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MEDICALIZATION OF SEX OFFENDERS

AN ETHNOLOGICAL STUDY OF A SPECIALIZED PRISON AND TREATMENT FACILITY IN FRANCE

Developing a medical and legal program providing treatment to sex offenders constitutes an emblematic case of medicalization, a process whereby problems that are at first glance considered non-medical are defined and treated as medical problems. Such a program, which combines punishment and medical treatment, was implemented in France in the late 1990s to deter and punish sex crimes more efficiently and fight against recidivism. It brought about the creation of court-ordered treatment (in replacement of or following an unsuspended term of imprisonment) and also developed in prisons under the form of "treatment incentives" since no form of coercive treatment can be administered within prison walls (1).

Thus, the law presents incarcerated sex offender treatment as an "option": it is not mandatory.

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As a result, sex offender management professionals, who are strongly urged to bring these inmates to follow treatment and thus prevent recidivism, stumble on the fact that prison cannot be a place for mandatory treatment and that any medical procedure requires consent. The issue is all the more delicate as sex offenders do not seem to show interest in treatment. How can they be brought to follow treatment? In other words, how can sex offender management professionals reconcile public safety with protection of individual rights and freedoms?

The present article deals with the implementation of this medical and legal program and the medicalization process. Special emphasis will be on the strategies that sex offender management professionals have developed and implemented in order to solve the problem and ensure that sex offenders start treatment. The research is based on an analysis of medical literature and legislation on treatment incentives and on observations and interviews conducted in one of the twenty-two French prisons specialized in sex offender management. It was carried out more particularly in one of the prison's treatment facilities which specialized in sex offender management (2).

SPECIALIZATION OF PRISONS, TREATMENT FACILITIES, AND PROFESSIONALS

The first way of ensuring that sex offenders start treatment is to devote special attention to them and group them together within specialized institutions and structures. A circular letter dated December 8, 2008, about health care institutions' fees pointed in that direction. It stated the need to scale up care provision and gear care towards that population, and introduced the idea of specialized prisons. In 2009, a list of twenty-two certified prisons was produced and an extra endowment of 185,000 euros to the regions willing to set them up was created. These prisons' residential health care facilities were to receive extra funding from regional health agencies to reinforce psychiatric care units, create mobile teams or set up any type of organization whose activities would match the needs of the region concerned.

Our research was carried out in one of those twenty-two prisons. At the time, 80 percent of its inmates were sex offenders. It was a *centre de détention*, i.e., it housed offenders serving a sentence of more than two years' imprisonment and liable to reenter society successfully. In 2012, the health care facility of that prison chose to

(1) Forcibly hospitalizing an inmate without their consent under the legal provisions on medical care without consent is only possible if the hospitalization has been prescribed by a doctor and if the inmate is transferred to a medical facility.

(2) This research was carried out within the framework of the Contrast research program and funded by the French National Research Agency.

create a treatment facility devoted to sex offenders. This new unit operated together with two other units specializing in, respectively, somatic and psychiatric care. It had its own premises, and its staff comprised a secretary, a supervising officer, three psychologists, a nurse and a doctor.

Professionals, too, were involved in specialization. This was made possible by the creation in 1995 of the Sex Offender Research and Treatment Association (Artaas – Association pour la recherche et le traitement des auteurs d'agressions sexuelles) and in 2006 of resource centers for sex offender management professionals (Criavs – Centres ressources pour les intervenants auprès des auteurs de violences sexuelles). Specialization has generated new knowledge and practices that are actively disseminated by Artaas and Criavs through meetings, conferences and training, particularly in medical schools. The professionals of the treatment facility we observed had received these formations, and one of them practiced within the resource center (Criavs) of the region.

The specialization of prisons, treatment facilities and professionals resulted in scaled-up health care facilities, medical and paramedical personnel. Treatment facilities and professionals also improved qualitatively. However, this is but one facet of the medicalization process. The question remains as to how sex offenders could be encouraged to visit these facilities since they are neither compelled nor willing to do so.

BLACKMAILING SEX OFFENDERS INTO TREATMENT

As previously said, legislation on treatment incentives is based on the rights of patients and the notion of consent, making treatment "optional." However, a close reading of legal texts reveals that they stipulate that following treatment can lead to extra sentence reduction and parole (articles 721-1 and 729 of the French Code of Criminal Procedure). Offenders can also be denied sentence reduction credits – which, though automatically awarded, are subject to forfeiture for inmate misconduct (article 721). The purpose is to make it known to offenders that even though treatment refusal is a right, they have no interest in using that right. Just as with court-ordered treatment, which warns offenders that treatment refusal can lead to incarceration or re-incarceration, offenders are made to consent under pressure. French lawyer Patrick Mistretta has defined this consent actually obtained through skillfully applied pressure by the legislator as an "illusory consent" (3). Court-ordered treatment and therapy for drug-dependent people have also been qualified as "quasi-coercive measures" – an expression perfectly conveying their binding character – by the European Committee on Crime Problems (4).

This type of blackmail could also be observed locally in the prison that we studied. Our observations and interviews have shown that following treatment was an eligibility criterion for the award of temporary absences and such privileges as individual cells and their extra space. The prison had a "trust area" reserved for inmates displaying exemplary behavior, i.e., who had not been involved in incidents, gave compensation to victims, worked or received professional training, and followed the treatment suggested to them. Like other prisons, the centre de détention had implemented a "sentence enforcement program" whose purpose was to incite inmates to commit themselves to regularly assessed projects. When treatment was part of a project, the prison administration regularly monitored the inmates' attendance and motivation.

PROACTIVE THERAPISTS

We have seen that the medicalization of sex offenders and specialization of professionals rest on newly developed knowledge and practices. Specialization is connected to the emergence of proactive rehabilitation clinics which, for the most part, apply the writings of Claude Balier and his colleagues. A psychiatrist and psychoanalyst, Balier ran a prison's regional medical and psychological service for about fifteen years. He has authored numerous reports, articles and books in which he explains that therapists must tailor their practices to the specificities of that population. Using the psychoanalytical concept of splitting, a defense mechanism, he explains that sex offenders do not suffer and do not feel the need for treatment. This, he argues, justifies a more proactive approach than in traditional psychoanalytical practice. In the mid 1990s, together with André Ciavaldini and Martine Girard-Khayat, he conducted a data-gathering study with 172 incarcerated sex offenders. Early on in the research, five to ten percent of the group volunteered for treatment. However, after completion of a specially designed form, fifty percent asked for therapy and sixty percent found the experience positive. Ciavaldini has synthesized these findings in a publication in which he proposes a "general course of action for this type of offender: the point is not to wait for them to volunteer for psychiatric care, but to actively incite them to volunteer"(5).

In the treatment facility that we observed, this course of action was first carried out by installing a procedure of identification and systematic, repeated appointment setting. The secretary in charge of identifying sex offenders among new inmates

(3) Patrick Mistretta, "L'illusion du consentement du délinquant à l'acte médical et aux soins en droit pénal," *Revue internationale de droit pénal*, 82/1 (2011): 19-39.

(4) Report by the European Committee on Crime Problems, *Instruments et activités du conseil de l'Europe relatifs aux mesures quasi forcées*, Strasbourg, 2012.

(5) A. Ciavaldini, *Psychopathologies des agresseurs sexuels*, Paris, Masson, coll. « Médecine et psychothérapie », 1999.

opened a medical file for each of them and scheduled an appointment three weeks after admission. The facility's supervising officer made the round of the cells and distributed appointment cards and brochures on the facility in person. If offenders did not honor the appointment, they were sent a second card a few days/weeks later by the therapist, and a year later if they failed to show up at the second appointment. In this way, the unit received the great majority of sex offenders of that prison.

However, it comes out from our interviews and observations that an inmate's presence in the therapist's office is only a first step. While inmates were fully aware of the benefits of seeing a therapist, they went to their appointment for expediency's sake, because they felt compelled to, or simply because they wanted to honor the appointment. Therapists had to face inmates who remained silent or whose inclination to speak was closer to chatter than real willingness to "work on themselves". Therapy then consisted in inspiring a desire for treatment and change in those who were reluctant. Therapists had their own strategies to achieve that goal and also used tools and techniques (forms, games, support groups, discourse strategies) aiming to obtain what Ciavaldini calls "forced speech." The purpose was to bring offenders to talk about their emotions, take a new look at themselves and feel empathy. Thus, therapy consisted less in reminding them of what the limits are and ensuring that they integrated them than in modifying their psychological makeup.

The medicalization of sex offenders thus involves the specialization of prisons, treatment facilities, and therapists as well as the institution of blackmail and the application of new knowledge and professional practices. The purpose of this process is to justify and administer "quasi-coercive" treatment on a – formally – consensual basis, but with the proviso that refusal would not be in the inmates' best interest.

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