FORENSIC PSYCHIATRY

DARYL B. MATTHEWS, M.D., PH.D.
345 QUEEN STREET, SUITE 900
HONOLULU, HAWAII 96813
TEL: 808-735-8505
FAX: 808-356-0739
EMAIL: dmatthews@jhu.edu

DIPLOMATE IN PSYCHIATRY AND FORENSIC PSYCHIATRY, AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

March 7, 2008

John Smith, Esq.
Smith Jones and Collins LLP
20 Wall Street
New York, New York 10001

Re: **Abdul R. [not detainee's real name]**

Dear Mr. Smith:

You have asked me to provide you with assistance in evaluating Mr. R.'s mental health situation in view of his ongoing detention at the United States Naval Base, Guantanamo Bay, Cuba. You have expressed concern about his mental condition, yet you have remained unable to secure an independent mental health examination. Because of this inability, with the assistance of my colleagues at the University of Hawaii Department of Psychiatry, I have relied on an attorney/translator-administered questionnaire which we believe to be appropriate for the proxy assessment of individuals in confinement without access to mental health evaluation. In addition to enhance the accuracy of this process I have reviewed personal information concerning Mr. R. compiled by your firm. This assessment is not, however, to be considered a substitute for a full psychiatric or psychological evaluation involving a personal examination of Mr. R..

My qualifications for conducting this assessment are outlined in the enclosed *curriculum vitae*.

Mr. R. is a native of [redacted]. He is the youngest of nine siblings. He attended school through the fourth grade. He remained home after this, receiving training in carpentry. He has no history of arrests in [redacted].

Mr. R. has no history of mental illness prior to his confinement. However, in confinement his mental condition has deteriorated profoundly according to his attorneys and translators to the point of incoherence and refusal to meet with them. He describes significant maltreatment by his captors. He was on a hunger strike for 20 months receiving forced nutrition by intubation.

He now suffers from ringing in the ears, back pain, stomach pain, eye pain, headaches, visual problems, and hearing problems, all of which he has said are a result of various aspects of his maltreatment. Mr. R.'s CSRT transcript indicates he has suffered a serious leg injury requiring hospitalization, and that he has had "three to four operations" while at Guantanamo.

He has been placed in the psychiatric unit of the detention facility and has been forcibly medicated by injection. He says that he is given an injection if he refuses oral medication. He complains of excessive tiredness as a result of his medication.

His mental status as described by attorneys and interpreters revealed an underweight man who presented as guarded although lethargic and distracted. He was motorically slow, slumping in his chair with the side of his head against the wall. Speech was normal in volume but sparse and slow, with vagueness and derailment. He showed flight of ideas and his speech had paranoid and religious themes. He smiled inappropriately and irrelevantly, otherwise his affect was flat. His mood was depressed.

Samples of speech recorded in notes provided by counsel include: "I love cowboys. I love Indians. I feel like they're my family. . . . I knew an Indian woman in [redacted]—she talked a witch language. I won't tell you her name because she might send me a witch curse. . . . Tarzan is a lovely person—very polite—he's my friend, though he doesn't [know] it. I don't watch for entertainment but for another reason—a secret—I won't tell you. . . . I live in heaven, heaven is in my chest. I love Jesus, I want to see him, and all the mermaids around them. [10/7/07]

According to the available history and the proxy evaluation of Mr. R. performed in January 2008, Mr. R. appears to have developed schizophrenia. Schizophrenia is a serious mental illness characterized by delusions (false beliefs), hallucinations (false sensory perceptions), and disordered form of thought--in this case fragmented, tangential, and irrelevant speech. In addition he endorses a great range of symptoms reflective of significant anxiety and depression. He is in substantial psychiatric distress with regard to these symptoms, but because of the simultaneous occurrence of schizophrenia, it is not possible to further diagnose what are clearly co-occurring anxiety and mood disorders.

The development of a psychotic illness (one involving loss of contact with reality) such as schizophrenia is one of the known adverse outcomes occurring, albeit relatively infrequently, in populations exposed to isolation and other forms of severe maltreatment in confinement. It is possible that Mr. R. may have had a predisposition to schizophrenia that was brought out by the stresses he has experienced. What is known of his psychiatric treatment is highly suggestive to me of the past and current administration of anti-schizophrenic drugs, rather than drugs of some other pharmacologic type.

Despite apparent forced compliance with his drug regimen, he remains psychotic. This in and of itself is a poor prognostic sign, as are the ongoing nature of the extreme stressors that he experiences, the absence of psychosocial modalities of treatment, and the lack of a satisfactory doctor/patient relationship. Medically, Mr. R. requires a complete (face-to-face) psychiatric re-evaluation and a re-appraisal of treatment. Because of his non-responsiveness to treatment and the many barriers he faces to recovery, it is my opinion that Mr. R. is unlikely to sustain significant improvement while confined at Guantanamo; rather, his condition is likely to deteriorate further.

You have asked about Mr. R.'s long-term prognosis assuming he is released from detention. In my judgment his overall prognosis is quite poor. At this point, there would exist severe

impairment in social and occupational functioning upon release. Given the extent and severity of his disordered thinking along with his other major psychiatric conditions, he would be unable to function in any employment setting in any capacity. To what extent this situation might be remediable by treatment is unknown. Appropriate treatment following release would require inpatient psychiatric hospitalization unless outstanding social support were available, and would at least require attendance at a highly structured a day-hospital program. Medication management visits with a psychiatrist and weekly psychotherapy visits which could be conducted by masters' level personnel would also be required. Even with the best of treatment it is highly unlikely that Mr. R. will ever return to his pre-confinement level of functioning and highly likely that he will require psychiatric treatment for the rest of his life.

Please let me know if you would like elaboration or clarification of these findings.

Sincerely,

Daryl Matthews, M.D., Ph.D.