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Fidelity, flexibility and leadership in national early intervention in psychosis implementation: lessons for mental health reform from England and Ireland

Karen O'Connor^{1, 2} Jo Smith OBE³

1. Department of Psychiatry and Neurobehavioural Science, University College Cork, Cork, Ireland

2. National Clinical Lead, Early Intervention in Psychosis Clinical Programme, Health Service Executive, Ireland

3. Emeritus Professor of Early Intervention and Psychosis, University of Worcester, Worcester, UK

Corresponding Author: Karen O Connor, Email: karen.oconnor3@hse.ie, Phone +353214233164

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Introduction

Early Intervention in Psychosis (EIP) is a specialist multidisciplinary team-based approach that provides rapid, phase-specific, evidence-based care for people experiencing a first episode of psychosis. Evidence supporting early, recovery-oriented care is now unequivocal, with consistent findings of improved clinical and functional outcomes, reduced relapse, reduced suicide risk, economic savings and better engagement with services.¹ Consequently, EIP has become a central plank of mental health reform internationally.

Implementation at scale has proven challenging, reflecting broader difficulties in translating evidence into sustainable national systems of care. Less attention has been paid to what happens when EIP is translated into a national system of care within overstretched health systems.

Ireland and England offer a useful lens through which to explore this challenge. England was among the earliest countries to commit to national EIP implementation. Following the establishment of the Australian Early Psychosis Prevention and Intervention Centre (EPPIC) in 1992, the first English Early Intervention Service was established in Birmingham in 1994, followed by the Lambeth Early Onset (LEO) service in 1997. These pioneer services informed the Initiative to Reduce the Impact of Schizophrenia (IRIS) programme and helped secure inclusion of EIP within national mental health policy in 1999, with national roll-out commencing in 2002. England now has 156 EIP teams across 54 Trusts.^{2, 3} Ireland is at an earlier stage of scale-up. The EIP Model of Care was published in 2019 with three demonstration sites funded that year⁴. A process evaluation of their implementation was published in 2022. As of July 2026, there are seven EIP teams in operation in Ireland with three more due to commence operation in 2026/2027.

In this Editorial, we use the national EIP roll-out as a case study to examine how evidence-based reforms can be sustained at scale, focusing on fidelity, flexibility, and system leadership. Without clarity about what must be protected, what can adapt, and how leadership is exercised, the promise of early intervention as a model for mental health reform risks being diluted just as population-level impact should be realised. The lessons presented are informed by the authors' leadership of national implementation in England and Ireland, implementation research, national policy and the National Clinical Audit of Psychosis (NCAP),

which has evaluated delivery of NICE-recommended EIP care in England (since 2018/19) and Ireland (since 2020/21).^{4, 5, 6, 7, 8}

Scale Changes the Problem: From Service Innovation to System Reform

England and Ireland differ in scale and health systems. However, in both instances nationwide roll-out has revealed a pattern whereby early enthusiasm and local success gives way to pressures associated with workforce instability, competing service demands, legacy systems and the challenge of sustaining momentum over time. The challenge is no longer whether EIP works, but whether systems are willing to prioritise, fund and reorganise around its core principles.

In both England and Ireland EIP has found it difficult to maintain its priority in the context of competing demands and shifting political and service level priorities. In England, the central challenge has been less the initiation of EIP than the sustainability of political support and funding over time. As the initial impetus of the National Service Framework has faded, governments have changed, and new health priorities have emerged within an insufficient overall funding envelope. EIP has had to continually re-justify its value.

Even though Ireland is at an earlier stage of implementation similar patterns have emerged. In this case, initiation has been slower and political and systemic focus has tended to favour the gradual creation of new services, frequently at the expense of maintaining and strengthening existing ones. This pattern is not unique to Ireland and is described in health reform across the OECD.⁹ While both countries struggle to maintain EIP as a sustained priority amid competing demands, the dominant risk differs: in England, it is long-term sustainability, whereas in Ireland, it's the imbalance between service creation and service consolidation. In both cases, the consequences for EIP are similar, as long-term outcomes depend on continuity and sustained investment rather than episodic programme development.

Assumptions That May Not Hold at National Scale

National implementation exposes assumptions underpinning EIP dissemination.

1. Local success does not automatically translate to system-wide success. High-performing services often depend on exceptional leadership, motivated teams, and informal adaptations that are difficult to replicate. Scale exposes variation in workforce capacity, infrastructure, leadership and governance that cannot be easily addressed.
2. Fidelity does not survive on goodwill alone. Clinical guidelines and model descriptions are necessary but insufficient. Without active stewardship, fidelity erodes under pressures arising from inadequate resourcing, expanding the service scope (age range, At Risk Mental State services), and a lack of understanding of the importance of adherence to key elements of the EIP model.
3. Roles cannot substitute for resources. The introduction of keyworker or care co-ordinator posts without protecting caseloads and time undermines the mechanisms through which EIP delivers impact.

4. Training alone is not a substitute for structural reform. Specialist training is important but will have little impact if people are unable to use what they have learnt because of workload, staff turnover or organisational constraints.
5. Local autonomy can undermine early intervention principles. In the face of acute demand and risk, services understandably prioritise crisis management. Without ongoing negotiation and support, early intervention is gradually reshaped to fit traditional models of care.

Fidelity: Protecting What Actually Matters

Attempting to standardise every element of EIP across diverse contexts is neither feasible nor desirable. What must be protected are the mechanisms that drive outcomes. These mechanisms are described in detail within NICE guidance and the EIP Model of Care.^{2, 4} Further work is needed to specify, the minimum core components of EIP that must be safeguarded across contexts, building on existing guidance and fidelity tools. For example, NICE recommends assessment within two weeks of referral, multidisciplinary phase-specific care for up to three years, assertive outreach and evidence-based psychological, vocational family and physical healthcare.^{6, 7, 8} If these functions are compromised, outcomes deteriorate. For example, staffing structures may vary locally, but access to core interventions such as case management, family interventions and psychological interventions should not.

Capacity thresholds are central to fidelity. Evidence consistently demonstrates that excessive caseloads and erosion of coordination time directly undermine effectiveness.⁷ In practice, fidelity depends less on intent than on capacity: rising caseloads, unfilled posts and erosion of care coordination time are early warning signs of model drift that directly undermine the mechanisms through which EIP achieves benefit.

Policy-driven expansion can also place core mechanisms and principles under strain. In England, extending the EIP age range from 14–35 to 14–65 substantially increased demand beyond initial projections, often without a proportional increase in capacity. This altered the culture and focus of services, shifting EIP from a predominantly youth-oriented model to a broader, more heterogeneous caseload. While such expansion aimed to improve equity, it illustrates how well-intentioned policy change can inadvertently dilute core functions if capacity is not considered and aligned.

Continuity of care is another non-negotiable. Fragmentation, staff churn and discontinuity erode trust and engagement. Models that rely on individual heroism rather than structural protection are inherently fragile. Finally, fidelity must be judged by outcomes, not activity. Measuring processes without attending to recovery and safety, creates the illusion of implementation without substance.

Flexibility: Adapting Without Diluting

Flexibility is not the enemy of fidelity; it is its necessary partner. Health systems vary widely in geography, workforce availability and legacy structures. For example, protecting access and outreach in rural teams may require different models of outreach or staffing configurations

than urban services. Allowing flexibility in service configuration enables EIP to take root in diverse contexts. Insisting on identical organisational forms can exacerbate inequity and encourage informal workarounds, including unprotected role expansion, dilution of specialist functions, or reliance on individual goodwill to compensate for structural gaps. However, EIP is not a 'pick and mix' model: core specifications relating to principles, roles and functions must be protected to achieve outcomes for individuals and families.

National roll-out also exposes geographical inequalities that are often implicit rather than explicit. EIP models were largely developed in urban settings. When applied to rural or geographically dispersed populations, limitations in transport, workforce availability, social networks and vocational supports can fundamentally alter what "access", "intensity" and "continuity" mean in practice. An inner London EIP team may serve a densely populated catchment extending only a few miles, while a rural team may cover multiple counties, islands, difficult terrain with limited public transport. Without deliberate adaptation and additional system support, such contexts risk apparent loss of fidelity for reasons unrelated to clinical quality.

Similarly, clinical pathways must adapt to the fluctuating trajectories of psychotic illness where non-linear recovery is common. Models must reflect this clinical reality and not exclude individuals who don't engage, disengage, or relapse. Flexibility is also required in the pace of implementation. National roll-out is a long-term endeavour. Forcing rapid expansion without readiness risks superficial coverage and long-term fragility. Phased implementation, adequate resourcing aligned with workforce development, is more likely to produce durable change.

Leadership: From Advocacy to Stewardship

Early intervention has always been as much a reform movement as a clinical model. At scale, leadership must evolve from advocacy to deliberate, system-level stewardship. Sustaining EIP at national scale requires ongoing narrative and relational work. In England, the retirement of early champions and repeated restructuring of national and regional leadership have weakened established networks that once provided coherence and advocacy. Furthermore, maintaining momentum has often required reframing EIP to align with shifting policy priorities, protecting support but risking fragility and distortion over time.

Leadership priorities evolve across political and organisational cycles. Sustaining reform therefore requires governance arrangements that protect core principles beyond individual leaders or changes in policy.

Distributed leadership, anchored by strong national consistency, appears most effective. Central leadership must articulate the vision, protect core principles and address inequity while enabling local innovation within clear limits. Clinical leadership is particularly critical. Leaders with clinical credibility are better able to challenge therapeutic pessimism, negotiate system pressures and maintain an EIP culture. For example, when staffing is constrained, teams may protect access by increasing caseloads rather than closing referrals, despite evidence that relapse risk increases as caseload increases, with an almost two-fold difference between lowest and highest caseload teams⁷. Leadership's task is to weigh up such trade offs

and support deliberate decision making rather than allowing caseloads to drift upward by default.

National roll-out requires long-term commitment. Early intervention is not a time-limited project but a generational reform. Leadership continuity is essential to prevent regression to reactive, crisis-driven care.

Box 1: What EIP Teaches Us About Mental Health Reform at Scale

Lessons from EIP Implementation
Fidelity as mechanisms, not manuals Outcomes are shaped less by strict adherence to detailed protocols than by preserving a small set of core mechanisms including access, intensity, continuity and competent delivery, while allowing adaptation to context.
Capacity as the hidden fidelity construct Without sufficient staffing, protected caseloads and time, fidelity cannot be sustained.
Transferable implications for other reforms
Design of national models of care National models specifying minimum capacity standards and essential activities that are non-negotiable but with local freedom in configuration are more likely to succeed.
Implementation strategies and training Training alone is not effective unless it is accompanied by ongoing supervision, facilitation, feedback, and local problem-solving.
Leadership architecture as a general requirement Sustained impact requires system-level ownership, embedded clinical leadership, stakeholder engagement, and continual adaptation.
Data for learning, not extraction Routine data should support learning, not surveillance.
Predictable unintended consequences
• Fidelity drift • Capacity erosion • Leadership discontinuity

Conclusions

National roll-out exposes both the promise and the vulnerability of early intervention and evidence-based mental health reform more broadly. England and Ireland demonstrate that while contexts differ, the underlying challenges converge. Early intervention works, but only when systems are prepared to reorganise around its core principles and to resource teams sufficiently to enable evidence-based EIP delivery.

The choice facing psychiatry is therefore clear. We can allow early intervention to be diluted into business as usual, or we can protect its mechanisms, adapt intelligently, and invest in ongoing, designated leadership (nationally and locally) to sustain reform. The stakes are high: failure to do so represents a lost opportunity for young people at the most critical point in their lives and adverse economic consequences for an already stretched healthcare system.

The unintended consequences outlined in Box 1 and the transferable lessons that extend beyond EIP reflect predictable pressures inherent in large-scale mental health reform. The extent to which leadership, capacity and stewardship are aligned determines whether these pressures undermine outcomes. Early intervention was never meant to be a boutique service. Its success at national scale will determine whether early intervention in psychosis can become the catalyst for a broader shift in psychiatry from late-stage crisis response to preventive, recovery-oriented care.

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