## EPP0060

## Ethical issues in assertive outreach and crisis intervention teams

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**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.

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**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