Social Exclusion in a Mental Health Court?

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Abstract

This article is based on a study, inspired by institutional ethnographic methods, of a mental health court (MHC) situated in Montréal, Canada. The focus of this article is on the qualitative results of the project, namely, the perceptions and experiences of accused (*N*=20) who were involved in the court as well as key actors (*N*=10) who make up the multidisciplinary team. In addition, findings from participant observation and a quantitative review of court files are drawn upon to flesh out the data. We argue that MHCs promote a special form of social exclusion based on *othering* that considers accused to be deviant, dangerous, or fragile. In an effort to control risk, MHCs target risky behaviours and reward individual mobilization efforts through their promotion of autonomy and self-regulation and their emphasis on psychiatric interventions. These new "socio-medico-juridical practices" bridge two systems of domination, psychiatry and the law, in an effort to "de-marginalize" mentally ill accused along three axes of intervention —juridical, therapeutic, and individualization and responsibilization efforts.

Keywords: mental illness, accused, risk, otherness, judiciarization, self-governance

Mental health courts (MHCs) belong to a broader category of specialized or problem solving courts (i.e., drug, intimate partner violence, community) that seek to channel accused from the mainstream processing of the criminal justice system into community-based treatment programs (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009). These courts emerged during the 1990s due to the growing concern that an alarming number of accused were cycling through the criminal justice system with a combination of mental health and substance abuse problems (McGaha, Boothroyd, Poythress, Petrila, & Ort, 2002), resulting in the "revolving door" syndrome (Wexler & Winick, 1996). The first of these specialized courts appeared in Florida, USA, in 1989 (Nolan, 2009). Roughly ten years later mental health and drug treatment courts surfaced in Toronto, Canada (Schneider, Bloom, & Hereema, 2007). While the literature on MHCs in Canada is not extensive, as of 2009, there were 14 tribunals in Canada, and 7 in the process of being established (Jaimes, Crocker, Bédard, & Ambrosini, 2009). To date, little is known about the inner workings and effects of such courts in Canada, as no evaluations have taken place (Baine, 2013).

There is only one MHC in Québec, Canada (Jaimes et al., 2009), established in 2008 at the Montréal municipal court as a joint venture between the City of Montreal, the Quebec Justice Department and the Quebec Ministry of Health and Social Services (Douglas Institute, n.d.). This is the court that will be explored in this article.

MHCs vary from court to court but rely upon the deployment of a multidisciplinary team consisting of judges, prosecutors, psychiatrists, social workers, and probation officers whose aim is to work collaboratively to provide a response, often treatment-oriented, to the needs of the individual[1] (Schneider, 2010). The key elements of such specialized courts are: a non-adversarial approach, voluntary participation, tailored intervention plans, more flexibility, a designated judge, and a separate docket for defendants (Hartford et al., 2004). These specialized courts combine legal and therapeutic strategies and practices to manage individual risk of recidivism. One of the primary aims of MHCs is to facilitate treatment for mental illness by linking defendants to a wide range of community-based supports. The courts do not create any new type of service, but rely on existing services and treatment facilities (Lerner-Wren, 2009). As many MHC accused are already familiar with health and social service programs, the MHC has a greater impact on the frequency of treatment received than on the kinds of treatment themselves (Luskin, 2013). In spite of a disconcerting focus on medication, there is no doubt that MHCs do facilitate access to a wide range of services, such as mental health, legal, housing, and social services (McNeil & Binder, 2010; Provost, 2010; Trupin & Richards, 2003). However, there is a dearth of qualitative knowledge regarding the experiences of accused taken up in these courts as well as those of court actors who make up the multidisciplinary teams (Provost, 2011; Slinger & Roesch, 2010).

To close this gap, this article unveils aspects of a study that utilized institutional ethnographic methods whose principal objective was to explore the processes and effects of a Mental Health Court (MHC) in Montreal, Canada. The aim of the study was to examine the points of view of the accused and those of key actors regarding the nature and scope of the court's work as well as to offer some preliminary outcomes in an effort to expand our limited knowledge of MHCs. It also explored the interprofessional practices and discourses that are central to the MHC's functioning. We begin the article with a brief resume of the MHC literature and its historical foundations, followed by the theoretical framework that guided the research. Methodological strategies and choices are then described. The results section illuminates accused and key actor's experiences: the contradictions and tensions that tend to manifest in MHC discourses and practices. A discussion section ties the empirical elements to the theoretical underpinnings of the study to deepen our understanding of MHCs. Lastly, the article advocates for future enquiries to probe deeper investigative work.

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[1] In the case presented here, the team was made up of a general practitioner (not a psychiatrist), caseworkers (not necessarily social workers), and criminologists.

Mental Health Courts: A Response to Mental Illness, Crime, and Marginality?

The mentally ill are over-represented in the criminal justice system (Crocker, Nicholls, Côté, Latimer, & Seto, 2010), and the rapid proliferation of MHCs is one response to this phenomenon. Some scholars have argued that MHCs are a stop-gap measure in response to failures of the social, health, and justice systems to meet the needs of those suffering from mental illness. For example, from an historical and structural perspective, MCHs could be considered as a solution to psychiatric deinstitutionalization, which failed to infuse Canadian communities with requisite supports (Bernheim, 2012; Otero, 2010). Changing socio-political and legal understandings of mental illness in North America more broadly have brought about "a shifting of responsibility onto the criminal justice system for the provision of basic mental health care services" (Schneider, 2010, p. 202). The *Québec Ombudsman* (2011) reported that 61% of incarcerated individuals had had at least one psychiatric and/or substance abuse diagnosis within the last five years; and, that 17.4 % of the detention centre population suffered from a severe and persistent mental illness (as compared to the 1–3 % of the general population of Quebec). There is evidence to suggest that the prevalence of mental illness among federally incarcerated offenders in Canada has increased since the 1960s, in direct response to the deinstitutionalization movement and to changes in the Criminal Code, notably the introduction of the NCRMD[2] status (Crocker et al., 2010). Some argue that the intersection of the justice, social, and health systems produce a form of re-institutionalization (Jaimes et al., 2009) or trans-institutionalization (Frappier, Vigneault, & Paquet, 2009), and posit that the tribunals are simply a form of "diversion to treatment intervention" (Wolff & Pogorelzki, 2005). In essence, these courts provide a way to circumvent failing social and health services and strong-arm intervention.[3]

The recent creep of police interventions with the mentally ill in Canada has resulted in their over-representation in police shootings, stun-gun uses, and fatalities (Brink et al., 2011) garnering widespread media, program, and policy attention (Coleman & Coton, 2014). Studies have shown that two in five people with mental illness in Canada have been arrested over their lifetime, and half of the interactions with police have involved alleged criminal behaviour (Brink et al., 2011). Scholarship on social profiling in America has demonstrated that police officers are twice as likely to arrest those who appear mentally ill, and more likely to charge them with minor offences than their counterparts who are not mentally ill (Bernstein & Seltzer, 2003, p. 143–145). Moreover, there is evidence that the mentally ill are "arrested at higher rates and spend more time incarcerated than similarly situated individuals; once incarcerated, they are victimized by other inmates, many do not

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[2] NCRMD: not criminally responsible due to mental disorder

[3] "The goals of mental health courts, then, are: 1) to break the cycle of worsening mental illness and criminal behavior that begins with the failure of the community mental health system and is accelerated by the inadequacy of treatment in prisons and jails; and 2) to provide effective treatment options instead of the usual criminal sanctions for offenders with mental illnesses" (Bernstein & Seltzer, 2003, p. 148).

receive proper mental health treatment, and their psychiatric conditions deteriorate" (Seltzer, 2005, p. 573). Furthermore, some Canadian authors have noted that police interventions view judiciarization[4] as a lever to access scarce psychiatric resources (Cardinal & Laberge, 1999). People with mental health problems in North America are commonly perceived to be more dangerous and violent than others; however, this is statistically unproven (Crocker & Côté, 2010; Stuart & Arboleda-Flòrez, 2001; Teplin, McClelland, Abram, & Weiner, 2005). This bias is frequently reinforced in the North American media (Lamboley, 2009), where people with mental health problems tend to be portrayed as dangerous perpetrators rather than victims of violence (Seltzer, 2005). This view is becoming more predominant and reinforces stigmatizing views that the mentally ill are violent, dangerous, and unpredictable (Markowitz, 2011). This linkage reinforces the notion of the criminal justice system as an appropriate response to mental health problems, and hence promotes a form of *othering*, of social profiling with regard to mental illness.

An extensive scholarship addressing the limits of the punitive state exists (Feeley & Simon, 1992, 1994; Garland, 2001; Waquant, 2009); however, there remains a gap in scholarship dealing with the specific intersections of punitive and preventative legal and penal practices that are integrated in MHCs. Current theoretical and empirical scholarship exposes certain contradictions between the goals underlying these practices and their effects (Hannah-Moffat & Maurutto, 2012; Miller & Johnson, 2009). For example, MHCs claim to reduce criminal recidivism among mentally ill offenders (Hiday & Ray, 2010) and increase participation in community-based treatment (Goodale, Callahan, & Steadman, 2013); however, researchers have found little empirical evidence demonstrating the ways in which they promote change (Canada & Gunn, 2013; Canada & Watson, 2013). Additionally, rather than developing alternative, responsive, and tailored interventions, MHCs have been observed to rely on a medicalized understanding of mental health problems, in which accused are surveyed over longer periods of time than is the case for most typical misdemeanants (Trupin & Richards, 2003). Recently, some authors have demonstrated that specialized courts have resulted in "extended supervision terms," resulting in deliberate sentencing delays, and that this runs counter to legal statutes that require sentencing as soon as possible after conviction (Hannah-Moffat & Maurutto, 2012). Moreover, these authors have revealed that bail orders contain proscriptive directions designed to "target an offender's deficits and to facilitate normalization and responsibilization" (p. 207). Our epistemological standpoint dovetails with their perspective that "'therapeutic justice' is not merely about imposing treatment; it combines preventative, welfare, and rehabilitative logics that are interwoven with punitive elements" (p. 206). However, these analyses are situated within community, drug, and intimate partner violence courts and demonstrate the profound absence of knowledge about the judiciarization processes and effects concerning the mentally ill, particularly with regards to social exclusion. Studies such as these have started to provide important

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[4] Increased recourse to court intervention, resulting in increased rates of court use (Campbell, Springate, & Trocmé, 2008).

insights into the practices and effects of specialized and alternative approaches to intertwining justice, prevention and treatment; however, most are American as well as descriptive (Slinger & Roesch, 2010). Accused's perceptions of MHCs are only now just beginning to emerge (Canada & Gunn, 2013; Ray, 2012), but they are limited in scope. The following section describes the theoretical underpinnings of this study that attempted to address these knowledge gaps.

Theoretical Framework

This study embraces Foucault's notions of social control and penal governance of managing risk. In particular, it takes up Foucault's (1995) analysis of the power relations embedded in the penal process, the self-regulation and individualizing practices that promote responsibilization, what Garland (1990) refers to as the "penological rationalities" involved in penalization. The management of marginalized populations based on dangerousness, deviance, or connotations of riskiness has never been more pronounced. Penal governance of the *disturbed* and the *disturbing* is evident in practices of mental health review boards and in a shift toward specific mental health laws to intervene when a feeling of danger is present (Otero, 2010). We intentionally take up the term *assemblages of control* (Hannah-Moffat & Maurutto, 2012, p. 203) to mean the integration of institutional structures (partnering agencies) involved in specialized courts that allow for an intersection of penal, health, and social service systems in the set of tailored responses ascribed to the accused's situation, and that are monitored over time.

> The concept of assemblages, adapted from Deleuze and Guattari (1998), can help clarify the interface between various kinds of knowledge and practices of governance that are increasingly shaping criminal justice sites. A focus on assemblages enables a more nuanced understanding of the integration of community into punishment … The concept also enables us to analyse the co-existence and assorted combinations of punishment, welfare, treatment and preventative practices that exist in local penal fields. (Hannah-Moffat & Maurutto, 2012, p. 203)

We believe it is this aspect of surveillance, techniques of control, and the management of risk that are at the heart of these socio-medico-juridical practices in an effort to produce responsibilized and self-regulating subjects (Foucault, 1988, 1991, 1995). However, remarkably little attention has been paid to the way in which differing forms of penal governance, these new "architectures of risk management" (Hannah-Moffat & Maurutto, 2012), infuse the therapeutic justice movement and influence the processes of subjectivation.

Therapeutic justice has been described as the wedding of law *and* psychiatry, displacing a previously contentious law *versus* psychiatry approach (Wexler, 2008). Advocates of therapeutic jurisprudence argue that it proffers a more "collaborative and individualized approach that differs from the traditional criminal justice system" (Slinger & Roesch, 2010, p. 258). However, little in-depth and intimate research has examined how the accused are assessed, monitored, and regulated at the varying intersections of these dominant normative systems over time (Hiday & Ray, 2010; Luskin, 2013). The intertwining of two authoritative systems such as the law and

psychiatry also translate into a powerful system of domination that can import "evidence" from either side to support their arguments for regulation and control, such as is the case with frequently made arguments in court regarding the future forecasting of dangerousness and mental illness based on the long-term refusal of psychiatric treatment (Fradet, 2009). Risk has become a powerful concept in offender case management (Andrews & Bonta, 2010), criminological scholarship (Feeley & Simon, 1992), and in psychiatric settings (Ryan, Nielssen, Paton, & Large, 2010). Risk assessments and tools have become popularized in many offender settings, matching level of risk to level of interventions to control threats and reduce recidivism, inciting rehabilitation (Hannah-Moffat, 2013). However, detractors of risk logics in psychiatric settings have argued that risk assessments are not necessarily reliable or effective (Large, Ryan, Singh, Paton, & Nielssen, 2011). Nevertheless, the notion of risk and "techniques of 'actuarial justice'" have become highly influential in criminology (Donoghue, 2013, p. 1), despite the lack of specific criteria operationalizing significant threat in the Canadian Criminal Code (Crocker & Côté, 2009). Some have argued that the use of risk is preferred in professional circles because plain danger does not have the aura of science and hence does not afford the pretension of control and calculative possibilities (Douglas, 1990; Lupton, 1999). The proliferation of risk impacts how mentally ill accused are assessed, managed, and treated; court-ordered interventions become a vector for imposing self-regulation, thus creating self-disciplining subjects (Foucault, 1988, 1991, 1995) and bringing threats under control. This is a particularly salient lens through which to consider the intertwined logics of risk, mental illness, and penal management, which create a form of social exclusion based on *otherness*.

While the purpose of this article is not to circumscribe social exclusion, it is important to underscore the intersecting forms of unequal relations of power that the accused in MHCs experience. Safely said, accused in a MHC are oppressed by blatant social exclusion indicators such as: "denial of participation in civil affairs, denial of social goods (health care, education, housing, income security, language services), exclusion from social production (social and cultural activities), and economic exclusion (participation in paid work)" (Galabuzi, 2010, p. 32), and these are modulated by varying degrees of oppression affected by race, gender, ethnicity, and disability status. Social exclusion does not only simply imply poverty and unemployment, but also a person's ability to be included, their symbolic status. It speaks to social status, identity, agency, and isolation. Mentally ill accused are characterized in a particular way that promotes a special form of social exclusion based on otherness due to their associated representations of danger, fear, and unpredictability. There is a critical gap in knowledge about how these forms of intervention are experienced by the people for whom the tribunal has been established (either to help or to control), the assumed "voluntariness" stance, and the impact they have on their lives (Frappier et al., 2009). The following section explains the methodological strategies used to illuminate outstanding queries.

Methodology

Inspired by institutional ethnographic methods, this research examined the "'maps' of the ruling relations and specifically the institutional complexes in which they [people] participate" (Smith, 2005, p. 51). Utilizing a multi-method approach we sought to understand how the MHC functioned and to document and analyze the procedures, discourses, and practices inherent in its processes. We wished to flesh out how accused are taken up, perceived, and managed at the intersections of socio-medico-juridical interventions, as well as to understand the accused's perceptions of their involvement.

Institutional ethnography is way of understanding the social relations governing institutions from the standpoint of those affected by these types of structures (Smith, 2005), as well as those actors involved in its deployment. This research utilized a mixed-method design combining semi-structured qualitative interviews with key actors (*N*=10) who comprise the multiprofessional team (judges, crown prosecutors, defence lawyers, caseworkers, probation officer, criminologists, and a doctor) and accused (*N*=20). Interviews with key actors inquired about the nature and scope of their work and their perceptions of their work and of the accused. Interviews with accused explored their perceptions and experiences of the MHC and team members. Researchers were invited to attend team meetings and court appearances to gain a better understanding of the tribunal's proceedings; thus, participant observation was an important method added to the project to encourage triangulation. Over a period of several months we observed the multiprofessional team meeting in which the accused's case (who was to appear in court in the afternoon) was presented and discussed and in which decisions were made about how to orient it before the judge. For instance, what kinds of recommendations needed to be made to the judge, such as whether linking to psychiatric or addictions services needed? Do conditions or sanctions, such as not consuming substances, have to be put in place? Typically the crown prosecutor presented the case and team members gave their opinion on how the case should be managed. In the afternoon, we attended court and witnessed how decisions that were made during the morning meeting were presented to the judge. During team meetings and court appearances, we noted how decisions were negotiated between the different professionals (crown prosecutor, defence attorney, caseworkers, probation officer, and sometimes the criminologist and medical doctor), and the nature of collaboration. Similarly, observing the court in the afternoon enlightened our understanding of how goals of therapeutic justice manifest in the courtroom, most often through the interactions between the judge and accused, and between the crown prosecutor and the defence lawyer.

Caseworkers also invited researchers to observe their interventions with accused (conditional upon the accused's willingness), which involved several days of shadowing their interactions with accused. Participant observation included a minimum of 30 team meetings and 30 courtroom audiences, totalling more than 125 hours of observation time. Quantitative methods extracted data from a random sample of 100 court files over a five-year period (since the court's inception). Each file had relevant police records, case notes, and relevant criminal, mental health, and social demographic histories, though the data contained therein was often patchy.

Data such as age, gender, mental health history, housing and homelessness, and judicial history were collected and analyzed to flesh out socio-demographic history, history of mental health intervention and treatment, and involvement with the justice system. According to Smith's (2005) theory, we paid particular attention to how multidisciplinary team meetings unfolded, meaning we were attuned to team culture, ambiance, and collaboration and negotiation, and to how decisions were made (who held the balance of power). We also observed the impact a more compassionate judge could have on an accused's disposition as well as the inverse: how a judge who was less human in their approach could severely destabilize, even provoke, an accused's demeanour.

The application for an ethical certificate to carry out the research was a three-step process. First, an ethical certificate was applied for and granted by the Université de Montréal, where the researchers work. A second ethical certificate approval was needed from the local health centre from which the court's caseworkers are deployed and with whom the court has a working partnership agreement (Centre de santé et service sociaux de Jeanne-Mance). This second step provoked serious concerns about the feasibility of recruiting accused for interviews, as well as about how this might affect the tenuous relationships caseworkers had with the accused. The principal investigator was invited to meet with the coordinator of the caseworkers to flesh out these issues and to adapt a recruitment strategy that relied heavily on the referral capacities of caseworkers. This proved to be quite an arduous task, as the caseworkers direct contact with participants was of a short duration in a fast-paced environment, and much of their work involved liaising with relevant health and social service professionals. Moreover, accused were often reluctant to meet with caseworkers or share information because their connection to these workers was of a less-than-voluntary nature, in the sense that referral was generally a condition of integration into the MHC. The caseworker coordinator's primary concern was that recruiting participants for the research might harm the tenuous psychosocial relationship they were attempting to establish with accused. She expressed concerns that coming to court is an anxiety-provoking experience for the accused, and she did not want the spotty contact caseworkers had with accused to be hampered. Thus, accused were informed that they could withdraw at any time from the study without notice or explanation, and that this would not affect any services related to the MHC's work, nor the accused's trajectory or outcome of MHC involvement. Ethical considerations were of central importance in this project, as the accused's information was of a sensitive and intimate nature, indicating a person's criminal, health, and social service system involvement.

Positionality[5]

The authors of this article are both white, middle-class academics. The first author and principal investigator of the project is an anglophone, who has a long

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[5] Positionality is a "concept articulated by Linda Alcoff (1988) and others, namely that gender, race, class and other aspects of our identities are markers of relational positions rather than essential qualities" (Maher & Tetreault, 1993, p. 118).

experience as a social worker working on a community mental health outreach team to homeless people. She now finds herself in the privileged position of being a new academic pursuing her passions regarding the treatment of people with mental illness. The second author is a francophone who took the leadership of the project on the ground, organizing data collection and analysis. She is currently pursing her doctorate regarding the effects of psychiatric diagnosis in a MHC. She has a keen interest related to the social construction of mental illness and stigma and completed her Master's in Social Work. While both researchers have never been diagnosed with a mental illness, they have both been affected by the effects of stigma and mental illness in their entourage and in their more public work endeavours, which catalyzes their passion for conducting research in this area. Researchers had no prior connections to the accused or to key actors, and contact with accused was brief, as data was collected at a single point in time. This also represented an obstacle to gathering in-depth data from accused, as no prior relationship, notably one based on trust, existed.

Results[6]

While the focus of this article is on the qualitative aspects of the study, we wish to offer some broad strokes of the quantitative findings in order to situate the resultant knowledge. Of the 100 files reviewed: a majority were men (82%), francophone (77%), and Canadian (69%). Also, 66% were prescribed psychiatric medications, 54% had previous psychiatric hospitalizations, and 48% had an addiction problem. The large majority of the accused (almost 80%) entered the MHC via police arrests. In some cases (23%), the arresting officers noted in the court file that they suspected the accused exhibited psychiatric symptoms.

The files showed 54% had judicial antecedents, with a significant number (23% of the total) having five or more previous charges. In 30% of the files, the accused were homeless. Among this latter group, the degree of homelessness, precarious social conditions, hospitalizations, and prescription of medications was higher. There was also a discontinuity in their diagnoses, and psychiatric services were spotty. Despite several treating teams being mentioned among this more complex group, a solid connection to treatment services was uneven. In sum, 27% of files resulted in charges being withdrawn, 25% were found to be not criminally responsible, resulting in a total of 52% that did not result in a sentence. We turn now to the qualitative results from interviews with key actors and accused, as well as findings drawn from our observations of team meetings and court appearances.

Key Actors

We interviewed ten key actors of the multidisciplinary team to understand their perceptions and experiences of the MHC and of the accused. One of the crown prosecutors described her work in this way:

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[6] The majority of interviews were conducted in French and were translated thereafter into English by the authors.

From the moment that you just take the time to listen and you allow the person to speak, often the accused have a lot of things to tell us, not necessarily legally pertinent, actually rarely relevant to the court procedures, but it is part and parcel of what the accused is experiencing in that moment of time, what concerns them. I know accused feel listened to and understood. That finally they have someone who will take the time to just listen. I do not know the number of times when we have reached the end of MHC's involvement that the accused turns to the judge and says: "Thank you your honour, I feel like it's the first time that a judge listened to me." And I am talking here about offenders who have already been in conflict with the law several times.

MHC Goals

The team indicated that the MHC had three major objectives, delineated by juridical, therapeutic, and individual goals, which we will draw upon further in the discussion section to better understand how the court deploys its interventions. Firstly, in the judicial stream, it was felt that the MHC filled the therapeutic jurisprudence mandate by attempting to stop the revolving door syndrome, that it promoted *dejudiciarization*, thereby reducing recidivism and severity of sanctions, and linking the accused to appropriate health and social services.

Therapeutically, objectives related to reducing the accused's stress and anxiety due to court involvement were achieved by offering a more human and compassionate approach. Specifically, listening to the person to reduce the accused's suffering, accompanying them through the judicial process, and liaising with their treating team in a harm- or risk-reduction approach were mentioned. For example, a caseworker cited that they "translated the legal jargon for accused, so they can better understand what is happening." They attempted to offer a more inclusive experience in a rigid environment dominated by a "justice vocabulary" that in its very nature excludes individuals who are not a part of the milieu. The exclusionary practices of the justice vocabulary meant that accused frequently did not understand what was happening and thus could not participate fully in decisions that directly affected them. In some cases this could have long-term effects such as developing a criminal record. On several occasions, we noticed that the accused appeared confused, disoriented, and in fact said very little unless instructed to by their lawyer. For example, we witnessed several accused answering simple "yes your honour, no your honour," but they appeared uncertain. On the other hand, we also observed that some judicial actors (judges, crown prosecutors, and defence lawyers) took the time to directly question the accused to ensure they understood the conditions emitted by the court. Currently, there is no standardized way for ensuring the accused understands the conditions emitted by the court and the consequences of non-compliance. On several occasions, we witnessed accused in a "breach," i.e., having broken their probation conditions, resulting in an immediate return to the court and triggering another charge. For example, breach situations resulted most often from: not abstaining from substances, frequenting forbidden milieus or people, and most commonly, not appearing at court dates. This resulted in accused acquiring further charges, which spurred longer involvement with the MHC.

A caseworker stated that one of the goals of the MHC experience was "to not unnecessarily judiciarize people, but instead we can use this therapeutic lever to help the person to access resources so that they can have a better quality of life, take better care of themselves." However, some team members were not comfortable with the use of the MHC as a therapeutic lever.

> We have to be careful not to be overzealous. That for me is the most important thing. I mean individuals who might never have been charged for committing a minor offence, and we believe there is a mental illness at play, the police or the prosecutor will charge them and pursue the accusation only to wind up withdrawing the charge because we feel they need help and that we can help them.… An individual who otherwise would have had a very minor punishment and yet because they have a mental health problem their case will be extended over a year, a year and a half, so that we can ensure progress has been made, that they have followed through; but if, however, they did not have symptoms their case would have been dealt with much more quickly.… We need to be wary of not transforming into a charge what otherwise would not have been. (Defence lawyer).

Another therapeutic element considered an objective of the MHC was the tailor-made responses to individual experiences and challenges. Using a case-by-case approach to individual circumstances and experiences again underscores the emphasis on humanizing judicial processes. This was understood as respecting the person's rhythm, taking into consideration the person's efforts, and helping the accused conform to legal and societal expectations by ensuring they understood the consequences of conditions emitted by the court. A probation officer stated:

> You take the person where they are, as they are, and you try to help them along, take them further than where they are able to get on their own. But you also try to responsibilize them for what has happened and, in particular, have them take stock of their mental health problems. In this way, we try to break the cycle of offending. By becoming more aware of their mental illness and the impact it has on their behaviour, we hope to stop the cycle of recidivism and make them more responsible, more aware of their mental illness and the effect this has on their delinquency.

Other advantages mentioned by the team included assisting the accused with housing, giving more lenient sentences in response to the context, avoiding criminalization, and connecting or reconnecting the accused to mental health services. Key actors viewed this last point as the most important overarching goal of the MHC, as the key to breaking the cycle of recidivism: specifically, the notion that accused understood they had a mental illness and engaged in a medication regime and maintained contact with treating teams.

Perceptions of the Accused

Team members explained that the accused represented a plethora of complex and diverse problematics. One of the recurrent preoccupations of team members was that many accused did not accept that they had a mental illness. According to key actors,

this produced a cascading effect on the accused's motivation and difficulties mobilizing resources, and hampered their abilities to follow suggested steps for recovery. Adding complexity to this analysis, accused with concurrent disorders—those with a mental health and an addiction problem and who experienced homelessness—were seen as especially difficult to work with and had less success in the MHC.

While some team members were critical of the justice system interventions when mental illness was the predominating factor, others maintained that there were consequences for certain behaviours, thus, evoking that some behaviours needed to be punished regardless of the person's situation and condition(s). There existed a tension in perceptions of the accused ranging from a more compassionate consideration of the individual's circumstances to a more arid, cut-and-dried approach to consequences, that is, the punishment should fit the crime regardless of mental health problems. However, most team members felt that the justice system was too rigid and fast-paced, and that relationships between the accused and lawyers were marked by aloofness. In this sense, the MHC attempted to compensate for a milieu where lawyers are typically not acculturated to adjusting their pace to the rhythm of their clients, listening to the accused's concerns, and explaining judicial processes. The criminal code, procedural justice, and the decorum of the court engender a kind of rigidity in the interactions with the accused that tended to promote a kind of exclusion and domination of the accused.

Indicators of Improvements or Deterioration

According to key actors, the reliance on information from the treating health team was the most trustworthy indicator of the accused's amelioration or deterioration. More specifically, if the accused presented inappropriate behaviours, lacked insight, re-offended, or if symptoms ballooned, this indicated that the accused was faring worse. A defence lawyer stated: "The experts that help guide us and the accused's treatment, as well the consulting doctor, tell us that the person is faring better or that their medication is adjusted; we see it, we observe it, we feel the difference."

That being said, we observed at almost every court appearance an overt obligation of the accused to demonstrate motivation, introspection, and insight, and to be active agents in their treatment plans by mobilizing resources and following through on interventions initiated by the court. For example, issues related to the non-adherence to medication regimes and the lack of insight regarding the accused's mental health problems were seen as critical challenges to the accused's success. Liaising with a treating team was seen as pivotal to the individual's amelioration in order to reduce recidivism and potential threats to their well-being or others.

We now turn our attention to the accused's perceptions of the MHC.

Accused

Twenty accused were interviewed (5 women and 15 men) regarding their perceptions and experiences of the MHC. They were between 19 and 53 years old (half were between 20 and 35 years old); their level of education varied between primary school and college. More than half were on social assistance and were

unemployed. All but two stated that they had been given a psychiatric diagnosis ranging from schizophrenia to Tourette's syndrome (personality disorders, depression, Asperger's, attention deficit disorder), with psychotic disorders being the most frequently named. Half of the accused had judicial antecedents, but most preferred not to identify them. In general, accused appeared quite guarded about these details. The most common criminal charge cited was assault, but others included robbery, mischief, and uttering threats. A quarter of accused indicated that they were under the influence of drugs or alcohol at the time of arrest. For six of the twenty accused, their charges were eventually withdrawn. Only two of the accused knew of the MHC prior to their arrest. Despite our small sample size, some interesting results emerged from our analysis.

Perceptions of the MHC

Most accused (*N*=18) had been involved with the MHC for a year, and some revealed that they agreed to participate in the MHC to avoid jail time or harsher legal consequences. Several noted that the MHC was more "human," less formal than the regular court system, that they felt listened to, and that it helped them. Despite these positive comments, many revealed that coming to the court provoked an immense amount of anxiety, that it was very stressful, and that they did not always understand what was happening. The lengthy wait times to appear before the court and the constant postponing of their case to a future date were seen as difficult to cope with. An accused explained that she preferred the MHC (compared to the regular criminal court system) because she felt taken care of and that this experience was somewhat responsible for getting "off the streets." She stated:

> For me the MHC is a good thing because I am done with being homeless, done with committing crimes and winding up at the court. I feel like things have finished well. This is a new beginning and that is a good thing.

Others lamented the long wait times at court, the slowness of decisions, and having to appear several times at court for minor offences.

> The one thing I find really difficult is how long they make you wait to appear before the judge. The first couple of times I had to wait several hours and I needed someone to watch my child. It was very stressful.

> Every time I appear at court I think my matter will be settled. I have hope that it will be over one day, but every time I appear my case gets put forward to another date. It makes me sick. I have been wasting my time at "appear dates" since last year. I am angry. I can't believe that I am treated like a criminal when all I did was call the ambulance because I was not well. My word means nothing and there were no witnesses to back me up.

> When I go to court I wait on the bench, wait to hear what the judge has to say, most of the time my case is carried over and nothing is resolved. But I am obligated to wait and see what happens. And it takes a long time for your case to be heard, and in the end it isn't settled anyways. It must take so long because they are studying what happened. They need to call other

people, doctors, witnesses, to get information, and they have to agree on how to proceed.

Another accused mentioned that they agreed to participate in the MHC to avoid harsher consequences, such as jail time, but instead they had to see a psychiatrist and take medication and meet with the caseworker to make sure they were following through on their court-ordered obligations.

One accused explained that because of the court's involvement she had speedier access to a psychiatrist. Previously she had been referred to a community psychiatrist by her family doctor and had been waiting over three years. Another mentioned that the MHC is more helpful than the regular court and more understanding of your difficulties, that they will be sure "you take your medication because you are not like everyone else."

Follow-up with a treating team (psychiatry and/or addictions) was a strong focus of MHC interventions, both in terms of integrating into the MHC and as conditional to liberation or a reduced sentence.

Social Inclusion

One of the goals of MHCs is to promote the individual's recovery through social inclusionary measures such as connecting accused to community services. In an effort to provoke reflection among accused about whether their involvement in the MHC promoted social inclusion, we asked them how their social lives were affected. Two responded that they developed new relationships because of their participation in the MHC. Three respondents indicated that they had developed new relationships, but it was difficult to decipher whether this was attributable to the MHC or not. The remainder stated that the MHC had no direct impact on their social lives, though some mentioned they did not tell their friends or family they attended a "special court." Others admitted that they were not aware they attended a MHC. Below are some excerpts of their responses to this exploration.

I changed all my friends, even my lifestyle since entering the program.

Yes, I changed everything. I have new friends, a new lifestyle so I could become better, become a better citizen.

Yes, I have made some new friends now that I attend groups, support groups. These are part of my conditions if I want to stay in R10 (the MHC).

Yes, I have made some new friends in the program, "jeunes en action." There are some people that are further along in their lives than me, and others who have not come as far. Some are good influences and others are not.

In these last two instances, accused are referring to the conditions emitted by the court if they want to have their case treated in the MHC. This was a frequent practice either for integration into the tribunal, or as part of their conditions of release, and often both. For example, the court frequently ordered accused to attend doctor or treating team appointments, attend support groups, abstain from substances, or comply with geographical or relational restrictions ("no-go" orders) if

they wished to continue in the MHC and/or obtain a successful outcome (resulting frequently in the withdrawal of charges). For instance, for the 100 court files reviewed, 166 conditions of release were emitted (typically: follow treatment, keep the peace and be on good behaviour, abstain from substances).

Homelessness, Transiency

We also asked accused about their housing experiences because of the high rates of homeless accused. Homelessness represents a certain kind of exclusion: a place-based form of marginalization due to the occupation of public spaces in non-normative ways (Taylor, 2013). Three of the accused indicated that they had experienced absolute homelessness during their involvement in the MHC. It was difficult to determine whether the MHC had an impact on their homelessness status, as their accounts were not always chronological, nor causal. Three accused also stated that they had experienced residential instability but did not identify these periods as necessarily ones of homelessness. However, there was certainly a residential transiency evident in their responses.

> So I went from living in X three years ago, to living at the Old Brewery Mission [shelter] for homeless people to l'Abri en ville [supportive housing].

> I was living in a rooming house, but I ended up moving eight to ten times because I was using drugs and the music was too loud. Eventually I returned to living with my father.

> I currently stay at the Men's shelter.

> I have lived there for six months, that's good right? Demonstrates a certain amount of stability?

> I moved 16 times. After that, I was in a youth detention centre for a year and a half. Once released from the MHC, I moved from apartment to apartment.

> When I went off the rails in 2008, I found it really hard. I wound up homeless. I wound up in the streets because of a court decision. I owed $96 for a food allowance I never paid back, I never took care of. That's how I ended up here.

The purpose of this snapshot is to demonstrate the transiency, the precariousness of their housing situations and social conditions and the accused's perceptions of how the MHC impacted, or did not impact, their trajectories.

We now turn our attention to accused's perceptions of team members and their work.

Perceptions of Multidisciplinary Team Members and Their Work

In general, accused viewed caseworkers as helpful, eager to listen, and encouraging. They also felt that caseworkers provided important information, such as decoding court proceedings and courtroom decorum. Some mentioned they felt no extra benefit or disadvantage to meeting with caseworkers, while others mentioned

that they felt it was another obligation in order to remain in the MHC. Accused mentioned that they had to meet with caseworkers prior to their court appearances and that the caseworkers verified information or steps taken by the accused with regard to following up with treatment, resources, etc. Some mentioned that they had to have written proof of their involvement and show this to caseworkers.

Caseworkers were described as follows by accused:

Yes, she asks me what I have been up to. If I met X for my appointment, attended my group … Sometimes she asks me for proof of a doctor's visit.

Well, like as I said, X takes the time to listen … but with the X, it's good, she's paying attention when I'm talking to her. She's paying close attention, she's not distracted or anything. I have to show her what I have been up to. The steps I have taken.

Yes, she's very nice, professional, everything. She took me under her wing, she made me believe everything was going to be alright. You know, one thing I can say about her, she never saw me as a criminal. She just saw me as a guy that made mistakes and the state of my being two or three years ago doesn't necessarily tell the whole story, because three or four years ago I was a different person. She treated my case like that, which means to never come back to the court.

I feel she's a good person to talk to. If I'm struggling in an area, I can discuss it with her and she can talk with the right people to try to get me the help that I need.

Accused had a much different perception of lawyers. In general, they felt that their meetings with lawyers were too rapid and that they did not communicate with them sufficiently. Some mentioned that their lawyers were very directive, telling them what to say in front of the judge or how to plead without explaining why or the impact of such decisions.

He's pretty good. Initially he wasn't. I really did not like him at first. During our first meeting at the courthouse, he didn't really understand what I was saying, in the sense that I wanted to be transferred to a hospital and not go to jail. I was feeling very suicidal and extremely depressed. So he wasn't fully on board with that, but then I spoke to the doctor at the court, and then I spoke to a criminologist, and they both agreed that hospital was the best place for me, so they spoke to him and together they spoke to the judge, and we were able to get that arrangement. But now, since that day, he's been very good.

Some accused explained that the judge was purely a procedural figure, telling them to respect their conditions, indicating their next court appearance. Sometimes accused were congratulated by the judge for the progress they had made or for the steps that they had taken. One respondent stated:

The judge said, "We are so pleased with your transformation, we hope to never see you back here at court." And she said, "The only person you

have to thank for that is yourself. No matter how much your family or your social worker did, you made the transformation." I made it.

Some accused talked about the team's work more broadly:

Yeah, the workers are like coaches checking up to see if you have done what you are supposed to, checking whether you have taken your medication, if you went to see your doctor, if you are eating well. Basically, all the things you are supposed to be doing to stay in check.

I need to prove to them that I am doing what I am supposed to be doing and in the right way. It's important I do what is expected of me in the right way to prove to the court that I want to get out. I need to follow the rules.

We now turn our attention to the context of exit from a quantitative standpoint to flesh out the bigger picture of the MHC's effects on social exclusion.

Context of Exit from the MHC

In 27 % of the 100 files reviewed, charges were withdrawn or dropped and a large portion were also given a NCR[7] status, resulting in a figure of 52% of files that were not criminalized or that were attributed to the Québec Review Board (TAQ). When we consider this result, their precarious social conditions, and how the accused enter the system—most frequently through police interventions—it raises the question of whether the criminal justice system is an apt response to these social and mental health crises. Moreover, from our observations we noted that social conditions such as housing status are clearly not a preoccupation of the team's work, and this is evident in their collaboration, court appearances, and even in court files and the conditions of release. In fact, accused were frequently released on probation from the MHC to a shelter, but there was no way of knowing whether they would be able to access a bed. There is much greater emphasis on the individual's psychiatric obligations (taking medication, follow-up with treating team) and their obligations to "keep the peace and be on good behaviour," namely to respect the legal conditions to reduce recidivism. The accused's level of motivation was a clear indicator of success to team members. This was particularly so in relation to their adherence a medication regime, to following the advice of their treating team, to reducing their substance dependence, and, most frequently, the accused's acceptance of their illness. In sum, there were no formal evaluation criteria with regard to the person's progress, and this was viewed in a very subjective light.

Discussion

Several tensions and paradoxes emerge from these findings. First, there was an overt dialectic between care and control, which reinforces notions of otherness and exclusion. Team members who defend public safety and security tended to focus on the criminogenic factors of the accused and retribution for victims (crown prosecutors, criminologists, and probation officers); while those in the helping

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[7] Not criminally responsible

professions tended to focus on the person's vulnerability, context and social conditions, degree of marginality (for example homelessness), severity of illness, poverty, and weak social bonds (caseworkers, doctor). Defence lawyers, too, promoted an accused's fragile status if it meant a more clement sentence for their client. Notions of justice (rigid applications of the law) were also confronted by notions of social justice (considerations of social inequalities, context) and thus imposed a delicate question among the team: Was justice really neutral, rigid, or could justice be manipulated based on a consideration of the person's symbolic status that was necessarily trapped in an otherness (dangerous, deviant, or fragile)? This tension was evident in team discourses and practices that hinged on risk, risk of further harm, either by perpetuating cycles of deviance or of victimization. While some team members (typically: caseworkers, doctor, defence lawyer), viewed the accused as a victim of their situation (often illness), thus requiring protection and compassionate responses (more clement sanctions), others viewed accused as dangerous and wanted to protect society and bring offenders into a normative context of responsibilization (typically: crown prosecutor, criminologist, probation officer). A preliminary mapping of this schema is offered in Figure 1. However, it should be noted that these categorizations are not absolutes but are dynamic conceptualizations and change over time and within actors responding to a multitude of often complex situations. These conceptualizations simply represent the broad strokes of our observations related to the roles actors played in the functioning of the MHC.

Moreover, we found that social conditions such as poverty, homelessness, and fragile social resources were not easily addressed nor taken into consideration in the MHC, even when it appeared that criminal acts were a direct consequence of these conditions. For instance, in many cases the accused had stolen food or articles precisely because they found themselves on the streets or in precarious socio-economic situations. That being said, there was little recognition of structural factors at play. The approach to dealing with the accused was embedded in medicalized and individualized responses. This had the double effect of placing more onus on the accused to be self-disciplining and neglected a larger and more critical reflection of the practices in place that brought accused individuals into the judiciary system in the first place (i.e., largely through police interventions) or of the structural factors at play (social inequalities).

There are also kinds of exclusionary discourses and decorum contained in the merging of psychiatry and the law that intensify processes of social exclusion. The formalities of court appearances do not simply disappear when one transforms the room into a MHC. While it is more relaxed compared to a regular criminal court, the respect for the judges, procedures, crown prosecutors, defence lawyers, and police officers are still stressed and proffer a kind of gravitas. These rigidities could be observed when a judge berated accused when they were not respecting decorum and taking matters seriously (e.g., such as laughing inappropriately to stimuli invisible to judge or audience, despite this being frequently equated as a symptom of psychosis).

Figure 1. Conceptualizations of Risk in a Mental Health Court
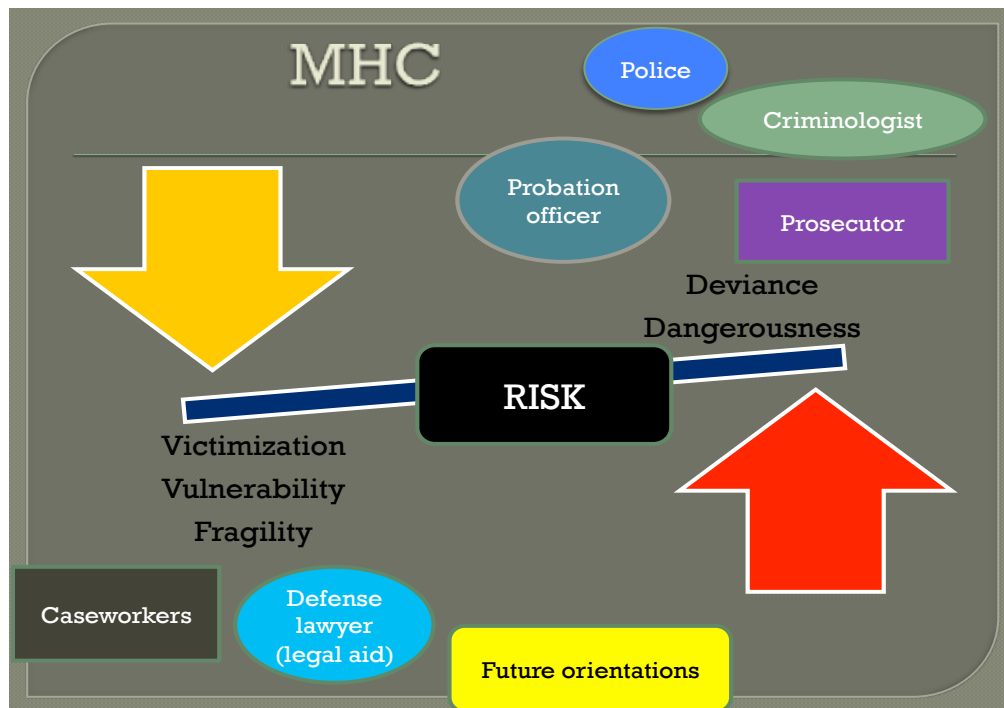
Furthermore, the consequences emitted in the context of certain conditions (abstain from drugs and alcohol, "no-go" orders with geographical or relational restrictions, etc.) are difficult at times to accept and respect, in light of the individual's history (addiction problem, intimate partner violence, etc.). The formalities inherent in court proceedings represent a barrier to the accused. They can be difficult to understand, particularly so for those who are struggling with mental health problems and may have difficulty concentrating. The rigidity of courtroom decorum also promotes a certain kind of exclusionary language and processes, which, coupled with the lengthy wait times to appear, are seen as especially challenging for this group, and were underscored by accused. In particular, we noted that the constant postponing of cases to give sufficient time for the person's situation to stabilize (largely understood to mean: connecting to psychiatric or addictions services) meant that their follow-ups in court occurred over a lengthy period of time before the sentence was delivered. For instance, on average accused were required to appear at court 6–10 times over a period of a year to a year and a half, for very minor offences (for the most part, mischief, theft, minor assault). Indeed, we believe that this surveillance and assemblages of control are activated along three axes of the MHC's work: juridical, therapeutic, and individualization and responsibilization goals deployed throughout the accused's involvement in the court that tends to reinforce notions of otherness. We have translated these empirical observations into a theoretical schema in Figure 2.

Figure 2. Theoretical Foundations of Control and Exclusion in a Mental Health Court
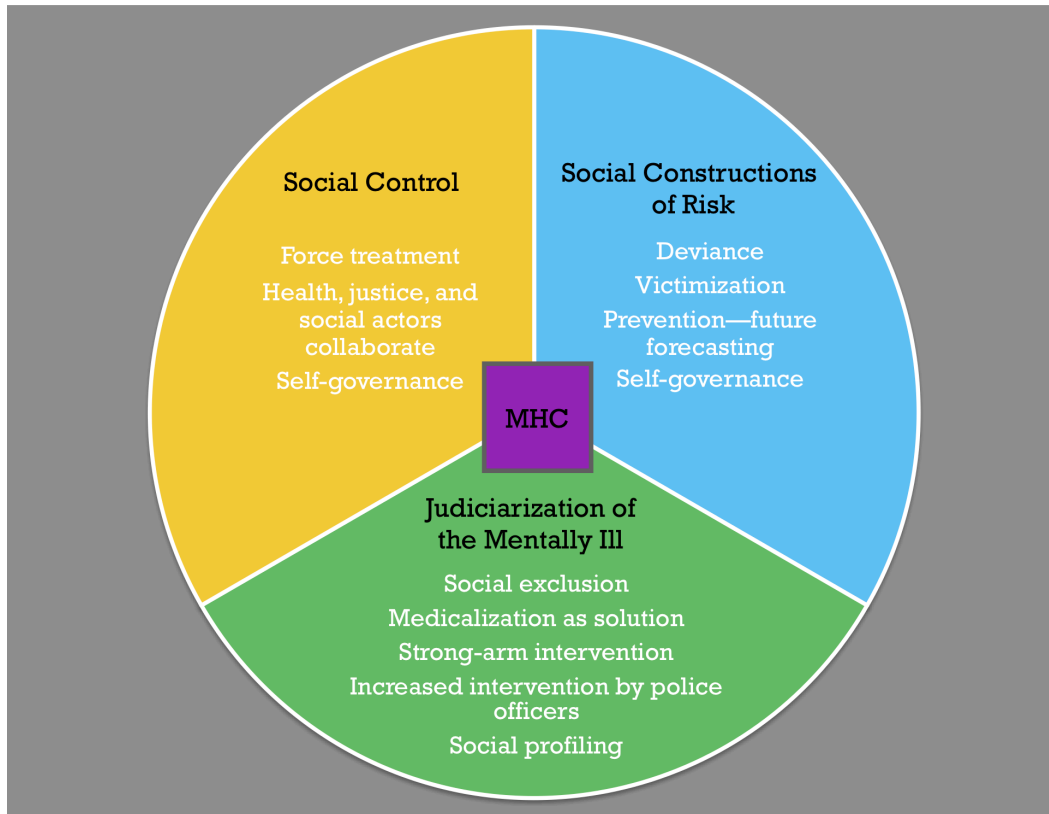
In essence, we propose that the MHC promotes a special form of social exclusion along these three axes: juridical, therapeutic, and individualization and responsibilization. By imposing a framework of normativity upon individuals in an effort to control deviance and dangerousness, and to halt further victimization, risk will be managed and curbed. Further, we argue that MHCs promote social exclusion based on othering accused. Sharing knowledge about the accused's status by health, justice, and social actors who collaborate and support treatment plans to ensure conditions are met is a form of social control. This knowledge is imported as evidence to demonstrate whether the accused is compliant in court (adhering to medication and treatment plans), resulting in self-discipline. Social constructions of risk, based on characterizations of accused as deviants or as victims, impose a form of self-governance on accused, in an effort to halt further potentialities of harm. A judiciarization of the mentally ill accused is founded on a special form of social profiling (we propose a social profiling of madness) that brings accused into the MHC based on their degree of otherness, that views them as disturbed and disturbing and proposes a strong-arm intervention.

Conclusion

While MHCs are a relatively contemporary phenomenon based on philosophies of therapeutic jurisprudence and measured justice, they are relatively absent of theoretical moorings to guide their work (Hannah-Moffat & Maurutto, 2012; Miller & Johnson, 2009). The proliferation of these courts has rarely been questioned, nor situated within paradigms of social constructions of deviance or victimization, nor, for that matter, offered a sober second thought on whether they promote social exclusion for mentally ill accused based on notions of otherness and on processes that encourage othering. We argue that MHCs target risky behaviours and reward individual mobilization efforts through their promotion of autonomy and self-regulation and their emphasis on psychiatric interventions. The twinning of these two dominant systems—psychiatry and the law—creates a special form of social exclusion whose access point rests on a form of social profiling (i.e., the dangerous, deviant, or victim of mental illness) encapsulated in representations of otherness of the mentally ill accused. Out of a desire to control difference, this system deploys legal and psychiatric interventions in order to achieve "successes" within the MHC, circumscribed by accepting one's illness, agreeing to medication regimes, and respecting conditions of involvement or release. These new "socio-medico-juridical practices" bridge two systems of domination (psychiatry and the criminal justice system) in an effort to "de-marginalize" mentally ill accused along three axes of intervention—juridical, therapeutic, and individualization and responsibilization. MHCs have rarely been examined in a critical light, nor have they been explored for their inherent contradictions or tensions that are evident in their discourses and practices. This article has attempted to flesh out some of these unknowns, but deeper work is needed to better understand these modern configurations as responses to social constructions of mental illness and risk.

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