EPP0061

Ethical issues in assertive outreach and crisis intervention teams

J. J. Martínez Jambrina

PSYCHIATRY, HOSPITAL SAN AGUSTÍN, AVILES, Spain
doi: 10.1192/j.eurpsy.2023.401

Introduction: Assistance to people suffering serious mental illnesses has undergone large variations in the last twocenturies. After World War II, The community became a new destination for them. But hardly anyone knew how to cope with mental illness in thecommunity. Thus, several initiatives arose in the US. Both social work and psychiatry,moved towards a pragmatic point of view by the rising tide of patients seeking help: initiatives trying to providesolutions to themost basic needs of patients: accommodation, food,medical care, takingof medication, etc. By the 1970s, Mary Ann Test and LeonardStein had proven the effectiveness of their-Life Coaching in Madison, Wisconsin. In 1981 his program is disseminated by several states under the name of Assertive TreatmentCommunity and thus spread throughout the United Statesand Canada, Australia and Europe. Psychiatry has recognized it as the program that got the most for supporting the community model. 50 years later the basics of the TAC model remain more or less thesame. But home interventions caused a continuous conflict in the ethical field notwell addressed…

Objectives: WHY IS AN ACT team a fertile ground for ethicalconflicts?This approach is coercive or assertive?There are several reasons. There is a specific ETHICAL ENVIRONMENT in THE ACT team

1."Diffusion of Responsibility"-

2. Mutual confirmation bias:

3. There is a tendency to think that professionals areethical by nature.

4. Biased search for information when problems arise.

Sources are sought to confirm us before clarifying whathappened

5. A special tendency to conformism.

6.Repetitive responses.

Methods: We will analyze the main ethical conflicts arising in ACT teams:

1. CONFLICTS OF AUTONOMY

2. PRIVACY AND CONFIDENTIALITY ISSUES

3. CONFLICTS OF DUTIES

4. ASSERTIVENESS VERSUS COERCION

Results: The great challenge is knowing how and when to intervenewith patients with variable decision-making capacity orwithout any insight, as well as the impact on theirautonomy. It is an exercise both in art and inphenomenological training: Because there are subtledeficits, difficult to appreciate, but there are otherdeficits that are obvious.

Conclusions: The challenge: balancing the needs and safety of thecommunity with the needs and safety of the individual.ACT teams staff must juggle both perspectives, whilemaintaining a therapeutic alliance.

The continuous contact with the patient in an ACT teamgives, especially to clinicians, a privileged place ofobservation to act correctly in those situations and to be asupport so that whoever arrives lacking in affectivity orwith relational problems could grow until reaching a moreprudent and competent judgment.

WHAT COULD HAPPEN IF WE TRAIN PROFESSIONAL IN BIOETHICS MORE IN PATIENT´S RIGHTS, A FIELD FOR LAWYERS??

Disclosure of Interest: None Declared

EPP0061

Medical Assistance in Dying in Psychiatry, An Ethical Analysis.

K. Keenan

Department of Psychiatry, Connolly Hospital, Dublin, Ireland
doi: 10.1192/j.eurpsy.2023.402

Introduction: Assisted dying (AD) is a general term in the literature to incorporate both physician-assisted suicide (PAS) and voluntary active euthanasia. In 2002 Belgium became the first country in the world to specifically acknowledge mental suffering in law as a valid basis for AD, specifically euthanasia, with other countries passing similar AD legislation more recently. Local legislation stipulates both substantive and procedural criteria that must be met for AD in jurisdictions, with only minor differences in procedural criteria noted accross sites.

In countries without AD legislation it remains a criminal offence for a physician to partake in AD, the offence prosecutable under local laws as manslaughter. It is a fiercely contentious issue within the medical, legal, political, religious and ethical fields with lack of consensus and on-going deliberation.

Objectives: The author examines literature regarding the ethical issues raised by medical assistance in dying in psychiatry.

Methods: A non-systematized review of the literature, using literature available on PubMed, PsychINFO and Medline.

Results: Findings from this review indicate that Beauchamp & Childress' biomedical approach of equilibrating the ethical principles of 'respect for autonomy', 'beneficience', 'nonmaleficence' and 'justice', to act in the best interests of their patients are those most used in contemporary psychiatric practice. There is a fundamental theme suggested in the literature that 'respect for autonomy' is both the prevailing and challenging ethical principle to soundly navigate in AD cases. Within this principle, the task of objectively assessing capacity remains dominant.

Psychiatry remains unique in its pathology, biological and social entanglement hence the literature suggests a limit to autonomous decisions be considered, due to the extreme vulnerability and vast potential for abuse of this patient cohort.

Ultimately, the literature suggests physicians adhere to available professional medical ethical guidelines (should they be available), using an objective scale for undertaking capacity assessments, and seeking advice from the courts rather than bearing any outstanding ethical burden in these most complex of cases.

Conclusions: Infinite complexities and dissensus surrounding practice of psychiatric AD. The ethical principle of autonomy retains a significant role in both AD and psychiatric debates, with specific attention drawn the quandary of psychiatric capacity assessment. In addition to the moral question of whether it is appropriate to assist psychiatric patients to end their lives, the appropriateness of this role for psychiatrists is yet to be determined

in light of professional disdain. Further analysis of cases are required, as they are published over time, to further reform the ethical and legal arguments.

Disclosure of Interest: None Declared

EPP0062

Who is 'the person of unsound mind'? The problem of terminological incompatibility in law and medical sciences in the context of the proper legal protection of people with mental disorders subjected to penal coercive measures

M. Burdzik*

Department of Psychiatry, Center of Psychiatry in Katowice and Institute of Legal Sciences, University of Silesia, Katowice, Poland
doi: 10.1192/j.eurpsy.2023.403

Introduction: Penal coercive measures (e.g., detention) seriously interfere with the individual's fundamental rights (especially the right to liberty). It is necessary to have proper guarantee mechanisms to protect an individual against the arbitrariness of decisions made in this regard. It is especially significant in the case of people with mental disorders (MD). This group of entities may not be able to take intended legal actions to protect their rights and, thus, requires enhanced legal protection. The effectiveness of legal solutions depends on the appropriate terminology. Vague, ambiguous, or archaic terms pose a risk of over-interpretation and create an area for abuse. An example of such solution is art. 5(1)(e) of the European Convention on Human Rights (ECHR) allows deprivation of liberty for "the person of unsound mind."
Objectives: The study aims to analyze the concept of "person of unsound mind" appearing in the ECHR and to define its semantic scope in relation to mental disorders. This procedure aims to determine whether the status of a person of unsound mind is the same as the status of a person with MD - both in legal and medical contexts.
Methods: The study consists of two stages. The first stage included the narrative review of the literature by searching the PubMed and Google Scholar databases with the keywords "unsound mind" and "person of unsound mind". The second stage included the analysis of the European Court of Human Rights judgments relating to art. 5 (1)(e) of ECHR, collected in the HUDOC database. Forty-four articles and 128 judgments met inclusion criteria and were included for further analysis.
Results: The study shows that the concept of a "person of unsound mind" is primarily indefinite. The term does not correspond to the current standards of medical terminology. It relates to mental disorders but has a narrower scope. The term "unsound mind" refers only to "true mental disorder", which is of that kind or degree that warrants compulsory confinement. To be considered a "true" mental disorder has to be of a certain severity. This term should be interpreted narrowly, but there are no grounds to limit its scope to psychotic disorders only. However, including some non-psychotic disorders in its scope may be questionable (e.g., antisocial personality disorder).
Conclusions: The structure of art. 5(1)(e) ECHR does not comply with the current medical terminology standards. This inconsistency in terminology and primary indefinite character of the "unsound mind" may implicate a lot of difficulties in precisely defining its meaning and scope of use in individual cases. It is dangerous from the perspective of the personal liberty of people with MD. This term should be replaced with the term "mental disorders," the meaning of which is well-established in medicine.

Disclosure of Interest: None Declared

EPP0063

Euthanasia and assisted suicide (EAS) in psychiatric patients

P. Pedro Felgueiras* and R. Silva

Psychiatry department, Vila Nova de Gaia Hospital Center, Vila Nova de Gaia, Portugal
*Corresponding author.
doi: 10.1192/j.eurpsy.2023.404

Introduction: A legal definition for EAS describes this procedure as "intentionally terminating life by someone other than the person concerned, at the latter's request". The number of requests for EAS has been progressively increasing in countries where this procedure is allowed, including concerning psychiatric patients (2% of all requests). EAS for reasons of unbearable suffering raises ethical concerns due to lack of criteria for psychiatric patients.
Objectives: To discuss the avaliable data about EAS and its controversial value in psychiatric patients.
Methods: Non-systematic review of literature on current knowledge about EAS, particularly in patients with mental disorder.
Results: In terms of sociodemographic and clinical characteristics, these patients were mostly women, with at least two psychiatric conditions; the main diagnosis is a (treatment-resistant) mood disorder, with some medical comorbidity. Psychological suffering was the main motivation, in patients with severe symptomatology associated with psychiatric and physical conditions (26% reported both psychological and physical suffering). These patients tend to be empowered and value self-determination. There is to highlight a high percentage of patients still alive after a not granted pEAS request (69%) and a high rate of pEAS requests withdrawals (37%).
Conclusions: Suicide prevention remains a priority in terms of public health. Thus, there is a need to ensure that EAS isn`t a way to increase suicide mortality by giving access to lethal methods to suicidal patients. In some cases, EAS request has a paradoxical value to regain control of life and it`s related to the transient nature of unbearable mental suffering.
The actual process provides a continued recovery-oriented care in parallel with the EAS evaluation, and a thorough evaluation which requires a multi-expert panel with the envolvement of mental health professionals. Ethical concerns remains about its paradox: unbearable psychological suffering is a target for suicide prevention and also a required criterion for EAS.

Disclosure of Interest: None Declared