Submission to Health Committee from Dr. Seán Ó Domhnaill,

Consultant Psychiatrist.

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Ladies and Gentlemen of the Health Committee, Members of the public and public representatives,

I am a Consultant in General Adult Psychiatry working in the public, independent and voluntary sectors where I deal with the broadest possible case-mix that one would encounter in Psychiatry in 21st century Ireland. I have also worked as a Consultation/Liaison Psychiatrist with particular responsibility for perinatal psychiatry in Ireland for over two years.

I began my career in Psychiatry in Jersey in 1997, sixteen years ago, in the year that the States of Jersey legalised abortion in accordance with the broad guidelines of the British Abortion Act of 1967.

My very first assessment of an attempted suicide in Jersey General Hospital, to which we provided a psychiatric consultation/liaison service, was in the context of a nineteen year-old girl who had taken a significant overdose in an attempt to end her life, because she had developed a major depressive disorder some six months after obtaining an abortion in Southampton in the UK.

I remember, in particular, the rhetorical question she posed to me when I suggested that she could move beyond that awful place she now found herself in, where life held no further attraction for her and death seemed to offer a welcome relief from her suffering.

She told me that she had been pressured by her parents and her boyfriend into having an abortion after she became pregnant without plan. As I attempted to assist her to gain some perspective on her mental state and the likelihood of recovery from a depressive illness brought on by her sense of loss, she asked me: “Can you tell me that I haven’t killed my own baby? Can you tell me that I can undo what I have done? Can you tell me how to bring my baby back?

I hope that today I would be in a better position to answer those awful questions that still impact on me to this day, or at least to assist the young victim of abortion in gaining a new perspective upon her loss. I have worked in post-abortion counselling and therapy on a pro-bono basis for the past 10 years.

I will be happy to answer any questions that you may have in relation to pregnancy and suicide but they have probably been addressed already by my psychiatric colleagues.

I am in agreement with the experts who stated:

- Abortion is not a treatment for suicidality or for any psychiatric condition which might lead to suicidality

- Suicide is pregnancy is extremely rare
- And that Irish experts working in maternity hospitals have not come across any women for whom an abortion is the only solution arising from the threat of suicide.

I would agree with Dr John Sheehan who noted that in our profession we will see people who are profoundly depressed and clearly the intervention in that case is to admit them to hospital and support them and help them and not go in and make a decision that is permanent or irrevocable.

That raises a key point since I wish to bring the reality of the Government's proposal to legislate in accordance with the X-Case ruling to your consciousness, because there is a reality attached, but one which has been ignored in the media and to which I have heard no-one allude in recent months. What will actually happen when a woman presents to a psychiatrist complaining of feeling suicidal, feeling the urge to end her own life, because she is pregnant and does not want to be?

What will actually occur when a young woman says that she will kill herself if denied access to a deliberate intentional ending of the life of her unborn child?

The answer is as follows. There are prescribed protocols for dealing with the threat of suicide, especially where that threat is of immediate harm to self. The patient must be considered to be telling the truth in the first instance. The initial position for the professional psychiatrist must be that the threat is real until proven otherwise or that the threat is directed toward some secondary gain by assessment of the apparently suicidal woman.

And here is the real difficulty that has not been taken into account by the various medical and other commentators in the past few months, when discussing abortion for suicidal risk:

1. The psychiatrist is ethically obliged to ensure the immediate safety of the patient. In the acute setting this will invariably involve admission to hospital and complete suicide risk assessment, including the presence or absence of a diagnosable psychiatric disorder.
2. If such a disorder is diagnosed, the onus is then on the treating psychiatrist to treat that condition, especially if the risk of completed suicide is considered to be a realistic threat.
3. The patient will be offered in-patient treatment of their condition, ie that condition that is causing acute suicidality. Pregnancy does not cause women to commit suicide. Acute stress associated with pregnancy, perceived as a crisis, is the condition to be treated. If the patient agrees to in-patient treatment they will be treated. If they refuse treatment, the treating psychiatrist will be obliged ethically to decide if the risk to the woman's life is such that it poses an immediate risk to her bodily integrity and if admission under the Mental Health Act 2001 is necessary to protect her life.
4. The Government's proposal to deal with the X-Case ruling is intrinsically flawed not least through its failure to request the expert testimony of a professional experienced in assessment of suicidal risk, is a gravely flawed

proposal. It will lead to clinical situations where women will need to be detained under mental health legislation to protect them from suicide while assessing suicide risk, not an assessment that can be carried out in one 45-minute interview.

5. The Government's proposal will drag psychiatrists into the draconian position of having to commit women while they are assessed if they are unwilling to stay voluntarily for assessment. The Mental Health Act 2001, Part 2, obliges us to act in a certain way if there is a real and immediate risk to the life of a person through suicide.
6. In our efforts to safeguard the human rights of patients, we have developed the 2001 Mental Health Act. We cannot "ditch" the human rights safeguards of all, in order to appease the so-called "liberal abortion lobby". This is a case where the liberals in Government cannot have their cake and eat it.
7. Psychiatrists should not have to take the fall for the politicians who want abortion legalised, but who are not prepared to sign those abortion warrants themselves. Nor will politicians carry out the killing of the unborn children that they deem to be less entitled to live than other children because of the circumstances of their conception.
8. It appears that Fine Gael, perhaps in a rush to appease supporters of abortion legislation in the Labour Party, have failed to examine the day to day realities of the assessment and management of those who threaten suicide.

I believe that the tragic and much exploited case of Miss C, a young girl a young Irish girl, [legally a minor,] who became pregnant following a brutal rape in 1997 should be particularly relevant to this Committee. She had been taken into care to protect her from the rapist, and was brought to Britain against the wishes of her parents. The case dominated the headlines for many days. In the years that followed, abortion campaigners repeatedly used Miss 'C's case to demand the legalisation of abortion in Ireland.

But then, twelve years later, Miss 'C' spoke out. She said that she had never requested an abortion, and that she had wanted her baby to be given up for adoption. Here's what she told the broadcaster, Pat Kenny "The nightmare still continues, with me going to England to have the abortion. I remember flying over on the plane with social workers to have the abortion..." "I didn't understand what was happening ... I thought I was getting the baby out".

Pat Kenny asks : "You thought there would be a living baby there?"

Miss 'C': "Afterwards. Yeah. Then I remember waking up from the abortion and screaming and screaming and crying with the pain so they gave me another injection to fall back to sleep, well I don't know, I fell back to sleep afterwards. I woke up then and I was in no pain so I asked for the baby and they told me there was no baby... "I wouldn't have wanted to keep it; I would have put it up for adoption or something. No I wouldn't have wanted to keep the baby but I would have liked for it to be put up for adoption..." "I still, still to this day I'm still suffering. I went to get a death certificate done for the baby. I named her Shannon. So, like, that was pretty hard for me to do as well. I went away for a week and I did that. That was pretty hard for me to do as well. But I had to have some dignity: to say that that child was still there... I've tried to

kill myself. I don't know how many times I've tried to kill myself. But I have a little five-year-old son now so he's keeping me, he is the best thing that has ever happened to me now..."

The appalling facts of this case reveal what are likely to happen when the State and abortion campaigners contrive to insist that abortion is best option for deeply traumatised young women. Once Miss 'C' had spoken out, abortion campaigners never mentioned her again. She didn't suit their agenda any more. That's to be expected; this is an industry that uses the vulnerability and suffering of women to further their own cause on a regular basis. I have been shocked however at the callousness and indifference recently expressed by abortion advocates as to the tremendous suffering heaped upon Miss C by the actions of the State - in which said abortion campaigners were certainly complicit.

Finally, it is important too to look at the experience of other jurisdictions.

The 1967 Abortion Act allowed for abortion under mental health grounds in the UK. What has followed as been well documented, with up to 200,000 abortions taking place every year, most on mental health grounds. In my time in psychiatry in Jersey, I saw evidence of a tick box mentality towards allowing abortion on mental health grounds.

Similarly in California, the Therapeutic Abortion Act of 1967 attempted to create a "balance" between the health of the mother and the state's interest in limiting abortion. To get an abortion, the mental illness of the mother had to reach the same medical standard for involuntarily committing a person to a mental health institution: "mental illness to the extent that the woman is dangerous to herself or to the person or property of others or is in need of supervision or restraint."

The woman needed a committee of two licensed doctors (or 3 if after the 13th week of pregnancy) to be in unanimous agreement to allow an abortion.

So, what happened? In 1970, just one year, there were 63,872 abortions approved and 61,572 performed. Virtually all of them, 98.2%, were approved and performed under the mental health exception.

We know abortion is never a treatment for mental ill-health or suicidality (we know that it results in elevated levels of suicidality) and such legislative creations are based on politics and not on sound medicine. There is simply an inherent ambiguity in the standard being applied, and doctors should never be in a position of deciding whether an Irish baby is deliberately targeted. It is by definition a corruption of their professional ethos to care for and heal life.

In closing, I would like to make one additional comment in relation to maternal mortality.

Some commentators point out that Ireland's low maternal mortality rate (MMR) offers evidence that women's lives are not put at risk by a ban on abortion. Others argue

that countries such as Italy, with legalised abortion, are sometimes ranked ahead of Ireland for maternal safety.

Commentators usually fail to take into account that there are many different factors that feed into and affect each country's MMR. Each health care system, and each country's social patterns are different, and in comparing two different countries you are not comparing like with like.

However we can point to one instance of a country where abortion was at first legal and subsequently banned, and which shows "that there is no scientific evidence of the potentially deleterious cause-effect relationship between abortion restrictive laws and maternal health."

That country is Chile. If abortion advocates were right, Chile's maternal mortality figures should have spiked after the change in their law, but the figures show that maternal deaths, which had been falling steadily, continued to decrease.

Leading Chilean researcher, Professor Elard Koch, gave an analysis of the Chilean experience at the International Symposium on Maternal Health in Dublin earlier this year.

He showed that when abortion was made illegal in 1989, the downward trend of their MMR remained on a steadily decreasing course. The graph of their year-on-year maternal deaths show an exponentially declining MMR which was not affected by the ban on abortion.

Incidentally, the beginning of that decline corresponded with the introduction of a major program of prenatal care and complimentary nutrition for pregnant women ("The Mother-Child Law"). Perhaps, that makes the best argument that the ethos in Ireland of focusing care on both mother and baby is the best one.

Chile has also seen a sharp downward slope in their abortion mortality rate since 1989, suggesting that in the absence of legal abortion a thriving backstreet abortion trade did not emerge. The abortion mortality rate fell by a massive 95% between 1989 (when abortion was banned) and 2007, official statistics show.

It seems that banning abortion is a better option for both mother and baby.