DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE AGUS LEANAÍ

JOINT COMMITTEE ON HEALTH AND CHILDREN

Dé Luain, 20 Bealtaine 2013

Monday, 20 May 2013

The Joint Committee met at 9.30 a.m.

MEMBERS PRESENT:

Deputy Catherine Byrne,
Deputy Ciara Conway,
Deputy Regina Doherty,
Deputy Robert Dowds,
Deputy Peter Fitzpatrick,
Deputy Seamus Healy,
Deputy Billy Kelleher,
Deputy Mattie McGrath,
Deputy Sandra McLellan,
Deputy Eamonn Maloney,
Deputy Denis Naughten,
Deputy Caoimhghín Ó Caoláin,
Deputy Mary Mitchell O'Connor,
Deputy Robert Troy,

Sentor Ivana Bacik,*
Senator Colm Burke,
Senator John Crown,
Senator Imelda Henry,
Senator Jillian van Turnhout,
Senator Jim Walsh.*

* In the absence of Senators John Gilroy and Marc MacSharry, respectively.

In attendance: Deputies James Bannon, Ray Butler, Michael Creed, Clare Daly, Bernard J. Durkan, Terence Flanagan, Dominic Hannigan, Kevin Humphreys, Colm Keaveney, Paul Kehoe, Finian McGrath, Peter Mathews, Olivia Mitchell, Michelle Mulherin, Seán Ó Fearghaíl and Aodhán Ó Ríordáin, and Senators Paul Bradford, Terry Brennan, Aideen Hayden, Fidelma Healy Eames and Rónán Mullen.

DEPUTY JERRY BUTTIMER IN THE CHAIR.

Heads of Protection of Life during Pregnancy Bill 2013: Public Hearings (Resumed)

Psychiatry and Perinatal Psychiatrists

Chairman: As we have a quorum we will begin in public session. I thank all present for being here bright and early on a Monday morning and I particularly welcome our guests. I remind everybody that mobile phones should be switched off rather than being in silent mode as they interfere with the broadcasting of proceedings, which is unfair to the staff. This is our fifth session in the series of hearings which the Oireachtas Joint Committee on Health and Children has been asked to conduct in discussing the heads of the protection of life during pregnancy Bill 2013.

I welcome the witnesses to the meeting this morning, as they are here to assist us in analysing the heads of the Bill. I welcome Dr. Anne Jeffers, Dr. Maeve Doyle, Dr. Joanne Fenton, Dr. Anthony McCarthy and Dr. John Sheehan, who will be here shortly. I remind members that we are discussing the heads of the Bill and any comments or questions should be referenced to those heads. To members in particular I say that the language we use should be temperate and moderate, and we should try to avoid being unfair to each other and witnesses. I would appreciate if members could keep that at the back of their minds. I will be very strict with time today, as I reviewed the hearings on Friday. The time allocations will be 70 minutes and 30 minutes and I will end the sessions at the appropriate times. That will mean some members will not be able to make a contribution at certain times, for which I apologise in advance, but we must be fair in the application of time.

Before beginning I remind members and witnesses that witnesses are protected by absolute privilege in respect of the evidence they give to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to do so, they are entitled thereafter to only qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of the proceedings is to be given and they are asked to respect the parliamentary practice to the effect that where possible they should not criticise nor make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice or ruling of the Chair to the effect that they should not criticise, comment on or make charges against either a person or persons outside the House or an official either by name or in such a way as to make him or her identifiable.

There are 50 minutes for opening statements so I ask Dr. McCarthy to begin.

Dr. Anthony McCarthy: I am Dr. Anthony McCarthy, president of the College of Psychiatrists of Ireland and a specialist in perinatal psychiatry at the National Maternity Hospital, Holles Street. I am also the psychiatric assessor for the confidential inquiry into maternal deaths in Ireland.

Our written submission has detailed comments on the heads of Bill and we recommend that close attention is paid to these points. Some practical points will need to be addressed and will require some technical amendments to the Bill. This submission was agreed by the council of the college, the sole organisation recognised by the Medical Council of Ireland as being responsible for the life-long training of all psychiatrists in Ireland. This council is the elected decision making body of the college and we know that among our 864 members there will be a wide range of opinions with regard to the sensitive issue of abortion, reflecting the deep divisions in society in general about this issue. Many of these views will be heard today but the submission is the official college position.

This Bill is about saving women's lives. We recognise that the Bill is restricted only to circumstances where the life of the mother is at risk rather than her mental health. We recommend that any woman who has suicidal ideation in pregnancy must be enabled to readily avail of expert psychiatric assessment, and that assessment must be individual, comprehensive, compassionate and not prejudged. Every maternity unit in this country should have such services, and there is a significant lack in such provision currently, as outlined in our written submission.

As so much will be said and heard today about the risk of suicide in pregnancy, I wish to make some brief overall points as someone who has been working as a specialist perinatal psychiatrist for more than 16 years in a service seeing in excess of 500 women every year. Suicide in pregnancy is real; it is a real risk and it does happen. This is always a tragedy as at least two lives are lost and many others are affected significantly. We must do everything we can to prevent such deaths. Much has been made and will be made about the so-called lack of evidence with regard to abortion and whether it will ever prevent a suicide. I believe there will never be statistical evidence to prove this point one way or other because trying to prove anything statistically for such a rare event is extremely difficult, if not impossible. Only a study involving thousands of women who were expressing suicidal ideation in pregnancy and wanted an abortion, and where half of them had that abortion and the other half did not, for example, if they were prevented from travelling to the UK, could answer this question about statistical evidence. This study will almost certainly never be done, I hope.

As doctors, we must always be aware of research but also be very aware of the limitations of research and of the questions which it cannot answer. In our clinical work, we search always for clinical evidence and not statistical evidence. As doctors, we assess suicidal risk as part of our everyday work and we rely on clinical evidence, our clinical skills and our experience and training in assessing each woman or child individually. There are extra challenges in assessing anyone in emotionally intense situations and where there are potentially serious outcomes, whatever the assessment concludes. Again I stress that we do these sorts of assessments regularly, even if most psychiatrists do not do so in this specific circumstance. Part of suicidal risk assessment always includes assessing the presence or absence of a mental disorder or mental illness and an assessment of the capacity of the individual to make an informed decision. That will be essential here too.

We also always assess for what are called psychosocial stresses, or life stresses. However, some in this debate have tried to present the case that these are somehow mutually exclusive, as if a woman who is at risk of suicide is either mentally ill and hence needs psychiatric treatment or that she just has a psychosocial stress - an unwanted pregnancy - and is then either not really suicidal or her case has nothing to do with psychiatry. Clinical reality and life reality is that frequently there is a complex interaction between major life stresses, mental distress and mental disorder. It is sometimes black and white but most often it is not so. Attempts to present it as

such not only does a great disservice to any women who may find themselves in this particular position but also to any person at any time in life who is suffering from major stress, depression or other mental disorder. They too require a comprehensive mental health assessment and treatment, one that does not focus exclusively on the presence or absence of a mental illness but on an holistic assessment and treatment which recognises the individuality of that person.

I will specifically discuss a phrase that is being quoted frequently at the moment that "abortion is never a treatment for suicide". This is true, and abortion is never a treatment for suicide, but neither is counselling, psychotherapy, antidepressants or anything else. There is no treatment for suicide. What society needs to address in general, and what we as psychiatrists have to do specifically, is try to prevent suicide, and this requires looking at the causes of suicide and what can be done to address those causes. The question is not whether abortion treats suicide but is there ever a case where a woman will kill herself because of an unwanted pregnancy, and if so, what can we do to save her life, and would that ever be a termination of pregnancy? This Bill is about legislating for that very small but real possibility.

There are concerns among many psychiatrists that somehow this legislation will result in them being placed in very difficult clinical circumstances. For some this is because of their religious, philosophical or ethical beliefs, and these must be respected. I welcome that those views will be heard today as well. For others, there is a fear of increased workload for their already overstretched services, and doing this with no extra resources. For others it is a fear of being faced with very difficult clinical issues and dilemmas where, for example, a woman may be genuinely highly distressed, such as after rape, and wants a termination but is assessed as not being actively suicidal because she does not want to die. This woman may just want an end to the pregnancy but she will have to be refused an abortion under this legislation. That will be difficult for her and us as clinicians. These are real concerns and difficulties but they still must be addressed. They cannot simply be ignored or denied by our profession or by society, and will not be by the college.

Many in the profession see this issue as being predominantly a social and political issue, which psychiatrists are now being asked to solve or arbitrate upon, an issue which society as a whole and the Legislature need to address, and are addressing, which is to be congratulated. As psychiatrists, we want to be there to care for and treat women appropriately, professionally and compassionately and not be placed in a position of social policing. However, again at the end of the day, this is about saving women's lives and we as psychiatrists must be prepared to use our professional skills and expertise to assess and treat pregnant women who have suicidal ideation or intent in pregnancy. If, as a result of this legislation, better psychiatric services are put in place so that expert psychiatric assessments and treatments are provided for all pregnant women in Ireland who wish to avail of such services, women and children's lives will be saved.

Dr. Joanne Fenton: I am Dr. Joanne Fenton, consultant adult psychiatrist and a specialist perinatal psychiatrist in the Coombe Women and Infants University Hospital. In my role as a perinatal psychiatrist I have treated women attending the Coombe hospital over the past ten years. These women have had a wide variety of problems and difficulties including illnesses ranging from severe and enduring mental illness like schizophrenia to those with less severe illness like anxiety or depression, but which may cause equal levels of distress.

Suicide is a real risk in individuals who have mental illness and has a devastating impact on all those involved with the woman. As psychiatrists, and in particular in my role as a perinatal psychiatrist, we are trained to assess women who express suicidal ideation or intent. It is my role to provide non-judgmental, compassionate care and treatment to these women. The

women who present with suicidal intent are in a great deal of distress and it is our aim to treat these women respectfully.

In my years in the Coombe hospital I have seen many women who have had a termination of pregnancy. Each woman has had a different experience and the effect has been different for each. I have never seen a woman where termination of her pregnancy was the treatment for her mental illness nor do I believe that a termination of pregnancy is a treatment for mental illness. However, that said, I cannot say that there will never be a situation where a woman is in such a state of distress and turmoil that for her, termination of pregnancy is a life-saving option.

The current legislation is very restrictive and many women will continue to travel abroad to seek terminations. There are a number of points which my colleagues and I will address further and are outlined in our written college submission. These include the under-18 age group and those who lack capacity. I believe that two psychiatrists, as outlined in the heads of Bill, should assess a woman who is suicidal and pregnant and be in agreement about their assessments, but should not have to see the patient at the same time. I believe that the obstetrician should assess the woman from an obstetric point of view but not be expected to assess suicidality, which is beyond his or her area of expertise. I believe that the timing between initial referral and assessment and the timing for appeal should be shortened as women in this situation are frequently distressed and a lengthening of time can cause a further deterioration in their mental health.

Many psychiatrists do not wish to partake in the assessments of these women for many reasons and their concerns must be respected. In my role as a perinatal psychiatrist I believe it is my responsibility to continue to assess pregnant women in distress and aim to provide the best and most compassionate care to them.

Dr. Maeve Doyle: I am Dr. Maeve Doyle, consultant child and adolescent psychiatrist and chair of the child and adolescent faculty of the College of Psychiatrists of Ireland. I welcome the invitation from the Joint Committee on Health and Children to make a submission on specific issues with regard to children, particularly because the X case involved a 14 year old girl, a child, who had been raped and sought a termination because she said that she was suicidal. The written submission, which was sent by the college, includes a number of key and detailed points about the care of children in circumstances where they may be pregnant and request an abortion and how the proposed heads of Bill must be amended to address these. My opening statement summarises some of these key issues.

On the definition of a child, the heads of Bill do not define the word "child". This is very important as in cases involving children there are very specific and complex issues regarding their care which must be addressed. On consent, under the Children Act 2001, and other legislation, a child is someone under the age of 18 years unless married. A person over the age of 16 years can give consent to surgical, medical or dental treatment and it is not necessary to obtain consent from parents and guardians. For psychiatric assessment the law has been interpreted as meaning that until the age of 18, children are still not in a position to legally consent to a psychiatric assessment and, as such, require consent from their guardians. For children in the care of the HSE the issue of consent is even more complex. I make these points to highlight the need for these issues to be considered by those drafting the final Bill.

The issue of confidentiality is also quite complex. Generally, when young people are first seen by a child and adolescent psychiatrist they are informed that what they say will remain confidential unless the information disclosed constitutes a risk to themselves or to others. This may well result in the young people censoring what they say. This is particularly true in the area

of sexual activity. The age of consent to sexual intercourse remains at 17 years. In many cases, however, parents of 17 year olds expect to be informed if their 17 year old child is sexually active, so issues regarding a possible abortion will require expert, experienced and sensitive handling and clarity for the child, family and professionals involved.

While there are no figures available, the occurrence of pregnancy within a population attending a child and adolescent mental health service is rare. For a pregnant young person to attend such a service, the consent must come from her parents. In addition, if the young person is under the age of 17, the professional will have to report to the HSE and the Garda. The likelihood of parents of pregnant girls seeking advice from a child and adolescent psychiatrist as to whether or not to proceed with a termination of pregnancy is, therefore, very low.

What may happen is that in the case of a young girl who is in the care of the HSE, becomes pregnant and indicates a wish to have a termination of pregnancy on grounds of suicidality, the HSE, acting *in loco parentis*, may well seek the advice of a child and adolescent psychiatrist in making that decision. This is probably the main group of pregnant teenage girls for whom the proposed legislation will, in effect, apply.

I hope that the foregoing will draw attention to some of the difficulties which would need to be overcome in any legislation involving young women, children in the eyes of the law, who present with suicidality in the context of pregnancy.

Dr. Anne Jeffers: I am Dr. Anne Jeffers. I am the director of external affairs and policy at the College of Psychiatrists of Ireland. I am also a general adult psychiatrist. I work with adults between the ages of 18 and 65 and I work in a community based service in east Galway. In an adequately resourced mental health service, general adult psychiatrists work with a multidisciplinary team made up of nurses, social workers, psychologists and occupational therapists. We receive referrals from general practitioners or the emergency departments of general hospitals. I will describe the issues as I see them in this legislation as they are likely to be seen by a general adult psychiatrist. When a woman finds that she has a crisis pregnancy and feels suicidal, she may follow a number of choices. She may decide to have a termination and may travel outside the State to have that. She may visit her GP who will complete a full assessment, including an assessment of her mental state and the risk of suicide. The GP will offer her counselling and may advise that she seek the advice of a crisis pregnancy counselling service. If he or she has concerns that the woman is at risk of suicide and requires a specialist psychiatric assessment, he or she will refer her to a general adult psychiatrist. The woman may alternatively present directly to an accident and emergency department, especially if she has attempted suicide or has self-harmed. In this case, she will be assessed by a liaison psychiatrist where one exists or be referred to the general adult psychiatrist in the area. Only in Dublin will there be the option of a referral to a perinatal psychiatrist.

A psychiatric assessment involves a private one-to-one consultation where the woman has an opportunity to describe her distress. The psychiatrist identifies the issues contributing to the suicidal risk. These issues include any symptoms of mental illness and the psychosocial stresses affecting the woman. Each woman's presentation and circumstance is unique and the psychiatrist will provide a comprehensive and non-judgmental assessment. A psychiatric assessment is therapeutic in itself where a woman is given an opportunity to discuss her concerns and stress in a confidential setting and a safe and supportive environment. For many women, the outcome of this assessment will reduce her fears and she may decide to continue with the pregnancy. Where the woman and the assessing psychiatrist and team believe the termination of the pregnancy is the only way to avert self-destruction, a second opinion would be requested.

Ideally, a psychiatric social worker or other key team member would also be involved in this assessment and in the provision of ongoing support for the woman. It is important to be aware that not all teams have social workers. It is anticipated that in all except rare cases, the psychiatrist will recommend interventions other than termination of the pregnancy. The legislation is extremely restrictive and it will not apply to the majority of women. In these cases, the psychiatrist will ensure the woman has access to non-directive counselling around the options, and these options include adoption, parenting or information about travelling outside the State for termination.

As psychiatrists, we are used to working within a legal framework in using the Mental Health Acts. We are used to the importance of wording within the law. Head 4 of this legislation clearly states that it would not be an offence to terminate the pregnancy only if the psychiatrists jointly certify in good faith that there is a real and substantial risk of loss of the pregnant woman's life by way of self-destruction and, in their reasonable opinion, that this risk can be averted only by that medical procedure. Reasonable opinion is defined to mean an opinion formed in good faith which has regard to the need to preserve unborn life where practicable. The emphasis is on the risk only being averted by termination and the regard to the need to preserve unborn life. This wording will restrict the use of this legislation to extremely rare cases.

Dr. John Sheehan: I thank the committee for the opportunity to contribute. I am a perinatal psychiatrist working in the Rotunda Hospital in Dublin. A perinatal psychiatrist is a psychiatrist based in a maternity hospital and he or she treats women in pregnancy or, for example, following delivery. I also work as a liaison psychiatrist in the Mater Hospital, Dublin, which has one of the busiest accident and emergency departments in Ireland. Last year, we had the highest number of treated episodes of attempted suicide in the State, and part of my work is assessing and treating people who present with attempted suicide. I therefore work both in a perinatal setting and in an accident and emergency department setting.

I will confine my comments to the aspect of the Bill that is pertinent to psychiatry, namely head 4, which is concerned with the risk of loss of life from self-destruction. It has major implications for psychiatrists. First, there is a fundamental difference in the management of medical and psychiatric emergencies in obstetrics. In obstetrics, medical emergencies and psychiatric emergencies require different interventions. In a medical emergency, speedy delivery of the baby is required while, in a psychiatric emergency, speedy delivery of the baby is contraindicated. It is exactly the opposite of that required in a medical emergency. In a psychiatric emergency such as when a patent is depressed and has suicidal intent, the patient may have impaired capacity and should be advised not to make irrevocable decisions. The patient probably cannot give informed consent. Those of us who see people with suicidal intent often see people who feel overwhelmed, unsupported and hopeless and who are often desperate and agitated. The person often has what is called cognitive constriction and can see no other option in front of them except ending his or her life. Such a patient needs professional help, not an urgent termination of pregnancy.

Second, psychiatrists are doctors, not judges. If head 4 is enacted, psychiatrists will be asked to determine if there is a real and substantial risk to the life of the mother in order that she may procure a termination of pregnancy. This is a role in which Irish psychiatrists have not been involved to date. Many will not see this as their role as medical practitioners. The role could be construed as making psychiatrists the gatekeepers to abortion. Psychiatric practice relates to assessment and treatment of patients, not assessment and adjudication. Psychiatrists are not judges.

My third point relates to the women who currently travel abroad for terminations. In the submission to the committee earlier this year, the three Irish perinatal psychiatrists - Dr. McCarthy, Dr. Fenton and myself - stated that with more than 40 years of combined clinical experience, we had not seen a single case where termination of pregnancy was the treatment for a mental disorder. If head 4 is enacted, however, it may well change the patient profile currently seen by Irish psychiatrists. It is likely that women will be referred from that population who currently travel for abortion. The extent of mental health problems and suicidal ideation among that population is unknown and, hence, the utilisation of the proposed legislation by that population is unknown.

Fourth, it is impossible for psychiatrists to predict the future. The explanatory notes for head 4 state, "It is not necessary for medical practitioners to be of the opinion that the risk to the woman's life is inevitable or immediate". The risk of a woman dying by suicide in pregnancy is between one in 250,000 and one in 500,000 live births. The risk is exceedingly small. In practice, therefore, it would be impossible for any psychiatrist to accurately predict which woman will die by suicide in pregnancy. Being unable to predict who will die by suicide is, therefore, likely to lead to multiple "false positives". Psychiatrists are trained to assess and provide evidence-based treatments not to predict the future.

My final point relates to the potential adverse effects on the woman's mental health due to late abortion. There is no time limit set in the heads. That is, termination could, theoretically, occur up to a very late stage of pregnancy. Late abortion could potentially have a very deleterious effect on the woman's mental health.

Chairman: I thank Dr. Sheehan. We are now moving into Members' time which is 70 minutes. I remind Members that questions are on the heads of the Bill. In the context of the language we use and the way we behave in the Chamber, if we could be tolerant and respectful towards each other it would be appreciated and, perhaps, remarks could be confined to the heads of the Bill.

Deputy Billy Kelleher: I welcome the witnesses. On head 4, how do the witnesses see the role of the panel in terms of a woman's crisis pregnancy? She may or may not visit her GP or may present at an accident and emergency unit. Her first port of contact, probably, will be through a psychiatrist if she is to go forward for assessment under the panel process. There would be a psychiatrist who would assess the woman in distress. If she felt that the only option available to her was a termination there would be a second assessment by another psychiatrist and an obstetrician. What I am trying to understand is whether the witnesses believe it should be just an assessment process or an assessment with care? In other words, when a woman presents to a psychiatrist I presume it is not a just a box-ticking exercise. I assume they would look at all avenues to see what supports this particular woman in crisis pregnancy needs, as opposed to just assessment, and moving her on to somewhere else. Many people are very concerned about this particular area. I would like clarity on where the witnesses see a role not necessarily on the adjudication but on the counselling, assistance and support.

There is another area I wish to question. Dr. John Sheehan points out that every year an unknown number of women go abroad in crisis pregnancy for a termination. We do not know the exact number who are in deep crisis mentally and psychologically. He said there could be an increase in the profile of people who will present under this legislation. One could argue it is a good thing that women would now try to seek support, assistance and counselling when in crisis pregnancy as opposed to just making the fateful decision of getting on an aeroplane and going to Britain without any supports or services around them. Perhaps he would elaborate on

that particular issue?

The other issue is that if legislation is passed, it will need resourcing, particularly if there is an increase in presentations by women who may be suicidal or with suicidal intent or suicidal ideation. One may argue that is a good thing because they would be making contact with the health services but do we have the resources in terms of psychiatrist assessment, supports and counselling if there is an increase in the number of women seeking assistance or a determination on their mental status?

Deputy Caoimhghín Ó Caoláin: I join with the Chairman in welcoming each of our guests this morning. I wish to put a question specifically to Dr. McCarthy. In relation to the five obligations of the State as set out in the expert group report two of them are referred to as follows: to establish criteria or procedures in legislation or otherwise for measuring or determining the risk to her life, and the other, to provide precision as to the criteria by which a doctor is to assess that risk. Does Dr. McCarthy believe that the draft legislation before us fulfils both of those two criteria from his professional perspective? For the panel, there is a requirement for three professional opinions, somebody from obstetrics and two psychiatrists. I would like to ask for your individual opinion. We would like to know, whether, in the witnesses' respective opinions, this number is too high? Does the requirement of unanimity of all three medical professionals render it difficult or, perhaps, even unworkable in practice and place an undue burden on the woman? In relation to their respective experiences - and they have indicated they reflect both City of Dublin and outside the City of Dublin experiences - will the issue of conscientious objection have any impact on the numbers available, those in practice associated with the respective 19 indicated-for-approval sites? Many psychiatrists are not actually associated with any of these yet one must be in terms of the way the draft legislation is presented. Do you see difficulties presenting there? In your own opinion, who should lead the process? It is not clear in the legislation whether it should be an obstetrician or two psychiatrists. One would expect it would be one, at least, of the two psychiatrists and that person would be attached to the individual site.

In regard to the appeals process because it is particular to head 4 on suicidality, is the timeframe reasonable and workable? Before the Chair pulls me up, as we have only three minutes to ask questions and elicit as much information as possible, I wish to ask Dr. Maeve Doyle, in her role as child and adolescent psychiatrist, if the Bill deals adequately or at all with consentive and minor adults or adults without capacity - that may or may not be under her particular expertise but perhaps she would like to offer her opinion. That is very important. She is only one of two voices coming from a child and adolescent view over the course of today's hearings. I would like to know each of your respective opinions.

Deputy Mattie McGrath: I too welcome our guests and thank them for their attendance. Part one of the test for abortion on suicide grounds, as per the X case, is that as a matter of probability there must be a real threat posed to the life of the mother by way of self-destruction. Can psychiatrists judge, as a matter of probability, whether someone will commit suicide? Can they point to any published research supporting their answer and their views? Would they contend that this part of the X case test is generally unachievable from a psychiatric perspective? The X case judgment stated that abortion could be the only way of treating suicidal ideation. Is there psychiatric evidence for what that judgment presupposed, namely, that abortion can be a form of unnecessary mental health treatment?

In paragraph four of his submission, Dr. John Sheehan said that in a psychiatric emergency, speedy delivery of the baby is contraindicated as it is likely that the patient has an impaired

capacity and should be advised not to make irrevocable decisions in such a state. This is particularly relevant in cases where a person may have developed a transient and negative pessimism, hopelessness or despair which, with treatment, is generally resolved, as stated earlier. In light of this, what does he make of the calls to drastically shorten the processes for deciding on whether a termination in such circumstances is permissible and should such processes be strengthened rather than shortened?

Chairman: I thank the Deputy. Does Dr. McCarthy wish to start? I will take questions in groups of three.

Dr. Anthony McCarthy: I thank Deputy Kelleher for his questions. He raised the issue of the number of women who may go abroad but who now might come here and maybe that is a good thing. It is quite extraordinary sometimes that those who are most opposed to any legislation here, almost totally disregard the fact that, yes, of the thousands who go abroad, most, no doubt, have no mental illness or anything of the sort. Unequivocally, within that group there are women who could do with expert psychiatric care that might well reduce their mental health difficulties. These women could be psychotic, have voices in their head telling them to kill the baby. It might be the worst they have ever done. We have seen some women who have suffered after abortions because they regretted them, and maybe if they had had a psychiatric assessment and treatment, those women would not have gone abroad and would have been treated here and they and their children would now be alive today. We completely disregard these women.

On those who are worried about and want to protect the unborn, we are completely ignoring this reality that there are women going abroad now. We want to pretend that they are not our issue, that if they go abroad and have an abortion that is just not our issue, and we only want to address those who are here now and who want to present in this tiny little narrow window.

This is a personal view rather than a professional view. I think it is a sign of our national ability sometimes just to ignore difficult questions and say let them go to England, Northern Ireland, Norway or wherever they go now to have their terminations or, increasingly, let them take their medication that they buy over the Internet and take it in their hotel rooms here or in their homes, and abort their babies here, as women over centuries have done. I have seen women, now in their 80s, who have talked about sticking knitting needles in themselves before abortion was available in England. There is a terrible Irish social history of the treatment of women in pregnancy who are in distress and if some of those women, who now go and maybe will regret it afterwards, could have professional care and support here, no doubt some of those women could well be treated, some of those women could well be helped and some of their children might be alive today, and that would be a very good thing.

With regards to the panels, the workings of the panels will be difficult. They must be organised. The reality is that the first psychiatrist will have to see the woman. If that psychiatrist, after that evaluation, comes to the conclusion that a termination would be important here - this is a very rare group because I re-emphasise, looking at the procedure here of seeing three different people, the vast majority of women will continue to go to England or take their medication or whatever it is as they are not going to come near us - he or she will then ask a second psychiatrist for a second opinion. I note Deputy Ó Caoláin asked the same question - do I think that is reasonable? In the current social situation in which we live in Ireland, but also as it is reasonable clinical practice, in difficult situations like this it is very reasonable to ask for a second opinion, as long as the obstetrician is not also being asked to assess her suicidality way beyond his or her level of competence. Some of the comments from some of the obstetricians on Friday last just showed a complete failure of understanding of mental illness and mental

distress and the reality of the sort of women with whom we deal in our clinics. That will have to be dealt with.

We need an increase in resources. Between Dr. Sheehan, Dr. Fenton and myself, if one added all of our sessions together, that is not one consultant post in this country. All of us are part-time. There needs to be a huge increase in resources. That is why I finished my opening statement saying that if the result of this is better resources in hospitals for women, that would be a really good thing.

To address Deputy Ó Caoláin's specific question on precision, some of the questions that Dr. Sheehan raised about psychiatrists not being judges and Deputy Mattie McGrath's question about probability, truthfully, we must make probable decisions every day of the week. When somebody comes in to me - not one psychiatrist the committee will hear today will not be regularly in a situation in an emergency department or in an inpatient psychiatric ward or wherever saying: "On probability, I will let this person go home because my clinical judgment is this person will not kill themselves." I make that decision every day of the week. Equally, there is not one psychiatrist who will talk here today, whether for or against this legislation, who has not written on a Mental Health Act form officially "I am certifying this person into a psychiatric hospital today against their will on the basis of a risk to their life.", because we are making clinical judgments here that there is a suicidal risk. If any psychiatrist standing up here today says we cannot make these predictions, ask that psychiatrist, "Have you ever written on a mental health form saying, "On the balance of probability, this person needs to be admitted into hospital against their will, and sometimes treated against their will, because my view is that they have a significant suicidal risk.". That is what we do in our work all of the time and it will not be any different here.

With regards to the issue of unanimity, it is important the psychiatrists are unanimous. Of course, they can be unanimous. Most likely, our unanimous view will be that a termination here is not likely to help. That is likely to be our view because of the tiny little group we will be seeing to whom it would apply. I have total confidence that in the vast majority of cases psychiatrists will be able to agree, "Probably, no," because of the restrictiveness of this legislation, but sometimes "Yes".

We pointed out in our submissions real practical difficulties because of conscientious objectors - I fully support conscientious objectors - about the heads of the Bill as there could be one, for example, Dr. Sheehan, working in the Rotunda on his own. If he does not agree or I do not agree in my hospital, there must be a panel of persons outside and that must be looked at in the heads of the Bill.

On appeals being too long, I am very concerned about the appeals process being so long, particularly because a small number of these women may be very mentally ill. A woman may be very unhappy that we have turned her down, and for two weeks she may have a mental illness untreated. People are worried about what the appeals process will lead to and suggest stretching it out so that no woman will have an abortion who might regret having an abortion. I am worried that if we stretch it out for too long women who need psychiatric treatment will be missed. That is very important. The committee should think of the increased risk because of that. That is the sometimes horrible reality for those of us who have dealt with patients who have gone on to kill themselves.

Dr. Joanne Fenton: In reference to Deputy Kelleher's questions, with regard to the panel and assessment, the psychiatrist is there to evaluate, to assess and to refer for treatment and it

will not be a tick the box exercise. That is our role as doctors - to care for the individual and to make the accurate assessment.

With regard to the women travelling abroad for a termination, we know that there are many who attend. We do not know the specifics of each woman and what her circumstances are, but certainly there would be a number of women who are most vulnerable and have mental health issues. We cannot ignore that group and we need to be able to provide for them here. We need to be able to care for those women.

With regards to resourcing, as has been stated, there are only the three perinatal psychiatrists in Dublin. There are no other perinatal psychiatrists in the rest of the country. Psychiatric care services need to be available for all pregnant women who are attending maternity hospitals. That is essential.

With regards to Deputy Ó Caoláin's questions, I think that there will be an agreement between the psychiatrists and the obstetrician because we are there to care for the individual. We want the best available care for her. It is not about us arguing with each other but providing care for this woman. I am fairly confident that there will be agreement.

With regards to the timeframe, it should be shortened. The longer we leave a woman in distress, the greater her risk of suicide.

On the last question, we are trained as psychiatrists over many years to do risk assessments and to care for and evaluate women. That is what we are trained to do. We cannot predict the future but we are there to give the best available care to these women. That is essential.

Dr. Maeve Doyle: On Deputy Kelleher's statement that 4,000 women go to the United Kingdom for an abortion, what is quite worrying is that there are no figures at all for children. I am being accused of being a broken record about children, but I will continue to be so.

Senator Jillian van Turnhout: Keep going.

Dr. Maeve Doyle: What we are most likely to see is the most vulnerable group presenting again. These are children in the full care of the HSE. They will be subjected to the process here and I do not think it has been thought through adequately.

In terms of resources, obviously child psychiatry is a younger speciality. There are approximately 90 consultants in the country and approximately 70 multidisciplinary teams. There are supposed to be approximately 100 teams. There are five approved centres - that has been referenced in the document - and only 60 beds there. Most of the child psychiatrists are working in the community in catchment area services. Therefore the stipulation in the heads of the Bill that a psychiatrist needs to be attached to an approved centre will not happen and those who are attached to approved centres are not attached to maternity units either. Those are two very practical points that will make this extremely difficult to work on.

The issue of consent, which Deputy Ó Caoláin brought up, will be very difficult for the legislators. If a child is placed in care voluntarily by the parents and is suicidal, pregnant and seeking a solution under this legislation, the HSE and guardians must give consent. What happens if the guardians disagree?

Head 4, subsection 4 states that the woman can always decide whether to proceed with any procedure. That is not elaborated on in the case of a child. How will children presenting with

acute psychosis or significant intellectual disability be able to decide whether to proceed? Our interpretation of the Non-Fatal Offences Against the Person Act is that a child may not refuse treatment as she is not viewed as having the capacity to refuse. Therefore, if a panel decides that a child can go ahead, the child may find herself undergoing a procedure that is potentially life-threatening without the capacity to refuse.

There is an appeals process for a woman. It is unclear who can appeal on behalf on a minor. While there is a review procedure, should a panel disagree among themselves on a course of action, there is no equivalent mechanism for disputing guardians. In respect of the unanimity of the panel, if the issue is suicidality, one would expect it would be the psychiatrists' view that would be taken primarily. We would certainly not be able to advise the obstetricians on when it is appropriate for them to carry out their procedures.

Dr. Anne Jeffers: Deputy Kelleher spoke about the role of the panels. We stated in our submission that we feel nothing in this legislation should subvert the usual pathway to care. We would expect that a woman who finds she has a crisis pregnancy would go to crisis pregnancy counselling services but that we would see anybody who needs input from a specialist psychiatric service. We suggested in our submission that if it is a case in which, perhaps due to conscientious objection, there is no psychiatrist to see the woman, she would be referred to a panel set up by the HSE.

In respect of women who travel, it is very clear, and we have the figures to show, that at least 4,000 Irish women are having abortions in the UK every year. We presume the vast majority of these women are mentally and physically very healthy. They have nothing to do with psychiatry and psychiatrists have nothing to do with them. My concern is for the vulnerable women who may have a crisis and may travel for an abortion and it may not be the right thing for them. We do not have a culture or environment in Ireland in which the woman feels she can discuss that and talk openly about it. The other woman is the one who travels for an abortion and believes that the only alternative to that abortion would be to kill herself. We need to ask what kind of a State we are that we would allow a woman to travel in that state. If this legislation can do something about that, it is to be welcomed.

My colleagues mentioned resources. For community mental health teams and particularly social workers, every community mental health team in the country should have the full multidisciplinary team.

In respect of the requirement for three doctors, we generally feel as psychiatrists that we are the ones with the expertise in managing suicide risk. There has been much talk about predicting suicide risk, but when anybody who is suicidal comes to us, it is our job to assess what is going on for them. What are the factors and what is happening that leads them to believe that killing themselves would be a thing to do? We engage with them - not just the psychiatrist but every member of the team - in finding a way to ensure we can keep that person safe. That is what we do as psychiatrists. We do it every day and we know how to do that well.

In respect of the timeframe, the decision should never be rushed, but a psychiatric assessment does not need to take days. For many of these women we would be talking about two or three hours for the assessment, but one can do a second or third one within a few days, so the important thing is that the woman is not left in distress.

In respect of the degree to which we can predict the risk of suicide, as I have emphasised, what is most important is that anybody who is suicidal feels able to access the service and talk

openly about their concerns and fears. I think I have covered most things.

Dr. John Sheehan: To reply to Deputy Kelleher's point about the extensive mental health problems of women travelling and whether some of those women present for help, it would clearly be a very good thing if that happened. One difficulty we have is that we may have a reasonable idea of the numbers of women who travel for terminations but we have no data on the extent of mental health problems in that group. We have no data on how many of those women are suicidal, so when people make comments about this group, they are entirely speculative because we have no data. Would anything that encourages women who travel for terminations to come for help be a good thing? Of course it would. One only has to look at people such as Bressie on the television last weekend or Alan Quinlan, the Lions and Ireland rugby player, talking about mental health issues and reducing stigma. Anything we can do to help people come forward and seek appropriate help is clearly a very good thing. If that happened, I would be delighted to see it.

Deputy Ó Caoláin raised the difficult question of the numbers - whether there should be two psychiatrists and an obstetrician, and the number of specialists that is required. The core of this question is whether anybody has the capacity to identify that one woman in 250,000 who will go on to commit suicide. Whether it is one, two or three doctors, the number does not improve one's ability to identify that woman in 250,000 to 500,000 because it is impossible to predict with any accuracy when one is looking at statistics as significant as that. The number issue is a difficult one because one is in an area of trying to predict something that is extremely rare.

It must also be said that when we look at the information from the confidential inquiries and the forensic examination of the case histories of women who died by suicide in pregnancy, we see that the very small number of women who die are women with major mental illness such as schizophrenia or bipolar disorder or with alcohol dependence or serious drug problems. This is the group we are dealing with. When one looks at psychiatric involvement, often the psychiatrist is looking at specific risk factors. As Dr. McCarthy mentioned earlier, when we see people with a mental disorder who are deemed to be an immediate risk to themselves or others, the current psychiatric practice is to detain that person is hospital. That, of course, is completely at variance with what is proposed in the heads because they propose that someone who is deemed to have suicidal intent is able to make a decision about having a termination of pregnancy. It is completely at odds with what one would call standard good practice in psychiatry. Deputy McGrath's point tied in with the question of probability which I covered. In the case of probability, doctors assess risk all the time; I do it every day at work. We assess risk in order to reduce risk, to care for the person and to intervene - including even in certain situations as I mentioned - detaining the person in hospital. That is different from what we are being asked to do and what psychiatrists are being asked to do in this Bill. It is also complicated by the fact that with regard to evidence-based practice there is no evidence base to show that termination of pregnancy prevents suicide. There is no data available.

The question comes up too about whether to shorten or lengthen the duration of the assessments. I do not think that the time is the central factor of importance. The woman's mental state is the central factor. As I mentioned at the start of my submission, a person may be extremely distressed, agitated, perhaps feeling abandoned and hopeless. We see people almost every week in the emergency department who may have been bullied at work or there is a crisis at work; they have self-harmed and they come to the emergency department. They then say, "I am resigning". We say to them: "Don't make any decision now. Wait." Such people need time out and support. They need to consider carefully all their options and then, with the level of

distress reduced, they can decide whether to resign or whatever. There seems to be this notion that because a person is expressing suicidal intent that the response has to be a rapid termination of pregnancy. That flies in the face of what we do at work every day of the week. It is exactly the opposite of what is regarded as good practice.

Senator Jillian van Turnhout: I thank all the experts for their very compelling contributions. I have specific questions about head 4 of the Bill. I refer to the submission from the College of Psychiatrists of Ireland which proposes that the term "absence of clinical markers" is incorrect. This has already been referred to this morning. They talked about the absence of biological markers but that there are clinical signs and symptoms. Given the debate and the discussion on Friday, it would be useful and informative if the expert witnesses could elaborate on the reason they propose that this would be deleted from the legislation.

Dr. Doyle raised the issue of the definition of "child" in the legislation. I say to Dr. Doyle not to be afraid to be a broken record on this issue. It is startling that "child" is not defined in the legislation. I am very mindful that we are talking about the X case. Dr. McCarthy said in his statement that, "Suicide in Pregnancy is real, a real risk, it does happen". That is a fact which needs to be clearly stated. He referred to the issue of consent, in particular, with regard to children. It is often the case that consent is regarded as one-way, that a person consents to a medical procedure. However, a person can equally refuse to give consent for a procedure. We need to be very mindful of the use of the word, "consent" with regard to the child. I am thinking in particular of children in care. If I am correct in reading between the lines, other children may have choices because their parents may choose to travel with those children but a child in care will not have that choice. What if the parents do not agree to that? What if that child is in care because of parental abuse, yet the parents may interfere in the choice made by their child? This is an extreme situation which may only arise in one case, but that is still a child in the care of the State.

In the view of the experts, should the legislation include a specific provision with regard to children in the care of the State? I am concerned that such a child could be almost smothered in the process by the number of people who may become involved. This would add to the difficulty for a child with suicidal ideation or intent.

Deputy Peter Fitzpatrick: I welcome the expert witnesses. If a patient is suicidal and suffering from mental illness, will she be legally competent to give permission for an abortion in accordance with head 4 of the Bill? Where a patient is suicidal, would the provision of full-time care, which includes close observation, reduce the risk of self-destruction to a significantly low level? If a patient has stated suicidal intent but is not suffering from mental illness, which criteria will be used by psychiatrists to decide that a real and substantial risk of suicide exists? If a patient is suicidal but not suffering from mental illness, what psychiatric and medical treatment can be provided?

Deputy Denis Naughten: Following from Deputy Fitzpatrick's last question, what happens in a situation where someone has refused alternative interventions? How would this situation be dealt with by psychiatrists? The College of Psychiatry of Ireland's submission is very clear that suicidal assessment should be left to the psychiatric profession. How does this fit into the system of multi-disciplinary medical teams?

How does it stand with regard to the tests that must be included in the psychiatric assessment regarding the need to preserve the life of the unborn? What are the particular skills of psychiatrists in making that assessment if they are doing so on their own? The witnesses have

stated that obstetricians should not be involved in this part of the decision, yet in the submission it is stated that child psychologists should deal with children but that perinatal psychologists should not necessarily deal with adults. I ask the witnesses to elaborate on that point. There seem to be contradictions in the presentations.

What happens if the risk of suicide is as a result of non-fatal but serious life-limiting foetal abnormalities? I am trying to find out the differentiation between early delivery and induction prior to viability. In the case of a patient with a medical illness, the obstetricians endeavour to continue the pregnancy in so far as it is possible but in some cases where the woman wishes to have a termination - please correct me if I am mistaken - I presume it is important that induction would take place prior to viability. How do doctors deal with such a situation if the woman presents late with a non-fatal serious foetal abnormality which is very close to that 22-week threshold of viability?

Dr. John Sheehan made the point that the procedure in the legislation contradicts good practice in psychiatry. I ask him to elaborate. I ask him to give his views on the fact that with regard to infanticide, women who have recently delivered are treated differently from anyone else in society who may be accused of murder.

Dr. John Sheehan: I will begin with the first question on the absence of a clinical marker in head 4. There is no specific clinical marker to assess suicidal risk. A risk assessment will include whether a person has a current mental disorder, such as depression or a depressive illness. It will also examine alcohol or drug use and then it will look specifically at a whole range of risk factors. We also take other factors into consideration such as gender because suicide is four times more common in men than in women; the peak in suicide depending on age with a peak in young men and in older people. There is a range of factors to be taken into consideration. However, there is not a scientific formula. There are different scales, for example, the use of what is called a hopelessness scale. These scales are helpful. However, I think all we could actually say it that these are helpful as opposed to being definitive. Therefore, there is not a definitive clinical marker in that regard.

The second question raises an interesting issue concerning a person who is suicidal and has a mental illness. The bread and butter of psychiatry is seeing people with mental illness or mental disorder who, for example, may be suicidal. Good standard medical practice comes into play there - that is, everything from evidence-based treatment, such as cognitive therapies, day hospital care and admission to hospital. There is a wide range and medication may be used. In those situations, dealing with a person who is suicidal with mental illness, the principles are to target the mental illness and keeping the person safe.

It gets more difficult when a person does not have a mental illness. Anybody who works in an emergency department, particularly in the inner city, regularly sees homeless individuals who essentially want a bed for the night. They will come in and say they are suicidal and I need to be admitted. When one delves down to what is going on, they need a bed for the night and that is what they are looking for. They know that by asking the question in that way, that is how they can access a bed. It becomes much more complex when one is dealing with issues that do not relate to mental illness or mental disorder as such.

The liaison psychiatry faculty, of which I am a member, represents doctors who largely work in emergency departments and see people who have attempted suicide. They would question the validity of an assessment of an individual who does not have a mental illness but who, for example, is requesting or demanding something. It can be quite difficult to be certain and

accurate in an assessment when a person does not have a mental illness or mental disorder.

I also wish to allude to some other points. If a psychiatric assessment is done by a psychiatrist or a member of a multi-disciplinary team, in certain services members of the multi-disciplinary team have conducted assessments of people presenting after self harm. Nationally, it tends to be a psychiatric assessment but there are services that have involved people from the multi-disciplinary team concerning people who have done self harm.

We warmly welcome the clinical care pathway programme which is coming down the tracks. It will involve having specialist nurses doing assessments of people post-self harm. We welcome that but it is not a psychiatrist doing the assessment there.

Finally, I will deal with the issue of infanticide, which is extremely rare. Resnick divided infanticide into two types: early and late. Early infanticide was where a mother killed her little baby within 24 hours after delivery. In that situation, the woman was often usually very young, completely unsupported and immature. She felt she had no other option but to do what she did, but certainly did not have a mental illness.

Infanticide that occurs later is related to major psychiatric illness and usually what we call psychosis. This is very rare and clearly very tragic when it happens. That is the issue concerning infanticide.

Dr. Anne Jeffers: To start with, we would see it as a question on the absence of biological markers, rather than clinical markers. I do not think people will be asking obstetricians to explain how they do their job. It is really difficult for me to distil down the amount of training and expertise I have, the 30 years' experience and working with multi-disciplinary teams, to try to adequately get across the expertise of a psychiatrist in assessing suicide.

I will give an example of somebody who might come to us in this situation, Often, it is a young woman who may herself have had experience of extreme abuse in her childhood, may have been raised in care, may already have had children taken into care, and may be coming to us with the prospect of going through another pregnancy when she fears that the child may be taken into care also. These are women who, because of their circumstances, have not been able to build up the normal social supports that the rest of us rely on to get by. They come to a psychiatrist and a multi-disciplinary team. A social worker will meet with them and a psychologist will be involved. Between us all, we will be offering support to this woman. We are not just talking about a once-off assessment, we are talking about ongoing care and support. The important thing is that we identify where the hopelessness is coming from, identify what the issues are and what we can do about them. That might describe how we, as psychiatrists, assess clinical risk.

I was interested in Senator van Turnhout's statement that we may only be speaking about one case of somebody who is in care or a child in care. A lot of the women we see in these stressful situations would themselves have been in care and often have children in care.

Senator Jillian van Turnhout: Okay.

Dr. Anne Jeffers: On the issue of whether somebody who is suicidal can give consent, once again it is about working collaboratively. That is what we do in psychiatry - we work closely with the individual who comes to us with the problem and we ensure that, as regards decisions that are reached, the person is capable of making that decision. It is very clear in the Bill that the person has to, although they have not addressed the issues where the person does not have

the capacity. We will certainly be working with the person who has the capacity.

If they do not suffer from a mental illness, this is a difficult area. The whole issue of what we do if somebody comes to us and we think there might be another intervention other than a termination, yet they are very determined that a termination is the only answer. The Mental Health Act would not be applicable in this case. There may be cases but it is hard to describe. I think we would have to try to understand why the person was reluctant to take on any of the treatments we are suggesting. That goes back to their childhood experience and their psychological make-up. There are usually reasons why people cannot avail of treatments that we may be offering. That is what we do in our day-to-day practice, but there may be cases where we have to say to women, "This law doesn't apply to you". They have autonomy and have to make their own decisions. In practice, that is not going to be a decision that is made by one psychiatrist - it is part of the team approach.

The question was raised concerning how one handles a situation where somebody will not accept treatment. The issues of early induction and infanticide were also raised. I will leave these matters to the perinatal psychiatrist.

Dr. Maeve Doyle: I was very pleased with Senator van Turnhout's contribution. It was heartening to acknowledge that we are here because of the predicament a child found herself in.

I will talk a little bit about child psychiatry. We work in a multi-disciplinary way and child psychiatry was probably invented in a multi-disciplinary way. That is because we consider the children as part of a system with family, school and the wider environment. As child psychiatrists we assess for the presence and absence of psychiatric disorder. We are well used to working with our colleagues and tend to devise protocols where we look at deliberate self harm and suicidal ideation, but we always have access to the psychiatrist to determine whether there is an actual mental illness. I think Senator van Turnhout's question on whether specific elaborations with regard to children and adolescents may be needed is a good one because the complexities of the situation with regard to consent, refusal, capacity and so on are not very well understood. I will give members a short example with regard to the admission of young people to inpatient units for mental health assessment and treatment. The child's guardians can sign the admission form on behalf of the child, assuming the relevant guardians are happy to so do. In the absence of that consent and if a determination has been made that a child requires admission to an inpatient unit either for assessment or treatment, then recourse is made to the Mental Health Act 2001. In addition, if a child is in the care of the HSE and admission is sought, the practice, based on legal advice, is that the protection of the Mental Health Act is sought. In cases in which a child is 16 or 17 years old and explicitly states he or she does not wish to be admitted, while his or her guardians are keen that he or she be admitted, it has been deemed prudent to seek the protection of the Mental Health Act in case a situation arises in which the treating team may be obliged to physically administer medication against the will of the young person. The overriding principle in all of this is that the welfare of the child is paramount. However, it is the appropriate adults who determine what is, in fact, in a child's best interest and perhaps something such as a guardian *ad litem* might help in this procedure. I really wish to highlight that it is not that the legislation is unworkable - we will work with it- but we need to flag, in particular for children and adolescents, the additional layers that must be considered.

Dr. Joanne Fenton: I will address some of the questions from Deputy Fitzpatrick, the first of which pertains to an absence of clinical markers. As Dr. Jeffers mentioned earlier, we are trained to carry out risk assessments and to look after carefully and treat the women. It takes many years to do this but we are very competent in making those assessments. In the case of

a woman who presents for an assessment stating she wants to have a termination and who is psychotic, it would be our role to treat that psychosis, rather than making the judgment to have a termination. Consequently, it is within the capacity. In addition, we would make that decision along with the obstetricians. We would make our psychiatric assessment and then would speak with the obstetricians, so we would work as a multidisciplinary team.

Dr. Anthony McCarthy: I thank members for a number of interesting and thoughtful questions. I will not refer specifically to the child issue because Dr. Maeve Doyle has covered it well and adequately. I note that, again, there are technicalities on which we really must work and while none of them is insuperable, we must work on them. In addition, I will not answer anything further about clinical markers, as that point already has been made.

Yes, suicide is a fact. When people talk about figures, such as one in 500,000 or one in 250,000, it is desperately important to note we actually do not have a clue because these figures are based on the fact that this is a country, the United Kingdom, in which abortion is directly available. I am on that confidential inquiry that considers those maternal deaths to which Dr. John Sheehan has referred but, yes, absolutely, those who commit suicide in the United Kingdom at present nearly always are mentally ill. However, that does not at all account for all the other hundreds of thousands of women who have terminations in England and who may well be mentally distressed and may well have that termination because they are suicidal. Nothing captures that at present and nothing will. Consequently, one must be very cautious about that sort of evidence.

Again, I will not address Deputy Fitzpatrick's questions too much because I believe I covered that issue in my opening statement. I agree that some people have mental illness and it must be treated. In the case of some people, it is mental distress. In the reality of our clinical work, we really are dealing with the complex interaction between stress, distress and mental disorder. If only life were black and white and one could say these ones are mentally ill and should be treated psychiatrically by getting them into hospital and observing them carefully, whereas these ones are in psychosocial distress and should be dismissed. That is not life and every one of you in this room knows that. It is much more complex than that and our jobs and experience are to weigh up these factors. As for the woman who refuses alternatives, we are not naive. If a woman comes to me, having refused all other alternatives, my question will be "Why?". Why is she sitting in front of me if her only option is a termination of pregnancy? Why has she not gone to England? This will be part of the process as we are not fools and it will be a highly complex discussion. The question will be whether she is trying to test the legislation or is it the case she cannot leave the country for some reason. As for the idea that this would be blocked in some way or that she will present in that way, namely, that she refuses everything else and consequently it is up to me, in itself that is a very complex interaction. We are used to dealing with people who put us under all sorts of stress to make decisions. Dr. John Sheehan made reference to people in the emergency department who threaten to kill themselves unless they are given some methadone because their methadone was stolen in the hostel. We are used to being put under pressure. While that might seem like a job that most of you would not like, I love my work. It is really complex but it also is very human. We are aware of the complexities and interactions and are not naive.

A member, whose name I did not get, asked a very good question about multidisciplinary teams. While we work in multidisciplinary teams, there are times when, as psychiatrists, we are the ones who must make that final decision. We have talked a bit about involuntary detention within hospital and it is the consultant's name that goes on that form. Similarly, for someone

who has been previously detained, it is the consultant's name that goes on the discharge from hospital form. If that patient appeals against his or her detention in hospital, I as a consultant must go into that room and defend. It is not my multidisciplinary team, just me. Consequently, as psychiatrists we are used to being the individuals who take these decisions. That is our responsibility and duty and is one for which we all are very well trained.

On the viability issue, I agree there are highly complex issues about viability. I think that really is up to our obstetric colleagues to deal with. There are of course complex, painful issues that sometimes must be dealt with. If a woman is six weeks pregnant, my conversation with her will be very different when compared with that with a woman who is 16 weeks or 26 weeks pregnant. We know that. Why does she wish to get rid of that baby? Does she wish to get rid of the baby or does she wish to kill herself? Moreover, if she wants to get rid of that baby, is it because she cannot bear having that baby inside her? Perhaps she has an eating disorder and already has taken three overdoses in the course of that pregnancy because she cannot deal with that real distress. I am sure it is difficult for all of you to understand but I refer to an anorectic who sees herself as totally fat and the issue actually is that she wants the baby out. This is in contrast to someone else who wants that baby killed because it is her father's child or because she actually is in a relationship with a guy who she should have left years ago. When she got pregnant, in that ridiculous way she would do, she kind of imagined that somehow having a baby with him might make him be nice. However, we know that, actually, men are more likely to have affairs during their partner's pregnancy and certainly levels of domestic violence increase during pregnancy. We men do not come out well out of all this. This is a woman who already has been kicked three times in the stomach in pregnancy and who knows now that if she is pregnant, her issue is that if she has this baby, she will never get away from him, because he will be the father of the child and she will be obliged to stay in this country because he will have rights. Consequently, she has a choice, namely, does she kill herself or does she get rid of that baby or perhaps both, but if she has that baby she is stuck. If this conversation takes place at 16 weeks or 22 weeks, yes, we would try to help as much as we can. However, if anyone can say there never will be a woman in this circumstance, he or she really does not understand the messy, horrible nature of life sometimes. I refer to the real mess, the bloody issues that go on. That is the reality which we must deal with and assess, not as cold pre-judgmental black-and-white people but as real professionals who understand mental illness, mental disorder and capacity, but who also understand that, sometimes, it is not black and white and is not easy.

Finally, while talking about bloody issues, let me get back to infanticide, to which I referred the last day I was here. I got a lovely letter from a priest afterwards thanking me for raising this horrible part of Irish history, namely, the history of hundreds of women who committed infanticide every single year in this country during the 19th century and the first 50 years of the 20th century. Wonderful studies have been done on this issue and these were real. The study to which Dr. John Sheehan referred is about infanticide now and not about infanticide then. Infanticide then was not all about mental illness or anything like that. It was about women who found themselves in extremely difficult situations. The treatment of unmarried women, women with unwanted pregnancies in this country is not great, is it? I refer to the Magdalen laundries, industrial schools and psychiatric hospitals. We as a profession played our part in having women in hospitals for many years. For what reason? We colluded with unwanted pregnancies. The reason I stand here, not just as a perinatal psychiatrist but as a human being and as president of the college is to say that should stop. We must do anything that will protect women in these circumstances. The women will be treated with dignity and respect. If at all possible, the life of their unborn child will also be preserved. That is not only my responsibility under the Constitution and the law but also as a human being and as a father. If a woman goes

on to kill herself, her child or children die as well. Such situations happen. They are real and it is our job to prevent that.

Chairman: We have 23 minutes remaining in the session. I apologise to members, as not everyone will get to contribute in this session. Six members have indicated to speak. The next three to speak will be Senators Ivana Bacik and Colm Burke and Deputy Mary Mitchell O'Connor.

Senator Ivana Bacik: I thank the witnesses for their compelling evidence and for clarifying a number of important points for us. First, that psychiatrists have the experience and expertise to assess suicide risk, that it is something they all do routinely and that in particular they are used to operating within the statutory framework of the Mental Health Act and of adjudicating on detaining people against their will on the basis of their clinical assessment. That is very helpful to us in the context of some of the comments we heard on Friday. It is also helpful to hear from them that abortion is not a treatment for mental illness but rather it may in rare cases be required in order to avert the risk of suicide. That is the language of the Supreme Court and of the heads of the Bill. That is helpful as that is what we need to work within.

Psychiatrists have also pointed out the highly restrictive nature of the legislation, and as a result the reality that for the majority of women who travel – the 4,000 women - every year for abortion will continue to do so and will not avail of the highly restrictive procedures in this country. Dr. Doyle put it extremely clearly that the majority of the very small number of women or girls who will avail of the measure will be those in the care of the HSE who are unable to travel otherwise. The comments on the amendments on children are very important.

I wish to ask a couple of specific questions on other points about amendments. In head 4 there are currently two specific restrictions on psychiatrists requiring that both of the psychiatrists will be employed at a centre registered by the Mental Health Commission and that one would be attached to an institution where a procedure is carried out, in other words, a maternity unit. Concern was expressed on Friday that this was too restrictive, as there would be too small a pool of psychiatrists from which to choose. Could the witnesses comment on the point and whether we should broaden the definition?

As a criminal lawyer I am extremely concerned about the definition of the criminal offence involved in a head that has not yet been referred to today, head 19, in particular the criminalisation of women. Some of the witnesses have pointed out the reality that many young women in particular are availing of abortion pills over the Internet resulting in self-induced abortion in this jurisdiction. Under the current wording they would be subject to criminalisation and a 14-year penalty. As psychiatrists, do the witnesses believe that would have a chilling effect on women seeking help in after care?

My final question is for Dr. Sheehan. I apologise if I misunderstood him, but is he suggesting that a girl like X who is suicidal because of her pregnancy and has been denied an abortion would never commit suicide? How would one care for a young woman or girl in that situation who wants to kill herself because she is denied abortion. She is very clear about that. Does he suggest she would be detained involuntarily for the duration of her pregnancy? That is a serious suggestion. I apologise in advance if I misunderstood his meaning.

Senator Colm Burke: I thank all of the contributors this morning. The submission on the role of psychiatrists in making the decision is in line with the Medical Council's proposed amendment under head 4, which was presented to us on Friday, namely, that the psychiatrists

would sign off on the psychiatric issue and then there would be consultation with the obstetricians. Do psychiatrists feel that GPs should have a more involved role in the decision-making process or are they happy with the Medical Council's proposal to deal with the issue?

The second issue relates to pregnant adults under psychiatric care at present. How is the issue of consent currently dealt with if, for argument's sake a decision is taken that a person needs a caesarean section? Does current legislation allow medical practitioners to take a decision without referral to a judicial process?

The third issue is one about which I have serious concern. It relates to expectant mothers aged under 18 or under 16. What clarification needs to be provided in the heads of the Bill to deal with the issue? What protection must be provided for the expectant mother, the parents and the doctors dealing with such cases? What clarification would the witnesses suggest is required under the section?

Deputy Mary Mitchell O'Connor: I thank Dr. Maeve Doyle very much for raising serious issues around the legislation. We must examine specifically what she has raised today. I thank those witnesses who mentioned compassion. As a woman and a mother I really appreciate that.

Dr. McCarthy stated that all assessments must be individual, comprehensive, compassionate and not prejudged. He stated that he is the president of the College of Psychiatrists of Ireland and a specialist in perinatal psychiatry. Does he foresee that some women will be prejudged by his profession if the Bill goes ahead?

It has been stated that there are 864 members in the College of Psychiatrists of Ireland. A recent survey was completed by approximately 130 members. I wonder why the other approximately 600 psychiatrists did not answer the survey. Was the survey widespread? In my ignorance I thought there were only approximately 130 psychiatrists in total.

Chairman: Could Deputy Mitchell O'Connor please address the Bill?

Deputy Mary Mitchell O'Connor: This is relevant because we received information on the survey by e-mail.

Dr. McCarthy asked a question which I would like to echo on whether psychiatrists have ever signed a form for involuntary detention of a patient due to the risk of them being a danger to themselves? Could they ever foresee that they might have to do that for a pregnant woman? I will leave it at that. Perhaps the Chairman will allow me to speak again if necessary.

Chairman: We will not have time but if I can I will. Three other members have indicated and I will take them now if that is okay. I accept it is difficult on the witnesses but I wish to be fair to members who have been present all morning. I call Senator John Crown, Deputy Catherine Byrne and Senator Jim Walsh.

Senator John Crown: In formulating the decision as to whether suicidality will be in the Bill, the five witnesses have the same rights as any five citizens of our country in a popular referendum. The decision has been made by the Supreme Court, which according to Article 34.4.6° of the Constitution states that the decision of the Supreme Court shall in all cases be final and definitive. That can be challenged by the people in popular referendum. That has happened twice. On the first occasion when it was asked clearly and unambiguously it was defeated by a margin of 2:1. There really is no constitutional mechanism for us in this Chamber to decide that we are not going to include suicidality or that we are going to specifically exclude

suicidality from a Bill which allows abortion to save the life of the mother.

What we need the witnesses to do, which they are doing very well, is to inform us about some of the relevant practical issues. The reality is psychiatrists do not change the Constitution but they determine psychiatric practice and the psychiatric evidence base. Therefore, when constitutionally mandated psychiatrists at some hypothetical – I believe it may never happen – occasion in the future are confronted with a pregnant woman who is suicidal and are asked to make an adjudication within the rules of the law which we will be asked to pass sometime during 2013, it is their job to formulate the evidence base which best informs the psychiatrists who will be in that position. In truth, what they have told us today is very useful.

I have a few specific questions to ask. One is to my very old and dear friend and colleague, Dr. John Sheehan. If we believe that there will be a net transfer of women who are now going to the UK for abortions to this country - in the event that this new regime occurs - we have to ask why. It will happen for one of two reasons. The first reason is that they are legitimately going to the UK because they are suicidal to seek a legal abortion which they believe might not be freely and legally available in this country. The other alternative is that they are not going to the UK because they are suicidal but will try to game our system. To game our system they will need to do it with the free, voluntary, informed collusion of two psychiatrists. There is no other way round this and some of our witnesses in January were tying themselves in knots about this, saying floodgates will open but women will not lie. They never explained what the mechanism would be. We will have informed psychiatrists who have the evidence, which tells them a woman is or is not suicidal.

I am a little confused by one thing. In the course of my job I must frequently take histories from people who are very distressed. Sometimes they say they often think of ending it. That is a red flag to me and I must refer them to a psychiatrist who is more skilled than I am in assessing the likelihood that suicide will nor will not occur. I am hearing this morning that psychiatrists cannot do that and I am troubled by that. I feel very vulnerable when I do not send someone to a psychiatrist in case some tragedy happens. As an oncologist who has had a patient commit suicide, I need to know we have the back-up of psychiatrists on this.

Deputy Catherine Byrne: This morning I looked at the logo for the College of Psychiatrists of Ireland - wisdom, learning and compassion - and those are what this Bill is about. We must have the wisdom to make the right decisions, the learning skills to listen to witnesses and above all, we must all have compassion. Unfortunately this is not about the lovely, beautiful 4,000 women who go to England every year. It is not about them. I agree about the length of time for the appeals.

Have any of the witnesses in their profession, because of the increase of illegal drug taking by young women, particularly in Dublin, any evidence that more young women who are pregnant with mental illness are contacting their practices? Is that leading to people wanting to end their pregnancies?

Senator Jim Walsh: Capacity to consent is an issue. Could we get some idea if what this entails? My understanding is that where a major decision is being made by someone who has a mental illness, not to talk about being suicidal, it does not stand up in law and he or she would be discouraged from doing it. Abortion is an irrevocable decision which would be recommended.

On a point made about the X case, would the witnesses comment on the progress in psychiatric medical evidence in the last 21 years since the X case? We know the Supreme Court and

the High Court got no psychiatric evidence at that stage.

When the obstetricians were in on Friday, they were very strong on doctors being ethically obliged to act on medical evidence. The institute chairman emphasised this in his report to us. Above all, they maintain "do no harm" and the two patient model was something they espoused. The witnesses today all agree abortion is absolutely not a treatment for suicide and I am glad that has been reinforced on the record. That would present a moral dilemma for them in that they will be asked after the decision is made by psychiatrists that someone is suicidal. How accurate is that prediction likely to be? We heard evidence on the last occasion that a British study showed there were 97% false positives.

A woman might present who is 26 weeks into the gestation period and who says she will commit suicide. She may well feel she is going to commit suicide because she wants an abortion, she does not want to have this baby. She is not happy with an early inducement, which does not satisfy her suicidality, she wants an abortion. What would the witnesses do? What would they certify with regard to abortion or inducement?

Chairman: We have nine minutes left in this session. I will be fair to everyone.

Dr. Anthony McCarthy: Absolutely, 14 years seems extraordinary, as we know so many women are already doing it here. That is the truth of the matter.

In reply to Senator Colm Burke, we agree with the Medical Council and recognise the role of the GP and the importance of consulting with the GP where possible. Consent for caesarean sections is an obstetric issue and as a psychiatrist, I have no comment to make about consenting to caesarean sections.

Specifically to answer the question about the survey of 113 psychiatrists, I am sure every one of the 864 members of the college got the survey, I certainly got it. When I saw myself misquoted or selectively quoted in it, and a comment that all psychiatrists who attended the last time all agreed, and the complete ignoring of comments that Professor Veronica O'Keane made, I thought it was survey not even worth answering because it just was not a survey that anyone could stand over scientifically.

Senator Crown asked a specific question about capacity. It is a complex issue and we could talk about it for hours. That is why the Legislature has been resting for a very long time trying to get capacity legislation. Capacity is not a simple concept. Someone can be mentally ill and still have capacity. Someone might not be mentally ill but not have capacity. A person could have capacity for some decision making but not others. It could be due to mental disability or brain injury. It is a complex issue but we certainly must think about it when making any of these decisions.

Have I ever certified someone? I have certified a woman into hospital who wanted to kill her baby. She had a delusional voice in her head telling her to do that. Clearly abortion would not have been the treatment of choice. She was very distressed at the time but very relieved afterwards. Equally, I have seen people who have stabbed themselves in the stomach and who have taken multiple overdoses in pregnancy who were not mentally ill, they were profoundly distressed and at serious risk to their own life and the life of the baby. We must dismiss the notion that somehow we can neatly discriminate between mental illness and distress because they interact.

I answered the question on the issue of the 26 weeks and suicidality the last time. I would

say to Senator Crown that if there are psychiatrists who will not assess his patients, I will be delighted to see them if necessary and will happily stand over my views.

Dr. Joanne Fenton: With regard to head 4, the number of psychiatrists being attached to the maternity hospital, it is restrictive and must be re-examined. There are only three of us attached to maternity hospitals.

The role of the GP is key. The GP will often know the patient best and be able to do initial non-directive counselling and refer on as needed. There was a question if women will be prejudged. Our role as psychiatrists is not to prejudge individuals presenting for assessments, our role is to act as treating psychiatrists and give care and compassion and not prejudge any woman. I do not think that is going to happen.

Have pregnant women been signed into hospitals for suicidal ideation? Absolutely. There are people who are psychotic and who need treatment for their mental illness. If they are treated for their mental illness, that will avoid the question of termination or the need they felt at the time.

I have seen people with an increase in substance use and suicidal ideation. Substance abuse is all around, particularly in the inner city, and in the suburbs. We must treat the individual on her substance abuse and suicidal ideation.

Dr. Maeve Doyle: On the role of the GP, some parents will take a child who is pregnant to their GP and some will not, and will take other decisions. It is important to note in some of the recent reports on children in care, only a third of the children in the care of the HSE had a GP. That is being looked at now.

There would have to be some easing out for child psychiatrists in the number of doctors on the panel given there are only six child psychiatrists working in approved centres, none of whom are attached to obstetric units. All the remaining child psychiatrists are in catchment area communities. I do not know who asked the specific question about how one would sort out the various consent issues that arise in respect of those aged under 16 years and 18 years. The Law Reform Commission produced an excellent document on this matter, the recommendations of which have not been enacted. Clearly, the matter needs to be addressed.

Dr. Anne Jeffers: On the issue of all doctors being linked to approved centres, our submission states that this issue needs to be examined. Not every maternity hospital has a psychiatrist working in the unit and this issue needs to be addressed.

The general practitioner is of great importance. As general adult psychiatrists, we work very closely with GPs and we believe it would be sufficient where it states that one of the psychiatrists would contact and discuss with the general practitioner. We will discuss with the GP in these cases at any rate.

On the issue of prejudgment, as we stated, at an individual level we do not judge before we have listened to and heard the individual's story and account of his or her difficulties.

On the survey, I was sent a copy of the survey and, likewise, my concern was the way in which the questions were posed. It was difficult to answer in a reliable way. As psychiatrists, we are trained to evaluate evidence and the literature and we drum it into our trainees that we have to be very aware of bias. We must look at who are the authors of the study and what their thinking may have been. We also have to be aware that when we are reading the literature we

put our own biases on what we read and we often remember and zone in on something that already supports what we believe.

On the practical issues, all psychiatrists would be very competent at assessing suicide.

On the capacity to consent, I emphasise that, other than in cases of psychosis which has been referred to, most people with mental illnesses have capacity and are able to make informed decisions.

On the accuracy of our decisions, in psychiatry our predictions are often more accurate than in other areas of medicine. Our work is about understanding where the individual is coming from. That is what improves the accuracy in assessing suicidal risk.

Dr. John Sheehan: I will reply to some of the questions that have not been covered so far. Senator Bacik asked if I could state that X would never commit suicide. I do not believe any psychiatrist or doctor can ever make a statement that a certain person will never commit suicide. It is equally true, however, that it is also impossible for a doctor to state that somebody will commit suicide. The position in which psychiatrists are potentially placed by the legislation is to state that there is a real and substantial risk that the person will complete suicide. Even studies that looked at very high risk populations, which do not include the population we are discussing, show that in such very high risk populations an expert will be wrong in 97 cases out of 100. Prediction is, therefore, very difficult; in fact, the word I would use is "impossible".

To tie this in with the issue raised by Senator Crown, psychiatrists are experts in assessment and treatment. However, this brings us back to the same area, namely, one of prediction, which is something psychiatrists cannot do. While we are extremely good at dealing with and managing risk, in other words, reducing risk, prediction of the future is something completely different.

On the issues of assessing people in a compassionate manner and prejudgment, I return to the point that the group we are talking about are individuals who are extremely distressed and may be utterly hopeless and see no way forward except ending their life. That is the reason I stated that the management of a psychiatric emergency in that type of situation is totally at odds with the management of an obstetric emergency.

Chairman: At this juncture, I formally welcome to the Chamber the former Democratic Senator from Arizona, Dennis DeConcini, his wife, Patty, and Mr. and Mrs. Jim Kelly from Washington.

We will now have 30 minutes for non-members. Seven speakers have indicated and I call Deputy Terence Flanagan, Senator Rónán Mullen and Senator Fidelma Healy Eames.

Deputy Terence Flanagan: I have questions for the experts on three areas under head 4. Has the Irish College of Psychiatrists given significant consideration to the way in which the health grounds for abortion in other jurisdictions have been abused, particularly by pro-choice physicians, to permit abortion on wider grounds? In the United Kingdom, for instance, some medical practitioners have flouted the law by pre-signing abortion consent forms. Should the proposed law be more cognisant of the real possibility that abortion safeguards will be flouted, especially by those who consider that such safeguards limit the expression of abortion rights?

If the experts formed the opinion that a patient who was 20 weeks pregnant was suicidal and this constituted a real and substantial risk to her life which could only be averted by the

termination of her pregnancy, would they feel obliged, under the proposed legislation, to try to delay the termination for a number of weeks until the baby was viable or should the law in this case explicitly provide for such an obligation? Are the experts familiar with what occurred in the State of California before the United States Supreme Court decided in Roe *v*. Wade that abortions could be performed for a variety of reasons, including to preserve the mental health of a pregnant woman, and only if a hospital committee consisting of two or, in some cases, three physicians unanimously agreed that the pregnant woman was suffering from a mental illness to such an extent that she was dangerous to herself or to the person or property of others or was in need of supervision or restraint? The standard was essentially the same standard as that used for civil commitment. It is highly relevant, despite this highly restrictive exception made in 1970, that more than 65,000 abortions were approved by hospital committees and almost 63,000 abortions were performed. Clearly, physicians who believed in the right to abortion manipulated the inherent subjectivity of the mental health ground for abortion to make abortion more accessible. On what possible basis can we be assured that, over time, this psychiatric exception in head 4 will not be similarly abused? Should the safeguards in the draft Bill not be strengthened to counter against such abuse?

Senator Rónán Mullen: I thank all the experts. I will first pose a housekeeping question which I have put to previous expert groups and will also ask subsequent expert groups. Will the witnesses indicate whether they have been consulted or contacted by the Department, Health Service Executive, Ministers or officials on the heads of the Bill since the expert group report was published? Were they consulted on the paper presented by the College of Psychiatrists?

Dr. Sheehan makes an interesting point that psychiatrists, as medical practitioners, do not view this as an appropriate function. Does he mean that this is not so much a matter of conscientious objection but one that is not considered to be good medicine by many psychiatrists?

He also states that speedy delivery is contraindicated. Is he saying that we are proposing to legislate for something a psychiatrist cannot know and should not do?

On the question of capacity, can it be said, definitively, that a person who is suicidal has capacity for making irrevocable decisions? Is it possible that suicidal thoughts always affect consent at some level? What are the witnesses' views on that issue? Are the witnesses concerned that what is being proposed here, following on from Deputy Flanagan's questions, could be the means of bringing about a greater demand for abortion for what might be termed social reasons, however tragic and difficult the human circumstances may be?

I wish to ask the psychiatrists generally whether there is any other case where psychiatrists certify for something, when a person presents with suicidal ideation, that is to the detriment of somebody else's rights. Is there a precedent for that? We hear of court cases where people ask, for example, not to be deported and mention that they are suicidal and we sympathise very deeply with such situations. Have psychiatrists ever certified for something that would be to the detriment of the rights of a constitutionally-protected actor, in this case the unborn, or indeed, somebody else? Have they ever certified against somebody else's best interests?

In the view of the psychiatrists, where abortion is certified, is there any way of knowing that this will not turn out to be adverse to a woman's mental health? We are conscious of the non-existence of any evidence based on the cohort of people who present as suicidal, but there does appear to be evidence, albeit contested, that there is a low to moderate increase in mental health risk to women associated with abortion. Could that include the cohort of women who are suicidal? Could a psychiatrist be concerned that, in certifying for an abortion under this

legislation, he or she might be exposing a person to such risk or indeed, have no way of knowing that he or she is not?

Senator Fidelma Healy Eames: I thank the panel for sharing their professional expertise with us and applaud their stamina. My first question is directed to Dr. Maeve Doyle, who is sharing her experience of the very complex area of child and adolescent mental health. Under this proposed law, could Dr. Doyle grant a 14 year old pregnant girl with suicidal intent an abortion without her parents' consent? Where are the parents in this situation? What about the situation where one parent agrees but the other does not, in the case of separation, for example? I am conscious that this is a very complex area. A young person in care may already have suffered abuse, abandonment and so forth, but are we not in danger of loading another injury on her with abortion, knowing that there is evidence that post-abortion, girls and women do experience suicidal thoughts?

My next question is directed to Dr. John Sheehan and concerns head 4. In the last few months we learned about a brave young man, Donal Walsh, now sadly passed on, who asked young people to turn away from suicide. With this Bill, are we in danger of normalising suicide, suicidal threats, suicidal ideas and so forth in society, by providing for a law that is a gateway to obtaining something else? Is this not a potentially dangerous practice, akin to a positive reinforcement? Suicide is being used to get an outcome, in this case, an abortion. Might I say, it need not be just an abortion? If the Government passed a law tomorrow morning providing a mechanism whereby a person could get a 50% reduction in his or her mortgage once there was a stated, certified risk that he or she was suicidal, a lot of people would surely avail of that. We are talking about changing behavioural norms here. We have seen this happen in other jurisdictions which has led to the opening of the floodgates. Why, therefore, should we have head 4 if there is even a possibility of its abuse, when balanced against two rights, namely, the right to evidence-based treatment for the pregnant woman and the right to life for the unborn child?

Deputy Brian Walsh: I thank the witnesses for their very helpful, valuable and insightful contributions to the proceedings this morning. Dr. Anthony McCarthy's contributions in January were equally insightful. To what extent does he believe that his contributions were taken on board in the drafting of the heads of the Bill that have been presented? He expressed very serious concerns on the national airwaves about the prospect of vulnerable pregnant women having to present in front of a panel of psychiatrists and obstetricians. He went on to say, subsequent to the interview he gave to "Morning Ireland", that he felt that many of his peers from the College of Psychiatrists would be very reluctant to engage in that process. Is there a fear that the void that creates - if it does create a void - could be filled by more liberal-thinking psychiatrists? Have the heads of the Bill, as presented, allayed any of the concerns of Dr. McCarthy?

My second question is more general. Can a trend be identified in research over the past ten or 15 years relating to abortion and women's mental health? I note that the Royal College of Psychiatrists in the UK issued a report in 2008 which very much departed from its earlier position on this issue. The college warned of the risk of mental health breakdown in women who underwent an abortion. Does the panel consider that such a change in position reflects in any way a trend in the findings of research over the last ten or 15 years?

Dr. Anthony McCarthy: The first Deputy who spoke referred to manipulation. He raised the prospect of doctors manipulating stuff, abusing their responsibilities, flouting the law and so forth. I cannot promise him that no doctor in the country will do that, in the same way that I cannot promise it for any politician, obstetrician or, indeed, anyone else in this country. I can certainly say that the standard in psychiatry, in general, is such that I would hope, at all times,

practitioners would not do that. Anybody who does that is breaking the law. There is a constitutional obligation to protect the life of the unborn, where that is practicable and I would hope that every psychiatrist in the country would practice that. I agree that society in general should be alert to the possibility that individuals may flout the law and it is the responsibility of the State to make sure that does not happen.

In response to Senator Mullen's question about Department of Health contact, as far as I am aware, as a college, we were not contacted in any way. As individuals, I cannot speak for Dr. Sheehan but I know that my other colleagues were not contacted. I had one telephone call from the Department, which fed into the radio interview referred to. I was asked to check if it was true that there were really only three perinatal psychiatrists in the country. In the body politic, the question had arisen of having three or even six people to assess women and having another six to assess on appeal. That would mean that 12 people would be involved and I was asked if it was true that there were only three perinatal psychiatrists here. I was also asked for some of the details of attachment. I was consulted about that specific question but not about anything else.

I was asked if I believed my contribution was taken on board. I would point out first that it was not my contribution but a joint statement to the Oireachtas agreed by myself, Dr. Fenton, Dr. Sheehan and Dr. Doyle. We agreed it together and it was not a formal position of the college. It was a contribution from three of us as perinatal psychiatrists and Dr. Doyle as a child psychiatrist, who we wanted to be there. No questions were directed to her on that day but I am pleased that she is here today and questions have been directed to her. As to whether that contribution was taken on board, I would hope so. We met here in January to inform and are here today again to inform. We are not here to tell the Legislature what to do. We are here to inform Deputies and Senators about the reality of clinical practice and the realities of the situations we have to face. I really do hope that our contributions are taken on board and I think some of the heads of the Bill do reflect some learning that is going on for the legislature and the Department.

Regarding the particular issue I spoke about in the aforementioned radio interview, I had heard that there was a possibility of many psychiatrists being involved. Then *The Sunday Times* published an article suggesting that up to 12 doctors might be involved in assessments. Frankly, I thought it was my responsibility, as somebody who deals with difficult women, to speak up. Who came up with the conception that a woman who might be suicidally depressed in pregnancy would see 12 people? What was he or she thinking? Was the thinking based on the idea of some young girl who got drunk one night and had casual sex, who did not take the pill and got pregnant, and who would come along and fool us and, therefore, we must have 12 people to hear her? Did he or she ever think that this woman may have been sexually abused or raped, that the baby might be her father's or that she might have already tried to remove that baby by stabbing herself in the stomach? How could such a woman be expected to talk to 12 people? That is why I came out so animatedly that morning on "Morning Ireland". If that has had an effect, I am very glad it has had an effect.

Dr. Joanne Fenton: The proposed legislation is very restrictive and with regard to my role as a perinatal psychiatrist, I would not be intending to abuse it. I think Dr. McCarthy has discussed that further. With regard to a lady 20 weeks pregnant who is suicidal, that consultation would be done with the individual and again with the obstetricians. I would discuss it clearly in depth with them.

With regard to having been contacted by the Department of Health, I have not been contacted by them. I was consulted with regard to our written submission today. Our role - certainly my role as a perinatal psychiatrist - in looking after pregnant women who present with mental

health issues is not just to look after the woman. I am looking after the woman and the life of the unborn child. That is my role and that is certainly not ignored by my colleagues and me.

Dr. Maeve Doyle: I think I will just confine myself to the specific questions. I am sorry I do not know the Senator's name.

Chairman: Senator Healy Eames.

Dr. Maeve Doyle: I believe she referred to the scenario of a 14-year old with suicidal intent. I was not clear whether that person was living in an intact family, but I think she meant she was. In this case, I understand the parents would have gone to the GP with the child.

Senator Fidelma Healy Eames: I am actually not saying that. I am asking-----

Dr. Maeve Doyle: The Senator had two scenarios, sorry.

Senator Fidelma Healy Eames: I am asking whether Dr. Doyle could certify an abortion or a termination for a 14-year-old girl, living in the family home but without the consent or knowledge of her parents.

Dr. Maeve Doyle: The answer to that is "No". We cannot carry out a psychiatric assessment without the parent's consent under the age of 17. Is that okay?

The second scenario, I think, was a young person in care. The Senator did not specify the age, but-----

Senator Fidelma Healy Eames: Similar.

Dr. Maeve Doyle: -----I think she was talking about the fact that the person had probably experienced a lot of abuse in life and family disruption. I suppose my view would be that we as society had failed that young person and indeed her parents. The question would be whether that child was in voluntary care - that is placed there with the agreement of the parents. If that was the case they would be guardians, likely, or may have applied for guardianship if separated and they would have to be consulted. If on the other hand it was involuntary care, then the HSE is in *loco parentis*. My understanding is that the HSE would apply for that from the panel and whatever decision the panel made would carry on. Is that okay?

Senator Fidelma Healy Eames: Could I-----

Chairman: No.

Senator Fidelma Healy Eames: Just to get the second part of that question.

Chairman: No, sorry. The Senator has been in twice already, sorry.

Senator Fidelma Healy Eames: It was not answered. To be fair it was not answered. I thank the Chairman again.

My question was as follows. By certifying an abortion for that young person, are we in danger of loading another injury on her, given the real evidence - post abortion - of suicidal intent and feelings?

Dr. Maeve Doyle: I suppose my view would be that would be expertly assessed by the two psychiatrists and whatever other relevant people from the HSE.

Dr. Anne Jeffers: On the question as to how we stop psychiatrists breaking the law, as psychiatrists, we do not want to get involved in anything that is not our job. As psychiatrists, we see ourselves as dealing with people who are vulnerable. Similarly to the obstetricians, we believe that the people, to whom this law will apply, will be coming to us anyway. I do not think a situation will arise where there will be opportunities for that.

On the next point on being contacted by the Department, I have not had any contact. On the fact that it is not appropriate for a psychiatrist to be involved in this process, as I said earlier, if we look at the numbers of Irish women who are having abortions in the UK, the vast majority of those women are mentally and physically healthy, and that has nothing to do with psychiatrists or psychiatry. Our concern and my concern would be for vulnerable women - the women who are making decisions to have an abortion and it may be the wrong decision for them, or the women who are travelling for abortions who are quite convinced that the only alternative to an abortion is to kill themselves. I feel we have a responsibility both as a State and as psychiatrists to see those vulnerable women.

On capacity and consent even though somebody is suicidal we see that all the time. People can have the legal capacity to make decisions even though they are very distressed.

I was asked whether there is any other situation where a psychiatrist would certify against someone else's best interest. We would emphasise - the law is very clear on this - that we are there in the best interest of the mother and the unborn. We are only talking about situations where if the mother dies the unborn also dies.

Is there any evidence to support that the psychiatrist has no way of knowing whether the abortion would, in fact, worsen her mental health? Certainly a vulnerable woman who has a termination in a country where she can receive care and support is surely in a much better position than a woman who feels she has to leave the State to have that termination.

On the issue about normalising suicide, we are very aware that we have a very serious problem with suicide. Reference was made to seeking a mortgage reduction. Tragically many people have completed suicide because of financial difficulties. In recent years, as general adult psychiatrists, we would have seen many people who on the face of it may have looked as if it was financial difficulties but in fact people, who have survived serious suicide attempts and have had an opportunity for expert and specialist care, have been able to work with us in resolving the difficulties and issues they have. It gets back to the point that for anybody who is suicidal the important thing is having the opportunity to talk about it to have that non-judgmental compassionate hearing where we can sit down with them and try to work out what the problems are and that there is always another option other than killing themselves.

On the college of psychiatry and the quotation of the report, once again I must warn - we have heard it from the beginning - about any evidence. This is a group that is extremely difficult to have any evidence on and we have to be very aware of the tendency towards bias.

Dr. John Sheehan: I will try to deal with a number of the questions. The first was whether the abortion safeguards could be flouted. At face value, the heads appear to be restrictive. Yet the international experience is that what initially appeared to be very restrictive, in practice has turned out to be not restrictive. At face value one could say the heads appear restrictive, but how it might work in practice is a different question. Again it ties into the point I made earlier on the application of the law to women who travel. We do not know the extent of mental health problems in that group or the extent of suicidal ideation. Therefore we cannot say with any

accuracy how this will work in practice. On face value it looks restrictive, but the practice is another question.

Senator Mullen asked about contacts with the HSE, the Department or a Minister. I have had no contact from any such people. He also mentioned the college position. I was not party to the college statement, which was devised by the council of college. It has been made available from this morning to college members.

The Senator made a point about good medicine. I have not looked at the issue of conscientious objection - I have been focusing on head 4, which deals with a woman who has suicidal intent and whose life can only be saved by a termination of pregnancy. As stated, Dr. McCarthy, Dr. Fenton and I, with more than 40 years combined experience, have not seen one case in our work as perinatal psychiatrists. The question about what the Bill, if enacted, might do to the position of psychiatrists was raised. That was one of the points I tried to address earlier. I believe it will cast psychiatrists into a role they have not been in to date. That is a change in role for psychiatrists. It is quite different from, for example, the working of the Mental Health Act, under which there is the option of detention of a person with increasing suicidal risk. This Bill as drafted deals with the woman with increasing suicidal intent whose life can only be saved by a termination of pregnancy, which is an entirely different situation.

On the question of precedent and whether any of us would have to certify an individual, which certification would depend on the rights of another individual, I am not aware of that. Again, as mentioned earlier we would detain a person in his or her own interest, which would not impinge on other rights. On the evidence of termination of pregnancy increasing the risk of mental health problems, there is evidence to show that termination of pregnancy can increase the risk of mental health problems. We see many women who suffer post-natal depression following normal delivery. The answer to whether termination of pregnancy could increase the risk of mental health problems, is "Yes, it could". There are many things that would do that.

The point made by Senator Healy Eames is interesting. It ties into the nature of our society. In my personal opinion, one of the reasons for the dramatic increase in suicide, particularly among young men, is because it is now an option. In other words, it has become "an option". There are a lot of very complex social factors as to why this is so. When one looks at the legislation and the message it sends out, that is a most interesting viewpoint in terms of whether this is potentially normalising suicidal threats. That is a serious aspect of this that probably has not yet been discussed or fleshed out here today. It is a relevant point.

Chairman: There are eight minutes remaining in this slot and seven speakers wishing to contribute. I will allow questions from Deputies Billy Timmins and Michelle Mulherin and apologise to those who did not get in.

Deputy Billy Timmins: I have two brief questions. With regard to the expert group, I heard Dr. McCarthy say on radio that the College of Psychiatrists in Ireland nominee was not accepted by the Minister.

Chairman: I ask the Deputy to speak to the heads of the Bill.

Deputy Billy Timmins: The heads of the Bill are founded on the expert group. As such, this is an important issue.

Chairman: With respect, we are dealing now with the heads of the Bill.

Deputy Billy Timmins: I may be wrong but as I understand it there are only three perinatal psychiatrists in this country. I would be surprised if one of those people was not a member of the expert group. Perhaps Dr. McCarthy will confirm if that is the case.

With regard to the survey referred to by Deputy Mitchell O'Connor, as politicians we accept the bona fides of everybody's evidence. Where a conflict of information or view arises, we try to drill down and find the basis for that conflict. It is clear to me based on what I heard in January and today and from various submissions I have received, that there is clear division within the profession of psychiatrists. Unfortunately, it is that profession with whom the buck will ultimately stop. I do not envy them their position. Dr. McCarthy stated that many in the profession predominantly believe that this is a social and political issue. Unfortunately, it has landed at the door of professional psychiatrists.

Dr. Boylan mentioned on Friday that the College of Psychiatrists of Ireland, which is an elected decision-making body representing more than 864 members, made a single submission on behalf of all members. I note Dr. Boylan is not a psychiatrist and may not even be a member of that body. If I understood Dr. Sheehan correctly that survey was made available to members this morning. Were all 864 members surveyed and what, if any, was the response? I note some of the witnesses were agitated about only 113 people having been surveyed, which issue I will take up with the drafters of the survey, some of whom may be here this afternoon. It is a serious issue if people are misrepresented in that survey.

Deputy Michelle Mulherin: I thank the psychiatrists who have presented to us. I have two questions for them. First, it was stated almost universally by the witnesses that none of them has experienced the type of case for which we are seeking to provide. Therefore, when we try to dig down we are at a bit of a loss, at least from our perspective. However, we have the experience of the X case. Do the witnesses believe the evidence presented in the X case would have been sufficient to justify a termination under this draft Bill? It is a case in point that is not mentioned.

Dr. Fenton stated in her address that she has not encountered any woman who required a termination of pregnancy as part of her mental illness treatment. However, she did not rule out there ever being such a case. I presume that best practice is in general based on clinical research. At what point would Dr. Fenton believe that would be a safe decision to make? Would it be at the point when there is clinical research to support such a decision or when suddenly a need arises? I do not mean to be over-simplistic. While the witnesses are the experts we are also looking to other jurisdictions. We are told there may be a limit or certain perspective on the evidence available here because we currently we do not have an abortion regime, except in respect of the X case, which is more vague. Could fears be allayed by the insertion, as is the case with the Medical Council guidelines, into the Bill that due regard be given to clinical research in the area of psychiatry? I find it difficult to understand how, never having encountered such a case, psychiatrists could suddenly find themselves able to deal with such a situation. I respect that it may happen but when it does would there not be a requirement to look to best practice, including in other jurisdictions if not available here, or would they wait until there is clinical research to show such a step would be required?

Dr. Anthony McCarthy: I am not sure if I should respond to Deputy Timmins's question about the expert group.

Chairman: It is not relevant to the heads of the Bill. Dr. McCarthy is not compelled to respond to it but may do so if he wishes.

Dr. Anthony McCarthy: I am happy to do so. Obviously, when any group is being established, nominations are sought from various bodies. I have been previously asked to nominate persons to other committees. As regards whether I have a problem with the nomination of a particular child psychiatrist to the expert group, the answer is "Absolutely not". I was asked the specific question of whether the college was consulted to which I responded that it had been and nominated Dr. Fenton and myself. The Minister selected the child psychiatrist, which is perfectly okay. I have no problem whatsoever with that and do not believe anybody in the college would have a problem with it either.

Of the 864 members of the College of Psychiatrists in Ireland, 113 responded to the survey in a particular way. It is a pretty small group of people. I am surprised it was not larger, reflecting the division in society in general and the uncertainty in political parties, among families and so on. We understand that there are people who disagree. We accept that.

Senator Fidelma Healy Eames: On a point of order, only 302 psychiatrists were surveyed.

Chairman: The Senator has contributed four times already and may not do so again.

Dr. Anthony McCarthy: With regard to the council of the college, to be a member of the council one must be elected. Every member of the council is elected.

(Interruptions).

Chairman: I ask for respect for the witnesses, please.

Dr. Anthony McCarthy: Each member is an elected member of council. The council made the decision. Like everybody else, we were given a brief time to consult our members. We quickly emailed every member of the college seeking their views on the heads of this Bill. Those who have made the most noise and expressed dissatisfaction with the college, claiming it is not representative, individually sent a written submission to the council. All were considered at council. Equally, we held a meeting, which included Dr. Sheehan, to discuss overall issues in advance of discussing them at council. As the elected decision making body of the college, council is the sole approved body recognised by the Medical Council. We made that decision unanimously and all of us on council would stand over it.

Clinical research would be impossible on the specific issue before us because abortion is available in England. I described in my opening statement - I do not know whether the Deputy was here - what such a study would have to do in order to prove this. In regard to whether there is a clinical study on suicidal assessment in general, absolutely there is. In respect of our guidelines and studies on assessing the risk of suicide, we can never predict a suicide with certainty. We are not actuaries but we are experts at assessing risk and, where we can, treating the causes of that risk and managing and helping the individual concerned. A significant body of research has been produced over many years on that specific issue. On the issue of abortions there never will be such a body of research and if we are waiting for that obviously there will be no legislation.

Dr. Joanne Fenton: I will answer the question on my written submission and the research to which Dr. McCarthy referred. It would be impossible for us to carry out a study of women who were suicidal and obtained abortions and those who did not. When a woman presents to me with suicidal ideation, I assess her and provide the best possible care and evaluation. I am not waiting for the paper to come up. I will assess the lady to the best of my ability and, in con-

sultation with another psychiatrist and obstetrician, make a decision in the interest of the health of the woman and the unborn child.

Dr. Maeve Doyle: My comments will be brief. On the question of whether legislation on the X case, with the evidence as presented now, would meet the requirements, it is impossible to know if I am not one of the two psychiatrists or the obstetrician making the decision. I am sure - or hope - they would know.

Dr. Anne Jeffers: I agree with the comments on the role of council as the governing body. As a college, we agreed to comment on the heads of the Bill in terms of how they relate to psychiatry and its practice but decided we would not comment on abortion. Many of those who expressed concerns about the college council feel that we should not be involved in this legislation at all. On the issue of whether we would suddenly be put in a situation in which we are not sure what to do, in practice a clinical decision would be made. It is tempting to speak about resources while we are here but many of the women concerned have difficulties in supporting their children and may have inadequate social worker care and other supports. Many of the women with whom we deal have had children who were taken into care. They often say to me that if they had more support they would have been able to look after their children.

Dr. John Sheehan: I will focus on the question of research because, as Dr. McCarthy pointed out, it would be almost impossible to conduct the sort of trials we are speaking about. However, it is true to say there is no evidence base to indicate that abortion prevents suicide. Much of what we speak about is in the abstract. We speak about suicidal ideation, intent or plans but when one tries to quantify the extent of the problem, one examines the number of women dying by suicide in pregnancy. That goes back to the confidential inquiries in the UK, which offer the only reliable data at present. Out of more than 2.5 million deliveries over a three year period, there were four deaths in pregnancy by suicide. Each of these deaths was likely related to serious mental illness. Although we do not have the research base to back it up, and we cannot say there is research evidence, we can quantify the numbers involved. That is the extent of the numbers.

Chairman: I thank our guests for voluntarily giving of their time to assist us. I also thank them for making their submissions. I apologise to members who did not have an opportunity to contribute but we have agreed our rules.

Sitting suspended at 12.05 p.m. and resumed at 12.20 p.m.

Psychiatry

Chairman: I again thank everyone for being here. This is our sixth session in a series of hearings that the joint committee has been asked to conduct to discuss the heads of the protection of life during pregnancy Bill 2013. I ask all members to be brief in their contributions. If people do not interject more than once, it will be fair to everyone. In the last session some members could not get in because certain things happened. If people could keep their comments brief, it will allow for greater participation by members.

I welcome to this session Dr. Yolande Ferguson, Dr. Peadar O'Grady, Professor Veronica O'Keane and Dr. Eamonn Moloney. Like all of our expert witnesses, they are here to assist and give of their time voluntarily. I thank them most sincerely for being here and assisting us.

Before we commence, I remind them of the position on privilege. Witnesses are protected by absolute privilege in respect of the evidence they are to give to the committee. However, if they are directed by it to cease giving evidence on a particular matter and continue to do so, they are entitled thereafter only to qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against a person or persons or an entity by name or in such a way as to make him or her or it identifiable. Members are reminded of the long-standing parliamentary practice or ruling of the Chair that they should not comment on, criticise or make charges against a person outside the Houses or an official either by name or in such a way as to make him or her identifiable. With that, I call on Dr. O'Grady to make his opening remarks.

Dr. Peadar O'Grady: I am very grateful to be able to make an opening statement to the committee. I am giving a statement on behalf of Doctors for Choice Ireland. I have had experience as a consultant child psychiatrist for the past 20 years but also some specific experience of certifying children and young adults under the terms of the Supreme Court judgment in terms of their eligibility to access an abortion, not something of which there is much experience. I understand Dr. Maeve Doyle referred to this earlier in terms of the types of women or children who might end up being dealt with under the legislation, as proposed.

According to the World Health Organization's 2012 document, Safe abortion, "In nearly all developed countries, safe abortions are legally available upon request or under broad social and economic grounds, and services are generally easily accessible and available". This largely applies to the services Irish women avail of in the United Kingdom every year. In Ireland the proposed legislation to deal with access to abortion services arose from the Supreme Court's judgment in 1992 that a 14 year old child had a constitutional right to have an abortion in Ireland because of the risk of suicide. Doctors for Choice Ireland welcomes any improvement in the care of women and children who choose to have an abortion. However, we believe reassurance is needed that the Bill will in practice provide for an effective and accessible procedure in a situation similar to that of the 14 year old child in the X case. The risk of suicide in the X case arose in a situation where a pregnant child had become suicidal when she was unable to travel, having decided to have an abortion while pregnant as the result of rape by an adult neighbour.

The opinion of many psychiatrists and other doctors internationally is that the risk of suicide is increased by having access to abortion restricted. While I am not going to go into the detail of how that came about, the internationally renowned psychiatrist Professor Robert Kendell summed this up well in 1991 in his review in the *British Medical Journal*. The title of the paper is, "Suicide in pregnancy ... much rarer now: thanks to contraception, legal abortion and less punitive attitudes", reminding us of the issue of stigma involved in suicide in pregnancy.

In Ireland restricted access to abortion services is most likely to arise as a result of an inability to travel, a point made well this morning by Dr. Anthony McCarthy, president of the College of Psychiatrists of Ireland. This means that women who are too sick, young, poor or disabled to travel are at particularly high risk. Women who are migrants or whose pregnancy involves a fatal foetal abnormality or which arose as a result of rape or child sexual abuse also experience difficulty in accessing abortions through impairment of their ability to travel. Children are not specifically mentioned in the legislation, even though they are more likely to experience difficulties in their ability to travel for an abortion and to be at increased risk of suicide as a result. The costs of travel for an abortion are higher for children as they usually require a parent or guardian to travel with them because of their greater requirement for practical and emotional

support.

Our concerns about the legislation come under three headings: delays in accessing abortion which might occur, the exclusion of certain categories from access to abortion and criminalisation of women and health workers who take part in abortions which do not meet the guidelines laid down.

As for delays, Doctors for Choice Ireland is particularly concerned that the Bill contains elements that will cause unnecessary delay in accessing abortion services, causing an unnecessary prolonging of an emergency level of risk and requiring more complicated procedures because of that delay, for example, surgical instead of medical abortions. In Britain most abortions are medical abortions. They do not involve a surgical procedure and do not, in fact, involve an obstetrician, which is a notable point.

In the case of eligibility for abortion on the basis of a risk of suicide, imposing a requirement for three doctors will cause unnecessary delay and, including the general practitioner, we may be talking about four doctors. There is no medical basis for differentiating between a medical emergency and a psychiatric emergency, as the Bill does, a point alluded to by Professor Murphy of the Medical Council on Friday. All psychiatric emergencies are medical emergencies. Only one psychiatrist or GP is required to certify eligibility for an abortion. It is clearly the view of Doctors for Choice Ireland that one does not need any doctor to certify eligibility for an abortion as a necessity, but, if one wants to, only one is required. Obstetricians should not certify eligibility in cases of suicide risk. This should be done either by a GP or a psychiatrist, and by that I specifically mean giving advice about eligibility on the basis of suicide risk, not his or her potential involvement in an abortion procedure, a point of practice in which the psychiatrist is not usually involved. If this legislation is enacted, it is likely that women and children will already have had non-directive counselling and will have given informed consent before seeking an opinion on eligibility of the grounds of a risk of suicide.

The Bill requires the psychiatrist certifying eligibility to be employed in an institution registered with the Mental Health Commission, which is another point regarding a delay. Most consultant child psychiatrists are not employed in this way. This is an unnecessary requirement. Specialists are required to be registered with the Medical Council and this should be the only stipulation. Specialists should not be required to be attached to any specific institution. Most abortions in developed health services are medical abortions and do not need any hospital facilities necessarily. The term "reasonable opinion" should be replaced by the term "opinion" and the term "unborn" should be replaced by medical term "foetus".

Regarding exclusions, women and children in situations of rape, child sexual abuse and fatal foetal anomalies will, unfortunately, have to wait for further legislation to allow for the option of abortion in those cases, as this Bill does not provide for this, and this is a serious limitation of it.

I take on board the advice of the Chairman, Deputy Buttimer, about keeping our language temperate and moderate but Doctors for Choice are at pains to point out that a 14-year criminal sentence is not a moderate or temperate element of the legislation. With regard to that, the inclusion of a criminal sanction of up to 14 years against women or doctors will hamper good practice and increase the risk of suicide in vulnerable patients through stigma and its emotional consequences - fear and distress. Fear of prosecution, a noted chilling factor, can only cause further delays in access. The notion that women who are forced to travel for an abortion in a situation of fatal foetal anomaly, for example, are carrying out the equivalent of a gravely serious

crime worthy of 14 years in prison is particularly offensive. The prospect of prosecuting children and or their parents or those carrying out a home abortion with medication bought on the Internet is also very concerning. The overwhelming support in 1992 for the constitutional right to travel for an abortion confirmed that Irish people do not consider abortion a grave crime, as did the lack of any prosecutions before then for abortions procured abroad. To our knowledge criminal sanction has not been seriously advocated by any party to the debate thus far on access to abortion services. As criminal sanction is thus dangerous, offensive and manifestly absurd, it should be removed from the Bill.

As there is a gross lack of expertise in Ireland, which I think the medical profession in Ireland is well ready to admit - we do not have abortion services located in Ireland, although we have abortion services for Irish women but they just happen to be located largely in Britain but also, in so far as we know, the Netherlands and perhaps Spain; we are not so sure where people access them because we do not count that, research it or follow it up - we humbly submit that the Oireachtas Joint Committee on Health and Children should take advice from a relevant health care agency that has experience in providing an abortion service. The British Pregnancy Advisory Service, for example, provides the majority of abortions availed of by women from Ireland every year and that service has already offered its assistance to the committee.

Chairman: I thank Dr. O'Grady. I call Dr. Yolande Ferguson and welcome her here.

Dr. Yolande Ferguson: I thank the Chairman. I am a consultant general adult and community psychiatrist based in the Dublin south central psychiatric service and also in Tallaght Hospital. I am a member of the faculty of the adult executive of the Irish College of Psychiatry and a member of the Joint Forum on Mental Health between the Irish College of Psychiatrists and the Irish College of General Practitioners.

I thank the committee for this opportunity and I welcome this legislation. Psychiatrists are unique among medical practitioners in that we deal with legislation as part of our everyday routine clinical practice in the form of the Mental Health Act 2001. We have extensive experience in performing assessments to ascertain whether our patients meet the legal criteria set down in that Act. We also routinely defend those decisions in mental health tribunals. We bring that expertise and experience to the enactment of this legislation.

I will restrict my statement to heads 4, 6 and 8. I believe the constitution of the assessment group in heads 4 and 8 requires revision. These heads address an infrequent circumstance. For the most part, this represents a woman or child in the early stages of pregnancy who is distressed because she is pregnant and generally does not have a mental illness. They are most likely to present to their general practitioner in the first instance. If the doctor dealing with them is sufficiently concerned, he or she will then make a referral to the appropriate local psychiatric service. Psychiatric services in Ireland, like most other countries, are arranged on a geographical basis with community mental health teams addressing the needs of the local community. There are also specialist teams who provide for the needs of children, as Dr. Peadar O'Grady mentioned, and for those with intellectual disability. The psychiatrists who are the clinical leads for these teams are expert in assessing suicidal risk, whatever the circumstance. The general practitioner has been assigned a peripheral role in this legislation, a consultative one. They should have a central role, followed by an assessment by one psychiatrist, in line with the procedures under the Mental Health Act. This means that two doctors would be involved in the assessment process, which would thus not differentiate psychiatry from other medical specialties in this legislation.

The assessment group in both heads is made up of an obstetrician and two psychiatrists. First, as was mentioned by Dr. Peadar O'Grady, there is a requirement that both psychiatrists are attached to an institution registered with the Mental Health Commission. This does not reflect psychiatric practice. Child and adolescent psychiatrists are rarely attached to such an institution. Some general adult psychiatrists who provide community-based care are also not attached to an institution because their services divide the inpatient and the outpatient roles. I suggest that this be replaced by a psychiatrist who is entered on the specialist register with the Medical Council. The head also states that one psychiatrist must be attached to an obstetric unit, and again this was raised as an issue this morning. The head and the explanatory note contradict one another in that the head states attached to "an appropriate place" and the explanatory note states attached to "the appropriate place". While clarification is required as to whether the head specifically demands that the psychiatrist must be attached to the unit in which the procedure would take place, I recommend that this requirement be removed. These are women and children who cannot contemplate reaching the point of the booking appointment for an obstetric unit that is the usual entry to perinatal psychiatry. This requirement imposes an unnecessary restriction. Their needs can be accurately assessed by an appropriate specialist, such as a general adult or child and adolescent psychiatrist.

I propose that a panel be established by the Executive, much as the Mental Health Commission forms a panel for the workings of the Mental Health Act. Ideally, the psychiatrist who is involved in their care would be on the panel to provide the psychiatric opinion. I should add that an obstetrician should not be expected to perform assessments out of their area of expertise. It is also proposed that a consensus must be reached between all three doctors. Could we envisage where an obstetrician is placed in a position where they veto the assessment of two psychiatrists on the assessment of the risk of suicide? As the head is currently written, the woman or child could have seen up to four doctors, including her general practitioner, at the end of the assessment process. If the case proceeds to an appeal, she will have been seen by a total of seven doctors. The time period for the appeal process set out in heads 6 and 8 should be shortened to a maximum of 72 hours for each stage of the appeal.

This legislation must serve to alleviate rather than add to the distress of the women and children for whose needs it seeks to address.

Chairman: I thank Dr. Ferguson. The next speaker is Dr. Eamonn Moloney.

Dr. Eamonn Moloney: I thank the Chairman and the committee for this opportunity to speak them today. I am not a member of any particular interest group in this area. I speak to them as a practising consultant psychiatrist and as a clinical director of one of the largest catchment areas of mental health services in the country. The inpatient base is at Cork University Hospital, CUH, where the approved centre is based, and on the site of that hospital is one of largest maternity hospitals in the country, Cork University Maternity Hospital. That hospital has more than 9,000 deliveries per annum. In CUH, more than 600 people are seen for assessment following suicidal behaviour on an annual basis, and many more present with suicidal ideation.

As clinical director I have overseen the implementation of new legislation in the form of the Mental Health Act 2001 within the service over the past six years, and as clinical director I have an ongoing responsibility to ensure that the appropriate legislative procedures are followed. My comments on the heads of the Bill are from that perspective and primarily relate to the practical application of this proposed legislation. I was also a member of the Mental Health Commission for five years up to April of last year and so I have a particular interest and exper-

tise in this area.

The current operation of the Mental Health Act 2001 leads me to believe that this legislation could be practically implemented but I will suggest some areas where I believe amendments would ensure that a suicidal woman with a crisis pregnancy is managed in the most appropriate, humane and timely manner. I will also describe the relevant proposed care pathway that I believe is the best way this legislation could be implemented.

I will comment on head 2, particularly in relation to the need for the number of medical opinions required, and talk about a proposed pathway. In my opinion the requirement for two psychiatrists and an obstetrician to certify that a woman is eligible for a termination of pregnancy is excessive. Two medical opinions should suffice. One of these opinions in my view should be a general practitioner and the other a consultant psychiatrist.

Although the heads of the Bill state that a general practitioner, GP, should be consulted where practicable, I believe the importance of the general practitioner needs to be recognised in their everyday care of patients. In terms of health strategy in Ireland, the importance of primary care physicians in primary care centres - primary care teams - is acknowledged. GPs have a wide range of experience of dealing with people presenting to them with emotional and psychological difficulties. The importance of the GP is recognised in the explanatory notes by virtue of his or her long-term and in-depth knowledge of the woman as referred to in head 4(2)(a)(1). The GP clearly has a unique perspective on the woman's particular circumstances in relation to, for example, her social supports, relationships, previous pregnancies, any history of sexual assault or abuse, and general family background.

It is likely in any event that the woman will consult her general practitioner in the first instance for confirmation of pregnancy and discussion of the options for what may be a crisis pregnancy. The woman's general practitioner would have experience in carrying out assessment of the woman's mental state, or perhaps more than one assessment, over a period of a few days. He or she may then certify that the patient is acutely suicidal, that there is a real and substantial risk to her life, and that this risk can only be averted by a termination of pregnancy.

A general practitioner is likely to have considerable experience of assessing suicide risk and of making a medical recommendation for detention of persons under the Mental Health Act. This has been referred to previously. Both GPs and consultant psychiatrists are used to dealing with these situations. The GP is well-placed to carry out a similar type of certification process under this proposed legislation. If the GP is satisfied that the appropriate criteria under the Act are met, he or she will inform the executive which will then either confirm an appointment with a psychiatrist that has already been made by the GP or arrange for an assessment by a relevant consultant psychiatrist. That is the first medical opinion.

The second medical opinion should be done by a consultant psychiatrist. This doctor should be drawn from a panel of consultant psychiatrists who are agreeable to operate the enacted legislation. This process is similar to the pathway for hospital admission under the Mental Health Act where a consultant psychiatrist must assess a person brought to an approved centre following appropriate application and medical recommendation. A consultant psychiatrist has a particular expertise in assessing suicide risk so it is appropriate for them to carry out this assessment.

This process of consultation with a GP and referral to a consultant psychiatrist for further assessment reflects the usual and ideal care pathway for all suicidal patients. It is likely to be

the least distressing process for the pregnant woman, the most appropriate way of accessing the assessment and care that the woman needs and is a process that is practical, as evidenced by the current operation of the Mental Health Act.

A further medical opinion is not necessary in my view and the explanatory notes for head 2(3) refer to the Mental Health Act 2001 to support the need for only two medical opinions where there is a risk of loss of life from physical illness. The assessment of suicidal intent is one of the core skills of consultant psychiatrists who are carrying out such assessments on a daily basis.

We have heard that there are no data to confirm the accuracy of psychiatrists in predicting suicide but the relative rarity of completed suicide and the inability to determine the number of people saved from death by suicide following appropriate suicide assessment and intervention means that this exact calculation is not possible because the studies cannot be done. They would be unethical and would involve not treating some people who were suicidal, treating another group and then comparing the outcomes or else denying one group of suicidal pregnant women access to an abortion, not denying the other and seeing what happens. These are impractical and unethical studies which will never be done. We have very clear data on self-harm in this country and it is clear that women in this age group are at high risk of self-harm, and self-harm is a single best predictor of subsequent suicide, with one in 100 people, following an episode of self-harm, dying by suicide in the following year.

The fact that we cannot accurately assess this does not mean that suicide risk assessment carried out by a woman's general practitioner and a consultant psychiatrist are inaccurate. In mental health services throughout the world, it is ultimately the consultant psychiatrist who makes the decision about suicide risk. Mental health legislation throughout the world, as in this country, dictates that the consultant psychiatrist decides on whether criteria are met for admission of an individual under the Mental Health Act, and one of those criteria is risk of suicide.

In my view the involvement of an obstetrician in the assessment of risk of death by suicide is not appropriate as it is outside their area of expertise, as others have pointed out.

I do not believe it should be necessary for the consultant psychiatrist to be attached to an institution where such a procedure is carried out as this would unnecessarily restrict access to appropriate and timely assessment, which could be done by a consultant psychiatrist not necessarily attached to that hospital.

Moving on to head 4 - formal medical review procedures, I believe the timescale proposed of up to seven days to convene a committee and up to a further seven days to form an opinion could lead to a potential delay of two weeks following a woman's appeal to a decision being made. This is likely to cause considerable distress, which could be alleviated by shorter timeframes of 72 hours to the convening and 72 hours to a decision being made.

In relation to head 8 - the review in a case of loss of life through self-destruction, again, the requirement that the consultant psychiatrist shall be employed at the appropriate location is in my view unnecessary. Most women at risk of suicide in the early stages of pregnancy would be most likely to be seen by a general adult community psychiatrist or a liaison psychiatrist following self-harm rather than a perinatal psychiatrist employed at an appropriate location. It has already been pointed out that there are very few perinatal psychiatrists. Despite the fact that Cork University Maternity Hospital is one of the largest maternity hospitals, it does not have a perinatal psychiatrist, although emergency care is provided by the liaison psychiatry team

based at the hospital. Again, the proposed timeframe is too long and a delay of up to seven days should be shortened to 72 hours.

The decision of the review committee should be by majority decision. This is the case for decisions made by the Mental Health Review Tribunal under the Mental Health Act where three persons on the tribunal decide on whether to revoke or affirm the detention of the person under the Act. A simple majority should be sufficient, and that should also apply under this legislation.

In summary, the certification procedure proposed here ensures that the most appropriate and relevant medical opinions are obtained and that the usual care pathway and referral processes for suicidal women are followed to minimise any unnecessary additional distress to the pregnant woman. This process is similar to the current procedures under the Mental Health Act 2001 and so the practical application of the legislation can be assured.

Professor Veronica O'Keane: My name is Professor Veronica O'Keane and I am a professor of psychiatry in Trinity College Dublin, a consultant psychiatrist for the HSE at the hospital in Tallaght and I run a research programme in perinatal depression. I led a national perinatal psychiatry service in London for five years in the Maudsley Hospital serving all of the UK. I was concurrently head of perinatal psychiatry in King's College Medical School, from where I led a research programme in perinatal depression. I have published extensively in the scientific literature and I have written a book on perinatal psychiatric disorders during pregnancy. I have co-authored the standard clinical assessment tool for perinatal psychiatric disorder and I was an expert for the National Institute for Clinical Excellence, NICE, UK guidelines for the management of perinatal depression in the UK. I have set up two general hospital psychiatric services, with one in Beaumont Hospital and another at Addenbrooke's Hospital in Cambridge. I have researched and published on the topic of suicide assessment.

I am delighted to be here today and to have the privilege of advising our legislators on the heads of the protection of life during pregnancy Bill. The sole purpose of this legislation is to provide law as established in the Supreme Court ruling in the X case; namely, to provide a service for women who, unless they have an abortion, are in danger of dying. A woman's right to this service has been established in Ireland in our law and Constitution. There has been vigorous campaigning against the right for women to have their lives protected during pregnancy established in primary legislation.

Our role, as psychiatrists, is to facilitate the provision of this proposed service for women who express suicidal intent and request an abortion in this context. Women who are suicidal because of an unintended or unwanted pregnancy - I will refer to this as a crisis pregnancy - will be the main users of this service, given the extreme rarity of requests for abortion in women who are mentally ill during pregnancy. Primary care, adult and child psychiatrists, rather than specialist services, should and will be the main service providers. We have been told by the European Court of Human Rights that the service should be "accessible and efficient". To this end, a national panel of those prepared to lawfully engage with this process should be established and an efficient executive should be put in place to efficiently administer requests for termination of pregnancy by Irish citizens. The GP should make the recommendation for an abortion and one psychiatrist should assess the suicidal risk. Details of the practical implementation of these recommendations are contained in my Oireachtas submission. My colleagues have given recommendations, all of which I agree with.

Some legislators may continue to hold and express views about the "suicide" clause. A

consistent argument is that "allowing" the suicide clause will remove the only effective barrier to "abortion on demand" and will provide a mechanism for women who want an abortion to get one, even if they are not genuinely suicidal. The argument goes that some psychiatrists will be complicit in this process or may not have the requisite professional skills to be able to predict suicide. Another argument is that abortion is not good for mental health and is not a treatment for suicidal intent.

Underlying all these arguments are deeply problematic assumptions about the credibility of women, the reliability of psychiatry as a medical discipline, the meaning and management of expressed suicidal intent and the concept that doctors or legislators have the power to control women's reproductive autonomy. The proponents of these arguments have caused some confusion, and the arguments require clarification so that head 4 can be implemented and run without unnecessary obstructions.

First, with regard to credibility of women, we do not practise psychiatry by disbelieving patients. A key ethical principle underlying all medical care is the relationship of trust that is taken to exist between a doctor and the patient. We regard all patients whom we see, in the first instance, as being truthful and credible. Second, with regard to the scientific evidence that suicidal ideation is difficult to assess, it has previously been said by people in the College of Psychiatrists of Ireland that we measure suicidal intent using clinically established markers. A crisis pregnancy is an emotionally traumatic experience which is potentially life-changing, and a woman who expresses sudden-onset suicidal intent is at a high risk of killing herself.

We do not require scientific evidence to understand the self-evident truth that young women in crisis kill themselves. Some 20% of deaths among young Irish women are by suicide or self-destruction, that is, in the same age range when women are most likely also to have an abortion. In other words, suicide is a common cause of death and is a recognised public health problem that is part of a national clinical programme in this country. The message that suicidal intent is difficult to assess and manage is untrue and the national office for suicide prevention is holding workshops for caregivers to help ordinary and non-professional individuals identify suicide risk, helping to increase the safety of individuals experiencing suicidal ideation and get further help. The message we want to get to people is that we can efficiently and safely manage suicidal ideation.

The phrase "abortion is not a treatment for suicide" has been iterated and reiterated, as has the contention that there was unanimous agreement among psychiatrists at the Oireachtas hearings in January that this was the case. This is not true. I gave evidence at the Oireachtas hearings in January and I did not give any evidence to support or reject the idea that abortion is a treatment for suicide. This is recorded as a matter of fact and was witnessed by this committee. The reason I would never say this is because a treatment implies that a doctor prescribes or at the very least recommends an intervention. A treatment involves a doctor in a process of active advice, and in the case of abortion, the woman rather than the doctor is requesting the procedure. The psychiatrist would only determine eligibility. Therefore, neither the woman's GP, the assessing psychiatrist nor the obstetrician carrying out the procedure would be advising a patient that she ought to have an abortion. Abortion is not a treatment as the doctor is not involved in giving advice.

There are no treatments for suicide and we manage underlying risks and issues that the individual presents us with. There is no evidence that any treatment prevents suicide. As outlined by Dr. Moloney and Dr. McCarthy earlier, such studies would unethical. There is scientific evidence from epidemiological studies that certain interventions reduce the suicide rate, for ex-

ample, such interventions would include treating depression or removing access to lethal methods, such as charcoal in eastern countries and domestic gas in the western world. Reducing access to such means of lethality reduced suicide rates. The same is true for abortion. Abortion legislation was introduced in the UK because unsafe and illegal abortion was the leading cause of maternal death in the 12 years prior to the introduction of the 1967 Act. In 1950s Ireland, 10% of Irish women who killed themselves were pregnant.

Studies about whether abortion is bad or not for a woman's mental health have been taken out of context. The studies subject to public debate have all taken place in countries where abortion services are available, and in those cases we are considering women with a choice of continuing with the pregnancy or having an abortion. In scenarios where abortion services are not available, unwanted pregnancy is a leading cause of death, which we know from geographical and historical studies. As I said previously, this is why we have abortion legislation.

My last point is that Irish women have an abortion service. It does need to be acknowledged that women in Ireland have abortion rights that they exercise as cognisant citizens through their right to travel. This very limited legislation that we are discussing is just a small concession to this reality in that it provides for the right to an abortion within our own health services when a woman is too sick or distressed to travel abroad. The constituency which is opposed to this legislation has spoken about suicide and abortion in abstract, moral terms. This is very regrettable. Irish women have often been portrayed as unreliable, sometimes manipulative and nearly always as passive. We need to acknowledge that it is the law that women who are in such dread about a pregnancy that they want to kill themselves and their foetus have a right to have an abortion in this country. As the Taoiseach said, this legislation is not conferring any new rights for women. This is an established right.

Chairman: Thank you. I acknowledge in the Visitors Gallery Mr. Paul Linton from Chicago. He is here assisting the Family & Life movement. I also welcome Mr. Patrick Carr who is in the Visitors Gallery and who has been here since Friday. We now have 70 minutes for members of the committee. I ask members to be conscious of time and to confine their remarks to the heads of the Bill.

Deputy Billy Kelleher: I welcome the witnesses and their contributions. We are trying to confine ourselves to the legislation before us in terms of the heads and what we will have to adjudicate on later. Dr. O'Grady said abortion should not be confined to the locations prescribed in the legislation and should be available elsewhere too. I want to get some clarity on that. While we are talking about the legislation, we are also obliged to act within Article 40.3.3° of the Constitution which states that there is an obligation to vindicate the life of the child. I presume one would need to carry out these procedures in a place where, if there is a viable foetus, that life would be saved, where possible and practicable. I presume that is only in a number of hospitals that would have all the neonatal services and facilities available, and all that flows from that. I would like some clarity on that.

Some women are suicidal in pregnancy and some are suicidal because they are pregnant. Is there a differentiation in how people would assess that? Many women in crisis pregnancy travel abroad to have an abortion and that happens day in day out in this State. There is no point in our denying this. Regarding the proposed panel system of two psychiatrists and an obstetrician, how would the witnesses see a woman presenting herself? Would they see it in terms of assessing her suicidality or assessing it and treating it and looking at options as opposed to ticking the box and referring her on to somewhere else? Would they see it as a doctor-patient relationship whereby they would assess, provide therapy and treatments if that was more suit-

able than a termination as requested by the woman, but which may not be suitable in terms of the treatment of her underlying condition?

In the context of the broader issue regarding obstetricians not being involved in the panel system, clearly an obstetrician would be the person who would have to carry out the procedure late in pregnancy at the very least. I assume there would have to be some discussion on how that multidisciplinary approach would work.

Deputy Caoimhghín Ó Caoláin: I join in the welcome to each of the panellists this morning. There is a number of shared common points in each of the presentations but I have picked on one to tease out - because that is our job, to get a clearer understanding - and that is the role of the general practitioner. It is very unusual and interesting that across the four psychiatrists before us this morning they have each, both orally and in their written submissions, placed great emphasis on the importance of an enhanced role for the GP. I hope they forgive me for focusing on that.

Dr. Ferguson, in her presentation, says the GP should have a central role and takes the view that only one psychiatrist is required, ensuring that there would not be a differentiation between psychiatry and the other medical specialties. On Friday we teased this out with others from across the field of obstetrics. A view was expressed there that two of the heads could be amalgamated so there would be no difference between the medical and the psychiatric approach. Would that be a shared view? Could each witness indicate that please?

Professor O'Keane makes the point that the GP should make the recommendation for an abortion and one psychiatrist assess the suicide rick. Is that the order in which it might happen? Could she elaborate on that so that I could have a better understanding of it? She also speaks about "no specific referral pathway reflected in the legislation". It has not been set down. She also makes the point that attendance at the applicant's primary care practice should be included in the legislation as the first point of contact on that pathway. Could she elaborate a little on that?

Dr. O'Grady also speaks of this area but says obstetricians should not certify eligibility in cases of suicide risk. It would be accepted even by obstetricians that two psychiatrists are crucial. I do not think any of the obstetricians would have argued that they would have primacy in that respect. However she then says this should be done either by a GP or a psychiatrist. I ask her to elaborate on that.

In conclusion and before the Chairman closes me off, I must ask Dr. O'Grady a question because the footnote on the first page of his presentation states that he has experience in certifying eligibility for an abortion. He is the first to say that before the committee either on Friday or today and I am sure he is not unique in that respect of those who will appear before us. It is a very important, relevant point. We are told this presents in only the most rare of cases. The perinatal psychiatrists this morning reconfirmed that over their combined 40 years' experience none of them has ever taken such a decision. Could Dr. O'Grady please expand on that to give us some sense of understanding of it? Would any of his colleagues like to share whether that has also been their experience?

Deputy Seamus Healy: I welcome our guests and thank them for their presentations. Dr. Moloney made a very important statement when he said it is his belief that this legislation could be practically implemented. I took it from some of his contribution that he was effectively speaking about the mirror imaging of the legislation here reflecting the procedure of panels

under the Mental Treatment Act. Am I correct in that? If so, could he clarify that and expand on it slightly for us? I have a brief question for Professor O'Keane. Accessibility was a serious consideration regarding the European case. Would she be happy that this legislation provides an accessible pathway?

Professor Veronica O'Keane: The first question Deputy Kelleher asked was the difference between being suicidal in pregnancy and being suicidal because of being pregnant and that is a very important distinction because if somebody is suicidal when they are pregnant it does not mean they are suicidal because of the pregnancy. When somebody is suicidal we would have a very open view about what is causing it. The individual may be depressed or there may be circumstances other than pregnancy. She may have been suicidal prior to the pregnancy and the pregnancy may be an additional stressor. There are all sorts of reasons somebody may be suicidal and we are looking specifically for somebody who is suicidal because of the crisis pregnancy. It is entirely credible that somebody would be suicidal because of a crisis pregnancy. A person might also have a series of stressors and series of difficult life circumstances and adding an unintended pregnancy to that could precipitate suicidal ideation but may not be the cause.

Our intervention is always aimed at what an individual presents us with and, in assessing an individual, we look at their vulnerabilities. Some people have a vulnerability towards motherhood and that might be a long-term psychotherapeutic issue. We look at their life circumstances. If it has been caused by a rape, that is a complicated issue. We, therefore, look at all the reasons somebody might be suicidal. This legislation is directing us towards evaluating suicidal ideation in the context of just having an unwanted pregnancy and if there are other issues - which relates to what Deputy Ó Caoláin said - when the assessment takes place, it will not be a unidimensional assessment just looking at whether this woman is suicidal because of a crisis pregnancy. A psychiatric evaluation is a complex, multi-layered assessment. We look at historical events, a person's biography, current mental state, social circumstances and personality characteristics. We would assess all those and intervene at whatever level is appropriate. That could be on several levels. The complexity of the case and the care pathway will depend on what we assess as the problem and on the patient's needs. If, for example, somebody was in a crisis and that was the straw that broke the camel's back, we would try to dismantle all the other causes and deal with them separately and singly. That is the way we approach problems. We try to break them down and deal with them individually.

However, there will be cases and that is what the legislation is about. We are not minimising the complexity of individuals' psychological make up, their biographies or their lives. We are saying we will deal with all that but there will still be rare cases where a woman will be suicidal because of an unwanted pregnancy and they are the cases the legislation is intended to address. In the case of the other ladies who present, they will get treatment as usual.

The second question related to the pathways to care, which I have probably answered and the final question related to accessibility. It is important that we make sure that the service is accessible. That is why we are pushing the role of the GP here because everybody should be registered with general practice. The role of general practice will become more important in the health care provided to citizens through primary care. The primacy of primary care in an individual's health is one of the major thrusts of health policy currently. The way to make this most accessible to women is to say, "Go to your general practitioners. They know you." They will be able to evaluate whether this is a real crisis requiring an abortion or something that requires counselling to help a woman come to terms with something. The role of the GP cannot be underestimated. It is also emphasised in the legislation but I would like this to be brought

into the regulations and the way the legislation is implemented in the same way it is in the Mental Health Acts. If somebody is unwell, he or she must go to a GP who then has to recommend that he or she be assessed by a psychiatrist. That answers the question about recommendation. The recommendation is if the GP thinks the woman is suicidal, she should be referred to the specialist panel for assessment of suicidality.

Dr. Peadar O'Grady: Just before answering the questions, I would like to point out that Doctors for Choice made a detailed head by head submission and members can read that at their leisure.

Deputy Kelleher raised the issue of a link between viability and location. There is quite a misunderstanding among many people in terms of where viability fits in with abortion. Many, including myself, argue that 100% of abortions should be completed long before viability becomes an issue. The situations in which abortion is an issue in terms of a viable foetus are extremely rare. It is not like the US has the most developed service one can get and, even there, one third of counties have no access to abortion facilities. We are not the only region that has difficulties with access. One in 1,000 abortions involves an issue of viability and therefore, is a small number, 99.99% of abortions happen without viability being an option.

The issue of whether an obstetrician is required is a clinical decision and in our presentation we are trying to distinguish clearly between doctors assisting legislators in certifying, something Doctors for Choice argue clearly is not required medically. If legislators required that from the point of view of assisting legislation and they are looking for certification as all of the witnesses today have said, this is something we can do. We should do it to assist things to move forward. Must we do it? Not in the scheme of things. In a proper system, we would not need to do it. In general, psychiatrists are not involved in the provision of abortion care. In terms of viability, there is no need to attach to an institution. Where care in a hospital is required, that should be an option recommended by the physician. It does not need to be legislated for. It is already good practice. We know how to distinguish between intervention and certification. The role of GPs is very much that they are the first responders. It does not always happen but we recommend it. They are the people who will start the process of advising a woman or a child about her state of health, including whether she is not pregnant. It is important in dealing with crisis pregnancies well before the issue of viability occurs. The leading reason for delay in abortions in terms of late term is the delay in the diagnosis of pregnancy or of a fatal foetal abnormality and the commencement of non-directive counselling could well be done in general practice as well as the acquisition of informed consent whereby having chosen an option, women in an unwanted pregnancy can choose to go ahead or choose to terminate early with the morning after pill or later through medical abortion, which can take place in a general practice setting. It does not require an obstetric facility to write a prescription and to advise a patient on how to manage medication and engage with follow up care.

With regard to Deputy Ó Caoláin's questions, GP consultation should be optional. It is good that the GP should be consulted even if he or she is not involved in certification. That should not be done without the patient's consent. Heads 2 and 4 should be amalgamated and this was strongly recommended by the Medical Council last Friday. I refer to the order in which it happens. From the point of view of certification, the major restriction we have all pointed out that the major reason for raising the risk of suicide is a restriction on travel. Soon after the Savita Halappanavar case, several women described on radio getting on a plane while actively miscarrying because there was no other option for them. That is the physical case of having to go to Britain while not fit to travel. This came up earlier and we hope such women will not be forced

on to a plane while too sick to travel. There may well be cases where women are too distressed to travel and may need to be facilitated to have an abortion in Ireland. In those cases, non-directive counselling will have happened and informed consent will have happened before the psychiatrist is asked to give their view as to whether eligibility for access to an abortion is met in this case from a mental health point of view. The other case that everybody has mentioned, which is much rarer, is where in the situation of pregnancy a mental health condition arises and the question of whether or not an abortion as an option would be best for the patient. Looking for a mental health input is a much more clinical situation we deal with, and one where Dr. McCarthy said he would be delighted to be asked for his help.

Deputy Caoimhghín Ó Caoláin asked about the GP and the psychiatrist. GPs certify many things such as absence from work. In terms of assessing people for mental health conditions, including suicidality, GPs are the first to respond and psychiatrists are generally quite happy to accept their first-off certification in many instances, and when they need our help they contact us. In regard to certification, I will take more specific questions about my experience. Mainly it had to do with the restriction on travel of children who were in State care where, because of the difference in their parenting arrangements, the decision about travelling with the child to access an abortion in the UK was more uncertain for the carers in those situations than for a parent to make, for example, in the X case. The decision for them was easier or less complex. They were clearly the parents and they took the decision with their child. It is worth mentioning in that case that the child did not become suicidal until after abortion was restricted, not before. I can answer more specific questions about that. Those were difficult. I think they reflected a genuine concern about the capacity to consent by the carers, but also a concern about the risk of suicide in vulnerable young children. If we have a margin of error in that regard - I think we should do - suicidality in children is a very serious concern and a very serious public health concern in Ireland and not one that any of us in any way take lightly.

In regard to accessibility, the key concern is delay regarding the number of doctors requiring unnecessary institutional restrictions, the dangers of conscientious obstruction and, finally, not ensuring a quick enough appeal time. All of these things can lead to delay and, as we are aware from other countries, are often focused on as ways of denying accessibility, which I think would be in breach of the spirit, at least, of the European Court's recommendations.

Dr. Eamonn Moloney: In relation to suicide in pregnancy and a person who is suicidal because she is pregnant, obviously the importance of the purpose of a consultant psychiatrist carrying out an assessment in this situation is in establishing whether there is a mental illness. If someone is suicidal in the context of a severe depressive illness, then the priority is to treat the severe depressive illness and, in those circumstances, one would not suggest that because the woman was suicidal she should have a termination. The priority there is to treat the mental illness but there are other cases where there may be no mental illness. Those situations are rare but they will occur and have occurred where a pregnant woman in a crisis pregnancy is suicidal and a termination is the only way of reducing and eliminating that suicidality.

In terms of a panel of psychiatrists, ideally the care pathway should be the GP doing the initial assessment and the certification and referring to a local psychiatrist who could do both, so to speak - see the individual, carry out an assessment, begin therapy if it is needed, or recommend whatever therapeutic intervention might be needed, but they could also certify. This will not always be the case but that would be the preference. I reiterate my belief that the role of the GP is very important and is central to this. I see them as being one of the medical opinions. I would see that one could amalgamate heads 2 and 4 so that two medical opinions are necessary and in

terms of the panels and this process, and the care pathway mirroring the Mental Health Act, I would say that the executive of the panel would be formed of eligible consultant psychiatrists and, as far as possible, that those assessments would be done by the woman's local psychiatrist so that there would be that continuity of care.

Dr. Yolande Ferguson: A number of issues have been addressed by my colleagues already so I will not repeat them. A couple of specific issues arise. Deputy Kelleher asked about the obstetrician role and to clarify that - the Medical Council highlighted this on Friday and to highlight it again - under the heads as currently written, the obstetrician would have an equal right to assess suicide risk as the two psychiatrists. Obstetricians are clearly not trained to assess suicide risk. Like all doctors, they can make a stab at it, so to speak, but they are not expert. That is what we are; as psychiatrists, we are expert. Obviously, it is important that they have a role, and our role would be to consult with them. We do this all the time for many different things. If I have a patient with a cardiac issue, I consult with a cardiologist in the same way as, on this topic, one would consult with the obstetrician, and obviously the obstetrician has an enhanced role if they are the person proceeding with the procedure.

Deputy Ó Caoláin asked me about the role of the general practitioner. All of us have highlighted that because it works very well with the Mental Health Act. The general practitioner is the person who knows the patient, often very well. They are the people who know the family circumstances. They know the social circumstances. They have a real sense of who the person is. As Professor O'Keane said, under the Mental Health Act the GP is the person who does the recommendation and then the psychiatrist does the certification. That works very well and it could be replicated here.

In regard to amalgamating heads, I do not think psychiatry should be differentiated. There is a long and sad history of psychiatry being seen as somehow outside medicine. Sometimes I hear people who are confused as to whether we are psychologists or psychiatrists. There is some confusion out there about what we do. We are all medically trained doctors. We have specialised in this area. We are as able to make decisions as anybody else. We have the same evidence to back up our practice. In my opinion, the heads should be amalgamated.

Deputy Seamus Healy asked about the Mental Health Act panels and whether I could see a mirroring. It works very well. The Mental Health Commission advertises and interviews for the mental health panels so there is a good screening process to ensure quality and I think that would work well.

Chairman: As ten Members have indicated, I would appreciate if they would be concise.

Deputy Ciara Conway: I thank all the doctors who have given evidence here this morning. My first question is a practical one, looking at that whole issue of pathways. We are very lucky to have four consultant psychiatrists in front of us today. If I was in crisis pregnancy, how long would it take me to see them? That is a real fundamental issue for women and it goes to the core of the issue about pathways. We had five consultants in here this morning. That is nine consultant psychiatrists in the Chamber this morning. If I was in a crisis pregnancy now and was suicidal, how long would it take me to see them? Unless we address that issue, I do not think the legislation can ever become a reality for women who are in distress and who are in crisis.

The second issue, which was touched on earlier, is the criminalisation of women who may have got medication over the Internet for abortion for 14 years. There is another Act and a precedence with which the witnesses may be more familiar than me - that is, the Suicide Act,

whereby the person who died by suicide was decriminalised but those who aided or abetted that person faced criminal sanctions. Is that something we should be seeking in this legislation - that we do not criminalise women who seek this life-saving abortion? Of course, we want a deterrent for people who would practise outside of medical guidelines and good medical practice. I would welcome the views of the witness on that issue. Going back to the issue of pathways, what we need to look at are things that do work in this country. The cervical cancer screening programme is a vital healthcare programme for women in this country that works so efficiently and so effectively and is rolled out by GPs all over the country, giving women an element of choice. Those are the kind of things that we need to look at if we are to make this legislation a practical, efficient and effective reality for women.

Chairman: I call Senator van Turnhout.

Senator Jillian van Turnhout: My question has been asked.

Deputy Peter Fitzpatrick: First, I want to express my gratitude to those present for attending the hearings this morning. I have just a few questions.

If a patient has stated that she is suicidal but is not suffering from mental illness, what other course is available to a doctor under head 4 other than to grant permission for an abortion?

What criteria will be used to make an objective judgment in the case of a patient who is suicidal but not suffering from mental illness? As psychiatrists, are they aware of any other life-changing decisions that a psychiatrist would recommend as treatment where a person is suicidal?

As psychiatrists, do they consider themselves competent in an expert sense to judge the risk of self-destruction of a patient who has stated that she is suicidal but is not suffering from any other mental illness?

Where a termination is being considered under head 4 near to the point of viability of the unborn child, what steps should be taken to deny a termination so as to improve the chances of survival for the unborn child?

Senator Colm Burke: I thank the psychiatrists for their contributions.

I want to raise the issue of their submission about the GP and the psychiatrist taking the decision on the psychiatric issue. The heads of the Bill refer to a joint decision between two psychiatrists and an obstetrician. The Medical Council talks about the two psychiatrists taking the decision and then the consultation with the obstetrician. Do the psychiatrists present have a problem with that proposal? If the decision was the Medical Council proposal would be taken on board, would the psychiatrists have concerns about that?

The second issue relates to the timescale. The psychiatrists stated that it should be amended to 72 hours. I refer to the smaller units and wonder whether 72 hours is adequate. If one takes for example someone who appears on a Friday evening of a bank holiday weekend, is there an availability of persons to take a decision in 72 hours? In dealing with that, I am merely thinking of such a scenario.

The third issue relates to the expectant mother under 18. What is the psychiatrists' proposal for putting a structure in place to deal with that adequately, both medically and legally; have they any views on how that should be dealt with?

Chairman: Does Dr. Ferguson wish to start? There are five other speakers.

Dr. Yolande Ferguson: I will keep it brief.

Chairman: I thank Dr. Ferguson.

Dr. Yolande Ferguson: First, Deputy Conway, referring to pathways, asked how long it would take to see me. Obviously, one would not have seen me this morning, but I have left two colleagues who were available for any emergency work. I work for a service that is highly responsive. I see persons where, "As soon as you can get here", is often the response. At weekends and out of hours, we have an on-call service.

I think that is the value of having the psychiatrist who is responsible for the patient's care being the person who does the certification. It allows that normalisation of the process. It is naturalistic. It is not her seeing some random psychiatrist whom she has never seen before and will never see again.

The criminalisation is a concern. The reality is there are many young women in Ireland who are buying their medication over the Internet and taking it at home, or whose parents are buying it and giving it to their children. It is rather distressing to think that these young women could be criminalised.

I suppose we, as professionals, have some anxiety about that aspect of the Bill. The chilling effect has not gone away and one worries that there could be potentially a case taken against one.

Deputy Fitzpatrick's issues generally tended to revolve around women and children who were suicidal but had no mental illness, and I think these are probably many of the women and children who will be addressed by this legislation. Assessment of suicide risk is complex. We approach a woman, not only as a person presenting who is (a) pregnant and (b) suicidal, but in a holistic manner. One looks at what are her circumstances, what is going on for her and what are her options. One explores all of that. One takes that time. We are part of teams and, often, the other team members become involved. At that point, if the only option that she can see is that if she does not have this she will die from suicide, then that is the answer to that question but one arrives at that after much discussion and consideration.

I apologise for not getting the name of the final questioner as I was too busy writing notes.

Chairman: It was Senator Colm Burke.

Dr. Yolande Ferguson: He asked if I would have any difficulty with the Medical Council recommendation of two psychiatrists. I would not particularly. The way the Mental Health Act operates is elegant, with the GP followed by the psychiatrist. I suppose I would not have any particular concerns about two psychiatrists but I think the other is better. I do have a concern that an obstetrician would be asked to make an assessment though.

Dr. Eamonn Moloney: In response to Deputy Ciara Conway, certainly, services are used to dealing with emergencies and someone in a crisis pregnancy who was suicidal would be an emergency and would be seen directly and straight away. Certainly, in the service that we run but, I would have thought, in any service throughout the country, there would be access. Whether that would be a home crisis treatment in some areas, the emergency department or attending the local unit, there would be some response. I can assure the Deputy of that.

I share her concerns about criminalisation of women. The word "compassion" was mentioned on several occasions this morning. That is the way we should look at this rather than looking at criminalising young women who are clearly in very distressing situations.

Psychiatrists and those who work in community mental health teams have an expertise in assessing suicide risk. They have an expertise in distinguishing the presence or absence of mental illness and they have an expertise in helping persons in emotionally distressing situations and crises. They can have a role in helping persons in the crisis situation to resolve that crisis and maybe helping to move her on to other services that may be able to provide more ongoing care and support.

The issue of foetal viability is a hugely complex issue that would involve much consultation with obstetricians and it is not an area to which I, as a psychiatrist, can give an answer. I think repeated reassurances have been given by obstetric colleagues that this will not lead to terminations in later stages of pregnancy or anything like that, and there should be no suggestion that this sort of legislation would lead to anything like that.

We were asked if there is a problem with the presence of two psychiatrists, and the answer is "No". I feel quite strongly that a GP should be involved. Certainly, it would lessen the burden on the individual woman. It is acknowledged that the GP has an important role to play in the heads of the Bill where it states they should be consulted where practicable. I would probably go further than that, but it is certainly workable with two psychiatrists. It just means it is an extra person to see. I suppose the two medical opinions I would see - a GP and a psychiatrist - are sufficient, but two psychiatrists would not make it unworkable in any way.

On timescale, I would hope that panels could be available. I agree with Senator Colm Burke in terms of practicality in those emergency situations which are rare. One is talking about a review panel.

On the issue of consent and capacity in under 18, I would defer to my child and adolescent psychiatry colleague, Dr. O'Grady.

Dr. Peadar O'Grady: In terms of Deputy Ciara Conway's question about pathways and the delay in referral, it is delay, delay, delay. The concern that we would have is that elements of the legislation are either designed to delay, which we hope would not be true, but also could be used to delay processes and procedures. How long to see one consultant? How long to see two? How long to see three doctors? Is this medically necessary? I think we are being very clear today that it is not. Outside the legislation, it is not necessary to see any psychiatrist at all unless consulted for a medical reason by a colleague. We are only addressing today the reasons a psychiatrist might be consulted on the legislative side in certifying for eligibility, which all of us have said we will try to integrate into good medical practice. I am trying to clarify that there are differences here. All of these delays around three consultants are to do with eligibility under the law. They do not have strong connection with good medical practice. As Deputy Conway has pointed out, one, two and three doctors is a matter of delay. There is no medical issue there.

On the question of criminality, as I pointed out earlier, it is dangerous to have criminality hanging over women who may then feel restricted from sharing their medical details openly and on which we rely constantly - even more so in psychiatry. We would not distinguish ourselves from our colleagues but much of what we do is putting someone at their ease so that they can tell us where they are at and guarantee them some degree of confidentiality so that they feel free to do so. It could happen, for example, that 14 years would be hang over someone who,

for example, has taken medication ordered over the Internet and would not then say that they had taken it because they feel that it is a criminal act to have done so. They might at some later stage need to undergo an anaesthetic. I would never want my anaesthetist not to know what drugs were in my body. That will put people at risk.

The second thing it does is add to stigma. There is much work being done by support and mental health agencies to reduce stigma and to say that travelling as one can, lawfully, to Great Britain and having an abortion in the case of fatal foetal anomaly or for any other reason. To say this is equivalent to a grave crime is stigmatising women unnecessarily. It makes absolutely no difference and seems only designed to stigmatise and delay and for that reason, is dangerous.

There is no need for specific laws to criminalise bad practice. If it requires a registered medical practitioner to carry out an abortion, which it does, anybody who is not so registered should be sanctioned. I do not have an opinion on that sanction but it is up to legislators if the sanction is a criminal one. If a registered medical practitioner engages in poor practice, there is already a process of sanction for poor practice. Most of what we are talking about is not seen as good or bad practice anywhere in Europe. It is not literally a medical issue.

In respect of interventions other than suicide, I see many of my colleagues go to extraordinary lengths. Very often I look at what a colleague, be they a social worker, psychologist, nurse or doctor, is doing and think that they are going above and beyond the call of duty to intervene to support a young person. Given the infrastructure of education, child protection and health with which we are trying to deal, sometimes extraordinary and heroic acts are carried out on a daily basis by the ordinary mental health workers around the country and they deserve much credit for that.

People have drawn attention to this notion of women hurt by abortion that needs to be addressed and I will take this moment to do so. Women are hurt by abortion. The WHO estimated that 40,000 women died in 2012 from unsafe abortions. The figure changes a lot because it is hard to count them. They were women hurt by abortions. A total of 5 million women were disabled by unsafe abortions. In countries where abortion services are well developed, we still have the concern about coercion. When we argue for choice, we mean choice in either direction. One should not experience coercion but we know that often people do, from relationships and economic stress. We should do everything in our power to make that decision as free from coercion as is humanly possible.

To return to the issue of criminalisation, we should also make it free of stigma. Before the decision is made, every support to make that decision with informed consent should be given. After the decision is made and an abortion or a birth is chosen, we should give absolute support to that person and not stigmatise them. As someone said, there is no right response to pregnancy or abortion. We support people no matter which decision they take, which is already the *status quo*. I do not think there are many left who are trying to demonise women going to Great Britain every year for an abortion. Unfortunately, this legislation does.

The key issues were raised this morning. These will likely centre on children in care with a concern about travel and the ability to help a young person make a decision. These raise issues of consent and the capacity legislation. I am not advising on legislation today and do not pretend to have any expertise in what sort of legislation will address this. The point we would bring up relates to children in care and the capacity of children to make decisions. The greater clarity is brought to that the easier it will be to deal with children under this legislation. I am not convinced there is anything specific required for under 18s in this legislation. There will

be concerns about applying it. The question of what appears in this legislation is a matter for the legislators.

Professor Veronica O'Keane: I will not repeat what my colleagues have said. I do not disagree with any of it. I would like to make two further points. In respect of the two psychiatrists, I believe it should be one psychiatrist because the initial point of contact will be the general practitioner. The general practitioner is in a very good position to look at a woman they know, hopefully, quite well over a long period of time and to say whether they think this woman is suicidal or not. It is not one opinion about suicidality. It is two opinions about it, one which belongs to the general practitioner and the other which belongs to the psychiatrist and, as Dr. Ferguson said, preferentially the local psychiatrist.

In response to Deputy Conway, time is of the essence. We work within structures that allow us to deal with emergencies so there is a certain amount of flexibility, obviously, within a normal medical timetable allowing for emergencies. We respond within hours. GPs and accident and emergency officers telephone us directly and we deal with them immediately. Another problem I have with two psychiatrists is that it potentially slows down the process and also causes unnecessary emotional distress because the woman must repeat her story twice. It is very difficult for people in distress to open themselves up twice. The process of opening up is quite painful and it is a very difficult for a person to tell somebody one is so vulnerable that one is suicidal and looking for their help. To have to do that twice is putting too great an emotional burden on women.

There is also a practical consequence. If it slows down the process and it could mean the difference between a woman being able to have a medical or a surgical abortion. About 50% of abortions in the UK are medical abortions. This involves taking a tablet and another tablet 12 hours later. This must be supervised medically but it can be done at a general practice level. In the future, more and more early abortions will be medical abortions and will not be complicated procedures. The best strategy in medicine is one that is least interventionist so we want to treat women as early as we can.

I know we are pressed for time but I have an important point to make regarding head 6, subhead (2). This relates to timeliness as well. I wanted to draw the committee's attention to the fact that the last sentence in subhead (2) implies that the medical practitioner in the initial certification procedure need not give an opinion. It is quite dangerous for us to allow the first group of medical practitioners who review a woman not to give an opinion. They should either give an opinion or not give one. If we allow people to not give an opinion, the review panel may also be in a position of not having to give an opinion so the woman could be going from one situation of not having been given an opinion to another. In my view it is absolutely fair that a group of medical practitioners may say they do not think this woman fulfils the eligibility criteria for an abortion. That is okay. The woman then says, "I want to appeal this decision", and she goes to an appeal panel. However, if a woman is left in a position where a group of experts say they are unable to make up their minds and they do not have an opinion, it is a very difficult situation for that woman. I ask the committee that it should consider that there should be an onus on the group of practitioners who see the woman initially to come to an opinion, even if that opinion is in the negative.

Senator Ivana Bacik: I thank the witnesses very much for their very helpful points and comments and for reminding us that the legislation is very restrictive but that its purpose is to provide for an accessible and effective procedure whereby women may vindicate their constitutional right to life. It is particularly helpful to hear from Dr. O'Grady who had the direct

experience of having certified eligibility under the X case criteria. That is very useful because there was some suggestion in earlier sessions that these cases never arise. I ask Dr. O'Grady to confirm for the committee that in fact they do, albeit in extremely rare cases.

I wish to raise a couple of specific points, first, in respect of the women who are affected. We are reminded that the majority of the 4,000 women who travel will not be affected by this legislation. The reality is it will affect young girls mostly in care or in emergency situations where women are restricted in travelling. The question was raised about specific reference to children. In the earlier session, Dr. Doyle suggested that "child" be defined in the legislation, given the slight anomaly between the legal age of consent to medical treatment and the Non-Fatal Offences Against the Person Act which is 16 years and then 18 years for psychiatric intervention. I ask if the experts have any comment on this anomaly.

I ask for clarification on some technical points. I take the point that all the experts are in agreement that the Mental Health Act gives us a very clear procedure involving one GP and one psychiatrist. The expert witnesses suggest that this arrangement be replicated, not that there be one GP plus two psychiatrists. I ask for clarification on that point because what is being suggested could potentially put another doctor into the certification process. Dr. Doyle referred to a very practical issue that one third of girls in Clare do not have a GP and asked what is to be done in those instances. The time limits under head 6 were pointed out and this is very important. I take Dr. O'Keane's point about head 6(2), which I think contradicts the language of head 6(1), which does not envisage that there would be no opinion. It envisages an opinion against certifying for eligibility.

On the final point about the issue of suicide under head 19, as Deputy Conway said, the person who commits suicide - indeed, anyone who attempts suicide - is not criminalised under the 1993 Act. Similarly, if we are using that model, I wish to confirm that the woman or girl who attempts suicide in Ireland should not be criminalised.

Deputy Denis Naughten: I have three brief questions. I ask for clarification from Dr. O'Grady about his earlier evidence. My understanding is that suicidal ideation in pregnancy peaks in or around the end of the first trimester. If that is the case, would a delay in a decision not lead to a greater number of medical terminations rather than surgical terminations, as stated in the evidence given to the committee on Friday by the obstetricians?

The case has been well made this afternoon about psychiatrists and GPs making the decision but that the obstetrician would not be involved. Under head 4 the definition of reasonable opinion specifically states that consideration must be given to the need to preserve the life of the unborn where practicable. I ask Dr. O'Grady to clarify how this can be done if an obstetrician is not involved.

What happens in the case of a woman who does not have a mental illness whose suicidality is based on the fact that she is pregnant with a baby with a very serious foetal abnormality? The decision, naturally enough at that stage, would be quite close to the threshold of viability. What happens in that case? Would it not be the case that there is a far greater frequency than one in a thousand in that cohort? How do we deal with the practical aspects of such a case? Sadly, this legislation means that such genuine cases will come before each of the doctors in the not too distant future.

Deputy Regina Doherty: I thank all four witnesses. My questions are for Dr. O'Grady and Dr. O'Keane. Dr. O'Keane spoke about the sudden onset of suicidal intent in a pregnant

woman. Dr. O'Grady is in agreement with Dr. O'Keane that psychiatrists do not treat suicidal intent; rather, they manage the issues underlying the risk and they deal with those issues. This is where my concern arises. She stated further that she understands the purpose of this legislation is for psychiatrists to assess the eligibility or otherwise of a woman seeking this procedure. She stated that in her view the process is too long, with too many medical people involved, and that the rush to appeal within seven days may mean the difference between a medical and a surgical abortion. While all this might be true, there is no treatment in the middle of all that process. I ask Dr. O'Keane to explain when, in the case of a woman who may present to a GP with genuine suicidal intent because of her pregnancy, does the treatment kick in? Do we immediately go through a process of assessing her eligibility or a certification for a medical treatment?

I am genuinely at a loss. In my head the reason I could satisfy my support of this legislation was that it was not a treatment for suicide but rather an option where all other options had failed. In that context I was happy to accept it. However, I fear from what Dr. O'Keane has described this morning that there is no treatment. A woman will go to the GP and say she is suicidal and requires an abortion and the process will immediately kick in whereby she will be certified as either eligible or not eligible. I am concerned that there will not be any medical care. I am probably mistaken in my interpretation but I ask the doctors to clarify the situation for me.

Senator Jim Walsh: I will preface my first question by saying that a reply to a freedom of information request from the UK Ministry for health recently identified that between 1992 and 2010, no Irish women availed of an abortion under that section which deals with saving the life of the mother. That abortion is not a treatment for suicide is the clear, unambiguous evidence we have been given at these hearings. Dr. O'Keane conceded this point. To be fair to her, she said that it was for an unwanted pregnancy rather than a treatment for suicide. Abortion can be a contributory factor in suicidal ideation in women who have had an abortion. Many women have committed suicide in these circumstances. What assurances can the doctors give that this can be avoided if they certify a termination? I refer, in other words, to the law of unintended consequences.

We heard evidence with regard to the assessment of patients that psychiatrists, by the nature of the profession, will err on the side of caution when assessing patients. Dr. O'Keane stated that she would believe a woman if she told her she was suicidal. On the other hand, we have heard from women hurt by abortion. Four or five women attended the committee last Thursday who had had abortions in Britain. Two of them said they were advised to seek an abortion on the grounds of being suicidal, even though they were not suicidal. They were subsequently certified by people in Britain in the same profession as the doctors present.

In the United States, there has been considerable liberalisation of abortion with regard to mental health and suicidality. I refer to Dr. Bernard Nathanson's book *Aborting Americ*. He states that the attack had to be made in the weakest area, the psychiatric indication, which was inexact and immeasurable, yet sufficiently threatening. He said that once a breach had been made in that area, once a few precedent-setting cases had been raised, they could then be poured through in unlimited number. He stated that the proposed threat of suicide was the logical battering ram. It was just a question of finding a squad of compliant psychiatrists. Given that that is the experience elsewhere, what engages us is how can we avoid that or how can we get any assurance that a similar thing will not happen here to corrupt the profession in this regard.

The late Dr. Anthony Clare, who was pro-choice but became pro-life in the 2002 referendum, clearly stated that that was his experience in other jurisdictions as well - that the situation of mental health and suicidality were areas that led to liberal abortion regimes in those coun-

tries.

Professor Veronica O'Keane: I will start with the last question from Senator Walsh. I thank him for clarifying that I did say abortion may be a treatment for an unwanted pregnancy and not for suicidality. That may be, indeed, what I did say. I have certainly never said the other.

As regards women being advised to seek an abortion, I can assure the committee that it would be against the spirit of this legislation and would be outside what would be ethically accepted medically for us to do that. Speaking for myself, I am absolutely not going to advise any woman who comes to see me whether or not she should have an abortion. That is entirely her decision; she is making the application to have the abortion. I am not making the application and I am not prescribing the treatment. She is making the application. I am employed by the State to determine, in my professional opinion, whether or not that lady is eligible for an abortion, according to the law. I will not act outside the law but I will enact the law once it is passed, which other psychiatrists may choose not to do.

As regards the question about treatment, everybody who comes to us will be treated. Every single individual who comes into the psychiatric services will be treated with psychotherapy and perhaps daily or twice-daily visits from home treatment nurses. We have access to immediate psychology for them if it is so required. We can talk to their families and can intervene with family therapy. We can bring together teams of professional carers and can assemble them rapidly in response to emergencies like this.

The reason we want to have rapid access is simply to reduce the amount of distress in so far as we can. We will obviously provide a full range of psychiatric treatments and care for every single woman who presents to us, regardless of what we do within the limits of this legislation, which I think is just saying that somebody is or is not eligible. As Dr. Ferguson has clearly pointed out, there is a whole range of interventions and people are treated holistically. They are treated in response to the individual needs and vulnerabilities that they present to us with.

The point I am making is simply that we are not prescribing the abortion. We are not saying to the woman "We think you should have this treatment". The woman is coming to us as an autonomous citizen, asking for an abortion. We are requested by the legislation - that, hopefully, will be enacted - to see whether or not this woman lawfully meets those criteria. While we do one, it does not mean that we do not provide care.

Dr. Peadar O'Grady: It may help to clarify this area from the point of view of Doctors for Choice Ireland. We are being very clear. The alternative to this legislation is to allow women to decide for themselves and not to require certification by doctors about their eligibility. That is what they do in Canada where there is no criminal sanction in making this decision. There is lots of good practice. If one wants doctors to certify, one cannot also tell them that they think it is a good idea. All one can ask them is whether they can carry out that certification. This is what we are trying to advise today. Does Doctors for Choice Ireland, for example, think it is a good idea? No. One does not need certification for eligibility for abortion. One only needs it where legislators put that requirement on one. On Friday, we heard from the Medical Council and the Irish College of General Practitioners. This morning we heard from the College of Psychiatrists of Ireland. Can we do it? Of course we can do it.

Legislators will have to own some of the complications that arise from the legislation. What we can do is to be as helpful as we can. Do the cases occur? Yes, they do, as Senator Bacik has

pointed out. They arise episodically. Why they might arise again the future, why there might be a restriction on travel, or why there might be concerns about whether or not consent is adequately given - we cannot predict in what way they will present.

I will not go into the 16 versus 18 issue in detail. That was well argued in terms of the whole capacity debate, which I really think is a separate issue. Does it apply to this area? Absolutely, it applies to this area, but not differently than it applies to any other area of medicine. Where a question arises around consent with a young person or someone, for example, with an intellectual disability, we do need a resolution concerning access to medical treatment. Whether they can give consent, but also whether they can refuse consent, is a whole other debate.

I would favour one GP plus one psychiatrist instead of an obstetrician and two psychiatrists. Obviously, the second doctor should be optional, in my view. As I have been at pains to point out, the first doctor is and should be optional also, in terms of eligibility - not in terms of advice, but in terms of counselling and helping someone to come to a decision, but not making that decision for them.

Deputy Naughten raised a point about suicidal ideation and pregnancy, which is absolutely correct and is often overlooked. Professor Kendall's study pointed out that, years ago, there was a coincidence between suicides and pregnancy, particularly before the Second World War and before the 1950s and 1960s when abortion was made more available in terms of being free, legal and safe. It very much coincided with missing the second menstrual period, which is literally when a woman starts to realise that she is pregnant. That is when the clusters of suicide in pregnancy occurred.

As the Deputy points out, one is likely to get those cases where suicide risk arises - not all of them, but the vast majority - in the first trimester, i.e. before ten to 12 weeks which is early. Medical abortions would be carried out predominantly in that period and a delay would lead to more surgical abortions. I am not sure what advice was given on Friday. I am not an obstetrician or a general practitioner. It is not my area of expertise but I am 100% certain on that point, that medical abortions are early, including the morning-after pill if one is of the persuasion that believes that is abortion.

As regards reasonable opinion, I think the issues of viability are best referred to obstetricians. It concerns that point in time. It is not that general practitioners will not be involved, but any decision about prolonging pregnancy in order to deliver a viable baby at that stage, rather than a foetus - that is, decisions about viability and the discussion with the parent about that - is an issue for an obstetrician. There is really no role in psychiatrists. In the same way as we might object to an obstetrician advising about the risk of suicide, I think that obstetricians would quite properly object to any psychiatrists giving their opinions about viability.

As the Deputy indicated, for most people, the word "fatal" in fatal foetal anomalies implies that viability is very much the moot point. It is the point around which the heartache of parents arises. The diagnosis of fatal foetal abnormalities often does not happen until the second trimester and, sadly, sometimes not even until the third trimester. The Deputy is correct in saying that these are the more difficult situations where someone had a wanted pregnancy. These are the changes that all of us are very sensitive to. There is nothing more tragic than wanting to have had a baby and where the mother decides she will call this a baby rather than calling it a pregnancy. Nobody, except doctors, really talks about a foetus. People either have a pregnancy or decide that they are going to have a baby. That is changed where that is not going to happen and it is a tragedy for all of us.

To come back to the issue of treatment, anyone involved in certification should never lose track of the fact that they are dealing with a human being. I do not care whether one is certifying that they need to be off work or off school, in my case - one is not just certifying and saying "Next". One is looking at a person and asking what else, besides the certificate, is going on with that person and whether one is missing something because primarily, one's role is as a doctor, and not as a form stamper and certifier. In jurisdictions where some of that is lost, stuff like advising someone to go for the suicidal option, about which people keep talking, can only occur in a situation in which there is a legal obstacle to access to abortion. Again, it is neither within the ability nor the job of doctors to deal with that. It is the job of the public and its relationship with the legislators. In the same way that doctors get accused of trying to open some kind of floodgate - I really object to the notion of women being like water flooding through a gap, which simply is objectionable - the notion that doctors might facilitate this is as objectionable as doctors who might obstruct the process. This is a social process and attitudes to abortion in Ireland have changed fundamentally. In the most recent poll, 92% of Irish people agreed with abortion in at least some circumstances. The change this causes from a legislative point of view is between the population and your good selves.

Finally, in response to the last question raised regarding suicide, I believe Professor O'Keane has dealt with that very well. On the issue of women being hurt by abortion, I reiterate the need to get rid of coercion. It is a poignant fact that people who have a personal ethical objection to abortion are a group to which we must pay particular attention. If they came under coercion to have an abortion, rather than feeling more free to follow through with their own ethical ideals and carry through a pregnancy, and if they chose to have an abortion, they would be a group of people we would be obliged to follow up very carefully. They would be likely to suffer feelings of regret, guilt, anxiety and so on. This means we should not be idle certifiers. We should detect, engage with and follow up risk and support people, no matter what their viewpoint. Again, this is the point made by Doctors for Choice Ireland. We are for choice, not for forcing our views on anyone else. I will leave it at that.

Dr. Eamonn Moloney: Many points already have been covered but I reiterate my opinion that just two medical opinions would be sufficient, one from a general practitioner and one from a consultant psychiatrist. We really are addressing the legislation before us here and are not really addressing the totality of care women need and obviously, to address Deputy Dowds's concerns, that would continue. Someone in distress, someone who was suicidal, will get the care she needs regardless and the certification procedure can go on. In order to reduce the need for a woman to see more and more psychiatrists, ideally the people who provide the treatment also could do the certification. This is the reason a process which mirrors the Mental Health Act would reduce the number of assessments through which a woman would be obliged to go. However, the woman at all times will get access to the health and care she needs at that point.

Similarly, most situations will arise early in the first trimester. Outside of that, when there are issues with regard to foetal abnormality or foetal viability, obviously there would be discussions as best medical practice would dictate there should be consultation, liaison and discussion with our obstetric colleagues. As for stating repeatedly that abortion is no treatment for suicide, the latter is associated with certain conditions for which treatment is available. Consequently, what we are talking about is not treatment but is about eligibility for someone to have an abortion. There certainly have been and again will be, rare circumstances in which a termination is essential to deal with a pregnant woman's suicidality associated with a crisis pregnancy. The use of extravagant language and exaggerated claims of some sort of conspiracy involving consultant psychiatrists, general practitioners, GPs, and obstetricians to open the floodgates of

abortion are simply exaggerations. They are what they are, namely, exaggerated claims.

Dr. Yolande Ferguson: To clarify for Senator Bacik, I do not mean a woman should be seen by three different doctors. The whole thrust of my opening statement was that it is not acceptable to put a woman through that. Professor O'Keane has highlighted that it is traumatic to tell one's story again and again. The Senator's other question was, if there is no GP, then what? Again, that pathway of care is different. One might see this happening a little more in the case of child and adolescent psychiatrists, where one might get referrals from school counsellors, for instance. In that case, the second doctor could be a psychiatrist or a GP because that girl should have a GP. If she did not have one before, she certainly should have one afterwards.

On Deputy Naughten's concerns about the obstetrician not being involved, I do not think any of us is suggesting the obstetrician is not involved at all. We simply are saying that when making a decision as regards to suicidal ideation, their role is a consultative one. While Deputy Dowds addressed his question to Professor O'Keane, it is really important to highlight something I mentioned in my submission at the outset, which is that as much as possible, we should follow normal pathways of care. This process should be best medical practice and best medical practice means following normal pathways of care. This means the woman is eligible for all treatments that are available to anyone who is in any situation in which he or she meets a psychiatrist.

Finally, in response to Senator Walsh, when I think of the United States, I do not think of it as a liberal abortion state but as somewhere that has very mixed and certainly very divided attitudes towards abortion. The Senator again talks about - I will not even repeat the word because my colleagues have referred to it - how psychiatrists somehow would facilitate an increase or allow an entryway into abortion on demand, which is another dreadful expression. I am a psychiatrist and I have spoken previously about how proud I am of my profession and how important it is to me that psychiatry is regarded with the same esteem as any other medical profession. This morning, Dr. Anthony McCarthy mentioned Ireland's sad history with women and pregnancy, both with the Magdalen laundries and, sadly, psychiatric institutions. None of us wishes to see a return to those days. None of us wishes to see our profession discredited.

Chairman: I thank the witnesses. The time for members-----

Senator Jim Walsh: May I comment?

Chairman: No, the time for members' questions has been exceeded. I apologise to members who cannot get in but the 70 minutes are up. I now wish to turn to the time allocated for non-members. Although ten people have indicated, because of the time allowed not all ten will get in and consequently, I apologise again. However, I ask people to be brief in the questions, rather than giving full exposure to their views. Deputies Terence Flanagan, Mathews, Durkan and Creed, in that order, will be the first four questioners.

Deputy Terence Flanagan: I have three brief questions and would appreciate it were the panel to answer them, because I posed other questions in previous sessions that did not appear to be answered. In light of the X case judgment that a termination of pregnancy is the only means of averting the risk to the life of the mother, does it follow that abortion becomes the only means available if the woman simply refuses all alternatives? Second, where a woman who is suicidal presents to the witnesses as treating psychiatrists and she refuses whatever treatments they offer, as she is entitled to do, at that point they will certify that a termination is the appropriate treatment, despite the fact there is no evidence that a termination will have any beneficial

effect for that woman in a suicidal crisis. Is it not fair to state that the law's operation, as the witnesses envisage it, will be inherently open to abuse as it will rely primarily on the will of the pregnant woman?

Third, how accurate do the witnesses expect to be in determining whether someone is actually suicidal and the only treatment is abortion? Were we to legislate on suicide as grounds for abortion, are we not legislating for a condition that has an incidence rate of one per 500,000 of population, as per Dr. Anthony McCarthy, with a positive predictive value of 3%, as per Professor Casey? Moreover, findings published in the *American Journal of Psychiatry* in 1997, state that as a treatment, abortion is not effective. The Finnish study which looked at all the registers between 1987 and 1994 found no cases of suicide in pregnancy but a threefold increase in the rate of suicide after abortion. Could the panel comment on whether abortion could make a woman suicidal? Recent media reports on the Miss C case indicated she had made further suicide attempts post-abortion.

Deputy Peter Mathews: I thank the doctors who have come before the committee today. I have been present on Friday and today. We are all agreed that what we want – whether professionally qualified or non-qualified citizens – is a good, ethical society, one that respects life. In essence, that is what we are here for.

This is not a debate in a vacuum. It is a debate about realities. The witnesses have told us of their experience. The gaping hole in the hearings, both the earlier ones in January and the ones today, are the women and girls who have had the experience. Perhaps they have been patients of the witnesses. They requested to be present to give their testimony and their offer was declined. By any measure, that is essentially wrong.

I am afraid that we might be rushing because of the approach to the issue. The professionals are reacting. Even on Friday, Dr. Boylan, one of the obstetricians and gynaecologists, said life is messy. Today, again, we hear that life is tough and life is messy, which it is. That is why care, compassion and supports are necessary, and all those things that eliminate the fear because no poor girl or woman who has had the unhappy experience of an abortion wants the experience. They have been motivated by fear, coercion or oppression. Even if it is imagined, the way to address the situation and eliminate the crisis is to get rid of what caused the fear. Dr. John Monaghan from Portiuncula Hospital pointed out on Friday that when he was working in the English midlands in the Liverpool area as a trainee obstetrician and gynaecologist, the number of medically-qualified people going into the profession started to decline seriously to 50% levels because of the ethical considerations of what was happening in the United Kingdom in the context of delivering medical care. Doctors undertake to do no harm. The five women who were declined an invitation to the committee were harmed and they said so.

Chairman: I thank the Deputy. His time is up.

Deputy Peter Mathews: It is a big omission if one fails to deliver necessary care by omission when one is young, vulnerable and in crisis.

Chairman: Go raibh maith agat.

Deputy Peter Mathews: I do not set out blame but I urge that we do not rush the legislation. We must think about it and look at the realities of the 7 million abortions in England and the 55 million abortions in America. We talked about children. There is a law in France-----

Chairman: I thank the Deputy.

Deputy Peter Mathews: -----that allows under-age girls to go to their GP and have an abortion without their parents' knowledge. They are realities.

Deputy Bernard J. Durkan: I thank the expert witnesses for their attendance today and their clear responses. I wish to comment on the Women Hurt group. It was suggested on Friday that in many cases women who had abortions outside of this jurisdiction and had feelings of guilt afterwards had a prior psychiatric condition. Is that generally accepted? To what extent has the evidence of the Women Hurt group, who came before another group in the House, been adduced, if at all?

Given the tendency in this country to have an Irish solution to an Irish problem, is there evidence to suggest that in certain circumstances, by virtue of the existence of conscientious objection, there is a possibility that some women presenting with a crisis pregnancy might find themselves unable to access treatment appropriate to their condition, either from a psychiatric point of view or medical point of view?

Is time a critical factor in determination of access to suitable treatment in the course of an examination of a case presented by a woman in certain circumstances with specific reference to suicidality?

My final question is an important one. We have heard both in January and in recent days considerable evidence on what has happened in other jurisdictions. Could I have clarification on whether it is clearly understood by all that the situation in this country is controlled by the written Constitution, as amended by the people, with the exception of the situation as determined by the Supreme Court? Reference to extreme treatments prescribed in other jurisdictions is not relevant.

Deputy Michael Creed: I thank the witnesses for their enlightening presentations. If memory serves me correctly, on Friday Dr. Tony Holohan, the chief medical officer in the Department of Health, said the Department did not have access to figures in respect of adolescents in care who might have access and entitlement to a termination on the basis of the circumstances of the X case.

In that context I will address my questions to Dr. Peadar O'Grady because in his cover note he states that he has experience of certifying permission for terminations in those circumstances. It would be wrong to distil this complex issue of trying to reconcile a Supreme Court judgment with the legislative intent of the people in 40.3.3°. I refer to evidence given by a consultant psychiatrist, Dr. McCarthy, this morning and a figure which has come up previously, although I cannot vouch for its authenticity. It suggests that the incidence of suicide in pregnancy is a rare phenomenon – one in 500,000 pregnancies - which would suggest that on the basis of the X case ruling in 1992, on the basis of approximately 100,000 pregnancies a year we would be looking at four to five similar cases in this jurisdiction. In his professional experience, how many times did Dr. O'Grady provide such certifications during his employment and the circumstances in which he might have been requested but declined to authorise entitlement under X case criteria?

I have a second brief question on the issue, namely, on the doctors who will make the determination. It is proposed under the heads that it would be two consultant psychiatrists and an obstetrician or gynaecologist. I do not intend to second-guess the professional view of the psychiatrists but there is another voice in the context of the complex issue that must be heard, namely, that of the obstetrician. That is something that must be taken into account. While tak-

ing on board the evidence of the psychiatrists it is also important to factor in the input of the obstetrician. I would welcome some response on those two issues.

Chairman: The time has almost expired so I will call Senators Healy Eames and Bradford. I would appreciate it if they would be brief.

Senator Fidelma Healy Eames: I thank the panel members for their time. What is Dr. O'Grady's professional view of the suggestion that the X case was determined by the Supreme Court without any psychiatric evidence?

Chairman: With respect, we are dealing with the heads of the Bill. The expert group in the Supreme Court decided fadó fadó.

Senator Fidelma Healy Eames: We are on head 4. Was that appropriate in the view of Dr. O'Grady? Dr. Veronica O'Keane made a claim that is of huge concern to me and I would like her to validate it. She said in point 5 that in situations where abortion services are not available, unwanted pregnancy is a leading cause of suicide. That is not known. Where is the evidence to support her statement? What source does she have? In January, Dr. O'Keane said just three out of every 100 patients who attended psychiatrists and were predicted to be at risk of suicide would eventually go on to commit suicide. That is a direct quote; she did not say they were pregnant women. I am very concerned also that she says she would like a GP to make a recommendation for an abortion. Did she mean a referral to a psychiatrist? Does Dr. O'Keane believe there should be any restrictions on the provision of abortion when a woman requests it?

Senator Paul Bradford: My first question is to Dr. O'Grady. He heard this morning, and will be aware from the evidence given on Friday and in January, that to a reasonable extent every witness has said abortion is not a treatment for suicide. The X case, which we are legislating for - I am referring to head 4 - will require certification to the extent that abortion is the only treatment available. Dr. O'Grady represents the group Doctors For Choice Ireland, an advocacy group, and is entitled to his opinion, and he has been frank and has put on the record that he has provided such certification. Can he tell me that in those certifications he was absolutely satisfied that abortion was the only treatment? Is part of his being satisfied the idea that abortion is the only suitable treatment, which legally it would have to be? Could he advise me what other treatments would be offered to those patients? We sometimes lose the importance of the language. The certification must have been that abortion is the only treatment. Was Dr. O'Grady satisfied in that regard? What other treatments had been offered? Dr. O'Grady also requested that we change the wording of the Bill to replace "unborn" with "foetus". What is his thinking on that?

Dr. O'Keane made the statement that the difficulty with evaluating suicidal ideation has been exaggerated. How can she justify that with what she said here before, along with others, about the 97% inaccuracy in that identification? She said the evaluation had been exaggerated, but if experts like her say that in 97% of cases she is incorrect, how can she justify the statement that this is exaggerated?

Dr. Yolanda Ferguson: I will start with that point - accuracy of assessment. There is a notion that psychiatrists do not have tools or measures to make assessments. We have clear experience and training in making assessments in all facets of people who present to our services, including suicide risk assessment. We do this every single day. We are highly trained and highly skilled in making these assessments.

Going back to the question of linking mental health issues with abortion, if we look at women who are more likely to seek abortion, it is not terribly surprising that those who have made that difficult decision did so because of a number of factors, including mental health issues. The phrase "refuses all alternatives and suicide is the only option" displays a cynical approach to women, that they are sitting there saying they will not do this, that or the other, that they only want one thing. That is not what we experience when we see women in crisis.

Deputy Mathews asked about women hurt by abortion. Support groups are usually founded by people who are dissatisfied with something. It is unlikely we would find a support group of women who are pleased with their decision.

It is important that conscientious objection be included in the Bill. That is why we suggest a panel. If a woman cannot avail of the normal pathway of care because her psychiatrist is a conscientious objector, that panel should be formed.

Dr. Eamonn Moloney: In response to Deputy Flanagan's question about women refusing to co-operate with treatment, it is best answered by Deputy Mathews, who says that no one wants the experience of an abortion. I do not think women will come along to deceive a psychiatrist. This is why the role of the GP will be particularly important, knowing the individual and having personal knowledge, with an experience of dealing with people and being able to assess whether someone is telling the truth. We spend our working days talking to people so we have a lot of experience in this and it is cynical to suggest this is what will happen.

Several of the speakers here this afternoon and this morning, particularly by Dr. Anthony McCarthy, have addressed the positive predictive value of 3%, with one in 500,000 suicides in pregnant women. We do not know what the rates of suicide would be among pregnant women if they did not have access to abortion. We cannot make any prediction, be it 3% or 93%. As I said earlier, one cannot ethically and reasonably do those studies to work it out with that degree of accuracy. We can only say what best international practice is, not just in Ireland but throughout the world, and that we have the ability to assess suicide risk and manage that, recommending the available treatments. It is spurious to use such terms to talk about predictive values. These are in populations where people receive treatment. That obviously affects the outcome.

I would not say we are rushing into anything. It is 20 years since the X case and it is about time. I am glad we are now at the point at which where we are legislating on the X case. Deputy Mathews's reference to obstetricians leaving upsets me because it might be due to other factors, such as the rising rates of litigation against obstetricians. I accept we have our own Constitution but we do not live in a bubble. We are part of Europe and a wider global community. If it is the reality that women are leaving Ireland to get terminations in other jurisdictions, it is relevant to mention that.

Many of the other questions were related specifically to Dr. O'Grady's area, so I will let him address them.

Dr. Peadar O'Grady: I will try to focus on the procedure's being open to abuse if it is left to the will of the pregnant woman. I hope I am not being unfair to the person who asked this question, but that is precisely the view of Doctors For Choice Ireland - that it is women to whom we should leave the final decision, having given all the advice and looked at all the possibilities and options. The final decision on whether to have an abortion is most safely left in the hands of a woman, and I do not consider that abuse; I consider it best practice.

I absolutely agree that a prior history of mental health problems and a history of violence, particularly sexual violence, are very important factors, and in many of the debates that have taken place about the connection between mental health and abortion, it has often been overlooked that women who suffer from mental health problems and violence are more likely to be in a situation in which they consider having an abortion. The connection is not with abortion; it is with the previous history. Deputy Durkan is correct in that, and it is the pro-choice lobby that has drawn attention to it. The most recent studies, a report by the American Psychological Association and a review done by the Academy of Medical Royal Colleges, have clearly stated there is no evidence of abortion causing mental health problems. There is controversy around this and, as I noted earlier, we are very conscious of a subgroup of women who have a negative response to an abortion. This very often occurs for the two reasons I mentioned - namely, the women feel coerced into having an abortion, or they strongly object to abortion from an ethical point of view but feel coerced into having an abortion. It is common sense that this subgroup may experience an increase in mental health problems after having an abortion. It is definitely a subgroup to which we should pay attention.

Speaking live on the "Morning Ireland" programme, Dr. David Fergusson, a New Zealand researcher, who was cited by the anti-choice, pro-life groups, blatantly contradicted the interpretation of his research and put Professor Casey right on it, when he stated he did not deal-----

Senator Fidelma Healy Eames: RTE issued an apology two or three days later.

Chairman: Please do not interrupt.

Dr. Peadar O'Grady: Dr. Fergusson pointed to three facts that are written in his paper. First, he did not do any research on women who are suicidal. Second, he did not believe the evidence he presented in his paper was strong and, therefore, it should not be used emphatically. Third, he argued in his paper for an easing rather than a tightening of the eligibility restrictions as a result of his research.

On the issue of women who have been hurt by abortion, I referred to the 47,000 women who die as a result of unsafe abortions and those who are disabled by their experience. I also spoke of the women who are at risk through coercion and stigma. It is also worth speaking of the women who are not hurt by abortion.

Deputy Peter Mathews: It would be useful to hear that from the women themselves.

Chairman: Deputy Mathews does not allow interruptions when he chairs the Dáil. He should respect the same rule in this Chamber.

Dr. Peadar O'Grady: I concur with Deputy Mathews that it would have been useful to hear representative groups of women explain the negative and positive experiences they have had in order that all of us can draw conclusions about how to make this experience better for everyone, allow women to make the best decision for themselves and ensure they are not coerced into having an abortion or stigmatised afterwards. These are the two major causes of distress. We should get rid of this fear, as Deputy Mathews outlined. The voices of these women can be heard at a later date.

As to whether conscientious objection would disrupt access, that could be the case, and the issue will have to be monitored. It has been noted in ethical papers that there is a conscientious objection to the restriction of abortion. Doctors such as me would face criminal sanction if we were to exercise our right to assist a woman in following up and having an abortion on the basis

of her decision of informed consent. This in contrast to those who wish to have a conscientious objection not to take part in the process. While I believe people should have every right not to take part, this right should not be an institutional one.

I was asked whether time was critical. That is absolutely the case. Around eight or nine weeks is the most critical period, as a delay at that point will make the difference between a medical and a surgical abortion. The latter increases complications for the person involved.

As to whether the jurisdiction is relevant, it is absolutely relevant. People have forgotten that the 1861 Act was not passed in an Irish Parliament but in the British Parliament and it is a British law. While we can blame the Catholic Church for many things, we cannot blame it for the 1861 Act. Jurisdiction is also relevant because the services that between 4,000 and 5,000 women from Ireland engage every year are in the United Kingdom. It is medically, if not legally, relevant.

I fully agree that no psychiatric evidence was presented in the X case. The key question for psychiatrists is whether they agree with the decision by the Supreme Court justices in that case to certify eligibility for access to an abortion. While opinions on that issue may differ among psychiatrists, in my view the Supreme Court made the right decision. For many of us, the alternative of restricting travel and access to an abortion and forcing a 14-year-old rape victim through a pregnancy was intolerable. Given our tendency to become too abstract, we should always consider what alternative options are available. Most people who examined the case at the time, including psychiatrists, concluded that the Supreme Court justices were correct and the alternative was appalling.

As to whether abortion is the only treatment available, I am fascinated by the current interest in the certification. I cannot even remember if it was the High Court or some other court because the issue was not brought before the court. The certification was straightforward and obvious at the time. The children in question had decided that abortion was the best option for them. What I had to do was ensure they had the best chance to engage in non-directive counselling and that any mental health complications that were current or might follow would be adequately dealt with. In the midst of that, the nature of my certification was not really at the top of anyone's agenda. I am in some respects glad that was the case. All of those involved in that process, including the social workers, mental health workers - due credit must be given to the Irish Family Planning Association, which dealt with the request for certification - and the judge in question, behaved rather well and did the needful in a good, thoughtful and timely manner. If anyone wishes to ask me any particular or specific questions about that, I will be pleased to answer them outside the room.

Professor Veronica O'Keane: Deputy Terence Flanagan indicated that some questions had not been answered and requested that some of his questions be answered. I am afraid I did not catch several of the Deputy's questions. He asked what we would do in the case of a woman who refused treatment and hung on, as it were, for an abortion. We would act in the same manner as we act in respect of all individuals who refuse treatment. If a person is refusing treatment in the context of a serious mental illness and we believe he or she requires this treatment, we would involuntary detain the individual in question and, if possible, give him or her the treatment we believe he or she requires. If, on the other hand, the person did not have a mental illness, as a free citizen it is entirely his or her right to refuse psychiatric treatment.

Another point was raised regarding the system being open to abuse. I cannot emphasise enough that we, the College of Psychiatrists of Ireland, the Irish College of General Practitio-

ners and the Medical Council, have come before the committee to help legislators bring in a law that will be effective and accessible to women. No one, as far as I know, has come before the committee to break the law. We want to co-operate. We do not want to abuse the law or help individuals we may be seeing to abuse the law. It is the individuals who do not agree with the legislation who are objecting to the law.

I am at one with Deputy Mathews in wanting to have a good and ethical society. I believe that providing for the protection of women's lives during pregnancy is providing for a good and ethical society.

Deputy Peter Mathews: We should protect both lives.

Professor Veronica O'Keane: It is very regrettable that some women are hurt by abortion. The majority of the more than 150,000 women in Ireland who have had abortions are not hurt because they are not coming forward; nor is that the experience in other countries where abortion is available.

We cannot be said to be rushing this legislation, given that we have waited for it for 21 years.

It is patronising to assume that women are being pressurised into having abortions. This service is a service for women and I am paid by the good taxpayers of this country to facilitate it. I will not pressurise anyone. Women are not being pressurised but are making their own choices, against the odds, to travel abroad to have abortions.

On conscientious objectors, it is important to ask whether it will delay a woman's access to an abortion if her local psychiatrist is a conscientious objector. This is an incredibly important point and it is the reason I and others have proposed the establishment of a national panel. We could screen the panel for people who are prepared to co-operate in the full spirit of the law. If the local psychiatrist is on the panel, that is fine, and he or she can be requested to determine eligibility. However, if he or she is not on the panel, the woman would be poorly served by seeing somebody who did not want to comply with the legislation. For this reason, it is important to have a panel where it is stated that specific psychiatrists are happy to work within the legislative framework.

In response to Senator Healy Eames, she is correct - that is what I said and I will repeat it again. In situations where abortion is not available, unwanted pregnancy is a leading cause of suicide. The studies come from countries not just where abortion is not legally available but also from countries where women are too poor and abortion is not economically available to them. These countries include the Caribbean states and countries in sub-Saharan Africa. I would be very happy to supply the references to the Senator.

Senator Fidelma Healy Eames: I would be delighted to receive them.

Professor Veronica O'Keane: Perhaps I could refer the Senator to some more general reading in this area. Clíona Rattigan's book, *What Else Could I Do?: Single Mothers and Infanticide, Ireland, 1900 - 1950* deals with about ten years in 1950s Ireland and the rates of infanticide and maternal morbidity associated with unwanted pregnancies. It is a horrible thing to say and I do not like the reality but before abortion services were introduced, infanticide was a common means of controlling one's reproduction. None of us likes this fact. We did have the Kerry babies case in Ireland and we have had situations like that within the last 50 years. Another book that the Senator should read if she is interested in this topic is Germaine Greer's book, *Sex and Destiny: The Politics of Human Fertility*, in which the author refers to the history

of infanticide and injury which preceded the legalisation of abortion.

On the question of whether I personally favour any restrictions, it is not down to me. I am here because I have been requested to be here to advise on this particular legislation. My only concern with this legislation is that if we are going to introduce a service, that such a service would be accessible, humane and will not involve unnecessary delays.

The last point I want to make relates to the difficulty of identifying the 97% of people correctly. Obviously if somebody is referred to the psychiatry services, we do every single thing we can to prevent that person from killing himself or herself. If somebody comes to us, of course, he or she is at risk of suicide. Nearly everybody who comes to us is at risk of killing himself or herself. The fact that 97% do not go on to kill themselves is exactly what we are trying to do. It is exactly the same with the abortion issue. What we want to do is prevent the suicide of the mother and the death of the foetus, baby, embryo. That is what we are here for.

Deputy Michael Creed: Dr. O'Grady did not answer one of my questions regarding the numbers of patients he may have certified and the numbers that may have been declined, as well as why cases may have been declined.

Dr. Peadar O'Grady: As I said earlier, I am a little loth to go through a series of my patients and talk about them publicly. Certainly I am very happy to share ---

Deputy Michael Creed: I am not looking for the individual details. I am just looking for the overall numbers.

Dr. Peadar O'Grady: I have not really done a study on that. What I am a little amazed by - and I am not dodging the question but pointing out another missing question - is that no-one has asked how many of them actually committed suicide, how many of them actually went through with the pregnancy and how many of them had an abortion. These are the kinds of statistics ---

Deputy Michael Creed: I am looking for all of those data, if Dr. O'Grady could provide it.

Dr. Peadar O'Grady: I would be glad, at a later stage, to collect those data and provide it to the Deputy.

Chairman: The 30 minutes allotted for non-members has expired. In fact, we have run over by five minutes and ---

Deputy Billy Timmins: On a point of order, Chairman ---

Chairman: No. I am chairing this meeting ---

Deputy Billy Timmins: I wish to refer to part of the written statement by Professor O'Keane about suicide in general ---

Chairman: I ask Deputy Timmins to respect the Chair.

Deputy Billy Timmins: I will address it in the next session.

Chairman: I will chair the meeting.

Deputy Billy Timmins: I will seek a response from Professor O'Keane in the next session. It is really important.

Chairman: I will chair the meeting and if I want the assistance of Deputy Timmins, I will ask for it. The time for non-members has expired and we are actually more than five minutes over time. I thank the expert panel, Dr. Ferguson, Dr. Moloney, Dr. O'Grady and Professor O'Keane. I apologise to Deputies and Senators who could not contribute but the 30 minutes allowed has expired. We will suspend the meeting now and resume at 3.30 p.m.

Sitting suspended at 2.55 p.m. and resumed at 3.35 p.m.

Chairman: I again welcome everybody to our deliberations and discussions. This is the seventh session in the series of meetings to discuss the heads of the protection of life during pregnancy Bill. I appeal to all Members to be balanced, fair and calm and to focus on the heads of the Bill. I again apologise to people who did not get to contribute in the sessions this morning. There is a time allocation of 70 minutes for members of the committee and 30 minutes for non-members of the committee. Members are requested to be as brief as three minutes - they need not take that much time. Members should ask questions on the heads of the Bill rather than giving statements of opinion, as that would assist us all.

Deputy Eamonn Maloney: I ask the Chairman to repeat that.

Chairman: I hope that people will ask questions and not give Second Stage speeches.

Deputy Eamonn Maloney: Say it louder.

Chairman: I again apologise to those who did not get in this morning. For the sake of fairness I will endeavour to call people who have not yet spoken in the committee hearings, be they members or non-members of the committee. I know a number of members were disappointed that they did not get in and I apologise to them for that.

I welcome most sincerely to our hearings this afternoon Dr. Jacqueline Montwill, Dr. Bernie McCabe, Professor Kevin Malone and Dr. Seán Ó Domhnaill. I thank them for coming here and assisting us. As I said to the witnesses this morning and on Friday, they are coming here voluntarily to give of their time to assist us, which we appreciate. I hope members respect that the witnesses have come here as experts to assist us.

Before beginning I remind members and witnesses that witnesses are protected by absolute privilege in respect of the evidence they give to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to do so, they are entitled thereafter only to qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of the proceedings is to be given and they are asked to respect the parliamentary practice to the effect that where possible they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice and ruling of the Chair to the effect that they should not criticise, comment on or make charges against either a person or persons outside the House or an official either by name or in such a way as to make him or her identifiable.

I ask Professor Malone to make his opening remarks. There are 50 minutes for all the witnesses to speak and they may split it 12 minutes each to be fair to the witnesses.

Professor Kevin Malone: I thank members of the committee for inviting me to make a submission, as I did earlier this year. In the interest of brevity, focus and, hopefully, clarity, I sent a more brief submission, which I will present now and which I believe relates to the heads

of the Bill.

I made a previous submission to the Oireachtas earlier this year. The legislation, which is based on the outcome of a 20-year-old risk assessment of suicidality, excludes 50% of the population - males. Such a focus in excluding men when dealing with legislation on suicidality further eclipses the problem of male suicide in Ireland. This morning I published a research report on suicide at the Royal College of Physicians of Ireland - I have only three copies left, but the Chairman may have the three - wherein the question of marginalisation and normalisation of suicide among young males is analysed. Members should note that suicidality is already a significant problem in Ireland, accounting for more than 12,000 emergency department presentations annually and more than 2,500 presentations to voluntary organisations. The rates for males attempting suicide are climbing all the time.

Based on the research evidence from my studies on this problem in Ireland for the past ten years - Ireland is unique and somewhat different from other countries with regard to this type of research - it is possible that this legislation could inadvertently accelerate suicide rates in younger men, where the real problem lies. Members should note that the problem of male suicide in Ireland is at least sixfold that of the theoretical problem of female suicide, which is rare. Contrary to the notion of it saving the lives of an extremely small number of females it may be placing a greater number of young male lives at risk. In terms of legislating for the whole of society, I bring this to the committee's attention. Overall, at a macro level the effect of legislation may be a greater loss of life in Ireland than life saving. Surely, that would be a law of unintended consequences. I wonder how mental health literacy will be taught in schools, in terms of explaining that suicidality is legitimised for women in certain circumstances, in respect of which the rate for pregnant females is 2 per million, but not for young men in respect of which the rate is 350 per million, or 150-fold.

My second point is whether abortion is an evidence-based treatment for mental illness in Ireland. My understanding - again I highlight this problem not from the point of view of either side of the debate but based on my clinical research experience - is that four psychiatrists in Ireland have been looking after perinatal psychiatry in Dublin for the past 30 years, including Dr. McCarthy, Dr. Joanne Fenton, Dr. John Sheehan and my late father, Professor Sean Malone who cumulatively have been in clinical perinatal practice in Dublin for close to 30 years. My father was consultant psychiatrist for 40 years at two maternity hospitals, the Coombe Hospital and Holles Street hospital. They are all on record as saying that they have not observed one clinical case where abortion was the recommended psychiatric treatment. As a clinician, I wonder how then it can overnight become a recommended psychiatric treatment in Ireland.

My third point is more for the profession but I will bring it to the committee's attention, namely, therapeutic alliance, which is the cornerstone of our clinical practice with regard to our "relationship" - I use that word in the professional sense - with patients. If the therapeutic alliance is to be preserved for psychiatrists and their patients becoming clinically involved in a decision on abortion one way or the other - again I stress "one way or the other" - in my clinical professional point of view, that comprises the therapeutic alliance and is therefore clinically contraindicated. Any kind of fee in such a situation further compromises this position.

While my submission runs to another page I will pause at this point in the interests of clarity and brevity.

Dr. Jacqueline Montwill: Chairman, members of the joint committee, ladies and gentlemen, I welcome the opportunity to address you on this important issue. My understanding of

this law is that it is to reassure the Irish people that no pregnant woman will be denied life-saving treatment because of her pregnancy. In my opinion, we do not need this law in psychiatry. We already have full clarity in terms of our assessment and treatment for patients. There will be no situation where the welfare of the foetus will eclipse the welfare of the woman.

Head 4 of the Bill is seriously flawed for three reasons. First, the treatment it proposes is not a treatment. Second, the treatment it proposes is never the only treatment. Third, if truly suicidal with mental illness the patient may not be able to give a valid consent. We have already heard that abortion is not an evidenced-based treatment for suicidality. Unfortunately, this Government is proceeding as if it is. There is no evidence to support the view that the abortion has any mental health benefits. There is evidence to support the view that in some women, abortion may be associated with small to moderate increases in risks of mental health problems, including suicidality. There is an ethical problem in offering a procedure as a life-saving treatment to a suicidal woman where that very intervention also poses suicidality as an outcome.

It is incorrect to say that abortion could ever be the only treatment for suicidal ideation. Suicidality is multifactorial. It is important the people of Ireland understand this. Our treatment packages take this into account. We work in multidisciplinary teams because we believe that the skills of each member of our team are essential for the proper and full assessment and treatment of our patients. Best practice treatment for mental illness is and always will be appropriate full assessment, psychological support and intervention and medication, if needed. It must be remembered that we have social workers, occupational therapists and psychiatric nurses who work with people in their homes and communities. We will work with patients in the community for as long as needed following discharge from hospital. The proper care of a suicidal pregnant woman would entail proper assessment, support and treatment throughout her pregnancy, delivery and postpartum. Longer term intervention may be required, depending on the circumstances. The point is that the woman will not be abandoned.

We are very aware that mental health intervention must include the assessment of all the stresses in the patient's life at the time in question. These stresses can include relationship difficulties, poverty, unemployment or lack of occupation during the day, accommodation issues, difficult current or past family dynamics and lack of other supportive relationships. These also are an indicator of very poor outcome post-abortion. It is within this holistic view that the treatment package for a suicidal pregnant woman would be appropriately assessed and delivered. Therefore, it is illogical to say that the only treatment for suicidal intent during pregnancy could be an abortion.

Valid consent to an abortion may not be possible while a patient is acutely suicidal due to mental illness or distress. This is important. It is important to note that a psychiatric emergency or crisis is fundamentally different to any other medical or surgical emergency. This is because of the nature of the disorder. In a true psychiatric emergency, the patient's judgment is frequently impaired. Our role at that time is to administer the most appropriate psychiatric treatment and support. It would be highly inappropriate and unethical to impose an irrevocable intervention at that time when the patient may not have sufficient mental capacity to give a valid consent to that intervention. We would in such circumstances be failing our patients. The patient's right to bodily integrity is paramount. It is my view that if a termination were prescribed and given at the time when a patient is in crisis, has an acute crisis adjustment reaction or is mentally ill, the patient would be in a strong position to accuse the treating team of failure in their duty of care. It could be rightly claimed that we as psychiatrists failed in our duty to adequately protect the patient during a period of mental illness. It should not be forgotten that mental illness responds

to treatment. Acute crises respond to treatment. They settle down, often in a short period. Any impairment of judgment in these situations will resolve with treatment.

With this law, the focus will be directed away from a full and proper assessment of the patient towards an assessment for a direct abortion. As treating psychiatrists we do not assess suicidality for any reason other than to prescribe the appropriate psychiatric treatment. Society should do the same. Society should validate rather than normalise an expression of extreme psychological distress. Mental illness is just as important as physical illness. Perhaps even more so. It affects a person's thinking, the ability to relate and relationships and the ability to function. It is exceptionally important to state that the proper response to stated suicidal intent should always be the appropriate evidenced based clinical treatment. That is what we do when we assess patients who threaten suicide. Direct abortion is not a clinical treatment. It is a social solution. This law will do damage way beyond the boundaries of simply legislating for a medical treatment that is without the foundation of medical evidence and good clinical practice. It will directly target and profoundly damage the very nature of the doctor-patient relationship. The interaction for a woman who is suicidal and pregnant will change from therapy to judgment and an adjudication interview for abortion. This will put her in an impossible situation, with outside demands impacting on her treatment and taking her out of the proper therapeutic alliance with her psychiatrist and treatment team.

For patients with mental illness, there is no evidence that abortion is a treatment for suicidal intent or threats. There is no situation in which it could be the only treatment indicated and the issue of valid consent to an abortion for someone who is truly suicidal due to mental illness poses serious ethical concerns. We have heard that the incidence of suicide in pregnancy is extremely rare and some people believe this law is going to relate to those patients. I do not believe that is true. In my opinion, the patients who will avail of terminations of pregnancy through this law are most likely to be those we discussed in earlier sessions, who have no mental illness but do not wish to be pregnant. What difficulties will this pose? Unfortunately, we cannot tell who is going to commit suicide. A study of patients in an acute psychiatric ward found that out of 100 patients who were seriously psychiatrically unwell and who psychiatrists thought would commit suicide, only three did so. We have no way of predicting who will commit suicide but in our assessments we treat everybody as if they will and we provide the appropriate treatment package for each patient on an individual basis.

Chairman: Our next speaker is Dr. Bernie McCabe, who is most welcome.

Dr. Bernie McCabe: I thank the committee for providing me an opportunity to present my concerns about this legislation in the absence of Professor Patricia Casey. As a consultant psychiatrist, it is my duty of care to my patients to provide them with a non-judgmental and evidence based treatment programme in accordance with their needs. It is my opinion that such treatment is their right and, in the absence of an evidence base, I am in breach of my duty of care to them and their rights. These ideals are reflected in the guidelines of my governing bodies, the Medical Council of Ireland and the College of Psychiatrists of Ireland. In view of the submission made earlier on behalf of the college, I now have to report to the committee that the text of its submission was sought last week by members but the request was refused until today. A growing number of members of the college no longer feel the speaker from the college is representing their views. The college has been informed of this in writing, as of Friday, 17 May.

It has been stated by a number of speakers at various Oireachtas hearings that evidence is not available for the use of abortion as a treatment in suicidality. Suicidality is a dynamic state which varies from suicidal intent, where a person has no hope and does not plan for his or her

future beyond his or her death, through suicidal ideas, to a crisis state where a person becomes aware of a sudden change in circumstances - in this case we are referring to an unplanned or unwanted pregnancy - and is now fearful or negative about the future. Clearly these are fearful, distressing and despairing states and have many underlying causes requiring a full multidisciplinary assessment of needs. It must also be emphasised that we have, as a scientific professional body, a number of evidence based treatments that work in terms of helping to remove a person from a despairing, distressing or mentally ill state to one where judgment is more robust and the person is again in a position to consider options for the future.

For those individuals who do not fall into the aforementioned categories, that is, people who do not have mental illness, are not despairing or distressed or have needs that cannot be met by a multidisciplinary psychiatric service, such as those who present to psychiatric services with social issues, it is important to accept that psychiatry has nothing to offer over and above those who are not trained as mental health professionals. These are social issues and, accordingly, psychiatry should not be involved. It must also be accepted that the prediction of suicide is recognised to be poor. This is a worldwide and evidence based view held by the profession. The test of whether there is a real and substantial risk to the life of the woman that can only be avoided by abortion cannot be met given that suicide cannot be predicted even among those with mental illness. Offering a pregnant suicidal woman an abortion if she says her pregnancy is the reason may seem like common sense. However, caution is required in this regard. Interventions that seem intuitively correct may turn out not to be so. Intuition is not enough. An evidence base is required. As we are members of a scientific profession which uses an evidence base for the planning of treatment, to expect psychiatrists to recommend abortion as a treatment for an unwanted pregnancy in the group I have just described is an abuse of the profession in order to facilitate the requirements of the State. The psychiatric profession has no role beyond saying that a person has no mental illness and we must not be used by the State to duck the ethical and constitutional debate that must take place or else the profession will once again fall into disrepute under the current proposals.

As it is currently constructed, head 4 should not be included in the legislation. It should be replaced by an evidence based clinical care pathway that would assist women who are suicidal in accessing psychiatric assistance because abortion as a treatment for suicidality is not evidence based. This view is supported by a growing number of professional colleagues. Of 302 consultant colleagues who received a postal questionnaire, over 130 responded and this number continues to grow. Some 90% of the respondents were in agreement with the aforementioned view. Some have sought to criticise this work but it must be made clear that respondents were asked to put aside their personal views and answer solely based on their clinical experience. It remains the only piece of work to consider the level of concern among practising consultant psychiatrists and it is worthy of consideration for that reason. In the event that the Government disregards these concerns and the recommendations expressed more thoroughly in Professor Casey's submission and proceeds with legislation, a number of concerns have been set out in the website submissions and are beyond the scope of this presentation.

There is a dearth of information on the value of abortion among suicidal pregnant women. It has never been studied. The Government is acting as though evidence is available to support this. Psychiatrists should not be involved except in so far as we can treat women with mental illness, which must be evidence based.

Chairman: Our final speaker is Dr. Seán Ó Domhnaill. I thank the witnesses once again for attending. I recognise that they only received short notice.

Dr. Seán Ó Domhnaill: I thank the committee for giving me the opportunity to address it. I am a consultant psychiatrist in general adult psychiatry employed by the Health Service Executive. I also work on a pro bono basis with Cuan Mhuire addiction treatment services. I have worked exclusively in psychiatry since 1997, having graduated form the Royal College of Surgeons in Ireland in 1994.

I will address my comments to head 4 in particular. I share some of the concerns expressed by Deputy Timmins and others in regard to whether this consultation can be truly meaningful if the Government is not prepared to take the expert evidence into account with regard to abortion and suicidality. There was almost complete agreement among the psychiatric experts who gave evidence in January that abortion - the direct and intentional killing of the unborn child - is not a treatment for suicidality. It is extraordinary that the Government has seen fit to disregard all the accrued evidence in proposing legalising abortion on the grounds of suicide. I draw the committee's attention to recent votes at the conferences of the Irish Medical Organisation and the Irish College of General Practitioners rejecting motions in support of abortion, even within the limitations envisaged in the X case ruling. It clearly emerged that the majority of doctors do not support legalising abortion on the grounds of suicidality. Our profession is very much evidence-based in its approach to its work. There is no evidence base for the proposal to allow abortion for suicidality, regardless of any attempts to restrict the scope of the proposal. If there is no case for treatment of suicidal intent using abortion, then there is no point in proceeding with this legislation. We should nail the lie at this point that Ireland has any obligation, imposed by the European Court of Human Rights, to legislate for abortion. The European Court of Human Rights has requested that we clarify our law, not that we write new law.

I will now turn to the Bill, which, I believe, has been misnamed. While every person wishes to protect women in pregnancy - I would support absolute clarity for those medical practitioners, including me, caring for pregnant women - the primary purpose of this proposal is not the protection of life during pregnancy but to provide a legal basis upon which the deliberate ending of one life may be carried out. It would have been possible to provide further clarity for the protection of women in pregnancy without legalising abortion, as the Bill aims to do. The Government appears to have chosen instead to include the deliberate destruction of unborn human life. This is an enormous change for Irish medical practice and, in my view, it is a hugely retrograde step. Abortion has no place in modern medicine. It is a medieval solution to crisis pregnancy. This Bill is not about saving lives because it allows for the killing of a physically healthy baby being carried by a physically healthy mother. All of this is despite the evidence which shows that abortion does not reduce mental health risks and may be associated with an increased risk of mental health problems.

There are five key points I wish to make about the Bill. First, how would this proposal operate in practice? Again, it is time for a reality check. I have enormous respect for Irish medical practitioners, particularly during these difficult recessionary times, who are invariably working under extremely difficult conditions and in under-resourced hospitals. However, I would like to introduce some clarity in respect of head 4 of the Bill. It is a fact that there are some psychiatrists who are ideologically supportive of abortion and who believe it should be available on request or on demand to Irish women. It stretches the boundaries of credibility to suggest that those psychiatrists would not be more likely to approve abortions if the Bill becomes law. As matters stand and from the submissions that have already been made, they are demanding that only psychiatrists who are in agreement with them ideologically should be allowed to participate in the assessment panels outlined in the heads of the Bill.

We have seen this play out in practice in many other jurisdictions. I remind the committee of the experience in California, where abortion was legalised in 1967 on several grounds. One of those grounds was to preserve the mental health of the pregnant woman under supposedly very restrictive conditions. There was a genuine effort to make these conditions as restrictive as possible so as not to open the floodgates. It was required that a hospital committee would be obliged to unanimously agree that the pregnancy was causing such an extreme mental health risk to the pregnant woman that she would be required to be committed to a psychiatric institution. Despite this, in 1970 more than 65,000 abortions were approved and almost 63,000 of these were performed. Some 98% of these were for reasons of mental health. Did all 63,000 abortions take place according to the spirit of the law? The notion is ridiculous. The California Supreme Court questioned the integrity of the process and stated that "Serious doubt must exist that such a considerable number of pregnant women could have been committed to a mental institution." That was the criterion that needed to be met in order to meet the conditions of the law. Evidently, some doctors who believed that women had a right to access abortion used the subjectivity of making a judgment on mental health grounds for abortion in order to make abortion freely available.

We all know of the experience in Britain. It mirrors almost exactly that of California and occurred in the same year. We need to be honest - something which has been lacking to a large degree in this debate so far - and stop fooling ourselves that matters in Ireland will be different than has proven to be the case in every other country that has sought to take this particular route.

My own experience in psychiatry has been that abortion can be harmful to women and that this is largely ignored by those supporting abortion legislation. It is most unfortunate that women hurt by abortion, many of whom have been in contact with me in recent months, have been excluded from giving evidence at these hearings. This is a broad-based consultative process, not simply a professional forum. Abortion is not primarily about medical or psychiatric emergencies; it is usually about psychosocial stressors and the choices people make in response to them. We have all heard or read about the tragic story of Miss C, who was forcibly taken abroad for an abortion by this State - into the care of which she had been placed - and which she says quite categorically left her suicidal and caused her to attempt to take her own life many times. The distress is very real and the loss felt by these women is extremely acute. The harshness and lack of sympathy expressed by abortion supporters for women hurt by abortion and Miss C is, quite frankly, breathtaking.

I am in full agreement with Dr. Coulter-Smith, who spoke for many of this colleagues when he said:

> our psychiatric colleagues tell us that there is currently no available evidence to show that termination of pregnancy is a treatment for suicidal ideation or intent and, as obstetricians, we are required to provide and practice evidence-based treatment ... It, therefore, creates an ethical dilemma for any obstetrician who has requested to perform a termination of pregnancy for the treatment of someone with either suicidal ideation or intent.

It is my opinion that psychiatry cannot support a provision which obliges obstetricians to deliberately end the life of a child being born to a physically healthy mother when the evidence that abortion is a treatment for suicidality simply does not exist. I noted, as did many others, that two obstetricians from the National Maternity Hospital gave evidence on Friday. I would have been most interested to hear the opinion of the master of the Coombe Women & Infants University Hospital, which is one of the largest and busiest maternity hospitals in western Europe, or that of a representative of the master.

The reality of abortion is being ignored at these hearings and in the wider debate in general. The idea that abortion is a political issue or is a matter for discussion in back rooms or in television stations is something really that we do not have the right to do. Abortion is a reality and anybody like me who has actually witnessed the corpses left behind by the victims of abortion would certainly not want that reality to be ignored. This Bill seeks to turn doctors into abortionists. We know from the website of the British National Health Service that unborn children before 12 weeks gestation will be sucked from the womb by a razor vacuum aspiration process, while after 15 weeks of pregnancy the doctor will have to cause a fatal heart attack and deliver the baby whole or piece by piece. We must not be fooled. The suicide clause in this Bill is not about early delivery; it is about ending the life of children in the womb.

Finally, the evidence of medical experts has been remarkably consistent during these hearings. The committee has heard from a representative of St. Patrick's University Hospital, one of Ireland's leading psychiatric hospitals, who said that there is "no evidence either in literature or from the work of St. Patrick's University Hospital that indicates that termination of pregnancy is an effective treatment for any mental health disorder or difficulty." The committee has heard from Professor Kevin Malone, who stated that abortion is not a treatment for mental illness and in his written submission referred to a textbook of psychiatry and asked how it can suddenly become a recommended psychiatric treatment in this legislation. These are the words of one of the world's leading suicide researchers, who comes from Ireland. He must be listened to.

This committee and the Government have heard much of this evidence before. I sincerely hope that they display the integrity expected of them by the people of this nation and that they respond to what they have heard on this occasion. Mothers and babies deserve far more than an ideologically-driven Bill which seeks to end rather than protect human life in pregnancy.

Chairman: Thank you very much, Dr. Ó Domhnaill. For the record, you made reference to the Master of the Coombe Women & Infants University Hospital. She was invited in and she communicated to the committee that the views she holds would be represented by the institute. That is for the record.

We now have 70 minutes for members of the committee. Again, I apologise to both members and non-members of the committee who did not get in earlier. To assist, I ask if members could be brief. It would allow for more people to be able to participate.

Deputy Billy Kelleher: I suppose we will speak on head 4 initially. At the outset, may I say that we are not ignoring the issue of abortion. The fact is that more than 4,000 Irish girls and women go abroad every year to Britain for whatever reason, and there are a variety of reasons. In that context, can I ask the witnesses, in their professional opinion, are they saying that there has ever been a case in which a woman has actually taken her own life because, for whatever reason, she was in a crisis pregnancy? There could be myriad reasons, but she was in a crisis pregnancy in her mind at the time. Has there ever been such a case? We are legislating for the fact that the X case obliges us to look at the issue of suicide because of the constitutional imperative that is there. I want to get clarity on that issue.

It has been stated by other psychiatrists who are eminently qualified that termination of a pregnancy is not in itself a treatment for suicide. That was said quite openly here by many people today. Equally, they say that in a very rare circumstance it may be the only option left to save the life of the woman. That was stated but in the context of extreme circumstances. If the witnesses are saying that there is no evidential or clinical-based research data to suggest that termination is a treatment for suicide, why would it ever be prescribed? Why would psy-

chiatrists ever prescribe a termination if the witnesses maintain that the clinical evidence is that it is never a treatment for suicide? In other words, why would the witnesses be concerned that this legislation would open up a more liberal form of abortion in this country if all the clinical evidence is that it is not a treatment for suicide? I am just asking that question.

We are aware that women go to extraordinary lengths when they are in crisis pregnancies, including self-abortion and self-imposed surgical interventions. We know what has happened with women in previous times; because they could not access abortion for whatever reason, they have done things and made interventions. That is still happening as we speak in this country, with abortive pills and so on. We know that women will go to extraordinary lengths. I am just asking the question. Is it possible that a woman would ever go to the most extraordinary length of all and take her own life?

On the issue of whether psychiatrists can decide whether a person would commit suicide, the witnesses say that of 100 people who were potentially suicidal, only three went on to actually commit suicide. Surely that shows that intervention, counselling and treatment actually work, in view of the fact that the witnesses have proscribed 100 people that in probability could have committed suicide, but only three actually did so. I assume it is because they all got treatment and because they were in a controlled environment. I assume they would have been assisted, assessed and counselled, so that treatment does work. The point I am making is this: if we have women who are at present going abroad, would it not be the case that instead of going abroad they might present themselves to the system here and that there could actually be interventions other than the extreme of actually going to England for a termination?

Deputy Caoimhghín Ó Caoláin: I welcome our guests here this afternoon. It is very important to say at the outset that despite the scepticism of some of the voices this afternoon in respect of the worth, value or legitimacy, even, of this set of hearings, whatever the respective views of Government, as an opposition voice I am accepting the bona fides of it, and it is hugely important that this is understood. That is why we are here: to listen to a wide variety of views, each of them equally respected. I welcome the respective contributions of the witnesses, as I have those that I have already heard.

To try to help us fully understand the position that each of the contributors has given, I wish to clarify a point in Dr. Montwill's contribution on consent. All I am asking is for is an elaboration and an explanation. She stated, under point five on consent, that a patient must give her consent for any medical procedure. It is accepted that ultimately it is the woman who will decide, if a determination is made in respect of legality or if this Bill were to pass. Dr. Montwell went on to state that it would be unethical to impose a procedure on a patient when the patient may not have full mental capacity or be able to give a valid consent to such a procedure. She went on to say that impaired judgment could be seen to affect the patient's capacity to consent to the procedure and her right to bodily integrity would be violated. If, ultimately, the decision is the woman's, Dr. Montwell is suggesting that in some or all cases it would be the professionals who made a decision, irrespective of the woman's view. It is open to that interpretation. As someone who believes that, in the event of the passing of this legislation, it is absolutely the case that the woman must have the final say - she cannot be compelled - then I believe we need an elaboration in respect of point five, please. That is the only reason I highlight it.

Dr. McCabe's executive summary states that claims have been made that some women are suicidal because of the pregnancy only. She goes on in the same paragraph to say that psychiatry has little to offer this group. Given the contribution of my colleague one moment ago I would have thought that psychiatry certainly has a role to play and that the whole purpose and

intent of the intervention is to assist, to help and to prevent the woman from taking that course of action, and that this is where we would work from at all times. Fully 0% is what we want to see, not any percentage. I find that a most unusual point in Dr. McCabe's executive summary.

Not to pass on Dr. Malone's contribution, but I wish to ask a question in respect of Dr. Ó Domhnaill's submission. One sentence of his stretches the boundaries of credibility - that is, his suggestion that those psychiatrists would be more likely to approve abortions if this Bill becomes law. In the context of Article 40.3.3° still standing, in the context of the extent of the wider interest in and the requirement to report all such decisions directly to the Minister of the day and in the context of the legal measures that many are uncomfortable about and that could be taken in the event of any abuse, does Dr. McCabe really believe that there are professionals in our psychiatric services in this country who would do as she has suggested and would take the risk if were only from a selfish point of view?

Deputy Mattie McGrath: I welcome our guests and thank them for the frankness and honesty of their approach. I will ask them a question I asked earlier. The X case judgment stated that abortion could be the only way of treating suicidal ideation. Is there psychiatric evidence for what that judgment presupposed, namely, that abortion is a form of necessary mental health treatment? The heads of the Bill also provide for abortion where it is the only way of avoiding a real and substantial threat that a pregnant woman will commit suicide. Are the guests aware of any in-depth studies that indicate that abortion can be the only way of avoiding the real and substantial threat of a pregnant woman's committing suicide or even that abortion can be a form of genuine mental health treatment? I think the guests have already made their position on this clear.

Unlike Deputy Ó Caoláin, I do not have the confidence that he expressed in the hearings that took place in January. The guests might expand on their view that the Government has ignored the evidence presented here last January. They believe there is clarity on the position already in the guidelines and that the guidelines would have sufficed.

Chairman: Does Dr. Montwill wish to reply?

Dr. Jacqueline Montwill: Deputy Kelleher asked if there had ever been a case of suicide in a crisis pregnancy. That is the difficulty, in that there is no data. What we are probably assuming is that some of the 5,000 women who go abroad are suicidal at the time they make that decision but we do not know if they are suicidal when they have a termination. We do not know, for example, if they bought their airline tickets and then changed their minds. We do not know how many women are suicidal on returning home. We also do not know how many women regret the procedure or would say they have no regrets. We have no data and that is the problem.

Many assumptions have been made. For example, Professor O'Keane described a 20% suicide rate in women of childbearing age, but that does not mean that is in any way related to crisis pregnancy, just because the women are of childbearing age. How can we not say that perhaps some of those women who committed suicide were women who had a suicidal reaction to an abortion? There is no data. A great many assumptions are being made. If members look through the submissions, they will note that many of them have no evidence or references in this respect.

The Deputy's second question was why a psychiatrist would ever prescribe a treatment that is not a treatment. I agree, but the problem is that we do not think we are prescribing this treatment; rather, as was said earlier, we will be certifying eligibility. Let us see if can we certify

eligibility and what the eligibility criteria are. There are no such criteria, because if a woman has mental illness or an acute crisis reaction, she will be in a state of crisis and people will recognise that. Even when people have a simple crisis in their lives, they will not be able to think straight. That is okay and can settle down within a day or two. If people are in that state, their capacity will be affected. We have to make, supposedly, in this law, a judgment that the woman still fully understands what is going on, has full capacity, is saying she is suicidal and meets the criteria that suicidality will mean that abortion is indicated when there is no evidence that it is, but we also have to make sure the woman is not so distressed that her judgment is impaired. As we know in our mental health practices as consultant psychiatrists, those patients' judgments are impaired and we never impose any life decisions on those patients at such times. We say to them: "Please wait; you are not in the right frame of mind, and in a day or two, or when the medication takes effect, things will be different." We have no criteria by which to apply a test for this law. It does not exist.

The research that Professor Casey talks about involves the worst cases we can think of - patients who are extremely unwell, in a psychiatric unit, and all, as far as a consultant psychiatrist is concerned, at the highest risk possible for committing suicide. In that situation, in which one would think we would have a very good prediction rate, we do not; we can only predict 3% of suicides. In all our assessment cases we make a full assessment and examine all the pressures surrounding the patient and why he or she is suicidal at this time. For example, we examine what has happened to this woman who is pregnant, what are her supports, whether she had mental illness previously and whether there was a risk of suicide. That is all part of our assessment.

Deputy Ó Caoláin asked for an elaboration on consent. That is the issue. We have three broad groups of women. The first group is women who have severe mental illness, which could include psychosis or depression. The definition of psychosis is that people can have strange ideas that are not true but they resolve with treatment. The second group consists of those with adjustment reactions. One can have a depressive reaction with suicidal ideation. This is in the psychiatric classification of diagnosis, and it settles with treatment. Both of those are classified in terms of mental illness. The third category includes people who are in a life crisis but have no mental illness. It could be rightly assumed that valid consent to an abortion must be given when there is no impairment of judgment and the person has the capacity to make that decision.

Moving on to Deputy Mattie McGrath's question, in terms of the X case judgment, the problem is that there is no study indicating that abortion can ever alleviate a real and substantial risk to the life of the mother. Professor Fergusson's research is incredibly important in this regard. In his hypothesis he examined whether abortion reduces rates of mental health problems in women with unwanted or unintended pregnancies, and for this reason he looked at all the research. When he was contacted he rightly said, with regard to the explicit question of a woman being offered an abortion when she is suicidal, that research had not been done. One could understand why that would happen because no doctor will offer a woman an abortion when she is acutely suicidal. I have grave reservations about colleagues stating that they think the timeframe should be reduced. If one had a woman who was acutely suicidal, one would help her get better so that she had a good capacity to make judgments about what she wanted in her life. That is all we are saying. When somebody is acutely suicidal the particular issue is that the person cannot make judgments and the person is not looking to the future. If somebody is truly suicidal, the person sees no future.

Dr. Bernie McCabe: I find it difficult to follow on in answering a number of those questions because Dr. Montwill has answered many of them. I emphasise that there is a difference

in the groups of people about whom I have specifically talked. I have talked about the mentally unwell, including people who have suicidal ideation and people with crisis pregnancies who are despairing and distressed. One can imagine one's self in a crisis. If one crashed one's car into a bollard, one would not be able to think straight for the next five minutes. Imagine how a woman would feel on discovering she is pregnant. It may take her a week, two weeks, three weeks or a day - it depends - to come to terms with it, but there are many problems in terms of her thinking processes during that time. I have dealt with those. We can help in those situations.

The situation in which we cannot help and in which we have no role is that of a woman who does not have any of those thoughts. A person can drive into a bollard and say to himself or herself, "I drove into a bollard - no problem." One can have a person with a crisis pregnancy who is a little bit more resilient and who does not get upset but finds herself before a psychiatrist because her GP is not quite sure what to do. The woman may say: "I am pregnant and I do not want to be. I have been told to come here, so here I am." Our job is to assess that woman and determine whether she has a mental illness and whether she has psychiatric or psychological sequelae with which we can or cannot help. If we cannot find anything to help her with, then we have no role.

We have people coming to us all the time as a result of the recession, as Dr. Seán Ó Domhnaill mentioned. We have a number of people coming and going. A person will present and say, "I cannot pay my mortgage. I am not depressed but I am distressed and I do not know what to do. I was sent here; what can you do for me?" As a psychiatrist, I can make sure the person is not ill. My psychiatric services are multidisciplinary, thanks to the junior Minister for Health, and I can make sure that my multidisciplinary team have nothing to offer the person. If we do have something to offer the person, then we do so, but if we do not, I can direct that person to outside services such as MABS, the bank or the social welfare officer. That is what I mean by that statement. There is a different group whose situation was not addressed earlier, and I am trying to address that.

Chairman: Does Professor Malone wish to make a comment?

Professor Kevin Malone: I was asked if there was evidence in this respect. With regard to Ireland, we have heard of four perinatal psychiatrists. It is important to bear in mind that consultant psychiatrists throughout Ireland manage the bulk of pregnant women. They refer to perinatal psychiatry if there is a particular problem around childbirth and for a period after but for the vast majority of the time it is the consultant psychiatrists of Ireland who are looking after women in pregnancy with any type of mental health difficulty.

This may be related to Deputy Kelleher's question. There is a challenge in predicting the future. Once that question is asked, one will never be certain about how one will predict the future. That is true of any clinical medicine; it is not just related to psychiatry.

In relation to the X case, to which I referred at the start of my presentation, that psychological evidence is 20 years old and we do not know how it would relate to modern psychiatric practice, but it is worth bearing in mind.

Dr. Seán Ó Domhnaill: I had better respond to the question about why I might have concerns about head 4 in relation to the assessment of colleagues who might deem people as being suicidal and who might be prepared to sign off on forms that would allow them to travel for abortions or to have abortions because of mental health issues. Quite honestly, the reason is that I have worked in other jurisdictions and in the very first jurisdiction in which I worked

where abortion was legal, which was Jersey in 1997, I saw consultant colleagues at that time who signed off in advance. I remember one particular individual who had a pile of forms pre-signed, and the reason for that simply was that the ideology of that individual was completely pro-choice and they had so little regard for the unborn child or for the rights of the unborn child. My concern is that we would reduce the value of the life of the unborn, as this Bill seeks to do for the first time ever. This is the first time legislation seeks to allow any human being in this country to be killed. That is how serious this is. We outlawed the death penalty. The only person at risk in this country at the moment of having a death warrant signed is an unborn child.

Deputy Ciara Conway: I thank our panellists. I have a number of questions arising from the previous questions of my colleagues and the witnesses' subsequent answers. Dr. Montwill spoke about abortion being a social solution and her colleague, Dr. Bernie McCabe, articulated that there are often social solutions to problems that confront people with mental health difficulties, that they work in a multidisciplinary way, that it is not always just a question of medication or some intervention, and that there can be social stressors. By that very deduction, is abortion not a solution to somebody who is facing a crisis and who is suicidal? If the person does not get that intervention, what do we do with them? What is the alternative? I would like to know the witnesses' thinking on that.

I raise a second issue. We have had 13 consultants before us today. I asked a question this morning and I will ask it again of the witnesses. If I was in crisis today, how long would it take me to access the services provided by the witnesses? That is a crucial question in terms of the pathway and engagement for women who are in crisis. It is very important because no woman would be lucky enough to have the access we have had today to 13 consultant psychiatrists. That is a point worth making.

In terms of the evidence we have heard from some of the other psychiatrists who were before us today, Dr. Anthony McCarthy said that suicide in pregnancy is a real risk and that there will never be evidence because it is such a rare event. I would like to hear the witnesses' views on that because it is very important. For me personally, as a legislator, that struck a chord in that even if it is only one, that is one too many.

Senator Jillian van Turnhout: To take up where Deputy Conway concluded, Dr. McCarthy told us this morning that suicide in pregnancy is a real risk. He concluded by saying, "It does happen." Professor Malone spoke about the therapeutic alliance. My question is: has he ever involuntarily admitted a patient? Surely it could be argued that involuntarily admitting patients is in breach of a therapeutic alliance. Earlier, Dr. McCabe stated that these are social issues and, accordingly, psychiatry should not be involved. There is not always one pathway. With the current financial backdrop we know that many other social issues are a factor when people end up availing of the witnesses' services. Life is messy and interlinked.

Earlier today we heard compelling examples of children in the care of the State who were impregnated by their fathers and sought psychiatrists in those situations. We heard about a woman with anorexia, and the X case. We know that very often there is distress, stress, and mental disorder, and that is what we have heard already today. I am trying to put myself in the shoes of that one in 500,000. I listened to Dr. Malone give figures on male and female suicide. My role as a legislator is to protect everyone and not to say that that is not a sufficiently large figure for us to examine. If I am that one in 500,000, what happens in those situations? Do we put our heads in the sand, knowing they will go to the United Kingdom? Is that the solution we are proposing, or do we ensure that the treatment is available for them and not tell them to wait two weeks? This one in 500,000 is a rare, extremely stressful case. These women are not

in a logical, rational place. If I am that one in 500,000, what would the witnesses say to me? It does happen.

Deputy Mary Mitchell O'Connor: I thank the expert witnesses. I refer to Dr. Anthony McCarthy's contribution earlier. We heard he was the president of the College of Psychiatrists of Ireland and that he was also an assessor on the confidential inquiry into maternal deaths in Ireland. I find it difficult. The witnesses are the experts and we are here genuinely trying to go through the information. Dr. Ó Domhnaill stated that it is extraordinary that the Government has seen fit to disregard all the accrued evidence in proposing legalising abortion on the grounds of suicide, yet we have heard different views from the psychiatrists, not just from masters of hospitals or anyone else. I assure the witnesses that we are genuinely trying to go through this information and take on board what is being said.

Dr. McCarthy said earlier that women should be able to avail of assessment which is individual, comprehensive, compassionate - that is very important - and not prejudged. I ask the psychiatrists before us if women coming to them will be prejudged.

Dr. McCarthy asked us to ask all the witnesses if they had ever signed a form under the Mental Health Act for the involuntary detention of a patient because he or she was at risk of endangering himself or herself.

Could it be foreseen that this might have to be done for a pregnant woman? If so, how would the case be managed? The witnesses mentioned the three in 100 that they are unsure of and I would like to know how they can be dealt with.

Senator Colm Burke: It is important to clarify that the master of the Coombe hospital was invited before us, together with the representatives of the other hospitals, on Friday.

Chairman: I did so.

Senator Colm Burke: People from six hospitals gave evidence on Friday. There has been criticism about the lack of legislation and it is important to refer to the judgment in the X case, particularly on page 82 of the judgment, where Mr. Justice McCarthy criticised the Legislature for not putting in place laws. The eighth amendment to the Constitution "guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right." The Supreme Court judgment criticised the Oireachtas for not putting in place laws to fully implement the amendment to the Constitution at Article 40.3.3°. It was 20 years ago that the Oireachtas was criticised in this respect and the courts indicated a need for legislation. In the judgment the courts relied on just one medical report, but the system we are discussing would have a requirement for reports from three medical practitioners. Which is the better option? There is nothing preventing the courts, in the absence of legislation, from putting their own interpretation on the Constitution at a future date, so legislation may clarify the issue.

Dr. Montwill referred to the need for support services in hospitals. In the 19 maternity units around the country, does she feel there is adequate support from psychological and counselling sources? Is there a need for a more structured procedure to be established in units around the country?

Chairman: Five other speakers are indicating so I would appreciate if the witnesses would give their replies now.

Dr. Jacqueline Montwill: Deputy Conway spoke about abortion being a social solution and

asked about the alternative. We must be very honest. There are only two options: the woman either will have her baby or she will not. The issue is whether we can accurately assess and diagnose somebody as suicidal so as to be eligible, under this law, for an abortion. The problem is that we cannot do so. We cannot say which woman will commit suicide and, more broadly, we cannot say which patient will commit suicide. It is important to understand that research has shown that we should be considering why the woman is seeking an abortion. Is the partner or boyfriend gone and is the woman on her own? Does the family know she is pregnant or is she on her own there as well? What are the pressures with regard to study and work? What coercive pressures will be placed on the woman in making her choice?

The alternative is a proper support care pathway for the woman when she presents and indicates she has an unwanted pregnancy and does not know what to do. That is if she feels suicidal. When we do our assessment, we must assess - as we do with every suicidal patient - whether immediate treatment is required, if the person must come to the hospital or if she can be treated in the community, if medication is required and if there is evidence of a depressive illness. We must consider whether there is evidence of an illness that leads people to commit suicide when pregnant, such as severe mental illness or psychosis. The two women in a million are not women with crisis pregnancies but with severe mental illness.

Considering maternity rates in the UK, it has been indicated in research that the women committing suicide have severe mental illnesses that are either under-diagnosed or inappropriately diagnosed. There is no reduction where abortion is freely available. They are not getting full and proper treatment, which is the issue. These women need best practice and full assessment. We should not skimp on that but this law will skimp on it.

A second issue is the idea that suicide in pregnancy is a real risk. It is absolutely a real risk. We deal with it all the time in pregnant women, and the highest risk is in the post-partum period. We are very aware of that, but it is not what this law is about. Listening to the four previous contributors, one can see that what we are talking about is not women with mental illness but rather women with a firm belief that they do not want to be pregnant. If a woman goes to a doctor and states that she is suicidal and will kill herself because of an unwanted pregnancy, if this Bill becomes law no psychiatrist will be able to say that this woman will not kill herself, and women will be processed through this law. They will also miss out on proper assessment, which is a problem.

Deputy Regina Doherty: How will women miss out and not get a full assessment?

Dr. Jacqueline Montwill: That is what I am concerned about. For example, I have heard that there is a reduction in time to 72 hours. The Bill is proposing that the period be seven days. If a person presents as being acutely suicidal, mental illness will respond to treatment, but only over time. If the person has severe depression or psychosis, antidepressants normally take four to six weeks to take effect. That is the nature of the disorder. We do not know how long acute crisis and adjustment reactions take, as it depends on a person's circumstances and how they present. Sometimes patients present with acute adjustment reaction on Friday evening and by Saturday morning, if they are in hospital with one-to-one support from nurses, they feel much better. It can be a wonderful thing. A young female came to me one morning and said she could not believe she was not suicidal. I had told her the treatment would work but she did not believe it at the time, although it worked. We have to hold with our patients while the treatment works. That is what we do. If a woman is acutely suicidal, she should get full and proper assessment and she should have the full assessment of the team. She should be admitted to hospital only if she needs to be admitted, as she may have psychosis or severe depression. She may have

overwhelming anxiety or a partner who is abusive or violent or is coercing her to have an abortion. This assessment must provide that knowledge to her treating doctor, or else she is being skimped on and is not receiving proper assessment. That is the issue.

There are no different views in how we deal with patients. We always deal with patients in a non-judgmental way, and a psychiatrist cannot be shocked, as we have heard it all before. There is no problem at all in hearing alternative life views or choices, as it does not matter. Our only role is to see whether there is a treatable psychiatric illness and to ensure it is treated promptly and appropriately.

Senator Burke spoke about the X case judgment. The problem is that the judgment was made with full integrity because the worst-case scenario presented itself. This was a 14-year-old girl who had been violated and raped and who stated she was suicidal, which is completely understandable. The girl went on to have a miscarriage, but the X case legislation was enacted for the C case, which was again a worst-case scenario of a suicidal girl. Our immediate instinct is to make it better; we say to junior doctors that they should not treat their own anxiety but rather that of the patient. What, in hindsight, was the best treatment for the patient? It was to manage her pregnancy in a safe and protected place, probably a hospital but perhaps a supported house or with her family. We now have the evidence, in hindsight, that she stated she never wanted an abortion and was never told about it. It happened, and she has been suicidal since. We must stick to best practice clinical guidelines and medicine, regardless of how distressing the presenting complaint.

Dr. Bernie McCabe: I repeat that what seems to be intuitively correct may not be so. In the past we have had debriefings for people who were involved in crises *en masse*, which has proven to be damaging. It looked good and sounded right but it was damaging. We now offer that service to people who want it. If we offer abortion when we know there is no evidence base, we are not being fair, right or just to our patients. Our patients deserve that we be just. The members are asking us why we are not offering these people these things: because it is not the right thing to do. We do not have the evidence base. Do the members want to receive a treatment that is not evidence-based, that has not been proven? I would not think so. I think that is okay; I am happy to go along with it. I will wait for the evidence. It may come.

The question about a pathway to services is a bit unfair. In fairness, services differ across the country. Efforts are being made to regularise those services and I again compliment the junior Minister for Health on her efforts in that regard.

Deputy Ciara Conway: How long does it take?

Dr. Bernie McCabe: At the moment patients have access to casualty and to any psychiatric service upon referral from their GP. If Deputy Conway is asking me my times, that is unfair. I can give them, and they are good, but it is unfair to other people who operate under different circumstances with different difficulties, so I will not.

On the question about social issues, I will stand over what I said before. If a cardiologist sees a patient who is having palpitations because he or she cannot pay his mortgage, the cardiologist will check that patient out, do an ECG, perhaps an angiogram and other things. If the heart is normal, the heart is normal and the cardiologist cannot deal with it. If you transfer that over to our slightly different situation, if there is no mental illness or distress, we have no role. We have outside services beyond our multidisciplinary teams to which we can refer people, and we do that. I remain adamant on that question.

Professor Kevin Malone: I think the question about pathways to service was a good one. We are currently in Dublin 2. One would go straight to St. Vincent's University Hospital where there is a protocol under which one would be seen, assessed and triaged psychologically and psychiatrically within eight hours. If one was identified as having a treatable mental illness one would be referred on to a community psychiatric team in Baggot Street or Irishtown and one would hopefully be afforded the full complement of clinical services. I would like to think that would be the same around the country. Unfortunately, it is not, but it is really important in all this to have evidence of good clinical practice. It gives hope and leadership. It is a good question.

The question on involuntary admission and therapeutic alliances is a fantastic one. They are both fantastic questions, but that is a particularly good one because it is a real challenge to treat somebody under an involuntary certificate and working longitudinally with a therapeutic alliance. It is something we do all the time and it is part of what we do. I would point out that there is still no evidence that abortion is a treatment for a mental illness. While Dr. McCarthy's point about suicide in pregnancy being real is correct, there is still no evidence that in those cases where a suicide death has occurred in pregnancy and there was a treatable mental illness, abortion was the right treatment for that person. Again, I come back to the four clinicians from the perinatal psychiatry service over the last 20 years, and indeed all psychiatrists around the country. I have not heard one psychiatrist say he or she has found a case in which abortion was a treatment for mental illness.

Dr. Seán Ó Domhnaill: On the issue of pathways to care, I concur with my colleagues. Apart from the fact that we have 24-hour accident and emergency cover, I know that in the service with which I work any patients identified as posing a significant risk are seen within a matter of hours. Suicide in pregnancy is rare and, as my colleagues have pointed out, tends to be associated with the more severe manifestations of mental illness, such as psychotic depression. The treatment in that case is to treat the psychosis and depression. The patient, when she recovers, would be fairly upset if she thought a doctor had ended her pregnancy because she was depressed or psychotic. The doctor would probably be sued.

I have to make this point to Senator van Turnhout. We cannot cover all the angles. She mentioned the one case in 500,000, but how many lives is she prepared to sacrifice for that one case? Once you open the gates - once you legalise abortion on mental health or suicide grounds - they are open. If we look at Britain, where in 1967 there were just under 80,000 abortions and last year there were just under 200,000, we can see the price they paid. It is over 4 million. It is a question that is worth reflecting on. It is something that we should all reflect on, as members of society.

The question was raised of what to do when one is presented with incredibly difficult cases. I have no doubt I have been presented with some of the most difficult, bizarre, unprecedented, GUBU cases that I could ever have imagined. Thanks be to God, and my colleagues, the patients have survived. We do what we do best. We manage psychiatric emergencies. I am very confident in the service, particularly in the emergency psychiatric service provided in this country. It is excellent. It is unfortunate that the Minister for Health and other politicians might feel it necessary to impugn consultant psychiatrists, but I can honestly say that most of my colleagues work far beyond the number of hours required by their contracts.

On the question of why have the fear that somebody is going to sign these forms if suicidality is not a ground for abortion, again, ideology is an incredibly strong thing and there are those who cannot see beyond their ideology. I believe and hope that as clinicians - many of

us consider ourselves somewhat vocational in our work - we are able to go beyond our own ideologies to provide the best possible treatment. However, the people who are watching and who will read the record of this hearing now and down the years may wonder what we were so afraid of. We read the newspapers. It is not often I get time to read them any more, but I do read the newspapers. The newspapers feed cynicism, if one is holding cynicism, and they have been particularly feeding it recently. A newspaper that I do not buy-----

Chairman: Please do not identify it.

Dr. Seán Ó Domhnaill: I will not. Members can take it for granted. This newspaper reported that Members of the Oireachtas were playing games in an attempt to get the Government to commit political suicide. Several hundred thousand people in this country read that report. How about dealing with that?

(Interruptions).

Chairman: I will chair the meeting. There are six speakers and a half an hour remains in this session. I ask Members to co-operate with the Chair in speaking to the heads of the Bill. I will call Deputies Peter Fitzpatrick, Catherine Byrne, Denis Naughten and Senator Jim Walsh in that order.

Deputy Peter Fitzpatrick: I welcome the witness and thank them for appearing before the committee. If a patient is suicidal and suffering from mental illness would that person be legally compelled to give permission for an abortion in accordance with head 4? When a patient is suicidal will the provision of full-time care, which includes close observation, reduce the risk of self-destruction to a significantly low level? I asked that question at the last session and I never got an answer. If a patient is suicidal but not suffering from mental illness which medical treatment can be given? If a patient has stated that she is suicidal but not suffering from mental illness what criteria will be used by a psychiatrist to decide that a real and substantial risk of suicide exists?

Deputy Catherine Byrne: My questions have been asked already. I want to make one or two remarks. I found the witnesses' comments interesting and sometimes disturbing. I came here to listen and to learn. That is my job at the hearings. There is nothing dark and cynical in this room. We have been at the hearings since Friday, which will continue until tomorrow, to listen to everybody's side of the story and their views. I do not question the witnesses' integrity and it is wrong to question ours. In his last statement Dr. Seán Ó Domhnaill said, "I sincerely hope that they display the integrity expected of them by the people of this nation". I take offence to that statement. Many of the women sitting here are mothers. I have beautiful children and, unfortunately, had five miscarriages. I know what it is like to lose a baby at 23 weeks and what it is like to hold a baby in my hands when it is born naturally. I can only imagine the dismay women go through when they have to go down the line of having an abortion or a termination of pregnancy. I do not think it is something that any woman does lightly.

Deputy Denis Naughten: May I pick up from Deputy Peter Fitzpatrick's last question. If a woman does not have medical or mental health issues what advice can be given to her if she is suicidal or how should be treated or should she come under the category as provided for in head 4? I want to ask Professor Kevin Malone about comments made on Friday about bad science by Dr. Peter Boylan and Professor John Crown. Professor Kevin Malone stated in his written evidence that the field of clinical assessment of suicidality in psychiatry has not reached

any kind of validity or reliability in relation to predicting suicide. How then can the legislation, which clearly states in regard to suicide intent that it can be the only mechanism for treating a person with suicidal ideation, be implemented based on the report he has given to the committee? What are the psychiatric clinical procedures for the assessment of suicidal risk? We were told this morning that an assessment can be made in two to three hours. Dr. Seán Ó Domhnaill said it is a subjective assessment but we were told here this morning by his own college that there are many clinical markers which are reliably used, while not absolute, to assess suicidal intent. His college is telling us one thing and he is telling us something different. Perhaps he will clarify that. Dr. Jacqueline Montwill made the point that women in this situation need help and support from psychiatrists but will they go to the psychiatrists if provision is not made in head 4 or some other head or will they not just travel to the UK? By going to the psychiatrists here, does it mean that more of those women will not have a termination and will see that pregnancy through?

Senator Jim Walsh: I will individualise my questions which may make for shorter answers. My first question is to Dr. Jacqueline Montwill. She states that suicidal feelings and thoughts can change and disappear - we got this evidence previously - so that one day a patient can feel suicidal and next day the patient is not suicidal. That raises certain issues regarding the validity of certification. How does she think that should be dealt with? She also mentioned that mental illness responds to treatment. To my surprise, Dr. McCarthy said this morning - I am not a professional in this area - that there is no treatment for suicidality, which astounded me. Perhaps Dr. Montwill would comment on that issue.

Chairman: To be fair, I do not think he said that.

Senator Jim Walsh: He did say that. Dr. Bernie McCabe mentioned that, "It is not necessary for the medical practitioner to be of the view that loss of life is inevitable or immediate. This in my opinion is a very low bar". How does she think we can deal with that issue if the bar is very low? Is she saying that the Bill will lead to more liberal abortion in Ireland? Dr. Sam Coulter-Smith and some of the witnesses this morning said that may be the outcome of this legislation. I am seeking her opinion in that regard.

Dr. Kevin Malone sent us a very interesting paper on 28 December 2012, in anticipation of appearing at the January hearings. He said that based on new research, knowledge and understanding of the epidemiology of suicide in Ireland there is a greater likelihood that this legislation will contribute to an increased risk of suicide in Irish males through foregrounding suicidality within the State for females consequent to this legislation. In other words, an amplifying cultural suicide signal through a normalisation effect. He also says it will have implications for non-pregnant young females. Will he please comment on that because I found that quite alarming.

My next question is for Dr. Seán Ó Domhnaill. We met Miss C last week. I understand she was the only person whose case was taken up by the State as a consequence of the X case. With regard to the psychiatric profession, we have seen in other jurisdictions and in Britain that it has given rise to a situation where abortion has become very liberal.

Chairman: The Senator's time has expired.

Senator Jim Walsh: What is it about the Irish profession of psychiatrists that would make it different and can they give us an assurance that will not happen here?

Chairman: The Senator is being unfair to other colleagues. I call Deputy Regina Doherty, to be followed by Senator Aideen Hayden, who is replacing Senator John Gilroy.

Deputy Regina Doherty: My first question is for Professor Kevin Malone. In his written testament - he also said it - he said he has a great concern, given that termination or abortion is not a treatment for suicide he questions about how it can suddenly become a recommended psychiatric treatment overnight on the passing of this legislation. Will he explain how and why he feels it will, given that psychiatrists say they will not prescribe it because it is not treatment for suicide?

Dr. Bernie McCabe said earlier that there is no criteria to medically assess a woman in a crisis pregnancy who is suicidal. What does she do today? If a woman presents to her who is suicidal because of a crisis pregnancy is she saying there is no assessment today to actually treat her? Will she please explain what happens?

Dr. Bernie McCabe: There is no criteria to medically assess a woman who is suicidal.

Deputy Regina Doherty: Dr. McCabe said earlier that there were no criteria to medically assess a woman in crisis pregnancy who is suicidal. I beg your pardon; it was Dr. Jacqueline Montwill who said that.

Dr. Jacqueline Montwill: Did I?

Deputy Regina Doherty: Will she please explain to me what she would do if a woman who is suicidal because of a crisis pregnancy presents to her today?

Chairman: I will take the final speaker, Senator Aideen Hayden.

Senator Aideen Hayden: I support the comments made by my colleague, Deputy Catherine Byrne, in regard to Dr. Seán Ó Domhnaill's comments. I appreciate that the witnesses are present voluntarily but my understanding is that we are here, on a point of information, to put a legislative framework on existing medical practice, as set out on foot of the constitutional amendment, on foot of the Supreme Court ruling and a requirement of the European Court of Justice on the Legislature. I was struck by a number of the categorical statements made by some of the contributors. To reiterate them - mental illness is as important as physical illness. I agree with that. The second statement was that there is no way of predicting who will commit suicide. The third is that we do not categorically know the motivations of the 5,000 women who leave this country.

I shall return to the questions raised by my colleagues Deputies Kelleher and Ó Caoláin. Why would a psychiatric colleague prescribe a treatment that does not stem from an evidence base? The evidence that was given to the committee on Friday from other colleagues was that this was not a feature of the Irish medical profession and they did not regard it as a serious threat. There seems to be an element of mistrust among members of the medical profession; they do not trust other colleagues.

I was struck also by comments made by speakers who suggested that the judgment of a woman who presented as suicidal was "impaired" and, as such, nothing that the woman would say, in effect, could be believed, for want of a better word. In other words, her threat of suicide could not be taken as a real threat. I was struck again by statement made by the girl at the centre of the X case, who stated that she only became suicidal after treatment was withheld from her. Can that be reconciled?

I want to ask Dr. Montwill a specific question. Given what she claims is a lack of evidence, can she guarantee - and I use the word "guarantee" in a legal sense - that a woman who presents as suicidal can be cured by her, without ever having recourse to termination of a pregnancy?

Chairman: I call on Dr. Montwill to commence. There are 20 minutes left in this session, and we will finish at 5.31 p.m.

Dr. Jacqueline Montwill: I want to clarify the issue of impairment of judgment. If any patient presents to the psychiatric emergency department with a severe mental illness, an adjustment crisis reaction in which she is threatening suicide and saying "I am completely upset, Doctor; I can't think straight," or severe symptoms of mental illness, then, during that emergency time, her judgment is impaired. That only means that we ask the patient to come into hospital or offer to treat her at home where our nurse can go and see her. If at that time the law says that the patient has full capacity to make the decision about an abortion, then that is the issue, not whether she is suicidal. We believe that what patients say is true for them. We always believe what the patient says because that is part of the clinical presentation. The issue about capacity is this: are you suggesting that we should offer an abortion to a woman who might be seriously psychotic, who might be severely depressed or who might be suicidal in a crisis reaction, when perhaps her judgment is impaired just for that period? What we are saying is that we should treat the woman, and when her judgment is more robust, then she will be able to make that decision - not when she is acutely suicidal.

Senator Hayden asked whether I can guarantee that any woman who is suicidal can be cured. We aim to cure all our patients, but the problem with suicide is that there could be an impulsive thought that comes into the patient's mind or there could be outside circumstances that we do not know about. The tragedy of a completed suicide must be assessed completely. The most important thing is whether the person got a full and proper assessment and proper treatment, whether he or she was complying with the treatment and whether we were managing him or her as closely as possible. We can never guarantee that a person will be completely cured. We would hope to.

Senator Aideen Hayden: The answer is "No."

Dr. Jacqueline Montwill: It cannot be guaranteed in any element of medicine. There is one other matter, however. The criteria that the Government has put into this legislation are not true criteria to assess suicidality. They are pretend criteria that it has made up to assess eligibility for abortion, but no such criteria exist. We cannot tell who will commit suicide, but we can say to every one of our patients that we will treat them as if they are going to commit suicide and we will make it as safe as possible for them.

It was stated that I said there were no medical criteria for assessing crisis pregnancy. I am pretty sure I did not say that. If I did then I must have been nervous. No; there is no question of anybody not getting the proper assessment, and that is the issue here. The problem is that the discussion is now moving from women with mental illness to women with no mental disorder. I have a little bit of an issue here, because I wonder at what point a woman will be completely over her crisis, will be completely adjusted and will have no mental disorder. My colleagues described that scenario earlier this morning, and I can see the scenario in front of me. It is a woman who comes in and says, "Doctor, I have an unwanted pregnancy. I have a right under this law to an abortion and I am telling you now that I am going to kill myself." We say, "We will treat you anyway, but we are going to put you through the pathway to see the panels." We ask the patient if she will see our psychologist, if she will give us the full background, and if

we can talk to her partner or family. She says, "No, I don't want any of that. I just want the abortion. I am telling you now I am suicidal." In those circumstances we will continue to offer treatments, but the woman will now go through into this process. In law there is no psychiatrist on the panel - as we said, we cannot guarantee anything - who will be able to say the woman will not commit suicide, so it is a direct pathway. What is happening, though, for that woman in crisis? Why will she not allow the assessment? What are the pressures being put on her? It would not be out of the range of possibility that a partner has urged the woman to go in there and tell us she is suicidal. That is my point. She is not getting a proper assessment.

Deputy Regina Doherty: Can I ask a question?

Dr. Jacqueline Montwill: Yes.

Deputy Regina Doherty: The law as it stands refers to circumstances in which all other treatments have failed and where abortion is the only option. In that scenario, it is not the only option.

Dr. Jacqueline Montwill: Exactly. Absolutely.

Deputy Regina Doherty: Just because I am saying "No, I do not want the other option," it does not mean the law is changed.

Dr. Jacqueline Montwill: I agree. The problem is when, as our colleagues this morning said, the woman is refusing all treatments. The reality there is that of course there are other options, but she is refusing them. That is her right. If she has no mental illness, in our practice we have to say, "These are our treatments and we offer them to you. Come back if you want them. Can we phone you tomorrow?"

Deputy Regina Doherty: Then the patient does not qualify for eligibility. She is not eligible.

Dr. Jacqueline Montwill: A woman who will come in and say, "I am entitled to my abortion. I am telling you now that I am going to kill myself"-----

Deputy Regina Doherty: She can say what she likes but she still will not qualify.

Senator Fidelma Healy Eames: There is a very low bar.

Dr. Jacqueline Montwill: The point is, that sentence is nonsensical. One cannot say abortion will ever be the only treatment. That is the point. This law does not make sense. That situation does not exist. There are loads of treatments.

Chairman: Does Dr. McCabe with to reply?

Dr. Bernie McCabe: With regard to the low bar, I think that was a reference to Professor Casey's submission online. This is a timing issue. The explanatory note to head 2 states that it is not necessary for the medical practitioner to be of the view that loss of life is "inevitable or immediate." It does not clarify how far into the future one should consider the risk to apply. Could it be six months, two years or ten years? That is the point that is being made. There is no bar. This can extend to anybody at any point in her life. I hope that I have answered the question.

With regard to having no way of predicting suicide, we do not predict suicide very well. I

mentioned that specifically in my earlier speech. We are very good at risk assessment, though. We do a lot of risk assessment and we do it very well. We put a lot of people into the high-risk category and we monitor a lot of people as a result. However, we have no real way of knowing who is going to proceed to suicide. We just do not. We know this from various studies. We have done studies ourselves, and there have been actuarial studies that did not involve practitioners. They basically told us that we are not good at predicting who will commit suicide, so we should not try to do so; we should be over-cautious and keep monitoring the high-risk people. That is what we do. We will never be able to predict. If we could predict - and it would be very nice if we could - we would not have any suicides.

With regard to mistrust of colleagues, I am not quite sure what that is referring to. Does it refer to the letter that went to the college on Friday morning because some members did not have access to the text of the college's submission? I am not sure if that is what is being talked about. That is an area of concern to members that will play out.

There was a question about whether a determination that a patient was lacking in judgment meant that we did not believe the patient. That is not the case and never will be the case. A lack of judgment is not necessarily a lack of capacity. It ranges all the way from being upset to not being able to form thoughts properly because one is psychotic. It encompasses a wide range and does not mean the patient is not believed. It does need psychiatric interventions of all sorts, ranging from psychotherapeutic interventions to admission, if necessary, and medication, if necessary. It does not equal not being believed. We do not refuse to believe our patients. We have no choice but to believe them, and we want to believe them. That does not mean we do not assess them. We will always assess them very thoroughly, and the assessment does not take two hours for every patient. For some, it might take two hours; for others, it might take two weeks or two months, depending on the circumstances. Who is to judge? We do not decide that until we get the patient before us. That really needs to be clarified. These matters are not written in stone. I hope that is helpful.

Professor Kevin Malone: I will try to answer two questions. The first relates to the science question. I refer the committee to a paper I wrote in the *American Journal of Psychiatry* in 1995 about clinical versus research assessment of suicidal behaviour in major psychiatric disorders which refers to the strengths and weaknesses of any type of predictive modelling, which was obviously peer-reviewed by international scientists.

The second point I make is that, because suicide in pregnancy, at 500,000:1, is such a rare event, it is statistically impossible to construct any type of predictive modelling. That is where we stand on that. One will never be able to construct a predictive model.

The third point I address relates to the question I have raised about normalisation through an amplified signal and in this legislation, writing suicidality into Irish law. I have just published a study on suicide in Ireland where the problem is very particular to young men and there is a clustering problem in young men. These young men are frequently at the margins of society and they are vulnerable. I think introducing something that makes suicidality okay for some people for certain social needs really creates a challenge for Irish society.

Then, on the second point, if one increases inadvertently male suicide - we have done a study of female suicides - there is a two-year lagged effect. When male suicide rates increase in Ireland, two years later one will get an increase in the female suicide rates. We have documented that over a 15 year period.

Dr. Seán Ó Domhnaill: Obviously, there was a misunderstanding in relation to someone stating that there were clinical markers for suicidality. We live off clinical markers. They are what we use to carry out assessments. In fact, I contributed the piece to the college's paper specifically on this because in the Bill it refers to the fact that there are no clinical markers and I said, "No, no. There are clinical markers. The problem is that there are no laboratory tests", and that is what the Bill should actually have said.

In terms of the Irish profession and in what way is our profession different specifically to our English-speaking colleagues in Boston and Birmingham, to whom I think we are closer than Berlin, the more time I spend in Boston and Birmingham the more I realise that, really, there is very little between us. All of the evidence is there. One need only look at one's children the way I look at mine and one will see that they are mimicking what they are seeing on television from America and Britain.

I am surprised - I am sorry I missed the Deputy's name because I could not see the sign-----

Chairman: Deputy Catherine Byrne.

Dr. Seán Ó Domhnaill: I am surprised and, I suppose, a little disappointed that the Deputy feels insulted or upset by my, for want of a better word, cynicism. I am actually not that cynical but, unfortunately, I must be quite honest with the Deputy and tell her that I voted in the last general election as an Irish citizen and I voted for the party that told me it would not bring in this piece of legislation.

Chairman: The heads of the Bill, if Dr. Ó Domhnaill does not mind. We are on the heads of the Bill.

Dr. Seán Ó Domhnaill: I should respond to Deputy Catherine Byrne. It would be rude not to answer her question. I suppose, having voted for Fine Gael-----

Deputy Regina Doherty: Apologise with impunity. Dr. Ó Domhnaill is doing it again.

Chairman: I will Chair the meeting. I thank Deputy Regina Doherty.

Deputy Regina Doherty: Bizarre.

Dr. Seán Ó Domhnaill: -----I am a little bit upset that I find myself here having to speak on a Bill that they told me would never present itself before the Oireachtas.

Dr. Jacqueline Montwill: I did not answer one question about criteria as to whether a patient with suicidal ideation would be legally compelled in terms eligibility. We will treat our patients regardless, but this pathway will ask psychiatrists to assess eligibility for an abortion process and, I suppose, we do not have criteria. The problem about that is that while I can see from earlier today that one of my colleagues described that he has already certified children, at least under the age of 16, perhaps 14, as eligible for an abortion procedure, I do not know what criteria he used. Criteria for that assessment does not exist. I am very concerned. There was no indication that any of these assessments had been monitored, there were no numbers coming out etc. That is the problem here. We do not have appropriate criteria to assess what the Government thinks we can do, which is eligibility for abortion. We have criteria to assess for risk factors and the best practice way to treat our patients when they are suicidal.

Deputy Regina Doherty: The question I asked Professor Malone was based on his written submission in which he asked how can it suddenly become a recommended psychiatric treat-

ment overnight by passing this legislation. Can he explain why he thinks that it will, given that all psychiatrists have stated that it is not a treatment for suicide?

Professor Kevin Malone: I do not think it is a treatment. If it comes into law and it is approved that psychiatrists are expected to deliver or to sign-off on it, one is proposing *de facto* that as part of a treatment plan. There is no evidence to support that.

Chairman: We are now moving into the section of the meeting for non-members. Eight members have indicated the wish to speak and there is half an hour available. If I could get everybody in, it would be great. However, I will not be able to and I apologise in advance. I take members' names as I see them and as they indicate, and there is no bias on the Chair's behalf. The first three are Senator Healy Eames, Deputy Terence Flanagan, and Deputy Timmins, in that order. Deputies Mulherin and Senator Bradford are the next two after that.

Senator Fidelma Healy Eames: I am struck today by the 13 or 14 psychiatrists we have had before us, by the care and compassion each of them has displayed and the holistic approach they use to assess their clients and patients. I am inclined to conclude, and agree with Dr. Ó Domhnaill, that abortion is a medieval solution to crisis pregnancy. How - he may have a legal opinion on this - can we clarify the law to satisfy the European Court of Human Rights without writing new law?

Chairman: That is for tomorrow.

Senator Fidelma Healy Eames: It is, but Dr. Ó Domhnaill may have taken legal advice on this. This was his question. How can we clarify the law to satisfy the ECHR without writing new law?

Chairman: We are dealing with medical evidence today. To be clear, it is psychiatry in this session.

Senator Fidelma Healy Eames: As a country we have the luxury and the benefit of looking at the evidence in so many other countries. We have the benefit of being compassionate here. While some say we have done the wrong thing by waiting so long, I believe we have done the right thing. We are in the top five in maternal health care in the developed world.

This question is to each of the psychiatrists. Given the difficulty of predicting suicide with accuracy, how many unborn babies' lives do we have to take to save possibly one in 500,000 lives, especially when there could have been a more appropriate treatment for the pregnant woman?

I understand Professor Malone is a leading world expert in suicide. Is he gone?

Professor Kevin Malone: I am here.

Chairman: Senator Healy Eames did not yet scare him off.

Senator Fidelma Healy Eames: I am sorry, I did not see him.

I am conscious of the following question. With this Bill, are we in danger of validating suicide in Irish society which is already at epidemic levels as a real option by legislating for it as a way to procure an abortion? I put that question to Dr. Sheehan this morning and he stated he has grave concerns. We must seriously look at what we are doing. We are here to look at abortion but we also may be legitimising suicide which is very dangerous.

Deputy Terence Flanagan: I will be brief. I have three quick questions.

The first is to Dr. Montwill. I note a previous speaker, Senator Walsh, asked about indications of the extent to which suicide ideation strengthens or weakens over a given timeframe, or even disappears. Perhaps the witness can comment on the Bill because there were calls earlier regarding the review process, to reduce it from seven days to 72 hours.

I also have two questions for Professor Malone. In this legislation psychiatrists will not only be asked to assess whether a woman is suicidal but also to certify that the only treatment is to terminate the pregnancy to address suicidality. Does Professor Malone think abortion is ever the only treatment to terminate a pregnancy? If not, what other treatments in current clinical practice in this country would be offered to someone who is suicidal? Does the Mental Health Act offer any guidance in this particular area?

Regarding the X case, part of the test for an abortion on suicide grounds is that as a matter of probability there must be a real threat posed to the life of the mother by way of self-destruction. Can psychiatrists judge as a matter of probability whether someone will commit suicide? Can Professor Malone point to any published research supporting his answer? Would Professor Malone contend that this part of the X case test is generally unachievable from a psychiatric perspective?

Deputy Billy Timmins: I apologise if I was trying to badger the Chairman a little bit in the last session, but I had a few important points to make. I would like to ask the panel about Women Hurt. I was deeply offended at the last session when Dr. Ferguson stated that people who are dissatisfied set up pressure groups.

Professor O'Keane said that there are 150,000 women out there who have had abortions and - I forget the exact terminology - not that many must have been affected because they have not come forward. Have any of them come forward to the witnesses? My understanding is that Women Hurt was invited in here and everybody was invited to hear them. They sent an invitation to everybody. They are still available for people to talk to. My understanding is that many of the people in that organisation have lied about the impact of their abortion and have not even told their psychiatrist about the abortion. They just recount their difficulties and look for a cure without coming up with a solution. I would like to hear the witnesses' views on that.

There appears to be a division and while it is not a clinical matter, it is important. This morning I asked Dr. McCarthy about the survey he referred to concerning 113 or 120 people. He questioned the accuracy or authenticity of it. One of the other speakers did also. Perhaps the witnesses could elaborate on that. I was surprised when I heard Dr. Sheehan. It appeared to me that he had not participated in the College of Psychiatrists survey, although I may be wrong. I would like to know if the witnesses got the one from the college, of which there are 864 members. Do we know how many people responded to that? I asked that question this morning but I did not find out. Perhaps the witnesses have that information.

I have a couple of points following Professor O'Keane's talk this morning. I will be brief but it is important. These questions are for Professor Malone. Professor O'Keane made a written submission on 9 May, which was circulated this morning.

Chairman: We cannot deal with that now, Deputy.

Deputy Billy Timmins: Yes, but there were slight differences in her verbal submission. I am wondering which one will go into the record. I want to clarify a few things in case the

record-----

Chairman: The record will reflect the written submission and will also reflect the testimony given at the hearing today.

Deputy Billy Timmins: Okay, so there will be a slight difference. That is fair enough. In her written submission, Professor O'Keane states that-----

Chairman: Your time is up.

Deputy Billy Timmins: -----the vast majority of people who kill themselves tell someone that they intend to do so and, therefore, should be believed. I think that is a very profound statement and will have an impact. From my brief understanding of suicide and the bereaved families I deal with, very few of them in that tragic situation seem to have been told, or knew anything about it, beforehand. Is there any evidence to sustain that? Perhaps that point could be clarified.

Professor O'Keane's written submission stated that in situations where abortion services are not available, unwanted pregnancy is a leading cause of suicide. In her verbal presentation this morning, she said it was a leading cause of death.

In Ireland in the 1950s, 10% of Irish women who killed themselves were pregnant. Do we have a figure on what the number was? Of the 10% who killed themselves when pregnant, do we have any statistics on what the basis was? Was it as a result of the pregnancy or prior mental health? Perhaps Professor Malone can answer those questions.

Deputy Michelle Mulherin: I have two questions. As regards the first one, I would appreciate it if the experts could give me a specific answer. As regards the heads of the Bill, the current position on the interpretation of the balance between the life of the mother and the life of the unborn is given in the X case. We are told by the Government that this will tighten up the situation and, in effect, make it better. As regards the tightening up and the clarification, I might guess how the experts will answer, but can they say whether they are in agreement with that, whatever they think or do not think about the X case? The current practice requires the X case with all its unknowns. The witnesses are operating under the X case at the moment concerning such matters. This legislation is supposed to provide clarification and tighten up things, as we are told, but I wonder if the witnesses agree that it does so.

The second question is a bit broader and comes back to the whole issue of treatments. A lot of us are hopeful and Dr. Montwill spoke in a very hopeful manner about addressing people who are in distress and seeing them through. That is very reassuring. We would all place a lot of significance and importance on the need for treatment. Unfortunately, I did not get a chance to speak when Professor O'Keane was here. I would like to have put the question to her to clarify it, because she is the main proponent of this position. When one treats somebody with a mental illness or psychosis, that treatment is invoked under the psychiatric services. If a person does not have a psychiatric illness or psychosis, they are not getting treated.

However, Professor O'Keane is envisaging another situation which is that a woman is suicidal because of her pregnancy, does not have psychosis or a mental illness but is in a heightened state of distress. As a lay person, I would think that if a person has a mental illness or psychosis, that is obviously more quantifiable by the witnesses. As regards somebody who is very distressed but does not have a mental illness, can that person even be treated? We are all reassuring ourselves that people are going to get treated, but is there actually a treatment for

such a person who does not have a mental illness? In that situation, and accepting what Professor O'Keane says, are the witnesses saying that this person is very upset and really believes - this is not about duping somebody or having them on - that they need to have a termination and therefore there is nothing the witnesses can do for them in that situation because there is no treatment where there is not a psychosis or a mental illness?

I would like to have some clarification. In my lay person's view, surely if I put myself in that boat, not having a psychosis or mental illness that I know of, and if I am in a heightened state because I am distressed because of an event, could the witnesses not talk me down? I would say that such people would be less likely to need suicide protection compared with a person with a mental illness. I would like to hear the witnesses comment on that.

Chairman: I will go to the panel now and call Dr. Montwill.

Dr. Jacqueline Montwill: I will try to answer that question first but I might need, if you do not mind, Chairman, to get-----

Chairman: Four people have offered to ask questions so I will come back to them if the panel so allows.

Dr. Jacqueline Montwill: I will answer that question. We are in a quandary here because some of our colleagues are describing that this law will be used for people with no mental illness. If anyone comes to my clinic or our emergency department where our junior psychiatric doctors are, and they are distressed for any reason, we will admit them. If they are suicidal and pose a risk to themselves, or if they are so distressed that we are very concerned about them, we will do a proper assessment. That sometimes takes two or three weeks and at the end of that assessment we will be able to formulate a proper diagnosis and a treatment plan. I do not know when a woman in a crisis pregnancy is going to go from having the acute adjustment reaction where she is saying, "This is the worst thing in my world; I want to kill myself; I cannot deal with this," to having no mental illness. I would follow that woman all the way through anyway if she ever had a situation where she was thinking of suicide.

However, we have to make a distinction in that, with this law, there will be women who will present with a firm belief that they are entitled to an abortion and who we can say, hand on heart, have no mental illness and will threaten suicidality. That is the issue. What do we do for those patients? I would say to them that they should not be threatening suicide, that suicidal ideation is not a good mindset to be in, and therefore let us do our assessment. However, if the woman is saying she does not want any of that, and when we have no concerns that they have a mental illness, we are in a quandary.

I will outline what we would say in our practice. In the case of a woman who came in and about whom we were absolutely sure, after a two-week assessment, that she had no mental illness, we would be able to say to her that we were terribly sorry, that we could not stop what had happened to her and that she had a crisis pregnancy. We would be able to say to her that while she was saying she was suicidal and that was not a good place in which to be, there were all these supports to which we could link her, including all the supports in the community, as well as being able to monitor her and make sure she was okay. However, after our assessment, we could tell her that she did not have a mental illness but had a crisis reaction.

The problem is it is very difficult to say, if a woman does not have mental illness and presents, in this law, that we will not be able to offer a treatment if she does not want one. This is

what the people who are advocating the law are saying and we must address that issue about saying what we would do. We have situations in our practice in which people threaten suicide and do not have a mental illness. They come in and ask for different things to happen in their lives, but after our assessment, we know they do not have a mental illness. We say to such people that they do not have mental illness that would respond to treatment but they have a huge problem with their mortgages or with their partners who are being completely unreasonable or with other stresses such as bullying, etc. and we will divert them to the proper treatments and supports for those problems.

It is confusing and, to be honest, I am half-confused myself because I will treat any patient who comes to me when he or she is distressed, and while we will not send anyone home, the people who advocate this law want to get out of the way of saying the patient has a mental illness because they know abortion is not a treatment for mental illness. Consequently, they now are saying that in the case of a patient who does not have a mental illness but who is saying she intends to kill herself, surely she should be able to have an abortion for that reason. All I can say about that is we do not have a test to be able to say who can commit suicide. Consequently, the problem is we have no criteria of which we know and if the Government insists on this, there is no way any psychiatrist can state that a woman will not commit suicide. That is all we can say. I do not know if that answers the question.

Dr. Bernie McCabe: I wish to answer Senator Healy Eames's questions as well as the question about the survey and the poll. In respect of how we predict and what must be done to predict suicide, we know we are poor predictors of suicide and I have mentioned this several times before. A number of studies show they are all over the place. While I am sure Professor Malone would add by a factor of ten what I will give to members, these studies also extend to actuarial studies. Even the latter, which were not done by psychiatric professionals and are purely statistical, have proven the prediction of suicide to be highly unpredictive, even in the high-risk groups. A paper produced in 1983 by Pokorny states the number predicted as being likely to die by suicide was 35 times greater than the number who would die. In other words, we over-predict and as a result have false positives. I hope that answers Senator Healy Eames's question. We are very poor at it. If one equates this to the number of pregnancies, that is a startling and distressing number.

Senator Fidelma Healy Eames: May I add a tiny-----

Chairman: No.

Senator Fidelma Healy Eames: It is about the number.

Chairman: No. Thank you. Dr. McCabe may proceed.

Dr. Bernie McCabe: In respect of the survey, there are two pieces. First there is what I will call a poll, for want of a better word. Three colleagues and I, who know one another from different areas and are friends outside of work, Dr. Montwill being one, were discussing our concerns about this law and decided to ascertain how many others had concerns. We tried to identify as many working consultant psychiatrists as possible. While the Irish college has a list, we were not allowed to use it because it is not used for such purposes. We generated 302 names - I believe there are approximately 350 - and sent out a postal questionnaire with a statement in respect of the evidence base. Arising from that, we received at least 130 responses. As the numbers continue to rise, I cannot really be sure precisely what number we have reached but we got 130 respondents. While 14 agreed with the proposals as indicated going through, more than

120 did not. This means that 90% of respondents to the poll did not agree with the proposals or had concerns about them. This indicates the level of concern among our consultant group.

As for the other issue regarding the college, on the Friday before the bank holiday weekend - I am unsure of the precise date - the college sent out an e-mail to more than 800 members. These included all levels of training and qualification-----

Chairman: I ask Dr. McCabe to stick to the Bill, please, because-----

Dr. Bernie McCabe: This was asked of me.

Chairman: I know, but the joint committee is not dealing with the college because, unfortunately, that is outside our remit. It is not part of our remit.

Deputy Billy Timmins: Chairman, I sought this information this morning from the college.

Chairman: Okay, but I would rather Dr. McCabe did not answer because, with respect, this is not part of our remit. We are not discussing the college.

Dr. Bernie McCabe: It relates-----

Chairman: Thank you; I will chair the meeting.

Dr. Jacqueline Montwill: It is important.

Chairman: I understand that, and I am responding to the question.

Dr. Bernie McCabe: A number of members seem to want me to answer this question.

Chairman: No. I will chair the meeting, with respect.

Deputy Billy Timmins: On a point of order, this information was given out this morning by Dr. McCarthy-----

Chairman: May I make the point-----

Deputy Billy Timmins: -----and it informs the debate.

Chairman: With respect, may I just make the point-----

Deputy Billy Timmins: The impression was given that-----

Chairman: -----that our remit is not the college. This is the Joint Committee on Health and Children and we are not dealing with what the college does or how it does its business. That is not within our remit.

Senator Fidelma Healy Eames: The information comes under our remit.

Chairman: No, it does not.

Senator Rónán Mullen: On a point of order-----

Chairman: No, I am not taking it. The Senator will be coming in shortly.

Senator Rónán Mullen: Yes, but there is a point of order that is outstanding.

Chairman: You may go ahead.

Senator Rónán Mullen: Earlier, the Chairman advised Dr. McCarthy that he might or might not answer a question as he saw fit. The same test should apply here.

Chairman: Okay; I accept that as a fair point. However, if you do not mind, I would prefer if we did not get involved in the politics of the college.

Senator Rónán Mullen: I understand that.

Chairman: While I know you wish to draw us into that controversy, I do not.

Senator Rónán Mullen: Please. That is not fair.

Dr. Bernie McCabe: The politics are not fair.

Chairman: I know, but I would prefer if we simply dealt with the heads of the Bill.

Senator Rónán Mullen: I was only asking for consistency.

Chairman: I know and understand that.

Dr. Bernie McCabe: Okay. Well, I would have been prepared to answer the question.

Deputy Billy Timmins: That is really unfair. The impression was given that the submission represented 864 members or whatever number was given by the president of the college. Let us find out. Why are we afraid of this information?

Deputy Mattie McGrath: On a point of order-----

Chairman: All I wish to do is to protect the joint committee from becoming involved in the issue which has no bearing for us at all.

Deputy Peter Mathews: It has a huge bearing. It was misleading.

(Interruptions).

Dr. Bernie McCabe: Shall I proceed with the answer?

Chairman: In the interest of fairness, Dr. McCabe may go ahead.

Dr. Bernie McCabe: My understanding is that 500 of these e-mails were opened and the college received 30 submissions. The problem that exists is the college did not allow a draft text to be circulated and the members of the college are uncertain that their views have been represented in full. That is the answer to that question.

Professor Kevin Malone: I will try to answer two questions that emerged. One was a question on legitimising suicidality. The question actually was about legitimising suicide, and I do not think that is fair. However, I think it potentially is legitimising suicidality, and that has the potential of running interference at deeper levels in Irish society than those to which we are giving full thought. That would be my feedback on that question. I heard someone mention Dr. Sheehan's grave concerns, and as a result of this, I would share his concerns in that area.

The other question that came up was about communication of intent, which is a good ques-

tion because communication of intent does increase the risk. In other words, people who say they are going to do something are more likely to do it. Unfortunately, one still remains in the realms of extremely rare. When one is trying to predict something that is as rare as one in 500,000, even though one can improve the odds, one will not improve them anywhere into the range of having any type of predictive validity. Consequently, the answer to communication of intent is yes, it increases the odds. For example, as I mentioned, we have more than 15,000 presentations to accident and emergency each year, many of which involve people who have made an attempt on their lives. While it may not have been of high lethality, they have made an attempt on their lives. The vast majority of these people will not take their own lives. Again, one is entering into the realms of statistical theory.

Dr. Seán Ó Domhnaill: I will respond to three points. One pertains to the issue of proportionality of risk and I suggest this is something that probably could be brought up with the legal experts because recent Supreme Court rulings have changed the position on the measurement of proportionality and that in turn will have had an impact on the X case, in so far as it now applies in law. Second, in regard to how one responds to somebody who looks one in the eye and threatens to do something unless one provides them with the specific treatment they seek, in the case of the Bill if someone is demanding an abortion or that they be given whatever it is they require to get an abortion, it would not be a new scenario. I have worked most of my life in inner city Dublin. I have had many hundreds of patients, at all hours of the day and night, look me in the eye and tell me that if I did not provide them with the specific treatment they wanted at the time, they would kill themselves. They usually referred to throwing themselves under a bus. The specific treatment they sought was invariably chemical and it was usually named benzodiazepine. To date, none of them went out and completed the act, despite the fact that none of them were given the specific treatment they requested. They were, however, given the treatment I would expect to give to anybody who was in an acute state of distress, which is support, counselling and time, which is probably the most important thing one would ever give to someone in psychiatry. Time allows them to come down from that heightened state and begin to look at their situation with a little more clarity so that there is more light when the heat subsides. I hope that psychiatry provides people with hope because in my experience that is probably in any age, and in particular in this recessionary interval, the best thing psychiatry can offer, certainly not the counsel of despair which is what I would consider the recommendation of abortion as a treatment to be.

Chairman: For the information of Deputy Timmins, I draw his attention to page 4.2 of the written submission of the College of Psychiatrists of Ireland. It states that the submission re the heads of the Bill has been agreed by the council, the elected decision-making body of the College of Psychiatrists of Ireland. It states that in a college with more than 864 members there would be a wide range of opinions with regard to the sensitive issue of abortion, reflecting the deep divisions in society about the issue and, therefore, they are confining their comments to the general scheme of the heads of the Bill rather than any overall comment about abortion.

Dr. Jacqueline Montwill: There are no data to support Professor O'Keane's point on approximately 10% of Irish women dying. This is all supposition. In Irish society most people know of an aunt or single woman who, because of society's norms at the time, committed suicide because she was pregnant. One would hope that would not happen in modern Ireland. There are no data to suggest that such a high rate existed. Dr. Dermot Walsh wrote a letter to that effect to *The Irish Times* and he has been the inspector of mental health hospitals for many years.

The other issue I wish to clarify is that there are no data for any of the assumptions on the suicidality of women who are going to England. If women have mental illness, we hope that their first port of call, their GPs, would be able to assess it, or their family, and we have to advocate that in society so that all mental illness is treated. That is the issue at stake.

It is important to reiterate what Dr. McCabe said on the submission from the college. We received the email on Friday. There are approximately 350 consultants in the college but I am not sure about the exact numbers. We sent in our submissions and only 30 of them were received by Wednesday evening. An emergency meeting was held on Thursday and a draft was supposedly unanimously agreed. We have no idea what was in the draft. None of us saw the text of the submission. We repeatedly asked about it by e-mail on Thursday and Friday and we were told it would only be published on Monday. I have not read the submission because I did not have time today, except for two points: 72 hours is far too short to have some poor suicidal woman going through a process and being directed immediately to an abortion. That is an abomination. The second point is how the College of Psychiatrists in Ireland does not mention evidence-based treatment for suicidality. The public should be informed of the evidence base for every treatment for suicidality. I have serious concerns about the submission but I have not seen the text. That is the issue. We have not seen the submission.

Chairman: Ten minutes remain in the session and five members have indicated. Unfortunately, they will not all get to speak. I ask speakers to be brief to help facilitate all five members to speak. That would be appreciated. First, I call Senator Bradford and Deputy Mathews, in that order.

Senator Paul Bradford: I will be brief. I have two quick questions for the witnesses. Virtually every speaker who has come before the committee to advocate for the legislation uses the following line: "This Bill is about saving women's lives." Could the witnesses comment briefly on that because some, myself included, who might have concerns about the legislation, feel quite angry at the insinuation that people with questions about the Bill are somehow not concerned about women's lives?

Second, a philosophical question is often asked of politicians, which is difficult for us to answer because we are politicians, but it might be easier for the psychiatrists to answer. It is what one would say to a parent of a 14 year old child who is a victim of rape or other dreadful crime. Is there a humane approach?

Chairman: I thank Senator Bradford for being brief. It would be great if Deputy Mathews could be equally brief.

Deputy Peter Mathews: I thank the witnesses for attending. I have a feeling this afternoon of great compassion, understanding, wisdom and professionalism. I thank them for that. I wish the Taoiseach and the Tánaiste were present for the hearings because this is their Bill.

Chairman: We are dealing with the heads of the Bill.

Deputy Peter Mathews: I know. We are even on the Title of the Bill.

Chairman: We are not discussing the Taoiseach's diary.

Deputy Peter Mathews: I wish the Minister for Health, the Taoiseach and the Tánaiste were here. They are in America celebrating 150 years of a Jesuit college but the focus for this country is the committee hearings.

Chairman: Does Deputy Mathews have a question?

Deputy Peter Mathews: One woman taking her life is too many. One baby's life lost while we mess around with the law is too many. I fear not just one baby's life will be lost but hundreds if we introduce the legislation under discussion. That is wrong.

Chairman: I would appreciate it if Senator Mullen could be equally brief.

Senator Rónán Mullen: I appreciate the job you are doing, a Chathaoirligh. One thing is clear to me having been present at the hearings for two days. The obstetricians are in agreement about the obstetrics, they are in disagreement with the psychiatry, and the psychiatrists are completely split. That tells its own story.

If I understand the situation correctly, and the witnesses might clarify if I am wrong, the one in 500,000 refers to women who commit suicide in pregnancy, and that is associated with mental illness. If I understand it correctly, it would be impossible to find that one person in the 500,000 and abortion would not be a treatment anyway. Therefore, what we are talking about is finding the cohort of women who say they will commit suicide and whom the earlier group of psychiatrists said must be believed. We all understand why that is important, but it seems they are not in the realm of medicine anymore and that they are really in the realm of certification, which might explain why Dr. Peadar O'Grady said this should not necessarily involve doctors at all. Is that the problem here, that to catch the cohort we are talking about, it is not a medical decision the psychiatrists are being asked to make? Is that the essence of their concern, that it is a question of some kind of intelligent guesswork they cannot do because they do not have the ability to predict who might or who might not? Do I understand the situation correctly?

Deputy Michael Creed: I thank the witnesses. Sometimes I see the situation with great clarity and other times I am in an indeterminable fog. Perhaps the witnesses could tell me what the case is at present. In their professional lives on a daily basis, the witnesses before us and their colleagues this morning adjudicate on the clinical risk of suicide and they make decisions on whether to admit, commit or treat as an outpatient. In head 4, as I understand it, what they are being asked to do is determine that there is a real and substantial risk of loss of a pregnant woman's life by way of self-destruction. The previous speaker alluded to the risk of one in 500,000 which exists, rare and all as it might seem. Psychiatrists are not subsequently being asked to prescribe a termination. Psychiatrists are being asked if in their reasonable opinion this risk can only be averted by a termination. If that is the best analysis of the individual situation, they are not being asked to prescribe any other treatment, they are being asked to include or exclude one option. Is it not the case that if it is their professional opinion that is at issue, and I accept the College of Psychiatrists of Ireland is divided on this issue, most agree there is no evidence for sanctioning a termination on the grounds of risk? Are they not really being given a veto in the legislation as a profession?

Psychiatrists are being given the ultimate authority and power. We are mere lay people trying to grapple with very complex issues but psychiatrists deal with the risk of suicide and it is not politicians who make the assessment, it is professional medical people; they are being given the power. Are we making a mistake that should assume that authority as non-professional people or are we right to give it to the people who have the best legal and medical training? The psychiatrists are only being asked to rule out. I accept there is no evidence basis for including termination as a treatment so I would expect the psychiatrists, be they pro-life or pro-choice, to ground their decisions on best medical practice.

Deputy Bernard J. Durkan: On the procedures to be followed by psychiatrists in the event of certain cases presenting, is it understood and accepted that there is a requirement to comply with the Constitution as determined in the X case by the Supreme Court? Notwithstanding whether or not a wish to have a termination may be based on one or other reason, to what extent do psychiatrists in general accept the need to be in compliance with the Constitution in so far as it has already been determined by the courts?

Dr. Seán Ó Domhnaill: Senator Bradford asked about the purpose of the legislation. Having gone through the minutiae of the legislation at great length-----

Chairman: To clarify, we do not have legislation yet, we have the heads of a Bill.

Dr. Seán Ó Domhnaill: Having gone through the heads of the Bill, it scared the living daylights out of me. That was my response and I communicated that to many people I know. I felt it was extremely loose and the terms used were poorly defined, with many of the them not defined at all. There were many omissions and I came to the conclusion that this is not the protection of human life in pregnancy Bill, it is the legalisation of the killing of one of the two patients in obstetrics Bill.

On morbidity and mortality, for women who have had terminations, the figures vary. In 16 years of psychiatry, and I am not someone who is not extremely busy, I have never come across a case of a woman who has killed herself because she was refused an abortion, either in my own practice or in the practice of anyone I have ever worked with, and I have worked in at least 20 different psychiatric units.

I have, however, dealt with the families of people who have ended their lives as a direct result of having a termination. In 1992, the year of the X case, I had the unpleasant experience of losing a colleague on the anniversary of her abortion. These are the forgotten people. In the psychiatry textbook I used, by Professor Basant Puri, the quotation that always struck me, because the word "only" was used, according to a chapter written by two female British psychiatrists, only 10% of women who undergo abortions suffer severe and/or protracted sequelae from abortion. That suggests nearly 20,000 women per year in Britain and at least 400 women per year in Ireland. Where are they going and who are they going to? I treat probably more post-abortion women than anyone else in the country by virtue of the fact that I am an easily identifiable pro-life person who understands the trauma associated with abortion. They avoid the doctors who sent them, and they certainly avoid the clinics that sent them, because they feel they have been let down and not informed and were never given any indication at any point they could end up severely depressed or suicidal as a result of having an abortion. Anyone who really cares about the welfare of women in this country should consider that as he or she looks at this legislation.

Professor Kevin Malone: There was a statement about there not being any treatment for suicidality. There is a substantial evidence base for the treatment of suicidality. There is a series of dialectal behaviour therapy studies by Marsha Linehan and there is a very strong cognitive behavioural therapy literature on the treatment of suicidality within and without of major depression and other psychiatric disorders. Marsha Linehan's work deals specifically with people who do not have access one psychiatric disorders, in other words people with personality difficulties who experience high levels of suicidality, who can be very effectively treated in terms of reducing the experience of suicidal ideation and attempted suicide. That is worth noting for the record.

Dr. Bernie McCabe: I would like to think I try to save the lives of women who are suicidal every day, we all do, and so do most of my colleagues, despite the idea that is going around that there is dissent in the college.

Dr. Jacqueline Montwill: There is a sentence that this Bill is about saving lives. It is not about saving lives because we want to work to save the life of anyone who is suicidal regardless of the costs. This Bill is about providing abortion procedures.

I remind the committee that the IMO defeated all those motions and during that time a motion was put to the IMO to change the words "abortion procedures" and to put instead "evidence-based, life saving treatment" and that was refused. All of the motions that wanted abortion procedures were defeated by the IMO and the ICGP.

Our survey was the equivalent of saying to colleagues that this is not right and asking what they think of what the Government is doing, regardless of any opinion of it being pro-choice or pro-life. We sent our letters to consultant specialists in the medical directory at their own addresses they had put in. It is my opinion that half of those letters did not get to the right address because the consultant had most likely left any home address. I think there are many more than 120 respondents who think we should not be involved in this because there is no basis in the medical literature available. That is the key; it is nothing to do with religion or being pro-choice, it is about the evidence base.

The actuarial equivalent number of babies is 35 to save one woman. The last question related to a humane response to a victim of rape and her family. Patients who have mental illness are heroic because society does not understand them, they carry a stigma and are fighting a losing battle and we must do our best to advocate for mental illness.

Moreover, sometimes the circumstances of a patient's family, home and social life are horrific. I would say to every patient: "I am terribly sorry this has happened to you and while we cannot stop what has happened, we can ensure you receive the best available treatment and support and we will take care of you." That is what should have happened in the case of the 14 year old girl. It may appear that we will lock up the girl, that is not the case. The reality is that when the adjustment reaction settles, she may no longer be suicidal. What is not being understood in this debate is that suicidality reduces, sometimes only with psychological support. A problem shared is a problem halved. That is the cliché and the reason people offload. As our colleagues will say, if the patient consents, members of the family will be contacted and the boyfriend or husband who may not be supportive may become involved in the treatment, which is very important.

Are we legislating for one in 500,000 women? The deaths of one in 500,000 women from suicidality are due to mental illness. Any cases members will have heard of that have come into the public domain - I do not know anything personally about these cases but I have read about them in the newspaper - are cases of mental illness where there was a systems failure. If there was a difficulty, abortion would not have been appropriate for any of the women in question and would certainly not have saved their lives.

Deputy Bernard J. Durkan: No one replied to the question on compliance with the constitutional determination of the Supreme Court.

Chairman: To be fair, that issue is probably not relevant, although it will arise tomorrow when we discuss constitutional law.

Dr. Jacqueline Montwill: On the view that psychiatry is divided, I will do everything I am meant to do by law. I will treat my patient, regardless of whether she is going for an abortion and if she has an abortion, I will treat her afterwards. I have come here to explain to members that what the Government is asking us to do does not make sense and is not based on good medicine. As doctors, we have to stand up and say this is not good practice. Best practice is full appropriate assessment.

Deputy Bernard J. Durkan: What is the witness's view on the Supreme Court determination?

Chairman: If I need help chairing the meeting, I will ask for it.

Dr. Jacqueline Montwill: So many questions were asked. I do not accept the outcome of the Supreme Court case because the judges stated there was a real and substantial risk that could only be averted by abortion. That is never the case because all real and substantial risk can be averted by treatment and assessment. There were some problems with the decision.

Chairman: I do not propose to rewrite it.

Senator John Crown: I apologise for leaving the meeting for a while; I had to attend at the hospital. With great respect to my professional colleagues, I also live and work daily in the world of evidence-based medicine.

Chairman: I ask the Senator to put questions rather than engage in commentary.

Senator John Crown: If I have a patient in front of me - there are sometimes two patients in front of me in one person - I will never make a decision that it is not the right decision for the patient. No one is ever going to ask physicians to do that. However, we are constitutionally bound as a result of Professor Binchy's interventions 30 years. The ambiguous constitutional position in which we have found ourselves, despite five referendums and a Supreme Court judgment, means there is no legal way that we can exclude suicidality as a potential cause. If the evidence base in medicine dictates that abortion is never the right thing to do, all psychiatrists will be asked to do is tell the patient before them that abortion will not fix their suicidality and refuse to sign off on an abortion. Why can that not be the case?

Dr. Jacqueline Montwill: I can answer that. Colleagues have already stated that they want to have a panel of doctors who will not obstruct the process. I presume, therefore, that there will be some kind of bias. The second issue is that, as we have stated from the beginning, there is no way we can say which patient will kill herself. To be honest, I am not sure how many women with a crisis pregnancy have committed suicide. However, we can never say that it could not happen. Under the proposed legislation, if a woman tells the panel she will kill herself, what psychiatrist can say she will not kill herself?

Deputy Michael Creed: Did Dr. Montwill not indicate that psychiatrists assess that risk every day?

Dr. Jacqueline Montwill: We assess that risk to aid our treatment. We decide, for example, that a patient needs to be in hospital or in a clinic.

Deputy Michael Creed: The preliminary question is whether termination is an appropriate treatment for the patient's condition as she presents. If it is not appropriate, the psychiatrist will indicate that is the case and may well indicate in a footnote that she should be treated in a

different fashion.

Dr. Jacqueline Montwill: The point is that the panel will never be able to say that a woman will not kill herself and the request will, therefore, be passed. As one can never say a woman will not kill herself, the request will be passed.

Dr. Seán Ó Domhnaill: To respond to Senator Crown, he knows my position on abortion. It has been made clear by some of the psychiatrists who have appeared today that anyone who holds my position on abortion should be excluded from the panels. If all doctors who believe that abortion is not a treatment for suicidality are excluded, we will be left with certain psychiatrists and their friends. We are relying on the Oireachtas to provide a safeguard. That is the simple truth of the matter.

Senator John Crown: On a point of information, the evidence base in medicine is available for all doctors who can all see the same evidence. There is not different evidence for different doctors.

Chairman: Members may not make points of information. I thank most sincerely Dr. Jacqueline Montwill, Dr. Bernie McCabe, Professor Kevin Malone and Dr. Seán Ó Domhnaill for taking time to come before the committee voluntarily to assist us.

Sitting suspended at 6.15 p.m. and resumed at 6.30 p.m.

Other Medical Specialties

Chairman: We will now resume in public session. I remind witnesses, Members and those in the Public Gallery to switch off their mobile phones. This is our eighth session in our series of hearings on the heads of the protection of life during pregnancy Bill. I thank Mr. John Saunders, Dr. Janice Walsh, Ms Eileen Lawrence and, when he arrives, Dr. Kevin Walsh, who are here today to assist us in our analysis of the heads of the Bill. I hope Members will come in to the Chamber for this session because our witnesses have come to this meeting voluntarily. I thank the witnesses for their attendance and apologise for the late start.

Before we commence, I remind witnesses that they are protected by absolute privilege in respect of the evidence they give to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter but they continue to do so, they are entitled thereafter to only a qualified privilege in respect of their evidence. They are directed that only evidence connected to the subject matter of this meeting is to be given and are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the House or an official, either by name or in such a way as to make him or her identifiable.

Dr. Kevin Walsh has sent his apologies - he hopes to be here by 7 p.m. I now invite Mr. John Saunders to make his opening statement.

Mr. John Saunders: I thank the Chairman for his invitation to this meeting.

As the Chairman and members of the committee will be aware, the Mental Health Commis-

sion is an independent statutory body established in April 2002 pursuant to section 32 of the Mental Health Act 2001. The commission was established to perform the functions conferred on it by that Act which was commenced in full in November 2006. The role of the commission is to promote, encourage and foster high standards and good practices in the delivery of mental health care services and to protect the interests of persons detained in approved centres. The commission's remit extends across the broad spectrum of mental health services. Mental health services are defined in section 2 of the Mental Health Act 2001 as "services that provide care and treatment to persons suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist".

The procedures referred to in the heads of the Bill do not fall within the definition of mental health services and by extension are not within the remit of the commission. All references to the Mental Health Commission in the heads solely relate to the registration of a centre at which the psychiatrists involved must be employed. There are two references to the Mental Health Act 2001, both of which indicate that this Act provided guidance to assist in the drafting of the relevant heads. The Mental Health Commission notes that the committee is seeking its views on how the proposed legislation will operate. The heads of the Bill clearly specify that operational matters will be the responsibility of the Health Service Executive, HSE, and agencies providing health and social care services on behalf of the HSE under section 38 of the Health Act 2004. It is suggested by the commission that the HSE and relevant Section 38 agencies are best placed to advise the committee on operational matters.

The regulatory body for an "appropriate location", as defined in head 1, is the Health Information and Quality Authority, HIQA, only and not the Mental Health Commission. The regulatory authority for the relevant medical practitioners is the Medical Council. Formal medical review procedures will be the responsibility of the HSE, which shall be required to establish a panel of relevant experts populated with nominees from the relevant colleges, including the Irish College of Psychiatry. Therefore, there is no role for the commission, under any of the heads, in assessment or oversight.

The Mental Health Commission, from its experience in implementing provisions of the Mental Health Act 2001, has a number of general comments on the heads of the Bill which, in the view of the commission, may assist the committee in formulating its report to Government.

On head 1, interpretation,"psychiatrist" means a medical practitioner who is registered in the specialist division of the register of medical practitioners established under section 43(2)(b) of the Medical Practitioners Act 2007, under psychiatry. The commission suggests that clarification is required to ensure inclusion of relevant specialties within psychiatry, for example, child and adolescent psychiatry. The term "self-destruction" is used in the heads of the Bill but the commission notes that there is no clear definition provided. There is no legal or medical dictionary definition of self-destruction.

Head 6, subhead (4) refers to the appointment and authorisation by the HSE of one or more of its employees with appropriate qualifications and experience for the purposes of establishing and convening a committee for the purposes of a review. It is unclear as to what constitutes "appropriate qualifications and experience". The Mental Health Act 2001 may provide guidance in this regard, specifically section 9(8), and the Mental Health Act 2001 (Authorised Officer) Regulations 2006 (S.I. Number 550 of 2006), whereby the grade of person who is authorised to perform the role of an "authorised Officer" is prescribed.

On head 4, clarification is provided in the explanatory note that the two psychiatrists in-

volved must be employed at an approved centre and one of them must be attached to an institution where the procedure will be carried out. The Mental Health Commission advises the committee that the above criteria may exclude psychiatrists working within specialist community mental health services, as they are not always employed at an approved centre, that is, a centre that is registered by the Mental Health Commission. A requirement that one of the psychiatrists involved must be attached to an institution where the procedure is to be carried out is a further restrictive criterion, as there are only three such psychiatrists in the country and they provide services on a part-time basis in the Dublin region only. The explanatory note refers to self-destruction as "suicidal intent". However, this term is not specifically stated within head 4 or in the interpretation section, head 1.

On head 5, the Mental Health Commission is of the view that the reasonable opinion of the medical practitioners should be required in writing, following an examination of the woman concerned and the reason(s) for the opinion should be provided. The definition of "examination" in Part 2 of the Mental Health Act 2001 may be of assistance to the committee. With regard to certain procedures under the 2001 Act, an examination means "...a personal examination carried out by a registered medical practitioner or a consultant psychiatrist of the process and content of thought, the mood and the behaviour of the person concerned".

The heads of the Bill are silent on a mechanism for appealing a decision of a review committee. I will now deal specifically with the heads of the Bill *vis-à-vis* a person under the age of 18. The heads of the Bill are silent on a requirement to hear, consider and document the views of a woman who has not yet reached the age of consent. Furthermore a child who has a mental disorder and is receiving care and treatment for that mental disorder in an approved centre is detained under section 25 of the Mental Health Act 2001. A decision, for example, on the administration of electroconvulsive therapy may only be provided by the District Court. The heads of the Bill are silent on children detained under the Mental Health Act 2001.

Dr. Janice Walshe: I thank the Chairman and members of the committee for the invitation to express my opinion as a medical oncologist on the proposed heads of the Bill as presented for cancer in pregnancy. I am a consultant medical oncologist in both St. Vincent's University Hospital and the Adelaide and Meath Hospital, Tallaght.

Cancer is a disease of increasing age so while cancer during pregnancy is encountered, it is rare. International data suggest that it complicates approximately 0.1% of all pregnancies, therefore in the absence of published Irish data we estimate there are approximately 60 to 70 cases diagnosed in Ireland per year. However, with increasing age of childbearing, it is likely that this number will increase. In pregnancy, a variety of cancers occur, but breast cancer, haematological cancers such as lymphoma or leukaemia, gynaecological and skin cancers are the most frequently encountered. As there are many gynaecologists who can comment on surgical cancer treatment on the panel, my focus is the administration of drugs during pregnancy. Agents used in medical oncology include traditional cytotoxic chemotherapies, biological therapies and anti-hormonal agents which for convenience I will refer to as chemotherapy.

When considering the implications of this Bill for cancer in pregnancy, two main questions arise. Does the pregnancy confer a worse outcome to the pregnant mother with cancer and, if so, will a termination of pregnancy improve her outcome? The literature here is consistent in demonstrating a lack of evidence to suggest that termination will abrogate mortality risk in pregnant women with cancer.

Does the administration of chemotherapy in the pregnant woman put that woman's life at

risk in a way that is not experienced in the non-pregnant woman? In clinical practice, we in the haematology and medical oncology field not infrequently navigate this challenging scenario. In the vast majority of cases, chemotherapy will be administered to the pregnant woman as curative or life-prolonging therapy without significant modification as per international guidelines. We work very closely with our obstetric colleagues to identify the optimum time for delivery of the baby, striving for foetal maturity rather than just foetal viability.

There are risks with chemotherapy administration in every trimester for mother and foetus. However, available evidence suggests that many of the agents used in the treatment of cancer have a safe profile, particularly if initiated after the first trimester thereby minimising risk to the unborn. As doctors, a challenge for us is balancing the risk of foetal abnormalities in the unborn as a result of the administration of chemotherapy during the first trimester or its deferral until a potentially safer time for the foetus but this has implications for the mother when immediate chemotherapeutic intervention is required. Organogenesis occurs during weeks five to ten of gestation. The administration of chemotherapy may have unintended complications, requiring intensive care unit management potentially threatening the life of the mother. May a termination be required to save the life of the mother in this circumstance? It is possible but these situations are exceedingly rare.

In answering these questions, I acknowledge a dearth of large prospective randomised trials investigating each question here but through retrospective cohort studies, case series and case reports the results achieved reach similar conclusions, regardless of the country where the study was performed. It is universally recognised that treatment recommendations in pregnant women with cancer will always rely on limited evidence.

My only comment in appraising the heads of the Bill is that should a situation arise where the life of the mother is at significant risk, it would be advisable that two medical practitioners on the specialist register with expertise in this area be involved in the certification process with the consultant obstetrician - for example two consultant medical oncologists or consultant haematologists, as they would have the medical expertise to advise and guide in this difficult area.

Chairman: For members who were late, I wish to inform them that Dr. Kevin Walsh will be late arriving. We expect him at approximately 7 p.m. The committee has already agreed to allow him to speak when he arrives.

Deputy Mattie McGrath: With respect to the guests and all of us, we are doing our best here. I believe that if we do not get a longer break than 15 minutes, we should arrange for some refreshments to be brought up - just something light. It is too far to go to the restaurant, which appears to be half-closed. I thank the staff who looked after us, but people are still trying to get some food.

Chairman: During the meetings in January we made that request but because of health and safety it is not allowed.

Deputy Mattie McGrath: In that case the Chairman should allow more time for breaks. It is not fair.

Chairman: With respect for our witnesses, we were delayed-----

Deputy Mattie McGrath: That is why I say it - because we are late coming back.

Chairman: I have not eaten since this morning at 8 a.m.

Deputy Mattie McGrath: That shows the indecent haste of the whole thing. It is ridiculous.

Chairman: I accept the point and we are doing the best we can.

Deputy Mattie McGrath: What is the indecent rush? We are Members of the House and we are expected to eat. With respect to our guests, we should be here on time for them. I only had tea and a scone, and I was glad of it, but it is not fair.

Chairman: I call Deputy Kelleher.

Deputy Billy Kelleher: My first question is for Mr. Saunders.

Deputy Caoimhghín Ó Caoláin: May I ask-----

Chairman: I should have said that Ms Lawrence is not making an opening presentation.

Deputy Caoimhghín Ó Caoláin: I understand. I beg your pardon.

Chairman: Sorry, I got sidetracked.

Deputy Billy Kelleher: My train of thought has been disrupted.

Deputy Caoimhghín Ó Caoláin: I am sorry.

Deputy Billy Kelleher: It is not the Deputy's fault - it is the hunger.

Chairman: Some people go to Lough Derg and it is no problem there.

Deputy Billy Kelleher: I ask about the Mental Health Commission's view on an examination-----

Chairman: I apologise. I ask the Deputy to stop because Dr. Kevin Walsh has now arrived and we will let him speak.

Deputy Billy Kelleher: Perfect.

Chairman: I apologise. It will allow the Deputy to get his train of thought back and he can dream of chocolate or whatever. We will suspend for two minutes to allow Dr. Kevin Walsh to take his seat.

Sitting suspended at 6.47 p.m. and resumed at 6.50 p.m.

Chairman: I welcome Dr. Kevin Walsh to our meeting and invite him to make his opening presentation.

Dr. Kevin Walsh: My role is in congenital heart disease in pregnancy. I jointly run a clinic for maternal heart disease with Dr. Peter McKenna in the Rotunda Hospital.

Advances in treatments for congenital heart disease over the past 50 years have created a cohort of survivors with heart disease that has been either palliated or repaired, but with significant residual problems requiring ongoing medical supervision and repeat catheter and surgical interventions. In the Republic of Ireland there are approximately 1,700 adults alive with complex congenital heart disease and 14,000 adults with simple congenital heart disease. Many women with repaired congenital heart disease wish to have children. There are now more preg-

nant women with congenital heart disease than acquired heart disease in the developed world. Pregnancy causes significant changes to cardiovascular physiology, with marked increases in blood volume, cardiac output, namely, increased stroke volume and heart rate, and a reduction in systemic vascular resistance, namely, reduced blood pressure. These changes may be tolerated poorly by women with pulmonary vascular obstructive disease of any cause - for my patients, usually Eisenmenger syndrome, very poorly functioning systemic ventricles or severe left-sided obstructive lesions.

Pregnancy also causes changes in the vascular wall, with a risk of aortic dissection in patients with coarctation of the aorta, Marfan syndrome and Ehlers Danlos syndrome. A prothrombotic state exists during pregnancy and women with artificial valves have an increased risk of life-threatening valve thrombosis. The oral anticoagulant Warfarin crosses the placenta and can cause abnormalities in the foetus, known as embryopathy, in the first trimester, haemorrhage and foetal loss throughout pregnancy. Heparin injections are often substituted as it does not cross the placenta but is a less effective anticoagulant. Even if meticulously monitored, the mother is at risk of potentially fatal valve thrombosis.

Preconception counselling is the most important part of the care of these women and should start once puberty is under way. Risk assessment and planning of management during pregnancy for these women is conducted through a joint Mater-Rotunda maternal heart disease multidisciplinary team meeting involving obstetrics, cardiology, anaesthesia and haematology. This results in three to four high risk women per year being delivered in the Mater Hospital rather than in the Rotunda so that they can be monitored more closely and go to intensive care for postpartum monitoring. With this Mater-Rotunda team approach there have fortunately been no maternal deaths in our group of patients with congenital heart disease over the last ten years.

In terms of experience elsewhere a paper published by Drenthen reports a 5% elective termination for congenital heart disease. Colleagues from the UK with large adult congenital heart disease practices report very small numbers of terminations for medical reasons - one or two a year out of a practice of 3,000 women with adult congenital heart disease. This lower than reported termination rate is probably because of good preconception counselling and means that most high risk women either do not get pregnant or know before becoming pregnant that the pregnancy will be very high risk. The terminations were either early following accidental pregnancy or late to save the mother's life. There have been approximately two in the past 13 years.

When termination is required to save the life of a woman with critical illness then it would have to be performed in the adult major teaching hospital with access to intensive care and the relevant specialists. This clearly would not be the case in any of the Dublin public obstetric hospitals. The termination would likely be on an urgent planned basis rather than immediate emergency basis.

Deputy Billy Kelleher: My first question is for Mr. Saunders of the Mental Health Commission. Mr. Saunders stated in his presentation that the commission is of the view that the reasonable opinion of the medical practitioner should (a) be required in writing, (b) follow an examination of the woman concerned and that (c) the reasons for the opinion should be provided. He then went on to define an examination. Head 5 of the Bill provides that the medical opinion should be in a form and manner prescribed by the Minister. Is Mr. Saunders suggesting that the Mental Health Commission's view of an examination and the reasonable opinion of the medical expert should be provided for in the legislation?

My next question is to Dr. Janice Walshe and Dr. Kevin Walsh. Has either doctor, in discus-

sions with their peers or personally, ever come across a case whereby a woman because of her physical condition, and based on medical advice that her life was under threat if she received a particular treatment, opted to terminate the pregnancy? In other words, have they come across a case whereby following explanation to a pregnant woman that a particular treatment could have a profound impact on her life or the quality of life of the foetus, that woman decided to terminate the pregnancy as a life-saving measure?

My final question is on head 12 and relates to conscientious objection. Are the organisations happy with the heads of the Bill as prescribed with regard to conscientious objection?

Deputy Caoimhghín Ó Caoláin: I join in welcoming each of our witnesses. I thank Mr. Saunders, chairman of the Mental Health Commission, for the points offered by the commission in relation to definition. Each of the other points offered were highlighted on Friday and earlier today. As such, they are confirmatory in terms of points already shared across each of the different disciplines.

My first question is to Dr. Janice Walshe. Dr. Walshe made reference to international research regarding the impact of chemotherapy treatments on pregnant women. How extensive is that research and across what cohort of international experience was it compiled? Is there a body of evidence already accrued based on the situation in Ireland and factored into this international research?

I thank Dr. Kevin Walsh for his presentation. I know a number of people who attend the Warfarin clinic at my local hospital. Is it the case that there is a lowering age group who may be exposed to the use of Warfarin, with the result that there might thereby be an increased risk to women in years when conception is realistic? Because women are now getting pregnant when they are older the use of coagulants is becoming more prevalent and the age profile is lowering. Therefore, there is an increased risk in relation to Warfarin intake because as Dr. Walsh indicated it crosses the placenta and can cause foetal loss throughout pregnancy. I would be grateful if he could elaborate on that point.

Dr. Walsh cited statistics obtained from colleagues across the water regarding adult congenital heart disease and the termination of pregnancy. Is the statistic of one or two women in every 3,000 particular to some practices or are they indicative? Can Dr. Walsh extrapolate from that in relation to the likely situation that applies across the neighbouring island?

Deputy Mattie McGrath: I welcome the witnesses and thank them for attending at this time in the evening. My first question is directed to Mr. Saunders. Mr. Saunders mentioned in his opening statement that the procedures referred to in the heads of the Bill do not fall within the definition of the mental health services or come within the remit of the Mental Health Commission. All references in the heads of the Bill to the Mental Health Commission relate solely to the registration of a centre. Perhaps Mr. Saunders would clarify the situation in that regard.

Mr. Saunders also stated that the heads of Bill are silent on the requirement to hear, consider and document the views of a woman who has not reached the age of consent. I recently had the privilege of meeting Miss C. We all know what happened in that case, which was not very pleasant. Perhaps Mr. Saunders would, if he can, comment on that matter.

It is necessary in the context of our discussion to look to other jurisdictions. Following the *Roe v. Wade* case in California in 1973 the Supreme Court decided that abortion could be allowed for a variety of reasons, including the mental health of pregnant women. They accepted

that the mental hospitals would be full if all the people permitted abortions on mental health or suicide grounds had been admitted. They had to change the law and it was beyond all proportion. Perhaps the witnesses can comment on that.

Mr. John Saunders: The experience of the commission in interpreting and implementing the Mental Health Act 2001 is such that we feel it is best practice, provides clarity and ensures safety to include as much detail as possible on procedures in the body of the legislation. If that is not possible, then perhaps clear statutory instruments supporting the Act could spell out these details, as opposed to leaving them to the Minister of the day. We could deal further with the issues that arise subsequent to the Bill's enactment if a mechanism is built in to allow a review of these procedures in light of experience, perhaps after one, two or three years. We do not know what is ahead of us in terms of this legislation.

In regard to the issue of children, nothing in the heads of the Bill addresses the different circumstances of children or women who are below the age of consent, which is 16 years or 18 years depending on the perspective one is taking. Specific mention should be made of children who find themselves pregnant, as opposed to adult women.

I cannot quote Roe *v.* Wade because it is history, but to my knowledge the main issue arising was the mental distress and well-being of the woman as opposed to her suicidality, which is a separate issue.

Dr. Janice Walshe: Deputy Kelleher asked if I had dealt with a case personally. I have not personally referred anyone for a termination.

Deputy Billy Kelleher: I did not use the word "refer".

Dr. Janice Walshe: I have not come across such cases. In terms of psychological distress, we encounter a lot of that among non-pregnant women and, of course, it is even greater among pregnant women. In terms of how one deals with the issue, when I meet a pregnant woman who has cancer, her main concerns relate to the risk to her own welfare and the risk to the foetus. Once it is explained that a termination is not likely to add anything in terms of outcome, that we will navigate the situation in clinical practice on a regular basis and that treatment can be administered safely for the most part, they tend to become less distressed and proceed with treatment.

In regard to Deputy Ó Caoláin's question, such is the rarity of cancer in pregnancy that it is difficult to have a perspective on randomised trials, but we have a considerable amount of data from retrospective studies, cohort studies and case series. These can be in the hundreds in some cases. We can extrapolate from these data to discuss them with our pregnant patients.

Dr. Kevin Walsh: I thank Deputy Kelleher for his question. On the need for termination, I think it would be unusual. Perhaps once every few years one would need to deal with a case because of something like Ehlers-Danlos syndrome or Eisenmenger's syndrome. The numbers are relatively small, but they are real and they are difficult problems when they occur.

We use warfarin increasingly but we walk a tightrope in this regard because while warfarin is good for the heart valve, it is not good for the foetus. The mother obviously wants the best outcome for the foetus and we want the best outcome for both, but primarily for the mother. We have to strike a balance between Heparin and Warfarin and occasionally this will lead us into trouble with a valve clotting. That is a situation in which one could end up with a termination, but foetal loss is usually part of that.

With regard to the experience in the UK and other centres, I spoke with more than one centre and they had encountered only a handful of cases over many years. There are one or two occasions per year in big practices when a woman's life may have to be saved by terminating a pregnancy.

Ms Eileen Lawrence: The Irish Nurses and Midwives Organisation is requesting that the conscientious objection clause be maintained in the heads of the Bill. We also ask that the legislation be clear in respect of nurses and midwives.

Deputy Ciara Conway: I thank the witnesses for giving us their time. Dr. Janice Walshe suggested that two consultant oncologists and one obstetrician would be her preferred option. Given that the Bill suggests one oncologist, I ask her to explain the basis of her opinion. When a woman presents to her primary care provider with concerns that her pregnancy is threatening her life, what is the preferred referral pathway? Perhaps Dr. Kevin Walsh can also respond on that issue. What if the woman was previously advised against becoming pregnant because of her condition?

How long should a referral take, and do the heads of the Bill include adequate safeguards so that a woman whose life is at risk can see a specialist and receive a decision quickly? Is time of the essence? In our earlier sessions we discussed the role of GPs in this process. Could the requirement to consult a GP act as an obstacle to women who require speedy interventions?

There was considerable discussion today about multidisciplinary approaches to women in crisis. I ask Ms Lawrence to outline the role played by midwives when assessing, alongside obstetricians, pregnant women in their care and deciding on appropriate referral pathways.

Senator Jillian van Turnhout: I thank the witnesses for attending the committee. My first question is for Dr. Kevin Walsh and Dr. Janice Walshe. I am trying to tease out the pathway for a woman making a decision. I imagine that she would have seen a specialist prior to finding out that she had become pregnant and must make a decision. The witnesses stressed that such cases are rare, but does Dr. Kevin Walsh agree with Dr. Janice Walshe that two specialists should be involved? Does the legislation before us confirm what the witnesses are doing in practice, or will it place obstacles in their way? I am trying to understand the role the legislation will play in medical practice.

Head 4 provides that the psychiatrist must be employed by an approved centre. Mr. Saunders indicated that not everybody works at an approved centre. Can he suggest a form of language that would ensure we do not get into a situation in which lists must be drawn up of those who will or will not do something? How can we develop a system that is balanced and fair? I note his comments on the silence of the legislation with regard to children. As several witnesses have raised this issue, it is something we will have to address.

Deputy Regina Doherty: I will ask Dr. Kevin Walsh and Dr. Janice Walshe the same three questions. As I did not hear the beginning of Deputy Kelleher's intervention, I am not sure if I will be repeating his questions. Were any medical terminations carried out in either of the witnesses' specialties in Ireland in the past several years? Were any of their patients delayed treatment, voluntarily or otherwise, or refused treatment because of their pregnancy? Do they know of any patients who were pregnant and travelled outside of our jurisdiction?

If this legislation is passed, I ask Ms Lawrence whether it will change how nurses and midwives react to pregnant women presenting with a medical emergency such as ectopic pregnancy

or pre-eclampsia, aside from mental health issues or the two specialties represented by Dr. Kevin Walsh and Dr. Janice Walshe. Will the legislation, if passed, change the way in which our guests would receive and treat that woman from the way in which they do so now?

Mr. John Saunders: For the record, it is Mr. Saunders not Dr. Saunders. The answer is already found in the interpretation of the heads of the Bill where it is stated that ""psychiatrist" means a medical practitioner who is registered in the Specialist Division of the register of medical practitioners established under section 43(2)(b) of the Medical Practitioners Act 2007" - simply to leave out the fact that the person needs to be employed in an approved centre.

Dr. Janice Walshe: I thank Deputy Conway for her questions. Having two medical practitioners in medical oncology might be wise because cancer in pregnancy is exceedingly rare. As I stated, we are seeing only 60 to 70 cases in Ireland per year. It is conceivable that there could be a medical oncologist or a haematologist who has never encountered this kind of situation. I would feel personally that, from a safety perspective and in order to ensure we make appropriate decisions, a second medical practitioner in that area should be consulted. In terms of the pathway, once that process had occurred, certification would occur in combination with the obstetrician. I would not envisage this happening often, as indicated through my data. It would be exceedingly rare that this situation would arise. In the context of timelines, we tend not to have extreme medical emergent situations so seven days would be adequate. The Deputy inquired as to whether GPs could be an obstacle. In terms of specialist care such as this, GPs tend to rely very much on the information they receive from us. I would not, therefore, see them as being an obstacle.

Some of Senator van Turnhout's questions overlapped in the context of the pathway and she asked if the legislation would help this situation. It arises so rarely that I am of the view it will be helpful. However, I hardly ever see it arising.

Deputy Regina Doherty asked if we know of patients who have travelled for terminations. I have heard of patients who have travelled in order to have terminations completed. That is more on the basis of foetal abnormalities in the first trimester if they receive treatment. Again, I have no personal knowledge of the ins and outs of that but I have spoken to colleagues about the matter. It would also be exceedingly rare.

Dr. Kevin Walsh: On Deputy Conway's questions, we usually would provide preconceptual advice in respect of pre-existing conditions. When they are known to the system, they have rapid access to us via nurse specialists and their general practitioners. There is no real problem with that. In terms of a critically ill woman where time would be of the essence, they would usually be very unstable, have blood pressure problems and be in hospital. That would be a pretty unusual event.

I must inform Senator van Turnhout on the prior advice, preconceptual warning, we may advise against it but we would fully support them if they went ahead with the pregnancy. We always make them understand that. We say that we do not think it is a good idea and we try to get their partners involved. However, if they go ahead, they will get full support all the way with it because that is ultimately their choice.

On the two specialists, the problem is that I am the only specialist in adult congenital heart disease. We have been waiting five years for the HSE to appoint another one. At the moment we would probably try to keep it simple and have one specialist. We are always going to be consulting obstetricians - as part of a multidisciplinary team involving all the specialists - in

order to make that sort of decision. For us, it would not be a bleeding emergency or something of that nature, we would have a day or two to organise things. The legislation clearly would be very important because it would place matters on a firm footing and would make it happen for women.

Deputy Regina Doherty inquired about women being obliged to travel. I have had two patients in the past number of years who were obliged to travel for terminations. Patients will sometimes delay heart treatment to try to get a pregnancy over but usually they have a reasonable set up in order that they can survive and manage it.

Ms Eileen Lawrence: I thank Deputy Conway for her question which, I think, has actually been covered by two of my colleagues. From a nursing point of view, it would be down to the consultants and they have covered it very well in the context of the pathways.

Deputy Regina Doherty referred to medical emergency as regards change in the treatment. I do not believe that this would lead to anything different from the treatment that is already being offered.

Deputy Peter Fitzpatrick: I welcome our guests and thank them for attending. I wish to pose three questions. Will doctors and nurses who, under head 4 of the Bill, wish to have no part in abortions - either directly or indirectly - be significantly protected in the context of their professions and livelihoods? Will doctors and nurses who, under head 4, wish to have no part in abortions - either directly or indirectly - be likely to be subjected to discrimination in their careers? In the interests of equality, should the proposed legislation make provision for consultations with the fathers of unborn children?

Deputy Denis Naughten: Mr. Saunders made the point that the commission has no role under the heads of the Bill. Is he of the view that it should have a role? He also commented on the fact that there are only three perinatal psychiatrists based in the Dublin hospitals. Is it his impression that decisions under head 4 would be made by perinatal psychiatrists? That is the impression some of us would have obtained but the psychiatrists provided different evidence earlier today. Will Mr. Saunders elaborate on that matter?

Under head 3, consultants will sign off on medical emergencies. Will senior midwives have a role to play in respect of this matter? For example, could they offer second opinions with regard to medical emergencies? Does the INMO have any concerns about the structure of the heads of the Bill, as they currently stand, and the impact they might have on some of the smaller units throughout the country, which are very much midwife-oriented?

Dr. Janice Walshe indicated that there is a dearth of large perspective randomised trials. That is understandable because one would not carry out randomised trials in respect of someone who has cancer. Is Dr. Janice Walshe satisfied with the quality rather than the quantity of the research available? While that research is limited, is she satisfied that she has available to her the medical evidence necessary to best advise a woman in those circumstances? Does she have access to colleagues who can assist her in making a determination?

Senator John Crown: I welcome my colleagues and thank them for their particularly learned, focused and well-informed presentations.

My first question is for Dr. Kevin Walsh. One of the issues which has exercised the committee in recent days relates to the quantification of risk, namely, the percentage chance an individual has of dying. It is clear that this becomes very nebulous and contentious in the area of

the highly hypothetical and probably-never-going-to-happen psychiatric indication. In various medical conditions, however, it is a very real concern. I refer to blood pressure complications, congenital heart problems etc. I am guessing that the answer to my question is "Yes" but perhaps Dr. Kevin Walsh could provide some reassurance. If someone comes to him with a particular congenital heart lesion which has caused a certain level of left ventricular dysfunction, valvular regurgitation or whatever, does he have available to him reasonably good guidelines which indicate what is the incremental risk of death to the woman in question if she carries her pregnancy to full term as opposed to her not doing so? At what level would he consider that the threshold is such that he would strongly urge that the risk to her life is so great that she really should have a termination?

My second question is for my colleague and very dear friend, Dr. Janice Walshe. Obviously, she and I work very closely in respect of cases of this nature and she has given the committee a really good insight into the various dilemmas relating to the life of the mother, the risk of foetal malformation etc. She is correct, we have worked out ways of trying to get the balance right. While we may not have cases where we send people for termination of their pregnancy, would the delegation hold that it is fair to say that sometimes we end up making compromises in what would be the absolute standard care for an individual person if she was not pregnant to accommodate the special needs of the developing foetus?

Mr. John Saunders: In respect of the question about the involvement of the Mental Health Commission, it is clear from the heads of the Bill that the services proposed arising out of the Bill will be delivered by the HSE and by the voluntary bodies under section 38 of the Health Act. It is also clear that the responsibility for regulation would be with the Health Information and Quality Authority, HIQA, and that the regulatory authority will be with the Medical Council. Therefore, it is more than adequately provided for that the Mental Health Commission will not have a central role in whatever legislation arises out of the heads of the Bill.

The second question was about perinatal psychiatrists. Our submission on the heads of the Bill includes an assumption that in the three large voluntary hospitals the perinatal psychiatrist is the person who would be involved in the procedures outlined. There is an assumption that the second one would be as well, but that is not entirely clear. However, we know there are 60 other centres throughout the country and, as far as we understand, those centres that are served by psychiatry could well be served by liaison psychiatrists from general hospitals or indeed by general adult psychiatrists. They would not necessarily be perinatal psychiatrists.

Dr. Janice Walshe: There was a question on randomised trials. As a background point, randomised trials are the cornerstone of cancer therapies. We perform prospective randomised trials in all areas of cancer management. The only thing that holds us back in terms of cancer in pregnancy is the dearth or the small number of cancer cases. It is very difficult to perform large randomised trials. I am comfortable with the data that is there. There are many retrospective cohort studies, case series and case reports that are all consistent no matter what country they have been performed in. In that regard I believe that the data can be extrapolated to the Irish situation and in that I am completely comfortable.

With regard to the question of Senator Crown on the challenges that we face for appropriate therapy of pregnant women with cancer, there is no question that we have to make small compromises, but they are recognised to be internationally acceptable. Where the real difficulty lies, however, is in the treatment of women where we do not have time to wait and in the first trimester. As a result of that we are certainly compromising in terms of the agents that we can offer.

Dr. Kevin Walsh: Senator Crown asked a question about the quantification of risk. We have some scores for major adverse cardiac events but they usually include death along with other complications. Generally, we consider a condition where the risk of death is 5% to 10% as being very significant. Mothers will take any chance to have a baby but a 5% to 10% risk is really significant. In the Eisenmenger patient the risk is up at 30% to 50%. That would be a case where if there was earlier identification we would certainly want to recommend an early termination. It is different. We have had Eisenmenger patients come to term or close to term. Equally, Eisenmenger patients have died in this city during pregnancy. That is the sort of level of risk.

Ms Eileen Lawrence: To answer Senator Crown's question, the senior staff nurse, of course, should have an input as part of a multidisciplinary team and as an expert in her field.

Deputy Denis Naughten: What about for smaller units? Does the Irish Nurses and Midwives Organisation, INMO, have any concerns about the heads of the Bill as they are currently drafted in respect of the smaller maternity units throughout the country?

Ms Eileen Lawrence: I cannot comment on that right now.

Senator Colm Burke: I thank the delegations for their contributions today. My first question is for Mr. Saunders in respect of head 4 of the Bill. I have raised this with several people already. The Medical Council and the Royal College of Psychiatrists of Ireland are suggesting that the heads of the Bill provide that three people would sign off on the issue in respect of where there is suicidal intent, whereas they are suggesting that two psychiatrists would sign off and then consult with the obstetrician. Will Mr. Saunders offer his views on that?

Mr. Saunders commented that the heads of the Bill are silent on the issue of people under 18 years of age. I wonder what structure-----

Chairman: Could we have one meeting with respect for the speaker, please?

Senator Colm Burke: In respect of people under 18 years, what structure would Mr. Saunders like to have put in place to deal with that issue in the proposed legislation? Mr. Saunders is right. The heads of the Bill are silent on that issue and it is an important point that he has raised.

The third question is for Dr. Janice Walshe. She suggested that two people should sign off in respect of the area that she deals with. I presume she would be happy that in an emergency one person would sign off, together with the obstetrician. Perhaps she will clarify the position.

Senator Jim Walsh: As someone who responds to different pronunciations of the surname Walsh, I believe I am correct to say that I am directing my questions to Dr. Janice Walshe and Dr. Kevin Walsh. I believe we have good maternal health outcomes in this country which compare favourably with any international comparator. Would the delegations agree with that?

My second question deals specifically with the physical medical emergencies and non-emergencies that arise. Given the provisions in the Bill, do the delegations believe that they will broaden the availability of abortion, or will they merely reflect current medical practice? Mr. Saunders made a sensible suggestion under head 5, which my colleague, Deputy Kelleher, referred to. It is a good recommendation to the effect that the reasonable opinion of the medical practitioner should be required in writing and that examination of the woman concerned would be documented, including the reason and the opinion. There are two points. Does Mr. Saunders believe that the word "reasonable" should be attached to the word "opinion"? Some have

been canvassing that the word "reasonable" should be removed and this concerns me. Does Mr. Saunders believe that as part of the recording of information - which I believe is essential in future for making decisions - the consultation with the general practitioner should also be fully recorded by the consultant involved in dealing with it?

Reference was made earlier to Miss C. As the delegations may remember, in 1997 she was brought to Britain by State officials to have her baby taken out, as she has described herself. She understood that would not lead to the death of the baby and it was against her parents' wishes. She subsequently has attempted suicide on a number of occasions. What should be included in the legislation in the opinion of the delegations to protect against this happening in future?

Mr. John Saunders: The first issue was around the difference between head 2 and head 4 in terms of the number of practitioners involved. When the commission was discussing the issues it noted the difference and that in the case of physical severe illness there was a requirement for a consultant obstetrician plus medical specialists up from the disease entity - that was the issue - whereas head 4 refers to two psychiatrists. This is explained in the heads by the statement that the provision for two psychiatrists in addition to an obstetrician arises from the recognised clinical challenges in accurately assessing suicidal intent and the absence of objective clinical markers. In these cases the Bill provides that the opinion will be jointly certified by an obstetrician gynaecologist and two psychiatrists. I suppose that is the answer. There is a recognition in general that the ability to predict the seriousness and consequence of suicidal ideation is a difficult one. There is a distinct difference between head 2 and head 4. One could argue conversely that perhaps it should be the same and that there should be an obstetrician and one psychiatrist in the same way that there is one obstetrician and one physical specialist in the case of head 2, but I believe it is a matter of debate and opinion rather than a matter supported by scientific fact.

The question of children was raised. We have noted the absence of any specific legislative proposals around children. Again, in most social legislation dealing with children and adults, a specific part of the Act details the provisions for children. This legislation should recognise that children who find themselves in a situation where there is a pregnancy are a particularly vulnerable set of people in the general population of women. Second, there is the issue of their capacity around their status as a child versus the wishes of their parents, for example, and there are also issues around decision making and competency around decision making. Members may be aware that there is also assisted decision making legislation on the schedule of the Oireachtas and both pieces of legislation will have to reflect the provisions of the other piece of legislation. To answer member's question about decision marking, there is the capacity and vulnerability of the person who is below the age of 18 as opposed to an adult. An additional group of people are children who are in care, usually of the HSE, and there is the matter of where the responsibility lies in terms of decision making on behalf of those children should one of them find themselves pregnant and in the situation that has been outlined.

Dr. Janice Walshe: In response to Senator Colm Burke's question, my idea for the two medical practitioners, as I said before, is related to the fact that this is a rare entity and we are dealing with a very small number of cases. In that regard, in a scenario where someone had not encountered this before, I felt it would be more practical that the person would be able to have the ability to seek advice from another medical practitioner in the same area. In terms of an emergency situation, I envisage that arising extremely rarely but I accept that would have to happen.

I thank Senator Walsh for calling me "Welsh". I only hear that when I go home to the west and I thank him for making me feel at home. In terms of the head of the Bill, as it stands, I think

it will reflect current practice and I do not envisage that it should be broadened.

Dr. Kevin Walsh: To answer Senator Walsh's questions, maternal outcomes are excellent but there is a problem with isolated maternity hospitals in Dublin. This is why, in terms of the location element of the heads of the Bill, termination procedures would have to be also in large adult teaching hospitals as well if we were really to address the lives of women. There is where critically ill women have to go. Equally, the fact that we still do not have a plan to have maternity hospitals and adult hospitals located right beside each other on the same campus continues to be a big concern. It was part of the problem regarding the children's hospital. With regard to whether allowing terminations would broaden the use of terminations, in terms of women with severe heart disease who have travelled to the UK to have a termination, they may be able to have it done in Ireland rather than England, and that is important because these women go abroad with major difficulties - financial, psychological and all those problems - so dealing with the problem ourselves has to be better.

Chairman: Does Ms Lawrence wish to comment?

Ms Eileen Lawrence: No.

Chairman: That ends the members' time. We now have a half an hour of time for non-members. Four Members have indicated and I will take the four together starting with Senator Fidelma Healy Eames.

Senator Fidelma Healy Eames: Good evening panel and I thank them for being here. I will direct my first question to Dr. Janice Walshe. It is particularly interesting that C in the ABC case - we are here because of the European Court of Human Rights judgment in that case - was a woman who had cancer. Could Dr. Walshe clarify for the record what is available currently in Ireland for a woman in the position of C? We know she Google-searched what she did not know was available here, and this has given rise to the European Court of Human Rights judgment. Does Dr. Walshe think the public would benefit from an information campaign on what is currently available regarding terminations to save women's lives in this position? How will this Bill change her practice for the better?

My question to Mr. Saunders is around the issue of mental capacity. To make a will, one has to be of sound mind, yet with this Bill essentially we will be certifying a woman who is suicidal, and in that respect she could be considered not to be of sound of mind, to make a final decision about her unborn baby. Does this make sense to him? Does a suicidal woman in his view have the mental capacity to consent to something that is so final and irrevocable as the taking of the life of her unborn child?

What role does Ms Lawrence currently play in psychiatric teams around the care and observation of women who are suicidal in pregnancy?

Deputy Terence Flanagan: I have brief questions and it would be great if the witnesses could answer them. Does the INMO have concerns about the extremely limited rights of conscientious objection in relation to abortions carried out under head 4? Has the organisation had an any consultation with its members regarding any changes as a consequence of this Bill? Can Dr. Walshe indicate in what percentage of cases where cancer is diagnosed before viability is it possible to manage treatment in such a way as to facilitate the safe delivery of the baby?

I have a question for Mr. Saunders regarding the Health Act 2007. We know that the Minister for Health has expressed a view that the 2007 Act offers scope for oversight of termination

of pregnancy permitted under the Bill and consistent under Article 40.3.3o of the Constitution. From the explanatory note under head 1 it is not obvious which provisions of the Health Act of 2007 would authorise the Minister to investigate, discipline and-or refer for prosecution a physician or a psychiatrist who would certify, without justification, that an abortion was necessary to prevent the woman from killing herself, or to remove a physician, including a psychiatrist. from the panel's consideration of an application for abortion or reviewing denials of such applications. Will Mr. Saunders indicate what authority exists in that respect under the 2007 Act?

Deputy Michael Creed: I welcome the delegation and thank the witnesses for their presentations. Mr. Saunders made a point in respect of a review mechanism in the legislation and its effect. There is a provision in head 10 or head 11 for a reporting mechanism back to the line Minister on the number of cases, the applications for review, etc., but there is not any role envisaged in that reporting mechanism for the Houses of the Oireachtas to be informed or consulted on its continuing operation based on the experience of the legislation to date. Can Mr. Saunders flesh out in greater detail his idea of a review mechanism in the legislation? I refer in particular to head 4 and how that might be expanded to include the Houses of the Oireachtas, or is that something to which he has given any consideration?

Mr. John Saunders: On the question on mental capacity, my understanding from the heads of the Bill is that the consultant obstetrician in conjunction with two consultant psychiatrists will be asked to assess the validity or otherwise of the suicidality that the woman is stating and, as such, it is not an assessment of her capacity, it is an assessment of the risk of suicide, as expressed, and they then have to make a recommendation based on that. That is a very different thing, as I and the commission understand it, from capacity. As a note of interest, the capacity legislation that is promised in the Dáil takes a view that capacity is neither 0% or 100%. One can have capacity in one area of life and not have capacity in other areas of life. The concept of partial capacity is the principle that people are applying.

In respect of the Health Act 2007, I presume Deputy Terence Flanagan means the Medical Practitioners Act 2007 in regard to the regulation of medical practitioners. If that is what Deputy Flanagan means, as I understand it every consultant psychiatrist and obstetrician has to be registered under that Act in terms of his or her speciality.

On the review of legislation, I can point Deputy Flanagan to a number of pieces of legislation where, within the Act, a Minister is given power to review either the Act in full or in part at a given period of time. For example, in the Mental Health Act 2006 the current Minister is given the power to review the full Act five years after commencement and therefore make changes in the light of experience. I know also that certain Acts will allow Ministers to act according to advice received on particular issues in the form of ministerial orders or miscellaneous provisions in legislation. Those are the types of legislative reviews that we need to build into the parent Act.

Dr. Janice Walshe: With regard to the first question pertaining to the C case, this was a lady who got pregnant on remission from cancer and got information via the Internet. Currently, somebody in the position of C will present to her medical oncologist where a detailed discussion will be held based on prognosis of that woman and the best way to proceed in terms of her treatment. We will discuss the risks to the mother as well as risks to the foetus. She will also have an interaction with the oncology liaison nurse, and we may involve a psycho-oncologist if we felt that was appropriate.

In terms of resources available, they are available in all of the units and therefore it would

be a fairly uniform approach in most units one would encounter in Ireland.

In terms of the information packs, to my knowledge there is no specific information out in this regard but it would be important going forward because this scenario is so rare and variable according to the cancer that arises. It would be an important matter. In terms of my envisioning this Bill changing practice, currently I do not see that it would change practice.

With regard to the percentage diagnosed in the first trimester, we do not even have numbers of cancers diagnosed in pregnancy in Ireland. We are extrapolating from international data and, therefore, I do not have those type of numbers but I can tell the member that if someone presents to us with cancer in pregnancy, in the vast majority of cases we navigate that very successfully. We will treat them with chemotherapy from their second trimester onwards with agents we know are safe in that regard, with very good success for both the mother and the foetus. We will strive for foetal maturity rather than foetal viability so we will bring them up to about 35 weeks gestation and then discuss the best way to proceed with delivery, depending on the cancer involved.

Dr. Kevin Walsh: I do not think I have any answers to that.

Chairman: Deputy Flanagan asked a question about consultation.

Ms Eileen Lawrence: Yes, and there was a question concerning-----

Deputy Terence Flanagan: I asked two questions on consultation and conscientious objection.

Ms Eileen Lawrence: To my knowledge we are welcoming of that being in the Bill, and also to be clear on the legislation for nurses and midwives.

Deputy Terence Flanagan: Was there consultation with Ms Lawrence's membership?

Ms Eileen Lawrence: Serious consultation regarding that will take place so that people will have choices as in the conscientious objection clause.

Deputy Terence Flanagan: My question is whether there has been a debate yet. Has there been a debate?

Chairman: Thank you. I call Senator Mullen.

Senator Rónán Mullen: I thank all our guest experts and specialists for their contributions this evening. It is reassuring to hear the last point about foetal maturity, with the ethos of care coming out strongly in terms of bringing both cherished patients to a safe place. I thank Dr. Walshe for the good work she does.

I have a question for Mr. Saunders. We heard earlier from Dr. Yolande Ferguson, one of the psychiatrists who appeared before the committee, who spoke about the way psychiatrists routinely defend their decisions in mental health tribunals. It struck me that given the far-reaching and fatal consequences for the unborn child of the decision to certify that a person is suicidal and that there is a real and substantial risk which can only be averted by a termination of pregnancy, would it not be appropriate that there should be a forum where such decisions would also be defended? That is arguably a more far-reaching consequence than something like detention, for example. That thought has struck me.

Turning it around, perhaps I have overlooked it but I do not see in Mr. Saunders' submission any comment on the fact that whereas a review is possible of the decision to refuse to certify that abortion would be lawful on the head 4 ground, there is no provision that any person or official would have the right to seek a review of the decision to permit a termination to go ahead. Again, given the far-reaching consequences for one constitutionally protected actor, does Mr. Saunders believe there should be, to use a phrase that became popular some years ago, parity of esteem and that there should be the possibility of a review in those situations?

I do not think Mr. Saunders made any comment on head 11, but head 11 essentially provides that records would be submitted to the Minister where a decision is made under head 4, or under any of the heads, permitting lawful termination of pregnancy. Again, with particular regard to head 4, it mentions that no notification shall give the name or address of the woman in respect of whom the termination was carried out. Everybody would agree that is right and proper, whatever people feel about the appropriateness of making any such certification under head 4. However, it goes on to state that the Freedom of Information Act shall not apply to any record under this head. Given that there would be no question of giving personal or identifying details, is that appropriate? Can Mr. Saunders think of any reason the Freedom of Information Act should not apply? If people are concerned about procedural abuses here, surely one important mechanism to allow us to know whether there is a procedural abuse is that the Freedom of Information Act should not apply. I would be grateful for any thoughts and insights Mr. Saunders has on that.

Chairman: The Senator's time has concluded.

Senator Rónán Mullen: Finally, would Mr. Saunders agree that the law in this area should reflect section 21.1 of the Medical Council guidelines, which requires due regard to be had to clinical research in the area of psychiatry in regard to any certification being made under head 4?

Deputy Peter Mathews: To recap on this morning's and this afternoon's-----

Chairman: We will not recap. I ask the Deputy to go forward.

Deputy Peter Mathews: It is to ask a question.

Chairman: That would be most helpful.

Deputy Peter Mathews: We know what the Constitution states; it is written in plain English.

Chairman: On the Bill, please.

Deputy Peter Mathews: We know the Supreme Court said that where there is a real and substantial threat to the life of a mother, it is legal for medical personnel from all disciplines - fire brigade officers, their executives, doctors, nurses and midwives, to do what needs to be done. We have heard also that where there is a threat or an intent of a distressed mother to be to take her own life, the answer is not a termination. What sort of word games are going on here? The last session answered that question and said that no matter what the Supreme Court said regarding the X case, which was a unique case in history, it will never be replicated. Every event in history is a unique event and therefore to legislate for a unique event that will not recur is logically absurd. What we are doing now is looking at real life situations within the constitutional framework of the value and sacredness of life from start to end to ensure we avoid issues such as euthanasia at the other end and abortion-----

Chairman: I ask the Deputy to speak to the Bill.

Deputy Peter Mathews: Why are we following all these long, drawn-out avenues into wordy discussions when we know what we are about? Also, what was said about unsound mind is very true. Lawyers can play with words and say unsound mind only applies to writing wills. That is nonsense. Unsound mind is where there is stress, duress, sociological, personal and guilt coercion. Conscience is about clear knowledge and full consent, regardless of what one is doing.

Senator Paul Bradford: I welcome the visitors. I apologise I was unable to be present for the commencement of their addresses but I have read through the scripts. I was interested in Dr. Walshe's very precise response to Senator Healy Eames who asked whether the proposed legislation would make any difference to her practice of medicine - I have paraphrased the question - and the reply was that it would not and that life, if one excuses the pun, will continue as heretofore.

In the previous session I asked for a response from the four witnesses on whether they agreed with the phrase which is becoming a mantra, that this legislation is about saving women's lives. Each one said they did not. If the legislation will make no difference to practice, and if it is supposed to be simultaneously about saving women's lives, are we in a position where women's lives are not being saved? I am as confused as everybody else. We are putting a new meaning on words. If this legislation will make no difference is the country a hugely dangerous place for Irish women at present from a medical perspective?

Chairman: We are discussing the heads of the Bill.

Senator Paul Bradford: The question is whether it would make a difference to medical practice and apparently the answer is "No".

Senator: She did not say that.

Chairman: Thank you. I am chairing the meeting.

Senator Paul Bradford: The answer to the question asked by Senator Healy Eames was that there would be no difference in practice. What does this mean? What we fear is the current inadequacy of the law with regard to women's lives. We cannot have it both ways. We cannot state we can change the law but nothing will change or that there will be no difference. I would like clarification if possible. I appreciate it is complicated.

Mr. John Saunders: A form of tribunal was suggested as a possibility. The committee may know the mental health legislation in place operates tribunals for third-party reviews of decisions made to detain people against their will in approved centres. It is a cumbersome and costly process but it is effective enough. I am not sure how it might translate to the situation included in the heads of the Bill.

With regard to third-party review, the issue I raised is that at some point in most appeals mechanisms one can make an application to court, usually the Circuit Court, to review a decision. The point I made is that under the heads of the Bill as read now, there is no provision beyond the initial review for any appeal to a court of any description, regardless of the decision made.

With regard to notifications under head 11, the commission examined this head and it ap-

pears to be quite sensible in the sense that ultimately the Minister and the Department are responsible for all health care service delivery and should have routine information provided to them to help them understand how the services operate. It is self-evident that details about personal names and addresses should not be included in this data. With regard to the Freedom of Information Act, I understand the Act already has provisions whereby information is withheld because of its sensitive or personal nature, so a decision will need to be made with regard to the information we are discussing under the heads of the Bill.

With regard to the questions on psychiatry, psychiatrists will be asked to make decisions on the evidence presented by a woman and it is a matter for psychiatrists to reach a conclusion. I am not a doctor and I cannot give a response.

Senator Rónán Mullen: A question was not answered.

Chairman: I will come back to the Senator. I will chair the meeting.

Senator Rónán Mullen: No-----

Chairman: If I need help I have a very good Vice Chairman.

Senator Rónán Mullen: I am very happy with how the meeting is being chaired, but there is a little ambiguity.

Chairman: I will bring the Senator back. He is very good at that himself.

Senator Rónán Mullen: Go raibh maith agat.

Dr. Janice Walshe: I wish to clarify the final point. I feel legislation is required in the unlikely event the mother's life is at risk as a result of the pregnancy, and to clarify my point, the likelihood of this legislation being enacted in my area is exceedingly rare.

Dr. Kevin Walsh: There is the potential to save women's lives. Patients with Eisenmenger's syndrome have died. Travelling abroad to have a termination in the UK with critical heart disease is not a good idea. We must deal with our own problems.

Chairman: Senator Mullen indicated but he cannot give a three-minute dissertation.

Senator Rónán Mullen: I understand this. Gabh mo leithscéal if there is a míthuiscint about what point one seeks to get a precise answer to a precise question.

Chairman: Tá a lán míthuisceana ann.

Senator Rónán Mullen: I am certainly happy to wait until other questions have been answered. With regard to the Freedom of Information Act, given that personal information is already excluded I asked whether there was any good reason the Act could not be used given the information being submitted to the Minister is not of a personally identifying nature anyway. With regard to the issue of review I asked for comments, not so much on the fact there is no further review beyond the existing one, but on the discrepancy between the fact there is a review possible of the decision to refuse but not of the decision to permit an abortion.

Mr. John Saunders: I cannot answer the last question because I am giving views on procedural arrangements. We noted there was no appeal to a court, regardless of the decision made by the review group and we stand over this. The Freedom of Information Act is about transferring information to the public domain and it has provisions on withholding personal informa-

tion. It is a matter for the Houses of the Oireachtas to decide whether the Act applies in total or not under this legislation.

Senator Jim Walsh: I wish to ask one small point of clarification. Dr. Kevin Walsh stated current practice will not be changed by the legislation and then stated women go to England because they have heart conditions which cannot be treated here. Will Dr. Walsh clarify this? It cannot be both. Does Dr. Walsh have evidence as to why people go to England? Last time we heard evidence of people going for a sixth abortion.

Dr. Kevin Walsh: We have too many Walshs. Dr. Janice Walshe said things will not change directly. There will be small changes. People have had to go abroad to get things which have not always worked out.

Senator Fidelma Healy Eames: Such as what?

Chairman: Sorry-----

Senator Fidelma Healy Eames: Chairman this is a very important point

Chairman: We are not in Ballymagash so please respect the witnesses, other committee members and this Chamber.

Dr. Walsh answered the question and I thank him. This brings us to the end of a session. I thank most sincerely Mr. John Saunders, Dr. Janice Walshe, Dr. Kevin Walsh and Ms Eileen Lawrence for coming before the committee. I thank the secretariat, the ushers, the stenographers, the sound personnel and the Houses of the Oireachtas staff for their work. I thank the expert witnesses who have attended all of the sessions. As I keep telling members they come voluntarily and change their schedules to assist us.

The joint committee adjourned at 8 p.m. until 9.30 a.m. on Tuesday, 21 May 2013.