Queensland Health

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Mental Health Alcohol and Other Drugs Quality Assurance Committee

Triennial Report
September 2023

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Queensland Government

Mental Health Alcohol and Other Drugs Quality Assurance Committee:

Triennial Report September 2023

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An electronic version of this document is available at https://clinicalexcellence.qld.gov.au/priority-areas/safety-and-quality/quality-assurance-committees/mhaod-quality-assurance-committee.

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Establishment

The Mental Health Alcohol and Other Drugs Quality Assurance Committee (MHAODQAC; the Committee) was established as a quality assurance committee by the Director-General of Queensland Health in September 2017, pursuant to Part 6, Division 1 of the Hospital and Health Boards Act 2011.

Committee Functions

The purpose of the MHAODQAC is to improve the safety and quality of public mental health alcohol and other drug (MHAOD) services through exercising the following functions:

- Obtain and review Queensland Health data on critical incidents as defined under relevant Chief Psychiatrist policies, including suspected suicides, and homicides of and perpetrated by a person with a mental illness, serious acts of violence, serious adverse clinical incidents and significant incidents involving consumers of public mental health, alcohol and other drugs services, to identify trends and system level improvements.
- Monitor and review qualitative and quantitative clinical and other information, including investigation documents (for example coronial reviews), as required, from relevant departments and entities to identify trends and system level improvements.
- Maintain confidential clinical data, reports and findings in a secure and confidential manner.
- Make recommendations to the Minister for Health on policy, standards, guidelines and quality improvement for public mental health, alcohol and other drugs services with the intent of improving patient safety and the quality of public sector mental health alcohol and other drugs services.
- Monitor the implementation of MHAODQAC recommendations.
- Guide and promote quality improvement activities by working in partnership with appropriate statewide, national, international key stakeholders, professional bodies and networks.
- Establish sub-committees to collect data/information, consider and make recommendations (where necessary).

Key achievements

Learning From Incidents Initiative

Queensland Health MHAOD services demonstrate a robust clinical incident management reporting culture and a commitment to prevent clinical incidents across the continuum of care. MHAOD services report a large number of incidents in comparison to other health service settings, which may focus primarily on the inpatient environment. The MHAOD service context has the added complexity of inclusion of suspected suicides in both community and inpatient settings and at times alleged homicides or other serious acts of violence under the category of clinical incidents. Increasing numbers of suspected suicides which impact upon clinical incident numbers in the MHAOD service context are recognised as a challenge nationally and internationally.

Given the high number of clinical incidents reported by services, together with dedicated focus on quality improvement, during the preceding triennial period the Committee directed its focus to strengthening and supporting clinical incident review by Hospital and Health Services (HHSs) and improving the quality of systemic recommendations for improvement. The Committee undertook an initial program of work, the Learning from Incidents Initiative, to enhance HHS capability to effectively undertake clinical incident reviews.

During the initial triennial period, the Learning from Incidents Initiative involved two components:

- Governance and Process Self-Evaluation Questionnaire (G&PQ): one-off measure completed by HHS to review overall incident management practices, processes and governance structures
- Learning from Incidents Questionnaire (LFIQ): completed for each clinical incident analysis Report undertaken by HHS to self-assess the quality of clinical incident analyses and clinical incident analysis report.

The G&PQ was collected from participating HHSs and then an initial six-month tranche of LFIQ were collected and reported on in the inaugural triennial period. Some MHAOD services elected to continue to complete LFIQs for a further six-month tranche. The results were considered by the Committee and collated into summary reports which were distributed to the participating HHSs.

However, in the third tranche, only one HHS completed LFIQs. After this tranche this HHS advised the Committee that its ongoing participation in the initiative was unlikely to yield any further benefit to that already realised. This HHS reflected that it had been a useful exercise that assisted in the development of their clinical incident analysis processes and practices.

As the LFIQ was no longer in use by any HHS, the Committee decided to commence work to understand the perceived value of the LFIQ and barriers to engagement - both from HHSs that had not participated at all and from HHSs that had completed some LFIQs and then stopped.

LFIQ Engagement and Improvement

Initially feedback was sought by Committee members in their own HHSs and then via invitation to the MHAOD Senior Leadership Group. The Chair also invited Clinical Directors, Executive Directors and relevant stakeholders from each HHS to an individual meeting, with the exception of the HHS who had already provided feedback.

Representatives from 14 of 15 HHSs attended meetings with the Chair to discuss HHS engagement with the LFIQ. A number of themes were evident in the feedback provided.

Twelve of these 14 HHSs reported that they perceived there would be benefits to be gained from completing the LFIQ. The two HHSs who did not anticipate benefit from participating in the LFIQ noted that this was due to robust clinical incident management processes in place. Of note, both of these HHSs had submitted LFIQs during the first and second tranche although there was staff turnover over the duration of this initiative.

The HHSs who had not participated in the Learning from Incidents Initiative provided one of the following responses as explanation:

- lack of awareness of the initiative, indicating that the initial communication strategy may have been ineffective in some instances (50% of respondents);
- lack of capacity to engage in the LFIQ at the time, with some HHSs commenting that this was due in large part to the COVID-19 pandemic (30% of respondents); or
- staff turnover, which meant that those who may have been aware of the initiative had since moved on (20% of respondents).

Among those that had trialed the LFIQ, or reviewed prior to the meeting, the following specific concerns were noted regarding the LFIQ:

- possible subjectivity / inter-rater reliability of the assessment tool
- Patient Safety or Clinical Governance teams separate to MHAOD services lead clinical incident analysis, which may be perceived to be a barrier for the MHAOD service to identify whether the elements required by LFIQ were included if they were not explicitly stated in the clinical incident analysis report (e.g., multidisciplinary representation on review panel).
- although the LFIQ was developed based on evidence-based practice for clinical incident management, some elements of LFIQ scoring were perceived to be inconsistent with practice – for example it may not always be necessary or relevant to conduct a literature search to understand a clinical incident, but regardless this would lead to reduced proxy quality score. Other specific concerns of stakeholders were that elements included in the LFIQ were based on

assumptions such as that external representation is required for an effective review, or that a review may not always identify appropriate recommendations.

Finally, a number of HHSs indicated they were aspiring to embed Restorative Just Culture principles within their clinical incident management systems and would like to see a measure that was aligned with this.

Next steps

A further iteration of the Learning from Incidents Questionnaire (LFIQ-2) has been drafted, taking into consideration the feedback noted above, and has been circulated to HHSs for their feedback. This feedback will be incorporated and a final LFIQ-2 will be developed. The Committee will then issue this revised questionnaire to HHSs with the tool to use at their discretion, finalising the Learning from Incidents Initiative.

Data Sub-committee activity

The contributory role of mental illness and harmful substance use in the commission of problematic and criminal behaviours has long been recognised. A question often raised and explored in cases of homicide / attempted homicide is the role of mental illness and an individual's mental state. Those charged with homicide / attempted homicide may have a history of contact, or come into contact, with Queensland Health mental health services, including Court Liaison Services, for the purposes of mental state assessment and diversion. Despite the seriousness of these offences and the importance of determining the role of an individual's mental health (if any) in their offending, this information is not currently available in a synthesised form to HHSs, nor at a statewide level. MHAOD services play a primary role in mental health assessment and treatment, both in risk mitigation as well as in the provision of services to those in the criminal justice system with mental health needs. It was determined that the MHAODQAC was in a unique position to collect and synthesise this data to support HHS's with risk assessment responses, including supporting and informing staff learning and development.

The data sub-committee is exploring Queensland homicide related data, and is specifically interested in exploring:

- The prevalence of homicide related offences among persons with mental disorder in Queensland and temporality of contact with public mental health services (pre and post index offence)
- Trends over time by HHS and subgroups (e.g. age, gender); whether the case was open/recently closed prior to the offence, regionality and treatment location (e.g. community vs inpatient), clinical features, and Mental Health Act status
- The examination of relationships in those charged with homicide/attempted homicide between socio-demographic, clinical, and other variables of interest.

An initial attempt was made to capture homicide / attempted homicide data via direct identification of cases by staff of the statewide Court Liaison service. However, two issues, the 1) infrequency of these offences and 2) reliance on staff initiating a data collection process, raised concerns regarding the level of confidence in, and quality of, the data captured. Further, a longitudinal approach was required to analyse and identify longer term trends in this offence type.

To enable a more comprehensive and reliable collection of longitudinal data, the sub-committee obtained data extracts from the statewide MHAOD clinical record Consumer Integrated Mental Health and Addictions application (CIMHA) covering the five-year period comprising financial years 2015-2016 to 2020-2021. The Committee is currently seeking to extend this data set by adding cases captured during the 2021-2022 year. The use of CIMHA has also ensured that any cases of homicide / attempted homicide having contact with the public mental health system in Queensland have been captured and minimised the duplication that can occur where data is extracted from multiple data sources.

Data variables extracted for the period above include:

- Consumer related variables (e.g., demographics, diagnostic variables, indigenous status)
- Offence type
- History of mental health service contact (e.g. any history of service episodes or referral, date/time (where available) of last contact (prior to offence date), and date/time seen on date of offence.

The sub-committee has developed a data analysis procedure with plans to finalise and report back to the Committee over the coming six-month period.

Communiques

Each HHS undertakes an independent review of Severity Assessment Code (SAC) 1 incidents, in compliance with the *Hospital and Health Boards Act 2011*. However, the lessons learned and recommendations from these incident analyses are not routinely shared between HHSs. The identification and sharing of lessons learned and themes forms part of the MHAODQAC work plan. The approach adopted was to conduct a thematic analysis of SAC 1 reports and prepare a communique for dissemination among HHSs.

The second in a planned series of Sharing Lessons Learned communiques was distributed on 18 August 2022. It highlighted a key theme emerging from the incident reviews that a number of consumers of MHAOD services who have died by suicide had co-occurring persistent pain conditions. The communique shared some relevant literature and provided improvement suggestions for services working with consumers with co-occurring mental health and persistent pain conditions.

Summary of activities and outcomes

Year 1: September 2020 – August 2021

The Committee met nine times between September 2020 and August 2021. During the first year of the second triennial period of the Committee, the Committee engaged in recruiting, selecting and appointing new members. Seven charter members remained on the Committee and an additional 11 members were appointed, with robust lived experience representation. The Committee agreed to adopt a restorative just culture frame of reference for its activities. Specific activities and outcomes for Year 1 are summarized in Table 1.

Table 1 Year 1 activities and outcomes

Administrative activities
• Mental Health Alcohol and Other Drugs Quality Assurance Committee Triennial Report September 2020 published. • 2020 Triennial Review of Functions completed, endorsed by Committee, and sent to Patient Safety and Quality Improvement Service (PSQIS) who received it on behalf of the Director General, Queensland Health. • 2019-2020 Annual Activity Statement submitted. • Recruitment, selection and appointment of new members including consumer and carer-representatives. • Terms of Reference updated and agreed. • Deputy-Chair position established and written into Terms of Reference. A Deputy Chair was appointed from within the Committee. • Planning meeting held May 2021 to determine workplan priorities. • Application made to receive SAC1 incident reports from PSQIS.
Consultation activities
• XXXXX Hospital and Health Service – Following a review of a clinical incident, an HHS made a statewide recommendation for QAC to undertake audit and report on anti-ligature products utilized in mental health inpatient units across Queensland. The recommendation was discussed and reviewed by the QAC and then referred to the Deputy-Director General of Clinical Excellence Queensland and the Office of the Chief Psychiatrist (OCP) to action the intent of recommendation. • Patient Safety and Quality Advisory Committee – In response to a request from the Patient Safety and Quality Advisory Committee, the MHAODQAC provided information about strategic risks for the committee and suggestions on potential treatments across HHS and statewide. • PSQIS – At the request of PSQIS, the Committee reviewed the Best Practice Guide to Clinical Incident Management.
Work activities initiated and progressed in Year 1
• Learning From Incidents and Quality of Recommendations – Review of LFIQs completed between June 2020 to December 2020, results considered by the Committee and summary reports sent to participating HHSs. – OCP proposal for a series of learning-focused incident review forums to examine clinical care where care was provided by multiple HHSs and identify lessons and potential opportunities for improvement was endorsed by MHAODQAC. The proposal included QAC stakeholders to be invited to participate in this panel. – Subcommittee convened to determine way forward to LFIQ. The subcommittee identified that a key theme from the LFIQs reviewed to date identified quality of recommendations as a potential avenue for further exploration. • Support of the Review of the implementation of the Queensland Health 2016 suite of safe environments guidelines led by the OCP

- After the Committee provided support of the governance and informed the methodology and approach to the review of the implementation of the guidelines in the preceding triennial period, a final report was prepared by the OCP and tabled with the Committee for endorsement. The Committee prepared and circulated key messages to HHSs on the findings of this review.

- Culture
  - The Committee endorsed the inclusion of restorative just culture in the Terms of Reference and elements of the Workplan.
- Communication and Collaboration
  - Communication with the OCP to encourage consideration of the role of the OCP in promoting restorative just culture.
- Data
  - Clinical incident data from MHAOD services between 1 March 2017 to 31 August 2020, extracted from Riskman, was reviewed by the Committee. Riskman is Queensland Health's integrated information management system for workplace and clinical incidents. The Committee reviewed collated data relating to incidents that were Severity Assessment Code 1 and 2.
  - Suspected homicide and serious acts of violence
    - A proposal was developed to evaluate the extent to which recommendations of the Queensland Sentinel Events review have been implemented and to review specific cases of suspected homicide or serious acts of violence to determine whether key implementation activities within the report were appropriately applied in those cases.
    - A data collection sheet for court liaison services was developed to capture charges of homicide and attempted homicide where a MHAOD consumer was involved.
  - Inpatient suicide events
    - Benchmark rates of suicide attempts per 1000 bed days across HHSs and amongst consumer groups with preliminary data collated and reviewed by the Committee.
    - A working group was established to determine ongoing data requirements for MHAODQAC.
- Communicating with HHSs
  - The MHAODQAC inaugural communique *Sharing of Lessons Learned* was circulated. The communique was distributed to the Executive Directors and Clinical Directors of MHAOD services across all 16 HHSs. This communique outlined the Committee's commitment to restorative just culture as it shares lessons learned from both positive and adverse events across HHSs. The communique also described the Learning from Incidents Initiative.

Year 2: September 2021 – August 2022

The Committee met on seven occasions during the Year 2 period, although only four of these meetings achieved quorum. This second year of the triennial period saw the Committee progress a number of workplan activities including publication of a Sharing Lessons Learned that detailed a trend identified in reviewing SAC1 incident reports, and a commitment to understand barriers to engagement in the Learning from Incidents initiative. Specific activities and outcomes from Year 2 are summarised in Table 2.

Table 2 Year 2 activities and outcomes

Administrative activities
• 2020-2021 Annual Activity Statement submitted • A self-evaluation of function was undertaken • Terms of Reference updated and agreed • The Deputy Chair resigned from the Committee. An internal expression of interest was undertaken but the Deputy Chair position was unable to be recruited from with the Committee. • Unsuccessfully tried to recruit a replacement for the role of deputy chair • The Committee agreed to move from four weekly to six weekly meetings to support member attendance.
Consultation activities
• Persistent Pain Network

- The Committee sought consultation from the Queensland Persistent Pain Network leadership prior to publication of the second Sharing Lessons Learned communique (see below) and then distributed the communique to the Queensland Persistent Pain Network following publication.

Work activities initiated, progressed or completed in Year 2

- LFIQ
  - The sub-committee undertook work aimed at exploration of barriers to engagement with the LFIQ and understanding how to increase engagement.
  - Members sought feedback from their own HHSs and the Chair met with the HHS that had completed the highest number of LFIQs before advising the Committee that they did not intend to continue using the measure. This meeting provided an opportunity for the HHS to provide feedback on the utility of the LFIQ.
  - A project plan developed to seek feedback from all HHSs
- Communicating with HHSs
  - The second MHAODQAC Sharing Lessons Learned communique was finalized and circulated in August. The communique described a trend in a series of SAC1 reviews undertaken by the MHAODQAC whereby a number of consumers of MHAOD services who died by suicide had a co-occurring persistent pain condition. The communique was distributed to the Executive Directors and Clinical Directors of MHAOD services across all 16 HHSs, other members of the MHAOD Senior Leadership Group, PSQIS and the Persistent Pain Clinical Network.
- Culture
  - The OCP Legislation Unit was invited to present on Restorative Just Culture in Chief Psychiatrist Investigations
- Clinical Incident Data
  - The Committee began receiving and reviewing SAC1 clinical incident analysis reports from HHSs provided by PSQIS under legislative provisions of the HHB Act.
  - Project plan developed
  - Three data portfolios
    - Homicide – data set requested from Clinical Systems Collection and Performance Unit, MHAOD Branch
    - Riskman
    - SAC1 Incident Reports
      - Project plan developed to describe program of incident data collection and analysis to identify themes and learnings as well as to identify reports with high quality recommendations
      - Extraction tool utilized on clinical incident analysis reports identified co-occurrence of persistent pain and suicide leading to development of Sharing Lessons Learned described above.

Year 3: September 2022 – August 2023

The Committee met eight times during the third year. Membership attrition meant the Committee membership was reduced to nine members and the Chair. This diminished the capacity of the MHAODQAC to progress workplan items. Consequently, an Expression of Interest was distributed amongst MHAOD services with new members to commence at the beginning of the next triennial period. Specific activities and outcomes from Year 3 are summarised in Table 3.

Table 3 Year 3 activities and outcomes

Administrative activities

- 2021-2022 Annual Activity Statement submitted.
- Review of progress against workplan undertaken and Workplan 2022-2023 developed and endorsed.
- Membership Expression of Interest

Consultation activities

- HHS

- The Committee sought feedback from HHS MHAOD leadership regarding effectiveness of second Sharing Lessons Learned communique and invited HHSs to provide requests for further communique topics.

- Patient Safety and Quality (formerly PSQIS)
  - A number of Committee members participated in a review of all Quality Assurance Committees commissioned by Patient Safety and Quality and undertaken by Deloitte

Work activities initiated, completed or progressed in Year 3

- Data
  - Homicide/Attempted Homicide
    - Data extract of CIMHA homicide and attempted homicide for preceding six financial years received and analysis commenced.
  - SAC1 Clinical Incident Reports
    - Project plan developed for review of defined group of SAC1 clinical analysis reports.
- LFIQ
  - An agenda paper was tabled at the MHAOD Senior Leadership Group meeting to seek feedback regarding HHS implementation of the LFIQ and barriers to engagement. An HHS staff member with considerable experience with the LFIQ attended to discuss their experience with MHAOD senior leaders. No feedback received.
  - The Committee Chair invited senior leaders and relevant delegates to individual meetings to discuss their HHS experience with the LFIQ and barriers to engagement. These were attended by 14 out of 15 HHS (one did not attend).
  - Based on feedback obtained from HHS meetings, a revised LFIQ-2 was proposed and circulated for consultation.

Privacy Policy

- Members of the MHAODQAC receive information that is clinically confidential, has privacy implications or may be commercial in confidence. All members of the MHAODQAC acknowledge their responsibility to maintain confidentiality of information by signing a Department of Health privacy and confidentiality statement /non-disclosure agreement.
- Pursuant to s.23 of the *Hospital and Health Boards Regulation 2012*, MHAODQAC adopts, by resolution, a written privacy policy.
- Members of MHAODQAC and relevant persons are prohibited from making a record of, divulging or communicating to any other person, information obtained in the course of their involvement in the MHAODQAC activities, unless this is undertaken for the sole purpose of enabling MHAODQAC to perform its functions.
- Data and/or information released by MHAODQAC while performing its function will not disclose the identity of an individual who is a provider or recipient of mental health alcohol and other drugs services.

Current Membership

The Committee's members were selected to reflect the diversity of services, geographical regions, disciplines, professional groups, consumers and carers and other stakeholders involved in the operation of public mental health alcohol and other drugs serivces and patient safety and quality programs.

Name	Role	Position	Qualifications	Experience relevant to the Committee functions.
Dr John Reilly	Chair	Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch, Clinical Excellence Queensland, Department of Health	MB, BS, DPM, GradDipEpid and Biostats, FRANZCP	Psychiatrist with experience in mental health legislation and mental health alcohol and other drug service clinical governance.
Ben Freedman	Member	Patient Safety Officer, Townsville Hospital and Health Service	Master of Conflict Management and Resolution, Bachelor of Social Work.	Allied Health Clinician with experience in patient safety and quality, clinical governance, workforce culture, and investigating and analysing high risk clinical incidents.
Paul Inglis	Member	Consumer Representative, Health Consumers Queensland	Certificate 4 in Mental Health Work, Certificate 4 in Mental Health Peer Work, Diploma of Professional Counselling, Bachelor of Human Services (current studies)	Consumer representative with experience working with consumers of government and non-government mental health services; membership on a range of Committees and Groups.
Carmen Delaney	Member	Project Officer, Zero Suicide, North West Hospital and Health Service	Bachelor of Education, Bachelor of Community Welfare and Social Work.	Consumer and carer representative with experience planning, developing, implementing and evaluating strategies to support recovery-oriented systems of care; representation on various groups and committees.
Dawn Miller	Member	Director, Mental Health Alcohol and Other Drug Services, Torres and Cape Hospital and Health Service	Diploma in Mental Health Nursing	Nurse with experience working in clinical, leadership and quality and safety positions within regional mental health alcohol and other drugs service.
Dr Thomas John	Member	A/Deputy Clinical Director, Gold Coast Hospital and Health Service	MBBS, MD, FRANZCP	Psychiatrist with experience in general adult psychiatry, rural and remote mental health alcohol and other drugs service delivery, clinical governance, medical leadership.
Tim Lowry	Member	Statewide Program Coordinator, Forensic Liaison Officer Network and Community Forensic Outreach Services, QLD Forensic Mental Health Service	MClinPsych, DPsych, MFMH, MPH	Forensic and Clinical Psychologist with experience working across metropolitan and regional/remote mental health alcohol and other drug services, staff performance, and development and review of clinical incidents both internally and externally to the health service.

Name	Role	Position	Qualifications	Experience relevant to the Committee functions.
Luisa Taituha	Member	Carer Representative, Health Consumers Queensland		Carer representative with experience working with consumers and carers via support groups and within a Hospital and Health Service as well as involvement as consumer and carer representative on recruitment panels.
Eliza Valentine	Member	Consumer Representative, Health Consumers Queensland		Consumer representative with experience working with consumers as a Peer Worker and involvement in various advisory and operational committees.
Graham Hall	Member	A/Director, Analytics and Systems, Patient Safety and Quality	BHMSC, GDipNutDiet, GDipIT	Experience managing datasets, data and reporting, clinical incident management reporting.

Retired Members (September 2020 to September 2023)

Name	Role	Position	Qualifications	Experience relevant to the Committee functions.
Dr Ankur Gupta	Member	Clinical Director, Mental Health and Specialised Services, West Moreton Hospital and Health Service	MBBS, F.R.A.N.Z.C.P (elect) CCT (Adult and Liaison Psychiatry, RCPsych) MRCPsych	Psychiatrist with a background working in acute mental health service settings and experience in patient safety, mental health service management, evaluation and improvement, clinical governance, clinical incident review.
Assoc Prof Balaji Motamarri	Member	Director Medical Services, Metro South Hospital and Health Service	MBBS, MD (Psychiatry), F.R.A.N.Z.C.P.	Psychiatrist with experience in clinical governance, patient safety and quality, change management, and medical administration.
Diana Grice	Member	Director of Nursing, Gold Coast Hospital and Health Service	Master of Healthcare Leadership, Postgraduate Forensic Psychiatric Care Certificate.	Registered Psychiatric Nurse with experience in clinical incident management and initiatives to support improvements in mental health service clinical governance, quality and safety.
Donna Bowman	Member	Operations Manager, Metro North Hospital and Health Service	Master of Education (Leadership), Bachelor of Health Science (Nursing).	Registered General and Mental Health Nurse with experience in mental health service delivery, education, management and quality; experience with critical incident governance and review through involvement on a range of committees.
Joanne Stitt	Member	Director of Allied Health Services, Allied Health Services Division, Townsville Hospital and Health Service	Graduate Certificate in Clinical Education, Postgraduate Diploma of Clinical Psychology Bachelor of Psychology with Honours	Psychologist with experience in clinical service provision, clinical education, professional leadership and management roles; experience with a range of mental health populations across multiple service settings and contexts.

Name	Role	Position	Qualifications	Experience relevant to the Committee functions.
Kelvin Lindbeck	Member	Director, Systems and Support, Patient Safety and Quality Improvement Service, Clinical Excellence Queensland, Department of Health	Master of Health Administration, Master of Science (Nutrition, Food Management), Graduate Diploma Dietetics, Bachelor of Education – Sciences (Biochemistry, Chemistry)	Experience managing datasets, data and reporting, risk management, clinical incident management reporting.
Mark Scanlon	Member	Nursing Director, Division of Mental Health and Alcohol and Other Drugs Service, Mackay Hospital and Health Service	Registered Nurse (Division 1), Graduate Certificate in Public Sector Management	Registered Nurse with experience in acute mental health and clinical incident management and review processes.
Melissa Pietzner	Member	Consumer Representative		Consumer representative with experience representing consumer voice on a number of Lived Experience advisory groups, steering committees and reference groups.
Richard Spence-Thomas	Member	Director, Psychology, Sunshine Coast Hospital and Health Service	Master of Clinical Psychology, Psychology Honours, B. Soc. Sci. Psych, Step-Up Queensland Health Leadership Development	Clinical Psychologist with experience in operational leadership and clinical service provision across the mental health services, including: acute care teams, forensic services, alcohol and other drug services, rehabilitation psychiatry and private practice and consultancy.
Dr Roanna Byrnes	Member	Clinical Director, Adult Mental Health Services, Townsville Hospital and Health Service	MB BCh BAO, LRCP&SI, MRCPsych, FRANZCP	Psychiatrist with experience in general adult psychiatry, regional mental health alcohol and other drugs service delivery, mental health legislation and medical leadership.
Robyn Bradley	Member	Executive Director, Mental Health and Specialised Services, Wide Bay Hospital and Health Service	Bachelor of Applied Science, Occupational Therapy, Commenced Units towards Master in Health Management	Occupational Therapist with experience as Deputy Chair for a quality review committee for significant incidents, resulting in policies and processes to support service improvement.
Ruth Heather	Member	Service Group Director, Rural Hospitals Service Group, Townsville Hospital and Health Service.	Master of Development Studies (Community), Post Graduate Diploma of Health Management, Registered Midwife, Registered Nurse with Current Practicing Certificate: Diploma of Comprehensive Nursing (including mental health)	Registered nurse with experience examining and using case data to inform the development of quality initiatives and full-scale system reform projects and programs; experience leading, initiating and implementing system and service reform.

Name	Role	Position	Qualifications	Experience relevant to the Committee functions.
Dr Sean Hatherill	Member	Clinical Director, Child and Youth Mental Health Academic Clinical Unit, Metro South Hospital and Health Service	MBChB, MRCP (Paediatrics), MRCPsych, FCPsych, Cert Child Psych, MPhil, FRANZCP	Psychiatrist working in child and youth mental health with experience with quality improvement in mental health service delivery.
Bob Green	Member	Program Co-ordinator, Statewide Community Risk Management Program	BA, DipTeach, BSW, MSW, PhD	Social Worker with experience in general and forensic mental health across acute, community and inpatient service settings; experience in undertaking clinical incident reviews; and mental health alcohol and other drugs research.
Dr Isabel Wesdorp	Member	Consultant Psychiatrist, Court Liaison Service, Queensland Fixated Threat Assessment Centre	FRANZCP	Psychiatrist with experience in general adult and forensic service setting across the continuum of care; participation in the Sentinel Event Review Steering Committee; medical leadership.
Dr Paul Henderson	Member	Clinical Director, Mackay Mental Health Alcohol and Other Drugs Service Division, Mackay Hospital and Health Service.	MBChB, MRCPsych, PGCertME, FRANZCP	Psychiatrist with experience in acute and adult psychiatry in a regional setting; medical leadership; clinical governance and service improvement.
Margaret Hoyland	Member	Clinical Governance, Quality and Safety Program Manager	BA(Hons), MPsychClin	Psychologist with experience working in child and youth mental health; involvement in clinical incident reviews and clinical governance.