

The Treatment of Personality-Disordered Offenders in Germany

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Offenders with mental illness challenge forensic systems throughout the world. Those with personality disorders present additional challenges. In this article, the authors describe relevant German legislation and the consequent forensic treatment of personality-disordered offenders in the German psychiatric and correctional systems, with a focus on the German state of Hessen. The development of laws and regulations are addressed, as are the parallels and distinctions between forensic hospitals and correctional settings. Current treatment approaches and programs are described. Research initiatives and future directions for the system, and comparisons with the system in the United States conclude the article.

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The literature documenting a high prevalence of personality disorder diagnoses in criminal offenders is small but consistent.^{1,2} There is also a growing body of literature on treatment of the mentally ill offender. However, very little is written or known about how different forensic systems manage and treat offenders with personality disorders. This article focuses on the approach to and implementation of management and treatment of the offender with a personality disorder in Germany. As in most developed nations, in Germany there are two systems dealing with the treatment of personality-disordered offenders, the correctional system and the forensic psychiatric system. Which system is utilized is based first on the determination of legal responsibility for the offense and second on the offender's risk of re-offending.

The Laws

Federal laws regulate the process, whether the outcome ultimately leads the offender into the correc-

tional or the forensic psychiatric system. This process includes investigative proceedings, pretrial assessment of responsibility and risk, conviction, admission to the system, discharge, probation, and the implementation and oversight of those measures.

In the correctional system, federal laws are also the basis for processes related to treatment and prisoners' rights and responsibilities. As a consequence of a current federalism reform, German states are expected to have more influence on the law of prison administration in the years ahead.

By contrast, the legal foundations of treatment during court-mandated forensic hospital treatment (hospital-order sentence) are already in the domain of state law. Generally, state laws define patients' rights and clinicians' authority and responsibilities. State law also regulates the conditions under which clinicians can gradually return the patient to the community. These laws vary considerably among the 16 German states. Recently, in response to public pressure, some states have shifted responsibility for decisions about release from a secure inpatient setting away from clinicians to prosecutors and to the courts.

Pretrial Assessment of Responsibility

In Germany, legal responsibility for criminal behavior begins at age 14. However, persons accused of

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criminal offenses may be judged not to be responsible for the offense or to have had diminished capacity. One of the legal categories for supporting such a determination is “another severe mental abnormality.” This category includes personality disorder. However, to be recognized as “severe” the personality disorder must cause a serious and global impairment of psychosocial functioning in all aspects of life (similar to those impairments presented by people with severe mental illness). The expert witness’s role is in theory limited to informing the court about the offender’s mental condition during the commission of the crime. While interpretation of the finding is left to the court, in reality, the psychiatric expert witness has considerable influence on the court’s decision. There is substantial variability in what is known as insanity standards in Germany, across both courts and expert witnesses, particularly on the assessment of the “another severe mental abnormality” factor. There is currently no consensus on how to judge the legal responsibility of offenders with personality disorders among either psychiatrists or legal experts. In the opinions of two of the authors (S.E. and R.M.-I.), when reading psychiatric assessments of such cases, one often has the impression that arbitrary judgments are being made.

Pretrial Risk Assessment and Assignment

In Germany, special measures for the prevention of crime, called Measures of Rehabilitation and Security, can be ordered by the court.³ Those measures include a hospital-order sentence and other detention measures for high-risk offenders. The use of reliable and valid structured instruments in risk assessment is as yet uncommon. Assessments based on unstructured clinical judgments are still the norm. Since the late 1990s, structured instruments designed to assess the risk of violent behavior, in particular the PCL:SV⁴ and the HCR 20,⁵ have been translated into German and are being used with gradually increasing frequency. Unfortunately, from the authors’ (S.E. and R.M.-I.) direct experience, many of the mental health professionals who have begun to use these instruments have no training in their proper administration and interpretation of the scores.

Offenders judged NGRI or guilty but having severely diminished responsibility for an offense punishable by incarceration may receive a hospital-order sentence in the forensic psychiatric system if their

risk of re-offending is high. In all other cases, the offenders are allocated to the correctional system.

A hospital-order sentence is unlimited in time. Annual reassessments are required by the court. The federal court (Bundesgerichtshof; BGH) restricts the application of hospital-order treatment to those offenders whose criminal acts are symptomatic of the mental disorder.⁶ The expert witness typically declares the offense to be in a causal relationship to the mental disorder that was assessed as being present at the time of the offense. This assertion is often made and accepted by the court, whether or not causality is, in truth, a reasonable assertion. In this context, when the expert report is read, a co-occurring diagnosis of an antisocial personality disorder is not included in the diagnostic summary even though all criteria are present and described in the report. Hospital-order patients receive a conditional discharge when “it can be expected that no further offenses will be committed” (Ref. 3, § 67, paragraph d). The patient is then on probation. However, probation is revoked if the patient:

... commits a crime during the period of probation, contravenes persistently or considerably the probation order, escapes persistently from the probation officer or the probation service, or during the period of probation it becomes evident, that criminal acts are to be expected because of the individual’s mental state [Ref. 3, § 67, paragraph g].

Offenders judged to be guilty but with severely diminished responsibility typically receive a dual sentence of both a determinate prison term and indeterminate treatment in a forensic hospital. The time spent in the forensic psychiatric hospital is subtracted from the total sentence. Usually, when the court orders a conditional discharge from the forensic hospital, the remaining time of the prison sentence that has not yet been served is served on probation status.

Correctional Facilities

In Germany, the idea of treatment in prison for the mentally ill offender dates back to the time immediately following World War II. In July 1969, a special measure for high-risk personality-disordered offenders, high-risk sex offenders, and young habitual criminals was passed, the so-called commitment to a social therapeutic institution (STI).³ Between 1969 and 1981, 11 STIs were established in the prison system as pilot programs.⁷ In 1984, § 65 StGB was canceled and replaced by a penal system protocol.⁸ Consenting prisoners could be assigned to

an STI if their rehabilitation would benefit from the special methods of social-therapeutic treatment, but there was no claim to treatment in the general correctional system anymore.

The law regarding mental treatment of prisoners changed again in 1998. After passionate public discussion of several spectacular sexual offenses, a bill to combat sexual offenses and other dangerous offenses was passed. In addition to the existing regulations, sex offenders with a prison term longer than two years have to be committed to a social therapeutic unit.⁸ Consequent to this amendment, the number of social therapeutic units has increased from 20 in 1997⁹ to 45 in 2005, with a total of 1,829 individuals in such treatment locations.¹⁰

While most individuals in the prison-based STIs have committed sex crimes, one of the defining characteristics of these offenders is the presence of a personality disorder. It should be noted that the treatment programs to date generally are not developed for the treatment of personality disorders, *per se*. Rather, there is an acknowledgment that the presence of a personality disorder typically complicates treatment and makes functional improvement more difficult. In general, the goal of treatment is limited to risk reduction.

In parallel with these changes, the conditions for early discharge from prison changed as well.^{3,11} For an offender to be eligible for conditional discharge from prison, a determination must be made that there is no further risk of dangerousness or re-offense. An expert risk assessment became necessary for all cases of a conditional discharge.

Current Treatment

The absence of standards in pretrial assessment of legal responsibility (particularly in the case of “another severe mental abnormality”) contributes to wide variability in the populations of mentally ill offenders in different forensic hospitals and correctional facilities throughout Germany. There is similar variability in the models of service provision, ranging from psychoanalytically derived to cognitive-behavioral interventions. Furthermore, the models of organization of the services differ from state to state. Hospital-order treatment in Germany is provided by forensic psychiatric hospitals, each with 250 to 380 beds, or by smaller forensic departments in general psychiatric hospitals. Treatment in the correctional system is offered by stand-alone so-

cial therapeutic units or by social therapeutic departments of large prisons. Within the federal guidelines, individual German states have developed their own criteria and procedures regarding the selection and placement of offenders with personality disorders into social therapeutic treatment programs.

Given these many differences, no general picture can be provided. Instead, we will describe the treatment of personality-disordered offenders in the one forensic hospital and the correctional facilities in the German state of Hessen with a population of approximately 6 million.

Hospital-Order Treatment

The Haina Forensic Psychiatric Hospital treats all mentally disordered offenders who receive hospital orders in the state of Hessen. It has 440 beds distributed in 25 wards and a staff of approximately 600 people, including psychiatrists, psychologists, social workers, work therapists, teachers, and nurses.

Fully one-third of the patients in the hospital have a primary diagnosis of a personality disorder. An additional 25 percent of the patients present with co-occurring anti-social personality disorder. As is typical in many countries, most of the patients with a primary or secondary personality disorder diagnosis have a history of substance abuse or dependence. They tend to have poor social skills, weak socialization, a history of psychiatric problems, and a long history of criminal justice problems. Most of them have a lifestyle conducive to deviant behavior, have a poor prognosis, and are at high risk of recidivism.

Treatment is intended to reduce the risk of re-offending. That context leads to a multimodal approach that addresses the full range of impairments that are potentially changeable and related to criminal behavior. Until the middle of the 1980s, treatment was based entirely on a medical model. By the end of the 1980s, however, this treatment model was replaced by a pragmatic, multimodal approach to reduce dangerousness by neutralizing, compensating, reducing, or eliminating factors that increase the risk of violence and crime. Antisocial acting out is viewed as a learned behavior. The individual’s personality and factors outside the individual (but associated with the criminal act) have gained weight in the treatment approach. Special consideration is given to problematic use of addictive substances, antisocial personality traits, a criminal identity and a history of living in antisocial environments.

In the 1990s, an evidence-based treatment paradigm gained strength. To improve our treatment attempts with personality-disordered offenders we began to introduce offender treatment components from multimodal cognitive-behavioral programs, based on the principles of risk, need and responsivity, and reduction of recidivism. In 1998, 22 clinicians of the hospital were trained in the Reasoning and Rehabilitation Program developed by the Correctional Service of Canada.

Social learning theory continues to provide one of the most generally applicable and theoretically well-grounded bases for offender treatment.¹² From that perspective, we began in 1996 to implement cognitive behavioral approaches. This approach now orients our interventions with patients who present with primary and secondary disorders.¹²

The psychiatric and criminogenic needs identified during assessment are operationalized as treatment targets. For each, an explicit plan specifies how change is to be accomplished. Each goal is in turn broken into a series of manageable steps, enabling the patient to envision how each goal may be achieved.

The risk of re-offending determines the intensity of service. The risk is assessed primarily on an actuarial basis, using reliable and valid instruments (Psychopathy Checklist-Revised [PCL: SV]³; HCR-20 Assessment of Risk of Violence⁴). Risk assessment is performed annually by using file records, direct patient interviews, review of any changes in dynamic factors, and team discussions.

Main treatment targets include reducing symptoms and modifying antisocial, procriminal values and attitudes, and fostering the development of prosocial peer groups. As approximately 90 percent of Haina patients have a history of violence, our treatment programs focus on management of aggressive behavior. The treatment approach acknowledges the complexity of the task. As individuals respond differently to interventions, the treatment programs take into account the individual patient's impairments. These are, for example, cognitive deficits, co-occurring Axis I and II disorders, and specific criminal behavioral tendencies.

In summary, the main approach in treating offenders with personality disorders focuses on interpersonal skill training and modifying criminal thinking by using cognitive-behavioral techniques. Pharmacological agents are applied in only a few cases. In some cases, selective serotonin reuptake inhibitors or carbamaz-

epine are used in an effort to reduce extreme impulsivity or lack of self control.

Correctional Facilities

On March 31, 2005, Hessen had 4,281 inmates in its prisons. Of those, 2,165 were sentenced to a term longer than 2 years.¹³ The Hessian Social Therapeutic Unit has only 140 slots, providing only a fraction of the needed treatment capacity. This lack of adequate treatment resources is a consistent problem in other German states, as well.

Criteria for offender assignment to the Hessian Social Therapeutic Unit (STU) include high risk of re-offending (treatment necessity), normal or near-normal intelligence, and sufficient verbal and interpersonal competencies to participate in a language-based treatment.¹⁴ Treatment necessity is unfortunately ambiguous. If other existing less-intensive treatment services may be of benefit and can be offered, then the offender is not eligible for the STU. Further, offenders are only eligible if the remaining sentence is longer than 18 months and shorter than 60 months. Some offenders are excluded from treatment because of these time limits. The time required to satisfy the administrative procedures for assignment to the STU can be substantial.

As is typical in the structure of STUs, offenders live together in small groups,¹⁰⁻¹⁴ separate from the normal prison environment. Single-person cells, a shared kitchen, and rooms for groups and group meetings, and services for the group are intended to create an environment that serves as an important therapeutic agent.¹⁴ Other basic essentials of treatment are attendance at school (if appropriate), work and vocational training, leisure skills training, and extensive discharge planning.

Current Hessian STU treatment is in general consistent with the programming offered in other German states. Group treatment programs include social skills training, empathy training, self-management, and health education. Specialized treatments include a Sex Offender Treatment Program (SOTP) and a subprogram for child molesters. Individual therapy and counseling and addiction treatment are also offered. It is important to note that since the legal amendment of 1998, the programming has changed.¹⁵ Evidence-based and -informed offender treatment programs from other countries have been

rapidly adopted, often without any training or accreditation procedures.

Current and Proposed Research

Most German states have Criminological Services located within their Ministries of Justice to support research and evaluation of therapeutic interventions in the correctional systems. There is a substantial body of outcomes evaluation (and to a lesser degree, research) regarding social and therapeutic interventions.¹⁶⁻¹⁸ Unfortunately, the results were primarily communicated among the members of the criminology field and published primarily in German. Furthermore, outcomes of social-therapeutic treatment were evaluated in total, without assessment of single treatment or component measures. This reflects the long-term absence of structured treatment programs in the treatment of offenders in Germany. This is gradually changing, in large part due to the evaluation of a structured sex offender treatment developed specifically for the German prison system.¹⁹

Consistent with many other nations, evidence-based structured offender assessment and treatment methods began in Germany in the forensic psychiatric system and only thereafter began in the correctional system. One such example is the Haina Forensic Psychiatric Hospital. Faculty at this hospital have, among other initiatives, translated and implemented the assessment tools PCL-SV,⁴ HCR-20,⁵ and Sexual Violence Risk (SVR)-20²⁰ in the early 1990s and translated and implemented the Reasoning and Rehabilitation Program in 1998. The knowledge and expertise gained from these and related experiences have been shared through multiple regional, national, and international workshops and congresses.

Currently, two collaborative international research projects on the treatment of personality-disordered offenders are under way: an adaptation of Dialectical Behavioral Therapy (DBT) to an offender population and an adaptation of the Canadian Reasoning and Rehabilitation Program.

Transition to the Community: Treatment During Probation

For 20 years, specialized outpatient offender treatment has been developed and established in the forensic psychiatric system in several German states.²¹ Despite individual differences in organization, there is consistently close cooperation between outpatient

treatment services and the legal system (court, probation officer), for joint coordination of risk management.

With one exception (an outpatient clinic for sex offenders created in 1998²²), such specialized clinic treatment services for offenders do not exist in the German correctional system. In most cases, similar to the North American model, a personality-disordered offender who receives an order for treatment during probation is committed to an ordinary psychotherapist, and it is a matter of chance whether the psychotherapist is trained and experienced in treating offenders. Funding of the treatment, cooperation, and communication with the legal system and confidentiality are further problems of current practice in the German correctional system. Rarely, there are local networks or incorporated societies for aftercare or probationary treatment composed of psychotherapists working with offenders, probation officers, prison employees, and members of the forensic psychiatric aftercare services. These are concerns identical to those concerning the system of care in the United States, where many personality-disordered offenders are ineligible for intensive community-based services.

Against this background, a bill in the German legislature attempting to reform and improve the supervision of psychiatric care for probationers is in discussion. The parallels with unfunded mandates in the United States are striking.

Conclusions

To those familiar with the systems of treatment of incarcerated individuals with personality disorder in the United States, the parallels with the German system are far greater than the differences. Despite different legal systems and precedents, there is a remarkable convergence in the resultant systems. Limited resources, poor recognition of severe personality disorder, scant targeted treatment, and poor or inadequate coordination with community providers clearly are shared process and procedural concerns. The structural parallels between the two countries' organization into forensic hospitals and prison treatment facilities are also quite similar; the limited treatment resources are evident in both environments. One optimistic parallel is that heretofore limited research in the arena of forensic treatment of personality-disordered offenders is now developing. Problems with clear and accurate diagnosis, access to care,

the need for development of evidence-based practice, and the provision of adequate transitional community services for offenders with personality disorders are concerns for providers in both systems. Further research, program evaluation, and political advocacy are clearly indicated.

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