

# The Control and Coercion of Disabled Individuals: The Injustice of Legal Violence of Medical and Pharmaceutical Interventions

Patricia De Vera

Department of Sociology, MacEwan University

## Abstract

Current medical and therapeutic practices include over-representing individuals with disabilities, mental disorders, and substance abuse disorders in the carceral system. Over-representation of disabled individuals is rooted in the mistreatment of individuals in institutions. Mental hospitals were typically known as asylums, housing individuals deemed clinically insane. These asylums stigmatized many individuals with disorders, often grouping individuals without significant reason to institutionalize them. People with mental disorders, mental health issues, substance users, and those who did not fit social norms were institutionalized without being able to defend themselves. Rather than being sent straight to institutions or carceral systems, current options include mental health and drug treatment courts. These courts claim to aid people with individualized programs to overcome their substance use disorders or help individuals with mental disorders comprehend their situation in the criminal justice system (CJS). Apart from drug courts, individuals already in the carceral system, namely forensic psychiatric or prison settings, with lasting mental disorders may be coerced into medication. An overlapping constraint with drug courts and coercive medication comes with surveillance and losing individual physical, emotional, and mental autonomy. In this paper, I will argue that medical and therapeutic practices implemented for criminalized people are rooted in controlling and surveillance of disabled people for government power and control. Rather than a system implemented to improve their well-being, the system aims to control and regulate individuals' behaviours to conform to a standard citizen's social standards.

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## Introduction

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individual physical, emotional, and mental autonomy. In this paper, I will argue that medical and therapeutic practices implemented for criminalized people are rooted in controlling and surveillance of disabled people for government power and control. Rather than a system implemented to improve their well-being, the system aims to control and regulate individuals' behaviours to conform to a standard citizen's social standards.

### Theoretical Framework

The regulation of disabled individuals is through the exertion of government power, which creates a hierarchy of the healthy individual's control over the unhealthy. Medical and pharmaceutical implementation on criminalized individuals can be affiliated with crippling criminology. Coined by Thorneycroft & Asquith (2019), *crip theory* focuses on the subjectivity of disabled individuals. The concept examines how individuals' bodies and lives are “constituted, regulated, governed and violated” (Thorneycroft & Asquith, 2019). Disabled individuals and people with disorders are criminalized because of their behaviour not adhering to social norms. The need for *crip theory* is a response to the over-representation and exclusion that disabled individuals experience in the CJS. *Crip criminology* further claims that the CJS is complicit in regulating, marginalizing, criminalizing, and institutionalizing disabled lives (Thorneycroft & Asquith, 2019). The government pathologized these disabled individuals to regulate them, rather than focusing on their individual needs. To regulate disabled individuals, they are seen as “passive victims,” which removes the agency from the person (Thorneycroft & Asquith, 2019). The government prioritizes its own needs, which is to remove disabled people from the public eye. Using *crip theory*, I will examine the connections between medico-legal treatment and the regulation of disabled individuals in the CJS. Through *crip theory*, the government can control what is obstructive or supportive for society. The governments regulate and obstruct the lives of disabled individuals, notably through medical-pharmaceutical means.

Government regulation can be described using Noam Chomsky's theory of manufacturing consent, there is a distinguishable difference between the bourgeoisie and the proletariat. Chomsky states that major decisions are created from higher positions, such as the government

(Chomsky's Philosophy, 2015). Notably, the government creates the overarching ideology of crime and decides who criminals are based on their standards. To specifically adhere to *crip theory*, it would be the differences between disabled individuals and the government. Significant ideologies are constantly alluded to by people who follow those rules, which are reproduced and recycled for the benefit of the government. Because the government creates laws and the overarching acceptance of them, it seems there is no other choice but to follow them; otherwise, there are negative consequences individuals must face. It is coerced in the individual because it creates the belief that this is their only choice. In the medico-legal context, disabled individuals would not have the choice to be institutionalized or partake in pharmaceutical medicine. The more disabled individuals are regulated and criminalized through manufactured consent, the more difficult it seems for individuals to have a choice in medical-pharmaceutical care. It makes it easier for the government to take advantage of the “passive” disabled individual, as the medico-legal overlap strips them away from their autonomy.

A product of manufacturing consent is “legal violence” (Menjivar & Abrego, 2012), which describes reinforcing forms of violence the law makes possible. The existence of legal violence creates a potential for medical professionals and the government to misuse their power over the autonomy criminalized people have. With the stigma for labelling criminalized individuals and their disabilities, government and medical experts may coerce individuals because the law allows them to—regardless of if it has adverse effects on the individual. Further, the law allows them to take control over the criminalized person(s) to mould behaviour to fit the social norms of society. The goal of controlling and surveillance of individuals with disabilities and disorders is to regulate behaviours based on government preference.

### The Pathway from Asylums to Incarceration

Asylums and institutions were initially implemented to confine individuals labelled as physically and/or developmentally disabled, with no best interest in improving their well-being or long-term care. Asylums and institutions housed individuals with disabilities with the involvement of surveillance by courts, social workers, and psychiatrists (Fritsch, Monaghan, & van

der Meulen, 2022). The involvement of different medical and social professionals allows for more range of control and regulation. For instance, medical professionals, such as psychiatrists, are employed by the government to regulate disabled individuals through medication. A key issue is government involvement. With increasing industrialization and standardization of labour, the exclusion of disabled people increased, thus leading them towards segregation through institutions. Asylums and institutions were hostile in their naming, with labels of *mental deficiency*, *insane*, or *incurable*. (Fritsch, Monaghan, & van der Meulen, 2022) The disabled individuals in question are not necessarily just disabled through physical or developmental means but include individuals who were not deemed “fit” for society. In hindsight, their crime was being unable to fit the norms of society. In response, the government incarcerates these individuals to control their behaviour and hide their disabilities.

Further than being seen as unstable, individuals in asylums and institutions were seen as potential criminals (Fritsch, Monaghan, & van der Meulen, 2022). Individuals being seen as *insane* or *mentally deficient*, and also labelled as potential criminals, further stigmatizes them and affects negative perceptions of governments and professionals. Labelling increases the risk of negative connotations from, but not limited to, medical professionals and family members (Welsh & Brown, 2012). Negative connotations may induce hostility and discrimination rather than support from relationships. The lack of support is attributable to the labelling and treatment received, as monitoring their behaviour is prioritized.

To increase the government’s involvement, the process of transinstitutionalization came to be; a process where individuals who were deinstitutionalized end up at different institutions, rather than being released completely. Transinstitutionalization explains the shift from being *insane* to a criminal or criminal behaviour. If disabled people were placed into asylums for the sake of control and to limit their place in society, incarceration creates the association that being disabled is a crime. This continues a cycle of harm: individuals continue to be labelled as *insane* and criminals, and perceptions from medical professionals and government regulations adjust to further regulate them. Despite a different means to treatment, incarceration

shares the same goal of control and coercion. Now that the CJS is involved with the control of disabled individuals, it further threatens the individual's autonomy and relationships. It is then easier for disabled people to be monitored in the carceral system, as they have no choice but to comply with the treatment that will be enforced on them. While there is a decrease in asylums, incarceration rates for disabled people and psychiatric disorders are increasing due to the lack of access to resources (Crowe & Drew, 2021). Furthermore, incarceration is a site of confinement away from the society they are supposed to be reintegrated back into. The reintegration could never be achieved if basic accommodations, such as accessibility and resources for disabilities and mental health, are limited (Vallas, 2016). The further separated they are from society, education, and work they are, the less likely people with disabilities or disorders are reintegrated. Keeping resources and access limited makes control and coercion effortless to achieve. The less access and resources people have to treat disabilities and psychiatric disorders, the easier it is to coerce and group people into their only choice of damaging treatment. The segregation from society is a punishment made worse when accessibility to mental health and disabilities resources is already limited. There is no care for the well-being of individuals when there is nothing to support them from the beginning of their sentence. The subjugation to segregation, incarceration, and limiting resources ensures behaviour complies with the government's requirements.

### Drug Courts

Surveillance is not limited to confinement, as there are other ways the government can implement control. The control of disabled individuals within the CJS can occur both before and during the incarceration period, such as in drug courts. Drug courts work with the participation of a person receiving treatment and working with treatment specialists (Revier, 2021). The drug court assumes responsibility for the drug user, including attorneys and treatment providers. Drug treatment courts aim to aid individual needs and drug addiction. However, there are incentives to completing this program; that is, participants can avoid or lessen their prison sentence by completing the program. Because of this incentive, individuals may only partake in the program to avoid prison, not necessarily to

improve their lifestyle. An issue with coercion contributes to more involvement in the CJS and the net widening of the treatment courts (Revier, 2021). While the intention of drug courts is to treat addictions, it creates more space for government control. The involvement of more people in this program only expands drug users as actors of crime rather than destigmatizing drug use and getting people out of the system. The impending argument that the interventions are unhelpful will widen the number of individuals who are controlled and mistreated regarding their disabilities.

Substance users are still labelled as criminals, whether incarcerated or taking the drug court route. The Alberta Court of Justice has its own specialized Drug Treatment Court (DTC), stating that it is “intended to break the cycle of criminal behaviour driven by drug addiction” (Alberta Court of Justice, n.d.). Similar drug courts have been implemented nationwide, especially in the United States (U.S.). DTCs claim it is individualized to a person’s needs, which enrol them in courses regarding “criminal and addictive thinking, relapse prevention” and other courses regarding risk (Alberta Court of Justice, n.d.). While the goal of DTCs seems in the best interest, individuals are still labelled as criminals, similar to the old notions of asylums. While the programs are individualized to a person’s needs, the programs and courses are still under regulation by the government and their definition of successful reintegration into society. Both the connotations of being a “criminal,” and programs, assume the need to control the criminality associated with drugs, and possibly disabilities. There are no implications of successful individualized results regarding what the participants want in their terms. The choice criminalized individuals make in drug courts is about incarceration, not about the improvement of an individual’s well-being. While drug courts are not necessarily in line with crim criminology and disabled individuals’ incarceration, common themes of control and surveillance occur. Individuals do not end up in the carceral system, records and associations remain with the drug court—which renders a court still involved in the CJS and controls disabled individuals. Inherently, drug courts serve no purpose but to benefit the government. Because drug courts are implemented after the fact of individuals consuming drugs and getting punished, drug courts are not necessarily preventative.

Drug courts are still aimed at regulating and removing drug users from the public as a means to control them and shape them to match the norms. While drug courts are already rooted in segregation for control, more mistreatment occurs when people with disabilities or disorders are incarcerated.

### **Control Through Medico-Legal System and Pharmaceutical Violence**

Like DTCs, convicted people consent to medical intervention through coercion. Medical treatment is available for the same reason as preferable sentences for individuals who arrive at the carceral system. The “medico-legal” system (Chandler et al., 2021) reflects the same issues with DTC: participants are coerced into a medical intervention to serve a preferable sentence rather than improve their well-being. Treatment options are frequently provided when the person is processed through the CJS. The medical interventions within the CJS expand the government’s control through medical and pharmaceutical means (Waring et al., 2016). Manufactured consent can be seen in the relationship between the government and the medical field—the government being a higher power. In this relationship, the medical field then creates or enacts treatments for criminalized individuals on behalf of the government’s standards. While the treatment options are intended to help, the settings in which they are brought up create pressure for the individual to consent to treatment. Chandler et al. (2021) gathered participants who had described treatment experiences in the CJS. Participants had expressed support for surveillance, as it ensures that individuals undergoing treatment commit to change. However, surveillance was intended to make the general public “feel” safer and control the people released from treatment (Chandler et al., 2021). The focus of medico-legal systems is never intended to help disabled individuals but is focused on helping maintain a public image of abled bodies—whether psychiatric or physical disabilities. Much like asylums, there is a generalization of all disabilities being seen as individuals who are unfit for society thus, the treatment is a harmful generalization of those individuals. There is a lack of accommodation and accessibility for disabled individuals, which worsens the effects of existing problems while incarcerated. No treatment accommodates different disabilities and the individual response to them, but instead focuses on how to control

their disabilities and disorders. Individuals have no choice in the treatment they get, as it is the only thing that seems viable to the government. In contrast, while the treatment seems supported, the practice is subjective and holds distrust. Participants placed distrust in the CJS: judges, lawyers, and including doctors. Individuals had concerns when they were getting their treatment, particularly the doctors sent to care for them. For instance, psychiatrists do not look at the medical files of the individuals, are only present to get grant money, or feel like the offenders do not have another option (Chandler et al., 2021). The negative treatment people receive is in conjunction with the government's influence and labelling criminalized individuals. Because the individual has been labelled as a criminal, medical professionals or advisors would not particularly care for the outcome. Medical and pharmaceutical access is not a secure and reasonable accommodation when criminality and disabilities are intertwined. Both the effects of labelling and treatment do not particularly care for well-being when control is prioritized over accessibility and resources. The manufactured consent exists between criminality and disabilities because of the prioritization of control over accessibility. The government still regulates the criminalized people, and medical professionals exist to provide legal substances to regulate the behaviours of criminalized people on behalf of the government. Because the government assumes their power, there is no room for disabled individuals to speak up against the maltreatment. The government believes their methods work due to the lack of accommodating treatment. Though it seems the governing bodies are helping disabled individuals, the disabled individuals are not the ones who reap the benefits of control. The medico-legal focus is on how disabled individuals could be controlled for the upkeep of the "public safety" image, rather than the well-being of disabled individuals. So long as disabled individuals are regulated within confinement, accommodating resources are not needed.

A key reason why the government assumes responsibility and control, is because of the criminalized individual's passivity to the control. Disabled individuals who are criminalized overlap with being marginalized, there is no choice but to accept medico-legal intervention. The inability to afford lawyers, or legal medical-pharmaceutical care stipulates the pathway to being criminalized. Non-

visible disabilities, such as learning disabilities or mental health diagnoses, influence court proceedings. Disabled or disordered people may not understand legal procedures or their rights and are subjugated to incarceration instead of appropriate treatment (Blanck, 2017). Instead, they are punished by the lack of resources in jails or prisons. By unwillingly and unknowingly placing disabled individuals through carceral facilities, there becomes an association that disabled individuals are criminals. The government then responds to that crime by attempting to "fix" those individuals through incarceration. However, medico-legal intervention in the CJS and incarceration worsen the criminalization of disabled individuals. Regardless if the goal is to reintegrate people back into communities when released, disabled people have lower rates of reintegration (Blanck, 2017). Disabled people are extensively reincarcerated because there is no treatment that adheres to their needs. In turn, the criminality of disabilities is upcycled because no treatment would lead to high recidivism rates. The cycle of reincarceration allows the government to assume a considerable amount of control, without fail, over disabled people. One method to recycle through reincarceration and criminalization is a lack of accommodation for individuals with disabilities and psychiatric disorders.

The regulation of individuals through coercion of medico-legal forces and the unintended adverse effects from pharmaceutical interventions and criminalization can be more harmful than beneficial. The typical victims of "pharmaceutical violence" (Flores & Barahona-Lopez, 2019) are women in the carceral system and pressure to take pharmaceutical drugs. A baseline for treating incarcerated women is rooted in early feminist criminology theories. The criminalized woman typically fits the narrative of being young, having mental health disorders (MHD), being marginalized, and having a history of abuse (Nelund, 2022). In the study conducted by Flores & Barahona-Lopez (2019), the content examines the mental health of Latinas at a juvenile detention center in California. The inmates of the study claimed that they could not refuse treatment (Flores & Barahona-Lopez, 2019). Within the study, the young women were generalized in their diagnoses and medication, with one participant claiming that "everyone is diagnosed with everything" or that the medical professionals were demeaning and

condescending (Flores & Barahona-Lopez, 2019). All the women would receive the same diagnoses and medication despite the symptoms being all different. Despite how treatment aims to be individualized for each person, individuals have different experiences towards their MHD. Generalizing the diagnosis and treatment can create more harm because the treatment does not accommodate each criminalized woman's need; they are unable to get a treatment that may be effective. If the goal were to rehabilitate and accommodate to disabled people or MHD, then why assign medical professionals who generalize or demean people who require reasonable accommodations? Irrespective of the women's vocal concerns about demeaning treatment, their needs and health were not prioritized. By taking advantage of the women's passivity and lack of choice, control is easier to assume under the lack of accommodation. The less accommodation, the more room for control over a group of criminalized individuals who are labelled and segregated together. This criminogenic effect ensures unsuccessful access to treatment, which again would keep the women incarcerated over time. Perhaps the criminogenic effect is in favour of keeping control over the same individuals. In partial overlap with previous marginalization, this treatment is their last resort to unwillingly repent for their crime.

Treatment is based on individual responses and needs, and by refusing to acknowledge that individualization, the adverse effects of medication would be more prominent than the positive. Treatment may work effectively for specific individuals but does not apply to all individuals whose symptoms vary. Apart from individual well-being, people with disabilities reap higher consequences, such as health complications compared to others without disabilities (Blanck, 2017). For example, the women in the study knew that once they were released, they would no longer be able to acquire their medication (Flores & Barahona-Lopez, 2019). In return, the women limited their intake of medication by hiding it in their mouths and throwing them away, taking fewer portions, and refusing medication altogether to avoid withdrawal symptoms when released (Flores & Barahona-Lopez, 2019). Once released, the women would have a similar lack of accommodations once released; thus, health problems from their disabilities or psychiatric disorders would appear. Again, reincarceration appears when

accommodations are also not available; there may be no access to treatment, resulting in acquiring treatment illegally. The government is complicit in keeping marginalized people marginalized and institutionalized to better regulate them. Regardless of impassivity or not, the women would either suffer from the negative side effects during and after incarceration or refuse medication and suffer consequences. Control through the use of the medical and therapeutic interventions involved had no effects on their compliance or their treatment outcome once released.

Due to the generalization of the disabilities, disorders, and treatments, medical intervention can be used to regulate women. When grouping the MHD of all the women into one, it becomes easier for the government to control them. It denies the women their autonomy rather than empowers them because they feel they have no control over their treatment. A cognitive-behavioural program is authorized in correctional facilities to extend to Canadian grounds of treating criminalized women's MHD and cognitive disabilities (Pollack, 2005). The goal of the treatment is to reduce recidivism by altering their behaviour permanently. Borderline personality disorder (BPD) is the expected target to alter behaviour in criminalized women, a psychiatric label attributed to intense emotions, anger, impulsion, self-damaging behaviours, and suicidal ideation (American Psychiatric Association, 2013). Adding this treatment in court targets women with BPD and results in criminalizing their disorder. The over-representation of criminalized women with BPD further pushes the notion that MHDs are criminal acts and must be regulated. This association creates stigma among criminalized individuals with MHD. Women with BPD are often seen as "extremely difficult" to work with, and professionals are reluctant to work with them because of the unpleasant interactions (Pollack, 2005). Medical professionals' existing presumptions about women and BPD may further harm the treatment of criminalized women and be more criminogenic in prison settings. For example, dialectical behaviour therapy (DBT) is a cognitive-behavioural treatment specific to criminalized women with BPD and ultimately aims to change the woman's feelings and behaviour (Pollack, 2005). An issue with DBT, especially in the prison setting, creates the key issue previously discussed: surveillance and lack of care for the well-being of incarcerated individuals. Pollack

notes the *distress tolerance* concept in DBT, where the primary focus is for women to tolerate their current situation (2005). The distress tolerance implies that the woman must be willing to accept their situation regardless if it is beneficial; that is, they must surrender their freedom to accept any harmful treatment. This therapeutic intervention limits the criminalized woman to controlling medico-legal options, previously considered harmful. While therapy can be helpful to individuals, the key issue of DBT is the prison environment. The setting may not be suitable to necessitate a successful change of behaviour, as exposure to adverse environments can impact behaviour negatively. A goal of DBT is self-surveillance but while the term implies an individual's autonomy and control, self-surveillance is given through state regulation (Pollack, 2005). The term self-surveillance is created from the state's definition of regulation, which still means that women are under state control. Consent is not a choice; it is something they must comply with as the creation of self-surveillance is rooted in the government's influence over medico-legal interventions. Further, because DBT is solely focused on the incarcerated woman, there is no implication of effective results once released. The therapeutic intervention may be effective within prison settings but could not be maintained when reintegrated into communities. Since DBT is the treatment the women must adhere to, there is a presumption that failure to comply would result in punishment. The chances of reintegrating back into communities and access to services and accommodation may be difficult because the women did not "fix" their behaviour to a standard suitable enough for society. Until the government successfully changes the women's undesirable behaviour completely, there exists control over them. If that behaviour were to reappear in communities, The women may be reincarcerated since behaviour was never fixed and will continue to be criminalized and under surveillance for their disorders.

### Counters to Control

A coming solution proposed by the Parliament of Canada (n.d.) is Bill C-202 (the first reading was completed on November 25, 2021), specifically to amend the Criminal Code on control and coercive conduct. Bill C-202 looks at the offences and their significant impact on a person, connections, proof of

facts, and punishment. Significant impact focuses on the distress and mental health of the person. If the person's mental health declines or is in distress, someone may be charged with controlling or coercive conduct. However, the limitations of this Bill may exude exceptions to counterarguments against harmful treatment. Exceptions to coercion are if the accused acted in the "best interests of the person," and the conduct was reasonable. This exception becomes problematic when coercion of the criminalized people with disabilities and disorders is from the government, CJS, and the medico-legal systems. The governing body is the highest power of carceral systems, thus, making it easily accessible for it to claim that medical and therapeutic interventions in the system are in the "best interests" of the person. The government and CJS were labelling criminalized individuals with mental disabilities and disorders; thus, their aims to "fix" the individuals and regulate them back to society can be argued as "best interests" and necessary. Ultimately, Bill C-202 still oversees the government's power and control over criminalized individuals with MHD and disabilities.

To effectively understand the harm of the medico-legal system, the focus should be on why disablist violence or ableist practices in government systems are present (Thorneycroft & Asquith, 2019). Continuously segregating disabled individuals does more harm than it does support them—the harm does not come from the consequences they face for their actions but from the maltreatment they get from incarceration. The government and the CJS have been responsible for marginalizing and regulating the harm, while disabled individuals are the target for that harm. Instead of separating disabled individuals, crip criminology can be used to understand why people with MHD or CDs are harmed in the system. Individual needs and accommodations should be prioritized over stigmatized disabilities and disorders. Before aiming for a solution to the harm, more openness to study ableist practices first. While the effects of the harm are detrimental, the issue is rooted in who is causing it in the first place. The CJs should shift the focus on why they are inherently ableist and harmful, instead of the attempt to "fix" disabled people.

## Conclusion

Despite decades after asylums were formed, the underlying roots of government control over people with disabilities and disorders are still present. While reforms and removal of the asylums and institutions were proposed, individuals with disabilities and psychiatric disorders are disproportionately marginalized and controlled within the prison system. No longer are criminalized people placed in asylums and institutions, but they are sent to prisons and court treatments that constitute similar values as asylums held. The overarching criticism of incarcerating individuals with disabilities and disorders is punishing them instead of accommodating them. Where treatments can be in place of the prison system, there are ways to provide treatment outside the carceral system. By doing this, individuals with disabilities and disorders are less likely to be labelled as criminals, which can decriminalize and destigmatize them. Further, it removes part of the control and coercion structured by the government in the carceral system.

Unfortunately, no perfect solutions allow for the complete removal of manufactured consent from the government. For example, restructuring systems still implies the government's involvement since the medico-legal interventions were created in their hands. Moreso, as the government's manufactured consent is upcycled relentlessly, with roots from a society that dates to asylums, creating new systems will be challenging to implement. Injustice against individuals with disabilities and disorders affiliated with medical and pharmaceutical is lacking research, making it challenging to create an accommodating system that lacks government control and coercion. While previous research associating theories can explain the maltreatment within the system, it creates a discussion of who the treatment is primarily beneficial for. Medical and pharmaceutical practices for criminalized individuals have only been expanded to be systems that benefit the government's need for control and regulation. Before attempting to create a solution for government surveillance, there needs to be an understanding of crip theory and the ableist violence that occurs and its roots in asylums. Rather than resorting to "othering" individuals, there must be an intervention on why it occurred in the first place. To begin with, future research and theories must ponder on

why the government assumed ableist and disablist control rather than prioritize the autonomy and needs of disabled individuals.

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