

# Mental Health in Lebanese Prisons

*Prevalence Study of Severe Mental Illness  
among inmates in Roumieh and Baabda Prisons*

*Catharsis  
Lebanon, 2015*



catharsis  
LEBANESE CENTER FOR DRAMA THERAPY



Funded by the European Union.  
In collaboration with the Ministry of Interior and Municipalities and the Ministry of Justice.

## Foreword

In 2012, while facilitating a drama therapy session in Baabda Prison, inmate “F. M.” walked into the room. It was the first time she joined the sessions; she rarely left her cell. She was pale and hardly able to participate in the exercises. When I asked her about the duration of her imprisonment, she said: “My sentence doesn’t state it clearly, but I guess I am sentenced for life”.

Indeed, after inquiring about “F. M.”’s case, we knew that her sentence stated: “She has to be incarcerated in a special psychiatry unit until the appointed tribunal decides to end such incarceration upon evidence of “cured”. “F. M.” was known to be suffering from a mental illness. I quickly read the related articles in the penal code, called 4 judges and met with them (among them was the judge who issued the verdict) as I needed to understand how exactly can we, in the 21<sup>st</sup> century, be waiting for “the cure from insanity” (as stipulated in article 232 in the Lebanese penal code) for a mentally ill person? How can we still allow the use of the word “insane”? And didn’t science prove that mental illness can be managed and not “cured”? And that recovery comes with proper treatment?

I also met with decision makers and the prison administration<sup>1</sup> (officers from the Internal Security Forces, Members of Parliament, officials from both Ministries of Justice and Interior) as I needed to know if they knew that mentally ill inmates are being incarcerated with non-mentally ill inmates. There is no psychiatry unit in all Lebanese Prisons except for a small building

---

<sup>1</sup> Lebanese Prisons fall under the Internal Security Forces (ISF) control (the ISF are managed by the Ministry of Interior). A 2006 agreement signed by the Justice and Interior Ministries is set to transfer the prison administration to the Ministry of Justice, but this transfer did not take place until now.

in Roumieh Prison: the Blue Building that has never been refurbished as a psychiatry unit since the day it was built in 2002. Some knew, others didn't... However all agreed that mentally ill inmates have a "dead end" situation under the current articles of the Lebanese penal code related to mental illness.

I felt the urgency to know how many "F. M."s there were in Lebanese prisons... I wanted to know how mentally ill inmates were treated in other prisons worldwide, and most of all what sentences do they receive? Therefore, in 2013, with funding from the European Union, Catharsis, the Nonprofit Organization I founded in 2007, started the project "The Untold Story of Forgotten behind Bars". The project includes four main outputs: a study investigating the prevalence of severe mental illness among an inmate population in Lebanon (the study in your hands now), a legal research including a comparative law study and ultimately a draft law based on the findings of both previous outputs, and the production of a theatre play interpreted by inmates from Roumieh Prison (*some of them suffering from mental illness*).

The current study started in October 2014, where the research team appointed by Catharsis visited Roumieh and Baabda prisons for 2 months for data collection. The complete study saw the light in September 2015.

I am very grateful to each person who contributed, whether directly or indirectly, to this study. I acknowledge the effort and patience of each one and the challenges they faced. I hope the recommendations from this study become a reality as it will change the lives of many forgotten persons behind bars - some of whom have been in prison for over 35 years - and it will prevent a similar "life sentence" fate for future mentally ill inmates.

**Zeina Daccache**

Executive Director of Catharsis -LCDT

## Brief about Catharsis - Lebanese Center for Drama Therapy

Catharsis is the first Drama Therapy center in Lebanon and the Arab Region. It is a Nonprofit Organization founded in 2007 operating under the direction of Zeina Daccache - MA in Clinical Psychology, Registered Drama Therapist with the North American Drama Therapy Association (NADTA).

Catharsis promotes and offers therapeutic actions through the use of theatre and art processes for individuals and groups of all ages. It offers services and programs in various social, educational and therapeutic settings such as substance abuse treatment centers, mental health facilities, hospitals, correctional facilities, schools, theatres and corporations. Also at its private practice clinic, Catharsis provides therapy for individuals and groups who wish to explore various life problems and expand their quality of life, using the healing power of drama and the expressive arts.

### What is Drama Therapy?

Drama Therapy is the intentional use of drama and/or theatre processes to achieve therapeutic goals. It combines the aims and techniques of drama/theatre with those of psychotherapy allowing for an active role in healing the self in a safe environment.

### Catharsis in Lebanese Prisons

Catharsis has been working in Lebanese prisons, mainly in Roumieh Prison (with male inmates) since 2008 and in Baabda Prison (with female inmates) since 2011, where it offers continuous

drama therapy sessions. In several cases, the Drama Therapy sessions result in an artistic product - such as the pioneering theatre play and award-winning documentary “12 Angry Lebanese” presented by the male inmates of Roumieh prison in 2009 and the play “Scheherazade in Baabda” and award-winning documentary “Scheherazade’s Diary” presented by the women inmates of Baabda Prison in 2012/2013. The work gives the inmates a tool for self-advocacy, thereby communicating their message to the society and decision makers.

Catharsis’ work has served as an example during the last 8 years of practical implementation of social activities within prisons, in order to transform the latter into a reform center of delinquency rather than merely a place of punishment. It promotes the visibility of the inmates’ isolated conditions and helps reduce discrimination and intolerance towards them. In 2009, the play and documentary “12 Angry Lebanese” have pushed for the implementation of Law 463/2002 for the reduction of sentences upon good behavior. This law was issued in 2002 only to be implemented in 2009. Since March 2013, Catharsis has been implementing Drama Therapy sessions with the mentally ill inmates residing in the Blue Building in Roumieh Prison.

## Acknowledgments

**Special thanks for those who directly contributed to the drafting, editing, revision and finalization of this study.**

### Research team

Lucy Tavitian	(MA Psychology, Doctoral candidate at Tilburg University-Netherlands)
Raffi Elmadjian	(MA Psychology)
Sarar Maalouf	(MA Psychology)

### Research assistants

Sarkis Keshishian	(MA Psychology candidate)
Fatmeh Farhat	(MA Psychology candidate)
Hadi Naal	(BA Psychology)
Rosy Kuftedjian	(BA Psychology)

### Reviewers

Zeina Daccache	(MA Psychology, Registered Drama Therapist with the North American Drama Therapy Association - NADTA)
Marianne Kallassy	(BA Medical social work)
Soline Daccache	(Mental Health and Drama Specialist)

### Technical translation from English to Arabic

Soline Daccache

### Special Acknowledgment goes to the

Minister of Justice Major General Ashraf Rifi  
Minister of Interior and Municipalities Nohad Machnouk  
General Prosecutor at the Supreme court in Lebanon Judge Samir Hammoud  
Chief of the commission for the reduction of sentences Judge Hamza Charafeddine  
General Director of the ISF Major General Ibrahim Basbous  
Chief of Gendarmerie Brigadier General Joseph Helou  
Head of the ISF Health Department Brigadier General Amer Zaylaa  
General Elias Saade  
Chief of Central Prison General Georges Elias  
General Antoine Zekra  
Head of Roumieh prison's medical center Colonel Dr. Habib Al-Taqsh  
Head of the ISF Prison Department Colonel Ghassan Othman  
Chief of Block A Building in Roumieh Prison Capt. Ihab Abi Ghannam  
Director of Baabda prison Mrs. Christiane Abou Nahed  
First Sergeant Kamal Saghbini  
First Sergeant Elie Hleiheh  
Warrant Officer Hussein Mahdi  
Araya Medical Center  
The Psychiatry Department at the American University of Beirut Medical Centre  
Dr. Ziad Nahas  
Mrs. Layal Mroue  
Mr. Khalil Frayfer  
All the ISF members in Roumieh and Baabda prisons

### Special Thanks to

The European Union  
All the inmates who participated in this study

This publication has been produced with the support of the European Union. The contents of this publication are the sole responsibility of Catharsis-LCDT and can in no way be taken to reflect the views of the European Union.

*Dedicated to*

*“F.M” who has been the driving force behind this study...*

## Table of Contents

<b>I- Aims</b>	17
<b>II- The Lebanese prison context</b>	19
<b>III- Background and Significance</b>	21
1- Severe mental illness: Psychotic and Bipolar Disorders	21
2- Crime and severe mental illness	22
3- Prevalence of severe mental illness in prisons in some countries	22
<b>IV- Objectives and Hypotheses</b>	25
<b>V- Methods</b>	27
1- Ethical considerations	27
2- Sample	27
3- Instruments	28
4- Procedure	30
5- Data analysis	31
<b>VI- Results</b>	33
1- Demographics and other information as reported by the inmates	33
2- Stage 1: Screening for psychiatric symptoms	36
3- Stage 2: Interview phase	38
4- Information from the Legal Records	41
5- Medical Information	42
a- Self-report	42
b- Medical Records	42

<b>VII- The Blue Building: An overall assessment</b>	45
1- Procedure	45
2- Sample	46
3- Results	46
4- Information from the Legal Records	48
5- Medical Records	49
<b>VIII- Discussion</b>	51
1- Addressing study hypotheses and reviewing current findings	51
2- Other findings	62
3- Blue Building	63
4- Recommendations based on findings	65
<b>References</b>	69

## List of Figures

1-	Prevalence rate for Psychotic and Bipolar Disorders among <u>male</u> inmates in some countries	23
2-	Prevalence rate for Psychotic and Bipolar Disorders among <u>female</u> inmates in some countries	23
3-	Gender	33
4-	Nationality	33
5-	Marital Status	34
6-	Education Level	34
7-	Information on the legal status as reported by the inmates	35
8-	Type of the current crime as reported by the inmates	35
9-	Prevalence of PDSQ symptom classes among inmates in Baabda and Roumieh prisons (Part 1)	37
10-	Prevalence of PDSQ symptom classes among inmates in Baabda and Roumieh prisons (Part 2)	37
11-	Prevalence of PDSQ symptom classes among inmates in Baabda and Roumieh prisons (Part 3)	38
12-	Prevalence of SCID-NP research version diagnostic categories calculated in Baabda and Roumieh prisons	39
13-	Prevalence of Bipolar disorders and Primary Psychotic Disorders in Baabda and Roumieh prisons	41
14-	Legal information (from the legal records) about the inmates who screened positive for mood disorders or Psychosis at Baabda and Roumieh prisons	42
15-	Rates of the symptom categories screened at the Blue Building	47
16-	Legal information (from the legal records) about the inmates interviewed at the Blue Building	48

17-	Blue Building: The diagnoses (Before imprisonment) as listed in the ISF medical report	49
18-	Blue Building: The diagnoses (During imprisonment) as listed in the ISF medical report	50
19-	Prevalence rate of Bipolar Disorders: The general Lebanese population (Karam et al., 2006) VS. Inmates from Roumieh & Baadba prisons (Catharsis, 2015)	52
20-	Prevalence rate of Psychotic Disorders: The general Finnish population (Perälä et al., 2007) VS. Inmates from Roumieh & Baadba prisons (Catharsis, 2015)	53
21-	Comparison between prevalence rates from different countries (including Lebanon) for Primary Psychotic Disorders and Bipolar Disorders among <u>male</u> inmates	55
22-	Comparison between prevalence rates from different countries (including Lebanon) for Primary Psychotic Disorders and Bipolar Disorders among <u>female</u> inmates	55
23-	Findings from hypothesis 3 and hypothesis 4	60



## I Aims

Compared to the general population, prisoners have been found to have a higher prevalence rate for psychiatric illness (Senior et al., 2013) particularly in low to middle income countries (Mundt et al., 2013). Yet, the mental health care provision and screening for inmates has been less than optimal and criticized worldwide as inadequate and ineffective (Senior et al., 2013). In Lebanon, such services even in their minimal form are barely available to inmates. No official screening of mental health is conducted at intake, or during the incarceration period, and those incarcerated with a known mental illness receive a sentence of imprisonment until recovery. Indeed, article 232 in the Lebanese penal code states that “insane” prisoners should be incarcerated in a special psychiatry unit until the appointed tribunal decides to end such incarceration upon evidence of “cured from insanity”. However, no accurate definition is provided as to what insanity entails and mental illness is usually managed not cured just as any other chronic physical illness (e.g. diabetes, hypertension etc...). It is managed to achieve stability and restore functioning through interventions such as pharmacotherapy and/or psychotherapy. And in addition, there is no psychiatry unit in all Lebanese Prisons except for a small building in Roumieh Prison: the Blue Building that was never even refurbished as a psychiatry unit since the day it

was built in 2002. Therefore, it is necessary to revisit the existing Lebanese penal code in order to provide sound sentences, incarceration, and follow-up. The penal code related to mental illness in use today was written over sixty years ago and has not been revised since 1943. Psychiatry has advanced greatly since, thus, it is imperative that the law advances with it.

With a lack of laws protecting mentally ill inmates and a lack of screening protocol to detect mental illness in Lebanese prisons, the likelihood of committing crime, of assaulting and being assaulted by others increases among those suffering from psychiatric disorders (Wood & Buttaro Jr, 2013).

The aim of the current study is to investigate the prevalence of severe mental illness, and more specifically Bipolar and Psychotic disorders (See section III 1.), in a sample of male and female prisoners from Roumieh and Baabda prisons respectively. Findings from this study will help the endeavor to amend the current law related to mentally ill offenders and improve the conditions of mentally ill inmates currently held at Lebanese prisons. Estimating the prevalence of severe mental illness among prisoners is crucial for the development of mental health services and the prevention of crimes related to psychopathology (Vicens et al., 2011).

## II The Lebanese prison context

Lebanon has a total of 21<sup>2</sup> prisons (CLDH, 2010), out of which 4 are specific to women. And there are 2 additional prisons dedicated to minors. Mental health screening and care is absent in Lebanese prisons. The lack of such a service becomes even more concerning considering the fact that depression was the most chronic illness found among inmates in Lebanese prisons, as reported by the Internal Security Forces (ISF) on data from 2009 (National Health Statistics Report in Lebanon, 2012). Similarly, a survey conducted over three years (2009-2011) by the Kham Rehabilitation Center for Victims of Torture (KRC), reported depression to be the most common psychiatric condition in Lebanese prisons, followed by anxiety disorders (KRC, 2012). It is noteworthy that the report excluded data from Roumieh prison, where inmates who suffer from mental or physical illness and substance use disorders are customarily sent, despite the lack of specialized care (National Health Statistics Report in Lebanon, 2012).

The only facility available for mentally ill offenders is a building called the “Blue Building” in Roumieh prison. Inmates with a known mental illness are held at the “Blue Building”, which has been built in 2002 by an initiative of

<sup>2</sup> Tripoli (for men), Tripoli (for women), Nabatiyeh, Tyr, Jeb Jennine, Rachai, Baalbeck, Ras Baalbeck, Zahleh (for men), Zahleh (for women), Tebnine, Jbeil, Batroun, Halba, Amioun, Zgharta, Jezzine, Aley, Roumieh, Barbar Khazen (for women), Baabda (for women).

a mentally ill inmate family, specifically for his residence. In 1994, decree n° 6164 was published in the Penal Code stipulating that a section in Roumieh Prison will be specific to inmates who have received a sentence of imprisonment in a psychiatry unit. And practically, the “Blue Building” in Roumieh became that psychiatry unit. The decree includes articles necessitating the refurbishment of that unit to meet health standards essential for a psychiatric unit, and the medical equipment needed for the mental health care of inmates. Currently (2015), around 40 inmates are held at the “Blue Building” and the building has never been refurbished despite the decree. It remains ill equipped and unfit for the care of inmates suffering from mental illness.

Considering the primary aim of this research, it was found necessary to provide also information about inmates currently held in the Blue Building. Hence, our research was expanded to assess the condition of mentally ill offenders held in the Blue Building in Roumieh prison. (See section VII).

### III Background and Significance

#### 1- Severe mental illness: Psychotic and Bipolar Disorders

**Psychotic disorders** are severe mental illnesses characterized by severe disorganization in behavior and personality (Jablensky et al., 2000). Some examples of Psychotic Disorders include Schizophrenia, Schizoaffective Disorder, Brief Psychotic Disorder, and Delusional Disorder. Two of the main symptom categories for psychotic disorders are delusions and hallucinations. Delusions are characterized by false beliefs that can be persecutory or grandiose among others. Hallucinations are false perceptions, whereby an individual sees, hears, or feels things that are not actually present in his/her physical environment (*Diagnostic and statistical manual of mental disorders (DSM)*, 1994). Psychotic disorders have been shown to manifest within the third life decade, with a median in the early twenties and an increase in prevalence between the ages of 15 and 17 (Kessler et al., 2007).

**Bipolar disorders** are characterized by marked and unpredictable mood fluctuations that may range from mild to severe. Characteristic symptoms include mania, hypomania, and depression with or without psychotic features (*Diagnostic and statistical manual of mental disorders (DSM)*, 1994). A manic episode is characterized by a distinct period of abnormally expansive, elevated, and irritable mood lasting at least one week, and

accompanied by at least three symptoms from a list that includes decreased need for sleep, pressured speech, distractibility, flight of ideas, grandiosity, and inflated self-esteem, among others. Hypomanic episodes share similar features with manic episodes but must be present for 4 days instead of 1 week (*Diagnostic and statistical manual of mental disorders (DSM)*, 1994).

Both Psychotic and Bipolar Disorders are of great public health concern as they are associated with elevated risk for self-harm and death by suicide (Winokur & Tsuang, 1975).

## 2- Crime and severe mental illness

Compared to the general population, crime whether violent or non-violent, seems to be elevated among individuals suffering from severe mental illness (Seena Fazel, Grann, & Psych, 2006; Seena Fazel, Lichtenstein, Grann, Goodwin, & Långström, 2010; Hodgins, 1992). Legal involvement has been shown to be elevated among individuals suffering from mania (Christopher, McCabe, & Fisher, 2012) and psychotic disorders, more specifically those with comorbid substance use (Tiihonen, Isohanni, Rasanen, Koiranen, & Moring, 1997).

## 3- Prevalence of severe mental illness in prisons in some countries

Figures 1 and 2 below present the prevalence rate for Psychotic and Bipolar Disorders among inmates in some countries.

Figure 1

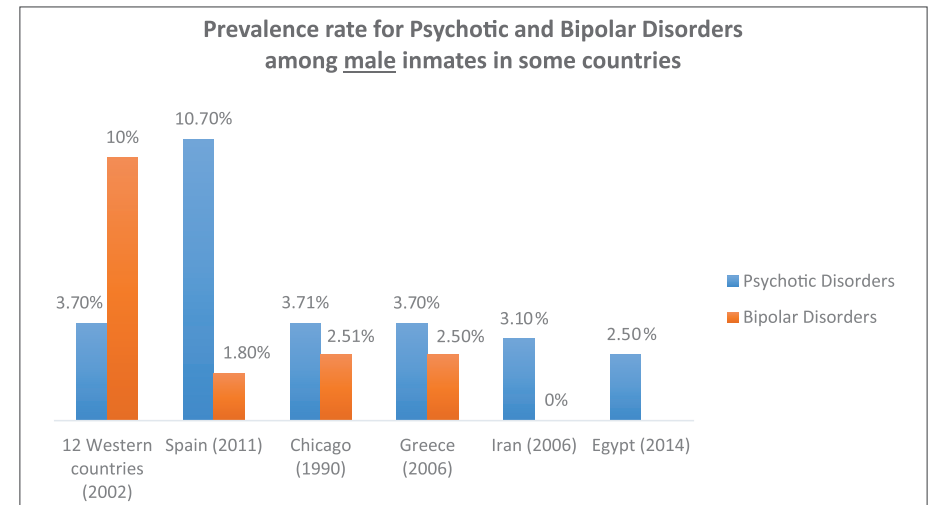
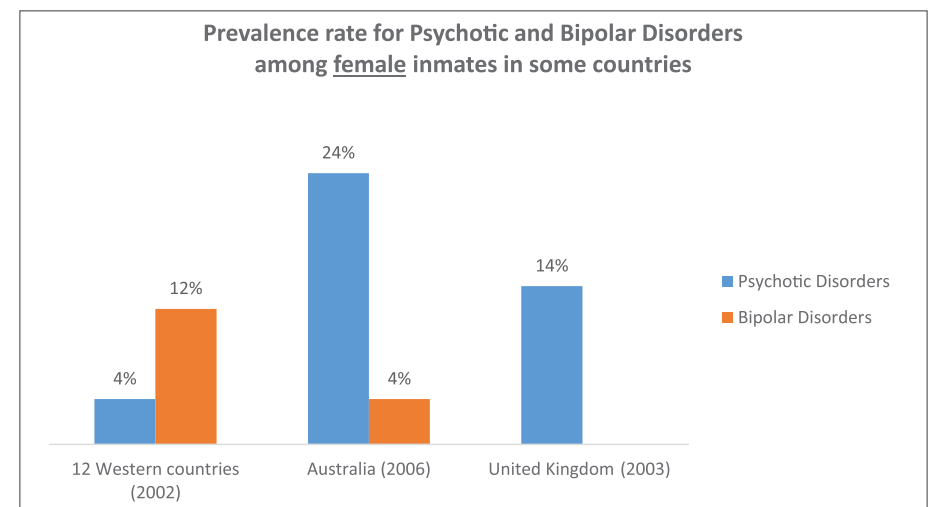


Figure 2



It is to be noted that a number of studies on the prevalence of psychiatric morbidity in the Middle East have been conducted but they are not comparable due to methodological differences. Nevertheless, they provide important insights in relation to the status of mental health among inmates. The most recent information comes from Egypt, where a 2.5% prevalence of psychotic symptoms (See Figure 1) was noted in a convenience sample of 80 male inmates (Ibrahim, Halim, Wahab, & Sabry, 2014). In another study by Assadi, et al. (2006) using the SCID-IV, 3.9% of detainees were diagnosed with current psychotic disorders and 48.7% with current mood disorders. Prevalence rates for specific disorders were not reported.

## IV Objectives and Hypotheses

The objective of the current study is to investigate the prevalence of psychiatric disorders, and more specifically Bipolar and Psychotic disorders, in a sample of male and female prisoners from Roumieh and Baabda prisons respectively (not including the Blue Building in Roumieh). Due to the lack of data on the prevalence of psychiatric illness within Lebanese prisons, and in light of the above research findings, the below exploratory hypotheses are proposed.

*Hypothesis 1* We expect to find a higher rate of prevalence of psychotic and bipolar disorders among the inmates compared to what is reported in the general population.

*Hypothesis 2* We expect to find a number of undiagnosed inmates who in the frame of this study screen positive for a serious psychiatric illness (psychotic and bipolar disorders) and are residing within the residences for non-psychiatrically ill inmates.

*Hypothesis 3* We expect to find a number of inmates who in the frame of this study screen positive for a serious psychiatric illness (psychotic and bipolar disorders) with an onset age prior to imprisonment, however the illness was not taken into consideration in the sentences of those who already received a verdict.

*Hypothesis 4* We expect to find a number of inmates who have developed a psychiatric illness during their stay in prison.

*Hypothesis 5* We expect to find a number of sentenced inmates who in the frame of this study, screen positive for a serious psychiatric illness (psychotic and bipolar disorders) and it is mentioned in their sentence that they should be incarcerated in a special psychiatry unit, but they are residing within the residences of non-psychiatrically ill inmates.

## V Methods

### 1- Ethical considerations

Prisoners are classified as vulnerable populations due to the involuntary nature of incarceration which makes them prone to coercion and undue influence (Schwenzer, 2008). To ensure the rights of inmates, an informed consent was drafted highlighting the aim and procedures of the research, as well as the time needed to complete the study instruments. Inmates were assured that confidentiality will be maintained. The informed consent also stated that participation is completely voluntary and the inmate could withdraw from the study at any point with no consequences ensued. Inmates were also assured that their decision to take part in or withdraw from the study would neither influence their relationship with Catharsis-Lebanese Center for Drama Therapy, nor influence their incarceration status, relation with guards, or their legal status. All inmates were required to read the consent form and indicate their approval through their signature. Research assistants were available for questions and assistance, specifically for illiterate inmates.

### 2- Sample

A total of 277 inmates, 261 from Roumieh and 16 from Baabda prisons met the study inclusion criteria (aged 18 years and above, who have a sentence of

three years and above) and were therefore eligible for participation. Of the 277 approached, 212 accepted to participate and completed the research protocol. The mean age of the sample was 39.71 with a minimum of 19 and a maximum of 84. **Participants were 198 males** (Mean Age=39.81) from one building in Roumieh prison (Block A building), **and 14 females** (Mean Age=38.17) from Baabda prison.

### 3- Instruments

Two instruments and a demographic sheet were used in the current study. Screening for psychiatric symptoms was completed using the Psychiatric Diagnostic Screening Questionnaire-PDSQ (Zimmerman & Mattia, 1999) and Psychiatric interviews were carried out using the Structured Clinical Interview for DSM-IV-TR Axis I Disorders - Research Version (First et al., 2002).

After completing a demographic form, all participants were administered the PDSQ. Following scoring of the PDSQ, participants screening positive for mania and/or psychosis were interviewed using the Structured Clinical Interview for DSM-IV-TR Axis I Disorders - Research Version<sup>3</sup>.

*Socio-demographic form:* The demographic form collected information on nationality, date of birth, gender, marital status, number of children, education

<sup>3</sup> The rights for using the Structured Clinical Interview for DSM-IV-TR Axis I Disorders - Research Version (SCID) and translating it into Arabic were obtained by Ms. Lucy Tavitian. For any info and enquiries, please contact Ms. Tavitian.

level, past imprisonment and type of past crime, type of current crime, whether he/she is awaiting sentence or already sentenced, duration of the current sentence, number of years (months) spent in prison and number of months until release in case he/she is sentenced.

*The Psychiatric Diagnostic Screening Questionnaire-PDSQ (Zimmerman & Mattia, 1999):* The PDSQ is a brief self-report scale designed to screen for the most common psychiatric disorders. The PDSQ includes 13 subscales screening for Depression, Post Traumatic Stress Disorder (PTSD), Bulimia, Obsessive Compulsive Disorder (OCD), Panic Disorder, Agoraphobia, Social Phobia, Alcohol Abuse, Substance Abuse, Psychosis, Anxiety Disorders, Somatization, and Hypochondriasis.

In the current study, the Arabic version of the PDSQ<sup>4</sup> was used. The scale was translated by the research team at the Psychiatry Department at the American University of Beirut Medical Centre. Catharsis got their permission for using the Arabic translation.

*The Structured Clinical Interview for DSM-IV-TR Axis I Disorders - Research Version (First et al., 2002):* The Structured Clinical Interview for DSM-IV Axis I disorders (SCID-I) is a semi-structured interview for making the major DSM-IV Axis I diagnoses. It has a clinical and a research version with 10 modules and is administered to adults aged 18 and above to diagnose current and

<sup>4</sup> For any info and enquiries concerning the Arabic translation of the PDSQ, please contact the Psychiatry Department at the American University of Beirut Medical Centre.



past history of mental illness. In the current study, four modules (A, B, C, D) of the research non-patient version of the SCID were used to diagnose Mood disorders<sup>5</sup> and Psychosis.

#### 4- Procedure

The current study employed a two-stage design. During the first stage, participating inmates were screened for psychiatric symptoms using the PDSQ (Zimmerman & Mattia, 1999).

Following stage 1, participants who screened positive for psychosis (subscale score  $\geq 1$ ) and mania (subscale score  $\geq 2$ ) were eligible for stage 2, where the SCID-NP research version (First, et al 2002) was administered in colloquial Arabic by the researchers and trained research assistants; each module was translated by teams of two, and a committee approach was employed to discuss the quality, accuracy, and flow of the translations. Following translation, the research assistants received training on the use of the SCID-NP, the rules and guidelines of Modules A, B, C, and D, making clinical judgments in relation to criteria of the SCID, and general skills necessary for psychiatric interviews.

Data from stage 1 were collected over 5 working days (4 days in Roumieh and 1 in Baabda). After giving their

---

<sup>5</sup> Mood disorders include, among others, major depressive disorder (MDD) and moods which cycle between mania and depression known as bipolar disorder (BD). Mood disorders may also be substance-induced or occur in response to a medical condition.

consent to participate, inmates proceeded to complete the PDSQ and the demographic sheets. The research team was readily available to provide assistance when needed. Following stage 1, inmates screening positive for psychosis and/or mania were interviewed using the SCID-NP research version. Seven interviewers carried out the interviews over 4 days in Roumieh prison and one day in Baabda prison. Inmates were seated such that their privacy was safeguarded to the extent the prison environment permitted.

#### 5- Data analysis

The data were analyzed using the Statistical Package for Social Sciences version 21 (SPSS 21). Sample characteristics were reported using descriptive statistics.



## VI Results

### 1- Demographics and other information as reported by the inmates

Figures 3, 4, 5, 6, 7 and 8 below present the self-reported sociodemographic and legal situation characteristics of the study sample. The majority of inmates were Lebanese (67.4%), had an elementary level of education (26.4%), and were married (36.8%) with children (31.6%). The mean number of children was 2.41.

Figure 3

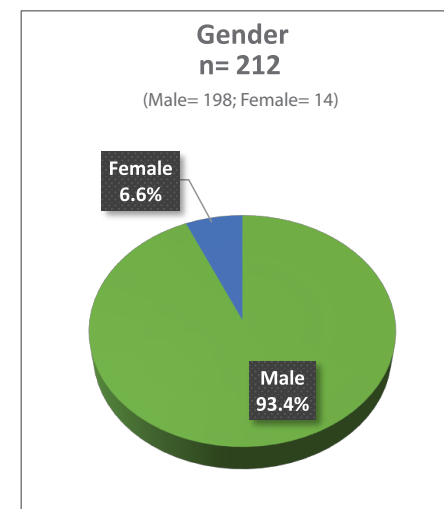


Figure 4

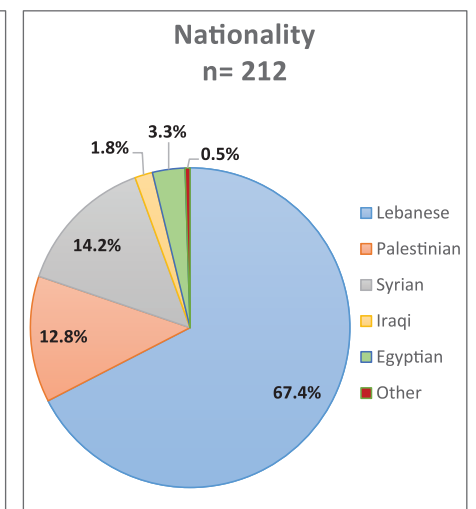


Figure 5

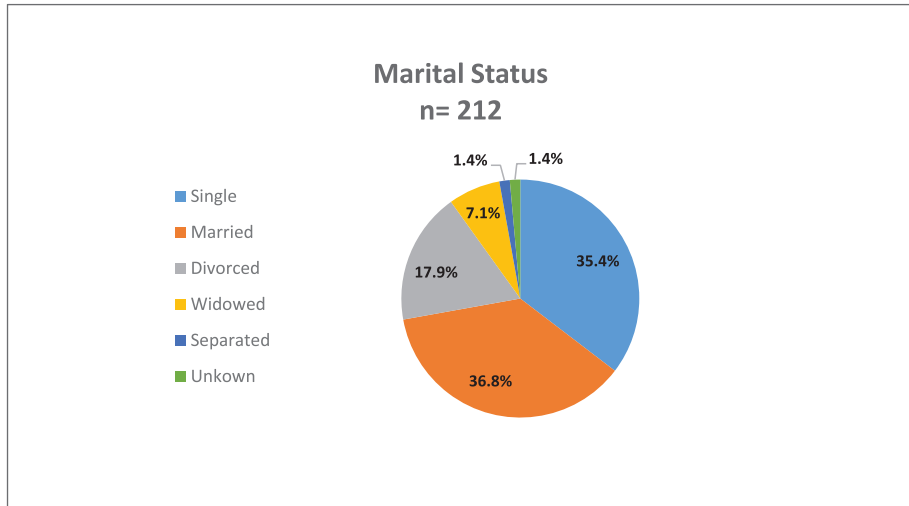


Figure 6

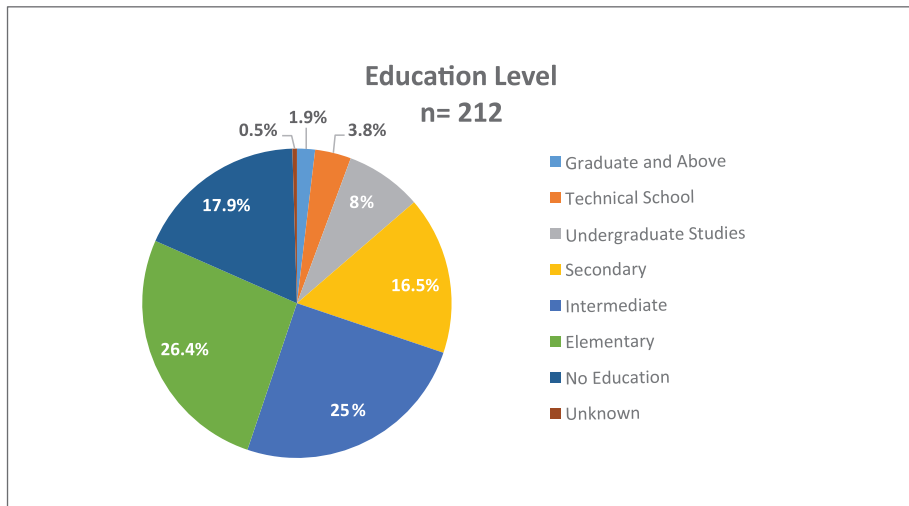


Figure 7

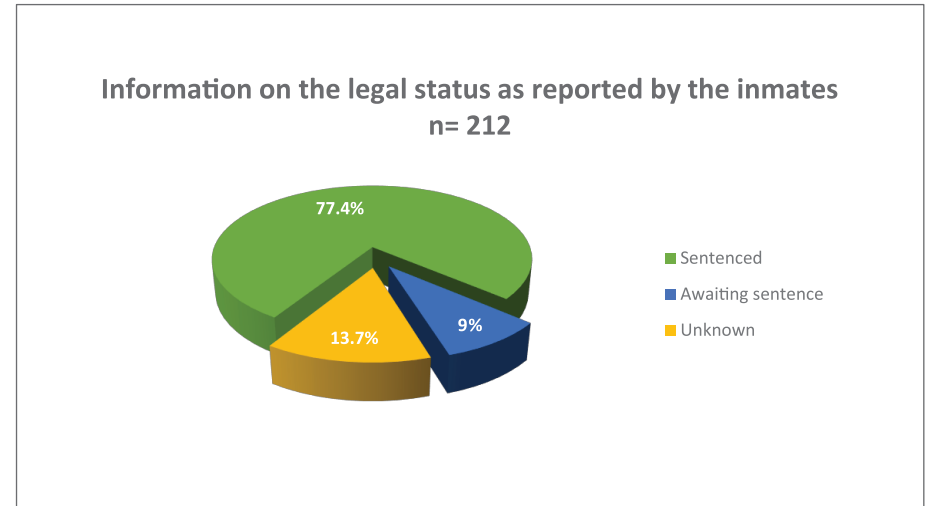
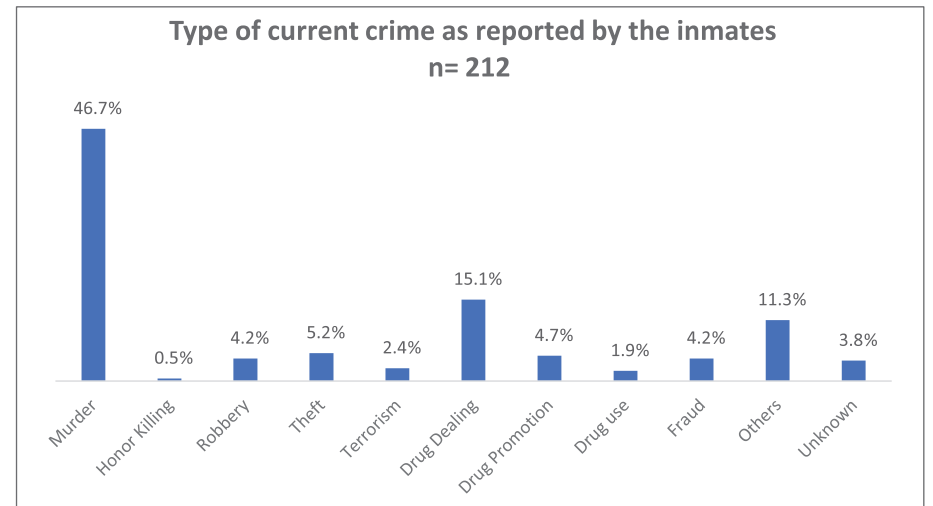


Figure 8



## 2- Stage 1: Screening for psychiatric symptoms

Figures 9, 10 and 11 depict the prevalence of PDSQ symptom classes among inmates in Baabda and Roumieh prisons. Depression was the most prevalent symptom class (62.3%), followed by PTSD (59.9%), Alcohol Abuse (47.6%), and Somatization Disorder (44.8%). It is worth noting that the prevalence of OCD was 76.4%; however the items were misconstrued and attributed to cleanliness and caution over ones belongings which are valued in the prison setting. As such, interpretations with regards to OCD should be approached with extreme caution. The prevalence rate for psychiatric symptoms was higher among females for all subscales but for alcohol and substance abuse subscales which were more prevalent among males. As for mania and psychosis prevalence rates, they were comparable across genders. Comorbidities were also observed as a result of the PDSQ<sup>6</sup>.

Figure 9

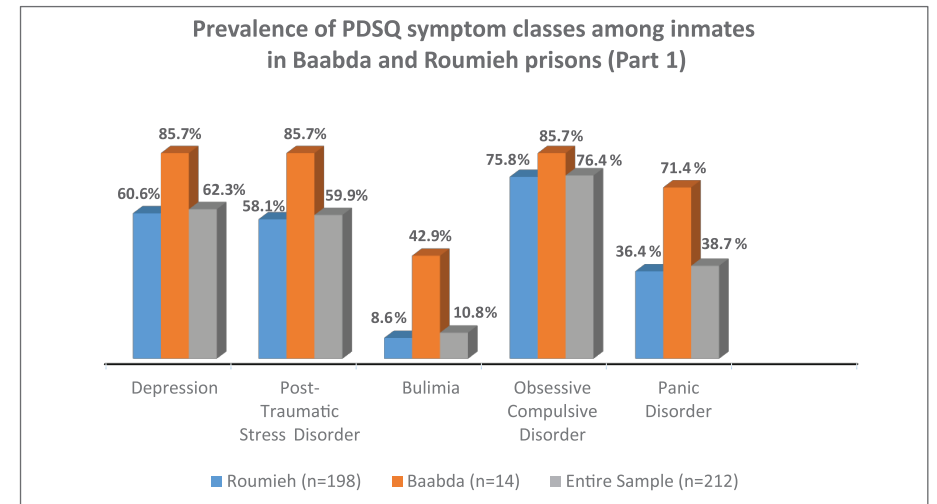
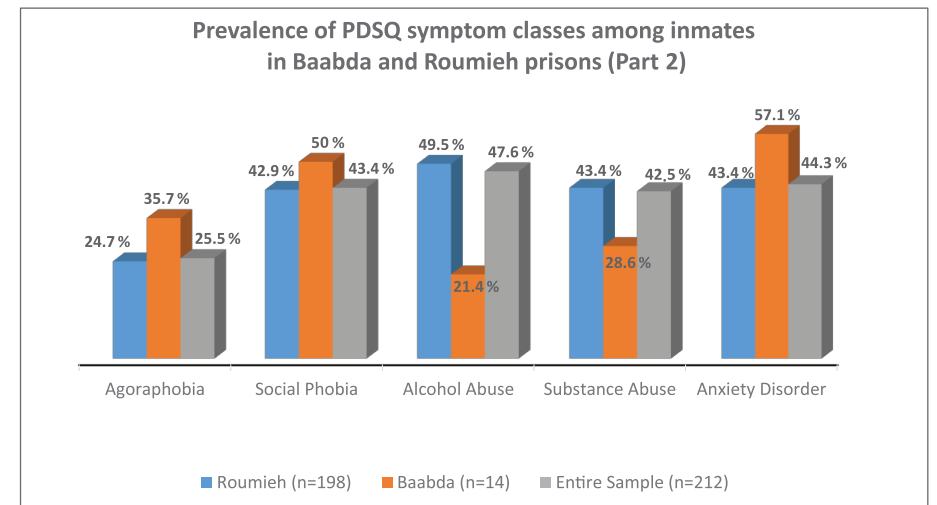
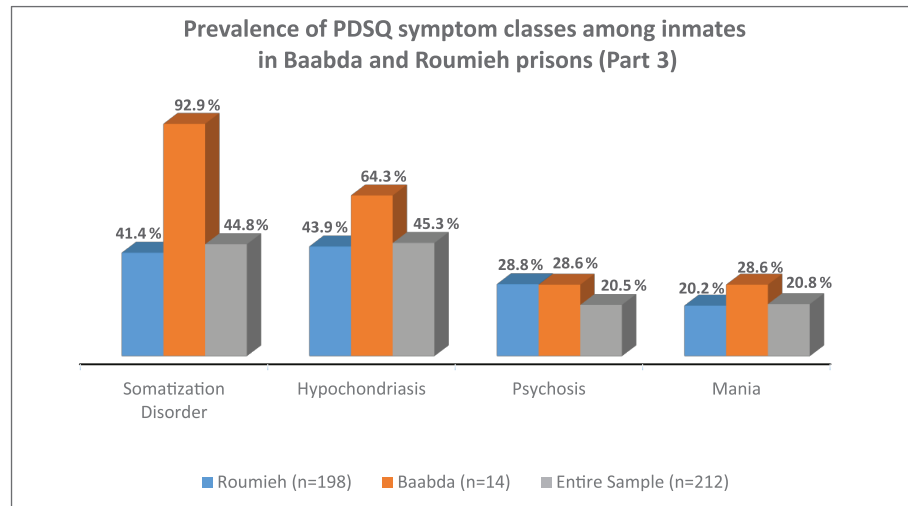


Figure 10



<sup>6</sup> Please contact Catharsis should you wish to have more info about the observed comorbidities as it is part of the full study.

Figure 11



### 3- Stage 2: Interview phase

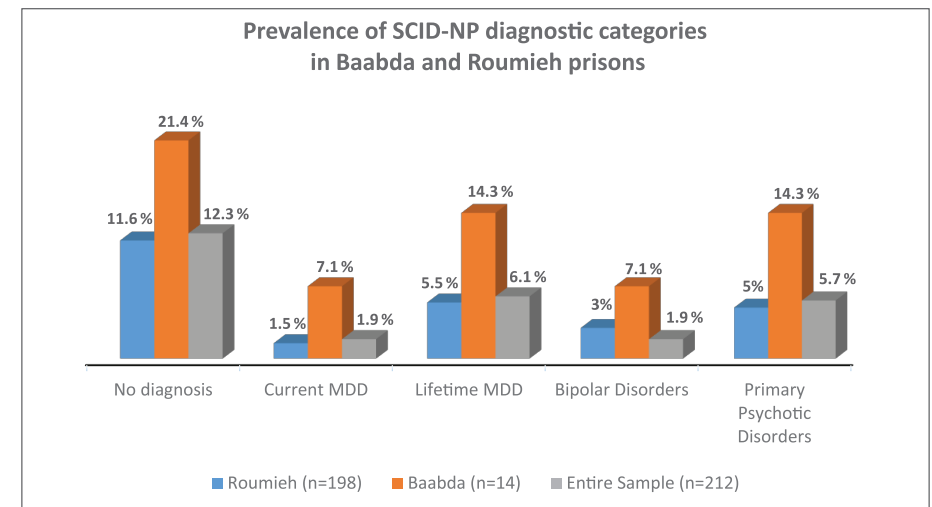
The screening phase (stage 1) indicated that a total of 79 (70 male; 9 female) inmates (37.3%) were eligible for stage 2 of the study. At the time of the interviews (administration of SCID), of the 79 eligible inmates, 20 inmates could not be reached for different reasons<sup>7</sup>. As such a total of 59 inmates (out of the original 79) were administered the SCID-NP research version (First et al., 2002). Six of the interviews were conducted with the inmate as well as a friend, cellmate, or incarcerated family member of the inmate and/or the social workers at Catharsis. This was done due to the inability of the inmate to provide coherent and reliable information. The rest of the interviews were conducted with the inmates themselves. The mean

<sup>7</sup> Seven were transferred to another prison, three were released, four were at tribunal, two refused to participate and four were asleep.

age of interviewees was 37.36 and their average time spent in prison was 9.2 years.

Of the 59 interviewed inmates, 33 (55.93%) were positive for any one category of the assessed psychiatric disorders (Mood Disorders and Psychosis). Calculated from a total of 212 inmates, the prevalence rate of any one category of the assessed psychiatric disorders (Mood Disorders and Psychosis) was 15.6% (33 out of 212). Figure 12 presents the prevalence of SCID-NP diagnostic categories calculated from the entire sample.

Figure 12

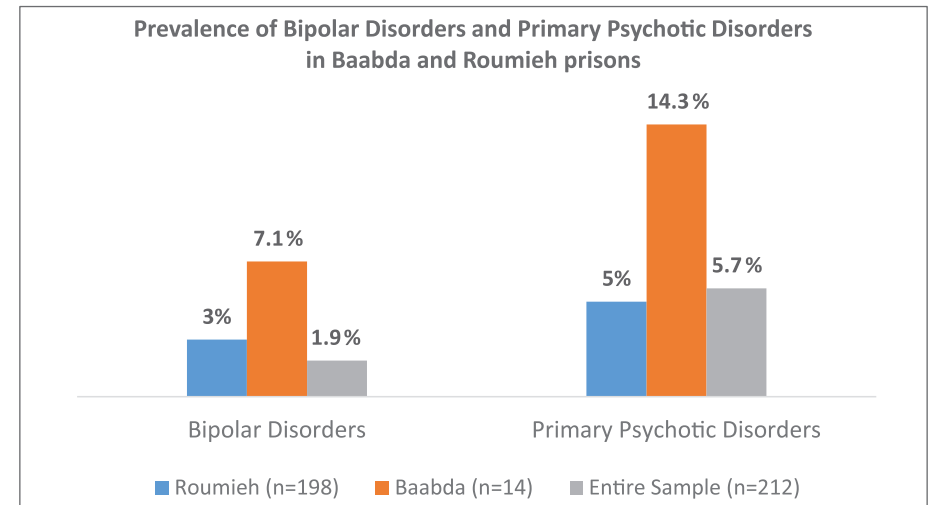


While no comorbid diagnoses were found among inmates in Baabda prison, comorbid Dysthymia, in addition to current and lifetime MDD, were found among 6 inmates in Roumieh prison.

Disorder onset age was available for 29 of the 33 inmates. 45.45% (n=15; 4 in Baabda and 11 in Roumieh) of inmates reported an onset age prior to imprisonment, and 42.42% (n=14; 1 in Baabda and 13 in Roumieh) reported that their symptoms started in prison, while the disorder onset age was not available for 12.12% (n=4). Disorder onset age was higher for inmates in Baabda (Mean Onset age=30.40) compared to inmates in Roumieh (Mean Onset age=26.92) with an overall mean age of onset at 27.52.

According to the SCID-NP, 20% of inmates screened at stage 2 (n=59) had Primary Psychotic Disorders and 6.8% had Bipolar Disorders and considering the entire sample of 212, the prevalence rate for psychotic and bipolar disorders is 5.7% and 1.9% respectively (See Figure 13 below).

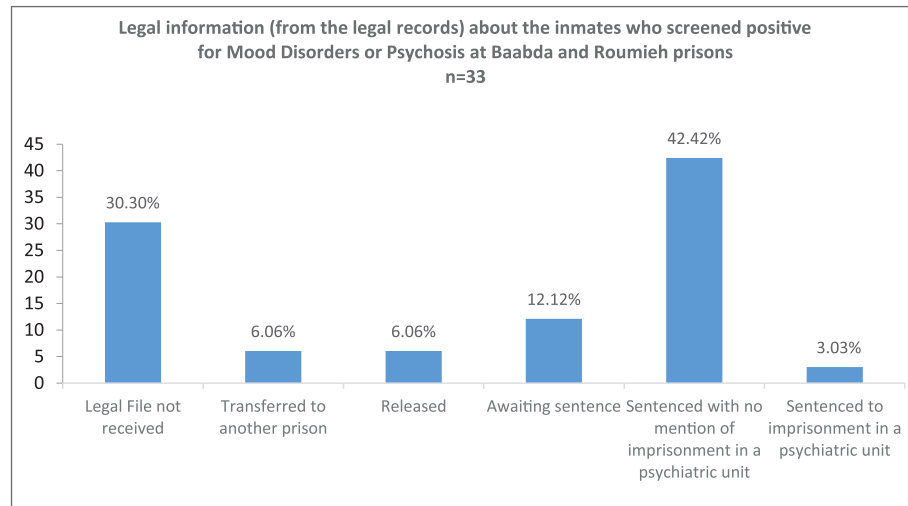
Figure 13



#### 4- Information from the Legal Records

Although the legal files of the 33 inmates positive for any of the assessed psychiatric disorders (Mood Disorders and Psychosis) were requested, information for only 23 out of 33 were received. Of the 23 inmates, two inmates from Roumieh prison were transferred to other prisons making the retrieval of their files difficult, and two were released. Four were still awaiting their sentences (two from Roumieh and two from Baabda), and 15 had been sentenced. Of the 15 sentenced inmates, only one inmate from Baabda prison had been recognized as mentally ill and had received a sentence of imprisonment in a psychiatry unit “until cured”, despite the fact that there is no psychiatric unit in Baabda or in any other prison, except in Roumieh for males.

Figure 14



## 5- Medical Information

### a- Self-report

Eight of the 33 inmates reported taking psychiatric medication and two reported past use of medication. Of these ten inmates, 2 inmates were taking 2 and 3 medications respectively. Five inmates provided the name of the medication which included Triptizol (n=3), Anafranil (n=1), Seroquel (n=1), Depacin (n=2), Atarax (n=1).

### b- Medical Records

A medical report summarizing the medical records of 33 inmates positive for any of the assessed psychiatric disorders (Mood Disorders and Psychosis) was requested and received from both prisons' Medical Centers that are managed by the Internal Security Forces (ISF). Six of the 33 inmates had been diagnosed with a mental illness. Specifically, at entry to prison, only one inmate

from Baabda prison was diagnosed with Chronic Psychotic Disorder and Acute Depression, for which she was being treated by medication. During their stay in prison, 5 inmates (4 from Roumieh and 1 from Baabda) were diagnosed for a psychiatric illness and were prescribed medication for their respective diagnoses. Two inmates were diagnosed with Major Depression and comorbid Insomnia, one inmate was diagnosed with Major Depression with a suicide attempt, one with anxiety Disorder, and one with Acute Psychosis with persecutory delusions and hallucinations. In total, the 6 inmates were placed on medication. Specifically, 2 inmates were on two classes of medication, 2 were on three classes of medication, 1 was on five classes of medication and 1 was placed on only one class of medication. The medication classes prescribed were: Antidepressants (n=6), anticonvulsants (n=2), antipsychotics (n=2), benzodiazepines (n=2), sedatives (n=1), sleeping medication (n=1), antihistamines (n=1), and medication aimed at reducing blood cholesterol levels. Of the 6, the medication regimen was discontinued for 3 inmates, one in 2003, one in 2014 and, one in early 2015 with no specification of reasons.

## VII The Blue Building: An overall assessment

Considering the primary aim of this research, it was necessary to provide information about inmates currently held at the Blue Building. Hence, our research was expanded to assess the condition of mentally ill offenders held at the Blue Building in Roumieh prison.

### 1- Procedure

Data collection at the Blue building of Roumieh prison was conducted in one working day. The interviews took place in a small hall where inmates customarily watch television. After obtaining the consent, the interviewers proceeded with completing the SCID. However, completing the SCID was not possible due to a number of difficulties. The first main obstacle to conducting a full SCID was the inmate's poor communication of their psychiatric history. In such cases, the SCID could be conducted with a friend, a family member, a nurse, or even a warden who knew the interviewee well enough to provide accurate psychiatric history. However, none of the wardens knew the inmates well enough to provide such information.

Due to these factors the interview approach was adjusted to screen for symptoms instead of disorders. The interviewers therefore inquired about medication status, the presence of substance abuse, delusions, hallucinations, manic symptoms, depressive symptoms,

and suicide ideation using questions from the SCID. When possible, information about past history of these symptoms was collected.

## 2- Sample

Out of the 40 inmates residing in the building, 27 inmates were interviewed; the rest either refused or were not available for interviewing. All interviewees were male with an age range of 19 to 70 and a mean age of 40.42 (n=24, as 3 persons didn't know what to answer). Seventeen were single, six were married, and four were not able to respond to the question on their marital status.

## 3- Results

The only legal information reported by the inmates (and not retrieved from the legal records) was the duration of imprisonment available for 20 inmates, with a minimum of 3.5 months and a maximum of 37 years.

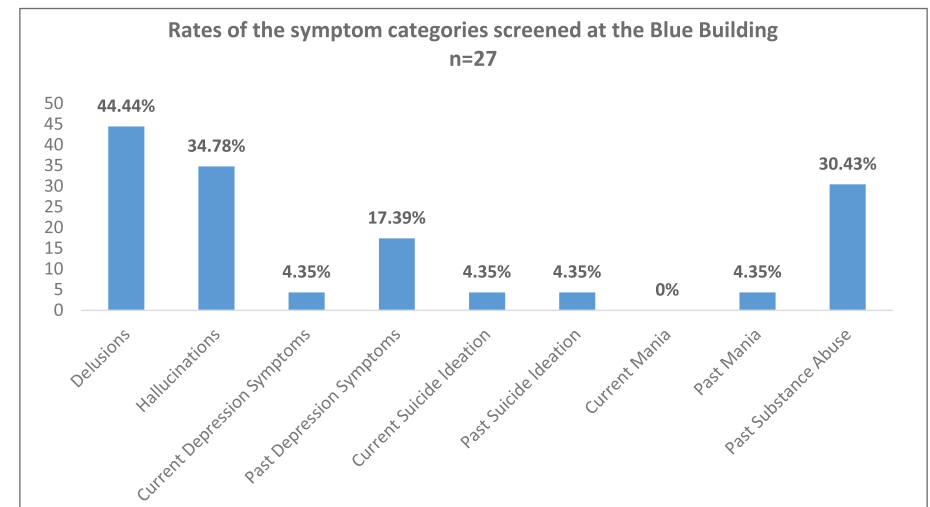
Most of the inmates reported taking psychiatric medication (n=22; 81.48%) and two (7.4%) reported not taking any medication for mental illness, and information on the medication status of three (11.11%) was unclear. The most commonly prescribed class of medication was antipsychotic medication. Twelve (44.44%) inmates had never been admitted to a psychiatric hospital while 10 (37.03%) reported that they have been hospitalized for treatment of a mental illness prior to imprisonment. Information on history of psychiatric hospitalization

was unclear for 5 inmates (18.52%).

Figure 15 presents the rates of symptom categories screened in the Blue Building: delusions, hallucinations, past and present depression, past and present suicide ideation, past and present mania, and substance use. Twelve (44.44%) of the interviewed inmates screened positive for delusions, eight (34.78%) screened positive for hallucinations, and one screened positive for past mania (4.35%). One inmate was currently depressed and suicidal (4.35%) and reported on-going auditory hallucinations.

A number of inmates were not interviewed due to the severity of their impairment.

Figure 15

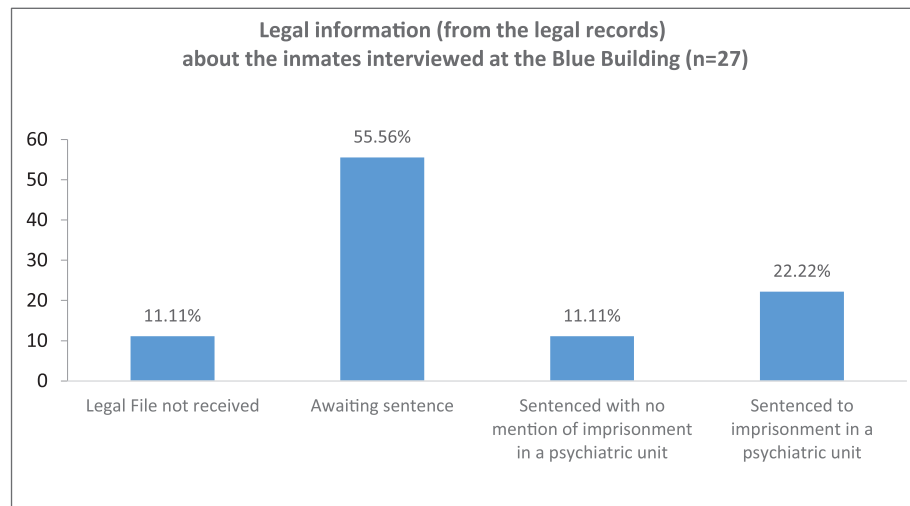




#### 4- Information from the Legal Records

The legal records of the 27 inmates held at the Blue Building were requested and information for a total of 24 was received. As presented in Figure 16, among the 24 inmates, 15 were awaiting their sentences, 9 were sentenced (6 for murder - among them one with an additional homosexuality charge - and 1 for attempted murder and for 2 inmates the charges were unclear). Six among the 9 sentenced had received a sentence recognizing them as mentally ill and therefore stating that they should be imprisoned in a psychiatry unit “until cured”, which in their case is the Blue Building.

Figure 16



#### 5- Medical Records

A medical report summarizing the medical records of 24 out of the 27 inmates screened in the Blue Building was received from Roumieh prison’s Medical Center that is managed by the ISF. Figures 17 and 18 present the diagnoses as listed in the ISF medical report (diagnoses before and during imprisonment).

Figure 17

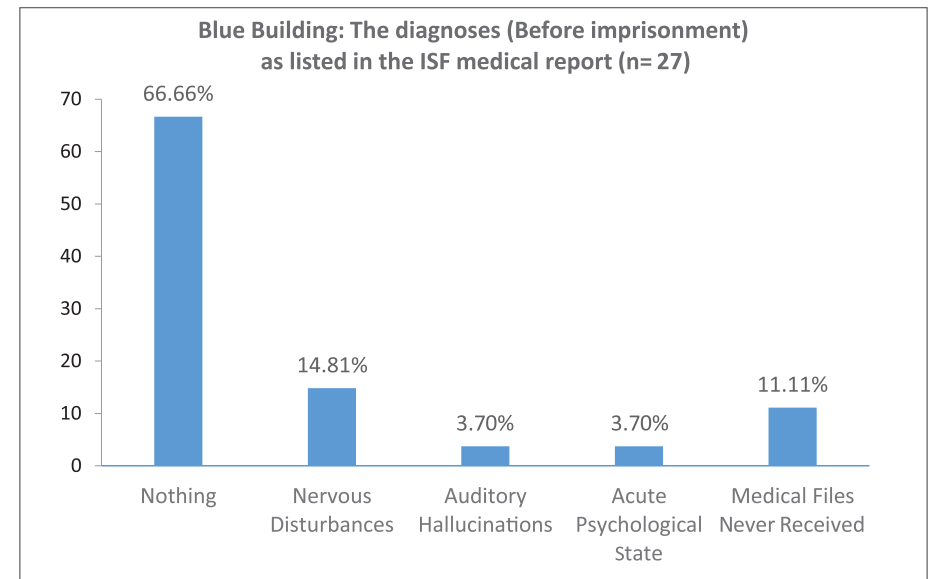
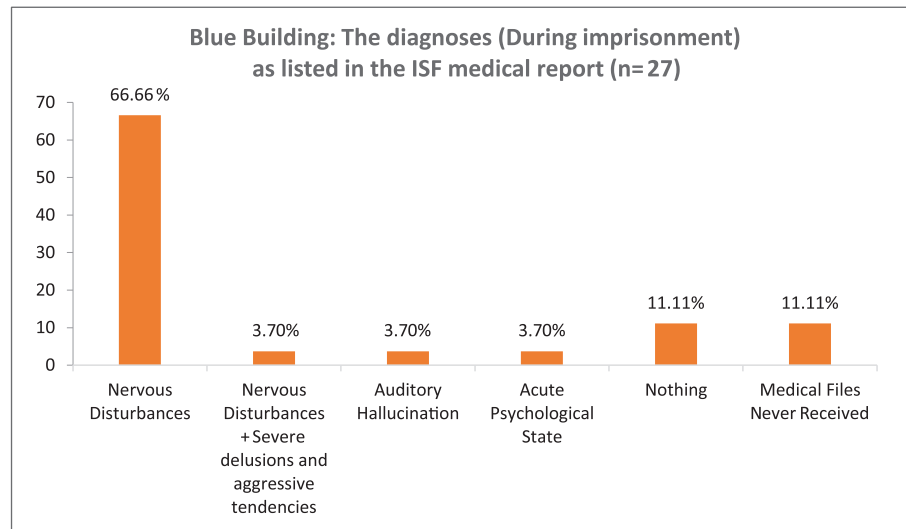


Figure 18



It is noteworthy that the diagnoses of “nervous disturbance” and “acute psychological state” are not featured in any diagnostic tool customarily used in psychiatric assessment (e.g. DSM-V, ICD-10).

As per the medical report received from Roumieh prison’s Medical Center 3, inmates (2 among them sentenced to imprisonment in a psychiatric unit “until cured”) were listed as having “nothing” (no mental illness) neither before entering prison nor during their imprisonment. Moreover, no medication has ever been prescribed to these 3 inmates during their incarceration at the Blue Building.

## VIII Discussion

The aim of the current study is to investigate the prevalence of severe mental illness in a sample of male and female prisoners from Roumieh and Baabda prisons respectively. A two stage design was employed whereby inmates were screened for psychiatric symptom classes using the PDSQ (Zimmerman & Mattia, 1999) and those scoring positive for psychosis and/or mania were administered a structured clinical interview using the SCID (First et al., 2002). A secondary goal developed after completion of data collection and expanded on inmates residing in the Blue Building in Roumieh Prison as such information is relevant to this project.

### 1- Addressing study hypotheses and reviewing current findings

Our **first hypothesis** (Hypothesis 1) stated that a higher prevalence rate for Psychotic and Bipolar Disorders would be found among the inmates compared to what is reported in the general population.

With regards to Bipolar Disorders the current study found an overall prevalence rate of 1.9% which is higher compared to the prevalence of 1.5% for Bipolar Disorders reported in a study on the prevalence of psychiatric disorders in the general Lebanese population (Karam et al., 2006) (See Figure 19).

As for Primary Psychotic Disorders, the current study found an overall prevalence rate of 5.7%. To the best of our knowledge, no study has assessed the prevalence of Primary Psychotic Disorders in the Lebanese general population however in a study assessing the prevalence of psychotic disorders in a community sample in Finland a 3.06% lifetime prevalence rate was found (Perälä et al., 2007) which is lower than the rate found in our prison population (See Figure 20).

Our findings are consistent with previous research indicating a higher prevalence rate for mental illness in prisons compared to the general population. Considering the vulnerable status of inmates in general (Schwenzer, 2008) and the lack of access to medical care in Lebanese prisons in particular, such a rate necessitates rigorous assessment at intake, and follow-up at incarceration (Steadman et al., 2009).

Figure 19

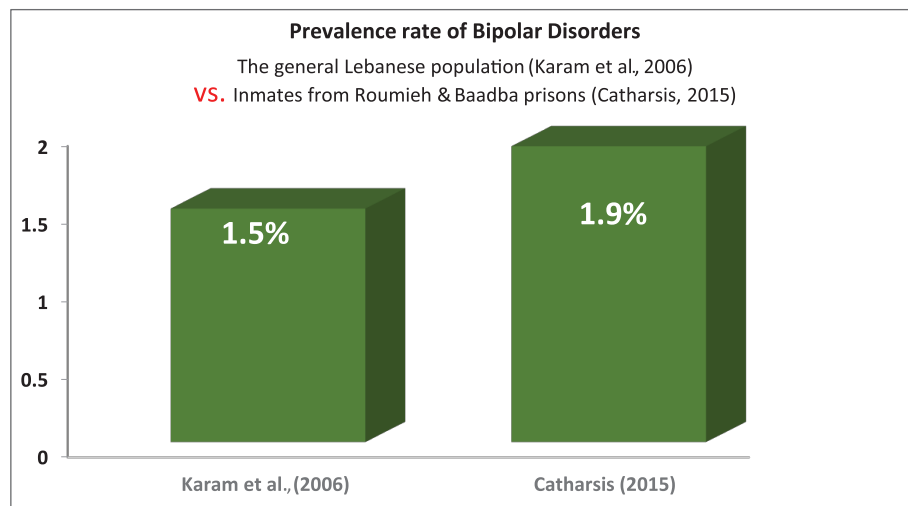


Figure 20

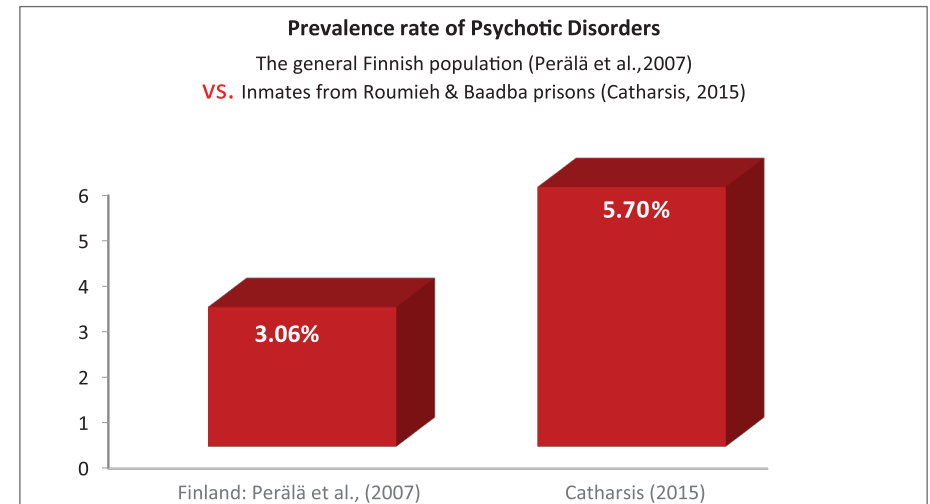


Figure 21 and Figure 22 display a comparison between prevalence rates from different countries (including Lebanon) for Primary Psychotic Disorders and Bipolar Disorders among male inmates and female inmates respectively. In the current study, the prevalence rate for Primary Psychotic Disorders among male inmates is 5% which is higher than the 3.1% and 2.5% found in Iran (Assadi et al., 2006) and Egypt (Ibrahim et al., 2014) respectively. The current rate was also higher than the 3.7% prevalence rate reported in a systematic review of 62 surveys from 12 Western countries (S. Fazel & Danesh, 2002). Also in the current study, the prevalence rate for Primary Psychotic Disorders among female inmates is 14.3% which is higher than the 5% rate found among male inmates. And this rate (14.3%) is considerably higher than the 4% reported in a systematic review of 12 Western countries (S. Fazel & Danesh, 2002) but

comparable to the 14% found in a study assessing the prevalence of psychiatric illness in a sample of adult female offenders in the United Kingdom (O'Brien, Mortimer, Singleton, & Meltzer, 2003).

Bipolar disorders were found in 3% of males and 7.1% of females. The prevalence rate of Bipolar Disorders found in our study among male inmates is slightly higher than the 2.5% found in a Greek sample of male inmates (Fotiadou, Livaditis, Manou, Kaniotou, & Xenitidis, 2006). Our prevalence rate for Bipolar Disorders among male inmates is not comparable to the Iranian study which did not find any inmate with a Bipolar Disorder (Assadi et al., 2006) or to the study conducted among male inmates in Egypt where Bipolar Disorders were not assessed (Ibrahim et al., 2014). The prevalence rate for Bipolar Disorders for females in our study (7.1%) was higher than the 12 month rate of 4% reported in a study of Australian female inmates (Tye & Mullen, 2006).

Figure 21

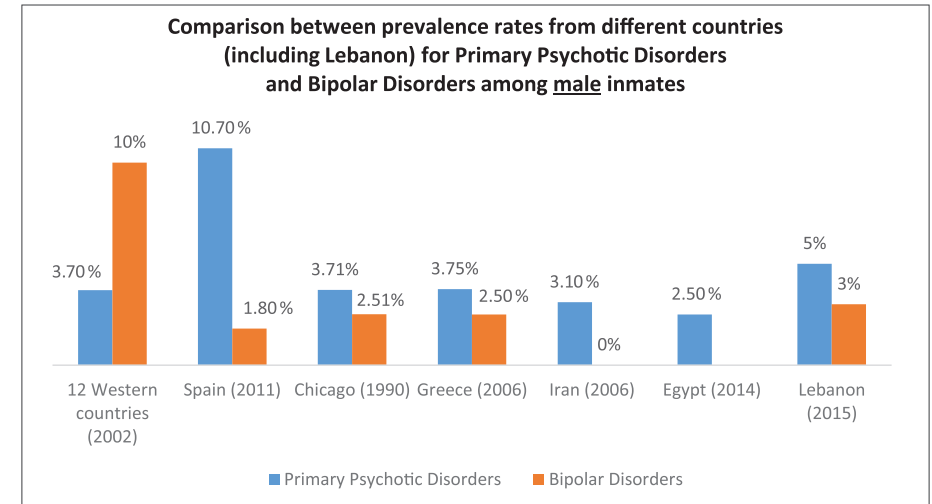
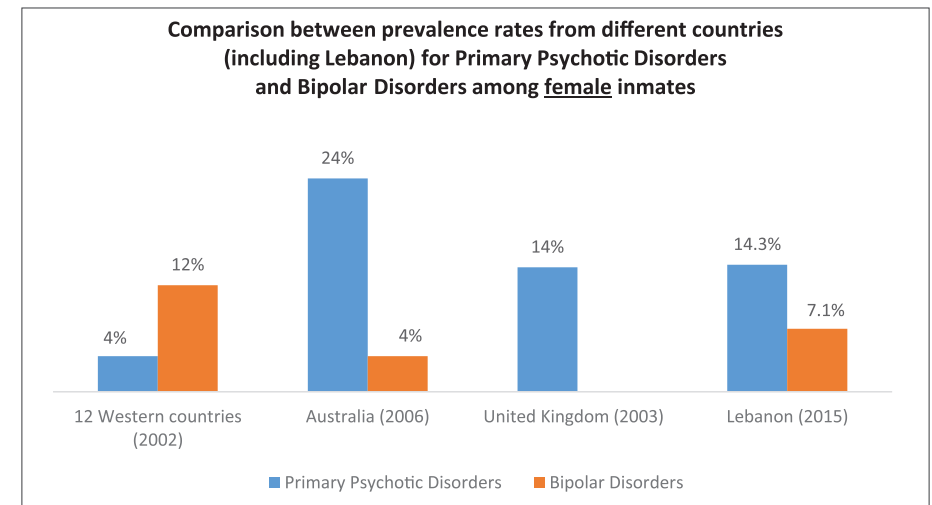


Figure 22



Our **second hypothesis** (Hypothesis 2) stated that we would find a number of undiagnosed inmates, who, in the frame of this study, screen positive for a serious psychiatric illness (Psychotic and Bipolar Disorders) and are residing within the residences for non-psychiatrically ill inmates.

As stated in point VI 5.b. (Medical Records), 33 inmates screened positive for any of the assessed psychiatric disorders (Mood Disorders and Psychosis) as a result of the SCID administration, among them only 6 were listed in the medical report received from both prisons' Medical Centers (the ISF medical report) as diagnosed with a mental illness, which means that 27 mentally ill inmates suffering from Mood Disorders or Psychosis were never diagnosed previously. It is to be noted that out of the 6 previous diagnoses done by the ISF, 3 did not match our diagnoses (done in the present study). All of the 33 inmates are residing within the residences of the non-psychiatrically ill inmates.

Since the focus of our study is more on serious psychiatric illness (psychotic and bipolar disorders), our study (using SCID) found a total of 16 inmates suffering from psychotic or bipolar disorders, among them only 4 were listed in the ISF medical report. While these 4 inmates screened positive for psychotic disorders as per our diagnosis, only 2 were listed in the ISF medical report as having psychotic disorders, and the other 2 were diagnosed with insomnia and comorbid depression, a diagnosis that doesn't match ours. Hence the question, what are the criteria used when assessing psychiatric illness among inmates and what are the qualifications of those assessing the inmates? The discrepancy between our diagnoses as generated

by the SCID-NP research version, and that found in the ISF medical report is an example of what could happen if psychiatric follow-up is not continuous, based on valid criteria and conducted by trained psychiatrists. The following question is also raised: Why would inmates, already known by the ISF as suffering from a mental illness, reside within the residences for non-psychiatrically ill inmates? It is to be noted that article 76 of the Lebanese penal code states that in case a prisoner "goes insane" while serving his sentence, he should be incarcerated in a special psychiatry unit where he will receive special care.

To conclude, 12 inmates (11 males and 1 female) among the 16 diagnosed with primary psychotic disorder or bipolar disorders were not reported to have any mentally illness in the ISF medical report and all 16 of them are residing within the residences for the non-psychiatrically ill inmates. This is a specifically troubling finding as it indicates a lack of screening of illnesses among inmates and a lack of specialized care for inmates who are in dire need for it. Research has indicated that untreated severe mental illness is associated with increased risk for self-harm and suicide attempts (Winokur & Tsuang, 1975), and elevated risk for violent behaviour (Swartz et al., 2014).

As stated in our **third hypothesis** (Hypothesis 3), we expected to find a number of inmates, who, in the frame of this study, screen positive for a serious psychiatric illness (psychotic and bipolar disorders) with an onset age prior to imprisonment, however the illness was not taken into consideration in the sentences of those who already received a verdict.

Among the 16 inmates diagnosed with either Primary Psychotic Disorder or Bipolar Disorders in the frame of this study, a total of 8 inmates' symptom onset age was reported to be before incarceration. Among them, 4 were sentenced and only 1 inmate from Baabda Prison among the 4, was recognized as mentally ill and sentenced to imprisonment in a specialized psychiatric unit until the appointed tribunal decides to end such incarceration upon evidence of "cured". This confirms our hypothesis, which states that 3 inmates, as per their symptom onset age, were mentally ill at incarceration yet their mental illness was not taken into consideration in the sentences they have received. Consequently, they have been sentenced as non-psychiatrically ill individuals. Such a finding calls into question the validity of inferences drawn from the inmates' trials.

Of the 4 remaining inmates who reported their symptom onset age to be before incarceration, we were unable to know the legal status of 1 and the 3 others were still awaiting sentences. Will these 3 inmates have their illness taken into consideration at the trials?

Research has shown that criminal defendants who suffer from psychotic disorders or severe psychopathology are incompetent to stand trial when compared to defendants who do not suffer from any psychiatric illness (Nicholson & Kugler, 1991; Pirelli, Gottdiener, & Zapf, 2011).

It is to be noted that among the 8 remaining ones from the 16 diagnosed with either Primary Psychotic Disorder or Bipolar Disorders, 4 were unsure of their symptom onset age and all of them had received a sentence not taking into consideration their illness.

The remaining 4 reported their symptom onset age to be after incarceration.

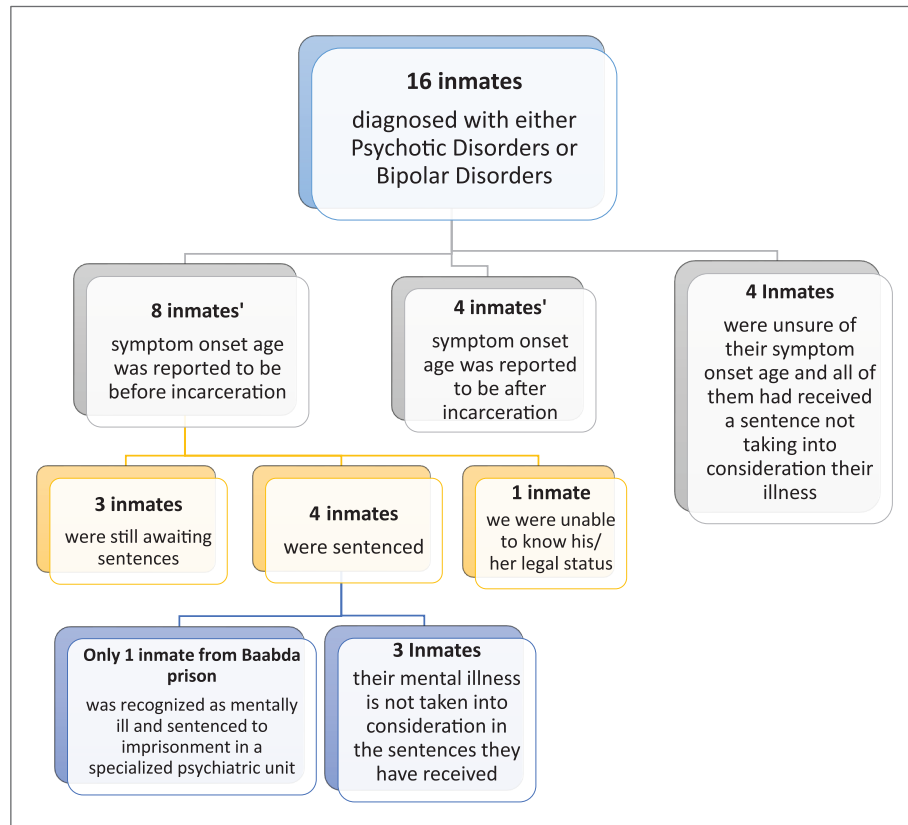
In our **fourth hypothesis** (Hypothesis 4), we expected to find a number of inmates who have developed a psychiatric illness during their stay in prison.

Our hypothesis was confirmed as 14 of the 33 inmates (42.42%; n=33), diagnosed with Mood Disorders and Psychosis, reported a symptom onset age that fell within their stay in prison.

And 4 out of the 16 inmates (25%; n=16), diagnosed with a serious psychiatric illness (Primary Psychotic Disorder and Bipolar Disorders), reported a symptom onset age that fell within their stay in prison. This indicates the need for continued monitoring and psychiatric care after incarceration (Vicens et al., 2011).

Figure 23 depicts findings from hypothesis 3 and hypothesis 4.

Figure 23



In our **fifth hypothesis** (Hypothesis 5), we expected to find a number of sentenced inmates, who, in the frame of this study, screen positive for a serious psychiatric illness (psychotic and bipolar disorders) and it is mentioned in their sentence that they should be incarcerated in a special psychiatry unit, but they are residing within the residences of non-psychiatrically ill inmates.

Among the 16 inmates diagnosed with either Primary Psychotic Disorder or Bipolar Disorders in the frame of this study, a total of 11 inmates have already received a sentence. **Only one inmate from Babbda Prison was sentenced to imprisonment in a specialized psychiatric unit but she is still residing with non-psychiatrically ill inmates.**

When questioned on the matter, prison authorities stated that this is due to the lack of psychiatric units in prisons (only the blue building in Roumieh) and that none are specific for females. Such a response is inaccurate; as decree n° 6164 of the Penal Code doesn't include any statement specifying the Blue Building as a male only psychiatric unit. Although the inmate in question has been prescribed psychiatric medication, she lacks the specialized care and follow-up needed for better symptom management. The need for continued care has been recognized as essential for the reduction of risk for multiple incarcerations among inmates with severe mental illness (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009).

Although Major Depression and Substance Abuse were not part of our objectives in this investigation, the high prevalence rate warrants mention.

A general prevalence of around 22% (n=59) was found for Lifetime Major Depressive Disorder at stage 2 of this study in both Roumieh and Baabda prisons, which is 6.1% of the entire sample (n=212). And a general prevalence of around 6.8% (n=59) was found for Current Major Depressive Disorder which is 1.9% (n=212) of the



entire sample. Such results are in line with results seen in similar studies. Ibrahim, Halim, Wahab, & Sabri (2014) suggested some factors that contribute to the high prevalence of depression (82.5%) in Egyptian prisons, namely: emotional isolation, continuous monitoring, lack of intimacy, and frustration. Add to that, conditions we observed at the two studied prisons: crowding, sleep disruption, nutritional deficiencies, substance abuse, poor health care and hygiene just to mention a few (Ibrahim et al., 2014). Of interest is that a few of the inmates in Roumieh prison indicated hope at incarceration time, but lost it and developed depressive symptoms all along the length of incarceration.

Our study found a high prevalence rate for substance abuse symptoms (43.4% among males and 28.6% among females).

## 2- Other findings

Out of the 33 inmates positive for any of the assessed psychiatric disorders (Mood Disorders and Psychosis), a total of eight inmates reported their current use of psychiatric medication and two reported their past use of medication; only one of the inmates' medication regimen was featured in the medical report sent to us by both prisons' Medical centers (the ISF medical report). This means that a total of nine inmates had been taking psychiatric medication and were regularly receiving it but this is not stated in their medical records. One might argue that the medications are used as illegal substances; however the reported medication classes

were two antidepressants, an antipsychotic, a sedative and an anticonvulsant. Of these medications, only the sedative (Atarax) has the propensity to be abused as a drug (Allgulander, Ljungberg, & Fisher, 1987) the rest do not. That said, why are these 9 inmates receiving psychiatric medication if such information is not featured in their medical records? Who is monitoring the dose, frequency of use, and side effects of these medications? The medication classes as highlighted above are not typically used as drugs and they are not readily available to the public. Does this mean that a prescription was made by a physician with no record being kept of such a prescription?

## 3- Blue Building

Although since 1994, as per decree n° 6164, a building (Blue Building) in Roumieh prison has been dedicated to mentally ill offenders, the services available are far less than optimal. In-house psychiatrists, trained psychiatric nurses and psychotherapists are absent. Detainees in the Blue Building are all male and are supervised and cared for by wardens who lack the necessary psychiatric training. This not only places a strain on inmates but also on the wardens in charge. While a holding facility currently exists, it is somehow specific for male inmates with a known mental illness, while the decree does not specify it as such. Which begs the question of why women offenders with a known psychiatric illness sentenced to imprisonment in a psychiatric unit are not placed in the Blue Building? Therefore, the improvement of the conditions in the



Blue Building and the assignment of one floor of the Blue Building for female mentally ill offenders are of paramount importance.

Based on the medical and legal information received, two of the inmates interviewed by our team had received a sentence of imprisonment in a psychiatry unit “until cured”, yet the ISF medical report states “nothing” (no mental illness) and no medication has been prescribed to these inmates. Therefore, if not mentally ill, why did these two inmates receive a sentence of imprisonment in a psychiatry unit? Based on what criteria are sentencing decisions being made?

Another inmate interviewed in our study was still awaiting his sentence and had no mention of any psychiatric illness in his medical record, yet again he was placed in the Blue Building. This raises another concern. Who is assessing these inmates after their incarceration, while awaiting their sentence, and deciding whether they should be placed in a specialized unit or not? Why is an inmate with no record of mental illness in his medical record placed in a facility recognized for mentally ill offenders?

What is striking about the diagnoses done by the physicians appointed by the Internal Security Forces during imprisonment is the use of the term “nervous disturbances” which appeared for a staggering number of 19 inmates to delineate their mental illness. First, such a diagnostic label does not exist in any of the diagnostic manuals customarily used to date (DSM-V; ICD-10) which begs the question,

what criteria are being used to diagnose the inmates? The term “nervous disturbances” is a lay term used by non-mental health professionals to describe mental illness that can range from mild Depression to Schizophrenia. The term in no way specifies which of the many psychiatric diagnoses the inmate suffers from. Therefore, on what basis are different medications being prescribed to different individuals who are all labeled as having a “nervous disturbance”? The use of such a vague, broad, and lay term calls into question the validity of the assessment procedure and the subsequent prescription of medication.

#### **4- Recommendations based on findings**

The current study highlights the need for restructuring the sentencing process of arrested individuals in Lebanon. There is a dire need of looking at whether these individuals are competent to stand trial, whether they have any psychiatric illnesses prior to incarceration and whether they developed any psychiatric illness during incarceration.

Although it is one of the most frequently required evaluations in Western countries (Melton, Petrila, Poythress, & Slobogin, 2007), assessing competency to stand trial is absent in Lebanon. Assessing competency of arrested individuals focuses on the individuals’ current capability of law comprehension, and of following legal actions, and of ability to work with their lawyer on their defense (Heilbronner, 2011). Many evaluation instruments exist (Ryba, Cooper, & Zapf, 2003). Competency should be assessed by

clinicians, using these questionnaires and standardized interviews, while being diligent on avoiding personal biases, and working on integrating clinical observations with psycholegal conclusions (Skeem & Golding, 1998). People who are deemed incompetent are not eligible to go through a conventional trial process; hence different measures need to be taken. Research has repeatedly shown that people with psychosis are deemed incompetent to stand trial (Cooke, 1969; Hart & Hare, 1992; Reich & Wells, 1985; Roesch, 1979; Rogers, Gillis, McMain, & Dickens, 1988; Ryba et al., 2003). Additionally, Cooper & Zapf (2003) found that individuals who received a non-psychotic major diagnosis (such as post-traumatic stress disorder or major depression) were more likely to be found incompetent to stand trial, as opposed to those with a non-psychotic minor diagnosis (such as personality disorder or adjustment disorder), and to those diagnosed with an alcohol or drug use disorder (Ryba et al., 2003).

To provide proper treatment for prisoners suffering from a mental illness, it is crucial to separate them from prisoners who have no such ailments. To achieve that, a quick assessment at intake can be performed using tools specifically designed for the prison setting. One such instrument is the Brief Jail Mental Health Screen (BJMHS) (Steadman et al., 2009), an 8-item questionnaire used to quickly screen detainees for the presence of a mental health disorder at intake. Administering the BJMHS takes a few minutes, and it indicates whether there is a need for further psychiatric

evaluation. Another such instrument is the Correctional Mental Health Screen for Men (CMHS-M) and for Women (CMHS-W). This is a 12-item questionnaire designed for early detection of psychiatric illness during the jail intake process. The CMHS will show whether there is a need for referral for further evaluation (Ford, Trestman, Wiesbrock, & Zhang, 2009). Such tools are designed to be quick and effective and can be administered by an officer or a warden.

A number of the inmates in the current study reported experiencing psychiatric symptoms after entering prison. This indicates the need for continuous screening for mental illness after incarceration. This would prevent suicide attempts as well as the aggravation of mild symptoms into pathology. Hopelessness and depression are the most commonly observed precursors for suicide attempts in prison (Daniel, 2006). Considering the nature of prison environments (Ibrahim et al., 2014) it is not uncommon for inmates to experience bouts of subthreshold depression, anxiety, and hopelessness. Screening may be completed by wardens at intervals of three to six months using brief inventories as the BJMHS (Steadman et al., 2009) or the CMHS (Ford et al., 2009).

## References

- ALLGULANDER, C., LJUNGBERG, L., & FISHER, L. (1987). Long-term prognosis in addiction on sedative and hypnotic drugs analyzed with the Cox regression model. *Acta Psychiatrica Scandinavica*, 75(5), 521-531.
- ASSADI, S. M., NOROOZIAN, M., PAKRAVANNEJAD, M., YAHYAZADEH, O., AGHAYAN, S., SHARIAT, S. V., & FAZEL, S. (2006). Psychiatric morbidity among sentenced prisoners: prevalence study in Iran. *The British Journal of Psychiatry*, 188(2), 159-164.
- BAILLARGEON, J., BINSWANGER, I. A., PENN, J. V., WILLIAMS, B. A., & MURRAY, O. J. (2009). Psychiatric disorders and repeat incarcerations: the revolving prison door.
- CHRISTOPHER, P. P., MCCABE, P. J., & FISHER, W. H. (2012). Prevalence of involvement in the criminal justice system during severe mania and associated symptomatology. *Prevalence*, 63(1).
- COOKE, G. (1969). The court study unit: Patient characteristics and differences between patients judged competent and incompetent. *Journal of Clinical Psychology*.
- DANIEL, A. E. (2006). Preventing suicide in prison: a collaborative responsibility of administrative, custodial, and clinical staff. *Journal of the American Academy of Psychiatry and the Law Online*, 34(2), 165-175.
- Diagnostic and statistical manual of mental disorders (DSM)*. (1994). American Psychiatric Association.

- FAZEL, S., & DANESH, J.** (2002). Serious mental disorder in 23000 prisoners: a systematic review of 62 surveys. *Lancet*, 359(9306), 545-550. doi: 10.1016/s0140-6736(02)07740-1
- FAZEL, S., GRANN, M., & PSYCH, C.** (2006). The population impact of severe mental illness on violent crime. *The American Journal of Psychiatry*, 163(8), 1397-1403.
- FAZEL, S., LICHTENSTEIN, P., GRANN, M., GOODWIN, G. M., & LÄNGSTRÖM, N.** (2010). Bipolar disorder and violent crime: new evidence from population-based longitudinal studies and systematic review. *Archives of general psychiatry*, 67(9), 931-938.
- FIRST, MICHAEL B., SPITZER, ROBERT L, GIBBON MIRIAM, AND WILLIAMS, JANET B.W.:** Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Non-patient Edition. (SCID-I/NP) New York: Biometrics Research, New York State Psychiatric Institute, November 2002.
- FORD, J. D., TRESTMAN, R. L., WIESBROCK, V. H., & ZHANG, W.** (2009). Validation of a brief screening instrument for identifying psychiatric disorders among newly incarcerated adults. *Psychiatric Services*, 60(6), 842-846.
- FOTIADOU, M., LIVADITIS, M., MANOU, I., KANIOTOU, E., & XENITIDIS, K.** (2006). Prevalence of mental disorders and deliberate self-harm in Greek male prisoners. *International Journal of law and psychiatry*, 29(1), 68-73.
- HART, S. D., & HARE, R. D.** (1992). Predicting fitness to stand trial: The relative power of demographic, criminal, and clinical variables. *Forensic Reports*.
- HEILBRONNER, R. L.** (2011). Dusky v. United States (1960) *Encyclopedia of Clinical Neuropsychology* (pp. 904-904): Springer.

- HODGINS, S.** (1992). Mental disorder, intellectual deficiency, and crime: Evidence from a birth cohort. *Archives of general psychiatry*, 49(6), 476-483. doi: 10.1001/archpsyc.1992.01820060056009
- IBRAHIM, E. M., HALIM, Z. A., WAHAB, E. A., & SABRY, N. A.** (2014). Psychiatric Morbidity Among Prisoners in Egypt. *World Journal of Medical Sciences*, 11(2), 228-232.
- JABLENSKY, A., MCGRATH, J., HERRMAN, H., CASTLE, D., GUREJE, O., EVANS, M., . . . HARVEY, C.** (2000). Psychotic disorders in urban areas: an overview of the Study on Low Prevalence Disorders. *Australian and New Zealand journal of psychiatry*, 34(2), 221-236.
- KARAM EG, MNEIMNEH Z, KARAM A, FAYYAD J, NASSER S, CHATTERJI S, AND KESSLER RC** (2006). *Prevalence and treatment of mental disorders in Lebanon*
- KESSLER, R. C., AMMINGER, G. P., AGUILAR-GAXIOLA, S., ALONSO, J., LEE, S., & USTUN, T. B.** (2007). Age of onset of mental disorders: a review of recent literature. *Current opinion in psychiatry*, 20(4), 359.
- KHIAM REHABILITATION CENTER FOR VICTIMS OF TORTURE** (2012). *Report of the Medical and Psychological Situation in Prisons* (KRC). Retrieved from the KRC website: <http://khiamcenter.org/en/p.php?lang=en&aid=289>.
- LEBANESE CENTER FOR HUMAN RIGHTS** (2010). *Report Prisons in Lebanon: Humanitarian and Legal concerns* (CLDH)
- MELTON, G. B., PETRILA, J., POYTHRESS, N. G., & SLOBOGIN, C.** (2007). *Psychological evaluations for the courts: A handbook for mental health professionals and lawyers*: Guilford Press.
- MUNDT, A. P., ALVARADO, R., FRITSCH, R., POBLETE, C., VILLAGRA, C., KASTNER, S., & PRIEBE, S.** (2013). Prevalence rates of mental disorders in Chilean prisons. *PloS one*, 8(7), e69109.

NATIONAL HEALTH STATISTICS REPORT IN LEBANON (2012)

- NICHOLSON, R. A., & KUGLER, K. E. (1991). Competent and incompetent criminal defendants: a quantitative review of comparative research. *Psychological bulletin*, 109(3), 355.
- O'BRIEN, M., MORTIMER, L., SINGLETON, N., & MELTZER, H. (2003). Psychiatric morbidity among women prisoners in England and Wales. *International Review of Psychiatry*, 15(1-2), 153-157.
- PERÄLÄ, J., SUVISAARI, J., SAARNI, S. I., KUOPPASALMI, K., ISOMETSÄ, E., PIRKOLA, S., . . . KIESEPPÄ, T. (2007). Lifetime prevalence of psychotic and bipolar I disorders in a general population. *Archives of general psychiatry*, 64(1), 19-28.
- PIRELLI, G., GOTTDIENER, W. H., & ZAPF, P. A. (2011). A meta-analytic review of competency to stand trial research. *Psychology, Public Policy, and Law*, 17(1), 1-53. doi: 10.1037/a0021713
- REICH, J., & WELLS, J. (1985). Psychiatric diagnosis and competency to stand trial. *Comprehensive psychiatry*, 26(5), 421-432.
- ROESCH, R. (1979). Determining competency to stand trial: An examination of evaluation procedures in an institutional setting. *Journal of Consulting and Clinical Psychology*, 47(3), 542.
- ROGERS, R., GILLIS, J. R., McMAIN, S., & DICKENS, S. E. (1988). Fitness evaluations: A retrospective study of clinical, criminal, and sociodemographic characteristics. *Canadian Journal of Behavioural Science/Revue canadienne des sciences du comportement*, 20(2), 192.
- RYBA, N. L., COOPER, V. G., & ZAPF, P. A. (2003). Juvenile competence to stand trial evaluations: A survey of current practices and test usage among psychologists. *Professional Psychology: Research and Practice*, 34(5), 499.

- SCHWENZER, K. J. (2008). Protecting vulnerable subjects in clinical research: children, pregnant women, prisoners, and employees. *Respiratory care*, 53(10), 1342-1349.
- SENIOR, J., BIRMINGHAM, L., HARTY, M., HASSAN, L., HAYES, A., KENDALL, K., . . . MILLS, A. (2013). Identification and management of prisoners with severe psychiatric illness by specialist mental health services. *Psychological medicine*, 43(07), 1511-1520.
- SKEEM, J. L., & GOLDING, S. L. (1998). Community examiners' evaluations of competence to stand trial: Common problems and suggestions for improvement. *Professional Psychology: Research and Practice*, 29(4), 357.
- STEADMAN, H., OSHER, F., ROBBINS, P. C., CASE, B., & SAMUELS, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60(6), 761-765.
- SWARTZ, M. S., SWANSON, J. W., HIDAY, V. A., BORUM, R., WAGNER, H. R., & BURNS, B. J. (2014). Violence and severe mental illness: the effects of substance abuse and nonadherence to medication.
- TIIHONEN, J., ISOHANNI, M., RASANEN, P., KOIRANEN, M., & MORING, J. (1997). Specific major mental disorders and criminality: a 26-year prospective study of the 1966 northern Finland birth cohort. *American Journal of Psychiatry*, 154(6), 840-845.
- TYE, C. S., & MULLEN, P. E. (2006). Mental disorders in female prisoners. *Australian and New Zealand journal of psychiatry*, 40(3), 266-271.
- VICENS, E., TORT, V., DUEÑAS, R. M., MURO, Á., PÉREZ-ARNAU, F., ARROYO, J. M., . . . LLUCH, J. (2011). The prevalence of mental disorders in Spanish prisons. *Criminal Behaviour and Mental Health*, 21(5), 321-332.

- WINOKUR, G., & TSUANG, M.** (1975). The Iowa 500: Suicide, in mania, depression, and schizophrenia. *The American Journal of Psychiatry*, 132(6), 650-651.
- WOOD, S. R., & BUTTARO JR, A.** (2013). Co-occurring severe mental illnesses and substance abuse disorders as predictors of state prison inmate assaults. *Crime & Delinquency*, 59(4), 510-535. doi: 10.1177/0011128712470318
- ZIMMERMAN, M., & MATTIA, J. I.** (1999). The reliability and validity of a screening questionnaire for 13 DSM-IV Axis I disorders (the Psychiatric Diagnostic Screening Questionnaire) in psychiatric outpatients. *Journal of Clinical Psychiatry*.

