We adapted a survey form to measure attitudes towards euthanasia, giving a score out of 16. 31% scored 0 (with very positive attitudes to euthanasia), 11% scored 16 (very negative), and the median was 2. Participants with negative attitudes to euthanasia had a higher degree of religiosity, were more likely to train outside of the UK, but had similar age distribution to the general population.

The second part of the survey looked at euthanasia in psychiatric patients. Only 14% agreed that it should be allowed for psychiatric illnesses, with 27% unsure and 59% opposed.

The most acceptable statement (86% agreement) was that psychiatric patients can find themselves in a medically hopeless situation. 75% agreed that psychiatric patients could suffer unbearably. 70% agreed that psychiatric patients may run out of treatment options.

Participants opposed to euthanasia also opposed it in psychiatric patients. They were more likely to doubt the above statements, but only one participant disagreed with all statements. Most disagreed with the statement that "a death request can be well-regarded and considered not only as a symptom of illness" (66%).

Of participants in favour of euthanasia in general, 42% said they were unsure of legalising euthanasia for psychiatric patients, while 21% were opposed. This group was more uncertain of the statement that "euthanasia assessment can be compatible with psychotherapeutic relationship" (50% disagreed or unsure).

Most participants had little education in this area. International Medical Graduates and those self-described as religious were more likely to have negative perceptions of assisted dying in general. While there was agreement that suffering from mental illness could be unbearable, very few supported euthanasia for mental illness alone.

Conclusion: There is a notable lack of education on euthanasia at both undergraduate and postgraduate levels which is known to have a strong influence on attitudes to assisted dying. There are aspects in medical ethics and medical law which need to be incorporated into curricula for medical training.

ASD and Perceptual Disturbances - Do People With ASD Have an Increased Risk of Visual and Auditory Hallucinations?

Dr Dawn Collins[1] and Dr Jo Lowe[2]

[1]NSFT, Great Yarmouth, United Kingdom and [2]NSFT, Norwich, United Kingdom

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Aims: To establish if there is data to support the clinical impression that people with ASD are more likely to experience perceptual disturbances (visual and auditory).

Methods: Literature search using Athens/Pub Med. Clinical observations had been that young people with ASD seemed to experience increased perceptual disturbances but that these did not respond to antipsychotics. Detailed history taking also suggested that, especially visual hallucinations, were often long-standing and had started in mid childhood (typically while at primary school). These tended not to cause distress initially but often increased during adolescence.

Results: There is little specific data on this subject: there are numerous studies and case reports considering the increased risk of psychosis and schizophrenia in people with ASD but not specifically on non-psychotic young people with ASD who have perceptual disturbances (in the absence of other symptoms suggesting psychosis). Limited data that was available noted that people with ASD were 3 times more likely to experience auditory and/or visual hallucinations than their counterparts. Suggested pathways for this included shared pathological pathways (between schizophrenia and ASD), overlapping DNA (not established), that ASD is a risk factor for later development of schizophrenia and living with ASD may incur increased social stressors (bullying, exclusion, marginalisation, isolation etc.).

Conclusion: Having ASD does appear to increase the likelihood of experiencing (psychotic and non-psychotic) perceptual disturbances. The reasons for this are largely inconclusive but may explain our clinical impression; that young people with ASD who are hearing voices or seeing things but who are not psychotic, do not appear to respond positively to antipsychotics. We would advise medications are used with caution in this (non-psychotic) patient group and that other avenues are considered for treatment, including self-help, psychoeducation and psychological support. We must be cautious about causing iatrogenic harm and over medicating. More research is needed in this field.

Formative Assessment Review Project

Miss Cherie Collins

RCPsych, London, United Kingdom

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Aims: Following the approval of the Assessment Strategy Review (ASR) in February 2023, the Formative Assessment Working Group (FAWG) was created to discuss areas for consideration, in relation to formative assessment.

The aim was to consider the broad range of the College's assessments, including written examinations, the Clinical Assessment of Skills and Competencies (CASC) and formative assessments undertaken throughout psychiatric training in the workplace. Whilst the ASR had a broad scope, one of the recommendations was to review formative assessment in detail, due to the varied nature of specialty and sub-specialty specific assessments and the differing experiences of resident doctors in the workplace.

Methods: The Formative Assessment Working Group (FAWG) met throughout 2023 and identified four specific areas for further consideration, development and implementation:

The introduction of enstrustability scales; a behaviourally anchored ordinal scale based on progression to competence, as part of workplace-based assessments (WPBAs).

Embedding formulation skills throughout training.

The introduction of feedback from patient and carers for resident doctors.

Consideration of guided supervision sessions relating to caseload-based discussion.

Results: Entrustability scales as part of WBPAs: An entrustability scale (ES) would not be suitable to all assessment types. Therefore, an adaptation of ES will be introduced to CS and ES reports. WPBA will see an improved version of the current Likert scale. Embedding formulation skills throughout training: Formulation training will be incorporated into case presentations. Resident doctors will be advised to undertake this yearly to demonstrate progression. For ST4 + trainees, one case-based discussion (CBD) will be replaced with a case presentation (CP), with the provision of presenting to MDTs.