DB003

Should we consider assisted suicide a clinically and ethically valuable option for people with mental disorders? - Pro Speaker

T. Pollmaecher[1,2]

[1]Center of Mental Health, Klinikum Ingolstadt, Ingolstadt and [2]Department of Psychiatry, Ludwig Maximilians University, Munich, Germany
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Abstract: In some European and non-European countries assisted suicide (AS), defined as supporting a person in committing suicide by providing e.g. a lethal dose of pentobarbital, is a common practice since decades. In most of these countries, AS initially was considered legitimate only, if a person has a limited expected survival time and/or suffers in an unbearable manner. Hence, AS was implicitly or explicitly not available for persons with psychiatric disorders.
Meanwhile, however, in some countries psychiatric disorders are acknowledged to cause unbearable suffering in certain cases and, in addition, a ruling of the highest court of Germany stated in 2020 that the right to seek suicide assistance might not be restricted to certain conditions or diseases, but solely tied to the competence to freely choose to end ones own life.
Because there is no indication that psychiatric disorders in general render affected person incompetent to freely choose suicide, a general exclusion of affected individuals from AS is incompatible with the biomedical principle of justice.
Clinically, however, psychiatric disorders in persons seeking AS must be seriously taken into account when a judgement has to be made on the individuals' competence to choose freely. This kind of judgements are particularly difficult because both, the persons competence and his or her will to seek AS might be quite variable across time.

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DB004

Should we consider assisted suicide a clinically and ethically valuable option for people with mental disorders? Con Speaker

J. Samochowiec

Deptartment of Psychiatry, Pomeranian Medical University, Szczecin, Poland
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Abstract: Several challenges exist rendering people with mental disorders particularly vulnerable to wrongful assisted suicide. Their desire to die may be a symptom of the mental illness rather than an autonomous choice; their decision-making competence may be compromised by the illness and hence more troublesome to determine; the severity of suffering may be more challenging to assess from an external perspective; the very wish to die may be variable over time; and prognostic uncertainty in mental illness may impede determining of whether severe suffering is, in fact, resistant to treatment. An ethically sound argument for excluding people with mental disorders from assisted suicide is their potential inability to make a free, autonomous decision. A person's request for assisted suicide should be considered in the context of an assessment of their capacity to make a well-informed and deliberated decision. Opponents of legalising euthanasia and assisted suicide agree that the suffering caused by mental illness can be just as severe and agonising as in cases of somatic conditions. However, one cannot with all certainty assume that the illness is incurable and that the suffering cannot be minimised to such an extent that the patient experiences relief. The task of psychiatry is to prevent suicide. What follows is that diseases such as depression should be treated, while the patients should be supported and not facilitated to part with their lives. Considering their potentially illness-affected request for suicide, it seems better to prolong their suffering than let them die. One cannot grant the right to die to all those who have the competence to make decisions. Furthermore, legalising euthanasia and assisted suicide also in the case of patients with mental illnesses risks distorting the doctor-patient relationship. Euthanasia is not a balance between the interest of the state and the benefit of the individual in terms of choosing the time and manner of their death. What happens if the interest of the state is not to protect the lives of citizens, especially the most vulnerable and defenceless, including the mentally ill? Once values are rejected, only practical 'benefits' remain, such as financial savings on psychiatric care and treatment. And this is extremely risky. Drawing a clear line in the light of the above considerations seems to be impossible. In the current situation, where many people are exposed to mental suffering, e.g. in the form of depression, the priorities are suicide prevention policies and funding programmes for psychiatric treatment. The debate will take into account arguments for and against euthanasia in patients with mental disorders.

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DB005

Do we need psychiatric asylums again? - Con speaker

R. Keet

GGZ Noord-Holland-Noord, Overveen, Netherlands
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Abstract: The expansion of institutional long-term psychiatric care, while well-intentioned, repeats the historical failures of the 19th century answer to severe mental illness: asylums—facilities often marred by neglect, abuse, and the marginalization of individuals with mental illness. Many of the handicaps of persons living in these asylums were not the consequence of the mental health disorder but were iatrogenic damage done by living in these asylums. Though modern psychiatric institutions are more regulated, institutionalization inherently limits autonomy and reinforces stigma, undermining recovery-oriented models of care. Instead of diverting resources to rebuild large-scale facilities, investment should focus on strengthening community-based services, supportive housing, individual placement and support and integrated care models that empower individuals with serious mental illness to live fulfilling lives within society. Evidencebased outpatient programs, Flexible Assertive Community Treatment teams, peer support networks, recovery colleges, mobile crisis teams, peer farms, respite houses offer more humane, cost-effective, and person-centered alternatives. Addressing systemic challenges—such as poverty, lack of housing, lack of social connectedness and fragmented healthcare systems—can better serve this population without reverting to institutional confinement. Long-term solutions must prioritize dignity, autonomy, and inclusion rather than a return to segregated care.

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