PERIODIC REVIEW BOARD FILE REVIEW, 24 JULY, 2018
MOHAMMAD MANI AHMAD AL-QAHTANI, ISN 063
DETAINEE STATEMENT

To the members of the Periodic Review Board

I am looking forward to speaking to you again. Since the last hearing I have spent many hours with Dr. Keram, even though those calls and meetings are painful for me, because I know these discussions are important for her to have a full picture of my psychological problems over time.

I have also tried my best to work with the doctors here in this facility even through that is very difficult for reasons I hope I will be able to explain at the hearing.

I hope you will return me to Saudi Arabia. I know I will have to live in a hospital and not be free, but the most important thing is for my condition to improve.

Thank You.

Signed:

Mohammed al-Qahtani

Guantanamo ISN 063

DEPARTMENT OF DEFENSE
PERIODIC REVIEW SECRETARIAT
[redacted]

27 JUN 2018

MEMORANDUM FOR Periodic Review Board

FROM: PRS Personal Representative CPT [redacted] SUBJECT:

Detainee Statements Posted on PRS Website ICO ISN 063

1. I have advised ISN 063 that his statements may be posted on the public Periodic Review Secretariat website, subject to any U.S. Government clearance procedures. I have also advised him that other documents relating to his case will be posted, including the government's unclassified summary, the statements of his PR and PC, and the unclassified summary of the final determination of the Board.

2. ISN 063 has agreed to permit the posting of any of his statements on the PRS public website.

3. I have advised ISN 063 that the statement(s) of his PR, PC and wittness includes his medical information. ISN 063 has agreed to permit posting this information to the PRS public website.

6/27/2018

X [redacted]

[redacted]

CPT PRS PR

Signed by: [redacted]

PR Form 26DET, DTD 10 JUN 2015

EXHIBITS

FOLLOWING PAGES CONTAIN INFORMATION UP TO

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Mohamed Mani Ahmad Al Kahtani (ISN 063) Family Tree

Number	Name	Age	Relationship	Residence	Profession
1.	[redacted]		Father	[redacted]	[redacted]
2.			Mother		
3.			Brother		
4.			Brother		
5.			Brother		
6.			Brother		
7.			Brother		
8.			Brother		
9.			Brother		
10.			Brother		
11.			Maternal Uncle		
12.			Maternal Uncle		
13.			Maternal Uncle		
14.			Maternal Uncle		
15.			Maternal Uncle		
16.			Maternal Uncle		
17.			Maternal Uncle		
18.			Brother-in-Law		
19.			Paternal Cousin		
20.			Paternal Cousin		
21.			Brother-in-Law		
22.			Brother-in-Law		
23.			Paternal Cousin		
24.			Paternal Cousin		
25.			Paternal Cousin		
26.			Paternal Cousin		
27.			Maternal Cousin		
28.			Maternal Cousin		
29.			Paternal Cousin		

[redacted]

[redacted]

Standing Committee for Transfer of Sentenced Persons

RE: Request for transfer of detainee at Guantanamo Bay Detention Center: Mohammed M. Al-Qahtani

To: Periodic Review Board for Mohammed M. Al-Qahtani .

Esteemed Periodic Review Board Members,

We write to affirm that the Government of the Kingdom of Saudi Arabia is willing to receive its detained citizen: Mohammed M. Al-Qahtani in Saudi Arabia should he be approved for transfer.

We take this opportunity to state that for over a decade, the government of Saudi Arabia has provided appropriate security and humane treatment assurences to facilitate the transfer of over 100 detainees from Guantanamo to Saudi Arabia. We hereby affirm the validity of these guarantees and assurences, which include a government-supported rehabilitation and aftercare program. Our country's rehabilitation program is among the most successful in the world, as evidenced by a low recidivism rate and continued repatriation of former detainees from Guantanamo to Saudi Arabia.

If Mr. Al-Qahtani is approved for transfer to Saudi Arabia, we look forward to receiving him in our rehabilitation and aftercare program. We affirm that we will accommodate Mr. Al-Qahtani's rehabilitation and integration into society as we have done for other former Guantanamo detainees.

The Standing Committee for Transfer of Sentenced Persons at the Ministry of Interior of the Kingdom of Saudi Arabia would like to take this opportunity to express to you its deepest respect and appreciation for your kind consideration of this letter.

Yours truly,

[redacted]

Director-General of Legal Affairs & International Cooperation
Chairman of the Standing Committee for Transfer of Sentenced Persons
Ministry Of Interi
Riyadh, Saudi Ara

[redacted]

August 16, 2015

In the Name of God the Beneficent the Merciful

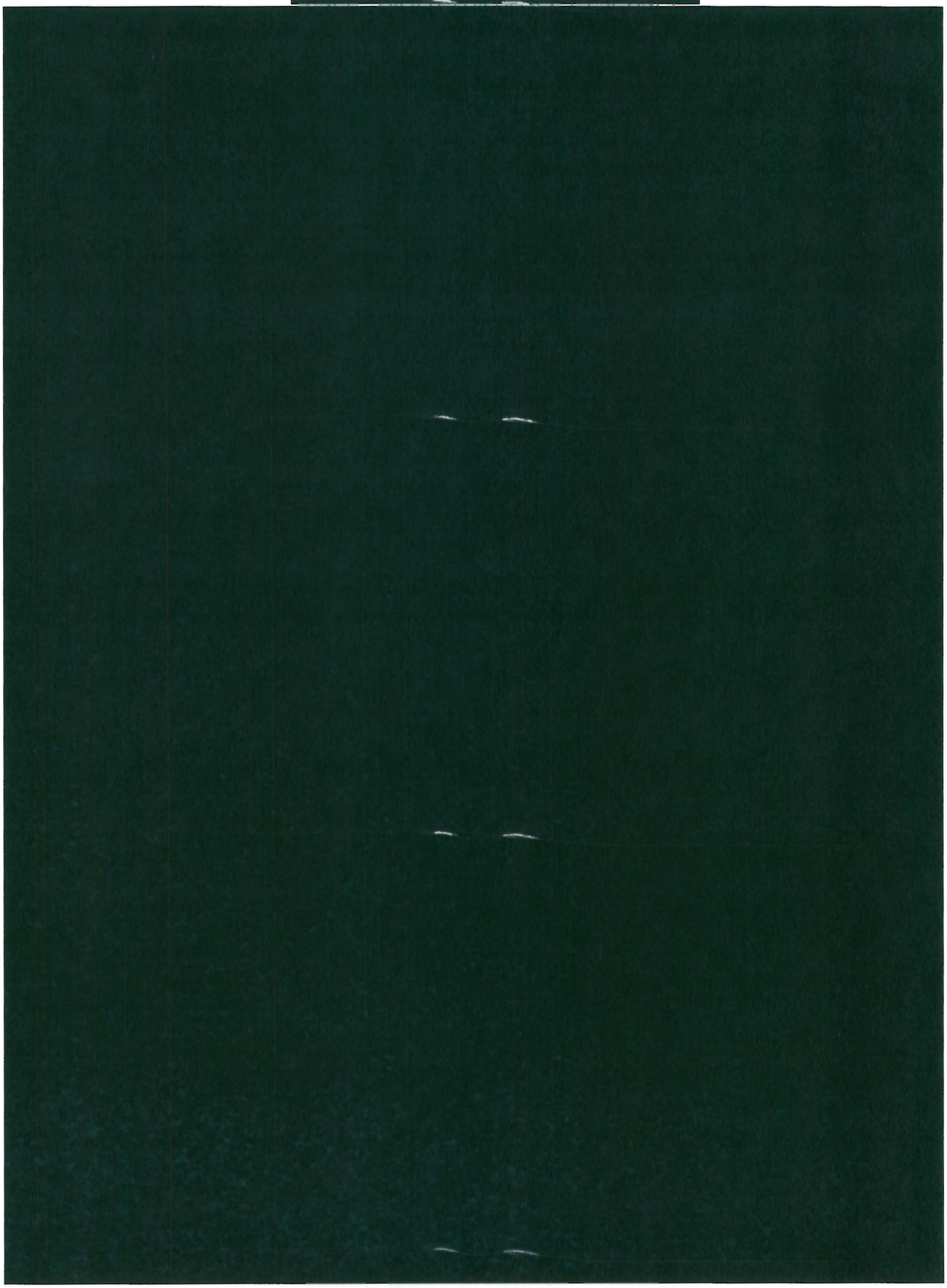
Respected Members of the Annual Review Board,

We, members of the family of Mohammad Mana Ahmad Al-Qahtani, who is being detained in Guantanamo Detention Camp, ISN (63),

Solemnly promise and commit to offer to Mohammad the assistance he will need: First, to reintegrate into the community by enrolling him in the Saudi Rehabilitation Center program, which is being conducted by the Interior Ministry, under the supervision of the Saudi Government; and second, to reintegrate him into our community in order to become like any other Saudi young man by finding him a wife, providing him with housing, and helping him in his life and in his quest for a suitable job.

We, the undersigned hereby, solemnly promise and commit to deliver the above mentioned assistance.

NAME	RELATIONSHIP	SIGNATURE & FINGERPRINTS
[redacted]	Father	\signature\ \fingerprint\
	Brother	\signature\ \fingerprint\
	Brother	\signature\ \fingeprint\
	Brother	\signature\ \fingerprint\
	Brother	\signature\ \fingerprint\



DEPARTMENT OF DEFENSE
PERIODIC REVIEW SECRETARIAT
[redacted]

27 JUN 2018

MEMORANDUM FOR Periodic Review Board

FROM: PRS Personal Representative CPT [redacted]

SUBJECT: Family Support Statements Posted on PRS Website ICO ISN 063

1. I have not advised the below family members of Mohamed Mani Ahmad Al Kahtani, due to unavailablity, that their statement, either written or in video, may be posted on the public Periodic Review Secretariat website, subject to any U.S. Government clearance procedures.

a) [redacted] (Father)
b) (Brother)
c) (Brother)
d) (Brother)
e) (Brother)

2. The family members have not agreed to permit the posting of their statements on the PRS public website.

6/27/2018

X [redacted]

[redacted]
CPT PRS PR
Signed by: [redacted]

PR Form 26DET, DTD 10 JUN 2015

APPENDIX

FOLLOWING PAGES CONTAIN INFORMATION UP TO

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EMILY A. KERAM, MD
1160 N. DUTTON AVENUE, SUITE 255
SANTA ROSA, CA 95401
TEL: 707.525.0800 FAX: 707.526.8868

June 5, 2016

Ramzi Kassem
City University of New York School of Law
2 Court Square
Long Island City, NY 11101

Re: Mohammed al-Qahtani

Dear Professor Kassem:

At your request, I evaluated Mohammed al-Qahtani, an approximately 36-year-old single Saudi Arabian national, who has been detained under the command of Joint Task Force Guantanamo (JTF-GTMO) since February 2002. I met with Mr. al-Qahtani in Camp Echo for approximately 39 hours from 5/22/15 to 5/27/15. [redacted]

The following report contains my evaluation and opinions regarding Mr. al-Qahtani. I reserve the right to modify these should additional material become available in the future. I will provide a supplemental report should you request additional opinions in the future. This report contains only unclassified information and information that was obtained through independent investigation.

Qualifications

I am board certified in Psychiatry and Neurology with sub-specialization board certification in Forensic Psychiatry. I have been in practice for over 20 years. I have treated patients with Posttraumatic Stress Disorder (PTSD) secondary to both combat stress and Prisoner of War confinement, at the US Department of Veterans Affairs Community Based Outpatient Clinic in Santa Rosa, CA for 14 years. I also have expertise in treating mood and psychotic disorders, as well as traumatic brain injury (TB). I have worked as a clinician and a forensic evaluator in a number of jails and prisons in the Federal Bureau of Prisons, state prisons, and local detention facilities in North Carolina and California. I am familiar with accepted standards of conditions of confinement and provision of medical and mental health services to individuals incarcerated in local, state, and federal confinement facilities in the United States.

I have evaluated several GTMO detainees over the past ten years at the request of the Office of Military Commissions-Defense Counsel, the United States District Court,

District of Columbia, and several habeas attorneys. The following are some of the issues I have evaluated in previous assessments of GTMO detainees:

1. Diagnostic assessment, functional assessment, required treatment, and prognosis
2. Capacity to participate in legal proceedings
3. Whether conditions of interrogation at Bagram and Kandahar Airfields and GTMO were consistent with conditions known to be associated with false confessions
4. Rehabilitative potential
5. Effects of conditions of confinement at GTMO on detainee mental and physical health
6. JTF-GTMO Hunger Strike policy and procedures
7. Joint Medical Group (JMG)-GTMO behavioral health services

With respect to testimony, I have qualified as an expert witness in the States of California and Arizona; U.S. District Courts in California, Washington, North Carolina and the District of Columbia; as well as in the tribunal of the Military Commissions at the U.S. Naval Station Guantanamo Bay, Cuba.

Reason for referral

Mr. al-Qahtani was referred for evaluation and opinion of the following issues:

1. Mr. al-Qahtani's psychiatric diagnoses prior to entering the custody of the United States
2. Effect of Mr. al-Qahtani's pre-existing mental illness on his decision-making
3. Effect of Mr. al-Qahtani's pre-existing mental illness on his vulnerability to conditions of confinement and interrogation while in U.S. custody
4. Impact of conditions of confinement and interrogation on the voluntariness, reliability, and credibility of statements Mr. al-Qahtani made to interrogators
5. Mr. al-Qahtani's current psychiatric diagnoses and their causation
6. Mr. al-Qahtani's treatment recommendations and prognosis

Collateral information

Collateral information reviewed in this matter was obtained from your office and included the following:

1. Medical and psychiatric records, King Abdul Aziz Hospital in the Holy Capital (Mecca), 5/20/2000 to 5/24/2000.

2. In addition, on May 28, 2016, I spoke with [redacted] immediate elder brother of Mohammed al-Qahtani by telephone. [redacted]

Re: Mohammed al-Qahtani

Medical and behavioral health records from the Joint Medical Group (JMG), JTF-GTMO that were reviewed in this matter will not be discussed in this report.

Classified materials that were reviewed in this matter will not be discussed in this report.

Non-confidentiality apprisal

At the outset of the evaluation, I explained to Mr. al-Qahtani that we did not have a physician-patient relationship. I informed him that I had been asked by his counsel to evaluate certain aspects of his mental health. I stated that I would not keep material we discussed confidential.

Opinions

The following are my opinions to a reasonable degree of medical probability. Please note that diagnostic criteria for mental illness are taken from the Diagnostic and Statistical Manual, 5th edition, of the American Psychiatric Association.

Mr. al-Qahtani's psychiatric diagnoses prior to entering the custody of the United States

Mr. al-Qahtani had the following psychiatric diagnoses prior to entering the custody of the United States:

1. Schizophrenia
2. Major depression, recurrent, moderate to severe
3. Rule out mild neurocognitive disorder due to traumatic brain injury (TBI)

Schizophrenia

Schizophrenia is a chronic and disabling brain illness that affects the way people think, feel, and perceive the world around them. The diagnostic criteria for schizophrenia include the presence of two or more of the following "active phase" symptoms; delusions (fixed false beliefs); hallucinations (sensory perception in the absence of stimuli, most commonly auditory); disorganized speech; grossly disorganized or catatonic behavior; and negative symptoms (i.e., restricted affect or asociality.) Symptoms impair functioning in major areas and must be continuous for at least six months. Finally, DSM-5 diagnostic criteria for schizophrenia require that other psychotic illnesses, substance use, or general medical conditions have been ruled out as the cause of symptoms.

With respect to his diagnosis of schizophrenia, Mr. al-Qahtani stated he developed psychotic symptoms in childhood. His illness presented with paranoid ideation that worsened in his teens and twenties. His brother recalled episodes of extreme behavioral dyscontrol, citing an example in which the Riyadh police called the family stating that they had found Mr. al-Qahtani naked in a garbage dumpster. Both Mr. al-Qahtani and his brother recall his experiencing auditory hallucinations. His brother recalled an episode in

which Mr. al-Qahtani threw his new cell phone from a moving car because he believed it was making him "tired." [I note that both Mr. al-Qahtani and his brother used the word "tired" as a euphemism for periods of time during which Mr. al-Qahtani experienced or exhibited psychotic symptoms.]

In May 2000, Mr. al-Qahtani was hospitalized for an acute psychotic break he experienced while in Mecca. He was treated at the King Abdul Aziz Hospital in the Holy Capital (Mecca). Medical records from this admission show that Mr. al-Qahtani was admitted from 5/20/2000 to 5/24/2000 on a memorandum issued by the al-Aziziya Police Station that described Mr. al-Qahtani as having made attempts to throw himself in the middle of the street. Mr. al-Qahtani was admitted to the men's psychiatric unit and treated with the antipsychotic Serenase (haloperidol) and the sedative hypnotic Valium (diazepam). Mr. al-Qahtani reported that he wanted to commit suicide. He reported a past history of treatment and was described as delusional during the admission. He was discharged to the care of his father. [Please see attached records.]

Mr. al-Qahtani described a brief period of outpatient treatment in Riyadh following his return home. As he did prior to the admission, he continued to see a "reader," a traditional healer who used the Koran to exorcise "djins" [spirits or demons] who are believed to cause psychotic symptoms in certain cultures.

Major depression, recurrent, moderate to severe

Mr. al-Qahtani developed episodic depression in response to the impact of schizophrenic symptoms on his life's trajectory. The number and severity of his depressive symptoms support a diagnosis of major depression with recurrent episodes, moderate to severe. The DSM-5 diagnostic criteria for major depression require the presence of five or more symptoms of depression present for at least a two-week period. These symptoms include depressed mood, anhedonia, weight loss, sleep disturbance, psychomotor changes, anergia, worthlessness, impaired concentration, and recurrent thoughts of death. Symptoms must cause significant distress or impairment in functioning. Other causes of mood symptoms must be ruled out to make a diagnosis of major depression. The diagnosis is followed by two specifiers. The first delineates the presence of one or multiple mood episodes. The second specifier indicates the number of symptoms, their severity and their impact on functioning. The specifier "mild" is used when the diagnosis of major depression is made based on the presence of the minimum number of required symptoms and/or when symptoms cause mild distress and impairment in functioning. The specified "severe" is used when the number of symptoms present far exceeds the number required to make the diagnosis and/or when symptoms cause severe distress and impairment in functioning. The specifier "moderate" is used when symptom number and intensity fall in between the mild to severe range.

Mr. al-Qahtani described four to five discrete episodes of major depression beginning in late adolescence and early adulthood. Early episode was precipitated by a significant failure in meeting his expected educational, occupational, or family goals and responsibilities. His more recent episodes were caused by the extreme conditions of his

confinement and interrogations. Symptoms included "strong depression," anergia, psychomotor changes, worthlessness, hopelessness, increased difficulty with concentration, and thoughts of death. Mr. al-Qahtani experienced more than the minimum number of symptoms required to make a diagnosis of major depression. Mr. al-Qahtani's functioning has experienced moderate to severe distress impairment of functioning during episodes of depression.

Rule out mild neurocognitive disorder due to traumatic brain injury (TBI)

In medicine, the term "rule out" is used to identify diagnoses that may be present but for which additional information may be necessary to make the diagnosis with certainty. For example, in this instance, neuropsychological testing would be helpful in assessing Mr. al-Qahtani's cognitive status.

With respect to the rule out diagnosis of mild neurocognitive disorder due to traumatic brain injury (TBI), Mr. al-Qahtani reported a history of several head injuries in motor vehicle accidents (MVA's). The first TBI occurred when he was approximately eight years old. He was in an MVA in which he was ejected from the vehicle. He experienced a loss of consciousness at the scene. He had a lengthy hospitalization followed by home convalescence before he returned to school.

Mr. al-Qahtani reported severe cognitive decline following the first TBI at eight years old. He developed chronic impairment in concentration, memory, learning and reading. Cognitive impairment negatively affected his academic performance. "It took me six years to finish middle school instead of three." He did not attend university and was not able to maintain employment.

Mr. al-Qahtani experienced a second MVA while in middle school. He hit his head but did not lose consciousness. He experienced another TBI in high school following an MVA in which he was driving. He suffered a loss of consciousness and was hospitalized for several days.

Effect of Mr. al-Qahtani's pre-existing mental illness on his decision-making

Mr. al-Qahtani's capacity for independent and voluntary decision-making was severely impaired by his pre-existing psychiatric diagnoses. At a minimum, the disruption in his educational, occupational, and social functioning, coupled with his cognitive impairment, psychotic symptoms, and mood disturbance left him profoundly unlikely to achieve his previous life goals of a career, friendships, marriage, and raising a family. This likely left him profoundly susceptible to manipulation by others who appear to offer meaningful relationships, a sense of belonging, and the opportunity to be a positive contributor.

Depending on the content of hallucinations or delusions he experienced, he may have also developed an irrational understanding of these relationships and contributions and was likely to be impaired in his ability to learn, understand, make decisions, and plan a successful course of action with respect to group activities. His psychological and

cognitive deficits would be recognized by others, leading him to be vulnerable to manipulation and coercion.

Effect of Mr. al-Qahtani's pre-existing mental illness on his vulnerability to conditions of confinement and interrogation while in U.S. custody

Included among the conditions of confinement and interrogation to which Mr. al-Qahtani was subjected were periods of solitary confinement, sleep deprivation, extreme temperature and noise exposure, stress positions including short-shackling, forced nudity, body cavity searches, sexual assault and humiliation, beatings, strangling, threats of rendition, and water-boarding. He was not allowed to use the toilet and was forced to urinate on himself repeatedly. Medical and mental health staff members were involved in his interrogations, for example, monitoring his vital signs, administering intravenous fluids, and influencing interrogation approach. This maltreatment took place in various locations, primarily when he was housed in the Brig. Even in the absence of pre-existing psychiatric illness, exposure to severely cruel, degrading, humiliating, and inhumane treatment such as that experienced by Mr. al-Qahtani is known to have profoundly disruptive and long-lasting effects on a person's sense of identity, selfhood, dignity, perception of reality, mood, cognitive functioning, and physiology.

Mr. al-Qahtani's pre-existing psychotic, mood, and cognitive disorders made him particularly vulnerable to disruptions of his sense of self, place, and time due to the conditions of confinement and interrogation he experienced. He described feeling profoundly isolated, hopeless, and helpless. "I can tell you I was all alone in the world. I couldn't find a way to stop the torture. I couldn't find a way to kill myself." Conditions in the Brig and interrogations were particularly difficult. "The intensity I had to kill myself was not the intensity to die, it was the intensity to stop the psychological torture, the horrible pain of solitary confinement…the symptoms of psychological torture were horrific. It was even worse than the effects of the physical torture."

Mr. al-Qahtani experienced psychotic symptoms during solitary confinement and interrogations. He described auditory and visual hallucinations of ghosts. He also frequently heard a bird talking to him from outside the Brig, reassuring him that he was still alive.

Mr. al-Qahtani stated that he found it difficult to find the words to describe the profound destructive effects of solitary confinement. "I need to tell you that solitary confinement has destroyed me. Just to describe it to you in a simple way, I will use simple words but it will mean a lot. Solitary confinement was like a huge mountain that was on top of me. And the pressure on me was so high it squeezed tears out of my eyes." Mr. al-Qahtani stated that he was living outside of time. "I had no sense of it passing, no definition to mark it. I found that I had pooped on myself. I would find myself in hysterics. I was crying and crying and crying. I found myself talking to myself, talking to the interrogators, talking to my family. And then I would feel an internal calmness. I found myself separating myself from myself. The pressure on me was so great." Mr. al-Qahtani described an endless cycle of talking to himself, the interrogators, and his family, then

finding himself crying, then being overcome by a deep stillness, and then finding that he had soiled himself.

Impact of conditions of confinement and interrogation on the voluntariness, reliability, and credibility of statements Mr. al-Qahtani made to interrogators

It is well established, both in the field and in academic literature, that the conditions of confinement and interrogation experienced by Mr. al-Qahtani are associated with false confessions. The profound physical and psychological torture Mr. al-Qahtani experienced during interrogations, coupled with his inability to control what was happening to him, led him to conclude that he had only two means of ending his suffering; suicide or compliance. He explained that he was unable to successfully suicide and so decided to provide his interrogators with the information he thought they wanted to hear. Thus, Mr. al-Qahtani's statements were coerced and not voluntary, reliable, or credible.

Mr. al-Qahtani's current psychiatric diagnoses and their causation

In addition to Mr. al-Qahtani's pre-existing psychiatric diagnoses, he has developed posttraumatic stress disorder (PTSD) as a result of the severely cruel, degrading, humiliating, and inhumane treatment he experienced during confinement and interrogation while in US custody.

PTSD is a psychiatric disorder caused by experiencing or witnessing a traumatic event that threatens life or physical integrity. Diagnostic criteria define several categories of symptoms. Re-experiencing symptoms include flashbacks, nightmares, and intrusive thoughts, images, or memories. Avoidance symptoms include avoidance of distressing trauma-related thoughts, feelings or external reminders of trauma such as people, places, conversations, etc. Negative alterations in cognitions and mood include traumatic amnesia, negative beliefs and expectations about oneself and the world, distorted blame of self or others, negative trauma-related emotions such as fear, horror, anger, guilt, or shame, anhedonia, feeling alienated from others, and a persistent inability to experience positive emotions. The final category of symptoms involves alterations in arousal and reactivity such as irritability, recklessness, hypervigilance, exaggerated startle response, poor memory, and sleep disturbance. Symptoms must be present for more than one month and cause distress or impairment. Other causes of symptoms must be ruled out.

Mr. al-Qahtani's PTSD symptoms include nightmares, intrusion, attempts to avoid distressing trauma-related thoughts, feelings, and conversations, negative expectations about himself and the world, fear, horror, shame, alienation, and difficulty experiencing positive emotions. He is hypervigilant with an exaggerated startle response. Pre-existing memory disturbance has worsened. Sleep disturbance is often present. These symptoms have been present for years and were present at the time of the current evaluation.

It has long been recognized that many skin disorders have a significant psychosomatic or behavioral component. Skin disorders with a psychophysiologic component are classified as psychocutaneous disorders. It is thought that inflammatory and immune-mediated

processes are activated in response to stress and anxiety in predisposed individuals. These processes result in the symptoms of psychocutaneous disorders.

Mr. al-Qahtani suffers from a psychocutaneous disorder thought to be either atopic dermatitis or lichen planus. Atopic dermatitis is produced mainly by scratching and flares with stress though psychoneuroimmunomechanisms. Worsening atopic dermatitis can further stress the patient, who then tends to scratch more and further worsen the dermatitis. Lichen planus, an inflammatory pruritic dermatitis, is often triggered or exacerbated by stress. The intense itching and discoloration with hyperpigmentation that typically occur with lichen planus can further fuel the stress.

Mr. al-Qahtani's cutaneous disorder was present throughout my evaluation. Skin lesions worsened in number and severity when discussing extremely traumatic events. These caused Mr. al-Qahtani obvious physical pain and psychological distress.

Mr. al-Qahtani's symptoms of PTSD are consistent with those exhibited by survivors of torture, cruel treatment, and coercion.

Mr. al-Qahtani experiences profound re-traumatization on exposure to reminders of maltreatment. My interview of him was extremely disruptive to his sense of identity and induced deep feelings of anxiety and shame. He often wept. Over the days of our interview he reported experiencing increase in the intensity and frequency of PTSD symptoms. These symptoms were triggered not only by discussion of the interrogations themselves, but also by discussions of subject matter his interrogators sought. Further exposure to these traumatic reminders should be avoided if possible.

Mr. al-Qahtani's treatment recommendations and prognosis

Appropriate treatment of Mr. al-Qahtani's psychiatric diagnoses requires a culturally-informed multi-disciplinary approach. Clinical treatment modalities should include supportive psychotherapy, cognitive-behavioral therapy, skills-based therapy, and psychotropic medication. Ideally this would first be provided in an inpatient setting to allow for a full assessment of his psychological and neurocognitive status and rehabilitation needs. Given his prolonged period of confinement, inpatient or residential treatment will likely be required until Mr. al-Qahtani gains the internal resources necessary to manage the stress of full re-integration into society. Given the nature of his diagnoses of schizophrenia, PTSD, and cognitive impairment, Mr. al-Qahtani will likely require lifelong mental health care.

In addition to clinical treatment, Mr. al-Qahtani requires culturally-informed approaches to understanding and addressing his symptoms. In his culture, symptoms of schizophrenia are thought to be caused by "djins" or spirits. Ridding a person of djins requires that a skilled healer read from the Koran over the affected person. This "reader" also assists in interpreting the person's symptoms in a way that allows them to continue to have a place in the family and society. In the United States, culturally recognized healers are often included in the larger treatment planning for patients with mental illness.

Re: Mohammed al-Qahtani

Finally, given the unique role of family in Mr. al-Qahtani's previous episodes of psychiatric illness, it is imperative that his family members actively participate in his treatment. He trusts specific family members who have provided him with care and reassurance in the past. Family members know how to discuss his psychiatric illness with him in a way that supports his recovery. Acceptance of Mr. al-Qahtani back into his family as a loved and valued member will assist in alleviating symptoms such as depression, anxiety, shame, hopelessness, and feelings of alienation and detachment.

It is my opinion that Mr. al-Qahtani would receive effective treatment for his mental health conditions if he were to be repatriated to Saudi Arabia and provided access to medical and mental health care in connection with the Saudi Rehabilitation Program.

It is my opinion that Mr. al-Qahtani cannot receive effective treatment for his current mental health conditions while he remains in US custody at GTMO or elsewhere, despite the best efforts of available and competent clinicians. Several factors preclude effective treatment. These include the inability to develop long-term doctor-patient relationships given the rotation schedule of medical staff, lack of trust in the medical and mental health staff due to previous clinician involvement in interrogations (see page 5 above), lack of culturally-informed treatment modalities, and unavailability of family members to participate in treatment.

Thank you for referring this matter to me for evaluation and report.

Sincerely,

Emily A. Keram, MD

DEPARTMENT OF DEFENSE
PERIODIC REVIEW SECRETARIAT
[redacted]

28 JUN 2018

MEMORANDUM FOR Periodic Review Board

FROM: PRS Personal Representative CPT [redacted]

SUBJECT: Witness Statement Posted on PRS Website ICO ISN 063

1. I have advised Dr. Emily Keram, that her statements may be posted on the public Periodic Review Secretariat website, subject to any U.S. Government clearance procedures.

2. Dr. Keram has agreed to permit the posting of any of her statements on the PRS public website.

6/28/2018

X [redacted]

CPT [redacted]
Personal Representative
Signed by: [redacted]

PR Form 26PC, DTD 10 JUN 2015

SUPPLEMENTAL DECLARATION OF EMILY A. KERAM, MD REGARDING MOHMAMMED AL-QAHTANI

Pursuant to 28 U.S.C. § 1746, I certify that the following is true and correct to the best of my knowledge:

1. My name is Emily A. Keram.

2. I am a medical doctor and am board certified in psychiatry and neurology with sub-specialization board certification in forensic psychiatry. I have been in practice for over 20 years. I have treated patients with Posttraumatic Stress Disorder (PTSD) secondary to both combat stress and Prisoner of War confinement, at the U.S. Department of Veterans Affairs Community Based Outpatient Clinic in Santa Rosa, CA for 16 years. I also have expertise treating patients with schizophrenia.

3. I have previously provided the Periodic Review Board with a written report dated June 5, 2016 and stemming from my evaluation of Mohammed al-Qahtani and related information. I also testified before the Period Review Board on June 16, 2016 during Mr. al-Qahtani's hearing. I respectfully offer this declaration to supplement my report and testimony.

4. Despite the availability of competent clinicians at Guantánamo, Mr. al-Qahtani cannot receive effective treatment from them and would not achieve therapeutic benefit from treatment there or in any other U.S. custodial setting.

5. It is impossible for Mr. al-Qahtani to form an effective doctor-patient relationship with clinician members of the Joint Medical Group (JMG). Mr. al-Qahtani's chronic symptoms of PTSD are the result of his confinement and the torture he suffered during interrogations at Guantánamo. Detention and medical personnel were involved in his confinement and interrogations. It is not realistic to believe that Mr. al-Qahtani would be able to benefit from treatment provided by clinicians whom he associates with the cause of his suffering.

6. Mr. al-Qahtani requires multi-modal treatment for his symptoms of PTSD and schizophrenia. Medication, although helpful in improving the frequency and intensity of some of his symptoms, is not sufficient to provide meaningful relief from his suffering. It may be possible to convince Mr. al-Qahtani to accept medication from JMG clinicians whom he does not trust, or from other visiting doctors. However, at best, medication would provide modest PTSD symptom improvement without fully addressing their underlying causes. It is also highly likely that Mr. al-Qahtani will continue to experience episodic worsening of symptoms as his indefinite detention continues. As a result, medications would likely need to be increased over time and would only be considered palliative. An effective, multi-disciplinary approach, away from the location in which PTSD-related trauma occurred and which involves his family, is necessary for him to repair the rending of his sense of self, dignity, and humanity. This rending underpins his underlying symptoms of depression, anxiety, and existential crisis.

7. As noted above, Mr. al-Qahtani does not trust medical personnel as a result of their involvement in his interrogations. This mistrust has generalized beyond JMG clinicians. I am aware that Mr. al-Qahtani would not meet with the original mental health expert retained by the defense. He was initially resistant to meet with me as well. Defense counsel and Mr. al-Qahtani have explained that his fear of meeting with defense mental health experts was based on JMG clinicians' participation in his torture.

8. During my testimony, the Board asked what current protective factors are in place that argue against the possibility of Mr. al-Qahtani engaging in future violence. I replied that Mr. al-Qahtani eschews violence and has accepted the limitations in occupational and social functioning imposed by his psychiatric illnesses. I also noted that from the perspective of a forensic psychiatric Violence Risk Assessment, Mr. al-Qahtani's psychiatric diagnoses do not place him at risk for future violence.

9. I would like to add another factor that further decreases Mr. al-Qahtani's risk for future violence. Protecting one's family honor is an individual duty whose primacy cannot be underestimated in Saudi culture. Mr. al-Qahtani is well aware of the shame that any sort of proscribed behavior on his part would bring to his family. His need to protect his family's honor will be a powerful factor in his future decision-making. It is my opinion that, had he known that his previous history could bring shame upon his family, it is highly unlikely that he would have engaged in any such activity.

10. Finally, I authorize the publication by the Periodic Review Secretariat of my testimony during the June 16, 2016 hearing.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 12th day of July, 2016.

Emily A. Keram, M.D.

EMILY A. KERAM, M.D.
1160 N. Dutton Avenue, Suite 255
Santa Rosa, CA 95401

SUPPLEMENTAL DECLARATION OF EMILY A. KERAM, M.D.
REGARDING MOHMAMMED AL-QAHTANI

Pursuant to 28 U.S.C. § 1746, I certify that the following is true and correct to the best of my knowledge:

1. My name is Emily A. Keram.

2. I am a medical doctor and am board certified in psychiatry and neurology with sub-specialization board certification in forensic psychiatry. I have been in practice for over 20 years. I have treated patients with Posttraumatic Stress Disorder (PTSD) secondary to both combat stress and Prisoner of War confinement, at the U.S. Department of Veterans Affairs Community Based Outpatient Clinic in Santa Rosa, CA for 16 years. I also have expertise treating patients with schizophrenia.

3. I have previously provided the Periodic Review Board with a written report dated June 5, 2016 and stemming from my evaluation of Mohammed al-Qahtani and related information. I also testified before the Period Review Board on June 16, 2016 during Mr. al-Qahtani's hearing. I respectfully offer this declaration to supplement my report and testimony, and in support of a request for an early second hearing before the Board.

4. I am aware that the Board's July 2016 decision was difficult for Mr. al-Qahtani to process. He initially reacted by withdrawing to his cell, attempting self-harm, and manifesting other forms of discouragement. His reaction was entirely expectable, especially in the context of the following factors:

    a. The length of his current indefinite detention;

    b. His strong desire to be reunited with his family;

    c. The fact that there has been an acceleration in the release of detainees;

    d. The availability of the Saudi Rehabilitation program; and

    e. The sincerity of his original statement to the Board.

5. Given that these factors underpinned his hope for a favorable outcome, I believe the implications of his reaction are that he sustained a period of increased depression, hopelessness, and awareness of his lack of control over his life.

6. That Mr. al-Qahtani was able to work through his initial response to the Board's decision likely reflects that he still has some hope that he will eventually be released. He then focused on the content of the Board's explanation of their decision, understood their reasoning, and accepted their recommendations. I believe this was likely an extremely difficult decision for Mr. al-Qahtani to make for the following reasons:

    a. His mistrust of Joint Medical Group (JMG) personnel; and

b. Exposure to JMG personnel is a likely reminder of being tortured given their participation in his interrogation. This means he likely experiences some increase in PTSD symptoms of intrusion (unwanted and painful thoughts, memories, and images of torture and other trauma), nightmares, anxiety, depression, insomnia, and hypervigilance with exposure to JMG staff.

7. His acceptance of the Board's recommendations is the strongest possible evidence of his resolve and commitment to get well and rejoin his family. The change is so significant that it warrants review of his case now. Factors to assess in the next review would include the following:

   a. Treatment compliance;

   b. His treatment team's assessment of his response to treatment; and

   c. The extent to which he has been able to develop trust in JMG staff, learn that they are different from JMG staff present during his torture, and can accept help from them.

8. It remains my opinion that, despite the availability of competent clinicians at Guantánamo and Mr. al-Qahtani's best efforts, he cannot receive effective treatment from them and would not achieve lasting therapeutic benefit from treatment there or in any other U.S. custodial setting. This is because he remains in the environment in which he was tortured, exposure to this environment causes continued symptoms, and the most effective treatment requires the involvement his family members.

9. It remains my opinion that Mr. al-Qahtani requires multi-modal treatment for his symptoms of PTSD and schizophrenia. Medication, although helpful in improving the frequency and intensity of some of his symptoms, is not sufficient to provide meaningful relief from his suffering. Although Mr. al-Qahtani is taking medication prescribed by JMG clinicians, at best, medication would provide modest PTSD symptom improvement without fully addressing their underlying causes.

10. It remains my opinion that it is also highly likely that Mr. al-Qahtani will continue to experience episodic worsening of symptoms as his indefinite detention continues. As a result, medications would likely need to be increased over time and would only be considered palliative. An effective, multi-disciplinary approach, away from the location in which PTSD-related trauma occurred and which involves his family, is necessary for him to repair the rending of his sense of self, dignity, and humanity. This rending underpins his underlying symptoms of depression, anxiety, and existential crisis.

11. It remains my opinion that there are protective factors in place that argue against the possibility of Mr. al-Qahtani engaging in future violence. These include Mr. al-Qahtani's rejection of violence and his acceptance of the limitations in occupational and social functioning imposed by his psychiatric illnesses. I also remain of the opinion that, from the perspective of a forensic psychiatric Violence Risk Assessment, Mr. al-

Qahtani's psychiatric diagnoses do not place him at risk of engaging in violence in the future.

12. It remains my opinion that Mr. al-Qahtani's desire to uphold his family's honor is an additional factor that further decreases his risk for future violence. Protecting one's family honor is an individual duty whose primacy cannot be underestimated in Saudi culture. Mr. al-Qahtani is well aware of the shame that any sort of proscribed behavior on his part would bring to his family. His need to protect his family's honor will be a powerful factor in his future decision-making. It is my opinion that, had Mr. al-Qahtani known that his previous history could bring shame upon his family, it is highly unlikely that he would have engaged in any such activity.

13. In its decision, the Board noted that a "lack of information prevented the Board from understanding how and to what extent his psychiatric condition contributed to his decisions" in the past. In late-January 2017, I plan to travel to Guantánamo to complete my evaluation of Mr. al-Qahtani. That will enable me to testify again before the Board to address this question during a second hearing.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 2nd day of December, 2016.

Emily A. Keram, MD

EMILY A. KERAM, M.D.
1160 N. Dutton Avenue, Suite 255
Santa Rosa, CA 95401

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

MOHAMMED AL-QAHTANI, Petitioner,	)	
v.	)	Civil Action No. 05-1971 (RMC)
DONALD J. TRUMP, *et al.*, Respondents.	)	

EXHIBIT 1

Declaration of CDR [redacted] MD, Senior Medical Officer (Aug. 21, 2017)

~~(U//FOUO)~~ DECLARATION OF COMMANDER [redacted] MD, FAAFP

Pursuant to 28 U.S.C. §1746, I, [redacted] hereby declare:

1. ~~(U//FOUO)~~ I am a Commander in the United States Navy with over 23 years of active and reserve service. I currently serve as the Senior Medical Officer, Joint Medical Group (JMG), Joint Task Force Guantanamo Bay (JTF-GTMO), Cuba. I am responsible for the medical care provided to 26 detainees at Guantanamo Bay and supervise the operation of the JMG that provides medical care to those detainees.[1] I have served in this position since April 21, 2017.

2. ~~(U//FOUO)~~ I completed my residency in Family Medicine in June of 2013 and have been board certified in the United States since that time.

3. ~~(U//FOUO)~~ I have personal knowledge of the procedures that are in place for the operation and application of medical care at JTF-GTMO medical facilities, and I am responsible for ensuring that they are followed. Due to my responsibilities, I have personal knowledge of or have received information in the course of my responsibilities concerning the matters raised by Mr. al-Qahtani (ISN 063) through his counsel in the Petitioner's Motion to Compel Examination by a Mixed Medical Commission filed on August 8, 2017. This declaration is based on information made available to me through my official duties, including discussions I personally had with Mr. al-Qahtani's Primary Care Manager (PCM), the JMG psychiatric consultants treating Mr. al-Qahtani, and who are familiar with his complete medical and mental health history, and other JMG medical staff involved in the medical care and treatment of Mr. al-Qahtani, as well as a review of pertinent medical and mental health records of Mr. al-Qahtani.

4. ~~(U//FOUO)~~ The JMG staff consists of licensed, board-certified physicians of different specialties. Specifically, as of August 2017, the medical staff has [redacted] professionally trained individuals, including one board certified family physician, one board certified internist, two board certified psychiatrists, one certified physician's assistant, a general dentist, licensed medical/surgical nurses, hospital corpsmen (formally trained Navy medical personnel akin to a "medic" in the Army), various technicians (lab, radiology, pharmacy, operating room, respiratory therapy, physical therapy and biomedical repair), and administrative staff. The United States Naval Hospital, Guantanamo Bay provides additional consultative services from numerous medical professionals including an anesthesiologist, general surgeon, an orthopedic surgeon, a licensed dietician, and a physical therapist. We routinely bring in subspecialists, including medical professionals practicing in the areas of dermatology, cardiology, otorhinolaryngology (ear, nose and throat), gastroenterology, urology and audiology, and have the ability to request subspecialists from other areas as needed.

5. ~~(U//FOUO)~~ All military health care personnel whose duties involve support of detainee operations or contact with detainees receive advanced training commensurate with their duties prior to evaluating patients. The purpose of this training is to equip them to provide quality care

[1] I do not provide or oversee medical care for the 15 detainees designated as "high-value detainees," or HVDs. HVDs have their own Senior Medical Officer. Mr. al-Qahtani is not an HVD.

in a detention setting by ensuring that they have a working knowledge and understanding of the requirements and standards for providing health care to detainees. Upon arrival at Guantanamo, permanent providers have mandatory orientation that includes classroom time as well as a two-week formal transition between incoming and outgoing personnel. Subspecialists permanently stationed off of the island and making their first visit to Guantanamo to offer subspecialty care have another medical staff member with them at all times to help acclimate and to assist in the provision of care. To maintain continuity of care with the detainee, we make every effort to keep the same subspecialists for their recurring visits to the island. Further, the Joint Task Force has medical linguists who have been assigned to the facility for many years allowing them to provide continuity during medical staff turnover.

6. ~~(U//FOUO)~~ According to Department of Defense Instruction 2310.08E, health care personnel responsible for the medical care of detainees have a duty to protect detainees' physical and mental health and to provide appropriate treatment. According to DoD Directive 3115.09, sec. 3.4.3, decisions regarding the appropriate medical treatment of detainees are the province of medical personnel. The professional provider-patient treatment relationship between health care personnel and detainees is exclusively for the purpose of evaluating, protecting, and improving detainees' physical and mental health. Health care personnel do not participate in detention-related activities or operations for any reason other than to provide health care services in approved clinical settings, conduct disease prevention and other approved public health activities, advise proper command authorities regarding the health status of detainees, and provide direct support for these activities. Per DoD Policy, medical personnel do not have any involvement in the supervision, conduct, or direction of interrogations.

7. ~~(U//FOUO)~~ The JMG is committed to providing appropriate and comprehensive medical care to all detainees. JMG providers take seriously their duty to protect the physical and mental health of the detainees and approach their interactions with detainees in a manner that encourages provider-patient trust and rapport and that is aimed at encouraging detainee participation in medical treatment and disease prevention. Detainees receive timely, compassionate, quality healthcare and have regular access to primary care and sub-specialist physicians. The healthcare provided to the detainees at JTF-GTMO is comparable to that afforded our active duty service members on island. All medical procedures performed are justified and meet accepted standards of care. A detainee is provided medical care and treatment based solely on his need for such care, and the level and type of treatment is dependent on the accepted medical standard of care for the condition being treated. Medical care is not provided or withheld based on a detainee's compliance or noncompliance with detention camp rules or based on his refusal to accept food or drink. Medical decisions and treatment are not made or withheld as a form of punishment or discipline.

8. ~~(U//FOUO)~~ All detainees, upon arrival at JTF-GTMO, receive a complete physical examination. Medical issues identified during the examination, or identified during subsequent examinations, are monitored by the medical staff. Detainees may make a request to guard personnel in the cell blocks or to the medical personnel who make daily rounds on each cell block at any time in order to initiate medical care. In addition to responding to such detainee requests, the medical staff will investigate any medical issues observed by JTF-GTMO guards or staff. In general, health care is provided with the voluntary and informed consent of the detainee

in accordance with DoD Instruction 2310.08E, Medical Program Support for Detainee Operations, Section 4.7. The availability of care through ongoing monitoring and response to detainee-initiated requests has resulted in thousands of outpatient contacts between detainees and the medical staff, followed by inpatient care as needed. Multiple diagnoses and successful treatments have come out of this intense availability of care for those detainees who have chosen to engage with the medical department. There are many detainees with common medical conditions such as diabetes, hypertension, high cholesterol, and musculoskeletal pains. Quality healthcare metrics consistent with Department of Veterans Affairs/Department of Defense clinical practice guidelines are achieved with medications, physical therapy and provider counseling. Multiple psychiatric diagnoses have been identified and controlled such as depression, anxiety, and schizophrenia, as well as a variety of personality disorders.

9. ~~(U//FOUO)~~ For most medical care requiring inpatient services, detainees are admitted to the JTF-GTMO Detainee Medical Center. This is a [redacted] medical facility, which is staffed to provide more intensive, inpatient medical care solely to the detainees at GTMO. An [redacted] Behavioral Health Services (BHS) staff supports the outpatient mental health needs of the detainees, and runs the [redacted] Behavioral Health Unit (BHU) designed for detainees requiring inpatient psychiatric care and monitoring. The BHU staff includes two board-certified psychiatrists and nine hospital corpsmen organized to support the behavioral health mission. The BHU staff conducts mental health assessments, provides crisis intervention, develops individualized treatment plans, formulates therapy for management of self-injurious ideations or behavior, and provides supporting care and psychiatric medication therapy, as needed to treat symptoms of major psychiatric disorders. The medical and BHU staff provide appropriate physical and mental health care for all detainees through a coordinated team approach based on individualized plans that account for each patient's condition and circumstances.

10. ~~(U//FOUO)~~ As explained below, Mr. al-Qahtani has had long-term daily access to medical and mental health care and often voluntarily has chosen not to seek or actively engage in treatment from the JMG. JMG staff members routinely stop by his cell to discuss any medical concerns or complaints that he might have, but Mr. al-Qahtani has demonstrated an ongoing unwillingness to attend medical appointments with his PCM, to allow outpatient care with specialists, or to meet with BHU staff in a manner that allows him to fully discuss treatment of his mental status and behavior. Despite his frequent refusals to constructively interact with medical staff or to attend medical appointments, JMG medical professionals have advised him on the importance of diagnostic procedures, attempted to provide him with educational materials, and continue to closely monitor his medical conditions. His most recent interaction that included a physical exam with a credentialed provider was April 29, 2017. Following that time he superficially engaged in his living spaces with the medical department for an abbreviated encounter on June 8, 2017 regarding his difficulty sleeping but he declined the appointment offered to him to discuss further. He refused to fully participate in his annual medical review with his PCM in July of 2017. Mr. al-Qahtani has frequent contact with JMG technicians who offer to administer scheduled and as needed medications to him, currently methotrexate, folic acid, sertraline, haloperidol, zolpidem, quetiapine, multivitamin, bisacodyl, cetirizine, diphenhydramine, and magnesium hydroxide.

11. ~~(U//FOUO)~~ As of July 19, 2017, Mr. al-Qahtani weighed 184.5 pounds (131.45% ideal body weight, body mass index 29.78). His medical history includes biopsy proven atopic dermatitis (a

form of eczema) with psoriatic features (lesions) on his face, arms and legs that has been moderately controlled with weekly methotrexate (and daily folic acid supplementation) and as needed topical steroids. He has refused recommended dermatology evaluations (last offered in March of 2017) as well as screening tests for long term methotrexate use (last offered in April of 2017). He was diagnosed with latent tuberculosis infection at in-processing in February of 2002 but has consistently refused treatment (last offered in July of 2017). He remains asymptomatic on annual active tuberculosis screening. He was treated for *Helicobacter pylori* and has a history of occasional dyspepsia (digestion problems) treated with anti-reflux medication (proton pump inhibitor). He has lactose intolerance managed through diet modification and idiopathic, asymptomatic bradycardia (slow heart rate).

12. ~~(U//FOUO)~~ Mr. al-Qahtani has participated in intermittent, long-term non-religious fasting that previously required enteral feeding. His last enteral feed was in May of 2013. There are no concerns for weight loss at this time.

13. ~~(U//FOUO)~~ Mr. al-Qahtani's last routine dental appointment was in July of 2017. His last eye exam was in June of 2013 and he has consistently refused follow up appointments, with his most recent refusal occurring in April of 2017.

14. ~~(U//FOUO)~~ Mr. al-Qahtani completed measles/mumps/rubella, hepatitis A and B series and tetanus/diphtheria immunizations between 2002-2004. He declined a tetanus/diphtheria/acellular pertussis vaccine booster in 2013. He has consistently declined annual influenza vaccination.

15. ~~(U//FOUO)~~ Mr. al-Qahtani has a documented psychiatric history of Adjustment Disorder, Unspecified Anxiety Disorder, Personality Disorder with Borderline and Narcissistic traits, Schizophrenia, and Posttraumatic Stress Disorder. These diagnoses were made in June-September of 2016 based primarily on symptoms that the detainee reported, reports by the guard force, and the detainee's mental health history as reported by letter from his private counsel to the Periodic Review Board in June of 2016. Because the detainee would not constructively engage with BHU providers, it was difficult to assess his condition. Prior to that time period in 2016, Mr. al-Qahtani had exhibited symptoms of Adjustment Disorder with Anxiety and Narcissistic traits and symptoms of Unspecified Anxiety Disorder, but did not meet the clinical criteria for a definitive diagnosis of either. Since June of 2016, the JMG has continued to observe him and has engaged with Mr. al-Qahtani as much as he allows. Based on the BHU's ongoing evaluation of Mr. al-Qahtani, his current diagnoses are Unspecified Psychotic Disorder (this means that his psychotic symptoms do not meet all of the diagnostic criteria for a specific psychotic disorder, such as Schizophrenia) and Unspecified Depressive Disorder (the BHU has been unable to confirm that Mr. al-Qahtani's non-specific symptoms are related to Posttraumatic Stress Disorder, given his refusal to fully participate in BHU services). In addition to one episode of parasuicidal behavior (meaning not intended to cause death) in 2013 (see below), he has a documented history of self-harm without lethal intent (1 cm laceration of left arm repaired with sutures) on one occasion in 2008. He has no history of violent behavior during detention.

16. ~~(U//FOUO)~~ Mr. al-Qahtani was first referred for BHU services in 2007 after he was observed to be "very emotional" in the context of prayer at which time he was given no diagnosis and did not return for recommended follow-up. He was referred again to BHU in 2008 after cutting his arm with his fingernail. In April of 2013 he was admitted to the BHU for parasuicidal behavior

(he was observed to have tied a shirt around his neck) that his psychiatrist described on May 17, 2013 as "a suicide gesture to gain attention." He refused BHU follow-up after his discharge. He was engaged again by BHU as a Detainee of Interest (for non-religious fasting) in 2015 but refused follow-up appointments.

17. ~~(U//FOUO)~~ Starting in March of 2016, and continuing through the summer, reports of his behavior from the guard force were concerning for an underlying psychotic process (picking at the air, talking to himself, and sitting or standing in one position for hours at a time). Also, the JMG was provided the June of 2016 PRB letter of Mr. al-Qahtani's counsel which indicated that he had a remote history of psychosis pre-dating his detention at Guantanamo Bay. He was started on an antipsychotic medication in September of 2016, namely aripiprazole. He gained approximately 40 pounds after starting aripiprazole and he reported that it was not effective. He refused to take approximately half of the doses of aripiprazole prescribed to him. Aripiprazole was, therefore, changed to haloperidol in April of 2017 with the hope that he would eventually consent to taking its long-acting injectable formulation to improve adherence, given that he has a history of refusing to take medication. Sertraline (an anti-depressant) was started in March of 2017 for the long-term management of his symptoms of depressed mood and anxiety with the plan to discontinue diazepam which had been prescribed for that same indication. Mr. al-Qahtani has refused to take these current medications daily as advised.

18. ~~(U//FOUO)~~ Mr. al-Qahtani has frequently complained of insomnia to medical and psychiatric providers. He has been educated about helpful sleep habits and has been prescribed medication for the treatment of insomnia but he often does not adhere to the prescribed medication regimen for his insomnia.

19. ~~(U//FOUO)~~ Mr. al-Qahtani is currently prescribed, but often refuses, psychiatric medications including haloperidol for symptoms of psychosis, sertraline for depressed mood and anxiety, zolpidem as needed for insomnia, and quetiapine as needed for insomnia.

20. ~~(U//FOUO)~~ Currently Mr. al-Qahtani's psychiatric condition is stable and has been since he began treatment in 2016 after the incidents discussed above. Subsequent to the change in antipsychotic medication that took place in April of 2017, Mr. al-Qahtani's symptoms attenuated and guard staff no longer report observing the behaviors described above. Additionally, Mr. al-Qahtani reported a subjective sense of symptomatic improvement at that time. In spite of his baseline partial adherence to treatment recommendations and his complete refusal of all psychiatric medications during Ramadan 2017 (May 27, 2017 – June 24, 2017), his condition did not deteriorate. There are no indications at this time that his mental health condition affects his ability to perform his activities of daily living or otherwise function normally in the context of detention. The JMG is currently equipped and manned for the purpose of delivering psychiatric treatment above the standard of care for a continental United States military treatment facility for Mr. al-Qahtani's psychiatric condition.

21. ~~(U//FOUO)~~ Although Mr. al-Qahtani often refuses to constructively interact with medical and mental health care providers and regularly refuses to attend appointments, the JMG continues to closely monitor Mr. al-Qahtani's current physical and mental health status and continually makes special efforts to engage with him. For example, BHU personnel routinely

visit Mr. al-Qahtani at his cell rather than in the medical space because he refuses to come to his appointments on a routine basis but will often speak to them cell-side. During those conversations Mr. al-Qahtani displays good hygiene, is engaged and maintains good eye contact, speaks articulately, usually in English, and is calm. Mr. al-Qahtani is able to discuss with BHU personal events occurring in his daily life that impact him (such as his PRB results and his relationships with other detainees) and he often discusses his medication regimen with them, discussing the effect certain medications have on him. It is the opinion of the JMG psychiatric consultants that Mr. al-Qahtani's condition is currently well managed with minimal residual symptoms and even if his condition were more severe, the JMG has capability in excess of what he would need to be treated. While Mr. al-Qahtani is not fully compliant with the providers' treatment plans as it relates to his mental illness, that is not uncommon for individuals with his illnesses either in detention or outside of a detention environment.

22. ~~(U//FOUO)~~ The JMG will continue to recommend appropriate evaluation and treatment to Mr. al-Qahtani as necessary for his medical and/or mental health conditions.

I declare under penalty of perjury under the laws of the United States of America that the forgoing is true, accurate and correct.

Dated: 21 Aug 2017

[redacted]

Commander, Medical Corps, U.S. Navy

EMILY A. KERAM, MD
1160 N. DUTTON AVENUE, SUITE 255
SANTA ROSA, CA 95401
TEL: 707.525.0800 FAX: 707.526.8868

Supplemental Declaration in Response to Declaration of Senior Medical Officer, Joint Medical Group, JTF-GTMO

1. The following is my response to the August 21, 2017 declaration of the Senior Medical Officer (SMO) for the Joint Medical Group (JMG) of Joint Task Force Guantánamo Bay (JTF GTMO), in Cuba.

2. The SMO's declaration corroborates my earlier finding that al-Qahtani has a diagnosis of a psychotic disorder. In arriving at al-Qahtani's psychiatric diagnosis, the SMO did not interview al-Qahtani but relied on discussions with JMG Psychiatric consultants treating al-Qahtani, JMG Behavior Health Unit (BHU) reports, the observations of Joint Detention Group (JDG) guards in 2016, and records from al-Qahtani's June 2016 Periodic Review Board (PRB) which described al-Qahtani's pre-detention history of psychotic symptoms. (SMO Declaration, paras. 3, 15, and 17.)

3. As noted in my declaration for the PRB, in formulating al-Qahtani's psychiatric diagnosis, in addition to interviewing al-Qahtani himself, I interviewed al-Qahtani's brother, who stated al-Qahtani developed psychotic symptoms during adolescence. These included paranoid delusions, auditory hallucinations, incoherent speech, and behavioral disturbance including being found in a dumpster by police. These symptoms resulted in al-Qahtani's academic and occupational failure. I obtained objective evidence for al-Qahtani's diagnosis of psychotic disorder when I reviewed inpatient treatment records from al-Qahtani's hospitalization for an acute psychotic episode in May 2000. Al-Qahtani was taken into police custody after experiencing paranoid delusions, auditory hallucinations, and running semi-dressed through the streets of Mecca, Saudi Arabia. Federal Bureau of Investigation (FBI) agents observed symptoms consistent with psychosis (speaking to non-existent people, apparent auditory hallucinations) in November 2002. During my evaluation of al-Qahtani in 2015 and 2017 he endorsed contemporaneous auditory hallucinations. The JDG guards' observation of al-Qahtani's psychotic symptoms in 2016, including picking at the air, talking to himself, and sitting or standing in one position for hours at a time (SMO Declaration, para. 17) further support my finding.

4. The SMO's declaration supports my earlier finding that al-Qahtani cannot develop an effective treatment relationship with JMG clinicians. The SMO wrote that al-Qahtani demonstrated an unwillingness "to meet with BHU staff in a manner that allows him to fully discuss treatment of his mental status and behavior." (SMO Declaration, para. 10.) The SMO described al-Qahtani's "refusal to fully participate in BHU services." (SMO Declaration para. 15.) The SMO documented the lack of a therapeutic relationship between al-Qahtani and JMG clinicians, but did not offer an opinion regarding its basis. Please see paragraphs 12-15 and 22, below, for my findings on this issue. In fact, the

conditions that both the SMO and I have diagnosed are so chronic as to preclude recovery in spite of treatment at Guantánamo Bay.

5. It remains my opinion that al-Qahtani's psychiatric diagnoses are Schizophrenia and Posttraumatic Stress Disorder. While the SMO concurs that al-Qahtani has a psychotic disorder, he offers a diagnosis of an Unspecified Psychotic Disorder because al-Qahtani's "symptoms do not meet all the diagnostic criteria for psychotic disorder, such as Schizophrenia." (SMO Declaration para. 15.) The SMO does not describe how al-Qahtani's symptoms fail to meet these diagnostic criteria.

6. The Diagnostic and Statistical Manual, 5th edition, (DSM-5) of the American Psychiatric Association provides diagnostic criteria for Schizophrenia—specifically, two or more of the following, each present for a significant portion of time during a one-month period: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, or negative symptoms (diminished emotional expression or avolition); for a significant portion of the time since the onset of the disturbance, level of functioning in one or more areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset; continuous signs of the disturbance for at least six months (may include prodromal or residual symptoms); and other diagnoses must be ruled out.

7. As noted above, beginning in adolescence al-Qahtani exhibited all of the diagnostic criteria for Schizophrenia. The diagnostic criteria do not require the presence of continuous acute symptoms. It is not uncommon for negative symptoms of schizophrenia to predominate over time.

8. At the time of my 2015 and 2017 evaluations of al-Qahtani he endorsed significant symptoms of PTSD in excess of those required to meet the DSM-5 diagnostic criteria. He endorsed symptoms in each of the five categories listed, In addition to exposure to actual and threatened death, serious injury, and sexual violence at Guantánamo (GTMO), al-Qahtani endorsed symptoms in each of the four categories listed. These include intrusive symptoms (intrusive and distressing memories, nightmares, and intense psychological distress and physical reactivity on exposure to reminders of trauma); avoidance of reminders of the traumatic event (avoidance of memories and avoidance of JMG clinicians); negative alterations in cognitions and mood (feeling "broken," experiencing horror, anger, and shame); and marked alterations in arousal and reactivity (irritability, hypervigilance, insomnia, exaggerated startle response, and decreased concentration).

9. The SMO's declaration indicates that al-Qahtani is diagnosed with an Unspecified Depressive Disorder and that "BHU has been unable to confirm that Mr. al-Qahtani's non-specific symptoms are related to PTSD, given his refusal to fully participate in BHU services." (SMO Declaration, para. 15.) However, the extreme torture to which al-Qahtani was subjected at GTMO, as well as the medical and mental health consequences of this torture (including medical hospitalization) are well-documented. This documentation is presumably available to JMG clinicians, whom the SMO described as, "familiar with his complete medical and mental health history." (SMO Declaration para. 3.)

10. The documented torture to which al-Qahtani was subjected at GTMO should have led BHU clinicians to broach this history and conduct a PTSD symptom review with al-Qahtani. During my evaluations of al-Qahtani he stated that no BHU clinician had discussed torture or conducted a PTSD symptom review with him.

11. I note that the SMO relied on external records to support a diagnosis of a psychotic disorder. He apparently did not give similar weight to the sections of my declarations that discussed al-Qahtani's symptoms and diagnosis of PTSD.

12. As noted in paragraph 4 above, it is my opinion that al-Qahtani cannot receive effective treatment for PTSD at GTMO. Al-Qahtani was subjected to extremely dehumanizing, degrading, and humiliating torture at GTMO. This torture resulted in profound disruption of his dignity, sense of self, and personhood. These effects were amplified by al-Qahtani's pre-existing psychotic disorder.

13. JTF personnel, including JMG clinicians, directly participated in al-Qahtani's torture at GTMO. This is the context in which al-Qahtani intermittently refuses to engage with current JMG and BHU clinicians. It is unreasonable to believe that a survivor of torture could divorce his experience of torture from reminders of that torture. For al-Qahtani, this incomprehensible violation of a clinician's primary duty to their patient ("first do no harm") resulted in an irreparable rupture in the trust that forms the basis of a therapeutic clinician-patient relationship. To maintain that the passage of time would mitigate this betrayal is to deny a patient his dignity.

14. Other factors pose impediments to effective treatment at GTMO. Indefinite detention is, of itself, traumatizing as it devastates any attempt the individual makes to re-establish some semblance of personal agency. Rotations of JMG clinicians preclude the development of the long-term therapeutic relationship required for trauma recovery. The SMO posited that long-term linguists create continuity of care. (SMO Declaration para. 5.) I do not find this argument persuasive. A linguist does not deliver care and is not a medical professional. They should not be relied upon to act as a clinical member of a treatment team. Furthermore, linguists at GTMO may come from cultural or religious backgrounds that make trust difficult for detainees to establish.

15. The SMO's declaration states, "JMG Clinicians receive training to equip them to provide quality care in a detention setting by ensuring that they have a working knowledge and understating of the requirements and standards for providing health care to detainees." (SMO Declaration, para. 5.) There are no standards for providing psychiatric care to detainees who have been tortured while they remain in the environment in which they were tortured. Similarly, there are no standards for the provision of care to detainees who have been tortured by the clinician members of the authority that perpetrated the torture.

16. The SMO's declaration states, "The level and type of treatment provided to a detainee is dependent on the accepted medical standard of care for the condition being treated." (SMO Declaration para. 7.) However, BHU clinicians do not provide care for PTSD as outlined in several well-accepted practice guidelines. These include the following:

a. Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder, United States Department of Veterans Affairs and United States Department of Defense, 2017;[1]

b. Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder, American Psychological Association, 2017;[2]

c. Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder, American Psychiatric Association, 2004;[3] and

d. Guideline Watch Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder, American Psychiatric Association, 2009.[4]

17. These practice guidelines review effective evidence-based treatments for PTSD. In the interest of brevity, I will provide just one example. The VA/DoD practice guideline recommends individual, manualized trauma-focused therapies over medication treatment. Recommended therapies have a primary component of exposure and/or cognitive restructuring. Recommended modalities included Prolonged Exposure Therapy, Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), specific cognitive behavioral therapies for PTSD, Brief Eclectic Psychotherapy (BEP), Narrative Exposure Therapy (NET), and written narrative exposure. Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder, United States Department of Veterans Affairs and United States Department of Defense, 2017, at pp. 44-46.[5]

18. I do not believe these treatment modalities are available to GTMO detainees.

19. I am unable to comment on al-Qahtani's medication regimen. I have not seen him since January 2017. As the SMO notes, BHU clinicians have not fully assessed his current mental state. I do not have adequate clinical information to assess the appropriateness of the medications he is currently prescribed. I do note that al-Qahtani was previously prescribed aripiprazole and is now taking quetiapine as needed. Both of these antipsychotic medications are associated with metabolic syndrome. Patients on these medications require a minimum of annual laboratory assessment of cholesterol,

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[1] Available at https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal082917.pdf (accessed Sept. 11, 2017).
[2] Available at http://www.apa.org/ptsd-guideline/ptsd.pdf (accessed Sept. 11, 2017).
[3] Available at http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/acutestressdisorderptsd.pdf (accessed Sept. 11, 2017).
[4] Available at http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/acutestressdisorderptsd-watch.pdf (accessed Sept. 11, 2017).
[5] Available at https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal082917.pdf (accessed Sept. 11, 2017).

triglycerides, fasting glucose, and HgBA1C. Al-Qahtani should be offered a medication for insomnia that does not require blood work if he will not comply with this regime for quetiapine.

20. The SMO admits that al-Qahtani has not been fully assessed by BHU clinicians. Al-Qahtani has demonstrated an unwillingness "to meet with BHU staff in a manner that allows him to fully discuss treatment of his mental status and behavior." (SMO Declaration para. 10.) Therefore BHU clinicians have an incomplete understanding of al-Qahtani's mental health history, current symptoms, and concerns about treatment. This calls into question the accuracy of the SMO's diagnostic assessment of al-Qahtani, as well as his findings regarding al-Qahtani's current symptoms and response to treatment, or lack thereof. Thus, the SMO's assessment that al-Qahtani's symptoms did not deteriorate during Ramadan is based on insufficient information. (SMO Declaration para. 20.)

21. The SMO noted, "It is the opinion of the JMG psychiatric consultants that Mr. al-Qahtani's condition is currently well managed with minimal residual symptoms and even if his condition were more severe, the JMG has capability in excess of what he would need to be treated." (SMO Declaration para. 21.) Again, this assessment in based upon insufficient information as supported by the SMO's admission that al-Qahtani has not been fully assessed by BHU clinicians.

22. The SMO noted, "While Mr. al-Qahtani is not fully compliant with the providers' treatment plans as it related to his mental illness, that is not uncommon for individuals with his illnesses either in detention or outside of the detention environment." (SMO Declaration para. 21.) This statement accurately describes patients who do not believe they have a mental illness or those who do not desire treatment for their diagnosis. However, al-Qahtani has a strong desire to reduce his symptoms of PTSD and schizophrenia. He is unable to be effectively treated while he is detained at GTMO.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 12th day of September, 2017.

Emily A. Keram, MD

Emily A. Keram, MD

SUPPLEMENTAL DECLARATION OF EMILY A. KERAM, M.D.
REGARDING MOHAMMED AL QAHTANI

Pursuant to 28 U.S.C. § 1746, I certify that the following is true and correct to the best of my knowledge:

1. Mr. al Qahtani and I last reviewed his psychiatric symptoms during an unsecure phone call on December 18, 2017. (The Privilege Review Team monitored the call, conducting classification review in real time.)

2. Mr. al Qahtani reported symptoms of Posttraumatic Stress Disorder (PTSD) including painful and unwanted intrusive thoughts, images, and memories, as well as nightmares. He explained, "Sleep is such an issue for me. I see frightening things in my sleep. I try to forget these things but when I sleep I see things I went through, the torture I experienced."

3. Mr. al Qahtani attempts to avoid trauma-related thoughts and feelings. He endorsed negative affect (depression), decreased interest in activities, and isolation. He stated, "I tend to stay alone these days." He had not gone outside is some time. He explained, "It makes me sad to go outside and walk in this terrible place. It's a place without love."

4. Mr. al Qahtani has difficulty experiencing positive feelings. He feels anxious and irritable.

5. Mr. al Qahtani has insomnia, impaired concentration and memory, hypervigilance, and exaggerated startle response. Additionally, he experiences hopelessness.

6. Although he denied suicidal ideation, intent, or plan, it was difficult for him to respond to questions about his desire to stay alive. He clearly ties this desire to the possibility to his future prospects. He explained, "I wish that I can build a life and a family and a future."

7. During our December 2017 phone call I asked Mr. al Qahtani about his contemporaneous mental health treatment with Joint Medical Group (JMG) clinicians. Mr. al Qahtani reported that JMG psychiatrists continued to change every 3 to 6 months. He sees them once a week to once a month with the frequency determined by the different psychiatrists. Each visit lasts approximately one hour.

8. I have asked Mr. al Qahtani's attorneys to share their observations of his mental health during their visits. In November 2017, Mr. al Qahtani's attorney described Mr. al Qahtani as restless. He muttered to himself and lost eye contact. Mr. al Qahtani stated that indefinite confinement caused him to feel under pressure so that he couldn't think.

9. From a February 2018 visit, Mr. al Qahtani's attorney described him as appearing to have lost weight. When asked, Mr. al Qahtani explained that personnel no longer tell detainees their weight. Mr. al Qahtani stated, "I'm not improving. I'm getting worse." He described daily episodes during which he screams, speaks to himself, and cries uncontrollably. He

reported that the Commander of the Joint Detention Group meets with the other detainees to enlist their help in looking after him.

10. During a March 2018 phone call, Mr. al Qahtani told his attorney that he had not improved since their February visit. He was taking two medications but could not recall their names. The medications were prescribed to help calm him, improve focus, and reduce insomnia. It appears that, consistent with his diagnosis of schizophrenia, one of the medications was likely an antipsychotic. Antipsychotics are used to address delusional thinking and hallucinations, symptoms of schizophrenia. Mr. al Qahtani reported that medications were prescribed to help him forget about "ghosts." Some people from Mr. al Qahtani's culture believe that delusional thinking and hallucinations are caused by "ghosts" or "djinns." Mr. al Qahtani reported that the medications were not very effective.

11. On the March 2018 call with his attorney, Mr. al Qahtani reported symptoms consistent with PTSD and Schizophrenia. As is the case for many patients suffering posttraumatic nightmares, Mr. al Qahtani noted he was afraid to sleep. He was experiencing insomnia. He had visions of being chased by ghosts during the day. At times he found himself screaming. He felt that he couldn't talk to people. "Those who see me would say I'm crazy."

12. During that phone call, Mr. al Qahtani exhibited increasingly impaired concentration. His attorney observed that Mr. al Qahtani episodically lost the thread of their conversation. He asked the attorney to repeat himself throughout their discussion.

13. Mr. al Qahtani told his attorney that JMG clinicians continued to see him but couldn't really care for him. "They just talk to you."

14. As described in my previous declarations, Mr. al Qahtani has still not been offered effective evidence-based psychotherapy for PTSD recommended in United States Departments of Defense (DoD) and Veterans Affairs (VA) PTSD treatment guidelines. For example, he denied being offered Prolonged Exposure Therapy, Imagery Rehearsal Therapy for Nightmares, or Cognitive-Behavioral Therapy for Insomnia. He has also not been taught skills that are helpful for managing anxiety and autonomic arousal symptoms such as progressive relaxation, mindfulness, grounding, and breathing. These skills are routinely taught to PTSD patients who are cared for by US DoD and VA clinicians.

15. Mr. al Qahtani is prescribed psychotropic medications. During our phone call and in discussion with his attorneys, he has been unable to remember the names of medications he has tried most recently. He reported trials of different medications which are discontinued secondary to adverse effects. At times he self-discontinues medications that he does not feel are helpful. I note that in 2017, JMG clinicians prescribed Haldol, an antipsychotic, and Zoloft, a medication for insomnia. This is consistent with his diagnosis of Schizophrenia.

16. It remains my opinion that Mr. al Qahtani is suffering from PTSD. As noted in my previous declarations, he is also diagnosed with schizophrenia, a chronic, severe psychotic illness. During our phone call Mr. al Qahtani reported ongoing auditory hallucinations. During his March 2018 phone call with his attorney, Mr. al Qahtani reported similar psychotic symptoms.

17. Based on the above, it is my opinion that Mr. al Qahtani's symptoms of PTSD and Schizophrenia have not improved from the time I first evaluated him in May 2015. As set forth in my June 2016 report and December 2016 supplemental declaration to this Court, as well as my July 2016 declaration to the Periodic Review Board, it remains my opinion that Mr. al Qahtani's symptoms of PTSD and Schizophrenia are chronic and are worsening. These symptoms will therefore continue beyond one year, will probably continue to worsen, and will be present throughout his lifetime. Goals of appropriate treatment are symptom management, not cure. Please refer to these documents for the bases of these opinions.

18. It remains my opinion that it is not possible for Mr. al Qahtani to receive appropriate treatment from the JMG-Guantanamo. The bases for this opinion are discussed in my July 2016 supplemental declaration to the Periodic Review Board and my December 2016 supplemental declaration to this Court.

19. As per the analyses set forth in my report and supplemental declarations listed above, it remains my opinion that Mr. al Qahtani's diagnoses of PTSD and Schizophrenia render him unable to join or return to any battlefield; psychiatric assessment of future threat places him at low risk for future dangerousness.

20. As per the analysis set forth in my previous report and declarations, it remains my opinion that, despite their clinical competence and desire, JMG clinicians are unable to provide appropriate treatment to Mr. al Qahtani for his diagnoses of PTSD and Schizophrenia. As previously set out, it remains my opinion that Mr. al Qahtani would receive appropriate treatment for these diagnoses were he to be repatriated to the Kingdom of Saudi Arabia, where his family resides.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 14th day of April 2018.

Emily A. Keram, M.D.

EMILY A. KERAM, M.D.
1160 N. Dutton Avenue, Suite 255
Santa Rosa, CA 95401