SCOI.10488.00008_0001

Dr John Jacmon, OAM, EdD, MEd, MEd Admin, Hons BSc, Hons BA, BSc, BEd, Dip Ed Admin, Cert Comp Studies, MAPS
Consultant Psychologist (Registered NSW)
Ph: Mobile:
e-mail: website: www.consultantpsychologist.com
Member Australian Psychological Society and College of Counselling Psychologists
Psychologist Registration No WorkCover Approval No
Medicare Provider
Practice Manager Sandra Stergenakis, JP

8 November 10

The Presiding Magistrate
District Court
Sydney

Your Honour

PSYCHOLOGICAL ASSESSMENT REPORT
Kellie Moses dob 85

I attach a medicolegal report for Moses Kellie addressing mental health issues.

With respect

DR JOHN JACMON, OAM
REGISTERED PSYCHOLOGIST

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PSYCHOLOGICAL ASSESSMENT REPORT
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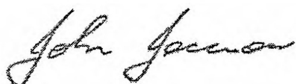
1. Conclusions

The assessment by testing and clinical interview has gathered considerable information on Mr Kellie's state of mind currently and at the time of the incident now before the court. On the basis of the results, the research and the background the following can be stated:

- Mr Kellie's day-to-day functioning is being impaired by posttraumatic stress disorder (PTSD), depression and anxiety at clinically significant levels. The impairment due to PTSD is likely to have existed since childhood when he witnessed many killings during the Sierra Leone civil war and had to bury people who died in the refugee camp in Ghana. Depression and anxiety are likely to have set in with succeeding life downturns including his inability to find employment in Australia and being refused unemployment benefits.
- The symptoms of the diagnosed disorders have the following ongoing effects on Mr Kellie's functioning:
  - Depression and anxiety cause sadness, marked loss of interest and pleasure in life, decrease in appetite, insomnia, agitation, fatigue, feelings of worthlessness, and cognitive impairments including (a) difficulties in concentration, memory, problem-solving and decision making, (b) confused thinking and (c) impulsivity. See research note (i) for amplification.
  - PTSD worsens these impairments and further debilitates the individual by bringing to mind intrusive distressing recollections of the traumatic event, causing efforts to avoid thoughts and feelings of the trauma and creating a state of overt and anxious alertness of the feared object. See research note (ii). and creating a state of overt and anxious alertness of the feared object. See research note (ii) for amplification.
- These impairments markedly diminish the individual's ability to formulate reasoned judgments. PTSD and depression are frequently associated with violent behaviour.
- Mr Kellie has been assessed at a borderline level of IQ. This level is characterised by significantly below-average general intellectual functioning existing concurrently with related limitations in two or more of adaptive skills areas such as communication and social skills. Behaviours may reflect poor attention and concentration, slowness in responding, general disorganisation, low frustration tolerance, mood swings, anger, poor common sense, and naïveté. Lowered self-esteem usually results. This is the lowest level of intelligence at which an individual may function independently ie without the need for carer assistance.
- Mr Kellie's actions which led to offending indicated markedly diminished capacity for judgment because there appeared to be little thought given to the consequences. Impaired judgment is also shown by not persevering with attempts to improve his life eg seeking to locate charities.

1. Conclusions - continued

- Mr Kellie has taken the opportunity to reflect on the incident and the consequences of causal actions. He was sorry that the incident occurred and the distress it created.
- Mr Kellie's disorders need treatment to address the symptoms, relieve distress and to enable positive outcomes in the future. Treatment should help safeguard against the manifestation of behaviour that may lead to offending. The treatment plan is presented in Attachment A. The rationale of the method underlying the treatment plan is outlined in Attachment B.
- Mr Kellie has been advised to contact the Transcultural Mental Health Centre on release. The Centre arranges psychological treatment for newcomers including those who were refugees and had been victims of civil war.
- Completion of treatment and continuation of support by significant others should ameliorate the disorders and markedly reduce the probability that Mr Kellie re-offends.



DR JOHN JACMON, OAM
REGISTERED PSYCHOLOGIST

2. Date and purpose of consultation

The assessment was held on 7 November 10 at the MRRC. Mr Kellie was informed that the purpose of the assessment was to provide a report on his psychological condition to his legal representative for submission to the court. Throughout the assessment Mr Kellie had difficulty in maintaining linearity particularly as he described distressing incidents in his life as a war refugee.

3. Background as related by client

Mr Kellie was born in Freetown, Sierra Leone. He has three older sisters. He grew up during the civil war which began in 1991 and ended in 2002. He related frequently witnessing people being killed and maimed by the rebels as they swept through the town every few days and attacked the defenceless population. He saw many dead bodies on the streets. Mr Kellie recalled the fears his family held for their safety at the sight of the approaching rebels.

His father went away to fight in the war leaving the mother to bring up the children on her own. He learnt later that his father was killed in 1999. He was 50 years old.

In 1995 the mother took the children to Guinea where refugee camps were set up to cater for the people of Sierra Leone who were able to reach them. The children reached the camp first. Mr Kellie learnt from other refugees that his mother who was some distance behild the children, was killed by the rebels. They often attacked people fleeing to the refugee camps in nearby countries.

Mr Kellie and the two younger sisters remained in the camp for about 11 years until they were granted refugee status and allowed to migrate to Australia. The oldest sister who was married left in 2004 for Australia with her family. After some time in Tasmania they moved to Sydney and settled in Blacktown.

In the camp the conditions were primitive. There was not enough drinking water and much of it was polluted. The water shortage prevented refugees from bathing. There was no sewerage. There were many deaths due to water-borne and other diseases. Mr Kellie helped bury many of the dead. The inhabitants received rations of corn flour and oil from the UN. There were no meat or vegetables. The corn flour was cooked with oil and eaten. Crime in the camp mainly consisted of thefts of food and families had to be vigilant to ensure that their supplies were not stolen.

During the day people sat around the camp with little to occupy themselves. There was no work. They could not leave the camp which was guarded by armed troops. In any case if they did leave they would run the risk of being killed by the rebels who were frequently roaming the countryside. Mr Kellie was able to continue with his schooling in the camp. He had begun school in Freetown and attended whenever the rebels were not around. In the camp he completed the equivalent of Year 5.

3. **Background as related by client (continued)**

In 2004 Mr Kellie and his siblings applied to come to Australia. They were approved in 2006. On arrival they moved in with their sister and her family in Blacktown. Soon after arrival Mr Kellie completed an English language course at the Blacktown migrant resource centre. Centrelink funded him to attend a Certificate II course at Wesley Mission in aged care. He completed work experience in a place in Parramatta but could not gain employment because a Certificate III was required as the minimum qualification.

At about the same time problems began with his oldest sister. Essentially the house was too small for her own family and her siblings. Mr Kellie decided to move out. He first went to Darlinghurst in late 2007 and three months later to Marrickville. He approached Centrelink to ask them to fund a Certificate III in aged care but was refused because he had already been funded for a course. He applied for job assistance and was allocated to an agency which found him part-time work in a warehouse at Padstow. He was dismissed after two months in early 2008 because he could not get there on time by public transport.

He applied for other positions but his level of English was not adequate. Centrelink did not believe that he had been applying an adequate effort in finding work and withdrew his benefits. He had no source of income. He had to leave his accommodation in Marrickville. Not knowing where to turn he began living in Moore Park. He reapplied to Centrelink several times but each time he was refused. He knew of no one who could help him. He was not aware of charities such as the Salvation Army or churches that might have assisted him.

In Moore Park the local food outlet provided him with a meal three times a week. He resorted to petty crime to provide him with basic necessities and some money. His activities also included stealing wine from a local supermarket. The alcohol numbed his distress albeit temporarily. He felt demoralised, desperate and saw no future. He lost confidence in himself. He had no one to talk to and his sole companion was a small radio. He was happy when he arrived in Australia and looked forward to making a positive start in life but he was now depressed and anxious about where his life was heading.

The many incidents of death and maiming witnessed have scarred him emotionally. They are never far from his mind and vivid memories cause him marked distress. He has frequent nightmares and flashbacks. He tries to avoid reminders such as television programs depicting wars. He has trouble sleeping and feels cut off from other people.

While in Goulburn jail he completed courses in drug and alcohol, and computing. He enjoyed learning and looked forward on release to undertake a practising qualification in aged care. He has arranged initially to return to live with his oldest sister. She visited him once while he was in custody in Goulburn.

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Mr Kellie was advised during the assessment that a treatment plan addressing diagnosed disorders would be prepared as part of the report for the court.

4. Assessment process

Mr Kellie's presentation and background revealed the probability of anxiety, depression and posttraumatic stress disorder. His IQ appeared to be at a low level. He was assessed by clinical interview and by psychological tests.

5. Psychometric assessment

Mr Kellie's current disorders and IQ level were assessed by the following tests.

(i) Posttraumatic Stress Diagnostic Scale (PDS)

The scale provides measures of the severity of posttraumatic stress symptoms and functional impairment. Mr Kellie's background indicated significant experiences of traumatic events in his formative years during the civil war and also in the refugee camp. To assess the extent of resultant trauma Mr Kellie completed the PDS with these events in mind. Mr Kellie's scores indicated severe posttraumatic stress symptoms and severe impairment of functioning.

(ii) The Depression, Anxiety, and Stress Scales (DASS)

The DASS measures symptoms of depression, anxiety, and stress and their effects on behaviour. Mr Kellie's results indicate clinically significant levels of anxiety, stress and depression.

(iv) Cognitive assessment - Raven's Progressive Matrices

The test is a nonverbal assessment of intelligence. Because these scales minimise the impact of language skills and cultural bias, they are used to measure the intelligence of individuals with reading problems or hearing impairment, as well as those whose native language is not English. The test measures two complementary components of general intelligence: the capacity to think clearly and make sense of complex data (eductive ability); and the capacity to store and reproduce information (reproductive ability). Items ask the examinee to identify the missing component in a series of figural patterns.

This level of intelligence is characterised by significantly below-average general intellectual functioning existing concurrently with related limitations in two or more of adaptive skills areas such as communication, self-care, home living, social skills, self-direction, health and safety, functional academics, leisure, and work. Behaviours may reflect poor attention and concentration, slowness in responding, tendencies to forgo task behaviour, general disorganisation, predilection for concrete activities, over-activity or passivity, low frustration tolerance, mood swings, fearfulness, dysphoria, anger, poor common sense, and naïveté. Lowered self-esteem usually results.

6. Clinical assessment

The tests and the background indicated posttraumatic stress disorder (PTSD), depression and anxiety. Mr Kellie was clinically assessed for these conditions on the basis of DSMIV (Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition)) criteria.

(a) Disorders at the present time

Mr Kellie's description of day-to-day functioning at the present time led to the identification of the following symptoms, classified in terms of DSMIV criteria:

(i) Posttraumatic stress disorder (PTSD)

In relation to the incident which Mr Kellie experienced the following criteria emerged:

A (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. Indicated.

A (2) the person's response involved intense fear, helplessness, or horror. Indicated.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Indicated.
2) recurrent distressing dreams of the event. Indicated.
3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Indicated.
4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. Indicated.
5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. Indicated.

6. Clinical assessment - continued

(i) Posttraumatic stress disorder (PTSD)- continued

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1) efforts to avoid thoughts, feelings, or conversations associated with the trauma Indicated.
2) efforts to avoid activities, places, or people that arouse recollections of the trauma Indicated.
3) inability to recall an important aspect of the trauma Not indicated.
4) markedly diminished interest or participation in significant activities Indicated.
5) feeling of detachment or estrangement from others Indicated.
6) restricted range of affect (e.g., unable to have loving feelings) Indicated.
7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span) Indicated.

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1) difficulty falling or staying asleep Indicated.
2) irritability or outbursts of anger Indicated.
3) difficulty concentrating Indicated.
4) hypervigilance Indicated.
5) exaggerated startle response Indicated.

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month. Indicated.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Indicated.

Having met criteria A(1,2) and a minimum of one out of B(1-5), three of C(1-7) and two of D(1-5), and E and F, Mr Kellie's symptoms indicate posttraumatic stress disorder.

6. Clinical assessment - continued

(ii) Major Depressive Disorder

- Depressed mood most of the day, nearly every day. Indicated.
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day. Both indicated.
- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Not indicated.
- Insomnia or hypersomnia nearly every day. Insomnia indicated.
- Psychomotor agitation or retardation nearly every day. Agitation indicated.
- Fatigue or loss of energy nearly every day. Loss of energy indicated.
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day. Worthlessness indicated.
- Diminished ability to think or concentrate, or indecisiveness, nearly every day. Both indicated.
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. Not indicated.

The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Indicated.

Mr Kellie's symptoms meet the indicated criteria. Specifically the symptoms meet at minimum five criteria including at least one of the first two criteria and the last criterion. Hence the condition can be diagnosed as major depressive disorder.

6. Clinical assessment - continued

(iii) Generalised anxiety disorder

A. Excessive anxiety and worry (apprehensive expectation) occurring on more days than not for at least six months, about a number of events or activities. Indicated.

B. Difficulty in controlling the worry. Indicated.

C. The anxiety and worry are associated with:
- Restlessness or feeling keyed up or on edge. Indicated.
- Being easily fatigued. Indicated.
- Difficulty concentrating or mind going blank. Indicated.
- Irritability. Indicated.
- Muscle tension. Not indicated.
- Sleep disturbance. Indicated.

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational or other areas of functioning. Indicated.

Mr Kellie's symptoms meet the indicated criteria. Specifically the symptoms meet criteria A, B, at least three of the criteria in C and criterion D. Mr Kellie's condition can be diagnosed as generalised anxiety disorder.

(b) Disorders at the time surrounding the incident before the court
The background indicated PTSD, depression and anxiety at the time surrounding the incident now before the court. Mr Kellie's description of functioning at that time indicated the existence of the same criteria for the disorders as at the present time.

(c) Summary of clinical assessment currently and at the time of the incident now before the court
1. Posttraumatic stress disorder
2. Depression
3. Anxiety

7. Research note (i): The effect of depression and anxiety on cognitive functioning

Several symptoms of depression and anxiety directly impinge on the capacity to make reasoned judgements. The most pervasive include (i) difficulties in concentration, memory, problem-solving and decision making, (ii) confused thinking and (iii) impulsivity. They affect practically every part of a person's life. The intrusiveness of depressed mood acts against the ability to think and interpret situations realistically. Sleep disturbances, which work against the individual's capacity to rest and recuperate, add an element of fatigue to functioning and worsen the already existing cognitive difficulties. Changes in appetite (especially loss) can slow brain functioning further and are also detrimental to concentration and cause greater difficulty in decision-making.

There is little energy for other than essential activities. Isolation and withdrawal from enjoyable activities markedly reduce opportunities to relax and rise above the distress, even temporarily. Anxiety adds the intrusiveness of a gnawing constant worry into thinking and causes more distress. Anxiety also sometimes causes rumination over worries and symptoms which further worsens concentration. Sometimes, anxiety can occur suddenly and very intensely and can prevent the person from focusing on anything except the situation that is making them anxious. This can prevent them from thinking clearly about their actions. There is impulsivity including in areas of high negative consequences, irritability and at times violence, mood swings and perceived worthlessness, hopelessness, and personal failure. Often the symptoms include suicidal ideation and with worsening depression the likelihood of self-harm increases.

Seeking relief from the debilitating nature of these symptoms often drives individuals to alcohol, gambling or drugs. They escape reality albeit temporarily. People with anxiety in particular are more likely to form addictive habits in an attempt to distract themselves. The short relief that these activities may bring tends to exacerbate the symptoms when their influence wanes.

Cognitive impairments caused by depression and anxiety linger even when the symptoms of these disorders are no longer present. Research has found that concentration, learning, and memory deficits remained for at least three years in patients that had recovered from these disorders (Airaksinen et al., 2004).

Sources

Airaksinen, E., Larsson, M., Lundberg, I., Forsell, Y. 2004, 'Cognitive functions in depressive disorders: Evidence from a population-based study', *Psychological Medicine*, vol. 34(1), pp. 83-91. Retrieved from http://diss.kib.ki.se/2006/91-7140-954-8/thesis.pdf

Austin, M.P., Mitchell, P. Goodwin, G.M. 2001, 'Cognitive deficits in depression', *British Journal of Psychiatry*, vol. 178, pp. 200-206. Retrieved from http://bjp.rcpsych.org/cgi/reprint/178/3/200.pdf

Westermeyer, R. 1995, 'The cognitive model of anxiety'. Retrieved from http://www.habitsmart.com/anx.html

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7. Research note (ii) : Posttraumatic Stress Disorder (PTSD)

The risk of exposure to trauma has been a part of the human condition since the evolution of humanity as a species. Attacks by saber tooth tigers or twenty-first century terrorists have probably produced similar psychological sequelae in the survivors of such violence. Post-traumatic stress disorder (PTSD) develops after a terrifying ordeal that involved physical harm or the threat of physical harm. The person who develops PTSD may have been the one who was harmed, the harm may have happened to a loved one, or the person may have witnessed a harmful event that happened to loved ones or strangers.

PTSD first came to attention in relation to war veterans, but it can result from a variety of traumatic incidents, such as mugging, rape, torture, being kidnapped or held captive, child abuse, motor vehicle accidents (MVAs), train wrecks, plane crashes, bombings, or natural disasters such as floods or earthquakes. MVAs are considered the leading cause of PTSD in the general population.

People with PTSD may startle easily, become emotionally numb (especially in relation to people with whom they used to be close), lose interest in things they used to enjoy, have trouble feeling affectionate, be irritable, become more aggressive, or even violent. Concentration and judgment suffer. Thinking becomes confused. They avoid situations that remind them of the original incident. Anniversaries of the incident are often very difficult. PTSD symptoms seem to be worse if the event that triggered them was deliberately initiated by another person, as in a mugging or a kidnapping. Most people with PTSD repeatedly relive the trauma in their thoughts during the day and in nightmares and night terrors when they sleep. Reliving a trauma is called a flashback. Flashbacks may consist of images, sounds, smells, or feelings, and are often triggered by ordinary occurrences, such as a door slamming or a car backfiring on the street. A person having a flashback may lose touch with reality and believe that the traumatic incident is happening all over again. The symptoms of PTSD can be frightening and are a cause of great distress.

A key distressing PTSD symptom concerns blocking out or dissociating aspects of the event. The event itself is not forgotten. For example a victim may block out an attacker's face or the weapon of an armed assailant.

PTSD has been described as a particularly sad disorder because it affects the entire functioning of an individual and the resultant debilitation can be lifelong. Many victims of the Holocaust, prisoners of war and war veterans continue to have PTSD. Individuals are often driven to drugs, alcohol or gambling as a temporary means of relief from the distress. When the relief that these activities bring comes to an end, the return to reality can be significantly demoralising. Unless PTSD is treated the distress can intensify to the extent that the individual is no longer able to function effectively. At this stage suicide increasingly becomes an attractive option.

Source: the National Mental Institutes of Health, USA. http://www.nimh.nih.gov/publicat/anxiety.cfm#anx4)

Attachment A - Kellie Moses dob [redacted] 85

TREATMENT PLAN

The plan is delivered through counselling sessions within a framework of Cognitive Behaviour Therapy. This is an evidence-based treatment for Mr Kellie's disorders. The rationale of CBT is outlined in Attachment B. The aim of the plan is to assist Mr Kellie address symptoms of PTSD, depression and anxiety and in particular find a place in the worforce.

The plan should take about six months to complete at the rate of weekly sessions initially. Mr Kellie's rate of progress will then be assessed and this may highlight the need for further treatment. The actual length of time would depend on Mr Kellie's responsiveness to treatment. The attached treatment plan indicative time table refers. From then on there would be a need for periodic sessions to address potentially distressing factors as they arise. This maintenance period is ongoing.

The plan includes:

a) Resolving to the extent possible experiences which continue to distress Mr Kellie including the incident, killings and maimings witnessed during the Sierra Leone civil war, deaths in the refugee camp, the loss of his parents and the discord with his sisters
b) Learning about the formation of stress, its effects on functioning and thoroughly practising techniques in its management
c) Learning and applying Cognitive Behaviour Therapy (CBT) principles in the management of behaviour
d) Extensively practising the challenging of negative thoughts emanating from a distressed outlook
e) Identifying and addressing environmental and behavioural factors that may trigger a recurrence of the disorders or lead to offending behaviour
f) Developing life problem-solving skills to obviate any tendency to relapse
g) Undertaking training in an area of choice, eg aged care
h) Supporting the development of a lawful lifestyle, wholesome life interests and being open to reconciliation with his siblings.

Attachment A continued - Kellie Moses dob [redacted] 85

TREATMENT PLAN INDICATIVE TIMETABLE

Treatment should be provided by a psychologist over up to twelve hourly sessions spanning the next six months. The outcomes are focused on the application of cognitive behavioural skills on day-to-day functioning. Medicare rebates normally apply.

The following sessions are considered to be sufficient to enable the delivery of the treatment plan. The dates will be set for the sessions at the commencement of the plan. The timetable may be varied depending on the individual's capacity to understand and practice the concepts involved in the plan:

Session No	Plan component
1.	component a
2.	component b
3.	component c
4.	component c
5.	component d
6.	component d
7.	component d
8.	component e
9.	component e
10.	component f
11.	component g
12.	component g,h

Following the end of the treatment program Mr Kellie should be advised to return for maintenance sessions as events occur which cause undue distress.

Attachment B - Kellie Moses dob ███ 85

APPROACH UNDERLYING THE TREATMENT PLAN

The attachment outlines the approach to the treatment plan in the previous attachment.

Type of treatment
Cognitive behavioural therapy (CBT) is a treatment of choice for psychological disorders. Treatment consists of cognitive restructuring, namely correcting faulty thinking by repeatedly confronting the individual with logical information through discussion, role-playing and behavioural homework assignments. Treatment includes focusing on the future and discussing career and life issues as they arise. Approaches used in treatment are essentially skills training in the application of logic to the management of mood and behaviour.

Principles learnt
Treatment begins with learning the key CBT principle that thoughts lead to mood and behaviour, namely that psychological disturbance arises because of thoughts about different life events which are found distressing. This is followed by learning the principle that there are different ways of looking at life events. Currently distressing events are analysed and are interpreted in less distressing ways. Treatment continues with discussion of Socratic questioning and Aristotelian principles, and their relevance to day-to-day functioning.

In this way the role of logical thinking over mood and behaviour is strengthened and impairments in judgment are addressed. In subsequent treatment sessions, instances of impaired judgment occurring since the previous session or earlier, are analysed and used to strengthen logical processes. This process continues until it is clear that the principles have been incorporated into day-to-day functioning.

Progression of treatment
Treatment begins with an exploration of life events that have led to the current distress. This takes from one to about four sessions. The next phase, the teaching of principles, normally takes up to five sessions. From then, as soon as practicable, sessions are held fortnightly and later monthly. This frequency is normally sufficient to monitor progress in the application of principles to day-to-day functioning. The progression is in harmony with Medicare arrangements which fund rebates for a maximum of 12 sessions a year. Should there be a relapse, session frequency may be changed to weekly in order to restore progress. The treatment is extended by additional periods for monitoring.

The effects of interruption
As with any skills training, interruption is likely to cause a reversal in progress and negate much of the success gained in applying logical thinking to managing mood and behaviour. Any vulnerability to act without thinking of consequences is likely to increase.

RESUME - JOHN JACMON
REGISTERED PSYCHOLOGIST NSW

PERSONAL DETAILS

Full name: Dr John Jacmon, OAM
Phone: (02) [redacted] Fax (02) [redacted]
Address: [redacted]
email [redacted] webpage www.consultantpsychologist.com

AWARD

Medal of the Order of Australia for services to the community and veterans.

EDUCATIONAL QUALIFICATIONS

EdD (Research doctorate in Clinical Psychology in the treatment of depression), MEd (Psychology: research into reinforcement theory), M Ed Admin (Administration), Hons BSc (Psychology), Hons BA (Sociology), BSc (Pure Maths, Statistical Maths), BEd (Maths & Science Education), Dip Ed Admin (Administration), Certificate in Computer Studies.

Language skills: read, write and speak Greek.

PROFESSIONAL MEMBERSHIPS

Member Australian Psychological Society (MAPS) and College of Counselling Psychologists
Registered Psychologist Australian Health Practitioner Regulation Agency
Accredited counsellor Victims Services Attorney Generals Department NSW
WorkCover approved treating psychologist.

PUBLISHED RESEARCH

Jacmon, J., Malouff, J. & Taylor,N. (2009). 'Treatment of Major Depression: Effectiveness of Cognitive Behavior Therapy with an Internet Course as a Central Component', *e-journal of Applied Psychology*, Vol 5, No 2. Pp 1-8.

WORK HISTORY

1996 - Current: Registered Psychologist in private practice (NSW)
Clinical and counselling: posttraumatic stress disorder, child and adult sexual assault victims, depression, grief, stress, anxiety, substance abuse, domestic violence, panic attacks, family, children and adolescents, aged, marital problems, gay-lesbian.

Medicolegal – assessments, pre-sentencing reports, court expert witness.

Occupational psychology - testing of skills and interests; career guidance; training in presentation, job interviewing, negotiation.

1994 - 1996: Recruitment Consultant (ACT)
Staff selection for public service departments, career guidance, counselling.

1974 - 1996: Volunteer Counselling: Life issues, domestic violence, substance abuse, veterans, age-related problems.

Earlier career
1987 - 1994: Director, monitoring institutional healthcare, Dept of Veterans Affairs, ACT
1984 - 1987: Director, recruitment policy and planning, Public Service Board Canberra.
1979 - 1984: Director, recruitment planning and control, Public Service Board.
1978 - 1979: Secondment to Foreign Affairs to lead six-month training project in PNG
1976 - 1978: Head, management development, Public Service Board.
1974 - 1976: Head, personnel Resources and projects, Public Service Board.
1971 - 1974: Psychologist, State Electricity Commission Of Victoria.
1961 - 1971: RAAF Education Officer (weapons trained) - squadron leader.
1957: RAAF National Serviceman.

CERTIFICATE OF EXPERT EVIDENCE

SECTION 177 OF THE EVIDENE ACT, 1995 AND UNIFORM CIVIL PROCEDURE RULES — SCHEDULE 7

This document (and the report attached hereto) constitute a Certificate of Expert Evidence pursuant to Section 177 of the Evidence Act, 1995 and has been prepared in accordance with the Uniform Civil Procedure Rules 2005 — Schedule 7 on Expert Witnesses in relation to the matter of: Kellie Moses dob [redacted] 85

a) I have read the Expert Witness Code of Conduct and agree to be bound by that code.

b) Name and address: Dr John Jacmon, OAM, Registered Psychologist
[redacted]

c) I have completed doctorate studies at the University of New England encompassing research on the treatment of depression. My other qualifications are a Master of Education (research degree in psychology) from Monash University, Master of Educational Administration and Diploma in Educational Administration from New England University, Honours Bachelor of Science (Psychology) and Honours Bachelor of Arts (Sociology) from the University of South Africa, Bachelor of Education and Bachelor of Science from the University of Queensland, and Certificate in Computer Studies from TAFE Western Australia. I am a full member of the Australian Psychological Society. I have received the Medal of the Order of Australia for services to the community and aged veterans.

d) I have specialised knowledge based on my training, study and experience in the area of clinical psychology including in the diagnosis, assessment and treatment of mental disorders.

e) The opinion held by me and detailed in the report attached hereto is wholly or substantially based on the subject knowledge derived from my training, study or experience referred to in (c) above.

f) Annexed hereto is my report dated 8 November 10 consisting of 12 pages.

DATED: 8 November 10

SIGNED:

John Jacmon