BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

Commissions of Inquiry Act 1950

Statement of Georgia Penny Lee Watkins-Allen

I, Georgia Penny Lee Watkins-Allen, of 148 Radford Road, Manly West in the State of Queensland, Clinical Psychologist, state as follows:

1. I am a clinical psychologist in private practice at Tyack Health at 148 Radford Road, Manly West, Queensland.

2. I provide this statement to the Barrett Adolescent Centre Commission of Inquiry (*Commission*) in response to a Requirement to Give Information in a Written Statement dated 19 October 2015 issued pursuant to section 5(1)(d) of the *Commissions of Inquiry Act 1950* by the Commissioner, the Honourable Margaret Wilson QC.

3. I address the questions asked in the Requirement to Give Information in a Written Statement below.

4. In this statement:
   (a) *BAC* means the Barrett Adolescent Centre
   (b) *CYMHS* means Child and Youth Mental Health Service
   (c) *PCMH* means The Park Centre for Mental Health
   (d) *HSMHU* means High Secure mental health unit at PCMH
   (e) *MSMHU* means Medium Secure mental health unit at PCMH
   (f) *QH* means Queensland Health
   (g) *WMHHS* means West Moreton Health and Hospital Service
   (h) *DBT* means Dialectical Behavioural Therapy
   (i) *DSH* means Deliberate Self Harm
   (j) *MDD* means Major Depressive Disorder
   (k) *PTSD* means Post Traumatic Stress Disorder

Q1. What are your current professional role/s, qualifications and memberships? Provide a copy of your most recent curriculum vitae.

5. I am a registered psychologist with an endorsement permitting an extended scope of practice in clinical psychology. I work in private practice at Tyack Health at 148 Radford Road, Manly West in the State of Queensland.

6. I was awarded a Bachelor of Arts (Psychology) (Hons) by Macquarie University in 1997 and hold a Masters Degree in Clinical Psychology from the University of

Queensland awarded in 2005. I am a member of the Australian Psychological Society.

7. **Attachment "A"** is a copy of my curriculum vitae.

Q2. From 2005 to present, I understand you have been working as a private psychologist. In that role,

a. outline and explain the services and treatment you provide; and

b. describe the types of clients you treat, including:
(i) the types of conditions for which clients seek your treatment;
(ii) whether you treat children, adolescents between the ages of 13 to 17 years (inclusive) and adults;
(iii) whether you treat young adults aged 18 years or older and if so, please specify the age limit for the young adults you treat;
(iv) the portion of clients you treat between the ages of 13 to 17 years (inclusive) and as young adults.

8. As a psychologist in private practice I provide clinical psychological services involving assessment, formulation and treatment. Patients may seek treatment from me directly or through referral. If the client's general practitioner or psychiatrist refers them to me through a Medicare treatment plan, I will report on the outcome of the provision of my services to the referrer.

9. I am typically sent referrals within the Diagnostic Statistical Manual V and predominantly work with Depression, Anxiety (Generalised, Social, Obsessive Compulsive Disorder, Phobias and Trauma), Adjustment Disorders, Psychotic Disorders (Schizophrenia, Schizo-Affective Disorders, Delusional Disorders and Bi-Polar), developmental onset disorders (Attention Deficit Disorders, Attention Deficit Hyperactive Disorders, Oppositional Defiance, Autistic Spectrum and Social Communication) and Bereavement.

10. I provide psychological interventions for children, adolescents and adults. I estimate that presently approximately 25% of my clients are aged from 13 to 17 years.

Q.3 Explain the nature and extent of your experience treating mental health patients between the ages of 13 to 17 (inclusive) and young adults with a high level of acuity, similar to the patients at the Barrett Adolescent Centre? By 'acuity' I refer to behaviours in adolescents and young adults requiring more staff interventions above the ordinary. These behaviours predominately include self-harm and attempted suicide and, to a lesser degree, aggression and absconding.

11. I first started working with mental health patients between the ages of 13 to 17 years inclusive in 2004 when I commenced employment on a part time permanent basis as a clinical psychologist at BAC. I continued in this role until April 2013. The patients I treated met the definition of acuity stated in Q3. I have continued to work with adolescents in private practice after April 2013 some of whom have met the definition of acuity.

Q4. I understand you have worked at the BAC treating patients. In that role:

a. what was the employment arrangement in place?

b. outline and explain your role and responsibilities;

c. describe the reporting structure including who supervised you and to whom you reported;

d. on average how many patients did you treat at a given time; and

e. provide a copy of your job description.

12. I was employed by QH as a part time permanent clinical psychologist from 2001 to April 2013. From 2006 I also maintained a part-time private practice. In the period up to 2004, I worked in the HSMHU and then the MSMHU. I was transferred from the MSMHU to BAC during 2004. After working at BAC for approximately three (3) years, I relinquished my position at the MSMHU upon instruction from management at the PCMH. I became a permanent relinquished officer and continued to work at BAC in a job shared full time position with the clinical psychology incumbent Danielle Corbett who was then working reduced hours following maternity leave. I was relocated on or about 30 April 2013 from BAC to the MSMHU.

13. I was the senior psychologist within BAC specialising with adolescents with critical care needs. My position was part-time. I worked Mondays, Wednesdays and Fridays for the last 4 years. My role entailed psychological assessment and the formulation and direction of flexible best practice evidence based interventions and program design, implementation and evaluation to enable recovery provided to adolescents with chronically complex psychological and behavioural difficulties, within and without forensic, ITO and Department of Communities – Child Safety status, situated in tertiary long term stay in-patient unit, including day patients, with referrals accepted across Queensland. This role required close collaboration within a multi-disciplinary treatment team, including a registered school, to appropriately co-ordinate client care service by developing comprehensive treatment plans that focused on accurate diagnosis and behavioural treatment of problems. In addition to providing individual therapy, my responsibilities included:

(a) formulating specific program design and adaptation for patients to develop understanding and skills (individual and group);

(b) working with all BAC patients at a minimum of once per week as the primary facilitator of the weekly DBT mandatory treatment group;

(c) assessing new patients during the intake process;

(d) providing daily, on and off ward, therapeutic work and support with all BAC patients at different stages and at different levels as they participated in BAC programs

(e) documenting patient information including service plans, treatment reports and progress notes;

(f) supervising psychology locums and students as primary or secondary supervisor, including as a primary supervisor for my last 4 years at BAC to Ash Trinder and all psychology students;

(g) attending daily ward meetings each morning (on my rostered days) with staff and patients;

(h) attending weekly ward meeting with staff to discuss treatment plans for the week;

(i) attending 6 weekly rotational "intensive case work-up" meetings for each client.

14. My BAC working days were generally structured in this way:

(a) Daily: on Monday, Wednesday and Friday I attended the daily morning ward meeting (refer paragraph 13(g) above) would be held. Staff and patients attended this meeting to discuss activities and patient movements for the day. As patients attended this meeting individual patient issues were not discussed, in that sense, the meetings focused on logistics. Thereafter on Mondays the treatment staff (psychologists, psychiatrists and nursing staff) would meet and discuss (refer paragraph 13(h) above) the progress of each patient and the charts from the weekend would be reviewed. In these meetings we would discuss the individual treatment plans. These two meetings would run until somewhere between midday and 1pm, and thereafter I would delivery individual therapy to patients;

(b) Wednesdays: following the daily ward meeting (refer paragraph 13(g) above) I would conduct a compulsory DBT group therapy session (refer paragraph 13(b) above). DBT is a treatment process that was developed for Borderline Personality Disorders in adults, but has many aspects, which are beneficial to children. It covers several aspects including: mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness. On Wednesdays we would then conduct an intensive case work-up of patients on a six weekly rotational basis (refer paragraph 13(i) above). In these meetings a thorough review of the patient's progress would be undertaken with reference to the assigned psychological therapist, the occupational therapist, the teaching staff, the speech therapist, the social worker and Dr Sadler. External treatment providers would also often telephone into these meetings;

(c) Fridays: on Friday I would conduct individual therapy sessions, which could last anywhere between half an hour and 1 and a half hours. On some days patients would have more than one treatment session.

15. I reported to a Line Manager Scott Natho (Senior Psychologist) until the restructure of BAC in early 2013. I then reported to Lorraine Dowell (Occupational Therapist) until the end of April 2013.

16. I also reported from time to time, when on the ward, to consultant psychiatrists, medical registrars and senior clinical and operational management. My principal supervisors while working at BAC were Maureen Barnes (a Senior Psychologist at the PCMH) and Professor Robert King (a University of Queensland Psychology Lecturer in the Masters in Mental Health Program also based at the PCMH). I was also supervised by Linda (whose surname I don't recall) (Specialty Non-Verbal Therapies), Jacqueline Robinson (West Moreton Acting Ethics Chair for Research and Masters in Mental Health UQ Lecturer), Danielle Corbett (Clinical Psychologist) and Dr Trevor Sadler (Director of BAC). This supervision was in addition to supervision and peer supervision by psychiatry registrars, social workers, family therapists and nurses.

17. There were generally about 15 in-patient clients at BAC at any one time. I generally treated five (5) individual clients at BAC at any given time. I would see all of my 5 clients on each of the days I worked each week. Of the other 10 in-patient clients, five (5) would be allocated to the person with whom I shared the role (Danielle Corbett or Ash Trinder) and the remaining five (5) clients would be shared between Dr Sadler, the Registrar and the social worker.

18. I also treated up to eight (8) clients who had transitioned in and out of BAC as in-patients or day patients who had accessed the program from the community. In addition there were out-patients who would make contact from time to time who we

would also treat. The BAC was not funded for these two categories of patients. As noted above, I also treated all BAC patients during the compulsory weekly DBT Therapy Group sessions. The psychology student would assist with these clients. Through conducting the DBT Therapy Group sessions and our weekly ward meetings the staff were able to remain informed of the status of the inpatients with whom they did not have the direct therapeutic relationship.

19. I no longer have a copy of my job description. I recall that the description of my job varied from time to time in the period from 2004 to 2013.

Q5. When did you become aware that there were plans to ultimately close the BAC?

a. how did you become aware that there were plans to close the BAC?

b. did the BAC management team provide any information to staff about the plans to close, including reasons for closure processes, transition arrangements, consultation arrangements and support? If so, state the information provided.

20. I recall a meeting I attended called by Lesley Dwyer (CEO of WMHHS) and Sharon Kelly (Executive Director of PCMH) close to Christmas in 2012 on a date I do not recall where the possible closure of BAC was first discussed with staff by management. The majority of BAC staff were at this meeting. I recall the meeting was held in the main meeting room at BAC. Prior to this meeting, I had became aware of proposed plans to close BAC following media reports relating to the Childhood Protection Commission in Queensland.

21. Following the meeting referred to in the previous paragraph, communication from senior management at WMHHS and senior staff at the PCMH about the proposed closure of BAC was sparse. I recall being informed some time after that initial meeting that an independent Clinical Reference Group was to be formed to assess the needs of patients of BAC and look into whether BAC was working within the recovery model of QH at that time to assess if we were able to support those needs under our current care model.

22. To the best of my memory, reasons given by management for the proposal to close BAC that were communicated to me prior to 30 April 2013 were:

(a) that BAC no longer was considered consistent with the current QH Mental Health Plan which had a priority for patients being treated within the community to minimise any negative impact on their recovery as a result of being removed from their community.

(b) funding cuts; and

(c) that clients at BAC were at a potential risk from the adult patients of the PCMH.

23. I do not recall being provided with any additional information regarding any of the matters referred to in Q5.b after I was transferred from BAC on or about 30 April 2013.

Q6. In 2013, to your knowledge, were there any management decisions related to the intention to close the BAC that impacted on the day to day operation of the BAC? If so,

a. state changes to staffing arrangements, if any, including who made the decisions in respect of the change, when was the decision made and communicated, how was the decision communicated, what was the change and the reasons given for the change;

b. state changes to patient care arrangements, if any, including changes to policies and procedures on patient case management, who made the decisions in respect of the change, when was the decision made and communicated, how was the decision communicated, what was the change and the reasons given for the change; and

c. state and describe any other relevant management decisions.

24. My knowledge of the impacts on the day to day operation of BAC to which Q.6 relates is limited to the first four (4) months of 2013 as I was transferred from BAC to MSMHU on or about 30 April 2013.

25. On a date in 2013 I cannot now recall but prior to my transfer from BAC, staff of BAC including myself were informed by Mr Tawanda Machingura, Senior Allied Health Executive, that he was tasked to review all allied health positions at the PCMH with the intention to restructure those roles due to significant funding cuts to QH services following direction from Federal and State government. Changes to staffing arrangements that I observed were as follows:

(a) David Ward, a social worker, who managed our family therapy and some individual therapy left his employment at BAC prior to April 2013. I do not recall any social worker or family therapist being employed to replace Mr Ward by the time I was relocated on or about 30 April 2013.

(b) The occupational therapist and diversional therapist/life skills therapist roles which had been filled by a 1.5 FTE equivalent by Kimmy Hoing and

Kate Partridge, was reduced to a solo full time OT position. This resulted in no direct support of adolescent patients of BAC in life skill development and community access program which was an integral part of the treatment program to enable effective recovery in the community.

(c) The senior supervisor position filled by Danielle Corbett was terminated leaving the nursing and allied health staff with no in-house supervision outside of any specific disciplinary support. Additionally, my services were relocated to the MSMHU.

(d) There was a lack of Charge Nurses who managed the ward which required registered nurses to act up in the Charge Nurse position;

(e) Nursing staff (both registered and enrolled nurses) who left BAC were not replaced by permanent fulltime staff but instead agency nurses were relied on to undertake clinical duties. In my view reliance on agency nurses resulted in a greater risk to patients and staff due to the lack of understanding, rapport and consistency required in such a complex and potentially dangerous unit. This put enormous pressure on the agency nurses and the staff of BAC.

Each of these cuts had a material adverse affect on the operation of the BAC and the quality of treatment able to be provided to the patients.

26. During early 2013, I attempted to review policies to understand how the restructure might affect my position at the BAC. The policies developed through the restructure were presented in 'draft' form or stated to be under review. I recall feeling very uncomfortable as I understood that previous policies were no longer relevant but new policies had not been finalised. When I say policies, I mean both from the perspective of human resources and administration.

27. I am unaware of who made decisions with respect to policy changes, or when those decisions were made, as I received no communication about such matters from senior PCMH management as I recall, either verbally or in writing. Any information I received came through line management. From my observation, staff within BAC attempted to continue to provide effective treatment on a day-to-day operational basis as best as possible within our standard recovery model, although this was difficult due to loss of staff and instability caused by the potential closure of BAC.

28. I was generally unaware of who made the relevant management decisions or when they were made.

Q7. I understand you ceased working at the BAC in 2013.

a. when did you cease work at the BAC?

b. describe the circumstances surrounding your cease of work at the BAC including why you ceased work at the BAC and when you became aware that you were going to cease work at the BAC?

29. I ceased work at BAC on or about 30 April 2013 when I was relocated to MSMHU.

30. I was first approached by PCMH management about my position at BAC just prior to my recreational leave in September 2012 when my potential redundancy or relocation from BAC was discussed due, I was told, to funding cuts. To the best of my recollection the management staff who approached me were Rachel Phillips (West Moreton Psychology Head) and Katherine White (Human Resources officer). I voiced my concerns at the time about the potential impact on adolescents at BAC if I were to be moved off the ward. In particular, I was the most senior treatment providing psychologist (in terms of length of service) and therefore had established patient continuity. I also stated that it was my preference to continue to work at BAC due to the level of experience I had gained working there, the quality of the work engaged in at BAC, and the high professional regard I held for the multi-disciplinary team.

31. However, I was informed that I had two (2) weeks upon my return from recreational leave to meet with management to provide them with my decision on whether to take a redundancy or agree to a relocation. The issue of the possible closure of BAC was not raised at this meeting.

32. I was not approached again until the newly created Senior Allied Health Executive, Mr Tawanda Machingura, arrived at the PCMH sometime in early 2013. I was called into a meeting with Mr Machingura, Rachel Phillips and Katherine White. This meeting was held in the main administration building at PCMH. I was informed that a redundancy was no longer on offer and that I would be relocated.

33. I advised those present of my clinical concerns about the negative impact on the adolescents at BAC due to the severity and complexity of their mental health difficulties, the heightened stress on the already vulnerable adolescents due to the uncertainty of the unit's ongoing existence, the time it takes to establish an effective trusting therapeutic relationship with this level of client difficulty especially when trauma was involved which was a predominant focus of many of BAC's patients, the stage and nature of the clinical work I was engaged in with specific patients, and the duration of my role at BAC providing a stabilising force and reassurance by secure working relationships with the patients and staff respective to the various duties I had

performed. I requested that I be given appropriate time to terminate the therapeutic relationships which I considered to be a minimum of six (6) months for the types of conditions involved.

34. I attended at least four (4) face-to-face meetings with Mr Machingura in early 2013 about my position and also engaged in numerous telephone discussions with him in this period. I recall Danielle Corbett was present at one of these meetings. Mr Machingura indicated that an EOI would be released for the other half of the BAC psychology incumbent's position for which I could apply. While I voiced concern about the EOI's availability being required urgently, I was hopeful that the restructure of BAC would support the high level of care to BAC patients to allow a minimum appropriate time for termination of the therapeutic relationships based on Mr Machingura's feedback acknowledging my concerns and stating "not to worry" as he would support my concerns.

35. On 27 February 2013 I recall being directed to attend a meeting with Mr Machingura, Rachel Phillips and Katherine White to discuss my relinquished officer status and position at BAC. I again expressed my concerns about the negative impact of removing my therapeutic services at BAC without allowing time for appropriate termination.

36. I recall being told by senior WMHHS and PCMH management (to the best of my knowledge being Tawanada Machingura, Rachel Phillips and Katherine White) that my position as a relinquished officer was separate to the impact my removal from BAC may have.

37. As I appreciated it, the concern, with my status as relinquished officer, was this: I originally worked at BAC on a secondment from the MSMHU. My position at the MSMHU was a permanent position. As I remained at the BAC for a lengthy period of time, QH wished to fill my permanent position at MSMHU but in order to do that I needed to vacate the position. I therefore become a relinquished officer (which I was told, at the time, would not adversely affect me) so that QH could advertise and fill the position at MSMHU. In the review it was identified that I did not have a "space" at BAC (or anywhere else) and that I needed to be "allocated" to a unit.

38. On or about 4 March 2013 Danielle Corbett (the incumbent clinical psychologist), Ashleigh Trinder (the psychology locum) and myself were called into a meeting with Rachel Phillips (WMHHS Psychology Head), Lorraine Dowell (new Non-secure Services Line Manager) and Scott Natho (PCMH Psychology Senior, and previously my line manager). In this meeting I was asked to sign a movement form to facilitate a transition into a terminated senior supervisor position at BAC for one month. I had accepted the reality by this time that I would lose my position at BAC and considered that I was in negotiation about how long I would remain at BAC to facilitate the

effective termination of the therapeutic relationship with my clients at BAC. I understood that management was creating a position for me for a month in order to explore options to keep me on to allow me to effect a proper termination of my work with clients having regard to the timeframe of six (6) months I had repeatedly raised with management to ensure the best clinical outcome for clients. I signed the form. A copy of that form is attachment '**B**'.

39. I had been informed by Mr Machingura in the week prior to this meeting that we would be meeting to discuss appropriate care of the BAC adolescents and I understood from that earlier meeting that there would be discussion around the EOI to cover the second half of the incumbent's position. Accordingly it was my understanding from what I was told at the meeting on 4 March 2013 that Ms Corbett would return part time to her clinical position as supported by QH maternity leave policies, that Ms Trinder would fill the other half of the role under a one month contract, and that I would work under a contractual arrangement in the terminated senior supervisor position until I was able to effect an orderly and appropriate termination of my work at BAC. As Mr Machingura had previously assured me not to worry about the care of the adolescents as the ongoing provision of my clinical psychological services to these vulnerable adolescents would be worked out and supported such that he alerted me to the reported upcoming EOI which I could apply for, I felt reassured that my concerns for the adolescents were being properly considered and managed.

40. On 6 March 2013 I sent an email to Ms Phillips attaching emails from Dr Sadler in which the point was made that it is desirable to maintain the current level of staffing for allied health professionals and if necessary a replacement social worker for Mr Ward could be deferred (see paragraph 25(a) of this statement). Attachment '**C**' is a copy of that email (which comprises documents WMS.0025.0001.15531-3). I had previously voiced my view to Ms Phillips that I needed a period of 6 months to effect a proper handover of clients and considered Ms Phillips supported my clinical view. My email was an attempt by me to persuade management to keep me on in the role instead of appointing a new social worker.

41. On 6 March 2013, I exchanged emails with Ms Phillips about the option of being relocated to CYMHS at either Ipswich or Goodna and then being seconded back to BAC. Attachments '**D**' and '**E**' are a copy of these emails (which are documents WMS.0025.0001.15409 and WMS.0025.0001.15498 respectively). Ms Dowell was copied into these emails and subsequently exchanged emails with Ms Phillips to which I was copied. Attachment '**F**' is a copy of those email exchanges (document WMS.0025.0001.15423). At this time I was still expecting that I would be allowed to stay at BAC to avoid any interruption of my care of clients.

42. On or about 11 March 2013, I received via email a copy of the movement form I had signed. I do not have a copy of that email. The form was accompanied by documents that I had not previously seen, being an Internal Briefing Note signed by Ms Dowell and Mr Machingura on 28 February 2013 and a Request to Fill Vacancy Form signed by Ms Dowell on 28 February 2013. Attachment '**G**' is a copy of those documents. The Internal Briefing Note refers to an 'agreement to offer [me] employment at 0.5 FTE against the Specialist Clinical Supervisor position for 1 calendar month to avoid disruption to specialist interventions and allow adequate clinical handover to occur.' I was concerned on reading this document that my monthly contract would not be renewed to facilitate a proper termination of my work as I understood from the 4 March 2013 meeting, but instead that I would be expected to handover in a month and now only had about two weeks left to do so. I note that the file note recording that agreement pre-dates the meeting of 4 March 2013. A one-month hand over was certainly not something I had, or would have ever, agreed to.

43. On 11 March 2013 I drafted an email to Ms Phillips after receiving the documents referred to in the previous paragraph. A copy of that draft email is at pages 6 and 7 of my statement dated 26 November 2015 provided to the Commissioner. I do not have a record of sending that email to Ms Phillips but consider that I would have done so as I recall feeling disappointed that I did not receive a response to it.

44. On 13 March 2013 I telephoned Ms Dowell and informed her that I would not have signed the movement form had I been shown the Internal Briefing Note given the concerns I had communicated on a number of previous occasions about the time I required to properly terminate the treating relationship with my BAC clients. Later that day Ms Dowell sent an email to me. Attachment '**H**' is a copy of that email (documents WMS.0014.0001.05352-3). Attachment '**I**' is a copy of my email in response (document WMS.0021.0001.00728).

45. On 20 March 2013 I attended a meeting with Paul Clare and Scott Natho about my position. On the following day Mr Clare emailed me a summary of the discussions held at that meeting. Attachment '**J**' is a copy of that email (document WMS.0025.0001.15381).

46. On 21 March 2013 Ms Dowell responded to Mr Clare's email of the same day to which I was copied. Attachment '**K**' is a copy of that email (document WMS.0025.0002.27165).

47. On 22 March 2013 I received an email from Mr Machingura. Attachment '**L**' is a copy of that email (document WMS.0025.0001.15378). Mr Machingura states that my contract would only be extended to 30 April 2013 to allow for handover. This was the first time I was given a deadline to undertake a handover of my clients.

48. On 25 March 2013 I sent an email to, amongst others, Mr Machingura, Ms White and Ms Phillips in which I express concern about not allowing me appropriate time to handover the care of my clients. Attachment '**M**' is a copy of that email (documents WMS.0012.0001.16835-8). The document at pages 3 to 5 of my statement dated 26 November 2015 provided to the Commissioner is an earlier draft of this email. The email was intended to alert the recipients of my serious concerns about removing my services from these vulnerable adolescents within a one month handover at such a crucial stage in their recovery which required appropriate time for termination. I felt that such a period of time was clinically inappropriate and that bureaucracy was dictating a practical, or documented, hand-over of the treatment of patients rather than an effective (and appropriate) termination and transfer of the therapeutic relationship. I do not recall receiving a response to my email.

49. I worked at BAC until about 30 April 2013. During this period I focussed on clinical care rather than writing handover reports. I did this following discussion with Dr Sadler with the intention of writing handover reports in the first week of May upon transfer to the MSMHU (also known as Secure Medium Mental Rehabilitation Unit). I then later commenced sick leave.

Q.8 When you became aware that you were to cease work at the BAC, how many patients were you treating at that time?

a. who were the patients?

b. what were the conditions you were treating for each of the patients?

c. what was the stage treatment for each of the patients?

50. I worked with all BAC patients at a minimum of once per week as the primary facilitator of the weekly DBT mandatory treatment group. However, at the time of my relocation from BAC in April 2013, the patients I was specifically working with, and their conditions, were:

(a) [redacted]

(b) [redacted]

[redacted]

(c)

(d)

(e)

51. The rest of BAC peers presented with similar conditions to those above, including emerging psychosis.

52. Treatment at BAC followed our recovery model which worked to enhance adolescence stages of development across multiple domains (i.e. physical, emotional, cognitive, school, peer, boundaries, care for self, life skills competency, moral maturity, identity formation, individuation, schema belief formation and sense of future). These different stages of development would advance, block and regress depending on the individual and their specific difficulties and external stressors. Due to the acuity of the BAC adolescence, the entire process of therapeutic work, from assessment to termination and transfer to alternate services, was critical to their effective long term "recovery" (i.e. defined as the capacity to understand, manage and live an effective life in spite of, and because of, their mental health concerns).

53. It was my practice to break up a patient's treatment into four phases. The phases are recorded and documented in the psychology treatment summary documents I prepared, being:

(a) WMS.0018.0001.0064 for

(b) WMS.0018.0001.00880 for

(c) WMS.0039.0001.0001 for ; and

(d) MSS.002.003.0616 for

I do not have access at this time to my treatment summary for

54. All of the individuals I was specifically treating were involved at different stages in relation to their individual treatment as experienced across the

different developmental stages. The stage of treatment for each of these patients by April 2013 was as follows:

(a) [redacted]

(b) [redacted]

[redacted]

Georgia Penny Lee Watkins-Allen Witness

(c)

(d)

(e)

Q.9 From when you became aware that you were to cease work at the BAC to when you did cease work at the BAC, describe:

a. the BAC policy, if any, for the casework handover and/or instructions you received from the BAC in respect of the handover;

b. whether you were aware if anyone was replacing you after your departure and if so, who was/were the person(s);

c. how you undertook the casework handover, including who you reported to in respect of the handover our communications with anyone who was going to be responsible for your casework and what information you provided in respect of the handover; and

d. how were your patients informed of your departure from the BAC, including, who informed the patients, when were the patients informed, what was the reaction of the patients, did any patients express concerns and how were patient concerns managed?

55. After working at the PCMH for many years I had been exposed to numerous occasions where a patient's clinical psychological treatment was to be handed over. (For example, when patients were transitioning out or into other units, or when I was going on maternity leave or recreational leave. For the avoidance of doubt, I had not previously had to permanently terminate longstanding adolescent patient relationships within a matter of weeks.)

56. This was typically managed by the relevant treating team with input from my psychology line manager at the PCMH. The standard process at BAC was similar to other units at the PCMH and from my recall typically involved notifying the patient as to my required relocation; supporting the patient to process this information specific to the therapeutic relationship and their treatment; and providing verbal and documented summaries of the patient's current treatment stage so the treating team could support this transition, including close liaison with the new psychology clinician if available and the patient's care co-ordinator so they could continue the clinical psychological work as required. I was not aware of any written policy regarding the handover process and nothing formal was ever presented to me by either senior WMHHS or PCMH management.

57. After my departure from BAC, I am aware that the BAC clinical psychology incumbent (Mrs Corbett) was required to return to her clinical position as her senior supervisory position was terminated.

58. My handover of patients in April 2013 involved me primarily reporting to the BAC director Dr Trevor Sadler, the new BAC allied health line manager Lorraine Dowell and the senior PCMH psychologist Scott Natho. I also had verbal handover with the incumbent clinical psychologist Danielle Corbett and the individual care co-ordinators for [redacted] referred to in paragraph 50 as well as the rest of the [redacted]

BAC team. The type and extent of the information provided to those staff regarding the treatment process and progress of the adolescents was already well established via our weekly multi-disciplinary team meetings, daily ward meetings and weekly individualised six (6) weekly Intensive Case Workups.

59. I spoke to each of my patients individually about the decision made to relocate me from BAC. All of them were already significantly distressed about the uncertainty of their treatment at BAC as they had informed me that they were aware of the potential closure of BAC. The patients expressed concern to me generally about the fact that the closure of BAC would result in the loss of their primary therapist which would have a long term impact on their recovery, due to the loss of a therapist they had trusted and confided in and concern having to, or being able to, restart this process all over again anew.

Q.10 Did you have any concerns in relation to your departure or casework handover? If so,

a. what were your concerns?

b. did you report your concerns to anyone? If so, when did you report your concerns and what was the response?

60. I had concerns about the wellbeing of the adolescents should I be relocated. My concerns arose due to the severity and complexity of their mental health difficulties; the heightened stress on the already vulnerable adolescents due to uncertainty of the ongoing existence of BAC; the time it takes to establish an effective trusting therapeutic relationship with this level of client difficulty, especially when trauma was involved which was a predominant focus of many of the BAC patients; the stage and nature of the clinical work I was engaged in with specific patients; and the duration of my role at BAC providing a stabilising force and reassurance via secure working relationships with the patients and staff respective to the various duties I performed in my role as senior psychologist.

61. I was concerned about the stage of treatment of each of my individual clients due to the time it takes to build a therapeutic relationship with such chronic acuity. I considered an appropriate termination period was necessary to prevent worsening acuity and regression via de-compensation, thereby helping to maximise and maintain a patient on their path to recovery. Due to the uncertainty around the unit and complexity and acuity of the BAC patients, I did not believe that, while possibly practically, a one (1) month handover was an adequate period to support these vulnerable teenagers. These patients had already chronically exhausted all their community health services in an attempt to recover with no lasting results, such that these young individuals' prognostic mental health and overall wellbeing was at

significant risk, to the point of potential death. I considered BAC to be the least restrictive safe management of these critically vulnerable adolescents.

62. At the meeting referred to in paragraph 30 of this statement which occurred just prior to my recreational leave in September 2012, I voiced my concerns about the potential impact of the BAC adolescents if I was moved off the ward given the significant period of time it had taken me to establish an effective trusting therapeutic relationship with them. Subsequent to my return from recreational leave I initiated a number of meetings with management at the end of 2012 and early 2013 to raise my concerns about my being removed from the BAC at a crucial stage of treatment with the adolescents I was working with, especially following information that came to my attention predicting that BAC was to be closed by the end of 2013. Of primary professional clinical concern was that while I could handover relevant information specific to the adolescents' treatment and recommendations in the requested period of one (1) month, this was not an adequate period to terminate this highly sensitive work where trust and attachment had taken considerable time to acquire and was paramount to their recovery due to the severity and complexity of their conditions. I voiced my concern at meetings I attended with Mr Machingura in early 2013 as referred to in paragraph 34 of this statement. I requested that I be given appropriate time to terminate the therapeutic relationships and advised that six (6) months would be the minimum period required with these types of conditions.

Q.11 State your employment history after you ceased work at the BAC.

63. After 30 April 2013 I was initially relocated to the MSMHU. After approximately one week on this unit, I was placed on sick leave by my general practitioner until I resigned my position with QH in November 2013. My illness was stress-related due to my departure from the BAC and the concerns I held for my patients. [redacted]. Learning of this, when I was down the road in the MSMHU was very distressing to me. During this period of sick leave my general practitioner was supportive of me working part time and thought that I would best manage my overall wellbeing if I directed my professional focus to private practice. Since resigning from QH in November 2013, I have gradually increased my private practice work to full time as my health improved.

Q.12 I am aware that after you ceased work at the BAC, patients you treated at the BAC sought treatment from you as a private psychologist.

a. who were those patients and when did those patients seek treatment from you?

b. how did you come about treating those patients in your role as a private psychologist? Did you or the patients initiate contact and how was contact initiated?

c. what were the reasons the patients stated as to why they sought treatment from you?

d. at the time when the patients sought treatment from you, what was the care arrangement for each of the patients? Were the patients still at the BAC, in community care, independent living or with family?

e. describe the nature and extent of the condition(s) for which the patient(s) were seeking treatment or services from you.

64. All the patients referred to in the previous paragraph presented to my practice at . They variously informed me that they found me either through the aid of their general practitioner, the internet or via other BAC peers who had found me through the internet. Each of their GPs had evaluated their condition, prepared a care plan for them, and requested that I provide treatment as per the Medicare referral process.

65. The reasons that these patients stated as to why they sought treatment from me was as follows:-

(a)

(b)

(c)

(d)

66. At the time when the patients sought treatment from me in my private capacity, the care arrangements for each of them were, as I understand:-

(a)

(b)

(c)

(d)

67. The nature and extent of the conditions for which these patients were seeking treatment or services from me are outlined in response to question 8 above.

Q.13 In relation to those patients who were still at the BAC when they were first referred to you in your role as a private psychologist:

a. did you have any communications with the BAC in respect of the progress or concerns in relation to hose patients? If so, who and when did you communicate with, was there any procedure in place in relation to communicating with the BAC, and what was the purpose and nature of the communications?

b. were any of those patients subsequently transitioned to alternative care arrangements due to the closure of the BAC?

i. who were these patients and when were they transitioned?

ii. ***for each of the patients, what were the transitional alternative care arrangements (e.g. community care, independent living, in-patient care or a combination of care arrangements)?***

iii. ***were you aware of any transition arrangements (including transition plans, treatment plans and risk assessment plans) for those patients? If so, please state your knowledge of the transition arrangements, how, by whom and when were you informed and what actions you took, if any, in respect of the transition arrangements.***

iv. ***were you consulted in respect of the transition arrangements? If so, please state who consulted you, when you were consulted, the nature of the consultation and what was discussed at the consultation.***

v. ***did you have any concerns in relation to the transition of the patients to alternative care arrangements? If so, explain any such concerns including to whom and when you reported your concerns, and any responses received.***

68. There was a standard process at BAC that existed before my relocation in April 2013 which enabled external clinicians to contribute in the review of progress of individual patients. I was aware of this process given that I had previously adopted the process when engaging with external clinicians. This process included telephone communication with patients' care co-ordinators initiated by either the external clinician or BAC staff. For example, after a difficult treatment sessions I would telephone either the therapists or nursing staff at BAC to advise them. Additionally, when the Intensive Case Workups were for the patients I was treating occurred I would – when possible – telephone in and participate.

69. Prior to the closure of BAC in January 2014, I made contact with the BAC unit on numerous occasions via the Intensive Case Workups and individual case managers. I also spoke with various medical, teaching and administrative staff in regards to these adolescents to discuss my input into their treatment and to enquire about their wellbeing and coping following and between sessions. As part of my responsibility as an external clinician, I approach any known treatment team to alert them of my involvement and to seek common treatment goals and collaboration for the welfare of the patient.

70. I recall specifically that my communications with the BAC unit in respect of those patients dealt with the following issues:-

(a)

(b)

(c)

(d)

71. I am aware from what I was told by these patients that they were transitioned out of BAC due to its closure or because of my having to leave BAC. However I do not have knowledge of the specific details regarding their formal care arrangements as I was not given any formal notification by the BAC transition team of the transitional alternative care arrangements or the specific dates when those patients were transitioned.

72. I later became aware of the alternative care arrangements for these patients as a result of what the patients told me or what their parents told me.

73. I was only aware of the treatment plans and risk assessments of these patients as discussed in the Intensive Case Workups and with BAC staff. I was not provided with any written transition plans.

74. The concerns I had in relation to the transition of these patients to alternative care arrangements were documented by me in the care plans specific to those patients before I left BAC. However I was not contacted directly by the transition care team at BAC about the transition of those clients. I spoke to BAC about the specific needs of my patients and their welfare only. As I understand it, my views were being presented via the communication process mentioned above as was the standard practice at BAC with external clinicians. For clarity, in my professional position before I left and when I called in as a private clinician, when asked I identified serious concerns for all of the BAC adolescents being transitioned as I did not believe there was anywhere that would adequately meet their complex and severe mental health needs at the stage of their development and treatment. BAC was unique to the care of these severely ill adolescents and was set up with them in mind and had there been adequate care elsewhere, they would have already been transitioned there or in the process of being transitioned there. Specific concerns for each of the patients that I recall were as follows:-

(a)

(b)

(c)

(d)

Q.14 Did any of the patients you were treating, express concerns as to the closure of the BAC and/or transitional arrangements? If so,

a. who and when did they expressed concerns?

b. what was the concern expressed? And

c. what action you took in response to the concern expressed.

75. Each of those patients expressed concerns to me upon hearing about the potential closure of BAC. They all presented with increased distress, which I observed had direct negative impact on their mental health, while I was still at BAC and later when I saw those patients in private practice. In particular I noted their anxiety level had increased and their coping capacity decreased.

76. The concerns these patients expressed to me were generally centred around how they would cope if BAC closed given the relationships they had formed with staff and peers and BAC.

77. My primary focus as a clinician was providing clinical therapeutic services to these patients to help them adjust to the potential, and later confirmed, closure of BAC. While still at BAC, I expressed my concerns with BAC management as I had reported previously in this statement. After April 2013 I sought to respond to these concerns during a clinical link ups via the Intensive Care Workups and in discussions with the clinical team at BAC when working as a private clinician.

Q.15 From late 2013 until early 2014, a number of BAC patients were transitioned to alternative care arrangements (transition clients). Who did you treat as a transition client (identify those you treated while they were still at the BAC)? For the transition clients referred to you after the transition, state when they were referred to you.

78. At this time [redacted] that I was working with privately. By late 2013 [redacted] and [redacted] No BAC patients were referred to me after the closure of BAC.

Q.16 Outline and explain how information was communicated between yourself and the alternative care arrangement provider(s) in respect of the transition clients treated by you. Explain whether there were any formal communication procedures.

79. As noted above, I communicated formally with BAC via teleconference at the Intensive Care Workups and spontaneously with care co-ordinators and other clinical

team members as required as per BAC practice. I had no formal communication directly with BAC management after leaving BAC.

Q.17 Where there were transitional plans in place for the transition clients, and you were aware of those plans, in your assessment, describe the progress each client made in respect of the plans?

80. I did not receive a formal transition plan from BAC in respect of any of the transition clients. I provided professional clinical services in accordance with what was stipulated on the Medicare plans the clients had presented to me from their general practitioners and also in accordance with discussions with the BAC clinical team prior to its closure. All of the treatment plans were significantly hindered following the proposed closure of BAC as much of our clinical work was focused on their adjustment to this process, rather than allowing the natural progression of the treatment programs they were working on prior to this news. I cannot recall clearly on the progress of each of the clients made in respect of the transition plans as I had no formal documentation. However I can note their progress as reflected in their Medicare plans. Those plans appear in my clinical files which I have produced to the Commission.

81.

82.

Q.18 Outline and explain each of the transition clients' condition and progress from the time of the transition to the present, to the extent that they received treatment from you.

83. All of the clients conditions are reported in response to Q8. The progress of each clients' treatment was as follows:

a)

b)

c)

d)

Q.19 Outline and elaborate upon any other information or knowledge (and the source of that knowledge) that you have relevant to the Commission's Term of Reference.

84. The information I have provided is to the best of my recall. Throughout the body of my statement I have provided comments where I feel that I have been able to, and there is no other specific information relevant to the Commission that I can recall or contribute (at this stage) that would add to the Terms of Reference.

Q.20 Identify and exhibit all documents in your custody or control that are referred to in your witness statement.

85. Relevant documents are exhibited to this statement save for patient files which have been produced to the Commission. Attachment '**N**' is a copy of an email exchange I had with Susan Daniel on 14 October 2013 about [redacted] (document WMS.6000.0005.00025). A copy of this email was provided to me by the Commission and does not appear in my private file.

I make this statement conscientiously believing the same to be true, and by virtue of the provisions of the *Oaths Act 1867* (Qld).

Signed and declared by Georgia Lee Watkins-Allen
at Brisbane in the state of Queensland on the
30th day of January 2016 before me:

[redacted]

Signature of person before whom the declaration is made

[redacted]

Signature of Declarant

GARY ANTALAN RAINBIRD
J.P. QUALIFIED

Full name and qualification of person before whom the declaration is made

Barrett Adolescent Centre Commission of Inquiry

Commissions of Inquiry Act 1950

CERTIFICATE

Bound and marked 'A' to 'N' are the attachments to the statement of **GEORGIA PENNY LEE WATKINS-ALLEN** signed January 2016.

Georgia Penny Lee Watkins-Allen

Witness

Reg. No. B5010

GARY ANTALAN RAINBIRD

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"A"

Confidential Curriculum Vitae

of

Georgia L. Watkins-Allen

2013

CURRICULUM VITAE

PERSONAL DETAILS

Name: Georgia Watkins-Allen

Home Address:

Telephone: Mobile:

E-mail Address:

Date of Birth: 18th June 1965

Current Profession: General registration as a Clinical Psychologist in Queensland, Registration No: 980710 with AHPRA, STAP registered Supervisor.

Qualifications: Masters in Clinical Psychology
University of Queensland
Bachelor Of Arts (Hons) Macquarie University, Sydney

Organisational Affiliations: Australian Association of Buddhist Counsellors and Psychotherapists (AABCAP)

Australian Psychological Society- Clinical College Member

Health Status: I am a physically healthy non-smoking mother of 2 and have been vaccinated against Hepatitis B, MMR and Tetanus.

PROFESSIONAL SUMMARY

I have 15 years' experience working with complex mental health and behavioural problems as a clinical psychologist within a multidisciplinary team, both in the community and in patient settings. For the last 9 years I have been based at the Barrett Adolescent Centre (BAC) working with chronic severely disturbed and vulnerable youth, within a family systems and milieu therapy framework involving acute management, family therapy and individual and group work. This complex level of therapeutic work and access to highly skilled clinicians has enabled me to develop an in-depth knowledge of the unique psychological, behavioural and developmental challenges specific to adolescence, in addition to skilled methods and procedures for diagnosis, treatment, evaluation, design and research. This collaborative team-oriented approach has helped me establish superior interpersonal skills via solid relationships with clients, colleagues, administration and local agencies. At the same time, I am able to work at a highly autonomous and adaptable level with multiple complex cases, as also enhanced by my private practice during the last 8 years, advancing my skills as an experienced senior clinician working with post natal depression and attachment issues, providing Triple P and working with young children with anxiety, mood, social and behavioural difficulties. In addition, as a STAP trained supervisor I have excellent experience supervising students and colleagues within various disciplines. My work has also enabled me to develop expert therapeutic skills and experience specific to complex comorbid cases involving trauma, anxiety disorders, depression, suicidal ideation, DSH, eating disorders, aspergers, ADD/HD and psychosis. As a critical thinker and seasoned mental health practitioner I thrive in high-stress professional environments, dedicated to delivering the highest quality of professional and compassionate care.

SKILL HIGHLIGHTS

- Suicide and DSH risk assessments and management
- Mood and anxiety disorders specialist
- PTSD and Complex PTSD specialist
- Dissociative disorders competency
- Psychosis specialist
- Extensive DSM-IV knowledge
- Eclectic evidence based therapeutic expertise- CBT, DBT, ACT, IT, Schema Therapy, Sand Play, & Psychodynamic
- Exceptional problem solver
- Family therapy experience
- Parenting skills educator - Triple P

PROFESSIONAL EXPERIENCE - PSYCHOLOGICAL

Nov 2004 – April 2013

BARRETT ADOLESCENT CENTRE (BAC),
The Park- Centre for Mental Health (PCMH), Clinical Psychologist,
Permanent, Part Time, shared with Incumbent & Locum
Supervisors: Prof. Robert King (UQ & QUT); Danielle Corbett (Clinical psychologist- BAC), & Jacqueline Robinson (Ethics Chair West Moreton & UQ Mental Health Masters Lecturer).

- *Psychological assessment and formulation directing flexible best practice evidence based interventions and program design, implementation and evaluation to enable recovery* - provided for adolescents with chronically complex psychological and behavior difficulties, with and without forensic, ITO and Department of Communities- Child Safety status, within a tertiary long term stay in-patient unit, including day patients, with referrals accepted across Queensland.
- *Collaborating closely with multidisciplinary treatment team,* including a registered school, to appropriately coordinate client care service by developing comprehensive treatment plans that focus on accurate diagnosis and behavioral treatment of problems- providing highest standards of professional, personal, ethical and compassionate care.
- *Specific program design and adaptation* to develop understanding and skills (individual & group)
  - DBT group run per school terms [Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness], incorporating
  - ACT skills and concepts [e.g., Values, Committed Action, Observing Self, & Defusion] via mixed media/ approaches;
  - Horse and Carriage Model (psycho-education and skills development teaching link between emotions, cognitions, body, behaviour and the self);
  - No Worries Group (core CBT education and skills for anxiety and depression);
  - Parent Child Relationship Art Therapy Group (Attachment and interpersonal effectiveness);
  - Anger Management, Relaxation skills, Impulse Control, Social Skills development
- *Aggression Behaviour Management (ABM) and Professional Assault Response Trained (PART)* - enabling quick and effective response to crisis following severe mental health and behavioral issues
- *STAP trained supervision* of psychology students and staff (i.e., Psychologists, Nurses, Registrars, Sand Play Therapists & Art Therapist.)
- *Staff education, training & professional development* delivery (i.e., Allied Health [Psychologists, Occupational therapists, Social Worker, and Speech pathologist, Registrars, Nurses and Teachers) in adolescent psychopathology and individual and group interventions and assessment.
- *Consultation & community liaison*- professional (intra and interagency) and family liaison efficiently gathered information from families and social services agencies to inform development of treatment plans.
- *Quality improvement* (e.g., via program design, implementation and evaluation; assessment, recommendation for training/ education, documentation and research opportunities)
- *Co-therapist in Family Therapy* as required with family therapist (i.e., Social Worker).
- *Effectively managed time* between weekly Case Conferences, Intensive Care Reviews (intra & interagency), Groups, Individual Therapy, provision of Supervision, Consultation and Liaison with staff, clients, families and Inter-Agencies, Program Design and Evaluation, Training and Education and Documentation.
- *Documented* all patient information including service plans, treatment reports and progress notes.

Nov 2005 – Current

TYACK HEALTH,
Clinical Psychologist, Part Time
Supervisor: Jacqueline Robinson (Ethics Chair West Moreton & UQ MH Masters Lecturer).

- Psychological interventions provided for full developmental spectrum general public referred by General Practitioners under Medicare Scheme, ATAPS, Psychiatrists, Pediatrician's and private referrals with specific interest and work with parents, children and adolescents.
- Psychological assessment, formulation, best practice evidence based interventions including CBT, DBT, ACT, Narrative, Interpersonal, Triple P and Psychodynamic with access to a multidisciplinary team (GP's, Chiropractors, Physiotherapists, Dietician, Occupational Therapist, Speech Therapist, Podiatrist, Remedial Massage, Acupuncture, Naturopathy, Yoga, and Pilates) for referrals and liaison.
- *Documented* all patient information including service plans, treatment reports and progress note s.
- *Consultation and Liaison* with referring GP's, Psychiatrists, local CYMHS, Adult MH Services, and Hospitals.

June 2002- Nov 2005

MEDIUM SECURE UNIT,
PCMH, Clinical Psychologist, Permanent, Part Time
,Supervisor: Dr. Maureen Barnes (Senior Psychologist at High Secure)

- Psychological intervention provided for acute psychiatric, forensic & ITO in-patient referrals accepted from within West Moreton Mental Health Services (WMMHS).
- Including psychological assessment, formulation, best practice evidence based intervention & program design & implementation (e.g., Psycho-education and Illness Management; Stress Management; Relaxation; Alcohol and Illicit Substance Management; & CBT) for rehabilitation within a multidisciplinary team. Further involving consultation & community liaison, staff education/ training, quality improvement, professional development & peer support.

Feb 2002-August 2002

HIGH SECURE UNIT,
PCMH (Formerly known as John Oxley Memorial Hospital),
Psychology Locum,
Supervisor: Luke Hatzipetrou

- Psychological intervention provided for acute forensic, ITO & classified patient referrals accepted from within WMMHS.
- Involving psychological assessment, formulation, best practice evidence based interventions & program design & implementation (e.g., Psycho-education and Illness Management; Stress Management; Relaxation; Alcohol and Illicit Substance Management; & CBT) for rehabilitation, within a multidisciplinary team.
- Consultation & community liaison, staff education/ training, professional development & peer support.

July 2001 – Nov 2001

ADVANCED COUNSELLING & PROCESS ISSUES IN THERAPY TUTOR
(POSTGRADS), University of Qld (UQ), Course Coordinator; *Dr. Andre Zagonski*

- Tutoring of 20-30 students & marking assignments that focused on providing advanced counseling and managing process issues with individuals seeking assistance in managing emotional, behavioural and psychiatric childhood & adult disorders.

Feb 2000 – July 2000

ADVANCED ASSESSMENT TECHNIQUES TUTOR
(POSTGRADS), UQ, Course Coordinators; *Dr. Kate Sofranoff & Dr. Maggie Bailey (Neuropsychologist)*

- Tutoring of 20-30 postgrad students & marking assignments that focused on assessing a variety of emotional, behavioural and psychiatric childhood & adult disorders.

Feb 2000 – August 2000

ASPERLY COMMUNITY MENTAL HEALTH,
(General Externship): *Supervisors: Mrs Leanne Casey & Ms Denise Robertson*

- Providing clinical counselling for clients presenting with severe psychopathologies being referred from the Prince Charles Hospital. Involving empirically based interventions for both in & outpatient services.
- Group therapy for Adolescents with psychosis.
- "Strengthening family Ties" project working with families of young people with psychosis.

Jan 2000 – Oct 2001

QLD ALCOHOL & DRUG RESEARCH & EDUCATION CENTRE (QADREC), "ALCOHOL RELATED INJURIES", Clinical Research Assistant. Dr Kerri-Anne Watson

- Providing clinical interviews assessing alcohol use & risk taking behaviour as well as providing brief CBT intervention within the Gold Coast Hospital Accident and Emergency Department, conducted on a quarterly basis.

Dec 1999 – July 2000

DRINKING IN MODERATION PROGRAM, Clinical Research Assistant.
Dr. David Kavanagh & Dr Natalie Shockley

- Clinical counseling, one on one, using a semi-structured CBT program utilizing exposure techniques and research duties including data entry of psychometric and behavioural data, literature searches, collation, summaries, reviews including monitoring and follow up of subjects utilizing timelines.

August 1999 – Feb 2000

RBH, (SPECIALTY EXTERNSHIP IN HEALTH PSYCHOLOGY- with ADOLESCENT & FORENSIC COMPONENT),
Supervisor: Dr. Betty Headley, Ms. Sandy Hutchinson, Dr. Margarat McFarlane (Adolescent Unit) & Marcus Kibel (Forensic Community Mental Health).

- Providing assessment, formulation and best practice empirical interventions for patients and their families experiencing difficulties with oncology, fertility, rheumatoid, endocrinology, and diabetes.
- Assessment of Adolescent in-patients and rehabilitation program design.
- Co-therapist/ assessor at Forensic Community Mental Health Service.

March 1999 – August 1999

BEHAVIOUR RESEARCH AND THERAPY CENTRE (BRTC), RBH, QLD. (INTERNSHIPs): *Supervisor: Dr. Betty Headley*

- Providing clinical counseling for clients across the developmental spectrum. Involving assessment, formulation, and best practice empirically based interventions for a range of DSM-IV psychiatric problems.
- Research participation (40 hrs) counseling clients from the "Drinking in Moderation Program" (Dr. David Kavanagh).

Jan 1999 – Nov 2001

PSYCHOPATHOLOGY TUTOR, UQ (UNDERGRADS),
COURSE COORDINATOR: *Dr. Ken Pakenham.*

- Tutoring of 20-30 postgrad students & marking assignments that focused on accurately understanding, diagnosing, formulating and treating a broad spectrum of DSM psychopathology incorporating a variety of emotional, behavioural and psychiatric disorders.

June 1998 – Feb 1999

BRTC, ST LUCIA,
(INTERNSHIP): *Supervisor: Dr. Tian Oei*

- Clinical counseling was provided for adult clients referred to the BRTC for problems relating to depression, anxiety, substance misuse, personality, & interpersonal relationships. It involved, assessment, formulation, and best practice empirically based interventions.
- Group "Parenting Strategies" with young adolescent mothers was also provided as part of a40 hr research participation.

Feb 1998 – June 1998

TRIPLE P (POSITIVE PARENTING PRACTICES), ST LUCIA, QLD.
Supervisor: Dr. Matt Sanders.

- Providing assessment, formulation and best practice empirically based intervention through education and training of parents of children with a range of emotional & behavioural issues & psychiatric disorders such as autistic spectrum disorders, eating disorders, sleep disorders, oppositional defiance & learning difficulties.

Jan 1996 – Jan 1997

LIFE LINE, SYDNEY

- Telephone counseling for individuals in crisis and in need of support.

PROFESSIONAL EXPERIENCE - GENERAL

1986 – 1988

MEDICAL RECEPTIONIST FOR DR. M.J.ALLEN, GENERAL PRACTITIONER, ADELAIDE, S.A.

Receptionist duties, secretarial duties, data entry, accounts, & general assistance with medical procedures.

1987 – 1988

KAPARA NURSING HOME & HOSPITAL, ADELAIDE, S.A.

Volunteer work assisting nursing staff with care of geriatric in-patients & day visitors.

Dec 1989 – Dec 1991

NATIONAL HEALTH NURSING AGENCY, LONDON, U.K.

Nurses aid involving care of geriatric patients in their home on a daily basis assisting them with acquiring daily living skills.

Jan 1989 – Dec 1989

PRIDE MARKETING AGENCY, LONDON, U.K.

Receptionist work, secretarial duties, telecommunications and data entry. (Working for a range of companies' -ie- from Banking to Advertising).

June 1989 – Jan 1992

RHINO COMMUNICATIONS (ADVERTISING GROUP), LONDON, U.K.

Assistant Personnel & Resource Manager. Primary duties involved personnel support & problem solving, as well as maintaining resources within the work environment & providing personal assistant duties for the Managing Director.

PROFESSIONAL DEVELOPMENT

Conferences/ Workshops/ Seminars:

- Roshi Joan Halifax, 2 Day workshop, Death and Dying, Australian Association of Buddhist Counsellors and Psychotherapists, Sydney, NSW, August 2012
- John Brier , 2 day workshop, Mindfulness in Trauma, Brisbane, Qld, 2011
- Dali Lama and multiple presenters including: Martin Seligman, Paul Eckhart, 2 Day workshop, Mind and Its Potential, Sydney, NSW, 2010
- Masterson's Psychodynamic Theory for treating Borderline and Narasisstic Personality
- FRIENDS for Life Program, Pathways, 2008
- Aggression Behaviour Management (ABM), 5 days initial training and 3 day refreshers, PCMH, annually from 2006-2013
- CPR and Fire safety, annually from 2002-2012
- ACT, Dr Russ Harris, 2 day workshop, PCMH, 2008
- Butterfly Foundation, 2006
- Cedar Koons, USA, 2 day workshop in "Dialectical Behaviour Therapy", Mercure Hotel, Brisbane, Qld, 2004.
- Dr Ron Dimond, (Clinical Director of High Secure Forenic Unit) USA, All day workshop entitled "Working with coerced patients", The Park- Centre for Mental Health-(PCMH), 2004.
- Lynn Ridgeway, Jacana ABI Centre, "Responsible thinking workshop", PCMH, QLD 2004.
- Dr Paul Genreau, Quebec, Canada, "Clinical versus psychometric assessment of Forensic clients", PCMH-, QLD 2003.
- Professional Assault Response Training, (School of Mental Health-SOMH) PCMH-, QLD 2002 & refresher training annually until 2005 when replaced by ABM.

- West Moreton Psychological Series Workshops including guest speakers on specific childhood & adult psychiatric disorders, psychological & neuropsychological assessment & empirically based treatment approaches, PCMH, Qld, 2002 & 2003

- "Legal, ethical & confidentiality issues in mental health", SOMH, QLD 2003.

- "Psychopharmacology for psychiatric illnesses", SOMH, PCMH, QLD 2003.

- "Symptom Management", SOMH, PCMH, QLD 2002.

- "Clinical risk assessment", SOMH, PCMH, QLD 2002.

- "Fire & Safety Management", SOMH, PCMH, QLD 2002.

- "CPR" training", SOMH, PCMH, QLD 2002.

- Charles Benight, University of Colorado, "Coping self efficacy and trauma recovery". UQ 2001

- Brendan McAuliffe, UQ, "Transforming the Nature of Positive Differentiation: The Effect of Individualist and Collectivist Group Norms". UQ 2001

- Dr Robert Kurzban (UCLA), "Commitment and reciprocity in social dilemmas". UQ 2001

- Dr Sonia Roccas (Open Uni of Israel) "Social identity complexity". UQ 2001

- Ms Jessi Smith (Uni of Utah), "The self-regulation of motivation process model: Understanding and expanding the question of "how". UQ 2001

- Dr Geoff MacDonald (Wake Forest Uni), "Examining the relation between self-esteem and relationship security". UQ 2001

- Dr Matthew Hornsey (UQ), "It's OK if we say it, but you can't: Responses to intragroup and intergroup criticism". UQ 2001

- Dr Brian Lewis (Syracuse Uni), "Domain specific esteem: The role of self-perceived mate value on interpersonal relationships including risky sexual behavior, susceptibility to sexual coercion, and relationship violence". UQ 2001

- Louis Costonguay's "Integration of CBT: Process of Change" (AACBT), Brisbane 2000

- Jeffrey Young's "Schema Focussed Therapy" 2 day workshop (AACBT), Brisbane 1999 .

- Annette Luke, "Coping with schizophrenia: An exploratory study". UQ 1999

- Andrew Glynne, Valley Community Mental Health Centre, "Symptom Management for Schizophrenia". UQ 1999

- Sandy Smith, Queensland University of Technology & Lucy Zinkiewicz, University of Southern Queensland, "Professional role identification and multidisciplinary work teams". UQ 1999

- Dr. Annemaree Carroll , University of Queensland, "Reputation Enhancement: A piece of the puzzle to understand adolescent drug use". UQ 1999

- Professor Mark Frank, Rutgers University, " Not all lies are created equal: Deceiving and detecting deceit". UQ 1999

- Dr Nola Passmore, "A Comparison of Adult Adoptees and Non-Adoptees in Terms of Identity Style, Self-Esteem, and Family Variables". UQ, 1999

- PTSD Treatments: CISD vs EMDR (AACBT), UQ 1998

- Using the WAIS-III (Psychological Corporation), UQ 1998

- Generalised Anxiety Disorder (Michelle Newman), UQ 1998

DISSERTATIONS

2003	UNIVERSITY of QLD, Brisbane MCP
CLINICAL MASTERS THESIS:	"The Role of Motivation on Written Trauma Disclosure: A Partial Preferential Randomised Design." *Thesis Supervisor*: Dr. Justin Kenardy *Topic*: An investigation into written trauma disclosure treatment effects and the potential role of motivation on treatment outcome. Presented at the AACBT Brisbane Conference, 2003.
1997	MACQUARIE UNIVERSITY, Sydney BA(Hons)in Psychology.
HONOURS THESIS:	"Allocation of Attentional Resources in Social Phobia." *Thesis Supervisor*: Dr. Ronald Rapee *Topic*: An investigation to assess whether individuals with social phobia focus their attention internally or externally during an anxiety-provoking situation. Individuals from the general population were screened, assessed and diagnosed by myself as suffering from social phobia according to the DSMIV criteria.

ENTERED

SAP ✓
WB ✓
E-mail ✓

Queensland Government

Employee Movement - Temporary (Higher Duties/Acting at Level)

An approved 'Validation of Claim Older Than Three Months Form' must be provided in addition to this form if this claim is older than three months from the effective date.

This form is to be used by Queensland Health employees and line managers to document a temporary change to an employee's existing position or temporary appointment to a position either in an 'at level' or higher duties capacity.

Employee Details

Person ID | Personnel assignment number (PAN) | Please indicate (✓) here if you work in more than one position in QLD Health ☐

Family name: Watkins-Allen

First name/s: Georgia

Visa Notification (if applicable)

If the employee to whom this movement applies holds a Temporary Business (Long Stay) Subclass 457 visa, the Department of Immigration and Citizenship (DIAC) must be notified within 10 working days of the transfer to a new location or position.

Email address: QLD.SponsorMonitoring@dimit.gov.au

Note: The sponsorship obligations for visa holders are transferred to the new HR Unit (refer HR Policy B45 for details).

Proposed Classification

Higher duties ☑ Acting at level ☐

Indicate below if this form relates to either a new appointment, an extension to an existing appointment or a modification of a previously documented appointment

New ☑ Extension ☐ Modification ☐

Proposed Position Details

Request to Fill a Vacancy Form attached ☐

Position ID	Position title	Classification (eg. AO4)
30469613	Specialist Clinical Supervisor	HP4

Start date: 04/03/2013

End date: 31/03/2013

Percentage of higher duties allowance payable applies only to employees under the provisions of the Public Service Act: Percentage of allowance: %

Organisational unit number: 70071583

Organisational unit name: Clinical Svs Allied Health MH The Park

Facility address: The Park Centre for Mental Health, Wacol, Qld

Job advertisement reference (if applicable):

Current occupant (if applicable): Danielle Corbett

Reason for higher duties / acting at level: Backfill

Concurrent / Aggregate: Please indicate (✓) here if the employee will continue to hold their existing position in conjunction with the proposed position ☐

Employment basis .

Full-time ☐ Part-time ☑ No. of part-time hours / fortnight: 38

Award/EBA Name: Health Practitioner (Queensland Health) Certified Agreement (No.2) 2011

Staffing Arrangements Details

Reason for vacancy: Danielle returning to substantive position

Work Contract

Working arrangements		Shift arrangements		Recreation leave accrual		Reason for additional weeks leave	
19 day month (ADO accrual)	☐	Single shift only	☑	4 weeks / annum	☑	Working public holidays	☐
Standard hours (non ADO accrual	☑	Two shifts	☐	5 weeks / annum	☐	Continuous shift work	☐
Variable working hours	☐	Continuous shift work	☐	6 weeks / annum	☐	Working with radium (radiographers only)	☐
9 day fortnight	☐	12 hour shift arrangement applies	☐				

Special conditions (e.g. RANIP Nurses, etc.). Please refer to the Payroll and Rostering Intranet Site (PARIS) for more information.

Professional Development Leave and Allowance

This area is provided for edge of fixing

14

Queensland Government

Employee Movement - Temporary - (Higher Duties/Acting at Level)

Employee Reference

Person ID [redacted] Personnel assignment number (PAN)

Work schedule

Please indicate (✓) here if this employee works either: A cyclic roster (where the roster pattern repeats at regular intervals e.g. fortnightly / monthly) ☑ OR A non-cyclic roster (a roster pattern that varies from one cycle to the next) ☐

Please complete the table below using 24 hour time format (eg. 07:00 - 15:30) to advise the employee's roster for their initial two week period of employment.

Week one

Day	Start time (hours)	Meal break* Finish time (hours)	Start time (hours)	Finish time (hours)	Total daily hours (e.g. 7.6)
Monday	7:30	15:36	12:00	12:30	7.6
Tuesday					
Wednesday	7:30	15:36	12:00	12:30	7.6
Thursday					
Friday	7:30	15:36	12:00	12:30	7.6
Saturday					
Sunday					
				Total weekly hours	22.8

Week two

Day	Start time (hours)	Meal break* Finish time (hours)	Start time (hours)	Finish time (hours)	Total daily hours (e.g. 7.6)
Monday	7:30	15:36	12:00	12:30	7.6
Tuesday					
Wednesday	7:30	15:36	12:00	12:30	7.6
Thursday					
Friday					
Saturday					
Sunday					
				Total weekly hours	15.2

*Where a paid meal break applies, please insert N/A for meal break start and end times.

This area is provided for ease of filling

Qualification payments

Please list here any approved qualifications that this employee possesses that will entitle them to additional payment (e.g. relevant AQF qualifications or nursing credentials) under Queensland Health policy.

Masters of Clinical Psychology

Supervisor certification (mandatory completion required)

I certify that I have:

- (where the employee is seeking release or extension of a previously approved movement from another work unit) successfully negotiated the terms of the agreement with the line manager of the employee's substantive position
- informed this employee of any changes to their FBT Concession Eligibility status as a consequence of this variation to their employment
- discussed with this employee the consequences of this change to their position, employment status, terms of employment and/or roster and
- informed the employee where this change applies to a temporary employee moving between temporary assignments, of any impact (i.e. the ending or likelihood of extension of their previous contract) as a consequence of accepting appointment to this proposed position.

Supervisor's signature	Date	Area code	Contact number
[redacted]	28/02/2013	(07)	[redacted]

Supervisor's full name (please print)

Lorraine Dowell

Supervisor's position title

TL Non Secure Services

Employee certification (mandatory completion required - refer note* below)

I agree to the above changes to my employment hours/position. I hereby claim for the extra remuneration for hours worked in a higher duties capacity (where applicable). I also certify that I have been informed by my line manager/supervisor of the consequences of this change to my:

- FBT Concession Eligibility status that may result from this variation to my employment contract and
- position, employment status, terms of employment and/or roster. I also acknowledge that as this appointment is of a temporary nature, the contract may be ended by my line manager with the appropriate notice in accordance with award provisions.

Employee's signature	Date	Line manager's signature in lieu*
[redacted]	4/3/13	

*In exceptional circumstances where the employee is unable to sign this form (as above) the Supervisor may submit this form for processing where it has otherwise been completed in full and details of the reason that the employee cannot sign the form is listed below. The signature of the employee must be obtained on this form as soon as they become available to sign the form so that it can be retained as a formal contract of employment.

Queensland Government

Employee Movement - Temporary - (Higher Duties/Acting at Level)

Employee Reference

Person ID

Personnel assignment number (PAN)

Delegate's Approval (mandatory completion required)

If the employee's entitlement to recurring allowance changes, please complete and forward the relevant form/s.

HES / SES Higher Duties only:
Will the employee be allocated a government owned motor vehicle for private use or home garaging during this period of relief? Yes ☐ No ☐

Delegate's signature

Date 6/3/13

Area code (07)

Delegate's Contact number

Delegate's full name (please print) SHARON KELLY

Delegate's position title CEO MHHSS

Lesley Dwyer
Chief Executive
West Moreton Hospital and Health Service
8/3/13

This area is provided for date of filing

Processing Area Use Only

Processor's signature

Date

Reviewer's signature

Date

Processed for fortnight ending

hr_emp_mov_high_dut/January2012v1

From: Georgia Watkins-Allen
Sent: 6 Mar 2013 09:13:23 +1000
To: Rachel Phillips
Subject: Fwd: Text of correspondence about psychology position

Hi Rachel

following are Trevors emails re-earlier discussion which highlight his position. There are also some useful ideas here.
regards
Georgia

Georgia Watkins-Allen
Psychologist
BAC
The Park Centre for Mental Health

>>> Trevor Sadler 3/1/2013 5:57 pm >>>
Dear Colleagues,

Below my name is the text of emails I have sent to various people about HP staffing, just so you can be clear what has been said in various discussions.

Kind regards,

Trevor

4/2/2013
Hello Rob,

Sorry to have not gotten back to you before now. I was on leave last week, and missed you today.

David's resignation came at an unfortunate time for our service, especially given the number of families for family therapy. However, he was not seeing many families on a regular basis.

We have a major crisis with our Allied Health Professionals at present.

- One vacant Social Worker position (HP5)
- One Occupational Therapist (HP3) on contract who has been told that her contract would not be renewed at the end of February.
- Two x 0.5 psychologist positions (HP4), one of whom is already past her contract expiry date, and has not been paid for the continued work she has done, the other whose contract will end at the end of February.

Given the uncertain future our unit faces, it is paramount that we have continuity of our current staff to continue vital therapeutic work with adolescents.

My strong opinion is to maintain the current remaining AH staffing as far as possible, even if it means that we have to do that at the delay of appointing a social worker. If the HSS agree to let us appoint a SW and the current staffing, then that would be my first preference. Maintaining existing continuity of staff is critical for our young people at this stage who have already been upset enough by the threatened closure. Having a temporary social worker come for perhaps a month or two will not contribute to clinical effectiveness as much as retaining the current AH staffing.

This is in no way to devalue the role of the social worker. Should our service continue in some form, there is no way I would consider operating without a social worker and our other current staffing. I emphasise that the above arrangement is my preference for these difficult, uncertain times.

Kind regards,

Trevor

11/2/2013
Hello Reeny,

Many thanks for making the time to come to Barrett this morning and advocate for filling the Social Work position. I really appreciate that.

I have attached the PD. It's pretty outdated. At the time, David had moved across at level as a locum, was more enthusiastic than he has been recently, and we advertised for the position to be made permanent, not paying too much attention to the delineating the role. It is a generic mental health PD, because that is all that we could get from HR at the time.

You mentioned what you consider to be the core skills of the role of the Social Worker, particularly with respect to transitioning young people and linking them back into their community.

I became aware 17 years ago that this was an area in which we failed young people, and so we have developed skills in doing this. We build in multiple levels of support and community linkage. This is time consuming, as I am sure you will appreciate.

David was involved in this in his early years at Barrett with one or two young people. His predecessor had also taken on that role a little. However, this has overwhelmingly been the role of initially the Care Co-ordinator during the mid 1990's, and then the Occupational Therapists from 2000 until the present time.

You questioned whether Occupational Therapists had the skill base to do this. I am eminently satisfied that they are most well equipped. They bring with them a strong developmental knowledge, which they use to integrate an adolescent's broad developmental profile with the suitability of community tasks with which they are being integrated. Moreover, they are trained in assessments of a wide range of occupational skills for vocational and day to day living. They have facilitated the adolescent's progress in these areas during their period at BAC. They are then in an ideal position to match up resources/activities in the community with their knowledge of the adolescent built up over the months.

They would welcome having a Social Worker being able to assist them in this role, because it is very time intensive.

However, I would not see it as being the core nor the specific role of the Social Worker.

I would be reluctant to not include reference to Family Therapy in the role (whether it is a short term or long term position). The Standards of the Quality Network for Inpatient CAMHS of the Royal College of Psychiatrists (a multi-disciplinary body) recommends 0.5 FTE Social Worker time + 0.5 FTE dedicated Family Therapy time for a 10 - 12 bed unit. (By their measures, as I mentioned, we are under resourced for Allied Health staff).

Kind regards,

Trevor

19/2/2013

Many thanks, Tawanda. This is excellent news. Well done.

(I do have to say that we will struggle with only one FTE psychologist - assuming the supervisor was converted to a psychology position - though. Boy is that a headache! We have 22 patients at present, 16 on the waiting list. Is there any chance of

- formally making the SW position HP 4, if we have to get another position description done. That adds a bit of time, but would open it to a wider pool of applicants of equivalent skill to the psychologists. As we discussed, the current HP 5 was an anomaly of the HP process, and did not reflect value to the unit.
- continuing with 1.5 FTE psychologists until the social worker is appointed or even have 0.5 SW if one at a community clinic was interested in a half time secondment to BAC - a potentially useful skills mix - and continue with 1.5 psychologists.

We have a number of adolescents who have experienced great instability of relationships in their lives. Four in particular are at critical stages of therapy, and losing their psychologist suddenly will be quite disruptive.

Again, I really appreciate all yo have done to try to ensure that we can deliver a service to as many adolescents as possible while we wait on the outcome of the review.

Kind regards,

Trevor

>>> Tawanda Machingura 2/19/2013 1:19 pm >>>
Hi all,
I can confirm that all Allied Health positions at BAU will continue to exist in their current form except for the Clinical Supervisor Position ID 30469613 which will be abolished.

This means that we can continue to extent contracts and recruit to AH vacant positions except for the position mentioned above.

Many thanks
Tawanda

Tawanda Machingura
Programme Manager/ Dir Allied Health

The Park Centre for Mental Health

West Moreton Hospital and Health Service
T:
Corner Ellerton Drive & Wolston Park Road, WACOL QLD 4076
Locked Bag 500, SUMNER PARK BC QLD 4074

From:	Rachel Phillips
Sent:	6 Mar 2013 10:34:46 +1000
To:	Georgia Watkins-Allen
Cc:	Lorraine Dowell
Subject:	Re: Fwd: Text of correspondence about psychology position

Thanks Georgia,
I was away yesterday but managed to get hold of Kathryn late Monday avro - she did not foresee any HR issues re secondment back to BAC from CYMHS - obviously it would need to be negotiated and would not be indefinite but the length would need to be considered in light of clinical need and handover. Once there is a clearer picture of length of time for handover your secondment could be discussed with the CYMHS TL and Tawanda,
Rachel

Rachel Phillips MAPS
Director of Psychology

West Moreton Hospital and Health Service
T:
E:

Psychology Department
Ipswich Hospital
Ipswich, QLD 4305
PO Box 73, Ipswich, QLD 4305
www.health.qld.gov.au

>>> Georgia Watkins-Allen 3/6/2013 9:13 am >>>
Hi Rachel

following are Trevors emails re-earlier discussion which highlight his position. There are also some useful ideas here.
regards
Georgia

Georgia Watkins-Allen
Psychologist
BAC
The Park Centre for Mental Health

>>> Trevor Sadler 3/1/2013 5:57 pm >>>
Dear Colleagues,

Below my name is the text of emails I have sent to various people about HP staffing, just so you can be clear what has been said in various discussions.

Kind regards,

Trevor

4/2/2013

From: Georgia Watkins-Allen
Sent: 6 Mar 2013 13:32:57 +1000
To: Rachel Phillips
Cc: Lorraine Dowell
Subject: Re: Fwd: Text of correspondence about psychology position

Thanks Rachel

forgot about the Goodna possibility as thought the restructuring would make it unlikely- but remember you said you would follow this up which I would greatly appreciate.

regards
Georgia

Georgia Watkins-Allen
Psychologist
BAC
The Park Centre for Mental Health

>>> Rachel Phillips 3/6/2013 1:29 pm >>>
hi Georgia,
I am on a TC but kathryn did say that the relocation policy and "reasonable placement" so you are right that it would be unreasonable to relocate to CYMHS. Just thought we would give you the option and see whether you could be based at Goodna but happy to strike it off the list!!

I have not managed to talk with Tawanda, I was away yesterday. Will try again today following my TC. Rachel

>>> Georgia Watkins-Allen 3/6/2013 1:21 pm >>>
Hi Rachel

thanks for pursuing this approach. My difficulty long term however with this option, is accepting a position that is greater than 1.20 mins from my home which has both a negative impact on my young family and financially as I already car pool to The Park- this is also consistent with Policy B36 12.6 Relocation to another position- which highlights reasonable placement regards to commuting arrangements (greater than 1hr) and family commitments- which Im sure you are aware.

I don't want to further muck any kids or another unit around long term as best as possible.

I have also been brain storming other options with Lorraine and the pros and cons of each. EFTRU still provides a viable option as identified earlier as it keeps me at the Park and potential to provide a better duty of care re-transition/ effective management of current work with BAC kids-
Im also trying to explore other options.
Have you come up with any suggestions after talking with Tawanda.

regards
Georgia

Georgia Watkins-Allen
Psychologist
BAC

From: Rachel Phillips
Sent: 11 Mar 2013 07:58:36 +1000
To: Georgia Watkins-Allen;Lorraine Dowell
Subject: Re: Fwd: Text of correspondence about psychology position

HI Lorraine,
Yes, I have been out of the office until today. This needs to be discussed with Catherine Lynch, TL CYMHS. I am seeing her today so will discuss, Rachel

>>> Lorraine Dowell 3/8/2013 1:04 pm >>>
Hi Rachel,

Is there a CYMHS based at Goodna that might be suitable as a permanent position for Georgia?

Rachel are you pursuing this option with Georgia and HR? I am aware that we only have a couple of weeks left.

Kind regards,

Lorraine

>>> Rachel Phillips 6/03/2013 10:34 am >>>
Thanks Georgia,
I was away yesterday but managed to get hold of Kathryn late Monday avro - she did not foresee any HR issues re secondment back to BAC from CYMHS - obviously it would need to be negotiated and would not be indefinite but the length would need to be considered in light of clinical need and handover. Once there is a clearer picture of length of time for handover your secondment could be discussed with the CYMHS TL and Tawanda,
Rachel

Rachel Phillips MAPS
Director of Psychology

West Moreton Hospital and Health Service
T:
E:

Psychology Department
Ipswich Hospital
Ipswich, QLD 4305
PO Box 73, Ipswich, QLD 4305
www.health.qld.gov.au

>>> Georgia Watkins-Allen 3/6/2013 9:13 am >>>
Hi Rachel

following are Trevors emails re-earlier discussion which highlight his position. There are also some useful ideas here.
regards
Georgia

"G"

Metro North Hospital and Health Service
INTERNAL BRIEFING NOTE

Chief Executive – Establishment Management Approval

Requested by: Lorraine Dowell Team Leader Non Secure Services **Date requested:** 28/02/2013 **Action required by:** 07/03/2013

RECEIVED
28 FEB 2013
FILE COPY

Action required

☒ For approval ☐ For information ☐ Other: <insert other action> ie: for escalation

SUBJECT: Request to appoint MsWatkins-Allen to a temporary 1 month position Specialist Clinical Supervisor as per negotiations (27/02/2013) with the Mental Health Allied Health Director (Mr Tawanda Machingura), The District Discipline Director of Psychology (Ms Rachael Phillips), HRM (Ms Kathryn White) and Ms Watkins-Allen.

Proposal
That the Chief Executive:
Approve the attached establishment management request.

Background, Service Need and Financial Implications
1. The following information is provided to support informed decision making and financial stewardship:
   - **Service context / service need**
     Ms Watkins-Allen relinquished her permanent substantive HP3 psychology position in Secure Mental Health Rehabilitation Unit (SMHRU), but not her permanency with Qld Health. She selected to undertake backfill of a psychology position in BAC, vacant as a result of parental leave. Negotiations are underway with Ms Watkins-Allen to secure a suitable HP3 level placement. As part of these negotiations, the need for comprehensive clinical handover has been noted as vitally important. Negotiations have resulted in agreement to offer Ms Watkins-Allens' employment at 0.5 FTE against the Specialist Clinical Supervisor position for 1 calender month to avoid disruption to specialist interventions and allow adequate clinical handover to occur.
   - **FTE in current budget build** 0.50 FTE
     <type here>
   - **Utilised FTE quarter by quarter last financial year and first quarter 2012–13** SEE ATTACHED
     <type here>
   - **FTE established permanently** 0.50 FTE
     <type here>
   - **Current financial position against budget** $56,784 UNDER EXPENDED AS AT 31/1/13
     <type here>
   - **Backfill for leave in budget (yes/no)** YES RECLEAVE BACKFILL ONLY 12/13
     <type here>
   - **Confirmation that service review has been discussed with Senior Manager**
     <type here>

Consultation
2. All signatures must be completed in sequence of authority. Sign off represents that due diligence has been attended by the signatory and that a review of current budget, operating position and service need has been undertaken in full.

Role	Name	Comment (endorsed / not endorsed / other detail to inform decision making)	Date
Line Manager	Lorraine Dowell	Endorsed	28/02/2013
Senior Manager	Tawanda Machingura	Endorsed	28/02/2013

MNSS 112.

West Wicklow Hospital and Health Service
INTERNAL BRIEFING NOTE

(If applicable)			
Business Manager	Laureance McDowell		28/2/13
Executive Director	Sharon Kelly	Supported	6/3/13
Executive Director Finance & Corporate	Ian Wrig	Recommend approval	7.3.13

Please forward completed internal briefing note along with the relevant EMP RTF Frontline or Non-Frontline form to Cheryl Cole, Turnaround Team at Workforce Planning, email address:

Queensland Government

West Moreton Hospital and Health Service
Establishment Management Program
Request to Fill a Vacancy – Frontline Position

PART A

[illegible]

[ ] Vacancy - Permanent
[ ] Extension of temporary employees, contractor or other arrangement
X Vacancy - Temporary
[ ] Higher Duties – extension
X Higher Duties - new

Is the position funded? X Yes [ ] No

Position Title: Specialist Clinical Supervisor	Position ID (where applicable): 30469313
Facility / Location: Barrett Adolescent Centre – The Park Centre for Mental Health	Division: West Moreton Hospital and Health Service

Position Classification (where applicable): HP4	Position Status: (perm, temp, casual, contractor) Temporary – Part-time	If currently vacant, how long has the position been vacant? Since 1/3/2013

Reason for vacancy:
Current employee is returning to her substantive position.

[illegible]

This position provides supervision to allied health working in the specialist field of Adolescent Mental Health. For the purpose of this proposed one month contract, this position will be providing highly skilled clinical services with a view to clinical handover of all clinical care within 1 month. This arrangement has been negotiated to avoid adverse clinical consequences associated with negotiations for Ms Watkins-Allen to secure a position in another part of the organisation secondary to having relinquished her permanent substantive position, but not her permanency with Qld Health. It is anticipated that this position will then be abolished as part of the turnaround plan.

[illegible]

Permanently	Temporarily X	Contractor	Start Date: 4/3/13	End Date:31/3/13

[illegible]

Surname:	First Name:	Person ID: (Where applicable)

[illegible]

Signature	Name (please print)	Position	Date
	Lorraine Dowell	Team Leader Non Secure Services	28/02/2013

[illegible]

Signature	Name (please print)	Position	Date
	SHARON KELLY	ED MHASS	6/3/13

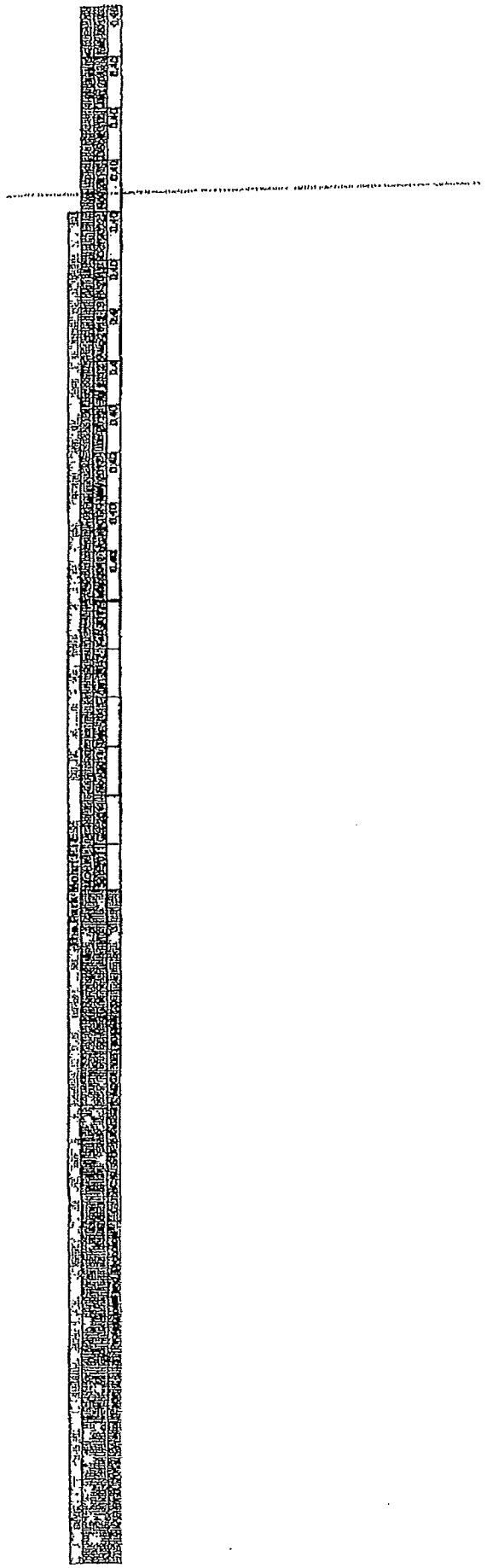
Please submit completed request for exemption to fill a vacancy form to: WMWorkforcePlanning@health.qld.gov.au

PART B

[illegible]

I support /do not support this request to fill this vacancy

Delegate Signature	Delegate Name	Position	Date
	Lesley Dwyer	WM HHS Chief Executive	8/3/13



Parameters:
Status:
Current Date:28/02/2013 2:47:54 PM
Username : mcdowell

Budget Position Internal Briefs

Queensland Government

Level 08 / Level 07	Actual	Budget	Budget Variance	YTD Actual	YTD Budget	YTD Budget Variance	Full Year Budget
Adolescent, Park							
Labour - Health Practitioners	26,370	48,607	22,237	279,936	336,720	56,784	578,244
Labour - General	5,455	3,808	-1,647	33,059	32,699	-360	57,006
Labour - Managerial & Clerical	5,267	5,866	599	35,157	41,456	5,299	72,728
Labour - Medical	34,703	13,343	-21,360	105,425	91,240	-14,185	162,716
Labour - Nursing	222,675	175,841	-46,834	1,365,299	1,466,751	101,452	2,604,379
Labour - Operations	1,118	11,787	10,669	66,582	84,583	18,001	149,607
Labour - Visiting Medical Officers	39,125	28,267	-10,858	186,721	210,785	24,064	365,545
Other Employee Related Expenses	2,165	2,356	191	13,135	18,413	5,278	32,290

Cube
Finance

Columns
Fiscal,Measures

Rows
Division QH_ALT_7,Account

Selected Members
Measures: Actual,Budget,Budget Variance,YTD Actual,YTD Budget,YTD Budget Variance,Full Year Budget
Account: All Descendants of Labour - Health Practitioners,Labour - General,Labour - Health Worker,Labour - Managerial & Clerical,Labour - Medical,Labour - Nursing,Labour - Operations,Labour - Professional,Labour - Technical,Labour - Visiting Medical Officers,Other Employee Related Expenses

From: Lorraine Dowell
Sent: 13 Mar 2013 10:31:44 +1000
To: Watkins-Allen, Georgia
Cc: Vella, Marcus;Phillips, Rachel;Natho, Scott;Machingura, Tawanda;Sadler, Trevor
Subject: Situation summary

Good morning Georgia ,

Thank you for speaking with me this morning.

Background:

I commenced in the position of Team Leader, Non Secure Services effective 18 February 2013. This role included operational line management of allied health positions in BAC.

Georgia, I understand your permanent substantive HP3 psychology position in SMHRU (then Medium Secure Unit) was relinquished, but not your permanency as a Qld Health employee, some years ago now. In the interim, your services have been engaged to backfill the vacant parental leave component of a psychology position in BAC at HP4. I note that recruitment to a temporary position held for more than 12 months was not undertaken.

The substantive employee of this position, Ms Danielle Corbett returned to this psychology position in a part time capacity effective 04/03/2013.

The need to locate a suitable position for yourself was identified.

You accepted appointment to the Specialist Clinical Supervisor Position, a known abolished position, extended for 1 month till 31/03/2013 to facilitated handover of complex care patients subsequent to a meeting held on 04/03/2013 with all psychology staff at BAC,the Psychology Discipline Senior at The Park, the District Director of Psychology and myself.

I acknowledge your comments to me this morning by phone, that you do not agree that clinical handover was agreed to at this meeting although an end date had been stated.

It is noted that you feel that 1 month is an inadequate amount of time to manage more complex consumers for whom handover of care would not be in their best interests. It is noted that you wish to continue to provide clinical services to consumers at BAC, despite there not being a position available after 31/03/2013.

Review Process

I acknowledge that you have expressed concern about the review process and the impact on the Specialist Clinical Supervisor position. I understand that as this position did not provide direct clinical services and was a generic supervisory position that could have been filled by any allied health discipline, there should not be an impact on available clinical psychological services. The current appointment to the Specialist Clinical Supervisor position for one month is in effect a short-term increase in clinical service availability.

BAC Review

It is noted that an outcome regarding the future location and service structure of BAC is not yet known. This is a stressor in addition to the local review processes. It is generally considered that The Park Centre for Mental Health with a large forensic representation, is not a suitable location for a service to vulnerable adolescents . It is noted that there are significant concerns with the building suitability and no funds available for refurbishment.

CYMHS Option:

I met and spoke with Catherine Lynch, Team Leader of CYMHS at a Financial Management Training session yesterday 12/03/2013. Catherine advised that they needed a psychologist (HP3) on board. It is unlikely that anyone appointed to this position would be permitted to continue to provide services to BAC. Catherine also advised that the service is in the process of establishing a single base at Ipswich Plaza. Goodna will not be a work site for much longer.

I appreciate your decision that travel for over 1 hour to the Plaza is not an option for you with your family commitments. You have declined the option of being considered for this position.

Other options:

HSIS - At this stage I am not aware of the outcome of discussions to have the HP3 position in HSIS retained at HP5.

EFTRU - Best advice that I have received is that there is considerable pressure for EFTRU to open this financial year. The proposed staffing profile for EFTRU includes a 0.8 FTE Psychology position @ HP3. At this point in time, this position has not been created and does not exist.

I understand that you have not been declared to be a surplus officer.

Request

Marcus, may I impose on you please for guidance for all stakeholders as to the process that now needs to be considered to support Georgia?

Scott may I request your ongoing professional support for Georgia and psychology staff providing services at BAC, to identify suitable transition planning processes that may include clinical handover at short notice should a suitable position become available for Georgia, temp contracts expire, or service relocation or closure need to be considered.

Georgia, I note your request for information to be provided to you in written form to avoid any confusion or misunderstanding. I hope this is helpful.

I believe that a clearly articulated managed plan that accommodates all the uncertainties in the current work environment may reduce any needless concerns.

Kind regards,

Lorraine Dowell
Team Leader Non Secure Services
The Park Centre for Mental Health

Ph: [redacted]

I

From: Georgia Watkins-Allen
Sent: 13 Mar 2013 13:46:47 +1000
To: Lorraine Dowell
Cc: Marcus Vella;Rachel Phillips;Scott Natho;Tawanda Machingura;Trevor Sadler
Subject: Re: Situation summary

Dear Lorraine

thank you for email. Due to the client load requiring my immediate care, I will separate out my responses from my immediate concerns about:
1) the appropriate care of the children at BAC as I am disappointed as I do not believe what has been detailed is an accurate representation, and
2) my Relinquished officer status.
Both of which I will provide feedback on Friday.

regards
Georgia

Georgia Watkins-Allen
Psychologist
BAC
The Park Centre for Mental Health

>>> Lorraine Dowell 3/13/2013 10:31 am >>>
Good morning Georgia ,

Thank you for speaking with me this morning.

Background:

I commenced in the position of Team Leader, Non Secure Services effective 18 February 2013. This role included operational line management of allied health positions in BAC.

Georgia, I understand your permanent substantive HP3 psychology position in SMHRU (then Medium Secure Unit) was relinquished, but not your permanency as a Qld Health employee, some years ago now. In the interim, your services have been engaged to backfill the vacant parental leave component of a psychology position in BAC at HP4. I note that recruitment to a temporary position held for more than 12 months was not undertaken.

The substantive employee of this position, Ms Danielle Corbett returned to this psychology position in a part time capacity effective 04/03/2013.

The need to locate a suitable position for yourself was identified.

You accepted appointment to the Specialist Clinical Supervisor Position, a known abolished position, extended for 1 month till 31/03/2013 to facilitated handover of complex care patients subsequent to a meeting held on 04/03/2013 with all psychology staff at BAC,the Psychology Discipline Senior at The Park, the District Director of Psychology and myself.

I acknowledge your comments to me this morning by phone, that you do not agree that clinical handover was agreed to at this meeting although an end date had been stated.

It is noted that you feel that 1 month is an inadequate amount of time to manage more complex consumers for whom handover of care would not be in their best interests. It is

From: Paul Clare
Sent: 21 Mar 2013 07:23:30 +1000
To: Rachel Phillips;Georgia Watkins-Allen;Lorraine Dowell;Scott Natho;Tawanda Machingura
Subject: Meeting Summary 20/03/13

Hello,

The following is a summary of discussion in a meeting between Georgia Watkins-Allen, Psychologist, Scott Natho, Allied Health Senior- Psychology and Paul Clare, Allied Health Team Leader Secure Services.

Wednesday 20 March 2013

A meeting was arranged for the purpose of:

- finalising paperwork to enable Georgia Watkins-Allen to transfer to Secure Mental Health Rehabilitation Unit (SMHRU)
- identifying a commencement date for this role.

Paul Clare outlined the twofold purpose of the meeting and acknowledged that while the transfer paperwork was to reflect a date of 1 April 2013, the timing for commencing in this role would be based on the conclusion of an agreed handover period.

Georgia Watkins-Allen indicated that she intended to apply for a forthcoming EOI for a psychology position at Barrett Adolescent Centre (BAC) and that she had understood that she may be able to remain in the BAC role until this EOI was finalised.

Paul Clare and Scott Natho indicated that they did not understand this to be the case and that commencement in the SMHRU role was dependant on the conclusion of a handover period rather than the finalisation of a separate EOI process. They further outlined that as the timing and outcome of the EOI process are at this stage unknown the conclusion of a handover period would be the clearer time frame to plan for a transfer.

Scott Natho indicated he regarded a month as a sufficient period for a handover of clinical work in the BAC setting.

Georgia Watkins-Allen indicated she did not agree this amount of time would be sufficient owing specific clinical considerations in BAC and her caseload. She reiterated her understanding that a commencement date in the SMHRU role relied on the resolution of the EOI process and that she would decline to transfer to the position if she was expected to commence in the new role in SMHRU after a period of a month.

At the conclusion of the meeting Georgia Watkins-Allen indicated she was not prepared to accept the offer of transfer to Medium Secure and would reconsider her options.

Regards

Paul Clare
Allied Health Senior- Social Work
Team Leader Secure Services
The Park Centre for Mental Health

West Moreton Hospital and Health Service

From: Lorraine Dowell
Sent: 21 Mar 2013 08:14:32 +1000
To: Phillips, Rachel;Watkins-Allen, Georgia;Clare, Paul;Natho, Scott;Machingura, Tawanda
Cc: White, Kathryn;Vella, Marcus
Subject: Re: Meeting Summary 20/03/13

Thank you Georgia for meeting with Paul and Scott yesterday.

May I add some factors to the mix please....

- Georgia's current temp contract ends effective 31/03/2013. We must all be against a position number at all times. I am not prepared to exceed aft in the current turnaround climate. This matter needs to be resolved quickly

- Best advice from the Discipline Senior - Psychology is acknowledged and accepted

- It is not appropriate to disadvantage consumers in another service area

- Action will be taken to initiate an EOI process for the currently back-filled parental leave component of the Psychology position in BAC in the near future. Priority is currently being given to vacant, fully funded positions where consumer care is being disadvantaged by these vacancies. I am unable to commit to a timeframe for this process at this time.

May I seek a resolution to this situation by COB Monday 25 March 2013.

Employee Relations advice is requested please.

Kind regards,

Lorraine Dowell
Team Leader Non Secure Services
the Park Centre for Mental Health

>>> Paul Clare 21/03/2013 7:23 am >>>
Hello,

The following is a summary of discussion in a meeting between Georgia Watkins-Allen, Psychologist, Scott Natho, Allied Health Senior- Psychology and Paul Clare, Allied Health Team Leader Secure Services.

Wednesday 20 March 2013

A meeting was arranged for the purpose of:

- finalising paperwork to enable Georgia Watkins-Allen to transfer to Secure Mental Health Rehabilitation Unit (SMHRU)
- identifying a commencement date for this role.

Paul Clare outlined the twofold purpose of the meeting and acknowledged that while the transfer paperwork was to reflect a date of 1 April 2013, the timing for commencing in this role would be based on the conclusion of an agreed handover period.

"L"

From: Tawanda Machingura
Sent: 22 Mar 2013 11:55:56 +1000
To: Rachel Phillips;Georgia Watkins-Allen;Lorraine Dowell;Paul Clare;Scott Natho
Cc: Kathryn White;Marcus Vella
Subject: Re: Meeting Summary 20/03/13

Dear Georgia,
Many thanks for contacting me today, I can confirm that I will wait until close of business Monday 25/03/2013 for you to either accept or decline the offer.

Please note that as advised by the psychology senior you now need to start the handover process. We will extend your current contract until the 30th of April 2013 to allow for this to happen.

If you accept the offer you will then be expected to start work in SMHRU from I May 2013. Should you successfully secure a secondment after accepting the offer, you will then liaise with the concerned line managers as usual.

If you do not accept the offer then we will notify HR of your decision on 26/03/2013 who will notify the ERP team and you will then start meaningful duties in an appropriate part of our business from 1 May 2013 (this may not be BAU).

Many thanks
Tawanda

Tawanda Machingura
A/ Dir Allied Health & Community Mental Health Programs

West Moreton Hospital and Health Service
T:
Ipswich Health Plaza, 21 Bell St, IPSWICH QLD 4305. P. O. Box 878, IPSWICH, QLD

>>> Lorraine Dowell 3/21/2013 8:14 am >>>
Thank you Georgia for meeting with Paul and Scott yesterday.

May I add some factors to the mix please....

- Georgia's current temp contract ends effective 31/03/2013. We must all be against a position number at all times. I am not prepared to exceed aft in the current turnaround climate. This matter needs to be resolved quickly

- Best advice from the Discipline Senior - Psychology is acknowledged and accepted

- It is not appropriate to disadvantage consumers in another service area

- Action will be taken to initiate an EOI process for the currently back-filled parental leave component of the Psychology position in BAC in the near future. Priority is currently being

"m"

From: Georgia Watkins-Allen
Sent: 25 Mar 2013 16:49:12 +1000
To: White, Kathryn;Phillips, Rachel;Machingura, Tawanda
Cc: Millward, Alan;Green, Kathy;Vella, Marcus;Kelly, Sharon;Ashleigh Trinder;Corbett, Danielle;Dowell, Lorraine;Clare, Paul;Natho, Scott;Daniel, Susan;Stedman, Terry;Sadler, Trevor
Subject: ROS
Attachments: ROSletter2013.docx

Dear Tawanda, Rachel & Kathryn

Please Find Attached my letter in response as requested regards the MS position.
regards
Georgia

Georgia Watkins-Allen
Psychologist
BAC
The Park Centre for Mental Health

25/03/2013

Dear Tawanda Machingura, Katherine White, and Rachel Philips

RE: Georgia Watkins-Allen - Relinquished Officer Status (ROS)

While I fully appreciate the need to abolish my ROS as part of Q Health's broader reshuffle, I am seriously concerned about the significant and direct negative clinical impact this will have on specific BAC adolescents and on the unit as a whole. Consequently, although I have been asked to separate these issues, this provides a clinical conundrum which works against my professional best practice specific to appropriate clinical management for the following reasons.

I Summary of Current events

- I have been doing 1 half of the BAC psychology incumbents position for close to 8 years. During my first meeting with HR, Tawanda and Rachel on 27/02/2013 to discuss my ROS, I highlighted my concerns about the care of the adolescents I was treating if I were required to leave before adequate completion of the complex trauma work I am currently engaged in which I indicated would take up to a minimum of 6 months. I was directed to meet with my clinical senior on the 4/03/2013 to explore appropriate clinical care and time frame to enable handover of these highly complex severely traumatised adolescents to the incumbent. On 4/03/2013 I was informed that as surplus officer I was to be moved from the 1 half of the BAC psychology position and asked to sign and be placed temporarily against the abolished Supervisor position at BAC for 1 month. I understood this was to provide time to explore appropriate care options. However when I received a copy of the temporary movements form, 2 weeks later, the internal briefing note (written and dated 28/2/2013) which I had not seen indicated that I had agreed to hand over the primary therapeutic care of these adolescents by the end of March. At no point in this meeting was it discussed explicitly, nor would I have agreed, that a 1 month handover was an appropriate management of these adolescents as I had already indicated previously. I would have sought extended professional advice being concerned that my professional code of ethics would deem it negligent and unprofessional, and at worst derelict of my duty of care to these very ill adolescents.

II Main Points

- **A) Most importantly,** contextually, [redacted], with the fifth being grief and loss work. [redacted] To enable this level of work the details of abuse are treated as confidential and would be damaging and unethical to handover (excluding any immediate reportable concerns around safety). **Furthermore due to the entrenched fear that these young people have of disclosure they have explicitly identified fear that the individual (therapist) privy to these secrets and/ or themselves will be punished if revealed. Removal of their primary therapist would in effect be highly damaging before this work was completed as it would entrench this belief and significantly hinder any new therapeutic relationship.** In effect, to hand this work over in 1 month is

seriously poor clinical management and will set these young peoples' progress back by months at minimum and is likely to have serious short and longer term consequences on their recovery, reducing their quality of life significantly and further placing greater strain on their families and Q Health's services. The adolescents are already sensitised about loss of therapist because of the review of BAC's Model of Service Delivery and threat of closure.

- **B)** In relation to the above point, I have been informed that accepting the MS position as my substantive would require me to hand over my BAC clients within 1 month to commence clinical work with MS clients. I would then be eligible to apply for an EOI for the other half of the incumbents position at BAC and if successful in that application I would then have to handover the MS clients and start with a new set of BAC clients. In addition to the above, this would provide major disruption to both MS and BAC consumers and on these services as a whole.

III Other Clinical Considerations

(This is in response to recent clinical discussions with seniors around this process)

- **A)** While I am an experienced clinician and have the clinical skills to hand these vulnerable clients over to other skilled clinicians, if forced to, this goes against all best practice guidelines within my profession and within Q Health's directives specific to client centred focus. In effect it would be unethical and could be considered a further abuse of these young people's human rights.

- **B)** In all respect to my seniors specific clinical experience and skills set, I do not believe that they have full appreciation of the process identified above, as having worked in High Secure, Medium secure, community settings and private practice for greater than 14 years, it is only during my work at BAC in the last 8 years that I have developed this level of skill and understanding of developmental complex trauma with these highly vulnerable children. None of my clinical seniors during my time at BAC, to my knowledge, have been present first hand at our weekly case reviews or 6 weekly intensive Care Reviews to enable them this level of understanding with this specialised population of young people.

IV Broader BAC Issues

- **A)** Removing me from BAC at this stage would also have impact on a mandatory part of all the adolescents treatment as I have been the primary facilitator and designer, specific to BAC, of a Dialectical Behaviour Therapy Group (teaching Mindfulness, Emotion Regulation, Distress Tolerance and Interpersonal Effectiveness) run across the 4 terms over the last 6 year as a result of 4 high level training opportunities, 2 of which were provided by the founders own trained facilitators. While the current locum has co-facilitated the group with me she has never received any formal training and while the incumbent has training she has never run the group.

- **B)** While there is only 1 fulltime psychological position at BAC we have not yet had the social work position filled, further reducing therapeutic contact with 15 inpatients and 7 day patients. Removing my therapeutic capacity at this stage would leave more than 10 of these children without a primary therapist. These numbers of therapeutic contact are well below standard patient therapist ratios in similar units around Australia and over sea's.

- C) With such a small allied health staff, the adolescents at BAC will be significantly disadvantaged by the loss of the Supervisors position alone, yet even more so that its flow on effect is to lose its longest standing therapist after Dr Sadler.

- D) In final consideration, the Mental Health directive provided in January 2013 clearly stated that BAC is not to be considered in the broader reshuffle due to its own review process. While my ROS is a separate issue which I acknowledge needs to be managed effectively, if I am forced to move out of BAC before I have an opportunity to at minimum complete the complex trauma work which I have indicated would take effectively 6 months at minimum, it will have significant repercussion's on the unit as a whole.

Respectful Request

I respectfully and sincerely request that operational, clinical and broader key senior Q Health leaders, as I have C.C.'d into this email, to please seriously consider and action the best care for these young people. **I respectfully request that you provide me the opportunity to accept the MS substantive position without disrupting MS or BAC services by providing me the time to apply and be reviewed for the EOI placed against the other half of the BAC psychology incumbents position and only if unsuccessful to then handover the BAC consumers to take up the MS position within an appropriate clinical time frame. Please consider as I have repeatedly put forward the opportunity to provide me with 6 months to do the handover by keeping me in the present Supervisor role and then have me take the MS substantive position.** MS consumers would not be disadvantaged in this process as an EOI could be immediately actioned in their support. I make this request based on the full consideration of the issues identified above in my attempts to provide Q Health with my highest professional practice and to minimise further unnecessary distress to BAC, a unit already under significant organisational and clinical stress. **I will accept the MS position even if you are unable to accommodate the clinical time frame I request yet ask that the 1 month period start after the school holidays as many of the adolescents will not be at BAC or only on occasion for the holiday program which does not incorporate therapy time.** As a professional I must advocate for best practice for these vulnerable adolescents mental health treatment and to ask me to do anything less is to go against both Q Health's and the psychologist's code of ethics. I ask nothing less of you.

Sincerely

Georgia Watkins-Allen

"Human beings of all ages are found to be at their happiest and to be able to deploy their talents to best advantage when they are confident that, standing behind them, there are one or more trusted persons who will come to their aid should difficulties arise."--- John Bowlby (1973, p. 359 cited in Dependency in the treatment of Complex Posttraumatic Stress Disorder & Dissociative Disorders- Jrl of Trauma & Dissociation, 2(4), 79-116)

Please contact me for further clarification or discussion on any of these points.

c.c. Sharon Kelly, Trevor Sadler, Susan Daniel, Terry Stedman, Alan Mildwood, Kathy Green, Marcus Vella, Danielle Corbett, Ashleigh Trinder, Jacqueline Robinson & Together Union.