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Justizvollzugsanstalt
Aachen

Clinical Activities Report

Svenja Göbbels
I6022471

Clinical Internship – Justizvollzugsanstalt Aachen
Forensic Psychology Master
Maastricht University
Faculty of Psychology & Neuroscience

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Introduction

This clinical activities report has two parts. First of all, I will describe my internship and will evaluate the internship experience. Then, I will describe different aspects of adult forensic mental health care in Germany. Subsequently, I will discuss potential ethical problems of the preventive confinement of German sex offenders.

The Internship

Description of the Internship Setting

The internship took place in the Penal Institution of Aachen (Justizvollzugsanstalt Aachen; JVA). Before, detainees and prisoners with short terms were imprisoned in a building in the inner city. However, this building was opened in 1984 and was not compatible with the central themes of a modern prison system. Therefore, the new, modern prison was opened in 1994 (see picture 1). Since an expansion in the year 2004, the JVA can accommodate up to 684 detainees and prisoners, and up to 50 persons serving preventive long-term detention (*Sicherungsverwahrung*; SV). In addition, there is a special sociotherapeutic section within the JVA, which can accommodate up to 35 prisoners (*Sociotherapy*.)

Picture 1 – The Penal Institution of Aachen[1]

The JVA is managed by Mrs. Blikslager. The director is supported by department leaders, who are responsible for the sociotherapy, detention, SV, and the four prison units. In addition, there are three subdivisions. The subdivisions are the enforcement division (Strafvollzug), the administration division (Verwaltung), and medical care division. The Psychological department is part of the first subdivision, so only this one will be described in detail.[2]

[1] http://www.jva-aachen.nrw.de/wir_ueber_uns/behoerdenpraesentation/index.php
[2] http://www.jva-aachen.nrw.de/wir_ueber_uns/orga/orgra.JPG

Professional Disciplines working in the Institution

First of all, the prison officers (Allgemeiner Vollzugsdienst) are responsible for supervising the inmates, of course. However, they also have multiple other very important tasks. For example, management of the education of future prison officers, controlling of the main gate, transportation of prisoners, managing the visitor's department, giving sport lessons to prisoners (additional license needed), working in the central security office, and so forth. [3]

Interestingly, when the prison officers are motivated, they can also participate in the professional treatment of the inmates. For instance, in sociotherapy they can function as a mentor and talk with their protégé for half an hour every week. In addition, they can be involved the treatment team of one of the two living communities in the JVA. In these living communities, the doors are open from 6 a.m. to 9 p.m. In addition once per week a plenum is taking place. In these plenums, problems or conflicts between inmates and other organizational topics are discussed. Usually, the meeting begins with one inmate presenting a phrase, and giving a personal comment on it. Sometimes relevant topics, like moral courage and perception of females, are discussed. The prison officers are participating in the treatment team, which consists of one social worker and one psychologist. When it is possible, they also function as mentors. Recently, this is not possible anymore, because of a lack of workforce.

The other disciplines are summarized under the term *Fachdienst*, which basically means that they are responsible for certain professional services. The medical service assures the medical well-being of the inmates. It offers medical care to the inmates. In additions, it is responsible for assuring hygienic conditions within cells, the kitchen, and so on. Additionally, they prescribe medication, when it is needed. Moreover, they try to avoid the infection with infectious diseases (e.g., HIV) by giving advice. Furthermore, they have influence on the daily menu. In addition they give recommendations to the manager of the JVA in medical questions and write expert reports about inmates. In the case of an emergency in one of the institution's factories, it offers first aid.

The pedagogical service offers schooling, and various courses, like German classes for migrants, computer courses, etc. In addition, they are responsible for the library for inmates and the prison magazine, which is mainly produced by prisoners. Furthermore, there is catholic and protestant pastoral care available for inmates, who have problems with their family, their partner, or other personal or spiritual concerns. Moreover, social workers assist the inmates in problems of daily life. They arrange therapy and support the inmates in finding a debt advisor. In addition, they support psychologists in working within the framework of living communities inside the prison. Additionally, they arrange apprenticeships for appropriate candidates to increase their chances on the labor market after their release.

Besides the paid staff, also 87 people work in an honorary position. They enter into a dialogue with the inmates and offer them a possibility to speak with somebody, who is not on the payroll of the prison system. They function as advisors. Therefore, mostly people with a lot of life experience are chosen for the honorary positions. The conversations can happen in a personal situation or in a group setting.[4]

The Role of Psychologist in the Institution

In sum, five psychologists are working fulltime in the penal institution of Aachen. One psychologist is responsible for detainees and the inmates with prison terms of less than two

[3] http://www.jva-aachen.nrw.de/aufgaben/berufsgruppen/avd/index.php
[4] http://www.jva-aachen.nrw.de/aufgaben/berufsgruppen/fachdienst/index.php

years. One other is responsible for the preventively confined inmates, the prisoners serving SV. In addition, five psychologists are working in the socio-therapeutic department.

First, I will describe the work of a psychologist in the general psychological service. The psychologists are responsible for the psychological care of all inmates. Usually, the psychologist works on different problems. Some prisoners want to talk to the psychologists, because they are willing to change themselves and hope that the psychologist can assist in handling the criminal past. These inmates hope that they will understand the motivations for their criminal behavior and are able to change their behavior in the future. This counseling can take place on an individual basis or in a group setting. In addition, external psychotherapists can assist in this particular task.

Very motivated or appropriate clients can be housed in one of the two *Wohngruppen*. These are departments inside the prison, in which the clients are supervised and supported by a psychologist, a social worker and prison officers. These departments have a strong therapeutic orientation, thus the doors are left open during the whole day. These departments are promoting social skills, and prevent social isolation, which is unfortunately happening quite often in prison settings.

But not only motivated inmates are in contact with the psychologists. Also prisoners, who came to the attention by being violent or suicidal, are referred to the psychologist. Also prison officers, who suffer from psychological problems, can contact the psychologist. Often a psychologist is contacted by an inmate and cannot really help with his problem, because it falls out of his or her competence, for instance low income, joblessness, or problems with the medical doctor.

However, the statement of a psychologist is necessary, when an inmate wants to have privileges, like a supervised or unsupervised prison leave. When an inmate requests such a privilege, the psychologist performs a thorough evaluation, if the privilege should be granted. This evaluation incorporates structured risk assessment Then, the psychologist writes a statement, which gives a recommendation to the head of the prison, who issues the decision. In the case of violent and/or sexual offenders, the assessment is even more rigorous.

In addition, the psychologist performs organizational tasks, like an assessment center for future prison officers. In addition, the psychologist is responsible for a part of the education of the prison officers. Moreover, interns are supervised by the prison psychologists.

In socio-therapy the treatment is the main focus. Whereas a prison psychologist is responsible for up to 200 inmates, a socio-therapist is responsible for far fewer inmates. Thirty to 35 inmates are accommodated in socio-therapy. Five psychotherapists, three social workers and 10-12 prison officers, who function as mentors, are treating the inmates. Once per week every inmate is talking to his mentor. In addition, every inmate receives individual psychotherapy.

Furthermore, sex offenders are participating in an offense analysis treatment group to reduce the risk of recidivism. This group is done with the mentors, a social worker, and a psychologist. Also, psychotherapy in a group setting of 5-8 inmates is taking place weekly. These groups are supervised by two mentors and one social worker.

Normally, all inmates of different departments work together in different factories. However, these factories are often used for drug trafficking and other subcultural activities. Therefore, to enhance the therapeutic environment, inmates of social therapy are isolated from these influences. They work in separate workshops. Here they can work with different materials, like wood and metal.

Overview of my own clinical activities

I had to conduct group sessions in the occupational therapy department (*Arbeitstherapie; ATP)* of the prison. The ATP is especially designed for prisoners, who have never worked outside. The aim is that they learn to handle a normal day structure, gain respect for authority, and that they can get a feeling of success when they complete something. There are two units. One is working with metal, the other with wood, similarly to the factory in socio-therapy.

My supervisor told me that the ATP was neglected psychologically for a long time, due to staff problems. On Monday and Thursday morning, I met with 8-10 inmates to discuss individual problems, conflicts in the group, and other topics which are of relevance for the inmates. In the beginning, this was very difficult. There were a lot of conflicts between the members, so the group atmosphere was not really productive. However, together with the group members, a fellow intern and the work prison officer, I succeeded and most of the meetings were productive. Problems between the inmates were analyzed and discussed critically. In addition, it was apparent that the group members began to trust each other and me, so they could discuss personal problems. Later, when most conflicts were sorted out, we also discussed topics, like future plans.

In addition, I had my own client. I was closely supervised by the chief of the psychological department, of course. After reading the whole personal file, and an expert report, I developed a treatment plan with the client. After he had committed several break-and-entries, he had robbed a supermarket. He was convicted for aggravated robbery in connection with aggravated assault. In the expert report, the psychologist emphasized a narcissistic personality problem, criminogenic attitudes ("thieves' honor"), possible motivators for crime, and traumatic childhood experiences. For instance, I talked with him about his traumatic childhood, because he was raised in an ambivalent environment. On the one hand, his mother was overprotective, spoiling. On the other hand, he had an emotionally neglecting and cold father, who was an alcoholic and physically violent. With various techniques, we worked on these problems.
Additionally, I participate in a treatment group of my supervisor. The group members were mostly sex offenders, who were serving SV. The group therapy was structured by transactional analysis ideas.

Besides, I was present at court hearings concerning the continuation or discontinuation of the SV. For these hearings, three judges, are coming to the prison, to interview the inmate, who is supported by his lawyer, and the psychologist's opinion. Most often, these hearings concern the developments the client has experienced. Usually, a new expert report is requested by the lawyer. This expert report is done by a psychologist, who does not know the client beforehand, to assure objectivity. To passively participate in the court hearings was very interesting, because the atmosphere is less formal than I thought.

Furthermore, I participated in the group therapy sessions guided by mentors and social workers in sociotherapy. Unfortunately, I was not allowed to participate in the offense analysis groups. The reasons for that were not given to me.

Furthermore, I assisted in the assessment center for prison guards by analyzing and interpreting test material and sitting in the final job interviews with the psychologists. Sometimes, I also assisted my supervisor in reading files for him and extracting important information from it, or doing scientific reviews.

Evaluation of the Internship

Evaluation of Clinical Learning Goals

I wanted to …

1. **learn to apply my theoretical knowledge.**
   In general, I was successful in doing that. However, not all the theoretical knowledge was necessarily applicable. Sometimes, I became aware of possible limitations in clinical research. For example, sexual deviation was most often diagnosed with the DSM-IV. Erectile measures would not be readily applicable in German samples.
2. **learn to apply practical knowledge, like risk-assessment tools, clinical interviews like the SCID and the PCL-R, and tests like the MSI.**
   I was also able to reach this clinical learning goal. I did the SCID and the PCL-R multiple times, and got to know specific test material. For example, I studied a specific German personality questionnaire, which was developed for prison populations.
3. **become more confident in the application of clinical tools.**
   Due to frequent practice I got more confident in using clinical tools. Also discussing potential problem with my supervisor was very helpful.
4. **practice diagnostics.**
   This goal was also met.
5. **be more independent than in my first internship in the prison.**
   I was far more independent in this internship than in the last one. I had my own patient and conducted group sessions in work teams to solve and prevent conflicts. I had my own office and my own key, so that I could walk independently to wards and cells.
6. **observe clients with personality disorders, especially ASPD and NPD**.
   This goal was met, because I participated in a treatment group of preventively confined offenders and in sociotherapy. It was very interesting to see the sense of entitlement a lot of inmates have, for example.
7. **read relevant literature about sex offenders, to talk to them, and participate in sex offender treatment also in regard to my research internship.**
   Tony Ward wrote in his book *Desistance from Sex Offending* (Laws & Ward, 2011) that most sex offenders are "people like us" (flap text). I already knew that sexual offenders aren't monsters. However, now I had closer and longer contact with sexual offenders and got a sense how it is like to work with them.
8. **gain new theoretical knowledge by doing a systematic literature research, when I recognize a knowledge gap.**
   When I recognized a knowledge gap (for example, necrophilia or violence in Asperger syndrome) I conducted a literature research and shared the articles with my supervisor, who was also very interested in those topics.
9. **learn how psychologists, social workers, and prison officers work together.**
   It was especially instructive to observe the treatment teams in the therapeutic departments. The team discussions were always very interesting.
10. **learn about the organizational structures of a German prison, and the psychologist's role in it.**
    I already had a grasp on this before I was an intern for the second time. However, now I have an impression how it is to be a more independent, more functional member of a team of psychologists.
11. **become familiar with personal files of inmates.**

In the beginning, I had problems finding relevant information in the very thick personall files of the inmates. Later, I was successful in finding important information fast.

12. **become familiar with the German style of writing experts reports.**
    The writing style of German expert reports is most often not reader friendly. The reports are very long and not always to the point. However, most of the expert reports were instructive and interesting.
13. **gain more insight in the German criminal law, especially on *Sicherungsverwahrung*.**
    I got insight into different aspects of the SV. I have learned about procedural, practical, judicial, ethical, and clinical aspects of the SV.
14. **be part in writing expert reports.**
    I have assisted my supervisor in expert reports by reviewing files. In addition, I was able to go to court hearings in which my supervisor had to testify.
15. **be concise in case studies.**
    I was able to be more concise in case studies after completing the internship. However, it is still difficult for me to decide what is relevant, and what is not. However, I am optimistic that I will learn to find a balance between accuracy and conciseness.
16. **get experiences in different types of therapy.**
    I was able to participate in individual and group treatments, which had a different focus. I observed psychodynamic and cognitive-behavioral individual therapy, and cognitive-behavioral, systemic, and transactional group treatments.
17. **participate in group therapy in the regular departments and especially in socio-therapy.**
    This clinical learning goal was also met. I participated in seven to eight treatment groups per week.
18. **conduct own simple therapeutic interventions.**
    I was able to conduct simple therapeutic interventions with my "own client". Of course, I was closely supervised. After these experiences, I can imagine to become a therapist.
19. **find out, if I could work here in the future.**
    I could definitely work in a prison in the future. However, I recognized that I am still too young to decide now that I want to work there forever. In Germany, prison psychologists are public officers and are generally employed for life. Therefore, I want to do a PhD first, if it is possible.

General Evaluation

In general, I am very satisfied with my clinical internship, although it was very laborious and demanding. However, I think it gave me a good insight into the occupations of a prison psychologist. If I have time, I will also do a short internship at a forensic psychiatric facility to get a full grasp on different aspects of Forensic Mental Health Care.

Suggestions

The only thing that bothered me a bit was that I was not allowed to participate in the offense analytical treatment group of sex offenders. They did not tell me the reasons for that, thus I was disappointed. However, this was the only drawback.

Forensic Mental Health Care in Germany

Only Forensic Mental Health Care for adults in regard to conciseness will be described here. There are six important facets of this topic: forensic psychiatry, detoxification institution, socio-therapy, prison psychology, preventive long-term detention (*Sicherungsverwahrung; SV),* and aftercare. The SV will be discussed in the 2nd chapter of this text, because of crucial relevance for the case studies. In addition, it is probably the most critical aspect of forensic mental health care, because also the European Court of Human Rights (ECHR) criticized the German authorities for this legislation.

Description

Forensic Psychiatry

Forensic Psychiatry was introduced in Germany in 1933. Historically, Forensic psychiatry was aimed at securing the public from highly dangerous "habitual criminals".

An offender can only be admitted to Forensic Psychiatry (§63 StGB), if he was not guilty by reason of insanity (*Schulunfähigkeit* §20 StGB), or if his responsibility was diminished (*verminderte Schuldfähigkeit,* § 21 StGB). In addition, the person can only be admitted to forensic psychiatry, if he or she is a danger to the public, because of his or her psychiatric disease. The major consideration is to protect the population from offenders with mental illness. The potential usefulness of a particular intervention is only second priority. Therefore, it could be the case that somebody is incarcerated basically for their whole life. Forensic Psychiatry functioned as a preventive long-term detention for mentally ill offenders. Since the 1980's however, therapeutic values came into focus.

When looking at demographic data, the forensic patients are more similar to general prisoners as compared with patients in general psychiatry. They have a low socioeconomic status, they come from broken families, almost 95% are males, and rarely completed high school. Most of the inmates never had a relationship, and have a criminal record.

Approximately 40% had a psychotic disorder as main diagnosis, 6% an organic personality disorder (due to brain injury), and 44% are suffering from a severe personality disorder. Substance abuse disorders, intellectual disabilities, and personality disorders are frequent comorbid disorders (Leygraf, 2006a). In general, the offenses forensic psychiatric patients committed are quite severe: 30% committed homicide offenses, 30% sexual offenses, 15% aggravated assault, 15% property crimes, and 10% arson. Recently, because of a lack of capacity, forensic patients were admitted to general psychiatry. This, however, is critisized, because treatment in psychiatry is generally voluntary, whereas admission under §63 is a measure, which is ordered by court. In addition, the stay of forensic patients is remarkably longer (years, even decades). Thus, the organizational structure is very different. Moreover, the dissocial development of most forensic patients might threaten vulnerable patients in general psychiatry. Additionally, staff needs different qualifications.

It is quite problematic, that the date of release cannot be determined by the patient, or the treatment staff, but by court. In addition, the forceful component of treatment in forensic psychiatry poses ethical questions. Because the inmates are dangerous offenders, the psychologist and psychiatrist are not bound by confidentiality. It is possible that the offender /patient cannot discuss delicate issues with the therapist, because he or she is afraid that these facts will interfere with release. In addition, the life histories of most offenders rendered them quite paranoid and skeptical, which further complicates a trusting, therapeutic relationship.

When the offender is admitted, the clinic already has important information about the person, because an extensive expert report is required to sentence somebody to this measure. In addition, the patient passes through a broad diagnostic process, to deliver appropriate therapy. An anamnesis is performed. In addition, third party information (partner, parents, friends, etc.) will be collected. In addition, administration of tests, somatic diagnosis, and behavioral observation are part of the assessment process.

With this information, a therapeutic plan will be developed. In forensic psychiatry, anti-depressants and anti-psychotic medication is frequently prescribed. Sometimes, paraphilic offenders, who are released, can receive antiandrogen medication.

Psychotherapy targets criminogenic needs of the patients. It is important to keep the individual patient in mind to tailor the therapy to his or her needs. Psychodynamic therapy is rarely done in forensic psychiatry, because it does not meet the needs of most patients. It is too focused on reflection and not practical. In groups, psycho-education and cognitive-behavioral treatments are given (Leygraf, 2006a). The patients receive the opportunity to acquire new skills, like self-control. Importantly, attitudes that condone offending, and cognitive distortions are treated. Also empathy with victims is enhanced. When the offender is awaiting release, privileges are given to practice the new skills in real life (see below). Those privileges are accompanied by a relapse prevention plan, which supports the offender in recognizing individual risk factors, and effective vs. non-effective coping strategies.

Forensic psychiatry is characterized by an active, therapeutic milieu. Different professions participate cooperatively in the patient's treatment. The patient is observed on the ward, at work therapy, and while participating in free time activities. In addition, the staff tries to involve all patients into the group to prevent social isolation. Furthermore, education and apprenticeships are offered to give the patients better opportunities on the job market when they are released. Occupational therapy and support in structuring daily life is offered. It is always important to assess the risk the offender poses within the institution to assure safety for all patients and staff.

Another important aspect are privileges to motivate the patients, but also to practice newly acquired skills. This is also very important when preparing release. The first step is going out with a staff member. Although the inmate is under constant supervision, he or she could recidivate or try to break rules. Therefore, every risk should be carefully considered.

The next step is unsupervised leaves. This privilege can only be granted, if the risk for recidivism is very low. In addition, the time and local framework should be very tight. The therapeutic relationship should be stable to assure that the patient will come back. The next step can be seen as a holiday from detention. The patient is allowed to stay at a special address over night. Regular contact with a probation worker or therapist is necessary. The degree of structure and control depends on the stability of the patient's mental state.

The last step of privileges is the admission to a minimum security forensic psychiatric department. In these departments, the doors are always open, and the patients have more freedom. It is crucial that the therapeutic effects are so strong that recidivating is very unlikely.
In all those privilege steps, evidence-based risk assessment and evaluation of therapeutic goals is very important.

If Forensic psychiatry is effective in reducing recidivism is debatable (Leygraf, 2006a). The scientific evaluation of this question will always face methodological problems. Even if one takes the consequentalist viewpoint, securing the public was not always successful. Leygraf (2006a) cites high-profile cases in which forensic patients on leaves committed homicide offenses. In my opinion, this is not really a scientific marker to evaluate the effectiveness.

If we look at recidivism rates, a study by Seifert (2005, cited in Leygraf, 2006a) indicates that the recidivism rate of forensic patients is 16.5%. The problem is that there is no appropriate control group, because all offenders who are not responsible because of insanity, or diminished responsible for their crimes are admitted to forensic psychiatry.

Especially with this problem in mind, it is unethical to keep some patients incarcerated basically for their whole life. Some offenders receive a label of "not-treatable", which is clearly unethical. Is living in freedom no realistic therapeutic goal for those offenders? Some chronically psychotic patients, patients with intellectual disabilities, or organic personality changes, are often not able to function in a non-structured environment. However, in Germany there are no long-stay units available, like in the Netherlands. In those units, the well-being of the patients and their social functioning should be emphasized. The atmosphere should be stimulating and supporting, and should preserve the competences and resources of the patient. It would be necessary that the offender gets the chance to switch from long-stay to therapy again, if there are any changes in his behavior or attitudes (Nedopil, 2008; Leygraf, 2006a).

Forensic detoxification centre

The admission of a person to a detoxification centre can be ordered by court. This is possible under the following conditions: a) the person has the propensity to consume alcohol or drugs excessively; b.) the person was sentenced, because of a crime he or she committed because of this propensity or he or she committed a crime under the influence, and was not held responsible for the crime, or only had diminished responsibility; c.) the person poses a risk for committing significant crimes in the future; and d.) the admission to the detoxification centre can cure the person from the propensity, or at least stops him to commit crimes, which are related to the propensity (§64 StGB).

Most of the people who are addicted, do not show violent or criminal behavior. However, alcohol and illicit drugs are present in both offenders and victims in many violent offenses. Substance abuse disorders are thought to be causally involved in violent and criminal behavior [reference needed here]. Besides psychopharmacological effects, substance abuse may lead to criminal behavior through social processes like drug business (systemic violence) and violence used to get drugs or financial matters for drugs (economic compulsive violence; see for a review, Boles & Miotto, 2003). Because of these criminogenic characteristics of drug use, abuse and addiction, forensic detoxification centers aim to cure these disorders.

It is debatable, if substance abuse disorders are indeed curable, because it is known that substance addiction develops a certain dynamic, which is not controllable by the addicted person. Therefore, addicted people often seek out deviant peer groups, because social functioning declines due to the addiction. This often ends up in a vicious cycle. To interrupt this vicious cycle is often extremely difficult.

As in every other type of therapy, the establishment of a trusting therapeutic relationship is very important. It is not productive, if the therapist aggressively confronts the patient. The therapist should assume the standpoint "firm, but fair" and should function as a role model for the patient. Moreover, it is very challenging to motivate the clients to change. Twenty years ago this motivational procedure involved aggressive confrontation with the negative consequences of the substance abuse and a very moralistic attitude towards the patients. Nowadays, this motivational concept is obsolete, because it only exacerbates the defensive attitudes of patients. Now, the motivational aspect of the therapy focuses more on establishing a hopeful picture of the future and a desirable life [reference needed here]. However, some confrontation is still very important within this framework. Confrontation is needed to make patients attend to their problems, which are not always perceivable by them.

Another potential problem is the prejudice that "all addicts lie". First of all, this viewpoint should not be assumed by any therapist. However, to assume that these clients, who are often very antisocial, are always honest is also not productive for therapeutic aims. Disingenuousness might be a maladaptive coping mechanism to avoid confrontation about the consumption with close others and to assure the availability of the drug. However, in therapy, insincerity may have other reasons. In therapy, the client might avoid the development of a trusting therapeutic relationship by constant lying. However, it might also be possible that the client only seldom lies, to appear in a socially desirable manner. This often happens when the criminal offense is in the focus of the therapy session. When the therapist suspects insincerity he or she should consult objective records. It is not aimed to embarrass or expose the client, but a productive, trusting therapeutic relationship can only be possible, when the client does not lie on a regular basis.
Once a trustful relationship is established, it is aimed to work together with the client to find more desirable behavior alternatives. Due to the addiction all thoughts and feelings circle around obtaining and consuming the drugs, and to deal with the consequences. Within the living group, the patients acquire new skills, but also new hobbies.

It is of major importance to acquire new competences and coping skills to deal with daily life (skills training). Patients often lost track of a normal day structure and have major financial problems. The patients are stimulated to handle their financial situation on their own, by contacting creditors, for example. In addition, it is aimed to provide professional training and schooling to the patients, to improve their perspectives on the job market.

Furthermore, it is crucial to improve affect regulation and frustration tolerance in addicted offenders. Often, these patients are not able to tolerate negative feelings and have difficulties in dealing with frustrations. These patients try to alleviate pressure by consuming the substances. To train affect regulation, dialectical behavioral therapy is used. As this treatment was developed for females, who show self-destructive behavior, the use of the treatment has to be tested in a forensic context.

In addition, it is possible that psychological treatment is supplemented by medical treatments, which suppress craving. Patients, who are addicted to heroin, receive substitution treatments.

Nonetheless, substance use disorders are a very frequent problem in prison populations. It is not possible, to detain all those inmates in forensic detoxification centers. Therefore, treatments are also offered within the general prisons. Importantly, there are several limitations. The extremely structured environment hampers skill acquisition. Moreover, a minority of prisoners becomes addicted within the prison. Realistically stated, the availability of drugs is not limited within the prison walls. Some inmates might even have a higher motivation to use drugs, because of the situation full of deprivations. In some prisons, special "drug-free" departments are established. Substitution programs are also offered within general prison populations (see for a review Schalast, 2006).

Socio-Therapy

Social therapy was invented in 1966 in Germany and Switzerland. Fourteen German and Swiss jurists postulated a new paragraph in the German Criminal Code. The main purpose of this new law was that very dangerous offenders should be re-socialized rather than locked up forever. The main aim of the new therapeutic units was to reduce recidivism risk and increase well-being of the offender client. The concept of socio-therapy was inspired by clinics, which were opened in Denmark (Herstedvester), and the Netherlands (Van der Hoeven Clinic). At first, admission was on a voluntary basis or after recommendation by prison staff.

The model was criticized by two different ideological schools. On one hand, the conservative scholars pleaded for higher sentences and lower psychological care. On the other hand, some critics saw delinquency as a social phenomenon rather than the manifestation of a psychopathological disorder. This intense discussion was fueled by the "Nothing works!"-Myth which was introduced by American scholars. In addition to these discussions, after the economic revival of the sixties, the recession came in the seventies and eighties. The financial measures were cut, and the plans for socio-therapeutic institutions were abandoned again. Therefore, the postulated new paragraph came never into action and was deleted from the Criminal Code in 1984.

After some high profile cases of sexual offenses, the idea of socio-therapy was re-invented in 1997. In 1998 a new law was introduced (*Gesetz zur Bekämpfung von Sexualdelikten und anderen gefährlichen Straftaten*). It contained measures to combat sexual offenses and other dangerous crimes. Since 2003 it was possible, to sentence offenders to socio-therapy. If a sexual offender is sentenced to a 2-year prison term or more, he or she has to enter socio-therapy. However, only if the treatment is presumed to produce beneficial effects (§9, StVollzG).

It is interesting that the law was finally introduced, after a public outcry. The public demanded that sexual offenders, who are dangerous, receive treatment. Thus, not the resocialization played the most important role, but the protection of the public. The ambitious aim to avoid future victims is at odds with the very limited number of places (only 1% of all prisoners) in social therapy, however (Egg, 2006).

In Germany there are 38 socio-therapeutic institutions. Only two of them are for females. In 2011, most of the inmates are between 25-40 years old. However, recently more and more old offenders are sentenced to socio-therapy. Only 8% of the inmates are minorities. Most of the inmates serve sentences between 3 and 7 years. More than 40% have no criminal record. 53,7 % are sexual offenders, 18,6% are general offenders, 14,9 % committed homicide (first or second degree), and 12,8% other offenses (Niemz, 2011).

The focus of socio-therapy is psychotherapy, usually with a psychodynamic emphasis. Psychotherapy takes place on individual basis and within a group setting. In addition, schooling and occupational training are offered. The main goal of socio-therapy is to identify and treat psychopathological disorders, which have presumably a causal connection to delinquency. In addition, relapse prevention programs, offense analysis, and social skills training are offered to decrease risk of recidivism. Importantly, also the living community poses challenges to its members, who can practice their newly acquired social skills in a quite safe environment.

The staff usually consists of three prison officers, one social worker, and one psychologist per ten inmates. The prison officers have the usual roles they also have in a normal prison; however, they are not wearing their uniforms, but normal clothes. In addition, they perform as "mentors", who regularly talk to the inmates. The social worker gives the group therapy sessions. The relapse prevention, and offense analysis groups are given by a psychologist, who also gives psychotherapy on an individual basis.

Every socio-therapeutic unit works differently, there is no unitary concept. Moreover, the focus is not on the "classical" psychodynamic treatment anymore, but more on cognitive-behavioral treatment programs, which are modular, and tightly structured.

Socio-therapy was evaluated in several studies. Egg (2006) cites two meta-analytic studies, which established an effect size of 0.11, and 0.13, respectively. This equals a recidivism reduction of 9-11%. In detail, psychoanalytical milieu therapies were less effective than modular cognitive-behavioral treatment with different additional treatments. Thus, socio-therapy is effective, however, only to a limited degree. However, it is important that socio-therapy is

further optimized and evaluated. Although one should not expect miracle healings of dangerous offenders. It is alarming that juvenile socio-therapy is not established yet, although young offenders have a higher risk of recidivism than offenders, who start offending later. Another problem is the aftercare after an inmate is released from socio-therapy. Often they are not followed-up or provided with adequate aftercare (Egg, 2006).

Prison Psychology

This part is predominantly based on my own experiences within the framework of my clinical internship. The prison psychologist is responsible for four important aspects: a) Diagnosis and risk assessment of violent and sexual offenders, as well as persons sentenced to life sentences (in Germany this means an indefinite period of imprisonment, but minimum 15 years, see § 57a, StGB), b) Crisis intervention in the case of suicidal or self-destructive behavior, c) Involvement in treatment of long-term prisoners, d) Involvement in the treatment of violent and sexual offenders. This aspect of forensic mental health care was discussed in very detail in the first part of this report (→ *The Internship).*

Out-patient Treatment Settings

As in many other countries, in Germany prison rates are rising. Therefore, out-patient treatments are needed. These treatments might be more effective, but are certainly more cost effective. Especially in juvenile these measures are more profitable than institutional treatment. In general, out-patient treatments are offered to offenders with lower risk of recidivism and less serious offenses. Aftercare is one of the most important out-patient treatment settings (see below; Leygraf, 2006b).

Aftercare

An often neglected division within the forensic mental health sector is aftercare. However, as indicated above, it is of crucial importance. Adequate aftercare is given after an offender is released. Especially in dangerous offenders, aftercare should involve the therapist, the institution (prison, forensic psychiatry, detoxification center), and the probation worker. Aftercare is extremely important to bridge the first time in freedom, when the offender is at high risk of recidivism. Aftercare is cost-effective, because it is possible to reduce institutional measures, which cost more. This is true for parolees from general prisons, forensic psychiatry, and detoxification centers (Leygraf, 2006b).

Preventive Long-Term Detention (Sicherungsverwahrung)

The court can order preventive long-term detention (*Sicherungsverwahrung*) additionally to a sentence. However, certain guidelines have to be fulfilled:

1.) if somebody is sentenced to a prison term of minimum 2 years, because of a deliberate criminal offense, which
    a. is a violent or sexual offense or
    b. falls under paragraph 1 (Compromising Democracy), 7 (Offenses against Public Order), 20 (Robbery and Extortion), or 28th (Dangerousness to Public Safety) paragraph of the StGB; violates a paragraph the Code of Crimes against International law; or a drug offense that can be sentenced with a minimum sentence of 10 years or

c. the offender repeatedly violates probation regulations (§ 145a) or committed an offense, which is named under a. and b. under voluntary, deliberate intoxication (*Vollrausch,* §323a)

2.) if the offender was sentenced because of one of the offenses named under 1. , which he committed before the index offense, twice to a sentence of 1 year
3.) if he was sentenced to a measure or a prison term of 2 years and
4.) if the evaluation of the offense and the offender suggest that the person has a propensity (*Hang)* to commit serious offenses against the bodily integrity or/and sexual self-determination to other people and thereby is a dangerousness to public safety.

[…][5]

Preventive long-term detention is one of the most debated legal measures in Germany. It will be further discussed in the next paragraph.

Judicial and Ethical Aspects of Forensic Mental Healthcare

Especially indefinite confinement or preventive long-term detention is associated with ethical, but also judicial problems. Therefore, the following paragraphs will mainly deal with these judicial and ethical considerations. Of all offenders, sexual offenders are the ones, where the public demands most severe prison sentences and measures. The public perceives sexual offenders as untreatable or even as pure evil. This political pressure has resulted in an erosion of laws regarding the confinement of high risk sexual offenders. This will be described in the next paragraph. The situation in Germany will be contrasted with the situation in the United States. However, this erosion of lawfulness can be observed in other countries as well (Lueb, 2000).

The German indefinite confinement – *„Sicherungsverwahrung"*

Recidivating sexual offenders pose an extraordinary risk to society. Some argue that only indefinite confinement of sexual offenders is a possible mean to encounter this risk. However, it is extremely difficult to balance the human rights of the particular offender with the need for society to be protected. In the US, sexually violent predator laws (SVPL) have been adopted to confine individuals who victimize others sexually. However, most of these laws are the reaction to an extraordinary awful behavior of a single person. In contrast, these laws are applied to a huge group of sexually violent offenders who are confined indefinitely and face an unlikely release, because of their still existing dangerousness (Janus & Logan, 2003 cited in Petrila, 2008). Even the most dangerous delinquent should only be confined as *ultima ratio,* hence his or her human rights should be protected.

Petrila (2008) argues that there has been an "erosion" of existing laws in the US. Petrila (2008) states that essential human right values are to some degree undermined, because of the premature assumption that persons who are prosecuted under the SVPL are per se untreatable. Interestingly, the question if offenders are untreatable is still under debate and not examined empirically (Frenken, Gijs & van Beek, 1999). Although there is an apparent lack of empirical evidence, some mental health professionals and courts take the assumption that these offenders are untreatable as a scientific, well-researched reality (Petrila, 2008).

Besides the problem if treatment works and/or is ethical, the work of assessors who are giving expert testimonies on the recidivism risk of SVP is not really monitored, although they influence the life of the perpetrator to a considerable degree. Consequently, the excessive use of

[5] http://www.gesetze-im-internet.de/stgb/__66.html

the former *ultima ratio*, the SVPL, has become a serious threat to the human rights of sexual offenders. According to Petrila (2008) it is very important to "maintain the integrity" (p.362) in these procedures and to target the quality of expert testimony, since the evaluation as *dangerous* is the most important condition for indefinite confinement. However, besides the use of the scientific assessment tools, file information and collateral information in assessing future risk, the correct communication of this risk estimate in court is of major importance. Thus, the expert should maximize the strengths of his or her professional opinion and in addition, should communicate important limitations also. Conversely, the latter does not constantly happen (Petrila, 2008).

The denial of all these important factors may have led to an overconfident attitude towards the reliable and valid prediction of recidivism risk and underestimation of the respective confidence intervals. Petrila (2008) criticizes the "erosion" of the SVP laws, which is not only apparent in US law. A similar trend is evident in the German SV. At first, the order of the traditional SV requires 1.) Two previous convictions, 2.) A severe index offense, 3.) A disposition to commit criminal offenses on a regular basis (*Hang*) and 4.) A high recidivism risk (*Gefährlichkeitsprognose*). Furthermore the SV was limited to 10 years in addition to the sentence. In German law, it is possible to decide the SV in the procedure of the index offense or after the regular sentence (subsequent preventive long-term detention – *nachträgliche Sicherungsverwahrung*). Juveniles and young adults were excluded from the SV law. It was not possible to sentence them to SV (Kinzig, 2010). However, as described by Petrila (2008) in regard to US law, Kinzig (2010) and Leygraf (2010) describe a similar "erosion" of the German law. After various reforms it is today possible to sentence offenders to SV who committed only one, but serious offense and are labeled as dangerous. Furthermore, the SV is not limited to 10 years and to adults anymore. Kinzig (2010) examined the statistics regarding the German SV and revealed that there are a lot of false positives among the confined offenders. Moreover, it becomes apparent that there happened something he labels as *senescence* of the SV, because, contrary to common assumptions that young males are the most serious offenders, older offenders (> 40 years) are the biggest subgroup in German long-term detention. Especially, the subsequent SV is under debate, because the European Court of Human Rights ruled that these are against human rights.[6]

It is evident that there are several ethical problems in association with the indefinite confinement of sexual offenders. However, it is obvious that the portrayed "erosion" (Petrila, 2008; Kinzig, 2010) of the laws concerning SVP is somewhat related to the selective attention of the media. Frequently, "reforms" of the laws in the US were preceded by horrible, although isolated single cases in which the public demanded stricter laws for sexually violent offender preventive detention. Besides, recidivism risk of sexual offenders is generally overestimated (Frenken, Gijs & van Beek, 1999) and further exaggerated in the media.

Recently, there was a case of an offender (Karl D.) in Germany. He had raped three teenage girls and was detained for 20 years[7]. When he was released, he lived with his brother in a village nearby Heinsberg. The district administrator warned the people that a sex offender will move into the neighborhood. It was not possible under the current law to apply subsequent SV to Karl D., so it was necessary to order 24 hours observation by the police, because D. is still deemed dangerous. Thus, the laws on SV are under debate again, so further erosion of the law may be on the rise.

[6] http://www.n24.de/news/newsitem_6588505.html

[7] http://www.focus.de/panorama/welt/kriminalitaet-heinsberg-klage-gegen-ueberwachung-vo sextaeter_aid_471740.html

The new law – ThUG

After the SV has been deemed against Human Rights by the ECHR, the German government was under pressure to enact a new law: The Law regarding therapeutic long-stay (*Therapieunterbringungsgesetz – ThUG).* After the ECHR had deemed the SV against human rights, some detainees had to be released, although they still had a high risk of recidivism. The new law was enacted to have a legal ground to keep SV-prisoners incarcerated, even if they served the full SV term of 10 years.

If a person detained under § 66 has to be released due to the ECHR ruling (see above), then the court can order ThUG, if the person suffers from a psychiatric disorder and this disorder in combination with the personality and the current situation will likely result in further offenses. Thus, ThUG can only be ordered, if a person is a major hazard for public safety. ThUG can be ordered, if the person is awaiting release, or already has been released (ThUG §1).
However, it is crucial that people detained under ThUG are not imprisoned in regular prisons. It is necessary to find suitable therapeutic institutions, which can offer the patient tailored treatment that targets release after a short time of therapy. In addition, the well-being of the offender/patient and public safety should be balanced. The threshold to mandate ThUG should be very high, because it is stigmatizing and a burden for the offender/patient (ThUG § 2).
The offender patient has the right to be heard, before ThUG is ordered and receives assistance by a lawyer (ThUG § 7). Moreover, before ThUG can be ordered, a formal hearing of evidence has to take place. This involves reports by two independent experts (psychiatrists), who were not involved in the treatment of the offender/patient. The expert reports should answer questions posed by the court. In the case that the report speaks for ThUG, the experts shall give advice, how the patient should be treated (ThUG § 8/9). ThUG can be ordered for 18 months and can be prolonged. Every extension requires another hearing of evidence, which, however, can be reduced to the expert reports.
As it is evident in the presentation of central aspects of German Forensic Mental Health Law, scientific risk assessment is crucial to guarantee a balance between the interests of society and human rights of the offender patient. Especially when an offender is preventively confined the risk assessment of the expert has a huge impact on the offender's life.

Risk assessment in sex offenders

The justice system is very interested in scientific assessment of recidivism risk. The justice system is interested in keeping very dangerous offenders incarcerated. The standard is to confine highly dangerous individuals, while preserving human rights. Therefore, the threshold to confine individuals after they have served their sentence should be considerably high. The judicial term "dangerousness" is not easily translated into a meaningful psychological concept. Somebody is dangerous, or not. This is a categorical judgment. Steadman (2000, cited in Jackson & Huyton, 2008) postulated the alternative concept of "risk for future harm". The decision about the risk allows a dimensional classification, which is more realistic. The assessor should focus on variables that increase or decrease risk for reoffending.

However, some decades ago most clinicians solely relied on intuition. With this approach, clinicians performed a little better than chance in predicting recidivism. Therefore, modern assessment tools were developed to structure risk assessment and to incorporate new scientific knowledge into clinical practice. In addition, scientific risk assessment should inform

treatment practitioners to develop tailored treatments, which are able to reduce the risk of recidivism (Jackson & Huyton, 2008).

Debate – actuarial vs. structured clinical judgment risk assessment

Within the framework of modern risk assessment, there are two different approaches, besides the unstructured clinical judgment (see above).

Sex Offender Risk Appraisal Guide – SORAG

Actuarial instruments are instruments that advocate statistical methods to assess risk. The items that are included in the risk assessment tool are variables which are related to the outcome variable (reoffending). This relationship has been established in empirical research. However, it is worth mentioning that the variables not necessarily cause violence, but are associated with the outcome. Thus, it is possible that the variables are only "proxy" variables, which are correlated with unidentified risk factors. These risk assessment tools do often not require trained staff, because the items are easily and concretely to evaluate.

Specifically for sexual offenders, the Sexual Offender Risk Appraisal Guide was developed by Quinsey, Harris, Rice, Cormier, and Washington (2006). It contains the items presented in Table 1.

Tab. 1 SORAG Items (Quinsey et al., 2006).

Item Number	Item
01.	Lived with both biological parents to age 16 (except death of parent)
02.	Elementary school maladjustment
03.	History of alcohol problems
04.	Marital status
05.	Criminal history score for nonviolent offenses
06.	Criminal history score for violent offenses
07.	Number of previous convictions for sexual offenses
08.	History of sex offenses only against girls under age 14
09.	Failure on prior conditional release
10.	Age at index offense
11.	Meets DSM criteria for any personality disorder
12.	Meets DSM criteria for schizophrenia
13.	Phallometric test results
14.	Psychopathy Checklist Score

The SORAG is accessible in German language on the internet[8]. As already described, the SORAG consists only of static factors.

Sexual Violence Risk 20 – SVR-20

Unstructured clinical judgment and actuarial risk assessment are two extremes. Structured professional judgment (SPJ) tools combine the strengths of both extreme approaches. It involves a clinician reviewing all data resources for the presence of specified static and dynamic risk factors and then coming to a structured concluding risk judgment. Thus, SPJ tools also assess empirically supported risk factors. However, the SPJ approach is far more flexible. In the individual case, the clinician can decide to derive to a final judgment of "low risk of recidivism" even if the total score on the items is very high.

[8] http://www.ri-sk.org/index.cfm?&content=9030

The Sexual Violence Risk 20 is a SPJ tool specifically developed for risk assessment in sexual offenders. The authors of the SVR-20 tried to identify risk factors that are empirically correlated with future sexual violence. The items were derived from a systematic literature review. However, also "clinically" useful items were incorporated. Interestingly, the SVR-20 involves factors that discriminate between sexual and violent offenders and items which are associated with a high recidivism risk in sex offenders (Jackson and Guyton, 2008).
The SVR-20 was used in German language. The official, authorized translation was published by Müller-Isberner, Gonzales Cabeza, and Eucker (2000). It is based on the Canadian original version by Boer, Hart, Kropp and Webster (1997).

Advantages and Disadvantages of Actuarial and SPJ Assessment Tools

Historical riak assessment tools have the advantage that they perform above chance level. However, actuarial methods face certain disadvantages, too. High scores indeed suggest a high likelihood of recidivism. But, they do not point to certainty! In addition, they are not able to predict severity of sexual violence. It can range from exhibitionistic or voyeuristic hands-off recidivism to sadistic, sexual homicide. However, the "dangerousness" standard requires danger to the public to confine individuals for a very long period of time. Strictly spoken, even if a specific offender has a 100 % chance to reoffend sexually, this does not allow to confine him preventively, because it is not known, if the future offenses are severe, or not (Johnson & Guyton, 2008). This concern is of special relevance in the presented case studies. These offenders committed very serious offenses. In the norm sample however, offenses of all severity levels are lumped together. Due to this, the SORAG might lose sensitivity and specificity.
Another problem is that the definition of "sexual violence" in the measure is sometimes different from the definition of violence in legal standards. If the clinician is not aware of this problem, then he or she can overestimate the actual reoffending risk (Johnson & Guyton, 2008).
Another difficulty of actuarial risk assessment is a merely statistical one. It is not possible to arrive to firm conclusions about an individual referring to aggregated data and its error rates. In this regard Cooke and Michie (2010) argue that group statistics might not allow precise predictions of risk in an individual case. They highlight that the accuracy of a prediction is undermined by:

> "The lack of reliability in the predictor and outcome variables; the relative weakness of the association between these variables; the inherent variability across individuals—and within individuals and their circumstances across time – and the multitudinous causes that result in violent crime." (Cooke & Michie, 2010, p. 270).

In sum, Cooke and Michie (2010) state that on the foundation of empirical results, statistics and logical reasoning, it is apparent that between-subject information does not allow a within-subject causal interference (Rorer, 1990, cited in Cooke & Michie, 2010).

Another consideration is that actuarial measures do not inform treatment staff, because it only incorporates unchangeable factors. Some authors argue that the violence risk a person poses is dynamic and flexible. It varies in regard to present levels of particular risk factors. Therefore, an increased awareness to changeable risk factors is important. It is assumed that targeting dynamic risk factors may reduce an individual's violence risk (Johnson & Guyton, 2008). Especially in offenders, who are detained preventively this point is of relevance. The goal should be to release them when they are not a danger to society anymore. So, ethical risk

assessment should inform treatment staff to give the offender patient a chance to be free again. This should also be the interest of the justice system.

SPJ tools do not offer clear algorithms or cut-off scores, but independence of clinicians. This independence also enhances flexibility. Even if an offender receives a very high score on the SVR-20, he or she has not to be deemed high risk. In addition, the assessor can give treatment recommendations. This is an advantage, however also a disadvantage, because then the assessor is not assisted by any empirical guidelines, which could increase biases and errors. Despite this imprecision, SPJ tools are used frequently and empirically tested (e.g., de Vogel, de Ruiter, van Beek & Mead, 1999).

However, it is also possible or even desirable, to use both methods. The result of the actuarial measure can function as an objective anchor and further work with SPJ tools can make the final estimation more flexible and tailor it to the individual offender patient (Johnson & Guyton, 2008).

Risk assessment has ethical implications. Especially when the risk assessment decides about preventive confinement, ethical issues have to be considered.

Ethical Implications

Jackson and Richards (2008) state: "The practice of civilly committing sex offenders remains controversial." (p. 184). They make this statement in regard to the US. However, this is certainly also true for Germany.

It all depends on the work of the assessor. The assessor should base his or her judgment on actuarial measures. However, as the offender already served his or her prison term, only highly dangerous offenders should be kept in captivity. Consequently, the expert cannot rely solely on actuarial measures. He or she should also incorporate dynamic factors, because confined offenders often receive treatment.

When the assessor is asked to evaluate the offender, if he should be confined in SV, he or she should be aware of certain ethical (and also clinical) issues: a) Labeling the offender patient; b) The evaluation is poorly regulated; c.) The performance of an extremely skilled and careful evaluation is necessary; d.) How to link the disorder to the criminal propensity (*Hang*).

First of all, labeling somebody as a sexually violent offender, who has to be confined, is stigmatizing. Importantly, the past offenses can only inform risk assessment. The establishment of future violence decides about preventive confinement. Thus, the evaluator should be very well informed, how to conduct assessments within such a framework.

Secondly, the assessment process is poorly regulated. There are no guidelines, how to perform such a specific assessment. Thus, the assessor depends solely on him or herself. Consequently, it is very important that he or she adheres to the highest standards of professional conduct.

This also involves that the assessor is able to estimate his or her own clinical skills and should seek supervision to handle difficult cases.

Finally, a very critical point is the difficulty to link a disorder (*Hang*) to criminal behavior. A thorough discussion of this point is beyond the scope of this paper. But, this remains one of the most difficult tasks the expert has to perform.

Johnson and Richards (2008) end their chapter with: "Individuals involved in SVP treatment programs or in conducting civil commitments for sex offenders should familiarize themselves with these issues." (p. 206).

Future Directions

As it became evident, risk assessment in repetitive sexual offenders is very complex and difficult. In accordance with the SORAG, offenders confined in SV have a very high recidivism risk, because they collected that many historical risk factors and cannot "get rid of them". If a clinician does not use the SPJ approach, these offenders have to be regarded as dangerous, even if they received numerous therapies and developed their personality in a positive manner.

It would be good to develop a risk assessment tool specifically for high risk populations. This research would face the following problems: a) Small sample size due to long periods of civil commitment; b) Biasing influences like selection bias; c) Problems with funding and practical issues; d) Low number of specific offenders and offenses (e.g. female offenders, sexual homicide offenders); e) Extremely long follow ups (at least 10 years). However, this research would contribute to the development of individually tailored risk assessment.

Another extremely relevant point is research on protective factors, because often offenders in SV acquired such a high degree of actuarial risk that only protective factors and changeable risk factors can change their status of a high risk offender.

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