IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

IBRAHIM OSMAN IBRAHIM IDRIS,
Detainee, Guantanamo Bay Naval Station,

MOHAMMED IDRIS,
Next Friend,

Petitioners,

v.

BARACK H. OBAMA,
President of the United States, *et al.,*

Respondents.

Civil Action No. 05-1555 (RCL)

MOTION OF PETITIONER FOR JUDGMENT
ON HIS PETITION FOR A WRIT OF HABEAS CORPUS

For the reasons stated in the accompanying memorandum of law, Petitioner Ibrahim Idris, by and through his undersigned counsel, respectfully moves this Court to (i) grant his petition for the writ of *habeas corpus* and (ii) order Respondents to take all necessary and appropriate diplomatic steps to facilitate his immediate repatriation to Sudan.

A proposed order is attached.

Dated: June 28, 2013

Respectfully submitted,

s/ Jennifer R. Cowan

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MEMORANDUM OF LAW IN SUPPORT OF PETITIONER'S MOTION FOR JUDGMENT ON HIS PETITION FOR A WRIT OF HABEAS CORPUS

INTRODUCTION

Pursuant to the Supreme Court decision in *Hamdi v. Rumsfeld*, Respondents may only detain Petitioner for the purpose of preventing him from returning to the battlefield. Petitioner's long-term severe mental illness and physical illnesses make it virtually impossible for him to engage in hostilities were he to be released, and both domestic law and international law of war explicitly state that if a detainee is so ill that he cannot return to the battlefield, he should be repatriated. When interpreted in accordance with domestic law and the principles of international law, the Authorization for the Use of Military Force ("AUMF") does not permit the continued detention of Mr. Idris. His petition for a writ of *habeas corpus* should be granted and Respondents should be ordered

to take all necessary and appropriate diplomatic steps to facilitate his immediate repatriation to Sudan.

BACKGROUND

A. Procedural History

Petitioner's petition for *habeas corpus* was filed *pro se* with the Court on August 2, 2005. Dkt. No. 1. Counsel was appointed to represent Petitioner in November 2005. Minute Order dated November 9, 2005. In meetings with counsel in 2008, Petitioner was completely non-communicative. In January 2009, based on Petitioner's continuing lack of communication and other behavior which, in counsel's non-medical opinion, was indicative of mental illness, counsel moved for the appointment of Petitioner's brother as next friend. Dkt. No. 158. In February 2009, Petitioner's counsel filed an emergency motion for a psychological evaluation of Petitioner and for access to his medical records. Dkt. No. 169. In connection with those motions, the Court ordered an evaluation of Petitioner by a military psychiatrist, who submitted a forensic evaluation dated April 21, 2009 (the "Forensic Evaluation") (redacted copy attached hereto as Exhibit A).[1] The forensic evaluation represents the most complete information available to counsel for Petitioner regarding Petitioner's health. Counsel for Respondents provided a brief update on Petitioner's health via email on March 7, 2013 (the "March 2013 Report"), which is attached hereto as Exhibit B.

[1] A redacted copy of the Forensic Evaluation is attached as an exhibit because the identities of the medical personnel disclosed in the document have been designated by Respondents as protected information.

In November 2009, Petitioner was cleared for transfer by the Review Panel of the Guantanamo Review Task Force. *See* Dkt. No. 264 (Notice filed by Respondents that Petitioner's transfer status was no longer deemed protected information). On December 18, 2009, the Court granted under seal Respondents' motion to stay the case based on Petitioner's transfer status and allowed either party to move "for cause shown" to lift the stay. *See* Dkt. No. 234; Dkt. No. 269 (unsealing the Order staying the action).

On June 11, 2013, the Court granted Petitioner's unopposed motion to lift the stay so that Petitioner could file this motion for judgment. Dkt. No. 269.

B. Petitioner Has Suffered From Severe Mental and Physical Illness For Many Years

Soon after Petitioner was brought to Guantanamo in January 2002, he was diagnosed with schizophrenia and during the course of his detention has developed a number of serious physical conditions. Forensic Evaluation at 3-4, 7. In 2009, the military psychiatrist observed that Petitioner's thought processes and speech were "grossly disorganized" and that he suffers from auditory and visual hallucinations which "command[] a great deal of his limited attention." *Id.* at 7. The military psychiatrist concluded that Petitioner was "operating in a delusional reality system, with little foundation in his real-world circumstances" and that he lacked "focus and attention to his actual surroundings" and instead gave his "ongoing attention to and focus on internal stimuli." *Id.* at 8. In the opinion of the military psychiatrist, Petitioner's mental illness

limited his ability to communicate because he was incoherent and unable "to effectively communicate either verbally or with non-verbal techniques." *Id.*[2]

In 2009, Petitioner was also suffering from several long-term medical conditions which limited his mobility and activities. In the Forensic Evaluation, the military psychiatrist noted that Petitioner was morbidly obese and suffered from pitting edema (an abnormal accumulation of liquid which results in swelling) and from problems with his circulation, digestion, joint flexibility, blood sugar levels, and blood pressure. *Id.* at 3, 7.

In the intervening years, Petitioner's mental and physical condition has deteriorated. When counsel met with him, he was frequently non-communicative and appeared to have gained more weight. In March 2013, counsel for Petitioner received an update on his mental and physical condition from counsel for Respondents. According to that report, he continues to suffer from schizophrenia, disorganized type and has "been observed to display disorganized behavior such as wearing underwear on his head, whispering to himself, moving his mouth as if he is responding to internal stimuli, and laughing and singing out of context. He has also exhibited disorganized, incoherent, and tangential thought process and nonsensical speech." March 2013 Report. According to Respondents, since 2009, Petitioner has refused medication for schizophrenia. *Id.*; Forensic Evaluation at 4-7 (reflecting a pattern of Petitioner refusing medication for his mental illness while at Guantanamo).

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[2] The descriptions of Petitioner's behavior in the Forensic Report are consistent with counsel's observations of Petitioner.

The concerns about Petitioners' blood sugar level that were noted by the military psychiatrist in 2009 have now become diabetes and Petitioner also has "hyperlipidemia" (significantly heightened lipid levels). March 2013 Report. In addition, the March 2013 Report stated that Petitioner had been hospitalized since February 16, 2013, both for a foot infection and because other detainees had grown less tolerant of his "psychotic behavior." *Id.*

ARGUMENT

I. The Government Does Not Have An Unfettered Right To Detain Petitioner

A. The Government May Detain Petitioner Solely To Prevent Him From Returning To The Battlefield

The government's right to detain Mr. Idris is based on the Authorization for the Use of Military Force ("AUMF"), which permits the use of "all necessary and appropriate force" against "nations, organizations, or persons" who planned the September 11, 2011 terrorist attacks and those who harbored them. AUMF, Pub. L. 107-40, § 2(a), 115 Stat. 224, 224 (2001). In *Hamdi v. Rumsfeld*, relying on "universal agreement and practice" in international law, the Supreme Court interpreted the AUMF as authorizing the detention of individuals subject to the AUMF for the duration of the conflict because detention "is so fundamental and accepted an incident of war as to be an exercise of the 'necessary and appropriate force' Congress has authorized the President to use." 542 U.S. 507, 518 (2004).

However, the Supreme Court concluded that detention is permitted only for the limited purpose of "prevent[ing] captured individuals from returning to the field of battle

and taking up arms once again." *Id.* at 518-519 (citing Yasmin Naqvi, *Doubtful Prisoner-of-War Status*, 84 Int'l Rev. Red Cross 571, 572 (2002)); *see also Clark v. Martinez*, 543 U.S. 371 (2005) (inadmissible alien may not be detained indefinitely but may only be detained for the period "reasonably necessary" to fulfill the purpose of the underlying statute); *Zadvydas v. Davis*, 533 U.S. 678 (2001). Such detention is not penal and "the object of capture is to prevent the captured individual from serving the enemy. He is disarmed and from then on must be removed as completely as practicable from the front, treated humanely and in time exchanged, *repatriated* or otherwise released." *In re Territo*, 156 F.2d 142, 145 (9th Cir. 1946) (*quoted in Hamdi*, 542 U.S. at 518) (emphasis added). The determination of whether detention is justified should look at the individual circumstances of the detainee, because "the position that the courts must forgo any examination of the individual case and focus exclusively on the legality of the broader detention scheme cannot be mandated by any reasonable view of separation of powers." *Hamdi*, 542 U.S. at 535-536 (Souter, J., concurring).

B. Domestic Law and The International Law Of War Recognize That Seriously Ill Detainees Should Be Repatriated

In determining the parameters of detention under the AUMF, the Supreme Court looked to "longstanding law-of-war principles." *Hamdi*, 542 U.S. at 521. The United States Circuit Court for the District of Columbia has also held that domestic law may inform a determination of whether an individual can be detained. *See Al Warafi v. Obama*, No. 11 Civ. 5276, 2013 WL 2278201, at * 2 (D.C. Cir. May 24, 2013). Domestic law and international law both recognize that under specific circumstances,

detainees should be repatriated prior to the end of hostilities. Specifically, both Army Regulation 190-8 and the Third Geneva Convention recognize that an individual detainee should be repatriated if he is seriously ill (or injured) and therefore cannot return to the hostilities. *See* Dep't of the Army, Army Reg. 190-8, Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detainees (Oct. 1, 1997) ("Regulation 190-8"), ch. 3, § 12; Geneva Convention Relative to the Treatment of Prisoners of War art. 109-10, Aug. 12, 1949, 6 U.S.T. 3316, 75 U.N.T.S. 135 ("Third Geneva Convention"). Here, Petitioner's significant mental and physical illnesses would make it impossible for him to "return to the battlefield"[3] and as his detention therefore serves no legitimate purpose, there is no basis for his continued detention.

1. Army Regulation 190-8 Requires The Repatriation Of Seriously Ill Detainees

Regulation 190-8 is domestic law, applicable to all branches of the military, which "implements international law, both customary and codified, relating to EPWs [enemy prisoners of war] . . . and ODs [other detainees][4] which includes those persons held during military operations other than war." Regulation 190-8 at ch.1, §1(b); *see also*

[3] Petitioner's activities prior to his detention are not at issue in this motion. Petitioner does not concede that he ever participated in the "battle" (and it would therefore be impossible for him to "return" to the battlefield), but nevertheless uses that formulation because of its use in the relevant opinions and legal analysis.

[4] The term "Other Detainees" is defined as "[p]ersons in the custody of the U.S. Armed Forces who have not been classified as an EPW [enemy prisoner of war] (article 4, GPW), RP [retained person] (article 33, GPW), or CI [civilian internee] (article 78, GC)." Regulation 190-8 Appendix B, Section II "Terms." Regulation 190-8 requires that Other Detainees be treated as EPWs until a legal status is ascertained by competent authority. *Id.*

Al Warafi, 2013 WL 2278201, at *2 (Guantanamo detainee may invoke Regulation 190-8 "to the extent that the regulation explicitly establishes a detainee's entitlement to release from custody"). With respect to sick and wounded prisoners, Regulation 190-8 provides that:

> The following EPW and RP ["Retained Personnel"] are eligible for *direct repatriation*:
> ….
>
> (2) Sick or wounded EPW and RP whose conditions have become chronic to the extent that prognosis appears to preclude recovery in spite of treatment within 1 year from inception of disease or date of injury.

Regulation 190-8, ch.3, § 12(l)(2) (emphasis added).[5]

When interpreted in accordance with Regulation 190-8, the AUMF does not authorize the continued detention of a severely ill detainee whose "prognosis appears to preclude recovery in spite of treatment within 1 year from inception of disease or date of injury" and whose detention therefore does not serve the purpose of preventing his return to the battlefield.

2. The Third Geneva Convention Requires The Repatriation Of Seriously Ill Detainees

In addition to domestic law, it is appropriate to look to "longstanding law-of-war principles" to assist in determining the rights of Guantanamo detainees. *See Hamdi*, 542

[5] Regulation 190-8 also calls for the establishment of a Mixed Medical Commission to determine whether prisoners are eligible for repatriation. Army Regulation 190-8 at ch. 3, §12(a)(2). However, the Mixed Medical Commission need not assess prisoners who are eligible for direct repatriation. *Id.* at ch. 3, § 12(k)(2). To the best of counsel's knowledge, no Mixed Medical Commission has been established for the detainees at Guantanamo.

U.S. at 521; *Hamdan v. Rumsfeld*, 548 U.S. 557, 630 (2006) ("Common Article 3 [of the Geneva Conventions] . . . affords some minimal protection . . . . to individuals associated with neither a signatory nor even a nonsignatory 'Power' who are involved in a conflict 'in the territory of' a signatory.").

Petitioner is not directly invoking the protection of the Geneva Conventions, see Military Commissions Act of 2006, Pub. L. 109-366, § 5(a), Oct. 17, 2006, 120 Stat. 2631, but is instead arguing that the government cannot meet its burden of establishing authority to continue to detain Petitioner given the limits on detention in the Third Geneva Convention, as an articulation of longstanding international law. The government has taken a similar position: "Principles derived from law-of-war rules governing international armed conflicts, therefore, must inform the interpretation of the detention authority Congress has authorized for the current armed conflict." Respondents' Mem. Regarding The Government's Detention Authority Relative To Detainees Held At Guantanamo Bay, *In Re Guantanamo Bay Detainee Litigation*, Misc. No. 08-442 (TFH) (D.D.C. March 13, 2009) 1 (Dkt. No. 1689) (attached hereto as Exhibit C); *id.* 6, 9 (citing to the Third Geneva Convention).

The Third Geneva Convention requires that certain prisoners be repatriated directly to their home countries:

> (1) Incurably wounded and sick whose mental or physical fitness seems to have been gravely diminished.
>
> (2) Wounded and sick who, according to medical opinion, are not likely to recover within one year, whose condition requires treatment and whose mental

> or physical fitness seems to have been gravely diminished.
>
> (3) Wounded and sick who have recovered, but whose mental or physical fitness seems to have been gravely and permanently diminished.

Third Geneva Convention, art. 110. This repatriation requirement is grounded in the principle that seriously ill detainees "are no longer likely to take part in hostilities against the Detaining Power." 1 Jean-Marie Henckaerts & Louise Doswald-Beck, *Customary International Humanitarian Law: Rules* 345 (Cambridge Univ. Press 2005). In fact, the Additional Protocol I to the Geneva Conventions defines the "wounded" and "sick" as "persons, whether military or civilian, who, because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care and who refrain from any act of hostility." Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 Aug. 1949 and Relating to the Protection of Victims of International Armed Conflicts (Additional Protocol I), art. 8, 1125 U.N.T.S. 3. This status supersedes a designation as "combatant," and "lasts as long as the disease or the wound keeps the individual *hors de combat*." Anicée Van Engeland, *Civilian or Combatant? A Challenge for the Twenty-First Century* 48 (Oxford Univ. Press 2011).

The government's detention authority is cabined by well-accepted provisions of the law of war that direct that a person so debilitated by disease or injury as to no longer be able to participate in the conflict must be repatriated, and the government has accepted, as a general matter, that its authority is limited by those principles of the law of war.

C. In *Basardh*, The Court Ordered Petitioner Released Because There Was Little Risk Of Him Returning To The Battlefield

Although not apparently related to the health of the detainee, *Basardh v. Obama*, 612 F.Supp.2d 30 (D.D.C. 2009), is precisely analogous to this situation. In *Basardh*, the court found that because the AUMF is designed to prevent future acts of international terrorism and its interpretation is informed by the principles of the laws of war, "the AUMF does not authorize the detention of individuals beyond that which is necessary to prevent those individuals from rejoining the battle, and it certainly cannot be read to authorize detention where its purpose can no longer be attained." *Id.* at 34. The court further concluded that Basardh's prospect of rejoining the entities defined in the AUMF was "at best, a remote possibility" and therefore granted Basardh's *habeas* petition. *Id.* at 35. Basardh was transferred from Guantanamo to Spain in 2010. The Guantanamo Docket, N.Y. Times, http://projects.nytimes.com/guantanamo/detainees/252-yasim-uhammed-basardah (last visited Jun. 27, 2013).

II. The Likelihood Of Petitioner Returning To The Battlefield Is Remote

The substantial deterioration of Petitioner's mental and physical health during his years of detention at Guantanamo would make it nearly impossible for him to engage in hostilities if he were to be transferred to Sudan, especially given the limited availability of psychiatric care in that country.

According to Dr. Stephen N. Xenakis, a psychiatrist and retired Brigadier General in the United States Army, Petitioner has a poor prognosis. Given his significant mental illness, he will likely continue to deteriorate and suffer "worsening cognitive decline" and

decreasing ability to care for himself. *See* Exhibit D, Declaration of Stephen X. Xenakis, dated June 26, 2013 ("Xenakis Declaration") ¶ 10. Individuals like Petitioner with a diagnosis of Disorganized Type Schizophrenia "are unable to initiate or engage in activities that require goal orientation or execute even simple work tasks." *Id.* ¶ 13. In addition, Petitioner is obese and has been diagnosed with diabetes and is likely to develop other debilitating medical conditions as he ages. *Id.* ¶ 11. According to Dr. Xenakis, it is "inconceivable that [Petitioner] could engage in any combatant action. *Id.* ¶ 14.

While medication can "sometimes help control bizarre behavior, hallucinations, and disorganized thinking, [it can] neither cure nor resolve the disorder," *see* Xenakis Declaration ¶ 10, and according to Respondents, Petitioner is currently refusing to take medication and has regularly refused to take medication while detained at Guantanamo. March 2013 Report; Forensic Evaluation at 4-7. Although Petitioner's family is eager to welcome him home to Sudan and to care for him, Sudan has limited mental health services and access to related medication, so unfortunately, there is little likelihood that Petitioner's condition would improve if he were transferred to Sudan.

According to the World Health Organization, there is no health insurance in Sudan and the cost of antipsychotic medication is 27% of the minimum daily wage (though it is available free of charge in emergency situations). *Id.* at 5.[6] There are only

[6] Given Petitioner's mental and physical condition, he is highly unlikely to obtain a job in Sudan, a country where unemployment is estimated at 20%. The World Factbook: Sudan, Central Intelligence Agency (May 15, 2013), https://www.cia.gov/library/publications/the-world-factbook/geos/su.html.

seventeen outpatient mental health facilities in Sudan, two of which are exclusively for children. Exhibit E, WHO-AIMS Report on Mental Health System in Sudan, WHO and Ministry of Health, Khartoum, Sudan, 2009 at 10. On average, patients are seen in such facilities 1.5 times; there is a lack of information regarding patients' medical history at the facilities, there is no follow-up care in the community, and "the health services suffer from acute shortages in trained personnel." *Id.* at 8, 10.

In addition to his significant health issues, Petitioner is also socially isolated. The March 2013 Report stated that Petitioner had been transferred to the hospital, in part because "[h]is fellow detainees have grown weary of tolerating his psychotic behavior." Exhibit B. Such frustration provides another independent reason why it would be impossible for Petitioner to rejoin the hostilities.

Given the precarious state of Petitioner's mental and physical condition, he could not realistically engage in hostilities if he were to be released. His longstanding mental and physical illnesses would qualify him for repatriation under both Regulation 190-8 and the Third Geneva Convention, and his detention is not necessary to prevent his return to the battlefield. His detention is therefore not authorized by the AUMF.

CONCLUSION

For the reasons stated above, Petitioner respectfully requests that his petition for the writ of *habeas corpus* be granted and Respondents ordered to take all necessary and appropriate diplomatic steps to facilitate his immediate repatriation to Sudan.

Dated: June 28, 2013.

Respectfully submitted,

s/ Jennifer R. Cowan
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DEPARTMENT OF THE ARMY
WESTERN REGIONAL MEDICAL COMMAND
AND MADIGAN ARMY MEDICAL CENTER
TACOMA, WASHINGTON 98431-1100

FORENSIC EVALUATION

NAME: Ibrahim Osman Ibrahim Idris
REGISTER NUMBER: ISN #36
CASE NUMBER: 05-1555
DATE OF REPORT: April 21st, 2009

REFERRAL INFORMATION

In a bench order on March 25, 2009, the Honorable James Robertson, United States District Court Judge for the District of Columbia, requested an evaluation of Mr. Idris for present competency to assist counsel. The order was understood to request the examiner's evaluation and opinion as to whether defendant Idris is presently suffering from a mental disease or defect rendering him unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense. The referral question is posed in regard to the defendant's current Writ of Habeas Corpus.

IDENTIFYING INFORMATION

Ibrahim Osman Ibrahim Idris is an (approximately) 49 year old Sudanese male who reported (in his Writ of Habeas Corpus) that he was arrested in Pakistan for unspecified reasons in 2001 by the Pakistani police, who "handed him over to the Americans." Subsequent to that, he was transferred to Guantanamo Bay, Cuba.

ASSESSMENT PROCEDURES

On April 19th, 2009 I attempted to evaluate Mr. Idris at JTF GTMO. He was advised of my presence, and my request to conduct this court ordered psychiatric assessment, but he refused to meet with me. After his initial refusal, he was asked a second time, at which point he grew agitated and refused to speak further with the Behavioral Health Unit (BHU) staff. Efforts at engaging with him were suspended for the day at this point.

On April 20th, 2009 Mr. Idris was again approached by BHU staff, requesting his cooperation with my clinical interview. This time, he agreed to see me but was unwilling to leave the BHU for the interview. Subsequently, he was evaluated in the enclosed outdoor recreation area of the BHU.

Prior to my clinical interview, I was able to observe him in his cell via closed-circuit video surveillance for approximately three hours. During that three hour timeframe, despite agreeing to meet with me, he was so grossly disorganized to behaviors and thoughts that he was unable to collect himself sufficiently to leave his cell. Over that three hours timeframe, I observed him in this grossly disorganized state manipulating the content of his cell without discernable pattern or purpose. This behavior including his arranging and rearranging his possessions, his bed sheets and pillows, mattress, shoes on the floor and paperwork in his cell. He also wrapped and re-wrapped items repeatedly in toilet tissue, again without discernable pattern or purpose. Prior to

his leaving his cell, he donned, removed and donned again multiple identical T-shirts and pants, layering one clothing item over another without rational cause.

After this three hours period of disorganized behavior, Mr. Idris did allow guard staff to escort him to the enclosed BHU recreation area. Once there, he was only marginally cooperative with the interview. He initially refused to speak with me in the presence of the first Arabic interpreter assigned the task of translating for this clinical assessment. That translator was dismissed, and another assigned. Mr. Idris again refused to speak to me in the presence of this second translator, and the interview was terminated.

Once both translators and this examiner had left the BHU recreation area, the defendant indicated to the guard in broken English that we was willing to communicate with me, without the translators present. I returned to the recreation area, and attempted to engage Mr. Idris in a clinical interview (with the help of the guard, with whom he had a reasonable rapport).

I spoke to Mr. Idris for approximately 30 minutes, during which time he was unable to communicate rationally or effectively with me. He appeared grossly disorganized to thought and behavior throughout the interview, frequently responding to auditory hallucinations of an apparent delusional tormentor he was experiencing standing next to him in the enclosed recreational area. During the course of the interview, the defendant engaged in a running dialogue with this invisible tormentor, speaking to it in a whispered tone but with agitation in his mannerisms. When he did relate to me directly, his interactions were disjointed with preoccupation to numbers that he was writing on the palm of his hand with an ink pen.

Mr. Idris' attention span was extremely limited during the interview as well, with him frequently wandering away from both my conversation and the running dialogue that he was having with his hallucination. His emotional affect was inappropriate to the context and surroundings of the interview as well, with him repeatedly laughing out loud without any external stimuli. He spent the majority of time pacing around the recreation area, generally oblivious to his surroundings.

At one brief point during the interview, I was able to draw his attention to the letter he sent to the District Court in August of 2005 that initiated his habeas case. If he was able to remember that letter, or to appreciate its significance in the evaluation at hand, he was only able to acknowledge by repeatedly saying "no Pakistan, no Pakistan." After approximately 30 minutes, with no headway made in establishing a rational dialogue, I terminated this clinical interview.

BACKGROUND INFORMATION ACCORDING TO THE DEFENANT

Family and developmental history Unable to assess, the defendant was too disorganized to thought to provide any information about his family or developmental history. His letter to the court, filed August 2nd, 2005 reports that he is "from a very poor family in Sudan" and that he is unmarried.

Education In august 2005, Mr. Idris was able to hand-write a cogent letter to the court, leading to the initiation of his Writ of Habeas Corpus. He indicated in that letter that he was "a Koran teacher" prior to his detention. This suggests some level of formal education.

Employment Mr. Idris was unable to discuss his employment history prior to his detention, but his letter did indicate that he was a Koran teacher in Sudan.

Substance use history Unable to assess

Medical The state of Mr. Idris' physiological health prior to his detention is unknown. Since his arrival at JTF GTMO, he has experienced problems with weight gain, bilateral lower extremity pitting edema and other somatic issues. He has not suffered any seizure activity during his detention, and has not experienced any significant head trauma.

Mental Health History Throughout his detention, Mr. Idris has denied any history of, or current problems with, his mental health. Given his age (late 5th decade of life) and the severity of his current psychotic state, it is likely that he experienced mental health problems prior to his detention, but this is only a presumption as there is no verifying factual information.

Legal History Unknown.

SUPPLEMENTAL INFORMATION

Legal: The legal documents available for review included:

1. Petition for Writ of Habeas Corpus on the accused, filed with the court on August 2nd, 2005 (photo copy of original and English translation)
2. Declaration of Jennifer S. Cowan, Esq. in support of Motion for Appointment of Mohammed Idris as Next Friend on the accused dated January 23rd, 2009
3. Declaration of John B. Missing, Esq. in support of petitioner's emergency motion to compel Psychological Evaluation and Access to Medical Records on the accused dated March 19th, 2009
4. Declaration of Matthew L. Leonard, Esq. in support of petitioner's emergency motion to compel Psychological Evaluation and Access to Medical Records on the accused dated March 19th, 2009
5. Draft (unsigned, undated) Declaration of [redacted], treating psychiatrist

Medical: The medical documents available for review included:

1. Mr. Idris' JTF GTMO medical record, dated January 2002 through present, including his mental health records.

Collateral contacts: During the course of this clinical assessment, I interviewed the detainee's treating psychiatrist, guard staff at the BHU, psychiatric technicians at the BHU and two Arabic translators [redacted] who have had extensive interactions with Mr. Idris at JTF GTMO

EVALUATION FINDINGS

Mental Status: Mr. Idris first arrived at JTF GTMO in January 2002. Very shortly after his arrival, he was identified by mental health staff as having mental health problems, exhibiting crying spells, periodic mutism and subjective reports of unspecified nightmares and auditory hallucinations of voices talking to him. As early as February 2002, he had been prescribed a

regimen of psychotropic medications which included antipsychotic drugs (Zyprexa) and antidepressants (Prozac). He remained on an evolving regimen of these medications for 20 months, ending in October 2004 when he appeared asymptomatic and had requested to stop taking them.

From the time of his initial presentation to mental health in February 2002 through the spring of 2004, Mr. Idris had reported episodic problems with hallucinations, and had episodically displayed clinical evidence of a primary thought disorder, most notably periodic mutisim, disorganized and mumbling patterns of speech, disorganized and inconsistent behaviors, disorganized thinking and response to internal stimuli. Multiple different treating psychiatrists throughout that first 20 month period documented waxing and waning periods of lucid thought, which gradually improved with treatment with psychotropic medications. Early in his treatment, his psychotic state was severe to the point that it interfered with his somatic medical care, as evidence by a note dated March 17th, 2002 where he was experienced tooth pain but was too psychiatrically ill to give appropriate consent for elective dental work. As a result, his dosing of antipsychotic medication was gradually increased to offer him maximum efficacy of treatment. Further, during this initial period of treatment, poor memory of facts and events was a documented clinical symptom of his psychiatric condition. Throughout this period, Mr. Idris showed minimal (if any) insight to his condition; consistently denying any psychiatric problem or complaint despite manifested the above referenced clinical symptoms.

By the spring of 2002, Mr. Idris' began to show improved mental health, with longer periods of rational thought while voluntarily taking his regimen of psychotropic medications. In a note dated June 25th, 2002, the patient himself reported that he was feeling "better than before," displaying an increased insight to his illness that is not uncommon in patient suffering with psychotic illnesses once they begin to respond to medication management. His clinical progress was also noted in his documented mental status examinations, with more organized thinking and behavior, fewer problems with memory and improved interpersonal functioning.

By the summer of 2002, in the context of improved function and decreased psychosis, Mr. Idris began to refuse his medication regimen feeling that he was "better" and no longer needed the drugs. Over time, his psychotic symptoms began to return, he once again began to exhibit periods of mutism, disorganized behavior and thought, response to internal stimuli and social isolation. By the fall he was taking his medication approximately half the time that they were prescribed, and he was becoming increasingly disorganized.

Throughout the fall of 2002, the winter of 2003 and into the spring of 2003, Mr. Idris began to show a pattern of social withdrawal, continued disorganization to thought and ongoing denial of acute psychiatric symptoms. Clinical documentation episodically reported confusion and other difficulties with his process of thinking. He continued to be only sporadically compliant with his medication regimen, a pattern of compliance and clinical pathology that continued through the summer and into the fall of 2003.

In late September 2003, Mr. Idris' condition deteriorated to the point that he grew agitated, confrontational and eventually aggressive with guard staff. On September 27th, 2003 in an increasingly agitated state, he was being moved to a higher level of care when he lashed out violently. He was eventually calmed down, and volunteered to psychiatric staff that he had been increasingly bothered by multiple imaginary people in his cell talking to him and "the electricity

talking to me." His medication regimen was adjusted, he responded well to these changes and he had no further episodes of aggressive behavior. Clinic notes documented reasonably organized thoughts and interactions throughout the remainder of the fall 2003, with the patient still isolated and displaying periods of disorganized behaviors but denying any clinical symptoms.

By January 2004, his isolation worsened and his communication with others (guard staff, psychiatric provides and other detainees) deteriorated. By March 2004, his disorganized behavior became increasingly apparent to guard staff and mental health providers. One clinic note dated March 27th, 2004 documented the detainee telling a guard that he wanted to be "taken to his car so that he could drive to his home in Japan." That note further documented the detainee repeatedly asking the guards questions in Arabic, and then asking them in English if they understood him. When he was approached by the mental health technician, his affect flattened and he was unwilling to speak further. By May 2004, his condition had deteriorated further, and he was observed displaying catatonic behaviors; "catatonic motor activity, non-responsiveness, not eating, odd mannerisms and posturing." He was subsequently moved to a higher level of clinical care, and his medication regimen was again adjusted. At this point, Mr. Idris was given Haldol decanoate, a monthly injection of a slow-release formulation of a potent antipsychotic agent.

Mr. Idris received his Haldol decanoate injection once every 4 weeks from May 2004 through October 2004, providing him with a continuous (uninterrupted) therapeutic level of antipsychotic medication for a period of approximately 6 months. This treatment has a profound positive effect on the patient, with remission of all clinical signs and symptoms of psychosis by the fall of 2004, including improved organization to thought and behavior, better interpersonal interactions and more effective communications with others. On October 28th, 2004, following a cogent and rational request to his treating psychiatrist to stop the medications because he no longer desired to take them, Mr. Idris' monthly shots were discontinued. From that point through now, he has not taken any psychotropic medications.

At the time of the discontinuation of his timed-release antipsychotic medication, Mr. Idris' psychiatric condition appears to have been in full remission. He was transferred to a lesser level of clinical care in the detention facility due to his improvement, and his clinical management grew significantly less intensive over time due to lack of need for more intensive services. Despite no longer taking even maintenance doses of his antipsychotic meds, he appears to have remained in remission for several years. In the summer of 2005, the timeframe in which he wrote his letter to the court which initiated his Writ of Habeas Corpus, his thought processes were linear, logical and goal oriented.

Between the fall of 2004 and the spring of 2008, Mr. Idris had minimal contacts with mental health services. By the summer of 2006, he was being seen on a quarterly basis only, and a note written on August 3rd, 2006 documented normal mental status and functioning. However, this status appears to have changed by the spring of 2008.

During the spring of 2008, Mr. Idris had again isolated himself socially, and was feeling threatened by other detainees. At one point, his behavior was grossly disorganized to behavior and he was found squirting water on other detainees. He was also unresponsive to verbal questioning and redirection, and subsequently returned to the BHU for clinical observation and care.

Mr. Idris remained housed in the BHU from July 2008 through the fall, where he was mute and responsive to questioning through non-verbal means only. During this timeframe, he was observed to be responding to internal stimuli occasionally in his cell via the closed-circuit video monitoring system. He was frequently seen having running conversations with imaginary "guests" in his cell. His treating psychiatrist offered him antipsychotic medications three times during this timeframe; all three times he either refused the medications, or only took a single does before choosing to discontinue using it.

Also during this timeframe, the detainee was visited by Jennifer R. Cowan, Esq., one of his attorneys. In her declaration dated January 23rd, 2009, Ms. Cowan reported that she had visited with Mr. Idris on July 16th, 2008 during which time he did not speak to her, or engage in any other form of communication. Ms. Cowen referred to the detainee as being "in a nearly catatonic state" during that evaluation.

In the fall of 2008, Mr. Idris was reassigned from the BHU back to Camp 4. Due to his disorganized state, he did not thrive in that environment, and he was returned to the BHU on October 28th, 2008. He remains in this environment now. Daily notes document ongoing symptoms of responding to internal stimuli along with grossly disorganized thoughts and behaviors. Mr. Idris appears overly invested in random, purposeless manipulations of items in cell, taking hours to move from one location in the cell block to another because of his disorganized behaviors.

On March 12th, 2009, John B. Missing, Esq., another of the detainee's attorneys, met with him at JTF GTMO. Mr. Missing described the detainee as "completely uncommunicative" during that meeting, able to speak but behaving "erratically." Further, he "repeatedly reacted to questions in a non-responsive and bizarre manner." Mr. Missing also reported that the detainee "would sometimes stop speaking abruptly in the middle of a sentence and just look at us, as if we should understand the import(ance) of his silence and his stare." Further, Mr. Missing reported that the detainee "laughed inexplicably and at inappropriate times given the topic under discussion. These outbursts of laughter would occur abruptly, in the middle of sentences, and after them, (the detainee) would continue to speak." During this meeting on March 12th, 2009, Mr. Idris was observed constantly moving his hands in a manner that was suggestive of non-verbal communication, but without clear meaning. The rate, tone and rhythm of his speech appear to have been variable during this conversation, and he appears to have engaged in tangential thinking, thought blocking and looseness of association. Lastly, during the latter portion of the meeting, Mr. Idris was observed by Mr. Missing to take a piece of toilet tissue, tear off several small pieces and used those pieces to erect a complicated design on the table in the interview room, with abnormal focus placed on the process of creating and then refining the design.

On March 13th, 2009, Matthew L. Leonard, Esq., yet another of the detainee's attorneys, met with him for approximately 3 hours. During that meeting, Mr. Leonard witnessed Mr. Idris as "completely uncommunicative, behaving erratically and repeatedly reacted to questions in a non-responsive and bizarre manner." Mr. Leonard also observed the detainee responding to internal stimuli ("whispering quietly to himself" in the meeting room), voicing sounds that were not words in either Arabic or English languages, along with smiling and laughing inappropriately to the context of the moment and conversation. Mr. Leonard also observed the detainee engage

in tangential thinking, loose associations, and derailment as did his colleague (Mr. Missing) the day before. It was these observations by the detainee's counsel that led directly to this forensic psychiatric assessment.

Current Mental Status Examination: **Appearance** - This is a well-developed, obese Sudanese male in no acute medical distress. He was clean, well-groomed with fair attention to personal hygiene. He wore a full beard and relatively short hair. He was dressed in several white JTF issued T-shirts and at least 2 brown JTF issued trousers. He arrived to this clinical interview in handcuffs and leg-restraints, escorted by two guards from the BHU. He was admitted to the outdoor recreational area adjacent to the BHU, and once safely inside all of his restraints were removed, giving him full range of motion and freedom of non-verbal communication. He was wearing orthopedic shoes due to significant (2-3+) pitting edema of his bilateral lower extremities. He was alert to person and place, but apparently not to circumstances of this interview. **Behavior** – He was hyperkinetic and somewhat agitated, walking back and forth at a brisk pace in the recreation area of the BHU. He would periodically walk to the far corner of the recreation area to do push-ups. His **eye contact** was overly intense and void of emotion. His **speech** was grossly disorganized, with decreased volume and a monotone. His **mood** was described as "good, O.K.," with a mood-incongruent, blunted **affect** with limited range and reactivity. His **thought processes** were grossly disorganized, with derailment and thought blocking and times and tangential at other times throughout the interview. His **thought content** included both auditory and visual hallucinations, which commanded a great deal of his limited attention during the course of this interview. **Judgment** was fair, given his cooperation with this clinical assessment. **Insight** was limited. **Higher Cortical Functioning** unable to assess. **Intelligence** unable to assess. **Impulse control** seemed fair at the time of this assessment

Psychometric Testing and Intellectual Functioning: Given that Mr. Idris is a Sudanese national who speaks Arabic as his primary language, no standardized psychometric testing instruments were given to him for the purpose of this evaluation. Since relevant testing instruments have not been translated into Arabic, and not normed to Mr. Idris' ethnic and cultural peer group, interpretation of these tests would be biased to the point that they would add no objective information to the evaluation.

Medical: During his seven year detention at JTF GTMO, Mr. Idris has undergone thorough and repeated physical examination, laboratory studies and imaging studies. He has problems with his peripheral vascular circulation, gastrointestinal functioning, joint flexibility, blood sugar levels, lipids and blood pressure which are all being closely monitored and treated with standard-of-care medical treatment (including medications). Mr. Idris is only partially compliant with his somatic treatment plans and medications, but is in fair physiological health, especially in light of his morbid obesity. He does not have any neurological illnesses; he has never had a seizure at JTF GTMO or any known history of seizure activity prior to detention. He has never had any known significant head trauma or any losses of consciousness.

Diagnosis: Based on the available information, Mr. Idris' diagnoses according to the criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, Text revision (DSM-IV-TR) are:

Axis I: (295.10) Schizophrenia, Disorganized Type. As manifested by a seven year (or longer) history of episodic delusions, hallucinations,

disorganized speech, grossly disorganized behavior, affective flattening, and avolition. The majority of these symptoms have been continuously present now for at least the past 6 months.

Axis II: Diagnosis Deferred on Axis II

Axis III: multiple somatic medical problems not causal to his mental illness

Prognosis: Given appropriate administration of antipsychotic medications, Mr. Idris' prognosis is good. This is especially true in light of the lengthy period of remission he has already experienced after he was treated with Haldol decanoate for the six month period between May 2004 and October 2004

Understanding of Criminal Charges, Court Proceedings and Ability to Assist Counsel:

Given Mr. Idris' current grossly disorganized state, his active delusional reality system, his ongoing issues with hallucinations, his ongoing responsiveness to those internal stimuli and his current inability to distinguish reality from fantasy, he is presently unable to participate autonomously in making important decisions that are likely to arise in the course of adjudication of his Writ of Habeas Corpus.

Mr. Idris in presently not able to display adequate knowledge of the charges he faces, the roles of the various courtroom participants, possible penalties he might be facing, the concept of plea bargaining, the adversarial nature of the American legal process or his legal rights during the courtroom process. Further, given his impaired mental state, he does not have the present capacity to absorb the needed knowledge of courtroom proceedings, manipulate that information cognitively, consider it abstractly, assigned appropriate relative values to it and use it to his best advantage in the courtroom. Mr. Idris presently lacks a factual understanding of the proceedings he is facing.

Further, Mr. Idris is presently operating in a delusional reality system, with little foundation in his real-world circumstances. He is presently incorporating his delusional reality in all of his behaviors, and all of the decisions that he makes. Because of this, he is presently unable to separate the reality of his legal proceedings from his internal fantasy world. Mr. Idris presently lacks a rational understanding of the proceedings he is facing.

Lastly, Mr. Idris' present grossly disorganized state, his lack of focus and attention to his actual surroundings, his ongoing attention to and focus on internal stimuli, his grossly disorganized thoughts and speech, his incoherence and inability to effectively communicate either verbally or with non-verbal techniques, his inability to conform his behavior to the requirements of a courtroom setting all contribute to a present inability to work effectively with his attorneys or to assist properly in his defense.

OPINION ON THE ISSUE OF PRESENT COMPETENCY TO ASSIST COUNSEL

It is my opinion, to a reasonable degree of medical certainty, that Mr. Ibrahim Osman Ibrahim Idris is presently suffering from a mental disease that is rendering him unable to understand the

nature and consequences of the proceedings against him. Further, this mental illness is rendering him unable to work with counsel and unable to assist properly in his defense.

Mr. Idris' mental disorder is a chronic condition, particularly if left untreated. It is recommended that Mr. Idris be involved in treatment, both psychosocial and with psychotropic medication, if he is to realize improvement of the condition, or prevent further deterioration of his mental health. However, Mr. Idris has routinely and consistently refused voluntary use of psychotropic medications offered him by JTF mental health staff. As such, he requires involuntary treatment procedures, with close monitoring and supervision over time to ensure that he remains treatment compliant.

[redacted]

LTC, MC, USA
Chief, Forensic Psychiatry Section
Madigan AMC
[redacted]

Leigh, Michael T.

From: Patton, Rodney (CIV) <Rodney.Patton@usdoj.gov>
Sent: Thursday, March 07, 2013 10:28 AM
To: Leigh, Michael T.
Cc: Warden, Andrew (CIV)
Subject: Idris/ISN 36 medical update

Follow Up Flag: Follow up
Flag Status: Completed

Michael:

I have received updated medical information about your client, Mr. Idris. Currently, Mr. Idris is housed in the Detention Hospital for a foot infection, where he has been since February, 16 2013. He has completed his 5 day course of oral antibiotics and periodically takes his oral diabetic medications. His foot infection has improved with treatment and his lab results are indicative of diabetes and hyperlipidemia.

Mr. Idris was admitted to the hospital not only to help with compliance in treating his foot infection, but for social reasons. His fellow detainees have grown weary with tolerating his psychotic behavior and have urged that he receive treatment for his psychiatric condition. Mr. Idris is currently diagnosed with Schizophrenia, Disorganized Type and has consistently refused to engage in any behavioral health services since 2011; he has refused antipsychotic medications since 2009. He has not demonstrated severe agitation or disruptive behavior during his inpatient stay and has periodic lucid episodes; however, he has been observed to display disorganized behavior such as wearing underwear on his head, whispering to himself, moving his mouth as if he is responding to internal stimuli, and laughing and singing out of context. He has also exhibited disorganized, incoherent, and tangential thought process and non-sensical speech. Nevertheless, he does not display any signs of self-harm, nor has he ever voiced or engaged in intentional self-harm behavior.

Thanks,

Rodney Patton
Trial Attorney

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

	)	**Misc. No. 08-442 (TFH)**
	)	
IN RE:	)	**05-0763 (JDB)**
	)	**05-1646 (JDB)**
GUANTANAMO BAY	)	**05-2378 (JDB)**
DETAINEE LITIGATION	)	
	)	
	)	
	)	

RESPONDENTS' MEMORANDUM REGARDING
THE GOVERNMENT'S DETENTION AUTHORITY RELATIVE
TO DETAINEES HELD AT GUANTANAMO BAY

INTRODUCTION

Through this submission, the Government is refining its position with respect to its authority to detain those persons who are now being held at Guantanamo Bay. The United States bases its detention authority as to such persons on the Authorization for the Use of Military Force ("AUMF"), Pub. L. 107-40, 115 Stat. 224 (2001). The detention authority conferred by the AUMF is necessarily informed by principles of the laws of war. *Hamdi v. Rumsfeld,* 542 U.S. 507, 521 (2004) (plurality). The laws of war include a series of prohibitions and obligations, which have developed over time and have periodically been codified in treaties such as the Geneva Conventions or become customary international law. *See, e.g., Hamdan v. Rumsfeld,* 548 U.S. 557, 603-04 (2006).

The laws of war have evolved primarily in the context of international armed conflicts between the armed forces of nation states. This body of law, however, is less well-codified with respect to our current, novel type of armed conflict against armed groups such as al-Qaida and the Taliban. Principles derived from law-of-war rules governing international armed conflicts, therefore, must inform the interpretation of the detention authority Congress has authorized for the current armed conflict. Accordingly, under the AUMF, the President has authority to detain persons who he determines planned, authorized, committed, or aided the terrorist attacks that occurred on September 11, 2001, and persons who harbored those responsible for the September 11 attacks. The President also has the authority under the AUMF to detain in this armed conflict those persons whose relationship to al-Qaida or the Taliban would, in appropriately analogous circumstances in a traditional international armed conflict, render them detainable.

Thus, these habeas petitions should be adjudicated under the following definitional framework:

> The President has the authority to detain persons that the President determines planned, authorized, committed, or aided the terrorist attacks that occurred on September 11, 2001, and persons who harbored those responsible for those attacks. The President also has the authority to detain persons who were part of, or substantially supported, Taliban or al-Qaida forces or associated forces that are engaged in hostilities against the United States or its coalition partners, including any person who has committed a belligerent act, or has directly supported hostilities, in aid of such enemy armed forces.

There are cases where application of the terms of the AUMF and analogous principles from the law of war will be straightforward. It is neither possible nor advisable, however, to attempt to identify, in the abstract, the precise nature and degree of "substantial support," or the precise characteristics of "associated forces," that are or would be sufficient to bring persons and organizations within the foregoing framework. Although the concept of "substantial support," for example, does not justify the detention at Guantanamo Bay of those who provide unwitting or insignificant support to the organizations identified in the AUMF, and the Government is not asserting that it can detain anyone at Guantanamo on such grounds, the particular facts and circumstances justifying detention will vary from case to case, and may require the identification and analysis of various analogues from traditional international armed conflicts. Accordingly, the contours of the "substantial support" and "associated forces" bases of detention will need to be further developed in their application to concrete facts in individual cases.

This position is limited to the authority upon which the Government is relying to detain the persons now being held at Guantanamo Bay. It is not, at this point, meant to define the contours of authority for military operations generally, or detention in other contexts. A forward-looking multi-agency effort is underway to develop a comprehensive detention policy with respect to individuals captured in connection with armed conflicts and counterterrorism operations, and the views of the Executive Branch may evolve as a result. *See* Declaration of Attorney General Eric H. Holder, Jr., ¶¶ 3, 11. The effort has been undertaken at the direction of

the President and is a major priority of the Executive Branch. *Id.,* ¶ 3. The Government will apprise the Court of relevant developments resulting from this ongoing process.

DISCUSSION

In response to the attacks of September 11, 2001, Congress authorized the President "to use all necessary and appropriate force against those nations, organizations, or persons he determines planned, authorized, committed, or aided the terrorist attacks that occurred on September 11, 2001, or harbored such organizations or persons, in order to prevent any future acts of international terrorism against the United States by such nations, organizations or persons." AUMF, § 2(a). The September 11 attacks were carried out by al-Qaida, which was harbored by the Taliban regime in Afghanistan. In October 2001, under the authority of the AUMF, the United States launched Operation Enduring Freedom to remove the Taliban regime from power and to suppress al-Qaida. The United States and its coalition partners continue to fight resurgent Taliban and al-Qaida forces in this armed conflict. Below, we set out the Government's position regarding the detention authority provided by the AUMF as it applies to those captured during that armed conflict and held at Guantanamo Bay.

I. THE AUMF GIVES THE EXECUTIVE POWER TO DETAIN CONSISTENT WITH THE LAW OF ARMED CONFLICT.

The United States can lawfully detain persons currently being held at Guantanamo Bay who were "part of," or who provided "substantial support" to, al-Qaida or Taliban forces and "associated forces." This authority is derived from the AUMF, which empowers the President to use all necessary and appropriate force to prosecute the war, in light of law-of-war principles that inform the understanding of what is "necessary and appropriate." Longstanding law-of-war principles recognize that the capture and detention of enemy forces "are 'important incident[s] of war.'" *Hamdi,* 542 U.S. at 518 (quoting *Ex Parte Quirin,* 317 U.S. 1, 28 (1942)).

The AUMF authorizes use of military force against those "nations, organizations, or persons [the President] determines planned, authorized, committed, or aided the terrorist attacks that occurred on September 11, 2001, or harbored such organizations or persons, in order to prevent any future acts of international terrorism against the United States by such nations, organizations or persons." AUMF, § 2(a). By explicitly authorizing the use of military force against "*nations, organizations, or persons*" that were involved in any way in the September 11 attacks (or that harbored those who were), the statute indisputably reaches al-Qaida and the Taliban. Indeed, the statute's principal purpose is to eliminate the threat posed by these entities.

Under international law, nations lawfully can use military force in an armed conflict against irregular terrorist groups such as al-Qaida. The United Nations Charter, for example, recognizes the inherent right of states to use force in self defense in response to any "armed attack," not just attacks that originate with states. United Nations Charter, art. 51. The day after the attacks, the United Nations Security Council adopted Resolution 1368, which affirmed the "inherent right of individual or collective self-defence in accordance with the Charter" and determined "to combat by all means threats to international peace and security caused by terrorist acts." U.N. General Assembly Security Council Resolution of Sept. 12, 2001 (S/RES/1368). "Since no one was seriously suggesting a State was behind the attacks, the Council was by definition implicitly acknowledging the acceptability of using military force against terrorists under the law of self-defense." Michael N. Schmitt, *U.S. Security Strategies: A Legal Assessment,* 27 Harv. J.L. & Pub. Pol'y 737, 748 (2004). The North Atlantic Treaty Organization and the Organization of American States treated the attacks as "armed attacks" for purposes of their collective self-defense provisions.[1] The AUMF invokes the internationally

[1] *See* Organization of American States, Meeting of Consultation of Ministers of Foreign Affairs, Terrorist Threat to the Americas (Sept. 21, 2001), http://www.oas.org/OASpage/

recognized right to self-defense. *See* AUMF, Preamble (it is "both necessary and appropriate that the United States exercise its rights to self-defense and to protect United States citizens both at home and abroad"). Other nations joined or cooperated closely with the United States' military campaign against al-Qaida and the Taliban. *See* Schmitt, 27 Harv. J.L. & Pub. Pol'y at 748-49.

The United States has not historically limited the use of military force to conflicts with nation-states:

> [A] number of prior authorizations of force have been directed at non-state actors, such as slave traders, pirates, and Indian tribes. In addition, during the Mexican-American War, the Civil War, and the Spanish-American War, U.S. military forces engaged military opponents who had no formal connection to the state enemy. Presidents also have used force against non-state actors outside of authorized conflicts.

Curtis A. Bradley & Jack L. Goldsmith, *Congressional Authorization and the War on Terrorism*, 118 Harv. L. Rev. 2047, 2066-67 (2005) (citing U.S. use of military force in the Chinese Boxer Rebellion, against the Mexican rebel leader Pancho Villa, and in the 1998 cruise missile attacks against al-Qaida targets in Sudan and Afghanistan).

Thus, consistent with U.S. historical practice, and international law, the AUMF authorizes the use of necessary and appropriate military force against members of an opposing armed force, whether that armed force is the force of a state or the irregular forces of an armed group like al-Qaida. Because the use of force includes the power of detention, *Hamdi,* 542 U.S. at 518, the United States has the authority to detain those who were part of al-Qaida and Taliban forces. Indeed, long-standing U.S. jurisprudence, as well as law-of-war principles, recognize that members of enemy forces can be detained even if "they have not actually committed or

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crisis/RC.24e.htm; North Atlantic Council, Statement by the North Atlantic Council (Sept. 12, 2001), http://www.nato.int/docu/pr/2001/p01-124e.htm; Statement by NATO Secretary General, Lord Robertson (Oct. 2, 2001), http://www.nato.int/docu/speech/2001/ s011002a.htm.

attempted to commit any act of depredation or entered the theatre or zone of active military operations." *Ex parte Quirin*, 317 U.S. at 38; *Khalid v. Bush*, 355 F. Supp. 2d 311, 320 (D.D.C. 2005), *rev'd on other grounds sub nom.*, *Boumediene v. Bush,* 128 S. Ct. 2229 (2008); *see also* Geneva Convention (III) Relative to the Treatment of Prisoners of War of Aug. 12, 1949, art. 4, 6 U.S.T.S. 3316 (contemplating detention of members of state armed forces and militias without making a distinction as to whether they have engaged in combat). Accordingly, under the AUMF as informed by law-of-war principles, it is enough that an individual was part of al-Qaida or Taliban forces, the principal organizations that fall within the AUMF's authorization of force.[2]

Moreover, because the armed groups that the President is authorized to detain under the AUMF neither abide by the laws of war nor issue membership cards or uniforms, any determination of whether an individual is part of these forces may depend on a formal or functional analysis of the individual's role. Evidence relevant to a determination that an individual joined with or became part of al-Qaida or Taliban forces might range from formal membership, such as through an oath of loyalty, to more functional evidence, such as training with al-Qaida (as reflected in some cases by staying at al-Qaida or Taliban safehouses that are

[2] Moreover, courts should defer to the President's judgment that the AUMF, construed in light of the law-of-war principles that inform its interpretation, entitle him to treat members of irregular forces as state military forces are treated for purposes of detention. *See* AUMF, § 2(a) (authorizing the President to use "all necessary and appropriate force" against those that "he determines" planned, authorized, committed, or aided the September 11 terrorist attacks or harbored those organizations); *The Paquete Habana*, 175 U.S. 677, 700 (1900) (court construes customary international law *de novo* only in the absence of a "controlling executive or legislative act or judicial decision"). A deferential approach in this context is consistent with the commonsense understanding that "[t]he war power of the national government 'is the power to wage war successfully,'" *Lichter v. United States*, 334 U.S. 742, 767 n.9 (1948) (citation omitted), as well as the Supreme Court's directive in *Boumediene* that "[i]n considering both the procedural and substantive standards used to impose detention to prevent acts of terrorism, proper deference must be accorded to the political branches," 128 S.Ct. at 2276 (2008) (citing *United States v. Curtiss-Wright Export Corp.*, 299 U.S. 304, 320 (1936)).

regularly used to house militant recruits) or taking positions with enemy forces. In each case, given the nature of the irregular forces, and the practice of their participants or members to try to conceal their affiliations, judgments about the detainability of a particular individual will necessarily turn on the totality of the circumstances.

Nor does the AUMF limit the "organizations" it covers to just al-Qaida or the Taliban. In Afghanistan, many different private armed groups trained and fought alongside al-Qaida and the Taliban. In order "to prevent any future acts of international terrorism against the United States," AUMF, § 2(a), the United States has authority to detain individuals who, in analogous circumstances in a traditional international armed conflict between the armed forces of opposing governments, would be detainable under principles of co-belligerency.

Finally, the AUMF is not limited to persons captured on the battlefields of Afghanistan. Such a limitation "would contradict Congress's clear intention, and unduly hinder both the President's ability to protect our country from future acts of terrorism and his ability to gather vital intelligence regarding the capability, operations, and intentions of this elusive and cunning adversary." *Khalid,* 355 F. Supp. 2d at 320; *see also Ex parte Quirin*, 317 U.S. at 37-38. Under a functional analysis, individuals who provide substantial support to al-Qaida forces in other parts of the world may properly be deemed part of al-Qaida itself. Such activities may also constitute the type of substantial support that, in analogous circumstances in a traditional international armed conflict, is sufficient to justify detention. *Cf. Boumediene v. Bush,* 579 F. Supp. 2d 191, 198 (D.D.C. 2008) (upholding lawfulness of detaining a facilitator who planned to send recruits to fight in Afghanistan, based on "credible and reliable evidence linking Mr. Bensayah to al-Qaida and, more specifically, to a senior al-Qaida facilitator" and "credible and reliable evidence demonstrating Mr. Bensayah's skills and abilities to travel between and among countries using false passports in multiple names").

Accordingly, the AUMF as informed by law-of-war principles supports the detention authority that the United States is asserting with respect to the Guantanamo detainees.

II. READ IN LIGHT OF THE LAWS OF WAR, THE AUMF AUTHORIZES THE NATION TO USE ALL NECESSARY AND APPROPRIATE MILITARY FORCE TO DEFEND ITSELF AGAINST THE IRREGULAR FORCES OF AL-QAIDA AND THE TALIBAN.

Petitioners have sought to restrict the United States' authority to detain armed groups by urging that all such forces must be treated as civilians, and that, as a consequence, the United States can detain only those "directly participating in hostilities."[3] The argument should be rejected. Law-of-war principles do not limit the United States' detention authority to this limited category of individuals. A contrary conclusion would improperly reward an enemy that violates the laws of war by operating as a loose network and camouflaging its forces as civilians.

It is well settled that individuals who are part of private armed groups are not immune from military detention simply because they fall outside the scope of Article 4 of the Third Geneva Convention, which defines categories of persons entitled to prisoner–of-war status and treatment in an international armed conflict. *See* Third Geneva Convention, art. 2, 4. Article 4 does not purport to define all detainable persons in armed conflict. Rather, it defines certain categories of persons entitled to prisoner-of-war treatment. *Id.,* art. 4. As explained below, other principles of the law of war make clear that individuals falling outside Article 4 may be detainable in armed conflict. Otherwise, the United States could not militarily detain enemy

[3] The "direct participation in hostilities" standard is taken from two additional protocols to the Geneva Conventions that the United States has not ratified. *See* Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 Aug. 1949 and Relating to the Protection of Victims of International Armed Conflicts (Additional Protocol I), art. 51(3), 1125 U.N.T.S 3 ("Civilians shall enjoy the protection afforded by this Section unless and for such time as they take a direct part in hostilities."); Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 Aug. 1949 and relating to the Protection of Victims of Non-International Armed Conflicts (Additional Protocol II), art. 13(3), 1125 U.N.T.S. 609. The United States recognizes the standard for targeting but its scope is unsettled.

forces except in limited circumstances, contrary to the plain language of the AUMF and the law-of-war principle of military necessity.

For example, Common Article 3 of the Geneva Conventions provides standards for the treatment of, among others, those persons who are part of armed forces in non-international armed conflict and have been rendered *hors de combat* by detention. Third Geneva Convention, art. 3. Those provisions pre-suppose that states engaged in such conflicts can detain those who are part of armed groups. Likewise, Additional Protocol II to the Geneva Conventions expressly applies to "dissident armed forces" and "other organized armed groups" participating in certain non-international armed conflicts, distinguishing those forces from the civilian population. Additional Protocol II, art. 1(1), 13.

Moreover, the Commentary to Additional Protocol II draws a clear distinction between individuals who belong to armed forces or armed groups (who may be attacked and, *a fortiori,* captured at any time) and civilians (who are immune from direct attack except when directly participating in hostilities). That Commentary provides that "[t]hose who belong to armed forces or *armed groups* may be attacked at any time." *See* ICRC, Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 Aug. 1949 and Relating to the Protection of Victims of Non-International Armed Conflicts (Additional Protocol II), ¶ 4789, http://www.icrc.org/ihl.nsf/ COM/475- 760019?OpenDocument (emphasis added). Accordingly, neither the Geneva Conventions nor the Additional Protocols suggest that the "necessary and appropriate" force authorized under the AUMF is limited to al-Qaida leadership or individuals captured directly participating in hostilities, as some petitioners have suggested.

Finally, for these reasons, it is of no moment that someone who was part of an enemy armed group when war commenced may have tried to flee the battle or conceal himself as a civilian in places like Pakistan. Attempting to hide amongst civilians endangers the civilians and

violates the law of war. *Cf.* ICRC, Commentary on the Additional Protocols of 8 June 1977 to the Geneva Conventions of 12 August 1949 and Relating to the Protection of Victims of International Armed Conflicts (Additional Protocol I), ¶ 1944, http://www.icrc.org/ihl.nsf/COM/470-750065?OpenDocument ("Further it may be noted that members of armed forces feigning civilian non-combatant status are guilty of perfidy."). Such conduct cannot be used as a weapon to avoid detention. A different rule would ignore the United States' experience in this conflict, in which Taliban and al-Qaida forces have melted into the civilian population and then regrouped to relaunch vicious attacks against U.S. forces, the Afghan government, and the civilian population.

III. THE GOVERNMENT IS CONTINUING TO DEVELOP A COMPREHENSIVE DETENTION POLICY.

Through this filing, the Government has met the Court's March 13, 2009 deadline to offer a refinement of its position concerning its authority to detain petitioners. The Court should be aware, however, that the Executive Branch has, at the President's direction, undertaken several forward-looking initiatives that may result in further refinements. Although the Government recognizes that litigation will proceed in light of today's submission, it nevertheless commits to apprising the Court of any relevant results of this ongoing process.

On January 22, 2009, the President issued two Executive Orders initiating Reviews addressing issues related to prospective detention policy. *See* Exec. Order No. 13492, 74 Fed. Reg. 4897 (Jan. 22, 2009); Executive Order 13493, 74 Fed. Reg. 4901 (Jan. 22, 2009). This effort is a Government priority. *See* Holder Decl. ¶ 3.

Pursuant to Executive Order 13,493, the Government is undertaking "a comprehensive review of the lawful options available to the United States with respect to the apprehension, detention, trial, transfer, release, or other disposition of individuals captured or apprehended in

connection with armed conflicts and counterterrorism operations, and to identify such options as are consistent with the national security and foreign policy interests of the United States and the interests of justice." Exec. Order No. 13,493, § 1(e). Fully developing the Government's prospective detention policy implicates important national security interests, including diplomatic interests. Exec. Order No. 13,492, § 2(b); Holder Decl. ¶ 11. Because the detainees are citizens of foreign countries, these detentions and their legal justification necessarily affect the United States' relations with other nations. Cooperation of the country's international partners is central to the United States' anti-terrorism efforts. And detention policy raises important national security and humanitarian issues. *See id.* Such issues are also being considered in connection with Executive Order 13,492, pursuant to which the Government is examining "the factual and legal bases for the continued detention of all individuals currently held at [Guantanamo Bay]" on an ongoing basis. Exec. Order No. 13,492, § 2(d). Highlighting the urgency and importance of the Review, the Executive Order required that the Review process "commence immediately." *Id.* at § 4(a); *see also id.* at §§ 2(b), 2(d), 4(c)(1), 4(c)(2), 4(c)(4).

The Government commits to apprise the Court of any relevant results of these ongoing processes.

CONCLUSION

For the foregoing reasons, the Government's new explication of who may be detained in this armed conflict is consistent with the AUMF and the laws of war that inform the scope of "necessary and appropriate" force the AUMF authorizes the President to use. If the judges of the Court desire oral argument relating to the scope of the Government's detention authority in these cases, the Government urges the Court to consider conducting a single argument in a consolidated manner before the Court and that the Court endeavor, to the extent possible, to reach a common ruling regarding the framework to apply to these cases.

Dated: March 13, 2009

Respectfully submitted,

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TERRY M. HENRY
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Attorneys for Respondents

I, Stephen N. Xenakis, M.D. hereby declare as follows:

1. I have been asked by counsel for Petitioner Ibrahim Idris to summarize my impressions and recommendations regarding Mr. Idris' mental and physical health, level of functioning, ability for self-care, and mental state.

2. I am board certified by the American Board of Psychiatry and Neurology in General Psychiatry, as well as Child and Adolescent Psychiatry, and have extensive experience in clinical psychiatry, research, teaching, and administration. I retired from the United States Army at the rank of Brigadier General and served in multiple positions of responsibility as a clinician and commander. I commanded medical activities, medical centers, and medical regions for most of the last ten years of duty. During my career, I served as an Assistant Inspector General for The Surgeon General of the Army and was the adjudicating authority for credentialing and privileging actions for numerous providers.

3. The Federal Courts and the Office of the Military Commissions have qualified me as a psychiatric and medical expert in numerous cases of detainees at Guantánamo Naval Base and accused terrorists. I have had multiple interviews with detainees at Guantánamo, advised attorneys on their respective cases, and spent cumulatively nearly three months at Guantánamo Naval Base over the past four years. I have reviewed medical, intelligence, and military files of nearly fifty detainees and accused terrorists as a consultant to attorneys, Government authorities, and human rights

organizations. The respective cases have included high-value detainees, convicted belligerents, and others awaiting release and return to their homes.

4. I have testified in cases of accused belligerents who were captured in the theater of operations and presented with extensive records of their association with and assisting identified terrorist organizations. Moreover, I have been qualified as a psychiatric and medical expert in the Military Courts Martial of a soldier convicted of involuntary manslaughter on the battlefield.

5. A full list of my publications is available in the curriculum vita attached as Exhibit A.

6. In preparing this declaration, I reviewed the following documents provided by defense counsel:

- Forensic Evaluation dated 21 April 2009 (the "Forensic Evaluation")
- Email message from Rodney Patton, trial attorney for the Department of Justice, to Michael T. Leigh, defense attorney, dated 7 March 2013. (the "March 2013 Report")

Findings

7. The Forensic Evaluation and the March 2013 Report concur with the diagnosis of Schizophrenia, Disorganized Type, a serious chronic mental condition that is characterized by bizarre behavior, disorganized thinking, hallucinations, and nonsensical speech.

8. Mr. Idris has shown little improvement over the years. Schizophrenia usually has its onset in early adulthood and persists throughout the lifetime of the individual. Mr. Idris' history, clinical course, and current mental state are consistent with

the diagnosis and evidence of this chronic, serious, unremitting psychiatric disorder. He has currently refused usual treatment that includes medication and behavioral counseling.

9. Mr. Idris suffers with diabetes and has been treated recently for a foot infection.

Assessment and Prognosis

10. The Forensic Evaluation and the March 2013 Report indicate that Mr. Idris suffers with a chronic psychotic condition (Schizophrenia, Disorganized Type) that has not improved since being detained at Guantánamo. The natural course of schizophrenia typically shows deterioration with age.[1] Patients manifest worsening cognitive decline and ability to care for themselves. Medications sometimes help control bizarre behavior, hallucinations, and disorganized thinking, but neither cure nor resolve the disorder. Patients require increasing supportive nursing care as they age that is often provided by family or organized community services. Mr. Idris demonstrates limited, if any, ability for self-care at this time.

11. Mr. Idris suffers with diabetes and is likely to develop other chronic debilitating medical conditions as he ages.

12. His mental state appears as grossly psychotic manifested by disorganized thinking, bizarre behavior, hallucinations, and nonsensical communication. He is

[1] Andreason, N.C., Liu, D., Ziebell, S., Vora, A., and Beng-Choon, H. Relapse Duration, Treatment Intensity, and Brain Tissue Loss in Schizophrenia: A Prospective Longitudinal MRI Study. Am J Psychiatry 170:6, June 2013.

described as not presenting a danger to himself or others, although is reported in the May 2013 Report that his behavior is becoming increasingly noxious to his fellow detainees.

13. Mr. Idris' illness of Disorganized Type Schizophrenia carries a very poor prognosis and a typical pattern of continuing deterioration in quality of life and ability for self-care.[2] Patients suffering with chronic schizophrenia increasingly require supportive care from institutions and family members and cannot sustain activities of daily living without assistance. They are unable to initiate or engage in activities that require goal orientation or execute even simple work tasks.

14. Mr. Idris' long history of schizophrenia complicated by diabetes disqualifies him from military service of any kind, and it is inconceivable that he could engage in any combatant action. His prognosis is very poor, and in my experience, men with his condition receive 100% medical retirement from the US military because they are incapable of any productive or constructive work.

[2] Sweeney, J.A. The Long-Term Effect of Schizophrenia on the Brain: Dementia Praecox? Am J Psychiatry170:6, June 2013.

15. Mr. Idris may stabilize in an environment like his home of origin and with his family and not deteriorate as rapidly as in a detention facility. The familiar surroundings of his native country and community can potentially have calming and beneficial effects. In all likelihood, Mr. Idris will suffer an accelerated downhill course with continued detention in Guantánamo.

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

Dated: June 26, 2013
Arlington, VA

Stephen N. Xenakis, M.D.
Brigadier General (Ret), U.S. Army

EXHIBIT A

CURRICULUM VITAE

STEPHEN NICHOLAS XENAKIS

DOB: July 5, 1948
PLACE OF BIRTH: Washington, DC
SPOUSE: Marianne Charlotte Szegedy- Maszak
CHILDREN: Nicholas John Xenakis - November 19, 1981
Lea Elizabeth Xenakis - July 29, 1985
Joanna Lena Maria LaRoche – December 24, 1992

RESIDENCE: 2235 Military Road
Arlington, VA 22207

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FAX: (703) 527-2448

MILITARY SERVICE

1970	Commissioned, Second Lieutenant, Medical Service Corps, US Army Reserve
1972-1974	First Lieutenant, MSC, US Army
1974-1978	Captain, Medical Corps, US Army
1978-1982	Major, Medical Corps, US Army
1982-1986	Lieutenant Colonel, Medical Corps, US Army
1986- 1994	Colonel, Medical Corps, US Army
1994- 1998	Brigadier General, Medical Corps, US Army

EDUCATION/EXPERIENCE

1966	Chofu Senior High School, Tokyo, Japan.
1966-1970	BA, Cum Laude, Chemistry, with Certificate in Science in Human Affairs, Princeton University, Princeton, NJ.
1970-1974	Doctor of Medicine with Certificate from Combined Accelerated Program in Psychiatry (CAPP), University of Maryland School of Medicine, Baltimore, MD.
1972-1975	Candidate, Baltimore-District of Columbia Psychoanalytic Institute, Baltimore, MD.
1974	Resident in Psychiatry/Director, Rape Crisis Center, University of Maryland, Baltimore, MD.
1974-1975	Intern, Rotating, Letterman Army Medical Center, Presidio of San Francisco, CA (ranked fifth out of twenty-four).
1975-1978	Resident in Psychiatry, Letterman Army Medical Center, Presidio of San Francisco, CA (ranked first out of six).
1978-1980	Fellow, Child Psychiatry, Letterman Army Medical Center and Langley Porter Psychiatric Institute, University of California San Francisco, San Francisco, CA.
1977-1980	Research Associate, Center for the Study of Neurosis, Langley Porter Psychiatric Institute, San Francisco, CA.
1978-1980	Consultant, Psychosomatic Service, St. Mary's Hospital, San Francisco, CA.
1980-1982	Chief, Department of Psychiatry and Community Mental Health Service; Director, Drug and Alcohol Service; Darnall Army Community Hospital, Fort Hood, TX.
1982-1984	Surgeon, First Cavalry Division; Child Psychiatrist; Darnall Army Community Hospital, Fort Hood, TX.
1984-1985	President and Student, Class 76, Armed Forces Staff College; Attending Physician, Sewells Point Navy Medical Clinic, Norfolk, VA.
1985-1986	Chief, Child, Adolescent, and Family Psychiatry Service; Department of Psychiatry and Neurology, Eisenhower Army Medical Center, Fort

Gordon, GA.

1986-1989 Deputy Commander for Clinical Services and Director for Graduate Medical Education, Eisenhower Army Medical Center, Fort Gordon, GA.

1989-1990 Student, United States Army War College, Carlisle Barracks, PA.

1990-1993 Commander, Blanchfield Army Community Hospital, and Director of Health Services, Fort Campbell, KY.

1993-1994 Deputy Project Manager and Project Manager, Task Force Aesculapius (Project Vanguard-AMEDD), Office of The Surgeon General, United States Army, Falls Church, VA.

1994-1995 Project Manager, TRICARE Region 3, Fort Gordon, GA.

1995-1997 Commanding General, Southeast Regional Medical Command and Dwight David Eisenhower Army Medical Center, and Lead Agent, Department of Defense TRICARE Southeast Region 3, Fort Gordon, GA.

1997-1998 Special Assistant to The Surgeon General, United States Army, Center for Total Access, Fort Gordon, GA.

1998-2001 President and CEO of eCareSolutions, Inc. and other privately held companies specializing in telemedicine technology and services. Private practitioner.

2001-2004 CEO & President, Lexicor Health Systems, Inc., Augusta, GA, and Boulder, CO.

2004- 2005 Attending Psychiatrist, Riverside Treatment Services, District of Columbia.

2005- 2007 Chief, Child & Adolescent Psychiatry, Psychiatric Institute of Washington, District of Columbia.

2007- 2008 Senior Consultant, Organizational Design, Inc.

2008- 2010 Senior Adviser, Chairman of the Joint Chiefs of Staff and Army Leadership.

2010- Private practice, research, and consulting. Contributing editor, The

Huffington Post & The Hill.

2011- Founder, The Center for Translational Medicine

AWARDS AND HONORS

Summer Fellowship, Woodrow Wilson School of Public and International Affairs, Princeton University, Princeton, NJ, 1969.

Class President, University of Maryland School of Medicine, Baltimore, MD, 1971.

President, Psychiatric Residents' Council, Letterman Army Medical Center, Presidio of San Francisco, CA, 1977.

Visiting Resident Award for Outstanding Graduating Resident in Psychiatry, Letterman Army Medical Center, Presidio of San Francisco, CA, 1978.

Skelton Award for Outstanding Graduating Resident, Letterman Army Medical Center, Presidio of San Francisco, CA, 1978.

Visiting Resident Award for Outstanding Graduating Fellow in Child Psychiatry, Letterman Army Medical Center, Presidio of San Francisco, CA, 1980.

Regional Finalist, White House Fellowship, 1982 and 1984.

Norbert Rieger Award for Outstanding Papers Published in the Journal of the Academy of Child and Adolescent Psychiatry in 1988.

William C. Porter Lecture Award, Presented by the Association of Military Surgeons of the United States, 1989.

Distinguished Paper, Senior Service College, Presented by the Chairman, Joint Chiefs of Staff, 1990.

"A" Professional Designator awarded by The Surgeon General, United States Army.

BOARD CERTIFICATION

National Board of Medical Examiners, 1975

General Psychiatry, American Board of Psychiatry and Neurology, 1980
Child Psychiatry, American Board of Psychiatry and Neurology, 1982
Medical Management, American Board of Medical Management, 1991

MILITARY AWARDS

Expert Field Medical Badge
Air Assault Wings
Legion of Merit with Oak Leaf Cluster
Meritorious Service Medal with 2 Oak Leaf Clusters
Army Commendation Medal
Army Achievement Medal with Oak Leaf Cluster
Order of Military Medical Merit

HOSPITAL AND TEACHING APPOINTMENTS

1974	University of Maryland Hospitals, Baltimore, MD.
1974-1980	Letterman Army Medical Center, Presidio of San Francisco, CA.
1976-1978	Doctors' Hospital, Pinole, CA.
1978-1980	University of California San Francisco, San Francisco, CA.
1978-1980	St. Mary's Hospital, San Francisco, CA.
1980-1984	Darnall Army Community Hospital, Fort Hood, TX.
1980-1982	Instructor, Creighton University Program for Physician Assistants.
1984	Sewells Point Naval Medical Clinic, Norfolk, VA.
1985-1989 & 1994-1998	Eisenhower Army Medical Center, Fort Gordon, GA.
1989-1990	Dunham Army Health Clinic, Carlisle Barracks, PA.
1990-1993	Blanchfield Army Community Hospital, Fort Campbell, KY.

1993 Walter Reed Army Medical Center, District of Columbia.

1994- Adjunct Clinical Professor, Uniformed Services University of Health Sciences, Bethesda, MD.

1995- First Visiting Professor of Telepsychiatry, Menninger Clinic, Topeka, KS.

1996-2004 Clinical Professor, Medical College of Georgia, Augusta, GA.

1998-2004 Private practice, Augusta, Georgia.

1998-2001 Attending psychiatrist, part-time, Charter Augusta Behavioral Hospital Augusta, Georgia.

2002 Attending psychiatrist, The Medical College of Georgia, Augusta, Georgia.

2004-2005 Attending psychiatrist, Riverside Treatment Services, Washington, DC.

2005-2007 Chief, Child & Adolescent Psychiatry, The Psychiatric Institute of Washington, Washington, DC.

ABSTRACTS

Xenakis, S. N.
Early History of the Japan Science Council, Senior Thesis, Princeton University, 1970.

Xenakis, S.N., Hoyt, M.F., Marmar, C.F., and Horowitz, M.J.
Therapists' Reliability in Rating their own Psychotherapy Session, Society for Psychotherapy Research, June 1980.

Xenakis, S.N.
Variations on Psychotherapy in the Military. Syllabus and Scientific Proceedings. American Psychiatric Association Annual Meeting, 1980.

Brooks, F.R., Xenakis, S.N., and Batson, P.M.
Combat Stress Training. Army Trainer, October 1982.

Ebner, D.G., Brooks, F.R., Xenakis, S.N., and Batson, P.M.

Combat Medics on a Chemical Battlefield. Army Trainer, April 1983.

Xenakis, S.N.
Course Co-Director, Training for Combat Stress. National Guard Medical Review, August 1983.

Xenakis, S.N.
Research and Training in Combat Stress, AMEDD Course in Division Psychiatry, April 1984.

Manning, D.T., Xenakis, S.N., Drain, M., Balson, P.M., and Willis, A.S.
Type A Behavior in US Army Active Duty, Recovering Alcoholics and Non-Alcoholics, and their Dependent Children. A Technical Report Submitted to US Army Drug and Alcohol Program and Technical Activity, ADCSPER, HQDA, 1984.

Xenakis, S. N.
Aftermath of an Air Crash: The Gander Tragedy. Grand Rounds to the Medical College of Georgia, April 1986.

Xenakis, S.N.
Supervision as Non-Therapy. Presented at the Forum on Training versus Treating the Psychiatric Resident. APA 139th Annual Meeting, May 1986.

Xenakis, S.N.,Jensen, P.S., and Blanco, A.P.
The Psychiatrist as a Multidisciplinary Team Leader. Presented at a Workshop on Psychotherapy: An Unaffordable Luxury. APA 139th Annual Meeting, May 1986.

Xenakis, S.N., Josephsen, A., Frey, J., and Maloney, C.
The Adolescent in Family Therapy: Integrating Individual and Family Dynamics. Workshop presented at the Annual Meeting of the American Academy of Child and Adolescent Psychiatry, October 1986.

Jensen, P.S., Xenakis, S.N., Shervette, R.E., and Bain, M.W.
Diagnostic and Treatment Practices for ADD in the General Hospital. Poster Session at the Annual Meeting of the American Academy of Child and Adolescent Psychiatry, October 1986.

Bartone, B. Cervantes, R.A., Garrigan, J.J., Ingraham, L.H., Radke, A., Wright, K. (Saczynski), Ursano, R.J., Vaitkus, M., Walborn, C., and Xenakis, S.N.

The Human Response to the Gander Military Air Disaster. Report WRAIR-NP-88-12, Walter Reed Army Institute of Research, Washington, DC, 20307-5100, and US Army Medical Research and Development Command, Ft. Detrick, MD, 21701-5012. Unpublished Report, 1987.

Xenakis, S.N., Marcum, J.M., Maury, J.L., and Duffy, J.C.
Consultation in the Aftermath of an Air Tragedy. Presented at the 14th Annual Scientific Assembly of the Academy Family Physicians, Salt Lake City, Utah, April, 1988.

Jensen, P.S., Shervette, R.E., and Xenakis, S.N.
Anxiety and Depressive Disorder in ADD: New Findings. Presented at the American Psychiatric Association, Montreal, Canada, May 1988.

Shervette, R.E., Jensen, P.S., Blackwood, A., and Xenakis, S.N.
Disordered Attachment and Attention Deficit Disorders. Presented at the American Psychiatric Association, Montreal, Canada, May 1988.

Jensen, P.S., Bloedau, L., and Xenakis, S.N.
Children's Psychiatric Symptoms: Effects of Stress, Supports, and Parental Psychopathology. Presented at the Annual Meeting of the American Academy of Child and Adolescent Psychiatry, October 1988.

Jensen, P.S., Xenakis, S.N., Wolf, P., DeGroot, J., and Bain, M.W.
The Military Family Syndrome Revisited: "By the Numbers." Presented at the Annual Meeting of the American Academy of Child and Adolescent Psychiatry, October 1988.

DeGroot, J.F., Jensen, P.S., and Xenakis, S.N.
Clinical Considerations in Using Parent-Child Rating Scales: Effects of Gender and Parental Psychopathology. Presented at the Annual Meeting of the Academy of Child and Adolescent Psychiatry, October 1988.

Xenakis, S.N., Clements, T.I., Griffin, R.F., and Spaulding, V.C.
Army Medical Department: 2005, US Army War College, Carlisle, Pennsylvania, April 1990.

Duchin, L.K., Hollis, G.P., Xenakis, S.N., and Garland, F.N.
Cognitive Impairment in HIV-Positive Soldiers: Relation to Mood and Immunosuppression. Presented at the Southern Medical Association Conference, Nashville, TN, October 1990.

Hodges, G.R., Xenakis, S.N., and Borden, S.
Public Sector/Private/Sector Cooperation. Presented at the American College of Physician Executives Perspectives in Medical Management, San Francisco, CA, May 1992.

Chappell, P.F., Xenakis, S.N., Angle, G., and Krug, E.F.
The Effect of Prenatal Stress on Neonatal Behavioral Organization Following Fathers' Deployment to the Persian Gulf War. Presented at the Biennial Meeting Society for Infancy Studies, Miami, FL, May 1992.

Xenakis, S.N.
Reorganization of the Army Medical Department: The Work of Task Force Aesculapius. Presented at the Menninger Military Psychiatric Meeting, February 1993.

Xenakis, S.N., and Clement, S.D.
Reorganizing for Greater Efficiency and Quality. Presented at the American College of Physician Executives Perspectives in Medical Management, Washington, DC, May 1994.

Xenakis, S.N.
Telemedicine and Future of Mental Health. Annual Army Psychiatry Conference, Miami, FL, August 1995.

Xenakis, S.N.
Forming Mental Health Product Lines. Annual Army Combined Mental Health Symposium, San Diego, CA, April 1996.

Xenakis, S.N.
Advanced Technology and Reengineering Healthcare. Worldwide Signal Symposium, Fort Gordon, GA, December 1996.

Xenakis, S.N.
Principles of Partnering and the TRICARE Contracts. Winter DOD TRICARE Conference, Washington, DC, January 1997.

Xenakis, S.N., Blakeslee, B.S., and Horner, J.
Possibilities for Peacekeeping: The Role of Telemedicine in International Initiatives.
Annual Meeting on Virtual Reality, San Diego, February 1997.

Xenakis, S.N. and Davis, C.
Future Trends in Military Healthcare and Mental Health. Annual Army Combined Mental Health Symposium, Tampa, FL, April 1997.

Xenakis, S.N. and Holloway, H.C.
Extending Psychiatric Services: Experiences in Space. PROMEDUS, Torino, Italy,
October 1997.

Xenakis, S.N.
Using Telepsychiatry for Provider-Sponsored Primary Care Integration. The Primary
Care/ Behavioral Healthcare Summit, St. Louis, MO, November 1998.

Xenakis, S.N. and Colwell, V.J.
Telemedicine and the Burn Center. American Telemedicine Association, Salt Lake City, UT, April 1999.

Xenakis, S.N. and Colwell, V.J.
When Managed Care Learns About Telemedicine. American Telemedicine Association, Salt Lake City, UT, April 1999.

Colwell, V.J. and Xenakis, S.N.
Low-cost Support to Community Outreach Clinics. American Telemedicine Association, Salt Lake City, UT, April 1999.

Xenakis, S.N.
Viewing Mental Health Through the Prism of Economics. Grand Rounds, The Medical
College of Georgia, January, 13, 2000.

Xenakis, S.N.
Stress Pathology During Disaster Situations. Disaster 2002: Are You Prepared?, Presented by The Medical College of Georgia at Hilton Head, SC, February 2002.

Snyder, S.M., Drozd, J.F., Xenakis, S.N.
Validation of ADHD Rating Scales, Letter to the Editor of the Journal of American Academy of Child and Adolescent Psychiatry, 43:10, October 2004, pp. 1189-1190.

Xenakis, S.N.
From the Medics: Unhealthy Silence. Outlook Section. Washington Post, February 6, 2005.

Xenakis, S.N.
Military Medical Ethics: Calling for Leadership. Presented at Grand Rounds at Cornell School of Medicine, New York, New York, April 27, 2005.

Xenakis, S.N
Medical Ethics in the Age of Torture. Symposium sponsored by the Center for American Progress, Washington, D.C., August 3, 2005.

Xenakis, S.N. and Lifton, Robert J.
Doctors must be healers, not interrogators. The Los Angeles Times, June 8, 2006.

Xenakis, S.N.
Moderator, First Do No Harm. Session Three: National Guantanamo Teach-in. Seton Hall Law School, October 5, 2006.

Xenakis, S.N.
Defending Dignity. The Power of Health Professionals as Human Rights Advocates. Torture by US Forces. November 4, 2006.

Allen, S. and Xenakis, S.N.
Our Duty to War Detainees. Boston Globe, January 22, 2007.

Allen, S. and Xenakis, S.N. Protecting war detainees. International Herald Tribune, January 23, 2007.

Xenakis, S.N.
Military Torture & Medicine: Cross-disciplinary Perspectives on the Occurrence & Ramifications of Torture. Panel Discussion sponsored by The Physicians for Human Rights. Dartmouth College. February 20, 2007.

Korb, L. J. and Xenakis, S.N.
On Personnel Readiness. Newsday, January 26, 2007.

Korb, L.J. and Xenakis, S.N.
Troop morale a casualty of in Iraq. Newsday.com, February 2, 2007.

Allen, S. and Xenakis, S.N.
Weaponized Medicine. The Sacramento Bee. February 2008.

Xenakis, S.N.
Detainee Health Challenges. War and Health: Annual Health Law and International Symposia. Whittier Law School's Center for International and Comparative Law. February 22, 2008.

Xenakis, S.N.
Ethical Conflicts of Health Professionals in Wartime. Iraq Action Group at UCSF. February 25. 2008.

Xenakis, S.N.
No Torture, No Exceptions. The Washington Monthly. March 2008.

Xenakis, S.N.
Ending Torture: Implications for US Policy. 2009 Marvin Weissberg Lecturer in International Human Rights, Beloit College, September 2009.

Rubenstein, L.S. and Xenakis, S.N.
Doctors Without Morals. The New York Times (op-ed). March 1, 2010.

Xenakis, S.N.
Why Soldiers Drink. Huffington Post. February 26, 2010.

Xenakis, S.N.
What *The Hurt Locker* Got Right. Huffington Post. March 10, 2010.

Xenakis, S.N.
Veterans' Healthcare Falls Short. *The Hill.* March 22, 2010.

Xenakis, S.N.
Remembering Military Suicides. Huffington Post. May 31, 2010.

Xenakis, S.N.
Radical jihadism in not a mental disorder. The Washington Post (Outlook). December 12, 2010.

Xenakis, S.N.
IEDs, Alzheimer's, and national defense. *The Hill's* Congress Blog. December

20, 2010.

Xenakis, S.N.
New Federal Research – subsidizing pharma. *The Hill's* Congress Blog. January 26, 2011

Xenakis, S.N.
Reforming defense healthcare. Comment. *The Hill.* March 16, 2011.

Xenakis, S.N.
"Speaking out on Torture: Misgivings and Challenges of a Military Doctor." Securing Accountability for Torture & CIDT: New Trends and Comparative Lessons. International Expert Workshop sponsored by the European Union. Jerusalem, Israel. April 4-5, 2011.

Xenakis, S.N.
The Struggle Against U.S. Sponsored Torture." Keynote for TASSC -- Torture Abolition and Survivors' Support Coalition. April 16, 2011.

Xenakis, S.N.
Agent Orange déjà vu. The Hill. June 9, 2011.

Xenakis, S.N.
Neuropsychiatric Evidence of Waterboarding and other Abusive Treatments. International Association of Forensic Sciences, Madeira, Portugal, September, 2011.

Xenakis, S.N.
Military Mental Health and Moral Choices. Duke Milites Christi. Duke University School of Divinity. November 12, 2011.

Xenakis, S.N.
Invited Article: Condemning Torture and Abuse. Psychiatric News. In press. 2011.

Xenakis, S.N.
Principles of Military Mental Health. William Beaumont Army Medical Center Symposium. January 19, 2012.

Xenakis, S.N.
Understanding PTSD. Invited Letter. The Wilson Quarterly. Winter 2012.

Xenakis, S.N.
After the war: Reaching our at-risk veterans. The Hill. February 8, 2012.

Xenakis, S.N.
The U.S. military doesn't know who is fit to fight. *Washington Post Outlook,* March 23, 2012.

Xenakis, S.N.
Speaking out on Torture: Misgivings and Challenges of a Military Doctor. On Torture. Adalah-The Legal Center for Arab Minority Rights in Israel, Physician for Human Rights-Israel, and Al Mezan Center for Human Rights, June 2012.

Xenakis, S.N.
Washington Should Stop Putting Toll Booths on the Information Highway, The Hill, August 6, 2012. http://thehill.com/blogs/congress-blog/healthcare/242337-stop-putting-toll-booths-on-the-information-highway

Xenakis, S.N.
An Un-Dangerous Mind, The New York Times. http://www.nytimes.com/2012/10/11/opinion/some-guantanamo-detainees-are-security-threats-omar-khadr-isnt-one-of-them.html?_r=0

Xenakis, S.N.
Rethinking PTSD. Invited Lecture, *The Erikson Institute for Education and Research of the Austen Riggs Center,* October 12-14, 2012.

Xenakis, S.N.
The Role & Responsibilities of Psychiatry in 21st Century Warfare. Invited Lecture, Annual Meeting of the American Academy of Psychiatry and the Law, Montreal, Canada, October 25-28, 2012.

Xenakis, S.N.

Time to end restriction on military personnel disclosing personal firearms. *The Hill.* December 15, 2012.

Xenakis, S.N.
Can We Improve Mental Health? The Hill. February 15, 2013.

Xenakis, S.N.
Demand a change on access to firearms. The Hill. March 20, 2013.

PUBLICATIONS

Brooks, F.R., Xenakis, S.N., Ebner, D.G., and Balson, P.M.
Psychological Reactions During Chemical Warfare Training. Military Medicine. Vol. 148, No. 3, March 1983, pp. 232-235.

Xenakis, S.N., Hoyt, M.F., and Horowitz, M.J.
Reliability of Self-Reports by Therapists Using the Therapist Action Scale. Psychotherapy Theory, Research, and Practice. Vol. 20(3), Fall 1983, pp. 314-320.

Hoyt, M.F., Xenakis, S.N., Marmar, C.F., and Horowitz, M.J.
Therapeutic Actions that Influence their Perceptions of "Good" Psychotherapy. Journal of Nervous and Mental Disease. Vol. 171, No. 7,1983, pp, 400-404.

Jensen, P.S., Lewis, R.L., and Xenakis, S.N.
The Military Family in Review: Context, Risk and Prevention. Journal of the American Academy of Child Psychiatry. Vol. 25, No. 2, March 1985, pp. 225-234.

Xenakis, S.N., Brooks, F.R., and Balson, P.M.
A Triage and Emergency Treatment Model for Combat Medics on the Chemical Battlefield. Military Medicine. Vol. 150, August, 1985, pp. 411-415.

Manning, D.T., Balson, P.M., and Xenakis, S.N.
The Prevalence of Type A Personality in Children of Alcoholics. Alcoholism: Clinical and Experimental Research. Vol. 10, No. 2, March-April 1986, pp. 184-189,

Manning, D.T., Xenakis, S.N., Balson, P.M., and Willis, A.S.
Prevalence of Type A Behavior in American Soldiers and their Children. Military Medicine. Vol. 153, No. 7, July 1988, pp. 358-359.

Jensen, P.S., Traylor, J., Xenakis, S.N., and Davis, H.
Child Psychopathology Rating Scales and Interrater Agreement: I. Journal of the American Academy of Child and Adolescent Psychiatry. Vol. 27, No. 4, 1988,

pp. 442-450.

Jensen, P.S., Xenakis, S.N., Davis, H., and DeGroot, J.
Child Psychopathology Rating Scales and Interrater Agreement: II. Child and Family Characteristics. Journal of the American Academy of Child and Adolescent Psychiatry. Vol. 27, No. 4,1988, pp. 451-461.

Jensen, P S., Xenakis, S.N., Shervette, R.E., III, and Bain, M.W.
Psychosocial and Medical Histories of Stimulant Treated Children. Journal of the American Academy of Child and Adolescent Psychiatry. Vol. 27, No. 6, November 1988, pp. 798-801.

Jensen, P.S., Grogan, D., Xenakis, S.N., and Bain, M.W.
Father Absence Effects on Child and Maternal Psychopathology. Journal of the American Academy of Child and Adolescent Psychiatry. Vol. 28, No. 2, 1989, pp. 171-175.

Jensen, P.S., Xenakis, S.N., Shervette, R.E., III, and Bain, M.W.
Diagnostic and Treatment Practices for Attention Deficit Disorder in the General Hospital. Hospital and Community Psychiatry. Vol. 40, No. 7, July 1989, pp. 708-712.

Francis, G.L., Grogan, D., Hardy, L.B., Jensen, P.S., Xenakis, S.N., and Kearny, J.
Group Psychotherapy in the Treatment of Adolescent and Preadolescent Military Dependents with Recurrent Diabetic Ketoacidosis. Military Medicine. Vol. 155, No. 9, September 1990, pp. 387-390.

Xenakis, S.N., Maury, J.L., Duffy, J.C., and Marcum, J.M.
Consultation in the Aftermath of an Air Tragedy. Military Medicine, Vol. 156, January 1991, pp. 23-26.

Jensen, P.S., Xenakis, S.N., Wolf, P., and Bain, M.W.
The "Military Family Syndrome" Revisited: "By the Numbers." The Journal of Nervous and Mental Disease, Vol. 179, No, 2, 1991, pp. 102-107.

Jensen, P.S., Shervette, R.E., III, Xenakis, S.N., and Richters, J.
Anxiety and Depressive Disorders in Attention Deficit Disorder with Hyperactivity: New Findings. American Journal of Psychiatry. Vol. 150, No. 8, August 1993, pp. 1203-1209.

Jensen, P.S., Irwin, R.A.C., Josephson, A.M., Davis, H., Xenakis, S.N., Bloedau, L.,

Ness, R.,
Mabe, A., Lee, B., Traylor, J., and Clawson, L.
Data-Gathering Tools for "Real World" Clinical Settings: A Multisite Feasibility Study. Journal of American Academy of Child and Adolescent Psychiatry, 35:1, January 1996, pp. 55-66.

Xenakis, S.N., Blakeslee, B.S., Horner, J.A. Possibilities for peacekeeping: the role of telemedicine in international initiatives**.** *Stud Health Technol Inform* January 1997 (Vol. 39, Pages 257-63).

Mease, A., Whitlock, W.L., Brown, A., Moore, K., Pavliscsak, H., Dingbaum, A., Lacefield, D., Buker, K., Xenakis, S.N.
Telemedicine Improved Diabetic Management. Military Medicine, 1999.

Xenakis, S.N.
More on: "Doctors Must Be Healers". Seton Hall Law Review, Vol 37, No. 3, 2007.

Rubenstein, L.S. and Xenakis, S.N.
"Prisoner of Wars: The Use of Torture and Psychological Warfare," in War and Public Health (Second Edition), edited by Barry S. Levy and Victor W. Sidel. New York: Oxford University Press, 2008.

Huskey, K. and Xenakis, S.N.
Hunger Strikers: Challenges to the Guantanamo Detainee Health Care Policy. Whittier Law Review, Vol 30, No. 4, Summer 2009.

Rubenstein, L.S. and Xenakis, S.N.
Role of CIA Physicians in Enhanced Interrogation and Torture of Detainees. Journal of the American Medical Association, August 4, 2010, Vol 304, No. 5, pp. 569-70.

Iacopino, V. and Xenakis, S.N.
Neglect of Medical Evidence of Torture in Guanta´namo Bay: A Case Series. PLoS Med 8(4): e1001027. doi:10.1371/journal.pmed.1001027.

PATENT

Systems and Methods for Managing Biological Data and Providing Data Interpretation Tools. (WO/2003/071391). August 28, 2003. with D. Joffe, M. Hickey, S. Snyder, and V.

Colwell.

VIDEODISC

Balson, P.M., Xenakis, S.N., Matcher, J., Danaher, B., and Brooks, F.R.
Crisis Counseling. Videodisc Simulation Script. US Army Academy of Health Sciences, 1983.

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MENTAL HEALTH SYSTEM

IN SUDAN

A report of the assessment of the mental health system in Sudan using the World Health Organization - Assessment Instrument for Mental Health Systems (WHO-AIMS).

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Please refer to WHO-AIMS (WHO, 2005) for full information on the development of WHO-AIMS at the following website.
http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

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Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Sudan. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Sudan to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Sudan's mental health policy was reformulated in 2006-2008. The last version of mental health legislation dates back to 1998 and requires updating. No national human rights review body exists. Review/inspection of human rights protection of patients in mental hospitals is sporadic and inconsistent. None of the mental health staff working in mental hospitals received any training on human rights.

Everyone has free access (at least 80%) to essential psychotropic medicines in psychiatric emergencies only. For those that pay out of pocket, the cost of antipsychotic medication is 27% and of antidepressant medication is 18% of the minimum daily wage (approximately 1 US$ per day for antipsychotic medication and 0.41 US$ per day for antidepressant medication) . There are no social insurance schemes. Worker's insurance scheme benefits a small proportion of the population.

In Sudan**,** the mental health system has most types of mental health facilities; however most of them need to be strengthened and developed further in terms of staff, treatment facilities and living facilities. There is an imbalance in favor of mental hospital inpatient care. The vast majority of financial resources and a substantial part of human resources are directed towards mental hospitals. Few facilities are devoted to children and adolescents.

The users treated in outpatient facilities are primarily diagnosed with mood disorders (47%) schizophrenia and related disorders (16%), however, collection of such data is poor. The average number of contact with the mental health facilities is 1.47. None of these facilities provide active follow-up care in the community, and there are no mental health mobile teams. In terms of available treatments in outpatient facilities, percentage of patients receiving psychosocial treatments is unavailable. All (100%) mental health outpatient facilities have at last one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or in a near-by pharmacy all year round. However, such medications are not provided free of charge except in case of psychiatric emergencies. Access to mental health facilities is unevenly distributed across the country, favoring those living in or near the capital city.

Primary health care staff training on mental health issues is weak, as is interaction between the primary health and mental health system. There is only one pilot scheme of integration of mental health with general health care in the Gazira state.

The total number of human resources working in mental health facilities or private practice per 100,000 population is 0.92. There is one family association' and consumer association in the country that were started recently.

There are formal links between the mental health sector and other sectors, but many of the critical links are weak or not developed (e.g., links with the welfare, housing, judicial, work provision, education sectors). There are no coordinating bodies to oversee public education and awareness campaigns on the mental health issues. There is no legislative or financial support for people with mental disorders.

The Ministry of Health publishes an annual report on the statistics of 5 clinical conditions. There have been 19 research articles on mental health published in indexed journals during the last 5 years. Some research on epidemiological and non-epidemiological clinical/questionnaires assessments of mental disorders and services has been conducted by non-governmental and international organizations.

Data relating to treatment contacts of person with mental illness are collected and complied with a variable extent. The mental health information system does not cover all relevant information in all facilities.

WHO-AIMS COUNTRY REPORT FOR SUDAN

Introduction

With an area of 2 506 000 km2, Sudan is the largest country in Africa. The heart of the country, in terms of population, lies at the confluence of the Blue and White Niles. The conurbation of the three towns, Khartoum, Khartoum North and Omdurman, is situated there and contains almost 20% of the population. The total population of Sudan is estimated to be 38 million (source of data 2008). The urban population is 36% of the total population. About 2.2 million are still entirely nomadic. There are about 19 major ethnic groups and a further 597 subgroups. Of the total population 42% are below 15 years, and 4% are above the age of 65 years (source of data 2001). In 2000, the total adult literacy rate and the female adult literacy rate were estimated at 50% and 49%, respectively. The crude death rate is 11.5 per 1000 population and the crude birth rate is 37.8 per 1000 population (data source 2004). The infant mortality rate is estimated at 68 per 1000 live births, and under-5 mortality rate is estimated to be 104 per 1000 live births. Total life expectancy at birth was 56.6 years in 2000. Maternal mortality ratio is estimated at 50.9 per 10 000 live births (2000).

The per capita gross national product in 2004 was US$ 578. The per capita Ministry of Health expenditure was US$ 2.1 in 2004. The Ministry of Health expenditure represented 1.6 % of the country's budget in 2006 while the expenditure on mental health is unknown.

In 2003, there were 1.8 physicians, 0.07 dentists, 5.1 nurses/midwives and 7.1 hospital beds per 10,000 of the population, respectively. Health has been declared the first national priority after security. The health policies give priority to family health and reduction in morbidity and mortality rates among mothers and children; encourage community involvement in the planning, implementation and supervision of the health services; reinforce primary health care and the delivery of its integrated components through the area health system; encourage scientific research into the more pressing health problems, including environmental pollution, endemic and epidemic diseases and malnutrition; seek improvement of the managerial skills of personnel at all levels; and emphasize coordination between health-related ministries and departments.

The design of the health care system in Sudan is based on primary health care and the "health area" concept, which is conceived as a decentralized health care system able to integrate, at district level, the existing vertical programmes, including preventive, curative and promotional activities. At village level, primary health care units represent the first level of contact between the community and the health services. Secondary health care is available in small towns through rural hospitals and urban health centres. Tertiary health care services comprise provincial, regional, university and specialist hospitals.

Committees for health have been established at both village and national levels. These committees are involved in planning, execution, resource finding and allocation as well

as supervision of health services in their localities. The committees are supported by national laws and regulations and are effective, powerful bodies. Nongovernmental organizations play a recognized role in the delivery of health care. The Ministry of Health has invited them to participate in planning sessions and meeting at national and local levels.

The health services suffer from acute shortages in trained personnel. There are no health human resources plans, and universities and other training institutions work in isolation from the Ministry of Health. Training and education are thus not directed towards the meeting of national needs.

The country is a low income group country based on World Bank 2004 criteria. The life expectancy at birth is 54.9 years for males and 59.3 years for females. The healthy life expectancy at birth is 47 years for males and 50 years for females. The literacy rate is 70.8% for men and 49.1% for women (Mental Health Atlas, WHO, 2005).

There are 72 hospital beds and 19 physicians per 100,000 populations in the public sector. In terms of primary care, there are 2031 primary health care clinics. These data are available only for the public sector. Health resources are strongly centralized in spite of decentralization policy, i.e. 72% of physicians are based in the main city, and the surrounding region, both of which congregate 16% of the country population (2004 Census).

The mental health system is hospital based. For the last 5 years efforts have been made to shift attention to the community, but with limited success. Overall, mental health system resources are scarce and centralized.

Data was collected in 2007 and is based on the year 2006.

Domain 1: Policy and Legislative Framework

Policy, plans, and legislation

Sudan's mental health policy was last revised in 2008 and includes the following components:
(1) developing a mental health component in primary health care, (2) human resources, (3) involvement of users and families, (4) advocacy and promotion, (5) human rights protection of users, (6) equity and access to mental health services across different groups, (7) quality improvement, (8) financing and (9) monitoring system. An essential medicines list is present in the country that included all categories of psychotropic medicines.

The last revision of the mental health plan took place in 2002 It included all the components of the mental health policy, and also the additional component of reforming mental hospitals to provide more comprehensive care. There is no disaster/emergency preparedness plan for mental health. The mental health legislation was established in 1998 and is currently under revision. A mental health act has been drafted and is waiting for approval from the parliament. The following components are included in the proposed legislation: access to mental health care including access to the least restrictive care, rights of mental health services consumers, family and other care givers, competency, capacity and guardianship issues for people with mental illness, voluntary and involuntary treatment, law enforcement and other judicial system issues for people with mental illness.

Financing of mental health services

The percentage of expenditures on mental health in Sudan is unknown. However, available funds are mainly oriented towards mental hospitals. There are no social insurance schemes and psychotropic medication is available free only in emergency psychiatric care. The cost of the cheapest antipsychotic medication is 27% of the daily minimum wages and cost of cheapest antidepressant medication is 18% of the one day minimum wage.

Human rights policies

None of the mental health workers receive special training in human rights.

Domain 2: Mental Health Services

Organization of mental health services

A national mental health authority exists under the umbrella of preventive medicine and primary health care at the federal level. However, it needs strengthening. It provides advice to the government on mental health policies and legislation. It is also involved in service planning, management and co-ordination. Mental health services are not available at the primary level, or organized in primary health care service packages. The main strategic goal is to introduce care for mental health at the general service level, especially at the primarily level. None of the mental hospitals are organizationally integrated with mental health outpatient facilities.

Mental health outpatient facilities

There are 17 outpatient facilities of which 6% are exclusively for children (Gazera & Khartoum state). These facilities treat 110 users per 100,000 population. Of all of the users treated in mental outpatient facilities 48% are female. The proportion of children and adolescents among users is 8%.

The users treated in outpatient facilities are primarily diagnosed with schizophrenia (16%), mood (affective) disorders (47%) and neurotic, stress and somatoform disorders (10%). None of the outpatient facilities provide follow-up care in the community, nor do any have mental health mobile teams. There is a lack of information regarding the patients' records in the health facilities. Also, the information available often does not reflect the real situation of the current problems. Moreover, there still is a great cultural barrier in seeking medical advice - most of patients go to traditional healers, especially in the rural areas.

The average number of contacts per user is 1.47. None of the mental health outpatient facilities provide routine follow-up or community care. There are no mobile clinic teams that provide regular mental health care outside of the mental health facility.

All mental health outpatient facilities have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

Day treatment facilities

There are no day treatment facilities available in the country.

Community – based psychiatric inpatient units

There are 9 community based inpatient units available in the country for a total of 0.9 beds per 100, 0000 population. None of these beds are reserved for children and

adolescents; 46% of the admissions to community–based psychiatric inpatient units are female and 2% are children / adolescent.

The primary diagnoses of admissions to community–based psychiatric inpatient units include schizophrenia (32%), mood disorders (17%), personality and behaviour disorders (15%) and neurotic, stress and somatoform disorder (11%).

On average, patients spend 10 days in community-based psychiatric inpatient units per discharge. The proportion of involuntary admissions to community-based psychiatric inpatient units is 17% while 11-20% of the patients were restrained or secluded at least once in the past year.

Community based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facilities or near by pharmacy.

Community residential facilities

There are 7 community residential facilities available in the country for a total of 1.75 beds/places per 100,000 population. These facilities treat 1.79 patients per 100,000 population. 43% of the patients are female and 37% are children. No beds are reserved for children and adolescents. On an average, patients spend 39 days in community residential facilities.

Mental hospitals

There are two mental hospitals available in the country for a total of 0.86 beds per 100,000 population. These facilities are organizationally integrated with mental health outpatient facilities. None of these beds in mental hospitals are reserved for children and adolescents only. Thirty percent of patients treated are female and 13% are children and adolescents. The patients admitted to mental hospitals primarily belong to the following diagnostic group: mental and behavioral disorders due to psychoactive substance use (10%), schizophrenia and related illnesses diagnostic group (15%), mood disorders (22%), neurotic stress-related and somatoform disorders (18%), disorders of adult personality and behaviour (11%) and others, such as mental retardation, epilepsy (24%). 24% of the patients were admitted involuntarily and 11-20% of the patients were restrained or secluded. The occupancy rate of these hospitals is 20%.

The average number of days spent in mental hospitals is 35 days. All patients spend less than one year in mental hospitals. Some (21-50%) patients in mental hospitals received one or more psychosocial interventions in the last year. All mental hospitals have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility. However, such medications are not provided free of charge except in the case of psychiatric emergencies. The number of beds has increased by 62 % in the last five years.

Forensic inpatient facilities

All forensic beds are in prison mental health facilities. Involuntary admission is common but the use of restraints or seclusion is sporadic. There are a total of 200 beds (0.5 per 100,000 of the total population). Forensic facilities treated 0.76 per 100,000 population, 66% stay less than one year, and no one stays more than 10 years .

Other residential facilities

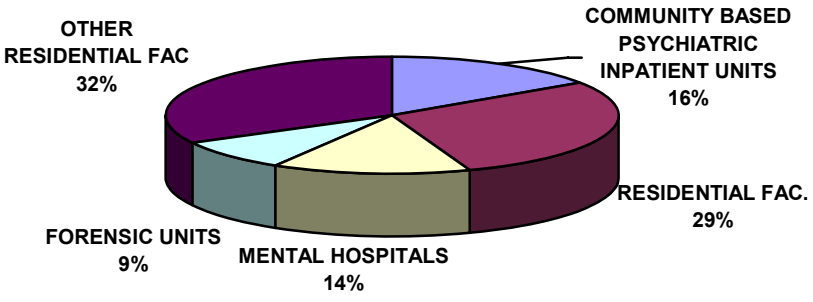
There are 7 community-based residential facilities in Sudan (more than 7, but the most important are 7 traditional healer centers) with an estimated total of 760 beds.

In Sudan the traditional healing methods are shaped by the religious, spiritual and cultural factors of different ethnic population groups. The practice is common in urban as well as rural populations. Traditional healers may require long stay of patients and this may prevent early detection of disease and early medical intervention by modern psychiatry. However, attempts have been made to promote reciprocal communication and intervention with traditional healers; there are many traditional healing centers.

Human rights and equity

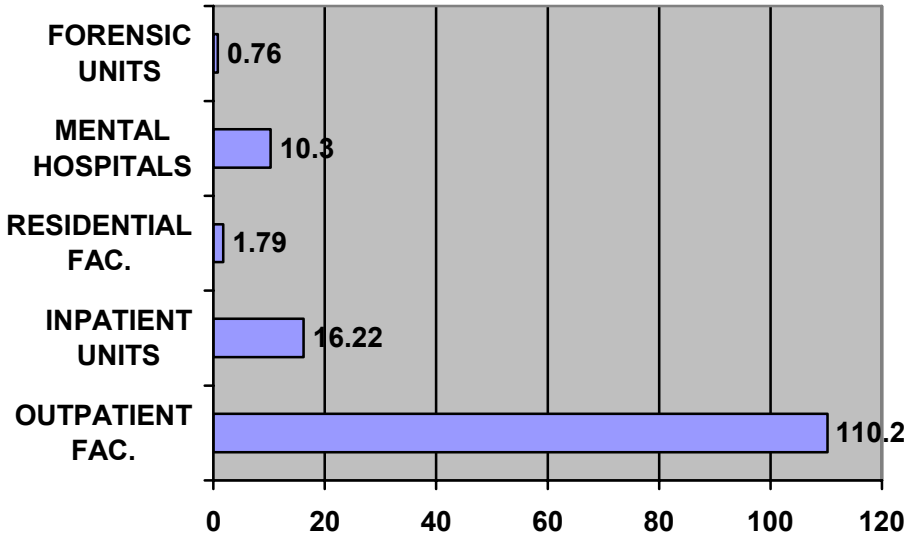
All mental hospitals and the majority of inpatient and outpatient facilities in the country are located in Khartoum City, the largest city in Sudan. Such a distribution of facilities prevents access to mental health services for rural users. Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is unknown.

GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES



The majority of beds in the country are provided by other residential facilities (facilities outside the mental health system), followed by community residential facilities.

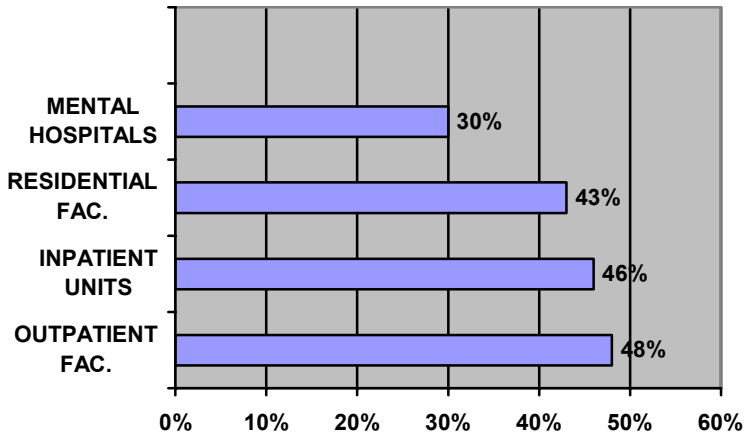
GRAPH 2.2 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES (rate per 100.000 population)



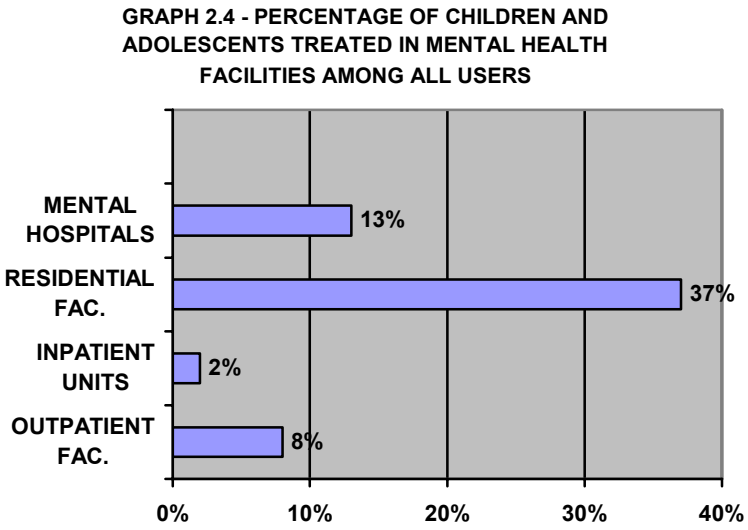
Note: In this graph the rate of admissions in inpatient units is used as proxy of the rate of users treated in the units. The number of patients in forensic beds on December 31 is used as a proxy for patients treated in forensic units.

The majority of the users are treated in outpatient facilities followed by community-based psychiatric inpatient units and mental hospitals.

GRAPH 2.3 - PERCENTAGES OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES

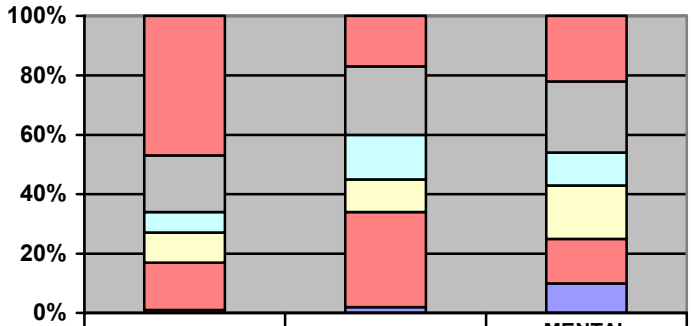


Female users represent over 40% of the total number of users of all mental health facilities in the country. The proportion of female users is highest in inpatient units and outpatient facilities and lowest in mental hospitals.



The percentage of users that are children and/or adolescents varies substantially from facility to facility (Graph 2.4). The proportion of children users is highest in residential facilities, followed by mental hospitals.

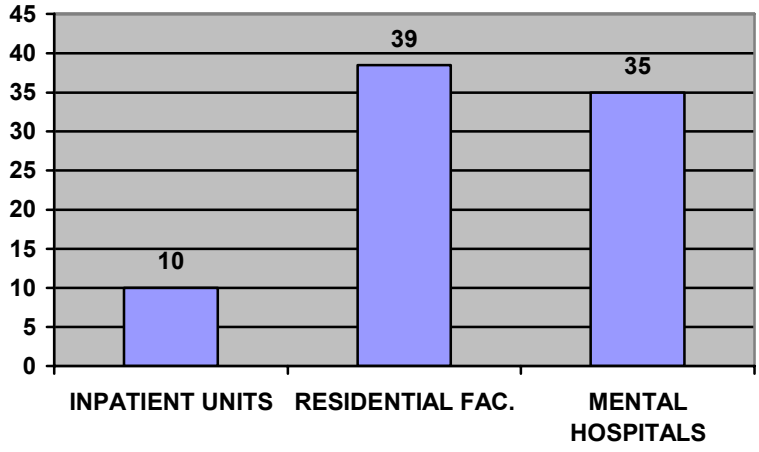
GRAPH 2.5 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS



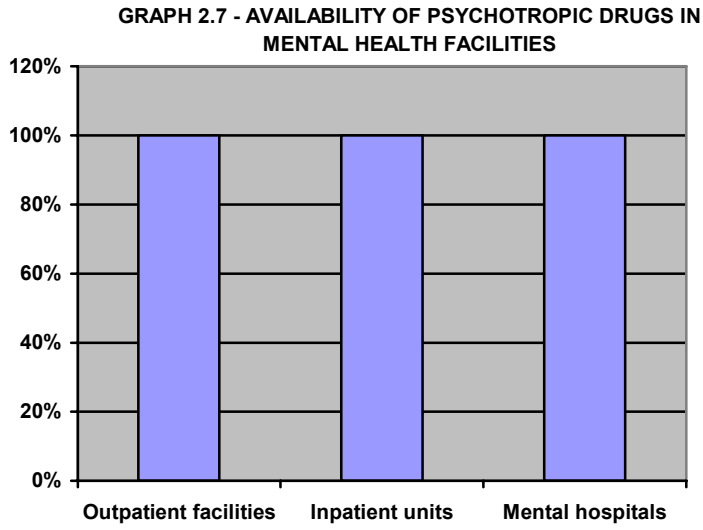
	OUTPATIENT FAC.	INPATIENT UNITS	MENTAL HOSPITALS
MOOD DISORDERS	47%	17%	22%
OTHERS	19%	23%	24%
PERSONALITY DIS.	7%	15%	11%
NEUROTIC DIS.	10%	11%	18%
SCHIZOPHRENIA	16%	32%	15%
SUBSTANCE ABUSE	1%	2%	10%

The distribution of diagnoses varies across facilities (Graph 2.5): in outpatient facilities mood disorders and other disorders are most prevalent, in inpatient units, schizophrenia and other disorders diagnoses are most common, and in mental hospitals mood disorders and "other" diagnoses are most frequent.

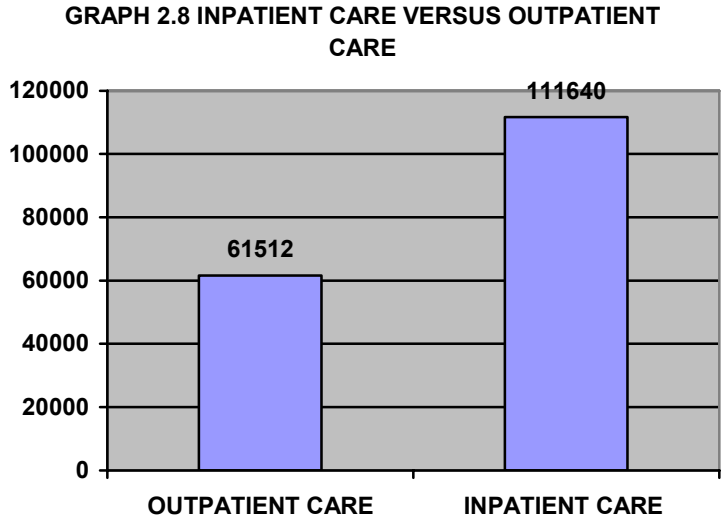
GRAPH 2.6 - LENGTH OF STAY IN INPATIENT FACILITIES (days per year)



The longest length of stay for users is in community residential facilities, followed by mental hospitals and then community-based psychiatric inpatient units



Psychotropic drugs are mostly widely available in all mental health facilities (i.e. mental hospitals, inpatient units and outpatient mental health facilities).



The ratio between outpatient/day care contacts and days spent in all the inpatient facilities (mental hospitals, residential facilities and general hospital units) is an indicator of the extent of community care: in this country the ratio is 0.55.This means that there is less than one outpatient contact per day spent in inpatient care.

Domain 3: Mental Health in Primary Health Care

Training in mental health care for primary care staff

2% percent of the training for medical doctors is devoted to mental health, in comparison to 4 % for nurses. In terms of refresher training on mental health, such a program has only sporadically been organized to provide refresher training to primary health care doctors, nurses and non-doctor/non-nurse. However, it has only been given to 20 doctors from various states during 2006 and none of the primary health workers received such training.

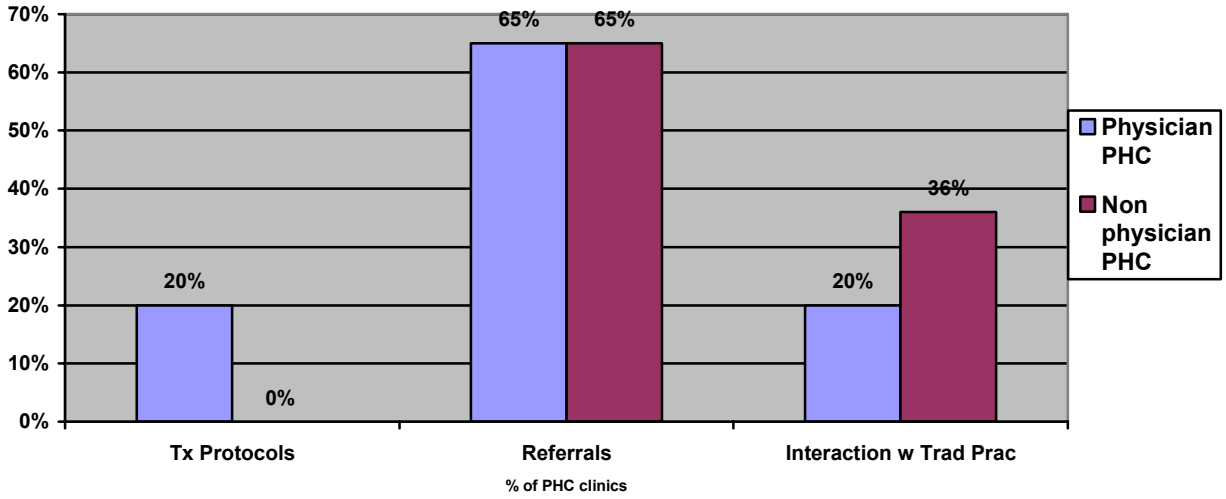
Mental health in primary health care

Both physician based primary health care (PHC) and non-physician-based PHC clinics are present in the country. However, data collected are not sorted as such. A few (<20%) primary health care clinics have assessment and treatment protocols for key mental health conditions available. In comparison, none of the clinics in non-physician-based primary health care have these protocols.

The majority (51-80%) of the primary health care clinics make at least one monthly referral to a mental health professional. The percentage of referrals from non-physician based primary health care clinics to a higher level of care (e.g., mental health professional or physician-based primary health clinic) is the majority (51-80% of clinics).

As for professional interaction between primary health care staff and mental care staff, a few (<20%) of the physician PHC facilities have had interaction with a complementary /alternative/ traditional practitioner, in comparison to some (21-50%) of the non-physician based primary health care clinics.

GRAPH 3.2 - COMPARISON OF PHYSICIAN BASED PRIMARY HEALTH CARE WITH NON-PHYSICIAN BASED PRIMARY HEALTH CARE



Prescription in primary health care

Nurses are not allowed to prescribe psychotropic medications in any circumstance, but psychiatric medical assistants are allowed to prescribe medications in some situations. Primary health care doctor are allowed to prescribe only essential psychotropic medications. As for availability of psychotropic medicines, none of the PHC clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) on a continuous basis in comparison to a few (1-20%) clinics of the non-physician-based clinics.

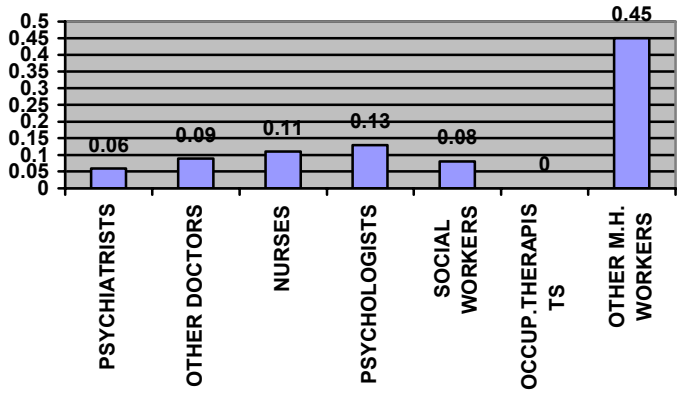
Domain 4: Human Resources

Number of human resources in mental health care

The total number of human resources working in mental health facilities or private practice per 100,000 population is 0.92. The breakdown according to profession is as follows: 0.06 psychiatrists, 0.09 other medical doctors, .12 nurses, 0.13 psychologists, .08 social workers, and 0.45 other health workers. Twenty-four psychiatrists work for the Ministry of Health in mental health facilities, while 42 work in other sectors such as higher education. Fifty Percent of the psychologists, social workers, nurses and medical assistants work only in the government administered mental health facility, 21% work in the non government or private setting and 29 percent work in the both. Private practice is largely unregulated, especially in the case of psychologists and social workers. Figures provided are best estimates based on official registration and data from professional associations & Annual health statistical report 2007.

There is an uneven distribution of human resources in favor of mental hospitals and the capital city Khartoum. Only **6** of the 25 states have psychiatric treatment facilities.

GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100.000 population)



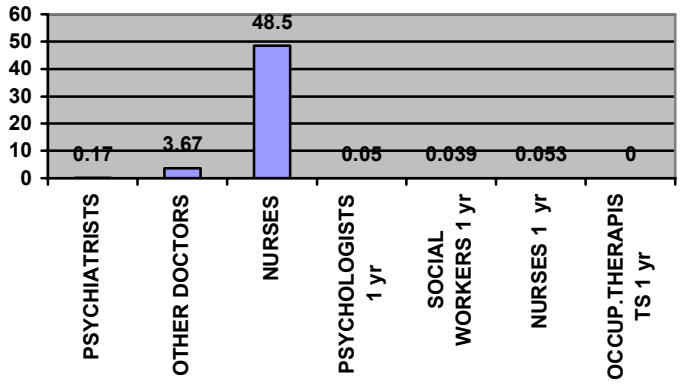
Regarding the workplace, since all out-patient facilities are subdivisions of inpatient facilities all psychiatrist working in government facilities work in both out and in patient units. Ten psychiatrists work part-time in the mental hospitals. As for other staff medical doctors (i.e., those not specialized in mental health), there are 35 non-specialized doctors working in mental health facilities in the country. Non nurses (with diplomas only) were working in mental hospitals. As for other mental health professionals, there are 50 psychologists and social workers working in mental hospitals. There are no occupational therapists.

The density of psychiatrists in or around the largest city is 4.49 times greater than the density of psychiatrists in the entire country. The density of nurses is 4.9 times greater in the largest city than the entire country.

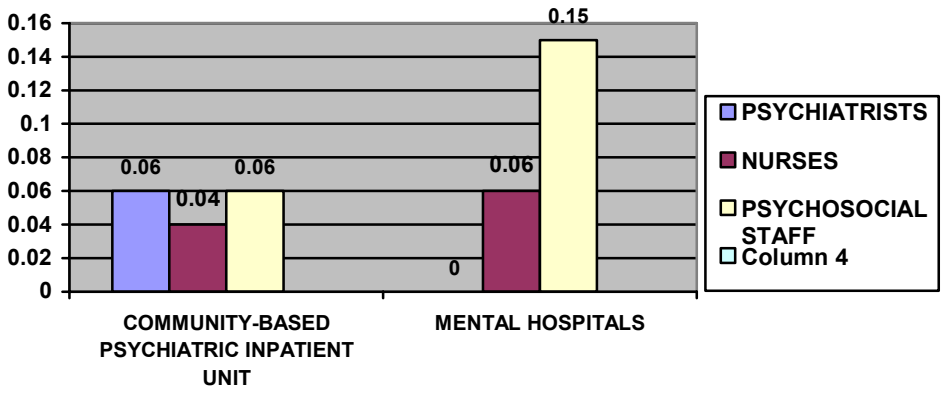
Training professionals in mental health

The number of professionals graduated 2008 in academic and educational institutions per 100,000 is as follows: 0.17 psychiatrists, 3.6 medical doctors, 48.5 nurses - none of the nurses have at least 1 year training in mental health care, 0.05 psychologists and 0.04 social workers with at least 1 year training in mental health care, 0.00 occupational therapists with at least 1 year training in mental health care. All or almost the majority of the psychiatrists emigrate from the country within five years of the completion of their training. No mental health care staff attended refresher training on the rational use of drugs, psychosocial interventions, 4% (1) psychiatrist was trained in child/adolescent mental health issues in an at least two days refreshing training.

GRAPH 4.2 - PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)



GRAPH 4.3 - AVERAGE NUMBER OF STAFF PER BED



Consumer and family associations

There are three members of user/consumer association and 124 members of family associations. The user association has started only in the last few months; the government currently does not provide economic support for either consumer or family associations. Few mental health facilities interact with these associations. In addition, there are other NGOs in the country involved in individual assistance activities such as counseling, housing, or support groups.

Domain 5: Public Education and Links with Other Sectors

Public education and awareness campaigns on mental health

There are no coordinating bodies that oversee public education and awareness campaigns on mental health and mental disorders. The promotion of public education and awareness Campaigns by government agencies, NGOs, professional associations, private trusts and Foundations and international agencies in the last five years are unknown.

Legislative and financial provisions for people with mental disorders

At the present time, there is no legislative or financial support for employment, provision against discrimination at work, provisions for housing, and provisions against discrimination in housing for people with mental disorders.

Links with other sectors

There are formal collaborations with the departments/agencies responsible for primary health care/community health, HIV/AIDS and substance abuse. One (1%) of the primary

and secondary schools have either a part-time or full-time mental health professional working in them. Few (1-20%) primary and secondary schools have school-based activities to promote mental health and prevent mental disorders.

The proportion of prisoners with psychosis and mental retardation is estimated to be less than 5% for each diagnosis. Regarding mental health activities in the criminal justice system, less than 20 % of prisons have at least one prisoner per month in treatment contact with a mental health professional. As for training, 2% police officers and 1% judges and lawyers have participated in educational activities on mental health in the last five years.

Domain 6: Monitoring and Research

A formally defined list of individual data items that ought to be collected by all mental health facilities does exist. The extent of data collection is variable among mental health facilities. The government health department received data from all mental hospitals, 100% community based psychiatric inpatient units, and 53% mental health outpatient facilities. The data are not presented separately for the different facilities. It appears in the annual health statistical report from the national health information center in the federal ministry of health.

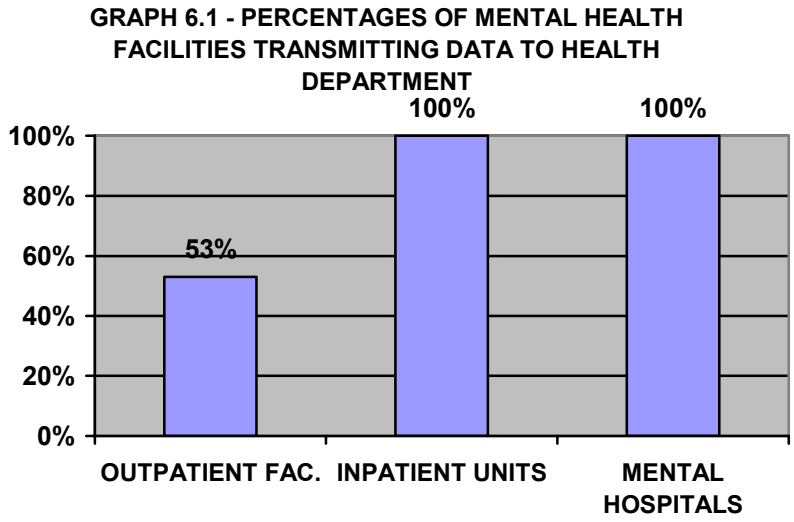
Research in Sudan is focused on epidemiological & community and clinical samples, and non-Epidemiological clinical/questionnaires assessments of mental disorders.

In terms of research, few mental health professionals (less than 20% of psychiatrists, nurses, psychologists and social workers) are involved in mental health research, as investigator or co-investigator (including dissertations and theses). There have been 19 mental health research publications in indexed journals in the past five years, which constitutes 2% of all indexed research in Sudan.

Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information

TYPE OF INFORMATION COMPILED	**MENTAL HOSPITALS**	**INPATIENT UNITS**	**OUTPATIENT FAC.**
N° of beds	100%	100%	NA
N° inpatient admissions/users treated in outpatient facilities	100%	100%	100%
N° of days spent/user contacts in outpatient facilities.	100%	100%	100%

N° of involuntary admissions	0%	0%	NA
N° of users restrained	0%	0%	NA
Diagnoses	100%	100%	100%



In order to put the information contained above into context, comparisons with regional norms are made. Sudan, like most countries of the Eastern Mediterranean, has a mental health policy. However, in comparison to other countries, it was revised only recently. Community care for patients is limited as seen in many low and lower middle income countries. Expenditure on mental health is not specified from the total expenditure following the trend of most low and lower middle income countries. The poor involvement of primary health care services in mental health is also a feature shared with many low and lower middle income countries. In contrast, the proportion of psychiatric beds located in psychiatric hospitals to the total psychiatric beds in the country is well above the average for the region of the Eastern Mediterranean. The number of psychiatrists per 100000 population is lower than that of the majority of countries in the region of the Eastern Mediterranean, and below average as compared to the lower middle income countries in the world (Mental Health Atlas WHO, 2005).The striking aspect of the manpower distribution is the concentration of 80% of professionals in Khartoum which has about 18 % of the population of the country.

In the last few years, the number of outpatient facilities has grown significantly throughout the country. Moreover, efforts have been made to improve the quality of life and treatment of patients in mental hospitals. Some aspects of life in hospital have improved, but the number of patients has steadily grown. Unfortunately, the lack of human and financial resources to community mental health is a significant barrier to progress in the treatment of patients in the community. As a result, no significant progress has been made in provision of affordable medication, housing or employment for patients in the community.

Next Steps in Strengthening the Mental Health System

Domain 1

- Improving the quality of mental health services according to the patient rights.

Domain 2

- Creation and the strengthening of community-based facilities (e.g., mental health outpatient facilities, community-based psychiatric inpatient units, etc.).
- Increasing availability of essential psychotropic medicines
- Improving equity of access to mental health services
- Increasing the mental health services for children and adolescents.

Domain 3

- Increasing the training in mental health for primary care staff.
- Integration the mental health with traditional healers

- Integration of mental health in the general services especially in primary health care.

Domain 4

- Increasing the numbers of psychosocial staff (e.g., social workers, psychologists, etc.).
- Development of mental health users and consumer & family association.

Domain 5

- Development of formal collaboration in the form of laws, administration, and programmes with (other) health and non-health sectors aimed at improving mental health (Mental health council)
- Increasing the mental health system's links with other key sectors (e.g., department responsible for HIV, education, etc).

Domain 6

- Improvement of the mental health information systems.
- Development of mental health campaigns.

SUDAN WHO-AIMS

As a developing country, there are a number of contextual factors that need to be considered in understanding the current state of the mental health system, of Sudan including the socioeconomic situation and poverty suffered by most of the population as well as the high proportion of illiteracy, especially among women. It is also important to note that Sudan has experienced natural disasters such as drought and floods, as well as man-made disasters such as civil war and tribal conflicts.

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Sudan. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. The results of the assessment illustrate positive areas of the mental health system as well as gaps that need to be studied and addressed. There are scarcities in mental health services at all levels, in terms of availability, accessibility and affordability. There is also a shortage of human resources and trained mental health professionals. The lack of mental health insurance schemes and the unequal distribution f mental health services, in favor of the capital city is also a concern. The budget allocated for mental health services is not known, and could not determined.

One of the biggest challenges is to introduce mental health services at the primary health care level, in order to increase the accessibility and availability of mental health care. Integration of mental health may help in fighting against social stigma as stigmatization against people with mental disorders is deeply rooted in Sudan. With regard to policies and laws on mental health, after a long waiting period, a national mental health policy was developed and is now in the process of being translated into the form of a strategic plan.

Protection of human rights with regards to the person with mental disorders it is untouched area, with little training available. Availability of data and research on health is severely limited for all aspects of health in the Sudan. However, for mental health the situation is worse as there are no studies to determine the magnitude of the problem.

Mental health has not received enough attention and priority until very recently. However, there are currently a number of ambitious programmes are in the pipeline.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

IBRAHIM OSMAN IBRAHIM IDRIS,
Detainee, Guantanamo Bay Naval Station,

MOHAMMED IDRIS,
Next Friend,

Petitioners,

v.

BARACK H. OBAMA,
President of the United States, *et al.,*

Respondents.

Civil Action No. 05-1555 (RCL)

[PROPOSED] ORDER

Upon consideration of the Motion of Petitioner For Judgment On His Petition For A Writ Of Habeas Corpus, it is hereby

ORDERED that the motion for judgment is granted; and it is

FURTHER ORDERED that the petition for a writ of *habeas corpus* is granted; and it is

FURTHER ORDERED that the Government take all necessary and appropriate diplomatic steps to facilitate Petitioner's immediate repatriation to Sudan.

IT IS SO ORDERED.

Dated:_____

_____
ROYCE C. LAMBERTH
Chief Judge
United States District Court