to experiment with medicines and monitor their effects" (Foucault, 1977, p. 203).

The contradiction of the simultaneous invisibility of the accused to the general public and the strict surveillance of the court is consistent with Foucault's (1977) arguments about punishment in a modern setting. He claims that punishment tends to become the most hidden part of the penal system. In 102 Court the punishment, at first glance, seems absent. But the analyses presented in Chapters Two and Three highlight the structural violence that accompanies participation in the court and the coercive threat of further sanctions that qualify the administration of pharmaceuticals. The question of whether treatment is therapeutic is not asked nor does it matter. Disordered bodies are re-ordered by discursive practices and under threat of legal sanction. The rationality of neuropsychiatry and the technologies of pharmaceuticals replace technologies of imprisonment.

Beyond the authority of forensic psychiatrists to establish the norm and the routes along which the pathological may be made to be consistent with the norm, Foucault argues that the law itself operates increasingly "as a norm" (Foucault, 1976, p. 144). He claims that in the modern era, judicial institutions are "increasingly incorporated into a continuum of apparatuses (medical, administrative, etc.) whose functions are for the most part regulatory" (Foucault, 1976, p. 144).

102 Court as a Space of Liminality

The first critical issue that emerged from this research is the potential for 102 Court to transform people's lives. The court held tremendous meaning for some of the accused who completed diversion. Put simply, it was a second chance; an opportunity

to change their lives. For some, like Big Al, 102 Court was essentially a threshold that he struggled through and which transformed his life from a pre- to a post-mental health court reality. For Brian, the transformative possibilities of 102 Court were more limited. He clearly recognized the legal advantages of having charges stayed or dropped as a result of participation in diversion, but he did not embrace a broader opportunity to transform his life as Big Al did. This seems to be the therapeutic *potential* of 102 Court. It is not in the collaborative legal process, or assuring access to community-based services, or even necessarily pharmaceutical treatment. Because for some accused who pass through 102 Court, those three mechanisms of therapeutic jurisprudence, may be anti-therapeutic. This apparent ambivalence may be explained by considering 102 Court as a threshold. Some accused (like Big Al) are transformed through the experience; other accused (like Brian) may cycle in and out of contact with the law and 102 Court, caught in an ambiguous space of precarious (in)stability.

The anthropological literature about thresholds and liminality began with the publication of *Rites of Passage* (1960[1909]) by Arnold van Gennep. Liminality derives from the Latin *limen*, meaning threshold. Generally, it refers to in-between situations characterized by the dislocation of established structures, a reversal of hierarchies, and uncertainty about the future (Horvath, Thomassen, & Wydra, 2009). Liminality was used by van Gennep to define the middle of three stages of rituals in small-scale societies. He recognized a pattern among rites of passage in many different societies. During the separation phase, likened to a metaphorical death, the initiand must leave something behind by altering routines and practices (van Gennep, 1960 [1909]). In the middle

phase, the transition phase, marked by liminality, a strict sequence of activities is followed under the guidance of a leader or master of ceremony. In the final stage, the incorporation phase, the initiand is re-introduced into society with a new identity (Van Gennep, 1960 [1909]). Thus the transformation is complete. These stages may be applied broadly to rites of passage such as Bat Mitzvahs or graduation ceremonies, but may also be productively applied to natural disasters such as transformations in the wake of Hurricane Katrina, for instance (Thomassen, 2009).

Van Gennep's work was taken up by Victor Turner who began writing on the topic in the mid twentieth century. Turner developed the concept of liminality, some of which (particularly his discussion of liminoid experiences (see Turner, 1974)) do not apply well to 102 Court. However, Turner suggested that a liminal state may become stuck or "fixed"; a dangerous situation in which the suspension of normal life characteristic of liminal stages becomes permanent (Turner & Turner, 1978). More recently, authors interested in liminality suggest it can be a tool to bridge interdisciplinary boundaries, specifically experience-based and culture-based approaches (Horvath et al., 2009). In other words, the model may be applied to voluntary and involuntary situations (Thomassen, 2009) working in various disciplines, but most generally liminality refers to an in-between period (Horvath et al., 2009).

For anthropologists interested in liminality, there have been, since van Gennep's work, many transformations of how liminality may be productively utilized (see Thomassen, 2009). Van Gennep's work on rites of passage and liminality remained marginal in the European academy for political reasons (see Thomassen, 2009 for a

discussion of van Gennep's relationship with Durkheim and his subsequent marginalization in anthropology). Thomassen says, "liminality is a world of contingency where events and ideas, and "reality" itself, can be carried in different directions" (Thomassen, 2009, p. 5). Van Gennep was interested in studying phenomena as they occur, and because of this perspective, "liminality makes sense only within social dramas" (Thomassen, 2009, p. 13). Using this model, I contend that 102 Court is fundamentally liminal. That is, the underlying characteristic that ties the themes discussed in Chapter Three together (including the variations) is liminality.

Liminality has both spatial and temporal dimensions and may be applied to many different subjects: individuals, groups, or entire civilizations. Van Gennep stressed that liminality may operate at the individual and collective levels simultaneously. Below (Table 2.) I adapt Thomassen's model for consideration of 102 Court accused (Thomassen, 2009, p. 17).

Table 2. Types of Liminality Experienced by Accused

| Time | Individual | Group | Society |
|---------------|---|--|---|
| Moment | Sudden event affecting one's life – traumatic arrest or crisis that led to 102 Court | n/a (there are no cohorts in 102 Court, but there may be cohorts associated with court-appointed services such as rehab) | n/a |
| Period | 102 Court reporting | 102 Court reporting every morning at 10:00 a.m. | Deinstitutionalization, implementation of universal healthcare in Canada |
| Epoch | Individuals standing outside society by choice or designated. Chronic framing of schizophrenia and bipolar disorder. Accused are marginalized socially, economically, and politically, usually for the duration of their lives and not by choice. | Social minorities - permanently marked status of mentally ill people. | Increasing pharmaceuticalization of medicine, stigma of mental illness (especially schizophrenia and bipolar disorder). |

By presenting Table 1. adapted specifically to the accused of 102 Court, it becomes obvious that there are accretions of liminality experienced by accused. Certainly, liminality operates simultaneously at the individual, group, and society-wide levels with various temporal dimensions as well. For the accused of 102 Court, it may

be argued that they are individuals who have been marginalized and stand outside society due to the symptoms they suffer with schizophrenia or bipolar disorder. But, perhaps it is more accurate to call them a particular social minority group; people who hear voices and suffer other psychotic symptoms that will chronically marginalize them from the mainstream. There are enduring experiences related to the stigma of serious mental health problems, the historic deinstitutionalization that occurred in Canada in the 1950s and 1960s, the implementation of universal healthcare and the subsequent pharmaceuticalization of medicine. There are degrees of liminality (Thomassen, 2009) and liminality among the accused is perhaps most acute at the individual level. Despite being part of a stigmatized social minority due to both mental health problems and legal problems, and the routinized solutions of 102 Court, accused are overwhelmingly framed as individuals. There are no formal cohorts of accused in 102 Court but informal cohorts may develop when reporting schedules overlap for periods of time. For instance, a group of accused may all be asked as individuals and by different social workers to report to court every Monday, Wednesday, and Friday for weeks. They all come just before 10:00 am, wait in the hall outside the courtroom, and eventually may take on the characteristics of a cohort.

Using the phenomenological data presented in Chapter Three, the accused experienced 102 Court as a threshold and in this regard it related well to van Gennep's middle stage of rites of passage, the transition or liminal stage. Basic rules of behavior are questioned and hierarchies are suspended in the liminal phase (Thomassen, 2009). In 102 Court, the adversarial process that defines the criminal justice system is

suspended, the regular rules of etiquette for courtrooms are relaxed, and one of the main goals of the court is to release people from jail as quickly as possible unlike regular courts. Liminal periods are characterized by a collapse of order and a loss of background structure (Thomassen, 2009). Arrest and imprisonment, uncertainty about future outcomes, loss of housing, disruption of personal relationships, and the confluence of panoptical medical and legal processes combine to exacerbate disorder and undermine the structures of regular life for accused. The leader or master of ceremony role might be considered the judge although typically a master is someone who has himself been through the liminal phase and therefore guides from experience. The reporting rituals are the formal, public, well known procedures that if completed properly will lead to a new status. If diversion is successfully completed by accused they are said to graduate from the program. This graduation parallels the graduation that occurs to mark passage out of liminality into a new status of reintegration.

But there is a danger, as Turner recognized, in being caught in permanent liminality (Thomassen, 2009), when a person gets stuck in one the three stages of rituals (Turner & Turner, 1978). Many accused of 102 Court cycle in and out of trouble with the law. They are cyclically on and off medication, adequately and inadequately housed, and are often committing the same crimes over and over again. Recall James who chronically dined and dashed pub lunches in Toronto. He became stuck in the liminal stage of 102 Court and his case illustrates the dangerousness of permanent liminality. When it became clear to the authorities of 102 Court, that diversion had not changed James' behavior and that it was very likely he would continue to cycle in and

out of trouble and the court, James was found not criminally responsible for his actions and remanded indefinitely to a psychiatric facility under the auspices of the Ontario Review Board. Turner called the permanency of transitional states “the institutionalization of liminality” (Turner, 1969, p. 107). Permanent liminality is indeed a dangerous state, one that may lead to indefinite detainment in a psychiatric facility in response to nuisance crimes. This institutionalized liminality becomes a zone of exception (Agamben, 1995) in which an accused becomes invisible to the world.

Turner understood that liminality went beyond recognizing the importance of in-between states and could also help understand psychological sequelae related to those experiences (Thomassen, 2009). Thomassen (2009) asserts that in modern societies rites are increasingly individual oriented; part of processes of individualization. The experiences of the accused of 102 Court offer a counter example where the ubiquitous pharmaceuticalization of accused and the routinized processes and language of the court homogenize accused as a group. This facilitates the management and specifically the surveillance of the accused by the court. The antipsychotic medications administered to so many accused have Parkinsonian side effects, replacing the public unmedicated symptoms like voice-hearing and associated distractions and talking (often visible and disconcerting for observers) with the flattened affect and masked emotions associated with Parkinsonism.

Racial Axis of Structural Violence

Comack and Balfour (2004) say that law is more than a set of rules; it is a “process that entails gendering, racializing, and classing practices” (Comack & Balfour, 2004, p. 10). Law is a normative system set up to control events, and I would add behaviors, that challenge those norms (Gigeroff, 1969). Farmer and Gastineau (2009) argue (as does much of Farmer’s work) for the symbolic centrality of health and listening to the sick and abused to uncover the violence at work in people’s lives. However, Farmer (1997) warns of the complexities of explaining or even describing extreme suffering. Glimpses into the structural and corporeal violence that marks of the lives of the accused of 102 Court permeated this study. In this section I will discuss the egregious racial disparity observed in 102 Court.

Chapter Two offered evidence that there is an over-representation of black men in 102 Court. Also, evidence indicated that there are critical outcomes of 102 Court processes that differ by race including remand to the Ontario Review Board for indefinite detention. Racial disparity in psychiatric diagnosis and disproportionate detention seems to indicate a degree of structural racism. However, it is difficult to contextualize these findings due to the lack of racial disparity data in Canada related to both the criminal justice system and the prevalence of serious mental health problems like schizophrenia. The scarcity of evidence (and formal and informal disinterest) pertaining to race contributes to the structural violence experienced by 102 Court accused.

Conversations with the national black advocacy group, the African Canadian Legal Clinic assure me that there is anecdotal information that are regularly presented

to them, but no dataset exists to their knowledge that documents the rates of black people who pass through the criminal justice system. That people diagnosed with schizophrenia are regularly found in the courts is common knowledge among community social service workers and advocacy groups, evidenced by the regular visits of representatives from the Schizophrenia Society of Canada to the Old City Hall courthouse. However, every conversation with professionals who deal directly with clients with schizophrenia yielded no information about rates of schizophrenia among racialized Canadians. A recent paper published in the Canadian Journal of Psychiatry reviewed 229 papers regarding the rates of mental illness among immigrants, refugees, ethnocultural, and racialized groups in Canada (Hansson, Tuck, Lurie, & McKenzie, 2012). They found “very little research on non-immigrant, culturally diverse populations in Canada” (Hansson et al., 2012, p. 111). None of the authors’ review articles focused on people suffering with psychosis (Hansson et al., 2012). Only aboriginal peoples regularly appear in the literature documenting over-diagnosis of mental illness among Canadians. Some research focuses on psychosis among immigrant and refugee populations (see for example Seeman, 2010) but this framing of people as immigrants focuses the critical lens on the process of movement and relocation and ignores questions about racism or othering. It also does not create the space to consider the effect of racism on mental health outcomes among racialized Canadians as has been recorded elsewhere (Noh, Kaspar, & Wickrama, 2007). Research from the United States records an over diagnosis of schizophrenia among African-Americans, particularly African-American men (Barnes, 2008; Metzl, 2009). As Hansson et al.

(2012) concluded, the lack of information about race and mental illness may result in less than equitable mental health services for Canadians.

A literature review was conducted for race and ethnicity in the Canadian judicial system. Evidence is plentiful from the United States that there are a disproportionate number of black men arrested and incarcerated (Alexander, 2010). There is a far murkier picture that emerges about Canadian people and the relevant social systems. There is an almost complete absence of racial disparity data that relates to black people in Canada.

There is more research regarding race and the judicial process compared with rates of schizophrenia but the picture is far from complete. The Toronto police services website acknowledges that they deliberately do not collect or publish racial data except for police stop data (Toronto Police Service, 2003). This policy and practice was intended as a means to reduce stigma and racism but it confounds attempts to contextualize these study results and may actually mask disparities. Some information about Toronto police profiling (police stop statistics) is available due the work of investigative journalists employed by the Toronto Star newspaper (Rankin & Winsa, 2012). The profiling is more egregious in some zones than others. For instance, in the downtown's Entertainment District, the ratio of young black men stopped to the resident population is 252:1, for young brown males it is 65:1, and for young white males it is 23:1 (Rankin & Winsa, 2012). Their analysis of police stop data in Toronto between 2008 and mid-2011 indicated that the number of black and brown males stopped by police in each of the city's patrol zones exceeded the number of young black and brown

men living in those zones (Rankin & Winsa, 2012). Arrest statistics do not exist for Toronto and Canadian incarceration rates are national in scope. Aggregate statistics often mask regional differences and I would expect incarceration rates of black men to be more concentrated in the large cities in which the majority of black Canadians reside: Toronto, Montreal and Ottawa account for 70% of the black Canadian population (Mensah, 2010). National statistics reveal there is an overrepresentation of black men in the prisons which is not as egregious as the situation faced by aboriginal men, but still of concern.

Certainly a limitation of the observational data collected in this study is that racial identity is not self-reported. Access to people being held in prison was outside the scope of this research and ethics approval because incarcerated people are considered vulnerable populations. Practically, there was no way to speak to accused held in custody to ask them how they would consider their racial identity. For that matter, given the numbers of people who report to the court out-of-custody, it was also impractical to interview them all as they report in rapid-fire sequence at 10:00 am. The point of entry into the criminal justice system is police arrest, which is often based on racial profiling. Therefore, observational data may more accurately simulate systemic prejudice than self-report. Recall that my investigation into race and gender began with the observation that there seemed to be a disproportionately high number of older white women and young black men in 102 Court as accused.

Due to the observational methodology, it was impossible to distinguish aboriginal accused from either white or other visible minority accused. Toronto's mental health

court may or may not have had aboriginal accused passing through it. The presence of an aboriginal specialty court in the same building may have reduced the numbers of aboriginal accused observed in 102 Court. But working aboriginal peoples into future research designs would be an important clarification.

Bio-power and pharmaceutical subjectivity

The final two critical issues that emerged from this research are the possibilities of involuntary pharmaceuticalization and indefinite psychiatric detention and the authoritative and de-politicized discourses that mask coercion. MacDonald, Hucker, and Hebert (2010) argue that the court system does what it can, but that it cannot determine best placement for the mentally ill nor can it address clinical needs. And yet 102 Court attempts to do just that. Justice Richard Schneider, writing about the establishment of 102 Court, specifies the deliberate attempt to direct disordered accused away from the legal system and back to the medical system where they properly belong (Schneider et al., 2007). The law medicalizes legal practices and transforms subjects from legal subjects to medico-legal subjects. The therapeutic jurisprudence that underlies 102 Court is premised, in part, on the notion that seriously mentally ill accused are before the courts due to illness. This approach, looking upstream for non-criminological causes is laudable. However, the cornerstone solution is pharmaceuticalization that helps some, is neutral or tolerable to some, and forecloses possibilities for others. The phenomenological data presented in Chapter Three gathered from Big Al and Brian are two examples of success stories that had different relationships with pharmaceutical

interventions. For Big Al, antipsychotic medications helped him through the worst times with his symptoms. It did not eliminate his voices, but helped him to tolerate them. But for Brian, the side effects were intolerable so he discontinued his medications, thereby threatening his successful diversion and forcing him to hide his non-compliance from physicians and social workers.

This reliance on pharmaceutical solutions mediated by the legal system is a perfect suturing of the once de-coupled anatomo-politics and bio-politics that accompanied deinstitutionalization. There are both disciplinary and regulatory techniques that overlap in 102 Court processes. Psychiatric treatment becomes involuntary, and the consequences of non-compliance legal. Psychiatrists and other health care workers become part of the mechanism of surveillance, mandated to report non-compliance. Accused are forced to present health care workers with synopses of criminal allegations. This disrupts the patient-provider relationship, when accused are fully aware that practitioners are part of the legal system as much as a psychiatric system. As arbiters of the norm, forensic psychiatric assessments and the mandatory compliance to their prescriptions authorized by the judge makes pharmaceuticalization a technique for ordering disordered individual bodies and the processes through which a problematic population of mentally ill accused may be managed.

Pharmaceutical compliance becomes a mechanism for incorporation (or re-incorporation) of marginalized seriously mentally ill accused into society in multiple ways. The symptoms of psychosis that render sufferers as “other”, outside the perimeter of social normalcy may, for some, be lessened, bringing the accused closer to “passing”

for normal despite lingering sentiments of isolation and persistent (if tamed) symptoms. Foucault calls this otherness “dividing practices” and offers three examples: the mad and the sane, the sick and the healthy, and the criminals and the good boys (Foucault, 1982, p. 777). The accused of 102 Court are divided from others in all three of these ways. It is the accumulation of dividing practices in this population that really poses a problem for governance. Their compliance with pharmaceutical treatment while in diversion helps accused avoid the legal slippery slope that may result in long-term detainment in a psychiatric facility. It may help break a cycle of recidivism and mounting criminal charges that threatens the freedom of accused despite the relatively minor nature of their legal transgressions. Foucault contends that the goal of discipline and punishment in the modern era is the production and management of useful, efficient bodies (Foucault, 1977). But there is no expectation that 102 Court accused will ever be useful and efficient. I argue that the therapeutic jurisprudence (as it is operationalized in 102 Court) is more of a regulatory technique, where inefficient bodies are rendered “normal”, and thus easily manageable. Compliance with pharmaceuticals becomes both the disciplinary technology and the regulatory technology.

One of the effects of 102 Court is the production of pharmaceutical subjects. Jenkins (2010) argued that the pharmaceutical self is amplified in the case of schizophrenia. Here, I argue that the pharmaceutical self is amplified even further when a person suffering psychosis becomes a medico-legal subject. Discourse about illness and medication contributes to the creation of pharmaceutical subjectivities for Jenkins (2010). But in criminal justice systems including 102 Court, the ubiquity and power of

routinized and legalistic discourse amplifies this effect. The accused of 102 Court engage the pharmaceutical self through the experience of taking antipsychotic medications, they engage the pharmaceutical imaginary when they interact with the institutional dimension of treatment (Jenkins, 2010). However, 102 Court adds additional layers of surveillance, a wider array of authorities, and additional institutional arenas of contact. Jenkins (2010) after Foucault (1976) asserted that, “the increasing medicalization of mental illness is the spread of a form of diffused governance that produces rational and technical categories and practices that vitiate the moral and political meaning of subjective complaints and protests” (Jenkins, 2010, p. 3), a state response to a perceived crisis (namely the deinstitutionalization and criminalization of the seriously mentally ill). Certainly this is consistent with work by Metzl (2009) about the political and historical deployment of the psychiatric category of schizophrenia in response to race protests in the United States (Metzl, 2009). The findings presented in Chapters Two and Three have little to do with subjective complaints or protests, but they do serve a purpose. Seriously mentally ill people are often unseen by the world. They live precarious lives on the edge of society, many are homeless, they are frequently marginalized economically, socially, psychically, and politically. Whether engaged with medical care or legal issues, seriously mentally ill people challenge efficiency and cost-effectiveness, which have become the hallmarks of modern, capitalist systems of governance. They are, as one accused father called them, the “unwanted”. So the processes of 102 Court may be considered a diffuse form of governance that produces rational and technical categories that make seriously mentally ill people invisible again.

The ideal resolution includes securing their freedom (at the cost of pharmaceutical compliance) to maintain invisibility and fits well within a decades long Canadian vision of a “just society”⁷⁶ but is perhaps more appropriately consistent with Foucault’s “normalizing society”, the historical outcome of technologies of power centered on life, such as bio-power (Foucault, 1976). But if the conditions of diversion are unable to be satisfied and cycling through the mental health court occurs, accused may either be shunted back to the regular system or detained in psychiatric facilities indefinitely. But by either route, they become invisible to society again. Biehl has claimed that psycho-pharmaceuticals “mediate abandonment” through the scientific truth value” and the physiological effects of drugs (Biehl, 2010, p. 95). In 102 Court, psycho-pharmaceuticals mediate invisibility and conformity.

The truth discourses deployed by authorities associated with 102 Court also mediate rationality. One of the contradictions that pervade the subjectivation processes of the court is the inconsistency of accused’s rationality as they proceed through the system. The irrationality and rationality of people who pass through 102 Court as disordered accused are strategically ascribed by authority figures such as lawyers, judges, forensic psychiatrists, and the social workers who work as part of the court team. I was cautioned by a judge and a forensic psychiatrist that it would be useless to interview or speak with accused because they are “completely irrational”. When accused appeared in 102 Court in custody and scream out allegations of abuse suffered at the hands of court officers, police officers, or corrections officers, their cries are

⁷⁶ The idea of a “Just Society” as a vision for Canada was used repeatedly by former Prime Minister Pierre Trudeau and has since become part of a national imaginary.

largely ignored due to ascribed irrationality. Yet there are several aspects of their participation in diversion that hinge on the rationality of accused. For instance, the voluntary decision to participate in diversion of 102 Court is framed as a rational choice informed by their counsel's explanation of responsibilities and outcomes associated with that choice. This expectation of rationality continues through the processes of diversion such as scheduling appointments for reporting to court and with community-based service providers. The penalties for breaching conditions of bail (i.e. further criminal charges) imply that breach of bail occurred with complete rationality. Ironically, many alleged crimes are presented as rational within a delusional framework. For instance, a man appeared in-custody in 102 Court accused of assaulting a woman and her young son on a city street. The mother and child were walking on a sidewalk, behind the accused and in the same direction. With a diagnosis of paranoid schizophrenia, defense argued that his client believed the pair were stalking him, he became increasingly fearful, and finally turned around, confronted them, and defended himself from this imaginary aggression by hitting them. The judge who heard this argument agreed that this was a rational response given the delusional and paranoid nature of his diagnosis. This strategic ascribed rationality is one aspect of the structural violence faced by accused. Their (ir)rationality becomes a strategy of silencing them and of holding them accountable for their own legal issues while creating a space where professionals do not need to address accountability regarding their clients⁷⁷.

⁷⁷ Several lawyers I interviewed suggested that there are, among their colleagues counselors who enjoy working with mentally ill clients due to lack of accountability that is possible with uncritical clients or clients that are in effect, voiceless.

Future Directions for Research

Social workers and social justice advocates are implicated in many of the processes and outcomes of 102 Court and all mental health courts regardless of structural organization. This dissertation research opens several avenues for future research, both qualitative and mixed methods and in both Canada and the United States.

The experiences of successful graduates of mental health courts beg the question of what happens to these successful graduates over a longer period of time. It also raises the question of how the experiences of successful graduates compare over an extended period of time with accused who fail to graduate or who opt to have their cases heard in the regular stream of justice. Also, some mental health courts have cohorts or peer mentors, two internal support mechanisms that may alter both outcomes and experiences among accused. These are some of the comparative and long-term research questions that emerge from this work.

Research regarding racial and gender disparities within the Canadian criminal justice system and the mental health care system is urgently needed. Large criminal justice and healthcare databases exist in Ontario, and Canada more generally, but access is restricted. It is possible to request the information although the process is often prolonged. However, quantitative analysis of population wide data about the demographic characteristics of who is prescribed antipsychotic medication is, at least

theoretically, possible⁷⁸. Given the specificity of certain medications, such as lithium, to treat diagnosed bipolar disorder, this approach may prove valuable. Similarly, data from the criminal justice system is also available upon request. Recently a report emerged in Canada regarding the soaring number of aboriginals in Canada's prisons (Sapers, 2012). The research, however, was conducted by the Office of the National Investigator, a federal government agency that had access to records that may not have been available to an outside researcher. Their research was reported widely in the Canadian media in the spring of 2013 with little discussion about disparities among other racialized groups in prison. There is little foundational work about prevalence rates of serious mental health problems and arrest and incarceration rates by race that could serve as the basis for asking more subtle questions about specialized courts in Canada⁷⁹. For instance, how do specialty courts work together? By this I mean there are locations, including the courthouse in Toronto in which I conducted this research where *Gladue* (a.k.a. aboriginal) court, drug court, and mental health court all operate with overlapping populations of accused. How are decisions taken by Crown attorneys and defense lawyers to determine who appeals to which court? It is entirely possible to have an aboriginal person suffering from a psychotic disorder and addicted to drugs. Are graduation rates from diversion programs variable by race and gender? Certainly the administrative judge of 102 Court would welcome an evaluation of the court.

I heard numerous expressions of concern about the Ontario Review Board [ORB] processes and as a site of discrimination. Review board hearings are, like 102 Court,

⁷⁸ It is difficult to determine exactly what fields are included in these large datasets.

⁷⁹ that are already being asked in the United States

open to the public although rarely attended. A brief ethnography of the ORB might reveal disparity and provide the evidence on which to base a broader study of the system of indefinite detention. Again, there may be a way to leverage the large provincial health datasets to explore who is detained in psychiatric facilities, with which diagnoses and for what length of time.

Much of my future research will be conducted in the Dallas-Fort Worth metroplex of the United States, an excellent location to conduct research given the extensive network of specialty courts and associated judicial and medical facilities. There are 13 specialty courts that operate in the metroplex. I plan to replicate the phenomenological part of this dissertation among accused who have passed through those courts and to establish a long-term protocol for tracking graduates. The Dallas-Fort Worth courts work with social services practitioners who serve these populations. Some research has been (and is being conducted) with these courts, so more is known of the demographics of accused and racial disparity in graduation rates and the courts are in contact with social work researchers. For instance, John Gallagher explored racial disparities in a Dallas area drug court for his dissertation and found that African American accused had lower rates of graduation than Caucasian and Hispanic counterparts (John Gallagher, personal communication, October 2012). Ethnography of the courtrooms would augment work done by Dr. Gallagher whose insights included that courtroom practices negatively impacted African Americans proceeding through the drug court, but he did not include actual research in the courtroom (John Gallagher, personal communication, October 2012). Also, I hope to establish a long-term qualitative study that explores

experience of the justice system, mental health care services, and recidivism among mental health court graduates compared with accused who were eligible for mental health court but chose the regular stream. The coordinated assessment units that serve the Dallas specialty courts would be an excellent location to explore decision-making processes that impact court demographics, processes, and outcomes.

There are several implications for social work practice that emerge from this work. First, understanding the experiences of the accused within mental health courts is an important component of practice, but practitioners in these settings are, as this research indicated, part of the system and may not be able to accurately collect feedback from their own clients, creating an opportunity for an independent researcher to mediate. Social work that utilizes a Foucauldian lens to reflect on practice is not unknown (see Chambon, Irving, & Epstein, 1999) but to my knowledge has never been applied to social workers associated with specialty courts. Finally, most of the social workers associated with 102 Court indicated how under-prepared they were for their positions. Forensic social work practice and pedagogical assessments are indicated and I have begun to speak with other qualitative and mixed methods researchers who work in mental health courts to pool data and draw comparisons crucial to practice in a comparative manner. Specific to the Toronto setting is a concern regarding the lack of attention to racial disparities and to matters of cultural influence and variation that might impact outcomes. While practitioners are directly implicated with these concerns, the target for future research would be provincial government policy makers who decide

which data variables to include and which to omit and who make the data they do possess very difficult to access.

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