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REGULATING MADNESS IN A MENTAL HEALTH COURT

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Abstract

This article explores the regulation of people with mental illness who are accused of committing minor crimes (e.g. mischief, minor theft, assault, uttering threats, etc.) and viewed as disturbing the public order. The results are drawn from a study of a Mental Health Court (MHC) in Montréal (Canada), illuminating the perceptions and experiences of MHC actors who are involved in its operation. Deploying a multi-method design inspired by institutional ethnographic methods, this study sought to explore the inherent tensions in regulatory penal practices that oscillate at varying degrees between prevention, punishment and therapeutic intentions. It is argued that MHCs symbolize a new form of governmentality, in an effort to create disciplined subjects by reigning in madness and controlling marginality.

Keywords: *mental illness, mental health courts, governmentality, discourses, subjectification, responsibilization*

Introduction

In Québec (Canada), research conducted about police practices has spawned debates illustrating the social profiling of homeless people (Aranguiz Fecteau 2000, Eid & Campbell 2009, Sylvestre 2010, Sylvestreet al. 2012), racial profiling (Brodeur 2003, Charest 2010a, 2010b, Melchers 2003, Waddington et al. 2004) and political profiling (Dupuis-Dérie 2006). Indeed, authors and activists have focused on these phenomena in order to demystify and understand why the police arrest and target specific social categories of people more than others (Sylvestre et al. 2012).

However, another kind of profiling has received scant attention – the profiling of madness. Studies have shown that two in five people with mental illness in Canada have been arrested over their lifetime, and half of the interactions with police involve alleged criminal behaviour (Brink et al. 2011). Indeed, little is known how people who are identified as having mental health problems become the focus of police energies (Brink & al. 2011, Coleman & Cotton 2014). This article will explore one aspect of this phenomenon, the regulation of people with mental illness who are accused of committing minor crimes and viewed as disturbing the public order (e.g. accusations of mischief, minor theft, assault, uttering threats, etc...) based on results drawn from a study of a Mental Health Court (MHC) that took place in Montréal (Canada).

Deploying a multi-method design inspired by institutional ethnographic methods, this study sought to explore the inherent tensions in regulatory penal practices that oscillate between prevention, punishment and therapeutic intentions. It is argued that MHCs symbolize a new form of governmentality (Foucault 1988, 1991, 1995, Miller & Rose 2008, Rose 1999, 2000). This article will illuminate the institutional discourses channelled through multi-professional team members' understandings and perceptions of the MHC's work.

Context

Hybridized models of justice – based on preventative, rehabilitative, and punitive stratagems - combining justice, health and social services practices and discourses are on the rise, but are poorly understood. MHCs are part of a larger specialized court movement underpinned by a «therapeutic justice» paradigm, combining legal and therapeutic strategies and practices to manage individual risk of recidivism (Nolan 2009). Over the past decade, these ‹specialized› (or problem-solving) courts have emerged as an alternative to traditional punishment frameworks, which have been seen as ineffective in addressing chronic and recurring forms of criminal involvement. In tandem, an awareness that an alarming number of mentally ill people are caught up in the criminal justice system has taken centre stage (Mental Health Commission of Canada 2012). MHCs belong to a broad category of specialized courts (i.e., drug, intimate partner violence, community) that channel mentally ill accused away from the regular criminal justice system into community-based treatment programs (Baillargeonet al. 2009). They offer a more responsive, tailored approach to meet the needs of a particular population (Schneideret al. 2007, Winick, 2003). They do not create new services per se but rely on existing services and treatment in the community, thus bringing together a variety of actors (health, justice, social service) to ‹solve› the overriding problem believed to be responsible for provoking the accused to commit a crime (Lerner-Wren 2009). The central goal is to diminish the risk of reoffending causing recidivism. These courts emerged during the 1990s due to the growing concern that a startling number of accused were cycling through the criminal justice system - transitioning between homelessness, jail, and psychiatric institutions (McGaha et al. 2002). This was coined the «revolving door» syndrome (Wexler & Winick 1996), and highlights the degree of marginality, precariousness and social exclusion experienced and witnessed.

The workings of MHCs fluctuate from court to court but their distinguishing feature is that they rely upon the deployment of a multidisciplinary team made up of judges, prosecutors, psychiatrists, social workers, and probation officers whose aim is to work collaboratively to provide a response, often treatment-oriented, to the needs of the individual[1] (Schneider 2010). The key elements of such specialized courts are: a non-adversarial approach, voluntary participation, tailored intervention plans, more flexibility, a designated judge, and a separate docket for defendants (Hartford et al. 2004). One of the primary ways believed to halt recidivism is viewed as linking the accused to treatment for mental illness, followed by other types of community-based supports. As many MHC accused are already familiar with health and social service programs, the MHC has a greater impact on the frequency of treatment received than on the kinds of treatment themselves (Luskin 2013). In spite of a disconcerting focus on medication, there is no doubt that MHCs do facilitate access to a wide range of services, such as mental health, legal, housing, and social services (McNeil & Binder 2010, Provost 2010, Trupin & Richards 2003). However, claims to break the cycle of incarceration of the mentally ill, reduce recidivism, proffer necessary supports and services to enhance participants quality of life, and in so doing, increase community safety, remain uneven (Boothroyd et al. 2005, Cross 2011, Sarteschi et al. 2009, Sirotich 2009). There is a dearth of knowledge regarding the experiences and perceptions of accused taken up in these courts as well as those of team members involved in its deployment (Provost 2011, Slinger & Roesch 2010). The focus of this article will be on the multi-professional actors' perceptions and understandings of the MHC, framed within a governmentality perspective.

Theoretical Framework

This study embraces governmentality approaches in attempting to understand the penal regulation of mentally ill in these new assemblages (Foucault 1995, Li 2007, Miller & Rose 2008, Rose 1999, 2000). Foucault's early work explored the role of big institutions, such as prisons, workhouses, asylums and hospitals, producing practices of discipline that acted on individuals through training and repetition to yield «docile bodies», resulting in the creation of certain types of subjects based on similar characteristics (Foucault 1977). Power was not invested in one person, one government, but involved a complex web of power relations and strategies, less focussed on who was governing as opposed to strategies employed to maintain social control and order through the regulation and repetition of practices (mostly of the body) (Foucault 1978). The body became the subject and access point for regulation: the promotion of hygiene from the eighteenth century onward was the strategy in which interventions were targeted to achieve a healthy, productive population and longevity, and methods of self-regulation became inculcated (Foucault 1980).

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

Power, knowledge and the body form a fundamental triad of Foucault's work. Foucault described the «capillary forms of existence» ingrained in mechanisms of power: «the point where power reaches into the very grain of individuals, touches their bodies, and inserts itself into their actions and attitudes, their discourses, learning processes, and everyday lives» (1980: 39). In such a way that any «exercise of power relies... upon a knowledge of the ‹target› or field of operation which is being addressed» (Garland 1990: 138). The power / knowledge nexus so central to Foucault's work shapes discourses and strategies, in a co-constructive fashion. According to Hall (2001: 72), «discourse is a system of representation». It is

> a group of statements which provide a language for talking about – a way of representing the knowledge about – a particular topic at a particular historical moment... Discourse is about the production of knowledge through language. But... since all social practices entail meaning, and meanings shape and influence what we do – our conduct – all practices have a discursive aspect (Hall 1992: 291 cited in Hall 2001).

Discourse then becomes the bridge between what one says (language) and what one does (practice). It «constructs the topic. It defines and produces the objects of our knowledge. It governs the way that a topic can be meaningfully talked about and reasoned about. It also influences how ideas are put into practice and used to regulate the conduct of others» (Hall 2001: 72). Thus, meaning, and ensuing practices are manufactured and produced by discourses. Hall argues that thorny subjects like «madness», ‹punishment› and ‹sexuality› only exist meaningfully within the discourses about them» (Hall 2001: 73). Thus, they are constructed by a certain kind of knowledge (*usually expert*[2]), that is always partial, and that are tainted by rules of acceptability, and unacceptability, framed by a certain historical moment, circumscribing practices for dealing with certain kinds of subjects (Hall 2001: 73-74). Moreover, knowledge and power are intimately intertwined and co-constructed. «Knowledge is always inextricably enmeshed in relations of power because it was always being applied to the regulation of social conduct in practice (i.e. to particular ‹bodies›)» (Hall 2001: 77). One of the central discourses circulating in MHCs, and pointed to as their reason d'être, is that mental illness is the culprit for the criminal gests. Thus, one of the central practices deployed is to responsibilize accused for their actions by encouraging an awareness and self-activation to take charge of their mental illness and well-being. Thus, the MHC project necessitates the creation of a certain type of subject upon which to focus its energies.

Creating mad subjects

Foucault argued that psychiatric knowledge emerged from the concept of degeneration, since «degeneration is the major theoretical element that justifies the medicalization of the abnormal. The degenerate is the abnormal, mythologically or better still, scientifically medicalized» (1999: 298). MHCs endorse a biomedical paradigm, espousing a discourse in which mental illness exists singularly within the individual, and if treated, can halt the revolving door. They repose on a biomedical approach, as well as ‹psy› disciplines[3] involvement, advocating a medical (usually psychiatric) and individualized, case-by-case approach. However, the social dimensions and construction of mental illness are rarely considered, and thus reinforces a singular degenerative, madness paradigm. By madness, I am referring to a

> range of experiences - thoughts, moods, behaviours – that are different from and challenge, resist, or do not conform to dominant, psychiatric constructions of ‹normal› versus ‹disordered› or ‹ill› mental health... madness [is] a social category among other categories like race, class, gender, sexuality, age, or ability that define our identities and experiences (Liegghio 2013: 122).

Mental illness and madness are also forms of social construction, shaped by different realities, understandings and experiences. According to Otero (2010, 2015), mental illness does not exist outside of society, but is shaped by it. Indeed, mental illness is shaped by its interactions with structures, discourses and practices. The way mental illness and madness are perceived, felt, understood, are mirrored by the ways in which one understands an other's multiple and evolving realities in a particular social and historical context. Unlike other illnesses that are more tangible in the way they are diagnosed and treated, the social dimensions of mental illness loom larger in our experience of this otherness. The subjects of these illnesses are more apt to be disqualified, stigmatized and subject to moralizing discourses, reinforcing their difference.

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[2] Author's emphasis

[3] By ‹psy› disciplines, I am referring to a whole range of related professions (e.g. psychology, social work, and nursing, etc...) who take up psychiatric paradigms, and to Rose's coining of the term (1999).

For many, «mental illness represents a recycled reality» (Smith 1990: 130), such that when an individual comes into contact with professionals and institutions, they unveil many intimate details about their lives that then become reinterpreted and even disqualified due to professional reformulations. In this way, the original knowledge becomes subjugated and a certain discourse about their reality becomes manufactured, and orients future actions.

> For an individual to be disqualified as a legitimate knower, certain constructions become necessary in order to justify the disqualification. For psychiatrized people, being constructed as «incompetent» and «dangerous» becomes a powerful mechanism leading to their disqualification and denying the person's knowledge and ways of knowing. The disqualification corresponds to a particular form of prejudice and discrimination faced by individuals deemed «mentally ill.»... It becomes the rationale for particular interventions, including the use of coercion and force (Liegghio 2013: 125-126).

According to Liegghio (2013), two processes of disqualification ensue: being disqualified as incompetent (disordered) and being disqualified as dangerous (or potentially dangerous). These elements found a discourse whereby, «a dangerous person is someone who is unpredictable, who cannot be trusted, who threatens the public order, and who, consequently, needs to be controlled» (Liegghio 2013: 126-127). The rise of madness profiling is based on generalized assumptions of dangerousness, unpredictability and incompetence (hallmarked by disorderliness) founded on certain moral discourses about the mentally ill. Behaviours are frequently associated with stereotypes, thus intervening becomes justified to prevent suspected (not yet happened) harm, and legitimizes action (Bellot 2014). Most of the cases dealt with in the MHC could be summed up as comprising deviant, disturbing and marginalized behaviours due to poverty, homelessness, and social precariousness, reflecting a society's moral standpoints regarding acceptable and unacceptable behaviour. Profiling logics have an impact on how the mentally ill (particularly those on the streets) are caricaturized, bringing them into sharp focus with those responsible for maintaining the public order. Profiling impacts how the mentally ill who are associated with the streets and marginality, and who often occupy public spaces, are perceived, treated and managed, and are hence contained, sanctioned and regulated. The rapid proliferation of MHCs needs to be understood within this context as producing another form of institutionalization (Frappieret al. 2009, Jaimeset al. 2009, Wolff & Pogorelzki 2005) at varying intensities depending on the subject to address the heart of «circuits of insecurity» in which excluded members of society become subjects of strategies of control (Rose 2000: 330). This mutated regulation is one without walls, that is boundless, and that operates at varying degrees and subtleties in an attempt to create disciplined subjects, based on their «elements, capacities and potentialities» (Rose 2000: 325).

Governmentality reposes on a bridging of thoughts and techniques that taken together comprise the ensemble of «institutions, procedures, analyses and reflections, the calculations and tactics», that devise the ways in which conduct is governed (Li 2007: 276 citing Foucault 1991a: 102). According to Li and Rose then, the art of governing must be rendered technical, that is, «an intelligible field with specifiable limits and particular characteristics...whose component parts are linked together in some more or less systematic manner by forces, attractions and coexistences» (Li 2007: 279 citing Rose 1999: 33). Drawing upon Miller and Rose's (2008) work, governmentality can be teased apart into two components: rationalities and technologies. Rationalities comprise the ways of conceptualizing and understanding the problem(s). While the technologies would include the kinds of interventions, assemblages of actors and services put in place to address the problem(s), to attenuate it, instruments put in place to «conduct the conduct» (2008: 16). Put more simply, it is the thoughts and the techniques taken together that comprise this art of governing (Li 2007). Inside of these two components, the elements that are mobilized to carry out this art of governing repose on subtle logics of responsibilization, individualization, singularization, to create disciplined subjects, and in our case here, to reign in madness and to halt criminal behaviours. However, forms of regulation are at varying degrees of intensities depending on the subject (the who) and demand us to move beyond Foucault's early analysis of the total institution, as these new configurations of control are made up of different constellations of actors and institutional arrangements. Moreover, according to Astier (2009), in these new structures of decentralized, subtle yet far-reaching assemblages of institutions, subjects are forced to become empowered, self-activating, self-regulating, and responsibilized for their well-being, and for their futures.

In the quest to comprehend these interwoven elements in the operations of MHCs, a method inspired by institutional ethnography was deployed.

Methodology - Institutional Ethnography

Institutional ethnography seeks to examine the «maps› of the ruling relations and specifically the institutional complexes in which they [people] participate» (Smith 2005: 51). It is an

unconventional method of research utilizing various strategies (interviews, participant observation, documentary analysis), to examine more largely, but inversely more intricately, the «relations of ruling» that shape local experiences (Smith 2006). According to Devault and McCoy, institutional ethnography «takes for its entry point the experiences of specific individuals whose everyday activates are in some way hooked into, shaped by, and constituted of the institutional relations under exploration» (2006: 18).

Inspired by this methodological approach, I sought to understand how the court functioned and to document and analyze the procedures, discourses, and practices inherent in its processes. In a way, it was to flesh out how accused are taken up, perceived, and managed at the intersections of socio-medico-juridical interventions, as well as to understand the accused and court actors' perceptions of their involvement in the court. In order to understand these sites of interconnection various methods were used. Site visits and key informant interviews were conducted with: users of the tribunal, and actors implicated in the MHC (judges, prosecutors, defence lawyers, case workers, probation officers, criminologists, doctor). Quantitative data encompassed the review of 100 individual court files, to collect data on: socio-demographic histories, mental health and judicial histories. Qualitative data collected information using semi-structured interviews with 20 participants and 10 team members. Participant observation methods collected data by observing team meetings, courtroom proceedings and shadowing of team members. Interviews with key actors inquired about the nature and scope of their work and their general impressions of the MHC and of the accused. Interviews with accused explored their perceptions and experiences of the MHC and team members. Researchers were invited to attend team meetings and court appearances to gain a better understanding of the court's proceedings. Participant observation included a minimum of 30 team meetings and 30 courtroom audiences, totalling more than 125 hours of observation time. Caseworkers also invited researchers to observe their interventions with accused (conditional upon the accused's willingness), which involved several days of shadowing their interactions with accused.

Results

For the purposes of this article, I will draw upon the data emanating from interviews with the multi-professional actors who make up the MHC team. Ten MHC professionals were interviewed regarding their perceptions and experiences of the tribunal. Specifically, interviewees were asked about their perceptions and understandings of the MHC, its purpose and operation, how it functioned and whom it aimed to serve.

Rationalities: The Meanings behind the MHC – the Why?

Team members were asked about their work and about the phenomenon that is the MHC, what needs it attempts to address. A team member explained the raison d'être of the MHC.

Well when you consider that imprisoning someone who has a mental illness is not effective on any level. In the sense that jail, in the grand principles of sentencing, is a tool used to dissuade individuals from reoffending. But an individual suffering from a mental illness often commits a crime because of their mental illness – well, jail serves no purpose. On the first hand, because of their mental state and secondly because offending is a bit out of their control, it becomes difficult to punish them and to make them understand... so the purpose of establishing a MHC was to create a type of bridge between the justice and the health systems; two systems that tend to operate separately and do not speak the same language.

Another team member explained that for them the MHC is like a «court of social justice»:

where the interests of the accused are really front and centre. We mustn't forget that in a regular court the criminal code punishes the criminal behaviour, and in so doing, attempts to dissuade the accused from reoffending... For example, a person who is mentally ill and assaults a police officer because of their illness, well we will take that into consideration and offer a more clement sentence depending on whether they are collaborative with the treatment plan, whether they follow medical advice, whether they have insight into their illness. We have to be empathetic, to put ourselves in the accused shoes. The MHC offers a more humanistic response...

Some team members argued that the justice system needs to be more flexible, to adapt to the «realities» of the clientele, echoing one of the therapeutic justice aims – to offer a more compassionate and tailored response. This speaks to the worthiness of the subject, to their «capacities and potentialities».

The justice system really needs to be more adaptable with this clientele, so that accused feel heard and understood, take into consideration their particular situations. Well the MHC attempts to do just that, to take into consideration all the factors affecting the offending behaviours, and their abilities. The goal is really to stabilize the person's situation and for them to collaborate

with all the providers in the system. We are able to tell if the person is faring better or not, and we try to encourage them to stay on a good path, to meet their potential. We try to adapt the system to meet their needs.

Rationalities also construct certain intentions and aims. They concern themselves with the «who» that is the target of the phenomena; that reinforce the MHC's reason for being. This in turn affects the intensity of the proscribed plan, creating certain subjects apt for its technologies. The discourses contained within illuminate the ways of thinking about the problem but they also construct a target for who should be considered, based on «who» they are, their capacities and potentialities. Thus, generating processes of subjectification, where individuals become subjects of the MHCs actions and legitimate it's operations.

Creating Mad Subjects – the Who?

There was a general consensus among team members for admission into the MHC that the accused had an overriding indication of a mental health problem, thus creating a medicalized subject.

It's not about conditions or factors but really based on general indications, is there an indication of a mental health difficulty. For instance, is the individual already followed by a psychiatrist, are they under the Review board (Quebec Review Board), is the person already known to the street team, does the person seemed disorganized, confused, so there really are no specific conditions needed to participate. Based on this initial information we will try to validate and deepen the information, either by our doctor regarding their fitness (aptitude) or through these different actors involved in the system, in the person's care.

Another team member stated that,

we know from the research that there are a number of mentally ill offenders who are in detention settings and shouldn't be there. So we examine, we study, each accused's file, to better understand their life context, their disorganization, why they committed the crime... it tells us about how they were faring, how ill and disorganized they are...what they are able to do.

Another member remarked, «we know from their mental health status that they are more like to commit a crime, so we need to bring them the support they need». Additionally, a different team member highlighted the severity of illness amongst accused, and the accused's non-conformity, illuminating their marginality, their otherness.

I can divide the accused I see into two parts: fit or unfit (aptitude). The majority of accused I assess are fit but very ill, lots of psychotic disorders and substance use - that is the usual bouquet. Another factor is non-compliance. For the most part, few of them take medication.

Though mental health status played a determinant function in how the actors viewed the accused in the MHC, there were also considerations for the marginalization and social exclusion they faced. This too shapes the perceptions of the accused (the «who») that tended to cycle through the MHC. Some team members understood the accused's context in a more global context, not one as purely a relation to level of illness, but reflecting a level of marginality, of precariousness, of difference and otherness, of social exclusion.

Yes there is a link between their mental health status and whether they commit a crime, but there are also other factors at play. Would the person have committed a crime if they had a decent place to live, a better quality of life, a reliable social network, better mental health?

Another stated, «but there are similarities between the people we see in the court. There aren't many who earn over 50 000 $ a year. It's often people who are already under a trustee or guardianship type of situation. Living precariously, they are disorganized.»

For the most part, team members described their work as collaborative, and recognized the particular expertise of each professional and their contribution to respond to the accused's situation. Team meetings were viewed as a special time when members shared the information they had gathered about the accused, to know how to orient and influence decisions that would be taken in court later on in the afternoon when presented before the judge. This collaboration formed the major strategy of the MHC's work, and supports the therapeutic justice paradigm of a measured justice approach.

Technologies: Regulating Madness – the What and the How?

Technologies refer to the practices put in place to address the problems. They are the strategies emanating from the discourses emerging from the ways of thinking about the

problem (rationalities). According to one team member, the MHC is a sort of bridge between different systems to allow for open communication and coordinated action between the panoply of multi-professional actors involved in the subject's care to guide their trajectory and hopefully bring about a better outcome for the individual.

The MHC is a bridge and allows individuals to transit between the justice and the health systems and allows for us to make connections between the two. Is the person keeping their appointments, following through on their conditions? Taking their medication? Consuming less substances or not at all? There are a whole packet of people deployed around this person that communicate and ensure the person is on the right path. This is one of the rare mechanisms where these two systems communicate. Where the probation officer is made aware that the accused has a social worker at X clinic, that their defence lawyer is X, that they have committed X offense. So sometimes we realize while we are following this person in the MHC that all these different actors are involved but we hadn't realized that all these different players were involved because everyone was operating in their own silo. But in the MHC all of a sudden we have all these conduits of information, channelling, circulating the information.

Another described the MHC as a «harm reduction approach», evoking a preventative ethos, whereby:

all the different actors collaborate: defence lawyer, doctor, criminologists, case workers, and then we communicate with the different health and social services actors, the treating team, to offer a coordinated response to ensure that the individual is on the right path, is faring better and does not become a recidivist.

Several team members also described how the MHC functions. «The MHC is like a funnel: we begin with a few general pieces of information and try to gather more information as we go to better orient the decisions we take regarding the accused's case». For instance, from this knowledge-gathering and knowledge-construction exercise the team discusses the strategy to be put in place to prevent future harm (and / or recidivism) or promote the person's well-being.

At team meetings we discuss what kind of strategy we are going to adopt to help the accused. Should they be referred to the doctor, to the criminologist, do they have a residence, what was the context of the incident, are they linked to services, etc... changes don't happen in a heartbeat, cases, people are complex. We try to do what's best for them.

Opening up conduits of communication between the MHC team and the accused's ongoing or possible health care and social services team(s) was useful in determining if the person was faring better, attending their appointments, following the treatment plan established, in short, to create suitable subjects. In particular, it was seen as a trustworthy indicator of the accused's amelioration or deterioration. A team member stated: «The experts that help guide us and the accused's treatment, as well the consulting doctor, tell us that the person is faring better or that their medication is adjusted; we see it, we observe it, we feel the difference.»

Several team members made reference to the MHC being a way for the accused to turn things around. One team member revealed that:

the MHC becomes a pretext, a lever: the accused is arrested, they did something foolish, they stopped their treatment, they didn't show up at their medical appointments... and voila, here is an opportunity to get them back on the rails, to restart treatment, to reconnect them to their social worker, to their team, to rehabilitate. So the tribunal becomes sort of a forced clinic, if you will.

One of the central concepts deployed in the MHC's work was the notion of responsibilization, for the accused to become more responsible regarding their mental illness and insightful regarding the consequences of their actions. In essence, to be empowered to take control of their lives, to become more self-activating, to harness their capacities.

One of the central concepts deployed in the MHC's work was the notion of responsibilization, for the accused to become more responsible regarding their mental illness and insightful regarding the consequences of their actions. In essence, to be empowered to take control of their lives, to become more self-activating, to harness their capacities.

One team member described the preventative function of the MHC, as well as its subjective dimensions.

So how do you approach the accused? Do you approach them like an investigator, a psychiatrist, a lawyer, a prosecutor or a judge? Even psychiatrists don't often agree on a diagnosis. There is a side to mental illness that is very subjective and dynamic because things are always changing. Therefore, it is not always

easy to know what is happening and how best to proceed. I like to err on the side of caution so I prefer to consider medically, therapeutically, what is best for this person and what is best for others. If I make a recommendation that they are unfit it's often because I worry about the danger to themselves or others. Sometimes I feel a little something, not things that are measurable but I have this impression that inside of them there is this anger, distress, that I worry they will be released and commit suicide or hurt someone, so I am more apt to work in a preventative manner.

Equally, one of the members questioned the social control function of the MHC's work but also underlined this as a rationale for surveying the accused a bit longer to promote a positive outcome, illuminating a prevention strategy.

It's also frustrating to see accused who are very ill, people that have been hospitalized at various moments for long periods of time - that are clearly more severely, chronically mentally ill, wind up here in the court. You wonder why they are not taken to the hospital and kept there. Sometimes the accused also has a rupture with the hospital, with the staff. And sometimes the hospital personnel don't understand the system too. In some cases, the person has assaulted a nurse, the hospital wants an immediate result, wants them to be sanctioned, the police are called, they are taken away, to be dealt with by the court. The hospital hopes the accused ‹learns their lesson›. On the other hand, we can follow them a little longer, put something in place, and see how they do. We have that flexibility.

We turn now to the discussion section to tie empirical elements to theoretical underpinnings to better understand this new form of penal regulation.

Discussion

The regulatory practices inherent in a MHC such as the ones described here are complex and varied. One of the MHC's central functions as described by team members was information gathering referring to a funnel phenomenon: the person enters the system generally through police interactions; a few scant details are known – criminal records are checked; an indication of a mental health problem is felt, believed, sensed and is generally noted by police officers; police officers suggest a psychiatric evaluation and referral to the MHC; the person undergoes a brief psychiatric examination at intake and is directed for further evaluation if needed; conditions of integration into the MHC are put in place; the person follows the recommendations or not and this affects the outcome – are charges withdrawn, dropped, pursued; the conditions of release are also determined based on the person's compliance, acceptance of their mental illness, willingness to collaborate...etc. During these steps, information is gathered from various sources (hospitals, health clinics, social workers, social services, previous criminal record) and produces knowledge about the accused, resulting in their subjectification. This institutionally-constructed knowledge manufactures institutional narratives, discourses and practices, thereby orienting decisions and conditions put in place. It also shapes the subject taken up in these new assemblages.

While the importance of expert psychiatric evaluations were not highlighted by team members in interviews, it was clear from observations of team meetings and court appearances that they were heavily relied upon to orient decisions and to determine if the accused was compliant, responsible and able to self-activate. Fernandez and Lézé studied the usage of psychiatric reports in a French district court and found that «law codification is retransformed into moral evaluation during the trial situation. When knowledge shifts from the written form (in the report) to the spoken word (during the hearing), there is a redefinition and moral construction of deviant Otherness» (2014: 47). In this sense, judges in the court they studied tended to appropriate psychiatric knowledge in order to determine the dangerousness of the person, but also to «judge a person, a personality» (Fernandez & Lézé 2014: 45). In our case here, psychiatric reports were used more broadly by all team members and then transformed in court to determine the accused's motivation, insight and to make projections about the future, and also about «who» the accused are as people, as citizens. The notion that the «punishment fits the crime» is better viewed here as the regulation fits: the nature of the illness (biomedical paradigm), the accused's insight and acceptance of their mental illness, the level of perceived harm, in essence – judging ‹who› they are. Moreover, the notion of responsibilizing subjects for their current circumstances in an effort to curb recidivism and promote better mental health formed a dominant undercurrent of the MHC's work and an overt aim of many interventions. In this process, an accused is instructed how, and is expected to - take charge of their life, become self-regulating and disciplined in order to be «successful» (obey conditions, complete the program) in the MHC, transforming their otherness into a more acceptable and self-regulated essence.

The notion that *a perfect justice* exists for each individual, one in which justice is flexible and based on the person's individual circumstances («the who and the what»), referred to

by some as a «social justice» approach, was a common theme and certainly supports the essence of therapeutic justice aims. However, the danger of such an approach is that it leads to an overemphasis on individualizing social problems, and reinforces responsibilization logics as a singular approach, fortifying dominant relations of power. A singularization approach, in which: certain elements are highlighted as important (psychiatric history, diagnosis); an accused's motivation and insight into their illness are evaluated; wherein the accused's collaboration is judged, limits an understanding of structural problems at play (homelessness, poverty, fragile social bonds) and orients the solutions put in place (e.g. self-activation, responsibilization logics – individualized approaches). In turn, this form of analysis perpetuates individual responses to social problems and also ignores the self-reinforcing power relations at play. It also means that those individuals who are more likely to eke out a living on the streets and viewed as disturbing the public order are more likely to be taken up into the criminal justice system. Picking up on Liegghio's notion of disqualifiers, there was a tendency to oscillate between conceptualizations of dangerousness and fragility when it came to the accused, wherein disqualifiers such as incompetence, disorderliness and dangerousness were inextricably linked.

Inspired by Fassin's (2015) work regarding carceral regulation and profiling (2011), this article concurs with his approach, that the goal here is not to question whether these institutions should exist (MHCs, prisons) but rather, to explore who is taken up into these systems and to what effect? The transformation of individuals into subjects, into targets of intervention and arrest stirs up many unanswered questions: for what purpose? ‹Who› become the targets of these focussed energies? It also reveals how processes of subjectification cement the accused in an otherness. This provides a moral rationale for intervention through a regulation of their practices and a hoped for reintegration into society. The dominant total institutions (prison, asylum, hospital, etc.) have gradually been replaced by more subtle mechanisms encouraging forms of self-discipline and responsibilization (Moore & Hirai 2014, Quirionet al. 2012), and amongst these different assemblages, replete with differing logics and varying intensities of control, regulation and resistances. Oscillations between care and control are inherent tensions in these new arrangements, operating at different levels of intensities depending on the subject, their «elements, capacities and potentialities» (Rose 2000).

One of the premises of the MHC is that it encourages interprofessional collaboration, opening several conduits of communication between justice, health and social service actors and in so doing actors become complicit in creating disciplined responsibilized subjects. It also promotes crossover of systems, systems that are not neutral but hotspots of irregular domination: the tentacles of the asylum reach into the community and the community also reach inside the ‹sanctity› of hospital walls. This back and forth becomes self-reinforcing. Thus the MHC legitimizes interventions – becomes a «forced clinic, a lever, a pretext» for restarting or starting treatment, medicalizing interventions, monitoring and intervening in the lives of marginalized mad people in an effort to normalize their behaviours and create disciplined subjects. These processes encourage a certain profiling of madness based on otherness, social exclusion and marginality.

Conclusion

In conclusion, this article is an attempt to understand how mentally ill accused committed of minor crimes are taken up, understood, and regulated at varying degrees in these new hybridized assemblages of intervention (justice, health, social services). A deeper understanding is needed to better comprehend the effects of these new assemblages that oscillate between care and control, and their impact on the development and the rise of madness profiling. An overemphasis on simplifying complex mental health and social problems (homelessness, poverty, precariousness, weak social infrastructure), and an overreliance on a medicalization approach perpetuates the MHC and the criminal justice system as apt responses to complex situations while reinforcing the involvement of authoritative actors (such as police) and the responsibilization of subjects. Studies such as these have started to provide important insights into the effects of intertwining justice, prevention and treatment modalities but deeper work is needed to better explicate the entry points into the MHC system as well as its effects, and in particular, explore the subject's understanding of their regulation, responsibilization and possible resistances to these manoeuvres.

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