# DÁIL ÉIREANN

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## AN COMHCHOISTE UM AN OCHTÚ LEASÚ AR AN MBUNREACHT

## JOINT COMMITTEE ON THE EIGHTH AMENDMENT OF THE CONSTITUTION

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*Déardaoin, 30 Samhain 2017*

*Thursday, 30 November 2017*

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Tháinig an Comhchoiste le chéile ag 3 p.m.

The Joint Committee met at 3 p.m.

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Comhaltaí a bhí i láthair / Members present:

| Teachtaí Dála / Deputies | Seanadóirí / Senators |
|---|---|
| James Browne, | Jerry Buttimer, |
| Lisa Chambers, | Paul Gavan, |
| Clare Daly, | Rónán Mullen, |
| Bernard J. Durkan, | Ned O'Sullivan. |
| Peter Fitzpatrick, | |
| Mattie McGrath, | |
| Catherine Murphy, | |
| Jonathan O'Brien, | |
| Kate O'Connell, | |
| Louise O'Reilly, | |
| Jan O'Sullivan, | |
| Bríd Smith. | |

Seanadóir / Senator Catherine Noone sa Chathaoir / in the Chair.

## Ancillary Recommendations of the Citizens' Assembly Report: Department of Health and the HSE

**Chairman:** We have received apologies from Senator Lynn Ruane. I welcome viewers who may be tuned in at home. Before I introduce the witnesses, as usual, at the request of the broadcasting and recording services, I ask members, those in the Gallery and witnesses to ensure their phones, at the very least when their microphones are on, are off completely.

This afternoon's meeting will examine the ancillary recommendations of the Citizens' Assembly that fall within the remit of the Department of Health and the HSE. We have representatives from the Department and HSE with us and they are all very welcome. From the Department of Health we have Dr. Tony Holohan, Chief Medical Officer, and Ms Geraldine Luddy, principal officer, and from the HSE we have Mr. Liam Woods, director of the acute hospital division, Dr. Peter McKenna, clinical director of the national women and infants health programme, Mr. Kilian McGrane, national programme director of the national women and infants health programme, Ms Angela Dunne, director of midwifery of the national women and infants health programme, and Ms Janice Donlon, from the sexual health and crisis pregnancy programme.

Before I commence proceedings, it is fairly safe to assume that witnesses are familiar with the Defamation Act and the privilege implications, so I will save us all from going through them. If anyone wants me to read out the note I am very happy to do so. I call Dr. Holohan to make his presentation.

**Dr. Tony Holohan:** I thank the Chair and members of the committee for the opportunity to address it. As the Chairman said, I am joined by Ms Geraldine Luddy, head of the bioethics unit at the Department of Health, and our colleague, Ms Aoife O'Brien, who is also from the bioethics unit.

I thank the committee for the opportunity to speak about the ancillary recommendations contained in the Citizens' Assembly's final report and recommendations on the eighth amendment of the Constitution. The committee received in September the Department's submission on the recommendations, so I will try to summarise them briefly.

The first ancillary recommendation which I will address concerns improved access to reproductive health care services, including contraception, sexual health services and termination of pregnancy. With regard to contraception and family planning services, the Department of Health launched the National Sexual Health Strategy 2015-2020 in October 2015, following Government approval. The strategy is being implemented under Healthy Ireland, the National Framework for Improved Health and Wellbeing. It is a cross-governmental policy, which is being delivered in partnership by the Department of Health, the HSE and the Department of Education and Skills. The national sexual health strategy's key aims are to improve sexual health and well-being, and to reduce negative sexual health outcomes.

The strategy aims to ensure that everyone in Ireland will receive comprehensive and age-appropriate sexual health education and information, and will have access to appropriate prevention and promotion services. It also aims to make equitable, accessible and high-quality sexual health services, targeted and tailored according to need, available to everyone. I will not address the service provision aspects of the national sexual health strategy, as I believe our colleagues from the HSE are in a better position to do so. They will address it as part of their

presentation and will support any questions committee members may have on it. However, just to note that implementation of the strategy got under way quickly, with an action plan prioritising an initial 18 actions, covering areas such as clinical services, education, communications and governance structures. All of these actions have commenced, and ten have already been completed, including the appointment of a national clinical lead for sexual health in the HSE, and the reconfiguration of the HSE crisis pregnancy programme to encompass sexual health as the new HSE sexual health and crisis pregnancy programme. As the Chairman said, this is represented at the meeting. In terms of achieving good quality outcomes, the Department considers that full implementation of the strategy, together with the measures outlined in the national maternity strategy, which I will address shortly, will significantly advance the good quality outcomes envisaged by the Citizens' Assembly.

The second ancillary recommendation which I will address concerns standards of obstetrical care in Ireland. I want to cover a number of elements of this. Over recent years, as members are aware, there has been significant focus on the development of a national maternity policy to ensure that our maternity services are developed in a coherent and evidence-based manner. Last year, we published Ireland's first ever national maternity strategy, Creating a Better Future Together 2016-2026, again following Government approval. The HSE's standards for bereavement care following pregnancy loss and perinatal death were also published in 2016, and I will speak a little more about these later. Also, in 2016, at the end of the year, HIQA's national standards for safer, better maternity services were launched. They aim to give a shared voice to the expectations of women using maternity services, service providers and the public. They are intended to show what safe, high-quality maternity services should look like.

Committee members may be aware that each of the 19 maternity units is now required to publish a maternity patient safety statement every month. The first of these was published in December 2015. They are published monthly in arrears, and report information on 17 metrics, dealing with clinical activities, major obstetric events, modes of delivery and other clinical incidents. Taken together, all of these developments are key building blocks which will enable us to provide a consistently safe, patient-centred, high-quality maternity service. They will also help advance the quality outcomes envisaged by the Citizens' Assembly in its ancillary recommendations.

In terms of overall governance structures, a national women and infants health programme has been established within the HSE, the leadership of which is represented here today, to lead the implementation of the national maternity strategy. It spans obstetrics, aspects of gynaecology and neonatal services across community, primary, and secondary care. The programme will oversee the establishment of maternity networks across the country, which will formally link all maternity units within each hospital group. It is recognised that smaller maternity services cannot, and often should not, operate in isolation as stand-alone entities. Given their size, some of these units cannot sustain the breadth and depth of clinical services required by the populations they serve. Through the establishment of maternity networks, we will ensure efficiency in the provision of, and access to, specialised services and support smaller units to provide safe and quality services.

The Department is aware that a key concern of the Citizens' Assembly in its ancillary recommendation was that all pregnant women, regardless of geographic location or, indeed, ability to pay, should have access to early scanning and testing. On this point, the maternity strategy is very clear that all women should have equal access to standardised ultrasound services. We know that there are challenges, but we intend to build capacity in our ultrasound services. To

that end, additional funding will be provided to the national women and infants health programme in 2018, subject to finalisation of the service plan, to develop a more equitable and consistent antenatal screening service. We will hear more detail on this from colleagues in the HSE in a moment.

The recently published maternity strategy implementation plan addresses the current regional inconsistency in service provision. Pending full implementation of the strategy's recommendations on anomaly scanning, the programme will continue to work with the six hospital groups to ensure increasing access to anomaly scans. In particular, it will work to ensure that clinical pathways are in place within each network, such that where clinically indicated, a woman can be referred to a larger maternity unit for such a scan.

As for the ancillary recommendation on improving counselling and support facilities for pregnant women, I do not propose to go into the detail on the service delivery side, given that colleagues from the HSE will address it. I am aware the committee previously had speakers before it on this from the HSE sexual health and crisis pregnancy programme, which is also represented here today. I will briefly note that the programme funds the provision of crisis pregnancy and post-abortion counselling services, which operate out of more than 40 locations throughout the country. All services also provide access to post-termination counselling and a number provide free post-termination medical check-ups. The national maternity strategy pointed to the need to improve access to mental health supports and to that end a number of its recommendations are relevant. The maternity strategy implementation plan addresses the issue and sets out specific actions to identify women at risk and ensure that they get the necessary support during their pregnancy and postnatally.

Earlier I referred to the national standards for bereavement care following pregnancy loss. I draw members' attention to the fact that they were published last year. We anticipate that the standards will drive the development of clinical and counselling services within our maternity services overall. The standards describe the standardised structures, clinical processes and compassionate responses that should be in place across maternity services for parents who experience a pregnancy loss or a perinatal event. The standards will also apply in situations where there is a diagnosis of foetal anomaly that may be life-limiting or fatal. The linkages between maternity bereavement care and other hospital and associated services such as primary care, public health nursing and palliative care are also outlined in the standards. Each hospital will have to have systems in place to ensure that bereavement care and end-of-life care for babies are central to the mission of the hospital and organised around the needs of babies and their families. The implementation of the standards has begun and teams are being established in each maternity unit and hospital around the State.

The HSE is today launching a perinatal mental health services model of care for Ireland. I expect we will hear something more about this from contributions by colleagues in the HSE. I note that the model of care is closely aligned with the national maternity strategy, and contributes to the implementation of the strategy's actions on mental health. The model is based on the maternity networks that I spoke of earlier. This means that specialist perinatal mental health services will be aligned within hospital groups and developed to provide for each of the 19 maternity units. It is a significant development in addressing the mental health needs of women both during pregnancy and in the year following delivery.

The Citizens' Assembly recommended that further consideration should be given as to who will fund and carry out termination of pregnancy in Ireland. I will preface my remarks here by pointing out that action in this area will be subject to deliberations of this committee and

further deliberation by the Oireachtas on recommendations this committee decides to make. It will also be subject to the outcome of the referendum which the Government has committed to holding next year.

Terminations of pregnancy carried out in Ireland at the moment, under the Protection of Life During Pregnancy Act 2013, are limited to the 19 public hospital obstetric units. That is to say, they are only done in the public system and are funded by the State. It was appropriate that terminations in this context took place in obstetric units to ensure all the expertise and facilities appropriate to provide safe medical services, and ancillary services, to pregnant women whose lives were at risk and to the unborn.

Other than in emergency situations, doctors who can certify or permit access to a procedure under the Act must be registered by the Medical Council in its specialist division. At the moment, a termination of pregnancy may only be carried out by or under the supervision of a consultant obstetrician. This is irrespective of whether the medical procedure for carrying out the termination is by medical or surgical means. On the point about medical terminations of pregnancy, I must note that there are currently no medicines indicated for the termination of pregnancy currently authorised for that specific use in Ireland. In the event of any change to the Constitution and to legislation around access to such services of drugs for medical termination, it would be the responsibility of the manufacturers of such medicines to seek - as they do - a marketing authorisation for such use in Ireland. This would be in line with the normal procedure for authorising any medicines to the Irish market. Members are aware that the Health Products Regulatory Authority, HPRA, is the competent authority responsible for the regulation of human medicines in Ireland. It has a structured assessment procedure in place for conducting this assessment process.

If there is a change to the eighth amendment and if the grounds for termination of pregnancy are widened from what is currently provided for, then this will have implications for the health service provision. Pending a decision on the policy direction, the Department of Health is working with the Office of the Attorney General and the Department of the Taoiseach to explore and research the constitutional and policy issues involved so that as much preparation can be done and drawn upon in the context of any recommendations or decisions that are made over the coming months. Once direction is clear, consideration will be given to the issue of funding and carrying out terminations of pregnancy in Ireland, and to drafting further legislation in order to ensure access to such services and good quality outcomes.

I thank the Chairman and her fellow committee members for the opportunity to address the committee today and I wish the Chairman well with her work. I also look forward to the report. I am available to answer any questions that members may have.

**Chairman:** I thank Dr. Holohan. We will move on to the next contributor before we take questions.

**Mr. Liam Woods:** I thank the committee for the invitation to attend the meeting. I am joined today by Dr. Peter McKenna, Mr. Kilian McGrane and Ms Angela Dunne from the national women and infants health programme and by Ms Janice Donlon, who is with the sexual health and crisis pregnancy programme.

In my submission to the committee I have addressed the points raised by the committee in correspondence with the HSE. With regard to improvements being made to counselling and support facilities for pregnant women during pregnancy, perinatal mental health features

strongly in the national maternity strategy recognising the potential impact it has on the mother, baby and the wider family. The national women and infants health programme implementation plan sets out a series of actions aimed at identifying at-risk women, and ensuring that they get the appropriate support throughout their pregnancy and during the postnatal phase. These actions include the appointment of clinical midwife specialists in each of the 19 maternity hospitals or units, to support and train midwives in identifying and supporting at-risk women and the recruitment of additional perinatal psychiatrists, so that each maternity network has a minimum of one perinatal psychiatrist. In line with the perinatal mental health model developed by the HSE's mental health directorate, a hub-and-spoke model will exist within each maternity network, with the psychiatrist based in the tertiary facility accepting referrals from individual units, and supported as required by local liaison psychiatry. Another implementation action is the training of all staff working in maternity hospitals or units to identify women at risk at booking appointments, or throughout their maternity journey, and in particular those with a mental health history.

While these developments are resource-dependent, the implementation process will commence with the launch of the HSE's implementation plan for the national maternity strategy. Perinatal mental health is a significant priority for the programme. The actions in the implementation plan will focus on providing the necessary support and counselling to women who are showing signs of stress and anxiety at the lower end of the spectrum, as well as those who have an underlying history of mental illness in the higher risk categories. The pathway for women will depend on the risk classification from their assessment. The model of care for perinatal mental health is being launched today by the mental health division of the HSE and we will arrange for information to be provided to the committee on its content. I have copies of the printed document from that session which I will provide to the clerk if that is helpful for committee members.

The model of care is based on the maternity networks recommended in the national maternity strategy. This means the specialist perinatal mental health services will be aligned to hospital groups and developed in a hub-and-spoke format so all 19 maternity services are included in the model. An allocation €1 million has been made in 2017 to start three specialist perinatal hubs in Galway, Cork and Limerick hospitals and to expand the small existing teams in the Dublin-based maternity hospitals - the Coombe, the National Maternity Hospital and the Rotunda. A further €2 million has been allocated for 2018 to complete each of these six hub teams. The model of care recommends the establishment of a national mother and baby unit. This will require further investment.

In August 2016, the HSE launched the national standards for bereavement care following pregnancy loss and perinatal death. These standards set out the care that families can expect following a maternity-related bereavement. An implementation team has been established and a clinical lead and programme manager have been appointed. The implementation team are visiting all 19 units to support the implementation of the standards. In 2016, resources were secured to appoint a clinical midwife specialist in bereavement to all maternity hospitals and units that did not already have one. Recruitment to fill these important posts is currently under way.

The provision of services and supports to women and their families experiencing a crisis pregnancy is part of the remit of the sexual health and crisis pregnancy programme, which is one of a number of national programmes led by the health and well-being division of the HSE. My colleagues, Janice Donlon and Helen Deely, made a presentation to the committee on the work of the programme on 15 November 2017, and Ms Donlon is here today to provide any fur-

ther inputs the committee may require. The programme presented on the current provision of counselling services in Ireland as funded by them and the range of supports available to women both during a crisis pregnancy and following termination.

The members will be aware from the presentation that the HSE programme currently funds 15 individual crisis pregnancy counselling services, which operate out of 40 plus locations nationwide to provide free crisis pregnancy counselling. These services are in a mix of rural and urban locations. Details of these crisis pregnancy counselling services can be found on *www.positiveoptions.ie*. Crisis pregnancy counselling and the provision of information on all three options - parenting, adoption and abortion - is provided under the legal framework of Regulation of Information (Services Outside the State for Termination of Pregnancies) Act 1995. The Act sets out how information about legal abortion services outside Ireland may be given to individuals or groups in Ireland.

All women should have the same standard of obstetrical care, including early scanning and testing. That was the subject of the committee's second question to us. The national maternity strategy, Creating a Better Future Together, sets out the roadmap for ensuring that all women can access standardised high-quality, safe care regardless of location. The HSE has developed and published an implementation plan for the national maternity strategy which seeks to address the current regional variations in provision of anomaly scanning as part of the overall approach. The implementation plan will be overseen by the HSE's national women and infants health programme, NWIHP. The HSE's maternity services will be managed through maternity networks, with larger tertiary centres working collaboratively with smaller regional centres.

The provision of a dating ultrasound in the late first trimester, 12-14 weeks, followed by a detailed foetal anomaly scan at 20-22 weeks is a recognised component of good antenatal care. Currently only seven maternity hospitals or units offer 100% of women access to anomaly scans, and five units do not offer any access. As part of the implementation plan for the national maternity strategy, the NWIHP has identified the need for an additional 52 sonographers to support the provision of both dating and anomaly scanning in all 19 maternity hospitals or units. In 2018 the priority will be on improving access for anomaly scanning, and funding for approximately 40 additional sonographers, subject to the approval of the HSE's national service plan for 2018, will be provided. Sonographers are a difficult grade to recruit, and if suitably qualified personnel are not available, existing staff will be trained to develop the required capacity. While this will take time, the recruitment of the additional staff will improve access. Further consideration should be given to who will fund and carry out terminations of pregnancy in Ireland. That was the final query. In the first instance this will be a policy matter for the Department of Health in the event of any changes in the legislation being passed in the future, following which the HSE may be invited to submit additional service proposals for funding through the HSE's annual service plan and Estimates processes.

This concludes my opening statement and with my colleagues we will endeavour to answer any questions the committee may have.

**Deputy Bríd Smith:** There is quite an army of witnesses here today to make the case. I thank them for coming in.

My first question is for Dr. Holohan. He said something that made me bristle. He told us he is working with the Office of the Attorney General to explore the constitutional issues and consider framing legislation. This committee is working hard to consider the outcomes of the Citizens' Assembly, to adjudicate on them and make some decisions that we can bring back

to the Dáil after we complete our report on 20 December. We, as elected representatives, will recommend what we think should be the structure of future legislation that can be put to the people in terms of a referendum, to accept the recommendations of the Citizens' Assembly, or put forward other proposals, or not. How does this marry with the job Dr. Holohan is doing with the Attorney General's office in framing legislation and effectively putting the cart before the horse?

**Dr. Tony Holohan:** We are doing no more than the Minister has said in public. We are considering what he and we have described previously as all the scenarios that might arise. We have considered the work of the Citizens' Assembly, tried to imagine any scenarios and tease out what it might mean were the Oireachtas or the committee to recommend in favour of any given option. We are trying to see what the different models might be and how they could be made to work in legal and service terms, without pre-empting in any sense any decision to be made. This will ensure we are in a position, when the committee has made its determination and recommendations, when the Oireachtas has had an opportunity to debate them and the Government has made a decision on this, to move as quickly as we reasonably can, whether we are going to legislate, or make constitutional change, to deal with the issues that might arise and put those decisions effectively into place. It is no more than trying to see around the corners as much as possible. We are not pre-empting the work of this committee or the legitimate work of the Oireachtas and ultimately the say of the people on any decisions to be made.

**Deputy Bríd Smith:** To put it simply, Dr. Holohan will have a menu of different legal options that may have to apply if this committee recommends A, B, C, D, or whatever. The Citizens' Assembly made 13 recommendations and we do not know what the outcome of a referendum might be, if one were held, or indeed what the question might be.

**Dr. Tony Holohan:** We are trying to see as many of those scenarios as possible and to consider what the Citizens' Assembly has said but not to confine ourselves necessarily to those if we think other things might arise that we have to have thought through. It is not in any sense to place any value judgment or priority on any of those but to say what it would take to make it operational. The decisions are not for us. They are ultimately for the committee in respect of its recommendations, for the Oireachtas in respect of what it considers and in respect of the Constitution for the people.

**Deputy Bríd Smith:** Dr. Holohan is getting ready for what we might say.

**Dr. Tony Holohan:** As the Minister said, we are simply preparing to ensure that when those decisions are made and a requirement might arise for legislation to be put in place, we are able to get through that work as expeditiously as possible.

**Deputy Bríd Smith:** One of the recommendations of the Citizens' Assembly in the ancillary module, which we are considering, was that obstetric services should be available to all women, regardless of location, socio-economic position etc. I found it fascinating that the British Pregnancy Advice Service was able to show us statistically that women who went from Ireland to Britain for abortions very often came back and were not able to afford follow-up contraception that was permanent and of a barrier nature because, for example, a coil would cost €250, an implant €250, or a cap €120. They would already have forked out in the region of €1,500 in travel, accommodation and having a procedure in Britain. Is the Department considering the recommendation of the Citizens' Assembly on the provision of permanent methods of contraception for women after a crisis pregnancy, or indeed before, in other words, the provision of full obstetric medicine available to all women and girls in respect of how we might deal

with crisis pregnancy?

**Dr. Tony Holohan:** In response to the question on crisis pregnancy, we can go into detail about some of the services that are provided. In respect of the scenarios we are trying to envisage in trying to see around the corners in as much as we can, we are trying to ensure that we consider things from a service point of view and what will need to be in place to ensure that, whatever form of legislation might be enacted, whatever form of constitutional change might take place, the legal and service implications of that can be made to operate, and to understand what that would mean in service terms. That may or may not take us into some of the issues that the Deputy is talking about.

**Deputy Bríd Smith:** There is evidence that the abortion pill is being used increasingly frequently by women in this country. It is accessed illegally and a woman is criminalised for accessing it, with a potential sentence of up to 14 years. Could Mr. Woods comment on the ranges of support that he said in his presentation are available during a crisis pregnancy and following termination? If a woman has accessed an abortion pill illegally and has had a medical termination, albeit at risk to her own health because it is unsupervised, how is she going to present herself to a general practitioner or another medical service if she has committed an illegal act? Where is the follow-up treatment for this woman or cohort of women? Mr. Woods says that the HSE funds and supports a range of services but it is impossible to give a woman who has committed an illegal act that could put her at risk of a sentence of 14 years follow-up services. Would he comment on that?

When Mr. Woods says all women have the same standard of obstetrical care, will he comment on how much of that care is available to migrant women, asylum seekers, women in direct provision who do not have the language, the skills, the access or the finances to access obstetric care and if they are treated differently from others?

**Mr. Liam Woods:** As the Deputy identifies, the mental health service and the model of care published today is intended for all women and there is no exclusion. I understand her point but in respect of care provision, the overall service is available to all women and that is the intention. We are investing in that at the moment.

Does Dr. Holohan have any observation on the point about women coming forward?

**Dr. Tony Holohan:** If women or anybody else in the population present themselves with a health need, irrespective of how it has occurred, that health need will be met without judgment on the part of the practitioners who are presented with those women. That is what we would expect. It is not the role-----

**Deputy Bríd Smith:** That is reassurance from the Chief Medical Officer-----

**Dr. Tony Holohan:** Yes.

**Deputy Bríd Smith:** -----to all women who use the abortion pill that they should seek follow-up care without fear.

**Dr. Tony Holohan:** If I can speak for the general practitioners - or presume to - that is one example of how the front-facing part of our health system will respond to the health needs of women on the basis of what those health needs are and not in respect of how those health needs have arisen.

**Deputy Bríd Smith:** They will be judged not on the fact that they have committed a crime in the eyes of the law.

**Dr. Tony Holohan:** The role of the health services and practitioners in the health service is to provide services and not to make judgments about individuals.

**Deputy Bríd Smith:** However, doctors could also be subject to that.

Do I have one minute left?

**Chairman:** My timer just broke down, so I will give the Deputy another minute. She can take advantage.

**Deputy Bríd Smith:** The presentations are full of worthy aspirations. In one part the HSE admits it will need 52 new people trained in scanning throughout the 19 maternity units to provide services that would be required depending on outcomes. Over the summer, 11 beds in a mental health unit for young people in Cherry Orchard were closed because the health service could not retain the nurses because they are not paid adequately. What is the HSE's plan to fund this wonderful aspirational improvement in obstetric medicine for women? I am all for it but the HSE will not pay nurses adequately. There is evidence of trained psychiatric and other nurses leaving the country because they are not getting proper wages. What is its plan to get these staff to train and stay?

**Mr. Liam Woods:** In answer to the Deputy's previous question, we also fund translation services to assist in access for people who may not have English as a first language. As she rightly identified, we have funding for 40 posts. Within the acute division, in the hospital sector, we are increasing our nurse numbers. As we flagged in our statement, sonographers are a difficult grade to get and we may have to train current staff in sonography. If we need to do that, we will do so. Our experience is that when we have the resource we can put the posts in place. In this instance we have the resource. Therefore all our efforts will go into recruiting and retaining those staff.

**Deputy Bríd Smith:** Mr. Woods has stated the HSE provides language services for migrants. Does it provide other obstetric services for them in direct provision centres?

**Mr. Liam Woods:** I would need to revert to the Deputy in terms of the centres themselves but the same services are available. I do not know if Dr. McKenna might have anything to add to that. The same services are available to all women.

**Chairman:** We need to conclude because we are at 11 minutes. We have time for a response.

**Dr. Peter McKenna:** I agree with that. I am unaware of women being denied anything because of their status in the country.

**Deputy James Browne:** I welcome the news of the launch of the special perinatal mental health model. As far as I know there are only three part-time perinatal psychiatrists in the country and all of those are based in Dublin. There is no mother-and-baby unit for severely depressed mothers or mothers with other perinatal mental health difficulties. It is difficult to believe that in 2017 we have such poor support for pregnant women. It is well understood that the consequences of not having proper support for pregnant women and postnatal women can be very serious in the short, medium and long term, even up to fatalities.

Why has pregnant women's mental health been largely ignored to date? We know that mental health services tend to be the poor relation of health services. Even within mental health services, perinatal mental health support seems to be at the bottom of the list of what has been provided to date.

We have A Vision for Change. We are in year 11 of a ten-year plan with approximately 72% to 75% of it implemented. What enforcement will be applied to ensure this plan is implemented? Is there an implementation body? Who will oversee its implementation? Will there be quarterly reports to ensure it is implemented and if it is not being implemented will there be accountability for its lack of implementation or certainly explanation as to why it is not implemented? Is there a step-by-step roadmap for its implementation?

Further to what Deputy Bríd Smith said, how will the HSE recruit and retain the staff? While plans are great, certainly in mental health there seem to be extreme difficulties in getting staff into place and retaining them. For example, psychiatric nurses are under huge pressure because of the lack of staff to support them. They are extremely stretched. They are coming under severe mental health pressures.

If the people vote in a referendum to change the system we have, how will terminations be facilitated? How will the HSE facilitate the necessary staff training? Are the facilities in place at the moment? If not, how will the HSE meet those demands and needs?

**Mr. Liam Woods:** Recruitment of perinatal psychiatrists is challenging. The Deputy is correct in saying that we are limited to the three part-time Dublin-based posts. As we said on our opening statement, we have funding to recruit additional psychiatrists. That will be a challenge. In the mental health services at large that has been a significant issue. We have had more success in recruiting psychiatrists in the acute area than we have into the community. We hope that we can use that to advantage in terms of attracting people back. I would not underestimate or understate the challenge.

The Deputy referred to A Vision for Change, monitoring against a plan, a roadmap for success, timescales, deliverables and reporting against that. The national women's and infants programme within the HSE service plan is monitoring the implementation of these developments. Some of them will also fall to be considered within the mental health division of the HSE. There is a process for that and we report on it. The Department of Health holds the HSE to account for our implementation of new services when new funding is provided. That is typically reported on within our published reports that we put online quarterly. We also report back to the Oireachtas committees and elsewhere. There is a process in place to monitor implementation and that is clear. I would not underestimate the challenge. It is something we have in place and we hope to progress that.

Recruiting any consultant is typically a 12-month journey. A fair amount of effort is required to attract consultants back. It is about attracting back consultants. Typically that will happen over 12 months. There are processes in place for that. We have increased the overall consultant numbers. The number in the acute division is up by about 59 year-on-year at the moment. We have a process. We will have to run that and see where it brings us - hopefully it will be successful.

Regarding capacity, as I said at the end of the statement, the HSE, as with any service, will respond to legislation in terms of scaling service requirement and costing that and submitting such costing and service requirements to the Department of Health based on a model of care as

and when that is required. That is our normal business and we would do that.

The HSE already has extensive training in place across a range of services. We would simply need to expand to cover these particular issues.

**Chairman:** The Deputy has four minutes left.

**Deputy James Browne:** I asked my questions too quickly.

The implementation body for A Vision for Change was regrettably abandoned under the previous Government. I have argued that the implementation body should be re-established. If it was - I understand there is no similar implementation body for this programme - would or could this come under it?

**Mr. Liam Woods:** The recruitment of perinatal psychiatrists could be included in it. In reality, we see it as primarily being implemented and monitored under the women and infants programme. Mr. Kilian McGrane, Dr. Peter McKenna and Ms Angela Dunne are part of that work. It is part of the HSE and the reports are to its acute division. A plan has been set out with these actions and there can be reports against them which can be made publicly available. Mr. McGrane might have his view, but I believe it would probably nest better within the overall women and infants programme because it is related to other actions under that programme.

**Mr. Kilian McGrane:** It is not just psychiatrists who will be recruited but also clinical midwife specialists in mental health. I am not suggesting they will be easier to get, but it is a post in which there is a lot of interest. We are not sure of the exact numbers until the service plan is finalised, but the aim is that there will be a minimum of one in each of the 19 units. That is an important part of the development which allows us to provide the first point of access. It also allows us to support midwives who are interacting daily with women, identifying needs and the referral pathway onwards. That is where the psychiatry service comes into it.

On the reporting component, we will be submitting reports regularly to the Department, but there is also a requirement for us to produce an annual report, which requirement is set out in the national maternity strategy. We produced an annual report early in 2017. Obviously, there was no programme office in place in 2016; therefore, the annual report was quite light. However, the 2017 annual report that will be published in the middle of the second quarter of 2018 will detail what we have done to date in 2017. It will include any development in the area of perinatal mental health.

**Senator Rónán Mullen:** I welcome the delegates and thank them for attending. One of them mentioned that in his work in the Department he was preparing for various scenarios, depending on what the Government and the Oireachtas eventually proposed. I ask him to direct his mind to another scenario when a referendum is held and the people decide to uphold the *status quo* to protect both babies and their mothers during pregnancy. I ask him to consider whether there are changes that will be required in that regard.

According to the figures presented to us many times, our birth rate is approximately one tenth of that in Britain. Were we to have an abortion rate one tenth of that in Britain, there would be 19,000 or 20,000 abortions per year. On the best evidence available from British figures for the number of Irish women having abortions in Britain, the very small number who do so in the Netherlands and if one were to allow for 1,000 or 2,000 people importing abortion pills, one is talking about between 3,000 and 5,000 abortions, which is one quarter of the rate in Britain. Do we have any knowledge of what has contributed to this? Is there evidence that the

provision of State-funded counselling, for example, is a contributory factor? Has it to do with the increased use of contraceptives? The figure has been declining, on the basis of the information available on the number of women having abortions in Britain. Has it to do with increased awareness? The emergence of 4D ultrasound scans has increased awareness of the wonder of life in the womb and its complexity and development from its earliest stages. Is there a new awareness of it? Any information in that regard would be helpful.

I wish to ask about non-directive counselling, about which I asked questions on a previous occasion when representatives of the crisis pregnancy programme appeared before the committee. I am operating from the understanding non-directive counselling is one of the many approaches that can be practised and is respected in the general area of counselling. Obviously, where one does not give an instruction on how to proceed, non-directive counselling clearly has its limitations. For example, I cannot imagine that it would be appropriate when counselling a person who is suicidal.

My question is in the context of the Constitution pledging that the State, as far as is practicable, will defend and vindicate the right to life of the unborn and there being a great deal of public messaging on matters such as obesity, drink-driving and so forth which is directive in seeking to protect not only oneself but also potential third parties who could be hurt by one's actions. In addition, I note what the 1995 Act states, as discussed on a previous occasion. There does not appear to be a definition or a requirement in law that counselling be non-directive. The 1995 Act states counselling must not take a form or manner which advocates or promotes the termination of pregnancy. Interestingly, as far as I am aware - I am subject to correction - there does not appear to be a counterbalancing injunction that counselling must not take a form or manner which encourages the protection of the unborn. Has any consideration been given to whether what clearly appears to be the preferred mode of non-directive counselling, in the context of the provision of State funding, is actually constitutional, having regard to the fact that the Constitution states in law and policy that there are two human beings to be protected? Has there ever been any discussion about whether the requirement for undefined non-directive counselling in some way offends the spirit of the Constitution? Having regard to the fact that some State funded pregnancy counselling organisations have a strong stated agenda to promote legalised abortion, it appears to be tilted in the other direction. On a previous occasion I drew the attention of the committee to how counsellors with the Irish Family Planning Association and other organisations, as reported in the *Irish Independent*, had been found in some circumstances to have been giving women dangerous advice which included telling them to lie to their doctor if they suffered complications after an abortion and to say they had had a miscarriage. In some cases women had been given information on how to access the abortion pill. I wonder whether non-directive counselling has been used as a cover, if anything, to push women towards having an abortion. Clearly, there is a block on counselling to encourage, not coerce, the taking of the life-saving option. Will the delegates tell me if the provision of non-directive counselling has been considered in terms of its constitutionality and whether there are other ways by which it could be done?

**Chairman:** The delegates can answer the questions, but we will have legal advice next week on the point raised by the Senator last week about non-directive counselling.

**Senator Rónán Mullen:** Have we not received some already? I was relying on it.

**Chairman:** We are getting more. We have received written advice. We will be briefed orally.

**Senator Rónán Mullen:** Thank you.

**Chairman:** We will have an opportunity to liaise with our legal adviser on that issue.

**Senator Rónán Mullen:** I meant to say in passing that after our previous exchange, I sought information, as it did not appear to be defined in law.

**Dr. Tony Holohan:** My apologies, but I must confess that I am not clear on what the first question was. The second was related to non-directive counselling. I am aware that the issue arose previously.

On the specific issue of whether consideration has been given to the constitutionality of what happens, if I am summarising the Senator's question correctly, it might well be the case that such issues were considered before my time because this relates to the 1995 legislation and a previous amendment. Other than it arising at the committee in the recent past, I am not aware of the question having arisen. Perhaps my colleague from the HSE, Ms Janice Donlon, who has addressed some of these issues in the past, might wish to add to what I have said.

If I was clear on the first question, I would be happy to answer it.

**Ms Janice Donlon:** I reiterate what we have presented to the committee on the non-directive, non-judgmental counselling provided with the funding provided through the HSE. It is good practice to provide that counselling for an individual. If I am right, the abortion information Act also states that if information on abortion services abroad is to be provided, it must be provided in a counselling session in which all options are explored. All options, including parenting and adoption, must be explored before the option of having an abortion is discussed. If requested by the client, it is discussed and under the legislation information can be provided. Non-directive counselling goes back to the good counselling practice. It is a matter of neither directing nor guiding an individual towards a certain pathway but rather making it the decision of that individual as to which pathway they may take.

**Senator Rónán Mullen:** My first difficulty concerns who it is who defines what good counselling practice is. Second, the term "non-directive" is not defined in legislation and yet it seems to be thoroughly relied upon. Third, from what Ms Donlon has said, she does not seem to have regard to the particular constitutional context, which is that there are two lives to be protected. I am not promoting coercive counselling now but I find it very difficult to understand the role of non-directive counselling. I find it strange, especially given that the non-directive approach is not the approach that one would adopt with someone who was suicidal. This would clearly not be a matter on which one would be neutral; it would not just a be a case of the good choice being whatever choice the person is fully informed about. That is clearly not the answer when counselling someone who is suicidal. I am not expert in this area and I am open to correction.

**Deputy Kate O'Connell:** The Senator's expertise is in gynaecology.

**Senator Rónán Mullen:** Where there is a life to be protected then, how can there be this reliance on a vague notion on good counselling practice? Who says?

**Chairman:** I will ask Dr. Holohan to come back in on that.

**Dr. Tony Holohan:** I would place this in the more general context of professional practice, irrespective of who the professionals are. What we as a society expect of professionals is that

the way in which they inform and support people in making decisions is to give them the necessary information to help them make those decisions. This is very much in conjunction with the person in any clinical sense. I am not talking about the particular situation outlined by the Senator, I am talking about any context. The days of the paternalistic practice of medicine and health care, when doctors, nurses or anybody else made decisions for people, are at an end as far as we are concerned. The expectation, particularly in professions like medicine where these ethical codes exist, makes it clear that the role of practitioners is to support people in making decisions and to give them the information as necessary to make those decisions. This applies to every clinical situation and not just to the one the Senator is talking about.

**Senator Rónán Mullen:** Does Dr. Holohan accept what I am positing about the exception being suicidality? A professional would hardly be non-directive there, would they?

**Dr. Tony Holohan:** In what respect? What type of medical intervention is the Senator talking about?

**Senator Rónán Mullen:** I am talking here about what might happen if a person with suicidal tendencies sought counselling. This is a very delicate area and I acknowledge that I am a layman. I might be wrong but I also think it is the case that the HSE, or officially approved websites at least, encourage people not to look at videos, for example, and that seems to me to be quite directive advice.

**Dr. Tony Holohan:** Even in the context of something like suicide, which is a very challenging issue to deal with from a medical practice point of view, practitioners engage with patients rather than coerce or prevent them from doing things. It is only in very express situations that people's liberty to make decisions-----

**Senator Rónán Mullen:** I made it very clear that we are not talking about coercion or prevention.

**Dr. Tony Holohan:** Yes. In those situations, interventions are very much about supporting and providing treatment, including counselling and medical treatment and so on, in respect of suicide.

**Chairman:** One last point.

**Dr. Tony Holohan:** Unfortunately, in most situations where suicide actually occurs there is no opportunity for a medical practitioner to make an intervention of the kind the Senator is describing.

**Senator Rónán Mullen:** I think that people who are suicidal do go for counselling.

**Dr. Tony Holohan:** No, I am talking about actual suicides.

**Senator Rónán Mullen:** I am talking about people going for counselling and the context in which the non-directional approach does not seem to be the only show in town. Let us go back to my first question, which concerned the apparent disparity in abortion rates between Ireland and abortion jurisdictions. I would like the witnesses to comment on whether there is evidence to show what they think might be causing the difference. Do they think that this is down to State-funded counselling?

**Chairman:** I will allow a response and then that will be it.

**Dr. Tony Holohan:** If I have understood Senator Mullen's question correctly, when it comes to the factors that explain a different rate of different experiences in different countries, irrespective of what those experiences are, the relevant role of different factors can vary. I would like to think that one of the reasons why we are making progress is that we have improved the quality of education and training and the understanding of the access that people have to a variety of services that they did not have 20 years ago. These make a positive contribution.

**Senator Rónán Mullen:** Have there been any studies?

**Dr. Tony Holohan:** There have been many studies.

**Senator Rónán Mullen:** Have there been studies on what makes the difference?

**Chairman:** I will take a response from Dr. Holohan and then I am moving on to the next member.

**Dr. Tony Holohan:** Is the Senator's question a more general one? He is essentially asking about the epidemiology of pregnancy in two different countries, the experiences involved and what compares and cross-compares. I cannot give a comprehensive account of that in the time available to me. Those factors have been studied, however, and are studied internationally.

**Chairman:** Perhaps this is something that could be followed up on by another questioner.

**Dr. Tony Holohan:** I refer to the basis of some of the specifics that would have fed into the development of a sexual health strategy, for example.

**Chairman:** Deputy O'Connell has ten minutes.

**Deputy Kate O'Connell:** I thank all the witnesses for coming in here today. I am familiar with some of them from many meetings of the health committee. I am a firm believer in prevention being better than cure. Looking at the report on folic acid as a preventive measure against birth defects in Ireland, for example, I note we actually have an increase in neural tube defects in this country. Such defects encompass spina bifida, though I do not need to tell Dr. Holohan that, of course, and many other things that might sometimes be classed as fatal foetal abnormalities. It looks like we are an outlier with regard to European standards and I am quite concerned by that. From what I have read, the rate seems to be increasing disproportionately in Ireland. The report contained options for the prevention of neural tube defects in Ireland. How are we getting on with that? I would like to see folic acid, a very safe and cheap B vitamin, being more readily available than it is currently on the GMS scheme. Many pregnancies, though not necessarily a crisis, are unplanned and from my own work as a community pharmacist, I am aware there is a huge amount of ignorance around folic acid. I have spoken before about people just using up the vitamins that are in the cupboard and then not getting around to buying a packet of folic acid until week 14 or so. Could the witnesses speak about this and about what we are doing in this area? If we can try to prevent neural tube defects we will then have healthier babies and ultimately fewer terminations. That is what we are all about here.

My second question arises from a point in Dr. Holohan's presentation about the medical professionals involved in the Protection of Life During Pregnancy Act 2013 being on the specialist register. Looking at international examples, my view would be that one would not need to be a specialist in the provision of medical abortion and that some of this could be done through the GP and the pharmacy. Thinking forward and assuming that the eighth amendment might be repealed, perhaps Dr. Holohan could offer this committee some advice on this matter in order

that we do not end in a situation where we need 15 doctors and three psychiatrists for a woman who is six weeks pregnant and looking for a termination. That would obviously be completely unworkable.

I would also like someone to comment on the current situation. Professor Veronica O'Keane, a professor of psychiatry, appeared before the committee and she spoke about her concern over patients with complex medical and psychiatric needs travelling abroad without their medical files or without a conversation. How does Dr. Holohan, as Chief Medical Officer, feel about this? Is there anything that we can do in the meantime, within our constitutional restrictions, to try to ease some of that pain? Is there anything we can do in the interim period before there is a referendum in this country? This is something about which I am quite concerned.

I was going to talk about contraception but I know that Deputy Bríd Smith-----

**Chairman:** I am going to allow two answers and then let Deputy O'Connell back in.

**Deputy Kate O'Connell:** I thank the Chairman.

**Dr. Tony Holohan:** In response to the first question, I completely agree with the Deputy's points about folic acid, the importance of the lack of an understanding that one would like to think exists and the measures that must taken in this regard. I know of a variety of different mechanisms in place here, not least the work being done through the women and infants programme, which is led by a number of obstetricians. Professor Turner, of whom the committee may be aware, is doing work on the development of guidelines on folic acid to deal with the very concerning increase in this country in the incidence of neural tube defects. There may be other factors to explain why we are seeing this increase but the use of folate is certainly not at the level at which we would wish it to be. This is a question that we have looked at and will continue to look at at a policy level, particularly in terms of the public health measures that could be taken to deal with this. I am conscious that I am in the presence of someone who is far more expert than myself in these matters, namely, the former Master of the Rotunda, Dr. McKenna, and he may be in a position to add something to what I have said here. I will deal with the other questions and then hand over to Dr. McKenna.

Members may be aware that the specialist register is essentially a mechanism through which specialist registration can be recognised in a number of different specialties, which are organised at European level. General practice is one of those specialties, so a doctor on the specialist register who is a general practitioner is covered. If the change in law was such as to enable both access to prescription and the dispensing of medicines, the types of services that have been described are well within the sphere of competence of a doctor who is on the specialist register in general practice.

On the question of complexity, in the current situation, a doctor who is in possession of medical records relevant to the care and treatment of a woman who is receiving services elsewhere is allowed to make those records available, if it is wished for. In a more general sense of course, in the case of anybody who has a medical procedure in one jurisdiction and travels in short order to another jurisdiction, the general concern one would have as a medical practitioner for the person's health and well-being would be significant.

**Dr. Peter McKenna:** Many pregnancies are unplanned, which is not to say unwanted, and it is unrealistic to expect people who are not planning to get pregnant to take medication in case they do so. In many countries this is solved by fortifying a common food ingredient-----

**Chairman:** Wheat, for example.

**Dr. Peter McKenna:** Yes. Flour is fortified. I am not quite sure what the difficulty was when this was explored here. It has been some time since I looked into this, but there was a problem here.

**Deputy Kate O'Connell:** The problem concerned the safe upper limits of water-soluble vitamins. The nerd in me is coming out.

**Chairman:** This is something I am very interested in and did a press release on recently. The arguments against it are in line with the fluoridation arguments. Obviously there are a lot of people who do not like the mandatory fortification of flour. It is complex enough, even though it seems very simple on the face of it. I am sorry to interject.

**Dr. Peter McKenna:** That is really the point. What appears to be a very simple solution, fortifying a staple food, will immediately run into difficulties and arguments. The converse is that one cannot expect people who are not planning on getting pregnant to take a tablet every day. That is not going to happen.

**Deputy Kate O'Connell:** The licensing of abortion pills was mentioned. I am concerned about the cost of a drug licence in Ireland, and the relatively small number of users, if we are using the figure of 5,000 terminations a year. I wonder if someone will actually seek a licence to manufacture it. It is something that may not be in the witnesses' remit. Drug companies are only interested if there are lots of people. I am also concerned about the protection of doctors, if no one gets a licence for it and it is used in an unlicensed way. I am trying to deal with the pitfalls. Would a witness like to comment?

People have spoken about the 20-week anomaly scanning. I refer to the maternal blood test that can be done at eight to nine weeks. I am not sure of the name. I know there is a brand called Panorama, but I am not sure if that is the actual technical term. Is that being examined within the maternity strategy and the increase in services? We have heard that is available in other countries. I cannot remember the figures from last week, but in Holland even if a woman cannot afford it, somebody sorts it out. Is early diagnosis of chromosomal abnormalities, etc., being examined as part of the wider scanning and diagnosis?

We have also heard in the health committee about the upskilling of nurses so that they can do specialist ultrasound work. Perhaps a witness could update us on how we are getting on with that. We spoke about it last year. For me, and I am sure for many women in this country, it is refreshing to see that the woman is at the centre of the maternity strategy, and I wish the witnesses the best of luck in rolling it out.

**Dr. Tony Holohan:** Regarding the licensing question, the potential costs and so on, I would only be speculating if I was to answer the question. I do not have the expertise to make a speculation on that. Some of the medicines are already in use in the State but for other purposes. Whether that would have any bearing on what would ultimately be commercial decisions, I cannot say. In respect of the next question, perhaps Dr. McKenna would like to offer a view.

**Dr. Peter McKenna:** In response to the last question, I note that one of the drugs commonly used, Cytotec, is very freely available here for another purpose. It is used routinely, or very frequently, in an obstetrics situation off-licence. I cannot imagine that not getting a licence would be an impediment to these drugs being used.

The other issue members raised, namely, Panorama and Harmony non-invasive pregnancy tests, is something of which we are very much aware. We were not asked whether we should go down the route of scanning or this route. Rather, it was mandated that 20-week scanning to look for anomalies was to be introduced, so that is the priority. However, in parallel to that, in time, these tests will be normalised, and should be available to everybody. When they were introduced three or four years ago they were very expensive. Each test cost about €900. That cost tumbled, and now it is about a third of that. I would expect that the more it is ordered the cheaper it becomes. I would envisage a situation, hopefully in the not too distant future, where this would be broadly available throughout the country. I totally agree that it is the way forward, and it is standard of care in some other countries.

**Deputy Kate O'Connell:** They are very helpful, especially for people who have had difficulties in previous pregnancies. They are able to have a maternal blood test done at eight weeks and know that everything is all right, so they are not waiting and dealing with the unknown. We talk about perinatal mental health, and I think the Harmony or Panorama tests offer great comfort to families.

**Mr. Kilian McGrane:** Specialist midwives were referred to. We have a hybrid model with sonography at the moment. We have radiographers and a number of midwives who are in training. If we cannot recruit radiographers, we have midwives who are willing to train, and there is a programme for them.

**Deputy Jonathan O'Brien:** I have a couple of questions for Dr. Holohan, as the Chief Medical Officer. This concerns patient safety, which is obviously his top concern. Would he agree that it is safer for people to access a medical procedure here, with the follow-up care and the support of their family and their friends available to them, than to travel to another jurisdiction to obtain that medical procedure?

**Dr. Tony Holohan:** Yes.

**Deputy Jonathan O'Brien:** In developing health policy, I presume the most effective approach would be to look at the needs, then to look at how the health system is organised to meet those needs and lastly to look at the legislation which is in place. Is there any other aspect of women's health care where the first step is to look at the law which is in place, then at an examination of how the needs can be met within that law and then at how the system is organised to suit that? For instance, abortions or terminations are illegal here. All the evidence we have heard in this committee indicates that access to terminations is a vital part of a woman's health care. Is there any other area of women's health care where the law prevents the most effective health care from being provided to women?

**Dr. Tony Holohan:** No.

**Chairman:** We are not used to one word answers.

**Dr. Tony Holohan:** I am happy to elaborate.

**Chairman:** That is fine.

**Deputy Jonathan O'Brien:** To be honest, I am glad they are one word answers, because nobody can misinterpret them.

The final question concerns the current legislation, the Protection of Life During Pregnancy

Act 2013. Can the witnesses give us some background on how well that is working? One of my concerns is that we have heard evidence that we do not keep a record of the number of people who have tried to access a termination under that legislation but have been refused. Therefore, we do not have accurate information on the effectiveness of the legislation. Can the witnesses comment briefly on the matter?

**Dr. Tony Holohan:** What I can tell the Deputy is in terms of numbers and what we know. As the Deputy may know, we publish an annual report. I refer to the numbers that we have reported under the Act, which provides for reports in respect of the three provisions, namely, a risk to life on grounds of physical health, a risk to life on grounds of mental health and then the emergency situation. We have a report in respect of the breakdown of that. The numbers are almost exactly the same from year to year and they are almost exactly in line with what we predicted beforehand. Whether that allows one to say the legislation is working well is another matter. The Deputy also had a question on reviews.

**Deputy Jonathan O'Brien:** As far as I know, the Department keeps information on the number of people who have been successful. Does the Department keep a record of the number of women who have been unsuccessful?

**Dr. Tony Holohan:** If there is an appeal we have a notification in that regard, yes. The numbers are very low. I can share those numbers with the Deputy if he so wishes.

**Deputy Jonathan O'Brien:** Yes, please.

**Dr. Tony Holohan:** I ask my colleague, Ms Luddy, to reply. She is better at reading her own handwriting.

**Ms Geraldine Luddy:** In 2014, there was one application to the HSE for review. This was one woman who had sought a termination under section 7, which is for physical health grounds. Her review was heard. It was found that the grounds did not quality her for a termination under the Act and her application was refused.

In 2015, one woman applied for her case to be reviewed under section 9, which is the mental health ground. Her case was heard and accepted. She qualified for a termination under the Act and she was certified. In 2016, two women applied under the aforementioned section 9. The two women were found to qualify for a termination under the Act.

We only know about women who appeal under the review system.

**Deputy Jonathan O'Brien:** Do we know how many people have been unsuccessful?

**Ms Geraldine Luddy:** We do not have figures for the number of people who have been unsuccessful as they do not go through this system. No.

**Dr. Tony Holohan:** If somebody requests certification or an assessment in line with the legislation and it is determined that she should not have a termination, the record of that is not kept. It is not notified to us unless the person goes through the process of review that the HSE has put in place.

**Deputy Jonathan O'Brien:** It should be kept. Would it best practice if that record was kept?

**Dr. Tony Holohan:** There is a question about why any of it would be known by us, in terms

of the practice. Our knowledge of these events makes no contribution to the medical practice whatsoever.

**Deputy Jonathan O'Brien:** I thank the witnesses for their answers.

**Deputy Peter Fitzpatrick:** I welcome the witnesses from the Department of Health and the HSE here today.

Today, the witnesses have talked a lot about the health of mothers and babies. I agree with them that doctors in this country do a tremendous job. However, I believe we can improve the services that are offered. I cannot see how abortion will improve the situation. It certainly does not improve the health of the baby. The only one thing that abortion does, from a medical perspective, is end the life of a baby in the womb. Yesterday, we heard that the abortion procedure involves giving the baby in the womb an injection to paralyse him or her and then another injection to end his or her life. If the eighth amendment is repealed this is what we would expect doctors to do. Do the witnesses agree that widening the grounds for abortion would mean training doctors to end the lives of babies, which would do real damage to the medical profession?

**Chairman:** The Deputy has asked a policy question.

**Dr. Tony Holohan:** It is not the role of doctors to make a determination on what should or should not be. That is the purpose of the legislation. At the moment the law is very clear on what doctors are or are not enabled to do in these situations. The Medical Council's professional practice code makes the behaviours expected of doctors very clear. If the law changes then medical practice will change in line with that. If the law changes then the guidance to doctors on professional practice will change in line with that.

**Deputy Peter Fitzpatrick:** I note that abortion already happens under the 2013 Act. How do the witnesses feel about the evidence given to the committee yesterday? Dr. Thompson from the UK talked about how one would have to give two injections to a baby in the womb to end his or her life and as late as eight months' gestation. Do the witnesses think this is something we should train our doctors to do? I always talk about the unborn child. One talks about the heartbeat, the movement, the stretching, the yawning and everything else. When a baby in the womb is administered an injection, he or she moves. Should doctors be trained to do this?

**Chairman:** Dr. Holohan can answer how he wishes.

**Dr. Tony Holohan:** I did not hear the evidence yesterday. I am not obfuscating the Deputy's question and understand what has been asked. If doctors are going to be involved in the provision of any service that is legal then they will be trained in whatever that procedure or procedures are. It is not the role of doctors to make a determination in respect of what is legal or illegal.

**Deputy Peter Fitzpatrick:** Is Dr. Holohan familiar with the injections that end the life of the unborn child?

**Dr. Tony Holohan:** I know what the Deputy is referring to, yes.

**Deputy Peter Fitzpatrick:** Can Dr. Holohan describe the procedure?

**Dr. Tony Holohan:** I do not have the expertise to describe it.

**Deputy Peter Fitzpatrick:** Does anyone from the HSE or the Department have such ex-

pertise?

**Dr. Tony Holohan:** I do not understand the question.

**Chairman:** Does Dr. McKenna want to speak about the point made? If Dr. McKenna wishes to comment he may do so.

**Dr. Peter McKenna:** It is not something that I have any personal experience of. I do know what the Deputy has referred to. Even in countries that have a liberal code, the people available to do this would be quite limited.

**Deputy Peter Fitzpatrick:** As late as eight months, two injections can be administered to end the life of an unborn child. To me, that sounds very cruel.

**Chairman:** The Deputy's comments are noted. Perhaps he could move on to another question.

**Deputy Peter Fitzpatrick:** Reference was made to the funding of abortion if the eighth amendment is repealed. We know that increased resources would help to alleviate some of the pressures on the health system in Ireland. I am very concerned that public moneys would fund abortions that end the lives of babies instead of going towards something that would help us save a life. Let me give one example. Yesterday, we heard about the number of the women in the UK who have had an abortion because their babies had a disability. Do the witnesses think it is right for us to allocate funding to pay for abortions where babies have been diagnosed with a disability instead of giving the money to a charity like the Special Olympics that works to help people with disabilities to reach their full potential?

**Chairman:** Do the witnesses wish to comment?

**Dr. Tony Holohan:** Again, it is not for us to comment. Ultimately, these are matters to be determined by the law. The role of the health system will be to provide whatever services are legally enabled.

**Chairman:** To be fair to the witnesses, it is probably not a question that they get.

**Deputy Peter Fitzpatrick:** Chairperson, I was a member of the Oireachtas Joint Committee on Health and Children and I recall the witnesses attending committee meetings. They repeatedly asked for money and stated how they could not keep the system going. Money is very tight at the moment but there are many good people and charities that want to help people with a disability live their full term of life.

I asked a question yesterday and will do so again today. I do not believe in abortion and believe there should be as many alternatives as possible. I seek a positive outlook. It is important that we support mothers and their unborn children. There are families in my area who want to adopt children but the current adoption system has made it almost impossible. What is the Department of Health and the HSE doing to speed up the adoption process? What are they doing to inform the public about adoption? Contraceptives and everything else are ways to end a baby's life. To me, adoption is an ideal alternative to abortion.

**Chairman:** I ask Dr. Holohan to comment on adoption. Yesterday, the Deputy made a valid point about the need to educate people in schools about the adoption process.

**Dr. Tony Holohan:** Again, I am not obfuscating. Adoption comes under the remit of the

Minister for Children and Youth Affairs and the services relating to it come under the remit of Tusla, not the Department of Health or the HSE.

**Chairman:** We discussed that yesterday.

**Deputy Peter Fitzpatrick:** If I am not mistaken, I think the Chairman said maybe that question could be asked today.

**Chairman:** I think that was on another point.

**Deputy Peter Fitzpatrick:** What alternatives are the Department and the HSE giving people? I would like to withdraw my comment about contraceptives ending a baby's life.

**Dr. Tony Holohan:** I will comment and perhaps my colleague from the crisis pregnancy programme might wish to comment. There are many alternatives if the subject of the question is unwanted pregnancy and the prevention of same, and limiting. It was stated earlier that prevention is better than cure. That is preferred. In broad terms, the set of services mandated through the sexual health strategy and the programme points in that direction, if that helps to answer the question. There is a wide range of alternatives available in terms of contraception and so on.

**Chairman:** To expand on Deputy Fitzpatrick's point, what is the incidence of adoption? Does Dr. Holohan have any comments on adoption as an alternative?

**Dr. Tony Holohan:** I do not for the reason I gave, that it is not under the remit of the Department of Health, the Minister for Health or the HSE. If I was to talk about that, I would be expressing nothing other than my personal opinion, which, I am sure, the committee is not interested in hearing.

**Chairman:** We cannot discuss it today but it should be discussed at a committee in due course.

**Deputy Peter Fitzpatrick:** Are the Department of Health and the HSE doing their best to inform people who have crisis pregnancies that all alternatives are being considered?

**Ms Janice Donlon:** Absolutely, if a woman who comes for crisis pregnancy counselling wishes to explore the option of adoption she is given as much information as available and is referred to the Adoption Authority of Ireland and Tusla, both of which have expertise in this area. The information is available should a client wish to explore that option. There is no barrier to that.

**Deputy Clare Daly:** There is no legal impediment to adoption. It is legal in this State and anybody who has a crisis pregnancy and who chooses that as an outcome can do it. Deputy Fitzpatrick seems to be concerned that there are not enough children. The only alternative is that we reverse the Chinese policy of restricting numbers of children and mandate every woman to have four children. Then, if she cannot afford a couple of them, give them up for adoption. It is not really practical.

On his point, however, this is the ancillary section. The Citizens' Assembly asked us to give this serious consideration and we have heard a great deal of evidence in recent weeks to the effect that the biggest, positive news is that the best way to reduce abortion rates is the availability of contraception. More than any restrictive legislation, this is what will change the situation and address concerns. What has been done in the way of a cost-benefit analysis of

the provision of free universal access to contraception as part of the health service? The most recent data in this regard come from the Irish Contraception and Crisis Pregnancy Study 2010, or ICCP 2010. We cannot make policy if we do not have data. Are we reviewing that? Are there plans to initiate a new study? Has the HSE costed contraceptive availability as part of the health service programme?

**Mr. Liam Woods:** I am not aware of recent studies.

**Ms Janice Donlon:** The last general population study was ICCP 2 in 2010. There are conservative plans to study that again in respect of sexual health and in a broad range of areas. It is in the discussion phase. Our programme and several others would welcome the commissioning of such a study again.

**Deputy Clare Daly:** Given the amount of debate on abortion and taking up Deputy O'Connell's point that prevention is better than cure, could I respectfully suggest that a key part of our strategy should be on developing a policy for universal contraception access and undertaking studies?

There is a contradiction in law such that people younger than 16 have the right to make decisions about their health care but not their sexual health. They have to be 17 in order to make decisions regarding the latter. This touches on the point about supported decision-making. Has that discrepancy caused problems or have the witnesses considered that too?

**Dr. Tony Holohan:** We are not doing any work specifically on that at the moment but I will take that as a positive suggestion to be considered by the Department and will bring it back and respond to it.

**Chairman:** There will be a lot of matters considered in our report that will involve recommendations to the Departments of Education and Skills, Health, Children and Youth Affairs.

**Deputy Clare Daly:** What about the difference between medical consent at the age of 16 and sexual consent at the age of 17?

**Dr. Tony Holohan:** It is a fraught area in the context of its impact on medical practice. I am not an expert in the area and would not profess to give an informed opinion. I know that work has been done. Perhaps my colleagues from the HSE may be familiar with it but those involved in work on the national consent policy are not among those who are here today. We would be able to give a more comprehensive answer on that if we are not able to do so now.

**Deputy Clare Daly:** One of the points which did not make the ancillary recommendation list but which featured very highly in the other opinions of the Citizens' Assembly relates to decriminalisation. In the presentations, the question of who will fund and carry out terminations arose. I think Dr. McKenna made the point that not getting licences for abortion pills and so on would not be an impediment to use. Many of the products that serve as abortion pills are already available. Have the witnesses considered how long it would take to make abortion pills available, post-repeal - if that is to be the case - and the decriminalisation of abortion? Presumably, there is no impediment to that if abortion is decriminalised. If the companies want to opt for a change of use, how long would it take?

**Dr. Peter McKenna:** I do not know the answer to that question. I imagine that it is quite a lengthy process. There is nothing to stop an individual doctor using a particular drug if is off licence.

**Deputy Clare Daly:** In the event of the eighth amendment being repealed, the protection of life provision being changed and the criminalisation aspect being removed, there would be nothing to stop that pill being available.

**Dr. Peter McKenna:** It is currently available. I am sure it will be available afterwards. I would, however, share the Deputy's concern about surgical termination, where it will be facilitated and what the effect would be on the rest of the health service. As we know, there are extensive waiting lists for gynaecological procedures. If a woman wants a termination, there is no point going on a waiting list because every week increases the morbidity. If surgical termination is to be widely available it will have to be resourced, otherwise there will be a very negative impact on other gynaecological waiting lists, which are already problematic.

**Deputy Clare Daly:** On that basis, I take it that the HSE would support the call of GPs to have a more enhanced role, particularly in the areas of medical abortion and the fact that over 80% of abortions would take place in the early stages of pregnancy and could be accommodated by the abortion pill, for example.

**Dr. Peter McKenna:** Everybody would know that the earlier it is done in pregnancy, the safer it is. If that journey is to start, the fewer barriers to getting to the end, the better and safer.

**Deputy Clare Daly:** If the abortion pill is relatively cheap and a GP prescribes it, the cost would not be enormous.

**Dr. Peter McKenna:** One of the components is very cheap. I do not know the cost of the other one.

**Deputy Clare Daly:** Which is the cheap one? We know the tablet is cheap. Is Dr. McKenna saying the doctors are dear?

**Dr. Peter McKenna:** No. I beg the Deputy's pardon. I thought she was talking about the drugs. One of the drugs is very cheap.

**Deputy Clare Daly:** The point I am making is that it is a relatively simple procedure in the context of Dr. McKenna's points about-----

**Chairman:** We have had evidence about that anyway. Dr. Holohan wanted to make a contribution.

**Dr. Tony Holohan:** I was going to make some similar points that have already been made. In the context of what I said at the very outset about scenarios, not just the legal scenarios, the service implications are exactly what we are working on in a primary care situation, a secondary care situation and so on. Regarding the point Dr. McKenna made about an intervention that could take place at one point but via medical means, as opposed to the same intervention with the same purpose taking place at a later stage by surgical means, there is a clear patient safety implication.

**Deputy Clare Daly:** The point I am trying to register is from a cost and service provision point of view, and concerns the witnesses advising us as a committee. What they are saying, I think, is that the facility to have, for example, the abortion pill would be far cheaper, more accessible and better for women's health, but also better from the point of view of putting less pressure on our health service, for which perhaps the surgical procedure later on might have implications.

**Dr. Tony Holohan:** Looking at all those different scenarios, the current legislation is centred around the definition, which is set out in the legislation and specifies 19 obstetric units. The scenario the Deputy describes, were it to come to pass that termination of pregnancy would be available via medical means, could, in technical and competence terms, be delivered in a primary care environment. We have more than 2,500 general practitioners in the country.

**Deputy Clare Daly:** My last question is whether the working group the Department has with the Minister for Health is on target for a May referendum, which is-----

**Dr. Tony Holohan:** All the work we are doing is very much ultimately in mind of the commitments the Taoiseach has made in public as to what he would like to see-----

**Deputy Clare Daly:** Good.

**Dr. Tony Holohan:** That is our starting point-----

**Deputy Clare Daly:** Is that a "Yes"?

**Dr. Tony Holohan:** -----and we will work back from there.

**Deputy Clare Daly:** That is a "Yes".

**Dr. Tony Holohan:** It is a "Yes".

**Deputy Clare Daly:** That is good.

**Dr. Tony Holohan:** It is not a one-word answer but it is a "Yes".

**Deputy Clare Daly:** Good.

**Chairman:** I have allowed a little more latitude because there are fewer members here today because it is Thursday afternoon. I call Deputy O'Reilly.

**Deputy Louise O'Reilly:** I had to leave, so if I ask a question that has already been asked, the witnesses should not feel the need to answer it. I can check back on the record.

I want to know about the recruitment of the 52 sonographers. We have already heard at this committee extensive evidence on the need to access scans for the purpose of detecting anomalies, dating and so on, so we know it is very important. I am conscious that Dr. Holohan said some of the work in preparation for a referendum has been done, and that is to be welcomed. However, on the flip side, none of this will be possible or easy unless we have the staff to do it.

Could the witnesses give us a timeline for the 52 sonographers? The witnesses will know as well as I do that the 20-week scans are screening scans. I would not ask the witnesses to take my word for it but, as the consultants in this area have told us, it is not necessarily possible to make a decision as to who will need a scan because it is a screening scan and one needs to screen to get the information. In the meantime, and pending the recruitment of the 52 sonographers, 140 midwives and all the other staff that would probably just bring us up to a fairly basic level of service, how many women access the anomaly scan, how is it decided they will need one, and what percentage of women need it? Since it is a screening scan, we will take as a given that all pregnant women should have access to it. What percentage of women are missing out? This will have serious implications in the event of the repeal of the eighth amendment.

I will ask one final question because I do not wish to delay any more than I have to. My col-

league, Deputy O'Brien, asked a question about recording those women who sought access to a termination under the Protection of Life During Pregnancy Act but who were not granted one and did not engage in the review process. One of the speakers - it might have been Dr. Holohan - alluded to the need for us to have evidence, and evidence must inform policy.

The Department of Health is fairly clear that collection of that information would not come under its remit. My view is that it clearly would come under the HSE's remit, not Mr. Woods's personal remit, that it would be the HSE's job. It is quite worrying that the information is not being recorded.

Perhaps Mr. Woods could explain to us why he feels it is not important to record that information and who he feels should be recording it. The Department has given its clear view that it is not a policy matter so it is not for it to record it. My view is that it clearly comes within the remit of the HSE. Mr. Woods can correct me if I am wrong on this, but I think we can all agree that the recording of this information is important. If it is not currently being recorded, and I suspect it is not, perhaps Mr. Woods might be able to tell us who within the HSE will have responsibility for recording it.

In the event that the eighth amendment is repealed and expanded access to services is brought in, and in order to be able to develop services further, we will need evidence, and we are starting from a fairly bad place if we are already neglecting to collect some of that evidence.

**Acting Chairman (Deputy Bernard J. Durkan):** Who wishes to respond to Deputy O'Reilly's comments?

**Mr. Liam Woods:** We flagged in our opening statement that we have approval on resource to recruit 40 sonographers. We have addressed the point about training existing staff in the event that we cannot recruit. The recruitment will take place during the course of next year. I will ask Mr. McGrane to say more about this because the funding is conditional on the approval of the 2018 service plan, which is going through a process at present. That funding will become available and the process of recruitment will commence next year. We have also flagged that training is ongoing in any event. I will ask Mr. McGrane to say a little more about this.

**Mr. Kilian McGrane:** The recruitment process, as Deputy O'Reilly knows, will take time. We have a combination at present of radiographers and midwives, who go off to do the training. There are a number of master's programmes and it can take up to 18 months to complete the process. I do not have an exact figure, but we have a number of people in training at present. However, even once we start to release the additional resource, those who have experience in the training relating to the dating scan will move on and start to receive anomaly scanning training. We will increase capacity straight away in that respect. Just getting that dedicated resource ring-fenced, subject to the approval of the service plan, is a big step forward from our perspective. As the Deputy knows, it has been lobbied for for a long period.

Regarding her second question about the percentage of women not currently accessing the scan, our colleagues from Cork University Maternity Hospital in UCC did a study on this and they published the data in July, I believe. There are currently seven units in which we provide 100% of women with access to a scan, seven units in which there is some access and five units in which there is no access. In those units in which there is access, it is usually by clinical indication, and I am sure Dr. McKenna can talk to those kinds of clinical indications that may be appropriate for it.

I cannot remember the exact figure, but I think approximately 64% of women are offered the scan, so we have quite a distance to travel. The 52 sonographers also carry out dating scans. Not all of our 19 units provide every woman with a dating scan, so we have tried to spread the resource as best we can. We are making anomaly scanning the priority for 2018. This is why we are looking at a 40-person sonographer resource, and the balance of the 12 would be a 29-person resource to ensure that every unit provides the dating scan at 12 to 14 weeks.

**Deputy Louise O'Reilly:** Those plans, which are ambitious, are very welcome, but I must be honest. In response to a parliamentary question I asked, the Minister, in what was not exactly a ringing endorsement, said, "Let us be very honest, the likelihood of finding all of that cohort in one go is slim." He is not convinced, I certainly am not, and that is very worrying because, as I and others have said here repeatedly, these are screening scans. When we have asked the professionals and the consultants, they have told us it is a screening scan so it is not possible to grade in those terms. I will take the answer of the witnesses anyway.

**Mr Liam Woods:** There was a further question.

**Chairman:** We have time.

**Mr Liam Woods:** There was one question we did not answer yet regarding the data on requests and if we know the volume of requests that are not appealed. The point was made earlier. At a national level the answer is no. On the second question, if I understand the Deputy correctly, the information exists locally and is not collated. I would be happy to take this away and think about it with Mr. McGrane in terms of where we might source such data.

**Deputy Louise O'Reilly:** I am looking for confirmation from the HSE that it believes it important that the information is collated centrally. I do not believe it would be good enough to leave the recording of the data to the local level. There should be some central aspect to it. I do not want to bounce Mr. Woods into saying something now and I would be happy for him to come back to me with his thoughts on it. That would be very welcome.

**Dr. Peter McKenna:** I am not minimising the importance of it but I see a certain amount of difficulty in that. In my clinic I see a woman who has a cardiac problem. She asked about her risk, should she take that risk or should she have a termination. I explained to her that her risk of dying could vary from 10% to much the same as for a normal woman. Is this inquiry a request or is it an inquiry? It is difficult to know when an inquiry becomes a request, if the Deputy knows what I mean.

**Deputy Louise O'Reilly:** I understand.

**Dr. Peter McKenna:** I explained to her what is the risk. It is then up to the woman to make the decision to request, or otherwise.

**Deputy Louise O'Reilly:** I would trust that in that scenario people would understand - the doctor would certainly understand - the difference between a casual inquiry and a request. It is certainly not a trivial issue to be contemplating.

**Dr. Peter McKenna:** My point is that there would have to be a certain level of formality to trigger a request that was denied. That level of formality currently is the lodging of an appeal. Short of that, what would trigger the formalisation of a request-----

**Deputy Louise O'Reilly:** Dr. McKenna's colleagues have just said that they believed this

information was available locally so clearly the difficulty that Dr. McKenna has outlined is not there.

**Dr. Peter McKenna:** I do not think it would be that simple to go into it really.

**Deputy Louise O'Reilly:** Both of Dr. McKenna's colleagues have said it.

**Chairman:** Would Dr. Holohan like to come in?

**Dr. Tony Holohan:** Not to take from the principle of the point, which I understand, about the flow of information and the generation of information in understanding the scale of the problem so we can properly plan for it, the legislation creates minimal flows of information in respect of two very specific things. One is, obviously, the fact of a termination having taken place under one of the provisions of the Act. We have a flow of information that we have shared in that regard. The other is when the review mechanism is triggered. I recall, in broad terms, the debates that took place when that legislation was passing through. The policy rationale was that the HSE is obliged to create panels from which people are drawn in order to support the review process and especially to make sure that when individuals lodge review requests they get access to an opinion very quickly. I believe that three days is the period of time as set out in the legislation, but I am subject to correction on that. It is, however, a short period of time so the HSE has to have standing panels in place and a range of procedures. The scale of review requirements needed to be understood to ensure the process of review mechanism was working, as opposed to any kind of measure of the scale of the problem. That was the broad rationale for it.

**Chairman:** Deputy Murphy has six minutes and, to be fair, a bit more if she wants.

**Deputy Catherine Murphy:** I thank the Chairman. For the record I was unhappy with some of the things that were said around the Irish Family Planning Association. I want it on the record that it should not be taken as a given that this is some sort of a rogue agency. The Senator does not like to be interrupted but it is only fair that we say that.

**Chairman:** I appreciate that Deputy Murphy waited to make that point. It can create argy bargy.

**Deputy Catherine Murphy:** The association is not here to defend itself.

The committee is envisaging writing a report. This is a two stage process - we have been through the Citizens' Assembly and we are considering its report. We are not looking, necessarily, at the existing resources. We need to look at what is the ideal, what is best practice, what we should recommend around screening, ratios in perinatal care, contraception, folic acid and what should the health promotion unit in the HSE, for example, do in that regard. We want to make practical recommendations with some sort of vision around the ideal of maternal services such as screening. It would be quite useful if the witnesses could point the committee to where we can find that kind of information. How does Ireland compare in where we are now and international best practice? Is it possible to find this information in one location for the committee to include as recommendations in its report?

**Dr. Tony Holohan:** I will allow other colleagues to come in but as a general point the challenge for us arises when things move from a debate to the reality of legislation and services that become provided for in that legislation, whether or not a change takes place. We will have to support that work and in parallel do, as the Deputy has rightly said, forward planning on how

to provide the best access to the services whatever they may be, and on how best to provide the services and in what settings. The planning will set out models that are not constrained - if I can use that term - by the current service models but are service models directed to supporting the operation of the legislation that ultimately becomes part of our law, whatever that may be. I wanted to make that point in principle.

There are aspects of the question that might apply to crisis pregnancy interventions, for example, where good practice questions can arise. In the examination of models, the Department is looking at countries internationally around various different approaches to service provision and legislation and how we might begin to operate for the provisions. This was part of our scenario analysis that I spoke of earlier. Perhaps Ms Donlon or others will comment on aspects of best practice in crisis pregnancy generally.

**Ms Janice Donlon:** With any potential changes in legislation we can certainly dial up those services we currently fund to meet additional demand for counselling services and so on. We have the ability to look at that. We are also considering introducing a national telephone counselling system next year, which we hope will improve access to counselling for a larger cohort of women. If legislation is changed and if there is a requirement to provide termination services in the State, the services we fund would be able to respond accordingly.

**Deputy Catherine Murphy:** I just have a few questions. We have heard a lot about criminalisation and about the concerns of people who work in labour wards around whether something can or cannot be done. One would need a barrister rather than an obstetrician in that scenario. When we consider the recruitment of staff and those who practise medicine - given that we are trying to recruit from a wide environment - does medical insurance play a role? Has it arisen as an impediment for people when considering a jurisdiction with this kind of regime?

**Dr. Peter McKenna:** I will address the insurance issue first. The State carries the insurance. Individual insurance tends not to be a problem currently. It was an issue until the State Claims Agency took over in 2002. As the obstetrics services have attracted much adverse publicity people do not wish to be associated with that and it can be a barrier. Some practitioners, either midwifery or medical, have found themselves in the spotlight and not in a way they would want to be. That is very negative. The HSE is aware of some colleagues who have attracted attention and it has made a very negative impact on their lives, probably unjustifiably. In that regard, it can be very difficult to attract some people in and keep them in because of the stress. Criminalisation is something I have heard referred to, but I am unaware of any instance where it has followed through into action. I could be wrong and perhaps it has happened and I have not heard about it, but I think it is more of a theoretical issue than a practical day to day problem.

**Deputy Catherine Murphy:** To switch to another topic, yesterday we heard about sex education in schools and that the National Council for Curriculum and Assessment comes up with the policy, which is then delivered by the schools. We were told that in some school environments how it is rolled out very much depends on the ethos in the schools. I do not know whether this is for the Department of Health or the HSE, but is there any concern that there is not a uniform approach or that an ethos may interfere with the quality of sex education and that it is not just about pregnancy and disease but that there is a much more rounded approach? Is there any concern or discussion about this? What input do the witnesses have into how such programmes are delivered or is it just about inputting into the design of the programme?

**Dr. Peter McKenna:** The Deputy asked earlier about what would be best practice with regard to contraception. It would be accepted that the fewer barriers in place between access-

ing the service and the user the better. Whether these barriers are financial or educational, they should be dismantled if at all possible. As regards what happens in schools, that is not a matter for us, at least I do not think it is.

**Dr. Tony Holohan:** It is more of a matter for us and, as I mentioned in my opening statement, we have done work on the development of the sexual health strategy, which involves actions by the Department of Education and Skills, to try to move us more towards a situation where we can increase the sense we can have an expectation of a uniform standard of high quality sex education for children as part of general health education.

Working with the Department of Education and Skills, which we do under the banner of the Healthy Ireland framework where we have a range of different measures, we are trying to improve the extent to which the school setting is seen as an environment in which children can learn and develop and where some of the objectives we have as a sector, whether it is in terms of obesity or physical activity, can be met, and sexual health is one such example.

The quality of the engagement between the two Departments in this area has improved substantially in recent years, but I would have to get a specific report to provide a state of implementation. We have an implementation plan with the actions I have set out, some of which fall to the Department of Education and Skills, and I would be very happy to communicate with the Deputy directly to give her an update if it would be of help.

**Deputy Bernard J. Durkan:** I might ask a couple of questions on the degree to which we can rely on the attention for and response to a woman in a crisis pregnancy. I want to have clarified the definition of a crisis pregnancy. It could be for a variety of reasons. It could be for health reasons, mental health reasons or stress. Are we satisfied we have a sufficient and adequate response, when a woman presents in a maternity hospital or a clinic, to what may initially appear to be a normal procedure but could suddenly transfer quickly to a serious life-threatening issue? I do not want to name any particular case, but I can think of one which made headlines and I can think of a couple of others that have also hit the headlines. I know outsiders should not comment on these things, but from an outsider's point of view I would like to think that when we legislate, whatever we do we have an adequate and responsive service available that takes into account all aspects of what can and might happen, even though initially it might not look as if that were necessary. What I am trying to ask is whether we have an adequate diagnosis to deal rapidly with that situation.

**Dr. Tony Holohan:** I am conscious my colleagues might want to add to this.

**Chairman:** By all means indicate to me. Dr. Holohan always indicates when he wishes to come in. If anyone wishes to come in they should stick up their hand.

**Mr. Liam Woods:** There are two dimensions to the question. In terms of the definition of a crisis pregnancy, it might be useful to ask Ms Donlon to give us a commonly used definition. In terms of clinical response to crises we have services in place, as women present at maternity hospitals as the Deputy referenced, to respond to a pregnancy crisis. Was the Deputy talking initially about crisis pregnancy as in the counselling piece?

**Deputy Bernard J. Durkan:** It could be a crisis due to a pre-existing health condition, for instance, such as blood pressure problems.

**Mr. Liam Woods:** I will ask Dr McKenna to discuss this, but there are services in place for this.

**Dr. Peter McKenna:** Will the Deputy give me a better picture as to what he means by crisis pregnancy?

**Deputy Bernard J. Durkan:** One or two come to mind. It could be a very young girl who is frightened or maybe terrified, and perhaps she has withheld information and did not consult with anybody. Perhaps she was in a serious mental and-or physical situation. How is that person identified? How does that person come to the attention of the health services?

**Dr. Peter McKenna:** In very general terms, my practice was in hospitals and the first port of call under the circumstances is hardly ever a hospital. It is in primary care. I would not be equipped really to deal with this. If a woman presents with a medical health problem, and that is presenting a difficulty and challenge to her life, then the services do exist to advise accordingly. The most common is a heart problem. In many years of working in this area, I do not think I have ever been approached by somebody who did not have a health problem, or by a doctor asking me on behalf of a woman who did not have a health problem, what would we do here. If termination is what is required, or what is requested under those circumstances, for no health reason it is not possible to facilitate it at present in a hospital here.

**Deputy Bernard J. Durkan:** It could be an intervention. It could be a termination or an intervention that would bring the pregnancy to a conclusion, whatever the case may be. I do not want to spend too much time but, for instance, in some of the cases that come from the past, albeit from a time when different legislation prevailed, nonetheless it would appear that in order to respond to the emergency-type situation there would have needed to have been a greater degree of alertness in the system to determine what needs to be done next to ensure the mother did not die or that the mother and child did not die unnecessarily.

**Dr. Peter McKenna:** If there is any risk to the life of the mother it becomes a medical issue and of course the question of termination can be discussed. If it is a social issue it should be directed to the social support services. As regards termination, that does not arise in Ireland at present.

**Deputy Bernard J. Durkan:** In the event of there being attendant medical or mental health issues, we could arrive at a situation fairly rapidly where it might be necessary to enter into the details of how best to deal with the situation. I hope we are not coming to the conclusion that we do nothing in that situation.

**Dr. Peter McKenna:** If there is a significant risk to the life of the mother the legislation comfortably allows one to discuss termination as an option. Is the system geared to follow through on that? The answer is "yes", and the numbers that are there can confirm that this is done.

**Dr. Tony Holohan:** Only a small number of such cases arise, approximately in the mid-20s each year. It has always been almost exactly the same number, approximately 25 or 26.

If I understand it correctly, part of the Deputy's question relates to a general concern in respect of the responsiveness and safety of services. Am I correct in that understanding?

**Deputy Bernard J. Durkan:** Yes.

**Dr. Tony Holohan:** Dr. McKenna is correct that in recent years there has been an increasing attention and focus on maternity services and there have been several publicly reported incidents, including some which related to delays or potential delays in diagnosis and appreciation

of risk and so on before appropriate interventions could take place. The measures that have been put in place in recent years, some of which were identified earlier in this meeting, do not allow us to say we responded fully to everything that required a response. However, there are several maternity strategy information systems in place. There is a national mechanism through the centre for perinatal medicine in Cork and another through the national perinatal reporting system at a national level that gives us the ability to track and monitor relevant events. The Irish maternity early warning system, IMEWS, which is a reporting system in regard to obstetric units, facilitates a monthly reporting arrangement. As I said, patient safety statements are published. All of those measures are geared towards increasing the transparency of activity and the awareness of risk in the environments in which obstetric practice takes place, with a view to increasing the speed of response. The delivery of health care is not a risk-free enterprise. None of the science, people or processes involved are perfect but we have to constantly ensure the systems are capable of learning from and responding to incidents and applying the benefits of that learning. The delivery of maternity services is an area in which significant improvements are taking place, but none of the witnesses present would say that all of the risks that might exist have been fully and adequately eliminated. That almost never arises in the context of medical practice.

**Deputy Bernard J. Durkan:** I have in mind a situation where there is currently very little support for a pregnant girl who may feel alone, isolated and does not know what to do. The only thing she can think of is to go abroad for a termination, as has historically been the case. Such a woman may not be in a good mental position at the time and going abroad for a termination may not be in her best interests. How does one identify such patients? They may not attend a GP or other services. I ask the witnesses to address the issues of advertising, health education or any other measure on which we can rely in that regard. There have been some very tragic incidents in the past 20 or 30 years. One incident in particular comes to mind, whereby the person was alone with no help from any quarter and was obviously forlorn and in a very bad situation.

**Dr. Tony Holohan:** I could identify several such cases and it is a complex issue. As Dr. McKenna said, there are multiple potential barriers for those in such situations and who are seeking to access services. In some cases, the health services have not given their best in responding as they could and should. I would like to think that people have an increasing understanding of what they are entitled to request access to because of the progress we are making in terms of crisis pregnancy, access to general practitioner services and increasing the awareness and provision of maternity and related services and increasing awareness of access to the kind of services we are discussing and with which the committee is concerned. Health services also have an understanding of their obligations in that regard. All of those things indicate-----

**Deputy Bernard J. Durkan:** Does Dr. Holohan think there will be an increased awareness of and reliance on support services?

**Dr. Tony Holohan:** I would like to think so, yes.

**Mr. Liam Woods:** From a crisis pregnancy programme perspective, the expanding presence on social media presence is very important. Data previously presented to the committee identified that the younger cohort of women are not contacting the agency as much as the 25 to 34 year old cohort. It seems, therefore, that there is an increasing reliance on social media. From a service perspective, that presence is very important because while it may be an unknown point of contact, it is a very important one.

**Chairman:** As regards the national standards for bereavement care following pregnancy

loss and perinatal death, which is mentioned on page 4 of Mr. Woods' presentation, he said that in 2016 resources were secured to appoint a clinical midwife specialist in bereavement to all maternity hospital units that did not already have one and that recruitment to fill those important posts is currently under way. At what stage is that process? Is it proving difficult?

**Mr. Liam Woods:** Mr. McGrane will deal with that question.

**Mr. Kilian McGrane:** As of September 2017, six hospitals had not filled that position. Ms Dunne will be able to address some of the challenges involved-----

**Chairman:** Six of 19 units have yet to recruit such a specialist.

**Mr. Kilian McGrane:** Fourteen and a half posts were approved in 2016 and there were six outstanding vacancies in 2017.

**Chairman:** It is difficult to chair the meeting and ask questions at the same time. That indicates that-----

**Mr. Kilian McGrane:** The challenges include the course that successful applicants are required to undertake and whether there are enough midwives available to do it. It was necessary to change the criteria. Perhaps Ms Dunne would like to comment in that regard.

**Ms Angela Dunne:** There are challenges in terms of job description and whether the post would be filled by a nurse or a midwife.

**Chairman:** Is the position unattractive?

**Ms Angela Dunne:** It is not unattractive but it is a challenging job and burn out can be high, in particular in bigger hospitals where------

**Chairman:** "Challenging" might be synonymous with "unattractive" in this context and also in politics. As regards the folic acid point raised by Deputy O'Connell, which is an issue I am very interested in and on which I have done some work, approximately 100 babies are born every year with a condition the incidence of which could be dramatically reduced were folic acid to be standard fare for women of childbearing age. Some 70% of those events are preventable but occur in spite of widespread knowledge that folic acid is required by women for the reasons that have been discussed, such as a baby not having been planned even though it is wanted and so on. The World Health Organization, WHO, has advocated the fortification of flour with folic acid. Does Dr. McKenna think there is any reason for that not to be done? Could it have a negative effect on the male population or on women for some reason? Folic acid is of benefit to most bodies, regardless of pregnancy. I may be asking a question to which Dr. McKenna does not know the answer but I am interested in his views on the matter.

**Dr. Peter McKenna:** Dr. Holohan will address the issue but I do not know what negative impact it could have.

**Chairman:** From his medical experience, does Dr. McKenna think there could be negative impacts to taking folic acid?

**Dr. Peter McKenna:** It is unlikely for there to be negative impacts. I will defer to my colleague, who knows the right answer.

**Chairman:** That depends on how one defines "the right answer".

**Dr. Tony Holohan:** There are other general health benefits attaching to the consumption of folic acid in terms of cardiovascular risk and so on but I am not offering a professional opinion in that regard. We have been working on this issue with the Food Safety Authority, including consideration of the question of mandatory fortification of flour and so on. I have not brought that work with me but I could correspond directly with the committee in that regard if that would be of assistance. Much work has been done over the years and fortification has been formally considered on several occasions but we have never recommended it.

**Chairman:** Why has it not been recommended?

**Dr. Tony Holohan:** There are many challenges. We would not reach the entire population through that mechanism. There are issues in regard to industry co-operation and-----

**Chairman:** Many people do not consume flour in their diet.

**Dr. Tony Holohan:** I will prepare a comprehensive response and update the committee on the work that has been done.

**Chairman:** Is it not true that the vast majority of people eat bread?

**Dr. Tony Holohan:** I do not have any reason to disagree with that statement.

**Dr. Peter McKenna:** The last time I recall being educated about the issue was when the Health Research Board, HRB, took an interest in it many years ago. The solution seemed blindingly obvious: that a staple food should be fortified. The consensus was that should go ahead. The difficulty was getting it done.

**Chairman:** That is the difficulty in respect of many issues in Ireland.

**Dr. Peter McKenna:** The difficulty was not that people did not want to do it but that a small number of people were able to derail a public health measure.

**Chairman:** I get accused of being a "nanny state" every day of the week. In fact, I got an award recently for being nanny of the year. Maybe I am trying to control everybody or something. It just seems to make total sense to me to have folic acid available in the food that we consume.

**Dr. Peter McKenna:** I think it does and this is a good example of the tyranny of the articulate. Some people who wage a very articulate programme or a very concerned programme will derail what is for the benefit of the majority.

**Chairman:** We just need to get it back on the rails and make it happen.

**Dr. Peter McKenna:** Yes, we do.

**Chairman:** I refer to two other brief items. This follows on from a point Deputy Murphy made about the availability of consultants. It is a question that applies in general but particularly to obstetrics, if I understand the witness correctly?

**Dr. Peter McKenna:** Yes, Ireland has the least *per capita* number of obstetrics and gynaecology consultants.

**Chairman:** Why does Dr. McKenna think that is the case?

**Dr. Peter McKenna:** A question was asked earlier as to why perinatal mental health facilities were so rudimentary in this country. The answer is because we had the confluence of two specialties that were regarded as not worthwhile spending money on. One was maternity and the other was psychiatry. The maternity services have arrived at where they are because of resource issues. A very easy measure of this is the number of consultants. There are about 120 or so consultants in this country. By any international standards that is very low.

**Chairman:** Have we made it too unattractive? There is a lot of talk about how well paid lawyers, doctors and all these professions are. I have a lot of friends who are medics and many of them have spent years abroad and came back reluctantly for family reasons. Australia is very attractive because of the work conditions. They are very satisfactory for family life, etc. With the new contracts and so on, has it become unattractive to Irish people abroad to come back? We cannot get them back. Would the witness think that is a fair comment?

**Dr. Peter McKenna:** I think there is no point in denying that finance and pay remuneration are major issues.

**Chairman:** It is not only finance, but conditions as well.

**Dr. Peter McKenna:** I am not saying it is the only one but it is a significant one. People will not be able to afford the lifestyle to which they would aspire.

**Chairman:** It is hard to know what we can do about it, practically.

**Dr. Peter McKenna:** If we are not going to pay people, then we have got to provide them with a work environment that is superior but that is not the case here.

**Chairman:** I will come to Mr. Woods in a second. In a previous life, that is becoming more previous as the days go by, I did a lot of medical defence litigation. In fact, the witness's name, when he was master, would have been mentioned when I worked in Hayes solicitors. Not that Dr. McKenna-----

**Dr. Peter McKenna:** I thank the Chair for keeping me out of the news.

**Chairman:** I understand where Dr. McKenna is coming from on that point because it is extremely stressful for consultants. It is an extremely maligned profession in many ways and deservedly in many instances over the years where we had consultants who felt like they were king of the castle and all the rest. However, the vast majority of consultants, and doctors generally, are extremely hardworking and committed. I could go on all day about that but I would be interested in anything the witness might have to say about that.

**Dr. Peter McKenna:** I suppose in my previous life I would have agreed with every word the Chair said. In my current life I am trying to bring people along and maybe change their behaviour a little bit and their malleability is something I would question occasionally.

**Chairman:** That is fair. Mr. Woods wanted to come in.

**Mr. Liam Woods:** The challenge also has to be put in terms of funding an appropriate number of consultants and seeking to recruit. As Dr. McKenna said, about 120 is the number at the moment. We know we need to grow-----

**Chairman:** Of obstetrical consultants.

**Mr. Liam Woods:** Yes. We need to grow that by a figure of up to 100-----

**Chairman:** By how many?

**Mr. Liam Woods:** Up to 100.

**Chairman:** By 100. How are we going to do that?

**Mr. Liam Woods:** There are two challenges. One is resources. There are some resources to recruit in 2018. The other ones are those the Chair spoke about, namely, the nature and attractiveness of the post and the location.

**Chairman:** That is another very complex issue.

On the issue of contraception and education in schools. Is it feasible for us to have free contraception in the near future under the current budgetary constraints?

**Dr. Tony Holohan:** This is something we can take back and commit to having a look at. Without prejudging it, many of the kinds of interventions that are effective contraceptions are not expensive. It is a question of cost, implementation and a range of things like that. If we were to do it, we would have to look at the various policy implications of it to provide universal access to one form of medication or one form of intervention, however we would define contraception. However, in broad terms, the specific interventions that make up the range of interventions that are contraception are not for the most part expensive.

**Chairman:** It is doable. Deputy O'Connell raised a point earlier about the licensing issue. This the last of my questions. My understanding is that there is no real issue when it comes to licensing because even a drug like Armour Thyroid - I do not know if the witnesses are familiar with it - is not available on licence but it is freely available once it is prescribed. Certain doctors would know about it. Is it a similar type of situation with the drugs that we discussed?

**Dr. Peter McKenna:** I would defer to the pharmacists but very few drugs are licensed for use in pregnancy. When a doctor prescribes a drug for use in pregnancy they are usually are doing that off-licence.

**Chairman:** Fair enough.

**Dr. Peter McKenna:** Would that be correct?

**Deputy Kate O'Connell:** I have a question for the Department on the amount of money it costs the State for the general medical scheme and for the drug payment scheme. I spoke to the Minister about it. There is an issue with quantifying the private patient on no medication because it is very common. In the UK, it is provided free universally. As far as I know from my time in the UK, it is for a year after one gives birth. Essentially one gets a temporary medical card while pregnant and for a year after. That was 12 years ago. Perhaps it has changed.

**Dr. Tony Holohan:** We have the mother and infant scheme here as well which has eligibility around pregnancy. The Deputy will be every bit as aware of this as I am but the Department is currently considering the details of its response to the Sláintecare report from the committee chaired by Deputy Shortall. That makes a whole series of recommendations, some of which touch on eligibility. There is nothing in the report specifically about free access to contraception. The general direction that the system will go in terms of implementation is something that we are working to finalise and to give the Minister proposals that he will bring to Cabinet in the

early new year. Beyond that, I cannot say. I could make a commitment here that would not be an honest one. I will look at the issue and-----

**Chairman:** That is perfectly acceptable.

**Dr. Tony Holohan:** -----bring back the message sympathetically.

**Deputy Kate O'Connell:** It did not form part of the Sláintecare report. It was an omission on my part and perhaps on my colleagues' part. Many of us were shocked last week when the Irish Family Planning Association, IFPA, said that 17% to 20% of people in the non-medical card cohort are having issues with access due to cost. It is out of that conversation that this has arisen and we have picked up on it as a committee. That is just to let the witnesses know where we came up with that idea.

**Chairman:** There are a lot of issues which the committee collectively has come up with that will be referred to committees generally and Departments. Indeed, yesterday evening we raised an issue with the Minister of Education and Skills. He is open to recommendations from this committee in the area of sexual education, etc. We learned yesterday that the curriculum has not been updated since 1999, in the sense that it has not been overhauled. Addendums, or whatever the right phraseology, have been made but we do need to do some work in that space. That has been the predominant theme.

I thank all the witnesses for attending today and for answering questions so carefully and with consideration.

The joint committee adjourned at 5.50 p.m. until 2 p.m. on Wednesday, 6 December 2017.