(MMPI-2) was administered during the 12-month follow-up. Participants aged between 18 and 65 years were included in the study, with body mass indexes (BMIs) exceeding 40 for individuals without comorbidities related to morbid obesity, and exceeding 35 for those with comorbidities related to morbid obesity, particularly related to glucose metabolism.
MMPI-2 scales previously confirmed to be related to SUD were analyzed, and common psychological comorbidities of SUD were searched for using these scales
Results: High scores on MAC-R, AAS, and APS scales are well-represented in the sample (Table 1).
The sample includes a high number of high scorers on Rc4 and a moderately high number of high scorers on Rc9 (Table 2).
Elevated individual scale scores form dual or triplet peak settings in the MMPI-2 results and may describe certain conditions, like SUD.
The majority of the subjects showed SUD-like personality settings (Figure 1). This study is constrained by limitations about sample size, a dropout rate exceeding expectations, stringent exclusion criteria, male-to-female ratio, short-term results, and the absence of longitudinal data on psychological characteristics.

Image 1:

Table 1. **Frequencies along the Supplemental Scales**

	No. of patients with high score	%
Anxiety (A)	5	31,25%
Repression (R)	5	31,25%
Ego Strength (Es)	1	6,25%
Dominance (Do)	2	12,5%
Social Responsibility (Re)	3	18,75%
College Maladjustment (Mt)	5	31,25%
Post-Traumatic Stress Disorder Scale (Pk)	6	37,5%
Hostility (Ho)	6	37,5%
Over Controlled Hostility (O-H)	3	18,75%
MacAndrews Alcoholism Scale Revised (MAC-R)	9	56,25%
Addictions Acknowledgement Scale (AAS)	4	25%
Addiction Potential Scale (APS)	6	37,5%
Gender Role - Masculine Scale (GM)	3	18,75%
Gender Role - Feminine Scale (GF)	6	37,5%

Image 2:

Table 2. **Frequencies along the Revised Clinical Scales (Rc)**

	High score	%	Low score	%
Demoralization (Rcd)	4	25%	0	0
Somatic Complaints (Rc1)	2	12,5%	0	0
Low Positive Emotions (Rc2)	7	43,75%	0	0
High/Low scores on Cynicism (Rc3)	5	31,25%	3	18,75%
Antisocial Behavior (Rc4)	7	43,75%	0	0
Ideas of Persecution (Rc6)	2	12,5%	0	0
Dysfunctional Negative Emotions (Rc7)	4	25%	0	0
Aberrant Experiences (Rc8)	1	6,25%	0	0
Hypomanic Activation (Rc9)	4	25%	0	0

Image 3:

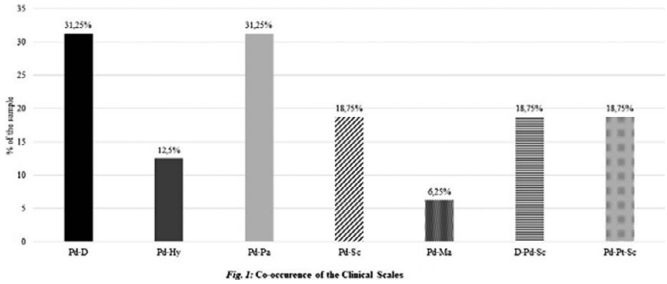

Fig. 1: **Co-occurence of the Clinical Scales**

Conclusions: We found the MacAndrews Revised (MAC-R) scale strong, with AAS and APS as intermediate indicators for non-substance-based behavioural addiction in our sample (Table 1). RC4 also seems to be a strong indicator (Table 2), along with Pd-D and Pd-Pa peaks (Figure 1).

Disclosure of Interest: None Declared

EPP078

Baclofen-Assisted Alcohol Detoxification with Minimal Diazepam Dosing: A Controlled Study at Corfu General Hospital Detoxification Unit

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Introduction: Alcohol withdrawal syndrome is a significant challenge in the management of alcohol use disorder, with traditional treatments often relying heavily on benzodiazepines like diazepam. This study aimed to explore the efficacy and safety of incorporating baclofen (30 mg/day) alongside minimal, tailored diazepam doses—adjusted according to alcohol intake and CIWA-Ar scores—to manage withdrawal symptoms more effectively than conventional diazepam protocols. By reducing the total diazepam needed and shortening detoxification time, the study highlights the potential of baclofen to offer a faster, safer approach to alcohol withdrawal treatment.
Objectives: To evaluate the efficacy and safety of combining baclofen (30 mg/day) with minimal diazepam doses—calculated based on alcohol consumption and adjusted by CIWA-Ar scores—in managing alcohol withdrawal symptoms more rapidly than standard diazepam protocols.
Methods: Sixty-nine patients with alcohol use disorder were enrolled and randomized into two groups. The baclofen group (n = 32) received baclofen 30 mg/day plus minimal diazepam, with initial diazepam doses based on average daily alcohol units consumed (1 mg diazepam per unit) and adjusted using CIWA-Ar scores. The standard group (n = 37) received a conventional diazepam-based detoxification regimen with fixed starting doses adjusted by withdrawal symptoms. Primary outcomes were the total diazepam dosage required and the duration of detoxification. Secondary outcomes included daily CIWA-Ar scores and incidence of adverse effects. Statistical analyses employed independent t-tests and chi-square tests, with $p < 0.05$ considered significant.
Results: The baclofen group required significantly less diazepam compared to the standard group (mean total dose: 30 ± 10 mg vs. 50 ± 15 mg; $p < 0.001$). They also experienced a shorter detoxification duration (mean: 15 ± 1 days vs. 19 ± 1 days; $p = 0.01$), indicating a faster withdrawal process. CIWA-Ar scores were consistently lower in the baclofen group throughout detoxification (mean: 6 ± 2 vs. 10 ± 3; $p < 0.001$), reflecting milder withdrawal symptoms. No significant adverse effects were observed in either group, including over-sedation, respiratory depression, or hallucinations.

Conclusions: Combining baclofen (30 mg/day) with minimal diazepam—calculated based on alcohol consumption and adjusted by CIWA-Ar scores—effectively controlled alcohol withdrawal, reduced diazepam use by 40%, and shortened detoxification by about four days. The protocol was well-tolerated and may benefit patients at risk from high benzodiazepine doses or in settings aiming to limit benzodiazepine use. These findings suggest baclofen can reduce medication needs and speed up recovery. Larger trials are needed to confirm these results and evaluate long-term outcomes like relapse rates and sustained abstinence.

Disclosure of Interest: None Declared

EPP081

Intervention for improving treatment retention and alcohol-related outcomes in patients with alcohol-related liver disease: a randomised controlled trial

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Introduction: Quitting alcohol use has been described as the main factor capable of modifying the prognosis of alcohol-related liver disease (ArLD). However, retention to the addiction treatment in these patients is low, and relapse in alcohol use is common. Misconceptions in the patients knowledge of the disease and the treatment impact retention. To improve retention, we have designed a blended intervention consisting in a presential brief intervention combined with a gamified webapp (MyWayUp). The intervention provides information regarding the liver disease and treatment, how to improve the prognosis, healthy lifestyles and how to achieve behavioural changes. The intervention was designed using a co-creation approach, and is based in well-stablished psychological principles (cognitive behavioural therapy, CBT; motivational interviewing, MI; psychoeducation; game-based learning).
Objectives: The main objective is to explore the efficacy of the MyWayUp for improving retention to the addiction treatment in patients with ArLD at six months follow-up. As secondary objectives we explore: retention at 1 and three months, adherence to the treatment (attended visits from the total programmed), patterns of alcohol use and quality of life.
Methods: Prospective, randomised controlled trial, 6 months. Patients with ArLD onset would be invited to participate. If signed the informed consent, they would be randomised to the experimental or control condition. The experimental group would receive the brief intervention and given access to the webapp with a unique access code. Patients in the control group received treatment as usual, and after six months, if they had not adhered to the addiction unit, they would be invited to participate as experimental group. Both groups would be programmed the first visit with a psychiatrist, and followed at months 1, 3 and six after inclusion. The study was blinded for professionals and patients, and only one member in the research team would know the allocation group of each patient.
At baseline, sociodemographical variables were collected, as well as clinical data (presence of comorbidities), pattern of alcohol or other substances use (AUDIT; timeline follow back, TLFB), quality of life (EQ-5D-5L) and functionality (FAST). Several measure were taken at months 1, 3 and six: being active in the treatment at the assessment point (retention); adherence; alcohol and other substance use (TLFB) quality of life and functionality.
Results: The final sample consisted of 82 patients, with a mean age of 55.3 (SD = 11.4). 38.2 % were women, and 53% of the participants were allocated to the experimental group.

Image 1:

VARIABLE	Experimental group	Control group	Statistic (p-value)
Retention month 6 (Primary outcome)	76.7%	40%	Chi = 12.24 (0.002)*
Retention month 1	81.4%	69.4%	Chi = 2.1 (0.34)
Retention month 3	72.1%	41.7%	Chi = 8.24 (0.02)*
Median of attended visits (SD)	4.5 (2.2)	2.7 (2.46)	2.3 (0.002)*
Adherence (attended visits/scheduled visits)	74.4%	45.2%	

Image 2:

VARIABLE	Experimental group	Control group	Statistic (p-value)
Prevalence of alcohol use month 1	38.3%	44%	Chi = 1.17 (0.56)
Prevalence of alcohol use month 3	22.2%	54.2%	Chi = 5.55 (0.019)
Prevalence of alcohol use month 6	20%	48%	Chi = 5.6 (0.024)