Opening Statement to the Joint Committee on the Eighth Amendment of the Constitution.

November 8 2017.

Thank you for inviting me to address the Committee. I hope to be able to answer any questions which members might like to ask by bringing the benefit of my experience and expertise, and my knowledge of the research in the field of pregnancy and mental health and illness. I have worked as a Consultant Perinatal Psychiatrist at the National Maternity Hospital in Holles Str for the past 21 years where over 500 women attend the clinic each year. Women are seen who are pregnant or who are in the first six months post pregnancy, (which includes pregnancy loss), and where a significant mental health issue is involved. Women attending may have a previous mental health history or a significant new crisis may develop during or after the pregnancy. Amongst those who attend will be many who have suffered a miscarriage. Others may have had a stillbirth or may have a baby diagnosed with a significant abnormality, of varying levels of severity, or may have had a previous termination or may be considering a termination.

I have previously spoken as an expert witness at the two Oireachtas hearings which led to the introduction of the Protection of Life During Pregnancy Act. I was also invited to speak as an expert witness to the Citizens' Assembly. I am also an expert assessor for the Confidential Enquiry into Maternal Deaths in the UK and Ireland. This involves detailed study of the records of women who have died during pregnancy or the first year afterwards, as a result of suicide or other mental health causes.

So what can I say now after all of these years of working in this area, and from my understanding of relevant research, and of history. That while having a baby is, hopefully, and fortunately for many, one of the most joyful and rewarding and meaningful experiences of their lives, as you all know, it is also unfortunately often not like this. You know this from your own lives, those of your families and

friends, and also of course from listening to many of the stories told here to this Committee and to the Citizens Assembly. Most of you have heard of, or personally witnessed stories of depression or distress, of unwanted pregnancies, of rape, or the discovery of major fetal abnormalities, or of the termination of pregnancies in the UK and here in Ireland. These are stories heard so regularly also in my clinic in Holles Str.

Abortion. Oh yes, in an ideal world it would never be needed or requested. But even if we exclude medical emergencies and severe life threatening indications, we cannot wish abortion away. It has been a part of the history of every country, including Ireland. And before it became legally available in the UK fifty years ago, and therefore available for thousands of Irish women every year since, it was illegally available here in Ireland for those who could pay. And, of course, there was infanticide too which was such a widespread practice. I would urge anyone who is unaware of the nature and extent of this to read Cliona Rattigan's seminal historical study:" What Else Could I Do? " a detailed study of hundreds of cases of infanticide in Ireland between 1900 and 1950. Or the work of Dr Elaine Farrell who studied 4645 infanticides in Ireland between 1850 and 1900 and published her work entitled " A Most Diabolical Deed". Dr Rattigan quoted a judge in Co Clare in the 1930's who described the "epidemic of infanticide cases" he had to hear. Both studies emphasize that these numbers were an underestimate of the true scale of infanticide in Ireland at that time. We don't want to go back to an era of illegal backstreet abortions and infanticide.

In my clinical work, of course, most of the women who I see for whom a termination of pregnancy is an issue, they are seeing me because of their or sometimes their partner's concern about their mental health. Sometimes that termination could potentially be very damaging for them. For example, a woman who has a planned and much wanted pregnancy, but who develops severe depression which is clearly clouding her judgement about everything in her life, and not just the pregnancy, keeps thinking that she should terminate because she would be a bad mother. She needs expert help for her depression. A termination is almost certainly not what she wants and could be very damaging to her mental health. But, for another, she is clear that she cannot continue the pregnancy, she

cannot cope and continuing the pregnancy would destroy her life. She is not mentally unwell but may be terrified of becoming unwell.

How any woman responds to a pregnancy is so personal to her. How she visualizes and imagines what is or is not growing inside of her is unique. For example, one woman who has an early miscarriage will say that what she lost was a pregnancy for her, not a baby, that she knows it happens in 1 in 5 of all pregnancies anyway, it's just nature's way, and it was just like a heavy period. For another, she may have a huge sense of loss of a baby, name it and grieve for it, even if the scan actually showed a so called "empty sac", or even if she has had a rare molar pregnancy where there was only ever placental tissue and no fetus but her pregnancy tests were repeatedly positive.

It is these sorts of inner perceptions and beliefs and imaginings that determine so much, and often more so than any biological reality. It is part of what makes us human.

For example, one woman with a baby with a fatal fetal abnormality may decide that she/they want to continue the pregnancy because she feels she wants to hold onto that baby inside of her as long as possible, and she hopes that the baby will die inside of her, and not shortly after, as it is safe and warm inside of her. Another will feel she can't bear to think of the baby suffocating inside of her, or being in pain, or the distress of it dying inside of her. Another will say she wants the baby delivered early and hopefully alive still so that she/they will be holding the baby for a few minutes before it dies. As doctors we must be aware of the complexities involved for everyone, and listen and not prejudge.

I wish now to address the question of the mental health outcomes after induced abortion and the research evidence in this area. This has been mentioned by members of the committee and some speakers in earlier sessions.

The first key point is that no significant research on this subject has been completed in Ireland and this is important. Research from the UK, the USA, Australia, etc, may not be applicable here, or may only be in a very limited way, as it is different here. Secondly, there are many other limitations to most of the

research in this area. These limitations included researcher bias, inadequate control for confounding variables and inappropriate control groups, and the failure to control for previous mental health problems. Therefore, my advice is to read any such research in a critical, informed and objective way.

The best overall publication in this area was by the Academy of Medical Royal Colleges in the UK. They published a systematic review of the mental health outcomes of induced abortion in which they reviewed all of the research evidence available and critically analysed all published research which reached basic scientific standards.

Their key findings were that :

a) An unwanted pregnancy was associated with an increased risk of mental health problems.
b) That the rates of mental health problems in unwanted pregnancies were the same after termination or after giving birth.
c) That the most reliable predictor of post abortion mental health problems was having mental health problems before the abortion.
d) That, in addition, women who were pressurized to have a termination, and women who were exposed to strongly negative attitudes towards abortion in general and to her personal experience, were likely to have worse outcomes.

However, for any and every woman who might seek mental health advice in this situation, it will be the specifics of her individual situation, and her distress and her history, and her personal beliefs and wishes, and often her partners too, which must be listened to and understood. The research evidence is helpful in general, but never specific to any individual life situation.

The dilemmas for women in such difficult situations will always be painful and distressing. I consider it my responsibility as a psychiatrist not to add to their pain and distress. I hope the Committee will be of the same view.

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