Submission to the Joint Committee on the 8th Amendment of the Constitution

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Introduction
I am a consultant psychiatrist practicing in the Tallaght Mental Health Services; and am also an academic in Trinity College Dublin. I have been asked to give my opinion, as an expert in the field of women's mental health to the Joint Committee on the 8th Amendment of the Constitution (JC), in relation to the findings of the Citizen's Assembly, 2017.

In this short document I will
(1) Outline my professional experience relevant to women's mental health and psychiatry;
(2) Lay out the findings of the Citizen's Assembly in relation to mental health; and
(3) Provide information relevant to these findings that I hope will be of value to the JC.
I refer to "woman/women" but would like the JC to understand that I also mean "girl/girls". Similarly, when I reference "Irish women" I'm referring to women who are resident in Ireland.

(1) Expertise & experience relevant to this submission

- My present appointment is a joint academic-clinical one.
    - I am a consultant psychiatrist in the HSE (Tallaght Hospital and the Community HSE Mental Health Services, Dublin South Central).
    - I am a professor in Clinical Psychiatry in Trinity College Dublin where I lead a research programme in depression, with a particular focus on perinatal depression. This research programme is a joint collaboration between the Trinity College Institute of Neurosciences, where I am based academically, and the national Obstetric Services.

Previous relevant experience

- Leading a National Perinatal Psychiatry Service in London for five years in the Maudsley Hospital serving all of the UK (2002-2007).
- Head of the section of Perinatal Psychiatry in King's College Medical School from where I led a research programme in perinatal depression.
- Publishing extensively in the scientific literature on the epidemiology, clinical treatment and neuroendocrinology (hormone-brain changes) in perinatal depression.[1-4]

- Writing a book, Psychiatric Disorders during Pregnancy (2007: Taylor & Francis, London. O'Keane V, Marsh M & Seneviratne G)
- Co-authoring the standard clinical assessment tool for perinatal psychiatric disorder in the UK.
    - Howard L, Hunt K, Slade M, O'Keane V, Seneveviratne T, Leese M, Thornicroft G (2008) Camberwell Assessment of Needs for Pregnant women (CAMS). Royal College of Psychiatrists Pubs.
- Expert for the NICE UK (National Institute for Clinical Excellence: the DoH guidelines for clinicians in different medical specialties) for the management of perinatal depression.
  www.**nice**.org.uk/**nice**media/live/11004/30433/30433.pdf
- Setting up two General Hospital Psychiatric services: this includes the Suicide Prevention Service in Beaumont Hospital (1998-2002).
- Expert witness at the Public Hearings following the publication of the report into matters relating to A,B,C vs. Ireland, chaired by Gerry Buttimer in 2013. The discussion then was largely dominated by the issue of whether, or not, the oireachtas should legislate for the "suicide clause".
- Expert witness at the Joint Oireachtas Committee on Health & Children Public Hearings on the Protection of Life During Pregnancy (Heads of) Bill in May 2013.
- Co-hosting of the **The World Congress on Women's Mental health** with the National Women's Council of Ireland in March 2017 in the RDS, Dublin.

In this submission and in my opening statement I will reference the academic literature and have provided support for the information provided in the list of references. There are many issues relevant to the Irish situation for which there can never be an academic literature: for example, we can never know the outcome of forcing a woman to continue with a pregnancy against her will, or what the outcome would be of preventing a woman having an abortion if she is suicidal because of being pregnant. Questions such as this cannot be tested for ethical reasons.

(2) Findings of the Citizen's Assembly
(https://www.citizensassembly.ie/en/The-Eighth-Amendment-of-the-Constitution/Final-Report-on-the-Eighth-Amendment-of-the-Constitution/Final-Report-incl-Appendix-A-D.pdf)

I would like to start by thanking the citizens and members of the CA. The process and governance of the Citizen's Assembly in relation to the 8th Amendement was an example of the best of democratic principles in action. I found the members to be highly engaged and sophisticated in their comprehension of the subject. The application of the information given by the expert presenters, most of which related to abortion services in other countries, to the particular context of Ireland was impressive. Their conclusions were solution-focused and not idealogically driven.

The extract containing the summary of the recommendations of the Citizen's Assembly (Index 1) is probably already very familiar to the members of the JC. Most of the recommendations are relevant to mental health but have been spelled out in

a helpful way that leaves no room for ambiguity. This clarity is one of the many strengths of the document.

A majority of Citizen's recommended 12 reasons for which termination of pregnancy should be lawful in Ireland. For each general health reason listed, there was a parallel mental health reason. For example, 99% voted that abortion should be lawful where there was a *Real and substantial physical risk to the life of the woman*; and 95% where there was a *Real and substantial risk to the life of the woman by suicide.* 93% and 90%, respectively, supported abortion where there was a *Serious risk to the physical health of the woman* and a *Serious risk to the mental health of the woman.* The same applied for *Risk to the physical health of the woman* (79%) and *Risk to the mental health of the woman* (78%).

There are two points that I would like to address in relation to these recommendations. The first point is that the support for risk for medical and mental health were very similar. In this regard, *in an additional question on the ballot, 72% of Members recommended that a distinction should not be drawn between the physical and mental health of the woman.*

The second point that I would like to highlight is that of risk. The CA considered three levels of medical risk: risk of death, risk of serious ill health and risk to health. This classification is sometimes used outside of the discipline of medicine. The pattern was that higher levels of risk were associated with greater endorsement for the availability of abortion services, but, the range of endorsement among the three levels was very small with close to 100% endorsing abortion where the woman's life was at risk, and almost 80% endorsing the availability of abortion services for the lowest level of risk.

I will now expand on these two points

(3) CA findings in relation to Psychiatry

<u>No differentiation between mental and physical health</u>

It is an enormous relief that the CA concluded that there should be no distinction between medical and psychiatric risk. It is a relief to those of us working in psychiatry and to allied mental health professions, to colleagues from other medical and surgical disciplines, and to the many Irish people who suffer from mental health problems. The mind-body division, dualism, has plagued our society and created much unnecessary suffering through stigmatisation and discrimination. Separation of mental from physical heath has been at the heart of the debate about abortion for the last three decades, following from the 1992 ruling that suicide risk constituted grounds for abortion, because it put the pregnant woman's life at risk. We have had two referenda, in 1992 and in 2002, where suicide was upheld by the majority of citizens as a legitimate reason for an abortion. We had a very difficult debate in 2012-2013 leading up to the Protection of Life During Pregnancy Act (PLDPA) in relation to suicide and how psychiatrists could or could not predict suicide. We

finally acknowledged in the PLDPA that risk of suicide constitutes a risk to the life of a woman in the circumstance where the suicidal ideation is being caused by an unwanted pregnancy. The CA understood, and made this understanding explicit, that the distinction between mental and physical health is a false one. The importance of this recommendation cannot be underestimated. It changes everything.

I want to say a few words about body-mind dualism because it has been a very destructive force in our understanding of mental health problems. The brain, of course, is organic matter and emotional disorders, such as depression and anxiety, are brain disorders. What is fed into our brain from the environment will determine largely how we respond to adversity. If one is being excessively stressed, the brain will respond to alert the body. The brain controls the body so that while one may feel sad in one's heart or anxiety in one's gut, this is being directed from the brain. Feeling emotionally distressed and highly anxious happens in one's body and can lead to medical diseases. The dialogue between the body and the emotional brain is never stronger than during pregnancy. This is because the pregnancy hormones, produced by the ovaries and the placenta cross into the pregnant woman's brain and modify her emotional brain. Emotional changes also occur because pregnancy is a very challenging event: parenthood is the most serious challenge that most of us will face in life. The stresses are coming from the biology of the feto-placental system and from the anxieties inherent in being pregnant and imminent parenthood. Pregnancy is associated with increases in anxiety and depressive symptoms and is the highest risk period in a woman life for depression.[5] My research group looked at rates of depression during pregnancy in Irish Maternity Hospitals. This was the first such study and was funded by the Health Research Board. We launched our findings in November 2016, with a "Well Before Birth" leaflet and poster campaign (see Index 2). Our rates of 16% of antenatal depression are somewhat higher than EU norms, in countries where comparable methods have been used.

Being depressed and pregnant is a very serious problem because not only is the pregnant woman intensely distressed but the stress hormones alter the fetal physiology so that the fetus is developing in a high stress milieu and is at an increased risk of being born earlier in pregnancy, and to be delivered with obstetric complications.[6] Depressed pregnant women are often not able to attend to their own health care needs and tend to be poorer attenders for obstetric care. Infants born to women who were depressed during pregnancy are more likely to suffer from childhood learning and behavioural difficulties and from depression in early adulthood.[7] All of this demonstrates that the emotional brain is important not only for the general wellbeing of the pregnant woman but also for the subsequent health of her baby and the baby's trajectory through life.[8] The treatment of psychiatric disorders in pregnant women is seen as a priority issue among colleagues.

Level of risk

It is well established that woman are more likely to become depressed if they have an unwanted pregnancy. Crisis pregnancies can and do evolve into unwanted

pregnancies that women will not want to continue. The reasons will vary from woman to woman and no situation is ever the same. Reasons for needing an abortion frequently centre arounds the the woman feeling that she cannot become a parent at this time in their life: she may have other children (60%), be a child or a student, have a psychiaric or medical disorder, or be in an abusive domestic sitution, or have been poorly parented herself and knows that she would not be able to cope with parenting. The solution, similarly, for each individual woman is specific to her circumstances, but will always require the option of an abortion.

An unplanned or an unwanted pregnancy increases the risk of depression during pregnancy.[9] A study published this year examined the relationship between unwanted pregnancy and perinatal depression. It forms part of a very large US study called the PRAMS (Pregnancy Risk Assessment Monitoring System) involving over 110,000 pregnant women from more than 40 states and the findings are being used to guide US health policy. They have reported that having an unwanted pregnancy increases the risk of perinatal depression by 50%.[10] These findings are difficult to argue with given the scale of the study and the methodology used. In this study, as in all other published studies from OECD countries, *the option of legal abortion was available*. Women from OECD countries, with the exception of Ireland and some very small states, have the option of having abortion care in situations where the pregnancy is unwanted. This indicates that women who go to term with unwanted pregnancies in countries where abortion is a legal option have opted not to have an abortion, rather than being forced down a pathway of parenthood because the option of abortion was not available. This point is made again in the meta analysis published by the Academy of Royal Colleges's report in London in 2011 (see Index 3). The authors make the point repeatedly that the academic literature only reflects studies done in countries where abortion services are available, so that an unwanted pregnancy in this context is not driven by the absence of the option of an abortion. There are no scientific studies from OECD countries on mental health outcomes where women are forced to go through with unwanted pregnancies because of not having the option of an abortion. In my practice I have had to try and help women who have become sucidal because of not being able to access abortion care. Level of risk can fluctuate unpredictably in pregnant women who have iunwanted pregnancies, particularly in situations where the option of abortion is not available.

This is the difference between Ireland and other OECD countries: an Irish woman's only option to obtain a legal abortion is to travel. Access to this service is legal and facilitited by state-funded information services. A service based in another jurisdiction is problematic and I want to address the mental health consequences for the two classes of women who need abortion services: those who can't travel and those who do travel.

There will always be women who will not be able to travel to have an abortion abroad: e.g., women without passports and women who are too poor or who do not have the educational resources to organise travel, and women who are too sick to travel. The issue of women with fatal fetal anomalies will be addressed later in this session. The situation of migrant women who are unable to travel has been painfully

laid out by the Case of Ms Y. I have seen women in my own practice who are unable to travel because of threats of violence by abusive partners or threats from their community because abortion is unacceptable culturally. Such women live in situations of constant danger and can become suicidal because of not being able to access an abortion at home. The category of women who are too sick to travel includes women with debilitating mental illness. We have patients who are challenged by coming to the Outpatient Clinic and can only attend accompanied by a community nurse. Most of the care that they receive is home-based. They may never have travelled outside of Dublin. It would be way beyond their personal resources to travel to the UK. Neither would they have the capacity to source the abortion pills on the web, and no one can legally help them in this regard because it is a crime to help procure an abortion. Women with very limited mental health resources are always vulnerable but are exceedingly vulnerable if faced with an unwanted pregnancy. These vulnerable women may not, in reality, have any option other than to to bring to term an unwanted pregnancy. Women with handicaps such as this should be compassionately cared for in settings appropriate to their needs. Sensitive and appropriate services are provided for our high-need patients in other medical and surgical areas, such as oncology or neurology. The second problem about having a *de facto* UK-based service is one that every Irish woman or girl who travels bears. The UK path to abortion is a sad and shameful one that Irish women have endured for five decades now. It is a cruel and degrading journey and it is damaging to women's mental health. It is filled with shame and humiliation. The woman is easily identified and sees herself as being easily identified. What shoud be a private and sensitively conducted procedure becomes a public journey.

Conclusions

At the heart of the problem of abortion in Ireland is one issue: that of unwanted pregnancies. It is self-evident that there always has been and there always will be unwanted pregnancies and that there will always be a requirment for abortion care. The mental health risks associated with unwanted pregnancies are high and are incalculable for women who are in a position where abortion care is not available. The mental health arguments for decent abortion services apply not just to the women who need abortion care and who can or who cannot travel, but to every citizen. We need a real-life solution to the real life problem of unwanted pregnancy and not a moral, ethical, metaphysical, philosophical discussion about abortion. We are applying an unworkable solution - travel to the UK or break the law by procuring the abortion pills - to this problem. Instead of this unworkable system we need compassionate care. The lived experience of travelling to the UK for an abortion has been made real by brave women (@TwoWomenTravel, and women who attended the CA). I would go further and say that the mental health of every person in Ireland is being damaged by the 8th Amendement. We are all shamed by the current situation.

To conclude, the recommendation of the CA are a welcome departure from the dualism of psysical versus mental health in their recognition that mental wellbeing is inseparable from physical wellbeing. Their recommendations that all facets of

mental wellbeing, from suicidal risk to damage to mental health, be considered as grounds for abortion takes into account the complexity of each individual woman's lived experience of an unwanted pregnany. The rigidity of constitutional absolutes is the polar opposite of what is required to deal with the need of women with unwanted pregancies. A solutions-based compassionate response to this problem will require the removal of the prohibition on abortion from the constitution. A legal framework that will allow for the unpredictability of obstetric and psychiatric risk needs to be put in place so that safe and compassionate abortion care can be provided for vulnerable women. While any constitutional ban remains in place, doctors will remain unable to practice medicine in line with the principles of best practice, and women's mental health will continue to be damaged.

References

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Index 1

Extract from the Citizen's Assembly, 2017

In summary, the Citizens' Assembly made the following recommendations by a majority vote:

- *- That Article 40.3.3° should not be retained in full. (87%)*
- *- That Article 40.3.3° should be replaced or amended. (56%)*
- *- That Article 40.3.3° should be replaced with a constitutional provision that explicitly authorises the Oireachtas to legislate to address termination of pregnancy, any rights of the unborn, and any rights of the pregnant woman. (57%)*

Put simply, the Members voted that they wanted to remove Article 40.3.3° from the Constitution, and for the avoidance of doubt, to replace it with a provision in the Constitution, which would make it clear that termination of pregnancy, any rights of the unborn, and any rights of the pregnant woman are matters for the Oireachtas. In other words, it would be solely a matter for the Oireachtas to decide how to legislate on these issues.

The Assembly then made further recommendations about what should be included in this legislation. Specifically, the reasons, if any, for which termination of pregnancy should be lawful in Ireland, as well as any gestational limits that should apply, were addressed.

64% of the Members recommended that the termination of pregnancy without restriction should be lawful. Of the Members who voted on that Ballot:

- *48% have recommended that the termination of pregnancy without restriction should be lawful up to 12 weeks gestation age only.*
- *44 % have recommended that the termination of pregnancy without restriction should be lawful up to 22 weeks gestation age only.*
- *8% have recommended that the termination of pregnancy should be lawful with no restriction to gestational age.*

In addition, a majority of Members recommended 12 reasons, for which termination of pregnancy should be lawful in Ireland. They also made recommendations as to gestational limits, if any, in respect of each of those reasons. Those reasons are as follows and the details of the voting on gestational limits, if any, for each will be outlined in Chapter 1:

- *Real and substantial physical risk to the life of the woman (99%)*
- *Real and substantial risk to the life of the woman by suicide (95%)*
- *Serious risk to the physical health of the woman (93%)*
- *Serious risk to the mental health of the woman (90%)*
- *Serious risk to the health of the woman (91%)*

- *Risk to the physical health of the woman (79%)*
- *Risk to the mental health of the woman (78%)*
- *Risk to the health of the woman (78%)*
- *Pregnancy as result of rape (89%)*
- *The unborn child has a foetal abnormality that is likely to result in death before or shortly after birth (89%)*
- *The unborn child has a significant foetal abnormality that is not likely to result in death before or shortly after birth (80%)*
- *Socio-economic reasons (72%)*

In an additional question on the ballot, 72% of Members recommended that a distinction should not be drawn between the physical and mental health of the woman.

Index 2

Index 3

This index summarises the literature on the mental health consequences of induced abortion. For ease of reference I have bolded the main studies usually quoted in relation to the mental health issues associated with abortion. This systematic review took these studies as counterpoints to represent the two opposing findings that abortion, on the one hand, has no adverse consequences on a woman's mental health and that abortion, on the other hand, is damaging to a woman's health. This paper is the most in-depth and comprehensive review of the literature in this area.

Extracts from document
INDUCED ABORTION AND MENTAL HEALTH

A SYSTEMATIC REVIEW OF THE MENTAL HEALTH OUTCOMES OF INDUCED ABORTION, INCLUDING THEIR PREVALENCE AND ASSOCIATED FACTORS.
DECEMBER 2011
Developed for the Academy of Medical Royal Colleges by National Collaborating Centre for Mental Health, London, 2011

https://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf

The present systematic review was commissioned by the Academy of Medical Royal Colleges and funded by the Department of Health, partly in response to the call for a further review of the best available evidence about the relationship between induced abortion of an unwanted pregnancy and mental health problems. The Steering Group consisted of 19 members, including representatives of the RCPsych, the RCOG, the Royal College of General Practitioners, technical staff from the National Collaborating Centre for Mental Health (NCCMH), and four members from the Department of Health who observed two meetings each and monitored progress.

Included in the analysis were all studies that had been published in English-language peer-reviewed journals between 1995 and 2009.

Questions asked…

1. How prevalent are mental health problems in women who have an induced abortion?

2. What factors are associated with poor mental health outcomes following an induced abortion?

3. Are mental health problems more common in women who have an induced abortion, when compared with women who deliver an unwanted pregnancy?

The systematic search of the literature across all review questions from 1990 to 2011 identified 8,787 references, excluding the initial search results from the APA review. When combined with the 73 references from the APA review this resulted in a set of 8,860 references.

The relationships between unwanted pregnancy, abortion and mental health have been the subject of much debate and research. In an explicit effort to clarify this area, the APA and Charles reviews have drawn together research addressing these relationships (APA Task Force on Mental Health and Abortion, 2008; Charles et al., 2008). These reviews concluded that abortion of an unwanted pregnancy was no more likely to lead to mental health problems than if the pregnancy went to full term. However, each review can be criticised on the grounds of either quality of included studies or breadth of the field of inquiry. More recently, a meta-analysis by Coleman (2011) concluded that abortion was associated with increased risks of mental health problems compared with no abortion.

The Charles review used quality criteria to identify studies of higher quality that were more able to compare the mental health impact of abortion with that for birth in an unwanted pregnancy. The Charles review did not undertake a broader examination of studies to assess the prevalence of, or to identify factors associated with, mental health problems following abortion for unwanted pregnancy.

Coleman also considered only the comparison between women who had an abortion and those who did not have an abortion. However, the Coleman review failed to provide any details about quality assessment, included a number of studies that quality and failed to control for previous mental health problems. A number of methodological problems with the meta-analysis conducted in the Coleman review have been identified, which brings into question both the results and conclusions.

What does seem to be more certain is that for women with an unwanted pregnancy, abortion does not appear to harm their mental health.

Findings

Taking into account the broad range of studies and their limitations, the steering group concluded that, on the best evidence available:

• The rates of mental health problems for women with an unwanted pregnancy were the same whether they had an abortion or gave birth.

• An unwanted pregnancy was associated with an increased risk of mental health problems.

• The most reliable predictor of post-abortion mental health problems was having a history of mental health problems before the abortion.

• The factors associated with increased rates of mental health problems for women in the general population following birth and following abortion were similar.

• There were some additional factors associated with an increased risk of mental health problems specifically related to abortion, such as pressure from a partner to have an abortion and negative attitudes towards abortions in general and towards a woman's personal experience of the abortion.

• Future practice and research should focus on the mental health needs associated with an unwanted pregnancy, rather than on the resolution of the pregnancy.

Recommendations

In the light of these findings, it is important to consider the need for support and care for all women who have an unwanted pregnancy because the risk of mental health problems increases whatever the pregnancy outcome.