# Mechanical restraint

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General

The Mental Health Act 2016 (the Act) makes provision for a range of safeguards and restrictions in relation to the use of mechanical restraint in an authorised mental health service (AMHS) that promote the national and state priority of reducing and eliminating mechanical restraint.

Mechanical restraint is to be used as a last resort to prevent imminent and serious risk of harm to patients and staff, where less restrictive interventions have been unsuccessful or are not feasible.

It is an offence to use mechanical restraint in an AMHS other than in accordance with the Act.

The use of mechanical restraint for the transport and transfer of patients is governed by separate provisions of the Act and is outlined in the Chief Psychiatrist Policy - Transfer and Transport.

The following principles must be applied in the use of mechanical restraint:
- maintaining the safety, wellbeing and dignity of the patient is essential
- protecting the safety and wellbeing of staff is essential
- mechanical restraint should only be used for the minimum period of time necessary, and
- all staff actions should be justifiable and in proportion to the patient’s behaviour and broader clinical context.

Scope

This policy is mandatory for all authorised mental health services (AMHSs). An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act must comply with this policy.

This policy applies to the use of mechanical restraint in an AMHS. Separate provisions of the Act apply to the use of mechanical restraint to transport a person.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.
This policy must be implemented in a way that is consistent with the objects and principles of the Act.

Policy

1 Application of the mechanical restraint provisions

Key Points

Mechanical restraint is the restraint of a person by the application of a device to the person’s body, or a limb of the person, to restrict the person’s movement.

Mechanical restraint does not include:

- the appropriate use of a medical or surgical appliance in the treatment of physical illness or injury, or
- restraint that is authorised or permitted under another law

The mechanical restraint provisions of the MHA 2016 may only be applied to a relevant patient in an AMHS.

A relevant patient is:

- An involuntary patient in an AMHS, subject to a Treatment Authority, Forensic Order or Treatment Support Order, or
- A person who is absent without permission from an interstate mental health service and who has been detained in an AMHS.

Mechanical restraint under the Act cannot be applied to anyone who is not a relevant patient. For example:

- patients who are detained for examination or assessment,
- patients accessing services voluntarily, or
- with the consent of a substitute decision maker.

Mechanical restraint may only be used in an AMHS if:

- the AMHS is a high security unit, or
- the AMHS has been approved by the Chief Psychiatrist as a service that is authorised to use mechanical restraint

The mechanical restraint device to be used must also be approved by the Chief Psychiatrist.
Any use of mechanical restraint on a relevant patient in an AMHS, including use under another authorising law, must be recorded in CIMHA. The Administrator of the AMHS must ensure that procedures are in place within their service to ensure these records are maintained.

Movement in and out of restraint must be documented in the Restraint Record which must be attached to the Authorisation of Mechanical Restraint.

Mechanical restraint must not be used:
- as a substitute for other less restrictive interventions
- as a form of discipline or punishment
- as a substitute for adequate staffing levels
- as a substitute for staff training in crisis prevention and intervention to manage aggressive, harmful behaviours, or
- when seclusion is being used simultaneously.

In determining whether the use of mechanical restraint is to be administered under the Act or permitted under another law (e.g. in complex cases where both psychiatric and medical treatment are required) consideration should be given to:
- if the person's impaired capacity is a result of their mental illness,
- whether mechanical restraint is required to administer a treatment for the person's mental illness or to address another medical issue or condition.

If the decision to use mechanical restraint is made under other legislation or alternate decision-making processes, evidence of the rationale for action taken must be well documented.

Hospital and Health Services should have local policy and procedures available for restraint provisions under other legislation or alternate decision-making processes.

1.1 Application and approval of mechanical restraint

Note: An Application for Approval of Mechanical restraint is considered on a case-by-case basis with consideration given to the facility, device and appropriateness of use under the individual circumstances. Each use of mechanical restraint under an approval requires authorisation by an authorised doctor (see section 4).
Key Points

The Chief Psychiatrist **must** approve all authorisations of mechanical restraint.

The Clinical Director of the service should notify the Chief Psychiatrist by phone that the use of mechanical restraints is proposed.

An **Application for Approval to Use Mechanical Restraint** must then be sent to the Chief Psychiatrist. The application **must** be completed by an authorised doctor and include:

- the name of the relevant patient
- details of the person's mental condition, including diagnosis and current treatment
- the purpose of mechanical restraint
- reasons that the authorised doctor believes there is no other reasonably practicable way to protect the patient or others from physical harm
- the way in which the patient will be continuously observed
- any proposed limitations on the use of mechanical restraint (for example, maximum time periods proposed by the doctor)
- the name of the AMHS in which the mechanical restraint will be applied
- a description of the mechanical restraint device to be applied
- the proposed period for which the approval is sought (not more than **seven (7) days**).

The Chief Psychiatrists approval is provided on the **Application for Approval to Use Mechanical Restraint**.

Approval provided is specific to the matter outlined in the application and is assessed on a case-by-case basis. The approval provided covers:

- the AMHS facility,
- the device specified in the application, and
- its use on the relevant patient the subject of the application.

The maximum period of approval provided by the Chief Psychiatrist is **seven (7) days**.

An application to the Chief Psychiatrist may be made verbally in certain circumstances. The Chief Psychiatrist may give verbal approval if urgently required.

- An application **must** be sent to the Chief Psychiatrist **as soon as practicable** after verbal approval is granted.
- The application **must** note that verbal approval was given.
1.1.1 Approved devices

The Chief Psychiatrist does not pre-approve any devices for mechanical restraint. Approval for a device will only be given if it is the safest way to protect the patient or any other person from harm.

Under no circumstances will handcuffs be approved as a device for the purposes of mechanical restraint under the Act.

Key Points

The Chief Psychiatrist will consider the following, at a minimum, when determining approval of a device:

- the device is appropriate for the purpose
- the device is safe (e.g. no hard/abrasive/sharp edges)
- relevant staff have been provided specific training in relation to the use of the device, and
- the device is in good working order (e.g. not dated, dirty or broken).

1.1.2 Approved Facilities

Key Points

The Chief Psychiatrist will, at a minimum, consider the following factors about a facility in providing approval for mechanical restraint:

- appropriately trained staff are available within the facility
- continuous observation requirements can be met,
- immediate medical treatment can be provided if there is a concern,
- sufficient bedding, clothing, food and drink is available, and
- there is access to toilet facilities.
# 2 Authorisation of use of mechanical restraint

## Key Points

Where the Chief Psychiatrist has approved the use of mechanical restraint, an authorised doctor may then authorise the use of the mechanical restraint on the patient.

- Authorisation for mechanical restraint is given by completing the [Authorisation of Mechanical Restraint form](#). This form must be recorded on CIMHA.

An authorised doctor's authorisation for mechanical restraint must be based on a face-to-face medical review of the patient.

This review must occur even if consecutive authorisations are made by the same authorised doctor.

Services must adopt evidence-based and best practice approaches to safely reduce and, where possible, eliminate the use of mechanical restraint.

The use of mechanical restraint can cause significant and lasting distress and injury to both patients and staff. The potential harmful effects of mechanical restraint must be balanced against the risk of harm of the behaviour in question.

## 2.1 Context for appropriately introducing mechanical restraint

When using mechanical restraint under the Act, staff must do all of the following:

- use verbal strategies, de-escalation techniques and other evidence-based strategies such as sensory modulation to help the patient safely gain control of their behaviour.

- be appropriately trained to protect the welfare, dignity and safety of the patient (training must include de-escalation strategies, trauma-informed care, recovery-oriented practice, de-briefing strategies and the use of relevant mechanical restraint devices).

- as far as practicable in the circumstances, explain to the patient the reason for mechanical restraint, what will happen during the mechanical restraint (such as clinical observations, access to food and drink, access to the toilet), and the circumstances in which the restraint may be removed.
2.2 Safety during restraint

- Ensure that no more physical force is used to apply mechanical restraint than is necessary and reasonable in the circumstances.
- Ensure the patient is in a safe body position at all times; a prone (face down) position must not be used, airways must not be obstructed and there must not be prolonged compression of the chest or abdomen.
- Ensure the patient is in safe clothing and that personal items do not compromise the safety of the patient or staff; where reasonable to do so, staff should also ensure the patient has access to physical aids they normally would use such as glasses, hearing aids or oxygen apparatus.
- Continuously observe the patient for indications of physical or mental distress; monitoring airway, breathing, circulation, skin integrity, body alignment and level of consciousness; for patients at additional risk, such as those who have been sedated, appropriate recording of oxygen saturation, pulse and blood pressure should be undertaken.
  - the use of CCTV is not a sufficient way to continuously observe a patient.
- Monitor patients where intramuscular or intravenous medication was administered within one (1) hour prior to the use of mechanical restraint or during the mechanical restraint and seek immediate medical treatment if there is a concern.
- Use added caution for patients with an underlying medical or neurological condition, who are intoxicated or have acute behavioural disturbance or ‘excited delirium’.
- Be aware of heightened vulnerability to significant psychological trauma from restraint, especially for minors, patients with a history of trauma, abuse or detention, and patients of Aboriginal and Torres Strait Islander backgrounds.

2.3 Post restraint

See section 4.2 for post restraint requirements.
2.4 Authorised doctor responsibilities

**Key Points**

The authorised doctor must be satisfied that:

- there is no other reasonably practicable way to protect the patient or others from physical harm
- the authorisation complies with the approval given by the Chief Psychiatrist
- the mechanical restraint complies with this policy, and
- the mechanical restraint complies with an approved Reduction and Elimination Plan (R&E Plan) (where a R&E Plan is in place).

The *Authorisation of Mechanical Restraint form* must include:

- the duration of the mechanical restraint, including start and finish times, which must not exceed **three (3) hours**
- specific measures to ensure the health, safety and comfort of the patient
- how the patient will be continuously observed while in mechanical restraint, and
- whether the health practitioner in charge of the unit may remove the patient from the mechanical restraint before the authorised period ends.

When authorisation for a period of mechanical restraint has expired, any further mechanical restraint requires a new authorisation.

A patient's total hours in mechanical restraint must not exceed **nine (9) hours** in a 24-hour period unless an approved Reduction and Elimination Plan is in place (see section 3).

Each authorisation must be completed on the *Authorisation of Mechanical Restraint* form and recorded on CIMHA.

2.5 Health Practitioner in charge of unit responsibilities

The health practitioner in charge of the unit must ensure that the application of mechanical restraint is documented on the Restraint Record which must be attached to the *Authorisation of Mechanical Restraint*.

The health practitioner in charge of the unit also has responsibilities to ensure the mechanical restraint authorisation is complied with. This includes:

- meeting observation requirements,
- ensuring any specific measures required by the authorised doctor for the patient's health and safety are carried out, and
• ensuring that a process is in place for tracking the amount of time a person is in mechanical restraints.

2.6 Restrictions on authorisation

Mechanical restraint must not be used on a patient in seclusion.

The maximum period for an authorisation of mechanical restraint is three (3) hours.

Consecutive authorisations may be made; however mechanical restraint may be applied for no more than nine (9) hours in a 24-hour period, unless a Reduction and Elimination Plan is in place (see section 3).

3 Reduction and Elimination Plan

A Reduction and Elimination Plan (R&E Plan) outlines measures to be taken to reduce and eliminate the use of mechanical restraint on a patient and to reduce the potential for trauma and harm.

The plan reinforces efforts to proactively reduce the use of mechanical restraint on a patient by ensuring clinical leadership, monitoring, accountability and a focus on safe, less restrictive alternatives to mechanical restraint.

3.1 Requirements for R&E Plan

Key Points

It is recommended practice for a R&E Plan to be in place in all instances where a patient is mechanically restrained, in particular where multiple instances of restraint occur.

An approved Plan must be in place for any patient who is mechanically restrained for more than nine (9) hours in a 24-hour period.

• Development of a R&E Plan should be initiated in advance if it is considered likely that the mechanical restraint of a patient could exceed nine (9) hours in a 24-hour period.

• An authorised doctor must apply to the Chief Psychiatrist for approval of a R&E Plan.
  o The Office of the Chief Psychiatrist will review the proposed Plan and make a recommendation to the Chief Psychiatrist about its approval.
  o The Office of the Chief Psychiatrist may contact the authorised doctor making the application for further information.
  o The Clinical Director and authorised doctor will be advised in writing of the Chief Psychiatrist's decision as soon as possible, but within two (2) working days of receiving the Plan

The Chief Psychiatrist may also direct, on his/her own initiative, that a R&E Plan be prepared for a patient.

• Where a direction is made, the treating doctor and relevant Clinical Director will be advised of this requirement via telephone and email.
The **R&E Plan form** is available within the MHA module in CIMHA.

- If the form is not completed on CIMHA, it must be completed manually and uploaded onto the patient’s CIMHA profile.

In urgent circumstances the Chief Psychiatrist may provide initial approval via email following a telephone discussion with the authorised doctor and receipt of an email from the authorised doctor containing:

- relevant clinical details regarding the patient,
- the reasons for use of mechanical restraint,
- the planned use of mechanical restraint and strategies for the reduction and elimination of use.

A full **R&E Plan** must be provided to the Chief Psychiatrist within **twenty-four (24) hours** of the email approval being provided.

A **R&E Plan** must not be approved for longer than **seven (7) days**.

- The timeframe for an approved plan cannot be extended.
- If a patient requires mechanical restraint over a period longer than **seven (7) days**, a new R&E Plan must be submitted to the Chief Psychiatrist for approval.

**Key Points**

A **R&E Plan** must be recorded on the patient's clinical file and must include the following details:

- the name and date of birth of the patient
- the name of the AMHS
- any previous use of mechanical restraint on the patient
- any strategies previously used to reduce the use of mechanical restraint on the patient and the effectiveness of the strategies
- a description of the behaviour that has led to the proposed mechanical restraint
- a description of significant risks to the patient or others
- the reasons that the authorised doctor believes there is no other reasonably practicable way to protect the patient or others from physical harm
- the proposed frequency and duration of mechanical restraint
- the strategies proposed to reduce and eliminate the use of mechanical restraint.

The approval of a **R&E Plan** does not replace authorisation of each individual period of mechanical restraint.

- An **Authorisation of Mechanical Restraint form** and a medical review must be completed by an authorised doctor every **three (3) hours**.
A single R&E Plan may apply to both mechanical restraint and seclusion. Only the Chief Psychiatrist may approve a R&E Plan that covers both seclusion and mechanical restraint, or mechanical restraint alone. Seclusion and mechanical restraint must not be used simultaneously.

4 Removal from mechanical restraint

Key Points

The authorised doctor must remove a patient from mechanical restraint prior to the end of an authorisation period if satisfied the mechanical restraint is no longer necessary to protect the patient or others from physical harm.

A health practitioner must remove a patient from mechanical restraint if:

- the authorised doctor has stated that a health practitioner may remove the patient from mechanical restraint before the authorised period ends in the Authorisation of Mechanical Restraint form, and
- the health practitioner is satisfied the mechanical restraint is no longer necessary to protect the patient or others from physical harm.

If the patient is removed from mechanical restraint prior to the authorisation ending, the restraints may be reapplied under the same authorisation if necessary, to protect the patient or others from physical harm.

- This movement in and out of restraint must be documented in the Restraint Record which must be attached to the Authorisation of Mechanical Restraint.

4.1 Removal from mechanical restraint on Chief Psychiatrist direction

The Chief Psychiatrist may also direct an authorised doctor or health practitioner in charge to remove a patient from mechanical restraint if satisfied the mechanical restraint is no longer necessary to protect the patient or others from harm.

- The authorised doctor or health practitioner in charge must comply with this direction.
- Reuse of mechanical restraint in these circumstances will require a new authorisation by an authorised doctor.
4.2 Requirements following mechanical restraint

**Key Points**

A medical review of the patient, including a physical examination if clinically appropriate and safe to do so, **must** be undertaken by an authorised doctor at the end of the mechanical restraint.

A review (or debrief) with the patient, and where appropriate their support person/s, **must** be undertaken as soon as is clinically appropriate after the mechanical restraint ends, in order to:

- enable open discussion about the restraint and the events leading to it,
- allow the patient to ask questions, and
- provide an opportunity to identify strategies that may assist in preventing the need for restraint in the future.

A review (or debrief) for all staff involved in the mechanical restraint of the patient **must** also be undertaken as soon as practicable after the mechanical restraint ends to evaluate:

- the triggers which resulted in the need to use mechanical restraint, and
- the methods used to respond to the need for mechanical restraint.

5 Notifications and recording

5.1 Notifications

**Key Points**

The administrator of the AMHS **must** ensure that processes are in place within the AMHS to ensure compliance with the notifications and recording requirements outlined in this policy.

The Chief Psychiatrist **must** be notified immediately where mechanical restraint results in, or is associated with:

- the death of a patient during or within **24-hours** following mechanical restraint of the patient, or
- significant harm to a patient or other person during mechanical restraint or within **24-hours** following mechanical restraint of the patient.

This notification process is in addition to the notification requirements contained in the Chief Psychiatrist Policy – Notification of Critical Incidents and Non-compliance under the Mental Health Act 2016.

Community visitors under the **Public Guardian Act 2014** may request information about the use of mechanical restraint on minors in an AMHS.
• AMHS staff **must** provide information as recorded under section 5.2 of this policy when requested by a community visitor (whether or not it is during or connected with a visit).

### 5.2 Recording

**Key Points**

Each time a patient has mechanical restraints applied, the health practitioner in charge of the unit **must** ensure the following information is recorded in the patient's clinical record on CIMHA:

- any current R&E Plan approved by the Chief Psychiatrist,
- the start and end times of each mechanical restraint event,
- the Authorisation of Mechanical Restraint form, and
- the Application for Approval to Use Mechanical Restraint.

Movement in and out of restraint **must** be documented in the Restraint Record which must be attached to the Authorisation of Mechanical Restraint.

In addition, the following information **must** be recorded in the patient's clinical record in CIMHA:

- the reasons for the mechanical restraint, including the events that led to the mechanical restraint,
- why there was no other reasonably practicable way to protect the patient or others from physical harm, including any strategies used to prevent the need for mechanical restraint,
- the patient's health at the time of the mechanical restraint, including signs of alcohol or other drug intoxication or withdrawal,
- the patient's behaviour during the mechanical restraint,
- whether physical restraint or seclusion directly preceded a mechanical restraint event,
- medications administered up to **one (1) hour** prior, during and immediately after the mechanical restraint,
- any adverse events related to the mechanical restraint (for example, injury to the patient or staff),
- the examinations that took place during and immediately after the mechanical restraint,
- the results of all medical reviews of the patient as required, and
- post-event review details.
Issued under section 273 of the *Mental Health Act 2016*.

Dr John Reilly  
Chief Psychiatrist, Queensland Health  
15 April 2020
## Definitions and abbreviations

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<th>Term</th>
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<tr>
<td>AMHS</td>
<td>Authorised Mental Health Service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.</td>
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<td>Approved device</td>
<td>A device approved by the Chief Psychiatrist that may be used under the MHA 2016 for mechanical restraint.</td>
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<td>CIMHA</td>
<td>Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.</td>
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<td>Clinical Director</td>
<td>Means a senior authorised psychiatrist who has been nominated by the administrator of the AMHS to fulfil the clinical director functions and responsibilities.</td>
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<td>Health Practitioner in Charge</td>
<td>A health practitioner in charge is any health practitioner with oversight, in control of or with responsibility for a given unit in an AMHS.</td>
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<td>HHS</td>
<td>Hospital and Health Service</td>
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| NSP           | Nominated support person - a family member, carer or other support person formally appointed by a patient to be their nominated support person. NSP rights include:  
  * must be given all notices about the patient that are required under the Act  
  * may discuss confidential information about the patient's treatment and care  
  * may represent, or support the person, in any hearings of the Mental Health Review Tribunal, and  
  * may request a psychiatrist report if the person is charged with a serious offence. |
| Patient       |  
  * An involuntary patient, or  
  * A person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under and Advance Health Directive or with the consent of a personal guardian or attorney. |
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<tr>
<th>Term</th>
<th>Definition</th>
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| Relevant AMHS administrator   | The relevant AMHS Administrator is:  
• the Administrator of the AMHS currently providing clinical services to the person, or  
• if the person is not currently receiving mental health services (i.e. no open service episode), the Administrator of the AMHS for the location where the person resides. |
| Support person/s              | Includes, a Nominated Support Person or, if the person does not have a Nominated Support Person, a family member, carer or other support person.                                                             |

**Referenced documents and policies**

- Chief Psychiatrist Policy – Management of Complaints about the Treatment and Care of Patients
- Chief Psychiatrist Policy – Notification of Critical Incidents and Non-compliance under the Mental Health Act 2016
- Chief Psychiatrist Policy - Transfer and Transport
- Guide to Patient Rights under the Mental Health Act 2016
- Form - Authorisation of Mechanical Restraint
- Form - Application for Approval of Mechanical restraint
- Form - Reduction and Elimination Plan (R&E Plan)
- The Hospital and Health Boards Act 2011
- Mental Health Act 2016
- Public Guardian Act 2014
- Guardian and Administration Act 2000
- Powers of Attorney Act 1998

**Document status summary**

- Date of Chief Psychiatrist approval: 15 April 2020
- Date of effect: 22 April 2020
- Supersedes version that took effect on: 5 March 2017
## Attachment 1: Key contacts

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<th>Key contacts</th>
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<th>Email:</th>
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<tr>
<td><strong>Office of the Chief Psychiatrist</strong></td>
<td>07 3328 9899 / 1800 989 451</td>
<td><a href="mailto:MHA2016@health.qld.gov.au">MHA2016@health.qld.gov.au</a></td>
</tr>
<tr>
<td><strong>Clinical Director</strong></td>
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<td></td>
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<tr>
<td><strong>Mental Health Administration Delegate</strong></td>
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<td><strong>Independent Patient Rights Adviser</strong></td>
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<td><strong>Local Aboriginal and Torres Strait Islander Cultural or Case work unit</strong></td>
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<td><strong>Multicultural Mental Health</strong></td>
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