Original Article

Therapeutic governmentality and biopower in a Canadian mental health court

Anne Nordberg

School of Social Work, The University of Texas at Arlington, 211 S. Cooper Street, Arlington, Texas TX 76019, USA.
E-mail: annenordberg@uta.edu

This article is an adaptation of the author's dissertation entitled "The Impact of Therapeutic Jurisprudence: A Critical Study of Toronto's Mental Health Court" available at deepblue.lib.umich.edu/handle/2027.42/99817.

Abstract Mental health courts (MHCs) are a response to the structural violence experienced by people with severe mental illness (SMI) involved in the criminal justice system. My ethnographic research of an MHC in urban Canada serves as the foundation for a discussion of court processes that are an example of biopower. The purpose of this article is to demonstrate how strategies for intervention in the name of life and health, truth discourses and forms of self-governance operate among criminal justice-involved individuals with SMI. This study reveals the tensions between the intense forensic gaze and invisibility and between treatment strategies that are beneficial for some people with SMI yet ultimately coercive and oppressive. The governance of this population is discussed, as well as what happens to people who fail or refuse to self-govern as the court compels them.

BioSocieties advance online publication, 26 October 2015; doi:10.1057/biosoc.2015.36

Keywords: biopower; governmentality; mental health court; structural violence; invisibility; people with severe mental illness

Introduction

The purpose of this article is to offer a contemporary example of biopower that demonstrates how strategies for intervention in the name of life and health, truth discourses and forms of self-governance (Rabinow and Rose, 2006) operate among criminal justice-involved individuals with severe mental illness (SMI). This study reveals the tensions between the intense forensic gaze and invisibility and between treatment strategies that are beneficial for some people with SMI yet ultimately coercive. My ethnographic research of a mental health court (MHC) in urban Canada serves as the foundation for a discussion of court processes that are an example of biopower. I will argue that the technologies of power and technologies of self [1]

1 Technologies of power and technologies of self are two of the four technologies identified by Foucault *et al* (1988, p. 18) that are instrumental for people to govern themselves.

deployed among criminal justice-involved people with SMI are disciplines of invisibility. Their invisibility does not render them useful but frees other bodies to be more productive. Police, courts, jails and hospitals operate more smoothly when people with SMI are compelled to be pharmaceutically compliant, rendering them more docile and manageable, even if chronically unproductive. If the systemic attempts to manage them fail, they may flounder in forensic units indefinitely, effectively imprisoned longer than they would have been while serving a sentence issued from a regular court.

Ethnographic Site

The Toronto Mental Health Court (TMHC) is located in Toronto, Ontario, one of several MHCs that serve the city. The court seeks to release people with SMI accused of minor crimes as quickly as possible, arrange needed social services including psychiatric treatment and break the cycle of recidivism that brings them to the court in the first place, conceptualized as having a psychological source. Professionals (judges, lawyers, social workers, forensic psychiatrists and clerks) rotate in and out of the court, often spreading their workloads between clients suffering from SMI and other, more traditional accused. Appearance before the TMHC is 'voluntary', although research points to the potentially coercive nature of the process (Poythress *et al*, 2002; Burns and Peyrot, 2008; Nolan, 2009; Redlich *et al*, 2010; Munetz *et al*, 2014). For instance, people with SMI are usually required to waive some rights as a condition of inclusion in an MHC, where voluntary participation is often framed as a way to avoid prolonged carceral detention, and where defense and prosecution cooperate, sometimes leaving accused feeling less than thoroughly represented. Participation also requires periodic reporting before the court to monitor treatment compliance, with potential sanctions including further criminal charges meted out for non-compliance. Substance misuse may be present among the accused of the TMHC, but the primary reason they were considered properly before the court was a serious mental health problem – in most instances schizophrenia or one of its subtypes.[2] These may include several psychotic disorders including brief psychotic disorder, delusional disorder, schizoaffective disorder, schizophreniform disorder and shared psychotic disorder, but most often schizophrenia, all classified as psychotic disorders characterized by delusions, hallucinations, and disordered thinking and speech (American Psychiatric Association, 2014). The behaviors associated with these symptoms, such as responding to imaginary voices, incoherent speech and erratic movements because of hallucinations, often result in contact with the law.

The TMHC is primarily a first-generation intervention, where reduced recidivism is sought through mental health interventions that include community treatment and case management services (Epperson *et al*, 2011). There are elements of second-generation interventions incorporated into case management such as the provision of adequate housing[3] and assistance with the navigation of various social services providers to maximize stability. Symptom

2 Subtypes of schizophrenia have been eliminated from the most recent version of the DSM (American Psychiatric Association, 2014), but were still used at the time this research was conducted based on DSM-IV-TR (BehaveNet, 2014).

3 This may range from a shelter bed to a more stable arrangement.

reduction and management (through social support networks, pharmaceutical intervention and stable housing) is a goal of the TMHC in as much as it is believed to decrease recidivism among TMHC participants. However, the effectiveness of first-generation interventions is questionable. Skeem *et al* (2011) reviewed studies of first-generation interventions and found no relationship between reduced recidivism and reduced symptoms of SMI. Incarnations of the MHCs vary depending on local laws, resources, institutions, populations and so on. First-generation MHCs re-frame criminal justice-involved people with SMI through the authoritative discourse of forensic psychiatry as bio-legal subjects whose criminal problems are rooted in biology controllable through medicine.

Method

This study, approved by a university Ethics Review Board, consisted of two research branches: phenomenological and ethnographic. The phenomenological branch has been formally reported elsewhere (Nordberg, 2014). I interviewed nine people with SMI who had successfully completed TMHC diversion and used an interpretative phenomenological analytic approach to explore the meaning of the MHC experience among participants (Nordberg, 2014). This article, however, relies primarily on the ethnographic branch of the research, which focused on the TMHC courtroom and its environs.

Ethnography is both a method and a product, often characterized by participant observation (Creswell, 1994). Using this method, the researcher becomes an instrument of data collection and analysis as they learn through first-hand experience of participation and direct observation. Consistent with this approach, I attended and observed the court from January to September 2012 with the knowledge of the administrative judge. The court and the courthouse are public spaces, and the proceedings of the TMHC are a matter of public record unless a publication ban is specified. On two occasions during the study period, the judge announced a publication ban, and therefore I simply stopped taking notes. Otherwise, details revealed in court (including the name of the accused and details of the allegation) may be reproduced as long as the revelation does not impact the resolution of the case.

Between mid-February and the end of April, 2012 I recorded appearances in court by race and gender and whether the accused appeared before the court in custody or out of custody. As many accused appeared before the court multiple times, I refined these data collection methods by May to record people by surname and to include race. Each day, I designed one sheet of paper for women, one for men. I divided each sheet of paper into four sections: White, Black, Asian and other visible minority.[4] For each individual I recorded their surname, whether they appeared in custody or out of custody, their return date and any outcomes that were determined (including fitness tests, treatment orders, conditions of release and remand to the Ontario Review Board (ORB) – all discussed below). If a forensic psychiatrist discussed a

4 The categorization is the author's subjective readings of race. This not optimal, but the court records were not available (because the cases were active) and may not have contained race data if they had been. There were few aboriginal people in the court, possibly because a dedicated aboriginal court was in the same courthouse. Visible minority is defined by Statistics Canada (2006) as not aboriginal and not White in skin color.

diagnosis I included that. For appearances that were more complicated or longer or involved the testimony of forensic psychiatrists, I took notes about the case. I tracked the cases of 483 people between May and September 2012.

I relied on an iterative process of organizing field notes to adjust questions, ethnographic gaze and data recorded to fully interrogate the processes at work in the court. The courtroom and immediate environs were the main event, while the duration of observation and detailed notes elucidated a process model similar to that presented by Bernard and Ryan (2010) that included historical context, triggers, and immediate and long-term consequences of the main event – in this case the court proceedings. Actors' behaviors and the biopsychosocial framing of those behaviors (also consistent with Bernard and Ryan, 2010) were recorded.

All ethnographic (and phenomenological) analyses were conducted without software. I analyzed my notes daily, an immersive process that allowed me to respond to questions and lacunae within my data collection. For example, observations were rounded out by semi-structured interviews and informal conversations with key personnel associated with the TMHC. Interviews with social workers, attorneys, volunteers, clerks, court officers and other staff were conducted (with oral consent) throughout the 8-month study period and recorded with pen and paper. I spoke with nearly 100 people with SMI and their families, with conversations totaling between 5 min and 10 hours depending on the duration of the relationship.

Daily Operation of the TMHC

The TMHC proceeds through a docket of approximately 10–20 cases per day. Appearances before the court include people who are both in custody and others who have been released from jail and are out of custody. The TMHC was in session Monday to Friday from 10:00 until the docket was complete. The daily schedule of session and recession was not predictable, nor was the total daily time in session. Typically court concluded by 15:00, but on occasion ran as late as 18:00. The routine varied according to multiple factors: the number of people on the docket; which lawyers were in attendance; whether in-custody accused had been brought to the adjacent prisoners' cells from the main cells; the schedule of the judge; and even the medical necessities of court clerks. Recesses were often loudly announced – "we'll reconvene in 15 minutes". However, there were times when there was no discernible announcement or the announced amount of time passed and the door remained locked. For the out-of-custody accused and me, this meant that waiting on the benches in the hall outside the court became part of the rhythm of the day. In the courtroom I was particularly interested in the processes and routinized language of the court, and the roles of professionals in relation to the accused and one another.

Biopower

Foucault (2003) discussed biopower briefly in *The History of Sexuality* (1976) and his lectures at the College de France in 1976. He proposed a bipolar schematic of power over life that

evolved from the ancient power of the sovereign during the seventeenth and eighteenth centuries and ushered in what he calls the "era of biopower" (Foucault, 1976, p. 140), which we are still experiencing. The first pole, anatomo-politics, operates at the anatomical level of the individual body and seeks to produce productive and disciplined bodies. Anatomo-politics deploys disciplinary mechanisms to increase the productivity and docility of individuals (Foucault, 2003). These mechanisms include separation, serialization, reports, inspections, training and surveillance to control and maximize the productivity of individual bodies (Foucault, 2003). Institutions including prisons, factories, schools and hospitals regularly deploy such mechanisms (Foucault, 1977). The second pole, biopolitics, operates at the population level and focuses on regulatory controls (Foucault, 1976). Biopolitics deploys regulatory mechanisms to address persistent population problems that weaken the population and consequently waste time and money and decrease productivity (Foucault, 2003). Mechanisms include processes such as forecasts and statistical estimates that intervene at the general level and attempt to establish an equilibrium that protects the population from an internal problem or threat (Foucault, 2003). For instance, recidivism rates and cost-benefit statistics are the biopolitical regulatory mechanisms *par excellence* of the criminal justice system. Foucault (1976) insists that these two poles are not mutually exclusive. Anatomo-politics and biopolitics are techniques of power that segregate, hierarchize, and guarantee relations and effects of domination (Foucault, 1976). For Foucault (2003), both anatomo-politics and biopolitics seek to maximize productivity, and taken together they constitute biopower. Medicine plays a critical role in Foucault's (2003) conceptualization of biopower because it possesses both disciplinary and regulatory effects. Medicine establishes a link between the scientific knowledge of both the biological processes that operate on populations and organic processes that operate on individuals (Foucault, 2003). This knowledge gives us the diagnostic categories and prevalence rates of people with SMI in contact with the law and the societal cost of these revolving door populations, as well as the authority to intervene at the individual level to ameliorate the organic disease.

One effect of biopower is that it distributes the living according to value and utility; it distributes them around a norm. The norm became increasingly important as the era of biopower evolved (Foucault, 1976). Foucault (2003) argued that the norm is one element that circulates between the disciplinary and the regulatory, can be applied to both the individual organism and the population, and can control the disciplinary order of the body while insulating the population from internal threat.

Rabinow and Rose (2006) argue that biopower is characterized by a minimum of three elements, which will form the structure upon which this article will hang: first, strategies for intervention aimed at populations in the name of life and health; second, one or more truth discourses and authorities who are considered legitimate to articulate them; and finally, modes of subjectification "through which individuals are brought to work on themselves" (p. 197). This notion of self-governance was part of Foucault's conceptualization of biopower. He described nineteenth-century therapeutic interventions that called on the madman to recognize his own madness, to work on himself, to exercise self-restraint and that produced a set of relations between those deemed mad and the men of reason who managed the interventions (Foucault, 1965). Later Foucault (1977) argued that the disciplinary practices (of anatomo-politics) "regard individuals both as objects and instruments of its exercise" (p. 170). The disciplinary subject internalizes the requirements imposed on him/her, so that

he/she governs him/herself, thus ensuring increased control without increased resources to control, surveil, report and so on.

Strategies of Intervention

In this section, I consider the history of strategies of interventions aimed at people with SMI. Following the deinstitutionalization of mental health across North America in the 1960s, many people with SMI fell out of systematic care. In theory, money saved from dismantling institutions would be diverted to community-based care programs that would work to integrate people with SMI into the community and provide more cost-effective care. However, most people with SMI have not been the consumers of community care services in Canada (Sealy and Whitehead, 2004).

The actual outcomes of deinstitutionalization were catastrophic, forcing many people with SMI onto the streets and out of care completely. By the 1970s the criminalization of people with SMI was apparent, with people who had formerly been patients in psychiatric facilities resident in jails and prisons (Abramson, 1972; Lamb and Bachrach, 2001; Schneider *et al*, 2007). The penal system has become a 'surrogate' for the mental health institutions of the 1960s and 1970s, with increasing numbers of adults accused of criminal activities diagnosed with mental health issues and substantial populations of people with SMI languishing in prisons (Canadian Mental Health Association, 2012). One recent Canadian study found the rate of serious mental health problems among inmates to be three times that of the general population (Olly *et al*, 2009). A meta-analysis including 12 countries found that approximately 14 per cent of people in the criminal justice system have at least one SMI (Fazel and Danesh, 2002). Schneider *et al* (2007) say that people with SMI have been entering the Canadian criminal justice system at an increasing rate, in excess of 10 per cent per year for the 12 years preceding 2007. It is unclear whether this is because of increased rates of the diagnosis of mental health problems among accused, increased interactions with the law, increased interactions with the law resulting in charges or some combination thereof.[5]

The nature of these problems results in a "revolving door" effect (Wexler and Winick, 1996), where people cycle in and out of the judicial system regardless of time in jail or charges conferred. Jails pay for medications for prisoners, must administer those medications, house prisoners safely and provide supervision in some cases for accused who pose a danger to themselves or others (McGaha *et al*, 2002). Court dockets (especially in urban centers) can become clogged with these revolving door populations that may take longer to process than other cases (McGaha *et al*, 2002). There have been many responses to this criminalization at various points of the criminal justice system. These include police training, crisis intervention teams, specialized probation and MHCs (Epperson *et al*, 2011).

MHCs vary considerably from place to place (for legislative definitional differences, see RCW 2.28. 180; 730 ILCS 168/10; Canadian Criminal Code, section 672). Post-booking/adjudication MHCs like the TMHC are characterized by six features: they maintain separate dockets for people with SMI; they seek to divert these individuals from the justice

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

system to community mental health programs; they mandate mental health treatment; they offer rewards for compliance and, ultimately, graduation, at which point charges may be dropped but can also impose sanctions for non-compliance; participation is voluntary; and the judge monitors treatment and program participation (Epperson *et al*, 2011 after Wolff, 2003).

The local nature of each MHC is a community response to the specific problems that people with SMI produce. The TMHC responds to the systemic inefficiencies produced in the courts by this community of criminally involved people with SMI. Specifically, each person accused of a crime must first be found fit to stand trial. The behavior of some people with SMI (treated or untreated) often leads unfamiliar legal actors to question their fitness and therefore delay case processing. If those with odd behavior are streamlined into an MHC operated by experts in SMI, fitness can be ascertained faster, whether through coaching or treatment orders, than could be achieved in the regular court system. The regular court can increase efficiency with accused not suffering with SMI and the accompanying behaviors that cause pause among the non-experts. The professional stakeholders of the TMHC believe recidivism is positively impacted by their efforts, but to my knowledge no evidence has been published. There is little evidence to support improved therapeutic outcomes in other MHCs, in part because few MHC evaluations include mental health outcomes, showing almost uniform preference for recidivism outcomes (Morgan *et al*, 2012). While the actual therapeutic validity of the courts is questionable, the framing of these new courts as therapeutic rests on more solid ground.

The framing and identification of the TMHC as therapeutic is consistent with therapeutic governmentality, which ethicalizes (Rose, 1996) its authority with discourses of benevolence toward the subjects it seeks to control or change (McFalls and Pandolfi, 2014). Operationally, the TMHC regulates and re-assembles networks of community-based professionals, organizations, peer-support groups and others as part of the intensive case management of the TMHC diversion participants. It is the structure and process that shapes the court, not extra funding. It coordinates and individualizes community care networks while empowering people with SMI to utilize those networks and to take responsibility for their well-being. In this way TMHC processes and the strategies of intervention increase the biopower at play in the court, consistent with characteristics of therapeutic governance (McFalls and Pandolfi, 2014).

The impetus behind the creation of the TMHC was to improve the processing of unfit accused through the criminal justice system (Schneider *et al*, 2007). Fitness is concerned specifically with the ability of a person to understand the proceedings of the court and to instruct his/her defense attorney. "Unfit to stand trial" is defined in the Canadian Criminal Code as "Unable on account of mental disorder to conduct a defense at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental disorder to (a) understand the nature or object of the proceedings, (b) understand the possible consequences of the proceedings, or (c) communicate with counsel" (Government of Canada, 2013). It is a test of the moment, and may change from hour to hour or day to day, and be administered many times with the same accused. The classic test of fitness is a series of questions posed by a defense counselor (usually) to an in-custody accused about the court and the roles of people in it. For instance, the defense might ask, "I am a defense lawyer, your lawyer. What is my job in court? The woman sitting up there [points to judge] wearing the sash is a judge. What is her job? Do you know what you are accused of? In general, not your case, if you are asked for a plea in court, you have two choices. What are your two choices?" The threshold for fitness tests is called "low" in court,

meaning that a basic understanding demonstrated without the use of legalese is sufficient to be deemed fit by the judge. However, this test is laden with assumptions.

There is inconsistency with the delivery of the fitness test. For example, the first fitness test I witnessed was delivered in less than 1 min and consisted of four questions: "What is the role of the Crown? What does duty do" – at this point I realized I had no idea what a correct answer might be. The questions continued with, "What does a judge do? How might you plead to the allegations against you?" The accused answered as I might have: he stumbled through the first two questions and answered the last two questions fairly well. The language used ("Crown" and "duty") is common in the Canadian legal system. They are short forms of Crown Attorney and duty counsel. Crown Attorneys are prosecutors under the auspices of the Attorney General of Ontario. Duty counsels are free defense attorneys that handle cases of people who come to court without legal representation. The use of these terms in a fitness test assumes knowledge of the Canadian legal system. This discourse is not general knowledge in Canada, where television and movie depictions of law are often imported from the United States and to a lesser degree the United Kingdom. Many of the accused in the TMHC were born outside Canada. Their exposure to this specialized language might be significantly less than many people born and educated in Canada. Furthermore, it assumes a strong grasp of the English language. Of 483 people I tracked in the TMHC over 3 months 7.4 per cent (or 36 people) required the assistance of a court translator to understand the proceedings. There were 25 translators employed during this period who translated between English and French, Tamil, Arabic, Korean, Spanish, Punjabi, Telugu, Urdu, Farsi, Cantonese, Vietnamese, Tibetan, Tagalog, Mandarin, Dinka, Somali, Ethiopian, Indriya, Hungarian, Russian, Polish, American Sign Language, Croatian, Portuguese and Hebrew. Of 63 fitness tests I recorded, 52 were performed among anglophones and 11 required a translator. The ratio of those deemed fit: unfit[6] among anglophones was 20:6 compared with a ratio of 5:6 among the allophones. Given the variation in languages translated and the possible variations of the legal systems in their home countries that might operate very differently from that of Canada, much more than mere word translation is required. It is impossible from these data to ascertain the quality of the translation[7] or the factors that might influence the differential in fitness test outcomes among anglophone and allophone accused.

Despite these inequalities, the creation of the TMHC was an attempt to address structural violence within the criminal justice system. Structural violence is concerned with the impact of inequalities such as poverty and discrimination on people's well-being (Farmer, 1999, 2004). It is explicitly concerned with the way social, economic and political systems shape people's risk and their experience of illness and treatment (Kelly, 2005). People with SMI experience structural violence in the regular stream of justice through incarceration, which may exacerbate their symptoms, lead to isolation and restraint in jails and prisons because of their conduct, the unlikelihood that their complex needs will be met through carceral treatment (if they receive treatment) and their cyclical contact with the law, which compounds their legal records. This structural violence is cited as one of the foundational concerns that informed the creation and operation of the TMHC. However benevolent the intentions of its founders, the

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

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

TMHC ameliorates some forms of structural violence while producing new forms. For example, the inequalities of outcomes between anglophone and allophone people with SMI cited above is a new form of structural violence. To be clear, outcomes between anglophone and allophone accused in the regular stream of justice may also be disparate; however, the processes of the court produce different forms of negative outcomes from the regular stream. The same may be said for disparities of gender and race (discussed below) that are maintained in the TMHC albeit with different peculiarities. It also reflects structural violence at other junctures of the criminal justice system. The production of new disciplinary subjects through the processes of the TMHC offers openings and opportunities for some accused, but forecloses possibilities for others. Moreover, being deemed a proper subject of the court is akin to walking along a razor thin mountain pass; fall one way and be met with services, housing and support but fall the other way and you face indefinite detention. Hannah-Moffat and Maurutto (2012) point to this fusion of therapeutic and preventive knowledge with punitive practices as a challenge to some conceptualizations of punishment and welfare. They assert that mandated treatment and social services give rise to new forms of punishment (Hannah-Moffat and Maurutto, 2012).

There is, according to problem-solving court proponents, an attempt to look upstream, where the criminal behaviors of the accused are envisioned as caused by mental illness, making treatment of the illness the most appropriate deterrent to future criminal behavior (Wexler and Winick, 1996; Marini, 2003; Schneider *et al*, 2007). This produces particular forms of subjectification and self-governance through forensic psychiatric discourses and authority.

Authoritative Discourses

Order and its antithesis disorder are of fundamental importance in the TMHC. First, there is law and order, which has been disrupted by the alleged criminal behavior that leads to arrest and eventually to court. Maintaining order is a mandate of the prosecuting attorney and must be considered for each case that comes before him/her. It is his/her job to insulate the general population from the internal threat posed by mentally disordered accused. The conceptualization of risky criminal behavior has expanded to include very minor infractions like panhandling, one of the few income-generating activities available to homeless people, as part of a slippery slope of criminality. If an accused, with SMI or without, disrupts that order to the detriment of the community, then an appropriate legal response ought to be meted out. But the disorder of disordered accused is not that which is created with criminal activity but a particular kind of internal state that is perceived to drive criminal behavior. Depression or the hyper-vigilance of someone suffering PTSD is not the disordered described here, despite being disordered in psychiatric nosology. People may be included in diversion in the TMHC following a psychiatric assessment that confirms a diagnosis that almost always includes psychosis. Therefore, although the accused in the TMHC have diagnosed disorders, it is only those disorders defined by disordered thinking leading to disorderly behaviors that are the disorders on display. Arrigo (2004) argues that although concepts of order and disorder are processes found in all systems, law artificially corrals disorder and expressions of disorganization. Disorder is disciplined in the TMHC; it is identified, labeled, reported and surveilled in a

classic anatomo-political display of power. The production of "good legal subjects" (Arrigo, 2004, p. 206) is the goal. This discourse is steeped in morality where order is associated with good legal subjects and disorder with bad subjects. The source of the disorder is clearly individual and internal and conceptualized as neuro-psychological. But the disorder of the individual's brain and any suffering associated with that are really not the object of interest in the TMHC despite discourses of treatment and therapy and the generally benevolent disposition of the court. The neuro-psychological pathology of the disordered accused spreads outside the boundaries of the individual to impact family, friends, work colleagues, teachers and landlords, and eventually, when the disorder spreads too far, can lead to friction with the police and hospitals. It is therefore the spread of the disorder like a contagion that is disturbing. The first, second, even the 15th instance of friction with the police may not result in trouble beyond a growing visibility among the police. When arrest finally occurs, the disorder has spread to such a point that 'good' subjects (that is, mentally healthy people not in contact with the law) are perceived as direct or indirect victims of the person's disorder. Good subjects are impacted directly if they are, for instance, the shop owner whose bottle of water was stolen, the victim of a nuisance crime. Indirect impact includes the increased police resources allocated to these nuisance crimes (and therefore unavailable for other police issues involving more deserving subjects). Depending on the behavior under review, the perceived potential for future escalation of the behavior or the potential threat to good subjects is a point of decision for the prosecuting attorney. For example, an elderly, homeless woman appeared in the TMHC accused of kicking another woman waiting at a streetcar stop who refused to give her money. The kick was singular and the only reported incident of its kind. The accused did not know the victim. The victim sustained no injuries, not even a bruise, and declined to make a victim impact statement. Yet the accused was compelled to give a DNA sample as a condition of her release from jail lest her criminal violence escalate in the future.

The truth discourses most clearly in effect in the TMHC involve the diagnoses and testimony of forensic psychiatrists. Their testimony is routinized and often exactly matches the passages of the Canadian criminal code that relate to mental health law. This is so consistent that I stopped noting the details of their testimonies after a few weeks of observation. The following passage is an excerpt from the Canadian Criminal Code (section 672.59 1991, c. 43, s. 4.) that details the evidence required based on the testimony of a medical practitioner necessary to *make* a person with SMI fit to stand trial. I have underlined the phrases that I observed routinely in the TMHC.

> The testimony required by the court for the purposes of subsection (1) shall include a statement that the medical practitioner has made an assessment of the accused and is of the opinion, based on the grounds specified, that:
> *(a)* the accused, at the time of the assessment, was **unfit** to stand trial;
> *(b)* the psychiatric treatment and any other related medical treatment specified by the medical practitioner will likely make the accused fit to stand trial within a period not exceeding sixty days and that without that treatment the accused is likely to remain **unfit** to stand trial;
> *(c)* the risk of harm to the accused from the psychiatric and other related medical treatment specified is not disproportionate to the benefit anticipated to be derived from it; and

(*d*) the psychiatric and other related medical treatment specified is the least restrictive and least intrusive treatment that could, in the circumstances, be specified for the purpose referred to in subsection (1), considering the opinions referred to in paragraphs (*b*) and (*c*).

Even when they admit no background information and a brief period of assessment (sometimes less than 15 min) forensic psychiatrists are able to and do make recommendations that might include involuntary pharmaceutical administration or indefinite detention in a psychiatric facility or the forensic psychiatric ward of a hospital. Detention is reviewed at least annually by the ORB but in theory and practice can result in years of detention for minor offenses. Foucault's idea of biopolitics includes the identification of problem populations within society and the targeted regulatory technologies that might protect society from this internal threat. In some ways, this protection of the social whole from a pathological sub-population is very clear. The prosecuting attorney's job is to weigh the good of the public against the rights of the individual. More subtly, the TMHC regulates the criminal justice-involved people with SMI, streamlining their interactions with state institutions like jails and hospitals to increase efficiencies that benefit the institutions involved in their care with discourses of helping, treating and caring for the accused. The subjectification processes of the TMHC stress that court is envisioned as therapeutic. However, in practice the TMHC remains an agent of discipline (as traditional courts are) and becomes an agent of regulation that employs neuro-biological authority, pharmaceutical technologies and rationalizing medical discourses to silence, isolate and otherwise render the accused invisible to the general public. Foucault tells us that disciplinary mechanisms produce docile bodies and regulatory mechanisms insulate society from risky internal abnormalities. The biopower of the TMHC insulates the public by rendering the accused docile and invisible. It is a suturing of anatomo-political and bio-political powers.

The truth discourses articulated by forensic psychiatrists parrot the Canadian Criminal Code, but their authority as therapeutic professionals rationalizes and de-politicizes even the most coercive and draconian treatment orders before the court. Forensic psychiatric discourses present psychotic symptoms as manageable and physiological, while framing the accused as de-contextualized, under-medicated symptom clusters. Pharmaceutical interventions are presented as "magic bullet[8]" solutions that will mediate the risk to the individual and risk to the community as a result of untreated symptoms that present as criminal behavior. Discourses and practices revolve around the merged concerns of risk management (risk of harm to self and society) and risk moderation through pharmaceutical technologies of self.

Resisting Authoritative Discourses

There is a sharp contrast between the discourses of forensic psychiatrists, lawyers and social workers and their authority to speak the truth about people with SMI compared with the people who tried to speak for themselves. Comack and Balfour (2004) argue that legal spaces are built on discourses that resonate with wider society. They emphasize the difficulty in

8 The "magic bullet" model of medicine seeks to discover the cause of a disorder and develop a treatment to counteract it (Whitaker, 2010).

tracing the structural violence of courts due in part to the (re)production of inequalities in discretionary spaces rather than the formal rules of the law (Comack and Balfour, 2004). MHCs like all Ontario courts are founded on principles of transparency, where accused must be present when forensic psychiatrists testify about their diagnoses and treatment recommendations. Sometimes the accused wanted to speak to the court outside answering the limited questions posed to them. However, the TMHC has no accommodation for accused to do so, as many problem-solving courts do (Petrucci, 2003; Berman and Feinblatt, 2005; Miller and Johnson, 2009), forcing those committed to being heard to behavior generally regarded as outbursts and interruptions.

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

The authority of professionals to interpret behaviors and offer opinions that go largely unchallenged is exacerbated in MHCs by the cooperation of the prosecuting and defense attorneys. One of the hallmarks of problem-solving courts is a suspension of the adversarial relationship found in traditional courts. This is usually explained as an innovation to ease the experience of the individual with SMI where both prosecution and defense agree that the person needs help more than punishment. Cooperation is a critical component of release plans and many professional relationships are of long duration. Defense attorneys have varying approaches to prosecutors in the TMHC who are, in effect, the gatekeepers of the court. Some defense attorneys limit challenges to treatment orders in order to leverage the best outcomes for their clients who will not need to endure a treatment order but may benefit from the court. Other defense attorneys sacrifice a smooth road of case processing for individual advocacy.

Self-Governance

Diversion through the TMHC is, after all, a voluntary endeavor, where accused are threatened or punished through criminal sanctions for withdrawing their cooperation in the form of missing court or non-compliance with a medication regimen. The modes of subjectification (Foucault, 1994; Rabinow and Rose, 2006) through which individuals are brought to work on themselves are a critical part of the operation of MHCs. Accused are encouraged (some might say coerced with promises of stayed or withdrawn charges) to embrace their sick selves and take the medicine that will make them better (subjects). They are expected to enter into a

contract with the court voluntarily and adhere to that contract through self-governance. Much of that self-governance relies on the tension between rationality and irrationality at play in the TMHC.

Irrationality and rationality are strategically ascribed to accused in both formal and informal ways. Formally, their participation in the legal processes of the court is premised on the assumption that they make a rational choice to proceed through the court's diversion process if they are offered that possibility. They are able to instruct their lawyers and if they are deemed unable to do so it is their fitness that is called into question. This rational choice to proceed through diversion or return to the regular stream, to plead guilty or not, to recognize and ably communicate that they understand basically where they are, what they are charged with and what is happening in the court, is foundational to their participation in the TMHC. It is also the rational decision that is invoked when they violate the terms of release. "But", says the judge, "you agreed to report to court every morning at 10:00 am and you have failed to do so". They are held accountable to the rational decisions they have taken. For bail conditions to be met, a set of restrictions and conditions must be recalled, agreed to and adhered to. They must find a way to move about the city to appointments and court and shelters. They need to stay on their medication regimes. However, I was discouraged from interviewing people with SMI who had graduated from the TMHC several times during this project because of their 'irrationality'. I was told by one authoritative professional stakeholder, "You can't talk to those people, they're totally irrational!" – a sentiment echoed by many others. People with SMI are often called 'irrational' and 'hysterical' when they allege violence or impropriety at the hands of jailers or cellmates. Hence, participating in a research study was deemed outside their cognitive capacity, but navigating the conditions of release within a system of reward and punishment was deemed within their capacity. This recalls Foucault's (1965) historical examination of nineteenth-century psychiatric practices that called for patients to self-regulate, to admit their unreason in exchange for greater corporeal freedom, and to submit to the authority and truth discourses of experts (psychiatrists then and an array of professionals today, including forensic psychiatrists). The ambivalence of ascribed (ir)rationality is a critical feature of the biopower leveraged by this court.

My phenomenological analysis revealed a variety of self-governance techniques that ranged from traditional pharmaceutical interventions to novel uses of AA meetings to cope with auditory hallucinations associated with schizophrenia (Nordberg, 2014). My interviews with TMHC graduates demonstrated great variation in success and reflect in some detail the tensions among TMHC participants between processes that help some people with SMI while failing others. The experiences of Big Al and Brian illustrate how similar cases may produce different outcomes that were both labeled 'successful'. Both are White men, born and raised in the Toronto area, who had graduated from diversion within three years of the interview. They both had been diagnosed with schizophrenia, although Brian had also been diagnosed at various times with bipolar disorder. They both had substance abuse issues and named alcohol as their substance of greatest issue while dappling in street drugs. Some of the same professionals helped them through the TMHC. They were referred to me by the same social worker who highlighted their stability, improved mental health, and what complete "success stories" of diversion they both represented. Big Al was a model of self-governance, incorporating the language of biomedicine in his recollection of his diversion experience,

having integrated the truth discourses of sickness that characterize the biopower at play in the TMHC. First, Big Al fully accepted the diagnosis of schizophrenia and conceptualized it as chronic but manageable, echoing Canadian biomedical discourse. He says, "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".

Big Al distanced his behaviors and actions from who he was as a person, emphasizing that the illness made him behave in particular ways. This is consistent with psychiatric discourses about mental illness that dissociates behaviors caused by illness and identity. He accepted anti-psychotic medications as necessary and beneficial and had a good working relationship with his current psychiatrist. "And if I feel the voices taking over kinda, I will take one [dose of anti-psychotic medication] 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".

He named the aspect of his illness ("psychosis") responsible for his behavior. … "I was out of control. I uh, I heaved a refrigerator off a balcony. I was very psychotic".

He accepted responsibility for the management of his illness and innovated coping strategies that helped him. He described attending AA meetings when his voices and emotions seemed overwhelming. "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".

He was well connected with a network of support. Previously, he had been isolated socially, having no friends, estranged from most of his family and no work colleagues, but was now repairing ties with his family, making new friends, even beginning a new job.

Brian, however, was no longer on his medication and had not been compliant for some time. He said, "I don't take the meds …. please don't tell them". He had difficulty tolerating the prescribed medications and said,

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

He admitted purposely deceiving the court and social workers regarding his compliance. He did not possess insight about his referral for rehabilitative services, felt no one had ever asked for his story and still felt completely isolated. He was planning to move to a different city, breaking any support ties he had gained through the diversion process. For Brian, TMHC diversion reinforced, possibly exacerbated, his isolation from support. Brian regarded helping professionals such as physicians and social workers as court workers and he did not trust them with the truth. He was likely to come into contact with the law again, given his

under-medication and plans to leave the infrastructure arranged for him by the court including stable housing.

Both Big Al and Brian were touted as successful diversion participants in part because of their perceived ability to care for themselves upon graduation. However, interviews revealed that self-governance belonged only to Big Al, who was the most successful participant I encountered. His story is a reminder that MHCs *are* effective for some people, even helping him be a productive member of society again. He fully embraced his sick self, innovated his own coping mechanisms, and leveraged the rationality conferred on him through pharmaceutical intervention. Big Al was stable and out of the revolving door of recidivism. Brian, through his own agency and a different sort of rationality, deceived the court workers sufficiently to fly below the radar. He worked the system to avoid the intolerable side effects of medication. It seemed unlikely, given his presentation during the interview, that he could sustain his charade of self-governance.

Bail Conditioned on Self-Governance

One of the goals of the TMHC is to release people from jail and link them with services to help keep them stable and out of contact with the law. Therefore, many accused are quickly released from custody albeit with conditions,[9] which are remarkably formulaic despite being theoretically individualized to suit a specific accused and his/her alleged offense. Release is conditioned on reporting back to the TMHC, which includes meeting with a social worker. Released people with SMI must follow the advice of psychiatric practitioners and mental health-care workers and sign any releases they require. Having a psychiatric appointment (or promising to have one soon) is a critical component of release. This is the treatment cornerstone of diversion, mandating medications and transparency among different kinds of providers. Psychiatrists are provided with court papers, and evidence of attendance and adherence from the practitioner's office will be expected. The descriptor "mental health-care worker" ranges from social workers to psychiatrists. This accords authority to a group of people with a broad spectrum of education ranging from no university education to specialized medical training who concomitantly differ in autonomy and power. Their positionality as satellites of the law is recognized by accused and by the professionals themselves. However, violation of these conditions may result in criminal charges. In other words, pharmaceutical non-compliance or ignoring the advice of a mental health-care worker is disciplined by the court and punishable by law. This disrupts patient–doctor relationships, nullifies confidentiality, and brings many doctors and social workers into the sphere of influence of the criminal justice system. Thus, despite claims that medical and social service interventions are not criminal justice interventions, the processes of the court render people with SMI legal subjects even as they interact with medical and social service professionals. Even more insidiously perhaps, these processes mandate that people whose work would, under other circumstances, be regarded as helping professions become part of the network of regulation and discipline at work in the lives of criminal justice-involved people with SMI.

9 There are additional conditions that I do not discuss in detail such as having an adequate place to sleep, often a reserved shelter bed.

Ordering Treatment: Coercive Pharmaceuticalization

If a person with SMI is deemed unfit, the prosecutor requests and is typically granted by the judge consultation with a forensic psychiatrist. The accused meets with the psychiatrist for assessment of psychiatric well-being, diagnosis and fitness. By most standards of assessment, these are very brief meetings ranging in duration between 5 and 15 min.[10] Following assessment, a fitness hearing is conducted during which the forensic psychiatrist takes the stand and testifies about the results of his/her private meeting with the accused.[11] Typically, the opinion of fitness offered by forensic psychiatrists, as experts, is accepted by the judge regardless of the defense's exposure of the brevity of the assessment.[12] If the psychiatrist's testimony is that the accused is fit, the fitness hearing ends and the court processes the case for release from jail. But if the psychiatrist assesses the accused as unfit, the prosecutor may (and usually does) apply for a treatment order, which mandates treatment in a psychiatric hospital or the psychiatric unit of a hospital for a period no longer than 60 days. This order is based on the testimony of the forensic psychiatrist that the accused is likely to be rendered fit after the administration of antipsychotic medication.

The term "treatment order" belies the coercive and involuntary nature of this legal order. The discourse of medicine saturates the discourses and processes of the court with benevolence, healing and help. Forensic psychiatrists assure the court of the benefits of antipsychotic medicine, where accused are sent to hospital, not jail. They are orders of 'treatment' administered by doctors in hospitals. The psychiatric testimony always includes, sometimes in response to the prosecutor's queries, a statement that in their expert opinion the treatment with antipsychotic pharmaceuticals is the 'least invasive' method to render the accused fit to stand trial. Voluntariness is suspended here; the cooperation of the accused is irrelevant because if they refuse 'treatment' antipsychotic drugs will be administered by injection, while physically restraining the accused if needed. Ironically, for the loved ones of accused who witness these hearings, many are so relieved to hear their family members will receive 'treatment' that they believe this is a benevolent judicial response to their loved one's suffering. Defense attorneys are openly aware of the coercive and draconian nature of this 'treatment' and are quick to disabuse client's relatives that treatment orders are necessarily a good thing. Unsurprisingly, it is the prosecuting attorney who will request treatment for a person with SMI as an avenue toward neuro-chemical restraint.

And thus fitness is reduced to a neuro-chemical imbalance, 'treatable' with pharmaceuticals. It *must* be so for this system to function. Cultural variation, language ability, or even the possibility that behaviors deemed symptomatic of psychosis might be intentional are theoretically recognized but rarely successfully invoked by the defense. For instance, muteness and not meeting the gaze of an assessing psychiatrist may be evidence of distraction because of voice-hearing or they may be intentional acts of non-cooperation by people experienced in

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

11 It is important to note that an accused may have multiple fitness tests in a day. The fitness hearing is characterized by the forensic psychiatrist testifying about the accused after assessing his/her well-being privately. Both the prosecution and defense ask the psychiatrist for details of that assessment.

12 However, on one occasion during my period of observation, the forensic psychiatrist testified about the details that informed her opinion of lack of fitness. The defense submitted that he believed the accused should be found fit and the judge agreed, thus overruling the judgment of the doctor.

poor treatment by those with authority, especially those associated with the criminal justice system.

Treatment orders are not dispensed equally. Women were sent on treatment orders more frequently than men. Of the 483 people observed, 19 men (5 per cent) and 10 women (9 per cent) were sent on treatment orders. While female accused made up 23 per cent of the accused I observed, they account for 53 per cent of the treatment orders executed. Taken together, 29 treatment orders were issued, or treatment was ordered for 6 per cent of accused.

Indefinite Detention

The most serious outcome if a person with SMI remains unfit to stand trial after they have been on a treatment order is remand to the ORB. There were 1622 accused under the jurisdiction of the ORB in 2010–2011 (Simpson, 2011). Each case is reviewed at least once per year to determine whether they may be eligible to face their charges – in other words, whether they have become fit to stand trial. If the ORB deems them fit, they return to have their fitness re-assessed in the court and proceed to bail. However, it is not unusual that the end result is detention in a psychiatric ward for years for alleged offenses as minor as mischief or theft of a bottle of water from a convenience store.

Of the 483 people observed over 3 months, 12 (11 men and 1 woman) were remanded to the ORB. While this number is small, it is disturbing that 8 of the 12 (67 per cent) people remanded to the ORB were visible minorities. This was echoed by several defense attorneys who shared concerns about racial and gender biases with indefinite detention. I spoke with a forensic psychiatrist who worked at one of the psychiatric facilities that people from the TMHC were admitted to following a finding of not criminally responsible. He spoke of the racism he witnessed in the facility. He had a patient who had been "detained"[13] at the hospital under the auspices of the ORB since 1988. The patient was Black and accused people in the hospital of racism. The psychiatrist said that he complained so loudly and regularly of discrimination that he was labeled "aggressive and uncooperative", which perpetuated his detention. A lawyer who regularly attended the ORB hearings about whether to release accused said that he was struck by the number of Black women being detained in psychiatric facilities who were denied release because they were deemed "aggressive". Further research is warranted concerning racial discrimination among people detained under these orders.

(In)Visibility and Biopower

There is a tension between the visibility and invisibility of the accused at play in the TMHC. Here is a system that by design is transparent, where the courtroom is open to the public, key courtroom voices are carefully recorded and transcribed, and the transcripts are available to anyone who orders them. Ironically, what actually occurs in this space to the people who pass through it as disordered accused is so unremarkable they are rendered almost invisible to the public. The court is open, yet the body (or observation gallery) of the court remains unoccupied by observers. Reporters do not record these proceedings; sketch artists do not

13 His word.

portray the scene. The accused rarely speak. In the theater of the court the accused are the courtroom equivalent of drama's unseen character, a role critical to the turning of the plot but never actually seen or heard. The unsolicited cries, pleas, screams and accusations of accused are not on script; they are dismissed as symptoms, and systemically ignored. In a complete contradiction, the accused are highly monitored by the court once they are released. Their housing, medication regimes, community appointments, personal relationships, geographical wanderings all fall under intense surveillance to keep them outside the gaze of police officers. In other words, they are regulated and disciplined to sustain invisibility.

The courtroom becomes the physical center of a wide web of connections and relations that are intended to support accused, managed by social service workers and supervised by the prosecuting attorney and the judge. However, it is also the center of power relations and surveillance. This recalls panopticism, which describes the development and deployment of observational technologies to produce disciplined and productive bodies (Foucault, 1977). Foucault (1977) draws on an architectural analogy, Bentham's Panopticon, a prison system that employs new techniques of surveillance to control prisoners. Prisoners are made highly visible, always scrutinized or always potentially scrutinized by authorities (Foucault, 1977). Foucault (1977, p. 198) emphasizes the "the capillary functioning of power" that characterizes panopticism, an apt analogy to the disciplinary foci that the TMHC becomes in the lives of accused. Foucault (1977) tells us that the Panopticon can also be a laboratory, to "alter behavior, to train or correct individuals …. to experiment with medicines and monitor their effects" (p. 203).

The contradiction of the simultaneous invisibility of the accused to the general public and the strict surveillance of the court is consistent with Foucault's (1977) arguments about punishment in a modern setting. He claims that punishment tends to become the most hidden part of the penal system. In the TMHC the punishment, at first glance, seems absent. But structural violence accompanies participation in the court and the coercive threat of further sanctions that qualify the administration of pharmaceuticals. The question of whether treatment is therapeutic is not asked, nor does it matter. Disordered bodies are re-ordered by discursive practices and under threat of legal sanction. The truth discourses of neuropsychiatry, the authority of forensic psychiatrists to speak that truth and the technologies of pharmaceuticals replace technologies of imprisonment. Good legal subjects effectively govern themselves, remain compliant with medication regimes and stay out of contact with the law, what Fabris (2011) has called "chemical incarceration".

MacDonald *et al* (2010) argue that the court system does what it can, but that it cannot determine best placement for the people with SMI, nor can it address clinical needs. And yet the TMHC attempts to do just that. Justice Richard Schneider, writing about the establishment of the TMHC, specifies the deliberate attempt to direct disordered accused away from the legal system and back to the medical system where they properly belong (Schneider *et al*, 2007). The law medicalizes legal practices and transforms and expands the notion of a good legal subject. The TMHC is premised, in part, on the notion that people with SMI are before the courts because of illness. This approach, looking upstream for non-criminological causes, is laudable. However, the cornerstone solution is pharmaceuticalization, which helps some, is neutral or tolerable to some, and forecloses possibilities for others.

This reliance on pharmaceutical solutions mediated by the legal system is a perfect suturing of the once de-coupled anatomo-politics and biopolitics that accompanied

deinstitutionalization. There are both disciplinary and regulatory techniques that overlap in the TMHC processes. Psychiatric treatment becomes involuntary, and the consequences of non-compliance legal. Psychiatrists and other health-care workers become part of the mechanism of surveillance, mandated to report non-compliance. Accused are forced to present health-care workers with synopses of criminal allegations. This disrupts the patient–provider relationship, when accused are fully aware that practitioners are part of the legal system as much as a psychiatric system. As arbiters of the norm, forensic psychiatric assessments and the mandatory compliance with their prescriptions authorized by the judge makes pharmaceuticalization a technique for ordering disordered individual bodies and the processes through which a problematic population with SMI may be managed.

Pharmaceutical compliance becomes a mechanism for incorporation (or re-incorporation) of marginalized people with SMI into society in multiple ways. The symptoms of psychosis that render sufferers as other, outside the perimeter of social normalcy, may, for some, be lessened, bringing the accused closer to 'passing' for normal despite lingering sentiments of isolation and persistent (if tamed) symptoms. Foucault (1982, p. 777) calls this otherness "dividing practices" and offers three examples: the mad and the sane, the sick and the healthy, and the criminals and the good boys. The accused of the TMHC are divided from others in all three of these ways. It is the accumulation of dividing practices in this population that really poses a problem for governance. Their compliance with pharmaceutical treatment while in diversion helps accused avoid the legal slippery slope that may result in long-term detainment in a psychiatric facility. It may help break a cycle of recidivism and mounting criminal charges that threatens the freedom of accused despite the relatively minor nature of their legal transgressions. Compliance with pharmaceuticals becomes both the disciplinary technology and the regulatory technology. The bodies of most people with SMI do not become more efficient within this system. However, their management does, thereby rendering *auxillary* bodies more efficient, namely, those charged with providing services to the population.

One of the effects of the TMHC is the production of pharmaceutical subjects. Jenkins (2010) argued that the pharmaceutical self is amplified in the case of schizophrenia. Here, I argue that the pharmaceutical self is amplified even further when a person suffering psychosis becomes a legal subject before an MHC. Discourse about illness and medication contributes to the creation of pharmaceutical subjectivities (Jenkins, 2010). But in criminal justice systems, including the TMHC, the ubiquity and power of routinized and legalistic discourse amplifies this effect. However, the TMHC adds additional layers of surveillance, a wider array of authorities and additional institutional arenas of contact. Jenkins (2010) after Foucault (1976) asserted that "the increasing medicalization of mental illness is the spread of a form of diffused governance that produces rational and technical categories and practices that vitiate the moral and political meaning of subjective complaints and protests" (Jenkins, 2010, p. 3), a state response to a perceived crisis (namely, the deinstitutionalization and criminalization of people with SMI).

People with SMI are often unseen by the world. They live precarious lives on the edge of society, many are homeless, and they are frequently marginalized economically, socially, psychiatrically and politically. Whether engaged with medical care or legal issues, people with SMI challenge efficiency and cost-effectiveness. Hence, the processes of the TMHC may be considered a diffuse form of governance that produces rational and technical categories that

make people with SMI invisible again. The ideal resolution includes securing their freedom (at the cost of pharmaceutical compliance) to maintain invisibility and fits well within Foucault's (1976) "normalizing society", the historical outcome of technologies of power centered on life, such as biopower. But if the conditions of diversion are unable to be satisfied and cycling through the MHC occurs, accused may either be shunted back to the regular system or detained in psychiatric facilities indefinitely. But by either route, they become invisible to society again.

In the TMHC, psycho-pharmaceuticals mediate invisibility and conformity and they are the means for "making live". Foucault does not explain what he means by life, but public order is among the examples he repeatedly offers when discussing it (Karskens, 2010). In this way, MHCs make live the people with SMI who properly progress through them. Public order is safeguarded by the courts through several avenues. Self-governance is mandated by conditions of bail. Treatment may be ordered and injected forcibly. If these routes of making live fail, confinement of undetermined duration may result. While this is short of letting die, there is a sort of social death, an abandonment that accompanies confinement – freedom is suspended for an unknown length of time, the person in effectively imprisoned, forcibly treated and socially isolated. Thus, the biopower operationalized in MHCs renders accused invisible at best. However, should the disciplinary and regulatory strategies deployed by the court fail, accused are warehoused in a forensic zone of indistinction (Agamben, 1995).

This research revealed the tensions and complexities that exist within the processes of the TMHC as well as its possible outcomes. The court clearly helps some people live more independently and more peacefully (Nordberg, 2014). However, it does not serve everyone equally. It reproduces some of the gender and ethnic inequalities already present in the criminal justice system. The court enables agency among some participants while creating novel forms of structural violence endured by those who do not respond well to the interventions deployed by the TMHC. Lacombe (1996) has suggested that Foucault's notion of power is best understood as both normalizing and liberating, that the power-knowledge of the court is not uniformly oppressive. The tensions revealed by this research support this conceptualization of Foucaultian biopower as the processes of the court sometimes enable agency and at other turns constrain it.

Acknowledgements

The author confirms that the study on which the research is based has been subject to appropriate ethical review. She has no competing interests – intellectual or financial – in the research detailed in the manuscript.

About the Author

Anne Nordberg is an Assistant Professor in the School of Social Work at the University of Texas at Arlington. She earned a dual PhD in Social Work and Anthropology from the University of Michigan, Ann Arbor. Her work focuses on the policies, processes and

interventions that shape the lives of people in contact with the law. Her interests include phenomenology and critical ethnography, power, race and social justice advocacy.

References

Abramson, M.F. (1972) The criminalization of mentally disordered behavior: Possible side effect of a new commitment law. *Hospital and Community Psychiatry* 23(4): 101–107.

Agamben, G. (1995) *Homo Sacer*. Stanford, CA: Stanford University Press.

American Psychiatric Association (2014) DSM-5 Development, http://www.dsm5.org, accessed 11 July 2014.

Arrigo, B.A. (ed.) (2004) Prospects for justice and the law-psychology divide: An agenda for theory, research, and practice. In: *Psychological Jurisprudence: Critical Explorations in Law, Crime and Society*. New York: State University of New York Press, pp. 201–230.

BehaveNet (2014) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, http://www.behavenet.com, accessed 11 July 2014.

Berman, G. and Feinblatt, J. (2005) *Good Courts: The Case for Problem-Solving Justice*. New York: The New Press.

Bernard, H.R. and Ryan, G.W. (2010) *Analyzing Qualitative Data: Systematic Approaches*. Los Angeles, CA: SAGE Publications.

Burns, S. and Peyrot, M. (2008) Reclaiming discretion: Judicial sanctioning strategy in court-supervised drug treatment. *Journal of Contemporary Ethnography* 37(6): 720–744.

Canadian Mental Health Association (2012) Mental health and the criminal justice system: Scope of the issue, http://www.cmha.bc.ca, accessed 8 April 2012.

Comack, E. and Balfour, G. (2004) *The Power to Criminalize: Violence, Inequality and the Law*. Halifax, NS: Fernwood Publishing.

Creswell, J.W. (1994) *Research Design: Qualitative and Quantitative Approaches*. Thousand Oaks, CA: Sage Publications.

Epperson, M., Wolff, N., Morgan, R., Fisher, W., Frueh, B.C. and Huening, J. (2011) The next generation of behavioral health and criminal justice interventions: Improving outcomes by improving interventions. Center for Behavorial Health Services Criminal Justice Research, http://ssascholars.uchicago.edu/m-epperson/files/2011__next_generation_monograph.pdf, accessed 28 December 2014.

Fabris, E. (2011) *Tranquil Prisons: Chemical Incarceration under Community Treatment Orders*. Toronto, ON: University of Toronto Press.

Farmer, P. (1999) Pathologies of power: Rethinking health and human rights. *American Journal of Public Health* 89(10): 1486–1496.

Farmer, P. (2004) An anthropology of structural violence. *Current Anthropology* 45(3): 305–326.

Fazel, S. and Danesh, J. (2002) Serious mental disorders in 23,000 prisoners: A systematic review of 62 surveys. *The Lancet* 359(9306): 545–550.

Foucault, M. (1965) *Madness and Civilization: A History of Insanity in the Age of Reason*. New York: Vintage Books.

Foucault, M. (1976) *The History of Sexuality, Volume 1: An Introduction*. Paris, France: Gallimard.

Foucault, M. (1977) *Discipline and Punish: The Birth of the Prison*. New York: Vintage Books.

Foucault, M. (1982) The subject and power. *Critical Inquiry* 8(4): 777–795.

Foucault, M. (1994) Subjectivity and truth. In: P. Rabinow (ed.) *Michel Foucault: Ethics, Subjectivity and Truth, volume 1*. New York: New York Press, pp. 87–92.

Foucault, M. (2003) *Society Must be Defended: Lectures at the College de France, 1975–1976*. New York: Picador.

Foucault, M., Martin, L.H., Gutman, H. and Hutton, P.H. (1988) *Technologies of the self: A seminar with Michel Foucault*. Amherst, MA: University of Massachusetts Press.

Government of Canada (2013) Criminal code, http://www.laws-lois.justice.gc.ca., accessed 6 July 2014.

Hannah-Moffat, K. and Maurutto, P. (2012) Shifting and targeted forms of penal governance: Bail, punishment and specialized courts. *Theoretical Criminology* 16(2): 201–219.

Jenkins, J.H. (2010) *Pharmaceutical Self: The Global Shaping of Experience in an Age of Psychopharmacology*. Santa Fe, NM: SAR Press.

Karskens, M. (2010) Biopower – A slip of the polemical mind. In: S. Binkley and J. Capetillo-Ponce (eds.) *A Foucault for the 21st Century: Governmentality, Biopolitics and Discipline in the New Millennium*. Newcastle Upon Tyne, UK: Cambridge Scholars Publishing.

Kelly, B.D. (2005) Structural violence and schizophrenia. *Social Science and Medicine* 61(3): 721–730.

Lacombe, D. (1996) Reforming foucault: A critique of the social control thesis. *The British Journal of Sociology* 47(2): 332–352.

Lamb, H.R. and Bachrach, L.L. (2001) Some perspectives on deinstitutionalization. *Psychiatric Services* 52(8): 1039–1045.

MacDonald, N., Hucker, S.J. and Hebert, P.C. (2010) The crime of mental illness. *Canadian Medical Association Journal* 182(13): 1399.

Marini, R.A. (2003) Mental health court. In: B.J. Winick and D.B. Wexler (eds.) *Judging in a Therapeutic Key: Therapeutic Jurisprudence and the Courts*. Durham, NC: Carolina Academic Press, pp. 59–66.

McFalls, L. and Pandolfi, M. (2014) Parrhesia and therapeusis: Foucault on and in the world of contemporary neoliberalism. In: J.D. Faubion (ed.) *Foucault Now: Current Perspectives in Foucault Studies*. Cambridge, UK: Polity Press, pp. 168–187.

McGaha, A., Boothroyd, R.A., Poythress, N.G., Petrila, J. and Ort, R.G. (2002) Lessons from the Broward county evaluation. *Evaluation and Program Planning* 25(2): 125–135.

Miller, J. and Johnson, D.C. (2009) *Problem Solving Courts: A Measure of Justice*. Plymouth, UK: Rowman & Littlefield Publishers.

Morgan, R.D., Flora, D.B., Droner, D.G., Miles, J.F., Varghese, F. and Steffan, J.S. (2012) Treating offenders with mental illness: A research synthesis. *Law and Human Behavior* 36(1): 37–50.

Munetz, M.R., Ritter, C., Teller, J.L.S. and Bonfine, N. (2014) Mental health court and assisted outpatient treatment: Perceived coercion, procedural justice, and program impact. *Psychiatric Services* 65(3): 352–358.

Nolan, J. (2009) *Legal Accents, Legal Borrowing: The International Problem-Solving Court Movement*. Princeton, NJ: Princeton University Press.

Nordberg, A. (2014) Liminality and mental health court diversion: An interpretative phenomenological analysis of offender experiences. *British Journal of Social Work*, doi:10.1093/bjsw/bcu104.

Olly, M.C., Nicholls, T.L. and Brink, J. (2009) Mentally ill individuals in limbo: Obstacles and opportunities for providing psychiatric services to corrections inmates with mental illness. Behavioral Sciences and the Law 27 (5): 811–831.

Petrucci, C.J. (2003) The judge-defendant interaction: Toward a shared respect process. In: B.J. Winick and D.B. Wexler (eds.) *Judging in a Therapeutic Key: Therapeutic Jurisprudence and the Courts*. Durham, NC: Carolina Academic Press, pp. 148–156.

Poythress, N.G., Petrila, J., McGaha, A. and Boothroyd, R. (2002) Perceived coercion and procedural justice in the Broward mental health court. *International Journal of Law and Psychiatry* 25(5): 517–533.

Rabinow, P. and Rose, N. (2006) Biopower today. *BioSocieties* 1(2): 195–217.

Redlich, A.D., Hoover, S., Summers, A. and Steadman, H.J. (2010) Enrollment in mental health courts: Voluntariness, knowingness, and adjudicative competence. *Law and Human Behavior* 34(2): 91–104.

Rose, N. (1996) The death of the social? Re-figuring the territory of government. *Economy and Society* 25(3): 327–356.

Schneider, R.D., Bloom, H. and Hereema, M. (2007) *Mental Health Courts: Decriminalizing the Mentally Ill*. Toronto, ON: Irwin Law.

Sealy, P. and Whitehead, P.C. (2004) Forty years of deinstitutionalization of psychiatric services in Canada: An empirical assessment. *The Canadian Journal of Psychiatry* 49(4): 249–257.

Simpson, S. (2011) Evil or ill? Forensic mental health services pave pathway to justice. *Crosscurrents* 8.

Skeem, J.L., Manchak, S. and Peterson, J.K. (2011) Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. *Law and Human Behavior* 35(2): 110–126.

Statistics Canada (2006) Visible minority groups, percentage distribution for Canada, 2006 census. Catalogue no. 97562XWE2006002. 2 April, http://www.statscan.gc.ca, accessed 31 March 2012.

Wexler, D.B. and Winick, B.J. (1996) *Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence*. Durham, NC: Carolina Academic Press.

Whitaker, R. (2010) *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*. New York: Broadway Paperbacks.

Wolff, N. (2003) Courting the court: Courts as agents for treatment and justice. In: W.H. Fisher (ed.) *Community-Based Interventions for Offenders with Severe Mental Illness*. Oxford: Elsevier Science, pp. 143–197.