An Arm of the Carceral State: Mental Health Social Worker Complicity in Police Violence

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ABSTRACT

Mass protests against racist police violence in the past decades have led to growing calls for anti-carceral alternatives, including replacing police officers with social workers for mental health crises. But this proposal deserves closer scrutiny considering how mental health social workers have long collaborated with the police. I explore the specificities of these collaborations, along with the discursive underpinnings. These practices are situated in their institutional contexts and the broader intermeshing contexts of racism, settler-colonialism, and disablism.

Mental health social workers-initiated police intervention is an integral part of daily social work practice. Institutional ethnographic interviews with mental health social workers and an examination of social work texts reveal three major elements informing mental health social worker-initiated police intervention. First, interviewees consistently cited fear of professional disciplinary measures and other professional obligations as fueling calls for police intervention as a standard response to certain scenarios. The professional ethos of social work, born out of efforts to achieve greater legitimacy and remunerations, and in particular the subjectification of social workers as agents of the carceral state enshrined with the power to intervene upon the lives of oppressed people, also underpins these social work practices. Second, the notion of risk is often brought up as rationale for mental health social worker-initiated police intervention, alluding to mental health social workers serving as specialized forecasters of future harm. This rationalization is tied to the mental health field's eugenicist origins that conceptualized mad and racialized people as dangerous threats to be contained through repressive measures like forced sterilization, anti-miscegenation, immigration restrictions, and confinement. Finally, mental health social worker-initiated police intervention exists in the context of the settler-colonial

capitalist order. The crisis situations described by interviewees as precipitating police intervention are rooted in structural factors, but social workers engage in the task of erasing or obfuscating these underlying processes as a part of their work as disciplinarians. This work illustrates how mental health social workers are a part of the institutional archipelago, the constellation of institutions and practices that operate through carceral logics in the service of maintaining Canadian settler-colonial capitalism.

DEDICATION

Dedicated to survivors and victims of state violence, and comrades in struggle.

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Love and Solidarity,

Edward Hon-Sing Wong

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Chapter 1: Introduction

In 2015, Andrew Loku, a Canadian Mental Health Association (CMHA) client and former colleague of mine was shot dead by the police in his residence. The following week, CMHA held a press conference calling for police reform (Herhalt, 2015); however, there was no mention of the role of the mental health field in this violence. This silence did not sit well with me. I thought of the police violence I had witnessed and been complicit in and had grown increasingly uncomfortable with my work as a mental health social worker. Ways in which mental health workers can be complicit in violence range from epistemic violence, like the dismissal of concerns regarding police surveillance as paranoia, to more overt forms, like the facilitation of psychiatric apprehensions.

The 2020 uprising in response to the police murder of George Floyd has sparked widespread condemnation of anti-Black police violence and growing interest in radical alternatives to the carceral system, including policing. I credit these protests for popularizing abolitionist discourse and creating an opening for my research. But alongside these developments came calls for social workers to replace police officers for the task of crisis and mental health interventions. For example, on 23 June 2020, the Centre for Addictions and Mental Health (CAMH) (2020) joined the chorus of condemnations after the murder of Ejaz Choudry by Peel Regional Police during a wellness check by arguing that “Police should not be the first responders [...] people in crisis [should be] first met by mental health responders”. In this statement, CAMH specifically identified the lack of training in crisis care as the reason police were not suitable for crisis intervention work and called for the funding of community mental health and early intervention programs.

Another prominent example of these demands is that from the Reach Out Response Network, an organization led largely by administrators and professionals from the non-profit sector that advocates for civilian-led crisis response in Toronto and calls themselves "subject-matter experts on non-police crisis response models" (Reach Out Response Network, 2020, p. 5). In the *Final Report on Alternative Crisis Response Models for Toronto* published in 2020, the Reach Out Network (2020) summarized their findings from engagement with over 800 Toronto residents through town halls, surveys, focus groups, and interviews. They highlighted critiques of police interventions for not allowing sufficient time for de-escalation, failing to make appropriate referrals to social and health services, and defaulting to transportation to hospital emergency rooms as outcomes. Based on these concerns, the Reach Out Response Network proposed the establishment of mobile crisis teams made up of peer workers and mental health professionals to be dispatched by 911 operators, or through a separate emergency number. They argued that this crisis service would help reduce the stigma of mental health crises, facilitate positive outcomes for those experiencing crises, save money, and allow for the police to re-allocate resources "towards preventing and solving crime" (Reach Out Response Network, 2020, p. 4).

In response to these demands, Toronto City Council voted in June 2020 to explore the "creation of non-police led response to calls which do not involve weapons or violence, such as those involving individuals experiencing mental health crises and where a police response is not necessary" (*City Council Meeting 22 Minutes*, 2020). An acknowledgment of the appeals for these services from Torontonians, presumably including the lobbying efforts of groups like the Reach Out Response Network, was contained in the final report submitted to the council (*Community Report: Re-Imagining Crisis Response*, 2021). In February 2021, Toronto City Council unanimously approved funding for four pilot programs reflecting the objective of

providing a non-police alternative to respond to crises, with three focused on Northwest Toronto, Northeast Toronto, and Downtown East—regions identified as having the highest rates of apprehension under the Mental Health Act and crisis calls, and a fourth focused on Indigenous communities (*City Council Unanimously Approves Community Safety and Crisis Response Pilots*, 2021). The pilots are run by the Toronto Community Crisis Service (TCCS), a partnership between CMHA Toronto, Gerstein Crisis Centre, TAIBU Community Health Centre, and 2-Spirited People of the 1st Nations, and involve multidisciplinary teams of crisis workers, including social workers, responding to mental health crises and requests for wellbeing checks (*Toronto Community Crisis Service*, 2022). The first pilot launched in March 2022, with others following throughout 2022 (Provincial System Support Program & Makwa, 2023).

While these projects envision a separation from the police as part of its mandate to act as a non-violent alternative, by its own admission, "the TCCS is characterized by collaborative partnerships between the City of Toronto, Toronto Police Services (TPS) … and lead community-based health organizations" (Provincial System Support Program & Makwa, 2023, p. 12). These projects also do not interrogate the existing collaborations between the mental health field and carceral institutions nor do they rectify the ongoing histories of harm perpetrated by social workers. Conceptualizations of social work-based alternatives to policing, like the proposal contained within the report published by the Reach Out Response Network, also fail to consider these elements. This is apparent with their framing of mental health crises, "Our network believes that a mental health crisis is a health crisis, not a crime" (Reach Out Response Network, 2020, p. 4). Yet, as will be discussed in this dissertation, conceptualizations of crime and health crises have historically been one and the same, with madness intrinsically linked to

criminality, and criminality considered a problem to be solved through eugenicist health interventions.

This differentiation made between ‘health issues’ and ‘crimes’ also serves to normalize policing as it pertains to criminal law enforcement, implying that policing should still serve an important function apart from mental health, going as far as arguing that the establishment of a non-police alternative could free up resources for the policing of crime. Unsurprisingly then, the network also sees a role, albeit a more limited one, for the police in mental health-related circumstances, failing to rule out collaboration. The Reach Out Response Network (2020) states,

> The new crisis teams will not be part of the police department or part of EMS; however, they will be closely linked with both agencies. The teams will be integrated into the 911 dispatch system, and we anticipate that like teams in Eugene, Olympia, Oakland, Portland, Sacramento, and Denver, the teams will carry police radios so that they can be dispatched to calls or self-dispatch to calls that involve a behavioural health component. (p. 85)

The Reach Out Response Network (2020) also discusses calling for police backup “when essential to ensure safety [and appeals for] strong working relationships and trust to be built between the teams and other emergency services, particularly police” (p. 85). They suggest that “the teams and police should see themselves as partners in supporting Torontonians in crisis and will recognize and respect the unique roles that each entity plays” (Reach Out Response Network, 2020, p. 48). These qualifications play out in the implementation of the TCCS. 911 and TCCS operators have dispatched police officers alongside crisis workers in situations of potential violence, and TCCS crisis teams have called for police reinforcements in order to facilitate

involuntary hospitalization. TCCS workers also participate in regular meetings with the police to share information (see Chapter 4).

This is not to say these types of non-police alternatives are meaningless, and I hope that harm is indeed mitigated. However, there needs to be a more thorough interrogation of the connections to policing and complicities with harm. For example, service users throughout the report by the Reach Out Response Network (2020) flagged concerns about the assignment of mental health professionals for crisis interventions, citing discomfort about the reliance on dominant medical models of care, fearing that professionals may "replicate the harms of these models" (p. 39). Service users also critiqued the exaltation of professional degrees through credentialism in ways that devalue the lived experience of peer workers and service users. Despite these concerns, the network consistently emphasized the desire for peer workers to be paired up with mental health professionals, including mental health social workers, as the alternative to police response to crisis intervention, failing to address potential for harm from social workers or recognize that the work of social workers is tied up with police violence.

Heeding Haritaworn's (2015) call for an "abolitionist imagination [that] might also involve attending to the way punitive and pathologising logics undergird informal sites, including those that identify as alternative, radical or progressive" (p. 140), I question these proposed 'non-police' alternatives. An abolitionist imagination demands that people recognize the potential harm and violence that even seemingly progressive spaces may facilitate. Mental health social work, as examined throughout this dissertation, is one such area that contributes to harm, despite the popular imagination of it as benevolent. These calls for social workers to replace the police is but a rush to innocence, erasing ongoing histories of violence and practices that cannot be explicatable from carceral institutions. It fails to consider how the mental health

and psychiatric fields emerged out of the same movements and discourses underpinning racial violence. It fails to consider how there exist countless collaborative programs and practices between the mental health field and the police, with no traction towards their elimination. It fails to consider the mental health field's own ongoing participation in racial violence, from involuntary hospitalization to coerced sterilization. In this dissertation, I engage with this disjuncture—how on the one hand, social workers can frame themselves as progressive and non-violent alternatives to the police, yet on the other hand, call upon police intervention as a part of their daily work. I do not believe this disjuncture is reconcilable and yet these practices continue because of specific processes and discourses in relation to the social work and mental health professions, madness, and the settler-colonial social order, that have persisted and been maintained.

Research Topic and Question

In this dissertation, I interrogate how social work practices in the mental health field are implicated in police interventions. For example, I consider how social workers deem a situation as requiring police intervention and how social workers coordinate with police officers during apprehensions for involuntary hospitalization. In particular, I examine how mental health social workers interpret and put into practice texts related to police interventions, including policies and training literature. These practices are situated in their institutional contexts and the broader intermeshing context of racism, disablism, and classism, as expressed through settler-colonial capitalism.

Objectives and Contribution

In addition to filling a significant gap in the literature regarding the relationship between the social work profession and police interventions, I explore how mental health social work practices intertwine with police interventions, in order to develop insights that allow social workers to engage with questions of ethical transgressions. My research is also a form of institutional witnessing, involving bearing witness to oppression. Gorman (2005) explains that witnessing includes recording narratives of power relations witnessed, the history of abuse shared by others, and also an understanding of how these power relations operate. This witnessing as research serves to contextualize and corroborate the experiences shared by psychiatric survivors, helping to reveal oppressive practices in institutions that may be less visible to the general public (Gorman, 2005). This research is also applicable to settings beyond the mental health sector, considering growing debate about the role of police interventions in sites ranging from nursing homes to schools (Castle, 2012; Jenkins, 2022; Lachs et al., 2007).

Literature Review

Social Work and Policing

The majority of the literature on the relationship between social work and the police is in relation to formal arrangements, such as the field of police social work. Roberts (1976) traces the roots of the field to the introduction of women to the police force in the early 1900s. Often with social work backgrounds (Lamin & Teboh, 2016), policewomen handled issues that were deemed too “petty” for the courts (Roberts, 1976, p. 295): counselling youth, providing mental health assessments, and even locating missing girls and young women, often in the context of returning those that had run away to their families. The growth of police social work was

hampered by sexism and, by the 1970s, police social work programs only existed in a small number of American cities (Roberts, 1976). Today, most police departments do not hire social workers and interactions with social services are limited to referrals police officers might make in their day-to-day work and on a case-by-case basis (Lamin & Teboh, 2016, p. 11).

Emerging in the 1970s, an area of collaboration specific to the mental health field is the crisis intervention team, made up of mental health workers—usually nurses or social workers—and police officers. The stated intentions of such programs are to divert people experiencing mental health symptoms from the criminal justice system to the mental health system (Lamb et al., 1995) and reduce the number of violent encounters (Morabito et al., 2012). The literature on this issue tends to be fairly uncritical, failing to consider the perspectives of those being intervened on. For example, Kisely et al. (2010) concludes that a mobile crisis team in Nova Scotia is worthwhile on the basis of efficiency and ability to facilitate access to mental health services. These practices are not assessed in terms of their potential harm to service users. Finally, most of the literature has a tendency to focus on more formal arrangements between police departments and social workers, such as police social work and crisis intervention teams (see Chapter 4). More informal interactions between social workers and the police are absent in the literature.

Mimi Kim coins the term “carceral creep” in her seminal work, *Dancing the Carceral Creep: The Anti-Domestic Violence Movement and the Paradoxical Pursuit of Criminalization, 1973 – 1986*, describing the continued integration of the anti-domestic violence social movement, including social service institutions and social workers (Brownell & Roberts, 2002; Schenwar & Law, 2020), with policing. As social movements contest state inaction in relation to domestic violence, they soften their contestation into collaboration as they aim to maintain

influence and gains within the criminal justice system. This collaboration is then formalized through hybridization, whereby new institutions emerge with close participation of social movement and criminal justice actors. These partnerships lead to the increasing legitimization of criminalization and the replication of enforcement-related institutions and practices. Conversely, law-enforcement becomes entrenched in the anti-domestic violence social movement and the movement becomes subordinated to law enforcement objectives. Other social work scholars have also examined the development of these forms of collaborations, but tend to focus on social work practices more specifically in relation to the prison system or social workers operating within the forensic system more broadly, with less attention paid to policing in the community (Brownell & Roberts, 2002; Richter & Emprechtinger, 2021). Schenwar and Law (2020) challenge the binary between community and prison by contending that the prison has expanded into community through the growing integration of law enforcement into community programs and social worker engagement in law enforcement functions alongside the police, such as in the area of child welfare and substance use and mental health treatment that might not traditionally be considered a component of the formal criminal justice system. This understanding of the carceral system as existing beyond the prison is also referred to as the carceral state (Beckett & Murakawa, 2012; Ben-Moshe, 2020; Kaufman et al., 2018), referenced in the title of this dissertation.

Since the George Floyd Protests in 2020, more authors have followed in Kim's stead to examine collaborations with law enforcement, such as through what is termed "carceral social work". In the article, "Defund the Police: Moving Towards an Anti-Carceral Social Work," Jacobs et al. (2021), define and examine carceral social work "as a form of social work that relies on logics of social control and White supremacy and that uses coercive and punitive practice to manage BIPOC and poor communities" (p. 39). They consider the history of this collaboration as

rooted in social control and White supremacy, and examine ongoing cooperation between social work and policing in the areas of gender-based violence, child welfare, schools, and health and mental health. For example, Jacobs et al. (2021) consider the use of police interventions "from surveillance to interrogation to arrest and detainment" (p. 51) in the context of mental health crises. Also highlighted are anti-carceral alternatives such as that represented by the Oakland Powers Project in California, a community-led organization that facilitates investigations of police violence and crisis intervention trainings for community members.

Preston (2021) also addresses the issue of social worker interaction with police by discussing potential social work practices that can mitigate harm and incorporate abolitionist approaches. Underlying the article is the recognition that despite the author positioning themself as an abolitionist, they have participated in calling for police as a social worker, and that there is a need to explore how social workers can navigate these scenarios. While police interventions should be avoided, should it occur, Preston (2021) recommends that social workers acknowledge the risks and desired outcomes of police intervention, accept personal accountability, and be directive to police officers about their expected role. There have also been new additions to scholarship that challenge the collaboration between social workers and the police through an abolitionist framework. For example, Wong, Rwigema, Penak, and Fortier (2022), James (2021), and Rasmussen and James (2020) all call for social work abolition to occur in conjunction with police abolition, in recognition that state violence occurs through the intertwining of both institutions.

Police Violence against Mad People

Police violence can have serious implications for mad people in relation to psychological trauma, in addition to physical injuries or death (American Public Health Association, 2016; Aymer, 2016). However, there is limited research able to produce concrete numbers on the scale of police violence. A database compiled by CBC researchers from 2000 to the first half of 2020 included 555 cases of fatal police encounters, with a 68% majority labelled as "suffering with some kind of mental illness, addiction or both" (Singh, 2020). A review of British Colombia coroners' reports from 2007 to 2014 found that 89 out of 99 deaths where police were present involved someone with a mental health issue, substance abuse, or both (Lupick, 2015). Investigative journalists Helen Slinger and Yvette Brend also uncovered 72 cases of police shootings involving mental-health crises nationwide from 2004 to 2014 (Slinger, 2015). Contact statistics can help illustrate the scale of policing in relation to mental health crises. In 2012, 18.7% of Canadians coming into contact with the police did so in relation to mental health crises (Boyce et al., 2015). The Vancouver Police Department reports that 21% of police incidents involved mental health issues, accounting for 25% of police time (Szkopek-Szkopowski et al., 2013). Studies have shown that the number of this type of police contact is growing in Canadian cities (Iacobucci, 2014; Szkopek-Szkopowski et al., 2013).

A number of sources highlight mad people's experiences of police violence. Published by a coalition made up of psychiatric survivors and ally advocates and academics, *Clearing a Path: A Psychiatric Survivor Anti-violence Framework* is a report that maps out various forms of violence against mad people, including police violence—"naming the violence" (Psychiatric Disabilities Anti-violence Coalition, 2015, p. 21), and proposes "a psychiatric survivor anti-

violence framework" (Psychiatric Disabilities Anti-violence Coalition, 2015, p. 26) through which additional research and action can be undertaken. Indeed, police violence can have serious implications for service users in relation to psychological trauma, in addition to physical injuries or death (American Public Health Association, 2016; Aymer, 2016), and may involve "hands on, arm lock, handcuffs, pepper spray, Taser, or low-lethality gunshot with beanbags" (Skeem & Bibeau, 2008, p. 202).

In Kittrie's (1971) *The Right to be Different*, it is argued that two principles underlie the treatment of mad people in the Anglo-Saxon tradition: the duty of the state to remove and incarcerate those that disturb the peace, and *parens patriae*. *Parens patriae* is the notion that the state—like a 'patriarch'—could and should intervene in the lives of people when the state deems it to be in the people's best interest (see Chapter 4). These principles are revealed with the justification of police interventions through the framing of those diagnosed with mental illness as dangerous. Menzies and Webster (1989) explains that the notion of dangerousness "entails an ascription of status and a projection that violent conduct might be exhibited at some future junction" (p. 117), unlike the notion of being violent, which refers to behaviour that had already occurred. Indeed, the process of obtaining authorization for police apprehensions mobilizes the discourse of dangerousness by alluding to ideas of individuals with mental health concerns as current or imminent risks to themselves or others. This labelling process can also engender significant psychological distress for the labelled person and is difficult to reverse (Anonymous, 2019). Joseph (2013) also examines how the framing of someone diagnosed with a mental illness as criminal serves to justify violence as the correct course of action.

Some scholars have also examined the intricacies of police interventions directed at people diagnosed with mental illnesses in the Canadian context. For example, Burstow (2015) provides a comprehensive examination of police apprehension of the "mentally ill" for involuntary hospitalization—commonly known as 'forming' in the mental health field—and highlights the trauma experienced by those subject to the practice. Menzies (1987) also examines the practice of police apprehension, concluding that

> the police functioned as forensic gatekeepers, alerting clinicians and other officials to signs of mental disorder and criminality and to appropriate courses of action. At the initial point of arrest, the police assisted in laying the groundwork for the subsequent institutional careers of medicolegal subjects. (p. 429)

This analysis flips the script and considers how police officers may initiate psychiatric interventions, just as mental health workers may initiate police interventions. Finally, Van Veen, Teghtsoonian, and Morrow (2019) consider how the formulation of increased police interaction with psychiatrized people can serve as a pretext for neoliberal policies that further incorporate the police in coercive mechanisms to address mental distress, citing the example of a report released by Vancouver's task force on mental health and addictions. This body of literature helps contextualize my research project within broader discussions of the intersections between the criminal justice system and mental pathologization.

Maria Liegghio has written a number of articles on police interventions in the context of child and youth mental health. Police interventions are the primary means by which children, and adults, expressing mental health crises enter the psychiatric or criminal justice system (Liegghio et al., 2020). In a study relying on intake assessments at a youth mental health agency located in Peel Region, an urban area north of Toronto, Canada, it was found that 16% of children and

youth experienced police involvement (Liegghio et al., 2017). Liegghio and Jaswal (2015) note that police are usually called by family members on children to deescalate conflicts involving harm or threats of harm to the child themselves or others, or based on accusations of illegal activity. The police are expected to use physical force "if required" (Liegghio & Jaswal, 2015, p. 307) to restrain the child or to escort them to the hospital. In interviews with family members, police interventions were described as helpful for deescalating high conflict circumstances, though dissatisfaction was also raised about how the child and their family members were often stigmatized through the process. Family members were accused of negligent parenting and children were thought to receive more severe police sanctioning because of their mental health diagnoses. Liegghio and Jaswal (2015) conclude,

> police involvement can officially implicate the mental illness as dangerous or as potentially dangerous; the distressed young person as a potential criminal; caregivers and families as incompetent and culpable for failing in their parenting/caregiving roles; and family members as helpless and victims in need of protection from loved ones. (p. 311)

The nature and process of police intervention contribute to broader discourses that link mental illness with dangerousness and criminality.

Whitehead (2016) explains that "Some suggest criminalization may occur due to the increasing presence and visibility of PMHDs [people with mental health disabilities] in the community in the wake of deinstitutionalization and may be exacerbated by the relatively high threshold of dangerousness and impairment required for involuntary civil committal" (p. 339). Iacobucci (2014), a former supreme court justice who reviewed policing practices in a 2014 report, for example, blamed the upsurge of police contacts on deinstitutionalization and "the modern principle that patients should have the freedom to decline mental healthcare except in

extreme cases" (p. 83). Rebutting these claims, Ben Moshe (2020) suggests that while deinstitutionalization was a victory for the mad movement, this framing of deinstitutionalization as responsible for police contacts is a part of a backlash against these developments and used as rationale for strengthening carceral institutions and practices. The framing of deinstitutionalization as responsible for police contacts is also inaccurate, as it conveniently ignores how transinstitutionalization[1], the movement of mad people from asylums to the criminal justice system, can be largely explained by neoliberalism, with its emphasis on criminal justice responses and the rise of the prison-industrial complex, and the state's disinvestment from social services.

Meerai, Abdillahi, and Poole (2016) further consider police violence against mad people in the context of anti-Black sanism, a "particularly perilous mix of [anti-Black racism and a specific kind of sanism]" (p. 20). Sanism refers to oppression, beliefs, and practices that allow for psychiatric diagnoses and therapies to debase, degrade, and harm mad people, in the name of health and safety. Importantly experiences of sanism are mediated through an interplay with class, gender, sexuality, race, and colonialism. Considering the shooting of Andrew Loku, Meerai, Abdillahi, and Poole (2016) trace how the injustice was made possible by the ongoing histories of scientific studies and conceptualizations of Black and African people that serve as

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[1] Ben-Moshe (2020) also complicates notions of transinstitutionalization by highlighting how the number of BIPOC institutionalized actually increased during deinstitutionalization in the 1960s and 70s, suggesting that "this is not an either/or form of social control but both at the same time" (p. 146).

justification for the violence and austerity imposed. Meerai, Abdillahi, and Poole (2016) conclude,

> Anti-Black Sanism enables us to see how these systems benefit from the 'mentally ill' Black body, how they create an economy (hospitals, prisons, etc.) and co-opt a knowledge base (holistic, anti-racist) at the expense of lost, murdered, marginalized, and uncared for Black/African lives. (p. 25)

This argument is akin to Wang's (2018) argument that anti-Black racism, and not profit motives alone, underpins the carceral system and that global capitalism is made possible by gratuitous violence and Black enslavement.

Social Work and Violence

Traditionally, social work literature on violence has focused on violence committed by clients against the practitioner (Arthur et al., 2003; Balloch et al., 1998; Newhill, 1995; Schultz, 1987; Shin, 2011; Tonso et al., 2016) or on the various forms of violence committed by service users, such as domestic violence (Ekström, 2015; Khan, 2015; Stanley, 1997; Svoboda, 2015; Van Soest & Bryant, 1995). Van Soest and Bryant (1995) critique this focus, arguing for a broader conceptualization of violence that considers structural or socially sanctioned violence. Nonetheless, while Van Soest and Bryant (1995) did not explicitly argue for an examination of violence perpetrated by social workers, my research still serves to address the gap in social work literature identified by Van Soest and Bryant (1995)—the tendency for social work researchers to have a narrow conception of violence that revolve around familial violence.

This absence is consistent with the whitewashing of colonialism in the mental health social work field. The bulk of reconciliatory efforts and literature focus on repairing what

Coulthard (2014) calls “the injurious legacy left in the way of history,” (p. 127) not the colonial relationship itself. This failure to consider the ongoing colonial relationship is consistent with what Pon (2009) calls a rush to practice. Mental health social workers are quick to rush to practice without carefully considering the way in which histories reverberate in the actions we take in the present, as it “often entails the challenging work of self-knowledge, including acknowledging how we are all implicated in contradictory relationships of oppression” (Pon, 2009, p. 69). Other social work theorists, especially Indigenous theorists, have made similar arguments (Baskin, 2006; Bennett et al., 2011; Sinclair, 2007; Tuck & Yang, 2014; Verniest, 2006). For example, the Mental Health Commission’s (2015) *Recovery Guidelines* and Regehr and Glancy (2014) address colonialism as the historical state treatment of Indigenous people through policies like residential schools. These state policies are then connected to mental health outcomes and “adverse social indicators” like poverty and incarceration. Regehr and Glancy (2014) fail to explicitly consider how these ‘social indicators’ are themselves ongoing processes of colonialism and not simply the natural result of past wrongs, nor do they consider continued practices of colonial resource extraction and displacement.

The mental health field’s contributions to colonialism through practices like forced sterilization and its historical support for white nationalism are also not considered. According to Chapman & Withers (2019), the few times when the social work profession has considered its own settler colonial history has often been done in a decontextualized fashion with little continuation or contemporary resonance (*CASW Statement on Truth and Reconciliation Commission of Canada*, 2016). That is, while the social work profession may acknowledge colonialism, it is understood as a historical wrong with little relevance to the present and with little consideration of social work’s participation. The result of these practices is to pacify

through assuaging settler guilt and absolving state and settler society responsibility for substantively addressing the effects of colonialism.

That said, critical approaches that reveal processes of violence perpetrated by social workers do exist. Indeed, a number of scholars argue that violence—and colonial violence in particular—is a key characteristic of social work's historical roots in Canada. Thobani (2007) explores how the social work profession secures exaltation as an embodiment of whiteness through its position as a 'civilizing' and colonizing force. Thobani (2007) further illustrates how these historical roots and practices are intertwined with colonialism by drawing on examples of violent assimilationist policies like residential schools and the widespread abduction of Aboriginal children by social workers since the 1960s (p. 124). The topic of social work engagement in colonial violence through these practices has been highlighted by a number of scholars (Alston-O'Connor, 2010; Crichlow, 2002; Fortier & Wong, 2019; Sinclair, 2007; Spencer, 2017). Chapman and Withers (2019) also challenge the 'standard account' of social work by providing an in depth examination of social work practice as violence throughout its historical and contemporary development.

However, there are fewer examples in the social work literature, especially in the Canadian context, that interrogate the specificities of social injustice perpetrated by social workers. One such example is Chapman's (2014a) appraisal of their own participation in restraining and confining Indigenous children in the context of a residential program. Chapman (2014a) challenges the idea that "violence and atrocities [are] always committed by people entirely unlike the rest of us, which I would suggest implicitly justifies psychiatric and penal abuse and incarceration, as well as war" (Chapman, 2014a, p. 17). Joseph (2013) likewise considers issues faced by racialized people, as he concludes that the use of violence in the mental

health system disproportionately affects racialized bodies. These acts of violence—such as the use of physical or chemical restraints and collaboration in practices of deportation—are often obfuscated. More prevalent have been examinations of more subtle forms of micro violence, especially from a post-structuralist perspective (Foote & Frank, 1999; Moffatt, 2016). For example, Foote and Frank (1999) examines grief therapy practices through Foucauldian ideas of power and discipline, concluding that grief therapy is a form of political violence as it frames grief not only as pathological, but as morally wrong, requiring the griever to seek treatment. Liegghio (2013) also considers practices of epistemic violence directed at mad people, defining it as that which render individuals of groups of people as illegitimate in relation to holding knowledge. As will be explored throughout this dissertation, social workers often engage in these practices, discounting mad people's perspectives, including that in relation to policing.

Lastly, a number of critical social work researchers have also looked at how violence perpetrated in the context of social work is made invisible. Chapman (2014a) recounts how they understood violence as something to be "psychologically 'worked through' and 'overcome' rather than politically and ethically attended to" (p. 23). Workers who participated in restraints would often be debriefed in acknowledgment of the instinctual discomfort with this type of work, but with the idea of having workers "accept perpetrating violence as necessary" (Chapman, 2014a, p. 25). Burstow (2015) adds that the cohesiveness of mental health teams also creates the conditions that allow for violence, serving to frame the pathologized other as dangerous. Violence is normalized through shaming members of the team that question violent practices for being uncooperative.

Terminology

In this dissertation, I use a variety of terms to describe the targets of psychiatric intervention. While generally used interchangeably, these terms do reflect specific contexts and emphases when used. I predominantly use the term mad people. While the term had pejorative connotations, it has since been reclaimed by the mad community in order to "acknowledge the experiences and voices of mad people without invoking (thereby resisting) the contemporary and often anachronistic psychiatric diagnoses such as schizophrenia, bipolar disorder, et cetera." (A. J. Joseph, 2016, p. 19). Though it should also be acknowledged that some in the mad community are apprehensive about this terminology given the potential romanticization of distress and a lack of consensus about meaning (Beresford, 2020). I use the term in this dissertation especially when discussions refer to a broader range of time that predates contemporary psychiatry, as people expressing and encountering behaviours, ideas, and experiences outside of the norm throughout history. This relationship with history is also significant as control and confinement were not always the default response to madness. In fact, prior to the "great confinement" in the 17th century, mad people were sometimes understood as holders of wisdom in parts of the world (Foucault, 1961). Medicalized notions of the insane and mentally ill were also not present in Indigenous communities on Turtle Island (including what is now known as Canada) prior to colonialism. Yellowbird explains that "Native peoples generally do not have a notion of 'insane' or 'mentally ill' in our cultures. Indeed, I have been unable to locate a Native Nation whose indigenous language has a word for that condition" (Yellow Bird, n.d., p. 4).

I also use the term psychiatrized people or psychiatric survivor to refer to mad people that have encountered diagnosis and navigated the psychiatric system. It is meant to recognize the

acquiring of psychiatric labels as a process imposed by mental health professionals and institutions. This imposition also tends to reify psychiatric categories. Indeed, Burstow (2015) argues that the diagnostic approach serves as an interpretive lens serves to "strip people of at once context and personhood" (p. 92). It pathologizes everyday practices. While these diagnostic models are represented as neutral and universal, these diagnoses themselves are heavily influenced by preconceived notions of race, class, gender, and sexuality. Consequently, and conversely, medicalization of marginalized groups is a significant means of social control. My use of this term thus serves to challenge reification and the self-evident nature of psychiatric labelling, to counteract its imposition.

I also use the term service user to describe mad people in relation to social workers. Generally, I am referring to people that are currently accessing services with a social worker or had accessed it in the past. In social work literature, it can also be used to refer to potential users of social services, but I use the more restrictive definition in this dissertation. There is also the suggestion that the term service user emphasizes agency, that people access services on a voluntary basis (Levin, 2004). However, I question this framing considering how accessing certain resources may be predicated on following certain rules or receiving certain services that a person may not actually want. For example, some forms of housing for psychiatrized people are provided alongside mandatory case management and other resources may require medication compliance (Voronka et al., 2014). Psychiatrized people may also accept services as a means to avoid confinement or further criminal sanctions (Schneider et al., 2016). Interviewees also described providing services on an involuntary basis, such as in the context of inpatient hospital units and prisons. These cases will be noted in the discussion.

Organization of Chapters

My dissertation is divided into eight chapters. This first chapter has considered the context of my research as linked to my experience as a mental health social worker witnessing and being complicit in police violence, as well as growing demands to have social workers undertake certain police functions. This context informed my research topic and question, an assessment of the intertwining of mental health social work practices and police violence. This research provides insights into ethical transgression in social work and is a form of institutional witnessing. Finally, a literature review covered the topics of social work and policing, police violence against mad people, and social work and violence. My examination of these areas shows that there is a gap in the literature in relation to the intricacies of mental health social worker involvement in policing, a gap which this dissertation attempts to fill.

In Chapter 2, I examine the theories underlying this research, the methodology, and the methods. This research leans heavily on historical materialism, conceptualizing that being studied as formed out of interlocking systems of oppression. Mechanisms of control, specifically ideology, ruling relations, common sense, and affect are also assessed. Finally, carceral practices and institutions are understood as political tactics, used for productive goals of reinforcing the existing social order. These practices are examined through an abolitionist lens that recognizes carcerality as temporal but intertwined with everyday practice. The methodology is an adaption of institutional ethnography (IE) that uses the examination of institutional practice as a starting point to map out processes and ruling relations, but also heeds Bannerji (2015a) and Gorman's (2005) corrective drawing institutional practices to the broader social organization through historical materialism. The research methods involve the use of semi-structured interviews with

17 mental health social workers and an examination of relevant texts that influence mental health social worker practice, including policy documents, textbooks, training material, and forms.

In Chapters 3 and 4, based on my interviews and social work literature, I examine the process of police intervention in the mental health social work context and how knowledge of these practices is developed. In Chapter 3, first, I discuss how mental health social workers learn about police intervention through organizational policies, schooling and training, and informal interactions in the workplace. I then discuss the steps taken prior to police intervention, including safety and crisis planning, family engagement, risk assessments, consultation, and de-escalation and intervention. In Chapter 4, I examine the steps taken during police intervention. Steps include calling the police, interacting with police officers on the scene, writing incident reports and case notes, and debriefing. The chapter ends with an exploration of legislation and programs that involve the collaboration of mental health social workers and the police in Ontario, Canada, such as forms for involuntary hospitalization, community treatment orders, police social worker crisis teams, and situation tables.

The next four chapters examine the underlying ruling relations and motivations or processes that inform or drive mental health social worker-initiated police intervention. The chapters focus on different scales and scopes, with the first two chapters on how social workers are regulated and how social workers understand themselves, Chapter 7 on the conceptualization of mad people, and Chapter 8 on the connections between mental health social worker-initiated police interventions and settler-colonial capitalism. Interspersed between these chapters are three shorter chapters comprising anecdotes drawn from my interviews. These shorter chapters serve the purpose of illustrating the work processes related to mental health social worker-initiated

police intervention from start to finish, exploring the different circumstances and context where these practices are engaged.

In Chapter 5, I consider formal measures of control, specifically the disciplinary powers of the Ontario College of Social Workers and Social Service Workers (OCSWSSW). While I did not come across any cases of mental health social workers punished through these mechanisms for failing to call the police, multiple interviewees raised concerns about the potential for reprimand. Thus, I analyze regulations pertaining to social work, including that contained in the Ontario Social Work and Social Service Work Act, and the various codes of ethics published by regulatory agencies in Ontario. I also describe the disciplinary mechanisms available to the OCSWSSW and examine examples of disciplinary cases. Through these examples, I explore how the codes and regulations have been interpreted by the regulatory body.

In Chapter 6, I explore the subjectification process in relation to professionalism. I examine the early history of professionalism, the emergence of specialized knowledge and the displacement of community-based and subjugated knowledges that run counter, and collaboration between mental health social work and the settler-colonial state. I argue that these elements provide social workers with their exalted status and presumption that they have the innate ability to intervene and impose upon other people.

In Chapter 7, I consider the representation and conceptualization of mad people by the mental health social work field. Connecting contemporary discourses and practices, to mental health social work's roots in the mental hygiene movement, I describe how social workers perceive mad people as threats to society. To address these threats, mental health social workers have worked in the carceral system to predict mad people's potential harm to oneself or others, what is conceptualized as dangerousness. Finally, coercive interventions are understood as a

default response to crisis, potential harm, and dangerousness. I consider resonances of eugenic practices advocated for and implemented by the Canadian mental hygiene movement in contemporary coercive approaches.

In Chapter 8, I examine mental health social worker-initiated police intervention in the context of the broader social order. First, I explore how the crisis situations used as justification for police intervention are rooted in structural factors, and in the Canadian context this organizing structure is settler-colonial capitalism. Second, I discuss the social worker as a disciplinarian, engaged in the task of erasing or obfuscating processes of disablement, debility, and slow death, as well as imposing psy- interpretations on to mad people. Police interventions are a significant component of this. Third, I consider how mental health social work practices, including the initiation of police intervention, are a part of the institutional archipelago, the constellation of institutions and practices that operate through carceral logics and in the service of maintaining the Canadian nation and settler-colonial capitalism.

In Chapter 9, the concluding chapter, I reiterate how proposals to replace police officers with social workers as a move away from the coercive handling of mental health crises are flawed considering the ongoing collaborations and connections between these professions explored in this dissertation. I also consider important future research directions, namely, a need for substantive appraisals of alternatives to professionalized mental health and crisis intervention rooted in abolitionism and an internationalist lens that can consider both carcerality and abolitionist movements as global projects. Through this examination of future research directions, I highlight a number of initiatives that contain the seed of an abolitionist future.

Chapter 2: Research Process and Underlying Theories

In this chapter, I examine the theoretical framework underlying my research as well as the research design. Underlying my research is a historical materialist theoretical framework that incorporates anti-racist, abolitionist, decolonial, and anarchist theories. Highlighted in my theoretical framework are concepts including the social, ideology, ruling relations, common sense, and social practices as political tactics. These concepts inform my adaptation of institutional ethnography (IE) as a methodology. First pioneered by Dorothy E. Smith in the early 1980s, IE allows for the mapping out of institutional processes and ruling relations that motivate everyday practices (Devault, 2006). My approach to IE incorporates a relational/reflexive method of social analysis, a corrective suggested by Himani Bannerji (1995d) to move local analysis towards consideration of how practices are shaped by social relations across a historical trajectory. This analysis relies upon reflective memos, interviews with 17 mental health social workers from a variety of social service settings, and a collection of policy documents, training literature, forms, and assessment tools.

Theoretical Framework

The Social and Interlocking Oppression

The central assumption underlying my research is that the material organization of society, as it has developed through history, informs human activity, including mental health social worker-initiated police interventions. This process can be uncovered by a historical materialist approach. Historical materialism conceptualizes daily realities through the social, defined by Himani Bannerji (1995a) as a “complex socio-economic and cultural formation, brought to life through myriad finite and specific social and historical relations, organizations

and institutions" (p. 4). The social refers to this complex integrated formation, which emerges day to day as very specific social relations (e.g. enslaved person and slave owner; stay-at-home wife and husband; wage labourer and employer; patient and mental health social worker) and institutions (e.g. healthcare, education, mental health social work). Bannerji (2015a) also explains that the social "involves living and conscious human agents and what Karl Marx calls their 'sensuous human activity, practice'" (p. 4). The social comes to fruition through people engaging in various practices—the employer hiring an employee, the social worker coming into a home to teach parenting skills—and does not exist outside of this human activity.

A key aspect of the Marxist definition of the social is its concreteness. Marx (1939) states, "The concrete is concrete because it is the concentration of many determinations, hence unity of the diverse" (p. 34). Understandings of the social cannot fragment or emphasize one part (e.g. class or race) over another as the social is concrete, resultant from the integration of many determinations—including social relations, discourses, or forms of consciousness. The 'unity of the diverse' suggests that all of these determinations come together at once and cannot be separated. Bannerji (2015a) draws on this definition to understand race as a social formation. This understanding of the concrete as the culmination of a diverse range of social relations suggests that race is inseparable from any socio-economic and cultural understanding. This also serves as a critique of forms of intersectionality that have been in vogue. These interpretations of intersectionality tend to consider race, class, and other identities or forms of consciousness as arising from their own specific social terrain before combining with other social positions (Bilge, 2013; Wong, 2018). This fragmented conceptualization of the social fails to consider the relational nature of these forms of consciousness; instead, there is a tendency to see discourses or

language as the sole determinant of the social—a position critiqued by Bannerji (2015a) and the Combahee River Collective (1977).

However, Bannerji also rejects class-reductionism, which understands race and gender as secondary to class, with culture and the social mechanically determined by the economic base, which refers to the means of production or the underlying economic structure (e.g. capitalism). Bannerji (2015a) does not see the relationship between the economic base, and culture or consciousness in a mechanical or unidirectional fashion. The activities that exist within the social are mediated and articulated "with their expressive as well as embedded forms of consciousness. Here, signifying and communicative practices are intrinsic moments of social being" (Bannerji, 2015a, p. 4). Communicative practices, affected by people's sense of self, serve as the language by which the economic base articulates itself within the social. Thus, social relations like race and gender cannot be understood as subordinate to class, as class relations are mediated and articulated by these cultural and social constructions.

Neither class-reductionism nor an additive intersectionality can serve as a basis of emancipatory politics as these approaches fail to accurately convey the experiences of people navigating the social. Indeed, Bannerji (2015a) contends that people experience the world not in an additive manner but "as being all together and all at once [...] not divisible separately and serially" (p. 103). If it is the case that the various social relations are experienced all at once, then, Bannerji (2015a) suggests, "we need to venture, therefore, into a more complex reading of the social, where every aspect or moment of it can be shown as reflecting others; where each little piece of it contains the macrocosm in its microcosm" (p. 105). This suggests that every aspect or moment, within the social, reflect the complex intermingling of an entire constellation of social relations, consistent with Marx's definition of the social as concrete.

This interpretation is also apparent in the initial incarnation of intersectional theory rooted in Black feminist movements. Intersectionality was first coined by Kimberlé Crenshaw (1989) in her critique of how antidiscrimination doctrine, feminist theory, and anti-racist politics often fail to consider Black women, whose experiences are "theoretically erased" (p. 139). Crenshaw (1990) elaborates on the concept in an examination of how violence against women is experienced by women from different social positions, "these examples illustrate how patterns of subordination intersect in women's experience of domestic violence. […] the imposition of one burden […] interacts with pre-existing vulnerabilities to create yet another dimension of disempowerment" (p. 1249). Intersectionality allows for recognition that multiple processes of subordination overlap to form unique experiences of oppression. Intersectionality builds on a history of Black feminist activist engagement in collective struggle and imagination (Carastathis, 2014). The development of the concept of intersectionality can be attributed to the work of various activist intellectuals and collectives—including Angela Davis (1981), The Combahee River Collective (1977), Audre Lorde (1984), Sojourner Truth (1851), Mary Ann Weathers (2000), and bell hooks (1984)—a body of work identified by Patricia Hill Collins (2002) as Black feminist thought, emerging as a collective political movement for self-definition in the context of interlocking/intersecting oppressive social processes.

An influence on standpoint theory to be discussed later in my methodology, Collins (2002) argues that Black feminist activists produce knowledge "by using their experiences as situated knowers" (p. 19). The centring of Black women experiences by activists like Truth "laid the foundations for what we would now recognize as intersectional analyses and methods". Crenshaw (1989) cites Truth's speech given at a Women's Convention in 1851 as an early example of intersectional analysis and an attempt to challenge racism within the women's

movement. While Truth (1851) highlights Black women's experiences of physical toil as a means of challenging the notion of women's weakness, another major objective of the speech was to compel white women in the crowd to reject racist discourses that presented Black women as "less than real women" (1989, p. 154). The reasoning was that this rejection was needed for white women to include Black women's experiences in their own critiques of patriarchy.

Crenshaw (1989), in elucidating the distinctions between Black women and white women's experiences to demonstrate the need for intersectional analysis, relies on "the development of a historical critique" (p. 154). For example, Crenshaw (1989) examines the history of Black women's involvement in the workforce as a critique of the generalized feminist notion of women being excluded from the public sphere. This use of historical analysis in Crenshaw's (1989) intersectionality framework is consistent with Davis's (1981) contention that an accurate assessment of Black women's experiences must "attempt to illuminate the historical matrix of her oppression" (p. 82). Likewise, Erevelles and Minear (2016) argue that the foregrounding of how social categories are "intermeshed with each other in specific historical contexts" (p. 357), especially as connected to disability, elucidates the structural conditions that produce these very social categories. While intersectionality complicates constructions of social categories, historicizing oppression allows for acknowledgment that these social categories emerge from specific social and political processes, shaping people's experiences.

Collins (2002) is careful not to suggest that these historical processes deterministically produce homogenous experiences for people placed within a social category. In a rejection of the additive model referenced previously, Collins (2002) states,

> There is no essential or archetypal Black woman whose experiences stand as normal, normative, and thereby authentic. […] Since Black feminist thought both arises within

> and aims to articulate a Black women's group standpoint regarding experiences associated with intersecting oppressions, stressing this group standpoint's heterogeneous composition is significant. (p. 28)

Collins (2002) suggests that the goal of Black feminist thought is not to create new categories. Instead, people should uncover how common challenges were constructed through historical processes and acknowledge that while common struggles related to various forms of oppression may exist, these processes do not operate in a deterministic or rigid manner. Any exploration or historicization of identity categories needs to recognize that there is a diversity of responses to these common struggles.

In addition to an emphasis on historicization of oppression, the concept of interlocking oppression—or matrix of domination—is a major aspect within Black feminist thought. The Combahee River Collective (1977) introduces the concept of interlocking oppression in their general statement of politics. The Collective describe how systems of racism, sexism, heterosexism, and classism intermesh with one another to produce the present conditions. While additive forms of intersectional theory can be understood as a challenge to understanding groups as internally homogenous, interlocking oppression represents the idea of interconnectedness between systems of oppression. The Combahee River Collective (1977) draws on the work of Black women activists, like "Sojourner Truth, Harriet Tubman, Frances E. W. Harper, Ida B. Wells-Barnett, and Mary Church Terrell, and thousands upon thousands unknown" to illustrate how "the major systems of oppression are interlocking". The Collective highlights the work of these activists in drawing awareness to how sexual identity intersects with racial identity in shaping their experiences and struggles. For example, the Collective cites the use of rape by White men against Black women as a means of political repression. An analysis that "separates

race from class from sex oppression" (Combahee River Collective, 1977) results in the erasure of context and contributing factors of rape.

Collins (2002) expands the idea of interlocking oppression with the concept of "matrix of domination" (p. 18). Collins (2002) considers the matrix of domination as an integral companion concept to intersectionality, as it "refers to how these intersecting oppressions are organized. Regardless of the intersections involved, structural, disciplinary, hegemonic, and interpersonal domains of power reappear across quite different forms of oppression" (p. 18). The matrix of domination alludes to the means in which various forms of oppression intermesh and are organized in specific sites and aspects of social order (e.g. housing discrimination, racial profiling, stereotyping media representations, or everyday racism). While the broader concept of intersectionality focuses on "micro level processes" (Hulko, 2009, p. 47), the matrix of domination emphasizes the macro level connections that create social positions such as race, gender, and class. Engaging in social analysis with an interlocking oppression or matrix of domination framework is crucial as it allows for a more complex reading of oppression, rejecting flawed interpretations of intersectionality that presents oppressive systems as additive or separate. Instead, race, class, gender, and other identity categories are understood as intermeshed to form the daily experiences within a society.

Intersectionality is also an increasingly important component of more recent Critical Disability Studies and Mad Studies. Bailey and Mobley (2019) argue for a Black feminist disability framework that can address Disability Studies' failure to address race and Black Studies' failure to address disability. These erasures have reinforced notions of Black people as both hyper able and inherently pathological, erasing the needs and lived experiences of Black disabled people. As referenced in Chapter 1, Meerai, Abdillahi, and Poole (2016) highlight the

issue of police violence against Black mad people through the lens of anti-Black sanism. The mental pathologization of Black people in historical and contemporary practice point to a need to consider the intertwining of racism, sanism, sexism, and other oppressions that produces the social conditions encountered. This article joins scholarship (Chapman, 2014a; Erevelles & Minear, 2016; Gorman, 2016; Mills, 2013; Tam, 2013; Wong, 2016) within Mad Studies that "seek[] to more generally decolonize and de-centre whiteness in mental health and mad places" (Meerai et al., 2016, p. 24).

The social as made up of connections between various social categories, social structures, and historical developments and as highlighted by Black feminist thought is illustrated by Bannerji's (2015a) definition of race. Unsurprisingly, Bannerji (2015a) does not accept race as a self-evident biological category, but instead, understands race as a "power-inscribed way […] of reading or establishing difference and for finding long-lasting ways to reproduce such readings, organization and practice" (p. 108). Race is a socially constructed category that serves as a means of segmenting people, and of maintaining 'readings, organization and practice' based on the differences associated with race. Race, as a segmentation of people, serves as the "social culture of colonialist and imperialist capitalism" (2015a, p. 108), or, in other words, the habits, meanings, and values within the form of capitalism we have today. This notion is evident when we observe the hiring practices of transnational corporations in the global south. These companies hire a predominantly female labour force for the purpose of raising profit margins, an arrangement which is tied to both "experiential as well as ideological knowledge about whose labour counts the least" (Bannerji, 2015a, p. 109). These knowledges are not ahistorical and are resultant from the concentration and intermingling of various social and economic relations, as discussed prior. Thus, any substantive analysis requires that research does not isolate the various

forms of social relations as these relations are projected on to, and shape private property and capital relations.

Civil society is another concept that illustrates Marx's understanding of the social. Marx and Engels (1845) state, "civil society is the true source and theatre of all history, and how absurd is the conception of history held hitherto, which neglects the real relationship and confines itself to high-sounding dramas of princes and states" (p. 163). Rejecting predominant narratives of history that focus on 'great men', Marx and Engels (1845) suggests that the true roots of social change throughout history are in production and social relations, the realm of civil society, not heroes or nations. Consistent with the notion of the concrete, Marx's discussions of civil society also point to the social as dynamic and integral. While the social is constantly evolving, aspects of past formations remain imprinted. The specificities of the social also depend on its spatial or geographical context. These specificities are a major focus of D. E. Smith's (2005) research. Focusing on more localized settings, people's experiences serve as "a point of entry into discovering the social that does not subordinate the knowing subject to objectified forms of knowledge of society or political economy" (p. 10). In other words, illuminating the social can be done through examining specific moments and experiences. D. E. Smith (2005) adds, "Individuals are there; they are in their bodies; they are active; and what they're doing is coordinated with the doings of others" (p. 59). The social is a historical process that includes both human practices, and the coordination of these practices with other activities and people. D. E. Smith's interest in the social is consistent with Bannerji and Marx in that the social is understood as involving actualities, an acknowledgment that the social is actualized by real people and not abstract concepts.

Ideology, Ruling Relations, Common Sense, and Affect

The social and structures of interlocking oppression serve as the context that mental health social worker-initiated police interventions exist within, but to understand the specificities of how these practices occur, I analyze these everyday practices and their underlying histories through concepts of ideology, ruling relations, common sense, and affect. These processes shape how mental health social workers perceive the world and inform their daily practices.

These aforementioned concepts are important elements found in the works of D. E. Smith and Bannerji—and indeed, much of Marx's own writings, that are critical of mechanistic approaches to political economy and place a significant emphasis on issues of consciousness. Bannerji (2015b) states,

> Marx's interest in [the connection between writing and the making of history] indicates that he placed the greatest importance on consciousness and its socio-historical and political role. This cardinal role he attributed to consciousness and epistemology, however, did not make him an idealist/cultural determinist, just as his emphasis on the economy did not render him an economic determinist. His understanding of different forms of consciousness is to be considered in relation to a material grounding of ideas in socio-historical processes. For Marx the production of ideas is as much 'real sensuous activity' as any other form of labour. (p. 164)

Bannerji (2015b) argues that Marx's interest in history, not as a collection of incontrovertible facts, but as something created through the writing of it, is made apparent by Marx's conceptualization of ideology. This conceptualization indicates an awareness of the significance of consciousness but not in a manner that elevates ideas and thoughts to the point of

determination. Instead, Marx still places the utmost importance in the notion of 'real sensuous activities' as determining social organization, but included as an example of 'real sensuous activity' is the production of ideas.

The production of ideas plays an important role in sustaining and maintaining social organization. Marx and Engels (1845) state,

> The ideas of the ruling class are in every epoch the ruling ideas, i.e. the class which is the ruling material force of society, is at the same time its ruling intellectual force. The class which has the means of material production at its disposal, has control at the same time over the means of mental production, so that thereby, generally speaking, the ideas of those who lack the means of mental production are subject to it. (p. 172)

On the one hand, the predominant ideas and knowledges of a specific period are generally consistent with the interests of the ruling class, specifically those that rule over a society's means of production. On the other hand, those that do not have access to means of intellectual production, such as serfs or manual labourers, are subject to it. To use Marx and Engels' (1845) example, under feudalism, with aristocrats in power, concepts of honour and loyalty were developed and made dominant. Today, under capitalism with the rise of the bourgeoisie, individualized conceptions of freedom and equality have been exalted. These ruling ideas, rooted in the division of mental and physical labour, become accepted through the process of ideological thinking that "detach[es] the ideas of the ruling class from the ruling class itself and attribute to them an independent existence" (Marx & Engels, 1845, p. 173). Thus, the ideological nature of these ruling ideas serves to obfuscate these ideas from the people that benefit from them, reinforcing the notion that these ideas are universal and separate from social context.

Marx considers ideology a specific way of interpreting society, reflected in traditional economics and sociological research that fail to be grounded in actualities. Marx speaks of ‘tricks' involved in the creation of ideology. As alluded to, the first trick is the separation of ruling ideas from the rulers or people responsible for the ideas. For example, theories of mental pathologization are seen as independent from both the authors of these theories (e.g. Eugen Bleuler or Emil Kraepelin) and the milieu these authors existed in (e.g. the mental hygiene movement or eugenics movement). This second trick involves making connections between concepts, connections that serve to universalize the idea. An example is how resonances of theories of mental pathologization began emerging across multiple disciplines, including scientific racism, psychiatry, and criminal anthropology. These disciplines supported each other, reinforcing and universalizing ideas of mental pathologization.

The final trick entails having the idea “changed into a person—“Self-Consciousness"—or, to appear thoroughly materialistic, into a series of persons, who represent the "concept" in history, into the "thinkers", the "philosophers", the ideologists, who again are understood as the manufacturers of history” (Marx & Engels, 1845, p. 175). This last trick involves what Bannerji (2015b) describes as secularization, the “movement from God to ‘Man’” (pp. 167-168). With this trick, the idea itself becomes personified and takes on agency, whereby history itself is understood to be moved by these ideas instead of people. A role reversal occurs, where people are seen as “mere bearers” of these ideas. This trick is evident in research with no basis in actualities, but instead involving the imposition of theories onto people and practices, resulting in a circular logic. An example would be the dehistoricization of mental pathologization, with mental pathology framed as a biological concept, not connected to the work of real people within a socio-political context.

Consistent with Marx's description of ideology, D. E. Smith (2005) contends that "ruling institutions create forms of thought that structure how those who are societal members view themselves and the worlds they live in" (p. xi). D. E. Smith has a particular focus on specific 'institutions' as producers of ideological forms of thought that shape perceptions. In fact, D. E. Smith finds limitations in Marx's analysis in relation to contemporary social organization. D. E. Smith (2005) states,

> Although Marx and Engels insist that consciousness must be recognized as always in and of individual people, they do not provide for us a way of understanding or analyzing those social relations - forms of coordination - that have emerged largely since their work was completed. (p. 69)

D. E. Smith (2005) responds to this absence in consideration of how consciousness is shaped by social relations by focusing on the incorporation of ideology in the organization of society as a more recent phenomenon beginning in the late-19th century in Europe and North America, and the specificities of this process in local settings.

Ruling relations are understood are relations mediated by forms of ideology that are prominent in institutional settings, which are constituted outside of the specific people and places subject to ruling relations (D. E. Smith, 2005). According to D. E. Smith (2002), ruling relations

> are relations that coordinate people's activities across and beyond local sites of everyday experience. We know them variously as bureaucracy, discourse (in the Foucauldian sense), management, mass media, institutions, and so on and so on. [...] they are extra- or trans-local and based in texts of various kinds. (p. 45)

In other words, ruling relations are the underlying processes that coordinate and govern social activity in a specific time and place. These processes exist beyond a local setting and endure in

texts that are often ideological. These texts may include “print, film, [or] television” (D. E. Smith, 2005, p. 227) and enable institutions to standardize practices and perceptions for those under its capture. For example, student codes of conduct, academic transcripts, and other texts, consistent with the ideological thinking that reinforces capitalist production and other forms of social relations, have a major influence on student behaviour. IE scholarship has also considered speech (C. A. Ross et al., 2018; D. E. Smith, 2016; G. W. Smith & Smith, 1998), “habits, training, and traditions” (2016, p. 9) operating in a similar role to text in coordinating practice.

Drawing from Antonio Gramsci, Bannerji (1995b) suggests that common sense works alongside ideology and is integral to examining ideological formations. It is important to note that common sense is an imperfect English translation of *senso commune*. While common sense can sometimes denote a positive practical sense that prepares a person to navigate the world, the original Italian carries no such connotations. *Senso commune* carries a more neutral tone,

> referring rather to the beliefs and opinions held in common, or thought to be held in common, by the mass of the population; all those heterogeneous narratives and accepted “facts” that structure so much of what we take to be no more than simple reality. (Crehan, 2016, p. 44)

Common sense is the contents of popular knowledge, though it can also be specific to “a fairly limited environment” (Gramsci, 2005, p. 330).

If ideology serves as the visible portion of an iceberg, common sense would be the portion submerged underwater (Bannerji, 1995c). Cited by Bannerji (1995c), Errol Lawrence explains,

> It is thought to represent the distilled truths of centuries of practical experience; so much so that to say of an idea or practice that it is only common sense, is to appeal over the logic and argumentation of intellectuals to what all reasonable people have known in their "heart of hearts" to be right and proper. Such an appeal can act at one and the same time to foreclose any discussion about certain ideas and practices and to legitimate them. (p. 44)

Common sense refers to something beyond comprehension through logic or intellectual argumentation, serving to end discussion and sustain practices based on its principles. It is often not consciously considered, yet it informs our daily practices and is a mould from which our perception of the world is shaped (Crehan, 2016). While ideology is represented through texts and a logical argumentation, albeit based on flawed logic, common sense is invisible as it does not involve argumentation; it is made self-evident. For example, the notion that it is preferable to behave or experience the world in ways that are consistent with norms as dictated by the psychiatric establishment. It is also often self-contradictory, "fragmentary, [and] incoherent … even in the brain of one individual" (Gramsci, 2005, p. 419). Such inconsistencies are apparent, for example, in the practices engaged in and rationales expressed by mental health social workers in this dissertation. And as Lawrence argued regarding common sense's link to practical experience, common sense emerges through the accumulation of "a few hundred years of pillage, extermination, slavery, colonization and neocolonization" (Bannerji, 1995c, p. 45), "shaped both by deep structural forces and more contingent history" (Crehan, 2016, p. 57).

Bannerji (1995c) believes in the importance of studying common sense, because "the history, ontology, and ongoing practice of an imperialist capitalist society appears to me to find its epistemology in the common sense of racism" (p. 45). In other words, common sense serves

to organize the socio-economic and cultural practices that are the subject of sociological research. In addition, textual forms of mediation, or the means in which ways of seeing are created by the ideological contents of texts, "draw[] on and systematize[], and often uncritically, cultural common sense [] and invest[] them with the status of knowledge (as social facts, norms, etc.) as well as knowledge-creating procedures (theories and methods)" (Bannerji, 1995a, p. 64). Thus, common sense, while closely related to and working in conjunction with textual mediation that is ideological in nature, also requires emphasis, in addition to ideology.

Though there is a tendency to focus on common sense as manifested in popular and folk culture, it is important to note that Gramsci recognizes that specialized knowledge, such as scientific knowledge, has significant influence on these forms of popular knowledge. Gramsci (2012) states,

> Philosophy and modern science are also constantly contributing new elements to 'modern folklore' in that certain opinions and scientific notions, removed from their context and more or less distorted, constantly fall within the popular domain and are 'inserted' into the mosaic of tradition. (p. 189)

It also operates in the other direction with popular knowledge, including notions of race, disability, class, gender, and so forth, underpinning the development of specialized knowledge (Gramsci, 2005). In other words, popular culture and specialized knowledge have a reciprocal relationship, influencing and informing one another. Gramsci (2005) states, "The philosophy of an age … is a process of combination of all these elements, which culminates in an overall trend, in which the culmination becomes a norm of collective action" (p. 345). This reciprocity also contributes to the formation of "social workers' own *professional* 'common sense'" (Garrett, 2009, p. 470).

Common sense also operates at the affective level. The circulation of emotions separates and binds people, driving their interactions. Using the example of anti-immigrant discourse, Ahmed (2013) discusses how White supremacist groups rationalize that it is love that brings them to what is understood as hate. And it is through hate that White-supremacist groups construct Whiteness and community, as a response to the other. The role played by emotions in shaping how people interact with others is what Ahmed calls 'surfacing'. The concept of surfacing "clearly challenges any assumption that emotions are a private matter, that they simply belong to individuals, or even that they come from within and then move outward toward others" (Ahmed, 2004, p. 117). This process, the emotions that drive our responses, produces the boundaries between 'we' and 'objects' or 'others'. For example, as is discussed in later chapters, the boundaries between the mental health social worker and the psychiatrized person as an object of intervention is partly shaped by affect.

Emotions are thus both generative and are produced in relation to broader discourses. They drive actions and draw people to the surrounding world. According to Ahmed (2013), emotions are not simply generated from within the self. Emotions are not just cognitive responses to objects and signs. Conversely, objects and signs do not have some inherent power to trigger specific emotional responses. The feelings of fear and anxiety expressed by social workers I interviewed are not universal or self-evident. Instead, the emotional response occurs based on how the person and the sign come into contact. In other words, emotions are relational, marked by reactions of "'towardness' or 'awayness' in relation to such objects" (Ahmed, 2013, p. 8). This 'towardness' or 'awayness' in relation to various signs are shaped by cultural histories and memories. The affecting object or sign also makes and leaves an impression on the person, which supplements the cultural history.

As stated, this process is not deterministic in nature. In fact, emotions are circulated in that a sign or object "may stand in for other objects, or may be proximate to other objects" (Ahmed, 2013, p. 8). Ahmed (2013) describes emotions as having rippling effects, "they move sideways (through 'sticky' association between signs, figures and objects) as well as forwards and backwards (repression always leaves its trace in the present – hence 'what sticks' is bound up with the absent presence of historicity)" (p. 45). For example, an affective response associated with psychiatrized people can extend out to all racialized people, given the presumption that racialized people have inherent mental defects rooted in the intertwining of scientific racism and psychology as will be discussed throughout this dissertation. To further illustrate this idea of emotional circulation, Ahmed introduced the concept of 'affective economies', which understands the economy as an analogy for how emotions occur. Marxian economics explicates the process by which that capitalists transform money into commodities, and then back into money. This circulation is what is known as capital and leads to the increasing accumulation of money through surplus-value or valorization. Likewise, affective responses and emotional ties to certain objects and signs increase in magnitude through circulation. Ahmed (2013) provides as examples speeches and texts that ascribe to asylum seekers feelings of fear and anxiety, based on the framing of migrants as invaders. This anxiety fostered fixes the asylum seeker as an object of hate, and the continued accumulation of further speeches, texts, and carceral practices serve to further amplify the affective response to asylum seekers. This process of circulation is consistent with the notion described above of historical accumulation of violent practices as leading to the formation of today's common sense. Ahmed (2013) also notes that objects retain these affective attributes through the erasure of "the processes of production of the 'making' of emotions". The significance of these conclusions are apparent in Ahmed's (2013) claim that "attention to

emotions allows us to address the question of how subjects become *invested* in particular structures" (p. 12). I use these concepts to investigate one such structure—carceral social work.

Political Tactics and Abolitionism: A Critique of Modernity and Progress

Finally, to assess the underlying purpose of mental health worker-initiated police interventions, it must be understood that state violence and carceral practices serve productive functions tied to the dominant socio-economic relations, what is most aptly described as settler-colonial capitalism in the case of Canada. In relation to settler-colonial capitalism in the North American context, state violence and carcerality are directed at racialized people to facilitate capital accumulation. These practices can be understood through three pillars: genocide/colonialism, slavery/capitalism, and war/orientalism (A. Smith, 2016).

Genocide/colonialism is centred around the notion that "indigenous peoples must disappear. In fact, they must always be disappearing in order to allow non-indigenous peoples rightful claim over this land" (A. Smith, 2016, p. 68). Canada as a country was founded on the dispossession and exploitation of Indigenous people, land, and resources. Through the Indian agent and the Northwest Mounted Police/RCMP, the state contained Indigenous populations to reserves. On these reserves and beyond, Indigenous people were infantilized as wards, as "powers over their lives and deaths were concentrated in the hands of the Indian agents" (Thobani, 2007, p. 50). Indian agents dictated where resources went, enforced provincial laws, and embarked on assimilating Indigenous people, a means to make Indigeneity "disappear". As discussed in Chapter 6, the social worker would take over the tasks of the Indian agent after its decline in the 1960s. The logic of genocide/colonialism remain a fundamental feature of Canadian social organization, as practices of land dispossession and resource extraction in

contravention of Indigenous sovereignty are ongoing. As a result, many Indigenous communities still struggle with environmental degradation (Junka-Aikio & Cortes-Severino, 2017; Leddy, 2017; Willow, 2014), lack of potable water (Bradford et al., 2016; Sarkar et al., 2015), abject poverty (Collin & Jensen, 2009; Macdonald & Wilson, 2013), and other social issues.

Another pillar is “slavery/capitalism”, which speaks to the enduring influence of anti-Black racism on daily life (P. H. Collins, 2002; Lorde, 1984). A. Smith (2016) states, “this logic renders Black people as inherently slaveable as nothing more than property” (p. 67) and thus, as valid targets of violence, including police violence. While capitalism commodifies all workers, in that people are obligated to sell themselves in the labour market in order to make a living, the logic of slavery means that a hierarchy exists, whereby Black people are especially impacted by this process, as is apparent with the income disparities and disproportionate incarceration rates experienced by Black people (Maynard, 2017).

The final pillar is “war/orientalism”. A. Smith’s (2016) application of orientalism in this context is not limited to Asia and involves the marking of certain nations and peoples as foreign threats. Examples include the racial profiling of Arabs in the context of the War on Terror, and the framing of racialized mad people as dangerous, as discussed further in Chapter 7. Orientalist logic appears in anti-immigrant discourse and border policies, serving to facilitate capital accumulation and as the “material, existential, and ideological practices that organize the contemporary exercise of power” (Sharma, 2006, p. 1). Borders structure competition between workers within a 'global regime of apartheid', whereby one set of laws regulates national subjects and another set of laws regulate “foreign objects” (Sharma, 2006, p. 7). The different regulations, along with an ideological component of national borders that serves as validation, place 'foreigners' at an inferior position in the social hierarchy and facilitate the hyperexploitation of

overseas workers, temporary foreign workers, and non-status people. The latter two categories illustrate how borders also exist within the nation-state, in that these groups are without access to protections and resources, leaving them open to exploitation through poverty wages and precarious work conditions.

This socio-economic order came into practice through the displacement of other forms of relations. As understood through the Marxist concept of primitive accumulation, capitalism emerged and transformed from pre-capitalist modes of production, like feudalism. The most prominent account from a European context is the enclosure movement that forcibly prevented commoners from accessing communal lands and provided said land to private owners. In the Canadian context, an example of the displacement of non-capitalist modes of production is the banning of potlatches by the Canadian government in 1884 (see Chapter 6). Potlatches are ceremonies practiced by various Indigenous peoples, involving the redistribution of food and other goods to ensure that the needs of all in the community were met. This practice was deemed unproductive and uncivilized by the Canadian government (Finkel, 2006). Based on this stated logic, displacement was followed by the imposition of capitalism, as well as practices that furthered capital, including Western social services and charity practices (Chapman & Withers, 2019). Instead of potlatches and other practices of self-reliant mutual aid, Indian agents and subsequently, social workers, dispensed social welfare benefits as a means of coercion (Fortier & Wong, 2019).

That said, this framing of Indigenous forms of social and economic relations as ‘pre-capitalist’ is also problematic as it erases Indigenous peoples’ continued resistance against efforts to destroy Indigenous economic and social relations. As a corrective to primitive accumulation, Nicholas A. Brown (2014) argues that the introduction of capitalism in a settler-colonial context

cannot be understood from a temporal basis. Temporal understandings of primitive accumulation consider the transition between modes of production as an event, but this transition is an ongoing process and should be considered a structure. Both decolonial and anarchist approaches to analysis highlight the need to learn from "actually-existing self-governing communities" (Graeber, 2004, p. 11) and recognize the ongoing efforts by state and capitalist actors to encroach and enclose these practices. Bennett, Zubrzycki, and Bacon (2011) argue that non-Indigenous social workers should participate in decolonization through recognizing and addressing "the ongoing nature" of colonization (p. 25). Likewise, Verniest (2006) expresses a need to reject social work histories that neglect continuation or contemporary resonance of colonialism.

Attempts to frame colonialism as an event from the past is one example of ideology facilitating settler-accumulation, defined by Brown (2014) as the process of naturalizing settler polity and denying or obstructing indigenous resistance to such. These processes are especially evident in the way Western discourses are presented as neutral and objective. Santiago Castro-Gómez labels this colonial positivism as the hubris of the zero point and defines it as the act of conducting research "from a detached and neutral point of observation[, whereby] the knowing subject maps the world and its problems, classifies people and projects into what is good for them" (Mignolo, 2009, p. 160). Such an approach is a hallmark of positivist research, though its influences go far beyond, with positivist approaches' assumption that analysis of human behaviour can exist in a vacuum, away from the influences of the researcher's—or psychiatrist's or social worker's—positionality (Chapman & Withers, 2019; D. E. Smith, 1990; Strega, 2005). However, Mignolo (2009) suggests that these claims of objectivity only serve to conceal the analyst, as the analyst is always implicated in the analysis and representation of social phenomena. More specifically, it is the analyst as rooted in Western epistemology that is

concealed. Conversely, the claims of objectivity and its concealment of the producer of the knowledge, can also "reaffirm the West's view of itself as the centre of legitimate knowledge, the arbiter of what counts as knowledge and the source of civilized knowledge" (L. T. Smith, 2021, p. 63). These claims justify the construction of the West as superior and knowledge, even when appropriated from colonized people, as something provided by the civilized West to colonized people—for their benefit and for which they should be grateful.

Inherent in this analysis of primitive accumulation and the hubris of the zero point is a rejection of conceptualizations of history as a progressive march forward, with society constantly improving on itself. This notion of progress is a key component of Western historiology that understands societies as going through phases of human development, from primitive—marked by simplicity and emotionality, to civilized—marked by complexity and bureaucracy (L. T. Smith, 2021). The penal system is one such area where this is apparent, despite its presentation as a system that has become more humane as policy makers have become more enlightened. Penality follows a pattern, but not one that reflects a periodization whereby society progresses in a linear fashion. Instead, forms of discipline change in relation to the objectives related to the dominant mode of production in a time and place, and are crucial to creating the conditions that allow for the mode of production to exist. It is for this reason that Foucault (1975) describes penality as political tactic, in the sense that it is neither completely determined by the means of production—a positivist Marxist interpretation, nor is it simply the product of political legislation, disconnected from economic and social processes. Instead, penality as a political tactic suggests that its manifestation serves as one part of a reciprocal and intertwining relationship with the mode of production, which Bannerji (2015a) defines as "the organizational

and social ground for production as well as reproduction and their entailed politics, administration and cultures" (p. 111).

While the notion of penality as a political tactic is often ascribed to Foucault, Heiner (2007) argues that these ideas were significantly influenced by the Black Panther Party (BPP). The connection between penality and the mode of production is apparent in Angela Davis' (2011b) contestation of the idea that slavery was truly abolished with the 13th Amendment of the United States Constitution. Instead, Davis (2011b) argues that slavery was simply replaced by institutions like lynching, segregation, and incarceration. After the abolition of slavery, formerly enslaving states quickly enacted legislation to control the activities of free Black people, including the criminalization of vagrancy, absence from work, breach of job contracts, and insulting gestures for Black people—entrenching the linkage of race to criminality. The continuation of slavery by other means is perhaps most apparent with the convict lease system, which involved the 'leasing' of prison labourers to private parties. Many of the industries that previously relied on slaves were provided with prison labourers. For example, much of Georgia's railroads were rebuilt by prison labourers. Davis (2011b) even argues that work conditions may have been worse for prison labourers compared to enslaved labourers, since, for enslaved people, there may have at least been some concern by slave owners at losing their investment through death or injury. Furthermore, while the convict lease system is no longer in existence, Davis (2011b) argues that parallels remain with today's "wide-ranging corporatization of punishment that has produced a prison industrial complex" (p. 37).

Just as the prison system continued slavery through other means, policing serves a political purpose linked to the dominant social and economic structure, maintaining subjugation by suppressing Black resistance. In response, the BPP formed to monitor police violence and to

provide legal education for Black communities (Kreitner, 2015). Bobby Seale (1970), co-founder of the BPP, argues that the "ruling class will use racist police departments and mass media to distort the real objectives of the BPP. The more we're successful with the programs, the more we'll be attacked" (p. 418). As community organizing efforts became more successful, the violent reprisal escalated. In discussing police attacks on Free Breakfast Program for Children, Bukhari-Alston suggests that the police actively work to restrict the ability of the Black community to engage in mutual aid and efforts at building self-sufficiency. Bukhari-Alston highlights the irony of portraying the BPP as criminals, and the children receiving breakfast as victims, when it was the state that had victimized these children and given rise to the movements that challenge its authority (Heiner, 2007). Davis (1971) states,

> On the other hand, when policemen are clearly indulging in acts of criminal aggression, officially they are defending themselves through "justifiable assault" or "justifiable homicide." [...] The political act is defined as criminal in order to discredit radical and revolutionary movements. The political event is reduced to a criminal event in order to affirm the absolute invulnerability of the existing order. [...] As the black liberation movement and other progressive struggles increase in magnitude and intensity, the judicial system and its extension, the penal system, consequently become key weapons in the state's fight to preserve the existing conditions of class domination, therefore racism, poverty, and war." (p. 330)

Criminality is a label imposed on people as a means of discrediting mass movements. The act of labelling is not an administrative task but a political act that works to preserve conditions of oppression.

A supposition underlying approaching penality through this analytical lens is encapsulated in Graeber's description of anarchist anthropology. Graeber (2004) cites as a key tenant the recognition that "institutions like the state, capitalism, racism and male dominance are not inevitable; that it would be possible to have a world in which these things would not exist, and that we'd all be better off as a result" (p. 10). Removing the assumption of inevitability allows for analysis that identifies the root causes of the problems being assessed as the organization of societies itself—in Canada's case: settler-colonial capitalism. This approach to analysis of the state also questions the "ideals" or stated objectives that are used to justify the existence of the state and calls for examination of the actual mechanics of state rule and how it corresponds with the former. For example, police violence against psychiatrized people is justified by claims of ensuring safety for the person as well as others, yet police intervention often escalates conflict and causes harm.

Failing to operate under this supposition not only leads to an incomplete analysis, but it also limits the possibility of responding to the needs of social movements by suggesting the existence of truly transformative alternatives that can challenge the violence inherent to the existing social order. Instead, Graeber (2004) suggests that mainstream social sciences tend to understand the "Low Theory", theory addressing immediate questions stemming from daily practices, as limited to policy research. Graeber (2004) opposes this type of research as policy

> presumes a state or governing apparatus which imposes its will on others. "Policy" is the negation of politics; policy is by definition something concocted by some form of elite, which presumes it knows better than others how their affairs are to be conducted. By participating in policy debates the very best one can achieve is to limit the damage, since the very premise is inimical to the idea of people managing their own affairs. (p. 9)

Echoing these critiques, Ben-Moshe (2018) argues that abolitionist dis-epistemologies, what she calls the assumptions central to abolitionist practice, involve a challenge to political demands that involve the reformation of states and carceral institutions. These political demands harbour carceral logics and end up continuing the harm done to oppressed people though in a different form, as they fail to address the inherent violence of the state and disregard intersectionality. For example, Ben-Moshe (2018) considers reformist demands from disability rights movements as stemming from the lack of race analysis and failure to recognize "policing, incarceration and its alternatives as disability issues" (p. 347).

Though I certainly analyze policy as a key component of my dissertation, based on the critiques raised, I address policy by confronting its underlying logics as rooted in the social order, hopefully, challenging notions of inevitability. Indeed, Crehan (2016), in describing the role of common sense, explains that "an ability to impose commonsense truths, which assume that existing power relations are the only ones possible, is a crucial dimension of any power regime" (p. 51). The rejection of common sense truths, or certainty (Ben-Moshe, 2018), or permanence (Crampton, 2015), allows for "fashioning new ways of envisioning the world and opening up opportunities that are not closed off by readymade prescriptions" (Ben-Moshe, 2018, p. 348). It also creates an opening to recognize radical alternatives that already exist beyond professional social work and state practices. This highlighting of existing radical alternatives relates to the notion that an anarchist epistemology rejects vanguardism, the positioning of certain intellectuals as elites meant to lead the masses (Graeber, 2004), and "letting go of the idea that anyone can have a definitive pathway for how to rid ourselves of carceral logics" (Ben-Moshe, 2018, p. 347). Thus, instead of situating myself as an expert prescribing the correct course of action, my desire is simply to open up the possibility of something different, that the

seeds of a more just society may already exist in practice and should be considered (see Chapter 9). This rejection of vanguardism is also apparent in my critique of social workers as exalted experts and the use of this framing to inform and justify harmful interventions upon psychiatrized people.

Methodology

I adapt IE to serve as my methodological framework (D. E. Smith, 2002, 2005). This is appropriate given IE's focus on formulating research to address a disjuncture, "a break or fissure in the person's life or people's lives" (Burstow, 2016, p. 7), exploring how this occurs in relation to institutional processes. In the case of this research, the disjuncture is the contradiction between notions of advancing service users' interest and fostering autonomy contained in social work's guidelines for ethical practice (Canadian Association of Social Workers, 2005a), on the one hand, and the widespread collaboration of mental health social workers with the police, on the other hand. With the lived experiences of those involved in the practices examined as a starting point, IE allows me to map out institutional language and justifications to reveal the material practices of mental health social workers in relation to police violence and how these practices are traceable to policies, professional discourses, and interlocking forms of oppression. Indeed, many critical scholars have recognized the appropriateness of IE for research on socially-sanctioned violence in institutional contexts (Bannerji, 2002; Nazemi, 2015; R. Ng, 1988; G. W. Smith, 1988; Turner, 2014), and the mental health field in particular (Burstow, 2015, 2016; Chapman et al., 2016; D. E. Smith, 1976, 1978, 1983). Nevertheless, I make a number of modifications to IE, which I will highlight and explain throughout this section.

D. E. Smith (2005) suggests that exploration of institutional settings should begin with standpoints. An alternative, or challenge, to positivist mainstream social sciences that assumes an 'objective' detached perspective in relation to knowledge production, a standpoint serves as "a point of entry into discovering the social that does not subordinate the knowing subject to objectified forms of knowledge of society or political economy" (D. E. Smith, 2005, p. 10). As a point of entry, no one standpoint is privileged; instead, multiple standpoints can be incorporated to provide insights into ruling relations and the institutional processes by which holders of these standpoints are engaged in. Interviews and ethnographic observations can aid in establishing these standpoints, with a particular focus on work knowledges, "what people know of [...] in their work and how it is coordinated with the work of others" (D. E. Smith, 2005, p. 229). These work knowledges serve to illustrate the everyday/night practices, which are then situated in their institutional setting and connected with the translocal by examining the relevant texts.

These methods are used to fulfill the objective of IE—to map out institutional processes and ruling relations. D. E. Smith (2005) explains,

> The overall aim of institutional ethnography […] is to produce for people what might be called "maps" of the ruling relations and specifically the institutional complexes in which they participate in whatever fashion. People's knowledge of their everyday world is thereby expanded beyond the scope of what can be learned in the ordinary ways we go about our daily activities. (p. 51)

Thus, IE, through this process of mapping, allows us to understand how daily practices are connected to a broader context. The use of mapping as an analogy is intentional. Just as maps "do not claim to be read independently of the terrain they map" (D. E. Smith, 2005, p. 161), research produced through IE is not meant to be imposed or universalized. Instead, IE is

grounded in the actualities and work knowledge provided by interviewees. D. E. Smith (2005) states, “The ethnography is to be interpreted as an explication and expansion of the work knowledges people have of the social terrain it claims to describe.” (p. 161). These work knowledges, derived from dialogue with people occupying diverse standpoints about understandings of their work—formal or informal—as connected to the work of others, are “fitted together so that the organization of the sequence, circuit, or other organizational form can emerge” (D. E. Smith, 2005, p. 229). In other words, the work knowledge of those occupying various standpoints is used to map out institutions and the underlying ruling relations.

Finally, D. E. Smith (2005) understands the extrapolation of ruling relations as central to IE. As previously discussed, ruling relations direct human activity especially in institutional settings. Ruling relations exist beyond a local setting, and may be transmitted through texts, allowing for the standardization of institutional practices. Thus, institutional texts like forms, policy documents, and guidelines are examined to elucidate this process of coordinating practices. D. E. Smith (2016) also contends that language itself, including informal speech, has a powerful role in coordination of practices. D. E. Smith (2016) references the concept of the verbal generalisation system, emphasizing how “words relating us to referents organise a standardisation of responses across the particularities of time, settings and people” (p. 25). These words can be communicated to others or can occur “in-skull” (i.e. through a person’s thought process). For example, researchers use IE to consider how workplace talk in nursing (C. A. Ross et al., 2018) and homophobic remarks in schools (G. W. Smith & Smith, 1998) can coordinate everyday practice.

D. E. Smith (2005) also notes in the discussion of text-reader conversation that texts should not be understood as deterministic. The text-reader conversation speaks to the interpretive

nature of text. The reader has to interpret and apply the text to "the situation and sequence of action in which reading is embedded" (D. E. Smith, 2005, p. 107). Thus, analysis should contain consideration of the reader's past history and tacit knowledge, as well as the fact that text itself is produced through work processes, including writing, editing, publishing, and distribution (D. E. Smith & Griffith, 2022). The authors intentionally constructed the sentences and phrasing contained within the texts. And these texts are also placed in the context of their respective genres. These attributes call for deeper analysis beyond a surface reading of texts. As Gramsci (2005) argues,

> If it is true that every language contains the elements of a conception of the world and of a culture, it could also be true that from anyone's language one can assess the greater or lesser complexity of [their] conception of the world. (p. 325)

Language in text can serve as significant entry points into revealing the processes underlying everyday/night practices.

Smith and Griffith (2022) also acknowledge that texts are not the only vehicles for the coordination of practices, habits and traditions also have significant contributions. This, along with a desire to take into account Ahmed's (2013) consideration of emotions as mediating and dictating people's daily practices, contributed to my decision to expand on the IE methodology by incorporating Himani Bannerji's "relational/reflexive method of social analysis" (Gorman, 2005, p. 35). According to Gorman, the relational/reflexive method serves as a corrective of D. E. Smith. Just as D. E. Smith suggests rooting research in actualities, Bannerji states that social analysis should begin in "the local and immediate" (Gorman, 2005, p. 35). But Bannerji urges researchers to expand beyond this step, and continue "thinking about the organization of social relations, and considering social relations across a historical trajectory" (Gorman, 2005, p. 35).

Adapting Marx's historical materialism for contemporary sociological inquiry, drawing on some of the concepts discussed in my theoretical framework section, Bannerji (2015a) presents a methodological approach that would allow the researcher "to venture, therefore, into a more complex reading of the social, where every aspect or moment of it can be shown as reflecting others; where each little piece of it contains the macrocosm in its microcosm" (p. 105). In other words, there needs to be a recognition that the context of complex socio-economic and cultural relations plays host to local issues, and an inclusive examination of all aspects of these relations are required to properly appraise a research question based on actualities.

Bannerji's approach centres on the concrete (discussed above), a concept first introduced by Marx as a critique of Hegel's emphasis on dialectics as born out in the realm of ideas (Marx & Engels, 1845). Bannerji (2015a) states,

> The 'concrete' as the social, we can see, has a dual character for Marx. It is, on the one hand, a mental or conceptual category and, on the other, an existing specific social formation. Thus, it is both 'a point of departure' (as the social) and 'a point of arrival' (as theory). (p. 110)

Historical materialist research that centres on the concrete is unlike traditional economics research, which begins by drawing concepts from the concrete—'a departure from'. For example, scholars may look at the population of a nation, its geographical and class distributions. This is precisely the problem, as traditional economists fail to recognize that this starting point without substantive analysis, or its acceptance as self-evident, is—in fact—an imagined concrete or what Marx calls a 'chaotic whole' (Marx & Engels, 1845). This chaotic whole is often derived from past knowledge and is itself an abstraction.

Indeed, there is no such thing as pure observation and to stop here would be to engage in the ideological practices previously discussed. Challenging these ideological practices, Marx instructs researchers to take a crucial further step of arriving back to the concrete. This can be done through analyzing how these concepts, down to their simplest formulations, connect back to the population or topic of examination. This analysis allows the researcher to understand the specificities of these concepts as born out of a particular temporal and social context. Only then, through this second step, does the "rich totality of many determinations and relations" (Marx & Engels, 1845, p. 41) get comprehensively captured.

Bannerji (2015a) adds that aspects of the concrete used as entry points into the social can be "highly specific or local in their scope - about neighbourhoods or homelessness in Toronto, for example - or can speak to cultural problems" (p. 104). The role of the researcher is then to connect this entry point, whether it is a particular issue or moment, to the "wider or extra-local context of socio-economic and cultural relations" (Bannerji, 2015a, p. 104). This approach is illustrated by Bannerji's (1995b) examination of an incident of sexual harassment, with the incident serving as the entry point. Bannerji begins with a description of what had transpired and the context. X, a 45-year-old Black woman, was subjected to pornographic materials, sabotage, ostracization, and derogatory sexual and racial remarks, by her White coworkers. Bannerji 'departs' from this experience and interrogates concepts like women, Black women, and sexual. With these concepts highlighted, Bannerji proceeds with the work of 'arriving' back at the concrete, concluding that all forms of social relations, including race, gender, and class, interlocked to create the moment of sexual violence experienced by X. Bannerji describes how racist sexualism "is the foundation on which racist sexual harassment is erected and that this occurs in the case of X and all other women who are non-white" (p. 128). Bannerji's conclusion

challenges conceptualizations of sexual harassment that revolve around narrow definitions and that universalize experiences of sexual violence faced by white women. This context of ideological understandings of violence and of racist sexism contributed to X being "denied the truth of her own work experience" (Bannerji, 1995b, p. 148). Bannerji's method, like D. E. Smith (2005), involves connecting the entry point—the experience of sexual violence—with the broader extra-local context, and vice versa.

Following their lead, I aim to root my research in local institutional settings and text, analyzing social relations and local practices in a way that considers its historical development or trajectory. This means of analysis will draw out how local practices serve as political strategies that work to reinforce and reproduce settler colonial capitalism. This follows Bannerji's (1995b) use of organizational culture, "the social and cultural relations of any particular workplace" (p. 131) as an entry point into exploring broader processes. Bannerji (1995b) states,

> Her workplace, similar to others, cannot be seen only as a place of economic production, but must also be understood as a coherent social and cultural environment which is organized through known and predictable social relations, practices, cultural norms and expectations. (p. 130)

Given the influence of these social forces on the work environment and organizational culture, practices that occur in these spaces are highly regulated and must not be considered random. The influence of these social forces must also not be abstracted; instead, the "'normal' character of her workplace … a piece of everyday life … needs to be … deconstructed to reveal a whole range of socio-cultural forces which play themselves out through forms of behaviour" (Bannerji, 1995b, p. 131) as specific to a history and locale. This process of deconstruction leads the researcher to connect workplace practices to the national and global context, as "*individual*

behaviour, workplace relations, daily life within its precincts all come within the purview of *social behaviour* and greater social and economic forces" (Bannerji, 1995b, p. 131). Individual practices both reflect and are a part of processes that occur at a national and global level, and needs be assessed through the lens of this broader history. In Bannerji's (1995b) example, the sexual harassment at the workplace was used to force a Black woman to quit a job she was deemed to have trespassed to occupy on the basis of her social identity. The sexual harassment practice was shaped by Canadian immigration and labour processes that segment Black women into certain labour roles, and cultural norms that ascribed inferiority through slavery and colonial histories to Black women.

This emphasis on historical trajectory speaks to the following quotation from Gramsci (1988),

> The starting-point of critical elaboration is the consciousness of what one really is, and is 'knowing thyself' as a product of the historical process to date which has deposited in you an infinity of traces, without leaving an inventory. Such an inventory must therefore be made at the outset.

Social practices from what is apparently another era engrains itself in contemporary practices, though these remnants are often obfuscated and require uncovering. Chapman (2014b) also suggests that the task of the researcher is to investigate how specific oppressions today are connected "to particular histories that were at times parallel and discrete, at times intersecting, and at times mutually constitutive" (p. 28). Instead of relying on abstractions to explain oppressive practices, or presume universality, the researcher should uncover the specific historical activities that have resonances and connections with what is being studied. This research practice can be considered an act of unforgetting, referenced by Shotwell (2016)

drawing on the work of Roxanne Dunbar-Ortiz. Central to unforgetting is a decolonial framework that rejects the framing of colonialism as a past event. Instead, it recognizes colonialism as an ongoing social structure that operates across time. With this framing, history is not simply events passed, it is inscribed in institutions and practices that exist today and shapes subsequent decisions. Shotwell (2016) explains,

> The past involves the present and the future, the present entangles the past and outlines what is to come, bringing the future into the past, and the future rests on a situated past and can only "happen" in the present; tense intermingles. (p. 334)

The act of remembering is about "opening questions, defamiliarization, and (perhaps) refusal of the social relations that produced events of the past" (Shotwell, 2016, p. 642). White settlers benefit from the act of forgetting; BIPOC communities are most impacted, as violence is rendered invisible. What is erased is shaped by political processes, advantaging those with the most power.

Conversely, what is remembered through memories is also inherently political in nature. This is apparent in Luchterhand's (1982) examination of memories of the Holocaust. Interviewing residents from an area near a German concentration camp, the willingness and ability to recall happenings were neatly mapped out onto the class structure, with upper class individuals much less willing to engage. While farmers and young children were able to clearly recount the burning of dead prisoners, with the smell and smoke permeating the village, those of higher social position, such as a widow of the Evangelical minister claimed ignorance. Another example is perceptions of the Canadian state as purveyors of peace, whether through its participation in United Nations peacekeeping or in its domestic policies (Thobani, 2007). But when we engage in unforgetting, we are able to recognize that almost every time the Canadian

military has been deployed on domestic soil was for the purpose of squashing Indigenous land claims. Unforgetting allows people to destabilize the notion of the Canadian state as providers of peace and towards recognition of its violent founding and maintenance.

The erasure of past violence and its connections to today's practices helps to obfuscate ongoing harm. Forgetting engenders "a feeling of acceptance and normalness about living with a lie instead of an unforgetting" (Shotwell, 2016, p. 39). It allows people to say 'I do not see colour', and step away from considering their own complicity and engagement in racist violence. Thus, the act of unforgetting is an act of decolonization. For example, Bennett, Zubrzycki, and Bacon (2011) argue that non-Indigenous social workers should participate in decolonization through recognizing and addressing the influences of colonial histories. Likewise, Baskin (2006) considers this recognition of complicity as an important component of a critical self-awareness. Unfortunately, while there are times when the social work profession has considered its own settler colonial history, it is often done in a decontextualized fashion with little continuation or contemporary resonance. That is, while the social work profession may acknowledge colonialism, it is seen as a historical wrong with little relevance to the present. For example, instead of recognizing the 'millennium scoop,' whereby Indigenous children continue to be taken by the state in disproportionate numbers, the social work profession frames the Sixties Scoop as an exceptional event (Sinclair, 2007).

Critical memory work crucially involves more than recalling past events. As previously stated, limiting memory work to that would contribute to the problematic framings of colonialism or racial violence as 'past occurrence'. Instead, critical memory work includes active engagement with the present, drawing connections between the past and today's practices in ways that may not be obvious. The Truth and Reconciliation Commission (TRC), initiated as a

part of the Indian Residential Schools Settlement Agreement, can be understood as contributing to forgetting and unforgetting (Shotwell, 2016). The initial framing of the TRC would have served as a memory practice that reproduces settler-colonialism through limiting its coverage to a time-limited examination of residential schools, denying colonialism as an ongoing process, and classifying victims to determine eligibility for redress. However, the TRC ultimately served as critical memory work, with Paulette Regan, the research director of the TRC, describing the process as involving the re/membering of actualities of violence and the discursive violence that underlay European dominance. Significantly, this act of re/membering and unforgetting is then used to inform work "to craft a future different from the horrific past we have collectively inherited and differentially live in the present" (Shotwell, 2016, p. 41). The TRC did so by publishing calls to action, with proposals spanning areas of child welfare, education, language and culture, health, and justice. Unforgetting is an act of "remembering for the future" (Campbell, 2014) that settlers should engage in to operate ethically. It is the process by which we can find alternative practices to remedy harms, while accepting that we cannot "stand outside the past in its horror" (Shotwell, 2016, p. 46).

My research process, including the engagement in unforgetting, also draws from post-structuralism, emulating D. E. Smith's (2002) incorporation of post-structuralist concepts in formulating IE. The elements of post-structuralism are further emphasized in my proposed incorporation of a genealogical approach to analyzing my interviews and other texts. Tamboukou and Bell (2003) advocate for this combining of modernist and poststructuralist approaches in their discussion of possibilities around drawing from both genealogical and ethnographic approaches. Tamboukou and Bell (2003) state, "Our attempt is a strategic mapping that will allow work to be done across and between these traditions of research, work that will interweave

a careful path between the pitfalls of one or the other" (p. 2). While Tamboukou and Bell (2003) acknowledge the dangers of mixing the two approaches given the differences in epistemological underpinnings, they also want to critique the idea of epistemological categories involving a "purity of divisions" (p. 3). Indeed, Tamboukou and Bell (2003) suggest that Foucault himself never intended to have his genealogical approach and the associated tools of analysis to be a closed theoretical framework; instead, he intended these tools of analysis to be used with various social research and historical methodologies.

Tamboukou and Bell (2003) suggest that there are a number of areas where these two approaches are compatible. Both approaches question the idea of a universal authority and the self-evident validity of science, "adopt[] context-bound critical perspectives, transgress[] closed theoretical and methodological systems, point[] out the limits of dominant power/knowledge regimes, recover[] excluded subjects and silenced voices, highlight[] the centrality of the body in sociohistorical analyses, and restor[e] the political dimension of research" (Tamboukou & Ball, 2003, pp. 4–6). There are also a number of important differences that Tamboukou and Bell suggest researchers should be aware of, tensions that I acknowledge need to be made explicit. In particular, Tamboukou and Bell speak of ethnography being associated with assumptions of progress rooted in a modernist paradigm. There is a desire to propose alternatives and to support emancipatory goals, unlike a post-structuralist approach that would caution against proposals given the dangers of reproducing discourses that the researcher is attempting to critique. Second, the two approaches focus on two different conceptions of power. While ethnography focuses on power as sovereignty—from the above, such as forms of state violence, a genealogical approach tends to understand power as a deployment, as unfixed and dispersed. Power is not seen as possessed by a specific group of people to be used against the oppressed, but instead as

something exercised by all, albeit unevenly. However, Tamboukou and Bell (2003) point out that Foucault himself never considered these two forms of power as mutually exclusive explanations; instead, Foucault suggests that these two forms of power may exist side by side, at times juxtaposed and at other times, interacting with one another.

This eclectic approach also reflects the analytical strategies common in Mad Studies. For example, Mills (2013) describes her own research as writing messily, involving being critical of what is accepted as evidence and considering what is not usually accepted. Part of this involves reading contemporary practices as reverberations or resonances of a past so often understood as distinct and irrelevant (Chapman, 2014a). Mills (2013) cites Fanon's rejection of rigid adherence to models and discourses, and suggests using concepts in ways that are "multiple, simultaneous, and in flux rather than presenting them as linear and discreet" (p. 13). Writing messily "is to move away from questions of being 'for' or 'against', 'pro' or 'anti'; it is to ask what these particular frameworks prevent us from seeing, and what alternative ways of intervening they might foreclose" (Mills, 2013, p. 12). It is also about refusing to claim authority. This dissertation is not meant to be an authoritative text, but instead hopes to open up questions and serve as a dissenting challenge to how coercion and violence operate in the Canadian mental health system and beyond.

Finally, as my research deals with violence faced by oppressed peoples, it is crucial to consider the warning issued by Tuck and Yang (2014) and their suggestion of approaching research through a pedagogy of refusal. Tuck and Yang (2014) state,

> Analytic practices of refusal involve an active resistance to trading in pain and humiliation, and supply a rationale for blocking the settler colonial gaze that wants those stories. Refusal can comprise a resistance to making someone or something the subject of

> research; it is a form of objectless analysis, an analytic practice with nothing and no one to code. Analytic practices of refusal can help researchers and the people who prepare researchers to avoid building our/their careers upon the pain of others. (p. 2)

Thus, refusal is not about giving voice to the voiceless in the sense of allowing research participants greater control over the research process. Refusal involves an active rejection of researching certain topics, especially those that pertain to the experiences of marginalized peoples.

More specifically, Tuck and Yang (2014) suggest that the researcher's gaze should be inverted back to the researcher themself, as well as, colonial institutions that facilitate these processes. Tuck and Yang (2014) present, as an example of refusal, Ken Gonzales-Day's series of photographs of lynchings, but with the victims removed. The intention is to transfer attention from the mutilated body to the "assembled onlookers/participants in the murder, to the space of the crime, and to the hidden gaze of the photographer and the viewers (ourselves)" (p. 4). Mignolo (2009) makes similar arguments about the need to focus more on enunciation versus the enunciated. In other words, we should be turning our gaze towards producers of dominant knowledge versus those whom the knowledge is enacted upon. Refusal also involves acknowledgment about the problematics of past and future research. Subjugated people are sometimes invited to participate in research, but almost always only to speak about their pain. The academy is not entitled to all forms of knowledge, especially when these "stories and experiences [...] already have their own place, and placing them in the academy is removal, not respect" (Tuck & Yang, 2014, p. 813). Indeed, Tuck and Yang (2014) and Linda Tuhiwai Smith (2021) acknowledge that research conducted in an academic setting may not be an intervention that addresses the needs of the communities that serve as research subjects. Research can often

be extractive in nature, appropriating knowledge from Indigenous and other marginalized communities for the furtherment of academic careers and the settler-colonial capitalist social order. This is consistent with Macías' (2016) and Skeggs' (2002) conclusions that the sharing and recording of experiences, whether in the case of archives or other settings, often serves to reinforce social control.

These recognitions challenge me to expand ethical considerations beyond institutional approaches to ethics that revolve around questions of informed consent (O'Connell, 2016). This proposition is also applicable to the field of social work, where many careers are built on the treatment of Indigenous suffering, while social workers frame themselves as innocent helpers despite the violence perpetrated (Chapman & Withers, 2019). As Kumsa (2015) suggests, with our finger pointed at 'outside' structures, the state, or the oppressor, we must be aware of the three fingers pointed back at ourselves and consider our complicity and contributions to oppressive practices. This principle informs my approach to this research.

Methods

IE begins with the experiences of various subjects, experiences used to establish the standpoint. These experiences are often drawn from the researchers themselves. For example, D. E. Smith (2005) started her inquiry into the role of mothering in schooling with her "experiences as [a] single parent[] (p. 32), which was further substantiated through the sharing of stories about mothering with her coauthor Alison Griffith, becoming their research problematic. Likewise, I began with my own experiences as a social worker in the mental health sector. I have personally witnessed and participated in incidents of police violence in the context of mental healthcare provision and have learned through discussions with targets of violence the serious physical and

emotional consequences of these forms of police interventions. I also have a first-hand understanding of how social workers engage in these forms of violence. An assessment of my experiences as a social worker through the writing of reflective memos allowed me to recognize my own role and complicity in the issues I have chosen to study, serving as an example of institutional witnessing. Gorman (2005) explains, institutional "[w]itnessing involves politically conscious human beings who can analyze their own roles in the story, and also provide the critical context for understanding the power relations in order to change them" (p. 8). And consistent with Heron's (2000) rationale for why she includes an interview with herself in her research on international development workers, the inclusion of my own experiences served as recognition of my own complicity in the practices described, to challenge notions of innocence and to highlight the fact that the work undertaken by my interviewees is in no way exceptional.

The assessment of my own experiences as a social worker informed my interview process, both in relation to the selection of informants and the structure of the interviews. Regarding the selection of informants, Devault and McCoy (2011) suggest that institutional ethnographers "conceive of this kind of selection in terms of diversity of experience rather than categorically" (p. 12). IE does not require a certain number of participants but, instead, places emphasis on participants being involved in a diversity of experiences and loci within an institution. Thus, a mixed purposeful sampling method was used (Patton, 2002) to select 17 mental health social workers as participants[2] (I elaborate on the backgrounds of these social

[2] I also interviewed an abolitionist activist on the policing of mental health crises and abolitionist alternatives to these practices.

workers in the subsequent section). With almost seven years of frontline experience, and continued engagement with the mental health field through training facilitation and committee work, I accessed my network of relationships to secure interviewees. I also posted a request for interviewees on a social work listserv to supplement my list of informants. I restricted social workers selected for interviews to those with social work experience in the Greater Toronto Area. This decision to select a geographic inclusion criteria allowed for a more in-depth examination of how social work practice operates within a specific delineated context. It also allowed me to limit variables by ensuring a consistent setting (e.g. there may be significant differences between practice in urban and rural areas) and regulatory environment. While not meant to be generalizable, this allows for the in-depth study of a particular case (E. Lee et al., 2010).

I made the intentional decision not to include survivors of mental health social worker-initiated police intervention as informants. de Montigny (2021) states,

> IE demands that we recognize the tensions or puzzles we face working in ways that are critical, feminist, and Marxist while also working inside the epistemic, ideological, and textual orders of our increasingly corporatized institutional locations. (p. 511)

IE entails not only critical assessment of informants' disclosures and texts, but it also involves being reflexive regarding our research practices in the context of the academic institution. Thus, I considered the dangers of contributing to harm through the research process when developing my research proposal, worrying in particular about producing "damage-centered studies, rescue research, and pain tourism" (Tuck & Yang, 2014, p. 811) that commerce in the pains of Indigenous and other marginalized peoples. I concluded that interviewing survivors of psychiatric violence was not necessary as there already exist accounts of police and psychiatric

violence published by mad people that can be relied upon. Instead, I therefore focused on interviewing social workers themselves in order to focus my gaze on the institutional practices engaged in by perpetrators.

My interviews were semi-structured, informed by an interview guide. With a focus on the activities of work and daily living, these interviews served as points of entry into understanding how activities are coordinated by policies and professional discourses (D. E. Smith, 2005, p. 51). The semi-structured interviews were not standardized, as subsequent interviews were informed by previous interviews, shaping paths of inquiries I foregrounded. This was a reflection of IE's emphasis on adapting the research process to what is learned from participants (Devault & McCoy, 2011). One significant issue identified in IE is institutional capture, referring to circumstances whereby "Institutional discourse swallows perspective, the local, the particular, and the subjective experience of workers" (D. E. Smith, 2005, p. 157). In other words, the dialogue remains at the superficial level of ideology, limited to "a description of the organizational rationale to what she does" (D. E. Smith, 2005, p. 156). Institutional capture is especially prevalent in the context of this project, since "both informant and researcher are familiar with institutional discourse and know how to speak it" (D. E. Smith, 2005, p. 156). Asking social workers why they call the police may elicit answers like 'to address potential risks in fulfillment of statutory requirements' or 'to protect both the patient and others around them'. These responses fail to capture the practices occurring within the institution and how these practices are coordinated. To avoid this problem, I focused on obtaining descriptions of actualities. For example, I inquired as to how decisions were made and how the work happened in relation to the institutional context. An effective way of asking these questions is to structure the interview around eliciting a chronological retelling of a work scenario. In my case, I asked

participants to recall a time they initiated police intervention in the context of work. I inquired as to the events that precipitated the call, how the call was conducted, and the aftermath. I also followed Nilsen's (2021) suggestion to ask "questions about actions and words used in an everyday and taken for granted way, and that the interviewees assume you are familiar with" (p. 368). For example, when interviewees mentioned that they practice a certain way to maintain their professionality, I asked them to elaborate on what professionality meant to them. Or when an interviewee mentioned that they conducted a risk assessment, I asked them to explain how a risk assessment is done. These questions ensured that narratives do not remain at the level of superficial jargon, and that actual practices are examined.

While D. E. Smith (2005) argues that "institutional ethnographers tend not to use formal analytic strategies" (p. 38), I decided to use process coding to analyze my data as I found it appropriate, given the shared emphasis on practices and actions. Process coding involves the use of gerunds in the coding process. Human actions examined can range from "simple observable activity" (Saldaña, 2021, p. 77) (e.g. phoning, telling, reading) to "more general conceptual action" (Saldaña, 2021, p. 77) (e.g. struggling, resisting, complying). Strauss and Corbin (2008) explain that this method is helpful for researchers that search for "ongoing action/interaction/emotion take in response to situations, or problems, often with the purpose of reaching a goal or handling a problem" (p. 96). Charmaz (2006) further supports this notion by claiming that coding with gerunds allows for the "discern[ing of] implicit connections" (p. 124). And just as this form of coding "gives researchers more directions to consider and already suggests emergent links between processes in the data" (Charmaz, 2006, p. 124), DeVault and McCoy (2011) considers information gleamed from interviews in IE as resources to inspire questions that can be brought "back to a political-economic context for the answer" (p. 40). That

said, Saldana (2021) discourages the use of process coding as the sole coding method, suggesting that it would be too restrictive to do so, limiting the researcher's analysis. Thus, I was not rigid in my coding process, incorporating elements of in vivo coding, emotion coding, among others (Saldaña, 2021). I also followed de Montigny's (2021) suggestion to pay attention to what was left unsaid, as these non-statements tend to be "as important for professional practice as that which was said" (p. 510). As stated, acts of forgetting and omission serve a purpose in allowing for practices to unfold. Pseudonyms were used when these interviews were referenced in this dissertation in order to ensure confidentiality.

The second component of my research involved analysis of texts that influence mental health social workers' practices in relation to policing. Basing my selection of texts on my own experience as a social worker and my interviews, I evaluated risk assessments, agency policies, social work textbooks, and involuntary hospitalization forms. Examination of these texts allowed for the experiences gleaned from the interviews to be further situated in their institutional settings, in that texts play an active role in these settings as coordinators of local practices (D. E. Smith, 2002). D. E. Smith (2005) explains, "The capacity to coordinate people's doings translocally depends on the ability of the text, as a material thing, to turn up in identical form wherever the reader, hearer, or watcher may be" (p. 166). Texts connect a local setting translocally, a means in which distant administrators, bureaucrats, or politicians can exert influence over local practices. However, in terms of IE, the work of the researcher is not to analyze these texts as one would for a discourse analysis. Instead, the institutional ethnographer traces how texts coordinate practices and perspectives, which allows for the revealing of "the institutional observability of the work of those involved" (D. E. Smith, 2005, p. 170). It allows for the appreciation of how texts serve to both coordinate the sequence of events that occur in

relation to an institutional practice and provide instructions for those assigned the role of overseeing the process for the purpose of ensuring standardization. My analysis of the interviews and relevant texts involved and served the purpose of mapping out institutional processes, uncovering ruling relations, and challenging ideological constructs. In IE, rigour does not rely on sampling methods or thematic analysis. Instead, it is assessed by "the corrigibility of the developing map of social relations" (Devault & McCoy, 2011, p. 33), through confirming and providing an accurate accounting of actualities of life. I did so by ensuring that my interviews contained questions examining these connections and triangulating these experiences by drawing on existing literature.

Interview Participants

The 17 interviewees included in this study worked at a diversity of settings and many had experience working in multiple workplaces. A small majority of interviewees—nine—worked in a community setting. This setting was the most open-ended. As Patty remarked, "it's working outside the box, like you can meet someone at their home or at a coffee shop". Other interviewees described meeting service users at school, community centres, libraries, restaurants, and shopping malls. One reason for meeting service users in the community was to ensure that service was accessible. Naomi stated,

> we realized transportation can be a big issue because since we serve Peel area, we have people coming in from Mississauga, Brampton, Caledon, sometimes it can be very challenging, especially parents working and not have the time to drive them up after work into our home office.

Another reason for meeting service users in the community was in recognition that service users may find attending at an office to be intimidating or may not have the motivation to make such a commitment to accessing the service. Tanya explained,

> I think one of the reasons is to meet clients where they're at, so let's say they are struggling with anxiety and they just cannot come to the agency or something about the agency is triggering. Let's say that we try to do our best to understand that and not discriminate and not provide service just because of that.

Tanya recognized that service users often had a preference for more familiar spaces in the community.

Six interviewees worked in housing provided to psychiatrized people, including shelters, dual diagnoses-focused group homes, and long-term housing. For long-term housing, social workers had an office located in the building with an open-door policy, and residents dropped in during office hours to access services from the social worker. For those unable to travel to the office because of accessibility issues, the social worker visited the service user at their apartment. Two interviewees worked at women's shelters, primarily focused on providing care and lodging for women with mental health issues and experiencing violence. One shelter also allowed for the women's children to stay at the location. Two interviewees worked at group homes specializing in care for people with dual diagnoses, a combination of mental health diagnoses with a developmental disability. Services were generally provided in the residence or within the neighbourhood, such as when the social worker went on walks with a resident. Five interviewees worked with service users primarily in their offices. This was usually the case for those providing psychotherapy. Finally, one interviewee, Deanne, worked at a juvenile detention centre. Deanne explained, the setting was "an open custody facility. It's still a locked facility. It's

still part of the justice system". When referencing the open custody facility, Deanne meant that it was operated like prisons in the sense that people were not allowed to leave the property and were surveilled at all times by staff. The difference was that instead of correctional officers, those detained were supervised by child and youth workers, some of whom were social workers.

One of the most common social work services provided, reported by seven interviewees, was case management. This is perhaps unsurprising given case management or case work served as an early defining feature of the social work profession, advocated for by Charity Service Organization, one of the earliest social work institutions. In 2010, 52% of Ontario mental health social workers that responded to a survey indicated that case management was one of their primary roles (O'Brien & Calderwood, 2010). Case management has an expansive definition, but generally involves coordination of services for a service user, including but not limited to medical care, social welfare, housing, and employment. Indicative of how pervasive this task is in mental health social work, Tanya, an interviewee, expressed that while their formal role was to provide psychotherapy, service users' needs inadvertently dictated that they attended medical and social service appointments with service users, thus fulfilling a case management role. Patty explained that

> case management involves overseeing someone's situation and helping them connect with other resources, doing that coordination between service providers. So, for example, if there is a psychiatrist, a therapist, a family doctor, I am that in between person that helps connect all the different people in someone's circle of care.

Patty also noted, that while visits to psychiatrists or family doctors were infrequent, a case manager may meet service users weekly and tended to do so in a community setting. Patty stated,

"It's working outside the box, like you can meet someone at their home or at a coffee shop, with the same goal of helping someone stay mentally healthy and work towards their goals".

Case management services often intersected with other sectors, such as the forensic system. Eva stated,

> my role [as a case manager] ranges from therapeutic support and building a therapeutic relationship to coordinating care, advocacy. I feel like I do a lot of advocacy in the realm of mental health diversion, which again is another problematic structure. I think often we are supporting folks diverting from the justice system to that system. I work with some people in the forensic mental health system, helping people with their personal goals, around wellness, or healing, or recovery.

Diversion refers to programs that shift people away from the criminal justice system. For example, Ontario's mental health diversion program is a court initiative that allows people with certain mental health diagnoses to avoid criminal charges in exchange for compliance with a psychiatric treatment plan. This program involves social workers supervising the program participant, potentially through regular community visits to ensure adherence, extending the reach of the court to the community. Should the program participant be deemed as failing to comply with the treatment plan, they may be brought back to court for prosecution (SSO, 2019). In Eva's work, part of the focus on case management was to support service users from having further involvement with the criminal justice system by connecting people to services. As another example, Chandra provided case management services for service users with mental health diagnoses at a community legal clinic.

Counselling and psychotherapy were equally prominent, with eight interviewees indicating that it was as a task undertaken as part of their job. This is unsurprising considering

the survey of Ontario mental health social workers indicated that 84% engaged in supportive counselling, 71% in crisis intervention, and 56% in psychotherapy (O'Brien & Calderwood, 2010). According to the NASW (2005),

> Psychotherapy is a specialized, formal interaction between a social worker or other mental health professional and a client (either individual, couple, family, or group) in which a therapeutic relationship is established to help resolve symptoms of mental disorder, psychosocial stress, relationship problems, and difficulties in coping in the social environment (p. 10).

Counselling and psychotherapy involve the use of rapport building and other skills to address psychological needs and resolve mental health symptoms. While the two terms are generally used interchangeably, sometimes a distinction is made with psychotherapy considered to be longer-term support and focused on addressing more acute psychological pathologies. Interviewees reported providing psychotherapy both on an individual and on a group basis.

Some interviewees provided counselling and psychotherapy to walk-in clients; in other words, people may just show up to receive counselling services, usually on a short-term basis, without need for prior registration or enrollment. Other interviewees provided counselling on a longer-term basis, with service users that returned on a sustained basis. Psychotherapy was also sometimes provided in more specialized settings. For example, Maya provided counselling at a hospital for service users belonging to a particular profession, while Tanya provided "short term intensive" therapy for students exhibiting truancy or mental health issues. This came in the form of weekly or biweekly therapy sessions that lasted between three to six months.

Four interviewees provided housing services, whether in a shelter or long-term residence. Housing services tended to have significant overlap with some of the other work discussed. For

example, Gabby mentioned similarities to case management, “it’s just a lot of referrals, working with community health centres, the central Local Health Integration Network”. Chandra, a housing worker, stated, “we would provide supports with finding work or getting someone their medication or getting them set up for their doctor’s appointment, making sure they were on time for school”. Interviewees employed at group homes also stated that they provided programming (e.g. movie nights, social events) and socialized with residents, which was described by Vanessa as an “informal kind of mental health counselling”. I have included special mention of housing services as there were unique elements to work conducted in this setting. For one, Chandra explained that social workers “would deal with conflicts that arise”, engaging in crisis intervention with consideration of multiple service users. Social workers also did the work of a landlord and acted in relation to protecting property or coordinating maintenance. Gabby explained that the “work is more [about playing] a supportive role, in which we focus on supporting tenants to maintain healthy tenancy”. The overt intention was to ensure that service users remain qualified for tenancy by supporting service users in keeping their living environment safe and hygienic, and ensuring that they do not engage in certain behaviours, such as criminal activities, that would lead to eviction. Gabby added that potential “issues that these tenants would face would include hoarding, pets, pests, just general maintenance of their property”. Valerie reiterated how case management tasks were connected with ensuring service users maintain their housing, “Some of them are at risk of losing their housing because of their mental health issues. I try to advocate for them and support them through processing documents, and anything that is related to their daily life”.

Two interviewees reported engaging in outreach. Carrie explained,

> I was doing outreach work with clients or people who may not have been diagnosed with mental illness yet, but were showing signs of symptoms. In terms of what we called the stages of change, these people were not at the point where they were ready for change, or ready to seek service, but they still knew something was going on. So, my work was to engage to move them from what we called the contemplation/precontemplation stage towards action stage

As Carrie described it, outreach work, through rapport building, is about moving service users from contemplation—where they are considering potential benefits of addressing their mental health symptoms, to action—where they start accessing clinical services. An example Carrie gave was meeting service users in the community as a means to help with rapport building, with the goal of motivating them to attend appointments at the office. As service users became more desensitized, they were more likely to accept referrals to more intensive services.

Two interviewees reported being involved in family support tasks. They provided education to family members of someone with mental health issues on providing support, as well as connected the family with relevant services. Patty recounted allaying fears held by family members regarding the mental health system by providing information and clarification about the treatment provided to people with mental health issues. Similarly, two interviewees explained that they provided training and education. Naomi stated,

> I provide mental health first aid training to workers, teachers, educators, faith-based leaders. I explained common mental health issues impacting young people, and how to deal with crisis situations, so that we do not escalate. I also do safe talk, which is a training on suicide prevention and awareness. So my work involved frontline knowledge mobilization, mental health training and awareness raising.

Naomi's work involved training other service providers in addressing mental health issues, especially that related to crisis and suicide. Mei provided similar mental health training to settlement workers.

Finally, three interviewees reported that they were managers. These interviewees explained that while they did sometimes interact directly with service users, they tended to focus more on supervision, only intervening during crises that their colleagues struggled to contain. Gabby stated,

> My frontline work was more around parachuting in when things are going south, I'd be the one coming in to address it. But it was never to go and be with the [service user], this was our plan, this was who we were going to connect with, this was what we were going to be doing moving forward. It was more around leading interdivisional meetings around a [service user]. If there was a problem that was coming up, I would bring it to folks' attention.

Gabby was involved in decision making around other workers' service users' emergencies. Their primary focus, however, was in coordinating care and raising concerns at interdisciplinary meetings that occurred as a part of a Situation Table (see Chapter 4).

Chapter 3: The Leadup to Police Intervention

I begin this study by examining the practice of crisis intervention and the specificities of how it plays out in the experiences of my interviewees. How a crisis is defined and intervened on has a significant influence on and often precipitates or includes police intervention as a component. Everstine and Everstine (2013) defines a crisis as "a situation or series of situations that cause the person to alter his or her patterns of living" (p. 1). Hoff et al. (2011) add, a "crisis, in a clinical context, refers to an acute emotional upset arising from situational, developmental, or sociocultural sources and resulting in a temporary inability to cope by means of one's usual problem-solving devices" (p. 4). A crisis as defined by social work and crisis intervention literature tends to understand the problem as arising from the individual service user, and even when broader social structures are referred to, the emphasis is still on a psy- framing that considers a crisis as an individual's "inability to cope" that "does not last long and is self-limiting" (Hoff et al., 2011, p. 4). Consideration of social factors might be limited to its contributions as a stressor. Yet, critical examination, as follows in later chapters, demonstrates that a crisis develops through broader social conditions and is defined and constructed by dominating discourses tied to these social structures.

Thus, the purpose here is not to take the crisis intervention framework as self-evident, but instead, to use the framework as a starting point, in consideration of the fact that these perspectives serve as the dominant discourse within the social work profession—especially in its intersection with policing. These discourses are articulated by my interviewees in their descriptions of calling for police interventions, framing these practices as a component of crisis intervention. The individualized framing of crises, mentioned above, leads to an individualized

response through crisis intervention, an "aspect of health service carried out by a crisis worker—nurse, social worker, police officer, physician, counselor, or minister … focuse[d] on resolution of the immediate problem through the use of personal, social, and environmental resources." (Hoff et al., 2011, p. 4).

In this chapter, I discuss how social workers develop subjectification—an understanding of their expectations as professionals, and acquire the knowledge and know-hows of crisis intervention through a combination of formal directives and informal conversations and observations. Interviewees speculated on the role of agency policies and their formal social work education or trainings, but also cautioned against overstating its influence since many interviewees were unable to identify specific documents or aspects of curriculum that informed practices. Instead, interviewees more commonly cited being influenced by informal learning in the workplace or community through conversation, job shadowing, or supervision. This in itself is significant as it directs attention towards broader discourses informing social work practices in the latter chapters. The subjectification and learning process, despite its disparate sources, has contributed to a consistency in how crisis intervention is approached, which often ultimately results in a call for police intervention. The second half of the chapter traces the common steps undertook by social workers in the precursor of calling for police intervention. Steps towards police intervention began at the start of a social worker's working relationship with the service user through the development of a safety plan that may include the possibility of police intervention. Social workers also educated family members and informed them of the need to call for police intervention in crisis situations. Risk assessments were conducted throughout the working relationship with a service user and should risks or crises emerge, the social worker would engage in de-escalation. As stated, crises can be understood as an inability to cope with

the current circumstances leading to potential harm to the service user themself or to others. Mental health social workers frequently understood this potential harm as inevitable and as stemming from the service user's internal conditions. The contributions mental health social workers and police officers make in instigating these crises and harm is seldom acknowledged. Should de-escalation be ineffective in 'resolving' the crisis, social workers often consulted with a supervisor or colleagues as a final step before initiating police intervention.

Subjectification and Learning What to Do

Agency and College Policies

When asked what policies informed social work practices connected to police intervention or whether any policies relevant to police intervention existed, most interviewees indicated that their workplaces did not have any policies outside of that related to mandated reporting, stipulating circumstances permitting breaches of confidentiality. As Patty stated, "I've read the policies recently, and I don't think there is one [related to police intervention]". She added,

> it's kind of more generalized when the police need to be called and what the reason is dictates what you need to do. But again, even with the CAS piece, it is much more detailed, whereas the policy for police involvement is a lot less.

Patty indicated that policies pertaining to child welfare far outnumber policies pertaining to police intervention. Mei also noted that "I don't remember whether there was any policy. I don't remember them talking about any policy". They speculated that this may be because the management at their agency presumes that immediate crises that may lead to police intervention

are not typical for their clientele. Helen suggested that there were no policies and that social workers determine whether police intervention is necessary on a case-by-case basis.

Tanya commented, “I think there's probably a policy, but I haven't read the policy”. They were unaware of the contents of the policy, arguably making the existence of the policy moot. Similarly, Carrie stated, “I don’t know about policy, to be honest, I am sure there will be policies stating that you have to go through confidentiality, but I don’t really remember anything that’s involved”. If there were policies, many interviewees were unaware of them and so they would presumably have very little direct impact on practices. Reflecting on my own experiences as a social worker, I was able to reference one relevant policy document, but I drew similar conclusions to Tanya and Carrie. There was a risk assessment policy in relation to client home visits on the internal staff website that made some references to the police, including instructing workers to practice preventative measures like obtaining information about the neighbourhood from the local police department, hiding a “Call Police” sign under the car floor mat in case of emergencies, noting the nearest police station, and saving the phone number for the police on the phone. However, I do not recall ever being instructed to review this policy. And, as I did not observe colleagues using the assessment tool or following the recommended practices, I largely ignored the prescriptions contained within the policy.

The only other relevant policies were regarding incident reporting. Sally explained,

> I mean, on the incident report, you're supposed to do it after the fact. You document why you [engaged in the particular approach]. And there's a checkmark saying, did you notify your manager, what happened? Why did you call the police? You have to justify what

> you did. But that's a very reactive document. In terms of being proactive, I don't think there's much.

In other words, many policies were limited to reactive measures, or steps that are to be taken after the police were called, with little to no stipulations informing calls for police intervention.

One interviewee did express contrary arrangements at their workplace. Naomi suggested that policy is contained in an employee manual that new hires are required to review. Naomi stated,

> We do have human resource resources. The policy is written in the manual for the organization. That is something we have to follow. It's clear when you get trained, coming in as a new hire, you are given the manual to read.

These policies were reiterated and reinforced during clinical meetings and supervision. The manual contained protocols requiring social workers to conduct suicide assessments. However, Naomi also explained that the protocol was very general, "and it's always open for revision". Social workers had leeway in interpretation and implementation, with clinical supervision playing a more significant role in shaping practice.

Policies were also embedded into agency paperwork. At Eva's workplace, social workers were required to complete a crisis plan with each service user. This crisis plan involved highlighting risk factors and developing responses to ensure service user safety. The plan also included a list of resources, and "911 is on there. There's mobile crisis in your area but also

911". The inclusion implied that police intervention is a legitimate response to mental health crisis for social workers and service users.

Another policy, though not always codified, was the requirement to consult the manager before major decisions, such as that involving calling the police. Almost every single interviewee indicated that they first consulted their managers or supervisors before calling for police intervention. Patty stated, "we always have to get approval from higher ups just to make sure that is the right step [and] we aren't jumping to a different option than what would be recommended by the manager. I believe that is the policy". Deanne, a manager in a forensic setting went a step further, suggesting that any crisis situation required immediate reporting to the manager, whatever the course of action. Deanne explained that "the protocol was staff would come to me immediately to let me know [about the crisis]. I would make a decision on what we need to do right in the moment for safety, [including] call the police". Valerie also suggested there was a policy "to make sure that if I feel the threat or danger, I have to immediately call the manager".

Policies also exist at the level of professional bodies. Both the Canadian Association of Social Workers (CASW) and the Ontario College of Social Workers and Social Service Workers (OCSWSSW) publish codes of ethics and accompanying practice guidelines that are meant to inform social work practice (Canadian Association of Social Workers, 2005a, 2005b; *Code of Ethics and Standards of Practice Handbook*, 2018). Certain studies have shown that social workers rarely rely on these documents to navigate ethical dilemmas and for decision-making. According to Rossiter et al. (2005), "Most participants treated ethics codes as irrelevant and they tended not to employ internal cognitive schemes to resolve ethical dilemmas. Participants saw such resources as esoteric and not useful in the real world of practice." (p. 93). Walsh-Bowers et

al.'s (1996) findings from interviews with Canadian hospital social workers "dovetailed" (p. 328) with Holland and Kilpatrick's (1991) American study concluding that "not a single respondent offered the profession's code of ethics as a resource for helping to deal with complex ethical issues" (p. 138). Rossiter et al. (1996) concludes that out of frustration at the rigid nature of the Code of Ethics and sense of inapplicability to daily practices, social workers "do not go into their office, shut the door, take the professional code of ethics off the shelf, and look up the best course of action" (p. 309).

While few of my respondents mentioned the specific use of codes of ethics and practice guideline documents in navigating situations that involved police intervention, many of my respondents did claim that the OCSWSSW as a disciplinary body weighed heavily on their decision-making process. Social workers feared losing their social work licence if they breached the Code of Ethics, describing the OCSWSSW and its disciplinary mechanisms as a "panopticon". There were concerns that a failure to call the police could trigger sanctions. Sally even phoned the OCSWSSW hotline to inquire about what situations required her to call the police in anticipation of future crises. Ungara (2007) also found similar deference to professional bodies in their study of social work regulation in Canada. While the previous cited studies on social workers' indifference towards codes of ethics, these studies do still suggest references, albeit limited, by social workers to codes of ethics, not that there was zero impact. Indeed, Holland and Kilpatrick (1991) describe social workers feeling "a tension of allegiance to the ideal of individual self-direction on ethical issues versus obligation to comply with authoritative external sources, norms, or traditions" (p. 138). Walsh-Bowers et al. (1996) mention that managers interviewed stated that "they relied on consultations with the College for

interpretations of the Code regarding dilemmas" (p. 325). A hospital director also recommended social workers escalate to consulting the professional social work body as the final step in navigating difficult ethical dilemmas. And if there appears to be a greater emphasis on the influences of the governing social work body on practice, it may be because the previously cited studies relied on interviews from the late 1990s, at a time when disciplinary practices in relation to social work professionalization in Canada had either just been put into practice or had yet to exist. In Ontario, formal social work regulations were only implemented in 1998. Prior to this, registration to professional social work bodies were voluntary. We will explore the possible influences of regulating bodies and codes of ethics on social work practice in relation to police intervention further in Chapters 5 and 6.

Education and Trainings

Surprisingly, post-secondary education was not a major source of learning in relation to police intervention. This is despite BSW and MSW degrees being a prerequisite for a social work licence across Canada. Some interviewees suggested that the topic of police intervention may have been broached during class discussions, but no interviewee could provide an example. The only examples of course content relevant to police intervention cited by one interviewee were discussions of limits to confidentiality and de-escalation skills. According to Carrie, training through post-secondary education and workshops provided the capacity to be proactive, instead of reactive. Social workers learned to anticipate problems arising and have an idea of how they might respond, versus having to improvise.

Exploration of police intervention was more likely to occur through role playing and practice sessions. Interviewees spoke of simulations with actors or classmates that were held at school. Students would practice presenting limits to confidentiality to 'service users'. The professor would then provide feedback. This occurred as a part of in-class course work and as extra-curricular practice sessions. In addition to limits to confidentiality, interviewees also reported learning about suicide risk assessments and appropriate circumstances for calling crisis services, including the police. Carrie explained that the instruction suggested discerning between passive and active plans for suicide. An active plan would involve an imminent threat with intention and access to tools for carrying out the suicide, necessitating a call for police intervention. Mei suggested that police intervention was taught as a default course of action when uncertainty was present. That said, they felt though that the school curriculum had a greater emphasis on Children's Aid Society (CAS) interventions, which Mei speculated may have been due to professors "ha[ving] a lot of experience" in that area.

Ultimately, many interviewees felt that their schooling did not directly address police intervention. The curriculum was mainly theoretical in nature. Tanya explained,

> I took classes that were helping me orient how I work, introducing harm reduction and social justice viewpoints. And we learned about police brutality and racial violence in a very academic way, but this was not a lay of the land and the reality of things approach to teaching. We weren't told this is how you do things.

This interviewee felt that while social workers were given a perspective on police intervention, there was little instruction or examination of practical application. John also described how

“education was super vague in general. You don’t really learn the stuff until you actually get into the work … I don't really remember anything that talked about crisis intervention in my education”. Vanessa could not recount a single moment when police intervention was addressed, and also felt that “There's a disconnect there between theory and practice”. And while Valerie found their education helpful, they believed that an emphasis on self-reflection to the neglect of practical knowledge meant “there are huge gaps in education”. Indeed, a number of researchers have identified the lack of instruction on practices related to mental health, addiction, and suicide in social work education (Kourgiantakis et al., 2022; Sharpe et al., 2014; Wilkey et al., 2013). Finally, despite the lack of direct instruction on practice, Eva believed that schooling impacted practices related to police intervention by “priming” social workers to embody “a specific ethos of professionalism” that makes it more likely for them to “maintain the status quo and just check these things off”. More on this aspect will be discussed in Chapter 6.

Direct instruction on topics relevant to police intervention were more likely to occur in workshops organized outside of formal education. Almost every interviewee spoke of attending workshops and trainings that addressed, albeit tangentially at times, police intervention. Workshops that some interviewees were required to attend by their workplaces include, Crisis Prevention Intervention (CPI), Applied Suicide Intervention Skills Training (ASIST), Universal Management of Aggressive Behaviour (UMAB), and pharmacology and hoarding trainings provided by Toronto Hostels Training Centre. Some interviewees also received additional training in therapy modalities, such as for cognitive-behavioural therapy (CBT).

Workshops sometimes emphasized the need for social workers to protect themselves. Vanessa reported,

> It closes down alternative ways of communicating. So, instead of reflecting on why she's doing this, it's all about ensuring your own safety and ensuring the safety of the agency ... I mean, obviously you don't want to hurt the client, but it's essentially for you to be safe. So, do whatever is necessary. It's similar almost to that police discourse in a way. Whatever is necessary to keep yourself safe.

This emphasis meant that social workers may be primed to perceive scenarios as inherently violent or as carrying the potential for violence, requiring police intervention. For example, the CPI training taught Vanessa to recognize "yelling as a beginning stage of the loss of rationality, or pacing, or questioning. So as soon as they start these behaviours, we move into CPI, which means [the service user is] going to get violent". These workshops trained social workers to interpret behaviours in a "linear" fashion that presumes escalation into violence.

Maya described how these trainings provided a model of practice. Referencing ASIST training, Maya stated,

> It has the structure. It has a clear-cut model. It has more of a manualized way to do this. So, to be honest, at that point in time, I was almost relieved to have something that was just, here you go. This is the steps you can take, because noticing my own emotional response, my own experience has been triggered in those interactions. I don't know what I'm supposed to do, having those ethical dilemmas happening in the midst of a one-hour session with someone.

Recognizing the challenge and anxieties triggered by crises, Maya found that the training was able to ground them during ethical dilemmas by providing a step-by-step process. That said, they

also had the space to “question and clarify and almost take the pieces that I felt were helpful and leave the others”. In particular, they recognized that the training could flatten the “complex human in front of you”. These trainings are popular because it introduces predictability, even though reality may not be so formulaic. These assumptions were seldom challenged at these trainings. Maya stated,

> I remember going through the training and being one of the only people who is supported an alternative perspective or didn't necessarily see suicide as a selfish thing. The instructor questioned these beliefs, and I was one of the few that had thought about it in that way.

For UMAB training, Deanne described how it emphasizes de-escalation. But Patty disagreed, suggesting that it involved physical restraints and is “more intrusive at some points than what CPI is”.

Not all trainings reinforced police intervention. Interviewees cited attending trainings rooted in alternatives to the biomedical or clinical models, and that encouraged a more critical approach to practice. Maya described a workshop called “Skills for Safer Living”, where they explored “Ways to provide people with more agency, more skills. Even if they were to go to hospital, we considered if there is a way to go on their own.” The training facilitated discussions around how to provide community support and how to build networks of support that deemphasized the use of police intervention. They also mentioned a workshop that approached suicide intervention in a way that avoided stigmatizing the choice to take one’s own life and considered the broader context of suicide.

While almost all interviewees reported participating in trainings, several interviewees felt the training was insufficient. Tanya stated, “there wasn't really a comprehensive training … we weren't trained on how to handle it. So, nobody would know how to handle it”. In fact, Carrie even suggested that the few trainings provided or made required were only done to fulfil accreditation requirements, with no substantive desire to provide workers with tools for engaging in crises.

Informal Learning in the Workplace and Community

When Sally consulted the OCSWSSW regarding whether to call the police based on reports of self-harm or suicidal ideation, the OCSWSSW replied that it was not cut and dry and that social workers must use their own “clinical judgment to read between the lines the best you can and make assessments based on different variables like the risk factors because of their age or gender”. Clinical judgment refers to a social worker’s decision made with discretion and based upon their “accumulation of knowledge and skills over time” (Embler, 2021). Referring specifically to risk assessment practices, Douglas and Wildavsky (1983) and Webb (2006) also argue more broadly that social work practices and expertise cannot be divorced from political and social contexts. Social work practices are “coloured by subjective judgments at every stage” (S. A. Webb, 2006, p. 76), influencing what a social worker finds relevant and how they decide to proceed. The framing of decisions as based on clinical judgment is often used as a means to self-justify, a “closed loop” (Tavris & Aronson, 2007) that confirms pre-existing notions and biases (Anastas, 2014). This accumulation of notions and biases also includes what Gramsci described as common sense (Gramsci, 2005) in that clinical judgment also relies on the harmful conceptualizations of race, class, gender, madness, and the exaltation of social work and its

wielding of state power, aggregated throughout history. This emphasis on clinical judgment may explain why formal agency policies that refer to police intervention are less common.

Instead, interviewees reported that their social work practice was more likely to be informed by informal unwritten agreements made between the agency and its workers. Sally stated, “these informal policies … I don't think they're written anywhere, but they're just the agreements that we have. I think we're a small agency. So, maybe that's why there isn't a policy to cover every single thing.” Likewise, Mei attributed practice knowledge in relation to police interventions to “organizational culture”. At their agency, they felt that the general sentiment among colleagues involved the notion that police intervention should be called whenever there is uncertainty. Mei gave the example of supervisors recounting stories regarding how “life was saved” when police were called, “they bring out different examples to make you feel like calling is the right way”. It was through these discussions of anecdotes that police intervention was encouraged, and organizational culture disseminated.

That agreements or instructions around police interventions were established through informal verbal discussions was also shared by Maya, “I don't know that they were formalized into official written policies, but there is definitely verbal discussion [about how to practice]”. Instead of policies, instructions were given through conversations with managers around how best to approach crisis situations. In this example, the interviewee explained that workers were told to engage in de-escalation and to attempt to access less intrusive services before calling the police.

Some interviewees stated that they learned about how to practice through informal conversations with team members in meetings. Eva explained,

> when I am in team meetings, people are suggesting or referencing moments where they have suggested to people that they could call 911 if they feel concerned. I think that's the agency's way of operating. I think it's a really large system of modelling that people are inducted into, not always uncritically from their perspectives, but I think uncritically on a larger scale. And I just think there isn't room to be critical.

Practices in relation to police intervention were learned through team meetings with little space for critical perspectives. One interviewee even suggested that learning occurred through conversations that happened through a group chat phone app. Sarah stated, "It was quite informal in that particular setting. I think we were always on a group chat through BlackBerry and sometimes we would just spontaneously consult. We would chat throughout the day". Carrie mentioned learning through "eavesdropping" in the office on other more experienced workers, "I think if I had been more isolated and hadn't eavesdropped on how other workers who were more trained and more experienced had asked questions, I wouldn't have known how to do it".

Colleagues can sometimes be more direct in instructing new employees. This may happen during "onboarding", when a new employee is trained and receives orientation from a more experienced colleague when they first begin work, or during a student's practicum placement, a required component of social work education. For example, Tanya explained that at their workplace, exiting employees would teach new hires expected social work practices. Tanya spoke of how an older colleague told them to offload the responsibility of calling for police

intervention on family members. While I did not receive any formal onboarding as a social worker, outside of shadowing colleagues for a couple of client visits, the person that previously held my position did leave behind some practice documents. In particular, a document on how to instruct family members to involuntary hospitalize someone in crisis was provided.

Ultimately, most of a social worker's practices were gained through "observing how my co-workers worked with their clients," according to Sarah. Sarah also noted, "all of those sorts of work settings, like your co-workers, very much model the culture of the organization". Carrie agreed with this assessment, "I think a lot of folks just generally go through the training, but then it's how you apply it that's important. And a lot of it is just learning on the job". In concurrence, Grady and Keenan (2014) suggest that clinical social workers are more likely to rely on field experience, rather than incorporating evidence-based research, and "do not like manualized treatments, and believe that research-based interventions are always structured as prescriptive procedures in a manual" (p. 102).

Part of learning on the job involved learning from service users. Patty explained that they became more "aware that I don't want to replicate [harm] or be more sensitive and aware so that they might be more open to share something" through her clients' stories. Tanya even suggested that they "learned more from my client and their families sometimes than what the agency could provide me in terms of staff training". Service users and family members would share their experiences of interacting with the police and this taught Tanya what to expect with police interventions. This emphasis on learning from clients is a consistent theme in social work literature (Marsh, 2002; Prilleltensky et al., 1996; Watson, 2007; Zayas et al., 2011).

Finally, Eva explained that they rely on their own lived experiences and that from friends who have survived the psychiatric system. This trauma or awareness of this trauma had led to them "question[ing] [them]selves as like an arm of social control" and trying "to hold on to some element of actually providing healing and spaces for connection to being in community". Tanya also suggested that conversations with other racialized people have been especially helpful,

> I think it's also conversations with racialized folk who have a different layer of experience and a different historical context of experience. So, a lot of that came honestly from being part of alternative perspectives in how to respond as critical social workers.

As will be elaborated further in our discussion of consultation as a final step before police is called, the reliance on conversation with colleagues and others to navigate ethical dilemmas is corroborated with existing research (Rossiter et al., 1996, 2005; Walsh-Bowers et al., 1996).

The informal unwritten policy, including learning through conversation and observation, described by interviewees are consistent with Preston's (2021) suggestion that the absence of formal guidelines actually "led to *more* police interventions" (p. 146) due to pre-existing common sense notions that normalize police interventions. These observations validate Kumsa's (2015) and Mukherjee's (2022) reminder that assessing informal culture—"unwritten but widely shared" (p. 154)—is crucial given its influence over practice. The idea of the informal unwritten policy is also consistent with the similarly named concept of the "implicit curriculum". Bogo and Wayne (2013) explain, "the implicit curriculum is conveyed through institutional policies, the physical environment, and human and interpersonal experiences with personnel involved in students' education, including course instructors in lectures and clinical instructors in practice

settings" (p. 6). The implicit curriculum also covers aspects of social work education discussed previously and has a specific emphasis on the function of "role models" like colleagues, professors, and supervisors to "acculturate … to attitudes and behaviours associated with professionalism" (p. 5). Social workers model the practices of those they engage with in social work and educational setting. For example, some instructors avoid engagement in contentious issues for fear of conflict in classrooms (Chan & Treacy, 1996); this can lead to students internalizing the notion that certain issues should not be openly addressed or examined (Bogo & Wayne, 2013). Indeed, Tanya reported that there was a reluctance to challenging racist practices at team meetings for fear of exacerbating burnout through conflict. The implicit curriculum demonstrates that formal policies and instruction may not be the primary, let alone only, means by which social work practice is developed.

Steps Leading to Police Intervention

The learning process has contributed to how the mental health social workers interviewed practice in relation to calling for police intervention. An analysis of the interviews revealed a pattern in relation to steps taken preceding a call for police intervention. In this section, I describe each preceding step by highlighting interviewee statements regarding the process and contextualize it with social work research literature.

Safety/Crisis Planning

Mental health social workers in a variety of settings engaged in safety planning at the start of their relationship with a service user. According to interviewees, safety planning

involved exploring with the service user potential triggers for emotional dysregulation[3], distress, or harmful behaviours, whether towards oneself or others. For some service users, schoolwork and exams may be a major stressor; for others, it may be entering into a crowded space. This information was recorded to aid social workers in anticipating problems before they arise.

Another major component of the safety plan was the identification of coping skills. Sally explained, “We tried to manage with a safety plan that didn't involve any outside intervention from police, but use resources, her circle of people, me as one of those people”. These coping skills tended to be in the realm of informal practices outside of institutional responses, also known as “natural crisis care” (Hoff et al., 2011, p. 86). Natural crisis care skills listed by service users included playing an instrument, going for a jog, cuddling with a pet, or chatting with a friend. Maya added that the safety plan is about “trying to find who are the people that [the service user] might be able to connect with in your community and places they might go. What are your other resources?” Through this line of questioning, the social worker can establish a circle of care, people that the service user can turn to for support in crisis situations. Natural crisis care is sometimes emphasized as someone with a diversity of natural crisis care resources is more likely to be able to resolve problems and mitigate stressors before a crisis escalates to a point requiring professional intervention according to social work literature. Though, as with

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[3] Patty defined emotional dysregulation as an inability to cope with the moment, which expresses itself through behaviours like pacing and repetition, but also biting and pulling hair. The term is also generally used in the mental health field to refer to socially inappropriate behaviour from a psychiatrized person (*APA Dictionary of Psychology*, 2022).

Sally's statement regarding the inclusion of contacting a social worker as a resource, "formal crisis care" (Hoff et al., 2011, p. 86) is still included in safety planning, even if it is at times de-emphasized.

The ostensive goal was for the service user to practice these skills when they recognize that they are beginning to become distressed. For the social worker, it provided crucial information on what they may encourage the service user to do or facilitate to de-escalate the situation. It was also thought to inadvertently strengthen the service user's will to live, serving as an inventory of skills, tools, and protective factors that challenges the narrative of the service user being isolated. That said, some interviewees speculated that safety plans are about limiting liability. Maya explained, "I think this might even be more a liability issue, [whereby the service user] agrees at some point that they can do their best to keep themselves safe or that they're not going to leave here and go kill themselves". Based on this interpretation, the purpose of a safety plan was to confirm that the social service agency had assessed for potential risks and prepared the service user to mitigate these risks.

Interestingly, while one interviewee suggested an emphasis on non-institutional approaches to crisis intervention, several other interviewees indicated that police intervention was built into the crisis or safety plan. A mentioned, Eva stated that their safety plan included a list of resources that had police and mobile crisis teams listed. Eva explained, "I don't think it's our team specifically, I think every team has its own sort of policing influence … [Police intervention is] embedded into assessments and into even our charting system … there's crisis plans that have 911 on them". Safety plans often included a page of contact information for resources like hospitals or crisis teams that do not involve the police, but often also listed the

emergency number that could lead to police intervention. There may also be specific instructions to call the emergency number if there is risk of harm.

Consistent with this inclusion is the fact that safety plans were used as a tool for determining whether police should be called. Naomi explicitly spoke to this,

> the person did not have a plan to de-escalate the suicidal intention, and whatever we do, we will assess, we will go through a safety plan, and the person would not follow the safety plan, or the person realizes the problem is so overwhelming that they want to take their life and kill themselves, and there's no point in turning back, so that's when the police will be involved

Police were often called if the service user in crisis did not demonstrate a willingness to engage in de-escalation or to work towards reducing the risk of harm. One way social workers at this particular agency defined an attempt at de-escalation was whether the safety plan was followed. Social workers explained to the parents that the consequence of their child not following the plan is police intervention, because 'safety' is paramount. Naomi stated,

> they are told, "this is the protocol, and you need to follow it, because safety is important." And if you cannot do it then we will have to involve the police and allow the police to take their sons or daughters to the hospital.

Finally, as was mentioned in the discussion of policy and learnings from education programs, limits to confidentiality were discussed with service users early in the relationship, often during intake procedures. Social workers warned service users about the possibility of breaching confidentiality and calling for police intervention in instances of potential harm to self

or others, or serious mental or physical deterioration caused by failure to take medications. Seltzer et al. (in press) mentions this step in their examination of the forensic mental health system, stating that social workers "begin our relationships with service users by stating our duty to report (i.e. call 911) should we suspect (not necessarily know) that someone may harm themselves or others" (p. 136). The requirement to inform service users of limits to confidentiality is also stipulated throughout both CASW's (2005a, 2005b) and OCSWSSW's (2018) codes of ethics and accompanying documents (see Chapter 6).

Family Engagement

According to Hoff et al. (2011), any crisis intervention plan must be "inclusive of the person's significant other(s) and social network" (p. 124), as crises are thought to be fundamentally rooted in social relations. But beyond the broader context of addressing triggers and stressors, family members were often recruited or taught to call on the police by social workers as a crisis intervention tool. When I began a new position as a social worker, a document was left behind by the previous worker with instructions on how to prepare family members to use the Form 2. The Form 2 allows anyone, including family members, to file a request with a Justice of the Peace to order police officers to apprehend someone and bring them to the hospital for assessment (Byrick & Walker-Renshaw, 2016) (see Chapter 4). The document first instructs the social worker to ask family members to create an outline of facts and concerns regarding the person to be hospitalized, including safety concerns for self or others, ability to care for oneself, mental health symptoms, timeline of events, and history of treatment and diagnosis. The family member is then asked to visit a Justice of the Peace office and submit the outline. If approved, the Form 2 will be provided to the police to initiate the apprehension.

Alternatively, the social worker may suggest having the family member personally deliver the Form 2 to the police to provide an opportunity to brief police officers prior to the apprehension. The document suggests advising the family members to ask the police to be gentle, to go to a specific hospital with familiarity to the person, and to suggest a specific approach if family members have prior knowledge of the person's preferences. Finally, the family members should be told to follow-up with the hospital.

Patty, who worked primarily as a family worker, highlighted the fact that social workers do not just educate family members, they actively motivate family members to call for police intervention. Patty stated,

> I have had to encourage other people, more so parents, to call the police when [their children are in psychosis]. When you have worked with psychosis before, you know if someone's psychotic and displaying symptoms, they're a threat to themselves, a threat to someone else. They engage in lots of risky behaviours for example, and need to be hospitalized.

Patty explained that people in the circle of care were told to call the police if their loved one displayed psychotic symptoms, is engaging is risking behaviour, or is a threat to themselves or others. Patty added,

> one thing I always tell families is that your job is to be a parent, your job is not to assess someone's safety. If you think that there is a safety risk, you call 911. I think again as a last case scenario, but when it comes to risk and safety, things go out the window. If you are fearful for them or for yourself, you have to call.

It was suggested that the threshold for calling the police should be much lower for family members and non-professionals. Since they are not trained to conduct a proper risk assessment, family members should not be putting themselves at risk of harm and should call the police at any sign of possible harm. Patty also suggested to family members that they should request for the mobile crisis team when they call 911.

That said, Patty also identified that police officers were less likely to cooperate with family members who make the request for police intervention. Patty shared how a client had attempted to reach the police several times over a weekend to intervene on their son, as the client knew the son was in distress. The police refused to attend to the scene and the young person took their own life. Patty explained,

> some issues I have with family is encouraging them to even get mobile crisis, as a frontline worker I have had the ability to call the precinct or division, and say I need to talk to so and so, I am a social worker, I work for blablabla, but then I have to try to guide a family member to do the same thing but they get hit with so many more obstacles like, "don't call the precinct, call the non-emergency line".

Because of these barriers, Patty often helped the family members make the call if they were available, as they found that the police were more receptive to requests from professionals. Conversely, Tanya discussed how a more senior colleague explained that it is preferable for other people, such as parents or school principals, to make the call for police intervention, over the social worker. Tanya stated, "we should try to offload that responsibility". Social workers at their agency would offer to drive the service user home or to phone their parents to pick them up.

If harmful behaviour continued, the parents would be the ones making the phone call to the police. The colleague never provided an explanation for this preference.

Patty indicated that they had tremendous hesitancy in encouraging family members to call the police. They asked themself,

> how am I supposed to tell this parent to call the police when I already have these feelings [that the police may cause harm]. I haven't shared it with them, but inner feelings of, for example, my heart starts to race, feel a little shaky just thinking about the idea [of bringing in police] based on previous experiences, past clients, and things that have happened that you don't want to happen again … Police, especially being in Toronto. Where I live in Scarborough, it's where, there's been great times when police have come in, but for every good story, there's five bad stories, where the police have killed someone or arrested someone.

It was past negative experiences of police interaction that drove Patty to feel culpability should the parents make a call that led to police violence. I also remember how a colleague had expressed immense guilt after instructing the mother of a service user to call the police. The service user was seriously injured by the police and my colleague had to face the distraught mother, who felt responsible for their son's condition. The mother told the social worker, "I am supposed to protect my child, yet I initiated this". Despite these types of hesitations, Patty indicated that they still proceeded to encourage families to call police, because "we can't get rid of that police being that last case scenario call to help". Patty saw no alternative resources to provide to the parents in cases of crises.

Patty recognized that it may be challenging for family members to make a call to the police, especially for family members with a negative history with the police. Patty stated, “no one wants to call [the police], [the social worker] validates that, but also [emphasizes that] we can’t risk [the family’s] safety and it’s not [the family’s job] to assess it”. For the social worker to achieve the task of convincing family members that may be reluctant to call the police to do so, they used skills of validation and emphasized the need to ensure the family’s safety. If the family was upfront and outright told Patty that they did not want to call the police, Patty would agree that the final choice lay with the family. Ultimately though, according to Patty, if a family member asked for the social worker’s thought on whether to call the police while also holding hesitations, the social worker would encourage them to call. Patty felt this was justified as families who have gotten to the point where they were exploring police intervention “are grasping for straws, something needs to be done, … it’s sinking in that their options are running out”.

Naomi suggested that the key to convincing family members hesitant to call the police is “transparency”. Like Patty, Naomi began with validating the family’s concerns. Afterwards, they walked the family through situations when police would be called, and what the police intended to do (e.g., bring the service user to hospital). Naomi explained to the family member,

> the police are just going to be a channel, just to transport [the service user] from the building to the hospital, to make sure they are ok. In other words, they’ll be able to maintain safety. They’re not here to arrest them or to put them in prison for having the thought that they have, but it’s more like a support role.

Naomi said that the family members and the service user usually felt more at ease regarding calling for police intervention after this discussion.

Interaction with family members by social workers has long been an integral task undertaken by the profession. Historically, the social worker was understood to be in an ideal position to influence family members for the purpose of enacting policies of eugenics and segregation (Taft, 1919). Today, as a part of the intake process, the mental health social worker often assesses a family's attitude towards the client and their willingness to assist in the treatment (Regehr & Glancy, 2014). Mental health social workers also often provide advice to family members and close relations on involuntary hospitalization, substitute decision-making, and police intervention, with Everstine and Everstine (2013) concluding that mental health social workers should help demystify and overcome fearfulness of the mental health system, and end resistance to treatment. In fact, family members are recruited to extend state surveillance practices, with social workers instructing family members to report patients to the police should they breach community treatment orders (see Chapter 4), such as by refusing to take medication (Seltzer et al., in press).

Risk Assessments

Risk assessments involve ascertaining "immediate or potential threat to life, either the life of the individual in crisis or the lives of others", along with potential harm or abuse (Hoff et al., 2011, p. 79). According to the accompanying booklet to trainings provided by Crisis Prevention Institute (2011), the need for skills in assessing and managing crises, previously most apparent for "those who work with individuals who are mentally ill" (p. 1s), are universal for those in the human services. Everstine and Everstine (2013) defined a crisis as "a situation that has reached a

critical point. Its origin lies in a sequence of events evolving over time" (p. xiii). It is also "a situation or series of situations that cause the person to alter his or her patterns of living" (Everstine & Everstine, 2013, p. 3). A crisis involves the disruption of daily routines brought by forces beyond a person's control. When others fear for the potential for danger associated with the person, a crisis moment has been reached. Crises require intervention and so social workers should constantly assess whether a situation has reached the crisis stage.

Risk assessments are often conducted right at the start of a relationship with the service user, during the intake process. Naomi explained,

> I think with the intake worker, the protocol, when you do the intake to receive counselling services, ["are you contemplating self-harm or harm to others"] is a question that is asked. It's a standard question that is asked in our initial appointment.

The risk assessment in this context involved outright asking the service user whether they would engage in harmful behaviour. The intake process also served as an opportunity to ascertain a service user's baseline[4], which can be defined as a person's usual behaviour when stable and not in crisis (*APA Dictionary of Psychology*, 2022). Sarah stated,

> this way of gauging what a client's normal is. And for some people, a normal is very high functioning and a very like, very coherent, very conversational, very, stable mood wise.

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[4] Baseline is sometimes more narrowly defined in psychology literature as a person's state before receiving treatment or intervention (in other words, a control state in the case of an experiment) (Cardwell, 2014). It takes on a broader meaning here.

> Another person's normal might be like: close to blackout drunk, most of the time, wandering the streets, even though they have a unit you might recognize, you sometimes might not, might be getting in fights, some days might be very pleasant … and that's someone else's normal.

Ascertaining the baseline, which can range from unspectacular to "blackout drunk", helps a social worker judge whether a service user's state is out of the norm. If it is out of the norm, it may be a sign of mental health decompensation or "that this person is not doing very well" and may represent a risk of harm to oneself or others. As mentioned with safety planning, the intake process may also ascertain possible triggers to decompensation, a psychological concept referring to a person losing normal functioning and experiencing heightened psychiatric symptoms (*APA Dictionary of Psychology,* 2022). This information helps social workers look out for situations that may induce risky behaviours.

Most interviewees reported conducting risk assessments before and during each interaction with a service user. Others would only conduct a risk assessment if there were signs of abnormality, based on what the service user was experiencing or how they were feeling when compared to their baseline. Naomi stated,

> [A] question [about harm] is asked [based on the] clinician us[ing] their own judgment. Because if the person is not suicidal, we don't always ask, "are you suicidal" every day. According to what the person says, the narrative of the story, what they are experiencing, what they're feeling, because I know sometimes someone feels like they're depressed, they can't get out of work, they have so many challenges, they aren't coping well. That's the lead way to basically inquire about suicidal ideation.

Most incidents understood as ‘risks’ triggering consideration of use of police intervention involved the social worker deeming that there is potential harm to the service user themself or to others. The examples provided include threats made to harm another person or suicidal ideations. Harm may also be directly observed by social workers, such as physical altercations between service users or threats directed at a fellow social worker. These types of interactions were more common in residential settings.

A service user may also be deemed at risk and requiring some form of police intervention if the social worker was unable to make contact and ascertain wellbeing for over a week. The social worker would have attempted to make contact by phone or in person at the service user’s residence. Mei claimed that a call for police intervention occurred after a service user who was “supposed to meet [a social worker] twice a week” did not pick up the phone despite multiple attempts to call. The decision to deem the situation high risk would usually require this inability to contact the service user to happen in conjunction with other red flags. These service users were usually facing multiple vulnerabilities, such as being transient and living on the streets. Sarah also suggested that there needs to be “real evidence of serious mental deterioration or physical deterioration as well”. An example provided was pre-existing health issues, where a service user had recently been hospitalized and gone septic.

The most common risk assessments revolved around suicide. Suicide assessments are conducted to provide clarity when working with “self-destructive people”, reduce disagreements between people supporting the person in crisis, ensure that treatment plan is evidence-based, determine whether hospitalization is appropriate, and reduce social worker anxiety (Hoff et al., 2011, p. 318). Carrie explained, the social worker assesses “how passive or how active is this

person in wanting to die … you are splitting into two streams". Passivity refers to the person thinking of suicide but with no immediate desire to act out the thought. Active suggests that the service user has a specific plan to kill themself, access to lethal tools to follow through with the plan, and the intent to do so (Hoff et al., 2011, p. 319). If the social worker is to detect any indication that the service user may be contemplating suicide, they should begin the assessment. Naomi stated,

> this person presents with certain things during counselling. Like something that is going on that suicide can be a factor. So, our protocol, we don't ask do you feel like hurting yourself? We ask directly as possible—are you feeling suicidal? Do you want to kill yourself?

The social worker would avoid indirect questions that rely on implication, and instead, directly inquire about whether the service user plans to kill themself. At times, the service user may deny that they have a plan to kill themself or "give us an answer that is not believable". In this scenario the social worker would remind them that it is a safe space to share, and that disclosing suicide would allow the social worker to provide assistance.

As a social worker, I was taught how to use a SAD PERSON assessment to screen for suicide, but was not required to use it. The SAD PERSONS scale assesses the risk of suicide based on a service user's sex—male; age—less than 20 or more than 45; depressive symptoms; previous attempts or access to psychiatric care; drug or alcohol use or abuse; psychotic or organic brain syndrome symptoms; lack of social supports; organized plan for suicide; recent divorce, separation, or loss of a spouse; and chronic/severe medical condition (Perlman et al., 2011). Each of these attributes adds one point to a scale with four levels: low risk, low to

intermediate risk, intermediate risk, and high risk. According to a SAD PERSONS scale document provided to me when I worked as a social worker, a service user deemed low risk should have their crisis plan reviewed and concerns regarding suicide should be followed up on at the next visit. A low to intermediate risk indication should lead to the social worker informing the service user's support network, increasing support, accessing mobile crisis teams, and scheduling an assessment with a psychiatrist. An intermediate risk indication should lead to a social worker facilitating an assessment at the hospital. Finally, a high risk of suicide should require an immediate assessment at the hospital, possibly requiring police intervention if the service user refuses voluntary hospitalization. A disclaimer attached to the document states that the screening is only to be used to determine need for further assessment and not to predict suicide. It is also not meant to "precede a clinician's clinical judgment".

Another assessment conducted at mental health settings is the mental status examination (MSE). The MSE is meant to be done throughout a social worker's relationship with a service user and is used to assess a service users' current state relative to their baseline (Robinson, 2008). It is also used to determine "whether a person suffers from symptoms of a mental health problem or major mental illness and the degree to which these symptoms impinge on the individual's life" (Regehr & Glancy, 2014, p. 87). At one setting, I was told to conduct an MSE at every meeting with a service user. With the MSE, the mental health social worker is assessing for signs consistent with psychiatric diagnoses, through considering a person's appearance, behavior, cooperation and reliability, speech, thought form/process, thought content, mood and affect, perception, insight and judgment, and cognitive functioning. For example, Robinson (2008) suggests how a person's attire may indicate mania if the person dresses flamboyantly with

a preference for the colour red, or schizophrenia if unkept. The MSE renders behaviours, thoughts, and presentations in medical terms and is recorded in case notes. The MSE is done to demonstrate that the social worker is actively assessing for risk, and any 'abnormality' should trigger further assessments.

As mentioned in Chapter 3, I had reviewed a risk assessment policy developed for client home visits that was available on the internal staff website at one of my previous workplaces, though this policy was seldom followed as it was not widely distributed. Contained within the policy were instructions on conducting a risk assessment. Involving five steps, the document began by instructing social workers to identify hazards. Hazard may include "chemicals, electricity, or broken steps", but also crowds, drug paraphernalia and pornography in a client's home, or an intoxicated client. The policy also asked the social worker to consider whether there is "a history of violent or aggressive behaviour by the client or others in the dwelling", "the violent/aggressive behaviour [is] directed toward a particular person or is it generalized", and the existence of "restraining orders against anyone in the household". With hazards present, the social worker should determine who may be harmed by the hazards and how; consider potential measures to mitigate or eliminate the risks; and implement these mitigating measures. Mitigating measures may include leaving an exit route, terminating a visit, and driving to a police station. These assessments should be done "at regular intervals".

Sometimes the risk being assessed may be external to the service user. The service user may have been a victim of violence or at risk of violence from others. Social workers may decide to assist the service user in seeking police assistance. Several interviewees provided examples of service users who experienced sexual or domestic violence and ended up seeking police

protection, though the outcome seldom led to safety. In response to these issues, the idea of contacting police sometimes came from the service users themselves, but other times, the social worker would make the recommendation.

While several risk assessment models were discussed, other interviewees described risk assessments as largely non-standardized. Several interviewees claimed there was no formal training provided. These social workers learned how to conduct risk assessments through observing co-workers' engagement with service users. Carrie stated, "I would hear intake workers ask, 'Do you hear and see things that other people don't hear or see? Do you feel like harming others? Do you feel like harming yourself? Have you ever attempted?'". Carrie explained that while it was unintuitive to ask these questions in everyday settings, overhearing other workers ask emboldened them to do the same. Chandra also suggested that they learned how to do risk assessments through informal instruction from colleagues.

Risk assessments are significant as they have "the effect of sealing the destiny of service users by determining whether or not an intervention or resource is required" (S. A. Webb, 2006, p. 74). Risk assessments were used by my interviewees to determine the next course of action. Chandra explained, "I think like doing a risk assessment or like a crisis assessment, an assessment of like what's happening, of the situation, helps contribute to how we respond to it". Depending on the risk levels, social workers may engage in de-escalation or bring in outside intervention. Outside intervention lies on a continuum, from offering to provide a taxi chit to travel to emergency short-term housing to calling upon a mobile crisis team or police intervention. Consistent with this logic, the Crisis Prevention Institute, in its non-violent crisis intervention trainings attended by many of those interviewed, divide crises into four levels as a

part of its “Crisis Development Model” (*Nonviolent Crisis Intervention*, 2011). The CPI suggests that assessing where a person falls within these four levels is a good way to predict whether the person will escalate into violence and this should be used to determine appropriate responses. At one end of the scale, the person in crisis begins to exhibit anxiety, before becoming defensive and angry, acting out in physical violence. The final stage marks the end of the crisis, with the service user returning to a state of calm. The Crisis Development Model will be further elaborated on in the discussion of de-escalation below.

Regehr et al. (2015)’s experimental study that assesses social worker clinical judgments around whether simulated clients required hospitalization (and thus, police intervention) shows some consistency with reports from my interviewees. Regehr et al. (2015) conclude that despite

> variability in clinical decision making[,] … [t]he strongest predictors of clinical judgment regarding the need for hospitalization were scores on [risk assessments, like] the Beck Suicide Scale and Columbia-Suicide Severity Rating Scale, suggesting that these measures are predictive of clinical decision making. This is heartening and demonstrates that clinical decision making was primarily based on well-known clinical indicators. (p. 299)

Significantly, considering the previous interviewee comments about the role of lived experience in shaping decisions around police intervention, Regehr et al. (2015) also found that “personal factors” served a mediating role, with younger clinicians and those who have experienced post-traumatic syndrome symptoms less likely to decide to hospitalize the service user.

Consultation

Before responding to crises, almost all interviewees consulted with colleagues or supervisors for advice or permission to proceed with a plan. Carrie stated, “I consulted with a social worker in the office. And I asked her, for this case, ‘I feel like I should call the police, do you think that’s the case?’” The social worker described this form of consultation as informal and impromptu, reaching out to whoever was physically nearby and available. As mentioned earlier, Sarah echoed these forms of informal team consultations, describing the use of a phone group chat app to “spontaneously” consult throughout the workday. This practice of consulting colleagues reflect findings from Walsh-Bowers et al. (1996). Hospital social workers interviewed by Walsh-Bowers et al. (1996) indicated that peer consultation allowed for the meaningful conversation about ethical practice given the degree of trust and lack of hierarchy between co-workers.

Helen explained that consultations serve as a check and balance, and to validate decision-making. Helen stated,

> How do we come up with these decisions? I would like to consult more because, in that way, if I'm making a wrong decision, somebody else can catch me on that. And we had a good team. We met constantly. It was helpful because other people have more experience and [social workers] can't just rely on what they themselves know.

Helen relied on their team for consultations to check whether there may be contrary perspectives and to be called out on if there were concerns, in recognition that others may offer different perspectives or experiences. Indeed, social workers interviewed by Rossiter et al. (2005)

explained that “dialogue helps us recognise our unconscious investments, our blind spots, unrecognised feelings, or unchallenged attitudes” (p. 96).

Helen added, “I like to consult also so that I'm not the only one making that decision”. A team consult allowed the social worker to share the burden of a difficult decision with the entire group. This sentiment appears consonant with how hospital social workers described the nature of their consultations reflecting a means to “cover your ass[, … mitigating] the fear of exposure, and the fear of vulnerability” (Rossiter et al., 1996, p. 309). Social workers approach consultations in this manner as they feared being perceived as incompetent or losing their employment (Rossiter et al., 1996; Walsh-Bowers et al., 1996). This use of conversation to justify potentially harmful practices like calling for police intervention by overcoming hesitancy also happens during debriefing meetings. I elaborate on the practice in the following chapter.

This reasoning also applied to consulting supervisors or managers. Supervisors were often available for consultation on site or through the phone. For some social workers, this was an optional resource. Helen stated, “generally you will call the on-call”, but because they “wouldn’t have time to call the on-call” in situations that they deemed as urgent, this was not always done. Sarah indicated that they would call only if there was a “liability issue or that it was a decision we were nervous about”. But in other circumstances, or in other settings, consulting the supervisor was mandatory or strongly advised. Patty reported this with their work in a residential setting,

> if we were to call the police, we’d have to call the on-call manager and get approval. If the on-call manager isn’t available, then the director. I’ve had to call the cops for missing person’s report before because the person had AWOLed. Even when it’s not about the

> police needing to intervene and go to someone's house, we always have to get approval from higher ups just to make sure that is the right step. I also think it's to make sure we aren't jumping to higher up to a different option than what would be recommended by the manager. I believe that is the policy.

Any call to the police would require permission from the manager or director. This applied to both calls for immediate police intervention in relation to an altercation or filing a missing person's report. The manager also ensured that the social worker did not call for police intervention when de-escalation from staff or other alternatives like a crisis team was sufficient. In another example, Valerie, who also worked in a residential setting, described how they were required to report to their manager any situation that entailed risk. This social worker was in close contact with the manager through a headset and GPS device, "that will track me everywhere I am during my work". Other studies have demonstrated that supervision meetings are perceived by social workers as a tool employed by managers for control and surveillance (Rossiter et al., 1996; Walsh-Bowers et al., 1996). Ultimately, most of my interviewees stated that supervisors tended to validate the clinical judgement of the social worker should they choose to call for police intervention.

Interviewee statements about consulting colleagues and supervisors to determine how to intervene are consistent with findings from some of the research on Canadian social work practices I previously introduced (Rossiter et al., 1996, 2005; Walsh-Bowers et al., 1996). Social workers at a family counselling agency, a hospital, and a child guidance clinic located at a school system, identified the centrality of dialogue, whether it is with "trusted colleagues or supervisors" (Rossiter et al., 2005, p. 93) or in team meetings, as a process to navigate ethical

dilemmas. Consultations ranged from informal “quick and dirty” (Rossiter et al., 1996, p. 308) discussions with co-workers to more formal supervision meetings with managers. But also consistent with my interviewees was the sense that dialogue was significantly inhibited by organizational hierarchies and external factors like financial constraints. Social workers gave examples of autocratic managers who monitored conduct and quashed honest expressions of viewpoints or of meetings serving as a platform for competition between different professions. These dynamics were born out of or exacerbated by factors like fear that substantive exploration of ethics could lead to damage to social work’s credibility in the context of threats to restructure and downsize the department within the agency (Rossiter et al., 2005). Just as Rossiter et al. (2005) argue that power relations impact ethical dialogic processes within social work settings, my research participant Chandra explained that managers may ultimately overrule decisions made by the team of frontline social workers. Chandra provided an example where the team felt that police should not have been called to address a crisis and thought that they could de-escalate and handle the situation themselves. Nevertheless, the manager disagreed and instructed the team to proceed with police intervention.

De-escalation and Intervention

According to Everstine and Everstine (2013), immediate intervention, including what might be understood as de-escalation, is necessary once a crisis is identified. Everstine and Everstine (2013) explain, “We view a crisis as an unstable situation, but one that has not yet escalated out of control. Without immediate intervention, the crisis will have the potential of developing into an acute emergency” (p. 7). The intent is to prevent a crisis from becoming an emergency where someone gets harmed. As stated, de-escalation tactics were used before

resorting to calling upon police interventions. Chandra stated, “calling the police with evictions and stuff like that was the absolute last resort, cause we at least try to de-escalate”. While this approach was never formalized in agency policies, managers often instructed social workers to approach crises in this manner. Shivani explained that before calls to the police at her workplace, social workers were required to first contact the supervisor to discuss possible alternatives. Maya stated,

> I don't know that they were formalized into official written policies, but there is definitely verbal discussions. And that was more like what are all the possible steps you could take before calling the police? So it was like, do this, de-escalate, try this.

Deanne, who works as a manager, also claimed,

> The whole goal is to be able to de-escalate that. As a supervisor of all staff, for the most part, I met weekly for supervisions [with] staff. My whole role is to just support the staff as well as help develop their skills and to make them competent by [encouraging them to use] client centred and strength based [approaches that avoided] getting into power struggles.

As a manager, she instructed staff to emphasize de-escalation as a goal and engaged in weekly supervision meetings to help staff develop de-escalation skills that prioritized the service user. In particular, the desire was for these skills to take precedence over antagonistic conflict between social workers and service users.

As mentioned in the discussion of risk assessments, it is suggested that the form of intervention must reflect the circumstances. Crisis intervention guidelines instruct social workers

to meet “verbal acting out” with verbal intervention, and “physical acting out” with physical intervention. The CPI argues that the response must be congruent to the behaviour, as a physical reaction to verbal acting out may escalate the behaviour, and a verbal intervention in relation to a physical acting out may be ineffective (*Nonviolent Crisis Intervention*, 2011).

Descriptions of de-escalation techniques practiced by interviewees closely resembled the approach outlined by the Crisis Development Model. The Crisis Development Model prescribes de-escalation and intervention techniques based on the state of the person in crisis as divided into stages. Beginning with anxiety, an individual exhibits a noticeable change of behaviour, such as pacing, finger drumming, and wringing of their hands (*Nonviolent Crisis Intervention*, 2011). According to crisis intervention literature, this is usually triggered by a failure of the person’s “habitual problem-solving measures” (Poal, 1990, p. 127) to address the stress experienced. The social worker should remain empathetic and non-judgemental, while attempting to alleviate anxieties through active listening (*Nonviolent Crisis Intervention*, 2011). According to Tanya, when de-escalation was practiced, the social worker ensures that they avoid “getting in [the service user’s] face” and provide space for the service user. Tanya agreed that social workers provide the space for service users to process their emotions, especially since the problem that may have provoked the crisis may not be easily solvable in the moment. Tanya explained that service users

> needed to know that you were able to sit with them in that moment and hold the moment without freaking out on them first. You have to show that you have the capacity for that. You might not be able to. I mean, most of the time you cannot solve whatever problems

> they have, but they need to trust you that you are going to be big enough to hold that moment with them.

This suggestion to hold space is also consistent with de-escalation techniques recommended by Hoff et al. (2011), which include instructions to "listen actively and with concern; encourage the open expression of feelings; help the person gain an understanding of the crisis" (p. 128).

Tanya explained that approaches to de-escalation like holding space were partly informed by service users they had worked with. Tanya stated, "we would ask the youth, 'what would you need right now' … the clients are fairly knowledgeable ... They will let you know what they need to do to still be in that moment with you" and avoid drifting back into crisis. These conversations with service users would also inform the use of more creative methods to de-escalate, such as by bringing the service user to a restaurant for a meal or escorting them home on public transit. However, they prefaced that this was only possible when there was already trust and rapport built with the service user. Typical forms of interventions by social workers at this point may also include facilitating "immediate medical care, separation of participations, medication, temporary shelter, disaster relief, vigiling or supervision by a trusted person, and hospitalization" (Everstine & Everstine, 2013, p. 7).

The next level in the Crisis Development Model is defensiveness, characterized as the start to a "loss of rationality", whereby individuals become belligerent and challenge "you, your institution, and your authority" (*Nonviolent Crisis Intervention*, 2011, p. 3s). The individual will use abusive language, which the CPI suggests is an attempt to test limits. Should the person detect that the social worker has lost composure—such as allowing the verbal abuse to affect one's professionalism and composure—the situation will escalate. In fact, some interviewees

reported this precisely happening. Patty recounted staff members instigating service users by acting antagonistic, sometimes because of grudges held against service users for past disruptions. Deanne stated,

> It was all a challenge for staff because, maybe a young person is saying something horrific to you. And you haven't slept. You had a bad night. I've got to be honest, most of the crisis, with the exception of suicides, happened as a result of escalating violence. That a staff was basically: "No, you're not doing that". You know what I mean? After that you're getting right down to their level to prevent that and that was very challenging for me as a supervisor, for often many of the staff provoked the situation.

This failure to practice de-escalation, such as by getting into arguments with service users, may instigate or exacerbate a crisis. Deanne added, “I would say 75 percent of the violent escalations could have been prevented had staff been able to, you know, not be so authoritative”.

Thus, the social worker is expected to begin setting limits in a directive fashion but coached in positive terms. Any limit set should be enforceable. For example, if the person is told that they would be removed from the area should they not calm down, the social worker should have the ability to follow through with the threat. Social workers interviewed reported the use of threat of consequences to elicit compliance. This use of threat was often framed as being “transparent” or “honest”. Deanne stated, “I always felt that by being very transparent with kids, letting them know what their options were and being really honest about it and allowing them to take responsibility and choose a different way worked the best”. Chandra similarly described how social workers would inform residents at a shelter that they may face eviction if they did not

cooperate. Chandra explained that the service user would recognize that, “if I don’t calm down, if I don’t try to resolve it, it could lead to my eviction”. With this recognition,

> most of the time, people come to talk to us, and then we talk them through [the consequences]. [We remind them that] these are the consequences of saying [certain things] out loud. I know you are just angry right now but if you repeat these things again and again. Then we have to take further steps. So, we lay out the consequences.

Chandra suggested that service users became more compliant after acknowledging the potential consequence of their behaviour.

The next stage in the Crisis Development Model is the “acting-out person”, a complete loss of control on the part of the service user that results in physical assault—whether it is against staff, other people, or themselves. The CPI suggests physical restraints as a possible response to acting out. With other means exhausted, the social worker should be “physically controlling [the service user’s] behaviour until he can regain control on his own” (*Nonviolent Crisis Intervention*, 2011, p. 4s). According to the interviewees, this was more common in forensic or developmental group home settings. Chapman (2014a) also discusses how the use of restraints is normalized in residential settings. While Deanne suggested that restraints were rarely used, it does come into practice with “really ill kids”. Patty also explained that while “in therapy I don’t restrain anyone, it’s more of verbal de-escalation, whereas in the res[idence] I was always taught physical restraints, because in the last case scenario, and again the residence is a different context”. Group homes were considered a unique context where physical intervention was allowed since, according to Patty, disruptive or violent behaviour, like when “someone throws a chair, tries to rip your hair out […] are guaranteed to happen”. This presumption of violence

from psychiatrized people is common in the mental health field (see Chapter 7), though the work of mental health social workers and police officers as instigators of this violence, as Deanne previously mentioned, is left out. Chemical restraints in the form of tranqualizing medication may also be used if previously prescribed “as needed” to the service user.

If verbal de-escalation or forced restraints fail, with the safety of the social worker potentially at risk, social workers are to remove themselves to a secure space. This often meant social workers locking themselves in the office. A manager at a forensic facility described a situation that led to this,

> [The service user] was becoming really violent, really aggressive really quickly. Fortunately, my office was right there with the metal door and I shut, I immediately locked my door. I was able within seconds to get into my door because I'm quite sure he would have hurt me very badly. All staff carry walkie talkies with them as well, so, I immediately advised all the staff to take the kids down to the basement area, lock the door and don't come out until I advised them for their own safety.

A disagreement about a decision made by the social worker had escalated into verbal threats and aggressive behaviour. Fearing for her safety and believing that de-escalation was not possible, she separated herself from the person and locked herself in the office, while instructing other workers to do the same in the basement. Other interviewees reported similar occurrences, usually in residential or shelter settings.

Interviewees reported that working in most other mental health settings meant they were not allowed to physically intervene due to legal implications and the danger it posed to the staff

and service users. Instead, physical intervention in this context would involve a call for police intervention. Interestingly, Everstine and Everstine (2013) argue that the police "can be valuable allies at various stages of an intervention" (p. 5). Unlike the understanding of most my interviewees that police interventions should only serve as a last resort, Everstine and Everstine (2013) suggest that police officers can "help a clinician defuse a crisis" (p. 5). While they do not elaborate on how this might occur, I speculate that they may be suggesting that the police's mere presence as an authority figure (Brigham & Marusek, 2017), and the threat of physical violence and entrance into the criminal justice system, may deescalate a crisis situation. The recommendation that police be recruited into the de-escalation process is alarming since as Mukherjee (2022) explains, the police often fail to engage in de-escalation, while also tending to use an aggressive and authoritative voice and quickly apply force—including lethal force. Preston (2021) adds that this police action actually "elevates the risk that harm, particularly physical violence, will occur" (p. 147), as Deanne and Patty also suggested. It should also be noted that these practices are inherently coercive in nature. Shivani also believed that social workers need to build relationships with police officers given that they operate within the same system, but suggested that this should be done in order to mitigate the potential harm of police interventions. For example, social workers may educate police officers to call in social worker-led crisis services instead of engaging in crisis intervention themselves or convince police officers to remain in the background and allow social workers to lead de-escalation efforts. This is not unlike recommendations made by Preston (2021) for social workers to mitigate police violence by providing firm directions to police officers prior to the intervention and de-escalating police officers when their actions may elevate the crisis.

Successful de-escalation should lead to the final stage in the Crisis Development Model. Labelled “tension reduction”, this stage involves a physical and emotional ‘coming down’ from the service user after the energy output from the crisis (*Nonviolent Crisis Intervention*, 2011). The CPI describes this as a “regaining of rationality” and control. It instructs social workers to use this opportunity to re-establish rapport by instructing the person in crisis to engage in deep breathing and to communicate next steps. The literature produced by the CPI does not consider the violence of restraints or police intervention and its impact on the physical and emotional wellbeing of the service user, not to mention the impact on the “therapeutic alliance”. As Kittrie (1971) contends, no meaningful therapeutic relationship can be established if the therapist serves as the guard and the service user is understood as a prisoner, occupying a “legally inferior” (p. 97) position. Instead, the focus is on how the service user could be “frightened” by their own “loss of control”, and not by the actions of authorities figures like social workers and police officers.

Only one interviewee remarkably referenced walking away as a de-escalation strategy in the face of imminent harm. Sarah described how her client “was screaming and yelling and she was really close up to my face and cussing and insulting me. I just had this feeling she was going to punch me. So, I stood up and I walked away. I just got off the street car”. This strategy was partly attributed to a desire not to have her client arrested, with Sarah suggesting that the client would likely have required years of therapy given how the traumatic nature of a police intervention. Sarah concluded, “The best option is probably to not get in their face or to walk away and maybe they'll sleep it off”. This response was seldom chosen, unfortunate perhaps, considering how other interviewees stated that social workers themselves often instigated and escalated crises.

Conclusion

In summary, I explore the subjectification and learning process in relation to practices of calling for police intervention. A consistent comment from research participants was that there was little mention of police intervention in agency policies. The OCSWSSW Code of Ethics and practice guidelines were also not often consulted. Instead, interviewees described the regulating body as exuding a panoptic influence, as social workers worried about the potential of discipline should they contravene expected practices. Education and training workshops informed social workers' knowledge of limits of confidentiality, de-escalation practices, and risk assessments. But ultimately, subjectification and learning were more likely to happen informally, through conversations with and observations of colleagues. This subjectification and learning process influences mental health social workers in their practices around police intervention, beginning with the development of a safety or crisis plan. These plans served to normalize and warn service users of the potential for police intervention, and provided social workers with a basis to assess risk. Mental health social workers also engaged with family members, informing them of the police intervention process, assuaging any hesitations, and encouraging them to also make calls for the police when concerned about safety. Throughout the working relationship with the service user, the mental health social worker engaged in risk assessments, ascertaining the service users' mental state and potential for harm. Should there be concerns, mental health social workers would consult with supervisors or colleagues before responding to the crisis. Alarmingly, some interviewees reported that social workers themselves were often the instigators of crises, through forceful and antagonistic behaviour. Some crisis intervention theorists argue that police officers can be incorporated into the de-escalation process, but research and

comments from participants suggest that this was much more likely to inflame and exacerbate the circumstances, leading to significant harm to service users. More commonly, police intervention was only initiated when de-escalation, including verbal practices and physical restraints, from social workers have failed.

Chapter 4: Police Interventions and the Legal Mechanisms and Programs that Facilitate it

After engaging in the steps outlined in Chapter 3, including engaging in risk assessments, consulting supervisors, and attempting de-escalation, police intervention was brought in, usually through a call to the emergency dispatcher or through a court order (i.e. “forming”). This chapter explores, alongside existing literature, the steps involved in initiating police interventions, the process of police intervention, and follow-up practices. During a call for police intervention, mental health social workers often had concluded that there was imminent or potential harm, though this was often contested. When possible, social workers would inform the service user that police had been called, and information about the service user would be shared to the police. Police interventions were often violent and degrading, resulting in the service user being apprehended and brought to a hospital emergency department for psychiatric assessment. When service users refused to comply, force was used, and in some cases, this resulted in death, a consequence that disproportionately impacts BIPOC and mad people. After police intervention, social workers were required to engage in incident reporting, producing reports for client records and critical incident databases. Finally, social workers both received debriefings and facilitated debriefings for service users that were the targets of police intervention. The second part of the chapter explores how the practice of police intervention for psychiatrized people is facilitated and informed by mental health law. The historical roots of mental health law in Ontario are examined, along with the specific legal mechanisms and programs—including Section 17, Form 1 and 2; Community Treatment Orders; situation tables; and co-responding police mental health teams—that produce the collaborative relationship between mental health social workers and the police discussed throughout the dissertation.

Making the Call and Follow-Up Practices

Calling the Police

When de-escalation has failed and there is a risk of harm to the service user or other people, social workers often decide to call the police. Social workers, according to Liegghio et al. (2020), may understand police interventions as a component of de-escalation, consistent with the framing by Everstine and Everstine (2013) previously cited. Liegghio et al. (2020) also states that child and youth mental health practitioners "access[] police services most often for support to deescalate high-conflict, physical, verbal, or emotionally charged situations" (p. 122) and that "in most instances, concerns for the safety of the child or others, in particular family members (when at home) or other residents or staff (in the case of residential programs) were determining factors for calling police" (p. 122). Many of my interviewees also described situations where calls for police intervention occurred after physical or verbal conflicts, or emotionally charged situations, escalated to a potential for harm.

It is important to note that there is not always consensus on what constitutes harm. For example, I recall a time when police were called upon at a housing site after a service user had become argumentative when maintenance workers attempted to access their unit without prior notice, as required by law. I did not believe there were any legitimate risks of harm and felt that the service user had good reason to be upset and protest. Chandra also cited examples of managers overruling frontline workers who felt that there were still opportunities to de-escalate and prevent harm without calling the police.

Risk and harm sometimes intersected with discipline, the enforcement of rules at social service settings, and especially residential sites (see Chapter 8). The contestation around definitions of risk and harm will be further explored in latter chapters. And as stated in the section on risk assessments, social workers may deem a service user to be at risk if there is an inability to make contact and there is a presence of further red flags. In this situation, a social worker may call the police to conduct a welfare or wellness check. Though there is a lack of a formal definition, wellness checks generally refer to police officers attempting to make contact to ascertain the wellbeing of the individual. Pearce and Simpson (2022) explain, in their study of emergency call data from a mid-sized police agency in Western Canada, that most calls for wellness checks came from the public—with 7 per cent of calls coming from hospital, mental health, or care-home staff—and may involve concerns about a person's mental health, physical health, or "behaviour, which could appear unusual and/or out of character (e.g. not reporting to work)" (p. 402). Other examples may include neighbours not making an appearance for an extended time, a senior not making a regular phone call and not picking up calls, and a friend experiencing suicidal ideation sending a suspicious text message (*What Is A Police Welfare Check?*, 2019). Sarah explained that the reasoning behind a social worker calling for a wellness check is that when service users "hear the cops at the door. They're more likely to answer and just confirm that they're alive, than if [it's] their workers at the door and they just don't really want to see me".

Social workers interviewed usually informed service users before calling the police. Sally explained to the service user that making the call for police intervention was due to worry for the individual, "I'm worried about the level of stress that you're under. And I'm really worried about

what could happen". Sally was very apologetic for making that decision when explaining. Naomi would explain what police intervention might look like to the service user before making the call. She felt that service users were more at ease after their explanation.

Some social workers also considered risks to service users before making the call. Tanya explained that a colleague made sure that a service user did not have any illicit drugs present on the scene before they called the police after discovering that the service user had engaged in self-harm. They also gave the example of avoiding calling the police and emphasizing finding unorthodox solutions when a service user who was contemplating suicide was also involved in drug dealing and sex work. They worried that the service user would get into trouble for their participation in the informal economy. Tanya added that they would be especially cognizant about service users' immigration status and would generally avoid calling the police for service users without status. Tanya also avoided documenting anything regarding immigration status. The importance of considering these factors before making a call is apparent in an incident recounted by Sarah. Sarah had convinced a service user to report a domestic violence incident to the police. When they arrived at the police station to do so, the service user was themselves arrested as they had an outstanding warrant. Marginalized peoples face dangers when meeting the police even in circumstances where they themselves are seeking police assistance (Incite! Women of Color Against Violence, 2016).

When some social workers called 911, they would ask for a mobile crisis intervention team to be sent instead of regular police officers. Naomi stated,

> The mobile crisis would be the step before the police. The police would be the last step. If you could get through mobile crisis, they may have some difficulties getting to the location, then the police are the last step.

The presumption is that a mobile crisis intervention team, an example of a co-responding police mental health program that sends teams made up of a mental health worker in addition to a police officer to crises, would "have more of an understanding" to handle a mental health crisis and would be less likely to rely on force, according to Patty. Nevertheless, seldom is the request met. Naomi explained,

> I have never [been able to have a mobile crisis team sent]. Sometimes when you call them, and they are like ok, there are nobody on staff, all the people are out, so they give us the option of going to the [regular] police.

Multiple interviewees indicated not being able to access the mobile crisis team. These experiences are supported by reports that Toronto's mobile crisis intervention teams are only able to attend to 20-25% of non-violent mental health calls because of a lack of capacity and costs (Reach Out Response Network, 2020). Deanne, a manager at a forensic site, said that mobile crisis teams can be used when a mental health crisis is anticipated and slowly escalating. In that situation, the mobile crisis team can be scheduled in advance. However, this was not an option when there was an immediate need to respond to a crisis.

Most social workers interviewed agreed that the police were brought in as a last resort and tried to access other crisis services before calling for police intervention. As Helen stated, police intervention was only used "when you saw that there was no other option. And I think we

always try to go another option. Even within our department, like even with these, with this young woman, the first thing was not to call the police". Maya added,

> We look at all the possible steps you could take before calling the police. So, it was like, do this, de-escalate, try this. And then there was discussion of when you did call the police was there are options to ask for a nurse? Were there options to say can you send only a few people, or can you wait outside?

Maya suggested that social workers go through a continuum of strategies attempting to access what could be understood as less intrusive and violent before bringing in the police as a last resort. Some social workers also mentioned attempting to specifically request an ambulance instead of the police when speaking to the 911 dispatcher. But Carrie stated that often, "the police would […] come with ambulance" any time a crisis was reported to the 911 operator. This was especially the case for people detained at forensic facilities.

When a social worker decided to call the police, they would provide information about the immediate risk and the pertinent details of the service user to the emergency dispatcher. If the service user was not on location, the information provided might also include the service user's name and address in order for police officers to locate them. If the social worker was also at the scene, upon arrival of the police officer, the social worker might brief the police officers on the location of the service user and further contextual details about the situation. According to Carrie, social workers relied heavily on information stored in client records held in the agency database for these contextual details. For example, I recount a time when a colleague shared with the attending police officer that the service user being responded to for self-harm had military experience, information gleaned from case notes summarizing an intake interview. The police

officer stated to our team that based on this information, they were going to approach the service user more carefully and place them in handcuffs.

Some interviewees emphasized that information sharing during their conversations with dispatchers and police officers was done in order to "control the message". This is akin to Preston's (2021) suggestion that being directive by explaining the situation and the expectations for police officers could mitigate harm. While mental health history is often used to justify violent intervention in relation to presumptions of risk of violence for psychiatrized people, some social workers felt it would lead to more understanding and patience from the police if they drew attention to the service user's mental health diagnoses and framed the incident as related to emotional distress. Sally stated that they told the 911 operator that "the [service user was] sort of fragile in terms of their mental health and not indicating any harm". Naomi would also report that the incident is of a mental health nature. In one case, where a police officer appeared to be more experienced handling mental health crises, Naomi indicated that the police officer themselves initiated inquiries about "a history of trauma, and a history of trauma with police in particular". Naomi perceived this police officer's intervention as empathetic, caring, and prioritizing the safety of the service user. Though, as will be discussed, this is more an exception than the norm.

Police on the Scene

With the arrival of police officers, their mere presence was often sufficient to draw compliance from service users. This process is illustrated by Sarah's discussion of wellness checks. Sarah explained that unlike police officers, social workers may often receive no response from service users during an attempted home visits because of shame, not wanting the social

worker to become aware of a relapse or deterioration in their state of living. The service user was more likely to respond to a police officer because “you know that you're going to be in trouble if you don't answer the door or especially if there's a repeat knocking or that the door is going to get opened anyways”. Service users would open the door because they fear legal or physical repercussions if they fail to do so. They may also feel it was inevitable that the police would obtain access to their dwelling despite their refusal, and that resistance was futile. Ultimately, it was the threat or actual use of force that secures compliance from service users. The police have discretion in whether to use force or the amount of force used, with some protections from legal liability, based on section 25(1) of the *Criminal Code*. Lethal force may also be used if the police officer believes that it is necessary to prevent death or grievous bodily harm (Whitehead, 2016).

Naomi felt that because her clientele was primarily youth, police officers treated them with more understanding and patience. Naomi stated,

> the approach that they take, I don’t know if it’s because of the younger population and how they conceptualize the younger population, but they come with a sense of understanding. The way they engage, the way that they talk, they don’t put any handcuff on the young person, they walk out willingly, and the young person walks with them willingly, and they are reassuring.

This is consistent with child and youth mental health workers interviewed by Liegghio et al. (2020), who described how

> positive police encounters were associated with the use of their roles, mandates, and, importantly, their authority to create and hold a space, both physical and emotional, that

> made the child and caregiver feel they were listened to, heard, understood, and ultimately, respected. (p. 123)

However, most interviewees described police officers as impatient and aggressive. When service users refused to comply with instructions given by police officers, force was used. The legally required level of compliance for a mental health apprehension remains unspecified under case law (Whitehead, 2016). In *Policing: A View from the Street*, a seminal ethnography on policing, Van Maanen (1978) explores typification assigned by police officers to people they intervene on, contending that the most stigmatized label was assigned to people that disagreed with or refused to comply with police expectations. These people were often subjected to physical violence because of their defiance (R. R. Johnson, 2011; Terrill & Mastrofski, 2002; Van Maanen, 1978; Worden, 1995). Though Van Maanen (1978) also argues that the officer's perception of capacity to cooperate (and one would presume someone understood as mentally ill would not be thought of as fully capable) could contribute to leniency, this conclusion does not fully bear out in empirical evidence, such as with the disproportionate arrests of psychiatrized people stemming from police encounters (R. R. Johnson, 2011).

I once witnessed the use of police violence during an attempted enforcement of an order for involuntary hospitalization. The service user, upon being told that the police officers would be escorting them to the hospital, requested to see the form ordering hospitalization that was signed by a psychiatrist and explained that they were willing to comply as long as they saw the document. Instead of respecting this request, the police officer displayed a notepad, mockingly claiming it was magical with the ability to transpose the form they had left in their vehicle. The

service user then attempted to close their apartment door but was tackled and dragged out to the police car through icy grounds.

In another example of police escalation and use of coercion to elicit compliance, Eva reported that the police were sent to apprehend her client, after a family member had called the hospital to report symptoms of psychosis. Since he was already under supervision of the Ontario Reviews Board (ORB) due to a previous not criminally responsible (NCR) conviction, a further refusal by the service user to attend to the hospital for assessment led to the ORB issuing a Form 49. A Form 49 orders police officers to apprehend and deliver a service user to a psychiatric facility for committal if ORB instructions are not followed by the patient (North Bay Regional Health Centre, 2017). With the service user refusing to open the door for the police, a tactical unit with submachine guns was ordered to the apartment. In preparation for the apprehension, a tactical officer placed black tape over the peep holes of neighbouring apartments. Despite pleas from Eva for the police to de-escalate and attempts to "humanize" the service user, the tactical officers intended to knock down the apartment door, with one officer remarking that the service user "could get killed". The situation was finally resolved when the service user eventually opened the door and raised his hands as ordered by the officers. The officers then cuffed him and brought him to a hospital via police car.

There was also an example provided of violence being perpetrated by the police after the immediate task of securing or forcing compliance from a service user was already fulfilled. Deanne reported that a minor transported by the police to her forensic facility was covered with bruises; "his face was a mess". When asked what had happened, the minor explained that he had run away from police officers sent to apprehend him. He had refused to comply with their

commands to stop, and when they finally caught him, they were angry and beat him up as reprisal. Deanne indicated that proper procedure should have involved bringing the minor to a hospital for immediate medical assistance, but that the police likely wanted to offload responsibility of care to somebody else. Deanne also suggested that "some agencies ran their facilities like maximum detention jail centres … and really didn't care", speculating that the police officers "were just hoping that would be the case", that there would be no follow-up or accountability in response to the injuries.

As is apparent with these examples, service users facing apprehension would often face threats of violence, or physical violence, including being tackled, struck, restrained, and handcuffed. This would occur even if social workers urged police officers not to use force. When Eva pleaded with police officers to deescalate, not only did they refuse to listen, their commanding officer even made a threatening phone call to Eva the following day, accusing them of acting inappropriately by challenging the officers and asking too many questions. Chandra's suggestion for officers not to use handcuffs as the service user did not pose a threat was similarly met with dismissal. While handcuffing appears to be a standard procedure, it carries symbolic significance given its association with criminality, and services users and family members alike have expressed concern about its use (Liegghio et al., 2020). Other attempts to mitigate police use of force, such as Maya asking that only one police officer instead of an entire group approach the service user, were also met by dismissal.

Other phrases used by interviewees to describe police action include, "dragged her out", "intrusive", "very confrontational", "very aggressive", and "made her feel very unsafe". Skeem & Bibeau (2008) echo these descriptions, stating that police violence may also involve the use of

force with “hands on, arm lock, handcuffs, pepper spray, Taser, or low-lethality gunshot with beanbags” (p. 202). Johnson (2011) has found that police officers use greater force for “mentally disordered persons” (p. 132). The Commission for Public Complaints Against the Royal Canadian Mounted Police has found that Royal Canadian Mounted Police officers used conducted energy weapons, including tasers, in 49.6% of mental health incidents, much higher than 39.2% for cases overall (*RCMP Use of the Conducted Energy Weapon (CEW): January 1, 2009 to December 31, 2009,* 2010).

Johnson (2011) suggests that the higher rates of police use of force may be because “people with mental disorders may have a higher likelihood than the general population to display a hostile demeanor, brandish a weapon, or fail to comply with an officer’s commands” (p. 132). Michalski (2017) also attributes police aggression to police officers perceiving mad people as “pos[ing] a threat to officers, who must respond in a matter of moments to nerve-racking challenges from unpredictable members of the public” (Michalski, 2017, p. 7). But as discussed in latter chapters, it must be noted that perceptions of hostility are closely intertwined with the conception of madness as tied to dangerousness and violence, especially when also interlocked with racialization and class distinctions. Police commands should also not be understood as self-evident, and resistance, such as by failing to comply, should not be presumed as problematic. Graeber (2012) also challenges the presumption underlying Johnson’s (2011) analysis that force is exceptional or a selectively used police tool. Instead, Graeber (2012) argues that inherent to policing is “the subtle or not-so-subtle threats of physical force that lie behind everything from enforcing rules [...], to the threats or physical intimidations or attacks that underpin the enforcement of tacit gender norms” (p. 106). The police in Canada are the few

allowed to openly carry weapons, advertising this threat of force. Violence is functional as it serves to "obviate the need for what I would call 'interpretive labor'" (Graeber, 2012, p. 117). Violence absolves police officers of the need to understand the mad people they are intervening on and allows for arbitrary decisions to be imposed.

Police violence can have serious implications for service users in relation to psychological trauma, in addition to physical injuries or death (American Public Health Association, 2016; Aymer, 2016). As discussed in Chapter 1, from 2000 to the first half of 2020, there were 555 cases of fatal police encounters. Black and Indigenous people were disproportionately represented, and a 68% majority was labelled as "suffering with some kind of mental illness, addiction or both" (Singh, 2020). Similarly disproportionate numbers were found in British Columbia coroner's reports (Lupick, 2015), and a significant number of police shootings involved mental-health crises nationwide (Slinger, 2015). Contact statistics nationwide also illustrate the broad scale of policing in relation to mental health crises (Boyce et al., 2015; Szkopek-Szkopowski et al., 2013), and studies have shown that these police contacts are growing in Canadian cities (Iacobucci, 2014; Szkopek-Szkopowski et al., 2013).

Though police officers generally have discretion to arrest the person in crisis, bringing them into the criminal justice system should the person in crisis be suspected of committing a criminal or statutory offence (Whitehead, 2016), in the majority of examples provided by interviewees, service users were brought by the police to the hospital for a psychiatric assessment. Section 17 of the Ontario *Mental Health Act* authorizes police officers to engage in apprehension if they witness threats or acts of harm in relation to a mental diagnosis. Police officers may also be sent to apprehend and escort individuals to a hospital based on a Form 1 or

2. These practices will be elaborated on later in the chapter. In the case of wellness checks, usually if the police officers felt that the service user was stable and had the capacity to make decisions based on their observations, no further action would be taken. But according to Sarah, if police officers felt that the service user was unwell, they may call on a mobile crisis team to have a psychiatric nurse conduct a capacity assessment, "a quick verbal assessment face to face with a person to determine whether or not they have the capacity to basically continue living as they are". More frequently however, due to the lack of availability of mobile crisis teams, police officers would bring the service user to a hospital emergency room for assessment.

The underlying rationale for apprehension, besides obtaining medical advice and treatment, is that social workers "cannot allow that person to return to the same environment, without the support that they need to ensure that they are safe," according to Fiona. Yet, unsurprisingly most service users did not feel a sense of safety while being detained against their will at a psychiatric facility. Eva stated, "the hospital is a place that feels very oppositional and harmful to [service users] … it's the same experience that people have in prison where you have to do what they tell you to and everything is recorded". Deanne explained that forensic patients transferred to a hospital from a detention facility would be put under even greater surveillance, with a police officer and a detention facility staff member stationed at the hospital room. The staff member would make observations and report regularly to the manager of the detention facility. While some individuals may attribute benefits to hospitalization—such as access to meals, a clean bed, or a sense of safety, these concerns regarding coercion and surveillance in relation to involuntary hospitalization have long been raised by psychiatric survivors (Capponi,

2005; J.-E. Lee, 2013; Morrison, 2013; *Organizing Guide for Psychiatric Survivors*, 2019; Prism, 2019; St-Amand & LeBlanc, 2013).

Incident Report and Case Notes

After the crisis is 'resolved', social workers were required to complete incident reports. Patty explained that incident reports must be filed anytime there is a serious occurrence,

> a serious occurrence could be if a client took their life or stuff related directly in terms of our work. In the moment, if we did have to call the police, it would just be based on high safety concerns, and we would have to fill out one of those forms to document it.

Chandra and many other interviewees reported the same requirement, that "any time after the ambulance or police are called to the shelter, you have to write a report".

Chandra stated, the incident report may come in the form of a questionnaire with "basic question like you had to record like the hospital, like if you called the ambulance what was the ambulance number. If you called the police, what was the police badge number". Other agencies asked for a written report, but consistent with all incident reports was the objective of capturing "a description of what had happened", as well as "the situation beforehand that led to the escalation", according to Vanessa. Every step of the process should be carefully documented, including the specific timeline and identifying information for people involved, including police officers or paramedics. Social workers were also asked to note down the service user's mental health status, which includes aspects like appearance, mannerisms, and affect, before and during the crisis incident.

Some agencies required the social worker to submit multiple incident reports, especially in cases where the agency received external ministerial funding. Patty reported submitting documentation to a ministry and having to speak directly with a government bureaucrat to explain why they had called the police and the context of that call. Carrie explained that they submitted an additional report to the Ministry of Youth and Child Services. Carrie believed the reports were used as a means to compile data in order to identify communities with higher needs.

Valerie questioned the efficacy of incident reports and did not understand their purpose. Valerie stated,

> That's why I don't take it so seriously. Because after that, nothing happens, they just put it on file. They just put it on file, like it's all on paper. It was good because they have to record it. They, let them, but after nothing really happens.

Ambivalence towards this form of record keeping was not unique. Tanya expressed that they found it cumbersome to have to submit a report, to the point where it made them hesitant to call on police intervention as they did not want to have to complete the paperwork. This was in addition to concerns regarding police interventions on ethical grounds. Tanya felt the incident report was designed to "hold practitioners accountable". Tanya had to submit the report to a government ministry, and felt that the inclusion of "whole names, addresses, what exactly we were doing what, what led to what" was meant to ensure there was a record of who was responsible for doing what, in case there was a need for discipline or follow-up in case of malfeasance. Deanne explained that incident reporting was done in accordance with provincial government regulations, a prerequisite to accreditation for their forensic facility. Deanne stated, "the province would come in to absolutely ensure we were following all of these protocols in

every situation". A major component of accreditation was paperwork, and "when it comes to crisis intervention and having to contact the ministry, the timeframe was written in stone".

Incident reports were entered as a part of service users' case notes into the agency's client database or into a separate database of crisis incidents, informing future treatment decisions for the particular client. The case notes also allow for continuity—such as when the primary worker is away or the service user is transferred, and serve as an educational tool for future scenarios requiring crisis intervention. In fact, Lillis (2017) suggests that problems with case records have often been blamed for incidents resulting in tragic outcomes.

Record keeping is an important component of the CASW and OCSWSSW code of ethics and standards of practice, requiring social workers to "keep systematic, dated, and legible records for each client or client system served" (*Code of Ethics and Standards of Practice Handbook*, 2018, p. 19). There is also further stipulation that the records "be in a format that facilitates the monitoring and evaluation of the effects of the service/intervention" (*Code of Ethics and Standards of Practice Handbook*, 2018, p. 19). Pamela Blake (2010), the deputy registrar of the OCSWSSW, adds that client records serve to help with "understanding the client and planning the goals" (p. 1). Client records are also done to limit liability, by being "evidence of the services rendered", and is especially useful to "account for their work" when "a complaint is made to the College about the conduct or actions of the member" (Blake, 2010, p. 1). Webb (2006) adds that risk narratives in case notes are written by social workers precisely in a way to justify decisions made and actions taken. Finally, client records serve as a means of surveillance, another tool alongside supervision meetings and debriefings for managers to monitor the work of social workers (Lillis, 2017). Lillis (2017) contends that this latent purpose is reflected

especially when case records are written in a present to past temporality, whereby the record is meant to be used as evidence for monitoring purposes. That said, case notes are also written in present to future temporality—especially when oriented towards future treatment.

According to de Montigny (1995), practices like report writing constitute "inscrib[ing] particulars into the structures of an organizational order" (p. 29). It allows every day/night activities to be visible, understandable, and actionable from an institutional perspective. Following D. E. Smith, de Montigny (1995) explains that these practices are ideological, involving the detachment of these activities from their social contexts, which are then "glued back together into some pattern using 'mystical connections' derived from an institutionally grounded social discourse" (p. 31). One such discourse dominant within mental health settings is the medical model, and the particulars from these incident reports may be framed and interpreted through that lens. The medical model ascribes fixed essential characteristics to disabled people, with a view to cure or fix, but with little consideration of how disabled people may themselves conceptualize their disability (Withers, 2012). Details surrounding a conflict stemming from concerns about privacy contained in an incident report that is then uploaded onto a service users' file in the agency database may be transformed into symptoms or behaviours precipitating mental decompensation. This reframing can then be used to justify or enact coercive practices in the future should observed behaviours be made to match the details contained in the report. For example, I once observed a social worker colleague engage in this reframing process with a service user singing out loud. While a person doing so in another setting may be perceived simply to be in a content mood, the social worker consulted the service users' case notes and concluded that this must be a psychotic symptom related to a schizophrenia diagnosis. The social

worker then informed the psychiatrist who increased the dosage of the anti-psychotic medication prescribed. The social worker noted the day's happenings in the client's case note and now the idea of singing out loud as requiring intervention for this service user is made into a self-evident truth for whichever health professional consults the documents in the future. And while these reports are usually kept confidential within an agency unless the service user provides consent, social workers may consult these documents when writing referrals to other services. Consequently, certain documented narratives may follow the service user throughout the mental health system, connecting a mental health setting with the translocal. As D. E. Smith (2005) explains, "The capacity to coordinate people's doings translocally depends on the ability of the text, as a material thing, to turn up in identical form wherever the reader, hearer, or watcher may be" (p. 166). Case records can connect a local mental health setting translocally, a means in which actors or practices can exert ongoing influence over a service user, including that related to police intervention, even if unintended. A previously cited example of a social worker informing attending police officers of a service user's military history after consulting client records exemplifies this point.

Debriefing with Social Workers and Service Users

In most agencies, the manager debriefed with the social worker after a serious incident involving police interventions. Some interviewees like Chandra and Eva, described formal meetings that occurred either with the entire team of social workers or just with the supervisor immediately after a crisis incident or the following day. Sally mentioned debriefing with an outside clinical consultant contracted by the agency to provide feedback, exploring "moment by moment sometimes to think about what was my decision-making and what could have gone

differently and how did that feel for me and what was that like for the client and the transference and the countertransference". Other interviewees described much more informal check-ins. For example, Carrie reported that she did not receive debriefing meetings in person. She would instead receive a quick phone call from her manager expressing concern about the crisis incident but with no further exploration of the incident. Vanessa similarly stated,

> Essentially, there's a phone conversation, and that's pretty much it. And it's not really talking much about what happened. It's more just like, are you OK? How are you feeling about this? And that's pretty much it.

Debriefings were ostensibly done for the emotional wellbeing of the worker. Chandra stated, "we had a debrief after the meeting, after everything happened, because it was very violent and upsetting for all of [the workers]". Debriefing meetings for Chandra involved the supervisor leading a discussion about what had happened during the crisis and its emotional impact on the social workers. Maya explained that the manager "made space to process, like people's feelings, like impacts around that". Patty also pointed out that debriefings were "just to make sure my mental health and what not was also taken care of". Debriefings may also provide space to analyze the event. During a debriefing attended by Chandra, the social work team and their supervisor noted how differently the police handled a service user who was White, applying much less force compared to a service user who was Black. This team also tried to explore alternatives to police intervention, a practice reported by multiple interviewees. These attempts were largely fruitless however, as debriefings were seldom successful in eliciting concrete suggestions. Maya stated, "I think the challenge in this case was literally just not knowing what else to do".

That said, there were also limits to what was examined during debriefing meetings. Eva complained that a supervisor during a debriefing did not consider the emotional hardship stemming from political disagreements with clinical practices. Eva expressed that "it was frustrating because I felt like she expressed feeling concerned for me, but she wasn't listening to what was causing me a lot of distress". Tanya also felt that team debriefings served to depoliticize crisis incidents. Tanya indicated that on the one hand, team members that adopted anti-racism as core to their political consciousness "thought [the team] should try at all costs not to bring the police". On the other hand, Tanya observed other colleagues expressing racist sentiment by "cherry picking clients" and specifically avoiding "Black male youth because they were afraid of working with [them]". The problem was that there was no chance to discuss these political differences in the context of a debriefing. Tanya added, "there wasn't any encouragement to talk about these hard to talk about things … there was orientation in the agency to divert to depoliticizing all these decisions". Instead of considering the political context, the framing was that "it's because of someone's personality that they did call or not call the cops". In other words, there was no recognition of the possible role of "anti-Black racism, harm reduction, or social justice orientations" in these determinations. Decisions were naturalized. The social worker speculated that the depoliticization may be tied to avoiding burn out that conflict may exacerbate.

The refusal to engage with politically contentious issues may also reflect the nature of mental health teams and the function of meetings as a means of eliciting compliance and consensus around problematic practices. Indeed, Burstow (2015) argues that it is precisely the cohesiveness of mental health teams that can create the conditions that allow for violence.

Violence is normalized through shaming members of the team that question violent practices, for being uncooperative. Chapman (2014a) finds resonances of Nazi practices in these social work debriefings. During the Nazi regime, 'average' people were transformed into perpetrators of violence through specific techniques. Eichmann and other Nazi operatives used rigid "language rules" or "winged words" in describing the daily atrocities of the regime. One of the more prominent examples of this was the representation of violence in medical terms, derived from the orders given for the construction of the first gas chambers for people with disabilities. The decree from Hitler issued in 1939 stipulated that "incurably sick persons should be granted a mercy death" (Arendt, 2006, p. 106) and was initially focused on people labelled mentally ill. While this program still faced opposition and was stopped in 1941, it demonstrates the use of language to obfuscate the violence of the act, framing the act of murder as the result of objective insights and done for the purpose of the betterment of society. Other examples include terms like "final solution," "evacuation," "special treatment," "deportation," or "change of residence" (Arendt, 2006, p. 83). Nazi operatives used this language as "they proved of enormous help in the maintenance of order and sanity in the various widely diversified services whose cooperation was essential to this matter" (Arendt, 2006, p. 83), soothing the conscience and overcoming the "animal pity" (Arendt, 2006, p. 104). Chapman (2014a) recounts how social workers understood violence as something to be "psychologically 'worked through' and 'overcome' rather than politically and ethically attended to" (p. 6). Workers who participated in restraining residents were often debriefed in acknowledgment of the instinctual discomfort with this type of work, but ultimately, with the intention of having workers "accept perpetrating violence as necessary" (p. 7). Social workers that resist against these efforts to engender acceptance may be unwelcomed by managers or colleagues (Burstow, 2015). Eva suggested that various health professionals did

not want her involved with interagency meetings where debriefing would occur since she would challenge team cohesion by critiquing mental health practices and the medicalized framing of the service user.

Debriefings are not only facilitated for social workers, they are also done for service users after critical incidents. Hoff (2011) prescribes a follow-up debriefing initiated by the social worker as crucial to the crisis intervention process, since people experiencing crises, especially that of a life-threatening nature, may not be able to reach out for help on their own initiative. Debriefing serves to allow service users to process their emotions related to the crisis and "accept the reality of what has happened" (Hoff et al., 2011, p. 477). Many of the social workers interviewed would engage in debriefing the service user after police intervention for this purpose. The hope was also to re-establish the therapeutic alliance. During a debriefing with a service user Sally had called the police on, Sally helped the service user process their emotions after what was described as a "scary" and traumatic situation. Vanessa also debriefed their service user, allowing the service user to discuss their experience of being apprehended by the police. In this case, the service user did not blame the social worker, rationalizing that while the social workers on duty could have showed more empathy and avoided calling the police, they may have been overworked, causing a misjudgement of the situation. This generosity shown by the service user is especially astonishing when we consider Deanne's comments in Chapter 3 that most crisis situations in her workplace were instigated by antagonistic behaviour from mental health workers. In other circumstances, such as the use of police intervention for the purpose of eviction at a shelter or residence, no debriefing with service users would occur as there would be no further contact with the service user.

However, police interventions were ultimately a major detriment to the therapeutic relationship between the social worker and the service user. Valerie stated,

> if we started to call the police, we would become the enemy for our clients. And we actually are looking to have a trusting relationship. You have to be really smart when you're calling the police because you're fully aware that they can actually harm you sometimes with the poor judgment they have.

The potential for harm from police intervention affecting the service user's trust in the social worker meant that the social worker must be careful when deciding to bring in the police. Sarah described how service users would often feel a sense of "major betrayal" as "vulnerable details of how [they're] feeling in [their] darkest hour" can be used to justify police intervention. Thus,

> you're not only potentially traumatizing your client needlessly, but you're really jeopardizing your relationship. If the client doesn't trust you, you can't do anything for them. You can't do your job and you're useless to them.

Sometimes, outside actors forced an end to the working relationship between a social worker and a service user because of disagreements over social work practice. Eva was discouraged from debriefing a service user as the agency ordered an end to the service relationship after allegations of "unprofessional behaviour". A police officer had complained about interference with police action, since Eva had advocated for the service user, and a hospital manager complained about boundary crossing, since Eva was observed bringing snacks to the service user's room after the apprehension.

Mental Health Law and Other Collaborative Mechanisms

Mental Health Laws

The collaborationist arrangements and calls for police intervention in relation to mental health crises and psychiatrized people discussed largely exist as mechanisms within Canadian law, much of which is stipulated within mental health law. Ostensibly, mental health law is meant to have the objective of ensuring access to healthcare, and protecting patients and the community (G. Richardson, 2007; Wilson, 2021). Regehr and Glancy (2014) further adds that mental health legislation attempts to balance:

> the civil liberties of individuals to live as they choose; the responsibility of society to ensure the safety and well-being of individuals who can't understand the consequences of their choices because of diminished capacity; and the responsibility of a society to ensure that the choices and behaviour of one individual do not compromise the safety and security of others (p. 42).

Fundamentally, however, this framing of a balancing act leads to mental health law serving to permit coercive practices towards psychiatrized people, in ways that would not be understood as justifiable when directed toward the 'sane'. These permitted practices range from protection for asylum superintendents, and hospital workers today, against lawsuits for assault and false imprisonment, to forced treatment (Gooding, 2018).

The legal basis of mental health law is the policing powers of the state and *parens patriae* (Burstow, 2015; Gooding, 2018; Kittrie, 1971; Wilson, 2021). The state's policing powers refers to the state's responsibility to ensure public peace and order. The term police emerged in the 16th century as a synonym of state policy and evolved to meaning a particular set of crimes that

impact the entire commonwealth or kingdom, differentiating from crimes targeting "private subjects" like homicide or assault (Legarre, 2006). According to William Blackstone (1830), an English judge and legal scholar who produced *Commentaries on the Laws of England*—a seminal text that influenced the development of English, Canadian, and American legal systems—police is defined as

> due regulation and domestic order of the kingdom: whereby the individuals of the state, like members of a well-governed family, are bound to conform their general behaviour to the rules of propriety, good neighbourhood, and good manners; and to be decent, industrious, and inoffensive in their respective stations. (p. 162)

Police specifically refers to behaving with decorum and respectability, the expected behaviours that match the person's position within society, with Blackstone (1830) using the analogy of citizens being "members of a well-governed family" (p. 6). Examples of breaches against public police given by him include clandestine marriages and bigamy, idleness and vagrancy, and common nuisance. As Legarre (2006) explains, common nuisance can refer to annoyances like a disorderly ale house. While an individual may have made a complaint to the government, the offence is one that impacts not just that individual neighbour, but the entire neighbourhood.

Emer de Vattel, a Dutch legal scholar, adds, "If a nation is obliged to preserve itself, it is not less obliged carefully to preserve all its members. The nation owes this to itself; since the loss of even one of its members weakens it, and is injurious to its own preservation" (De Vattel, 1835, p. 21). Police powers is rooted in the *raison d'etre* of the nation state, to preserve itself, and by virtue of that, to preserve people it recognizes as its members. The state is framed as a benevolent, "tender and wise father [engaging in] the well-ordered pursuit of the common good" (De Vattel, 1835, p. 36) by preventing its children from behaving immorally and without

manners. The state is obliged “to inspire the love of virtue, and the abhorrence of vice” (De Vattel, 1835, p. 92). Kittrie (1971) concludes,

> The state as protector of the peace may exercise its general policing powers in all cases where public order is disturbed or threatened. This power of the state to protect the peace and the public welfare (commonly referred to as the "police power") by necessity included the right to restrain the violent and was recognized as one of the inherent rights of the sovereign. (p. 58)

The nation state has ordained itself with the right to intervene when public order is infringed upon and can use force in service of this objective.

In the case of Canada, policing powers or the maintenance of legal order has a reciprocal relationship with settler-colonialism. On the one hand, this function of the nation-state is a settler-colonial imposition; on the hand, this legal order is also deeply integral to sustaining of settler-colonization (Fortier & Wong, 2019). While the national mythos interprets the establishment of Canada as involving Western civilization bringing about the rule of law and modernity to the “lawless heathens and warring tribes” (Thobani, 2007, p. 34), Thobani (2007) suggests that coercive violence was central to this process of nation building. First, a foundational violence allows for the conquest of Indigenous lands and the colonial power to assert itself as the only valid authority within a set of borders. In Canada, this came in the form of poisoning food and blankets given to Indigenous communities, offering bounties for scalpings, and threatening or engaging in military violence. Second, legitimating violence involves the importation of European legal systems and norms to rationalize and justify the continued conquest of Indigenous lands. Settlers were constituted as juridical subjects, while Indigenous people were erased from conceptualizations of the land in order to proceed with the

Doctrine of Discovery, the right to take over land that is unclaimed, *terra nullis*. Finally, violence occurs in the service of maintaining these power relations (Agamben, 2020). This violence can manifest in a banal fashion, occurring in day-to-day life (Thobani, 2007). This includes the creation of reservations, the stripping of Indigenous sovereignty, the apprehension of children by social workers, and coercive mental health measures targeting Indigenous people.

In other words, not only did 'lawfulness' first come about through colonialism, it is complemented by and intertwined with the colonial "violence that upholds it" (Thobani, 2007, p. 35). Thobani (2007) argues that popular understandings of lawfulness as an absence of violence and as disconnected from the sovereign are fundamentally incorrect. Instead, the law requires state violence to be established and maintained. This entanglement of law and colonial violence allows for colonial sovereignty to be maintained.

The legal doctrine of *parens patriae* is the second underlying element of mental health law and also exhibits the paternalistic mindset held by colonizers. *Parens patriae* suggests that the state—like a 'patriarch'—could and should intervene in the lives of people when the state deems it to be in the people's best interest. This often applies to children and vulnerable populations—"persons who are deemed incapable of protecting their own interests by reason of their particular personal characteristics" (Hall, 2016, p. 188). *Parens patriae* powers serve three types of paternalism: the prevention of physical, psychological, and moral harms (Gooding, 2018).

Mills and Lefrançois (2018) argue that the *parens patriae* doctrine, alongside *in loco parentis*, which allows for another person or organization, the state in particular, to take on the functions of a parent, infantilizes and positions Indigenous and racialized peoples as children. This notion serves to exalt social workers, who are established as experts or 'parents' of

Indigenous and racialized people. As stated, the *parens patriae* doctrine at one point covered both mad adults and children. Children were perceived as property, with interventions justified through conceptualization of the child as "objects for adult and institutional intervention".

This is especially consequential for Indigenous people, as Chrisjohn and McKay (2017) argue,

> The Indian Act, for example, on the assumption that we were, essentially, children in grown-up bodies, placed the government in position of control over our economic resources. Search the histories of what royalty deals Canada, *in loco parentis*, made in our name with oil companies, and ask if you want *your* parents to behave like this. (p. 167, emphasis in original)

There has long been an infantilization of Indigenous people that interlocks with the infantilizing construction of madness. This framing views Indigenous people as inherently pathological due to their supposed child-like nature and, in a circular logic, Indigenous people are deemed child-like due to their inherent mental pathology. Based on this construction, *parens patriae* and *in loco parentis* are used to justify the extraction of Indigenous children from their communities and the imposition of colonial rule on Indigenous nations. The construction of children as objects to be intervened upon because they had "undeveloped mental skills" was a distinctly Western conceptualization. Conversely, the Iroquois conceptualization of child simply refers to inexperience in certain areas, and does not carry a negative connotation or invite intervention (Mills & Lefrançois, 2018).

While the Supreme Court of Canada in Re Eve suggested that the origins of the *parens patriae* doctrine was "lost in the mists of antiquity", Hall (2016) argues that it may have first emerged out of the personal authority and responsibility of King Edward I. Burstow (2015) adds

that an eleventh-century decree of Aethelred II stipulated that “the king is the protector of the stranger who has no kin to protect him” (p. 27). Another component of *parens patrie* was the inheritance of the right of feudal lords to “naturally take possession of the land of a tenant unable to perform his feudal duties”. These tenants were often persons deemed to be “lunatics”, people who may be described today as mentally ill, or “fools”, people who may be understood today as having a developmental disability (Hall, 2016). As it was a profitable venture to take hold of others’ property, the wealthy readily took advantage of this doctrine (Burstow, 2015).

Sir James Munby also considers how *parens patriae* may have developed through the powers of medieval kings to take “responsibility for those without the capacity to look after themselves” (Munby, 2014, p. 66). The responsibility was then handed over to the Court of Wards and Liveries in 1540. When this court was abolished in 1646, *parens patriae* jurisdiction was split between the Chancery, which was in charge of infants, and the Lord Chancellor for mad people (Hall, 2016). Finally, the jurisdiction of the Lord Chancellor for mad people was removed in the United Kingdom in the 1960, with the establishment of the Mental Health Act of 1959. But this was not the case for Canada, where *parens patriae* jurisdiction remained for adults deemed incapable. There exists a narrow core or “inherent” jurisdiction not addressed by parliament or provincial legislation unless a constitutional amendment is made. According to Rosario Joseph (2005), this inherent jurisdiction includes “parens patriae, punishment for contempt of court, judicial review, bail and jurisdiction over officers of the Court” (Hall, 2016, p. 220).

The first set of laws related to mental health enacted in Canada was the County Asylum Act in 1839. As was the case with other former British colonies like India and Hong Kong, and a reminder that mental health legislation is rooted in colonization (Cheung, 2018; Davar, 2015),

the County Asylum Act was imported from the United Kingdom and initially passed by the British House of Commons in 1813 (Byrick & Walker-Renshaw, 2016). The County Asylum Act allowed for the establishment of institutions for those deemed mentally ill and authorized medical superintendents to have free reign over these asylums, though admissions and discharges were managed by the courts (Regehr & Glancy, 2014). The first asylums were established in Ontario a decade after, many of which were converted prisons that were overcrowded and in poor condition (Swigger & Heinmiller, 2014). Further stipulations around how asylums were to be governed only emerged with "An Act respecting Asylums for the Insane", enacted in 1871. The act stipulated that individuals could only be involuntarily hospitalized if ordered to do so by the lieutenant-governor, with the agreement of three medical professionals that the individual was indeed a "lunatic" after a comprehensive assessment (Regehr & Glancy, 2014). The Mental Hospital Act followed in 1935, allowing physicians to determine involuntary hospitalization without involvement of the courts. This act also coincided with the development of pharmacological treatment and community psychiatry, which informed the inclusion of the first stipulations around the release of patients from hospital in the legislation (Byrick & Walker-Renshaw, 2016; Regehr & Glancy, 2014). This legislation marked the start of what Wilson (2021) describes as "the medicalization of mental health law" (p. 44) and Gooding (2018) calls "a swing from legalism towards clinical discretion" (p. 4), with a shift in decision-making emphasis to medical professionals as madness was beginning to be understood as primarily biological and genetic in nature, versus being rooted in spiritual, social, or moral roots.

Today, a key legislation pertaining to police intervention for mental health issues in Ontario is the Mental Health Act, first introduced in 1960. The Mental Health Act, one of 13 in the country—one for each province and territory (O'Reilly & Gray, 2014)—includes statutes

governing voluntary, informal, and involuntary admission to psychiatric facilities, management of outpatients under Community Treatment Orders, and assessment of capacity for persons with mental health issues to manage property. These legislation also includes patient rights—such as, rights advice, reviews for admissions, capacity, and CTO decisions (Byrick & Walker-Renshaw, 2016; Frankenburg, 1982). The initial Mental Health Act allowed patients to be committed for "observation, care, and treatment", also known as "the welfare standard" (Frankenburg, 1982, p. 174). This act was further modified throughout the 20th century, to introduce "the safety standard", whereby patients could only be committed "in the interests of his own safety or the safety of others" and stipulations were made around the length of hospital detentions and requirements for psychiatric assessments (Frankenburg, 1982). For example, amendments in 1987 shortened the initial period of involuntary admission from five to three days, though mechanism in the legislation allowed this period to be extended with cause (Byrick & Walker-Renshaw, 2016; Regehr & Glancy, 2014). In other areas, the criteria for involuntary admission would broaden. The 1968 legislation had previously stipulated that involuntary admissions were permitted for people at "imminent and serious physical impairment of person". By 2000, the word imminent was removed from the criteria (Byrick & Walker-Renshaw, 2016). As mental health legislation evolved, coercive practices permitted against psychiatrized people were simultaneously restricted and loosened.

In the 1990s, the Mental Health Act was amended to include protections of patient rights and the requirement for rights advice to be provided (Byrick & Walker-Renshaw, 2016), partly in response to pressure from the disability rights movement (Burstow, 2015). To ensure that the rights and interests of patients are protected, the Mental Health Act includes safeguards so that decisions to admit patients are reviewed. Patients can also apply to the Consent and Capacity

Board to appeal the decision for detention (Byrick & Walker-Renshaw, 2016). However, Burstow (2015) critiques these protections as hollow and co-optive in nature. While provisions to contest confinement and forced treatment are not meaningless, the concern is that the main body of coercive mental health legislation has remained intact—including forced confinement and treatment. Burstow (2015) suggests that notions of "mental patients' rights" leads to an obscuring of the real picture, that "minimal rights are being permitted in a context in which basic rights have been suspended" (p. 68). The minimal rights serve as a distraction from more serious infringements on freedom and autonomy.

In addition, despite the inclusion of provisions ostensibly to protect mad people, mental health laws have not necessarily become more lenient or tolerable for mad people. The notion of the "dangerous mental patient" has become increasingly popular, which has led to new regressive legislation, such as the community treatment order, which will be discussed below (Burstow 2015). Burstow (2015) also describes the proliferation of community mental health services, such as Assertive Community Treatment teams, as part of the trend of psychiatric control extending far beyond the hospital. Abbas and Voronka (2014) contend that "any experience of 'community living' is conditioned by the threat of what happened to those deemed mentally disabled historically, as well as what new mechanisms of policy and power are currently being enacted" (p. 135). While mad people are treated in the community, the constant surveillance and threats of confinement means that the carceral logic remains ever present, made possible by the ongoing collaboration between the mental health sector and the police.

Legal Mechanisms and Programs of Collaboration

Specific legal mechanisms contained within mental health law and collaborative programs used to initiate police intervention, many of which were mentioned in my interviews, include Section 17, Form 1 and 2, Community Treatment Orders (CTO), situation tables, and co-responding police mental health teams. These mechanisms allow social workers to order police officers to apprehend individuals and escort them to psychiatric facilities or facilitate information sharing and partnership between social workers and police officers. Please note that this list is not meant to be exhaustive. The programs considered reflect a particular focus on the community mental health sector, though social workers also have strong collaboration with the police in other areas, like the forensic mental health sector (Seltzer et al., in press).

Section 17, Form 1 and Form 2.

The most common legal mechanism used in the cases recounted by my interviewees were Forms and police powers of apprehension. In Ontario, Forms are legal tools, issued by a physician or a justice of the peace, used to order the police to bring a person involuntarily to a psychiatric facility, usually a hospital but also a physician's office or other facilities in certain circumstances. Psychiatric facilities are places "designated for observation, care and treatment of persons suffering from mental disorder, and designated as such by the Minister" (Byrick & Walker-Renshaw, 2016, p. 38). The *Mental Health Act* provides these facilities with the lawful power to detain a patient against their will, should they meet certain criteria. It is claimed that the "MHA balances the liberty and autonomy interests of persons suffering from mental disorder with society's interest in protecting persons who, due to mental disorder, are at risk of harm to themselves or others, or who are at the risk of substantial physical and mental deterioration"

(Byrick & Walker-Renshaw, 2016, p. 38). Restrictions should only be placed on a person should there be a risk of them hurting themselves or others because of mental disorder. Restrictions may also be placed if there is the possibility of significant physical and mental deterioration to the patient should they be released from the psychiatric facility.

The Form 1 is issued by a physician and permits the service user to be "detained, restrained, observed, and examined" (Byrick & Walker-Renshaw, 2016, p. 44) to ascertain whether a person needs to be "admitted for further care in a psychiatric facility, as an involuntary or voluntary patient, or if they should be discharged" (Ontario Hospital Association, 2013). The person may be held for this purpose for no more than 72 hours. If the person is not currently at the hospital, the Form 1 orders police officers to take the person into custody and deliver them to a psychiatric facility (Ontario Hospital Association, 2013). To qualify for a Form 1, the physician must have examined the person within the past seven days, though they can also rely on reports from others. Social workers often share their observations with physicians for this purpose. Two sets of criteria must also be fulfilled for a person to be eligible for a Form 1. The first set, falling under "Box A", considers serious harm. The physician is required to have observed or received reports of threats, acts of violence, or an inability for the patient to care for oneself, and to believe that the patient's mental diagnosis will result in serious bodily harm or impairment to themselves or another person. Box B, the second set of criteria, was added in 2000, allowing for the involuntary hospitalization of patients likely to experience bodily harm, substantial mental or physical deterioration, or serious physical impairment, should they stop receiving medical treatment. These criteria specifically apply to people with a recurrent mental disorder who have received and are assessed as having responded well to medical treatment. The

person has to be experiencing symptoms from the same mental disorder as the one they had previously been treated for and be found incapable of consenting to treatment in a psychiatric facility. Police officers also have the authority to use their own discretion to apprehend someone for transportation to a psychiatric facility for assessment by a physician under Section 17 of the *Mental Health Act*, should the police officers deem the person to have engaged in "disorderly conduct" and the criteria set out in Box A is met. The circumstances must also be deemed to be too dangerous to first obtain a Form 2 to qualify for a Section 17 apprehension.

After the completion of the psychiatric assessment at a psychiatric facility, the physician fills out a Form 3, which provides three possible paths:

> (a) To release the person from the psychiatric facility if the attending physician is of the opinion that the person is not in need of the treatment provided in a psychiatric facility;
>
> (b) To admit the person as an informal or voluntary patient if the attending physician is of the opinion that the person is suffering from mental disorder of such a nature or quality that the person is in need of the treatment provided in a psychiatric facility and suitable for admission as an informal or voluntary patient; or
>
> (c) To admit the person as an involuntary patient by completing and filing with the OIC a certificate of involuntary admission if the attending physician is of the opinion that the conditions set out in the subsection 20(1.1) or 20(5) are met. (Byrick & Walker-Renshaw, 2016, p. 40)

The patient may be released if no treatment is required, admitted as an informal or voluntary patient, or admitted as an involuntary patient. Patients deemed voluntary are free to leave the

facility should they wish, even if this contradicts medical advice. Informal patients are those that have been admitted to a psychiatric facility with consent from another person. This may be a minor or someone deemed incapable with respect to treatment. Finally, patients admitted under a Form 3 without consent are considered involuntary (Byrick & Walker-Renshaw, 2016). While a Form 1 cannot be appealed at the Consent and Capacity Board (CCB) on grounds that the criteria for issuance were not met, the Form 3 may be repealed if the preceding Form 1 carried "significant deficiencies … [,] completed in a manner that was not in compliance with the MHA" (Byrick & Walker-Renshaw, 2016, p. 45).

Social workers can also directly apply for involuntary hospitalization through the Form 2. A social worker, or indeed anyone including family members and passers-by, can appear before a Justice of the Peace (JP) to apply for a Form 2 by providing sworn information, in written or oral form, that the patient fits the criteria set out by Box A and B from the Form 1. Should the JP determine that the information does indeed meet the criteria, the Form 2 order is then provided to the police to apprehend the patient and bring them to a psychiatric facility, usually a hospital emergency department (Byrick & Walker-Renshaw, 2016).

While there are no statistics on involuntary hospitalization by race for Canada available, Dhand (2016) surmises that "Ethno-racial people with mental health disabilities interacting with Ontario's civil mental health system experience multiple inequities such as … a higher involuntary admission rate" based on similar findings in other jurisdictions (Britain & Commission, 2014; Care Quality Commission, 2011; Dhand, 2016; Freeman & Pathare, 2005; Saltus et al., 2013). For example, the Care Quality Commission (2011) found that Black people in the United Kingdom were disproportionately detained under the Mental Health Act, ranging

from 19% to 32% above average. Racialized people were 44% more likely to be involuntarily hospitalized and more likely to have police involved in their psychiatric apprehension (Keating, 2015). The World Health Organization also concludes that "minorities" experience higher rates of involuntary detention (Freeman & Pathare, 2005).

Community Treatment Order.

Community Treatment Orders (CTO) came into practice across Canada in the 1990s, with Saskatchewan being the first to enact CTO legislation in 1995 (J. Dawson, 2016). In Ontario, CTO legislation was passed in 2000, a response to public outcry against 'violent and dangerous mentally ill people' fanned by the media and advocacy work from a coalition consisting largely of organizations representing families and medical professionals that found support in the governing Progressive Conservative Party (Swigger & Heinmiller, 2014). The government accepted recommendations made in the coroner's inquest for the murder of Brian Smith by a person diagnosed with schizophrenia and appealed to public sentiment by naming the bill "Brian's Law" (Regehr & Glancy, 2014). The legislation allows for forced treatment to occur in the community, following a pattern whereby periods of liberalization in the treatment of psychiatrized people are met with pushbacks after highly publicized violent acts (Burstow, 2015). The rationalization of CTO legislation is to address "revolving door" patients (Byrick & Walker-Renshaw, 2016), people that are repeatedly readmitted to psychiatric units shortly after discharge due to presumed inability to maintain "independent life in the community" because of a discontinuation of treatment (D'Orta et al., 2021, p. 2). The failure of these individuals to maintain their treatment, such as by "going off medication", was thought to pose a threat to others ("Talking About Community Treatment Orders and Discrimination," 2015). Echoing the

early concept of police as a form of crime against the public, advocates argued “the community has a right to be safe” (Swigger & Heinmiller, 2014, p. 254), that the very presence of psychiatrized people in the community was a problem, and that safety was to be achieved through imposing restrictions on psychiatrized people. Advocates for CTO legislation also argued for a paternalistic approach to mental health care that allows for the imposition of treatment against the preferences of the patients and that families should have a say in treatment planning (Swigger & Heinmiller, 2014).

To qualify for a CTO in Ontario, the patient must have had two or more hospital admissions totalling up to 30 days of stay during the past three years. The patient must also have been assessed by a physician in the 72 hours prior and be deemed to be “suffering” from a mental disorder, requiring ongoing treatment and supervision in the community. Without this ongoing care, the patient is understood to likely cause bodily harm to themselves or another person or suffer substantial mental or physical deterioration. The physician must also conclude that the patient can comply with the order and that treatment or supervision must be available in the community (Byrick & Walker-Renshaw, 2016). While a patient must be offered an opportunity to consult with a rights advisor and consent to a CTO, consent may also be provided by the substitute decision maker (SDM), which is usually a family member, if the patient is deemed incapable (J. Dawson, 2016).

The CTO involves the creation of a community treatment plan by the physician, with input from the patient, family members, and social workers. The plan outlines how treatment will be maintained in the community (Byrick & Walker-Renshaw, 2016). The CTO is enforced through a Form 45, which requires the patient to sign off on an agreement “to comply with all

my obligations as set out in the community treatment plan" (Ontario Ministry of Health, 2000a, p. 45), including attending all medical appointments to the best of their ability. CTOs enforce treatment through the threat of involuntary psychiatric assessment and hospitalization (J. Dawson, 2016). Should a patient be deemed not to have followed the treatment plan in the community, a physician can issue a Form 47 (Order for Examination), which orders the police to apprehend and escort the patient to a psychiatric facility for assessment and could potentially lead to involuntary hospitalization. The Form 47 includes a space for the physician to provide a physical description to aid police officers in locating the patient and requires the physician to notify the police if the patient voluntarily attends to the assessment prior to apprehension (Ontario Ministry of Health, 2000b). The assessing physician then can decide to release the patient, issue a new CTO, or detain the patient for 72 hours for additional assessment (Swigger & Heinmiller, 2014). The CTO expires after six months. While the patient can decide to terminate the CTO prematurely, this will automatically trigger a psychiatric assessment within 72 hours, from which the physician could determine that the patient is unable to live in the community and requires hospitalization (Byrick & Walker-Renshaw, 2016).

There is recognition among the legal community that these practices infringe on the rights of psychiatric survivors, but Dawson (2016) argues that courts are likely to consider these restrictions justified, as long as the laws governing CTOs meet judicial definitions of fairness, allow for independent review, and do not impose excessive powers disproportionate to the need. In addition, CTOs are sometimes justified on the claim that they are less repressive relative to involuntary hospitalization, and studies have demonstrated that CTO programs are effective at reducing hospitalization (Mfoafo-M'Carthy et al., 2018; O'Brien et al., 2009). Yet, Burstow

(2015) counters that while avoiding institutionalization in the short-term may be preferable, the false binary of involuntary hospitalization and community surveillance to ensure safety should not be taken for granted and there must be recognition of the reality that "being subject to ongoing control [becomes] the new norm" (p. 125) with CTOs. Indeed, the surveillance and coercive elements of CTOs make service users feel undignified, with one person under a CTO explaining that "it's shameful – if a cop wanted to he could just pick you up, or if you missed your meds or looked "off" they could just pick you up – I've been hurt by a cop before" (Mfoafo-M'Carthy et al., 2018, p. 651). Other participants described feeling like they were being treated as a "'criminal' being punished" and "on a leash" (Mfoafo-M'Carthy et al., 2018, p. 651), due to concerns regarding the lack of privacy, unnecessary restrictions, and the use of police officers to escort service users to the physician when the treatment plan was not followed. Though some participants expressed that they appreciated the services made available after receiving a CTO (Brophy & Ring, 2004; Mfoafo-M'Carthy et al., 2018), it is important to note that coercion does not and should not be the prerequisite to providing resources and assistance.

A 2014 study on experiences of racialized people on CTOs in Toronto found that while most participants denied experiencing racism in the context of the program, others noticed that the majority of people on CTOs were racialized and felt that this was the result of systemic racism (Mfoafo-M'Carthy, 2014). Though there is no available data to assess these claims regarding the racial makeup of CTO patients, as stated, Black, Indigenous, and people of colour are disproportionately targeted with coercive mental health practices. Participants also reported feeling excluded from services due to race and expressed alarm at the involvement of police in CTOs. One participant attributed their distrust of the police to their racialized status, which I

presume could be related to ongoing concerns regarding racial violence perpetrated by the police (Mfoafo-M'Carthy, 2014).

Situation Table.

A newer invention is the situation table. Correctional Services Canada describes situation tables as "a venue for service providers from various sectors (police, education, addictions, social work, mental health, etc.) to regularly convene and discuss clients who meet a defined threshold of risk" (Correctional Service Canada, 2017). This venue serves as a space to evaluate people deemed at risk of 'harm', with cases brought to the situation table by social workers, police officers, and other service providers to determine appropriate interventions to address the issue "before harm occurs", and in order to lower their risk levels (Munn, 2019). The objective is to initiate intervention within 24 to 48 hours of the discussion. Interventions are often police-led, including informal check-ins, forced hospitalizations, or even arrests. More than 100 of these programs exist across Canada, with 37 in Ontario as of April 2018 (Roberson et al., 2020).

The evaluation process involves the use of a provincial "Risk-Drive Tracking Database" of sensitive personal information of vulnerable persons that were targets of intervention, amassed by social workers and other frontline workers (Munn, 2019). This information includes, age, sex, location, and risk factors like criminal involvement, drugs, anti-social behaviour, housing, suicide, unemployment, and physical violence. The most prevalent risk factor ascribed for all age groups is mental health. These vague risk factors are all that is necessary to justify interventions. Children aged 12 to 17 are the most prevalent age group to be intervened on and added to the tracking database, with more than 300 discussions held in 2017.

The first situation table to be established in Toronto was Focusing Our Communities by Uniting Services Rexdale (FOCUS Rexdale), established in 2013 in the northern part of the city made up largely of racialized residents (*Neighbourhood Profile: Rexdale-Kipling*, 2018; S. Ng & Nerad, 2015). The project is modelled after a situation table setup in Prince Albert, Saskatchewan, a community with a large Indigenous population (*Community Profile*, 2020), and involves a partnership between Toronto Police Service and local social service and health agencies including but not limited to, Albion Neighbourhood Services, Etobicoke North Probation; Reconnect Mental Health; and Toronto Public Health (S. Ng & Nerad, 2015). Participants, including social workers, are asked to introduce situations of Acutely Elevated Risk (AER) to weekly meetings that last between 45 minutes to two hours. From 2013 to 2014, most cases were introduced by Toronto Police Services, and 126 out of 203 cases, or 62 per cent, involved mental health risks. After an initial discussion, a lead and assisting agency is assigned to the situation based on capacity and agency mandate. Toronto Police Service was most often assigned as the lead agency in 2013, before dropping to the third most often assigned in 2014. They were also the second most assigned assisting agency in both years. Reconnect Mental Health was most often assigned as the lead agency in 2014. The representatives from the assigned agencies record the situations of AER into the database, inputting demographic information and risk factors outlined prior.

An intervention is planned for within 48 hours of the meeting, and usually involves the two assigned agencies participating in "joint home visits or 'door knocks'" (S. Ng & Nerad, 2015, p. 22). In other words, interventions are often undertaken jointly by police officers and mental health workers. Between 2013 and 2014, for 58 per cent of interventions, the intervenee

accepted the referral for services, while intervenees refused services 10 per cent of the time. The remainder of interventions were not tracked or involved the agencies being unable to contact the intervenee. While a list of anecdotes with largely positively-framed outcomes were included in an evaluation of the program published in 2015 (S. Ng & Nerad, 2015), there is limited details on the nature and specifics of situation table-led interventions in the literature. Gabby, an interviewee of mine, did provide an example of introducing a problem that had arisen with a tenant living in agency housing to a situation table. During the meeting, discussion focused on how the police can participate in the intervention and arrangements were made to receive support from a specialized police unit to help "remove someone from a home to get them somewhere else". Consistent with practices at FOCUS Rexdale (S. Ng & Nerad, 2015), a report on the intervention and results were presented at the subsequent meeting.

Situation tables are a form of 'predictive policing' which, according to Roberson et al. (2020), involves "enabl[ing] law enforcement agencies [...] to draw inferences through the use of mass data processing in the hopes of predicting potential criminal activity" (p. 1). Situation tables are a part of a broader trend by police to use algorithmic technologies (i.e. big data) in their surveillance and enforcement practices. Frontline workers are not obligated to receive informed consent to collect personal information for the tracking database. While the Ontario Information and Privacy Commissioner provides guidelines around obtaining consent and suggests that "Situation Tables that deviate from the IPC's guidance risk breaching [individuals'] privacy", a Ministry of Community Safety & Correctional Services internal briefing stipulates that situation tables were not required to follow IPC guidelines. Consistent with this arrangement, interventions initiated by situation tables also do not require prior consent from the

person intervened upon. A social worker interviewed by Vice estimated that around 50 percent of all Situation Table interventions were non-consensual, many involving people with addictions (Munn, 2019). Situation tables also pose a further privacy concern, as the information collected in the database can be used to "re-identify" people by cross referencing with other information sources (Roberson et al., 2020).

These concerns are further heightened by the less publicized use of situation tables for police surveillance and investigative purposes. According to Gabby, police sergeants and detectives would often use situation tables to conduct environmental scans, to learn the lay of the land in a specific neighbourhood. Gabby stated,

> if they're looking for specific information in a particular community, they'll just go to a different focus or spider table cause there's one per every neighbourhood improvement area for the most part … because agencies are there, a lot of city services are there, someone knows something. The community crisis response will be there as well. So, there's a lot of exchange of information.

Police officers would also attend situation tables to see if relevant information or observations emerge in relation to cases they were currently investigating.

Co-responding Police-Mental Health Programs.

Co-responding police-mental health programs are one of three responses to the increase in police interaction with people in mental crises involving police partnership with mental health services, the other two being crisis intervention teams with police officers specially trained in mental health intervention, and programs involving the use of mental health consultants to assist

police officers by phone or on site. The co-responding police mental health model involves having a team made up of mental health workers—usually nurses or social workers—and police officers (Shapiro et al., 2015). Of the three models, the co-responding model is the most popular in Canada. With this model, the team is dispatched to intervene in crisis situations either after an initial response or conjointly with a regular police unit (Kean et al., 2012). A study conducted on a co-responding team in Quebec found that the majority of crises responded to were suicide-related at 59.9%, and only 7% of people intervened upon displayed aggressive behaviour (Blais et al., 2020). Morabito et a. (2018) explains that co-responding teams usually respond to the "grey area" of policing, situations that may be disruptive or concerning but are not criminal in nature. On the scene, the police officer can be in charge of handling security and violence concerns, while the mental health worker can address the emotional needs for the person in crisis, such as through supportive counselling or de-escalation (Kean et al., 2012).

The stated intentions of such programs are to reduce the number of violent encounters (Morabito et al., 2012), divert people experiencing mental health symptoms from the criminal justice system to the mental health system (Lamb et al, 1995), reduce pressure on the healthcare system by limiting visits to the emergency room, prevent injuries to the person in crisis and mental health responders, and refer service users to appropriate mental health services (Shapiro et al., 2015). Another belief is that the natural outcome of collaboration is that the police and mental health sector will be better able to "serve consumers and each other effectively" (Rosenbaum, 2010, p. 176).

As stated in the literature review, assessments of these programs seldom explore harm, and instead focus uncritically on efficacy as measured by the capacity to facilitate access to

mental health services (Kisely et al., 2010). Baess (2005) reports that in Vancouver Island, clinical staff felt safer engaging in crisis intervention when partnered with a police officer, and police officers felt that participation in the program helped them gain a better understanding of mental health issues. However, these practices are seldom assessed in terms of their potential harm to service users. The few examples of studies that examine this issue found that while arrests decreased with these programs, there is mixed evidence that use of force by police officers also reduced (Shapiro et al., 2015). A 2012 study did report that there were less use of force incidents reported by police officers on co-responding police-mental health programs compared to regular police officers, but the difference was insignificant (Allen Consulting Group, 2012). Though a 2018 study on a Toronto-based program did find that escorts to an emergency department were more likely to be voluntary compared to police-only teams (Blais et al., 2020; Lamanna et al., 2018), a survey of studies shows mixed evidence that these programs actually decreased hospitalization (Shapiro et al., 2015). There may also be concerns regarding privacy, as co-responding teams engage in information sharing for the stated purpose of finding and serving the subject of intervention, with police officers and mental health workers accessing both criminal justice and healthcare records that they would previously not have had access to independently (K. Bailey et al., 2018). There is limited data on co-responding police mental health programs in relation to race, except for Bailey et al.'s (2018) findings that a co-responding team in Indianapolis disproportionately intervened upon Black people.

An example of a police-mental health team in Toronto is the Mobile Crisis Intervention Teams (MCITs). Formed out of collaboration between the Toronto Police Services and six hospitals in the city, MCITs involve partnering a police officer specially trained in mental health

intervention with a psychiatric nurse (Lamanna et al., 2018). These teams are sent by emergency dispatchers to situations involving people experiencing a mental health crisis. MCITs are considered co-responders, attending to the scene alongside a regular police unit, if no weapons are present. At the scene, the team will clinically assess the person in crisis, attempt de-escalation, stop the person from engaging in serious harm, and provide supportive counselling. Ultimately the MCIT will either make a referral to an appropriate mental health service or apprehend the person under the *Mental Health Act*, coordinating and facilitating transportation to the hospital emergency department in the latter case (*Mobile Crisis Intervention Teams (MCIT)*, 2022). The program claims as benefits, the combining of mental health and police expertise, seeing service users in their own setting, and preventing injuries. The dispatching of MCITs to crisis calls have increased from 4,119 times in 2013 to 7,500 times in 2020. Though with the dramatic rise in overall person-in-crisis calls from 20,562 to 40,000, this actually represents a decrease from 20% to 19% of all crisis call responses (Amin & Bruno, 2021; Dunbar, 2018). Other police-mental health teams, at least 12 in Ontario, employ mental health social workers alongside police officers (Longworth et al., 2019). Examples include Hamilton Police Services' Crisis Outreach and Support Team and Mobile Crisis Rapid Response Team (*Mobile Crisis Rapid Response Team – a First for Ontario*, 2014), and Peel Regional Police's Mobile Crisis Rapid Response Team (MCRRT) (*Peel Regional Police Launches the Mobile Crisis Rapid Response Team (MCRRT)*, 2020).

A variation of the co-responding police-mental health programs is non-police led crisis intervention programs, like the Toronto Community Crisis Service (TCCS) pilot discussed in the introductory chapter. While the stated objective is to reduce the reliance on police for crisis

intervention calls, as stated, collaboration and co-response with the police still has a major presence with this initiative. Indeed, during the first six months of operations, 11% of calls—or 333 calls out of 2489—for the service still involved some form of police involvement (Provincial System Support Program & Makwa, 2023). 911 operator had often dispatched both police officers and crisis workers to co-attend a crisis, or in 90 occasions, crisis workers themselves had called for the police. For example, 24 calls occurred in order to apprehend the individual for hospitalization as they deemed the individual in crisis as meeting the dangerousness criteria. And although the pilot project involved the establishment of a separate non-police emergency number reached by dialling 211, TCCS's own operators also redirected 121 calls to 911—where police would likely be dispatched—when it was deemed that "There is an identified need for emergency services (e.g., police, fire, paramedic) to be involved due to there being an imminent safety risk" (Provincial System Support Program & Makwa, 2023, p. 13). 211 dispatchers expressed that there was no consensus on the violence threshold for determining if crisis calls should be transferred to the police or if their own crisis workers should be sent out. Due to this confusion about what constituted violence, and since "the safety and wellbeing of TCCS crisis workers" (Provincial System Support Program & Makwa, 2023, p. 38) were prioritized, both 211 and 911 dispatchers tended to err on the side of caution fearing personal liability, sending police instead when there were signs of potential violence. Other than attending crises together or calling for police reinforcement, the TCCS also collaborated with the police through weekly status and issue meetings and 911 "parades', which refer "to information-sharing sessions and/or presentations regularly delivered to staff throughout 911 and TPS" (Provincial System Support Program & Makwa, 2023, p. 38). In the six-month evaluation report, it was recommended that TCCS staff increase their attendance at these parades to facilitate better working relationships

and trust with the police. It was also suggested that more job shadowing and ride-along opportunities with police officers are provided for TCCS staff.

Conclusion

In this chapter, I explore the process of calling for police intervention. When de-escalation failed and a risk of harm from the service user to themselves or others was present, police were called, though there was seldom consensus on what constitutes harm. A lack of contact was also constituted as risk and used to justify a call for police intervention. Most mental health social workers interviewed agreed that police were only called as a last resort. When the police arrived, oftentimes their mere presence was sufficient in achieving compliance from the service user. In general, interviewees found police officers impatient and aggressive. Disagreement or non-compliance from service users were likely to result in the use of force from police officers, ranging from threats of violence to tackling and restraints. Pepper spray, Taser, bean-bag shots, but also firearms, were also used by police officers. Police interventions resulted in psychological trauma, physical injuries, and deaths. In the aftermath of police action, incident reports and case notes were filed. These documents involved a retelling of the crisis incident, to be used to inform future treatment but also to rationalize the decision to call for police intervention. Debriefing also occurred between supervisors and social workers, and between social workers and the service user intervened upon. Debriefing was ostensibly done to address the emotional wellbeing of the social worker, but was also done to normalize coercive practices.

These practices occur in the context of mental health legislation and formal collaborative mechanisms between the mental health field and the police. Mental health legislation provides allowances for coercive practices against psychiatrized people that otherwise would not be

permitted. The basis of these allowances are the legal doctrines of policing powers—the state's responsibility to maintain the public peace, and *parens patriae*—the state as the "parent of the nation", intervening on behalf of people deemed unable to serve their own best interests. Legal mechanisms and collaborative programs like Forms 1 and 2, CTOs, situation tables, and co-responding police mental health teams allow mental health social workers to facilitate police interventions, with apprehension and escort to psychiatric facilities as potential outcomes.

Anecdote A

Sally was employed at a small community mental health agency. Her primary role was to provide case management. The agency used to also provide psychotherapy, but this had been less emphasized since psychotherapy became a regulated profession in April 2015 (College of Registered Psychotherapists of, 2015). That said, counselling skills were still incorporated in the provision of case management, whereby services were not just geared towards addressing practical needs but extended towards developing insights into a person's emotional life. For example, social workers not only provided support around medication or ensured that service users had access to safe housing, but they will help service users establish goals and work towards them. Outside of case management, the agency also provided ongoing group activities, including group therapy and psychoeducational workshops on wellness and recovery. Many service users received long-term support lasting just under two years, though some received shorter-term support at around six months.

Sally also expressed frustration at the professionalization of psychotherapy as it meant she had been afforded less tools for the purpose of providing care to service users. She stated,

> I would love to be able to offer therapy to people. But just given what people come in the door expecting, yeah, it sort of makes sense. I think there also is like a gap in services. There needs to be more therapy offered to people. So, it would be good if we could do that.

Sally believed there is a clear need amongst service users for therapy but was prevented from providing this by the regulations even though there is "such a gray space between supportive counseling, which is what we sort of label what we do, and psychotherapy". Instead of providing

psychotherapy, Sally made referrals, though she explained that there is a dearth of services available.

Sally reported that they called for police intervention five times while employed at this workplace. She recounted an incident that arose when dealing with a service user with “a really high trauma background and a lot of challenges with dissociation”. Sally felt she had strong rapport with this service user. This rapport meant that the service user was comfortable enough to inform the interviewee that he was feeling very stressed out from a conflict that had arisen with someone in his life. He stated that he wanted to go to the person’s place of work with a BB gun. Sally stated, “I had the sense that they just wanted to scare this person because they were so angry and upset. And that seemed like what was within their control to be able to do about the situation”.

Sally added that she was

> really quite worried that that would involve police like it was this bit of a paradox where I was worried that someone, a co-worker of this other person or the other person themselves might phone the police, which would then put my client at risk as carrying what looks like a weapon, even though it. It wasn't they had no intention of actually they've stated they had no intention of actually hurting the other person, but my concern was actually for my client and that that could trigger just a regular police officer coming in, seeing someone with something that looks like a gun and putting the client at risk.

Sally was immediately concerned that the police would become involved whether or not she made the call. She thought that if she was not the person to call, the police may not be aware that the gun was a toy and that the likelihood that the service user may be harmed by the police would increase. Sally was concerned that the service user “would be the victim of violence”.

Upon being told by the service user about the desire to scare someone with a BB gun, Sally indicated appreciation for the service user's honesty, validated the service user's stress level, and asked to step aside to speak to a colleague. After consulting with her colleague, Sally returned to the service user and expressed her concern about the possible repercussions from the police. First, Sally suggested going with the service user to a particular hospital. The service user had apparently considered that hospital to be a safe place, often stayed in the vicinity of the hospital building when distressed, and had sometimes even voluntarily admitted himself to the psychiatric unit. The service user said that while he understood why the Sally was suggesting this course of action, they disagreed and was going to leave the premises alone.

It was then that Sally decided to contact the police, explaining

> And so, at that point, I thought it would be better to involve the police in a way that I had some control over the messaging around, as opposed to someone else calling the police and the messaging just like part of the story being missing. About the person being sort of fragile in terms of their mental health and not indicating any harm and just wanting to scare someone.

Sally wanted to ensure that the police were aware of the intentions of the service user as well as his mental state in hopes that this would mitigate the violence the police would use towards the service user. Sally called 911 and had a police officer dispatched to the agency office; however, the service user had already left before the police officer arrived. Sally attempted to have the mobile crisis unit, a co-responding police mental health program that pairs an officer with a psychiatric nurse, attend to the issue, but since they were unavailable a regular beat officer was sent instead. When the police officer arrived, they spent a significant amount of time questioning Sally about the service user. Out of concern for the service user, Sally decided to breach

confidentiality and disclose personal information about the service user, such as the history of trauma.

Sally later discovered that the service user had returned home and decided against pursuing their plan as they had calmed down. The police visited the service user twice at their home. Feeling assured that the service user no longer posed a threat to others, the police officers decided against arresting the individual or pursuing other avenues. Sally debriefed with the service user some time after the incident and was told that it was a "scary" experience for the service user. While Sally struggled to remember details about the debriefing, she noted that this occurrence deeply tested the therapeutic relationship with the service user and that she had thought the service user would end his services at the debriefing. This did not occur, and the service user continued working with Sally.

Sally also expressed on reflection,

> Had [the service user] been of a different racialized group. Yeah. I think it would have potentially increased the risk of harm to her if police were called period, but especially if police were called without at least my efforts to try and share the whole picture and help with that intervention.

She concluded that the outcome could have been much worse if the service user was not a "White presenting" woman, considering how police violence is disproportionately directed at racialized people.

Sally explained,

> It's always a fraught experience, I think, to involve the police, because you do it as a registered social worker. There are some lines that get crossed and it's shit, the trigger has been pulled. Very shitty metaphor, but like something's been activated. And now I have

> to like I've heard this, I seen this, and now I have to take these steps. And that's one of the harder things about being a registered social worker, I think […] This is what I feel like my hand is being forced to have to do […] it's an awful, awful choice to have to make, like like sometimes it feels like I'm doing this because this is what my college I know would require me to do. If someone was looking at the notes from this day and I didn't call. Am I going to get in trouble or something like that? And then it feels like my butt over someone else's potential well-being. (Participant 16, personal communication, September 11, 2020)

She attributed the decision to calling the police, while unenviable, to fulfilling one's responsibility as a registered social worker. She believed that once a decision is made, a sequence of events must follow.

Sally described the potential repercussions from the Ontario College of Social Workers and Social Service Workers (OCSWSSW) for not following the correct course of action (in this case, calling the police) as a "neurotic fear" that was also "quite legitimate". She feared that if the service user ended up harmed and that she had not called the police, an upset family member may choose to report them to the OCSWSSW, sparking disciplinary measures. Sally felt that while OCSWSSW disciplinary measures served a purpose, it also acted as a threat that shaped social worker practice. When asked about what the specific concerns were, she brought up the shame and embarrassment of having disciplinary findings published in *Perspective*, a magazine published by the OCSWSSW. The ultimate fear, however, was that she could lose her Registered Social Worker (RSW) designation and not be able to continue working as a social worker. She remarked that "losing my ability to do the work that I do [would be especially upsetting] because I've worked really hard to do the job that I do".

As discussed in Chapter 5, Sally inquired with the OCSWSSW about what situations necessitates a 911 call in relation to self-harm or harm to others. She was told that she had to use clinical judgment to make an assessment based on risk factors. In other words, there is a significant grey area, as the OCSWSSW was not necessarily prescriptive in relation to requiring a 911 call. The OCSWSSW representative was reluctant to walk the interviewee through scenarios, and instead emphasized that "it is your decision that you make based on varying factors". Nevertheless, while she acknowledged it was unlikely that the practices recounted in this scenario would warrant a serious reprimand based on the instructions given to them by the OCSWSSW, Sally still felt the mere possibility of repercussions alone was enough to put pressure on a social worker to call 911.

This was further complicated by her supervisor suggesting that the police should be called if a service user communicates that they have a specific plan to harm themselves or someone else. Sally described these suggestions as "informal policies", an unwritten agreement between management and staff. Sally was concerned about whether her employer would defend her in a situation where these informal policies conflicted with her obligations to the OCSWSSW.

Chapter 5: Regulating the Profession and Ensuring Compliance

In Anecdote A, Sally worried about the implications of breaching Ontario College of Social Workers and Social Service Workers (OCSWSSW) expectations,

> I'm doing this because this is what my college I know would require me to do. If someone was looking at the notes from this day and I didn't call [the police]. Am I going to get in trouble? It feels like my butt over someone else's potential well-being and yucky doesn't even begin to describe it.

Sally felt conflicted following the regulatory body's expectations, as it was privileging their desires to remain in the profession and to avoid punishment over the service user's interests. Maya added,

> [being] certified by a college of social worker or social service worker or a psychotherapist college ties in to our responsibility, the duty to report. And I think that that comes up a lot even just in me is will I lose my license? Will I lose my capacity to do this work? I felt a duty to the college or the duty to that looming presence like that, panopticon of the college

OCSWSSW was thought of as a looming presence or a panopticon, whereby the threat of losing one's social work licence leads to self-policing amongst social workers. Maya explained that "when I'm wearing this [social worker] hat, I have this legal obligation". Maya asked herself, "What are my ethical obligations here? I think that the liability and the punishment was a factor

[in determining whether to call for police intervention]". The fear of punishment ensured that reporting practices, including to the police, were followed in day-to-day social work practice.

Social workers interviewed by Ungara (2007) echoed the concerns raised by my interviewees, expressing anxieties about potential judgment of their daily practices by the OCSWSSW. They stated that professionalization and regulations infringed on social worker autonomy. That said, these interviewees also felt that regulation and surveillance helped increase the status of the profession, that registration was a prerequisite of legitimacy. Since legitimacy helps with obtaining higher salaries and recognition, social workers are invested in following the profession's rules and expectations.

Because of this, while we must also acknowledge that social workers do not always consult OCSWSSW codes of ethics and practice guidelines (see Chapter 3), professional regulations may still have some influence on practice. In this chapter, I first examine the Ontario Social Work and Social Service Work Act. This legislation is the primary document that coordinates social work practice and regulates the profession in the province, dictating membership criteria, and establishing the OCSWSSW, including specific committees responsible for investigating and enforcing professional standards. These rules are outlined in the Canadian Association of Social Workers (CASW) and OCSWSSW codes of ethics and practice guidelines, the evolution of which are explored in the second section. While CASW documents are not enforceable, they do serve as a basis for OCSWSSW's equivalent documents, which both inform practice and define professional misconduct. Examples of relevant sections within these documents that may relate to police intervention include considering the best interest of clients, limits to confidentiality, and the prevention of abuse, though other stipulations like respecting

self-determination appear to contradict its use. OCSWSSW disciplinary organs rely on these documents and the final section explores a number of OCSWSSW disciplinary cases. While there were no examples of social workers being disciplined for a failure to initiate police intervention in relation to mental health issues, there are disciplinary cases in relation to failures to report domestic violence, sexual violence, and child abuse. My consideration of these cases in no way absolves the potential harm and neglect committed by social workers. Instead, these cases allow me to consider how OCSWSSW maintain its standards of practice through disciplinary measures, how guidelines are interpreted, and how these interpretations may be applicable to mental health social worker-initiated police intervention.

Regulations Pertaining to Social Work in Ontario

Ontario Social Work and Social Service Work Act

The Social Work and Social Service Work Act (1998), hereinafter referred to as the Act, stipulates the manner in which the social work field should be regulated in Ontario and ordered the creation of the OCSWSSW to supervise the profession. The Act stipulates that the OCSWSSW has the responsibility "to regulate the practice of social work and the practice of social service work and to govern its members" (Social Work and Social Service Work Act, 1998). The OCSWSSW also develops and maintains membership qualifications; approves professional education programs that serve as prerequisites for being a social worker; issues, renews, amends, suspends, revokes, and reinstates certificates of registration; and promotes standards and quality assurances in relation to social work practices. Regulation is done through further stipulations regarding objectives of OCSWSSW "To establish and enforce professional standards and ethical standards applicable to members of the College" and "To receive and

investigate complaints against members of the College and to deal with issues of discipline, professional misconduct, incompetency and incapacity" (Social Work and Social Service Work Act, 1998).

The governance of the OCSWSSW is the responsibility of a council composed of seven social workers and seven social service workers elected by the membership, along with seven people appointed by the Lieutenant Governor representing the government. The council designs standards, qualifications, and other requirements for holding the title of social worker or social service worker. Most importantly in relation to the concerns raised by interviewees, the council is also charged with "defining professional misconduct for the purpose of clause 26 (2) (c)" (Social Work and Social Service Work Act, 1998). The council is a major actor in shaping regulations in relation to defining misconduct, beyond what is already stipulated in the act.

In terms of enforcement of regulations, the Act orders the council to establish a Complaints Committee, Discipline Committee, and Fitness to Practice Committee. Each committee should include at least one elected social worker, one elected social service worker, and one appointee, with at least one-half of members being elected and one-third being appointed (Social Work and Social Service Work Act, 1998). The Complaints Committee receives, considers, and investigates grievances from the public. The social worker that is the subject of a complaint will be given 30 days' notice and opportunity to submit a written explanation concerning the matter. The Committee can then issue a caution to the member if the complaint was deemed to be founded. If a complaint is deemed related to professional misconduct, incompetence, or incapacity, and is found to be not frivolous, the matter may be

referred in whole or in part to the Discipline Committee or Fitness to Practice Committee (*Complaints Guide*, 2021; Social Work and Social Service Work Act, 1998).

The Discipline Committee "hear and determine allegations of professional misconduct or incompetence on the part of a College member, directed or referred to it by the Complaints Committee, the Council, or the Executive Committee" (Keogh, 2019). A guilty verdict in relation to professional misconduct may be rendered if a member is found to have contravened the Social Work and Social Service Worker Act; Ontario Regulation 384/00 of the Act; OCSWSSW by-law (*Code of Ethics and Standards of Practice Handbook*, 2018); or any previous order given by the Discipline Committee, the Complaints Committee, the Council, or the registrar (Ontario Regulation 384/00, 1998). A social worker can also be found to be guilty of incompetence if the member was found to lack knowledge, skill, or judgment in relation to their professional obligations, or have demonstrated disregard for the welfare of a person or persons. For a member found guilty, the Discipline Committee may revoke registration, suspend registration for a period not exceeding 24 months, impose conditions on the registration, reprimand or counsel the member, impose a fine to a maximum of $5000, and publicize the disciplinary findings (*Discipline*, 2021; Social Work and Social Service Work Act, 1998). On the last point, findings can be found in *Perspective* (2021), a magazine published by the OCSWSSW, and on the OCSWSSW website (*Discipline Committee Decisions*, 2021).

The Fitness to Practice Committee serves a similar function, though for allegations of incapacity. Incapacity is defined in the Act (1998) as "suffering from a physical or mental condition or disorder such that" the member is unable to fulfill their professional responsibilities.

As with a misconduct finding, should the Fitness to Practice Committee confirm an incapacity finding, the committee may revoke, suspend, or impose conditions on membership.

Another major component of social work regulation through the OCSWSSW is the registrar. The registrar, an OCSWSSW employee appointed by the council, is responsible for issuing certificates of registration for social workers and social service workers. The registrar may refuse to issue a certificate if an applicant does not fulfill requirements or is deemed to lack the capacity to perform their duties as a social worker or social service workers in accordance with the law, including that stipulated in the Ontario Social Work and Social Service Worker Act, Ontario Regulation 384/00 of the Act, and OCSWSSW by-laws. The registrar also enforces judgments made by the Discipline Committee or the Fitness to Practise Committee in denying applicants reinstatement should they be barred from the profession (Social Work and Social Service Work Act, 1998).

Ontario Regulation 384/00 of the Social Work and Social Service Work Act provides definitions of professional misconduct. Examples of professional misconduct include rules in relation to misuse of the social work title (e.g. failing to identify as a social worker), business practices (e.g. submission of false charges), providing services that the social worker knows will not be helpful, providing services despite a conflict of interest, ending services prematurely, and working under the influence of a controlled substance or while ill/dysfunctional (Ontario Regulation 384/00, 1998).

There are elements within the regulations that are more relevant to mental health social worker-initiated police intervention, potentially construed as either permitting the initiation of police intervention or stipulating how it must be done. For example, the section on breaches of

confidentiality include exceptions where allowed by the law, such as situations involving imminent harm (see Chapter 7). A social worker must also keep records as required by regulations and standards, such as case notes in relation to police intervention, and these records cannot include falsifications (Ontario Regulation 384/00, 1998). Under a section labelled miscellaneous, further misconducts are listed, such as breaches of federal, provincial, territorial, or municipal public health laws/bylaws. This stipulation is especially relevant to social workers providing services to children, as failure to comply with mandatory reporting rules contained in provincial law could be defined as professional misconduct. This section also reiterates the disciplinary powers of the OCSWSSW, stipulating that misconducts also include failures to comply with orders given by or agreement entered into with the Complaints Committee, Discipline Committee, or Fitness to Practise Committee of the College; failures to cooperate in College investigation; and engagement in social work practice while suspended (Ontario Regulation 384/00, 1998).

Ultimately, as is apparent with the already listed definitions, what is construed as misconduct by the Ontario Social Work Act is broad. This is further affirmed with misconduct being defined as "Engaging in conduct or performing an act relevant to the practice of the profession that, having regard to all circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional", and "failing to meet the standards of the profession" (Ontario Regulation 384/00, 1998). Ironically, as mentioned in my introductory chapters, some of the stipulations could be interpreted in a way that frames calls for police interventions as social work misconduct. For example, social workers are supposed to obtain consent before taking action, something that seldom happens for police interventions. Other rules

that can be construed this way include stipulations against the physical, sexual, verbal, psychological, or emotional abuse of a client; and using information learned through services as a social worker "to coerce, improperly influence, harass or exploit a client or former client" (Ontario Regulation 384/00, 1998). For example, psychiatric survivors have long described police interventions as a coercive means to impose treatment. The OCSWSSW disciplinary committees do not appear to share this interpretation.

The Codes of Ethics and Standards of Practice

One of the more explicit means by which professionalization gets codified and serves as a ruling relation is through codes of ethics and standards of practice. Though Weinberg and Taylor (2014) suggests that social workers' ethical decision-making processes are more likely to be impacted by the broader political structure, the service users they work with, and their own affect, several interviewees maintained that desires to ensure that their practices was consistent with the Code shaped their determinations around calling for police intervention. The CASW and OCSWSSW Codes of Ethics and Standards of Practice serve as particularly useful entry points for understanding social workers' decision-making processes and professional norms as they serve as overt articulations of expectations on how social workers should engage in their work. As revealed in Anecdote A, it was the code of ethics and standards of practice that Sally was concerned about breaching in relation to calling for police intervention.

One of the earliest formal guideline to social work practice in Canada was the CASW Code of Ethics, first published in 1938 (Wilson Marques, 2010). The latest iteration of the document influenced and was adapted for the OCSWSSW Code of Ethics, a one-page document made up of 11 principles. The OCSWSSW Standards of Practice, in the form of a 47 page guide,

supplements the Code and "sets out minimum standards of professional practice and conduct" (*Code of Ethics and Standards of Practice Handbook*, 2018). The Standards of Practice Committee, made up of at least one appointed councillor, one elected social worker, and one elected social service worker, reviews standard of practice guidelines for the OCSWSSW (Social Work and Social Service Work Act, 1998).

CASW Code of Ethics.

While the CASW Code of Ethics is not relied on for the OCSWSSW disciplinary decisions, the CASW code is meant to inform social work practice across the country. The CASW Code of Ethics was also adapted for and significantly influenced the OCSWSSW Code of Ethics and Standards of Practice (*Code of Ethics and Standards of Practice Handbook*, 2018).

After the publication of CASW's Code of Ethics, the document was revised in 1940, 1956, 1960, 1964, 1970, 1979, 1983, 1994, and 2005 (Wilson Marques, 2010). The Montreal branch of the CASW formed a committee to draft bylaws and establish ethical standards in 1927 (Jennissen & Lundy, 2011). The national branch formed their own committee to develop a code of ethics in 1935, with the first draft circulated among the branches in 1938. A final draft was adopted by the CASW in 1940. Emphasizing humanity, specialization, and competency, the code included this preamble:

> It is assumed that a professional social worker is motivated by interest in the well-being of humanity rather than personal gain or advancement; that he will have knowledge and competence in his field; that he is a person of integrity and open-mindedness. (Roy, 1954, p. 6, as cited in Jennissen & Lundy, 2011)

The rest of the code included sections on tasks undertaken by social workers, relationship with colleagues, personal conduct in relation to professionalism, conduct in the context of employment, and continued education and study.

As the Code of Ethics further evolved in 1956, there was an emphasis on guidance, assistance, and education, but punitive measures were always available should the other measures fail. The Code of Ethic stated that the CASW must "provid[e] mechanisms for determining the professional person's relationship to the CASW, or the agency's relationship to the CASW in circumstances where consultation services do not work" (Roy, 1954, p. 5, as cited in Jennisen & Lundy, 2011). In other words, the Code orders CASW to develop mechanisms to remove members in breach.

Another new addition to the code in 1956 was confidentiality. While recognizing that social workers need to guard information pertaining to clients, it was stipulated in *The Social Worker*, the official magazine of the CASW, that

> circumstances may be such that it cannot guard its knowledge, or indeed, should not do so. Social workers often appear undecided as to which of these courses to follow. Possibly their uncertainty explains one reason why the public is not convinced or does not readily assume that social workers always keep people's secrets. Fuller knowledge of the significance of confidentiality should help social workers to use the concept with greater assurance and discrimination. ("Confidentiality Report Prepared by Ethics Committee, Toronto Branch," 1958, as cited in Jennisen & Lundy, 2011)

In 1958, the Toronto branch of the CASW's Ethics Committee further explored the issue of confidentiality, and a report was presented at a CASW meeting and published in *The Social Worker*. This report examined the concept of confidentiality, definitions and implications, relevant laws, agency policies, case records, inter agency exchanges of information, and relationship with law enforcement (Jennissen & Lundy, 2011).

The 1983 Code of Ethics expanded on confidentiality. Section 6.7.10 mentions that it is justified to breach confidentiality in order "to prevent a crime, to prevent clients doing harm to themselves or to others", though social workers are asked to do so "with reasonable care and with the client's knowledge, unless informing the client would impede the due process of law or violate the duty to warn others". Social workers are also required to warn intended victims, "notifying the police, or taking whatever other steps are reasonably necessary under the circumstances" (Canadian Association of Social Workers, 1983, p. 6).

The 1983 Code also includes other references to legal requirements and circumstances that are deemed to require police intervention. Section 3.6.6 requires social workers to hold knowledge of social policies and laws relevant to social service practice. Section 5.5 expresses that principles of mutuality—a reciprocal relationship between social workers and service users involving "shared control responsibilities between the client and the social worker toward the achievement of agreed to or acknowledged outcome goals"—should be practiced with consideration of legal restrictions. Mutuality may not be practiced in cases of involuntary clients and should not take precedence over "the rights of the community and others to protection" (Canadian Association of Social Workers, 1983, pp. 4–5).

This next edition of the Code of Ethics, released in 1994, reiterated the duty to report and limits to confidentiality. Section 5.26 stipulated that "A social worker shall disclose information acquired from a client to a person or a police officer where the information involves a threat of harm to that person" (Canadian Association of Social Workers, 1994, p. 16). Section 9.1 also called on social workers to help enforce the code by reporting others in the profession that breached the code and caused harm to social service users.

The most recent revision to the Code of Ethics occurred in 2005. This latest iteration was influenced by social work codes of ethics from Australia, UK, US, and the International Federation of Social Workers (IFSW). Elements of this code appear to contradict police interventions. For example, the CASW Code of Ethics Value 1: Respect for Inherent Dignity and Worth of Persons stipulates that "Social workers uphold each person's right to self-determination, consistent with that person's capacity and with the rights of others" and "respect the client's right to make choices based on voluntary, informed consent" (Canadian Association of Social Workers, 2005a, p. 4). These statements suggest an emphasis on self-determination, and voluntary and informed consent. Yet, police interventions not initiated by the client themselves could be understood as infringements on values of self-determination and certainly do not involve voluntary and informed consent. Value 1 further contains statements calling social workers to "respect the unique worth and inherent dignity of all" and "respect the diversity among individuals in Canadian society and the right of individuals to their unique beliefs consistent with the rights of others" (Canadian Association of Social Workers, 2005a, p. 4). Considering policing's use of coercion as a means to elicit conformity and the disproportionate targeting of oppressed communities, stipulations to demonstrate respect for diversity and

inherent dignity do not seem consistent with police intervention. Other aspects of the code that could suggest a need to reject police interventions include Value 2: Pursuit of Social Justice, calling on social workers to challenge injustices, especially that which affects vulnerable peoples; and Value 3: Service to Humanity, which mentions "bringing about fair resolutions to conflict and assisting those affected by conflict" (Canadian Association of Social Workers, 2005a, p. 6).

However, the final statements from Value 1 clarify:

- Social workers uphold the right of society to impose limitations on the self-determination of individuals, when such limitations protect individuals from self-harm and from harming others.
- Social workers uphold the right of every person to be free from violence and threat of violence. (Canadian Association of Social Workers, 2005a, p. 5)

It is explicitly stipulated that a social worker upholds *parens patriae*. As previously stated, this principle refers to the state's authority to act in ways to further the best interests, as the state interprets, of its citizens. In particular, the Code of Ethics considers interventions for the best interest of citizens as in relation to self-harm or harm to others. This is further reinforced by the next statement on upholding the right to be free from violence. Ironically, calls for police intervention on these principles often result in violence towards the person being intervened on, posing a significant and contradictory dilemma. Ultimately, Mullaly (2006) contends that this Code's conceptualization of social justice is narrowly defined along redistribution. Thus, the

objective is to compensate victims of injustice, instead of substantively challenging inequity through radical societal change.

Likewise, Value 5: Confidentiality in Professional Practice, with principles reminding social workers not to disclose confidential information without the informed consent of clients, also stipulates that "Social workers may break confidentiality and communicate client information without permission when required or permitted by relevant laws, court order or this Code" (Canadian Association of Social Workers, 2005a, p. 8). The Code urges social workers to brief clients regarding limits to confidentiality early in the relationship.

The CASW Guidelines for Ethical Practice, a companion guide to the Code, provides even more pointed references to police interventions. Once again, the guidelines include general statements that can be interpreted as in opposition to police interventions, such as opposition to discrimination (1.1.2; 4.1.4; 8.2.1) in recognition of the disproportionate policing of racialized and poor people, promotion of client self-determination and informed consent (1.3; 1.3.5), respecting confidentiality (1.5), and notifying clients about decisions made about them (1.4.5). Section 4.1.7 even suggests that social workers should "uphold their ethical values, principles and responsibilities even though employers' policies or official orders may not be compatible with its provisions" (Canadian Association of Social Workers, 2005b, p. 16).

Yet, these "ethical values, principles and responsibilities" discussed in the guidelines involve significant limitations to values of anti-oppression and self-determination. For example, section 1.4.2 discusses how social workers should aim to "minimize the use of compulsion" (Canadian Association of Social Workers, 2005b, p. 5). Stopping short of restricting compulsion completely, the stipulation leaves open the possibility of violating or diminishing civil or legal

rights. The only qualification is that the social worker should only use compulsion “after careful evaluation of the situation” (Canadian Association of Social Workers, 2005b, p. 5). Section 1.1.5 hints at situations that might justify compulsion:

> In exceptional circumstances, the priority of clients' interests may be outweighed by the interests of others, or by legal requirements and conditions. In such situations clients are made aware of the obligations the social worker faces with respect to the interests of others (see section 1.5), unless such disclosure could result in harm to others. (Canadian Association of Social Workers, 2005b, p. 3)

This section emphasizes the potential conflict between the interests of individuals and the broader public, suggesting that there will be times where social workers need to serve the broader public even if it is against the interest of the client. This may be due to legal obligations or based on the social worker’s clinical judgment.

> This is reinforced by the introduction to Section 8—Ethical Responsibilities to Society,
>
> Social workers advocate for change in the best interests of clients and for the overall benefit of society, the environment and the global community. In performing their responsibilities to society, social workers frequently must balance individual rights to self-determination with protection of vulnerable members of society from harm. These dual ethical responsibilities are the hallmark of the social work profession and require well-developed and complex professional skills. When social workers’ legal obligations require them to break confidentiality and limit client self-determination they do so with

> the minimum compulsion required by law and/or the circumstances (see Value 1). (Canadian Association of Social Workers, 2005b, p. 24)

Enshrined in this principle is the idea that social workers carry two loyalties—to the service user and to the abstract notion of society. In particular, social workers are asked to put constraints on self-determination in the interest of preventing harm to society, albeit with minimum compulsion. This is consistent with a significant change from the 1994 Code of Ethics deprioritizing the service users' interests from being the "primary professional obligation" (p. 9) to that of "a priority with due regard to the respective interests of others" (Canadian Association of Social Workers, 2005b, p. 3). As noted by Mullaly (2006), this need to balance the interests of others serves to take "away a very powerful tool for resisting policies and directives of social work workplaces that militate against the best interests of clients" (p. 146).

There are further references to dual ethical responsibility in section 1.4, which considers practices in relation to "Responsibilities to Involuntary Clients and Clients Not Capable of Consent" (Canadian Association of Social Workers, 2005b, p. 5). Section 1.4.1 specifically explains limitations to the ability of social workers to promote self-determination when a client is deemed to be incapable of making decisions. This is also apparently the case when clients are involuntary (e.g. court appointed social services or interventions for clients that "pose a serious threat to themselves or others" [Canadian Association of Social Workers, 2005b, p. 5]). Section 1.4.4 further stipulates that the right to self-determination is restricted by "duty of care (e.g., client intent to self-harm), the law (e.g., child abuse), or court order" (Canadian Association of Social Workers, 2005b, p. 6). The social worker is only to "assist clients to negotiate and attain as much self-determination as possible" (Canadian Association of Social Workers, 2005b, p. 6).

Section 1.6 - Protection of Vulnerable Members of Society, outlines circumstances requiring social workers to report to authorities. Sections 1.6.1 and 1.6.3 demands that social workers report child abuse and adult abuse as required by provincial/territorial legislation to proper authorities. Section 1.6.2 contains the only direct mention of the police in the guidelines, stipulating that "Social workers who have reason to believe that a client intends to harm another person are obligated to inform both the person who may be at risk (if possible) as well as the police" (Canadian Association of Social Workers, 2005b, p. 8). Section 1.6.3 further adds that if the social worker believes that a client plans to harm themselves, they are

> expected to exercise professional judgement regarding their need to take action consistent with their provincial/territorial legislation, standards of practice and workplace policies. Social workers may in this instance take action to prevent client self-harm without the informed consent of the client. In deciding whether to break confidentiality, social workers are guided by the imminence of self-harm, the presence of a mental health condition and prevailing professional standards and practices. (Canadian Association of Social Workers, 2005b, p. 8)

Though it does not directly stipulate to call the police, it does provide implicit permission to do so by permitting breaches of informed consent if self-harm is imminent and the client has a mental health condition. And while it is unclear if this suggests that there is no obligation if no formal mental health diagnosis is present, I suspect the inclusion of that clause serves more as rationalization for breaching consent. While self-harm is not interpreted by psy professionals as a definitive sign of mental illness, it is understood to be a possible sign and can also be understood as a risk factor for suicide (*Self-Harm*, 2013). The social worker is also asked to consider

whether the breach would be consistent with "prevailing professional standards and practices" (Canadian Association of Social Workers, 2005b, p. 9). Section 1.3.4 instructs social workers to brief clients on these limitations on confidentiality at the "earliest opportunity".

The nature of harm, threat, or the level of constraint are not clearly defined in any of the sections, however, and its final determination falls to the social worker. In fact, Bonnycastle (2006) argues that this latest revision of the Code involves limited guidance around how concepts might be implemented in practice overall. Generalities tend to be interpreted through an individualized and symbolic lens, with social workers avoiding interpretations that motivate collective action. This could also mean a greater reliance on 'common sense'—which as defined by Gramsci refers to the accumulated norms around class, race, gender, and other cultural values (Patnaik, 1988)—and a lesser likelihood of social workers questioning harmful practices that have been made self-evident.

OCSWSSW Code of Ethics and Standards of Practice.

The latest OCSWSSW Code of Ethics and Standards of Practice was adopted in 2008 (*Code of Ethics and Standards of Practice Handbook,* 2018). There are no direct stipulations around requirements to call for police intervention. The Code and Standards of Practice are intentionally written in a vague and broad manner. It is stated in the explanatory note attached to the Standards of Practice Handbook that the Standards of Practice are to be interpreted in conjunction with legislation and a social worker's professional judgement when applied to practice (*Code of Ethics and Standards of Practice Handbook,* 2018). There is also acknowledgment that different social workers may vary in their approach, with the understanding that the major causes for this variation are the "scope of practice" and "demands

of a particular situation". This fluid and open nature means that it can be used to justify refusing or proceeding to use police interventions in response to crises. For example, the first section of the Code of Ethics speaks to maintaining "the best interest of the client" (Ontario College of Social Workers and Social Service Workers, 2008b). Section 1.6 of the Standards of Practice also asks social workers to separate their needs from those of clients and to consider clients' interests paramount within a professional relationship, but the Standards do not define how interests are determined. Section 2.1.1 of the Standards demands that referrals to other professionals and services are "guided by the client's interests", though also "the College member's judgment and knowledge" (*Code of Ethics and Standards of Practice Handbook*, 2018, p. 11).

The vagueness of the Code and Standards of Practice leaves questions unsettled around the tensions between social workers calling for police intervention based on the need to remain legitimate in the eyes of the profession or to assuage their own worries about the service user, and service users' own wishes for autonomy and safety from police intrusion. It also does not address whether it is in the best interest of the client to engage in self-harm or have police officers intrude and bring them to a hospital. The answer to these questions remains ambiguous based on how the code of ethics is written. Other examples of ambiguous sections in the Code (2008b) include a call to "respect the intrinsic worth of the persons", "carry out her or his professional duties and obligations with integrity and objectivity", and "not provide social work or social service work services in a manner that discredits the profession of social work or social service work or diminishes the public's trust in either profession".

As with the CASW Code of Ethics, a key element of the OCSWSSW Standards of Practice relevant to social workers calling for police intervention are sections on limitations to confidentiality. Standards of Practice section 4.4.1 stipulates that “Members may disclose information from the record to third parties without the client's consent only if disclosure is required or allowed by law” (*Code of Ethics and Standards of Practice Handbook*, 2018, p. 23). This in fact appears a number of times in the Standards of Practice. Section 5.3.3 states that breaching confidentiality is allowed “When disclosure is required or allowed by law or by order of a court”, and section 5.3.6 states that “Disclosure without consent is justified if the disclosure is required or allowed by law” (*Code of Ethics and Standards of Practice Handbook*, 2018, p. 28). Section 5.4 does provide a related condition, stipulating that social workers are to discuss limits to confidentiality early in the social worker-client relationship but, in general, very few limitations are placed on disclosure of confidential information in these circumstances.

Other aspects of the Standards of Practice leave it open to interpretations that contradict decisions to bring in police interventions. Section 1.3 calls on “College members [to] respect and facilitate self-determination in a number of ways” (*Code of Ethics and Standards of Practice Handbook*, 2018, p. 9), though the specific example provided was to do so by allowing clients to determine “which problems they want to address as well as how to address them”. A footnote in the Standards also specifically emphasizes that “Limitations to self-determination may arise from the client's incapacity for positive and constructive decision making, from law, from the order of any court of competent jurisdiction and from agency mandate and function” (*Code of Ethics and Standards of Practice Handbook*, 2018, p. 10). This exception provides cover for social workers

to breach service user self-determination through defaulting to the law or notions of incapacity that are deeply rooted in ‘common sense’ discourses of sanism, racism, and other oppressions.

Section 2.2 of the Standards of Practice calls on social workers to protect clients from abuse during and after service provision, considering the context of social workers being in a position of power and responsibility. Information obtained through the professional relationship and a social worker’s position of authority should not be used “to coerce, improperly influence, harass, abuse or exploit a client” (*Code of Ethics and Standards of Practice Handbook*, 2018, pp. 12–13). Based on this section, it could be argued that scenarios where a social worker calls for police intervention after a client shares information about what is interpreted as potential harm could constitute abuse and a means of coercion to compel a client to follow a certain process, such as involuntary hospitalization. Finally, Section 3.4 stipulates that social workers avoid discrimination based on race, ethnicity, gender, sexual orientation, disability, economic status, among other social categories. Considering the disproportionate policing of marginalized communities, and well documented police violence against BIPOC, the use of police intervention can also be considered to contravene this Section of the Standards of Practice.

The Enforcement of the Code and Standards Through the Disciplinary Process

A key aspect of professionalization is to engender conformity through surveillance, and the investigatory and disciplinary powers of regulatory bodies is the major mechanism through which this is accomplished (Ungara, 2007). Consistent with comments shared by my interviewees, Ungara’s (2007) social worker interviewees described the OCSWSSW as “a watchdog of the profession” (p. 63) and also identified how social workers themselves were

recruited into the surveillance process given obligations to report colleagues in cases where the Code was breached.

As stated, the OCSWSSW is empowered by the Social Work and Social Service Work Act to enforce the Code through a complaints process. The OCSWSSW states, “the College’s complaints process is designed to protect the public by assessing and responding to complaints about the conduct of College members” (*Complaints*, 2021). The general public, though usually service users, can submit complaints about OCSWSSW members in person with the “Complaint Form” (*Complaints and Discipline*, 2021). Complainants cannot be anonymous, though the OCSWSSW promises to keep the complaint confidential, with the exception of information sharing in relation to the investigation and disciplinary process. The information may also be presented at a discipline hearing, which is generally open to the public. The complainant is updated throughout the process and a copy of a decision will be provided. There is no appeals process and the decision cannot be used in civil court (*Complaints Guide*, 2021).

Generally, the OCSWSSW only has jurisdiction over behaviour that occurred while the respondent was an OCSWSSW member, but for serious misconduct, OCSWSSW may also consider complaints about actions that occurred before the respondent became a member (*Complaints Guide*, 2021). An alternative to the complaints process is a report process designed for concerns not relevant to services rendered. For reports, the OCSWSSW registrar will determine whether there are grounds for an investigation. There is also no appeals process for reporting. A reporter will not be provided updates or a copy of the decision (*Complaints and Discipline*, 2021).

In addition to Ontario Regulation 384/00 of the Social Work and Social Service Worker Act, sections 66(1), 66(2), and 66(5) of the OCSWSSW bylaws stipulates that social work misconduct in Ontario is defined through the OCSWSSW Code of Ethics and Standards of Practice. Section 66(5) of the OCSWSSW bylaws states,

> The Code of Ethics and Standards of Practice prescribed by By-law No. 24, as amended by By-law Nos. 32 and 48, and the Standard of Practice prescribed by By-Law No. 19, continue to apply to any investigation, consideration of the results of an investigation or hearing of any matter regarding the conduct or actions of a member which occurred, or is alleged to have occurred. (Ontario College of Social Workers and Social Service Workers, 2008a, p. 2)

These three texts are relied upon for investigations and disciplinary measures in relation to misconduct.

Between 2003 to 2021, there were a total of 83 cases pending or already addressed by the Discipline Committee (*Discipline Committee Decisions*, 2021). Of these 83 cases, the most common complaint involved romantic boundary crossing with 32 cases. Six cases involved sexual abuse or harassment. Seven involved title violations. Other violations included conflicts of interest, failures to comply with complaint or discipline committee penalties, improper or falsified record keeping, and business-related issues (e.g. fees). There were also a number of cases of unprofessional practices. For example, one social worker claimed, without a diagnosis, that a client had Obsessive Compulsive Disorder (OCD) and suggested their parenting skills would suffer because of it. Based on this conclusion, the social worker recommended that the client's access to his children be limited (*803466 (Discipline Decision Summary and Reasons)*,

2019). In another example, the social worker regularly missed appointments, showed up late to work, and falsified timesheets (*801139 (Discipline Decision Summary and Reasons)*, 2015).

An aspect of the Discipline Committee findings most relevant to police interventions was cases where social workers were deemed to have failed to intervene in situations of violence (*Discipline Committee Decisions*, 2021). My examination of these cases in exploring the potential influence on mental health social worker-initiated police intervention is in no way an endorsement of the social workers' actions or inactions, which likely contributed to service users being harmed. In many of these cases the service user may not have been opposed to intervention, unlike how police interventions often play out. Nonetheless, these cases do still provide an idea of how regulations and standards of practice might be interpreted and applied in circumstances similar to those where police intervention is called on.

Summary of Alleged Misconducts and Penalties

In a 2020 Discipline Committee decision, DS was accused of failing to screen for and recognize domestic violence in 2017. The client claimed to have informed DS of her partner "forc[ing] her to perform humiliating acts", "shout[ing] at … [her] for hours", calling her names, and threatening to kill her cats (*778075 (Discipline Decision Summary and Reasons)*, 2020, p. 6). The client also claimed to have disclosed that her romantic partner had a history of domestic violence with previous relationships. Despite this disclosure, the social worker failed to ask follow-up questions, blamed the client by asking her what she could have done to trigger her partner, and neglected to develop a safety plan. As a result of the guilty verdict, DS was reprimanded in person, required to complete a continual education course on intimate partner abuse approved by the Registrar, receive supervision at her own expense for a period of two

years with a particular focus on issues pertaining to intimate partner abuse, meet with the Registrar within six months to discuss the 2017 misconducts and strategies for prevention of reoccurrence, and pay $5000 in costs to the OCSWSSW. Should DS fail to comply with these conditions, her Certificate of Registration will be suspended for one month (*778075 (Discipline Decision Summary and Reasons)*, 2020).

In a 2018 Discipline Committee decision, LB was charged for failing to report sexual violence committed by sibling of a client in 2016. While hospitalized for depression, anxiety, and expressed thoughts of harming people and animals, the client had disclosed to LB during a therapy session that an older brother had sexually abused them and attempted to sexually abuse their two sisters on a number of occasions. The social worker warned the parents that they were not to leave the youngest sister alone with the perpetrator and that the social worker had professional and legal obligations to report to Children's Aid Society (CAS). Despite this warning however, LB failed to make notes regarding the matter and did not promptly report the issue to CAS (*328496 (Discipline Decision Summary and Reasons)*, 2018). The Committee decided to reprimand the member and suspend the certificate of registration for three months. Within eight months of returning to activities related to social work, LB must report the return to the registrar, obtain supervision in private practice or through employment, review with a supervisor reporting requirements under the Child and Family Services Act, share documents pertaining to the Discipline Committee hearing with the approved supervisor, and pay $5000 in costs pertaining to the disciplinary process to the OCSWSSW (*328496 (Discipline Decision Summary and Reasons)*, 2018).

In a 2016 Discipline Committee decision, RC was charged after it was discovered that he had failed to report that a minor in his care had disclosed sexual abuse from the father. RC claimed that he had thought the student was 16, and thus, was not required to make a report. RC was suspended for two months, with a potential for another month of suspension if the member did not provide evidence that they reviewed various protocol documents with an OSSTF representative. He must also report his scope of practice and changes in employment upon returning to work, seek supervision, provide his supervisor with documents pertaining to this Discipline Committee hearing, and pay costs of $2000 to the OCSWSSW (*521174 (Discipline Decision Summary and Reasons)*, 2016).

The final case involved WM, who worked as a Child Protection Worker and was found guilty by the Discipline Committee in 2011. WM was accused of multiple occurrences of failure to follow up on child welfare concerns, despite disclosure from sources like daycare workers and observations of injuries, like a broken leg or red marks over an eye. WM misrepresented reports from a daycare facility regarding aggressive and sexually inappropriate behaviour and possible domestic violence, claiming the facility had no concerns regarding a family. There were incidents where no risk assessment or safety plan was completed for children at risk. WM was reprimanded by the Discipline Committee in writing and he was made to pay costs amounting to $5,000. As WM had already resigned his certificate of registration as a social worker, no further action was taken with regards to his social work title (*326918 (Discipline Decision Summary and Reasons)*, 2011).

Interpretation of the Ontario Social Work and Social Service Worker Act, Code of Ethics and Standards of Practice

All four social workers by virtue of being found guilty breached section 2.2 of Ontario Regulation 384/00, which refers to "Failing to meet the standards of the profession", testament to its underlying circular reasoning. All these misconducts also redundantly contravened section 2.28 of the Ontario Regulation 384/00 by "Contravening the Act or regulations or by-laws" (*326918 (Discipline Decision Summary and Reasons)*, 2011; *328496 (Discipline Decision Summary and Reasons)*, 2018; *521174 (Discipline Decision Summary and Reasons)*, 2016; *778075 (Discipline Decision Summary and Reasons)*, 2020). However, the findings also identified other sections of the Standards and Ontario Regulation 384/00 breached, that provide insight into how stipulations are interpreted by the OCSWSSW and the expectations on social practices in circumstances with some relevancy to mental health social worker-initiated police interventions.

Addressing Client Concerns.

In two of the cases, the social workers breached section 1.1 of the Standards regarding working with the client together "in setting and evaluating goals" and in all four of the cases, social workers breached section 1.2 of the Standards, which states that "College members observe, clarify and inquire about information presented to them by clients." (*Code of Ethics and Standards of Practice Handbook*, 2018, p. 9). The Discipline Committee referenced DS failing to follow up on any of the information pointing to concerns around abuse, including in the notes from a previous counsellor that spoke of "anger" and "abuse" in relation to the partner. LB breached section 1.2 as she failed to report sexual abuse to CAS despite legal obligations and

failed to provide a written report to colleagues that were providing care to the client over the weekend (*328496 (Discipline Decision Summary and Reasons)*, 2018). In other words, despite the concerns being made evident by the clients, LB failed to make further inquiries and act on the information. In the case of WM, the Discipline Committee further made note of a breach of section 1.1.1 of the standard, which more specifically stipulates that goal setting is for "strengthening … the capacity of clients to adapt and make changes" (*326918 (Discipline Decision Summary and Reasons)*, 2011, p. 4).

A related breach, which happened in three cases, was that of section 3.2 of the Standards, regarding providing services and responding to client queries or concerns in a timely and reasonable manner. This section was associated with failing to identify issues of domestic violence in the case of DS (*778075 (Discipline Decision Summary and Reasons)*, 2020). The Discipline Committees did not include a specific explanation of why RC and WM were in breach, but we can surmise from DS's ruling that RC was likely in breach for failing to adequately address the student's disclosure of sexual abuse (*326918 (Discipline Decision Summary and Reasons)*, 2011; *521174 (Discipline Decision Summary and Reasons)*, 2016; *778075 (Discipline Decision Summary and Reasons)*, 2020). While RC claims that he was unaware that the student was a minor, an adequate response to the query would have included confirmation of the student's age (*521174 (Discipline Decision Summary and Reasons)*, 2016). As for WM, they failed to follow-up on numerous reports and queries regarding physical abuse, sexual abuse, and negligence from family members. WM was also found to have breached section 3.11 of the Standards of Practice, "College members deliver client services and respond to client queries, concerns, and/or complaints in a timely and reasonable manner" (*Code of*

Ethics and Standards of Practice Handbook, 2018, p. 16). WM had failed to notify and make arrangements with the clients during a number of absences from work (*326918 (Discipline Decision Summary and Reasons)*, 2011).

LB and WM breached sections 1.5 and 1.6 by "failing to provide or document information vital to the Client's care and wellbeing" (*328496 (Discipline Decision Summary and Reasons)*, 2018, p. 7) and, in particular, this occurred with a client who was deemed vulnerable (*326918 (Discipline Decision Summary and Reasons)*, 2011). This indicated that "The Member failed to distinguish her needs and interests from those of her Client to ensure that, within her professional relationship, the Client's needs and interests remained paramount" (*328496 (Discipline Decision Summary and Reasons)*, 2018, p. 7). Both LB and WM were found to have failed to prioritize the client's interests in their conduct and practice.

Legislation, Policies, and Social Work Knowledge.

Section 1.7 of the Standards of Practice, which stipulates that "College members employed by organizations maintain an awareness and consideration of the purpose, mandate and function of those organizations and how these impact on and limit professional relationships with clients" (*Code of Ethics and Standards of Practice Handbook*, 2018, p. 10) was breached by WM (*326918 (Discipline Decision Summary and Reasons)*, 2011). WM failed to follow Children's Aid Society policies and mandates, and in a way that affected their practice and professional relationship with their clients.

Section 2.1.1 of the Standards was breached by DS for failing to recognize the limits of their skill and competency, as indicated by their failure to use the appropriate assessment tool for

intimate partner abuse (*778075 (Discipline Decision Summary and Reasons)*, 2020). Section 2.1.2 was similarly breached as the therapeutic approach undertaken by the social worker was inconsistent with current social work knowledge. DS breached both these sections by questioning the client in ways tantamount to blaming the survivor and failing to develop a safety plan.

All four social workers breached section 2.14 of the Standards of Practice, which stipulates that the work undertaken, or recommendations or opinions provided by social workers must be evidence-based, "substantiated by evidence and supported by a credible body of professional social work knowledge or a credible body of professional social service work knowledge" (*Code of Ethics and Standards of Practice Handbook*, 2018, pp. 11–12). For DS, the Discipline Committee did not believe that her approach to domestic violence was consistent with the current body of social work knowledge and this became even more problematic since she was previously warned about similar concerns by the Complaints Committee in 2013 (*778075 (Discipline Decision Summary and Reasons)*, 2020). For LB, the Discipline Committee cited the lack of a written report about the client's disclosure of sexual abuse and the decision to put the client's siblings at risk by leaving them at home with the perpetrator of sexual violence as practices that "no credible body of professional social work knowledge … would support" (*328496 (Discipline Decision Summary and Reasons)*, 2018, p. 7). No specific reason was cited in the Discipline Committee reports for RC and WM, but it could be surmised that RC's failure to confirm the client's age and report disclosure of sexual violence is inconsistent with professional social work knowledge (*326918 (Discipline Decision Summary and Reasons)*, 2011;

521174 (Discipline Decision Summary and Reasons), 2016). The same could be argued for WM's numerous examples of negligent behaviour.

Section 2.1.3 of the Standards was breached as three of the social workers failed to "maintain current knowledge of policies, legislation, programs and issues related to the community, its institutions and services in their areas of practice" (*Code of Ethics and Standards of Practice Handbook*, 2018, p. 11). The Committee suggests that since DS had been aware of intimate partner abuse, she ought to have ended couples counselling and referred the client to appropriate services (*778075 (Discipline Decision Summary and Reasons)*, 2020). The Committee did not specify what these "other available services" might entail but suggests DS should have knowledge of available services as a social worker. LB had failed to follow this standard since even though she was aware that section 72(1)3 of the Child and Family Services Act required reporting of sexual abuse and exploitation, she did not understand that it had to be done "forthwith" (i.e. in a timely fashion) (*328496 (Discipline Decision Summary and Reasons)*, 2018). RC also contravened section 72(1)3 of the Child and Family Services Act by failing to report sexual abuse (*521174 (Discipline Decision Summary and Reasons)*, 2016). And had he confirmed the age, he would have realized that the client was classified as a child under sections 3(1), 15(3)(a), and 37 of the Child and Family Services Act. This demonstrated a lack of understanding of relevant policies and legislations.

Section 2.29 of Ontario Regulation 384/00 of the Social Work and Social Service Work Act, which makes it an act of professional misconduct to breach federal, provincial, or territorial law or a municipal bylaw in relation to public health or suitability to practise, was also deemed relevant by the Committee in the cases of LB and RC (*328496 (Discipline Decision Summary*

and Reasons), 2018; *521174 (Discipline Decision Summary and Reasons)*, 2016). The Committee referenced LB's failure to comply with section 72(1)3 of the Child and Family Services Act, R.S.O. 1990, c. C.11, which requires professionals working with children to report any

> reasonable grounds to suspect that the child has been sexually molested or sexually exploited by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual molestation or sexual exploitation. (*328496 (Discipline Decision Summary and Reasons)*, 2018, p. 7)

LB may have been aware of this rule, and even mentioned it at the counselling session with the client's parents, but as she failed to make the report in a timely fashion, she "did not demonstrate adequate knowledge of the importance of a timely report and the potentially harmful consequences to the Client and his siblings of a delay in reporting" (*328496 (Discipline Decision Summary and Reasons)*, 2018, p. 7).

> Also relevant to legal obligations is section 4.4.1, which stipulates that
>
> College members inform clients early in their relationship of any limits of client confidentiality including with respect to the client record. [Only w]hen clients or their authorized representatives consent in writing, College members disclose information from the record to third parties within a reasonable time. (*Code of Ethics and Standards of Practice Handbook*, 2018, p. 23)

Section 4.4.1 also provides an important exception, "Members may disclose information from the record to third parties without the client's consent only if disclosure is required or allowed by

law" (*Code of Ethics and Standards of Practice Handbook,* 2018, p. 23). The Discipline Committee interpreted this passage to mean that the section is breached since RC failed to make this disclosure of information to the Children's Aid Society as "required or allowed by law" (*521174 (Discipline Decision Summary and Reasons),* 2016, p. 3). In this case, section 72 of the Child and Family Services Act, R.S.O. 1990, c. C.11 was the law that was contravened by RC.

Social workers are also obligated under the Social Work and Social Service Work Act (1998) to be knowledgeable of "organization policies and practices relating to the management of client information" under section 5.2, including: process and purposes for which the organization "collects, uses, modifies, discloses, retains or disposes of information"; organizational safeguards and practices in relation to information; the process to access or request correction of information; and the process of making a complaint in relation to organizational policies and practices. According to the Discipline Committee, LB and RC breached section 5.2 by not following up on the clients' disclosure and not making a report on the issue forthwith as required by their organizations (*328496 (Discipline Decision Summary and Reasons),* 2018; *521174 (Discipline Decision Summary and Reasons),* 2016). LB further contravened the School Board Protocol for Youth Worker/Social Worker Services, the School Board's Child Abuse and Protection Policy, and the Board Regulation under the Child Abuse and Protection Policy by failing to report in a timely fashion (*328496 (Discipline Decision Summary and Reasons),* 2018).

Recordkeeping.

Another area covered by the Standards and the Misconduct Regulations is records. WM breached sections 4.1.1, 4.1.4, 4.1.5, and 4.1.7, which discuss social worker responsibility with

regards to accurate and timely records. WM had failed to maintain "systematic, dated and legible records" (*326918 (Discipline Decision Summary and Reasons)*, 2011, p. 5) for many of his clients, with information not being noted as events occur or as soon as possible. WM did not include in the record, sources, means of information gathering, and case identifying data. Notes were also not in chronological order. WM exhibited extensive failures to "provide sufficient information" (*326918 (Discipline Decision Summary and Reasons)*, 2011, p. 2). Examples include failing to provide an explanation on contradictory information regarding a parent's history of alcohol abuse, and to record sexualized behaviour exhibited by the children. Also, no investigations relating to reports of physical punishment resulting in a broken leg, intoxication while providing caregiving to children, and violence towards a child were documented, despite WM noting that "none of these allegations have been founded" (*326918 (Discipline Decision Summary and Reasons)*, 2011, p. 2). The Committee concluded that due to these issues in record keeping, WM's records did not "facilitate[] the monitoring and evaluation of the effects of the service or intervention" (*326918 (Discipline Decision Summary and Reasons)*, 2011, p. 5).

LB was the only social worker to be found to have contravened section 4.1.6 of the Standards (*328496 (Discipline Decision Summary and Reasons)*, 2018), which stipulates that "Information is recorded when the event occurs or as soon as possible thereafter" (*Code of Ethics and Standards of Practice Handbook*, 2018, p. 20) and section 2.20 of Ontario Regulation 384/00, which stipulates that records must be kept in accordance with the regulations and standards of the profession. The Committee referenced her failure to document a safety plan despite having knowledge that her client's siblings were at risk and informing the client's parents not to leave the youngest daughter with the accused perpetrator of sexual violence (*328496*

(Discipline Decision Summary and Reasons), 2018). The Committee also referenced her failure to record information pertaining to sexual abuse in relation to the section 2.20 breach. Strangely, sections 4.1.6 and 2.20 were not recorded as being contravened by WM, despite the Committee concluding that he had not recorded information in a timely fashion after relevant events had occurred (*326918 (Discipline Decision Summary and Reasons)*, 2011).

Self-Surveillance and Protecting the Profession.

As DS did not seek out supervision around issues of intimate partner abuse, despite being issued a warning from the Complaints Committee in 2003 regarding a similar incident, she also breached section 2.1.5 of the Standards, which stipulates self-review and evaluation of social work practice (*778075 (Discipline Decision Summary and Reasons)*, 2020). RC and WM also breached section 2.1.5 (*326918 (Discipline Decision Summary and Reasons)*, 2011; *521174 (Discipline Decision Summary and Reasons)*, 2016). For example, WM failed to report the concerns regarding the clients to his supervisor and "seek consultation when appropriate" (*326918 (Discipline Decision Summary and Reasons)*, 2011, p. 5). As stated, the complaints process reveals the work of professional bodies in the surveillance of its members. The interpretation of section 2.1.5 further reveals that the OCSWSSW recruits social workers to assist in this surveillance, not just in relation to reporting colleagues but also by encouraging self-evaluation and policing.

Surveillance is enacted not only to 'protect' service users and the broader community, but also the profession itself. Three of the social workers (*326918 (Discipline Decision Summary and Reasons)*, 2011; *328496 (Discipline Decision Summary and Reasons)*, 2018; *778075 (Discipline Decision Summary and Reasons)*, 2020) were found in breach of section 2.2.8 of the

Standard, which states, “avoid conduct which could reasonably be perceived as reflecting negatively on the professions of social work or social service work” (*Code of Ethics and Standards of Practice Handbook*, 2018, p. 13). Three also breached (*328496 (Discipline Decision Summary and Reasons)*, 2018; *521174 (Discipline Decision Summary and Reasons)*, 2016; *778075 (Discipline Decision Summary and Reasons)*, 2020) the similarly worded section 2.36 of Ontario Regulation 384/00, which states, “Engaging in conduct or performing an act relevant to the practice of the profession that, having regard to all circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional”. This was substantiated by claims that DS used inappropriate therapeutic methods that did not meet professional standards and put the client at risk of personal harm. These practices were considered “dishonourable and unprofessional” (*778075 (Discipline Decision Summary and Reasons)*, 2020, p. 9), “consistent with the findings of the Discipline Committee in other cases in which members used inappropriate therapeutic approaches that were not substantiated by credible social work knowledge” (pp. 11–12). LB was also deemed to have breached sections 2.2.8 and 2.36 of Ontario Regulation 384/00 by failing to report the sexual abuse to CAS promptly and putting the client’s siblings at risk. The Committee concluded, “The Member’s conduct falls short of what the public rightly expects of registered social workers” (*328496 (Discipline Decision Summary and Reasons)*, 2018, p. 9).

Possible Relevancy to Mental Health Social Worker-Initiated Police Intervention

Based on the OCSWSSW Discipline Committee’s interpretation of various sections of the regulatory documents used for convictions, mental health social workers may be cautious around challenging norms related to calling the police out of fear of breaching the following

elements. The Discipline Committee found that two of the social workers failed to adequately explore and address intimate partner abuse and child abuse in a timely fashion, based on section 1.2 of the Standards. The Discipline Committee made a similar interpretation of section 3.2, which was used to charge RS with failing to follow up on red flags of abuse. It is apparent that there can be overlap within the Code, Standards, and Acts, that allow for the Discipline Committee to make different rationalizations as they see fit. As for police interventions in relation to mental health, there may be concerns that these stipulations around adequate and timely inquiry may also apply to any issue of risk to harm.

Section 1.2 and Section 2.3 of the Standards, and Section 2.29 of Ontario Regulation 384/00, were referenced by the Discipline Committee in relation to breaches of legal obligation. There may be concerns that not calling the police could also be a breach of legal obligations. Legal obligations around a duty to report and protect stem from the Tarasoff v. Regents of the University of California Supreme Court of California case in 1976. This case established that psychologists and psychiatrists have a "duty to warn a potential victim when they were or should have been aware that a patient presented a serious danger to an identifiable person" (*Smith v. Jones*, 1999, p. 480). Interestingly, in this case, the psychologist had actually called the police after a client had informed him of intentions to kill a specific person. The police briefly detained the client but after release, the client ended up murdering the victim. The victim's parents sued the team of psychologists and psychiatrists responsible for the client's care for failing to warn their daughter. The court found that it was not sufficient for the mental health professionals to report to the police, that they should have also warned the victim. However, in a rehearing in 1976, the court concluded that

> The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances. (*Tarasoff v. The Regents of the University of California*, 1976)

Notification of potential violence to the police is required when there is foreseeable risk to a particular person. The court also ruled that patient privacy does not outweigh the duty to prevent harm. Partly in response to this judgment, most Canadian provinces passed permissive duty to protect legislation (Benjamin et al., 2009a). In Ontario, the Personal Health Information Protection Act (PHIPA) allows for disclosure in order to prevent or mitigate "a significant risk of serious bodily harm to a person or group of persons" (Personal Health Information Protection Act, 2004). Unlike mandatory duty to protect legislation passed in many American states, a permissive duty to protect means that mental health professionals are allowed to breach confidentiality to report risks of harm, though are not required to do so. Mental health professionals cannot be found civilly liable in these circumstances (Benjamin et al., 2009a). However, a 2006 Ontario Court of Appeal ruling found "that the court may recognize either a statutory or common law duty for a hospital to warn third parties of a danger posed by a psychiatric patient" (Benjamin et al., 2009b, p. 85). This means that while nothing in PHIPA requires disclosure, mental health professionals may be required based on caselaw. There is potentially a legal obligation for mental health social workers to report potential harm to the police, and thus, failing to make that call to the police is a potential breach of the relevant stipulations in the Standards and the Act.

Stipulations around awareness and adherence to organizational policy and mandates could also influence mental health social workers in relation to police interventions if the agency has clear stipulations around situations that require a call to police services. Examples in the tribunal findings include Children Aid Society and School Board policies regarding mandatory reporting. That said, as stated in Chapter 3, this type of policy was rare for mental health services directed at adults.

Just as DS was reprimanded for not recognizing their inadequacies by failing to use appropriate assessment tools for partner abuse, it could be interpreted that social workers must properly use risk assessments to determine potential harm and whether to call for police intervention. It may be argued that using risk assessments are a component of evidence-based practice, which is also a requirement under the Code of Ethics. However, as discussed in Chapter 7, risk assessments are seldom accurate, despite its general acceptance by the mental health and criminal justice systems.

As highlighted in the examination of the OCSWSSW Code of Ethics, social workers are unable to claim requirement of informed consent as a reason against disclosing potential harm to the police as the Discipline Committee findings explicitly pointed out allowances when disclosure is allowed or required by the law. And as stated, PHIPA allows for breaches in confidentiality in relation to risk of serious bodily harm. Instead, the tribunal admonished social workers that did not inform service users of this expectation at the start of the relationship. The rules around recordkeeping was also relevant as social workers were charged for failing to pass along information to colleagues through case notes that could have allowed for colleagues to report abuse to authorities. The same argument regarding recordkeeping and information sharing

could potentially be made for failing to document information on mental health crisis that could have led to a colleague identifying warning signs and calling the police. The failure in recordkeeping was framed by the Discipline Committee as a failure by the social worker to prioritize the interest of the client over their own. The assumption is that intervention is in the interest of the service user, though it is unclear what the specific wishes of the service users were in these cases. Had the service users disagreed with the intervention, would it still be considered in the interest of the service user? Along these lines, the Discipline Committee also argued that any concerns regarding harm should be communicated to a supervisor. This rule happens to align with procedures for initiating police intervention described by many of my interviewees in Chapter 3.

Finally, all of the allegations against the social workers were found to breach rules around avoiding conduct that could be interpreted as negatively reflecting the profession or be regarded by other members as disgraceful, dishonourable, or unprofessional. This stipulation is of course vague, but reveals that discourses related to professional social work outside of that articulated in the Code, the Standards, and the Act, may be considered by the Discipline Committee. It speaks to the relevancy of expectation both from the public and from other professionals in the disciplinary process. These expectations are shaped by the accumulated cultural histories of mental health and social work professions, and their approach to mad and other oppressed people, which will be discussed in Chapters 7 and 8.

Conclusion

While an examination of OCSWSSW disciplinary cases found no examples of social workers sanctioned in relation to failing to initiate police intervention, interviewees remain

concerned about the possibility, often citing the formal regulations associated with the social work profession as a contributor to decisions regarding mental health social worker-initiated police intervention. In Ontario, the Ontario Social Work and Social Service Work Act grants the OCSWSSW powers to regulate social worker practice based on its Code of Ethics and Practice Guidelines. These documents are ambiguous around the question of police intervention, emphasizing service user autonomy and safety in some sections, but clearly permitting or even encouraging calls to the police for certain situations in other sections. Breaches of the principles outlined by these documents could lead to sanctions ranging from reprimands and fines to temporary suspensions or revocations of registration to the college. Though not specifically related to mental health crises, an appraisal of four disciplinary decisions for cases involving alleged failures to report harm and violence found that the OCSWSSW judged the social workers guilty based on failure to address client concerns in a timely and reasonable manner, adhere to legislation and policies, maintain timely and accurate records, and uphold the reputation of the profession. The rationale provided by the disciplinary committees and the documents they rely upon to make these decisions can conceivably be interpreted as requiring social workers to call for police intervention in response to any risk of harm consistent with law or policy, or at the very least, that the supposed need to intervene in crises through calls for police intervention trumps principles of confidentiality, consent, and autonomy.

Chapter 6: The Ethos and Practices of Professionalization

Based on the observations and assessments made by Sally in Anecdote A, along with other interviewees, it is apparent that social work professionalization still partly motivates making calls for police intervention. Maya added, “for those who [were registered to a] college, there was more of that sense of the legal boundness. Whereas for folks who might not have had a college, they weren't OK with that happening”. As someone with experience both as a non-registered frontline worker and as a Registered Social Worker (RSW), Maya observed that workers that were registered to a college felt bound to practicing in certain prescribed ways, while those that were not registered had more freedom to be critical of involving the police in crises. Describing the aftermath of an incident where police was called after a service user had disclosed the desire to take their own life but refused to follow through on the safety plan, Maya noticed that non-registered frontline workers were more outspokenly critical of the actions taken during the incident and the debriefing meeting. Maya expressed that this was consistent with their own experiences transitioning from being non-registered to becoming an RSW, “To be honest, I've been on that other end and it feels a little easier to critique those who do have that responsibility because you don't have to make that final decision”. But they also remarked that it was because there was “less of that sense of punishment” that may be inflicted by the OCSWSSW.

The influence of professionalization likely goes beyond the stipulations of OCSWSSW regulating documents, given the contradictory notions contained within the code, the fact that social workers often fail to review these documents, and the lack of concrete examples of actual discipline directed at a failure to initiate police intervention. These regulatory measures cannot

wholly explain the practice. Instead, I further explore the subjectification process through which social workers impose on their consciousness professional expectations and understandings. I connect this process to the project of social work and mental health professionalization.

Edward Said (1994) argues, albeit in relation to intellectuals and writers, professionalization leads to certification that allows authority to dictate acceptable practice and ultimately, an "inevitable drift towards power and authority in its adherents, towards the requirements and prerogatives of power, and towards being directly employed by it" (p. 3). Said (1994) also mentions that professionalization leads to specialization that introduces a narrow bound on legitimate knowledge. I use this analysis from Said as a starting point in my examination of the connection between professionalization and mental health social worker-initiated police intervention.

This link between mental health social workers and the police in the context of professionalization involves the power enshrined in social workers, whether formally or discursively, to intervene in the lives of others. This power is rooted in an ongoing history of social workers advocating for better status, legitimacy, and work conditions, through establishing itself as a specialized group that can support the objectives of the state. I first examine this early history of social work professionalization, with many social work leaders arguing for recognition alongside medicine, law, and education to improve material conditions, eschewing collective labour action. Around the same time, the Canadian mental hygiene movement, with social workers making up a considerable portion of its membership, began gaining steam with similar intentions of growing the mental health sector in both legitimacy and size. Organizations like the Canadian Association of Social Workers (CASW) and the Canadian National Committee for

Mental Hygiene (CNCMH) would take the lead in fighting for the recognition of these two interlinked fields.

As Said argues, professionalization requires and contributes to both specialization and linkage with authority. For a profession to be recognized as such, it must be distinguished from other fields and from lay approaches and practices. This occurs through the displacement of Indigenous and subjugated approaches to care and social provisioning through delegitimization and violent state repression. Social work fills in the gap through specialized knowledge and approaches that are disseminated through education. Casework was the dominant approach, with further evolution into empirical clinical practice, and evidence-based practice. These approaches encompass elements that are fundamental to the professional ethos mental health social workers embody and contribute to mental health social worker-initiated police intervention. Professionalization also requires assistance from the state in certification and regulation. But conversely, in the wake of the displacement of lay care practices, professionalized social work has filled the gap as mediators between the state and the community. Social workers reinforce the settler-colonial capitalist state by taking over the social welfare work previously held by the Indian agent. Indeed, mental health social workers occupy a crucial position in the carceral/institutional archipelago, working alongside the police and other institutions, to maintain the existing social order.

Early History of Professionalization, the Rise of the Mental Health Field, and the Depoliticization of the Field

While social work is now generally accepted as a profession alongside various healthcare providers, the history of the field has been marked by debates around whether social work can

count as a profession. There were also decades of work to legitimize the various institutions linked to social work for it to establish itself as a recognized profession.

According to Edwards, Shera, Reid, and York (2006), in order to qualify as a profession, an occupation must be distinguishable based on the work involved and an associated body of knowledge; must involve education and training to "expand and refine that body of knowledge and to disseminate it to future and current practitioners of the profession" (p. 28); and must involve credentialization, controlling how professional practice is undertaken and who can participate in the practice. Other core elements of professional practices cited by scholars include the following: individual responsibility and ability to autonomously dictate course of action; establishment of professional associations and codes of conduct; ongoing assessment of professional competency; acknowledgment that work being done is for the public good or altruism (Carey & Foster, 2013; Jennissen & Lundy, 2011); and meeting market demands (Leigh, 2014).

Whether social work qualified based on these definitions was hotly contested since the field's inception. During the 1915 National Conference of Charities and Corrections, Abraham Flexner, an American reformer of medical and higher education, argued that social work did not fit the definition of a profession. Flexner (1915) stated,

> The social worker takes hold of a case, that of a disintegrating family, a wrecked individual, or an unsocialized industry. Having localized his problem, having decided on its particular nature, is he not usually driven to invoke the specialized agency, professional or other, best equipped to handle it? There is illness to be dealt with—the

> doctor is needed; ignorance requires the school; poverty calls for the legislator, organized charity, and so on. (p. 585)

The primary reason cited for social work not qualifying as a profession was that the field was too broad, and the work of a social worker was primarily focused on being a mediator for other professions like doctors and teachers. In other words, instead of providing services autonomously—a key element of a profession, social workers were thought to largely rely on and provide referrals to other services (Jennissen & Lundy, 2011).

These sentiments were common during that time period. According to David M. Austin (1983), the doctors and lawyers that frequently collaborated with social workers for individual and family rehabilitation "viewed the social workers as at best well-intentioned volunteer amateurs" (p. 360). Social service agency boards also perceived social workers not as professionals but, leaning heavily on gendered discourses considering how the profession was largely made up of women, as "well-intentioned, committed volunteers who would soon get married" (Austin, 1983, p. 361).

The American debates around social work as a profession had major influences on Canadian social work (Baines, 1998). The field in the two countries were intricately linked. Canadian social workers sought accreditation and membership in American social work associations, and participated in American social work journals and conferences. American associations were formed as early as 1912 with the Intercollegiate Bureau of Occupations including a division of social workers (Hoffer, 1947), and in 1917 the Social Workers Exchange sought to explore professionalization and this led to the formation of the American Association of Social Workers in 1921 (*American Association of Social Workers*, 2016; Austin, 1983).

Leaders in the field of social work, particularly social work educators, recognized these perceptions of social work as lacking professionalism and set out to fulfill the criteria set out by Flexner, seeking to make changes so that the general public recognize social work as a profession (Austin, 1983). This push for professionalization would be a major focus for the nascent field of social work. Professionalization leads to a number of possibilities for social workers. An explicit purpose was to "help legitimize members in provision of programs and services that helped buffer most extreme poverty" (Jennissen & Lundy, 2011, p. 21). But professional status can also help provide social workers with a competitive advantage in the labour market through the establishment of a collective identity (Carey & Foster, 2013; Jennissen & Lundy, 2011). There was a desire to address this as the social work field was predominantly women, with agency boards often believing in the stereotype of the social worker as well-intentioned volunteers who would soon be supported financially through marriage. Social workers during this time may have received stipends for the work, but this is incomparable to the income of other professionals. Austin (1983) adds, "This was an attitude that individual social workers could hardly hope to change, but one that might be modified by acting together to gain recognition as professionals" (p. 361).

An early means of professionalization was through the formation of Canadian professional associations to represent social workers. While there was significant interplay between the social work profession in the United States and Canada, Canadian social workers also recognized the need for greater independence to further professionalization strategies that match local contexts. Howard Falk, the first director of the Department of Social Studies and Training at McGill University, argued that since the social work profession is shaped by

government legislation and policies were formed on this basis, Canadian professional organizations were needed (Graham, 1998; Jennissen & Lundy, 2011).

The establishment of a Canadian professional association was spearheaded by social work education program administrators and university-trained social workers. At the 1924 National Conference on Social Work, a transnational conference made up of American and Canadian social workers, C. A. Dawson and James Alfred Dale, directors of social work programs at McGill University and the University of Toronto respectively, founded a committee to explore establishing the Canadian Association of Social Workers (CASW) (Graham, 1998; Jennissen & Lundy, 2011). The committee consulted social work agencies across the country on the feasibility of this initiative. An additional subcommittee formed at a subsequent meeting developed objectives for the newly formed the CASW, including,

> (1) to promote professional standards and proficiency among social workers; (2) to organize and maintain a placement bureau; (3) to inform the public about the social work profession; (4) to publish a bulletin; and (5) to promote research in areas that relate to the above functions. (Jennissen & Lundy, 2011, pp. 28–29)

In 1926, the CASW was established, with endorsements from almost 60 representatives from coast to coast (Jennissen & Lundy, 2006). Provincial branches would emerge later in 1938 (Wilson Marques, 2010). An announcement of the launch of the CASW in *The Compass* and *Social Welfare*, magazines published by the American Association of Social Workers and the Social Service Council of Canada respectively, described how the establishment of the CASW marked the maturation of social work, “a profession with a technique all its own, demanding a

rigorous training, and a code of ethics and standards to be lived up to" (Jennissen & Lundy, 2011, p. 30).

Its constitution was approved on September 1, 1926, stipulating the objective of the organization

> To bring together professional social workers for such co-operative effort as may enable them more effectively to carry out their ideals of service to the community. To this end the Association shall seek to promote professional standards, encourage proper and adequate preparation and training, cultivate an informed public opinion which will recognize the professional and technical nature of social work, issue an official organ, maintain a professional employment service, conduct research and carry on such other activities as it may deem appropriate. (Canadian Association of Social Workers, 1926, p. 3)

The CASW's objective was in line with the mission of professionalization, focused on establishing standards, training, and public awareness of social work.

Also in line with the professionalization process was the exclusive membership. Membership in the CASW was initially open to anyone involved in social welfare. Changes though were spurred by debates around the need for restrictions and exclusivity. Some demanded that membership be restricted to people who identified as social workers and had training in social work. G. B. Clarke, the chair of CASW, writing in a 1926 issue of the journal *Social Welfare*, argued that social work and case work is a specialized field that requires specific "qualifications in both education and personality" (Moffatt, 2016, pp. 25–26). The first set of

criteria restricted membership to those with social work training or "who have been professionally occupied with the work of social work education, organization or adjustment, and whose professional standards of behaviour are in conformity with those of the association" (Jennissen & Lundy, 2011, p. 31). CASW and its provincial branches were pivotal in demarcating the bounds of the profession, and as will be discussed in the final section, subsequently successful in advocating for state regulation of the profession and formal credentialization.

Occurring alongside CASW's emergence was the development of the Canadian mental hygiene movement, which served to professionalize psy- professions, including mental health social work. The mental hygiene movement, the precursor to the mental health field, formally began in the United States in 1909, and expanded to Canada in 1918, as an extension of the twentieth-century public health movement. William Sweetzer first coined the term mental hygiene in 1843, defining mental hygiene as the maintenance of the health of the mind, believing that a failure to do so could contribute to physical illness (W. Mandell, 2012). Isaac Ray, one of the founders of the American Psychiatric Association, adapted the term in 1863, placing less of an emphasis on the connections between mental health and corporal health. Instead, he defined mental hygiene as:

> the art of preserving the mind against all incidents and influences calculated to deteriorate its qualities, impair its energies, or derange its movements. The management of the bodily powers in regard to exercise, rest, food, clothing and climate, the laws of breeding, the government of the passions, the sympathy with current emotions and opinions, the

> discipline of the intellect—all these come within the province of mental hygiene. (Ray, 1863, p. 15)

Mental hygiene took on the meaning of preserving mental health through one's lifestyle and behaviour. One pillar of mental hygiene evident with the mention of management of bodily powers like exercise and rest was a shift from a focus on confinement of all mad people in asylums to providing interventions in the community. Mental hygiene framed mental health preservation as an endeavour to be undertaken by everyone, and mental hygiene workers had a responsibility to facilitate this. The eugenics component of mental hygiene is also evident considering the mention of "the laws of breeding". "The laws of breeding" and other aspects were understood by mental hygienists as tied to the perfection of "both the body and mind of man as well as his society" (T. R. Richardson, 1989, p. 9). Eugenics, a central pillar of the mental hygiene movement, will be more closely examined in Chapter 7.

In Canada, organizations such as the Canadian National Committee of Mental Hygiene (CNCMH) were responsible for promoting these perspectives, influencing public discourse, and advocating for eugenics policies (Dowbiggin, 1997; A. J. Joseph, 2012, 2016; MacLennan, 1987; McLaren, 1990; R. J. Menzies, 1989; Wong, 2016). The CNCMH was founded by Hincks and Clifford Beers, founder of the American National Committee of Mental Hygiene in 1918. In addition to public discourse and advocacy, the CNCMH also provided psychiatric examination of military recruits and immigrants, cared for soldiers dealing with mental health issues, and lobbied for the expansion of Canada's psychiatric system. It is now known as the Canadian Mental Health Association and remains one of the largest mental health organizations in the country with branches in every province.

The CNCMH heavily influenced professional social work practice and social workers made significant contributions in conceptualizing and putting mental hygiene theories into practice. A significant portion of the research contained in the Canadian Journal of Mental Hygiene (CJMH), a journal published by the CNCMH between 1919 to 1921 that served as its primary mouthpiece, was conducted by social workers, including contributors like Jessie Taft and R. M. McIver. As well, many of its articles relied on field research conducted by social workers, most prominent being a series of surveys of psychiatric infrastructure in various Canadian provinces. In the Foreword (1919) to the first issue, it is recognized that "as a result of psychiatric clinics and trained social workers, considerable information has been amassed regarding [mental hygiene]" (p. 1). Just as a great deal of research conducted by social workers informed psychiatric literature, it is argued that psychiatric findings should inform social work practice and the CNCMH successfully advocated for the inclusion of courses on mental hygiene and psychiatry in social work education.

As stated, the mental hygiene movement served to define professional mental health work as "a program of 'preventative medicine.'". This meant a reliance on ancillary workers that assisted psychiatrists. According to Dr. C. K. Clarke, the co-founder of the previously mentioned outpatient clinic at the Toronto General Hospital, suggested that this field would be made up of "large staffs of specially trained social workers and nurses [who will do] follow up work as well as make investigations of home conditions" (MacLennan, 1987). More generally, the CNCMH's efforts in raising public awareness of psychiatry helped build legitimacy in all psy- professions, with Clarke commenting that this promotional work was necessary to prevent "encroachment of 'amateurs'" on the work conducted by psy- professionals.

As discussed in Chapter 4, Tanya, my interviewee, shared her experience of social work tending to depoliticization, where colleagues were reluctant to consider the role of racism and other forms of oppression. The process of professionalization facilitated by the CASW and the CNCMH contributes to Tanya's observations around the depoliticized and conservative nature of social work practice. Professionalization, especially as embodied by the actions of the CASW, was partly sought out as an alternative to unionization to secure better work conditions. While several CASW committees conducted studies that concluded unions were the most effective means of protecting social workers as employees and improving labour conditions relative to professional associations, staff associations, and board-staff committees, the majority of its members still opposed union organizing. In the context of the red scare, even social workers that did ultimately form unions, such as those from the Jewish Child Welfare Association, avoided labelling themselves as a union out of fear of appearing unprofessional. This was not without merit considering how even the labour movement engaged in red baiting. The United Office and Professional Workers of America (UOPWA) had succeeded at unionizing a number of Jewish social service agencies but these efforts were curtailed by their exclusion from the Congress of Industrial Organizations because of allegations of leftist involvement; workers were also discouraged by CLC from joining the UOPWA (Jennissen & Lundy, 2011).

Many social workers also shared these sentiments. When Hazel Wigdor, a social work labour organizer, complained about the lack of initiative shown by CASW in promoting unionization, CASW executive secretary Joy Maine responded that it would simply antagonize the majority of CASW members who were opposed. According to a report by the Montreal branch of CASW, many social workers held concerns about "unions being dominated by

communists, and unions being ‘beneath our dignity’” (Jennissen & Lundy, 2011, p. 157). The concern about dignity was also linked to classism, with social workers associating labour unions with blue-collar workers and antithetical to the professionalized identity of social work. Unionization linked social workers with other workers, but this diminished social work’s social status. According to Jacob Fisher, a major impediment to unionization was that social workers felt that case work was not comparable to other forms of employment. Social workers felt that case work is a “philosophy of life” that transcends work (Jennissen & Lundy, 2011, p. 58). Some of these sentiments may have continued into later years, with social workers belonging to the Nova Scotia Association of Social Workers voting against pursuing unionization in 1974 (Harris & Beals, 2011).

Instead, social workers emphasized organizing through professional associations like CASW, where labour conditions were only understood through the context of work performance and strategies were limited to internal and public education through studies and statements. Social workers joined these associations to further the profession, to gain status through membership, and to network with others in the profession. Social workers also created staff associations, which engendered trust between management and staff, but seldom challenged work arrangements (Jennissen & Lundy, 2011). Professionalization directs critiques away from the industry and social structures, and towards individual social workers. Ungara (2007) cites the example of the OCSWSSW encouraging individual social workers to seek help from employers regarding workload stresses, and how this would also be beneficial to service users, but with little analysis of the social and economic context that bring about these heavy workloads. Collective action and direct advocacy are discouraged. This eschewing of labour struggle is

consistent with Mullaly's broader critiques that "professionalism emphasises technical aspects of helping, such as impartiality, emotional neutrality, and apolitical service. Thus, it masks the political component of social work practice" (R. P. Mullaly, 1993, p. 192).

Professionalization also means agreement "to play by the rules of a market economy and thereby has a conservative effect on the organization since it needs to compete to maintain a position of centrality in a competitive labour market" (Jennissen & Lundy, 2011, p. 34). While some within the profession have pushed for and adopted more radical strategies for social change, the move towards professionalization meant a much greater emphasis on individual-focused top-down casework and Freudian psychology (Haynes, 1998; Ungara, 2007). As will be elaborated on in the following two sections, this had a major impact on all aspects of social work, as membership, education, and professional standards were all geared towards "producing the commodity—casework" (Jennissen & Lundy, 2011, p. 34). This specialization was in order to meet the objective of ensuring exclusivity and authority for the CASW members. Likewise, the CNCMH was able to secure professional status for mental health social workers through control and production of specialized knowledge and through positioning the field as the intermediary between the community and the state by virtue of holding this 'specialized knowledge' (MacLennan, 1987).

Expert Knowledge and the Displacement of Lay Practices

MacLennan (1987) argues that "an important aspect of the professionalization of [psy-] disciplines was the production and control of specialized knowledge", as it helped legitimize "a network of institutions and services that would increase significantly the social influence of psychiatry" (p. 8). Johnston and Tester (2014) explain, "In order to be seen as a profession,

social work has to lay claim to skills and forms of practice that distinguish it from other professions, and relationships and practices that occur in the 'everyday world'" (p. 115). Professionalization can only be achieved through "laying claim" or monopolizing specific skills related to providing services in relation to the management of communities.

In the context of social work and mental health fields, this meant the displacement of Indigenous and other subjugated practices and knowledges of care and mutual aid (Chapman & Withers, 2019). Burstow (2015) describes the development of social work, and professionalized mental healthcare in particular, as part of the ongoing enclosure of the commons. Burstow follows Silvia Federici's (2004) definition of the common as including practices that nurture "relationships of mutuality with fellow commoners and developing the framework for new ways of organizing society" (Fortier, 2015, p. 19). Practices associated with the common cannot exist alongside professional social work, as the field would lose its raisons d'être, as the one legitimate approach for addressing social issues. Chapman and Withers (2019) describe the presumption of care practices and social provisioning being the exclusive domain of White professionals as one such displacement, as it renders work conducted by racialized communities, including those that informed later White social workers, invisible.

Philosophies of care outside of professional social work and the mental health field have been marginalized. While Mi'kmaw society did not stigmatize hearing voices or seeing things that others did not, colonialism meant the foisting of Western medical approaches that understood these behaviours as pathological and requiring professional intervention onto Mi'kmaw and other Indigenous communities (Chapman & Withers, 2019). Inuit Qaujimajatuqangit (Inuit traditional knowledge) has also become marginalized, with beliefs

around the need for collective remedies to harm replaced by punitive approaches that blame individuals for maladaptation. Johnston and Tester (2014) partly attribute the decline of Inuit Qaujimajatuqangit to the 1953 attempt by the Canadian settler state to apply the Northwest Territories Child Welfare ordinance to Inuit people. This meant that professional social workers from southern Canada were sent to assess the welfare of Inuit children.

Displacement also came in the form of criminalization and state violence. A prominent example of this is the state response to a free breakfast program for children organized by the Black Panther Party (BPP) in the late 1960s. The breakfast program was a major component of BPP's programs of survival, a series of initiatives designed to allow community members to have their basic needs met to have the capacity to engage in social change (Hilliard, 2010). Huey P. Newton (1972) explains, "We recognized that in order to bring the people to the level of consciousness where they would seize the time, it would be necessary to serve their interests in survival by developing programs which would help them to meet their daily needs" (p. 3). This perspective echoes Russian anarchist Pyotr Kropotkin's (1892/2008) classic argument that "it is bread that the Revolution needs!" (p. 97). Without addressing basic needs, revolutionaries are unable to operate beyond empty platitudes and fail to demonstrate new possibilities. The BPP survival programs were also meant to be prefigurative, serving as "a model for all oppressed people" confronting the structures that breed inequity and repress (Hilliard, 2010, p. 3). It is because of these lofty ambitions and the BPP's success at reaching community members that the Chicago police chose to raid its pantries and destroy provisions, even urinating on food so as to make it unsalvageable (Heynen, 2009). Alongside this disruption of BPP's survival programs, the United States government massively expanded a school breakfast program that was run

through the Department of Agriculture in 1975, responding to the political pressures stemming from BPP organizing.

Another example is the banning of potlatches by the Canadian government from 1885 to 1951 (Mustonen et al., 2021). Potlatches were ceremonies practiced by various Indigenous peoples from the North American west coast and the north, involving the redistribution of food and other goods to ensure that the needs of all in the community were met, though there are significant differences in how potlatches are carried out by different societies (Rosman & Rubel, 1972). For the Kwakwaka'wakw of the Pacific North West Coast, these ceremonies often occurred on special occasions, like births and deaths, and tended to happen in winter (Graeber, 2001). This practice was deemed unproductive and uncivilized by the Canadian government (Finkel, 2006, p. 23). Correspondence between British Columbia and Ottawa in the lead up to the ban indicated a desire to "regulate, and ultimately to destroy the social systems of the British Columbia First Nations" (Bracken, 1997, p. 1), as it was argued that potlatches "retarded civilizing influences and encouraged idleness" (p. 35). In a letter from George Blenkinsop, a government official, to Israel Wood Powell, the first Indian superintendent in Victoria, British Columbia, it was stated that the potlatch had to be stopped in order to "bring [Indigenous people] under the sway of civilization" (Bracken, 1997, p. 37). It is important to note that potlatch ceremonies continued to be held in secret after criminalization, testament to Indigenous resistance and resilience (Mustonen et al., 2021). But ultimately, the attempted displacement of Indigenous and subjugated knowledges and practices of self-reliant mutual aid was followed by the imposition of Indian agents and subsequently, social workers (Chapman & Withers, 2019; Fortier & Wong, 2019).

The services provided by social workers and mental health workers were represented as based on a social work knowledge distinct from the lay knowledges and practices that were displaced, which Simpkin (1983) considers as a primary means by which social workers could claim to be a profession. This distinguishment is consistent with Said's (1994) claim that the pressure of specialization in relation to professionalism causes a narrowing of one's scope of knowledge and a disconnect from experience and context through an "increasing technical formalism" (p. 2). This was why social work leaders argued for a more systematic, science-based process in how charity is dispensed during the early days of social work (Healy, 2014).

One such systematic approach that would come to dominate social work and mental health fields was casework (Hugman, 1991; Moffatt, 2016). At the same 1915 conference Flexner presented at, Porter Lee, chair of the NY School of Philanthropy, claimed that social workers were qualified to promote social welfare in ways other professions cannot—through the practice of case work. Social work practitioners and scholars like Mary Richmond, who also served as the president of the National Association of Social Work, contributed to this specialization. Richmond published *Social Diagnosis,* a book on casework, two years after the conference, with a focus on individualized diagnosis and treatment (Jennissen & Lundy, 2011). This publication quickly became an authoritative social work text, articulating a form of casework that combined the disparate approaches to the practice in the field and differentiated the task of social workers from other professions (Okpych & Yu, 2014). Applying the scientific method to social work practice, Richmond proposed that social workers gather facts to develop a hypothesis that can then be tested (Healy, 2014). By the 1930s, both the CASW and the Canadian Council on Child and Family Welfare declared casework as "the basis of modern

social work" (Moffatt, 2016, p. 27). Okpych and Yu (2014) describes this period from 1920 to the 1960s as "an era of normal practice," a reference to Thomas Kuhn's "normal science", a time period marked by the dominance of an established paradigm from which scientists operate. Okpych and Yu (2014) explain that "an expanding menu of practice methods derived from expert practitioners were refined and faithfully employed, and specialized areas of practice multiplied and broadened" (p. 13).

This specialized knowledge was partly disseminated through social work education. Graduates, as recognized holders of this specialized knowledge, can identify as professional social workers (Baines, 1998). As stated in Chapter 3, while most interviewees did not directly attribute their social work practice to their education, one interviewee did suggest that education was important in "priming" social workers to embody "a specific ethos of professionalism". This is in line with Nilsen's (2021) argument that a "*professional ethos* [is] brought forward through academic systems and professional institutions" (p. 361), and scholarship that notes how the "implicit curriculum" of schooling accultures students to expected attitudes and behaviours associated with the profession. For example, Kelly and Chapman (2015) explain that

> In many training contexts, professionals are formally taught to trust their own knowledge and that of other professionals and are given techniques for managing resistant and noncompliant patients and clients. Professionals are commonly taught that professional knowledge is objective and impartial and that they therefore know better than client groups. (p. 55)

Social workers may be taught through the training process to exalt the specialized knowledge associated with the profession and invalidate the perspectives of service users.

Conversely, having educational programs linked to social work was crucial to its acceptance as a profession. Just as all the other recognized professions, including law, medicine, and theology, were associated with college and university programs, according to Austin (1983), establishing social work education helped assert the legitimacy of social work professionalism. Helen MacMurphy, a prominent mental hygiene movement activist, echoed this sentiment, proposing that "the expert knowledge on which to base programs of mental hygiene will be produced under the auspices of Canadian universities" (MacLennan, 1987, p. 15). And considering greater legitimacy to the profession would also lead to greater legitimacy for social work education, many social work scholars were also "committed to furthering the social work professional enterprise in alliance with field practitioners and through the medium of formal education" (Graham, 1998, p. 181).

Inspired by the first training courses for social workers organized by the New York Charity Organization Society in 1898, informal lectures on social work were organized throughout Canada in the early 1900s. One of the earliest initiatives involved the Social Science Study Club, made up of 275 women, largely from the social elite, and the Toronto Social Workers' Club, made up of 21 women leaders from the social services dedicated to improving professional standards (Graham, 1998; Jennissen & Lundy, 2011). In 1914, these two organizations collaborated with the University of Toronto to establish Canada's first Department of Social Services. With 281 students enrolled part time and 12 enrolled full time, the program provided courses on social psychology, economics, and community practices. In 1918, a

department of social studies and training was also established at McGill University in Montreal, providing the first university degree that taught social work theory and practice courses, though the program was geared towards male clergy (Jennissen & Lundy, 2011).

In 1919, social work schools throughout the United States and Canada formed the US Association of Training Schools for Professional Social Work, known today as the Council on Social Work Education. The association had the mission of creating standards for social work education, with a strong desire to emphasize casework. This mission was a challenge, however, as there were disagreements between and within schools of social work on how to approach social work education (Baines, 1998). At the University of Toronto, some refused to shift focus away from teaching social advocacy and a more generalist liberal arts education. But despite this opposition, casework still became a significant component of the curriculum (Graham, 1998), as was a strong focus on individualized interventions (Moffatt, 2016).

This push for casework also happened alongside the inclusion of mental hygiene and psychiatry in social work curriculum. In the CJMH, R. M. MacIver (1919), a professor and acting director of University of Toronto's Department of Social Service, criticized the current social work curriculum for being inadequate and proposed including psychiatry and psychology courses. Gordon S. Mundie (1920), the CNCMH's medical director, also argued, "To fulfil all these conditions the social worker must have a good general education, a course in general social work, a course in neuro-psychiatry, including case-taking and field work" (p. 245). Mundie believed the inclusion of these courses was necessary given the social work field's close relationship with psychiatric work. The CNCMH established a two-month course in mental hygiene at the University of Toronto's Social Service Department in 1919. By 1922, Hincks

recognized that “many Colleges have made provision for the instruction of social workers … in mental hygiene” (MacLennan, 1987, p. 16).

The post-World War II period saw continued professionalization in the context of education. The University of Toronto social work program now required all instructors to have a graduate degree and increased its emphasis on more specialized forms of psychiatric casework. More and more social workers were also obtaining social work academic credentials. The annual number of university social work program graduates gradually increased, from 351 in 1948-1949 to 853 in 1968-1969. And while there were only three social work schools in 1939, by the 1970s, there were seven additional MSW programs, 18 BSW programs, and over two dozen college or CEGEP programs related to social welfare (Graham, 1998).

By the late 1960s, efforts to legitimize the profession of social work faced a major crisis, with multiple studies concluding that social work interventions lacked efficacy, and funding bodies and governments, including the Nixon administration in the United States, scrutinizing the field and demanding accountability for their investment. These findings spurred the emergence of a new dominant approach in social work: the empirical clinical practice movement (Healy, 2014). The three main elements of empirical clinical practice include: appealing to the effectiveness of an intervention instead of authority; using research methods to assess, treatment plan, and evaluate social work practices; and combining practitioner produced research with large-scale evaluations in order to develop an empirical knowledge base for the profession (Okpych & Yu, 2014).

Empirical clinical practice would evolve into evidence-based practice. This approach to social work was deeply influenced by evidence-based medicine (Crampton, 2015). As had

occurred with social work in the late 1960s, medicine attracted significant scrutiny in the 1970s and 1980s after studies uncovered inconsistent clinical decision-making and inappropriate care. While there is no consensus on what evidence-based practice means in social work, a survey of MSW educators indicated an association of evidence-based social work with the evidence-based medicine's five-step process and the use of empirically supported interventions (Okpych & Yu, 2014). The five-step process involves: asking a question; seeking information and evidence relevant to answering the question; assessing the evidence; applying evidence based on clinical judgment and bottom-up accountability; and evaluate the effectiveness and efficiency of the entire process (Straus et al., 2018).

Evidence-based practice is now enshrined in social work practice through the CASW's Guideline of Ethical Practice and the OCSWSSW's Standards of Practice (Canadian Association of Social Workers, 2005b; *Code of Ethics and Standards of Practice Handbook*, 2018). As examined in the previous chapter, Section 2.1.4 of the OCSWSSW's Standards of Practice state, "College members ensure that any professional recommendations or opinions they provide are appropriately substantiated by evidence and supported by a credible body of professional social work knowledge or a credible body of professional social service work knowledge" (*Code of Ethics and Standards of Practice Handbook*, 2018, pp. 11–12). In other words, it is considered a misconduct and unethical to not engage in evidence-based practice and social workers must practice in this manner or risk discipline. Similar stipulations exist in the United States (Anastas, 2014).

Despite the positioning of evidence-based practice as a response to past inadequacies, evidence-based practice did not actually serve as a clean break from past approaches. It actually

further reinforced the principles underlying existing practices in the ongoing quest for professionalization (Taylor & White, 2001). For example, it served as a continuation of Richmond's call to apply the scientific method, but instead of relying on single case studies, empirical clinical practice relies on "more robust scientific methods, preferably experimental designs, for designing and testing social work approaches" (Healy, 2014, p. 98).

But perhaps more importantly, the central issue of the displacement of Indigenous and subjugated approaches and the elevation of social workers over community members remain in all these different iterations of professional social work practice. While evidence-based practice is sometimes framed as a shift away from authority-based practices that rely on individual judgment, in truth, formulations of evidence-based practice always include three components: research evidence, client values, and clinical judgment (Zayas et al., 2011). Clinical judgment remains integral to how social workers practice (see Chapter 3), though social workers may no longer appeal to authority when justifying their clinical judgment. They may instead appeal or rationalize their decisions based on evidence gathered from experience and research, though ultimately it is still their own judgment imposed onto the community. As noted in Anecdote A, even the OCSWSSW refused to offer prescriptions, but instead called on Sally to use her clinical judgment to determine the course of action. Valerie, another interviewee, also noted that clinical judgments were an important component of daily practice. She appreciated that she had the autonomy to practice and was not "micromanaged". Indeed, some social work scholars are even arguing for a greater renewed emphasis on clinical judgment in evidence-based practice, rejecting mechanical application of prescribed best practices (Grady & Keenan, 2014; Zayas et al., 2011). As I discussed in Chapter 3, my research participants and other clinical social workers

interviewed (Grady & Keenan, 2014) reported a greater focus on field experience. The 'new' approach continued to cement the conceptualization of the social work profession as expertise based and top-down.

Clinical judgment operates alongside the biomedical approach, which has dominated the profession from its earliest days. Richardson (1989) notes that the CNCMH's understandings of mental disorder were heavily tied to this approach, the "Canadian mental hygiene movement was similar to the United States movement in that it popularized a medical perspective in eliminating social problems prior to any substantial advances in scientific research concerning the causes or cure of mental abnormality" (p. 73). Consistent with Richmond's social diagnosis, this framework understood the work of the social worker as a diagnostician, identifying problems as rooted in the individual. This approach neglects or ignores the structural or societal causes of issues faced by service users. The target for change is the individual themselves and not policies or social structures. This approach was an attempt to mirror the practices of the established medical profession, with its focus on locating maladies in biological causes and pathologizing deviations from the norm, devaluing and delegitimizing the perspectives held by mad and other oppressed people (Healy, 2014; Withers, 2012). Another element of this diagnostician approach is a purported ability to predict dangerousness, or future harm committed by mad people. This will be elaborated on in Chapter 7. The biomedical approach is also apparent in the terminology used and framing of crisis situations by interviewees discussed in Chapters 3 and 4.

These professional social work approaches cement social workers' position as the expert tasked with producing 'active citizens'. This framework paints marginalized peoples as the opposite—'bad citizens'—so that social conditions are individualized and pathologized,

attributed to “aspects of the interior world” (Bonnycastle, 2006). Social workers are brought in as ‘virtuous’ and ‘benevolent’ helpers to address the problem of “people and their communities lack[ing] the emotional and psychological resources necessary to deal with change and make choices”. Action and agency is possessed by the social worker, “and leaves no active role or source of expertise to others” (Crampton, 2015, p. 5). Most importantly, Bonnycastle (2006) argues that social workers aim “to help vulnerable clients make the reasonable choices they would make for themselves, if only they had the strength of will and human agency” (p 87).

The top-down, distant, and unidirectional nature of professionalized social work is especially apparent with Indigenous communities. Through professionalization, the relationships formed between social workers and the communities that they seek to ‘help’ are circumscribed by a set of principles that position the social worker as the provider of knowledge/services and Indigenous peoples as the recipient or beneficiary, a common settler colonial trope. The previously mentioned introduction of professional social workers to Inuit communities through the imposition of the Northwest Territories Child Welfare ordinance is illustrative of this process. This move has been criticized for leading to social provisioning that is “aloof and impersonal and [...] bound to be or become bureaucratic, indifferent, dilatory and inefficient” (Sissons, 1962, p. 1). Today, Nunavut’s child welfare system continues to be guided by Western concepts of child welfare that fail to cede autonomy and authority to Inuit communities, and the incorporation of Inuit social workers is often seen as a token gesture (Johnston & Tester, 2014).

Social workers, including in Nunavut, use a number of techniques to maintain ‘expert status’. One such technique is professional distancing (Green et al., 2006; Johnston & Tester, 2014). Professional distance involves social workers being task focused, creating social distance,

emphasizing formality (Walsh, 2011), and expressing themselves through jargon (Green et al., 2006). This focus on the establishment of an 'appropriate' client-worker relationship leads to challenges in connecting with the local community and limits opportunities for community accountability. Professional distancing transforms face-to-face contacts into "contact between things", whereby "social relations become confused" (Rojek, 2012, p. 38). Professional distancing operates like the use of "winged words", as discussed in Chapter 4, easing any resistance or apprehension against engaging in coercion and violence. In fact, Nilsen (2021) notes that professionals that were closer to management or more educated were more likely to use professional language, creating a greater "disjuncture between word and experience … more distant from the everyday life" (p. 368). The use of professional distance is also a keystone of managerialism, eschewing practices of relationality.

Managerialism entails an emphasis on bureaucratic procedures and policies, marked by a focus on competency-based practices and efficiency. This is in part a response to a fear of complexity, reframed as risk (which is another crucial factor in mental health social worker-initiated police intervention to be discussed in Chapter 7). The bureaucratic procedures and policies referenced are an attempt to contain or mitigate risks (S. A. Webb, 2006). Dominelli (1996) explains that managerialism creates

> highly stressful and poorly resourced conditions. These realities are structural problems which cannot be dealt with by the competency-based approach which presupposes that: what needs to be done in each situation is known and infallible; resources are adequate for the tasks at hand; and social work relationships operate in a social vacuum. (p. 168)

Competency-based social work, a bi-product of managerial relationships, fails to consider local contexts or address structural problems created by settler colonialism, a problem that also has significant impacts on non-Indigenous communities. Social work practices de-emphasize relationship building in favour of efficiency, expediency, and expertise. Rather than meet its treaty and social obligations to Indigenous communities through land repatriation and the transfer of fiduciary responsibilities back under control of Indigenous communities—which would go a long way towards addressing the acute issues faced by Indigenous peoples—the settler state focuses resources on monitoring and supervising people, the realm of the professional social worker as previously stated.

Crampton (2015) frames these practices as based on notions of permanence, whereby professional social work practices are understood as universal. Permanence in evidence-based practice is established through scientifically derived evidence that is replicable and consistent over time. Usually, this means a reliance on work produced in an academic setting. But this approach does not address concern of local contexts. Taylor and White (2001) offer a similar description of professional social work practice, stating that it "Primarily [] offers certainty in the very uncertain and continually changing world of social work and health and welfare more generally" (p. 39). Other critics have also argued that evidence-based practice lacks flexibility, and fails to recognize the importance of therapeutic relations and practice wisdom (Okpych & Yu, 2014).

These discourses and practices associated with professionalization serve as the bedrock for many of the discourses that motivate and are used to rationalize mental health social worker-initiated police intervention. It is these areas of practice and subjectification—clinical judgment,

biomedical approach, production of active citizens, professional distance, managerialism, permanence, among others—that are fundamental to the professional ethos mental health social workers embody. As will be discussed in the following chapter, this professional ethos fosters the notion that coercive responses to psychiatrized people are the default approach, a perspective buttressed by the historical accumulation of discourses and practices that represent mad and other oppressed peoples as threats to society. The positioning of social workers as experts provides ideological justification for social workers to impose this coercion upon psychiatrized people, as social workers understand themselves and are understood by others as having the specialized knowledge to identify problems and make the 'better' decisions that psychiatrized people ought to have agreed to had they been of sound mind.

The displacement and delegitimization of lay alternatives to professionalized social work approaches discussed earlier in this section also means that mental health social workers, including many of my interviewees, perceive police intervention as the only response to crises. As discussed in Chapter 4, my interviewees reported that social workers often struggled to come up with alternatives to police interventions. In discussing possible alternatives, Maya commented, "I think the challenge in this was just literally not knowing what else to do … it really just felt like we didn't have another option." Chandra also felt that as soon as the crisis escalated to a point of imminent harm, no alternatives to police intervention existed. The few alternatives that did emerge were still within the confines of the medical system, such as ambulances, crisis intervention teams made up of nurses, and short-term mental health crisis residences. Maya imagined the possibility of non-carceral and non-medical alternatives but suggested this would require "more resources pumped into creating these spaces". In other

words, they did not exist at the moment. In Maya's example in the introduction, non-professional workers were more likely to be critical of police intervention, though presumably they may not have had as much influence over decision-making given that legitimization and professionalization cannot help but delegitimize those that do not benefit from them. It is no surprise that social workers struggle to find alternatives when existing alternatives are foreclosed through delegitimization—at least in the view of professional social workers—or starved of resources.

Collaboration with the Settler-Colonial Capitalist State

As alluded to throughout the last section, the state has a significant relationship to social work professionalization, a relationship that is especially relevant to the issue of mental health social worker-initiated police interventions. The state is reliant on social workers to serve as mediators with its population and as a key element of the carceral/institutional archipelago. Indeed, the specialized knowledge discussed above has allowed social workers to promote themselves as the appropriate group to manage state programs. Conversely, social workers are reliant on the state for recognition and legitimacy as professionals. Said (1994) explains, "To be an expert you have to be certified by the proper authorities; they instruct you in speaking the right language, citing the right authorities, holding down the right territory. This is especially true when sensitive and/or profitable areas of knowledge are at stake" (p. 77). A key authority to lend legitimacy to a profession is the state. So, by virtue of attempting to legitimize itself as experts through professionalization, mental health social work draws itself to the state, and by extension, to the broader social order (Yu & Mandell, 2015). In fact, Yu (2015) argues that "social work cannot exist and operate independently of and beyond the political-economic

regime within which its professional identity is defined and from which it derives legitimacy and professional authority" (p. 169).

These perspectives on professionalization as inviting the state to dictate terms of practice to serve in the maintenance of settler-colonial capitalism, makes it even more ironic that some social workers thought that professional associations could serve to defend social worker autonomy. Several cases demonstrated that the politics underlying professionalization were not geared towards all forms of autonomy, and especially not for political expression that challenged the existing power relations. In 1947, Mary Jennison, a founding member of the CASW, the editor of *The Social Worker* (Jennissen & Lundy, 2011), and a major figure in the settlement and peace movements (Marion, 2017; Yerichuk, 2015), was fired by the Dale Community Centre in Hamilton on suspicions of being a communist. Jennison had been under RCMP surveillance for her political activism in Quebec since the 1930s (Jennissen & Lundy, 2006), and was also the target of red-baiting from journalist Ronald Williams (Guard, 2019), who identified her in an article entitled *Are you a Stooge for a Communist?* in *Chatelaine,* a women's magazine (Williams, 1949). Nora Rowe, a national representative of the CASW, initially declined to address the matter, claiming that Jennison had not requested assistance and suggesting Jennison "had breached social work ethics" through her political activity (Jennissen & Lundy, 2011, p. 122). Instead of providing support, Rowe recommended that the CASW branches should study the issue of professional ethics.

Though the CASW after investigation concluded "political affiliations of social workers are a matter of personal conscience, and should not be the reason for dismissal", it also stated that "social workers must realize that the result of their affiliations and actions politically are

their individual responsibility" (Jennissen & Lundy, 2011, p. 124). This qualification meant that the CASW only offered meek protest and appeared to distance itself from Jennison, rejecting a suggestion to make Jennison an honorary member, despite Jennison being a founding member (Jennissen & Lundy, 2011, 2006). This lack of support meant that Jennison was unable to find employment in the social work field. In a 1948 letter published in *The Social Worker,* Jennison stated that blacklisting from the profession was not a tactic uniquely applied to her, and that others had also been blacklisted for their political inclinations.

Indeed, in another example, Derek Decker, a Newfoundland social worker, was fired in 1951 for criticizing the Minister of Welfare. The CASW refused to intervene and Joy Maine, the CASW executive secretary, even argued that the firing was not an ethical concern since she was sure the Minister would have good reason to fire someone and that the CASW had no authority over those outside the profession. It is evident that the professional association had no intention to protect member autonomy in relation to actions that contradict the status quo (Jennissen & Lundy, 2011). These two cases bring into question the notion that professionalization and professional associations serve to protect social worker autonomy—at least in the context of political activism. The cases also illustrate the cozy relationship professional associations can have with the state, with leadership quick to defend state officials, even suggesting that oppositional political activity could constitute a breach of professional ethics.

In a more contemporary example, Deena Mandell, a professor of social work at Wilfred Laurier University, wrote of how the university department hosted a talk by community activist Alex Hundert on the G20 protests. Hundert had been out on bail after being arrested on charges related to the protests and was rearrested as his participation in the university event was

deemed by the police as a breach of bail conditions. It was later revealed that undercover police were present at the university event, and evidence collected was used to justify the arrest. Mandell was dismayed at the apathy shown by fellow social workers, including professors and students, towards the arrest and the presence of state surveillance apparatuses at the university. Mandell and Hundert (2015) stated, "Although members of the social work faculty and staff were individually sympathetic and personally supportive … the absence of a coherent, outraged response was profoundly disappointing. Calls to action were met with responses that ranged from none to limp" (p. 10). Mandell and Hundert (2015) attributed this apathy to professionalism, that "social workers' preoccupation with professionalization is a clear sign that we are invested in a system of privilege and alliance with power that makes true push-back unlikely" (p. 11). They believed that professionalism denotes acceptable social work practice and that while social justice and economic concerns are a core responsibility for the profession, the investment in the existing social order means operating within its confines. Since political action and community organizing are not considered part of the repertoire of acceptable professional practice, there was a lack of impetus to intervene on issues of surveillance and political repression in such a manner.

Mandell and Hundert (2015) also attributed a failure to challenge repressive norms to the fact that "Our social work system is too dependent on state funding for social workers to act freely as agents of conscience" (p. 11) Much has been written regarding the role of state funding as a means of social control. In the previous example of the state reprisal against the BPP survival programs, it was mentioned that the American government attempted to limit the influence of BPP through funding its own breakfast program. This act is consistent with Robert

L. Allen's warning about the co-option of the Black Power movement by the Ford Foundation as early as 1969. The Ford Foundation flooded money into charity initiatives, diverting energy and funds to non-profit agencies for the purpose of "monitor[ing] and control[ing] social justice movements; [...] manag[ing] and control[ing] dissent in order to make the world safe for capitalism" (A. Smith, 2007, p. 3). A similar process occurred in the context of the disability movement. Michael Oliver (2009) explains that the disabled people-led activist organizations that gained prominence in the 1970s through the civil rights movement met a decline with the establishment of big charities not run or led by disabled people, a process termed disabling corporatism. These major charities, with greater resources, are more effective at competing for government contracts, while appropriating ideas and languages developed by disabled activists.

A. Smith (2007) describes these relationships between charity organizations, states, and capitalists as the non-profit industrial complex (NPIC). The NPIC employs a significant proportion of social workers for the purpose of surveillance and control as mentioned above. A major means of accomplishing this purpose is to encourage "career-based modes of organizing [, or professional social service provision,] instead of mass-based organizing capable of actually transforming society" (A. Smith, 2007, p. 3). An emphasis on career-based modes of organizing has meant that the non-profit sector is led by 'economic instrumentalists', who join these organizations as a means to build up their careers, or 'political instrumentalists', who genuinely believe that there are no other means to improving the lives of disabled people beyond working within the system. Both political and economic instrumentalists tend to fear radical change, and the organizations they lead reflect this mentality (Oliver, 2009). This mindset also means that political resistance, including resistance against police intervention, may be discouraged "as

being beyond the limits of legitimate professional action … [as] professional action [is confined] within the policy and legal framework of the established order" (Yu, 2015, p. 169).

Despite this history of the state being a major actor in punishing social workers for political activism and professional social worker associations' patchy record in defending workers from reprisal, some professional association representatives blame the lack of state regulation for impediments on social worker autonomy. In 1992, Dan Andrae, head of Project Legislation, an Ontario Association of Professional Social Workers (OAPSW) committee that advocated for regulation of the profession through government legislation, argued that

> The lack of regulation will mean a significant reduction in the autonomy for social workers in the system and will continue to affect the social worker's ability to influence policy, especially in health care delivery. The social service and health care systems in Ontario are being radically restructured and, unless social work is a regulated profession, it stands in danger of ' falling between the cracks' ... Social workers must be committed to the issue of regulation and to the fact that, with no regulation, the public is not protected and we are marginalized. (Phillips, 1992, p. 3, as cited in Ungara, 2007)

The CASW pushed for licencing and professionalization across the country, though for much of the century, provincial governments refused to pass legislation. This meant that people without accredited social work university degrees or people deemed to have engaged in unethical practices could still call themselves social workers. The Canadian Association of Schools of Social Work, the precursor to the Canadian Association of Social Work Education (CASWE), also advocated for licensure and professionalization (Hardina, 1994). It was certainly in its

interest, since it guarantees enrollment to Social Work programs for those intending to work in the profession.

In Canada, regulation of the social work profession occurs at the provincial level. One of the first provinces to regulate the social work profession was Manitoba. In 1966, the Manitoba Institute of Registered Social Workers was made responsible for setting standards of practice and adding social workers to a public registry (Wilson Marques, 2010). Inclusion in the registry required the applicant to possess a minimum of a Bachelor of Social Work (BSW) and 40 hours of professional development in the year preceding the application. While registration was voluntary, to use the title of Social Worker or Registered Social Worker, one must belong to the provincial association. Most other provinces do not make the distinction between use of title and registration (Ungara, 2007). Throughout the 1990s, the Maritime provinces and Newfoundland and Labrador made holding a minimum of a BSW the requirement for use of social work title. In Nova Scotia, the government also requires 2500 hours of supervised social work experience (NSCSW, 2022). Quebec also has mandatory registration. A BSW is required to use the social work title, while a social service diploma allows access to “social service technician” or “human relation agent” titles. Quebec requires candidates who completed their social work education in another language to pass an examination demonstrating proficiency in French (D. Collins et al., 2002). Alberta was the first province to pass social work legislation in 1966 (Ungara, 2007). A diploma in social services, and not a BSW, was all that was required to use the title of Social Worker. With the Agreement on Internal Trade, which requires transferability and consistency between provinces, coming into force in 2005, Alberta now obligates social workers to have a

BSW at a minimum. British Columbia and Saskatchewan also require either a BSW or a MSW (D. Collins et al., 2002).

While the Ontario Association of Social Workers (OASW)—also known as the Ontario Association of Professional Social Workers (OAPSW) for a time—was formed in 1962 to advocate for social work legislation in the province, Ontario was one of the last provinces to formally regulate the profession. Though the Ontario College of Certified Social Workers was created by the OASW in 1982 as a regulatory body, membership and, thus, regulation was voluntary (Ungara, 2007). The reason for the late implementation of regulation was because of organized opposition, including from other professions—like psychologists and doctors, and politicians (Hardina, 1994). But opposition also appeared within social work, especially from the Canadian Union of Public Employees (CUPE), which represented many social welfare workers, and the Social Work Education Action Team (SWEAT). The New Democrat (NDP) government in office from 1990 to 1995 was not receptive to what they viewed as privatization of the profession (Ungara, 2007). The Ontario Ministry of Community and Social Services under the NDP also raised concerns that regulation of social work would lead to the exclusion of Indigenous social service workers and those in racialized communities, many of whom did not have the correct credentials (Hardina, 1994).

But with the Ontario Progressive Conservatives coming into power in 1995, OAPSW's lobbying, and especially its emphasis on stopping social worker misconduct, finally met friendly ears (Swain, 2001; Ungara, 2007). The Social Work and Social Service Work Act, as first discussed in Chapter 5**,** was passed in 1998, formalizing the regulation of the social work profession in the province. Opposition from within the social services field continued to express

concern that the campaign for regulation overstated the problem of social worker malpractice (Hardina, 1994). CUPE felt that social work legislation unfairly painted social workers as the source of problems or as having competency issues. It was felt that this framing deflects away from critiques of government underfunding and social inequities. Those opposed to regulation also felt that OAPSW had spent the majority of its resources on advocating for regulations at a time when these resources were needed to advocate for marginalized groups.

The Social Work and Social Service Work Act required registration with OCSWSSW to use the titles of Social Worker or Social Service Worker. The former requires a BSW or MSW and the latter, a SSW diploma (D. Collins et al., 2002). BSWs and MSWs must be issued by a Canadian university accredited by CASWE or an American university accredited by the Council on Social Work Education. Applicants must separately apply for assessment of academic qualifications and experience if their BSW was from a program outside of Canada and the United States without CASWE accreditation. The applicant must also be supervised for 700 hours by a RSW within the year (*Register as a Social Worker*, 2022). If someone was to use the title of "social worker" without registration with the OCSWSSW, the first offence would result in a fine of $5000 and the second offence would result in a fine of $10,000 (Ungara, 2007). And not only did these regulations mean that the state would help maintain exclusivity around who can identify as a social worker, it also made upholding the law as a prerequisite to maintaining membership in the profession. As discussed in Chapter 5, sections within the OCSWSSW Standards of Practice and Ontario's Social Work and Social Service Work Act stipulate that social workers must be knowledgeable of legislation and define a breach of federal, provincial, territorial, or municipal laws and bylaws as professional misconduct.

Therefore, just as professionalization draws social workers towards the state in their demands for regulation, it has also coincided with greater collaboration with state carceral institutions. During my interview, Eva commented, “I think I just feel inherently—when you are an RSW, I think you are tied to the state, an arm of the state in some capacity”. This statement was made in relation to mental health social workers’ connection with state carceral institutions through the use of coercive practices like Community Treatment Orders (CTO) and forming, and the modelling of police responses in their emphasis on these forceful measures during crises. Eva tied this approach directly to registration with the OCSWSSW.

Eva’s statement has resonance with the emergence of social work expertise and professionalization coinciding with an increased demand for social workers during the Great Depression in the 1930s, with the expansion of bureaucracy in relation to the distribution of relief, mental health services, and eugenics practices (see Chapter 7). Professionally trained social workers marketed themselves to the government as especially well-suited to efficiently manage social programs relative to seconded government employees and volunteers. In particular, social workers, like Charlotte Whitton of the Canadian Council on Child Welfare, argued that their specialized skills in investigative casework made them effective gatekeepers, skills that would help social workers distinguish between those worthy and unworthy of support. Social workers often made this argument in coalition with business groups concerned about the financial cost of the relief programs in terms of its impact on state coffers and on the work ethic of the general population (S. Ross, 2005; Struthers, 1983).

Social workers also volunteered to oversee Indigenous communities. The Indian agents did not simply disappear, as the work of the Indian agent was divested to other members of

settler civil society, and social workers in particular, in the lead up to major revisions of the Indian Act in 1951. In a joint brief submitted to the Special Joint Committee responsible for examining the Indian Act, the CASW and the Canadian Welfare Council (CWC) "advocated the full assimilation of Canada's Indigenous population while emphasizing the importance of nominal community autonomy but with the extension of settler-controlled provincial services including health and education into Indigenous communities" (Fortier & Wong, 2019, p. 441). The joint brief emphasized the need to recruit 'qualified personnel' (i.e. social workers) to provide and manage the services that were previously the responsibility of the Indian agent. This submission and its recommendations were accepted by the committee not because "they were original but rather that they agreed with what was already becoming evident in federal Indian policy" (Shewell, 2004, p. 192). In effect, the CASW and CWC helped the state legitimize colonial violence by reframing it as benevolent and professional social services provided for the betterment of Indigenous communities. Fortier and Wong (2019) conclude, "The transition of the social welfare roles of the Indian agent to professional social workers was seamless" (p. 441). By 1949, nine social worker positions had been created to assist in Indian welfare in offices across the country. With the revisions to the Indian Act in 1951, social workers now occupied key responsibilities previously held by Indian agents, including: general welfare services, children & family welfare, recreation, and adult education.

The Canadian mental hygiene movement's campaign for professionalization and greater resources placed a significant emphasis on "encouraging the state to assume greater responsibility in the area of public health [and the] … management of social problems" (MacLennan, 1987, pp. 10–11). In particular, the movement claimed scientific backing for the

state to incorporate psy-professions in the "formulation of social policy and the provision of social service" (p. 11). The CNCMH was successful in its lobbying efforts, with state officials instituting psychiatric rehabilitation of veterans returning from war, psychiatric assessment of immigrants, and forced sterilization.

The institutionalization of these practices meant mental health social workers became significant contributors within the broader psychiatric and carceral systems (this notion is elaborated on in Chapter 8). For example, mental health social workers in guidance clinics helped identify potential candidates for sterilization in the community (see Chapter 7). Indeed, social workers were considered an arm of the hospital and courts that extended their reach into the community. In the CJMH, Arthur J. Morphy (1920), a professor of psychiatry at McGill University, explained,

> [psychiatric hospitals] must of necessity be in the centre of things, not removed to a secluded spot like a hospital for the insane. It is the centre of a co-operative system consisting of ... social workers who are in touch with the public through the various Social Agencies found in a large city. (p. 172)

Social workers were seen as facilitating the positioning of the mental hospital in the midst of the community, through providing services directly to the public. Social workers were also seen as having the role "of an assistant to the physician. Through her he extends the range of his observations into the environment of his patient" ("Book Reviews," 1920, p. 130). Social workers go where the physician may not, providing relevant information and observations from the community to the physician. The legal mechanisms and collaborative programs discussed in Chapter 4 reflect this arrangement. For example, mental health social workers help administer

CTOs through monitoring program participants. Social workers report any change in behaviour or risk to the psychiatrist, which may lead to police-intervention and involuntary hospitalization. These programs illustrate Schenwar and Law's (2020) argument in *Prison by Any Other Name,* that the monitoring and surveillance function of social workers crucially broaden the scale of mass incarceration, and does not serve as an alternative.

Conclusion

The subjectification process experienced by social workers has a major influence on decisions around mental health social worker-initiated police intervention, a process heavily informed by the professionalization of social work in Canada and Ontario. In its early history, social workers struggled for recognition as a profession, especially against more established professions like doctors and lawyers. Social work was understood as subservient to these other professions, compounded by gendered discourses in relation to the profession being made up largely by women. With time, the social work profession gained legitimacy through the establishment of social work university programs and professional associations like the CASW. Alongside these developments was the emergence of the mental hygiene movement. With heavy influence from social workers, the mental hygiene movement played a key role in popularizing eugenics discourses and practices. The mental hygiene movement would ultimately evolve into today's mental health field, with social workers established as specialized technicians in this field. This move towards professionalization also marked a rejection of unionization as a means of securing improved work conditions and remunerations, a reflection of the conservative nature of those with the most influence in social work. Instead, professionalization meant the production of expert knowledge and the monopolization of certain skills and practices. This has

meant the displacement of Indigenous and community-based forms of care and mutual aid with professionalized social services. This occurred in conjunction with the state repression of community-led care, such as with the banning of the potlach and the repression of BPP breakfast programs. With this displacement, social workers attempted to exalt themselves as experts with legitimacy to intervene upon oppressed people and their communities, engaging in surveillance and control. This work occurred in collaboration with the settler-colonial state. In exchange for aid in recognition and legitimization, the profession secured itself a role as managers of oppressed communities, all the while failing to protect those within its ranks willing to challenge these arrangements. The initiation of police interventions by social workers occurs in this broader context that has both placed social workers in a position of authority to engage in these practices and helped extend the reach of the carceral state into the community.

Anecdote B

Maya was employed at a mental health agency to run group programs designed to provide psychosocial and therapeutic supports for youth. The social worker would also provide one-on-one walk-in counselling. This work was provided out of the agency office, and not in the community.

Maya described how during a one-on-one counselling session, a racialized service user disclosed that they intended to kill themselves. The social worker followed standard protocol in response to this disclosure by attempting to formulate and seek agreement to a safety contract. As stated in Chapter 5, safety contracting involves trying to discover supportive people that the service user may be connected with, coping skills, and resources that may help dissuade the service user from taking their own life. Drawing from this knowledge, the social worker attempts to seek agreement from the service user to not attempt suicide. Maya speculated that agreement to a safety contract was documented in case notes in order to avoid possible liability should the service user attempt suicide after leaving the office.

When the service user refused to commit to a safety plan, Maya first attempted to secure assurance from the service user that they will not proceed with their plans of suicide, that the service user “will be OK when they leave”. Without that assurance, Maya then attempted to discern whether the service user had any friends or family members they could locate and ask to attend to the location in order to support the service user through this crisis. The social worker also attempted to convince the service user to voluntarily admit themselves to a hospital, but the service user refused. Maya stated, “at some point, I felt like we couldn't let [the service user] go

out because there was nothing that felt safe, and they didn't have people that were willing to come to connect with them".

The social worker struggled to brainstorm solutions, with Maya stating, "I don't know what else to do … and so what are my options really?". The team found the situation very challenging and spent a "long while to decide what the next call was". After these consultations with the team, it was decided to call for police intervention.

After making the call, the social work team attempted to mitigate the stress associated with police intervention by placing the service user in a location where they might feel more secure. They also urged the two police officers that attended the scene to consider only having one of them approach the service user so that it would be less intimidating, but the police officers refused that request. Maya described the police intervention as taking "a long while", since the service user refused the police officers' orders to leave with them. The police officers ended up carrying the service user away to the squad car. The police officers then took the service user to a hospital.

After the incident, the entire team gathered for a debriefing. The debriefing provided an opportunity for staff to process their emotions in relation to the incident and to reflect on the decisions made. Maya described the general sentiment as a sense of struggle around grappling with an "intense ethical dilemma" (see Chapter 10 for more on this dilemma). While team members recognized that there was the potential for violence and trauma when police are called, especially for racialized service users, they were also concerned about the significant risk of harm if they had let the service user leave the office without some form of intervention. In fact, the word risk came up numerous times in the interview, mainly around risk of the service user's

harm, but also around risk of being investigated or disciplined by the Ontario College of Social Workers and Social Service Workers (OCSWSSW) should the service user take their own life if they had declined to call the police.

While the agency did not have any particular policy relevant to police interventions, again consistent with other workplaces, management did provide verbal instructions and engaged in discussions about what to do in relation to crises. Practices were strongly informed by Applied Suicide Intervention Skills Training (ASIST) training, which was a required at this workplace. As mentioned in Chapter 5, Maya did find the training helpful in that it provided steps that helped with clarity in decision-making, as they often found the ethical dilemmas during counselling sessions debilitating. But they were also critical of representations of suicide as a selfish act by colleagues at this training. Maya believed that ASIST trainings are popular because in the face of complexity, "predictability" is desired. Predictability is often emphasized, or at least that was how these approaches to suicide were perceived by mental health social workers.

This desire for predictability was partly due to a refusal to operate in discomfort. Maya mentioned how even colleagues that were invested in mainstream social work approaches began questioning whether it was actually beneficial for service users to have police called on them when confronted with "firsthand stories of people … the impact it has on their clients". Maya felt that some social workers ultimately end up rejecting this questioning, preferring to practice in certainty. There was the constant worry about the risk that a service user will follow through with suicide. Maya recounted colleagues feeling haunted when receiving a coroner's report and the immense burden both emotionally, and out of fear for potential liabilities. Because of these concerns, mental health social workers sometimes feel it is necessary to get police involved, even if it means "retraumatize[ing the service user] through police intervention".

But for Maya, they felt it was important to keep these tensions between stopping suicide and respecting autonomy and protecting service users from the police in the forefront, but also found this "exhausting" to the point of burnout and wishing to leave the profession. Maya stated, "here I was doing my best to support this person, to not necessarily get them involved and retraumatize [the person] through police intervention. And yet there is this idea that the burden is on me". Maya sometimes wished that she was not part of the profession, so that she could fully believe in the principle of autonomy. These contradictions were also drawn from their own experiences, having been in situations with themself or with friends that had intended to take their own life. After some time, they no longer intended to. "Buying time" meant saving a life, so they wondered if interventions to eliminate the risk of suicide but went against the autonomy of the service user could still be ethical.

Chapter 7: The Construction of Mad People as Targets for Police Intervention

In the previous chapter, I explore the pressures and influences of professionalism as an ideology and the control mechanisms associated with the social work profession on practices in relation to police intervention. In this chapter, I shift focus to the construction of mad people as threats or risks and the response to this in the ongoing history of the mental health field. As identified in the previous discussion of risk assessments and de-escalation in Chapters 3 and 4, the determination and conceptualization of risk play a significant role in mental health social workers deciding to initiate police intervention. In the case of Maya's scenario, they were driven to call the police out of consideration of the risk for harm. Maya explained that concern about risk was a major fixture in the work of their mental health agency. Other interviewees also reported similar concerns about risk of service users committing harm, not just to themselves but also to others.

While I am not suggesting that a potential for harm does not exist, this idea of risk deserves scrutiny. Determinations of risk and presumptions of harm are shaped by deep seated discourses around race, class, madness, gender, and so forth. Just as the enemies in the War on Drugs or on Terror are preconceived, there is a particular notion of the dangerous mad person requiring intervention that is inseparable from the hierarchies foundational to the Canadian nation state.

This notion and its associated discourses were apparent at the very roots of the Canadian mental health field. When assessing how social workers perceive and represent people targeted for police intervention, we need to consider the accumulation of these relevant discourses and practices throughout history. It is for this reason that we begin this chapter by considering the

understanding of mad people as threats to the nation and as being at risk for committing harm against themselves and others. This framing is tied to the mental health field's roots in the intellectual project that produced scientific racism and the eugenic construction of mad people as a threat to society, integral components of Canada's settler colonial socio-economic order. In particular, the mental health field, through the mental hygiene movement, which I pay particular attention to since it served as the precursor to the contemporary mental health field, has further reinforced these discourses that have framed mad people, and indeed all racialized people, as criminals and as social burdens to varying degrees. These discursive frameworks evolved into today's concept of dangerousness. Closely mirroring mental health social workers' articulations of risks pertaining to psychiatrized people, dangerousness has become a fixture in mental health legislation, used to determine whether a psychiatrized person should be apprehended and subjected to coercive treatment.

The second section focuses on the work of psychiatric professionals, including mental health social workers, in the legal system, in predicting dangerousness. Despite the trust placed on these professionals to make these predictions, the presumed reliability and accuracy of these techniques are dubious at best. Instead, what is framed as empirically supported are but a restatement of past attempts at assessing criminality as innate features of certain social groups. It is not so much a prediction, rather it only serves as justification for coercive measures against certain people. Indeed, for the final section, I examine the explanation by mental health social workers interviewed that findings of dangerousness necessitate police intervention as a default action. This response is contextualized with the ongoing history of the mental health field as advocates for a state response to the 'problem' of mad people as threats to society, and as perpetrators of violent measures to contain the threat of mad people in the service of the nation.

The specific practices that emerged became the key tasks of the mental health field, practices that remain to this day—namely, coerced sterilization, family planning, immigration controls, and confinement. These ongoing practices reinforce underlying discourses of mad people as a threat to be contained, excluded, or eliminated, and prime today's mental health social workers to perceive service users as requiring intervention.

Madness as a Threat

Carrie, an interviewee, explained that her approach to risk assessment and intervention was informed by her formal education. During her MSW training, Carrie was made to practice explaining limits to confidentiality, something she was also required to do at her agency. The significance of stipulations around confidentiality is that it outlines the circumstances where confidentiality can be broken and reveals the types of risks that are deemed to require reporting to higher authorities. The criteria for when confidentiality can be broken was written on the confidentiality consent forms that clients were made to sign. These criteria included threat to self or others, child in danger, or being ordered by the courts. Carrie claimed that social workers were expected to be "aware" of and "memorize" these criteria.

These mandated limits to confidentiality serve as a good framework or approximation of institutional definitions of risk, namely: harm to self, harm to others, or danger to a child. An additional limit to confidentiality is court-mandated requests for information, such as through a subpoena, which might also be interpreted as implying that risk is presumed when determined by the courts, such as through a Form 2. Many of my interviewees agreed that the limits to confidentiality and its attached duty to report inform calls for police intervention.

This institutional definition of risk closely mirrors the definition of dangerousness contained within the Ontario Mental Health Act that was first introduced in 1978. The definition can be gleaned from the Mental Health Act's Box A criteria discussed in Chapter 4, also known as the "serious harm test", which states,

> 15.(1) Where a physician examines a person and has reasonable cause to believe that the person,
>
> (a) Has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
>
> (b) Has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or
>
> (c) Has shown or is showing a lack of competence to care for himself or herself,
>
> and, if in addition, the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,
>
> (d) Serious bodily harm to the person;
>
> (e) Serious bodily harm to another person; or
>
> (f) Serious physical impairment of the person,
>
> the physician may apply in the prescribed form for a psychiatric assessment of the person. (R.S.O. 1990, c. M.7, s. 15 (1); 2000, c. 9, s. 3 (1), 2000)

Dangerousness here denotes both past or present harm committed by the psychiatrized person to themself or others as identified by a psychiatrist, but also takes on a predictive element with the reference to the potential for the mental disorder to result in future serious bodily harm to the self

or others. A second set of criteria, Box B, was added in 2000 after lobbying from organizations led by family members of psychiatrized people like the Schizophrenia Society. It can be used by physicians to determine involuntary hospitalization should the Box A criteria not be met (Burstow, 2015). Box B stipulates,

> (a) Has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person; and
>
> (b) Has shown clinical improvement as a result of the treatment;

and if in addition the physician is of the opinion that the person,

> (c) Is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;
>
> (d) Given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment; and
>
> (e) Is incapable, within the meaning of the Health Care Consent Act, 1996, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decisionmaker has been obtained. (R.S.O. 1990, c. M.7, s. 15 (1); 2000, c. 9, s. 3 (1), 2000)

Unlike Box A, Box B has a much lower threshold for fulfilment as it does not even require a perception of potential danger or harm. Instead, dangerousness is presumed as likely by virtue of the person discontinuing medical treatment for their mental disorder. There does not need to be evidence of potential harm, but physicians only need to hold the opinion that the suspension of medical treatment, often pharmacological treatment, could lead to deterioration that results in harm to the person themself or others. This harm also does not need to be imminent. Given the widely held though questionable presumption that medical treatment is necessary to maintain the wellbeing of psychiatrized people, this criterion serves to give psychiatric professionals free reign to incarcerate, and central to this is the presumed link between mad people and dangerousness. Dangerousness is thus a fixture in mental health law, including as a criteria for involuntary apprehension and hospitalization, found in a wide range of countries, including but not limited to the United States, United Kingdom, Australia, Israel, Russia, and Taiwan (Large et al., 2008; Saya et al., 2019). Within Canada, dangerousness provisions are included in the mental health legislation of every province and territory (Nunnelley, 2016; Yukon Mental Health Act, 2002).

The dangerousness criterion was introduced in various North American mental health legislations in the 1960s and 70s, ostensibly as a response to advocacy by anti-psychiatry and civil rights movements, occurring alongside deinstitutionalization (Schneider et al., 2016). Meant to tighten the discretion to order involuntary treatment, further requirements around dangerousness were added to these legislations that previously allowed for forced treatment for anyone deemed to be mentally ill and requiring intervention (Phelan & Link, 1998). But the emergence of dangerousness in its current state needs to be understood in the context of psychiatry being further integrated into the legal system, with psychiatric professionals being

recruited to make determinations on whether a person should be subject to intervention. This integration is characterized by increased collaboration between psychiatric professionals, police officers, prosecutors, lawyers, judges.

This integration has earlier roots in the advent of the prison in the nineteenth century, and the introduction of discretion by administrators to adjust prison sentences based on good behaviour; prisoner labour; regimented schedules; system of rewards; isolation; and collection of individualized knowledge for each prisoner. This carceral system was developed to produce disciplined and docile people, supplying capitalists with productive workers, and limiting disruptions to the socio-economic order. This form of social control is of a much broader scale than forms of penality that dominated previous periods, integrating the prison with the police, schools, social services, and other institutions (Foucault, 1975, p. 198). The further entrenchment of psychiatry into the legal system was another step in this process, and meant "the increasing enlistment of clinical professionals to justify carceral or therapeutic detention on the basis of presumed potential for future violence" (R. J. Menzies, 1989, pp. 216–217). As stated in Chapter 4, mental health legislation from 1935 onwards marked what is described as "the medicalization of mental health law" (Wilson, 2021, p. 44), which involved a greater emphasis on madness as biological and genetic in nature, and thus, a greater reliance on psychiatric professionals for decision-making in relation to apprehension and incarceration.

But dangerousness is a trait not uniformly read in all mad people. While some mad people are primarily considered pitiable and requiring supportive treatment, disabilities associated with BIPOC and poor people are more likely considered threats to be met with policing and other forms of coercive violence (Chapman, 2022; Erevelles, 2011; Gorman &

LeFrançois, 2017; A. J. Joseph, 2016; Metzl, 2010; Wong, 2016). This specific conception of dangerousness and the perception of certain mad people as threats have even deeper roots in the cultural history of madness in the context of Canadian settler-colonial capitalism. Social workers interviewed expressed affective reactions of fear and anxiety around uncertainty, not wanting to be held responsible should harm occur in the future. Carrie mentioned feeling fear towards the potential of risk coming to fruition, "if I didn't call and it was real [...] he actually did it". She expressed concern about failing to address something that was "preventable", stating that "It's better safe than sorry". There is significance in social workers citing emotions as a cause for taking action, as this is in line with Ahmed's (2013) conceptualization of emotions as productive. As stated in Chapter 2, Ahmed informs us of the need to consider how an accumulation of cultural history motivates emotional reactions, and emotional reactions motivate actions and practices. While this history may not consciously register in the mind of the person, it operates in the form of Gramsci's 'common sense' previously discussed that is born out of and contribute to the maintenance of the existing settler-colonial socio-economic order.

Thus, the emotive response that partly drove mental health social workers into calling for police intervention and the racial dimension of these forms of carceral violence are a continuation of the effects of the cultural history of settler-colonial capitalism, especially as it pertains to madness and psy- knowledge. These frameworks emerged out of specific social conditions and practices. Scientific racism, the notion that empirical evidence justifies racial hierarchy, and psychiatry have shared roots in the theory of degeneration. Developed in the late-18th century, degeneration theory posits that all races have a common origin in the 'Caucasian race', and that racial differences developed through deterioration and devolution caused by environmental factors like climate, nutrition, and cultural upbringing (Lenoir, 1980). This

degeneration was thought to cause both differences in physical appearance, and the deterioration of mental and intellectual capacities, exhibiting itself as mental disorders. German psychiatrist Emil Kraepelin, who published one of the first compendiums of mental diagnoses in 1883, argued that degeneration "certainly play[ed] a part in the development of dementia praecox" (Kraepelin, 1921), the forerunner to schizophrenia, and could be used to explain many psychological disorders.

The concept of degeneration influenced Francis Galton's theory of eugenics, "the first [set of] cohesive ideas about a class of disabled people" (Withers, 2012, p. 13) and an approach that underpins both the mental health field's historic formation and current mental health social work practices. Eugenics was defined by Sir Francis Galton in 1865 as

> the science of improving inherited stock, not only by judicious mating, but by all the influences which give more suitable strains a better chance [and as a way] to give the more suitable races a better chance of prevailing speedily over the less suitable. (Galton, quoted in Withers, 2012: 1865, p. 99)

Eugenics is the science of "improving" the genetic quality of a population and designed to combat degeneration. Two approaches to eugenics were developed and complemented one another: *positive eugenics* for 'normals' and 'supernormals', and *negative eugenics* for 'abnormals' (Withers, 2012). Positive eugenics refers to policies that encourage reproduction for White non-disabled people who were deemed desirable, while negative eugenics refers to policies that discourage reproduction or eliminate those deemed undesirable. Negative eugenics is overtly expressed in the *Manual of the Mental Examination of Aliens* used at the United States border,

> Physical disability may give rise to dependency, but with the death of the individual the nation is relieved of the burden. In the case of the insane or mentally defective there is imposed a burden which tends to perpetuate itself. Each mental defective may become the progenitor of a line of paupers, vagrants, criminals or insane persons which will terminate only with the extinction of the race. ("Notes and News," 1919, p. 285)

The manual advocated for a solution to the 'problem of insanity, criminality, and pauperism' through "extinction of the race"—or in other words, the elimination of all whom fit within these categories. While race is used here to describe a broader range of people that might not be considered racialized in today's context, including potentially White paupers and vagrants, these ideas would give rise to policies, to be discussed in the next section, that targeted more specific group of people, such as Indigenous people in Canada.

The deep entanglements between disability and race in the eugenics approach are not surprising given that this approach gained prominence in the context of colonialism (Levine, 2010). Eugenics simultaneously was influenced by, and helped to justify, colonialism by presenting the people of the colonized world as less abled, child-like, and sub-human; consequently, their subjugation was not considered a moral transgression and instead, simply a natural phase within human evolution. In fact, in a ranking of personal fitness developed by Galton, Black people were "automatically ranked two grades lower than what he considered to be the least-fit white person" (Withers, 2012, p. 17).

The conceptualization of mental disorder as rooted in race provided the ideological justification for white supremacy and was employed as a means of control. A particularly stark example of this is drapetomania, the "mental disease" assigned to Black enslaved people who ran

away. The use of physical violence was prescribed as the cure to return Black enslaved people to their 'normal' state of subservience (Mama, 2002). As will be elaborated on in the final section, psychiatrists also diagnosed thousands of Black civil rights activists with schizophrenia to justify their detention in asylums in the 1960s and 1970s. These activists' resistance against White supremacy was represented as pathological.

Eugenicist perspectives on race underpinned the emergence of the mental hygiene movement, which later evolved into the modern mental health field as discussed in Chapter 6. The Canadian National Committee for Mental Hygiene (CNCMH) was explicit in their understanding of mental health as limited to that of White people, and their concerns that non-White mad people posed the greatest threat to the preservation of this mental health. The citing of Sir James Barr by J. D. Page (1919), Chief Medical Officer for the Port of Quebec, speaks to this notion: "You have, here, a virgin soil and you should see that it is peopled with a vigorous and an intellectual race. You should shut out all degenerate foreigners as you would exclude a mad dog" (p. 59). The White race, vigorous and intellectual, is considered the rightful inheritors of Canadian land. While Barr's use of the term "degenerate foreigners" appears to be a restricted reference to "the insane population[s]" (Page, 1919, p. 59), the idea of the insane populations was deeply intertwined with processes of racialization (Wong, 2012).

Articles in the Canadian Journal of Mental Hygiene (CJMH) revealing clear racial delineations that governed access to Canadian identity. Dr. Jasper Halpenny (1919) classified Canadians with other ethnic groups including the "English, French, Irish, Scotch, Icelandic and American", explaining that these groups "spring[] largely from common stock" (p. 225). Halpenny (1919) added, "Icelanders are also included with Canadians because we find them

more quickly Canadianized than any European group, except those who are British born" (p. 225). W. G. Smith (1920) similarly "group[ed] the Canadian, British and American (because of "Springing from Common Stock") [together and] add[ed] the Scandinavian and French (who are "quickly Canadianized")" (p. 76) in his discussion of immigration statistics. People of Western European descent were considered to possess a shared identity, as differentiated from inherently 'foreign' people belonging to the rest of the world. Sakamoto (2003) defines foreignness as an idea imposed on a person or group, marking them "as too dissimilar to become part of the dominant culture" (p. 169). This imposed idea of unlikeness is evident with the concept of biological differences rooted in eugenics: the idea of "Common Stock", and the idea of cultural flexibility for specific ethnic groups seen as having the capacity to change: the idea that some can be "quickly Canadianized". By constructing the category of Canadian belonging—which includes, the 'Canadian', British, and American, and to a certain extent, Scandinavian and French—they are also constructing the 'Other'. The Other is seen as inherently inassimilable or undeserving of assimilation (W. G. Smith, 1919b, 1919c). It is also important to note that this definition of White, in terms of whom it encompasses, was more specific and limited when compared to contemporary understandings that might include Eastern Europeans, Southern Europeans and other groups.

As previously discussed, eugenics is deeply intertwined with race, emerging as one means of reinforcing colonialism. This is also true for Canada, where these notions of racial delineation became integral to how eugenics was understood and implemented in the country. Thobani (2007) argues eugenics policies in Canada are both a product of and acted to reinforce Canada's foundation as White, through emphasizing the reproduction of those who were White and non-disabled. For the nascent Canadian mental health field, the fundamental approach to

manifest destiny and building the nation was to address eugenicist fear of the growth of the 'mentally ill' population. The concern was "that feeblemindedness is highly hereditary" (Fernald, 1919, p. 104), resulting in Canadians being 'poorly' born and 'poorly' transitioned to adulthood. This concern was mentioned in the quote from the *American Manual of the Mental Examination of Aliens* published in the CJMH referenced above ("Notes and News," 1919, p. 285). Charles Baragar (1921) also stated, "Faulty or tainted heredity has been variously regarded as bearing an important causal relationship to mental disease" (p. 194). Adolf Meyer (1919) expressed concern about "letting them out-marry the marriageable and out-multiply the fit" (p. 152). Mental defects were believed to pass on from one generation to another and thus, pauperism and criminality is also being passed on. In addition, there was a great fear that the 'mentally deficient' would quickly outnumber 'normal' citizens.

Immigrants, especially racialized migrants, were especially feared, based on the idea that they would ruin Canada's gene pool both through miscegenation and overtaking White people in numbers through higher reproductive rates. The work of Prescott F. Hall, an American lawyer that championed eugenics, was highlighted in one issue of the CJMH,

> Immigration tends to sterilize the people on the higher social and economic levels who are already in the country ... The low-class immigrants have not only diminished the numbers of the natives, but have also dissipated the energies of the latter by introducing elements of conflict into the nation, and thus, prevented the development of many of those kinds of ability which are most worth cultivation. ("Abstracts," 1919, p. 245)

Low birth-rates amongst White upper-class people were understood as the result of non-White working-class immigrants bringing chaos to the nation through criminality and mental defect.

This speaks to a discourse of the 'unfit' out-multiplying the 'fit', or as Tait (1921) expressed in more overtly racial terms, a commitment of "race suicide" and a "detract[ion] from our racial integrity" (p. 34).

The concerns about the impact on 'Canada's gene pool' were predicated on the intertwining conceptualizations of mental disorder and race. There were numerous references to the foreign 'Other' as disproportionately affected by mental disorders in mental hygiene literature. This was emphasized in multiple articles and provincial surveys. For example, in the *Mental Hygiene Survey of the Province of British Columbia* (1920), it was reported that despite 43.14% of the population being born in the country, "the foreign born constitute 72.72% of the admissions [to Hospitals for the Insane], a showing that is quite out of proportion to that expected" (p. 48). Baragar (1921), the Superintendent at Brandon Hospital for Mental Diseases in Manitoba, also discussed how the majority of individuals admitted to Brandon Hospital in Manitoba were born outside of the country (p. 63). All these statements had as their common argument the idea that a significant number of people understood as 'mentally defective' were immigrants.

Connections were then made between immigrants and all people labelled as "mental defective", and criminality. Dr. Clarence Hincks (1919) stated, "It is probable that about 60 percent of our criminals belong to the mentally abnormal group" (p. 25). As evidence, Hincks (1919) referred to a study of the gaols in Manitoba that found that over 60 percent of inmates were mentally deficient, insane or psychopathic. C. K. Clarke (1921), in *A Study of 5,000 Cases Passing Through the Psychiatric Clinic*, suggested that a great proportion of sex workers were 'mentally defective', measuring "low in the scale of intelligence" (p. 147). Hincks (1919) also

described how 30 per cent of juvenile delinquency and 60 per cent of sex work could be attributed to people with ‘mental defects’ (p. 26). Similarly, Gordon S. Mundie (1919) expressed that “Crime, prostitution, illegitimacy and immorality have all been questions which have worried every person who is public spirited enough to want the community in which he lives in to be better mentally as well as physically” (p. 123), making a link between madness and criminality. This connection between madness and criminality has clear resonances with contemporary social work practices that consider social location in assessing dangerousness, as will be elaborated on in the next section.

Seeing as racialized people and immigrants are considered to carry mental defects disproportionate to the general population, many mental hygiene advocates made the leap from ‘the mentally defective are criminals’ to ‘immigrants are criminals’. In *Mental Hygiene Survey – Province of British Columbia* (1920), the following is stated,

> Mrs. Harris stated that she and three other policewomen pay particular attention to the problem of immorality. It was her opinion that the Chinese contributed to immoral practices through the sale of drugs and the enticing of white women. With regards to drugs, it was stated by Chief McRae that a large percentage of those arrested were addicted to their use and that delinquency was often a natural consequence. Immorality is apparently practised extensively by lower grades of the Greeks, who do a large restaurant business in the city. It is the belief of the Police staff that the Greeks seek out girls for employment, with immoral purposes in view. (pp. 39 - 40)

Anecdotes from policewomen, who interestingly often had social work backgrounds during this time period (Lamin & Teboh, 2016; Roberts, 1976), were used as evidence of apparent crime,

especially with regards to drugs, associated with the Chinese and Greek communities. Afterwards, the writer cited statistics from the Vancouver Gaol, making special mention of the 598 Chinese people detained—a disproportionate 17 percent of the total. The writers concluded, "the sum total goes to prove that, as in other parts of Canada, the foreign born elements furnished far too large a proportion of defectives and delinquents" ("Mental Hygiene Survey of the Province of British Columbia," 1920, p. 41). In a review of *The First Year of the Canadian National Committee for Mental Hygiene* (1919), it was also expressed under the section on immigration "that these individuals were playing a major role in such conditions as crime, juvenile delinquency, prostitution, illegitimacy, spread of venereal disease, pauperism, certain phases of industrial unrest, and primary school inefficiency" (p. 74). In the *Mental Hygiene Survey of Saskatchewan* (1922), the writers described how an immigrant had 99 convictions recorded and should never have been allowed in the country (p. 389). Lastly, Halpenny (1919), in an editorial decrying the threat of immigration, concluded that

> If the reader will . . . note the undue proportion of our court cases which spring from our alien, and our foreign and other immigrant population, he will be compelled to come to the conclusion that our immigration policy has been grossly defective in the past. (p. 226)

Much of Halpenny's (1919) article consisted of crime statistics linked to immigrants, and also statements on the mental abnormality of immigrants based on the assumption that crime is connected to 'mental defect'. This theory was an extension of popular early theories of anthropological criminology—also known as positivist criminology—promoted by Cesare Lombroso in the 19th century, which will be elaborated on in the next section.

The discourses of immigrants and racialized people as ‘mentally defective’, criminal, and fundamentally foreign, together frames these groups as burdens to the Canadian state and in conjunction, the Canadian nation. People with ‘mental defects’ can be seen throughout the CJMH to be understood as being an encumbrance on state coffers. Examples include the discussion of how “the unrestricted sex activities of one defective and delinquent woman” cost the government $6,300 in hospital fees and fees for the care of her children (“Abstracts,” 1920, p. 354), and an examination of the Juke family, a popularly cited case that blamed the Juke bloodline for producing an abundance of mental defectives, criminals, and paupers. Colin K. Russel (1920), a lecturer in neurology at McGill University, remarked that the “economic damage inflicted upon the State of New York by the progeny of the 5 Juke sisters in 75 years was estimated at more than $1,300,000, to say nothing of diseases and other evil influences which they helped to spread” (p. 93)

Considering the linking of immigrants and racialized people with ‘mental abnormality’, that all immigrants and racialized people would be attached to such ideas of dependency and encumbrance is unsurprising. In the *Mental Hygiene Survey Province of British Columbia* (1920), it is pointedly stated that “the following [mental hospital admission] figures demonstrate the fact that poorly supervised immigration is adding burdens to the Province” (p. 48). This burden is often depicted in financial terms. W. G. Smith (1919b) stated,

> Since the beginning of the century, 3,253,796 immigrants have come to Canada, and 168,820 have been rejected, and 12,850 deported after admission – a total exclusion of 181,670, a rate of 1 to 18. But during that period, Canada has spent in promoting immigration $10,327,929 and $8,602,475 in regulating it, a total of $18,930,404 spent in

> obtaining 3,253,796 persons, a per capita cost of $5.81. If we now consider the large number of rejected and deported at that price then these people cost the country nearly a million dollars. If they had been allowed to live here they might have cost the country a great deal more. (pp. 138 – 139)

W. G. Smith (1919b) expressed concern that a great amount of money was being wasted on promoting immigration, given the numbers of rejected and deported immigrants. W. G. Smith (1919b) also worried that 'mentally defective' immigrants who are able to pass screening were costing the country even more money (p. 138). W. G. Smith (1919a), quoting the Deputy Inspector-General of Hospitals, described the immigrant as someone who arrives in the country destitute and reliant on charity, "In this way emigrants have often accumulated in Quebec at the end of summers, encumbered it with indigent inhabitants, and formed the most onerous burden on the charitable funds of the community" (p. 52). The blame is placed squarely on the immigrants' inherent ignorance and naiveties, with no consideration of systemic factors. These concerns about the burden of immigrants, racialized people, and mad people, overlapping categories, were used to justify and formed the underlying logic for eugenic practices historically and contemporaneously perpetrated by the mental health field.

The notion of a connection between madness and criminality, and the representation of mad people as a burdensome threat to society, was a foundational discourse that emerged during the very beginnings of the conceptualization of disability, madness, race, and eugenics. These intermingled discourses are imbued in and would evolve into the contemporary psycholegal concept of dangerousness introduced at the start of this section. As Menzies (1989) argues, this concept is but a restatement of past eugenicist claims of mad degeneration being a threat to

society in more acceptable ‘scientific’ terms. This restatement is done to magnify deviance and justify legal decisions within the carceral system, including in the mental health field. Apprehension, incarceration, and other punitive measures were seen as a preventative tool or “a rational method for dealing with dangerousness” (R. J. Menzies, 1989, p. 175). Menzies (1989) found that psychiatrists tended to recommend more intense punitive measures, such as incarceration, to the courts when they believed the person was dangerous.

The inclusion of danger to self or others in consideration of apprehensions for mental health reasons reinforces the notion of a causal link between mental disorder and dangerousness (Dallaire et al., 2000, p. 683). Burstow (2015) explains, “the impression created is that there is a dangerous substratum of people with menacing “disorders” such that unless stopped, they will necessarily cause “serious bodily harm” to themselves or someone else or “seriously impair” themselves” (p. 108). Phelan and Link (1998) also directly connect their findings around the growing public perception of psychiatrized people as dangerous to the addition of the dangerousness criterion in mental health law. Phelan and Link noted that surveys conducted in 1950 and 1996 show increased usage of dangerousness criterion language among the general public in the United States, suggesting that mental health legislation introduced the notion of “dangerous to self or others” into popular culture.

‘Predicting’ Harm

As stated, the significance of the concept of dangerousness in the context of the carceral system is its future orientation. It is not a classification limited to past behaviour; instead, it has a predictive element in that people can be classified as dangerous simply based on the presumption that they may engage in harm to themselves or others. Mental health social workers and other

psychiatric professionals are entrusted by the legal system to make these predictions, though the validity of these predictions is questionable at best.

The future-oriented nature of dangerousness is evident in Dallaire's (2000) definition of the concept,

> a situation, a thing or a person presenting a danger for the physical or human environment, or for oneself. This notion refers to the potential, possibility or probability of an undesirable, unrealised event; not a current event but rather a *risk* and, by extension, to the capacity to *foresee* such eventuality. (p. 681)

This element of dangerousness is wielded by psychiatric professions, including mental health social work, to access the state-sanctioned power to incarcerate or restrict freedom of movement towards people who have not necessarily committed a crime, the usual prerequisite. Alongside security certificates which target permanent residents and non-citizens perceived to be a national security threat (Aitken, 2008), the dangerousness criterion is one of the few elements of Canadian law that allows for pre-emptive intervention not otherwise permitted in criminal law (Chandler, 2016). The decision to coerce is based solely on "what others worry [psychiatrized people] will do" (Burstow, 2015, p. 108). Maya explained that mental health social workers are also invested in assessing risk since social workers seek predictability in the face of the complexities of their daily practice working with human beings, something also observed by Mandell and Hundert (2015). Maya attributed the strong emphasis of risk assessment in the mental health field and the popularity of trainings in suicide assessment to this desire for predictability.

Predicting harm has its roots in the earliest formation of criminology in the 19th century, with the desire for predictability in assessing criminal risks as one of its primary motivations. Considered the founding father of criminology in the 19th century, Lombroso argued for the existence of biological determinants of crime. Certain people were thought to be born criminals with 'physical defects', and their confinement or elimination was deemed a necessary component of public safety (Linden, 2016). A believer in degeneration theory, Lombroso contended that criminality was associated with atavism, the state of a person being at a less-developed mental stage or devolved from 'modern' human beings. The 'born criminals' could be classified through examining physical features, the practice of anthropological criminology (Mazzarello, 2011). Serving as an army surgeon in the Italian army during the occupation of the Kingdom of the Two Sicilies in the late-1860s, Lombroso examined the bodies of brigands, Southern Italian peasants who rebelled against the Piedmont-dominated government (Mezzano Jr, 2009). While conducting an autopsy on Giuseppe Villella, one such brigand, Lombroso discovered a depression at the base of the skull, which he thought resembled the skull of apes and rodents. This led to his conclusion that criminals possessed distinct physical features that were the result of atavism. Besides the fact that the inherently subjective and political nature of criminality is made evident by the fact that criminality was specifically assigned because of Villella's opposition to the Italian nation-state, bringing into question that criminality is a self-evident category, classifications of atavism also closely mapped on to racial hierarchies. For one, Villella was of Southern Italian descent and the feature Lombroso identified was widespread in Southern Italy (Ciliberti et al., 2018). Southern Italians were racialized in the efforts to subjugate the people in the name of Italian unification and Lombroso spoke of how Southerners exposed "foreign contamination" through their facial features (Epstein, 2001). Mezzano Jr. (2009) adds

that American classical racialists would claim that "one of the reasons southern Italians, particularly Neapolitans and Sicilians, were undesirable was an infusion of African blood through their ancestors, so that their blood was corrupted and therefore racially inferior to that of the Anglo-Saxon or Teutonic races" (p. 49). In fact, Lombroso also identified characteristics like "the projection of the lower face and jaws (prognathism) found in negroes" and "oblique eyelids, a Mongolian characteristic" as stigmata, signs of atavism (Simon, 2014). There is little distinction between finding 'born criminals' and pointing at racialized people.

Efforts to identify the 'born criminal' have not ceased despite anthropological criminology falling out of fashion, and neither has the framing of dangerousness and criminality in explicitly racial terms in this context. This has been especially prevalent in anti-violence initiatives. In 1992, the "Bush Violence Initiative" was established in the United States, underpinned by the assumption that violent behaviour could be linked to particular genetic predisposition and brain disease. It had a focus on identifying Black youth in schools with these predispositions to begin preventative chemical treatment. Frederick Goodwin, the head of the program and the director of the National Institute of Mental Health, described inner city youth as "'monkeys' in the jungle who only wanted to copulate and kill each other off" (Burstow, 2015, p. 67). Goodwin also alluded to degeneration theory by suggesting that these dangerous youth were going backwards in evolution. Note that while I previously mentioned that dangerousness is a restatement of eugenicist ideas in more palpable terms, clearly at times the quiet part is still said loud. Anti-violence initiatives in response to the Columbine High School Massacre in 1999 similarly focused on the supposed link between mental disorder and violence. Hilary Clinton, then the first lady of the United States, remarked that the goal of government intervention would be to "identify [mental health issues] and get help to children who need it, whether or not they

want it or are willing to accept it" (Burstow, 2015, p. 67). This linkage was also apparent in *The Review of the Roots of Youth Violence*, published by the Ontario government in 2008 in response to a wave of gun violence in Toronto. While some of the chapters included in the report concluded that violence is tied to deep-seated issues of racism and poverty affecting youth, instead of addressing these root issues, the report recommended an increase in mental health services in racialized neighbourhoods to identify at-risk youth. The starting point with references to structural problems may differ from the eugenicist literature previously discussed, but the conclusion remains the same, that racialized people should be pathologized as a means of preserving "the social fabric of Ontario" (Aubrecht, 2010, p. 62).

Identifying the potential for criminality and violence has been a major emphasis when clinicians conduct assessments in legal contexts. Indeed, Foucault et al. (1978) argue that psy-professionals attempt to proliferate the notion of criminal insanity as a means to justify themselves as people with the specialized knowledge necessary to forecast certain types of crime engaged by persons whose condition "remains invisible until it explodes" (p. 7). Clinicians incorporate predictions of dangerousness into recommendations regarding bail, hospitalization and incarceration. The significant contributions and integration of psychiatric professionals into the legal system is apparent with the courts' deference to clinicians' judgments. A Canadian judge in a dangerous offender hearing once stated, "the courts really have nowhere to turn except to those who have experience in the field of psychiatry" (R. J. Menzies, 1989, p. 160). Numerous studies in North America and the United Kingdom have found significant concurrence between psychiatric advice and court rulings. For example, Steadman (1973) concludes that 87 percent of psychiatric findings of incompetency based on dangerousness were accepted by courts in New

York. A study in Ontario also found that psychiatrist recommendations for inpatient treatment were honoured by the courts in four out of every five cases. Though interestingly, recommendations for outpatient treatment were less readily accepted, at one out of every three cases (Greenland & Rosenblatt, 1972). Courts were more willing to listen to psychiatrists when it resulted in incarceration (Greenland & Rosenblatt, 1972; R. J. Menzies et al., 1980), substantiating the argument that mental health clinicians rationalize and justify carceral practices within the legal system.

Dallaire (2000) explains that the scientific justification for the inclusion of dangerousness in mental health law relies on actuarial data, population-based studies that draw a connection between "particular mental illness characteristics to indicators of dangerousness (e.g. a significant statistical relationship between a diagnostic category and the incidence of violent behaviour)" (p. 684). But ultimately, the decision for a psychiatrist to issue a form or for a social worker to call the police for apprehension relies on an individualized clinical assessment, "the object here being to determine whether a particular individual might commit acts dangerous for self or others" (Dallaire et al., 2000, p. 684). Indeed, the widespread implementation of the criterion was partly underpinned by the confidence lawmakers placed on the ability of the psychiatric professions to reliably assess dangerousness for individual patients (Large et al., 2008).

Despite this trust placed on the psychiatric professions to make predictions, Dallaire (2000) explains that multiple studies have demonstrated that clinical predictions of dangerousness are unreliable and inconsistent. That is partly since the idea of dangerousness is inconsistent, with no consensus around behaviours that fall under this category and whether the

focus should be on past, present or future acts. Even the American Psychiatric Association (APA) found that for a group of patients that had already committed an act of violence, predictions of future violence by clinicians were incorrect two times out of three, concluding that "psychiatrists have no special knowledge or ability with which to predict dangerous behaviour" (Dallaire et al., 2000, p. 685). The APA also produced an amicus brief for the United States Supreme Court concluding, "The unreliability of psychiatric predictions of long-term future dangerousness is by now established fact within the profession" (Liptak, 2004). That said, this deputation was unable to sway the Supreme Court justices who ruled that expert opinion on dangerousness should still be permitted in court. Justice Byron R. White stated, "We are not persuaded that such testimony is almost entirely unreliable" (Liptak, 2004).

While some empirical studies, the actuarial data previously referenced, have successfully identified certain factors correlated with violence (Dallaire et al., 2000; Norko & Baranoski, 2008), they do not translate well to an individualized clinical setting. These studies are able to accurately separate a population into high or low risk groups, but have trouble being applied in predictions of future violence. Mossman (2009) concludes that even with these seemingly accurate models, there is still too high a chance of violence among the low-risk group, and conversely a significant portion of the high risk group that will not perpetrate violence. This conclusion means that the model fails to provide justification for differential treatment of people categorized in the two respective groups. Though some of these empirical studies cited were able to accurately categorize 83% of the population, a method would be required to do so with 99% accuracy to be "truly useful to clinicians deciding upon different management options" (Norko & Baranoski, 2008, p. 80). The need for such high accuracy is because the proportion of psychiatric patients that commit violent acts is ultimately very small, only a slightly higher rate than the

general public, meaning “that the occurrence of erroneous predictions of violence (false positives) is high” (Dallaire et al., 2000, p. 685). When rates of violence are low, the accuracy of these tests plummet. Szmukler (2001) explains that if serious violence is being perpetrated by only one percent of a population, a test with an area under the curve of 0.76 and a true-positive rate of 0.7 (in other words, a fairly accurate test) would still be wrong 97 percent of the time.

Large et al. (2008) further argue that dangerousness cannot be consistently ascertained, as inter-rater reliability has not been demonstrated for these forms of assessment. In other words, assessments of the same subject would vary from clinician to clinician and are subjective in nature. Suicide assessments are even less reliable (Large et al., 2008, p. 879). For example. Regehr et al. (2015) find significant variability in an experiment involving social workers and social work students conducting suicide assessments of actors presenting identical scenarios. Participants were asked first to determine whether the scenario required hospitalization, and then complete the Beck Scale for Suicide Ideation, the Hamilton Rating Scale for Depression, and the Columbia-Suicide Severity Rating Scale. While participants’ decisions to hospitalize were consistent with how they scored the assessments, there was significant variability between participants on their decision to hospitalize and their scoring of the assessments. Only a third of participants decided to hospitalize in one scenario and two thirds for the other.

In fact, the predictive ability of psychiatric professionals is no higher than the general public and clinicians often over-predict violence or danger (Faust & Ziskin, 1988). Echoing my interviewee responses, Dallaire et al. (2000) find that overprediction is attributable to a sense that the consequences of an incorrect prediction of danger is less grave than an incorrect prediction of non-danger. In other words, there is a greater concern that someone may be deemed safe to be

free in the community and then commit violence, versus taking pre-emptive action through apprehension or involuntary hospitalization for someone that would not have ultimately harmed themself or others. As Carrie expressed, “better safe than sorry”, or as Mei stated, “you don’t want to have certain liability. [So,] when you’re in doubt, call police”. Seltzer et al. (in press) also note that social workers sometimes rationalize involuntary hospitalization with the thinking that “at least [the service users] are in a safe place” (p. 136) so as not to harm. But note once again that the focus is on the risk to the public through potential violence, and the risk to the social worker’s career through liabilities. The only risk to the service user considered is if it is inflicted by themself, with less consideration paid to the potential for harm caused by police officers and the mental health workers to the service user as a result of the clinicians’ prediction. For example, the so-called 'safe space', a place of coercive confinement, is hardly conducive to a sense of safety for many service users. This reaction may be partly attributed to the public calls for control of psychiatrized people and litigation by family members or victims sparked by well-publicized acts of violence committed by people alleged to be mentally ill (Burstow, 2015; Dallaire et al., 2000; Large et al., 2008; Swigger & Heinmiller, 2014; “Talking About Community Treatment Orders and Discrimination,” 2015). These reactions place significant pressure on clinicians to overpredict dangerousness. For example, Hewitt (2008) identifies this context as a factor in influencing mental health nurses to manage risk and predict violence. This “culture of fear and blame” means that the “only way to prevent failure might be to subject far more people than would actually go on to commit an offence to compulsory measures of some form” (Hewitt, 2008, p. 191).

Yet, the purported causal links between mental illness and dangerousness are not well established by the evidence. Evidence is mixed, with the relationship only being apparent in

certain limited circumstances. In the case of violence, a relationship is only identified in people with severe mental diagnoses (especially that involving symptoms of psychosis) and engaged in substance abuse (Dallaire et al., 2000; DeAngelis, 2021; Norko & Baranoski, 2008; Steadman et al., 1998; Van Dorn et al., 2012). This finding also appears in my interviewees' rationale for coercive interventions. Deanne for example, characterized service users deemed to require restraints as "really ill kids", linking the severity of the mental disorder to the need for containment. Chandra spoke of associating a "tendency to blow up" and difficulties around "coping with change or authority" with the service user's diagnosis of mood disorder and bipolar personality disorder. Chandra felt that these diagnoses increased the potential for disruptive behaviour and served as an explanation for past violence. Patty also suggested that if someone is experiencing psychosis, they are a risk to themself or others. But Dallaire et al. (2000) question even these limited findings in their failure to acknowledge that someone engaging in dangerous behaviour or in conflict with family and community members is more likely to enter the mental health system and receive a diagnosis, compared to someone who does not engage in this behaviour. The 'severe mental disorders' mentioned have also increasingly included language about violence in its diagnostic criteria. There would be a higher number of people with severe mental disorders engaging in dangerous acts because of these overlapping definitions.

The inclusion of language about violence in diagnosis criteria is apparent with schizophrenia. Occurring in the context of state repression against Black liberation movements and as a further evolution of the connection made between madness and criminality discussed in the first section, the addition of violence as a criterion for schizophrenia speaks to how scientific racism remain imbued in psychiatric frameworks and how these frameworks work to reinforce the socio-economic order. Prominent radical organizers during the Civil Rights era, including

Malcolm X and Robert Williams, were diagnosed with schizophrenia, as they failed to perform "subtle restraint". According to declassified government documents, the Federal Bureau of Investigation had diagnosed Malcolm X with "pre-psychotic paranoid schizophrenia" (Metzl, 2010, p. 122). These diagnoses were made possible by the definition of schizophrenia at that time. The DSM II included in its definition of schizophrenia the notion that "the patient's attitude is frequently hostile and aggressive, and his behavior tends to be consistent with his delusions" (American Psychiatric Association, 1968, p. 35). Metzl (2010) states, "at an institutional level, particular aspects of the new definition of paranoid schizophrenia preferentially selected African American men, including men whose antiestablishment projections and aggressions previously connoted antisocial personality disorder" (p. 107). In 1968, psychiatrists Walter Bromberg and Franck Simon published an article that understood schizophrenia as an explanation for Black people's responses to racism and white supremacy in the United States. Specifically, they described how Black men developed "hostile and aggressive feelings" and "delusional anti-whiteness" after listening to people like Malcolm X and joining militant Black liberation organizations. The authors warned of the threat these Black dissidents played "not only to their own sanity, but the social order of white America" (Metzl, 2010, p. xiv). The DSM II also included the idea that "the [schizophrenia] patient manifests the mechanism of projection, which attributes to other characteristics he cannot accept in himself" (American Psychiatric Association, 1968, p. 35). Thus, a rejection of Anglicized names, the adoption of Islamic names, and subscription to Islam were seen as a "delusional anti-whiteness" and a "paranoid projection of the Negroes to the Caucasian group" (Metzl, 2010, p. xiv), symptoms of schizophrenia.

The inclusion of violence in the diagnostic criteria for schizophrenia also further cemented the diagnosis as a Black disorder. In an analysis of patient charts at the Ionia Hospital,

Metzl (2010) found that while from the 1930s to 50s, patients with schizophrenia were largely White, the proportion of White patients diagnosed with schizophrenia would drop significantly towards the 1960s. Conversely, during the same time periods, Black male patients with schizophrenia would increase dramatically. The adjectives used to describe patients with schizophrenia would also change with the association of schizophrenia with Black people. While terms like aggressive, hostile, and threatening were equally used for both White and Black patients from 1935 to 1950, from 1960 to 1975, characteristics of hostility and aggression were disproportionately assigned to Black men diagnosed with schizophrenia (Metzl, 2010). Vitols et al. (1963) wrote in the American Journal of Psychiatry,

> It is often considered that the Negro places particular emphasis on impressions and experiences [causing him to react out of proportion] … The Negro may admire the positions and opportunities of the white. It might be expected that a conflict involving unexpressed hostility and envy would manifest itself in psychotic production. (Metzl, 2010, p. 152)

Psychiatrists were explicit about their presumptions that racial delineations underlie the different presentations of schizophrenia. Complaints of police repression and conflicts with prison personnel were framed as projections onto White authority figures. Metzl (2010) concludes,

> incarcerating people with schizophrenia only makes sense if schizophrenia is believed to be a disorder that requires containment rather than integration. And diagnosing schizophrenia as disproportionately violent or black only makes sense when using the definition of illness that came of age in the 1960s. (p. 190)

The linking of schizophrenia with dangerousness was crucial to justifying the incarceration of thousands of Black liberation activists in psychiatric hospitals and conversely, this was made possible by the ongoing history of mental disorder conceptualized as tied to dangerousness and requiring containment. Menzies (1989) argues that attachment of certain diagnoses, including schizophrenia, to a person alone are sufficient to make a prediction of dangerousness, whereby "non-dangerousness could be held up as a rare exception to the implicit association between violence and insanity" (p. 189). This presumption is apparent in an example drawn from case notes written by a forensic psychiatrist who concluded that a patient "showed some schizophrenic features … Basically he has a lot of aggression, which when mixed with his antisocial trends, makes him a significant danger in the community" (R. J. Menzies, 1989, p. 189).

Though not explicitly framed in these racial terms, interviewees recounted the continued prevalence of using social location and categories as a component of the risk assessment process. Sally stated,

> You sort of have to use your clinical judgment to sometimes read between the lines the best you can and make assessments based on different variables like the risk factors because of their age or gender or what have you.

Sally spoke to considerations of social location in assessing risks, considering certain demographics as risk factors in themselves. I also recall being taught in a mental health course and Applied Suicide Intervention Skills Training (ASIST) training that self-harm and suicide were more common with certain demographics like younger people and Indigenous people. Though there were cautions about using the social location as a direct predictor of suicide, the

training taught that there should be an awareness of increased risk when social workers engage with these groups. Ramsay et al. (2004) in the *Suicide Intervention Handbook* used in ASIST trainings, state, "If you know that someone has a particular high-risk characteristic, you should be more sensitive to any invitations you observe" (p. 43). The SAD PERSONS scale discussed in Chapter 3 also includes certain demographic variables as risk factors, as does the provincial "Risk-Drive Tracking Database" discussed in Chapter 4. Information compiled by social workers in the database includes age, sex, location, criminal involvement, drugs, anti-social behaviour, housing, suicide, unemployment, and physical violence. This data is used to ascertain risk, with service users calculated to be of high risk facing uninvited social work and police intervention. Unsurprisingly, considering the presumption of dangerousness for those with mental health diagnoses discussed, the most prevalent risk factor used to justify police intervention for all age groups is mental health diagnoses, which as discussed throughout this dissertation is strongly correlated with race and class.

In addition to overlapping definitions of mental disorder, social location, and dangerousness, Menzies (1989) also finds that psychiatric professionals rely on a plethora of arbitrary "dangerous facts", or interpretations of behaviours, to label a psychiatrized person as dangerous. These behaviours subject to interpretation tend to be forms of resistance by psychiatrized people, such as a lack of cooperation in the psychological assessment or oppositional body language, which are presented as predictors of dangerousness. Ironically, a refusal for the person to recognize that they themself are dangerous, understanding "his aggressive behaviour as acts of self-preservation" (R. J. Menzies, 1989, p. 188), is also a predictor. Seltzer et al. (in press) similarly argue that expressions of distress that are "normal

responses to inhumane conditions", including in response to the mental health system's practices of detainment and seclusion, are rendered as pathological and requiring intervention. Patty also described how if the service user "is so emotionally dysregulated and to the point where [workers] couldn't restrain", social workers were instructed to remove themselves to a secure space and to call the police. The referencing of emotional dysregulation frames crisis incidents or dangerousness as rooted in and the result of the service users' inability to express a socially acceptable response to the circumstances. These responses are often perceived as a pretext to violence (Fabris & Aubrecht, 2014).

Non-compliance and resistance register as signs of dangerousness and thus, a justification for forceful intervention, a similarity of note between police officers and social workers. Menzies (1989) finds that Toronto police officers had a tendency of interpreting a lack of respect or disruptions of official routines as "a harbinger of present mental illness or future violent behaviour" (p. 69). In the case of mental health social workers, Naomi, an interviewee, explained that one consideration for determining whether risk of harm was legitimate was whether the service user follows their safety plan. If they refuse to follow the plan, the service user was deemed to be dangerous, and police were called. Eva similarly recounted a scenario where police were called after a service user refused to attend an appointment with a psychiatrist after a family member had informed the mental health team of changes in the service users' mannerisms and behaviours. As Dallaire et al. (2000) argue, since causality is believed to run from mental illness to dangerousness, behaviour from psychiatrized people is much more likely to be interpreted as posing a threat.

Ideas of risks and dangerousness can also be tied to unpredictability, a characteristic many interviewees cited as being the reason for calling for police intervention. When a person's behaviour does not match social norms, with explanation for this 'strange behaviour' inaccessible, risk and dangerousness is also perceived to be heightened (Dallaire et al., 2000). When information is not available, often at no fault of the psychiatrized person, risk is also considered to be heightened. For example, a lack of contact registers as a risk factor. Carrie explained that the inability to confirm information increased the likelihood of the social worker initiating police intervention due to concerns about liability and the notion of "better safe than sorry". Though, again, it is important to ask safety for whom. Tanya also presented a scenario where police were called after a service user locked themself in a therapy room. The rationale for making the call was that as the mental health workers could not monitor what was happening, the service user may try to find something to hurt themself.

The criterion of "serious physical impairment of the person" contained in Box A and B of Ontario's mental health legislation is also exceedingly broad. Evidence supplied to demonstrate the potential for future acts of self-harm include failure to practice self-care. For example, a person deemed to have not dress appropriately in inclement weather or whose antagonistic behaviour is thought to potentially draw retaliation from others have been submitted as evidence of impairment (Hiltz & Szigeti, 2006). Burstow (2015), explains that "the legitimacy of very different standards of care … are ignored, as is agency itself" (p. 108); instead, this behaviour is attributed to the supposed mental disorder. The fault for violence being directed in response to antagonistic behaviour is also placed onto the victim. Instead of protecting the victim, the victim is apprehended and incarcerated pre-emptively.

A study conducted from 1977 to 1980 found that the number of patients involuntarily hospitalized stayed relatively constant despite changes to the criteria used to determine involuntary hospitalization. Previously, mental health legislation had required a report of assaultive behaviour, but an amendment led to the addition of a health deterioration criterion. When the law was amended, there was a major drop in the number of patients reported to have been committed due to assaultive behaviour. Appelbaum (1988) concludes that clinicians had previously exaggerated the assaultive behaviour in order to justify involuntary hospitalization. Likewise, while the dangerousness criterion was initially introduced to limit the discretion to apprehend psychiatrized people in mental health legislation as a response to advocacy by anti-psychiatry and civil rights movements (Schneider et al., 2016), this stated claim is dubious considering the impact, or lack thereof, of this addition. The numbers of patients involuntarily hospitalized did initially decrease, but these numbers would recover to previous levels in subsequent years in almost all jurisdictions (Large et al., 2008), suggesting that it is another example of reforms that fail to challenge the fundamental logics and injustices of the carceral system.

Just as criminologists have observed that police officers use criminal law after an arrest to justify their actions, these study findings suggest that determinations of dangerousness have more to do with justifying hospitalization than a bona fide attempt at empirical assessment. Indeed, Dallaire (2000) considers that the application of the dangerousness criterion in involuntary hospitalization and apprehension is much more likely to be influenced by

> changes in application of the law, decreasing age of patients released from psychiatric institutions, a greater sensitivity of psychiatrists to the decisional consequences

> (especially the risk of being sued for professional error and failure in civil responsibility), and change in community attitudes toward recourse to psychiatric internment. (pp. 682 – 683)

In other words, while dangerousness is consistently cited by the mental health social workers I interviewed as the reasoning behind calls for police intervention, it is far from being the empirically proven variable as suggested by mental health legislation and clinical practice. Instead, the concept of dangerousness—the imbued representation of mad people as threats to be contained, is a social construct shaped by policies, laws, and the wider White settler-colonial socio-economic structure, an accumulation of the discursive roots of the mental health field, and eugenic practices of forced sterilization, family planning, and immigration controls. This construct of mad people as risks is pivotal to the integration of mental health social workers with the police and the wider carceral system, serving to direct social workers towards coercive action and to justify detainment after the fact.

Another parallel with policing is that these practices are a form of algorithmic policing, with its proponents targeting anxieties around uncertainty, a reason cited by some mental health social workers interviewed for enacting coercive interventions. Algorithmic policing

> promise[s] to remove the existential terror of not knowing what is going to happen by using data to deliver accurate knowledge about where and when crime will occur. Data installs itself as a solution to the problem of uncertainty by claiming to achieve total awareness and overcome human analytical limitations. (Wang, 2018, p. 239)

Risk assessment and predictive practices undertake to bring order to the disordered environments and circumstances mental health social workers confront in their daily practice. Algorithmic

policing is becoming increasingly popular, with growing confidence at the use of its tools for anticipating and preventing crime, instead of only responding to it. Some advocates of predictive and algorithmic policing claim that "it would be possible to calculate the likelihood that someone will engage in criminal activity before they are born, presumably by analyzing family wealth and support, place of residence, race, and socioeconomic factors" (p. 43).

But as is apparent with the previous discussions, this is not necessarily an innovation; instead, it is another rehashing that relies on presumptions rooted in the ongoing histories of social hierarchy. Advocates like Richard Berk, professor of criminology and statistics at the University of Pennsylvania, make no qualms about the use of race in predicting crime, not dissimilar to Cesare's anthropological criminology. Unsurprisingly, as many as four separate research teams analyzing algorithmic policing found racial bias, with one concluding that Black defendants "were twice as likely to be incorrectly labeled as higher risk than white defendants" (Wang, 2018, p. 50). The reality is that even in cases where explicit indicators of race are not used in the calculation of risk, proxies for race and class, like neighbourhoods are sometimes used. This trend of algorithmic policing has significant implications on the carceral system according to Wang (2018), who suggests that predictions of crime booms can spark a rapid expansion of the carceral system, including the "construction of prisons and the passing of harsh sentencing laws" (p. 49). As with heavily publicized cases of violence perpetrated by psychiatrized people, such forms of prediction can also be used by politicians to justify more punitive responses. Coincidentally, this mirrors how predictions of future harm are used to justify coercive measures against psychiatrized people through mental health legislation. Wang (2018) concludes, "predictions do much more than present us with a probable outcome, they enact the future … An unequal and racist society will use algorithms to preserve inequality and

protect the status quo" (pp. 49 - 52). Mental health social work's predictive practices present itself as future-oriented, and it certainly is in the sense that it produces the future through prescription. But it is also about re-entrenching previously established boundaries and hierarchies by targeting and serving to justify coercive practices against oppressed communities.

Coercive Intervention as the Default Response and its Resonances with the Eugenic Practices of the Mental Hygiene Movement

Dangerousness as a classification is significant because it is used to make determinations around what action to take in daily social work practice, especially around whether to call for police intervention. Eva stated, "I feel like the whole system is predicated on jumping very quickly to mechanisms of control based on liability, based on classifying people as ultimately violent and dangerous". She recognized that risk assessments are essentially a labelling process, but also that the process moves quickly towards coercive intervention. Indeed, Eva suggested that coercive responses get presented by social workers as "the only options to people we work with". Eva added, "my team still very much operates with the same interventions of forming, of CTOs, of modelling police as the standard response to crisis". Eva perceived that social work practice 'modeled' police by emphasizing coercive measures as a means to intervene for crisis situations. Patty also thought that they had to call emergency services, as well as Children's Aid Services (CAS) in the case of a minor, if the dangerousness criterion is met, which she defined as circumstances where a service user discloses a threat to either themself or someone else. This necessarily means police will be a part of the intervention since emergency dispatchers will not send an ambulance without accompanying police officers as noted by a number of interviewees. Maya echoed this sense of obligation to take into account the potentiality for harm, and the need

to consider police intervention when potentiality is established. This process is further intensified for service users involved in the criminal justice system, whereby further labelling may occur through a Not Criminally Responsible (NCR) finding leading to an even greater presumptions of potential violence. It was this label that was used to justify a police tactical unit being deployed to apprehend one of Eva's service users.

As discussed in Chapters 5 and 6, almost every social worker interviewed commented on notions of fear of liability motivating calls for police intervention. Interviewees elaborated that this fear drove them to consider any sign of risk as necessitating police intervention. Police intervention was a default response. Carrie mentioned that since she was "privy to this knowledge [about risks] that others don't have", she had an obligation to intervene. If she failed to intervene, she feared some unknown legal consequences or disciplinary action from her employer. Regarding liability, Mei added,

> For example, when I was at [agency]. It's always like they want you to have this safety guard like always like call police. And it's like you don't want to have certain liability. When you're like, essentially. But it's when you're in doubt. Call police. When you are in doubt call CAS and it's kind of drilling by so much in the students and sometimes you can't. Not really. Have your honest discussions. What if this happens. Like what if I'm in doubt but I'm not inclined to call CAS or the police.

Mei explained that it was relayed to her that due to liability concerns, again unspecified, calling the police or CAS should always be done if there were risks or concerns around harm. Mei's supervisor would often recount anecdotes of positive police interventions, such as a time when police officers were able to assist with a service user experiencing a drug overdose. This strong

emphasis meant that Mei was unable and uncomfortable to have discussions about hesitations or contradict decisions to call the police. Chandra stipulated that much of the police interventions were justified through notions of safety, but she questioned whom this safety was for since in the scenario she presented the service user had already calmed down before the police were called. Chandra claimed police intervention proceeded anyways, since her supervisor "can't take that risk" of the service user carrying out a plan to attack other residents, even though Chandra did not perceive a high likelihood of this happening.

Conversely, as discussed previously, there was little consideration of potential harm from police officers and other authority figures, bringing into question the notion of "better safe than sorry". It must be asked, safety for whom? While a number of social workers interviewed indicated assessing potential risks of harm from police officers to service users, this was usually only done to mitigate the potential harm of police intervention, such as by ensuring illicit drugs were not present at the scene. This seldom led to halting the call for police, failing to challenge the central logic of requesting police interventions. The few exceptions were Tanya, who acknowledged refraining from bringing in the police for especially vulnerable service users, such as those without immigration status or involved in the drug trade or sex work, and Sarah, who chose to walk away from an angry service user instead of calling the police (see Chapter 3). This was partly out of consideration for harm should the police be called. However, as stated above, most social workers indicated that alternatives were not considered or that they struggled to find alternatives, that when a certain line was crossed, police intervention was still a necessary outcome.

Only one social worker interviewed, Maya, described sometimes deciding against calling the police as "a risk we took to say I'm just going to trust that you're going to do your best out there". Though ultimately, this did not happen unless Maya felt service users "can do their best to keep themselves safe" and not harm themselves. This was likelier for service users that Maya had greater familiarity with or someone willing to give assurances that they would refrain from harm, such as through agreeing to a safety contract. In other words, concerns about police harm to service users were generally overruled in circumstances that met institutional definitions of risk (i.e., one with a narrow focus on the service user's actions). Carrie added that feeling fearful of making the wrong decision that could lead to more harm was one of the primary drivers of calling for police intervention. Carrie did not have the confidence to challenge conventional institutional wisdom around what constitutes as risk and harm in her decision-making.

Even when the harm of police intervention was recognized, mental health social workers did not consider alternatives to policing. Chandra stated,

> When we debriefed, I don't think we had a centred conversation about how we would not involve the police. It was more like we acknowledged that the police were very violent, but I don't think the conversation actually ever shifted to how do we not get them involved every time.

Chandra explained that the team may consider engaging in de-escalation differently, but as soon as it reached a certain point where harm was deemed inevitable, policing was the only option. Indeed, Chapman (2014a) argues that social service workers tend to struggle with imagining a world without coercion as coercive practices are understood as necessary for "maintaining safety for them and others" (p. 24). Chapman (2014a) adds, "Our violence was only ever a response to

their violence". In other words, it is the psychiatrized person's fault if coercion is used, with the broader context involving acknowledgment of the construction of psychiatrized people as inherent threats or "The possibility of imagining their individual violence as a response to our structural, epistemic, *and* individual violence" (Chapman, 2014a, p. 24) obfuscated from ethical consideration.

Ultimately, interviewees presented determinations around police interventions and alternatives as involving the conceptualization of crisis intervention as occurring on a continuum. Carrie described how after risk is ascertained through an assessment, the social worker then must determine the correct remedy along a continuum of interventions from less to more coercive. In the case of suicide, "how passive or how active [...] this person [is] in wanting to die [determines] when you need to call crisis service, and police is part of the crisis service". On one end of the continuum, the social worker may simply develop a safety plan with the client, or have a family member stay with the client until the crisis is resolved. On the other end, police may be brought in to facilitate a Form 1 or 2. Carrie emphasized that the priority is to determine a method along the continuum to "get the service user to a crisis service". How far along the continuum the social worker decides to proceed depends on whether the potential for harm has been established and the willingness of the service user to comply, "because you don't just tell them to go". If the service user refuses to follow instructions, more coercive measures further down the continuum will be used.

This use of a continuum in decision-making is consistent with the concept of the least restrictive environment (LRE), an approach that emerged in the context of health providers determining the appropriate educational setting for disabled students. The principle understands

that the clinician's primary objective should be to provide education free of coercion to the greatest extent possible. But the latent implication is that the student's circumstances may dictate that a more restrictive setting is necessary for safety and wellbeing. Liat Ben-Moshe (2020) argues that the LRE principle "points to the ways the incorporation or inclusion of disability is only made possible within the status quo, which often legitimates the actual segregation (exclusion) of disability in spaces of incarceration (psych hospitals and developmental centers, in this case)" (pp. 197-198). The LRE principle, despite its purported claims of supporting the interests of disabled people, actually does more work reinforcing and justifying carceral measures that harm disabled people. As long as life in a congregate institution seems like a valid option, and as long as people with (mostly "severe" disabilities) are seen as qualitatively different (childlike, special), the institution will always seem like a rational "choice." (p. 200). In the case of mental health social work, the retention of the police intervention option is often justified by citing extreme cases of violence. But as Burstow (2015) contends, coercive policing has not been able to prevent these cases of tragedy and instead "in our aggressive efforts to forestall them, we at once create widespread misery and exponentially multiply the jeopardy" (p. 254).

Just as the notion of dangerousness is not a new invention but rooted in cultural history, the use of police interventions as the default response to dangerousness should also be situated in the ongoing history of the mental health field's response to the 'threat' of mad people previously discussed. Influenced by its discursive roots, the mental health field and its precursor, the mental hygiene movement, engages in practices that demonstrate an ongoing pattern of violent and coercive interventions towards psychiatrized people. The most prominent examples involve the mental hygiene movement's successful advocacy for and implementation of coerced

sterilization, family planning, immigration restrictions, and mass segregation and confinement, all of which explicitly target BIPOC communities. Much of these practices remain to this day, sometimes with alterations to its form, but with very similar practical results. These practices occur alongside and in collaboration with carceral forces like the police. These practices also resonate with and inform calls for police intervention by mental health social workers as a part of the accumulated cultural history of the mental health field, rationalizing the coercive interventions against psychiatrized people as a necessary action in protection of the Canadian settler-colonial capitalist order.

Coerced Sterilization

To ensure that "the hereditary class of defectives […] not be allowed to perpetuate their decadent stock" (Fernald, 1919, p. 110), Jessie Taft (1919), the Social Service Director of the New York State Charities Aid Association, suggested that "Sterilization of the feebleminded is logically the solution for the problem of prevention of propagation of the mentally unfit where feeblemindedness is due to heredity" (p. 166). Baragar (1921), the Superintendent of the Brandon Hospital for Mental Diseases in Manitoba, also suggested that sterilization should be applied to the "feebleminded", including: "imbeciles", "morons with antisocial or marked sexual tendencies", and "psychopathic individuals [...] with hypersexual tendencies" (p. 194). Sterilization techniques were refined through experimentation on mad people that took place in mental institutions (Boyer & Bartlett, 2017).

Forced sterilization was put into practice in several Canadian provinces, disproportionately targeting Indigenous peoples. Not only was the mental health field a strong proponent of sterilization, but its practitioners were also important in facilitating forced

sterilization. In Alberta, Indigenous peoples were disproportionately diagnosed as ‘mentally defective’, which allowed the state to waive the consent requirement for sterilization under the Sexual Sterilization Act of Alberta, which was made into law in 1928 (Stote, 2012). Consequently, a quarter of all sterilizations in Alberta were conducted on First Nations and Métis people despite this group making up less than three percent of the Albertan population (Withers, 2012). Social workers helped “[b]y identifying and supervising cases of “mental deficiency” in their respective districts, collecting case histories” (Samson, 2014, p. 146). In particular, social workers “were able to infiltrate the home environment and recommend individuals for sterilization” (Oliveira, 2016, p. 79).

To facilitate sterilization, guidance clinics were established throughout the province with mental health social workers often placed at their helm. At these clinics, individuals were given physical, psychiatric, and psychometric or IQ examinations. Should these examinations conclude that the individual was ‘mentally deficient’, recommendations were made for “‘sterilization and supervision,’ ‘medical and surgical treatment,’ ‘modified school work,’ ‘special class at school,’ ‘placement in a good home,’ ‘deportation,’ and ‘institutional training and care.’” (Samson, 2015). The significant contributions mental health workers made in facilitating sterilization is apparent with the chief psychiatric social worker Mary Frost’s claim that Guidance Clinics’ effectiveness in sterilization can be correlated with the number of workers trained in mental hygiene in a 1942 report (Samson, 2014). Frost advocated for the employment of greater numbers of mental health social workers to increase the rates of sterilization. By the 1950s, the number of public health nurses involved in sterilization declined; these nurses were replaced by social workers (Oliveira, 2016).

While British Columbia had a less expansive sterilization program, the government did create boards, consisting of a psychiatrist, a judge, and a social worker, to make decisions around the sterilization of any "inmate of a provincial institution who 'would be likely to beget or bear children who by reason of inheritance would have a tendency to serious mental disease or mental deficiency'" (McLaren, 1990, p. 129). While the number is imprecise as records were destroyed, it is estimated that between 200 and 400 people were sterilized under the British Columbia's Sexual Sterilization Act, which become law in 1933 (McLaren, 1990).

Eugenics practices like forced sterilization are commonly understood to have fallen out of favour after World War 2 with the publicization of Nazi atrocities[5]; however, this is not entirely true in practice. Sterilization continued in Alberta and British Columbia until and even after the repealing of the legislation in 1972 (Oliveira, 2016) and 1973 respectively (McLaren, 1990). In fact, coercive sterilization has remained a practice across Canada. One reason coerced sterilization continues to be practiced is that it can still be legally justified through the *parens patriae* doctrine discussed in Chapter 4. According to Joshua Shaw (2015),

> Children and adults can still be sterilized pursuant to the parens patriae jurisdiction of the superior courts of each Canadian province, provided there is a gap in provincial legislation. Unlike earlier eugenic legislation, on the few occasions that the parens patriae

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[5] Nazi eugenicist policies infamously resulted in the mass murder of Jewish people, but also targeted Romani people, queer people, people with mental and physical disabilities, and others. It is important to note that these policies enacted by the Nazis were heavily influenced by eugenicist movement and policies in North America (Withers, 2012).

> jurisdiction was invoked in Canada, case law provided safeguards for sterilizing persons with intellectual disabilities. (p. 2)

This safeguard established in a Supreme Court of Canada court case—E (Mrs.) v Eve—stipulates that the *parens patriae* doctrine can only be invoked for therapeutic purposes. However, Shaw (2015) maintains that there are opportunities for abuse and this qualification does not effectively stop coercive practices.

Indeed, the most recent documented case of coerced sterilization occurred in 2017, when an Indigenous woman was asked, while under anesthetics and in a state of panic, to undergo sterilization (Kirkup, 2018), and there is no evidence to suggest that these practices have stopped. In 2012, another Indigenous woman explicitly refused sterilization, but the procedure was done anyways (Kassam, 2017). Hospital and Child Protection social workers would often participate in this coercion, with practices ranging from the ‘gentle’ coaxing of a patient to undergo sterilization to informing a patient that they were not to leave the hospital without sterilization. Past and current involvement with child protection services is also often used as reasoning for coercion into sterilization (Boyer & Bartlett, 2017). In one example, Liz, a 17-year-old was coerced into having an abortion and sterilization by a Children’s Aid worker at a northwestern Ontario hospital in the late-1970s. Liz explained, “It was a matter of me almost [being] cornered, if you will, by my worker at the time saying, 'You better have an abortion because if you don't, either way, we are going to take that child from you'” (Kirkup, 2018). Class action lawsuits against various levels of government regarding forced sterilization have been filed in British Columbia, Alberta, Saskatchewan, Manitoba, and Quebec, turning up thousands

of incidents that occurred as recently as 2010 (Agecoutay, 2022; Barrera, 2019; *Defending Consent*, 2018).

Family Planning

Family planning was another eugenicist policy advocated by the CNCMH. Meyer (1919) stated, “Love is very justly nature’s and mankind’s ablest matrimonial agent. Love plays many pranks and is said to be blind; but love, like any other capacity, can be made to grow better or worse” (p. 153). For ‘love’ to grow better, Desloges (1919) argued, “candidates for marriage will have to show their sanitary testimonials in order to be allowed to legally do so” (p. 116). It was suggested that medical experts should assess individuals before allowing them to join in marriage and have children.

As a component of family planning, the mental health field also advocated against racial mixing. With regards to people of Asian descent, W. G. Smith (1919c) stated, “And if assimilation is so backward what indication is there that amalgamation, or blending of races, is practicable or even advisable?” (p. 219). W. G. Smith (1919c) expressed concern about interracial relationships on the basis that people of Asian descent were understood as fundamentally alien to the dominant Anglo-Canadian population. And considering another one of W. G. Smith’s (1919a) statements, “a polyglot population intensifies on every side the task of assimilation and makes the hope for one uniform and national language recede into the distant future” (p. 56), it appears that W. G. Smith, and other members of the CNCMH, desired the maintenance of Anglo-Canadian norms in the country. Clarke (1921) also implied that a psychiatric patient’s selecting of “foreigners, such as Greeks, Chinese, etc. as her companions” was immoral (p. 13). While a direct explanation of the reasons behind discouraging racial mixing

seldom occurs in the text, other literature published during this time argued that racial mixing must be prevented as it weakens the genetic makeup of the white race. Spiro (2009) explains that it was thought that "miscegenation between higher and lower peoples does not produce a blend of the two races but rather a specimen that reverts to a mentally inferior—and probably infertile—type" (p. 101).

While formal anti-miscegenation laws were never passed in Canada, Debra Thompson (2009) suggests that elements of the Indian Act closely mirror American anti-miscegenation laws in logic and outcome. Legislation passed by Upper and Lower Canada in 1850 established classification of Indians as based on Indian blood, descendance, and, for women, marriage to an Indian man. In 1876, revisions to the Indian Act included Section 12.1.b, stipulating that Indian women who married non-Indians lose their Indian status, and children of these marriages are not entitled to obtain status. In addition to discouraging racial mixing, loss of status served to "diminish[] the collective claim of underlying Aboriginal title to the land, and simultaneously alleviate[] the burden of Indian administration on the Crown" (Thompson, 2009, p. 360).

Interracial relations were also prevented through other legal means. For example, in 1939, Velma Demerson, a White woman, was arrested and incarcerated for nine months under the Female Refuges Act, which permitted parents to bring about legal intervention for women under the age of 21 deemed "unmanageable or incorrigible" (Valpy, 2002). Demerson's father reported his daughter as he was unhappy that she had chosen to live and have a child with Harry Yip, a Chinese man. Demerson was also stripped of her Canadian citizenship as she had married a non-Canadian (Demerson, 2006). Extralegal violence was another method of anti-

miscegenation, with the Ku Klux Klan sometimes recruited by disapproving family members, harassing or kidnapping inter-racial couples (Backhouse, 1999).

While some family planning proposals made by the mental hygiene movement, such as the requirement to obtain medical permission for marriage, failed to be made into law, the underlying ideas persist and continue to influence the daily lives of psychiatrized people. Hamid-Balma (2004) explains that the general public "frequently implied or even stated that people diagnosed with severe mental illness should not marry or have children because they are too psychologically fragile, carry a genetic predisposition, or are incapable of providing a stable home environment". Medical professionals, including social workers, also often tell psychiatric survivors not to have children (Hamid-Balma, 2004; Jeffery et al., 2013). Most alarmingly, Mary Ellen Turpel-Lafond, British Columbia's child advocate, even recommended the screening of all current and expectant parents for mental illness in the aftermath of the tragic death of three children to parents with mental health issues (Livingston, 2014). Arguing that "a parent's mental illness, if left untreated, will have obvious impacts for any child" (Turpel-Lafond & Turpel, 2012, p. 75), Turpel-Lafond made four recommendations: identification of parental role for expectant parents with mental illness, development of procedures for identifying and reducing risk factors for children of parents with mental illness, referral to mental health services, and early detection of risk factors for families associated with mental illness. The Ministry of Health and Ministry of Children and Family Development has since identified best practices and developed a tool kit for "protocols, tools and processes" (Provincial Office of Domestic Violence, 2014), but it is not apparent whether this tool kit has been implemented.

Family planning practices should also be contextualized by considering social workers' engagement in reinforcing settler colonialism through the extraction of Indigenous peoples from their communities and thus playing a central role in facilitating the ongoing dispossession of Indigenous peoples from their territories. The Sixties Scoop is perhaps the most well-known example of such extraction, with almost 20,000 Indigenous children taken by social workers and placed in foster homes or with white middle-class families. But in truth, the apprehension of Indigenous children from their communities by social workers continues to occur in what Sinclair (2007) calls the "millennium scoop", whereby Indigenous children continue to be taken into the care of the state in vastly disproportionate numbers. In fact, almost half of all children under the age of 14 in the Canadian foster home system are Indigenous according to the 2021 census (*Reducing the Number of Indigenous Children in Care*, 2023). The mental health social worker and the broader mental health field is also complicit in this process. Of the 11,652 cases of child apprehension in Canada that occurred between September 2003 and June 2004, 2525 (21.8 percent) referenced maternal mental health issues in the notes (McConnell et al., 2013). Mothers with mental health diagnoses were three times more likely to have a child apprehended than mothers without (McConnell et al., 2013). This is not surprising given the widespread preconceptions that people pathologized as mentally ill make bad parents (Dolman et al., 2013), in part because of their dangerousness.

Immigration Controls

Finally, perhaps the most prominent eugenics policy successfully advocated for and implemented by the mental hygiene movement is immigration controls. Nancy Ordover (2003) argues that immigration controls is illustrative of how eugenics "served, and was served by,

nationalism […] For eugenicists, immigration was the peril from without. To truly "purify" the nation, racially and culturally, the perils from within also demanded attention" (p. 56). Much of the literature published by the CNCMH focused specifically on immigration controls in relation to individuals understood as having mental health concerns—though as stated, the literature also tends to understand immigrants and racialized peoples as particularly prone to mental issues (Baragar, 1921; Mundie, 1919; Page, 1919). Baragar (1921) explained,

> From a national and social standpoint the prevention of mental disease involves the exclusion of immigrants whose capacity for mental adjustment is low. […] The conclusions are obvious. Stringent regulations are required to prevent those physically and mentally unfit from entering or becoming citizens of Canada. (p. 196)

There was a consensus amongst authors of the CJMH that immigration controls were necessary.

Post-confederation Canada's first piece of immigration legislation, the Immigration Act of 1869, provided border agents and medical superintendents the authority to identify passengers as "lunatic, idiotic, deaf and dumb, blind or infirm" (*Immigration Act, 1869*, 2018). Those identified were prohibited from entry or required to pay a bond to compensate the state and charitable institutions for the additional expense required for their support (Hanes, 2009). While this policy was undoubtedly discriminatory, the implementation of these restrictions remained largely limited. On the one hand, border inspections lacked rigour due to rudimentary measuring techniques and to poor understanding of how disease spread. On the other hand, the goal of expanding settlement to prevent American annexation of territories to the west of the newly found Canadian nation-state also meant that inspections were relatively lenient and primarily concerned with assessing the usefulness of immigrants to the economy (Whitaker, 1991).

As the fear of intergenerational contagion and concern that a more open immigration policy was negatively affecting "national efficiency [and causing] societal degeneration" (Fairchild, 2003, p. 146) became increasingly popular through advocacy by the mental hygiene movement, the taxonomy of 'prohibited' or 'inadmissible' classes in immigration policy was expanded. While these restrictions only resulted in 0.46 percent of arriving immigrants being rejected from 1902 to 1911, 40 percent of those rejected were for reasons of medical inadmissibility (Fairchild, 2003). The 1910 Act included mental conditions, barring those deemed 'mentally disabled' from entry into Canada except on the condition of family support (Capurri, 2010). That said, entire families were sometimes rendered inadmissible if their accompanying dependents were labelled as 'mentally disabled' (Chadha, 2008). These controls were not enough to satisfy the mental hygiene movement however, and more stringent regulations, with greater resources and training provided to immigration inspectors, were demanded. Page (1919) explained, "with the chronic weakness of our system of inspection . . . a demand has already been created for a more rigid inspection of arriving aliens to determine their exact mental and physical status" (pp. 59 - 60). Once again responding to pressure from the mental hygiene movement, the 1927 Act further increased scrutiny and expanded the list of mental disabilities.

The mental hygiene movement also pushed for the deportation of immigrants, and immigration policy would allow for the deportation of those who had become 'public charges'. A prominent case involved the deportation of 65 Chinese mental patients from Vancouver to Hong Kong in 1935. Chineseness was understood as inherently pathological. In medical notes, Cantonese-speakers were described as 'speaking in tongues', expressing a symptom of "some unseen pathology" (R. Menzies, 2002, p. 214). The existence of 'mad' Chinese men in the

community was often framed as an issue of public safety, with Chinese men construed as sexual deviants. This framing, along with case notes provided by mental health workers, was used to justify detainment and deportation.

Immigration policy from the early 20th century until the late 1960s retained the eugenicist logic of earlier policies, with an ever-expanding list of diseases and disabilities as well as more precise methods of identification that shifted decision-making power away from border officials towards medical doctors. While a third major overhaul of immigration policy, the Immigration Act of 1976 (c. 52, s. 1), removed mentions of specific diagnoses and further limited the discretion of immigration officials to identify disease and disability (Kelley & Trebilcock, 1998), the Act also reflected an increased emphasis on "more politically acceptable" criteria of inadmissibility, such as the likelihood to place an "excessive demand on health and social services" (Mosoff, 1998, p. 155). The concern with 'becoming a public drain' was not new, but in the context of emergent publicly funded health and social services, the 'excessive demand' criteria became a seemingly non-discriminatory mechanism wherein the associated 'costs' of disease and disability were regulated through a series of scientific calculations. Families like the Maengs and the Kincses faced deportation on this basis (*Mother, Disabled Daughter Face Deportation*, 2013; Wallace, 2011).

This imperative grew in importance with the adoption of the equality clause in the Canadian Charter of Rights and Freedoms (1982, s 6(2)(b)), which meant legislation could no longer formally discriminate against enumerated groups, such as people with disabilities. Consequently, the 1992 amendment to the 1976 Immigration Act removed all references to disease, disorders, impairments, and disability. But, the 1992 amendment also clarified the

meaning of ‘excessive demand’ to mean “demands that the immigrant may reasonably be expected to make on health services and social services […] in the five years following the medical examination of the immigrant, [which] exceed five times the average annual per capita costs in Canada” (Mosoff, 1998, p. 12). The Medical Officer’s Handbook was also introduced, outlining a standardized set of costs associated with particular diagnoses. Thus, the changes from these amendments did not alter the exclusionary logic of immigration policy, they gave the “appearance of social rationality” (Mosoff, 1998, p. 4).

The Points System, implemented in 1967 and introducing criteria to assess and recruit migrants considered more likely to integrate into the Canadian workforce and society, is another example of these new mechanism to exclude (Knowles, 2000). By relying on seemingly non-discriminatory criteria such as education levels and language proficiency, the Points System provides the appearance of neutrality and merit-based admissibility. In truth, it places applicants with disabilities at a disadvantage. For example, El-Lahib and Wehbi (2012) find that the strong emphasis on employment and educational attainment by the Points System is exclusionary for disabled people, considering how disabled people often lack access to the necessary qualifications due to discrimination. While the Points System places all disabled people at a disadvantage given constructions of disabled people as unproductive, it especially targets racialized disabled people who face multiple forms of marginalization and are often made disabled in the first place by colonial violence (Gorman, 2016, 2010).

In 2018, Immigration Minister Ahmed Hussen suggested that changes to the “excessive demand” clause meant that disabled immigrants would no longer be considered a burden (Hill, 2018). The changes involved the tripling of the cost threshold for determining inadmissibility

and shortening the list of services considered in calculating cost, but this was not a repeal of the clause (MacIntosh, 2019). Alongside the Points System, the latest reforms do not mark a substantive shift away from the discourses and practices of racist violence promoted by the mental hygiene movement. The mental health field remains entangled with border control, another major pillar of the state's carceral system.

Segregation and Confinement

As first mentioned in Chapter 1, practices of segregation and confinement have its roots in the 17th century, in a period Foucault (1961) calls the Great Confinement. This time period saw the emergence of houses of confinement, with almost one percent of Paris' population locked up. In 1667, Louis XIII decreed that institutions with the purpose of confining the mad were to be established in every French City. Treatment provided by doctors at these institutions were not popular with common folk, given the doctors' reliance on torture (Burstow, 2015). Thus, mad people were more commonly in the care of family members, with only those deemed disruptive and without family members willing to fulfill obligations of care and control taken to institutions (Chapman et al., 2014). It is important to note that racialized people were not confined, primarily because the ruling classes relied on alternative controls and practices of elimination towards these groups, whereby "unrestrained violence was normatively and unapologetically used against enslaved and colonized peoples" (Chapman et al., 2014, p. 4).

Practices of confinement were subsequently brought from Europe to North America. In Canada, practices of confinement for mad people predate the mental hygiene movement. As stated in Chapter 4, the first set of laws related to mental health in Canada was with regards to confinements. The County Asylum Act of 1839, facilitated the establishment of institutions for

the incarceration of mad people, and empowered asylum attendants to dictate the movements and daily lives of those confined (Byrick & Walker-Renshaw, 2016). During this time, a constellation of carceral institutions in addition to asylums, ranging from prison to residential schools to poor houses, were built across North America (Chapman et al., 2014). These institutions were partly built on the basis that individuals can be rehabilitated through interventions occurring in these spaces. The establishment of these institutions coincided with the enactment of the British New Poor Law, which aimed to reduce the cost of welfare by putting poor people to work, and the Bill for the Total Abolition of Colonial Slavery, which abolished slavery in Canada and the United Kingdom. These legislations were "premised on the idea that paupers and slaves could undergo tutelage to ready them for the responsibilities of 'economic freedom'" (Chapman et al., 2014, p. 5) and the various institutions of confinement would facilitate this. Each institution 'served' a different category of people, with the purpose of transforming individuals based on normative standards to become menial labourers through confinement and elimination of the original self. Indigenous people were sent to residential schools to "exterminate the Indian but develop a man" (Chapman et al., 2014, p. 6), as Indian Commissioner William Jones infamously stated. Women were institutionalized for contravening norms around sexuality and gender.

The mental hygiene movement recognized the expansion of these existing policies of segregation through institutionalization as the most preferable response to containing mad people, relative to the other options previously discussed. Taft (1919) stated,

> Segregation much more than sterilization offers a practical solution to part of our problem at least and may eventually be the final, most practical solution … by segregation we

> mean a fairly complete shutting off from society of all the feebleminded, including types of the higher grade. (p. 166)

The authors of the *Survey of the Province of Manitoba* (1919) likewise pushed for the institutionalization of the 'mentally unfit', and along with Meyer (1919) demanded additional segregation by gender, out of eugenicist fears of procreation.

But interestingly, Taft (1919) also expressed skepticism at the mental hygiene movement's ability to successfully advocate for an expansion of confinement practices. Taft (1919) explained that the proposal for mass segregation fails,

> [f]irst, on the human side … we ignore a profound aversion on the part of people in general to confinement for life for any human being, particularly when no offense has been committed commensurate with such punishment and when the individual to be segregated seems to the ordinary observer not to be very different from himself. This combined with the feeling which relatives, particularly of the high-grade feebleminded, have against segregation, makes any very complete programmed of this kind quite impossible for some time to come. (p. 167)

Popular opposition to such measures were predicted, due to the notion that laypeople would find targets of incarceration quite similar to themselves, the seeming lack of justification for the punishment of those being targeted since confinement in these circumstances are meant to be preventative (i.e. before a crime had occurred), and likely protests from family members. The second area of concern was the economic impact. Considering the high number of people deemed to require institutionalization, an "approach towards complete segregation is bound to mean a construction of institutions on a scale which will postpone realization of the scene to an indefinitely distant future" (Taft, 1919, p. 167), given the high costs. Taft (1919) added,

> we have no basis for deciding at present whether segregation can ever be made to utilize the labour of the feebleminded to as great economic advantage as some other plan which would allow of the employment of feebleminded in the industry of the outside world. (p. 167)

There was apprehension that opposition to such plans may form from those concerned that expansion of segregation and confinement policies would lead to too many people removed from the workforce.

Taft's (1919) predictions about the challenges to implementing mass confinement was clearly inaccurate, as today, mass incarceration is more widely accepted especially because of penal populism, the process of engendering public sentiment and support for carceral practices as politicians compete with one another to be 'tough on crime' (Freiberg & Gelb, 2008). The sentiments engendered overcome any concerns about the economic cost of institutionalization. As for the concerns that the public and family members would oppose confinement on humanitarian grounds, today, family members themselves are often the most vocal advocates of institutionalization (Ben-Moshe, 2020). As discussed throughout this dissertation, institutionalization and incarceration whether in psychiatric institutions or prisons has expanded and remains a fixture in contemporary mental health practice, one tied closely with mental health social worker-initiated police intervention. While the 1960s and 70s were marked by a period of deinstitutionalization whereby a number of psychiatric institutions were shuttered, the number of BIPOC incarcerated actually increased during this period, as stated in Chapter 1. And as discussed in Chapter 4, forming practices that lead to involuntary hospitalization are mechanism regularly used by mental health social workers.

Conclusion

The practice of mental health social worker-initiated police intervention relies on the construction of the mad person as a threat to the social order to justify coercive measures that fall outside of the norms of the criminal justice system. Interviewees described using the concept of dangerousness as a determining and justifying factor for calling for police intervention. This idea of psychiatrized people having a greater potential to cause harm is rooted in the intertwining of scientific racism and eugenics, which informed the beginnings of the Canadian mental health field. This project held and promoted the belief that racialized people were inherently mentally defective, that the process of degeneration led to racial differences, whether physical or mental. These defects were understood to lead to criminality and burden to the nation. In addition, these defects, and the people that had them, were viewed as threats to the Canadian gene pool, with fears that miscegenation would lead to the decline of Canada as a White nation and negatively affect the population's intellectual capacities. These ideas paint mad people, and all racialized people, as threats to society, sparking a desire to develop means of detection and prediction. The field of criminology began out of this desire, with Lombroso contending that certain racial characteristics were signs of born criminality. Today, mental health social workers have maintained this legacy, entrusted to predict dangerousness in psychiatrized people. Despite little evidence of the ability to predict, social workers rely on psychiatric diagnoses, social location, and psychological interpretations of human behaviour, to label people as dangerous. When people are labelled as dangerous, coercive practices, including police interventions, become the default response. This again is a resonance and continuation of the ongoing histories of the Canadian mental health field as perpetrators of coercion and violence against mad people,

through forced sterilization, family planning, immigration restrictions, and segregation and confinement, in service of maintaining the settler-colonial capitalist order.

Anecdote C

Chandra was a mental health social worker at a homeless shelter for woman-identified people. The shelter had two components: housing for long term residents and a temporary shelter. Each component was serviced by separate teams of social service providers, and Chandra belonged to the shelter team. Residents included youth and adults, the vast majority of whom were connected to the psychiatric system. Many had been diagnosed with mental health issues in the past. Chandra had a caseload of about 15 clients for case management. The interviewee would also participate in shift work, which involved everything from room cleaning to crisis intervention. Chandra explained,

> during the day we would deal with conflicts that arise, we would provide supports with like finding work or getting someone their medication or getting them set up for their doctor's appointment, making sure they were on time for school.

On one occasion, during the evening, a colleague heard a service user, a Black woman, in the hallway yelling and slamming on doors. The colleague, also a social worker, approached the client to assess the situation. The service user responded, "I am missing my money and I know [other resident] took it. I know it for a fact." The colleague attempted to de-escalate by suggesting that they look around before assuming that the other resident had taken the money. They also reminded the service user that the shelter had a policy of having residents lock up their money or keeping it on their person at all times to avoid theft. This approach to de-escalation did not appear to calm the service user down, and she remained agitated, continuing to utter threats towards her roommate. At this point, the service user was warned that staff would have to take action, and by that they meant the service user would be asked to leave the residence if the

threats did not stop. Upon hearing this news, the service user became upset and stated that she did not want to leave and will be waiting for the person she threatened to return.

By the time shift change had happened, which involved the morning team—the team that had initially responded to the service user—being replaced by the afternoon team, the service user remained agitated. The afternoon team engaged with her, but "it got to a point where there was just no calming her". Chandra explained that the service user continued yelling that she was going to "grab a knife and hurt [the roommate]". Upon hearing this threat, Chandra and her colleague informed the service user that since she had a "well thought out plan to hurt somebody", the service user would definitely need to leave the premise. Chandra indicated though that she regretted how this news was delivered, as she could have been more patient and given the service user more time. Chandra explained, "I think that was definitely a part that escalated it, 'because she was trying to perhaps calm herself down and we didn't read it well".

At this point, the team had yet to call the police. They simply told the service user to "leave at a certain time" and offered to retrieve bags for her and help her pack. These comments appeared to trigger the service user, as "that's when she got really aggressive and started yelling and screaming and ran towards us". Staff members stepped out of the bedroom and the service user slammed the door shut. Returning to their office, staff members then discussed their options, proceeding to phone the shift supervisor, whom they usually contact for advice. The shift supervisor was also a social worker but not a superior, their role was to assist in emergencies. After the shift supervisor was contacted, the manager was also notified. It was through these discussions that the decision to call the police was made. The manager had felt an obligation to protect other residents and staff. The manager was concerned that the service user did not just

make threats but had a plan to harm. The manager considered the question of "Is being evicted the more serious consequence or her being charged with assault a more serious consequence and result for the other resident there."

Chandra indicated that they took the situation especially seriously as the service user's case notes indicated that she had a history of following through with these threats. In fact, the service user had a previous one-year ban from the shelter after she physically assaulted another resident. Concern about the service user's history was also related to diagnostic history. Chandra associated the person's inability to control their temper in relation to change or authority with their mood disorder and bipolar personality disorder diagnoses. That said, Chandra also explained,

> If she didn't have a history with the shelter, if people didn't know how she behaves or how she react to things because of her mental health, because of her experiences of living on the streets all these years, it would've been done differently as well. I think people wouldn't have been as patient if we didn't know. I think that helped us be more patient. And to try different techniques before escalating to that point.

While the service user's prior history of disruptive behaviour meant greater concern from shelter workers, it also meant greater patience and sensitivity to the person's behaviour before escalation to police intervention.

Chandra described negotiating with the service user, worried that their roommate would soon return. The team wanted to avoid a serious altercation. This was also framed as being done

in the interest of the service user, as they worried that the service user would pick up additional criminal charges. Chandra stated,

> I don’t think it was anyone's proudest moment. I think we were all, the whole team, thought about how we could’ve handled it differently, without escalating to the point that it did, because unfortunately, we did have to call the police, since she threatened to harm workers.

The police then arrived, handcuffed the service user, and escorted them out. Chandra described the intervention as traumatic,

> since all the other residents saw that. And felt really violated, because that was their home, and they had to witness like their friend essentially being handcuffed from their home and being escorted out and dragged essentially. And it was a really violent incident.

While staff members asked the police officer to not handcuff the service user, the police officer refused. The police officers did not arrest the service user, but she was escorted off the property. She then waited until a staff member brought her belongings out, along with directions to another shelter. Chandra noted the racial disparities in police treatment of service users. Chandra observed that this service user was treated much more harshly relative to other service users whom were not Black. For example, Chandra recounted that another service user whom was White and in a similar situation was not cuffed by the police.

Chandra indicated that much of these practices were learned through other team members. She stated, “as a team we kind of talk about it a lot. We have weekly meetings. And like what the steps are”. Chandra also mentioned that her work knowledge came from the

accumulation of experiences from previous social work jobs. Without a clinical background, Chandra indicated that she had not received formal training, though she attended workshops (e.g. solution focused therapy methods or cognitive behavioural therapy) that informed her approach to crisis intervention. Chandra also spoke of mandatory trainings organized by Toronto Hostel Training Centre. Shelter workers are required to complete this training in their first year of employment, involving topics like mental health, pharmacology, hoarding, and bed bugs.

Chandra regretted the course of action. As previously mentioned, she believed that the service user may have calmed down if they had given them more time. During the team debriefing, the team

> went through each of the steps that everyone took and what brought it to that escalation. I go back and I think about the fact that we told her in the room really triggered her to become even more aggressive and volatile in that moment. We should've left her alone to calm down for like an hour or two.

Chandra also suggested that the team could have waited downstairs for the return of the roommate accused of theft and made other arrangements. Ultimately, Chandra felt that police intervention was not the only solution to the problem.

Chapter 8: Mental Health Social Workers as Disciplinarians in the Settler-Colonial Capitalist Nation-State

In the circumstances described by Chandra in Anecdote C, multiple social factors and processes converged to create the crisis which ultimately involved mental health social worker-initiated police intervention. The service user, a poor Black woman, took up residence in the shelter system because class, gender, and racial inequities meant accessing long-term housing was unviable, stemming from housing disparities created through settler-colonial capitalism. This housing disparity also includes that cramped conditions at the shelter, marked by a lack of privacy and security, which aggravates and contributes to conflict between residents and staff. In this chapter, I consider the context from which circumstances deemed as requiring intervention emerge. I also examine the work of mental health social workers and the broader carceral system in settler-colonial capitalism. First, with the examples drawn from my interviewees, it is apparent that capitalist driven inequities have fostered the environments that trigger conflicts and other crises. These conditions contribute to disablement, debility, and slow death, concepts that acknowledge the role of broader socio-economic and political structures in fostering emotional distress that can lead to intervention from mental health social workers (Gorman, 2016; Puar, 2017). Yet, mental health social workers tend to ignore these factors when they analyze the issues through a psy- lens. Second, I consider the work of mental health social workers as disciplinarians. It is evident in many of the examples, especially those in residential settings, that mental health social worker-initiated police interventions occur in relation to the enforcement of rules, while failing to address root causes behind the circumstance. These disciplinary practices are used to facilitate rehabilitative practices that aim to mould a person towards a certain norm

and are sometimes framed by social workers as beneficial to the service user. In the final section, I consider how discipline operates in a broader national context, whereby nation-states delineate who is within the moral community and works to contain or eliminate those deemed to be on the outside. This work is accomplished through mental health work operating within the carceral and institutional archipelago, a conceptualization of the criminal justice system as linked to other sectors to serve its social control and productive functions. Mental-health social worker-initiated police interventions are a key example of this connectivity.

The 'Crisis' Rooted in Settler-Colonial Capitalism

Crises can come in many forms. In Anecdote C, Chandra discussed how residents at a shelter she worked at would often come into conflict with one another. The cramped shared rooms would often contribute to conflict between residents. Chandra attributed the suspicions expressed by one resident that her property was stolen to the lack of a sense of security stemming from the shared accommodations. Despite attempts at de-escalation, the service user remained agitated, continuing to utter threats towards her roommate and staff. Chandra indicated that concern for both workers and other residents led to calling for police intervention. More fundamentally though, this crisis is a result of constraints posed by capitalist processes of housing. Chandra indicated that the limited space, the nature of shared accommodations, and the lack of privacy significantly contributes to conflict.

Other interviewees echoed this sentiment, recounting crises stemming from oppressive social structures. Helen was working with a service user who was a Black woman and a single parent exeriencing serious mental health issues. This service user also had Children's Aid Society (CAS) involvement in relation to the care of her child. This service user reported being

abused and sexually harassed at the building they were residing in. When the service user informed Helen of this, Helen tried to get support from Toronto Community Housing (TCHC) special constables, and the Toronto Police but the police were not receptive. Helen described the phone calls with the police officers as involving the "very insensitive" questioning of the service user. The service user was "just not supported" and the police officers would stall for time, asking the service user to wait "a couple of days". While the police did finally speak to the person commiting the harassment, the behaviour continued. Helen believed the police officers judged the service user negatively, since the service user had invited the perpetrator into her home. They asked her, "if you are running away from these people, why are you going to them?" The lack of support from the police exascerbated the service user's distress and trauma. She began hallucinating insects in her apartment. Helen stated, "she just couldn't stand everything", juggling sexual violence on top of parenting and other responsibilities. The distress ultimately led to her losing her job and returning to the shelter system.

Helen's client's distress was rooted in double victimization, the combination of sexual violence perpetrated by a neighbour and the refusal by the police to properly address the matter. This lack of support, including long delays from the police and her housing provider when she requested to move, was both partially attributed to her identity as a psychiatrized person and subsequently exacerbated her emotional state. The client was also overwhelmed by a lack of support in relation to caring for her child. This scenario very much speaks to Burstow's (2003) statement that "trauma is inherently political [and] … inherently involves others and societal structures" (p. 1306). Helen's client's emotional distress is clearly tied to the permissive societal response to sexual violence that occurs in the context of sexism, racism, sanism, and so forth, as

well as class inequities integral to capitalism that have left her without access to basic necessities like safe shelter.

Other interviewees also discussed how resource constraints limited their ability to provide adequate support to mitigate crises. Gabby highlighted the concern regarding large caseloads preventing social workers from fully supporting service users. Though Gabby stated that individual social workers at their agency were no longer responsible for "10 buildings in that this area … with each building having anywhere between 50 units to 2000 units", each social worker was still responsible for a not insignificant three buildings. Gabby suggested that "minimiz[ing] the workload and caseload for staff" meant social workers were better able to support service users. Chandra also mentioned how having 80 residents at her shelter made it a challenge to build rapport and relationships with service users, elements that could help prevent crises. John, who worked at a women's shelter, concurred, stating that "relationship building is really key with a client because then they feel more comfortable to tell us when their abusive partner is either texting them or perhaps when they have to drop their children off for custody" appointments. Those are often times when an abusive partner can act violently, so having that knowledge through trust can help social workers support the service user in that circumstance, something not possible when the caseload is too heavy.

These circumstances described by my interviewees as leading to crises were shaped by settler-colonial capitalist driven inequities. In the particular case of housing, relevant in the previous anecdotes mentioned, capitalism produces both the housing scarcity that pushed people into accessing shelters and the constraining conditions of the shelters themselves that serve as a powder keg for conflict. It is helpful to contextualize this with the notion of disablement, a

concept which Gorman (2016) uses as a critique of conceptualizations that overemphasize disability as a predetermined category versus one produced through social structures and violence. Gorman (2016) warns that this overemphasis without consideration of disablement can reinforce colonial processes by obfuscating its role in producing the conditions faced by disabled and colonized peoples. Thus, instead of recognizing the role of residential schools in the "high rates of trauma, injury, malnourishment, and illness" (Chapman, 2014b, p. 35), disability as associated with Indigenous people is naturalized. In other words, Indigenous people are recognized as disproportionately disabled, but without consideration of who and what might be responsible for this. The Canadian state and corporations' contributions to the disablement of people internationally, many of whom are denied entry into the country because of Canadian immigration policy, is also ignored. Examples of such include disablement caused by Canadian corporate practices (e.g. mining operations that lead to the pollution of environments that local communities rely on and to armed conflict with locals opposed to business practices) and Canadian participation in war and occupation (Gordon, 2010).

Puar (2017) adds that disablement as a concept must also be expanded so as not to limit the disabling process to a specific "event of becoming disabled" (p. xiv). Puar believes that debility is a more accurate and inclusive concept as it recognizes that the processes described by disablement can occur for long periods of time and are ongoing. Debility also recognizes that not all people have access to the disability label, which can allow for the acquiring of certain rights and resources, after experiencing the violence previously discussed. Puar (2017) argues that disability is too often defined with the assumption that racialized people are inherently supposed to endure pain or injury. Indeed, debility tends to be associated with the peripheries, including

oppressed communities in Canada and across the globe. The condition of debility in these communities is normalized. This is not dissimilar to how the "sick man of Asia" trope was linked to Chinese slums in cities like Hong Kong and Vancouver, where disease and poor living conditions were understood as innate characteristics of Chinese people, instead of being a product of a refusal to provide city services and segregationist laws and attitudes that forced Chinese people to stay in poor quality swampland (Anderson, 1991).

In the discussion of debility, Puar (2017) also references the notion of slow death. Coined by Berlant (2007), "slow death refers to the physical wearing out of a population and the deterioration of people in that population that is very nearly a defining condition of their experience and historical existence" (p. 754). Berlant discusses the so-called obesity epidemic, critiquing how it gets framed as a crisis rooted in Black culture and poor decision-making by the individual. Berlant argues that this framing redirects from attention on the structural causes of obesity, including food scarcity, precarious employment, and healthcare inaccessibility. And as with debility, the concept reframes the temporality of the issue from that of an immediate event to that of an ongoing process. Berlant (2007) states,

> Slow death prospers not in traumatic events, as discrete time-framed phenomena like military encounters and genocide[6] can appear to do, but in temporal environments whose qualities and whose contours in time and space are often identified with the presentness

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[6] Berlant's (2007) use of genocide here is problematic given its framing as exceptional or discrete, rather than as an ongoing process as discussed in Chapter 2.

> of ordinariness itself, that domain of living on, in which everyday activity; memory, needs, and desires; diverse temporalities and horizons of the taken-for-granted are brought into proximity. (p. 759)

This suggests a recognition of the cause of poor health or distress as that of the ongoing environment, and not limited to a particular event. The framing of debility as resultant from individual choice or innate racial characteristics hinders recognition of slow death, as a key element of capitalism.

The concepts of debility and slow death also harkens to Gilmore's (2007) definition of racism as "the state-sanctioned or extralegal production and exploitation of group-differentiated vulnerability to premature death" (p. 28). Mental health social worker-initiated police interventions encapsulate the two elements of state practice. The slow death and debility associated with 'letting die' create conditions and environments that spark conflict or circumstances interpreted by mental health social workers as 'crises' requiring intervention. Police intervention is then called upon, which can lead to 'taking life'. Making live and letting die was a major development in the State's approach to manage its populations that emerged in the 19th century, sometimes termed "control", and differentiated from the sovereign power to make die and let live, termed discipline (Foucault, 2003). As Foucault (2003) emphasizes, control practices did not replace discipline but complemented it. Gilmore's (2007) definition of racism also emphasizes the state's participation in facilitating the early death and debility of oppressed communities through its capacity to "make live and let die". As mentioned in Chapter 6, mutual aid and community care practices have been displaced through settler colonialism and the ongoing enclosure process. In reference to the police disruption of the Black Panther Party

(BPP) breakfast programs, Bukhari-Alston suggests that the police in the United States actively work to restrict the ability of the Black community to engage in mutual aid and efforts at building self-sufficiency (Heiner, 2007). The overarching goal was to ensure that oppressed people rely on the "breadcrumbs" provided by the state to "pacify us, to keep us quiet" and to prevent self-determination (Heynen, 2009, p. 415). This was explicitly articulated in Chicago Police Department internal memos.

As with the articulations of the Chicago police, displacement of Indigenous practices (and people) created conditions that fostered dependency among Indigenous peoples on the welfare of the settler state, though also hypocritically preaching self-reliance as a virtue of liberal capitalism (Fortier & Wong, 2019). This includes the imposition of the Indian agent, who used the dispensation of vital social welfare benefits—including food, clothing, and shelter—as a means of subjecting Indigenous people to the rule of the settler state. Taiaiake Alfred (2009) explains,

> the material conditions of First Nations life, pressures exerted on Indigenous people from settler society and this state of overall dependency has created a reality characterized by discord and violence experienced as daily facts of life in most First Nation communities. (p. 43)

The displacement and dependency process has the effect of deteriorating community capacity to mitigate "discord and violence" that may be used as the pretext for mental health social worker-initiated police intervention. Gilmore (2007) draws similar conclusions, contending that incarceration has "hasten[ed] the demise of the informal customary relationships that social calm depends on" (p. 16). Criminalization and carceral practices have the effect of disrupting

relational and conflict resolution practices that occur in communities. In the case of families with loved ones incarcerated, financial and emotional capacities are stretched thin having to use those resources "from neighbourhood to visiting room to court room" (p. 16). Clear et al. (2003) discuss how high concentrations of incarcerated peoples from a neighbourhood "disrupt social networks by damaging familial, economic, and political sources of informal social control" (p. 2), such as "voluntary associations, kin/friend networks, and local organizations" (p. 3).

Suicides are especially illustrative of the human responses to the disablement and debility process. In fact, suicides were one of the primary sources of tension in my interviewees' work as mental health social workers. Chrisjohn et al. (2017) remind us that suicide is difficult to define. Suicide is often defined as someone intentionally killing themself, but intention is not something measurable; it must be inferred. Another attempt at a definition, described by Chrisjohn et al. (2017) as one with admirable clarity, is by Thomas Szasz (2002),

> I use the word "suicide" to refer to taking one's own life voluntarily and deliberately, either by killing oneself directly or by abstaining from a directly life-saving act; in other words, I regard any behavior motivated by a preference for death over life that leads directly (perhaps only after a lapse of several days) to the cessation of one's life as suicide. (p. 15)

This too is imperfect but lends itself to less of a need for presumptions around underlying factors. Chrisjohn et al. (2017) also note that contemporary understandings of suicide should not be taken for granted, highlighting that while suicides have been a regular occurrence throughout history, "no one seems to have noticed it for quite a long time or thought it important enough to

give it a name" (p. 17). Instead, suicide, with all the accompanying baggage and as a behaviour that required specific interventions, is a very modern concept.

May, an interviewee, explained that when they heard service users express suicidal ideations, they tried to respect that the service user "have the tools to figure this out for yourself", but there was always the worry that a service user would follow through with suicide. As stated in Anecdote B, Maya recounted colleagues feeling haunted when receiving news of suicide and feeling an immense burden both emotionally and in relation to the potential liabilities discussed in Chapters 5 and 6. A desire to prevent this burden sometimes drove calls for police intervention. Maya also described social workers as grappling with an "intense ethical dilemma", stating

> [The team grappled with] whether they should have called the police or not [in relation to suicide]? I think even the folks who may not have [been directly involved] had that tie; they were also not sure what to do. We can't call the police because of this. And yet, what do we do to support this person? It very much felt like a catch 22.

Staff, including social workers, were uncomfortable with the decision but also did not have alternatives as they worried that the service user would follow through with their intentions to take their own life. They felt that "in a sense, I think the concern for this person's life was very high". Maya concluded, "I walk that line pretty much all the time".

Almost every interviewee reported being involved in at least one mental health social worker-initiated police intervention in relation to suicide. Gabby stated, "Most of our calls to the police are for a threat or for someone harming themsel[f] directly". Tanya reported that their colleague called the police after a service user phoned the social worker to inform them that they

had cut their arm up with a piece of glass. Deanne reported that a significant portion of police calls from the juvenile detention site they worked at was in relation to suicide. Suicide attempts were so common that a "rescue knife" was present on every floor, so that staff had the tools to immediately cut down someone if they attempted to hang themself[7]. The person is brought to the hospital by the police, but often, a worker from the detention centre will monitor the person at the hospital for the entire duration of the stay since the person is still in their custody.

Marx examined the underlying causes for suicide when he was commissioned in 1845 to produce a German-language translation of Jacques Peuchet's memoire of his time as a French bureaucrat in charge of interviewing family members of people who have died of suicide. Chrisjohn et al. (2017) notes that it was "less a rendering of Peuchet's words or expressions than [an] expression[] of Marx's own thinking on the topic of suicide" (p. 80). Marx contends, "Suicide is in no way unnatural, as we witness it daily. What is contrary to nature does not occur. It lies, on the contrary, in the nature of our society to cause so many suicides" (Chrisjohn et al., 2017, p. 80). Chrisjohn et al. interprets this notion of 'the nature of our society' inducing suicides through two interconnected forms of alienation. Settler-colonial capitalist societies cause Indigenous people to become alienated from their communities through occupation, displacement, and the apprehension of children. Capitalist organization also induces suicide through the alienation of labour, suggesting that capitalism produces alienation through the

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[7] While I did not ask Deanne for elaboration on this point, one could speculate that the consequences of harsh conditions of confinement, and a lack of supports available may be contributing to suicide as an expected outcome for people held at these facilities.

atomization that occurs when “workers do not own what they make and owners do not make what they own”. Through this process, workers are disconnected from the ability to dictate their own actions in the context of labour, as they are directed by the bourgeoisie who own the means of production. Alienation in turn leads to fatalistic suicide, a fourth type of suicide described by Durkheim as that caused by excessive regulation, oppressive discipline, and authoritarianism. Chrisjohn (2017) explains,

> alienation is not a feeling or an experience or an emotion or anything like the gremlins-in-the-mind [such as depression, alcoholism, schizophrenia, and other psychiatric diagnoses] we have been studying; it is not consciously, unconsciously, or subconsciously held. It is a social fact of capitalism, whether or not you’re aware of it. (p. 84)

Alienation does not describe an internal psychological or biological process; it is resultant from social organization.

Capitalism in Canada must be understood in the context of colonialism and dispossession. Chrisjohn et al. (2017) state, “Because we were not capitalists, we were not (indeed, could not have been) alienated in Marx’s sense until European colonizing nations undertook to destroy our Native economies and force our peoples to operate within the European economic system” (p. 96). Chrisjohn et al. (2017) uses the term “double alienation” to describe how Indigenous people do not just experience alienation from the capitalist disjuncture between workers and production, but also displacement of Indigenous political economic systems and forms of life described prior resultant from the imposition of capitalism. In Europe, capitalism replaced another authoritarian social organization—feudalism. The bourgeoisie replaced the hereditary nobility and the church, but loss of land, poverty, and division of labour all remained fixtures. In North America, “the templates and terrains for non-capitalist forms of life have

remained available to indigenous peoples for a much longer time than European peoples had their own alternatives at hand" (Chrisjohn et al., 2017, p. 107). Chrisjohn et al. (2017) describe suicides in this context with the analogy of

> someone trapped at the top of a burning building, having to make the choice between being burnt alive or jumping to his or her death on the ground below … It is the fire, it is the lack of rescue, it is the unavailability of any alternative that drives the behavior. (p. 134)

This sense of inevitability is produced by the debility and slow death fostered by settler-colonial capitalism, "designed to break us, either by driving us over a literal or metaphorical cliff, or by achieving our surrender" (Chrisjohn et al., 2017, p. 134). Though as I will discuss in the concluding chapter, this sense of inevitability should not mean nothing is to be done; that would be no different than the state's facilitation of slow death. Instead, this acknowledgment of inevitability in the current social structure should inform collective political action for radical change.

It is important to note that in describing expressions of emotional distress, I am not suggesting that these behaviours are automated and deterministic responses to external stimuli and social structures. Tew (2015) explains that "Mental health survivors have been careful not to situate themselves as passive victims of external circumstances (however extreme these may have been) and they have started to reinterpret distress experiences" (p. 74). While psy-professions may interpret self-harm as pathological or irrational maladaptation, this alternative perspective emphasizes psychiatrized people's agency, recognizing these behaviours can be a means of resistance against systemic oppression and violence. During the Hong Kong protests of 2018 and 2019 against the attempted legislation of an extradition bill, in the face of broad scale

police violence, young people responded with a spate of suicides (Manzoor & Liu, 2022). Many left suicide notes referencing the protests. This type of suicide is also common across East and South Asia, including among farmers struggling against neoliberal policies (Kim, 2021; Lahiri, 2014). Women in abusive relationships can also sometimes take their own life as a final act of agency (Hayes, 2013). Behaviours deemed harmful can also be "creative (but desperate) ways of surviving in almost unliveable circumstances" (Tew, 2015, p. 74). These behaviours are a means of communication, a language for "expressing experiences and embodied memories that cannot easily be expressed in any other way" (Tew, 2015, p. 74). Resonantly, Burstow (2015) discusses how survivors of childhood trauma may use cutting as a means of distraction, soothing, and resistance, which she therefore calls "survival skills" (p. 1305).

Despite the wealth of literature on the links between settler-colonial capitalism and suicides, seldom do psy- professionals recognize these factors as underlying suicides. Suicides have historically been considered a sin or a moral fault, but today's psychiatrization bears little difference, as the framing of people as mentally ill still carries presumptions of being "abnormal, dangerous … and treated with suspicion" (Chrisjohn et al., 2017, p. 17). Biological and psychological explanations of suicide dominate the mental health social work field (Burstow, 2015), and are apparent when interviewees mention risk of harm attached to certain diagnoses. Biological approaches pay particular focus on the role of mental illness and brain chemistry factors like serotonin deficiency. Psychological models look at depression, feelings of hopelessness, frustration, an inability to cope, and denialism about their circumstances, as reasons for suicide. Violence has also been framed as internally rooted in crisis intervention literature, as discussed in Chapter 3. The Crisis Prevention Institution describes a person in crisis as lacking in rationality and says that emotional distress is the result of their own "loss of

control", shifting attention away from the environment and structural contexts of these emotional responses (*Nonviolent Crisis Intervention*, 2011). And, as referenced in the introduction, mental health social workers interviewed shared this interpretation. Patty described calling for police intervention when service users became "so emotionally dysregulated and to the point where [workers] couldn't restrain" or de-escalate the situation. Patty's use of terms like emotional dysregulation, which she defined as an inability to cope with the moment, expressed through socially inappropriate behaviours like pacing, repetition, and biting, points to the locating of risk in the internal workings of the service user. Eva similarly described how a "not criminally responsible" (NCR) label would suggest that because of the mental disorder, a service user would inevitably engage in violence should medical treatment be discontinued.

As mentioned in the discussion of terminology in the introduction chapter the use of the medical approach as an interpretive lens serves to pathologize everyday practices. This is a process mediated by preconceived notions of race, gender, and sexuality and is a significant means to maintain social control of marginalized groups. As mentioned in Chapter 7, drapetomania was a diagnosis used to describe Black enslaved people who resisted their predicament by running away as pathological (Mama, 2002). Not only was this diagnosis used to justify physical violence, but it was also both reliant on and reinforced stereotypes that naturalized the enslavement of Black people. Similarly, Metzl (2010) argues that the diagnosis of schizophrenia was used to pathologize and detain thousands of Black American civil rights activists in the 1960s and 1970s.

Social workers have since developed the biopsychosocial approach, attempting to fill in the gaps presented by biological and psychological approaches by taking a more holistic perspective. This approach has attempted to consider the role of unemployment, familial

challenges, immigration process, and absence of crisis resources as explanations of suicide and distress. However, Chrisjohn et al. (2017) argue that most sociological approaches descend back into the psychological paradigm. One example is the framing of the refugee and migration process in psychological terms. Regehr and Glancy (2014) explain, given that refugees "experience[] a variety of traumatic events, including war, genocide, violence, famine, and political persecution[,] […] [they] have increased rates of post-traumatic stress and depression" (p. 78). Southeast Asian refugees are referenced as an example of a group facing these circumstances, but with no mention of how colonialism has shaped migration. Consistent with this logic, Hong Fook Mental Health Association's (HF) Journey to Mental Health Project—a training provided by mental health social workers to educate settlement workers on mental health issues—describes the migration process as inherently involving maladaptation and pathologies like depression and anxiety (Botor et al., 2010). While migrants can suffer tremendous distress while migrating and settling in Canada, HF locates this distress in the individual and not in the racism of the immigration system and Canadian society. Botor et al. (2010) describe each step of the migration process in individualized terms: "during the preparation stage, individuals are excited about the possibilities of living in a new country. They usually overperform"; and, "During the migration stage, there is a dip as the actual move can be difficult, stressful and filled with uncertainty" (Botor et al., 2010, p. 15). Consequently, based on this logic, it also frames the individual migrant as responsible for reaching an equilibrium through "adjusting to the new environment" (Botor et al., 2010, p. 15), and assimilating into Canadian society. Botor et al. (2010) speak of the need for migrants to be resilient and to develop protective factors through "religious participation, volunteerism and neighbourhood collaborations" (p. 17). While this

training material appears to illustrate a way out of pathologization for the sufferer, it really implies that migrants are inherently pathological.

This pathologization of responses to oppression also prominently occur in notions of trauma from colonialism in relation to Indigenous peoples (Chrisjohn et al., 2017). Structural processes are understood only as "stressors". Speaking about the characterization of Indigenous suicides in particular,

> [associated with Indigenous suicides is] a long list of objective characteristics of the on-reserve living conditions (then as now) of Native peoples (e.g., inadequate housing, lack of employment, disorganized band administration, restricted means of transportation). These characteristics all have strong factual support. But rather than leave his analysis at the point of describing the 3rd-World living conditions of many Indians, he chooses to "congeal" them into a psychological gremlin, stress … colonialism turns into powerlessness, (and not resistance), marginalization becomes low self-esteem (and not self assertion), and even societal breakdown becomes anomie, conceptualized as a personally felt experience. (Chrisjohn et al., 2017, pp. 51–52)

There is little consideration about how these factors came to be, with structural factors naturalized or mystified. The responses to these stressors are characterized in a way that removes agency, erasing "anger, unrest, determination, protest".

The Mental Health Social Worker as a Disciplinarian

The eclipsing of disablement, debility, and slow death, through bio-psycho interpretations coalesce in mental health social work's latent function of rule enforcement and discipline, of

which mental health social worker-initiated police intervention is a significant component. In Anecdote C, Chandra discussed how the service user was warned that staff would have to evict the service user in response to her threatening and disruptive behaviour. Upon hearing this news, the service user became upset and with continued escalation, the decision was made to evict the service user. When the instructions to vacate the premises sparked even more aggression, the decision was made to call the police. Chandra explained that police intervention was commonly used to enforce disciplinary rulings and evictions.

Being firm during the enforcement of rules is interestingly framed as a component of crisis intervention. As stated in Chapter 3, some crisis intervention models suggest that people in crisis tend to challenge "you, your institution, and your authority" (*Nonviolent Crisis Intervention*, 2011, p. 3s), an attempt to test limits. Thus, the Crisis Prevention Institute prescribes setting limits in a directive fashion, with enforceable limits, such as with the threat of eviction previously discussed. Many of my interviewees also described responding to crisis situations by setting limits and being clear on the consequences with service users. Though, as stated, these attempts to set limits tend to escalate or provoke conflict. Deanne recounted an incident where a patient destroyed property and threatened staff at a juvenile forensic detention facility after overhearing a conversation about how he was to be transferred to another facility. Deanne described how "this young man had a serious personality disorder and a variety of mental health issues. I did not want to keep him because I did not feel we could manage him." Deanne assigned fault to the patient, "It was out of my control. I had to follow the direction given on the provincial level to take this kid. And he continued to escalate for a number of weeks. It was becoming really hard." Deanne also felt that his mother exacerbated the crisis, first, by being "in complete denial about her child" and "enabling" him, and second, by stepping

into the facility “although I directed her to please not come on the premises”. Six police officers arrived to handcuff him and take him away. Deanne felt that it was a failure to follow the rules that led to the crisis.

Residential settings often have a myriad of rules that residents must follow, or risk being discharged or evicted. A short-term residence for people with mental health issues I previously worked at required service users to sign an agreement listing prohibited behaviours that included the following: opening the doors of the residence without staff permission, sharing room code with other residents, pulling fire alarm, panhandling, selling drugs or sex, smoking, and viewing pornography or inappropriate internet content. While a breach of the rules did not automatically lead to the police being called. The warnings and evictions that were the consequence of rule breaches often led to confrontations, from verbal threats to physical aggression. This would result in mental health social worker-initiated police intervention. A more egregious example was when a resident was formed (the initiation of police apprehension for involuntary hospitalization) after expressing disagreement and refusing access when maintenance workers arrived at his unit without prior notice (see Chapter 4). Chandra mentioned that the women’s shelter she was employed at did not permit guests on the property, a rule that often led to conflict between service users and social workers. The police were called when service users refused to leave the premise after being ordered to do so because of conflict with other residents or other breaches of agency rules. Patty also described how the dual diagnoses support home she worked at had strict rules around residents needing permission to leave the premises. Police would be called if residents breached this rule, which became a challenge when the rule conflicted with a resident’s coping method. Patty recalled how a resident often tried to calm themself down from distress by finding some privacy, often by going on walks, but would have the police called on

them. The team rationalized that she had broken the rules and could harm themself by being out in the community unsupervised. Seltzer et al. (in press) also discuss how various behaviour presented by psychiatrized people in their forensic facility, including

> asking questions, making suggestions on how to improve one's care, regular expressions of joy or individuality, touching or making contact with family members, wearing clothing in a way that is seen as not presentable to the staff, or expressing concern with side-effects of medication. (p. 140)

could all be interpreted as a lack of cooperation and thus, a rule breach. Rule breaches were met with punishment from staff, like "seclusion, restricted access to food or products from outside, and limited privileges to leave hospital" (Seltzer et al., in press, p. 140). These forms of punishment isolated psychiatrized people from their support network and were extremely harmful to their physical and mental wellbeing.

Mental health social workers take a disciplinary approach to suicide. Naomi expressed that at her agency, which serves youth in an office setting, there was an expectation to involve the police in situations of suicide. Naomi explained, "Because safety to us means a lot, so we cannot allow that person to return to the same environment, without the support that they need to ensure that they are safe". If a service user

> has active suicidal thought and has an active plan to go home and hurt themsel[f], and they do not have that support at home, or that protective factor at home, where they feel safe and not follow through with [the safety] plan that they have,

then the social worker is told to call the police. Naomi recounted a time when police were called because she felt hospitalization would be safer for the service user, as the service user did not have adequate supports at home. Carrie also described similar expectations at her agency,

> Being in a community setting, we were then encouraged to not let the client leave. You would have to either call 911, get an ambulance to come get them, or maybe make sure they're escorted to the ER by someone you know who will keep them safe.

Carrie was instructed to respond to imminent suicide risks by keeping the service user in place and calling emergency services. The only alternative was to have the service user escorted to the hospital emergency room by someone else. Patty also said that even when police were not needed, the goal was to have the service user hospitalized.

> Ultimately, Pat Capponi (2005), a psychiatric survivor, indicates
> the current response to the pain of those labelled mentally ill is to block up all the exits—the bridges, overpasses, and subways—where people try to commit suicide. … Society seeks to confine those brought to the edge to protect them from themselves, but there is little in place to guard us from these protectors. In the hospital, staff remove "dangerous" belongings and reduce patients' identity to narrow plastic bracelets. It can feel more like being in a prison than a hospital. (p. 96)

The predominant approach to suicide being that of prevention, even through physical coercion or pharmacological treatment to "chemically pave[] over … inconvenient behaviours" (Chrisjohn et al., 2017, p. 119), is consistent with the practices described prior. This is partly explained by the notion that suicide prevention work is "not for [psychiatrized people themselves], but rather to reassure the rest of society" (Capponi, 2005, p. 112). This approach may also assuage the worries

about risk of liability or harm so many of my interviewees reported. Ironically, according to David Webb, a survivor and researcher of suicide, psychiatric institutions that suicidal people are held in often exacerbates suicidality. Webb (2015) states, “This condition poses a huge challenge to our current mental health system because the psychiatric ward, which is where suicidal people are usually detained, is a distinctly *unsafe* and dangerous space” (p. 165). People contemplating suicide are better off left alone in the community than to be coerced and detained at a psychiatric facility, since the oppressive experience “increase[es] the risk of suicide” (D. Webb, 2015, p. 166), perhaps like the juvenile detention facility previously described. Likewise, as previously mentioned, a number of interviewees recounted how mental health workers were often responsible for the emergence of crises and conflict through provocation or a heavy-handed approach to interactions with service users and residents.

The approach of stopping suicides at all costs conflicts with the belief that people have the right to choose to take their own lives. Thomas Szasz (1989) argues that suicide should be considered a human right, stating “In a free society, a person must have the right to injure or kill [them]self … being “dangerous to oneself” should never be considered a legitimate reason for depriving a person of [their] liberty” (p. 229). Chrisjohn et al. (2017) comment on this argument, that

> diagnosing a person as insane and depriving him/her of the capacity to carry out the deed by incarceration or by the administration of drugs — was an unwarranted intrusion into personal liberty. This is an important and unique perspective, in that (1) it provides a political perspective on what is ordinarily taken as a purely individual and mental one, and (2) it takes a diametrically opposed position from existing ones on the desirability of suicide intervention. (p. 25)

Maya, an interviewee, agreed with the sentiment that agency around suicide should be respected, expressing that “I believe in people's capacity to choose and that that is a part of their right as a human”. As stated in Anecdote B, Maya sometimes wished that she was not part of the profession, so that she could fully believe in that principle. But this principle also sometimes contradicted their own experiences, where “buying time” meant saving a life, as they witnessed people, including themself, no longer wanting to take their own life after some time. There are also ongoing tensions between desires to stop the possibility of suicide, such as through calling on police intervention discussed above, legal and professional obligations, and prior training.

This rights model is also incomplete however, in that while it politicizes suicide in terms of emphasizing autonomy, it also depoliticizes and decontextualizes the socio-economic factors underlying suicides mentioned in the first section. The right to die by suicide has also been complicated by recent critiques of Canada’s Medical Assistance in Dying (MAID) program, which facilitates suicides in relation to “grievous and irremediable medical conditions” (*Medical Assistance in Dying*, 2016). MAID will also be available to those with mental diagnoses in 2023. According to Syrus Marcus Ware (2022), the MAID program is not actually about respecting BIPOC choices around suicide, but instead opens up the possibility that BIPOC people will be disproportionately recommended to undergo euthanasia, since these groups already lack access to resources and, considering the ongoing history of eugenics, will amount to the medical profession’s increased role in eliminating BIPOC disabled and debilitated people. The fundamental problem is that euthanasia is presented as the only alternative to people’s suffering and that self-determined consent may not be possible for oppressed groups, since people’s choices are subjected to significant constraints. For example, in February 2022, a woman by the name of Sophia chose medically-assisted death after failing to secure affordable housing

appropriate for someone diagnosed with multiple chemical sensitivities (Favaro, 2022). A contributor to a Disability Justice Network Ontario (DJNO) panel on the MAID program also reported considering medically-assisted suicide as they were struggling to afford healthcare and other needs while on the Ontario Disability Support Program (ODSP) (Anonymous, 2022). Sara Jama, a founder of the DJNO, concludes, “We’re not in a place in Canada where I think MAID can exist, or even be expanded, where people won’t be coerced [into receiving it]” (Gillmore, 2022). Elements of this critique can also be gleamed from interviewee Maya’s statement,

> it's possible that society has made your life so hard that [suicide] feels like the only option right now. Can we support you in some way to keep trying, so that there's a possibility, that hope element that things might shift for you at some point and that we could honour the dignity of your life. So, it's really hard to just say you can make that choice. And also, how has the world made that your only choice? And is it possible to shift that in some way?

Maya asked, how can we accept a person’s choice to take their own lives when we know there are practical solutions to addressing the needs that underlie this decision. In fact, Chrisjohn et al. (2017) also suggest that the Canadian state approaches Indigenous people with the practices of “letting ‘nature take its course’” (p. 119) or slow death—negligence that allows Indigenous people to die off by failing to address root causes.

It must be noted however, that the stated purpose for the discipline engaged in by mental health social workers is not limited to the enforcement of rules. Mental health practices are connected to rehabilitation, the moulding of people to align with social norms. This central task was already evident with the embryonic social work field. It was at the 1892 National Conference on Charities and Corrections—generally accepted as one of the precursors of the

social work profession (referenced in Chapter 6), that Captain Richard Henry Pratt infamously stated,

> A great general has said that the only good Indian is a dead one … In a sense, I agree with the sentiment, but only in this: that all the Indian there is in the race should be dead. Kill the Indian in him, and save the man. (Chapman & Withers, 2019, p. 61)

Pratt argued that the interactions between White staff and Indigenous children at Indian boarding schools could foster assimilation, an alternative approach to achieving genocide—though it must be acknowledged that death was also very much a feature of these schools. Other early social work practices, including settlement houses and friendly visitors, also had goals of assimilation and rehabilitation.

Today, mental health social worker-initiated police interventions initiate entrance into rehabilitation through practices like forming, or ensure compliance with rehabilitation programs—as with Community Treatment Orders and forensic mental health stipulations that are enforced by the police should there be a failure to comply with treatment (see Chapter 4). And as mentioned in previous chapters, these practices, in resonance with early social work history, disproportionately target BIPOC. Two key examples of rehabilitative treatment include psychotherapy and counselling. 84 per cent of Ontario mental health social workers listed supportive counselling as a major responsibility in a 2010 survey, and 56 per cent listed psychotherapy (O'Brien & Calderwood, 2010). An especially popular approach is Cognitive Behavioural Therapy (CBT), which involves assisting service users in identifying "trauma-related dysfunctional beliefs that influence response to stimuli and subsequent physiological and psychological distress" (Regehr & Glancy, 2014, p. 141). Service users are taught that certain

beliefs are erroneous or distorted and should be caught before they develop into distressful emotions. The intended outcome is to prevent these beliefs and emotions from affecting daily activities; however, it has also been critiqued for obscuring the causes of distress at best, and policing supposedly deviant behaviours at worst (Chapman, 2014b; W. Davies, 2011). While psychotherapy can be helpful in alleviating distress, it is also important to acknowledge its other functions, evident when considering its history. Psychotherapy emerged to treat distress "without disrupting the economic arrangements of consumerism" (Cushman, 1996, p. 6). The "therapeutic ethos", the idea that illness, including psychological maladies, should be treated through application of science allowing for a return to "normal society", popularized and made psychotherapy an accepted practice. The therapeutic ethos was also marked by an "intensely private sense of well-being" (Cushman, 1996, p. 67), which became the end goal of therapy. There was an emphasis in individualized conceptions of self, and a rejection of collectivity. The individualized conception of the self and the therapeutic ethos combined to create the idea of treatment in a vacuum, neglecting to approach issues on a social scale.

In addition to psychotherapy and counselling as a means of rehabilitation, psychopharmacological treatment is perhaps an even more widely administered treatment for mad people. Capponi (2005) explains, "if we assume everything is related to physiology then the primary, "sane" response is to treat mental illness with pharmaceuticals – a clean, easy solution, and one we have a lot of comfort with in the twenty-first century" (p. 4). Bentley, Walsh, & Farmer (2005) explain that 80 per cent of American social workers surveyed claim to very frequently discuss medications with clients; 71.9 per cent make referrals for medication assessment; and 70.1 per cent discuss psychopharmacological treatment goals. Capponi (2005)

also reports that pressuring someone to take medication is still seen as acceptable and in the interest of the patient. In fact, medication monitoring is often a task done by mental health social workers in forensic settings and in relation to CTOs (*Social Worker Transitional Rehabilitation Housing Program 2*, 2018). Social workers are to report to the psychiatrist should medication monitoring reveal non-compliance, which may result in involuntary hospitalization. As with psychotherapy, some psychiatric survivors may find benefit to medication; however, there are also important critiques that should be recognized. Capponi (2005), drawing from their own experiences in the mental health system, argues that while people often think of straight-jackets and quiet rooms when issues of coercion in the context of mental health facilities are brought up, medication is actually the most ubiquitous means of control. Medication can be used in the hospital and other contexts as a blunt tool to reinforce norms. Burstow (2015) explains that "as substances which impede people's ability to think, feel, act, these drugs constitute a form of incarceration in their own right" (p. 123). Medication dosages may be increased in response to behaviour deemed deviant by medical professionals. Abnormal behaviours are often interpreted as the dosages being too low and a mental health social worker may recommend reassessment of medications by the psychiatrist. In fact, Capponi (2005) argues that psychopharmacological treatment acts as restraints outside of the treatment setting; "chemical restraints are as effective in the community as the physical four-point restraint that tied us to our hospital beds" (p. 112).

While the disciplinary and rehabilitative practices facilitated by mental health social workers through police intervention are fundamentally coercive in nature, these practices have sometimes been demanded by the service users themselves. According to Chandra, a service user requested "assist[ance] in getting formed", explaining that they "had been trying to access mental

health services and wasn't able to get access to it". The service users felt that apprehension was the only means of access. I can also recount a time when a service user suggested to me that "at least in jail, I'll have a roof over my head and food on the table." Other service users, despite recognition that police intervention was unpleasant, would try to convince social workers to call 911, as they felt that this was a way for hospital staff to take them seriously. They wanted hospitalization to access supports, shelter, and food, but were often denied as the emergency room doctor would judge the circumstances as non-severe and hospitalization unjustified if the service user attended the hospital on their own accord. Comfort (2002) discovers similar attitudes among some family members and prisoners themselves towards the prison system. Referencing correctional facilities playing host to family meals, weddings, and sleepovers, family members interviewed commented that "in spite of the enormous sacrifices, degradations and curtailments exiged by the authorities as requisites for prison visiting", the arrangements can be "attractive compared to the dire conditions with which women contend in free society" (p. 491). For example, one interviewee was homeless while her husband was incarcerated. Thus, she felt that visitation involving the privileges of "spending a few days in a fixed environment in the company of her kin was a closer approximation of 'home' than she normally enjoyed" (Comfort, 2002, p. 489). Importantly, Comfort (2002) concludes that neither are these people irrational nor are the arrangements ideal. Instead, these sentiments are a reflection of the prison as "the most prominent, powerful, and 'reliable' state institution in the lives of the poor and dispossessed" (Comfort, 2002, p. 491) in the context of mass incarceration and austerity.

Poverty driving a desire for hospital commitments has been documented as early as the mid-19th century. The advent of long-term commitments as the primary response to madness

coincided with the development of formal administrative procedures for these confinement practices. These procedures gave significant discretion to public officials like the overseer of the poor or the police to determine whether to send people to poorhouses, prisons, or hospitals. In other words, the classification of deserving and undeserving poor, is a fundamental element of the social worker's job. Kittrie (1971) explains,

> the reason behind the procedural requirements of the early period was not so much to prevent the improper commitment of unwilling innocent people as to exclude paupers and vagabonds who were only too willing to be admitted to the institutional benefits. But the growth of mental institutions and the concomitant increase in the number of commitments finally resulted in complaints of abuses and the institution of several suits alleging illegal commitment. (p. 64)

Kittrie argues that these procedural requirements serve as the foundation of modern commitment procedures, born out of a concern for ensuring people do not 'take advantage' of hospital resources rather than any desire to mitigate against 'false commitments'. This echoes our previous discussion in Chapter 7 about reforms ostensibly enacted to limit discretion in the name of protecting psychiatrized people were actually a response to demands for greater control of psychiatrized people, in which the interests of psychiatrized people are secondary. Even when reforms are enacted in response to disability justice movements, the resultant policy tends to actually expand state power in relation to psychiatrized people.

A number of interviewees emphasized how police intervention would be for the betterment of the service user. They argued that police intervention and subsequent involuntary hospitalization could be helpful since it would facilitate access to more intensive services,

services that either were previously rejected by the service user (and now can be provided involuntarily) or were only available after apprehension. Carrie recounted working with an Indigenous minor who "physically acted out" towards other people. During a team meeting to determine how to respond, Carrie suggested police intervention. Ultimately, the team decided against calling the police as the father agreed to escort the child to the hospital for an assessment. The father failed to bring the child to the correct location, and the child was left unassessed. Reflection on this sequence of events, Carrie concluded that they "should've called police at that point to get her hospitalized". Carrie explained, "some clients have to crash and burn to get them help. And she wasn't getting appropriate help. And that would've been the opportunity". Carrie's reasoning was that the child's disruptive behaviour—"crash and burn"—created an opportunity to obtain involuntary hospitalization, which would in turn lead to access to intensive treatment, and "mandated mental health service" in particular. Carrie stated, "had I called the police, the kid would've been hospitalized and gotten the mental health treatment." Carrie further rationalized that they had exhausted all other options, including CAS, who was unable to assist as this was not a child protection issue. The other problem was that since much of the mental health services were voluntary, the child could decline the recommended services.

Eva described a very similar approach in their work as a family worker. They would inform family members that service users sometimes "just need to go to hospital and get better", since there was a "lack of support" in the community. I also had a similar conversation with the family members of service users. Reflecting back, I think my intention was partly to give the family members hope, that this time of crisis might provide an opportunity for their loved ones to get help. But, I also think I may have been mirroring comments I heard from other social

workers, comments that could be considered a cliché within the sector. With hindsight, these statements could serve to justify or at least obfuscate coercive treatments. I even recall joking to a service user that a silver lining to their arrest was access to Mental Health and Justice housing, which has a relatively short waiting list compared to supportive housing. I now have mixed feelings about these comments, especially considering I struggle to recount a time when apprehension actually led to long-term resources that the service user wanted. These sentiments around framing coercive practices as opportunities to access resources share a very similar logic with concerns that the MAID program will be foisted on to people as a false binary that reinforces the existing social arrangement as the only possible reality.

This framing of coercive mental health practices also speaks to the profitability of debilitation for mental health social work and the broader non-profit industrial complex (NPIC). The role of maiming and debilitation in settler colonialism is not necessarily elimination; it is also profitable economically and ideologically. Assessing Palestine, Puar (2017) finds that Israeli and international Non-Governmental Organizations profit from the donations from the very companies that profited from Israeli military campaigns. For example, Elbit, which produces drones, often raised money for reconstruction efforts, only to contribute once again to the destruction of Palestine. These donations are subject to significant administrative oversight from Israel and the United Nations to avoid the use of such donations for Palestinian resistance efforts. Maiming is also ideologically beneficial as it serves to ensure that the death toll is not too high, while still debilitating the population. A death toll too high is problematic as in “a Euro-American sphere acculturated to the Holocaust, Palestinians become more attractive and rhetorically persuasive when dead than when alive” (Puar, 2017, p. 147).

In the context of mental health social work, the material benefits are obvious with the mental health industry receiving $15.8 billion in public and private sector spending in 2015 alone, and employing 52,823 social workers in 2019 (*A Lens on the Supply of Canada's Health Workforce*, 2021; Moroz et al., 2020). Ideologically, the mental health sector, exemplified by the comments from interviewees of accessing resources through police intervention and hospitalization, act as what Kivel (2007) calls 'a buffer zone'. The sector seeks to alleviate the worst sufferings resulting from capitalism, ableism, settler colonialism, white supremacy, heteropatriarchy, etc., while also delegitimizing the tangible solutions put forward by communities asserting their sovereignty and autonomy from the state. Indeed, Louise Tam (2012) suggests that the mental health sector, even when recognizing mental distress as resulting from structural processes, through a "positive representation of disability as 'wounded soul'" (p. 282), still propose individualized remedies, instead of structural change. When hospitals and psy-professionals stop suicides or "block up all the exits", they echo some of these logics, preventing what is understood as the worst possible outcome—death, without providing substantive solutions to the root issues. As Capponi (2005) states, "This is easier than improving the quality of their desperate lives" (p. 96). Though the MAID program, as stated, complicates this notion of blocking suicides as the easier solution somewhat, flipping the logic on its head, with euthanasia as the Band-aid solution, even when the person indicates that straightforward alternatives like safe housing could address their needs. This context of inaccessibility and debility is "evaded" through the state's implementation of the MAID program (A. J. Joseph, 2022).

The operation of the mental health sector as a buffer zone is also apparent even with mental health services that are delivered with recognition of discrimination and exclusion, that frames its provisions as addressing gaps in society. According to Gorman (2005), this conception

"obscures social relations and social actors, and it is so general that it is effectively meaningless" (p. 23). It discounts how the circumstances faced by mad people are produced by settler-colonial capitalism. For example, in the case of employment services, this failure to consider the nature of class and capitalism encourages a shallow conclusion that the labour market only needs to be less competitive (Gorman, 2005; Tam, 2013). Such reforms will do little to substantively address inequities, and will at best mitigate marginalization for certain disabled people. The concept of exclusion is also dehistoricized, obfuscating how these conditions are produced by actors through space and time. This failure to historicize is consistent with what Pon (2009) calls a rush to practice, the tendency for social workers to engage in practice without considering the influence of ongoing histories of oppression, as referenced in Chapter 1.

A more specific example of how mental health social work profits from debility is the Bell *Let's Talk* campaign. The mental health sector benefits materially with the initiative raising more than $100 million from its inception in 2011 to 2019 for mental health services and research ("Bell Let's Talk Day Raises More than $7.2M, Breaks Previous Record," 2019), funding the employment of mental health social workers. Conversely, Bell gets to launder its image as a leader in mental health, benefitting through brand promotion leading to increased sales. This is despite contributing to debility in relation to mental health. Their corporate practice, which involves pushing for greater productivity from a downsized workforce, has been reported to produce serious mental health issues for employees (Ho, 2016). A CBC investigation reported that "current and former employees describe[d] panic attacks in the workplace, stress-induced vomiting and diarrhea. Some also reported crying before starting call-centre shifts and said taking stress leave is 'common'" (E. Johnson, 2017). Another issue being deflected is Bell's exorbitant pricing in relation to telephone services in prisons. Contrasting this issue with Bell's

purported support of mental health, activists emphasized the implications of inaccessible telephone services on the mental health of prisoners. A mother of a prisoner mentioned how their son experiences significant anxiety and fear when unable to reach family by telephone. Indeed, families often support prisoners through mental health crises, with the telephone being the only means to do so, which of course is yet another example of the erosion of informal support networks. Bell Canada maintains that the rates are consistent with their public rates, failing to recognize that prisoners have no alternatives to the telephones operated by the company (Laucius, 2019).

The Institutional Archipelago in Service of Nationalism and Settler-Colonial Capitalism

These forms of discipline extend beyond the specific institutions mental health social workers are employed at, as "disciplines in fact always tend to escape the institutional or local framework in which they are trapped … they easily take on a Statist dimension" (Foucault, 2003, p. 250). Discipline needs to be contextualized at a transinstitutional and national level. These micro-level disciplinary measures are feeding into discipline at a much broader scale. Disciplinary measures are a fundamental aspect of the nation-state. As Cunneen (2014) remarks,

> the state defines itself as synonymous with the nation (Anderson 1990) and the boundaries of the moral community within it (Pettman 1996, p. 47). To be outside the moral community is to be susceptible to the violence of the state. (p. 6)

Nation-states engage in discipline at the level of demographics, determining which groups to include within the moral community (i.e. people we consider to have an intimate connection to and thus, should avoid enacting harmful behaviour enacted towards them). Those outside the boundaries of the moral community are subject to slow death and debility, as well as state

violence, including police intervention. As discussed in Chapter 7, psychiatrized people, a classification intertwined with racialization and other social categorizations, were considered perennial threats to society, outside of the moral community.

While individual mental health social workers enact discipline at a much smaller scale, nation-states set the parameters that inform these disciplinary measures. Also discussed in Chapter 7, restrictive immigration policies, sterilization practices that disproportionately targeted BIPOC communities, and anti-miscegenation policies are all examples that demonstrate how different strands of oppression, including race, class, gender, and so forth, interlock through state policy to eliminate or contain undesirable populations, those beyond the moral community. These practices were first advocated for by the mental health field, before being adopted by the state and, again, implemented by mental health workers across the country. The roots of psy-discourses are also intricately tied to theories of race, degeneration, and eugenics. These theories informed the use of psychiatric diagnoses like drapetomania, as mentioned in the prior section, to discipline BIPOC communities. In fact, Burstow's (2015) contends that a North American (and I would add: White, middle-class, heteronormative, cisgendered) way of living and experiencing is exalted and made universal—and other ways are pathologized—through psy- approaches. For example, while affective responses like melancholy are understood as pathological in psychiatry, it may not be considered deviant in contexts outside North America (Watters, 2010). In the United States, entire towns of Black residents were classified as "insane" in the 1840 census, and the end of slavery, between 1870 and 1880, was marked by a significant increase in psychiatric diagnoses (Schenwar & Law, 2020). The disproportionate diagnoses of racialized people have continued to this day (Baker & Bell, 1999; Gone & Trimble, 2012; Kielland & Simeone, 2014;

Minsky et al., 2003; Pinto et al., 2008; Schwartz & Blankenship, 2014; Schwartz & Feisthamel, 2009; Zhan, 2003). These ongoing practices and the discourses that underlie the mental health field inform contemporary mental health social work practice, including mental health social worker-initiated police interventions, as evident by the disproportionate targeting of BIPOC for coercive mental health practices like involuntary hospitalization.

The notion of risk associated with psychiatrized people discussed in the last chapter also intersects with race and class. In addition to the historic linking of racialized communities with criminality by the mental hygiene movement, the practices of predictive policing so central to the work of mental health social workers help establish a risk society, whereby BIPOC and poor communities are consistently considered potentially dangerous, justifying ongoing surveillance. Indigenous people, for example, are especially targeted. Cuneen (2014) states,

> race and indigeneity are reduced to a potential risk factor for involvement with the criminal justice system, akin to alcohol and drug abuse, offending history, or age … Being an indigenous person has been and is risky, and an important part of the process of renaming and reconceptualizing "crime" is to consider the problem of crime against indigenous peoples who have been victims of profound historical injustices and abuses of human rights over a long period of time. (p. 6)

As discussed in the first section, these factors serve to obfuscate systemic issues rooted in colonization and displacement. Individual factors like drug use or offence history are framed as self-evident, removed from its context. Each factor is considered as "discrete "facts" that can be separated, quantified, measured, and subject to regression analysis" (Cunneen, 2014, p. 8). It

should also be noted that these types of risk factors are consistent with the risk factors considered by the Situation Tables discussed in Chapter 4. Furthermore, Cuneen (2014) argues that risk aversion has accelerated with the advent of the risk society, meaning a “decline in tolerance and a greater insistence on policing of moral boundaries” (p. 7). This further reinforces the disciplinary practices of the state directed towards both internal and external ‘enemies’. This tendency is especially apparent with the discriminatory measures against Muslims associated with the war on terror, and the targeting of Indigenous sovereignty activists and their political activities as a national threat to be contained.

The national scale of the mental health field’s disciplinary work is also apparent in the mental hygiene movement’s stated mission to serve the Canadian nation-state, and especially in relation to settler-colonial goals. In *The Scope and Aims of the Mental Hygiene Movement*, Dr. Clarence M. Hincks (1919), the co-founder of the CNCMH and whose name adorns a major mental health centre in Toronto today, stated, “the brains of a nation constitute its most important asset. No country can be truly great, and remain so, with a population possessed of mediocre mentality” (p. 20). A nationalist desire for Canada to be ‘truly great’ was a major component of CNCMH’s raison d'être, with a particular focus on improving mental aspects of the Canadian people. This could be seen throughout the Canadian Journal for Mental Hygiene (CJMH). Hincks (1919) explained that the CNCMH aimed to “assist the nation in conserving and developing a most precious asset” (p. 22)—the 'precious asset' being the mental capacities of white Canadians. Similarly, Dr. Antoine-Hector Desloges (1919), General Medical Superintendent of Insane Asylums of the Province of Quebec in 1919, urged the public to "help build a nation" (p. 116) by refusing to “speculate on human degeneration” through inaction or

unsound social policy. Canada as a democratic nation could not function if the policies advocated for by the CNCMH were not institutionalized. Along those lines, Agnes L. Rogers (1920), professor of education at Goucher College, explained that while "An autocratic ruler may govern without science, a bureaucracy may dispense with science, but no democracy can survive unless its education is sound" (p. 72). William D. Tait (1921), professor of psychology at McGill University, also argued that scientific measures against the propagation of people with 'mental defects' need to be put in place to ensure that the leaders available in a democratic country are of a high calibre. These overarching goals resonate in contemporary framing of the purpose for mental health services. In 2010, the Mental Health Commission of Canada (MHCC) (2013) published a report entitled *Making the Case for Investing in Mental Health in Canada*, arguing for the need for greater investment in mental health services by highlighting the "life and economic impacts of major mental illness" (p. ii) on a national level. The MHCC concluded that mental health issues cost the Canadian economy at least $50 billion annually, through direct health care and social services costs and the impact of mental health issues on the productivity of the Canadian workforce. The implicit message is that a nation's goal is increased economic productivity and that mental health issues impede this goal.

These nationalist objectives coincided with the articulation in Canadian mental hygiene literature of several foundation myths that form an integral part of Canadian identity. A major myth that has justified the formation of the country and colonialism is the representation of Canada as barren, a tabula rasa (McKenzie, 2001). As first introduced in Chapter 7, J. D. Page (1919), in the CJMH, cited Sir James Barr: "You have, here, a virgin soil and you should see that it is peopled with a vigorous and an intellectual race. You should shut out all degenerate

foreigners as you would exclude a mad dog" (p. 59). Canada's soil is considered untouched and the White race, vigorous and intellectual, is considered its rightful inheritors. Virgin soil alludes to the idea of Manifest Destiny and the frontier discourse of civilized White men conquering uninhabited lands (N. Smith, 2005). The CNCMH, through the CJMH, rendered colonial violence invisible through the framing of colonialism as the labour of White people bringing about progress. W. G. Smith (1919a), Professor of Psychology at the University of Toronto, stated, for example,

> From the day when to the astonishment of the red men the pale faces began to arrive from the East and press their way forward toward the West, to the present day, when the results of the labour and endurance of the hardy pioneer are manifested in "the star of Empire". (p. 47)

Not only is the violence of colonialism not mentioned, but colonizers are also celebrated for their "labour and endurance".

The tabula rasa and virgin soil myths are one means of erasing the ongoing history of displacement previously explored. The displacement of Indigenous and subjugated knowledges and practices are done to seriously damage the ability of communities to be self-sufficient and to practice self-determination. This displacement of the commons, alongside a subsequent erasure or obfuscation of this process, allows for the positioning of the settler-colonial nation state as inevitable and necessary, the only plausible entity that can provide care and address daily needs. While state social welfare intervention are actually done as means of pacification and "radical transformation of the modes of production of Indigenous communities in order to facilitate ongoing dispossession, as the Elizabethan Poor Laws had functioned in England" (Fortier &

Wong, 2019, pp. 439–440), the state is able to present itself as acting in benevolence, reproducing notions of White civility (Chapman & Withers, 2019). This process also allows the state and the social work profession to "perpetuate[] the notion that capitalist social relations are natural and normal functions of an industrialised society" (R. P. Mullaly, 1993, p. 192).

These state-led services and mental health practices, and the institutions that facilitate them exist within a broader system of penality. Penality is a system of investigation and punishment that reinforce the existing social order and connects mental health practices and institutions with policing. As described in Chapter 2, Foucault (1975) considers penality a political tactic that serves as one part of a reciprocal and intertwining relationship with the mode of production. Thus, forms of discipline change in relation to the objectives relevant to the dominant mode of production in a time and place but are also crucial to creating the conditions that allow for the mode of production to exist. Settler-colonial capitalism in Canada is thus reinforced and made possible by the carceral system. Mental health social workers contribute to this, complementing the police in their repression of Indigenous resistance to settler-colonialism through surveillance and physical coercion (Dafnos, 2013). In fact, as discussed in Chapter 6, professional social work organizations lobbied to take over from the work of the Indian agent. In their work as front-line workers in the prison industrial complex, social service providers participate in surveillance by exchanging intelligence with the Department of Indigenous and Northern Affairs and the Royal Canadian Mounted Police targeting specific individuals, groups, and communities who aim to assert their sovereignty (Dafnos, 2013). Mental health social workers are also key players in what Sangster (1999) calls the "censuring process", distinguishing the immoral from the moral through the production of discourses based on

gendered, racialized, and economic power relations; note the similarity here to the responsibility assigned to early social workers in sifting worthy from unworthy recipients of social welfare. In her study of the incarceration of Indigenous women in Canada, Sangster (1999) argues that the more rebellious Indigenous women in communities or those who refuse to abide by settler colonial expectations and incite their communities to fight back have often faced incarceration after they have rejected the "help" offered by social workers and psychologists seeking to "diagnose" their problems through individualized and decontextualized methods.

These developments were part of the broader trends around integration of social work into the carceral system, which emerged with the return and rise of the prison. The Mettray, a French facility for juvenile delinquents founded in 1840, was illustrative of the new prisons. The staff at Mettray were described as "technicians of behaviour: engineers of conduct, orthopaedists of individuality" (Foucault, 1975, p. 294), combining the work of social workers, judges, foremen, teachers, and parents. This combination facilitated the two major practices within the Mettray: regimented training and permanent observation. The former served as a concentration of many "coercive technologies of behaviour" (Foucault, 1975, p. 293). Inmates were divided into hierarchized groups: modelling the family and the military. Inmates also laboured in workshops and received schooling. But of course, there remained a strong judicial component, with punishment inflicted for even the most minor of offences, usually in the form of further confinement and isolation. The latter involved the continuous collection of biographical information on each juvenile, beginning from the point of intake and "constantly built up from the everyday behaviour of the inmates" (Foucault, 1975, p. 294), not unlike the everyday mental health social work practice of case notes referenced in Chapter 4.

Human sciences, which emerged partially out of this emphasis on the study of people as individualized entities, also coincided with the development of the norm, the standard which people are measured against. Alongside the norm—sanity, an aberration—insanity, also must exist, creating a target of penality. No longer limited to the enforcement of regulations, such as those residential rules discussed in the previous section, penality was now also focused on adapting people to this norm. Schwan and Shapiro (2011) explain, "'disciplinary punishment' is '*corrective*': it punishes us in order that we follow the models of behaviour, it is a kind of training device" (p. 118). Confinement and other techniques practiced at the Mettray and subsequent iterations of psychiatric and carceral institutions were directed at rehabilitation, reforming a person back to the norm. Stiker (2019) adds,

> rehabilitation marks the appearance of a culture that attempts to complete the act of identification, of making identical. This act will cause the disabled to disappear and with them all that is lacking, in order to assimilate them, drown them, dissolve them in the greater and single social whole. (p. 128)

In other words, rehabilitation is a technology for social conformity. Individuals more open to assimilation may be directed towards counselling, while those less open or deemed 'inassimilable' are subjected to more coercive forms of rehabilitation, or at least sequestering through the asylum or prison system. Kittrie (1971) explains that "the state's therapeutic function is often authoritarian and may be exercised on a deviant individual for the asserted public interest with little or no consideration of [their] own choice" (p. 41). These more coercive forms of rehabilitation are often facilitated through mental health social worker-initiated police intervention.

Rehabilitation towards the norm ensures a supply of productive and cooperative labourers for the capitalist class. Foucault (1975) states,

> discipline produces subjected and practised bodies, 'docile' bodies. Discipline increases the forces of the body (in economic terms of utility) and diminishes these same forces (in political terms of obedience). [...] If economic exploitation separates the force and the product of labour, let us say that disciplinary coercion establishes in the body the constricting link between an increased aptitude and an increased domination. (p. 138)

The production of the ideal labourer requires that the body be made submissive and docile, and then engaged in processes to transform and improve it. The need for submission is an important component of the carceral system in relation to mad people considering the understanding of mad people as disruptive and dangerous. Docility also fulfils a key objective of these carceral institutions to facilitate an environment that is conducive to production and consumption. Gilmore (2007) states,

> These institutions of modernity, shaped by the rapid growth of cities and industrial production, faced a challenge—most acutely where capitalism flourished unfettered—to produce stability from "the accumulation and useful administration" of people on the move in a "society of strangers". (p. 11)

Carceral institutions help reproduce settler-colonial capitalism by maintaining stability through discipline to ensure production and consumption can continue unabated. The need for reformation into productive labourers is also important considering the framing of mad people, and disabled people in general, as unproductive, and burdensome to society (see Chapter 7).

The Mettray—with discipline exerted through family, labour, schooling, and religion—soon became a microcosm of arrangements outside its confines. This new form of social control is of a much broader scale than forms of penality that dominated previous periods, encompassing the prison but also the police, schools, social services, healthcare, and other institutions. Penality as existing through capillaries means that social control is no longer centred on the judges and executioners. The privilege to judge has been broadly diffused across what Foucault (1975) describes as the "carceral archipelago" (p. 297), a whole assortment of institutions, including social work, that work in conjunction with the prison. As Foucault (1975) explains,

> We are in the society of the teacher-judge, the doctor-judge, the educator-judge, the 'social worker'-judge; it is on them that the universal reign of the normative is based; and each individual, wherever he may find himself, subjects to it his body, his gestures, his behaviours, his aptitudes, his achievements. (p. 304)

Consequently, coercion or violence cannot be understood as exclusively under the purview of the police officer or soldier, who instead, only "act[] where [the spaces of discipline – e.g. schools and hospitals] could not intervene, disciplining the non-disciplinary space" (Foucault, 1975, p. 215). These practices exist within a context that includes a network of supervision that has a goal of ensuring normalcy. And the fact that penality now exists in the form of a "capillary functioning of power" (Foucault, 1975, p. 198), amorphous in nature, makes it insusceptible to substantive change.

Acknowledging that with deinstitutionalization in the 1960s, the carceral component of the archipelago may no longer be as central to disciplinary control in relation to psychiatrized people, Chapman, Carey, and Ben-Moshe (2014) further nuance the concept of carceral

archipelago by introducing the term institutional archipelago. While I argue that incarceration does remain a major component of penality as directed towards psychiatrized people, it is no longer the self-evident response to disability. Instead, the institutional archipelago as a concept emphasizes the “diverse services and spaces that all trace back to undifferentiated confinement and its ongoing reform” (Chapman et al., 2014, p. 14). Mental health social work is one capillary in the institutional archipelago, working closely alongside other disciplinary institutions, including the police.

The grafting of positivist criminology to the classical penal system, including as a hybrid system applied to psychiatrized people, is illustrative of the institutional archipelago. As discussed in Chapter 7, positivist criminology involves carceral practices “designed to fit the particular needs of the offender … the substitution of the indeterminate commitment that "fits the criminal" for the inadequate determinate sentence that merely “fix the crime”” (Kittrie, 1971, pp. 343–344). The hybrid system made up of the incorporation of this approach into classical penal approaches that emphasize deterrence and addressing criminal acts is termed the therapeutic state and designed to engage in social control through the treatment and rehabilitation of offenders (and potential offenders). According to Foucault et al. (1978), these interventions can come in the form of “definitive elimination (by death or by incarceration in an institution), temporary elimination (with treatment), and more or less relative and partial elimination (sterilization and castration)” (p. 13). As discussed throughout this dissertation, mental health social workers have been and continue to be involved in all three forms of intervention. The approach is “tinged with a lingering desire to defend society by isolating and controlling socially dangerous persons”

(Kittrie, 1971, p. 42) and adopts the medical approach previously examined, with a focus on curing illness over retribution.

Though the therapeutic state has been described as a much more recent phenomenon (Szasz, 1989), aspects of it can be observed from a much earlier time period. The therapeutic state has roots in legal principles, *parens patriae* in particular, from as early as the 11th century, and its broader implementation in Canada is associated with the advent of asylums (Whitaker, 2015). As stated in Chapter 4, the asylum system emerged in the 19th century with the enactment of the County Asylum Act. Consistent with the significant increase in asylum incarceration across Western countries, the construction of asylums in Canada also coincided with a rapid increase in asylum patients (Wright et al., 2013). Between the mid- to late 19th century, the number of asylum patients in Ontario rose from a couple hundred to over a thousand, with over 12,000 people held in Ontario psychiatric hospitals throughout that time period. The Canadian therapeutic state would continue to proliferate through the advocacy work of the mental hygiene movement discussed in Chapters 6 and 7.

While Kittrie (1971) frames the rise of therapeutic approach rooted in positivist criminology as coinciding with the divestment of classical, deterrence-based, approaches of the criminal justice system, I contend that this is an overstatement. In truth, the positivist approach has actually grown alongside the classical approach, which has remained a fixture. This is evident considering how incarceration rates have continued to increase largely on the rationale of deterrence. Anti-Black racism also remains at the core of the carceral system as understood through an Afro-pessimistic lens, which considers gratuitous violence and Black enslavement as a condition for global capitalism (M. C. Dawson, 2016; Wang, 2018). In other words, the

rehabilitative elements of positivist criminology have not completely supplanted other rationales for carcerality. Instead of replacement, as Schenwar and Law (2020) argue, the increased funding into the other arms of the institutional archipelago simply expands the number of people under surveillance and containment, with mental health social workers facilitating involuntary detainment in hospitals and forensic psychiatric facilities, or surveillance in the community through practices like CTOs. Positivist criminology actually complements the classical penal system by inhabiting the noncriminal arena, "free from the traditional safeguards imposed upon the exercise of coercive powers under criminal law" (Kittrie, 1971, p. 42). For example, instead of conceptualizing people as criminals, the targets of intervention are understood as "non-persons". The non-person is someone "who is immature, unworldly, and incapable of making effective decisions with regard to his own welfare and future" (Platt, 1977, p. 318). In the case of the non-person, interventions are designed to address "the offender's total personal deficiency" (Platt, 1977, p. 318). This provides the carceral system, including mental health social workers, with greater discretion in its treatment of psychiatrized people. Instead of definite sentences, people may be incarcerated or monitored indefinitely (Schenwar & Law, 2020). The substitution of the criminal with the non-person as the framework for understand targets of intervention also serves to present a "kinder and gentler" face to carcerality, which sustains the carceral system by making coercive practices "more acceptable and less of an urgent priority to confront" (Schenwar & Law, 2020, p. 12). Finally, as Schenwar and Law (2020) warn, even if positivist criminology replaces classical approaches, this "only change[s] the look and feel of the sentence … the criminalization machine is being adjusted to keep up with the times, but it remains well-oiled and well-functioning" (p. 11). Instead, as Kittrie (1971) acknowledges, hybridity means that the penal and therapeutic models are "imbued with certain attributes of the

other" (p. 373). The so-called new model still relies on "captivity and control" and still targets the same oppressed communities.

Mental health social workers also participate in the institutional archipelago by extending the reach of institutions like the courts and hospitals. This innovation involved a shift from a focus on confinement of mad people in asylums to providing interventions in the community, partly influenced by prominent mental hygiene advocates like Hincks, a psychiatrist mentioned earlier in the chapter who established the first Canadian outpatient psychiatric clinic (MacLennan, 1987). The promotion of community-based treatment meant broadening the scope of that considered abnormal, also referred to as totalization (Whitaker, 2015). For example, the number of psychiatric diagnoses has grown tremendously since the publication of the 1918 Statistical Manual for the Use of Institutions for the Insane, what is considered one of the first attempts at the creation of a formal catalog of diagnostic labels for mental health, and a predecessor to the modern Diagnostic and Statistical Manual of Mental Disorders (DSM) (McCarron, 2013). Human behaviour previously understood as 'normal' have been progressively medicalized and framed as requiring professional intervention. As Foote and Frank (1999) argue, it is suggested by mental health professionals that everyone has the potential for grief through loss or death and therefore, everyone potentially needs treatment. This process also echoed in forensic mental health. Foucault et al. (1978) notes that while psy- professionals initially referenced the notion of a hidden pathology that is liable to erupting in extreme forms of violence, the relevancy of mental pathology later extended to all forms of "minor delinquency". In agreement, Kittrie (1971) concludes, "in the therapeutic *parens patriae* realm we often ignore the question of whether a particular offense has been committed and instead are moved to

exercise therapeutic sanctions by a finding of the general social undesirability of one's condition or status" (p. 48). In other words, any behaviour deemed socially undesirable may be sufficient to justify intervention.

The broadening of what was considered pathological occurred alongside another aspect of totalization promoted by the mental hygiene movement—the proliferation of obligations to seek mental health treatment (Cushman, 1996; MacLennan, 1987). Whitaker (2015) states,

> we are supposed to be on constant guard for signs that we are straying from this norm, and if so – if we are feeling anxious, depressed, or overly rambunctious – then we are promoted to conclude that something is wrong with us, and we need help. (p. 337)

The movement called for preventative mental health practices—in line with the preventative objectives of positivist criminology, promoting the idea that psychotherapy was akin to brushing one's teeth or taking a bath; in other words, it was a basic requirement for everyone to attain good health. The idea of cleansing suggests a "concrete, material conception of the [healthy] mind" (Cushman, 1996, p. 71) that should be returned to through mental health treatment. These public campaigns promoting mental health practices as prevention were crucial, as "[mental health] professionals required some mechanism, some connection with the community, by which they could transcend their isolation in traditional institutions" (MacLennan, 1987, p. 19) like the asylum.

Mental health social workers reinforced this obligation in their daily practices, reminding service users of their responsibilities and encouraging them to seek treatment. In fact, some of the interviewees' work as mental health social workers involved identifying and convincing service users to enlist in more intensive mental health services. Mental health social workers

have been involved in this work since the early emergence of the mental health field in Canada (Wong, 2016). Mental health social workers in guidance clinics helped identify potential candidates for sterilization in the community. Mental health social workers also aided with informational collection, an aspect of the work that made the profession an arm of the hospital and other institutions that extended into the community (see Chapter 6).This is consistent with contemporary examples discussed in this dissertation, including work involving outreach to identify potential patients for intensive psychiatric treatment, CTOs, situation tables—involving social workers identifying potential psychiatrized people for police to intervene upon and the sharing of relevant information, and case management programs.

Franz Fanon (1963), a theorist and a psychiatrist, elaborates on Gramsci's theories around the relationship between professionals like social workers, as part of civil society[8], and more direct perpetrators of coercive violence, like police. Civil society supplements this direct coercive violence. Fanon (1963) describes how teachers, social workers, or counsellors, as members of civil society, "create around the exploited person an atmosphere of submission and of inhibition which lightens the task of policing considerably" (p. 38). Or to use Foucault's phrasing, civil society helps foster docility as part of the institutional archipelago. The social workers' responsibility is to create conditions of hegemonic control to secure compliance so that the need for "pure force" from the police is minimized. Fanon's conclusion also recognizes the

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[8] Note that Gramsci's definition of civil society differed from that of Marx examined in Chapter 2. Gramsci understands civil society as one of two overlapping elements of the capitalist state that relies on ruling by consent.

work of the mental health social worker that precipitates a call to the police. It is why my interviewees frame the call as the "last resort". De-escalation, rapport building, counselling, these are all social work techniques that are used to further overarching goals of rehabilitation or containment, ideally without the need for physical force, while avoiding substantive engagement with the root issues related to settler-colonial capitalism. And, it is usually when these skills are exhausted that police force is then relied upon.

Social workers are what Gramsci calls the "traditional" intellectual, in that social workers engage in "organizing, administering, directing, educating, or leading others" and through this work, contribute "directly or indirectly on behalf of a dominant social group to organize coercion and consent" (Forgacs, 1988, p. 300- cite from Whalebone). As "traditional" intellectuals, social workers impart and inform common sense in order to establish hegemonic control, suggesting a reciprocal relationship between common sense and social work practice. In relation to police interventions, I have discussed mental health social workers' work in organizing coercion by making calls for police intervention. But mental health social workers also facilitate consent to the practice of police intervention itself. For example, as mentioned, social workers often convince family members to call the police in situations where the risk of harm is present by framing this action as the only option and dismiss concerns about the harms of police violence and surveillance raised by psychiatrized people. Social workers normalize police intervention through these practices.

Finally, as I emphasize throughout the dissertation, the establishment of compliance through 'soft' coercion through the social worker cannot be clearly separated from the 'hard' coercion practices by the police. Even when social workers are operating independently, the implicit threat of police intervention, especially through programs like CTOs, remain ever

present. The collaborative nature of techniques to secure compliance and forceful coercion is made even clearer with the partnership of police officers and social workers in crisis intervention teams as one example. Police officers secure a scene, by force if needed, for social workers to 'safely' operate (Landeen et al., 2004), while social workers allow for greater efficiency in police interventions (Kisely et al., 2010). Returning to Fanon's (1963) statement on the purpose of civil society, it is important to note that while Fanon discusses this as a means of juxtaposing the severity of coercive violence in the colonies with the abated violence mitigated by civil society that characterizes social control in the West, Fanon does not suggest that social workers replace the need for police in the West or settler-colonial nations. Each group, in partnership, facilitates the work of the other in service of broader control mechanisms that maintain settler-colonial capitalism.

Conclusion

In this chapter, I examine the tasks undertaken by mental health social workers, especially in relation to crisis intervention and police or carceral collaboration, in the context of the broader settler colonial capitalist social order and the Canadian nation-state. A major element of these tasks is the reconceptualization of crises in a way that serves to redirect focus from structural change to individualized intervention. While mental health crises are often considered by mental health social workers as stemming from internal processes, I contend that this framing obfuscates the true roots of mental health crises in the underlying settler-colonial capitalist social order. It is this social order that has produced the inequitable conditions that trigger conflict and emotional crisis, contributing to disablement, debility, and slow death. Instead of addressing these structural causes, social workers intervene as disciplinarians. This is especially apparent in

the use of police intervention to evict service-users in residential settings, to enforce program rules, and to restrict the self-determination of mad people. But discipline is not limited to rule enforcement, rehabilitation is another important component. Mental health social worker-initiated police intervention often serves as an entry into rehabilitative measures, such as psychotherapy or psychopharmacological treatment, with the goal of moulding mad people based on social norms. Mental health social workers engage in these disciplinary tasks as a part of the institutional archipelago, the collection of interlinked institutions that serve a disciplinary function in society, crucial to maintaining the status quo. While mental health social workers engage in their work at an individual micro level, the state sets the broader demographic parameters that frames and influences this work. This influence is apparent when coercive psychiatric practices, from forced sterilization to involuntary hospitalization, disproportionately target BIPOC communities. Thus, collaboration between mental health social workers and police do not only operate at the level of individualized interventions, mental health social workers also supplement the work of the police in maintaining the Canadian nation-state and the settler-colonial capitalist social order.

Chapter 9: Conclusion

As discussed in the introductory chapter, social work has often been proposed as a solution to police violence. But as we have considered in this dissertation, social work is entangled with policing as a practice and an institution, and the proposals making the call for social workers to replace police fail to consider how policing remains an integral component of the suggested alternative.

Social workers are influenced by professional regulations to call for police intervention at signs of harm or dangerousness. Even though there is no evidence of social workers being reprimanded for failing to call the police, the possibility of censure, suspension, or banishment from the profession is sufficient to influence some social workers to call upon police intervention. Elements of Ontario College of Social Worker and Social Service Worker regulatory literature, including codes of ethics and practice guidelines, can also be interpreted as encouraging the use of police intervention. But beyond formal regulations, the subjectification of social workers as professionals also contributes to these practices. Social workers know themselves as holders of specialized knowledge, exalted to intervene upon the lives of mad people. Professionalization also embeds social workers to the settler-colonial state, with the state legitimizing the social work profession on the one hand, and social workers serving the state in maintaining and controlling the populace on the other. One way this work serves this social control objective is to obfuscate the roots of crises and disablement, debility, and slow death in settler-colonial capitalism, disciplining mad people's responses to the social order. This work occurs as a part of the institutional archipelago, a collection of carceral institutions and practices that reinforce and uphold settler-colonial capitalism in Canada. By conceiving and spreading

discourses of mad people as inherent threats to society, mental health social workers engage in the task of predicting risk of harm associated with mad people, labelling targets for intervention as ‘dangerous’. Those marked as ‘dangerous’ are then subject to police intervention as a default approach by mental health social workers.

As discussed in Chapters 4 and 7, mental health social workers determine interventions along a continuum from non-coercive to coercive. Even if the desire is to select interventions that are on the less coercive side of the spectrum, police intervention remains a possible tool at the other end of the continuum. And as long as certain conditions are met, especially that of dangerousness, a label intrinsically linked to mad bodies, especially BIPOC and poor mad bodies, police intervention will likely be brought in. Indeed, even the proposed alternatives of replacing police interventions with non-police led crisis interveners, including social workers, first discussed in the introduction, do not actually eliminate the use of police. The Reach Out Network (2020) proposal suggests mental health workers develop strong working relationships with the police and call for police back-up when there are concerns about safety. And as discussed in Chapter 4, the Toronto Community Crisis Services (TCCS) despite its ostensive purpose of reducing the use of police intervention for mental health crises, still involve significant collaboration with the police, such as attending crisis calls together, dispatching police reinforcements to facilitate involuntary hospitalization when the dangerousness criterion is met, and participating in regular meetings with the police to share information.

The inclusion of police intervention in the continuum of approaches also serves to legitimize these policing practices, suggesting that while police intervention is unenviable, there are circumstances that necessitate coercion—ostensibly to ensure safety and peace. In Chapter 6, I reference how these initiatives claiming to mitigate the harms of coercive psychiatric practices,

what Burstow calls “minimal rights”, serve to obfuscate the fundamentally violent principles and practices central to the institutional archipelago. A similar argument is made by Voronka (2008) regarding how adoption of ‘progressive alternatives’ by mental healthcare institutions serve as a means to launder or white wash its reputation without fundamentally altering or eliminating harmful practices (Voronka, 2008). While I do not believe that people advocating for or involved in non-police alternatives to crisis intervention do so with this explicit intention in mind, these projects may inadvertently achieve these objectives.

Concerns about these projects extend beyond the reinforcement of current practices. These initiatives could also conceivably lead to an expansion of policing and carceral practices. In Tam's (2017) assessment of police violence against mad people held in immigration detention centres, they reference calls for investments in mental health services as a response to these incidents. Yet, the Trudeau government's investment in psychiatric services, with $138 million earmarked for holding centre renovations and enhanced mental health services, did little to address the violence. Instead, the "increased mental health assessment and treatment of immigration detainees is not only paradoxical but further exacerbates conditions of distress by contributing to the expansion, rather than the abolition, of the detention and deportations system" (Tam, 2017, p. 340). Black and Indigenous people are already targets of mental health interventions that serve to criminalize. For example, Tam (2017) describes a police murder involving a Somali migrant who entered the immigration detention system precisely because of psychiatrization and resultant community surveillance, with neighbours calling the police regularly. He ultimately died while receiving psychiatric treatment at a hospital, after being held in isolation and restrained by police officers. Despite these circumstances, the Special Investigation Unit, in charge of scrutinizing police-involved deaths, ruled that the officers were

not culpable as the post-mortem examination excluded asphyxiation. Unable to ascertain cause of death, the main reference to his death was "agitation", a symptom often ascribed to victims of police violence and understood as a component of mental pathology. Tam (2017) critiques this framing and suggests instead that

> “agitation,” describes the social tension between the nurses, police officers, and Abshir. Abshir was not agitated, but he did agitate the neighbors who called the cops, the officer who restrained him, and the nurses who sedated him. His speech and his movements as a Black, Somali, Muslim man were agitating. (p. 341)

The label and other practices of psychiatrization are used to justify and initiate the coercive institutional practices that lead to countless injuries and death. While understandably speculative in nature, the expansion of practices involving social workers as intervenors in crises, such as the Toronto non-police led crisis intervention pilot project, could risk increasing surveillance and police violence. This suggestion is based on the idea that these projects could further normalize professionalized interventions in daily life, with the general public becoming more comfortable calling emergency services to intervene upon crises due to the perception that social worker-led options are less harmful and coercive. Ultimately, this would put more people into contact with the institutional archipelago.

Miriame Kaba (2021) suggests that initiatives need to be assessed in terms of whether they further abolitionism. Kaba argues that any reform that increases funding to the police, or leads to increased police and policing, do not qualify. As Schenwar and Law (2020) argue,

> Innovation, in itself, is no guarantee of progress. In so many cases, reform is not the building of something new. It is the re-forming of the system in its own image, using the

> same raw materials: white supremacy, a history of oppression, and a tool kit whose main contents are confinement, isolation, surveillance, and punishment. (p. 17)

The carceral system is itself the product of reform; indeed, prisons are a reformation of previous modes of carcerality. Burstow (2010), in a keynote speech at the 2010 PsychOut conference, applies similar criteria to psychiatry, arguing that any reform that moves society away from abolition, that legitimizes psychiatric institutions, or that "widen[s] psychiatry's net" (p. 5) must be problematized. The final criterion refers to "allowing more and more people and more and more situations to fall under the auspices of psychiatry" (Burstow, 2010, p. 5).

The growing use of social workers for crisis intervention, including the TCCS pilot program that attempts to replace police officers with mental health workers, is an example of 'reformist reforms'. These are reforms that may only benefit a segment of people and reinforce or expand the carceral system. Examples of these are reforms that focus on non-violent offenders over violent offenders or political prisoners over social prisoners. In the context of mental health crises, the division is often around the notion of dangerousness. But this supposed separation between dangerous and non-dangerous mad people, especially for BIPOC, is not so self-evident as has been discussed throughout this dissertation considering how mad people are presumed to be or intrinsically linked to the dangerousness label. And as Frieda Afary and Lara Al-Kateb (2020) argue, any distinction made as a part of a political strategy will only serve to draw focus away from the carceral system. These initiatives also breach criteria around the expansion and legitimization of coercive state practices given mental health social work's ongoing collaborations with the police and the potential for expansion of policing associated with this relationship, as mentioned.

As for reforms worthy of support, Kaba (2014) asks activists to consider questions like whether the initiative decreases or redirects police funds, disarms the police, or offers reparations to victims of police violence. Dean Spade (2015) suggests considering whether the reforms deliver material assistance or exclude an especially marginalized group from its benefits. Harsha Walia (2013) asks a broader question of whether these reforms advance and strengthen "long-term vision of naming and transforming the root causes of injustice" (p. 184). Burstow (2010) argues that initiatives must be “compatible with the creation of a caring society” (p. 10), empower mad people, and serve to reclaim the commons. These are what André Gorz (1987) calls non-reformist reforms. The notion speaks to reforms that “don’t make it harder for us to dismantle the systems we are trying to abolish [and] will help us move toward the horizon of abolition” (Kaba, 2021, loc. 1911).

Non-reformist reforms contribute to or at least do not rein in the possibility of the emergence of practices and institutions that reject carceral logics. The way forward cannot be restricted to the elimination of carceral institutions, but is rather a task which involves naming the entanglements of current social service provision with the goals of carceral capitalism, what I have focused on in this dissertation. Carceral abolition must also involve building emancipatory alternatives, and include recognition that abolitionist critique has never just centred on the carceral system, but also considers the forms of society that give rise to carceral institutions. The mission of carceral abolition can only succeed alongside the nurturing of an “abolition democracy,” described by Angela Davis (2011a) as an “an array of social institutions that would begin to solve the social problems that set people on the track to prison, thereby helping to render the prison obsolete” (p. 96).

Referencing W.E.B. DuBois, Davis (2011a) explains that the abolition of slavery associated with the 13th amendment of the United States constitution only occurred in the negative. Alongside the calls for an end to slavery was the demand for forty acres of land and a mule. This demand originated from a military order that gave abandoned Confederate land to freed Black people and reflected the recognition from the formerly enslaved people that "slavery could not be truly abolished until people were provided with the economic means for their subsistence" (A. Y. Davis, 2011a, loc. 1013). Formerly enslaved people also argued that there was a need to have access to education and other political rights in order to achieve the goal of abolition. The need for abolitionist democracy is also evident in the struggles to abolish the death penalty and prisons. In order to achieve both these goals, capital punishment cannot simply be replaced with life sentences, there needs to be new institutions and practices that can address the root causes related to criminalization. Davis (2011a) concludes that, "Prisons have thrived over the last century precisely because of the absence of those resources and the persistence of some of the deep structures of slavery" (loc. 1027).

I contend that this argument can also be applied to the institutionalized and normalized practice of police-intervention for mental health crises. As discussed in Chapter 8, mental health crises can be understood as a product of settler-colonial capitalism-produced inequities and oppression, a connection obfuscated by psy- discourses. There is also the presumption among social workers that mutual aid and community-led approaches to crisis-intervention are unavailable or untenable. An abolitionist democracy in this context would mean counteracting these presumptions by addressing immediate material needs, while facilitating community-led and non-coercive forms of conflict resolution and emotional care. Importantly, the imagination

of alternatives is not detached from practice. The act of imagination can rely on the multitude of ongoing practices of abolitionist democracy, some of which will be highlighted below.

"Walking, we ask questions": Finding Answers Elsewhere

The issue of coercive state violence points to the urgent need for research, discussion, and most importantly, praxis, on abolitionist alternatives. The following discussion of abolitionist practices is not meant to present these initiatives as flawless or in a prescriptive fashion. Instead, I suggest that these practices contain the seeds of an abolitionist future, illustrating new possibilities in the context of the current social order marked by violence and oppression. As Anna Tsing (2014) suggests, "Blasted landscapes are what we have, and we need to explore their life-promoting patches" (p. 108). Following the Zapatista principle of "walking, we ask questions" (Notes from Nowhere, 2003, p. 506), people should draw from these models but proceed forward with questions, instead of holding certainty about correct answers. This approach lends itself to non-hierarchical structures of leadership and a rejection of dogma. There needs to be a constant assessment of possible perpetration of harm in order to further notions of self-determination, and readers should approach the following examples not as an instructional manual, but as references or generative tools that should be adapted for different contexts.

Abolitionist Crisis Intervention

Considering my critiques of professionalized mental healthcare, and the calls to replace one institution of state violence through a strengthening of another, I instead argue that people should consider responses to crises informed by perspectives from mad people themselves. Mad movement activists have long called for mad literacy, a willingness to understand those whose behaviours do not conform to social norms, and skill sharing, to allow for community-driven

approaches to crisis intervention not predicated on violent coercion. For example, Burstow (2015) suggests efforts at de-medicalizing the language and practices directed at people, developing non-psychiatric services like self-help or withdrawal centres, and fostering and defending of mad culture. These ideas could inform practices of community befriending, an approach to crisis intervention that is marked by an emphasis on basic human relationship building by community members to creatively support a person before, during, and after a crisis.

To demonstrate what this may look in practice, Burstow (2015) recounts the story of a woman who would occasionally run around her apartment complex naked, banging on doors, and yelling “emergency, emergency”. While today’s social norms, social work knowledge and ruling relations may suggest that this behaviour warrants a call for police, or at the very least some form of expert-based mental health intervention, community befriending may entail apartment residents coming together to discuss solutions. Perhaps a committee of volunteers could be organized, whereby, on a rotational basis, neighbours could sit and comfort the individual during nights of anxiety. A major component of this work would involve neighbours developing mad literacy. Though the woman’s behaviour may be disruptive to neighbours, it is not an incomprehensible irrationality that underlay these actions; instead, Burstow concludes that these ‘psychotic episodes’ are an expression of feeling overwhelmed at a number of legitimate social concerns, including war, that the person wishes to warn her community about. Community befriending can assist in gaining that understanding, which in turn can help with developing ways of supporting the neighbour. These solutions may appear vague, but the idea is to harness the creativity of the community instead of relying on prescriptions. Burstow (2015) calls for the “commoning of services” (p. 241), returning healing back to the commons. A return of healing to

the commons requires the challenging of expert knowledge, including the idea that mental health care should remain in the purview of the police—and mental health professionals.

Elements of Burstow's proposal exist in Toronto's Bloordale community, where Gita Rao Madan, an education worker and activist who organizes around the intersection of school and carceral systems, founded the Bloordale Community Response (BCR), a neighbourhood-based affinity group in the midst of the COVID 19 Pandemic. In an interview, Madan explained that she had often intervened during street altercations and police harassment in an attempt to de-escalate and resolve conflicts while living in a neighbourhood and sought to expand this work. In 2020, Food Benders, a local restaurant, faced increased surveillance and harassment by the police after displaying a "fuck the police" sign in solidarity with the George Floyd protests. The restaurant had also faced ongoing attacks by Zionist activists in response to their expressed solidarity with Palestine. After learning of this, Madan reached out to the restaurant owner, offering to drop by with others whenever they needed support. Madan also made a Facebook post appealing for community members to assist. Community members regularly mobilized to defend the restaurant during times of harassment and also organized public actions and art projects in support. The BCR was born out of this initiative, operating through an "SOS" Signal[9] group that allows for rapid mobilization when crises emerged.

Madan explained that the BCR's mandate is to have "neighbours keeping neighbours safe without the intervention of the state, but also keeping people safe from state intervention". BCR thus engages primarily in two tasks—community defence and crisis intervention, with

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[9] Signal is a chat app that allows for encrypted communication.

recognition that the police are largely unhelpful at protecting people and that people themselves need protection from the police as is apparent in the case of Food Benders. Madan stated,

> We don't want people to call the cops on other people, because that does not bring safety. But also, there are situations where the cops have already been called and the state is already involved. It might not even just be the cops, it could be any state agents. In those cases, we have to think about whose safety is at risk as a result of that and what strategies and tactics we can use to mitigate those situations and ensure that people who are being targeted can walk away safely.

One example of mitigating police harm and seeking accountability is an intervention undertaken by the group that occurred after a member had observed police officers congregating outside a midrise apartment building yelling orders at a Black man standing on a balcony. The activist had later learned from a family member that this man had been ‘formed’ and the police were attempting to apprehend him for hospitalization. Out of concern for police violence, this activist began a live stream and called for others to join in witnessing. A dozen community members mobilized promptly, and many more kept watch through the livestream. People on the scene made it known to the officers that they were concerned about potential harm and decried the rapid escalation of the police. Police officers attempted to convince the crowd to leave, but they refused. While ultimately a tactical unit abseiled into the unit and apprehended the man, the violence may have been worse had there not been community witnessing and documenting the process. This is possible especially considering the very similar circumstances that led to the deaths of Regis Korchinski-Paquet and Ejaz Choudry.

The second component of BCR’s work is crisis intervention. The ongoing relationship-building work in the community has meant that local businesses and residents will often call

BCR for help with de-escalation and conflict resolution when needed. For example, a call for support was posted on the Signal group when a passerby had threatened to call the police after witnessing a young Black man in a mental health crisis. In response to the call, a number of BCR members showed up to engage with the person in crisis. BCR members began by speaking to the person "to try to figure out what was happening … what are the needs". Madan labeled the approach taken by BCR intervenors as "community-based trauma-informed", and juxtaposed it with a "professionalized social work" approach to crisis intervention that involves a top-down, directive, and authoritarian responses that focused on reminding the person of potential negative consequences—"you need to do this, or else bad things are going to happen to you". 'Bad things' may involve police intervention, involuntary hospitalization, or both. The former approach involving building rapport and understanding the person's needs allowed BCR members to find ways to support the person in crisis, including connecting him with his family members. Importantly, as abolitionists, Madan stated that they will never call the police as a principle, and BCR intervenors have never once made the call. This does not mean that situations are always handled perfectly, or that crises are always de-escalated through their intervention, but this rejection of calling the police as an option meant that intervenors are pushed to approach the person creatively and are willing to dedicate a longer duration of time, sometimes hours, when holding space with the person in crisis in order to seek understanding.

But de-escalation is not the end point of BCR's crisis intervention work. Recognizing Chrisjohn, McKay, and Smith's (2017) argument that emotional distress is a social problem rooted in material inequalities linked to racism, sexism, capitalism, and colonialism, the BCR acknowledges that the most urgent response to mental health crises must be to build social movements that address these material inequities. While Madan admits that resources and

capacities are limited, there is a desire to harness the neighbourhood to address these material needs through mutual aid, whether in relation to food or housing. Addressing these material needs is an important pillar in the work to prevent future conflict, violence, or harm. The BCR also recognizes the emotional toll on intervenors, and an explicit component of the intervention process is to engage with intervenors after the incident to provide any emotional care or material assistance necessary. This challenges the saviour model of social services, allowing care providers to themselves ask for and receive help, and ensures that BCR practices are principled on sustainability over disposability.

Another similar example of community-led crisis intervention initiatives is the Mental Health First initiative organized by the Anti-Police Terror Project (APTP), "a multi-ethnic, multi-generational, Black-led coalition of organizations and individuals committed to eradicating police terror in all its forms" (McGee, 2021), in Sacramento, California. This organization marries abolitionist principles with mutual aid practices. Asantewaa Boykin, a founder of APTP, states,

> We're abolitionists. Now, do any of us know what abolition looks like in real time? We absolutely do not. I think our primary goal is to try everything we can until something sticks, to get us closer to abolition. We do have full faith that those answers exist in our community already, and that it's our job to find them. (McGee, 2021)

Born out of recognition that people were often killed by the police when needing some form of care, and that APTP organizers had substantial experience collaborating with one another rather than relying on the police, they decided to launch the initiative in 2020 to make use of that experience to address crises within the community. With this initiative, program volunteers, often explicitly recruited for their own experiences of police violence, answer phone calls from

community members requesting assistance for incidents of mental health crises, substance use or family violence. Calls often come from family members or community members concerned about someone they witnessed. Volunteers dispatched aim to "de-escalate the situation where police would likely escalate it, providing folks with trauma-informed peer support by talking with them and helping them plan their next steps" (McGee, 2021). Volunteers engage in de-escalation by holding space and listening, with an emphasis on dispelling or withholding assumptions of dangerousness. Should the person wish, volunteers may also assist in connecting or transporting them to relevant services. Boykin notes that this work is reinforced by their lack of authority to initiate involuntary hospitalization. Just as Madan described regarding the work of BCR, not having that power pushes volunteers to approach a situation creatively and focus on maintaining a space where the person feels supported. Another key component of this work is nurturing relationships with community members through canvassing and delivering supplies. These relationships help community members build trust and knowledge to contact APTP for support. While recognizing that people are socialized to think that "if we call, [the police], this problem will be fixed" (McGee, 2021), APTP have worked hard to challenge that notion, and volunteers have also never once called the police during their work.

Policing as a Global Institution; Abolitionism as a Global Movement

Burstow's call for the return of healing to the commons has strong similarities with healthcare initiatives in Rojava that emerged after the liberation of territory from the Syrian state. People in Rojava endeavour to democratize health-care on the basis of "self-determination and mutual solidarity" (Giorgi, 2021), with decisions and provisions proliferated throughout the community. This model was contrasted with capitalist healthcare marked by commodification

and dependency. For example, a health policy document published by the First Kobanî Health Congress on December 25, 2015 stipulated that healthcare must be "based on the socialization of health and health care in the community" (Knapp et al., 2016, p. 190). This approach was thought to foster self-sufficiency, heavily influenced by concerns about oppressive power dynamics fostered by hierarchical and dependent healthcare. Heval Azad, member of the health committee for Jazeera Canton, states, "The problem is that before the revolution there was a deep connection between health and the power of the state. So we are building up a new system with a new basis – trying to remove this connection" (A. Davies, 2016). According to Azad, "the main aims for health in Rojava are: To solve the problem of relations between health and power/the party; To critique and rebuild the relationship between society and doctors; To return ownership of health to society" (A. Davies, 2016). Healthcare practices in Rojava are coordinated by self-organized committees, who work to decentralize health knowledge and care. To move away from professionalized hierarchies, each commune elects two health committee co-chairs that receive training from doctors. These co-chairs then provide first aid and advanced care training to community members interested in learning these skills. Health education is thought to also encourage autonomy by allowing people to make informed health decisions, such as around the use of birth control, and to prevent ailments.

Closely related to the mission of building a democratic society and relevant to the issue of crisis intervention is the peace committees of Rojava. Peace committees operate at the residential street level, made up of five to nine residents, with gender parity, elected by neighbours (Knapp et al., 2016). The committee's objective is to address conflicts in the community, while avoiding reproducing the violence of carceral practices. In fact, peace committees are not authorized to imprison people (Duman, 2017). This approach is also

informed by a desire to address root causes of conflicts and to rebuild relationships in order to prevent future violence. Given the responsibilities involved, members of the peace committee tend to have skills in conflict resolution, with rotation happening regularly to ensure that all community members develop these capacities (Knapp et al., 2016). Conflict resolution and transformative justice are understood as the responsibility of the entire community, instead of something delegated to a professional police force. The committee listens to the perspective of all sides of a conflict, aiming "to understand the complaints, demands and needs … to establish a platform for reconciliation" (Duman, 2017, p. 86). For example, in order to resolve a 27-year-old dispute between two families that had led to serious violence, the committee engaged in three months of mediated meetings between the parties, relying on community and religious organizations for support in finding common ground. The committee was able to secure forgiveness from both families and commitment to continue dialogue. Unresolved conflicts may lead to sanctions, including education and work assignments, but imprisonment is avoided. Patriarchal violence is addressed by specialized peace committees led by women.

In Hong Kong, conflict with the state has also led to an organic emergence of abolitionism in relation to social services and healthcare, though not necessarily in that name, alongside broader critiques of policing. There is growing recognition that social service and healthcare sectors are closely intertwined with policing in Hong Kong and are in no way neutral bodies. Examples range from the use of child protection orders against younger protesters to separate them from their families to allegations of non-consensual information sharing between hospitals and the Hong Kong Police Force (HKPF) (Creery, 2019b; L, 2019). Abolitionist critiques have also led to abolitionist solutions. Mutual aid practices have been highly visible in the protest movement, from the supply stations that have formed wherever protests happen,

containing rolls of toilet paper, saline, asthma inhalers, eye masks, and the ubiquitous umbrellas, to aunties sneaking into occupation sites to cook food for student protesters ("Three Mothers Who Entered PolyU to Cook for Their Children," 2019). Unique mutual aid practices have also emerged in response to concerns regarding health and social service collaboration with the police. The distrust of hospitals has led to the development of underground clinics, providing healthcare to people outside of and in opposition to the state. These practices also extend to emotional care. An underground clinic volunteer spoke of how they rushed to the scene after receiving a photo from a patient sitting atop a rooftop (Creery, 2019a). Two clinic volunteers managed to talk the person away from the ledge and introduce them to volunteers for long-term support. Activists have built networks to connect people with volunteers to address mental health needs and suicide prevention. These networks are on alert for crowdsourced suicide attempt locations, rushing to support these individuals. Activists have also sheltered and cared for children kicked out of homes due to political differences with their families, creating networks of politicized chosen families.

The examples of abolitionist critiques and practices in Rojava and Hong Kong also points to internationalist analysis as a crucial future research direction for the abolitionist movement and the realization of emotional care disentangled from the coercive violence of the state. There is a tendency for activists and scholars in the West to focus narrowly on the Western context, yet

the work of activists across the peripheries[10] provide fantastic lessons not just on abolitionist possibilities but also on the violent practices of Western institutions globally.

For example, just as psychiatry was imposed on Indigenous people on Turtle Island, psychiatric institutions and practices were also imposed and reinforced by Western institutions in the rest of the world. It was mentioned in Chapter 7 that 65 Chinese asylum patients were deported from British Columbia in 1935, but the story did not end with the ship's departure from Canada's shores (R. Menzies, 2002). In the then British colony of Hong Kong, John Moriarty, a Canadian Ministry of Labour officer, with British Vice Consul Cameron as an intermediary, negotiated with Chinese officials, agreeing to provide HKD5000 to refurbish the Honam Municipal Hospital for the Insane and HKD200 per asylum patient in exchange for accepting the deportees. The Honam Municipal Hospital for the Insane was itself the creation of American missionaries in 1898, the first in China. John G. Kerr, an American Presbyterian medical missionary, and Professor Edward P. Thwing, also of the American Presbyterian Mission, and an advocate for the use of "Western methods with insane Chinese" (Blum & Fee, 2008, p. 1593), were key figures in the establishment of the hospital. Despite a lack of receptiveness from the

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[10] Peripheries is a term used by some non-Western leftists as a rejection of global south framings that sometimes conflate oppressed peoples in the colonized world with states in the global south that perpetrate violence against them. The term also acknowledges conflict as existing beyond Cold War dynamics centred on nation-states. Joey Ayoub (2021) explains, "China and Russia and Iran are peripheral to "the West," and any and all activists in China and Russia and Iran are peripheral to their governments."

locals, they pushed on with the hospital project "whether or not the Chinese themselves wanted one" (Blum & Fee, 2008, p. 1593), with Thwing arguing that "We ask, not what they want, but what they need. The heathen do not ask for bibles and missionaries, but they need them all the same" (Blum & Fee, 2008, p. 1593). Christian missionaries were also responsible for the construction of other asylums in the country during this time period, including the Elizabeth Blake Hospital in Suzhou, Jiangsu, most of which were modeled after asylums built in mid-18th and 19th century Philadelphia (Fan et al., 2020). This critique of Western imposition is not to romanticize the treatment of mad people prior to the establishment of asylums in China. While, some mad people were supported as integral members of their communities, others were held in chains. But what the founding of these asylums by Westerners did was mark the establishment of contemporary forms of detainment directed at mad people, expanding coercive elements of existing practices in the country and shifting away from community and family-focused care to that delivered by professional physicians (Chiang, 2014). While missionary psychiatrists critiqued the familial care of mad people as backwards and barbarian, they incorporated coercive local practices into their own approach. For example, the use of pig baskets by locals to transport mad people to the asylum closely resembled the wire restraints developed for use in these asylums. Mental hygiene discourses, discussed in Chapters 6 and 7, were also spread to China by these missionary psychiatrists, who demand the control of sexual improprieties among local women and the use of social service investigations in psychiatric practices.

Similar processes occurred in India and parts of Africa, with an emphasis on the centrality of the asylum in these colonial and capitalist systems (Keller, 2001; McCulloch, 1995). As Mills (2013) explains, "psychiatry is exported to the global South 'by economic and political forces allied to western power'" (p. 6). This is an ongoing process, with biomedical psychiatry

containing to proliferate, “involv[ing] the imposition of western values, customs and practices on non-western cultures” (Mills, 2013, p. 6). Importantly, psychiatry also reinforces and provides the foundation for other elements of colonization, as referenced in this dissertation, such as the obfuscation and pacification of Indigenous resistance.

Returning to the case of the deportation of the 65 Chinese asylum patients, upon arrival in Hong Kong, the asylum patients were escorted by colonial Hong Kong police officers from their ship to a ferry that transported them to their final destination across the border in Guangdong province, China. There, they were met once again by the police, this time Chinese. Moriarty stated, “the Chinese authorities were taking no chances against violence and had on hand some twenty policemen, armed with clubs, whips, chains, handcuffs” (R. Menzies, 2002, p. 218). The use of police to transfer the Chinese asylum patients to their new facilities demonstrates that policing is a global institution, with collaboration and interplays between geographically disparate carceral forces. These practices have remained. For example, in an upcoming article, I discuss the interplays between Western states and the HKPF (Wong, 2023). Much of the enforcement powers held by the police in Hong Kong, including mental health legislation and child protection orders, like Canada, are vestiges of British colonial rule (Cheung, 2018). The Hong Kong government has not hesitated to use the colonial-era *Emergency Regulation Ordinance*, which gives the state carte blanche to institute wide-ranging restrictions on civil liberties, to pass a mask ban during the protests, similar to Canada’s own anti-mask laws (Chien & Chan, 2019). The new *National Security Law*, with its allowance for indefinite detentions and the formation of a specialized police unit targeting political acts is modelled after the colonial-era police special branch and ‘white houses’ used to detain anti-colonial activists (“Hong Kong Security Law Suspects May Be Held in Special Detention Centres,” 2020). Western universities

assist in HKPF recruitment and training, and arms manufacturers profit from the sale of weapons and equipment (Wong, 2020). In the other direction, much of the riot-control technology and police tactics now commonly used across the globe first originated in Hong Kong, which served as a testing ground for novel ways to control crowds during the 1967 riots (Cocking, 2014; Schrader, 2014). During the riots, police killed 23 people, injured countless more, and helped popularize new innovations in "less-than-lethal" weapons—such as the wooden bullet and CS tear gas—which became the blueprints for modern riot-control equipment, and a key feature of contemporary tactics of political repression (Puar, 2017). Chinese nationalist sentiments, especially fervently promoted by Chinese state media during the Hong Kong protests, have also had the effect of reinforcing pro-police views in Chinese diasporic communities, reinforcing the carceral system in North America (Zen, 2020).

From the perspective of activists based in the West, these interplays should add further credence to the idea that abolitionist developments in the peripheries should be viewed as openings for critical engagement and learning. This can only be done by conceptualizing abolitionism as a global movement and adopting an internationalist outlook. Moving away from silos in the West provides the opportunity to strengthen abolitionist practices through skill sharing and drawing parallels and nuanced differences between contexts of struggle. An internationalist outlook to abolition is crucial for building ethical relationships with oppressed and colonized communities. The building of ethical relationships and learning from other decolonial and abolitionist struggles can further the development of abolitionism globally and help build a world not predicated on violence and coercion.

Final Thoughts

Reflecting on my critiques of mental health social workers-initiated police interventions and the broader engagement of the field in carcerality, I am wary of discounting the possibility of resistance occurring within the context of social work practice. I am reminded of a story told by Launa Lea, a social service worker from Seattle on a podcast that partly influenced my own decision to leave frontline social work practice and embark on this research ("Red Sox, Jerusalem, and Coming Home," 2015). Lea, while working at a community centre, encountered a service user who pulled out a knife after becoming agitated because her boots were stolen. Though Lea's training dictated that she should lock herself in the office and call the police, Lea chose to stop and think. Drawing from Lea's own experiences of being unhoused, she recognized the look in the eyes of the service user. The service user was not using the knife as a weapon. The knife was only a prop, a means by which to communicate her exasperation and desire for respect, in a context where showing weakness led to vulnerability. With that in mind, Lea chose not to follow the expected course of action and instead, allowed the service user to finish speaking before asking "would you please put the knife down". The service user complied. Lea explained that,

> I wasn't afraid of her; I was afraid for her. If I had called a police officer to the scene, what do you think the odds are that a gun would have been drawn on her? And if a woman had bled out on the floor that day because I called an officer to the scene who didn't understand street language, who didn't recognize they were basically watching theater, then that would've been on my conscience for the rest of my life. So, I went off book and I followed the code of the street … It's my responsibility to simply shut up and

> simply listen to someone who has been talked at, talked over, and spoken for, speak for themselves, even if it's not a language I fully understand. ("Red Sox, Jerusalem, and Coming Home," 2015)

This story is a poignant reminder that social workers are not without agency, and can make an active decision to reject practices of violence and harm, to really listen to the people we work with. There were also glimmers of this resistance throughout my interviews, from an interviewee walking away from an agitated service user as they recognized they were a source of agitation instead of escalating by calling the police, to another confronting a police tactical unit sent to apprehend a service user. These acts of resistance are meaningful, and it is probably not an exaggeration to say that these actions likely saved lives.

But my critique of mental health social work practices is also not meant to suggest that harm is squarely the result of individual failings, the inability of individual social workers to resist the broader institutional and societal processes, common sense, and ruling relations that foster coercive practices. To come to such a conclusion is to fail to recognize how mental health social work as an institution, as practice, and as discourse, is thoroughly intertwined with the police and other carceral institutions, an intertwinement that is deeply rooted in the ongoing histories of interlocking oppression and entrenched in the institutional archipelago that maintains settler-colonial capitalism. These ongoing histories of violent practice and the institutional archipelago also serve to uphold the social order by limiting the imagination of abolitionist futures and furthering the notion that change can only be limited to minor tweaks and adjustments within the parameters of the institutional archipelago, whereby carceral logics remain. Yet, this previous discussion on abolitionist practices at home and abroad shows that a different world is not only possible, but being born out of ongoing struggles, like plants breaking

through concrete. Ultimately, a comprehensive end to coercive practices in mental healthcare can only be achieved through collective action towards the abolition of the institutional archipelago and the social structures that underlie it, alongside the nurturing of abolitionist democracy.

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