Conceptualization of Justice:

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My research and teaching center on how to craft practical reforms of criminal justice institutions that advance both procedural and substantive justice for offenders and ex-offenders. In the following, I describe how several current projects explore *justice as recognition of an individual's humanity, autonomy and human needs* (individualized justice). My work is based in the belief that this recognition is a necessary part of criminal justice processing in a just society.

My most recent research and writing has involved prisoners in solitary confinement and their use of grievance procedures, the multiple goals of advocates for addressing sexual violence, convicted sex offenders and their efforts to shape legislative reform, and an ongoing ethnography of two reform efforts that have focused on specialized criminal justice programs (an established mental health VOP court and a proposed prostitution diversion program that would provide an alternative to arrest or incarceration). In the following pages I provide an example taken from this research which illustrate the challenges of providing for individualized justice in contemporary justice systems.

Gendered expectations of Mentally Ill Probationers

My involvement as an observer and occasional consultant to a Violation of Probation Mental Health Court (MHC) in a Northeastern city over a two year period focuses on how the MHC team members used their lay beliefs about mental illness to determine the needs and deserts of the probationers who participated in the court. Specifically, I address how the participants' needs were perceived by the MHC and how their related construction of the participants' criminal responsibility was shaped by gender as well as lay beliefs about mental illness and addiction.

To examine these issues, I pay special attention to selection criteria for participants in the court, as well as the compliance expectations that the team members expressed about participants in both the pre-status meetings which took place in chambers as well as in open court. The court was actively engaged in formalizing its procedures, so on multiple occasions the team members explicitly discussed the eligibility criteria for participation as well as the inclusion of particular individuals. In contrast to the explicit language of help and individualization found in the MHC's policies and procedures, a generally unstated model of personal responsibility and strict compliance with medications and drug tests more often shapes the way participants are held accountable within the court. Ultimately, I argue that the MHC's goals in this jurisdiction is fatally undermined by the over-riding discourse of personal responsibility and free will.

This is evident in a number of cases, of which the following is representative:

Alicia's Story

When Alicia, a 19 year old Caucasian female who presents herself as a pierced and tattooed punk, complete with mohawk, was first considered for the MHC calendar, she was nearly rejected by Probation as an offender with a history of violence. When pressed, this "violence" referred to a

note in her lengthy casefiles from DFS that she had, as a 2 year old, tried to smother her infant sibling. But the predominant view in the prestatus discussion was that this was one incident among many in her life history of family abuse and addiction that added up to a series of failed opportunities for state intervention. She was therefore admitted partly in recompense for the state's past failures.

As is common with MHC participants, Alicia was admitted to the court but held in prison until appropriate placements could be found for her. While in prison, Alicia attempted suicide, despite her PO's numerous communications with the prison staff about her psychiatric precariousness.[1] Nonetheless, the judge would not order her moved to the state psychiatric hospital, as she felt that Alicia would be vulnerable to sexual predation there (this is a documented problem at the state hospital, which does not have a separate unit for women). Eventually, a specialized residential treatment program accepted Alicia.

However, Alicia was kicked out of residential treatment because of self-mutilation. The staff construed her cutting as a violation of the house rules as opposed to a psychiatric symptom that required treatment. As a result, Alicia was imprisoned again because the residence would not file paperwork to have her civilly committed and her probation officer did not want her in the community. That is, the warrant to violate her probation specified that she was a "direct threat to herself" -- language which also would have fulfilled an order to hospitalize her if anyone had been willing to file the paperwork with the state.

After her violation, no member of the MHC team acted to find an alternative placement for her, rather, she sat in prison for several weeks more. During this time, she wrote out a three page self-plan with her top ten coping mechanisms. It included numerous clear statements that supported her desire to be on probation in the community rather than confined to prison or a secure treatment facility. This included

> I am in a better place emotionally than I was before. I don't feel a correctional facility will help me. I may consider going back on my ADHD meds, but otherwise I don't feel medication will help me. I need to be in the real world where there are lots of treatment options instead of in facility where there just one, and it isn't even for a person who self-mutilates. I have a lot of confidence in my ability to do well in society, I don't think a drug program that basically ignores my self-mutilation will help. I don't feel that I am the type of person that needs to be institutionalized. Please consider this plan, I am really serious about following it.

After six more weeks in prison, the residential program that kicked her out agreed to take her back. The residential program staff came to court to get "on the record" regarding their expectations for her:

PROBATION OFFICER: She looks healthy, and I just hope she understands that if doctors order medication this time around, that that means you do have to take them. And I know you were kind

[1] The attempt was made while she was under suicide watch; I learned of it through the judge. When I examined her psychiatric casefiles from the prison, there was no mention of this attempt, indicating that it was not recorded.

of trying to get away from that, but the doctor wants to help you. We want to help you, and most of all, I would like to see you complete this probation and sooner than later.

THE DEFENDANT: What happens if I don't take them?

THE COURT: If we have a doctor who's evaluated you and provided an evaluation that says it's in your best interests and medically necessary and psychiatrically appropriate for you to take meds and you don't take them, we're going to have an issue.

THE DEFENDANT: I mean, I have started on a medication while was in prison, but, I mean.

THE COURT: What's your resistance?

THE DEFENDANT: I don't -- I don't -- there's a few things. I just -- I don't like being on medication. There's too many side effects for the most part. And they've -- for some reason I had a hard time matching my diagnosis with the medication. And, also, I believe that I -- that I shouldn't rely on a substance to get better that -- because what -- if that substance is taken away, then I'll be weaker than before.

THE COURT: But if you were a diabetic, let' assume you were a diabetic and you couldn't be healthy unless you took your insulin, would you deprive yourself of insulin?

THE DEFENDANT: No.

THE COURT: A mental illness is no different. It can be -- it can be a chemical imbalance in your brain. You're just missing one thing or you have too much of another. It's like being a diabetic. And I understand not wanting to be dependent. I know. I get that. But if it is for your health, then you got to do it.

THE DEFENDANT: The thing about it is that there have been stretches of time when I could deal with things on my own. It doesn't seem like -- like, the depression seems situational instead of clinical. I mean, I was talking to the psychologists over there about that. And it's like it's not really clinical. I don't have it no matter what all the time. It's situational. So that's not so much a need for medication, but of coping skills.

[more emphasis by Court and PO that she should try meds]
THE DEFENDANT: Yeah. But what happens if I don't take it?

THE COURT: Then you're going to be violated. And you could risk being thrown out of the program.

A RESIDENTIAL PROGRAM REPRESENTATIVE: And, also, Alicia began to kind of dictate her treatment, and we're not going to allow her to dictate her treatment. We want to work with her. She knows it. We like Alicia a lot. We want to help her through this crisis. But she told us that she was not going to take medications, other than the Wellbutrin. Now, she also gave us a list of all the medications she has taken, which is quite a bit. So we kind of understand her concerns and we kind

of hear that. However, we want her to be open to what the doctor may mention to her, if it's something that she's taken before and there's some side effects that she has, not to just down-play and just disregard what the doctor recommends..

THE COURT: Well, I have to tell you, the Court is very, very grateful for your willingness to give her a second try. I understand what we're asking you folks to do and I am deeply appreciative. I really am.
And I'm hoping that you will accept this to see how many people want you to succeed and do what they're asking. Okay? Because, really, the only motivation motivating people in this courtroom is for you to feel good and be healthy and be everything you can be, you know. And I respect your decisions regarding your own body with respect to medication, but I also think you need to be open minded and you need to understand that these people have more expertise, more knowledge. And that you might not always be the best judge of what's best for you at a given time. Do you understand?

THE DEFENDANT: All right.

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There is much to be said about this courtroom exchange, including many presumptions that are not borne out by practice. For example, Alicia does not have a diagnosis for which any of the medications she has been prescribed would be offered. That is, her most recent psychiatric evaluation available to the court confirms her own sense that her depression is situational, and not symptomatic of a major disorder. The other false presumption is that there will be opportunities for her to adjust her medications within reasonable time frames. There is no psychiatrist on staff at her facility; rather, it is one of numerous facilities one psychiatrist visits biweekly or monthly. But the most significant theme that emerges from this exchange is the dominance of the medical model in the Mental Health Court, and the assumption that the authorities know best.

It is standard practice, nationwide, not to coerce medication unless the patient is a danger to self or others. The State own Division of Health and Human Services uses the recovery model to treatment, in contrast with the medical model. This approach is strengths-based, and emphasizes building independence and self-determination. For example, in a 2008 training for Division staff, the consultant emphasized the importance of training staff to work with clients, not to coerce them:

- It is the supervisor's job to get the staff person to learn how to partner with consumers and facilitate the recovery process
- Since a person can't be forced or tricked into recovery, only staff persons who **"work with"** rather than **"do to"** consumers can facilitate recovery.
- A **partnership relationship** with a consumer allows for differences of opinion while eliminating much of the conflict that often exists when the staff person's goals are not the same as the consumer goals.

Clearly, the recovery model has not reached the courtroom or the Department of Corrections. Individual treatment staff, such as the one who assisted Alicia in writing her self-plan, are aware of

the recovery orientation. But none of the MHC treatment staff are empowered to speak up. They are very low-paid, and therefore all work second jobs in other state agencies (including the prisons and the residential treatment programs which they need to approach adversarially at times on behalf of their MHC clients). But their low pay and low status means they have much to lose in advocating on behalf of MHC clients. Further, Probation and Parole dominates the discussion of participants and the appropriate "sanctions" for them, partly because of personality type but also because in standard Violation of Probation proceedings the state is represented by Probation. But perhaps most importantly, the recovery model is in direct conflict with the Correctional view of participants. Even the extraordinarily-therapeutically minded officers still view participants as essentially bad guys over whom they must exert power in order to ensure compliance and public safety. They are by no means "partners." When clients are not viewed as "bad guys" in the eyes by these officers, they are viewed as having diminished capacity that must be rigorously monitored—in essence, a medical model of criminality that views mental illness as a problem to be fixed.

MHC team members recognize that the justice system fails to account for mental illness, but cannot move beyond traditional criminal justice perspectives in order to accommodate the mental health needs and the limited capacities of the participants. MHC team members are almost all self-taught with regard to mental illness and treatment; lay concepts borrowed from substance abuse therefore dominate. This reifies norms of conduct for women that privilege compliance over assertiveness and acquiescence over self-determination. But even problematic women are offered multiple "chances" and tend to be held in MHC longer, with the unintended consequence of more incarceration, but not necessarily more treatment.

Similar norms of compliance and acquiescence held out for men lead to termination for those that reject them ("I don't need this"), often with short prison sentences or straight discharges from probation. Men who accede are "rewarded" with graduation and validation, only to decompensate when the benevolent attention is withdrawn.