34%. These proportions depended heavily on the definition of concomitant somatic conditions as an exclusion criterion. Substance use disorders contributed significantly more to schizophrenia RCT ineligibility than to MDD RCT ineligibility. However, the risk estimates for primary outcomes were considerably larger for MDD than for schizophrenia when comparing ineligible with eligible individuals.
Conclusions: RCTs may face challenges in representing real-world individuals with schizophrenia and MDD. More inclusive eligibility criteria for RCTs are needed to improve the generalizability of trial evidence and the foundation of treatment guidelines.

Disclosure of Interest: H. Taipale Grant / Research support from: Janssen, Speakers bureau of: Gedeon Richter, Janssen, Lundbeck, Otsuka.

SP075

Digital therapeutics, for a few dollars less

B. Bolea Alamanac* and Toronto

Psychiatry, University of Toronto, Toronto, Canada
*Corresponding author.
doi: 10.1192/j.eurpsy.2026.10317

Abstract: In the post-pandemic context, demand for mental health care has increased substantially worldwide, exceeding the capacity of traditional service delivery models. While integrated care and task-shifting approaches have partially addressed this gap, scalable solutions that reduce reliance on highly specialized staff are increasingly needed. Digital health technologies offer significant potential to improve access, efficiency, and equity in mental health care delivery.
Tools such as mobile apps, web-based platforms, wearable devices, and digital phenotyping can support diagnosis, monitoring, and intervention, particularly in settings where mental health professionals are scarce.
National health systems are obligated to deliver evidence-based care equitably and efficiently. However, evaluating and implementing digital mental health interventions presents unique challenges. Unlike pharmacological or psychological treatments, apps lack clear placebo equivalents, face high attrition rates, and often exclude individuals without access to compatible devices or sufficient digital literacy. As a result, evidence derived from traditional randomized controlled trials may not fully capture real-world effectiveness, usability, or reach, particularly among vulnerable and marginalized populations.
A key advantage of digital interventions is their capacity for continuous data collection at minimal cost. This enables ongoing evaluation before, during, and after implementation, analogous to post-marketing surveillance for medications but without reporting delays. Continuous monitoring of clinical outcomes, engagement, and potential harms—including privacy breaches, misuse, and unintended increases in healthcare utilization—should be a prerequisite for apps adopted by national health systems.
Robust evaluation frameworks are required to assess not only clinical outcomes and population reach, but also usability, acceptability, safety, and ethical use of data. Clear distinctions are needed between apps that claim therapeutic benefit and those supporting lifestyle or wellness goals, with corresponding regulatory standards. As app prescription becomes more common, dedicated expertise may be required to guide safe and effective use, similar to the role of pharmacists in medication management. Looking ahead, advances in artificial intelligence may further expand the role of digital tools in mental health care, reinforcing the need for adaptive, continuous, and system-level evaluation approaches.

Disclosure of Interest: None Declared

SP076

A dimensional approach to care: implementing a stepped model for ICD-11 personality disorders

F. G. Di Leone

Sahlgrenska University Hospital, Gothenburg, Sweden
doi: 10.1192/j.eurpsy.2026.10316

Abstract: The ICD-11 introduces a dimensional, severity-based approach to personality disorder (PD) diagnosis, moving away from categorical typologies. While generally well received by clinicians and service providers, concrete examples of its implementation in clinical practice remain limited.
This presentation draws on an ongoing study examining the learnability and acceptability of the ICD-11 model across clinical and training settings in Sweden. We focus on experiences at the Unit for Personality Disorders, Sahlgrenska University Hospital in Gothenburg, using clinician reports and organizational observations to assess how the new framework influences routine care.
Early observations highlight practical challenges in integrating severity-based assessment into diagnostic workflows, treatment planning, and multidisciplinary collaboration. Organizational factors—including aligning level of care with severity, establishing a shared clinical language, and coordinating planning across specialties—emerge as important for facilitating implementation. Clinicians report potential benefits of the stratified approach, such as more nuanced clinical descriptions, improved communication, and individualized care planning, alongside ongoing hurdles in translating the model into practice within existing organizational structures.
These initial findings provide insight into the feasibility and implications of ICD-11 adoption in Sweden. They illustrate both the opportunities and practical challenges of implementing a dimensional model for PD, offering lessons relevant to other European and international settings.

Disclosure of Interest: None Declared

SP077

Findings from the Norwegian multicenter study of the DSM-5 alternative model for personality disorders: baseline and 8-year follow-up

B. Hummelen* and I. Eikenæs

Clinic Mental Health and Addiction, Oslo University Hospital, Oslo, Norway
*Corresponding author.
doi: 10.1192/j.eurpsy.2026.10315

Abstract: Predictive validity is the sine qua non of any diagnostic system. Although prior research supports the clinical utility of the

https://doi.org/10.1192/j.eurpsy.2026.10317 Published online by Cambridge University Press