of Physicians. In principle, there are therefore more than enough well-known recommendations on how to handle a request for termination of life from a patient with psychiatric issues.
Nevertheless, occasionally something goes wrong due to misinterpretation of the legal criteria or due to careless actions by the consulting or performing physician.
In 2010, a female patient died by euthanasia because of unbearable mental suffering, which was unacceptable for her family. The family decided to initiate a court case to have the inaccuracies in the decision-making process and the execution of the euthanasia evaluated by a judge. In 2020, three involved doctors, including a psychiatrist, were prosecuted for this euthanasia. An analysis of the court case and the media coverage of this case will be discussed.

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WS005

Euthanasia and assisted death from a Spanish perspective

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Abstract: Medical assistance in dying is an increasingly available option for people suffering (solely) from psychiatric disorders. Initially promoted to alleviate the suffering of terminally ill people, a growing number of jurisdictions are adopting it for any cause of intractable and severe suffering, including mental disorders. Today, the BENELUX countries, along with Spain and Switzerland, explicitly authorise it or allow it de facto. Other countries, such as Canada, are considering implementing it. Although in jurisdictions where it is permitted it is argued that it is discriminatory not to consider mental suffering as sufficient cause, there are reasons for concern. The procedure is likely to be used as an alternative to care, that is, as a gentler form of suicide, more commonly used by women. The long-term impact of this practice must be considered, as it sends the message that mental illnesses may not be curable, and that it is not worth the effort to treat them, or to demand the necessary care. Furthermore, all of these factors must be considered in the context of highly stigmatized disorders to which clearly scarce resources are allocated.

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WS006

Lessons from Belgium: Physician-assisted dying for (neuro)psychiatric suffering after 23 years of Belgian euthanasia legislation

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Abstract: In 2002, the euthanasia law was voted in Belgian parliament, depenalising physician-assisted dying under certain conditions for irremediable physical or mental suffering caused by an incurable condition for which all therapeutic options have been exhausted. The euthanasia request needs to be repeated, well-considered and voluntary and the patient should be competent. If the patient is not in a terminal condition, there should be at least one month between the written request and the euthanasia and three independent physicians have to be involved in the evaluation. Psychiatric suffering was not excluded in the law, but there is discussion whether the possibility of psychiatric euthanasia was intended by the legislator. In the first years after the euthanasia law, psychiatric euthanasia was limited to a few cases, but then rose to a mean of 25 cases per year. There was a peak in 2013 of 54 cases, but after 2013 there was no more increasing trend.
In 2017, the Flemish Association for Psychiatry issued an advice regarding due diligence in psychiatric euthanasia. Controversy regarding psychiatric euthanasia kept stirring the public debate, especially after one court case in which a psychiatrist and general physician were accused and acquitted after a psychiatric euthanasia. Another prominent topic in the public debate in Belgium is broadening the euthanasia law for advanced dementia based on an advance directive. Now euthanasia is only possible in the earlier stages of neurodegenerative disease, when competence is still sufficiently intact.

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WS007

Current situation in Europe – different perspectives from Poland

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Abstract: The presence of large numbers of Ukrainians looking for refuge in Poland is a new experience for Poles. The ongoing war and the uncertainty of the situation of those displaced may cause anxiety and lead to stressful reactions, exacerbated by endlessly circulating information on hostilities. Therefore, the sense of security may be threatened not only among Ukrainians who have fled to Poland, but also among people who support Ukrainians, who offer them help and shelter. Prolonged support, if not accompanied by proper selfcare can increase the risk of burnout as well as lead to distressful emotional states, such as a feeling of helplessness, reluctance to provide further help, or even demonstrate hostility. The Polish government and polish NGO's have pledged to help refugees from Ukraine, including the provision of mental health care. Raising awareness of the whole society and training employees from sectors other than medical may help in the proper protection of mental health of refugees and the people supporting them. Dividing the organization of mental health care into the four levels (Intervention Pyramid (Inter Agency Standing Committee, 2007)and offering support depending on the needs, ranging from building a basic sense of security, acceptance, and support for meeting the needs of refugees, to the level of highly specialized psychological and psychiatric assistance, enables the use of the resources of the entire society and specialists in an appropriate manner. By activating refugees themselves and training employees and volunteers of