Neutral Citation No. [2011] NIQB 64 | *Ref:* **TRE8255**

Judgment: approved by the Court for handing down | *Delivered:* **08/07/11**
*(subject to editorial corrections)**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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QUEEN'S BENCH DIVISION (JUDICIAL REVIEW)

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JR 52's Application [2011] NIQB 64

AN APPLICATION FOR JUDICIAL REVIEW BY JR 52

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TREACY J

[1] Between May 2004 and March 2007 the applicant was in receipt of psychiatric and psychological care and treatment provided by the Belfast Health and Social Care Trust ("the Trust") at Woodstock Lodge.

[2] As originally conceived the target of the proceedings was the Trust's cessation of these services following an incident on 22 March 2007 when the applicant assaulted a nurse and behaved in an aggressive manner.

[3] The applicant contended, on various grounds, that the removal and failure to restore the pre-existing services was unlawful.

[4] The case has, however, evolved considerably since its inception. Following a meeting of the professional clinicians on 16 March 2011, directed by the court, the parties agreed as follows:

(1) Diagnosis – A has a personality disorder the exact category of which is not important.

(2) It is agreed that in depth psychological treatment for the underlying condition would be harmful.

(3) It is agreed that he does require long term supportive care (currently this is day centre, access to life line, access to a key worker).

[5] This development effectively neutralised the applicant's challenge since the clinicians were agreed that the treatment he sought to have restored would in fact be harmful.

[6] Following the meeting of the clinicians in March 2011 an amended Order 53 statement was furnished which added a further ground in essence challenging the decision of the Trust not to provide the applicant with consultant led *support*. In her affidavit of June 2011 Dr Maria O'Kane, Consultant Psychiatrist in Psychotherapy and Adult Psychiatry, the acting Associate Medical Director for the Social and Primary Care Directorate of the Trust, averred as follows:

> "**8. In relation to the meeting of the clinicians in this case which took place [on 16 March 2011] . . . it is clear that all present were in agreement that A could not tolerate active specialist psychological treatment and that what was required was an appropriate level of on going support, described by a Professor Casey as "TLC" (tender loving care). [I interpose to observe that the minute of meeting records Professor Casey as having said that the applicant needed general TLC *and* support and advice]. The dispute between those present at the meeting really related to *who* was best placed to provide that support. Professor Casey advocated the involvement of a consultant in the active provision of that support but her opinion must be seen in the context of her practice in the Republic of Ireland where, as in the United States, the provision of such treatment/support is privately funded and is provided by consultants. The same approach is not followed in the NHS. [I interpose to observe that in the minutes of the meeting Dr O'Kane having stated that in the new Belfast Trust system psychiatrists didn't provide general/supportive care that Dr Mulholland stated that this approach was specific to the Belfast Trust and that Dr O'Kane agreed. Therefore it does not appear to be correct to assert as she did in her affidavit that this approach was NHD wide. Prior to obtaining a report from Professor Casey, the applicant's solicitors obtained a report from Dr Mulholland, Consultant Psychiatrist . . . [which] is generally supportive of the Belfast Trust's management of A's problems.**
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> **9. An NHS consultant is best placed to make a diagnosis and recommend treatment strategies and**

in some very complex cases actively administer treatment such as specialist psychologist treatment. However, it is not an appropriate use of the valuable resource of consultant time to engage in the provision of "TLC" to a person such as A. The tiered model for the provision of mental health services as described in the "new way of working" strategy document published by the Royal College of Psychiatrists has been adopted in the Belfast Trust since 2006-2007 and under this model a person with A's problems would not be deemed to require regular specialist psychiatric of psychological input from a consultant. What is required is on going community support from a lower tier in the mental health service provision structure.

10. The affidavit prepared by Mr Michael Creaney sets out the level of on going support which is available to A should he choose to avail of it. Dr McCutcheon, A's General Practitioner, is A's named mental health professional in the community. Mr Creaney, the manager of Ravenhill Day Centre, is a Senior Mental Health Social Worker with vast experience in dealing with a range of mental health presentations. Mr Paul Mercer is an Adult Day Care Worker, specialising in arts and mental health. *This provision of support in the community is the level of support appropriate to A's needs.* A also receives on going support from the Combat Stress organisation in Scotland and is able to avail of the services of Oonagh Torrens, a Patient Advocate, through Bryson House. A is not under the care of a named consultant psychiatrist at this time. However, having regard to the skills base of A's General Practitioner and Mr Creaney, if A's condition were to deteriorate so that it was considered that he was or may be suffering from a psychosis or other mental illness or was at significant risk of suicide or self harm, these individuals would be able to immediately refer A for specialist psychiatric assessment if deemed necessary.

11. A's present needs are *not* such as to require the direct involvement of specialist community psychiatric services, still less do they require regular one to one sessions with a consultant. A is not suffering from mental disorder. He has a

> **personality disorder, considered by the Trust's clinicians to be of a paranoid/anti social type. Specialist psychological therapy is contra-indicated as his paranoia causes him to feel undermined and threatened by such therapy and, indeed such therapy could well result in the development of a full blown psychosis. What is required is support in the community. Such support does not require one to one sessions with a clinician as such sessions could and would only comprise of the provision of TLC. The sessions could not be used for the provision of specialist psychological therapy. Such TLC as is required can be provided at a lower tier in the service provision structure of the Trust. This level of support is consistent with the recommendations set out in the NICE guidelines for borderline personality disorder adopted in Northern Ireland in January 2009. This NICE guidance recognises the potential for psychological harm to be cause if services are not provided at the appropriate tier for the patient (in this case Tier two rather than Tier three)."**

[7] The focus of the original challenge has now considerably narrowed and morphed into what is referred to in the minutes as a slight disagreement between the professionals as to *who* should provide the support.

Decision

[8] In cases involving professional clinical judgments there is limited scope for intervention by way of judicial review. In *R v. Cambridge Health Authority, ex parte B* [1995] 2 All ER 129 [a case involving a decision by clinicians not to provide further treatment to a child suffering from leukaemia] Sir Thomas Bingham MR stated, at page 136 letter b :

> "**The courts are not, contrary to what is sometimes believed, arbiters as to the merits of cases of this kind. Were we to express opinions as to the likelihood of the effectiveness of medical treatment, or as to the merits of medical judgment, then we should be straying far from this sphere which under our constitution is accorded to us. We have one function only, which is to rule upon the lawfulness of decisions. That is a function to which we should strictly confine ourselves."**

[9] More recently, Sedley LJ, in *R v. Camden and Islington Health Authority, ex parte K,* [2002] QB 198 at page 233 [para 55] stated:

> "**No judge can realistically sit as a court of appeal from a psychiatrist on a question of professional judgment. What a judge must be able to do is to ensure that such judgment, to the extent that its exercise is a public law function, is made honestly, rationally and with due regard only to what is relevant. Within the boundary more than one legitimate judgment . . . may have to be accommodated . . .".**

[10] The fact that Professor Casey may disagree with, inter alia, Dr O'Kane as to *who* should provide the general support it is agreed the applicant requires for his personality disorder is in my view a plainly insufficient basis to justify intervention by this court. It is not the function of this court to sit on appeal from psychiatrists on questions of professional judgment and the applicant has not established, even arguably, that there is any public law basis for interfering with the impugned decision and accordingly the application must be dismissed.