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Liminality and Mental Health Court Diversion: An Interpretative Phenomenological Analysis of Offender Experiences

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Abstract

Seriously mentally ill people are a 'revolving-door' population in criminal justice systems where they cycle in and out of courts and jails. In response and consonant with the principles of therapeutic jurisprudence, mental health courts (MHCs) have flourished in North America and Western Europe in attempts to divert this population away from jail and provision them with the social services they require to avoid legal contact. Little research has focused on the perspective of the accused in MHCs and there has been little information about which aspects of the court and diversion processes contribute to therapeutic processes in MHCs. This qualitative study reports the experiences of nine successful graduates of a Canadian MHC. The data were analysed according to the principles of interpretative phenomenological analysis. The marginality of the accused and their liminal experiences in mental health court diversion are discussed. Social workers have a role to play in the success of clients in diversion and the results of this study may influence service delivery.

Keywords: Mental health court, phenomenology, liminality

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Introduction

Chronically and seriously mentally ill people live precarious lives at the margins of society. Following the deinstitutionalisation of people with mental health problems across North America that began in the 1950s,

many people fell out of systematic care. The money saved from dismantling institutions was in theory, intended for local, community-based care programmes, but most people with severe and persistent mental health issues have not been the consumers of community care services in Canada (Sealy and Whitehead, 2006). The consequences of deinstitutionalisation were catastrophic, forcing many people onto the streets and out of care completely, effectively increasing their degree of marginalisation. Q2

By the 1990s, concerns emerged in the USA about mental health and substance abuse problems among people entering the criminal justice system (McGaha *et al*., 2002). Research estimated that the prevalence of mental health and substance abuse issues may have been over 60 per cent among offenders (Ditton, 1999) and recent research in Canada and the USA estimated prevalence rates of 75 and 74 per cent, respectively (CMHA, 2012; James and Glaze, 2006). Another recent Canadian study found the rates of serious mental health problems among inmates to be three times that of the general population (Olly *et al*., 2009) with people suffering mental health problems entering the criminal justice system at an increasing rate, in excess of 10 per cent per year between 1995 and 2007 (Schneider *et al*., 2007). Not only are people with mental illness increasingly entering the criminal justice system; they are also jailed two to three times longer than their counterparts who did not suffer mental illnesses (Alexson and Wahl, 1992).

Thus, the penal system has become a 'surrogate' for defunct mental health institutions, with increasing numbers of mentally ill adults accused of criminal activities and languishing in prisons (CMHA, 2012). Mentally ill people are routinely and repeatedly accused of minor crimes, cycle in and out of courts and jails, and are released only to be swept off the streets by police in a feedback loop of arrest, jail, release and re-arrest. Mentally ill people are, therefore, identified as a 'revolving-door' population within the criminal justice system. The purpose of this research was to explore the experiences of people with mental illness caught in this feedback loop in the criminal justice system in Canada.

Literature review

'Problem-solving' courts such as drug courts and mental health courts (MHCs) developed to address the problems of revolving-door populations, increase efficiency in the courtroom and jails, and help people in need. Eventually, problem-solving courts evolved to understand and address the underlying issues of addiction and mental health and to help people deal effectively with these problems to break the cycle of reappearance before the courts. These courts tend to reframe legal problems as bio-psychosocial problems, with concomitant shifts in approach from punishment to therapy based on the theory of therapeutic jurisprudence (Wexler and Winick, 1996).

Therapeutic jurisprudence (TJ) is an interdisciplinary field of inquiry that focuses on the therapeutic and anti-therapeutic consequences of legal rules,

processes and the behaviour of legal actors (Wexler, 2011). TJ is intended to address the emotional needs of accused and the psychological impact of the criminal justice proceedings upon the accused (Wexler and Winick, 1996). The impact of this concept on reshaping the delivery of legal services and fashioning a generation of lawyers has been enormous (Stolle, 2000). It is clear that problem-solving courts are part of a trend of judicial innovation that attempts to humanise and improve outcomes for litigants, victims, defendants and communities facing chronic problems (Berman and Feinblatt, 2001). These TJ courts operate under the philosophy that traditional punitive responses to criminal behaviour among the mentally ill accused are inappropriate and ineffective (Schneider *et al*., 2007). In recognition that this particular population is in trouble with the law because of illness and the precariousness of marginal lives (e.g. poverty, homelessness, social isolation), not criminality, professionals endeavour to 'divert' those accused of minor crimes away from jail and towards the social services they need (Slinger and Roesch, 2010; Wexler and Winick, 1996).

US drug treatment courts (DTC) were the first TJ-oriented, problem-solving courts and their promising recidivism rates (Goldkamp, 1994) resulted in rapid expansion across the USA with over 2,700 DTCs in operation in the USA today (NADCP, 2014). Early research produced key components of drug courts (NADCP, 1997) to promote fidelity among courts. These include the importance of an assigned judge and an adequate duration of programming (Carey *et al*., 2008). The US DTC model was exported and transformed for local contexts in Canada, Europe, Australia and beyond. Soon, other versions of the court, specifically MHCs, evolved to serve a different revolving-door population: people with serious mentally health problems (McGaha *et al*., 2002; Wexler and Winnick, 1996).

Unlike DTCs, there is little agreement about what the MHC key components might be and which of these might be therapeutic. MHCs vary considerably from place to place in terms of differences in mental health law, social services, psychiatric services, funding strategies and even the legal definition of 'mental health court'. Evaluation of MHCs is challenging due to the relative complexity of the processes compared with DTCs and the dynamic, informal environment of the MHC (McGaha *et al*., 2002) and some report *negative* recidivism outcomes (Christy *et al*., 2005; Cosden *et al*., 2010). The literature relating to Canadian MHCs is not deep. Dewa *et al*. (2012) identified factors that programme developers deemed important for inter-ministerial collaboration in Ontario. Hannah-Moffat and Maurutto (2012) conducted a study of over 2,000 cases in four Canadian jurisdictions. They conducted fifty interviews with professionals associated with three kinds of problem-solving courts (Hannah-Moffat and Maurutto, 2012). Their work, however, excludes MHCs and the perspective of disordered accused. Evaluative studies of Canadian MHCs are absent (Slinger and Roesch, 2010) and there are, to my knowledge, no published studies from the perspective of the Canadian disordered accused. There are only a handful of phenomenological studies of legal

processes. Notable among these is a Swedish study that employed interpretative phenomenological analysis (IPA) to explore the experiences of sexually abused children with the legal process (Back *et al*., 2011).

An example of such a problem-solving court operating under the TJ philosophy is the Toronto mental health court ('102 Court'). It was established in 1998 and was the first problem-solving court of its kind in the country (Toronto Drug Treatment Court, n.d.). It was modelled on similar American courts and modified for the Canadian forensic context. 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, nonviolent offenses among accused with psychotic features (usually diagnosed with schizophrenia or bipolar disorder). Court social service coordination occurs through a provincial Ministry of Health initiative that employs six full-time social workers who manage community-based case managers for offenders participating in diversion. They track clients 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. 102 Court coordinates psychiatric services with the Centre for Addiction and Mental Health (CAMH), a large public mental health hospital located in Toronto. CAMH forensic psychiatrists attend 102 Court daily to conduct assessments and provide testimony as necessary.

While the discourse of TJ emphasises the therapeutic and anti-punitive nature of interventions, the medicalisation and socialisation that define 102 Court and similar courts are grafted onto forensic outcomes, making their deployment part of the techniques for managing marginalised people (Wacquant, 2009*b*). But there is good evidence for the complex and not fully understood relationship between biological risk for serious mental illness like schizophrenia and social factors including socio-economic disadvantage and homelessness that may exacerbate illness in a feedback loop of increasing marginality (Kelly, 2005). Marginality itself, often operationalised as social capital, is related to the risk for psychosis (Kelly, 2005). Kelly (2005) suggests that forensic psychiatry may play a role in the violence that structures risk and treatment in the lives of schizophrenia sufferers.

To delve further into marginality, Wacquant posits that the retreat from welfare in the USA and the retrenchment and expansion of the penal system have 'converged to penalize social marginality' (Wacquant, 2009*a*, p. 2). He links the popularity and globalisation of 'law and order' policing that target the 'incivilities' of poor people with the warehousing of marginalised people in prisons (Wacquant, 2009*a*, 2009*b*). Neo-conservative discourses and policing including 'zero tolerance' strategies have been exported and adapted in Canada (Comack and Balfour, 2004) as elsewhere (Wacquant, 2009*a*). Policing minor street crimes results in homeless mentally ill people being repeatedly swept into contact with the criminal justice system and labelled 'disordered accused' (e.g. Schneider *et al*., 2007). For instance, following the 1999 introduction of legislation that targeted panhandling,

the number of tickets issued by police in Toronto increased 795 per cent between 2000 and 2006 (Chesnay *et al.*, 2013). In the province of Ontario, where Toronto is located, constructing people as 'disorderly' has been central to the neo-conservative management of some of the province's most marginalised people including the mentally ill (Maidment, 2006). While this is not the dismantling of welfare as described in the USA by Wacquant, it does represent a significant shift in the values of equity that once underpinned Canadian institutions (Hermer and Mosher, 2002). Wacquant argues that expansion of prisons, police and courts is central to the market-oriented policies that target and penalise marginality (Wacquant, 2009*a*). The rapid multiplication and expansion of problem-solving courts globally may be largely in response to the problems created by welfare retrenchment and the rise in the use of the penal system (broadly conceived to include policing, courts, and jails and prisons) to manage marginalised seriously and chronically mentally ill people.

The diversion of disordered accused away from jail and into social services that occurs in MHCs attempts to initiate transformational changes in clients' lives thereby leading them through, what will be considered in this paper, a rite of passage, through a phase of liminality. Liminality and marginality are inextricably linked and need some explanation. Mazzotta describes marginality and liminality as flip sides of the same coin (Mazzotta, 2012). The etymology of 'liminality' is the Latin 'limen' or threshold and this conceptualisation informed Van Gennep's framework for rites of passage, where initiands pass through phases and transition from one state or status to another (Van Gennep, 1960). Initiands move towards greater integration with the social majority. Marginality is, according to Mazzotta, the less optimistic side of the liminal–marginal coin, where there is no movement towards greater social integration. Those who occupy the margins of society are cast permanently in a condition of precariousness (Mazzotta, 2012). The purpose of this phenomenological study was to explore the experiences of accused who offered an opportunity to positively impact their marginal status through the processes of 102 Court.

This research was designed to add to the knowledge base from both critical and consumer perspectives. The project therefore included both an ethnographic and a phenomenological branch. This paper reports the findings from the phenomenological branch of the research. The research question for the phenomenological branch of the study was: What are the experiences of accused who successfully graduate from 102 Court in Toronto?

Method

Ethics and consent

The study was approved by the Institutional Review Board. Informed consent for participation was obtained verbally with particular emphasis on voluntary

and anonymous participation and their right to withdraw consent at any time. All transcripts and audio-taped interviews were kept confidential.

Participants

Purposive sampling was used to recruit nine participants over a four-month period and strategies included referral from community contacts, opportunities that arose during participant observation of 102 Court and snowball sampling. All participants were adults over eighteen years of age (eight men, one woman) who had completed diversion through 102 Court as mentally disordered offenders, had all been diagnosed with a mental health problem that featured psychosis and had been accused of a minor crime within the city of Toronto. Six men were white of various ethnic backgrounds, one was of black Caribbean descent and one was a sub-Saharan African immigrant. The female participant was white. The two most common diagnoses among this group were schizophrenia and bipolar disorder (Dinshaw, 2010). This study did not enquire directly about diagnoses and there was no triangulation of diagnostic revelations made by participants. Only persons formerly processed through 102 Court who had been released to the community and not classified as prisoners under Canadian law were considered for inclusion.

Data collection

Open-ended interviews were conducted over a four-month period. All participants were compensated twenty Canadian dollars for their time before the interview began. The method of recording interviews was determined by the participant. Two of the nine interviews were audio-taped. Many of the offenders I spoke with had symptoms consistent with schizophrenia, some with paranoid tendencies, and therefore the use of an electronic recording device made some uncomfortable. Notes were taken during all interviews including those that were electronically recorded. Interviews spanned one to five meetings per person and were roughly ten minutes to over four hours in duration.

Data analysis

Analysis of data followed the principles of IPA (Smith *et al*., 2009). I transcribed the audio-tapes and written notes. Analysis involved focusing line by line on the experiential 'claims, concerns, and understandings of each participant' to begin to organise the data and trace themes among participants (Smith *et al*., 2009, p. 79). First, I considered each person's experiences

individually. Then, I compared the narratives for recurring themes. Two super-ordinate and three sub-ordinate themes emerged from this analysis.

Results

Super-ordinate theme 1: diversion as a threshold

Seven of the nine people interviewed spoke of the court as a significant threshold in their lives demarcated by a distinct 'before diversion' and 'after diversion' narrative divide. Participants who relayed a negative experience in the court and/or diversion recognised the potential threshold of the court if only to have charges dropped. Diversion 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 and even repair damaged relationships. For some participants, diversion had a tremendous impact:

> For years I've been in trouble with the court system because of alcohol and drugs, and schizophrenia and everything. Just acting psychotic and . . . and 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.

> 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.

One person said '[diversion was] kind of a godsend'. He did not understand why he was sent to drug rehab and had many issues with court processes. But he leapt at the chance to have his charges withdrawn and diversion provided an opportunity to do that.

Sub-ordinate theme 1a: social isolation

Almost all participants spoke about the isolation from their family and their general loneliness. The symptoms they suffered caused a fair amount of isolation. Some were from distant places, had family in other countries and had not seen them in years. For instance, one participant spoke of her estrangement from family, describing 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 anybody anymore for it to be real and safe.

A man described his enduring isolation, saying 'my family has nothing to do with me, I'm on my own'. Another man painfully described his estrangement from his father who pressed charges against him. His father called the police

on Christmas Eve, leading to his traumatic arrest. At the time of the interview, he was homeless because his father's home (which he had been sharing) was inaccessible due to his bail conditions. His sister would not speak with him and he could not stay with her. Perhaps most difficult for him was the death of his mother from cancer a year earlier. Another participant was 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 . . .. 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. Dad went through hell and high water. He was with me the whole time . . .. He was at wits end and didn't know what to do. I'm surprised he put up that long.

Sub-ordinate theme 1b: key supports

All participants named particular people associated with diversion as keys to their success. One participant was tempted to relapse but did not do so when he thought of the promise he had made to the judge in court—a finding consistent with other problem-solving court research (Goldkamp *et al.*, 2001). He simply did not want to disappoint the person who had given him another chance, who believed in him. However, this research indicates that it was not a particular person or professional that helped the accused, but that the presence of someone or a handful of people who were trusted, dedicated or honest was a key factor for the completion of diversion. One man credited 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 father was there through the whole thing.

However, this participant saved the highest praise for a layperson—a cellmate who helped him realise 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. I told my lawyer I was an alcoholic. He told the judge. 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. And even though I was behind bars away from society someone had reached out with some help.

Social workers, both forensic and community-based, 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 [102 Court social] workers 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.

Sub-ordinate theme 1c: innovative coping strategies

Many of the participants described their own coping strategies, which were outside the interventions suggested by social service workers and case managers. 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 component of their illness and well-being. One participant said:

> 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.

Another participant 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 people about herbal combinations and medicinal food alternatives. One man 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 explanatory models and the many years of labelling (medically and forensically) coincide with an ambivalent relationship with their diagnoses. For some, the diagnosis had changed over the years. One man, even after rehab, diversion and ongoing psychiatric care, asked me what bipolar meant. He said he understood what schizophrenia was, but this new diagnosis was not something he understood. Another man was an especially bio-medically 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 and 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.

The woman participant used drugs to numb the pain and fear of the sexual vulnerability of living on the streets *and* to qualify for a bed in rehab—a safe, though temporary, residence. Once clean, she was ejected from rehab back onto the streets and the cycle continued.

Super-ordinate theme 2: continuum of violence

Narratives of all participants included stories of violence, perpetrated both against and by offenders. The strongest theme was violence against the accused by the police and court officers. There is no doubt that court officers are the sharp end of the disciplinary stick in the courthouse and one participant had a particularly difficult time with them. Every time I spoke with him, he told me the same story of being beaten badly by court officers. 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 scheduled list of prisoners, they may legitimately leave the person in the jumpsuit. But if the list 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 participant explained that the officers would routinely leave him in jail garb even when his name appeared on a short prisoner list. This marked him on the street as a criminal and, when he failed to find additional clothing, the jumpsuit was utterly inadequate during cold winter weather. Certainly the brutality of some court officers was legendary among accused and court workers. One participant said 'some of them have short fuses so they popped off on some inmates'. Another man claimed court cells were more brutal than jail cells. He said 'Anyone would prefer jail to court cells'.

Police interactions with mentally ill people are cause for public debate in Toronto, with the police shooting of a runaway psychiatric ward patient making headlines during the course of this research (Rush, 2013). 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 in court about mistreatment by police. Certainly, many of the interviewees I spoke with described the violence of their arrests. For instance, one participant recalled his last arrest:

> . . . I was out of control. I uh, I heaved a refrigerator off a balcony. I was very psychotic. They sent the ETF [Emergency Task Force, the tactical unit of Toronto Police Services mandated to deal with high risk situations like kidnapping or emotionally disturbed people]. 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. Well that's alright I deserved it anyways . . . they brought me out into the hallway. And then the ambulance [guy] said are you alright?

Another participant told of his arrest on Christmas Eve at his father's home:

> 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.

In addition to alleged brutality, women face additional structural violence. For instance, women have fewer available community resources like shelter beds and women-specific programming, which sometimes causes delays in release planning. The gendered axis of violence (both physical and structural) was evident in the female participant's interview, which is most appropriately considered a trauma narrative. Her life was marked by violence. She experienced childhood sexual abuse and she fled her life and family in a distant province 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.

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.

She described the challenges of living on the monthly support given her by the Ontario Disability Support Program (ODSP) which provides annual income of $12,647, roughly 68 per cent of the poverty line in Ontario (Poverty Free Ontario, 2013). But the shortage of money was only part of the problem for her. In order to cash the cheque, she ran a gauntlet of predators waiting for ODSP recipients at downtown businesses known to cash government cheques 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 her. 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 her life is marked by violence. For instance, there are long waits for female-specific programming and many services are clustered in neighbourhoods with drug dealers. She said:

> And if you're hungry, especially in the morning if you're 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.

Discussion

A critical issue that emerged from this research is the *potential* for diversion to transform some lives. The successful graduates I interviewed experienced MHC diversion as a threshold and in this regard it related well to Van Gennep's (1960 [1909]) middle stage of rites of passage, the transition or liminal stage. Basic rules of behaviour are questioned and hierarchies are suspended in the liminal phase (Thomassen, 2009). In MHCs, the adversarial process that defines the traditional criminal justice system is suspended, the regular rules of etiquette for courtrooms are relaxed and, unlike regular courts, one of the main goals is to release people from jail as quickly as possible. Liminal periods are characterised 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 medical and legal processes combine to exacerbate disorder and undermine the structures of regular life for accused. 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 programme. This graduation parallels the graduation that occurs to mark passage out of liminality into a new status of reintegration.

Table 1 illustrates the accretions of liminality experienced by offenders. Certainly, liminality operates simultaneously at the individual, group and society-wide levels with various temporal dimensions as well. For MHC accused, it may be argued that they are individuals who have been marginalised 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 may chronically marginalise them from the mainstream. There are enduring experiences related to the stigma of serious mental health problems, the historic deinstitutionalisation that occurred in Canada in the 1950s and 1960s, and the pharmaceuticalisation of psychosis. Liminality among the accused is perhaps most acute at the individual level (Thomassen, 2009). Despite being part of a stigmatised social minority due to both mental health problems and legal problems, and the routinised 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.

But there is a danger, as Turner recognised, in being caught in permanent liminality, when a person gets stuck in one the three stages of rituals (Turner

Table 1 Types of liminality experienced by accused

Time	Individual	Group	Society
Moment	Sudden event affecting one's life—traumatic arrest or crisis that diversion	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	Reporting to MHC as part of diversion process	All diversion candidates reported to court at 10:00 a.m.	Deinstitutionalisation, implementation of universal health care in Canada
Epoch	Individuals standing outside society by choice or designated chronic framing of schizophrenia and bipolar disorder. Accused are marginalised 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 pharmaceuticalisation of medicine, stigma of mental illness (especially schizophrenia and bipolar disorder)

Adapted from Thomassen, 2009, p. 17.

and Turner, 1978; Thomassen, 2009). Turner called the permanency of transitional states 'the institutionalization of liminality' (Turner, 1969, p. 107). Many less successful accused of 102 Court cycle in and out of trouble with the law. They are on and off medication, adequately and inadequately housed, and are often committing the same crimes repeatedly which may lead to a finding of not criminally responsible. Permanent liminality is indeed a dangerous state—one that may eventually lead to indefinite detainment in a psychiatric facility in response to the intersection of nuisance crimes and chronic mental illness. This institutionalised liminality becomes a zone of in-distinction (Agamben, 1995) in which an accused becomes suspended as a ward of the state as a forensic subject and in effect becomes invisible to the world outside forensic teams.

Conclusion

There are multiple marginalisations that mark the lives of accused and many face those marginalisations with little familial support. They are disconnected from services before diversion, many are homeless, they are usually unemployed and often unemployable, and they suffer from stigmatised mental health issues that cause behaviours that unnerve and sometimes frighten other people. For those who hear voices, they are perpetually

distracted, even overwhelmed by their own thoughts. Many accused are turned away at hospitals, deemed problematic at shelters, and are known to police as trouble-makers. The accused in this study experienced diversion 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 diversion *might* improve the 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 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' court-ordered pharmaceutical interventions. Isolation from family, either enduring or before diversion, was a strong theme among participants. Violence marked the lives of all accused but was especially acute for the woman participant. The structural and physical violence that marked her life was overwhelming and beyond the scope of diversion 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 abuse even if survivors constitute a significant portion of women in the criminal justice system (Browne *et al*., 1999). The relative scarcity of female-specific resources in Toronto and the vulnerability of street life due to her gender amplify her needs and confound routinised solutions. A more subtle form of violence was discussed in interviews, where words were as strong as, if not stronger than, a fist or a foot thrust into a body. Discourse heard in the courthouse reveals how some regard the accused as less than people. When court is in session, it is important to have a 'brief and a body' for a case to proceed. One lawyer, discussing a client, was overheard saying 'I'm trying to locate a body. Where is it? Is it on its way? Is it in transit?'. This dehumanising characterisation is a glimpse into some forms of structural violence faced by accused in the courthouse.

This research casts light on the difficulty in defining 'success' in such a court. Exit survey is a common method to analyse client experience but may be compromised by its administration by members of the court team, even social service workers. Admission of non-compliance during diversion and 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 were audio-taped, resulting in variations in detail among transcriptions. Follow-up investigations with this population should require audio-taping interviews, even if that means an extended recruitment period. 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 this research population, follow-up interviews were difficult in some cases and it was impossible to contact participants to go over transcripts to ensure I captured their opinions and stories appropriately. Finally, clustering people by diagnosis and gender might further homogenise the sample and strengthen the study.

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