shifts versus incremental integration) "the age-old single-case studies, may sometimes provide clinical insights that outweigh those from big data analyses."

Disclosure of Interest: None Declared

WS011

Neurodevelopmental Challenges: Dealing with ADHD and Addictions

A. Schellekens

Psychiatry, Radboudumc, Nijmegen, Netherlands
doi: 10.1192/j.eurpsy.2025.200

Abstract: Attention Deficit Hyperactivity Disorder (ADHD) and Substance Use Disorders (SUD) frequently co-occur. Patients with this comorbidity report poorer qualtiy of life, and have worse treatment outcomes for both disorders, including high relapse rates of the SUD. In this case based discussion, clinical dilemma's in the diagnosis and treatment of patients with this comorbidity will be discussed. Recent findings of the International Collaboration on ADHD and Substance Abuse (ICASA) will be used as background, including findings from ICASA's most recent work: the longitudinal International Naturalistic Cohort Study of ADHD and SUD (INCAS), where nearly 600 patients with both ADHD and SUD in treatment were followed for nine months. In addition, ICASA's consensus statements on diagnosis and treatment of co-occurring ADHD and SUD in youths and adults will be shortly discussed.

Disclosure of Interest: None Declared

WS012

Discussion on the case from neurodevelopmental and transdiagnostic perspectives

A. Lingford-Hughes

Psychiatry, Imperial College London, London, United Kingdom
doi: 10.1192/j.eurpsy.2025.201

Abstract: During the workshop about this complex case, I will discuss aspects of the case and the challenges the individual has faced from a neurodevelopmental and transdiagnostic perspective. It is the norm that those presenting for treatment or support with problematic drug/alcohol use will also have co-occurring neurodevelopmental, mental and physical health traits or disorders. Their relationships are often complex and ingrained. It is generally unhelpful to consider such complexity in terms of 'primary' vs 'secondary' as this may lead to exclusion from some services. For instance, someone with depression and problematic alcohol use may not be seen by psychiatric services or psychologists due to their drinking and an 'addiction' service may not have sufficient mental health expertise for managing their depression. Such 'silos' are common and need to be addressed through better understanding of the relationships between problematic drug/alcohol use and co-occurring neurodevelopmental, mental and physical health traits or disorders, through better training of health and social care staff and reducing stigma.

Disclosure of Interest: A. Lingford-Hughes Grant / Research support from: Research supported by Lundbeck, GSK, Indivior; unrestricted funds support from Alcarelle for a PhD, Consultant of: Silence, NET Device Corps, Sanofi-Aventis, Astra Zeneca and also consulted by but received no monies from Britannia Pharmaceuticals, GLG, Opiant, Lightlake and Dobrin, Paid Instructor of: Received Honoraria paid into her Institutional funds for speaking and Chairing engagements from Lundbeck, Lundbeck Institute UK, Janssen-Cilag, Pfizer, Servier; receives Honoraria for teaching for British Association for Psychopharmacology.

WS013

Neurostimulation in Addictions: a retrospective study in patients with Cocaine Use Disorder undergoing a rTMS protocol

A. Gual[1,2*] and P. Lusilla[3]

[1]Health and Addictions Research Group, Fundació Clínic - Idibaps; [2]Centre Bonanova and [3]Psychiatry Department, Hospital Vall d'Hebron, Barcelona, Spain

*Corresponding author.
doi: 10.1192/j.eurpsy.2025.202

Abstract: There are clear unmet medical needs in the treatment of Cocaine Use Disorder (CUD), since there are no pharmacological treatments approved. The neurobiological circuitry of addiction has been described in recent years, and it provides a solid rationale to target specific brain regions to treat addictive behaviors, including CUD. The stimulation of the left Dorsolateral Prefrontal Cortex (DLPFC) with repetitive transcranial magnetic stimulation (rTMS) has proved to reduce craving for various drugs, including cocaine. We present the results of a retrospective study performed in a private setting with 93 patients with CUD, who were treated with rTMS following the protocol from Terraneo et al. In 12 weeks patients received 32 sessions of 2400 pulses (100% MT; 10 Hz; 60 pulses per train, 15 seconds interval; 40 trains per session), for a total of 76800 pulses.

The main outcome was total abstinence of cocaine (self-reported plus urinalysis). Abstinence rates at days 30, 60 and 90 were 55,9%; 40,8%; and 34,4% respectively.

Psychiatric comorbidities (insomnia, depression and anxiety) were also assessed with validated questionnaires. Drop-out was directly related to recent cocaine use, but initial levels of psychological distress did not predict drop-out.

No relevant side effects were reported. Mild and transient headache was reported by a few patients after the first session.

In conclusion rTMS was well tolerated, drop out rates were high and 34% of the patients remained abstinent after the 90 days treatment period.

Disclosure of Interest: None Declared