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.

Disclosure of Interest: None Declared

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.

Disclosure of Interest: None Declared

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

various sectors and fields of support, the goal of mental health promotion is spread across many environments, which mental health professionals themselves cannot cope with in these new, difficult conditions.

Disclosure of Interest: None Declared

WS008

Workshop of the Task Force on Migration and Mental Health

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Abstract: Introduction: Sweden has a long history as a host country for refugees. In recent years there has been a shift from being one of the most generous host countries in Europe to one of the most restrictive. In Sweden, refugees with a residence permit have a full right to care, but asylum seekers and undocumented migrants only have a right to care that cannot be deferred. Despite relatively good formal access to mental health care, and so far, the availability of free language interpreters, refugees face barriers to and within mental health care.
Aims: To give a brief overview of the current challenges for mental health care in Sweden and the work on solutions for people on the move.
Research methods: Ongoing research and clinical development are summarised in parallel with the identification of challenges.
Findings: A complex picture of the development and challenges of mental health care for people on the move in a situation of increasing social pressure on refugees is described.
Conclusions: There is a need for equal treatment of people on the move without discrimination and exclusion.

Disclosure of Interest: None Declared

WS009

Current situation in Europe – different perspectives

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Abstract: Germany is one of the countries that has taken in a large number of refugees. Around 2.25 million now have recognised protection status in Germany. In addition, Germany has taken in over 1,215,048 refugees from Ukraine. All of these people are very vulnerable refugees who are exposed to many risk and stress factors before, during and after their migration. As a result, they have a high prevalence of mental disorders such as post-traumatic stress disorder (PTSD), depression, anxiety, substance use and persistent grief disorder. At the same time, refugees face numerous barriers to accessing medical care, such as language and cultural barriers, administrative barriers, structural, institutional and interpersonal discrimination and racism. There is also unequal treatment in Germany between refugees from Ukraine and other regions of the world. In addition, healthcare provision has recently been tightened due to changes in the Asylum Seekers' Benefits Act. This presentation will focus on the sitaution in Germany and discuss üossible solutions.

Disclosure of Interest: None Declared

WS010

Seeing Affective and Psychotic Disorders through Addictions: Case Studies to Review the Challenges for the Survival of both "the Patient on the Edge" and "Therapeutic Alliance"

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Abstract: Comorbidities in addiction: It is a rule rather than an exception. The story starts in childhood; even before, in infancy, and may be in prenatal life. The dimensional traits have already been there, existing obviously far before any DSM-5 diagnosis. Among these traits, the developmental features named as stress sensitivity, impulsivity and emotion dysregulation are the leading ones. Comorbidity research addressed childhood abuse, neglect or other childhood adverse experiences as a definite risk factor for adolescence and adult mental disorders, particularly substance use disorders. Developmental and environmental adversities in a mutually amplifying pattern make a vicious cycle in which the individual finally finds an illusionary exit, a pathway to addiction. This presentation aims to discuss the complexities and challenges for the diagnosis and treatment of cases presenting with ASUD (alcohol and substance use disorders) and comorbid neurodevelopmental and affective or psychotic disorders . The history as well as the life and the management charts of the patients are reviewed in the light of information collected during the follow-up years revealing significant alterations with regard to diagnoses and therapeutic approaches. A specific focus of the case studies will be the missed or mis-diagnoses, and the impact of them on the treatment courses and the outcomes. One of the case studies with an eight year follow-up period, shows ADHD traits, alcohol use disorder, affective disorder and a later emerging severe stimulant use disorder. The second case with a similar ADHD history, presents with a stimulant use disorder, co-occuring with a severe psychotic disorder, that has been mis-diagnosed as schizophrenia. The life and management charts of the studied cases convey the drawbacks of the diagnostic difficulties, the treatment failures and the implication of efficient therapeutic strategies.
The challenges faced by clinicians due to co-occuring disorders that have become a common practice for addiction professionals. should be managed by transdiagnostic and integrative modalities. While big data or empirical large datasets can have their own limitations to help the practitioner for overcoming such complexities of real world situations, as stated in Stein's article (2022, Psychiatric diagnosis and treatment in the 21st century: paradigm