BRIEFING 68

CENTRE FOR MENTAL HEALTH

EARLY INTERVENTION IN PSYCHOSIS SERVICES
IMPLICATIONS OF THE EXTEND STUDY

SUMMARY

- Early Intervention in Psychosis (EIP) services provide community-based treatment and support to people during their first episode of psychosis
- This briefing summarises recent research into the outcomes EIP services achieve for the people they serve
- It is vital that EIP services offer and provide the full range of interventions that are recommended in current guidance: for example, talking therapies, medication, family interventions, employment support and physical health care. Gaps in support lead to poorer service user outcomes
- Care coordinators play a vital role in EIP services. Ideally, they should have caseloads of 15 people or fewer to be effective, as exceeding this is associated with poorer outcomes for service users
- People from racialised communities have worse outcomes from EIP services
- Most people are discharged from EIP services after about three years, either to an adult community mental health service or to general practice. The quality of this transition is crucial to support longer-term outcomes. Some people feel 'abandoned' at this time if the transition is not well supported
- It is important for EIP services to work closely with, and support, carers. This is associated with better outcomes for service users.

WE RECOMMEND

1. The Modern Service Framework for severe mental illness should set out clear expectations that EIP services must remain faithful to the model for early intervention in psychosis, including providing the full range of interventions and maintaining caseloads of 15 or fewer for each care coordinator. It should also stipulate that the time at which a person is moved on from EIP to other services must be based on their needs, not imposed artificially.
2. NHS England should develop a set of investment, intervention and outcomes measures for EIP services to accompany the existing waiting time standard. It must ensure EIP services are resourced to collect this data and that it is publicly available to enhance accountability and set priorities for improvement.
3. Integrated care boards and NHS mental health trusts must ensure that their EIP services are fully meeting the quality standards set out by NICE and the Royal College of Psychiatrists and resourced sufficiently to do so.
4. The Department of Health and Social Care must ensure that the Patient and Carer Race Equality Framework is sustained and fully resourced. Transparent data should be provided to enable NHS trusts and integrated care boards to assess how well their EIP services are meeting the needs of service users from racialised communities, and to address any gaps or inequities.

INTRODUCTION

ABOUT EARLY INTERVENTION IN PSYCHOSIS

Early Intervention in Psychosis (EIP) services are commissioned in England by the NHS to provide community-based treatment and support to people during their first episode of psychosis. They typically work with people experiencing psychosis symptoms, and their families or carers, for up to three years. They offer a range of interventions that are recommended by NICE including:

- Case management with a specified 'care coordinator'
- Pharmacotherapy
- Cognitive behavioural therapy (CBT) for psychosis
- Family intervention
- Physical health assessments and intervention
- Employment and education support
- Carer support.

At the end of a person's time being supported by an EIP team, they may be discharged from mental health services to general practice or offered ongoing support from an adult community mental health team.

ABOUT EXTEND

The EXTEND study is an academic project led by Professors Paul French and Belinda Lennox along with researchers across the country that has explored the relationships between the duration of EIP treatment and outcomes for people using these services. EXTEND was funded by the National Institute for Health and Care Research (NIHR). It has drawn on longitudinal data (anonymised information collected over time about people who have used EIP services) to assess any differences in outcomes relating to how long a person received support from an EIP team. The study also included qualitative work to understand the experiences of people using EIP services, carers, a range of health care practitioners, and commissioners.

Centre for Mental Health is supporting the EXTEND research team to explore the policy and commissioning implications of its findings. This briefing paper is our analysis of the study's findings and what they mean for national policy and local commissioning. It is relevant to EIP services in the devolved nations and internationally, but written in the context of the English NHS, where the study was carried out.

CURRENT POLICY AND PRACTICE

EIP services are an essential part of any mental health service. In England, they are available in all local areas. They were first brought to the NHS at scale as part of the 1999 National Service Framework for Adult Mental Health, and they were included as priorities within both the Five Year Forward View for Mental Health in 2016 and the NHS Long Term Plan of 2019.

The NHS in England has also adopted a mandatory access and waiting time target for first episode psychosis for people to begin NICE-recommended treatment within two weeks. This is a rare example of a nationally mandated access standard for mental health care, and it has resulted in near universal implementation of services designed to meet the target. In the most recent data provided by NHS England for the three months up to May 2026, 2,351 out of 3,216 people who started EIP treatment did so within two weeks of referral (NHS Digital, 2026).

Current policies and commissioning practices assume that a person will remain in contact with an EIP service for up to three years. This is despite the fact that NICE guidance (2020) questions whether this cut-off is appropriate in all cases.

OPPORTUNITIES FOR POLICY AND COMMISSIONING

The Government's ten-year health plan seeks to achieve significant shifts in health care delivery, from treatment to prevention, from hospital to the community, and from analogue to digital. (Department for Health and Social Care 2025). EIP is a community-based service that has a major role to play in preventing long-term harm for people living with psychosis and supporting recovery. Getting the duration of EIP right for each person will have both immediate and longer-term benefits for them, as well as reducing future health and care costs.

The creation of a new Modern Service Framework for severe mental illness is a golden opportunity to embed the learning from EXTEND nationwide. This can be supported further in the Government's planned mental health strategy for England.

WHAT THE STUDIES FOUND

CRITICAL COMPONENTS OF EARLY INTERVENTION IN PSYCHOSIS

Early intervention in psychosis services are expected to provide people with a range of interventions and types of support, in teams with sufficient staff to meet their needs. The EXTEND study found that many of these are essential for good outcomes (Williams *et al.*, 2025; Williams *et al.*, 2024). These include:

- **Caseload sizes**: keeping care coordinators' caseloads small produces better outcomes. Increasing caseload sizes means people using the service are more likely to have a relapse of psychosis.
- **Prescribing**: people who are eligible for clozapine are less likely to have a relapse of psychosis if it is prescribed to them. People are eligible for clozapine if they are still unwell after taking two other antipsychotic medicines. This comprises around 30% of people using EIP services.
- **Talking therapy**: people who received CBT for psychosis were less likely to have a hospital admission under the Mental Health Act or to face restrictive interventions such as the use of psychiatric intensive care or restraint in hospital.
- **Physical health interventions**: people who received support to maintain a healthy weight or to address alcohol problems had a lower mortality rate than people who needed these services but did not get them. Support with smoking, alcohol or substance use also lowered people's emergency department attendances.

The importance of keeping care coordinators' caseloads small is especially clear. Current guidance in the UK (Royal College of Psychiatrists, 2021) is for a whole-time care coordinator to support no more than 15 people at a time. The average actual caseload is currently more than 17, with many services running at much higher caseloads (for example at more than 25). The study notes that the gap between the smallest and largest caseloads in England represents a 50% greater risk of relapse over a period of three years (Williams *et al.*, 2025).

The EXTEND study also found that EIP teams offering the full range of interventions and smaller caseload sizes provided a better experience for service users and led to self-reported improvements in mental health (Williams *et al.*, 2023). Specific interventions that were associated with greater satisfaction included CBT for psychosis, family therapy, and targeted interventions for carers.

RACIAL INEQUITY

The EXTEND study found that outcomes from EIP were poorer for people from racialised communities (Williams *et al.*, 2025). These included restrictive interventions such as admission to psychiatric intensive care unit admission and physical restraint (Williams *et al.*, 2026). This is common across a range of mental health services in the UK and a reflection of deeply entrenched racial inequities in both society and the NHS. Experience measures, by contrast, were more positive among people from racialised communities, but they may have been under-represented in the survey resulting in reporting bias (Williams *et al.*, 2023). This raises questions about the ways experience and satisfaction are measured in mental health services, given the significantly poorer outcomes for these groups. It is also important not to homogenise the diverse experiences of people from a range of racialised communities.

DURATION OF EARLY INTERVENTION IN PSYCHOSIS

The EXTEND study found that the length of time a person stays on an EIP team caseload is variable, but for very different reasons. Some people are discharged from EIP before three years, for example because they no longer require support or, more worryingly, because they are described as engaging poorly with the service. Likewise, some people stay in contact with EIP services for more than three years. This may be a response to their individual needs, or a result of delays in getting access to a community mental health team.

For people who didn't feel ready to be discharged after three years, if this was applied to them anyway, they felt abandoned and disempowered by the process (Rickett *et al*., 2024, Rickett *et al*., 2025). For some, the loss of the relationship with their care coordinator and the more intensive support provided by EIP made navigating health care following discharge difficult. Carers played an important role as patient advocates but were rarely offered support themselves.

Where people are discharged early, the reasons for this are crucial to its success. If it is because the person is ready to move on, it can be a positive experience for service users and carers, but if discharge is a result of disengagement, people feel their mental health gets worse.

Similarly, for EIP that lasts for longer, if the reason is delays accessing community mental health team support this can be worrying and destabilising for service users and their carers. By contrast, where EIP was extended because the person needed support for longer (to complete a course of therapy, for example, or due to major life events affecting their mental health such as pregnancy or bereavement, or because of additional needs such as neurodivergence requiring further support to be in place), this flexibility is seen as helpful (Rickett *et al*., 2025).

GP INVOLVEMENT

The EXTEND qualitative study looked at the relationships between EIP services and people's general practitioners (GPs). It found that while EIP practitioners believe their service is easy to access, many GPs struggled to understand the criteria they used and felt frustrated when they referred patients who were rejected by EIP teams (Rickett *et al*., 2024). GPs were also uncertain about how far they were expected to support people on EIP caseloads – for example whether they or the EIP team should be conducting essential physical health checks annually.

VALUE OF EARLY INTERVENTION IN PSYCHOSIS SERVICES

The EXTEND study found that EIP services were highly valued by service users, carers and practitioners in other health services. The role of the care coordinator was critical to their success. They built relationships with people and offered a holistic approach to their needs. They made service users feel supported and understood, and able to better understand their mental health condition (Rickett *et al*., 2024).

QUALITY OF TRANSITIONS

A clear message from EXTEND is the importance of having a positive experience of moving from an EIP service into either primary care or a community mental health team. Well managed transitions, that were centred on a person's needs and wishes, regardless of the duration of EIP contact, were felt to help people move on successfully.

A well-managed transition was one where discharge was planned collaboratively, with the service user, their carers, and the services they are moving to; where care coordinators were supportive; and where people felt equipped and prepared to move on and live independently (Rickett *et al*., 2025). Being involved in discharge planning ahead of time was especially important for people to have a positive experience. By contrast, where service users were not given choices about discharge, or it felt rushed or motivated by an arbitrary cut-off, they had a poor experience and felt disempowered (Rickett *et al*., 2025).

For some people, however, the intensive and personalised support provided by EIP teams was missed when they were discharged, regardless of when this happened or how well it was managed. Other mental health services are unable to replicate that support, and this made people feel lost and abandoned.

The transition process when a person moves onto a community mental health team caseload was reported to include a handover meeting between the service users, their EIP care coordinator, and the care coordinator in the community mental health team (or it should but does not always). For people discharged to primary care, by contrast, the transition was less well managed, with a letter being sent from the EIP service to the service user's practice. This letter was perceived by GPs as being received late and containing limited information about the person's ongoing care or medication needs. GPs described feeling uncertain about how to support service users on discharge, which is worrying for the individual, leading some people to feel unsupported, unheard, and fearing a relapse (Rickett *et al*., 2024).

SUPPORT FOLLOWING DISCHARGE

Once people have moved on from EIP, those who were transferred to community mental health teams reported mixed experiences, depending on the relationship they had with their new care coordinator. Those moving to primary care, by contrast, were more likely to describe feel abandoned and found contacting their practice difficult. Some people described how they had lost contact with primary care whilst in contact with an EIP service. Some people reported being told that they could get back in touch with EIP if they needed extra support after being discharged, but the reality was that this was difficult or impossible. Similarly, carers of people using EIP services reported getting little or no support following discharge (Rickett *et al*., 2025).

IMPLICATIONS FOR POLICY AND PRACTICE

CASELOAD SIZES ARE ESSENTIAL

The number of people a care coordinator is supporting at any time is a critical determinant of both experience and outcomes. It is essential therefore that EIP teams are enabled to keep caseload sizes to 15 or below and resourced sufficiently to ensure they do not compromise on caseload sizes to meet levels of need in their local areas.

PROVIDE THE FULL RANGE OF INTERVENTIONS

Early Intervention in Psychosis Services that offer the full range of interventions recommended by the National Institute for Health and Care Excellence (NICE) provide a better experience for service users and are more likely to produce better outcomes. It is essential that national policies, such as the forthcoming Modern Service Framework for severe mental illness, underline the importance of fully NICE-compliant EIP services, and that NHS commissioners fund them sufficiently to maintain this standard.

TACKLE RACIAL INEQUITY

People from racialised communities have poorer outcomes from Early Intervention in Psychosis Services. The NHS in England has begun a major systemic change programme, the Patient and Carer Race Equality Framework (PCREF). It is essential that PCREF addresses inequities in EIP services, and in each locality EIP teams are able to benefit from anti-racism work and fully equipped to practise with cultural sensitivity and adopt trauma-informed approaches (Hassan *et al*., 2026). This must include robust monitoring of access, experience and outcomes, to ensure that any inequities are identified and addressed quickly and comprehensively.

PRESCRIBE THE RIGHT MEDICATION AND SUPPORT PHYSICAL HEALTH

The EXTEND study shows that EIP teams produce better outcomes when they offer a wide range of interventions. That includes ensuring people are prescribed the necessary medication for their needs, and that they get effective physical health monitoring and support. There is compelling evidence that physical health inequalities among people with severe mental illness are at their most pronounced among young adults (Public Health England, 2018). Taking effective action, for example by supporting healthy weight management and smoking cessation, and providing help with alcohol or drug use, may help to reduce the life expectancy gap long term as well as dramatically improving people's quality of life in the short term.

FLEXIBLE APPROACH TO DURATION OF EARLY INTERVENTION IN PSYCHOSIS

It is clear from EXTEND that applying a standard rule of three years' duration of EIP is unhelpful for many people. While three years is often sufficient, it is not right for everyone. Personalised transitions, at the right time for the individual, can enable them to move on successfully when they are ready.

JOINING UP EARLY INTERVENTION IN PSYCHOSIS AND PRIMARY CARE

For people using EIP services, it is important to retain a connection with primary care services. This could, for example, be for the annual physical health check. It would also facilitate a better experience of discharge at the end of their EIP use, for which a meeting with practitioners from EIP and primary care would help to ease the process for all concerned.

POST-EARLY INTERVENTION IN PSYCHOSIS SERVICES

Many people describe feeling abandoned and unsupported after they are discharged from EIP services, especially if they are discharged to primary care. Offering easy to access support after discharge might provide an option for those who need it.

RECOMMENDATIONS FOR NATIONAL POLICY AND LOCAL IMPLEMENTATION

1. The Modern Service Framework for severe mental illness should set out clear expectations that EIP services must remain faithful to the model for early intervention in psychosis, including providing the full range of interventions and maintaining caseloads of 15 or fewer for each care coordinator. It should also stipulate that the time at which a person is moved on from EIP to other services must be based on their needs, not imposed artificially.
2. NHS England should develop a set of investment, intervention and outcomes measures for EIP services to accompany the existing waiting time standard. It must ensure EIP services are resourced to collect this data and that it is publicly available to enhance accountability and set priorities for improvement.
3. Integrated care boards and NHS mental health trusts must ensure that their EIP services are fully meeting the quality standards set out by NICE and the Royal College of Psychiatrists and resourced sufficiently to do so.
4. The Department of Health and Social Care must ensure that the Patient and Carer Race Equality Framework is sustained and fully resourced. Transparent data should be provided to enable NHS trusts and integrated care boards to assess how well their EIP services are meeting the needs of service users from racialised communities, and to address any gaps or inequities.

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