Statement of Reasons

This is an edited version of the statement of reasons issued pursuant to section 756 of the *Mental Health Act 2016*. The patient and persons attending have been de-identified and, in some cases, may be allocated pseudonyms for privacy reasons. Other details that may lead to the identification of the patient may have also been modified or omitted. The modification or omission of these details does not affect its decision or its reasons for the decision.

Matter	Forensic Order (Disability) Review
Attendees	
Patient:	Attended
Patient's Legal Representative:	Attended
Psychiatrist:	Attended
Case Manager:	Attended
Attorney-General's Representative:	Attended
Other attendees:	Attended
Decision	The Forensic Order is revoked

The patient is an elderly man living independently and on his own in a regional town. There were two separate incidents precipitating the forensic order for review.

The patient was charged with assaulting his neighbour and later he was charged with assaulting his lawyer. Both assaults were alleged to have occurred in the context of the patient perceiving some conflict with the victims.

The Mental Health Court found the patient to be permanently unfit for trial regarding the assault of the neighbour. The Court accepted a submission from the parties at the hearing describing the making of the forensic order as '*overkill'*, but was of the view that there was no alternative, and that the patient was a risk to the community if unsupported. The Mental Health Court stated:

> *"It may very well be that if the treating psychiatrist is able to obtain an NDIS funding package and the patient is able to get some support through that means, the forensic order can be discharged fairly shortly on review in the Mental Health Review Tribunal."*

Unfortunately, as the treating psychiatrist explained to the Tribunal, the patient's age precluded him from access to the NDIS. He would have been a candidate for aged care supports however his functioning was high. At the time of this review, the only support he had been eligible for was some assistance with information technologies.

At a later date, the MHC amended the forensic order to include the assault charge involving the lawyer.

The patient attended this periodic review hearing. Upon his arrival he was not able to prove to the receptionist that he was vaccinated for Covid-19. He was initially denied entry to the building, until staff members who were familiar with him assisted to establish his vaccination status and brought him into the hearing room.

Following this, the Tribunal was required to delay commencing the hearing as the representative for the Attorney-General was appearing in another hearing that had run longer than expected. The patient then waited in the hearing room (with one of the case managers involved in a recent interaction described in the clinical report) and another staff member for about 20 minutes.

The patient was terse following these challenges, but calm. He listened to the members and expressed his views in a civil manner. He did not appear to become irritated by the clinical staff in the hearing room.

At the start of the hearing, the representative for the Attorney-General applied for an adjournment on the basis that the patient had not been reviewed by a doctor for more than 6 months. She reasoned that the evidence would therefore not be sufficient to support a revocation, which was the treating team's recommendation.

The treating psychiatrist gave evidence that she had deliberately not reviewed the patient herself. She said a decision was made at the last Assessment and Risk Management Committee (**ARMC**) meeting that the patient would not be required to have a medical review. The plan (supported by the committee, including a Community Forensic Outreach Service (**CFOS**) consultant psychiatrist) was to observe the patient in the community by case management and collect collateral information. The Tribunal noted that this unconventional approach had indeed been successful. The risk consistently remained low despite the team providing almost no clinical management.

The treating psychiatrist added that the mental state examinations in recent years have been 'exactly the same'. She noted that the examinations were very challenging for the patient. She told the Tribunal that she had full confidence in the case managers to manage the patient. She noted that the patient remained stable. She opined that an adjournment to require a medical review would not be the patient's interests and would not change her clinical report or her recommendation to revoke the order.

The patient's legal representative submitted that the hearing should proceed based on the evidence from the treating psychiatrist.

The Tribunal deliberated. The treating psychiatrist's evidence was accepted by the panel, and application for adjournment was refused. The Tribunal agreed that an adjournment for a medical review was unlikely to uncover any more evidence.

Statutory Framework

Appendix A to these reasons is a summary of the provisions of the *Mental Health Act 2016* (**Act**) that are relevant when the Tribunal reviews of a person's forensic order.

Clinical Report

The patient received the clinical report on 24 April 2022.

Matters to which the Tribunal must have regard

The Tribunal had regard to the factors in section 432 of the Act as follows.

The relevant circumstances of the person subject to the order

Mental State and Psychiatric History

The clinical report contains information about the history of the patient's mental condition. He has a diagnosis of major neurocognitive disorder. He underwent a left anterior temporal lobectomy for the treatment of seizures many years prior to the hearing. The seizures appear to have been caused by viral meningoencephalitis decades prior.

A significant personality change was noted following the surgery. He then had further seizures and sustained some head injuries because of the seizures. The patient was reviewed by a psychiatrist at the time. It was noted that he had experienced an accentuation of his preoperative behavioural traits, in particular an increase in aggressive outbursts, lowered mood, disturbed sleep and anxiety. He now has poor memory, recall and processing alongside other frontal lobe deficits including impulse control, irritability, and behaviour. However, this had not destabilised in the period prior to this hearing.

In the clinical report, the treating psychiatrist stated that the patient's acquired brain injury and deficits continue to be prominent features in his presentation, with ongoing poor memory and frontal lobe deficits. She stated that his poor memory of the index offences, confabulation about events and lack of reasoning skills with poor verbal comprehension have led to him becoming increasingly frustrated with the forensic order and anything associated with it.

Around the time the forensic order was first made, the treating psychiatrist held a more optimistic view about what her treating team could do to care for the patient given enough time. She said in an earlier clinical report:

> *"I would however hesitate at this time to revoke involuntary treatment which allows us to monitor his mental state and perhaps more importantly his social setting - it would not be appropriate for him to take on another lodger and we will need to monitor any emerging situation with his neighbours. With ongoing follow-up, it would be hoped that sufficient rapport and trust can be fostered to allow guidance in the event of any psychosocial stress emerging."*

Three years on, at this hearing, the treating psychiatrist explained that the medical reviews, Tribunal hearings and case manager contact had caused frustration for the patient. Limited rapport had been achieved. However, outside of the mental health service settings, the consistent collateral information obtained by the team suggested that the patient was calm and polite. When confronted with conflict in the community the patient's response had been to walk away.

This was consistent with the evidence of the case manager. He said that the patient did repair work for the local church, as well as for members of the community. There had not been any incidents outside of the team's own interactions with the patient. He was dealing directly with many different members of his local community daily, and without any support. The treating team were not aware of any incidents despite this. The Tribunal noted that this information was consistent with the treating psychiatrist's evidence that the patient's functioning was high. Performing home repairs for members of the community not otherwise known to him was identified by the Tribunal as an activity that would demand some level conflict resolution and reasoning on the patient's part.

The only evidence before the Tribunal indicating any elevation in risk in the last review period was the interaction that case managers had with the patient earlier in the year. A clinical note about that meeting appears in the clinical report. The patient was angry, oppositional, and he used course language. He did not make threats and was not noted to be aggressive. He calmed down quickly.

Intellectual Disability

The Tribunal noted the MHC's comments in the context of assessing his fitness for trial:

"…and I rather suspect that if someone was to go and examine the house renovations or how it is that he lives independently, that it would not be – I rather suspect he would not be living well…"

The evidence before the Tribunal at this hearing (some three years after the first forensic order was made) revealed that the patient's functioning had indeed been observed by the treating team to be high over the period of the forensic order. His skills in renovating remain engaged by his church and the wider community. He adequately cares for himself and requires no support to complete basic activities of daily living. He has managed to avoid further escalations of conflicts in the community over the last 4 years, despite being rather active within his community.

The team had achieved assessments of the patients' functioning while he was subject to the forensic order. A recent psychology report was attached to the current clinical report. It noted that *'his WAIS-IV performance did not vary from the (previous) cognitive assessment conducted'* The current clinical report referred to the patient cooperating with an occupational assessment which found that he was able to manage independently.

The evidence presented at the hearing persuaded the Tribunal that the patient was no longer a significant risk to others in the community because of his intellectual disability. He had established a routine that included ways of managing his deficits. He was active in the community on an almost daily basis which mostly involved volunteering his time to complete renovations or attending his church.

Social Circumstances, including, for example, Family and Social Support

From the clinical report, the Tribunal was aware that the patient is a divorced man with two daughters. One daughter lives overseas and his other daughter resides in a nearby town. The patient was said to complete his own cooking and shopping. He uses a diary to manage his memory difficulties.

The patient told the Tribunal that he does various voluntary repair work to the church he attends regularly. He also works on other homes in the community for people who request his services after hearing about his skills from 'word of mouth'. He was proud of the work he does which appeared to be both a protective factor as well as a demonstration of the patient's level of functioning in the community.

The patient's ex-wife was said to provide some emotional and financial support, though she lives remotely and has not seen the patient for many years. He also receives some support from an aged care provider to navigate information technology as needed. According to the treating team, this level of support in the community suited the patient's needs. The treating psychiatrist described him as *'an incredibly independent gentleman'*.

Response to Treatment and Care and the Person's Willingness to Receive Appropriate Treatment and Care. If Relevant, the Person's Response to Previous Treatment in the Community.

The patient does not receive treatment for a mental condition.

An intended function of the forensic order was to provide him with involuntary care to protect the community from him. However, it was clear from the evidence before the Tribunal that the treating team had been providing involuntary care in a very limited way, if at all. As the treating psychiatrist explained, attempts by the treating team to increase formal support in the community had been hindered by the patient's age and high level of functioning. He was not eligible for the types of services that the Mental Health Court might have reasonably envisaged. Further, the team had found meaningful engagement with the patient challenging due to his lack of understanding as to their role, and the role of the forensic order.

The patient did not see why he needed to attend appointments with mental health staff. He could not understand the forensic order or why it was in place. He was content with consulting his general practitioner and other health practitioners as required and had been doing so appropriately. There had been some communication between the treating team and the general practitioner. The treating psychiatrist said that the treating team would give the general practitioner a 'hand-over' if the forensic order was revoked.

The nature of the relevant unlawful act and the period of time that has passed since the act happened

The patient is alleged to have assaulted his neighbour as he believed the neighbour had sprayed herbicide on his plants. That assault involved pulling on the victim's shirt and then throwing a multi-tool at him.

Two years later, the patient attended an office demanding to see his lawyer about an account. The patient was aggressive and threatening towards his lawyer. He pushed the victim and slapped his face, then continued to threaten and abuse the victim. When another staff member entered the room, the patient left. He was subsequently charged with serious assault to a person over 60.

There had been no offending since the second index offence. The Tribunal noted that both offences occurred in the context of the patient's own perception of some conflict with the victims. The Tribunal also noted that the patient had no further contact with the victim of the first offence, and that he had not had any issues with his current neighbours. This was even though the patient told the treating team he did not like the trees that hung over his fence from his current neighbour's property.

There was also evidence that he had encountered the victim of the second offence in public and avoided any contact. This was self-reported to the treating team by the patient despite his clear preference to have no contact with them.

Summary of evidence and findings

Is the forensic order necessary, because of the person's mental condition, to protect the safety of the community, including from the risk of serious harm to other persons or property?

The oral evidence as to the patient's behaviour generally in the community was positive. Members of the community outside of the mental health service that the team had spoken to (including the aged care support worker) unanimously described the patient as a pleasant and friendly man. This included interactions with health staff *outside* of the mental health service. The Tribunal acknowledged that this 'collateral' gathered by the team was hearsay, however it was consistent with the overall picture of risk before the Tribunal. There had not been any incidents that would paint a different picture of the patient's behaviour in the community, outside of interactions with the treating team.

The treating psychiatrist explained that although the patient complies with the conditions of the order (other than engaging with the team), his compliance is incidental. The patient is not able to recall the conditions himself, however he wants to remain living alone in his current home (conditions 1 and 4), and he does not want to have any contact with the victim of the index offence (condition 3). The treating psychiatrist added that the patient disclosed seeing the victim in a public place and staying away 'of his own volition'. To that end, the treating psychiatrist was convinced that the patient's behaviour would not change if the order was revoked. From this evidence, the Tribunal struggled to find any risk that was actively or passively being mitigated by the conditions on the order.

It was clear that the patient was unwilling to accept any care directly from the mental health service. However, on balance, the evidence did not suggest that the patient required any particular care to protect the community from him.

Of course, the patient's treating team are also members of the community that may require protection from him. On that issue, the Tribunal was persuaded that the continuation of the forensic order would be the only reason that incidents such as that which occurred earlier in the year might be repeated. Further, that interaction with the case managers involved irritability and anger on the patient's part, but there was a lack of threats and aggression. His behaviour was rude and may have been frustrating for the case managers trying to perform their roles. However, his behaviour was not violent and did not appear to have placed the case managers at risk of harm.

The treating psychiatrist was asked by the Tribunal to speculate as to what type of unsafe incident might arise between the patient and another member of the community. She posited that an interaction may escalate if the patient was to deal with someone with a brain injury like himself. She qualified this by saying that the patient's *'natural tendency is to back down and apologise'*. She concluded that she did not think there was a risk of the patient acting aggressively in reaction to his misinterpretation of interactions in the community.

The Tribunal noted that this contrasted with the written opinion of the independent psychiatrist which was before the Mental Health Court which stated:

> *"I do feel that he may not be that willing to engage with services and lacks awareness of his limitations. Therefore, the future management of the patient is somewhat complex, and he does not fit a usual support model that is provided for clients with Intellectual Disabilities."*

It was not necessarily clear to the Tribunal as to why the patient's risk to the community had reduced over time. The best evidence before the Tribunal was the treating psychiatrist's assessment that the patient's establishment of a healthy routine including ways to manage his deficits had, over time, reduced the likelihood that he might react aggressively to his misinterpretation of interactions with others.

Additionally, the patient's progress over the last review period had been considered at the recent ARMC meeting, which included a CFOS psychiatrist. The committee concluded that "*[The patient's] treatment and care needs and risk to the safety of the community has significantly reduced to the point where he no longer requires the level of clinical management and oversight under a Forensic Order."*

The evidence presented at this hearing revealed that such risks of aggression had significantly reduced. Over time, the concerns underpinning the relevance of the forensic order have eroded.

The representative for the Attorney-General's primary submission was that the patient was breaching condition two of the order and was not receiving adequate supervision or care. She said that the patient *'remained a high risk of aggression and violence'*. She noted that the risk to the treating team (because the patient does not want to engage) is not relevant to the Tribunal's consideration of section 442. She said that the appropriate way to deal with an increase in risk to staff and the community may be an inpatient admission.

The legal representative for the patient confirmed that his patient held a limited understanding of the forensic order. He pointed to the lack of 'major concerns' raised in the community despite the planned reduction of support by the treating team. He pointed to the Mental Health Court's reasoning in making the forensic order. He noted that since then there have been no further concerns or risk to the broader community. He mentioned his client's well-structured routine and high functioning. He pointed to the lack of ongoing issues with neighbours and the victim of second

offence, despite seeing him around town. He said that the tribunal should follow the recommendation of the treating team.

On balance, the Tribunal was persuaded by the consistent body of evidence before the Tribunal that the patient presented a low risk to the community. The Tribunal was not satisfied that the forensic order was necessary to protect the community (including the treating team) from the patient. There was nothing to suggest that the patient's risk to the community would escalate if the forensic order was revoked, because the forensic order itself did not appear to be the reason for his ongoing stability. One reason put forward by the Attorney-General's representative in support of confirming the order was that it provides a structure for the care and support that the patient requires. That submission was difficult to accept because the overwhelming evidence before the Tribunal was that neither the forensic order or the treating team had any meaningful role in providing any care or support. It was limited to providing some supervision, which did little more than irritate the patient and assemble collateral evidence in support of revocation.

The Tribunal did not consider the order to be necessary to protect the safety of the community. In making this decision, the Tribunal noted that there is no other order or authority under the Act which would allow involuntary care to be provided to the patient. The Tribunal was satisfied that involuntary care was no longer required.

Human Rights

The patient's human rights were not limited by the Tribunal's decision to revoke the forensic order.

Conclusions of the Tribunal

For these reasons, the Tribunal revoked the forensic order (disability). No further orders were made.

Presiding Member

APPENDIX A

Statement of the law regarding Forensic Orders

The main objects of the *Mental Health Act 2016* (**Act**) are set out in section 3(2) and must be achieved in the way outlined in sections 3(2) and 3(3).

Below are extracts of sections from the Act relevant to the Tribunal's review of a forensic order.

432 Matters to which tribunal must have regard

(1) In making a decision under this part in relation to a review of a forensic order (mental health) or forensic order (disability), the tribunal must have regard to the following:
   (a) the relevant circumstances of the person subject to the order;
   (b) the nature of the relevant unlawful act and the period of time that has passed since the act happened;
   (c) any victim impact statement given to the tribunal under section 155 or 742 relating to the relevant unlawful act;
   (d) if the Mental Health Court made a recommendation in the order about an intervention program for the person—the person's willingness to participate in the program if offered to the person.

   Examples of decisions in relation to a review of a forensic order:
   - deciding whether to confirm or revoke the order
   - deciding whether to confirm or change the category of the order
   - deciding whether the person is to receive any treatment in the community
   - deciding whether to change or remove a condition to which the order is subject or to impose a condition on the order.

(2) Subsection (1) does not limit any other provision of this part that requires the tribunal to have regard to a stated matter

433 When reviews are conducted

(1) The tribunal must review (a periodic review) the forensic order:
   (a) within 6 months after the order is made; and
   (b) at intervals of not more than 6 months after the review under paragraph (a) is completed.

(2) Also, the tribunal must review (an applicant review) the forensic order on application by:
   (a) the person subject to the order; or
   (b) an interested person for the person mentioned in paragraph (a); or
   (c) the Attorney-General; or
   (d) if an authorised mental health service is responsible for the person—the chief psychiatrist; or
   (e) if the forensic disability service is responsible for the person—the director of forensic disability.

(3) Further, the tribunal may at any time, on its own initiative, review (a tribunal review) the forensic order.

(4) If the tribunal receives written notice under section 213(3) of the amendment of the forensic order, the tribunal must review (also a tribunal review) the order within 21 days after receiving the notice.

(5) This section is subject to sections 434 to 437 and chapter 16, part 2, division 6, subdivision 2.

441 Decisions

(1) On a periodic review of the forensic order, the tribunal must decide to:
   (a) confirm the order; or
   (b) revoke the order.

Notes:

1 See subdivision 2 for the orders the tribunal may make if it confirms the order.

2 See subdivision 3 for the orders the tribunal may make if the order is a forensic order (mental health) and the tribunal revokes the order.

(2) On an applicant review of the forensic order, the tribunal:
   (a) must decide whether to make the orders sought by the applicant; and
   (b) may make the orders under this division it considers appropriate.

   Example for paragraph (b):

If an applicant seeks an order changing the category of the forensic order from inpatient to community, the tribunal may decide not to change the category of the order, but may order that the person have limited community treatment of a stated extent.

(3) On a tribunal review of the forensic order, the tribunal:
   (a) must decide any particular matter stated in the notice given under section 439(3); and
   (b) may make the orders under this division it considers appropriate.

442 Requirement to confirm forensic order

(1) The tribunal must confirm the forensic order if the tribunal considers the order is necessary, because of the person's mental condition, to protect the safety of the community, including from the risk of serious harm to other persons or property.

(2) Also, during any non-revocation period for the forensic order, the tribunal is taken, for section 443, to have confirmed the order.
   Note:
   The tribunal must not revoke the forensic order during the non-revocation period for the order. See section 452.

(3) Subsection (2) does not apply if the forensic order is a forensic order (mental health) and the tribunal decides to revoke the order under section 457.

444 Change or confirmation of category

(1) The tribunal may change the category of the forensic order.

(2) However, the tribunal may change the category of the forensic order to community, or confirm the category of the order as community, only if the tribunal is satisfied there is not an unacceptable risk to the safety of the community, because of the person's mental condition, including the risk of serious harm to other persons or property.

(3) This section is subject to section 445.

445 Inpatient category – orders about treatment in the community

(1) This section applies if the tribunal:
   (a) confirms the category of the forensic order as inpatient; or
   (b) changes the category of the forensic order to inpatient.

(2) The tribunal must do 1 of the following:
   (a) order that the person have no limited community treatment;
   Note:
   An order made under paragraph (a) may not be amended by an authorised doctor. See section 212(2).
   (b) approve that an authorised doctor under section 212 or a senior practitioner under the Forensic Disability Act, section 20 may, at a future time:
      (i) authorise limited community treatment for the person, to the extent and subject to the conditions decided by the tribunal; or
      (ii) change the category of the order to community, subject to the conditions decided by the tribunal;
   (c) order that the person have limited community treatment:
      (i) of a stated extent; and
      (ii) subject to the conditions decided by the tribunal, including whether, or the extent to which, an authorised doctor under section 212 or a senior practitioner under the Forensic Disability Act, section 20 may amend the forensic order in relation to treatment in the community.

(3) The tribunal may make an order under subsection (2)(b) or (c) only if the tribunal is satisfied there is not an unacceptable risk to the safety of the community, because of the person's mental condition, including the risk of serious harm to other persons or property.

(4) In deciding whether the tribunal is satisfied of the matters mentioned in subsection (3), the tribunal must have regard to:
   (a) the purpose of limited community treatment; and
   (b) the fact that:
      (i) if an authorised mental health service is responsible for the person—an authorised doctor may increase the extent of treatment in the community for the person only if satisfied of the matters mentioned in section 212(3); or

(ii) if the forensic disability service is responsible for the person—a senior practitioner under the Forensic Disability Act may authorise treatment in the community for the person only if satisfied of the matters mentioned in the Forensic Disability Act, section 20(2).

446 Community category – orders about treatment in the community

(1) This section applies if the tribunal:
   (a) confirms the category of the forensic order as community; or
   (b) changes the category of the forensic order to community.

(2) The tribunal must:
   (a) order that an authorised doctor or a senior practitioner under the Forensic Disability Act must not change the category of the order to inpatient; or
   (b) approve that an authorised doctor under section 212 or a senior practitioner under the Forensic Disability Act, section 20 may, at a future time, change the nature or extent of treatment in the community received by the person, to the extent and subject to the conditions decided by the tribunal.

   Example of a change of extent of treatment in the community:
   changing the category of the forensic order from community to inpatient, with or without limited community treatment

447 Conditions

(1) The tribunal may:
   (a) change or remove a condition to which the forensic order is subject; or
   (b) impose a condition on the forensic order.

(2) Without limiting subsection (1), the tribunal may impose a condition that the person must not contact a stated person, including, for example, a victim of the relevant unlawful act.

(3) However, the tribunal may not impose a condition on the forensic order that requires the person to take a particular medication or a particular dosage of a medication.

450 Making of treatment support order

(1) The tribunal must decide to make a treatment support order for the person if the tribunal considers a treatment support order, but not a forensic order, is necessary, because of the person's mental condition, to protect the safety of the community, including from the risk of serious harm to other persons or property.

(2) For making a treatment support order under subsection (1), sections 144 and 145 apply as if:
   (a) a reference in the sections to the Mental Health Court were a reference to the tribunal; and
   (b) a reference in the sections to the person the subject of the reference were a reference to the person subject to the forensic order.

451 Making of treatment authority or no further order

(1) If the tribunal considers that neither a forensic order nor a treatment support order is necessary, because of the person's mental condition, to protect the safety of the community, including from the risk of serious harm to other persons or property, the tribunal may:
   (a) make no further order for the person; or
   (b) make a treatment authority for the person.

(2) The tribunal may make a treatment authority for the person under subsection (1)(b) only on the recommendation of an authorised psychiatrist who considers, after examining the person, that:
   (a) the treatment criteria apply to the person; and
   (b) there is no less restrictive way for the person to receive treatment and care for the person's mental illness.

(3) The treatment authority must state the following:
   (a) the category of the authority;
   (b) the authorised mental health service responsible for the person;
   (c) the nature and extent of any limited community treatment the person is to receive;
   (d) any conditions the tribunal considers necessary for the person's treatment and care, other than a condition requiring the person to take a particular medication or a particular dosage of a medication.

(4) The tribunal may decide the category of the treatment authority is inpatient only if the tribunal is satisfied that 1 or more of the following can not reasonably be met if the category of the authority is community:

(a) the person's treatment and care needs;
(b) the safety and welfare of the person;
(c) the safety of others.

(5) However, if the person is a classified patient, the tribunal must decide the category of the authority is inpatient.

(6) In deciding the nature and extent of any limited community treatment under subsection (3)(c), the tribunal must have regard to the purpose of limited community treatment.

(7) If the tribunal decides the category of the treatment authority is community, the tribunal must decide whether an authorised doctor may, at a future time, reduce the extent of treatment in the community received by the person.

(8) The treatment authority is taken to be a treatment authority made under section 49 by the authorised psychiatrist mentioned in subsection (2).

(9) Despite subsection (8) and section 413(1), the tribunal must review the treatment authority:
(a) within 6 months after the authority is made; and
(b) within 6 months after the review under paragraph (a) is completed; and
(c) at intervals of not more than 12 months after the review under paragraph (b) is completed.

(10) Sections 53 and 59 apply to the treatment authority as if a reference in the sections to the authorised doctor were a reference to the authorised psychiatrist mentioned in subsection (2).

(11) As soon as practicable after the treatment authority is made, the authorised psychiatrist mentioned in subsection (2) must decide the nature and extent of the treatment and care to be provided to the person under the authority.

452 Orders with non-revocation period

(1) The tribunal must not revoke a forensic order under division 4 during any non-revocation period for the order.

(2) Subsection (1) is subject to section 457.

453 Order for person temporarily unfit for trial

(1) This section applies to a person subject to a forensic order if:
(a) a finding of unfitness has been made in relation to the person; and
(b) the proceeding against the person in relation to which the finding of unfitness was made has not been discontinued under section 490 or 491.

(2) The tribunal must not revoke the forensic order unless a treatment support order is made for the person under section 450.
Note:
If, on a review under part 6, the tribunal decides the person is fit for trial, the forensic order ends on the person's appearance at the mention of the proceeding for the relevant offence. See section 497(2).

454 Order for person charged with prescribed offence

(1) This section applies if a forensic order for a person was made on a reference in relation to a prescribed offence allegedly committed by the person.

(2) The tribunal must not revoke the forensic order unless:
(a) the person has been examined, under an order made under section 721, by an examining practitioner; and
(b) the tribunal has obtained and considered the examining practitioner's written report on the examination.

(3) This section is subject to section 452.