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## Psychiatric Euthanasia, Suicide and the Role of Gender

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### Summary

The preponderance of women among persons who request and receive euthanasia and assisted suicide based on a psychiatric condition, as shown by data from the Netherlands and Belgium, is virtually unexplored. In this Analysis, we provide a critical discussion of this gender gap and propose it can inform a key debate point in the controversy over the practice, namely its tension with suicide prevention.

### Introduction

Euthanasia and/or medically assisted suicide when primarily based on a psychiatric disorder (“psychiatric EAS”), is permitted in some European countries such as Belgium and the Netherlands, but remains controversial.(1, 2) In those countries, EAS is permitted for persons who suffer unbearably and irremediably due to a medical (including psychiatric) condition (Box). Women account for the majority (69–77%) of persons who request and receive euthanasia based on a psychiatric condition.(3–6) While this is one of the most consistent finding emerging from the research on the topic, the gender gap and its meaning have received virtually no discussion.

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In this paper, we discuss how understanding this gender gap can inform a key dispute in the debate about psychiatric EAS, namely its tension with suicide prevention. One way to address this tension is to argue that psychiatric EAS and suicide are different phenomena, characterizing suicide as an impulsive act of violent self-destruction, and EAS as a planned and well-considered act.(7) However, it is unclear whether this distinction is empirically founded. We will examine whether and how the gender gap can inform this question in an evidence-based manner.

In the following sections, we first critically examine current accounts of the difference between psychiatric EAS and suicide. Next, we turn to ideation-to-action theories of suicide, arguing that, when combined with the gender gap in psychiatric EAS, such theories support the hypothesis that differences between psychiatric EAS and suicide are not based on impulsivity, but rather on the notion of suicide “capability”. Finally, we outline the implications of this finding for the practice of psychiatric EAS. We argue that the pool of potential psychiatric EAS requestors and the associated risk for error might be higher than previously assumed, and explain how current guidance might contribute to this risk. We conclude by drawing some implications for public policy.

## Understanding the gender gap in psychiatric EAS

### Current explanations for the difference between psychiatric EAS and suicide

Current explanations for the difference between psychiatric EAS and suicide describe different phenomena, with emphasis on the alleged different role of impulsive action in both cases.(7, 10, 11) The American Association for Suicidology states that suicide and EAS, *including* psychiatric EAS, are in general quite distinct, involving different patient characteristics. They characterize suicide as associated with violent self-destruction, isolation, loss of meaning, ambivalence and psychological pain. On the other hand, they describe persons requesting EAS as, instead, engaging in a planned act of self-preservation, experiencing intensified emotional bonds with loved ones.(7) Others have also characterized suicide as a quasi-impulsive, violent and lonely act, to be distinguished from EAS, seen as a carefully executed, non-violent plan in dialogue with others.(10) Some guidelines on psychiatric EAS state that suicidal behavior “usually involves impulsive behavior”, as opposed to the death wish in psychiatric EAS.(12) Currently, the same distinction is proposed to explain the different gender distributions in suicide and psychiatric EAS: suicides are violent and impulsive (hence involving more men), whereas psychiatric EAS is planned and controlled (hence involving more women).(5)

Such contrasting portrayals of persons who die by suicide versus those who die by EAS as fundamentally different rely on unfounded assumptions.(11) Their key reliance on impulsivity can be challenged, as the role of impulsive action in suicide has been overstated and only very little suicidal behavior (lethal or non-lethal) occurs without planning.(13–15) In fact, impulsive attempts are associated with *lower* psychopathology,(13) while individuals who are at particularly high risk for suicide (i.e. those with depression, substance use, a history of childhood sexual abuse) are less likely to engage in impulsive attempts. Impulsive action is neither necessary nor sufficient for suicide and cannot explain the difference between suicide and psychiatric EAS, nor its different gender distributions.

We should therefore reexamine this empirically unsupported assumption. For this purpose, we will consider the usefulness of ideation-to-action theories, which focus on the suicidal *process* from suicidal ideation to behavior.(14–16) This framework has received considerable clinical and research attention.(15, 17) Rather than emphasizing the role of suicide risk factors, it focuses on the concept of suicide “capability”, which determines the transition from suicidal ideation to (lethal and non-lethal) suicidal behavior. Within this framework, “capability” includes practical factors (knowledge of and access to highly lethal means) and psychological factors (fearlessness of death, pain tolerance), both of which can be acquired over time.(14–19) In the following sections, we analyze the gender distributions in suicide and psychiatric EAS and examine the potential role for capability as an alternative, empirically-grounded explanation for the relation between suicide and psychiatric EAS.

### Capability, gender and suicide

The difference between the gender distribution in suicide and that in suicide attempts is well-known and is referred to as the suicide “gender paradox”.(18, 20) The most consistently cited explanation for this paradox is the gender difference in methods chosen: women choose less violent and lethal methods than men.(18, 21) For example, men tend to use methods such as hanging or fire-arms, while women often choose self-poisoning. Research suggests that differences in capability among suicide attempters is what accounts for why more men die by suicide than women.(15)

The choice for low lethality methods may indicate lower suicide capability, especially as it relates to the psychological aspects, since these methods may be perceived as involving less physical pain and be relatively less frightening.(15, 22) Furthermore, the robust finding that women show a higher number of non-lethal attempts prior to a lethal attempt is consistent with the claim that through repeated attempts, women gradually increase their capability and the lethality of their attempts.(13, 16, 18, 23)

We note, however, that other authors emphasize socio-cultural beliefs and attitudes towards suicidal behavior in explaining gender differences in suicide.(17, 24) For example, in Western countries, non-lethal suicidal behavior is considered more socially acceptable for women than for men, but this may be different in non-Western countries.(24) High female suicide rates in countries like China (25) show that women’s so-called low capability for suicide in Western countries may vary depending on the socio-cultural context.

### Capability, gender and psychiatric EAS

The above capability framework suggests a natural explanation of the gender gap in psychiatric EAS and better conforms to the known literature on suicide than an explanation based on impulsivity. EAS is a painless and highly lethal method of death, that is professionally and socially approved in countries where it is legal. The important psychological components of capability involve the ability to face death and to enact something painful to one’s own body. (16, 19) The latter barrier, for instance, is removed when someone receives EAS, as it does not involve pain or violence.

This finding is analogous to the well-known case in suicidology of high female suicide rates in rural China. This is attributed to men's and women's equal access to readily available, non-violent yet highly lethal pesticides, as opposed to the less toxic analgesics and psychotropic medications commonly ingested in high-income countries.(17, 18, 25, 26) The case of rural China shows that mortality significantly increases when persons with a strong death wish have access to non-violent, lethal methods.

If the different gender distributions in suicide and psychiatric EAS are primarily accounted for by differences in capability, we should expect similar gender ratios between suicide *attempters* (as opposed to completers) and persons receiving psychiatric EAS. And this is what we find. Men are 2 to 3 times as likely to die by suicide than women in most countries, including in the Netherlands, while women are about twice as likely (2.1:1) to *attempt* suicide.(3, 17, 26, 27) The women:men ratio in psychiatric EAS (2.3:1) is virtually identical to that of suicide attempters, not completers.

This suggests that the relation between suicide and psychiatric EAS is not based the problematic concept of impulsivity. Rather, capability is more likely to explain why some patients resort to EAS rather than suicide. This suggests that patient profiles of people requesting and receiving psychiatric EAS could be more similar in terms of suicidal behavior than previously assumed.(11) Persons with a strong death wish but low capability, who might not die if they attempt suicide, can achieve death if they use EAS instead.

## Discussion

Whether psychiatric EAS conflicts with the duty to prevent suicide remains a topic of debate. One way to address this tension is to distinguish between suicide and (psychiatric) EAS, by characterizing suicide as an impulsive, typically violent action, and EAS as planned and well-considered.(7) However, this distinction is not well-grounded empirically and does little to refute the claim that psychiatric EAS is in tension with suicide prevention. Ideation-to-action explanations of suicide, focusing on the suicidal *process*, suggest that the distinction is not as straightforward as some have argued. The notion of capability that they invoke suggests that the "gender paradox" in suicide is closely related to the gender gap in psychiatric EAS: women resort to psychiatric EAS as a form of suicide of which they are "capable". And, as we have shown, the numbers are consistent with this analysis. Persons requesting and receiving psychiatric EAS tend to be similar to those attempting suicide, a finding corroborated by emerging data from the practice of psychiatric EAS.(3, 11, 28, 29) In suicide terms, the use of EAS turns attempters with low capability into completers. This raises several, so far underexplored, implications for the practice of psychiatric EAS and public policy.

First, it suggests that the number of persons engaging in suicidal behavior, *both* non-lethal and lethal (i.e. suicide attempters and completers) could provide an approximation of the pool size of potential psychiatric EAS requestors. For example, in a country like Belgium with 11 million inhabitants -and with notoriously high suicide rates- the region of Flanders counts 3 suicides and an estimated average of 28 suicide attempts per day.(30) This amounts to 1,095 suicides and over 10,000 suicide attempts per year – 9 attempts for every suicide.

It is reasonable to assume that a significant proportion of these persons might consider psychiatric EAS at some point during their suicidal process, as psychiatric EAS becomes better known as an option. Hence, the pool of potential requestors is likely large, perhaps more so than previously assumed.

For some, providing a more humane alternative to persons who would otherwise die by suicide is the aim of psychiatric EAS.(31, 32) For example, psychiatrist Lieve Thienpont, one of the three physicians acquitted in the Belgian Tine Nys court trial, stated that “We have 3 to 4 suicides per day in Flanders, 90% of whom suffer mentally. What can we do to shift this suicidal thought to a request for euthanasia?”.(31) However, this view does not take into account that such a shift would not be limited to suicide completers only.

Second, a large pool of potential requestors that mostly consists of suicide attempters raises the issue of an increased opportunity for error, i.e. the risk for avoidable deaths. The risk for error is a known area of dispute in the debate about psychiatric EAS.(32) Scholars disagree on whether it should count as an argument against psychiatric EAS or merely as grounds for caution. Regardless of where one stands, the dispute has so far mainly referred to potential errors in assessing the irremediability of the person’s psychiatric condition, their unbearable suffering or their decision-making capacity. The findings of our analysis point to a different *type* of risk, namely the one associated with not detecting suicidal behavior that could respond to treatment. The question is particularly salient for subgroups with low suicide capability and a more protracted suicide process, like women or younger adults.(17, 18) as the choice of psychiatric EAS over traditional means of suicide could result in substantial increase in mortality. That is, the difference between expected mortality rates through suicide versus through EAS could be highest in these subgroups and the risk for error may, on average, come at a higher cost for each individual.

One way to address this conundrum is by establishing clear guidance for clinicians, to identify those whose requests for psychiatric EAS stem from suicidal ideation and behavior that could respond to treatment. Currently, guidelines are silent on whether suicidal ideation and behavior should play a role in how “irremediability” is defined, potentially exacerbating the risk for error. In fact, they define the criterion exclusively in terms of treatment options for the underlying psychiatric condition.(12, 33) This may be due to the assumption that treating a psychiatric condition will also improve associated suicidal behavior. However, this assumption is mistaken. Treatments targeting a psychiatric condition do not necessarily reduce suicidal thoughts or behavior.(15) Furthermore, while established evidence-based treatments for suicidal behavior exist, including pharmacological and psychological treatment, only about 60% of people with suicidal ideation and behavior receive treatment.(15) This raises important questions about the extent of unmet needs among persons at risk for suicide who request psychiatric EAS.

For example, psychological treatments such as dialectical behavior therapy for borderline personality disorder or cognitive therapy for recent suicide attempters have proven effective. (15, 17) However, in a recent analysis, we found that these interventions are rare among persons receiving psychiatric EAS: cognitive therapies were reported in 14% and dialectical behavior therapy in none of the 74 included personality-related disorder cases, while 47%

had attempted suicide once and 36% multiple times prior to their request.(29) To reduce the risk that a psychiatric EAS request actually stems from suicidal behavior, further discussion is needed about the role for established suicidal behavior treatments in current guidance defining irremediability. This also points to the need for sufficient and independent expertise in these evaluations going forward, as both the Netherlands and Belgium continue to face difficulties recruiting psychiatrists willing to be actively involved in these evaluations.(31, 34, 35)

Finally, the similarities between persons at risk for suicide and those requesting psychiatric EAS calls for further attention to population-wide suicide risk factors that may apply to psychiatric EAS. For example, the effect of media reporting on imitation behavior is a risk factor targeted in key population-level suicide prevention strategies.(17) While the regulation of media reporting does not apply to (psychiatric) EAS, similar patterns of imitation could be expected in persons who consider requesting psychiatric EAS. To assume that the same patterns do not apply is only tenable if the clinical profiles are distinct, but not if they appear similar. Yet patients' perceptions and attitudes towards others' deaths by psychiatric EAS remains an open empirical question.

The overlap between suicide and psychiatric EAS calls for further research to better characterize persons who request psychiatric EAS. Given that the majority of suicide attempters are women, particular attention should be paid to women's reasons for requesting psychiatric EAS. This includes possible reasons for why women are more likely to express a death wish in the first place, why some persons with a death wish request psychiatric EAS while others do not, and why some proceed with their request once it is granted, while others withdraw. But, if some of the reasons also include known actionable societal or gendered risk factors for mental disorders and suicidal behavior, this raises additional issues warranting attention in the context of psychiatric EAS *and* public policy.

For example, gender-based violence, affecting 35% of women worldwide, is a clear example of a gendered environmental risk factor for mental disorders and suicidal behavior that is common among persons requesting psychiatric EAS,(28, 29) and an important public health issue for which prevention and management remains suboptimal.(36, 37) Other gender-specific risk factors for common mental disorders include gender-based discrimination and unfavorable social and economic circumstances such as low employment, income inequality, low social rank and status, and the unequal division of domestic labor and care.(37) Hence, the findings of this analysis raise implications for policy and research that go far beyond the boundaries of psychiatry.

## Conclusion

Despite being empirically well-established, the gender gap in psychiatric EAS has been underexplored so far. An analysis of its meaning using the ideation-to-action suicide theories shows that the gender gap provides key evidence that persons requesting and receiving psychiatric EAS could be more similar to persons engaging in suicidal behavior than previously assumed. This raises important implications for the practice of psychiatric EAS and public policy.

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## References

1. Griffith J, Weyers H, Adams M. Euthanasia and Law in Europe. Portland, OR: Hart Publishing; 2008.
2. Jones DA, Gastmans C, MacKellar C. Euthanasia and Assisted Suicide: Lessons from Belgium: Cambridge University Press; 2017.
3. Kim SY, De Vries RG, Peteet JR. Euthanasia and Assisted Suicide of Patients With Psychiatric Disorders in the Netherlands 2011 to 2014. *JAMA Psychiatry* 2016;73(4):362–8. [PubMed: 26864709]
4. Thienpont L, Verhofstadt M, Van Loon T, Distelmans W, Audenaert K, De Deyn PP. Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study. *BMJ Open*. 2015;5(7):e007454–2014.
5. van Veen SMP, Weerheim FW, Mostert M, van Delden JJM. [Euthanasia of Dutch psychiatric patients in 2015–2017]. *Tijdschr Psychiatr*. 2019;61(4):241–7. [PubMed: 31017282]
6. Dierickx S, Deliens L, Cohen J, Chambaere K. Euthanasia for people with psychiatric disorders or dementia in Belgium: analysis of officially reported cases. *BMC Psychiatry*. 2017;17(1):203. [PubMed: 28641576]
7. Creighton C, Cerel J, Battin M. Statement of the American Association of Suicidology: "Suicide is not the same as "Physician aid in dying". <https://suicidology.org/wp-content/uploads/2019/07/AAS-PAD-Statement-Approved-10.30.17-ed-10-30-17.pdf> 2017 (Accessed Dec 2018)
8. Onwuteaka-Philipsen BD, Legemaate J, van DerHeide A, van Delden H, Evenblij K, El Hammoud I, et al. Derde evaluatie Wet toesting levensbeëindiging op verzoek en hulp bij zelfdoding (*Third Evaluation of the Dutch Termination of Life on Request and Assisted Suicide Act*). Den Haag, The Netherlands; 2017.
9. EuthanasiaCode. Review Procedures in Practice. <https://english.euthanasiacommissie.nl/thecommittees/code-of-practice>. Regional Euthanasia Review Committees 2018 (Accessed June 2018)
10. den Hartogh G. Two Kinds of Suicide. *Bioethics*. 2016;30(9):672–80. [PubMed: 27666925]
11. Kim SYH, Conwell Y, Caine ED. Suicide and Physician-Assisted Death for Persons With Psychiatric Disorders: How Much Overlap? *JAMA Psychiatry*. 2018;75(11):1099–100. [PubMed: 30090927]
12. NVVP. Nederlandse Vereniging voor Psychiatrie. Levensbeëindiging op verzoek bij patiënten met een psychische stoornis. [https://richtlijnendatabase.nl/richtlijn/levensbeëindiging\\_op\\_verzoek\\_psychiatrie/startpagina\\_-\\_levensbe\\_indiging\\_op\\_verzoek.html](https://richtlijnendatabase.nl/richtlijn/levensbeëindiging_op_verzoek_psychiatrie/startpagina_-_levensbe_indiging_op_verzoek.html) 2018 (Accessed June 2019)
13. Anestis MD, Soberay KA, Gutierrez PM, Hernández TD, Joiner TE. Reconsidering the Link Between Impulsivity and Suicidal Behavior. *Pers Soc Psychol*. 2014;18(4):366–86.
14. Klonsky ED, May AM, Saffer BY. Suicide, Suicide Attempts, and Suicidal Ideation. *Annu Rev Clin Psychol*. 2016;12(1):307–30. [PubMed: 26772209]
15. O'Connor RC, Nock MK. The psychology of suicidal behaviour. *Lancet Psychiatry*. 2014;1(1):73–85. [PubMed: 26360404]
16. VanOrden KA, Witte TK, Cukrowicz KC, Braithwaite SR, Selby EA, Joiner TE Jr. The interpersonal theory of suicide. *Psychol Rev*. 2010;117(2):575–600. [PubMed: 20438238]
17. Turecki G, Brent DA, Gunnell D, O'Connor RC, Oquendo MA, Pirkis J, et al. Suicide and suicide risk. *Nat Rev Dis Primers*. 2019;5(1).

18. Schrijvers DL, Bollen J, Sabbe BG. The gender paradox in suicidal behavior and its impact on the suicidal process. *J Affect Disord* 2012;138(1–2):19–26. [PubMed: 21529962]
19. Franklin JC, Hessel ET, Prinstein MJ. Clarifying the role of pain tolerance in suicidal capability. *Psychiatry Res* 2011;189(3):362–7. [PubMed: 21868104]
20. Canetto SS, Sakinofsky I. The gender paradox in suicide. *SuicideLife Threat Behav* 1998;28(1):1–23.
21. Hawton K. Sex and suicide. Gender differences in suicidal behaviour. *Br J Psychiatry*. 2000;177:484–5. [PubMed: 11102320]
22. Nock MK, Hwang I, Sampson NA, Kessler RC. Mental disorders, comorbidity and suicidal behavior: results from the National Comorbidity Survey Replication. *Mol Psychiatry*. 2010;15(8):868–76. [PubMed: 19337207]
23. Isometsa ET, Lonnqvist JK. Suicide attempts preceding completed suicide. *Br J Psychiatry*. 1998;173:531–5. [PubMed: 9926085]
24. Dahlen ER, Canetto SS. The role of gender and suicide precipitant in attitudes toward nonfatal suicide behavior. *Death Stud*. 2002;26(2):99–116. [PubMed: 11871460]
25. Turecki G, Brent DA. Suicide and suicidal behaviour. *Lancet*. 2016;387(10024):1227–39. [PubMed: 26385066]
26. WHO. World Health Organization: Age-Standardized Suicide Rates: Male: Female Ratio (Per 100,000). Available online: [https://www.who.int/gho/mental\\_health/suicide\\_rates\\_male\\_female/en/](https://www.who.int/gho/mental_health/suicide_rates_male_female/en/) 2019 (Accessed Aug 2019)
27. Bernal M, Haro JM, Bernert S, Brugha T, de Graaf R, Bruffaerts R, et al. Risk factors for suicidality in Europe: results from the ESEMED study. *J Affect Disord* 2007;101(1–3):27–34. [PubMed: 17074395]
28. Verhofstadt M, Thienpont L, Peters GY. When unbearable suffering incites psychiatric patients to request euthanasia: qualitative study. *Br J Psychiatry*. 2017;211(4):238–45. [PubMed: 28970302]
29. Nicolini ME, Peteet JR, Donovan GK, Kim SYH. Euthanasia and assisted suicide of persons with psychiatric disorders: the challenge of personality disorders. *Psychol Med* 2020;50(4):575–82. [PubMed: 30829194]
30. Vancayseele N, Portzky G, van Heeringen K, Cloots H, Hendrickx E, Kongs A, et al. Agentschap Zorg & Gezondheid. Kenmerken Suicidiepogingen in Gent en Vlaanderen. [https://www.zorg-engezondheid.be/sites/default/files/atoms/files/EZO\\_su%C3%AFcidepogingen\\_2017.pdf](https://www.zorg-engezondheid.be/sites/default/files/atoms/files/EZO_su%C3%AFcidepogingen_2017.pdf). 2018 (Accessed Feb 2020)
31. Truyts J. Psychiater Lieve Thienpont strijdvaardig na vrijspraak op euthanasieproces: "Ik zet mijn werk voort, dat is zeker". <https://www.vrt.be/vrtnws/nl/2020/02/02/euthanasieproces-zevende-dag/> 2020. (Accessed Feb 20, 2020)
32. Nicolini ME, Kim SYH, Churchill ME, Gastmans C. Should euthanasia and assisted suicide for psychiatric disorders be permitted? A systematic review of reasons. *Psychol Med* 2020; 50(8):1241–1256. [PubMed: 32482180]
33. Vandenberghhe J, Titeca K, Matthys F, Van den Broeck K, Detombe T, Claes S, et al. Hoe omgaan met een euthanasieverzoek in psychiatrie binnen het huidig wettelijk kader? Adviestekst van de Vlaamse Vereniging voor Psychiatrie (VVP) over te hanteren zorgvuldigheidsvereisten. 2017 [http://vvponline.be/uploads/docs/bib/euthanasie\\_finaal\\_vvp\\_1\\_dec.pdf](http://vvponline.be/uploads/docs/bib/euthanasie_finaal_vvp_1_dec.pdf) (Accessed Dec 2018)
34. Huisman. Levensindekliniek kan de vraag niet aan en zoekt tientallen nieuwe artsen. *De Volkskrant*. 2017 (Accessed Dec 8, 2018)
35. van de Wier. Drie jaar vechten om te mogen sterven: wachten op euthanasie in de psychiatrie. *Trouw*. 2019. (Accessed Dec 19 2019)
36. Oram S, Khalifeh H, Howard LM. Violence against women and mental health. *Lancet Psychiatry* 2017;4(2):159–70. [PubMed: 27856393]
37. World Health Organization Department of Mental Health and Substance Dependence. Gender Disparities in Mental Health. [http://www.who.int/mental\\_health/media/en/242.pdf](http://www.who.int/mental_health/media/en/242.pdf). Geneva, Switzerland 2001 (Accessed March 2019)



**Box.****Background information on psychiatric EAS in the Netherlands and Belgium****Legal requirements for EAS**

According to the Dutch Termination of Life on Request and Assisted Suicide Act (2002), the substantive requirements are that the attending physician must be satisfied that the patient's request is voluntary and well-considered and that the patient's suffering is unbearable and without prospect of improvement and must have come to the conclusion, together with the patient, that there is no reasonable alternative in the patient's situation. (8, 9) The Belgian Act Concerning Euthanasia (2002) has similar albeit differently formulated key substantive requirements: the physician must come to the conviction, together with the patient, that the request be voluntary, that the disorder be serious and incurable and must ascertain that the physical or mental suffering of the patient cannot be alleviated.(2) (See below for procedural requirements and the main differences between the two jurisdictions.)

**Process and oversight systems for EAS**

The Belgian Act requires that the physician consult a second physician—a psychiatrist in cases of psychiatric EAS—and requires a waiting time of at least one month for all non-terminally ill cases, including requests based on a psychiatric disorder. While the Dutch law requires that the physician consults at least one other, independent physician, it does not specify that this be a psychiatrist for psychiatric EAS cases. However, in these cases, a psychiatric consultation is required by the Dutch Euthanasia Review Committees. Both countries have established services providing such consultants: Support and Consultation for Euthanasia in the Netherlands and Life End Information Forum (LEIF) in Belgium. All EAS cases need to be reported to the Regional Euthanasia Review Committees and the Federal Control and Evaluation Commission on Euthanasia, respectively in the Netherlands and Belgium. These committees review the EAS reports to assess whether the physician who performed EAS conformed to the legal due care criteria.(2, 9)