


# Implementation of early intervention clinical services within the National Health System in Italy: Third wave survey with focus on structures, resources, and fidelity to the evidence-based model

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## Abstract

**Background:** Early intervention in psychosis (EIP) is a well-established approach aimed at detecting and treating early signs and symptoms of psychosis to prevent its long-term consequences. The present study aimed at detailing the current status of EIP services in Italy, covering all the Departments of Mental Health (DMHs) operating in 2018.

**Methods:** All directors of public DMHs operating in Italy in 2018 ( $n = 127$ ) were invited to fill in a Census form about EIP structure and activities. The first episode psychosis services fidelity scale (FEPS-FS) was used to investigate fidelity to the EIP model of the centre.

**Results:** An active EIP service was reported by 41 DMHs (32% of the total DMHs; 56% of those who took part in the survey). Most EIP services had an autonomous team. The large majority of the Italian EIP centres provided psychosocial interventions to their patients, principally psychotherapy, family support, and psychoeducation. Among those with an active EIP, 29 DMHs filled in the FEPS-FS. Internal consistency was good when based on the replies of the respondents, but reliability was weak when measured on the basis of an independent evaluation (Cohen's kappa = 0.571). The fidelity to the guidelines for early intervention was uneven, with some criteria met by most centres, especially those peculiar to the Italian community psychiatry.

**Conclusion:** A further spreading of the early intervention model across the Italian DMHs was found. A lack of resources might limit the use of specific psychosocial treatments, such as cognitive-behavioural therapy or manualized family support.

## KEYWORDS

community mental health services, early intervention, early psychosis, guidelines, schizophrenia, ultra-high risk

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## 1 | INTRODUCTION

Awareness is growing that early identification of vulnerabilities to mental illness and the delivery of evidence-based interventions should be implemented as widely as possible (Patel et al., 2018). Within this perspective, early intervention in psychosis (EIP) is a well-established approach aimed at detecting and treating early signs and symptoms of psychosis to prevent the long-term impact of behavioural problems and the related psychosocial deficits (Albert & Weibell, 2019; Correll et al., 2018; Sizer et al., 2022). Implementation of EIP services in the mental health care system is the best way to attract help-seekers at risk of, or with first-episode psychosis (FEP) (Csillag et al., 2018). Nevertheless, with some exceptions, namely Australia, England, Denmark, Norway, and Canada, in many countries EIP service availability remains restricted to academic centres (Csillag et al., 2016). Italy is a country with a particularly favourable framework since, by law, all interventions concerning the prevention, treatment, and rehabilitation of psychosocial disabilities have to be carried out in community service facilities since the closing of all mental health hospitals (Barbui et al., 2018; Carta et al., 2020). Over the past 40 years since the 1978 reform (De Girolamo, 1989), the community-based system of mental health care in Italy has been consolidated (Carta et al., 2020). However, the limited availability of resources, including a decreasing staffing level, and still too high variability in service provision across the country caused repeated concerns that the goals of the reform would be not achieved (Barbui et al., 2018; de Girolamo et al., 2007). Limited resources and the lack of an acknowledged standard of care in the face of growing needs in the mental health field made the system somehow rigid; indeed, in most cases the organization of services has hardly changed over the last decades (Amadeo & Barbui, 2018; Carta et al., 2020). The strengths and weaknesses of the Italian mental health system (MHS) are especially evident in the care of people with severe mental disorders (Lora et al., 2016; Lora et al., 2022).

Despite its rigidity, the Italian MHS welcomed the introduction of the early intervention approach. Prompted by the experience of a pilot centre, Milan's Programma2000 (Cocchi et al., 2008; Meneghelli et al., 2010), and the publication of the national guidelines on 'Early intervention in schizophrenia' (De Masi et al., 2008), between 2005 and 2010 about half of Italy's mental health centres planned the development of specific interventions for FEP (Munizza et al., 2011). Over time, increasing interest was devoted to people with at-risk mental states or at ultra-high risk (UHR) of psychosis (Cocchi et al., 2013; Cocchi et al., 2015; Comparelli et al., 2013). Nevertheless, most of these interventions were not based on internationally agreed guidelines or some established protocol (Ruggeri et al., 2008). Italian EIP services providing adequate evidence-based interventions were between 20% and 30% in 2010 (Ghio et al., 2012), with a modest increase in the five subsequent years (Cocchi et al., 2018). Overall, fidelity to the model is expected to contribute to attaining the results that the EIP services are expected to deliver (Addington et al., 2013; Addington et al., 2021). Within

the field of mental health, there is some evidence that adherence to specific programmatic standards is necessary to produce the expected outcomes (Drake et al., 2001; McHugo et al., 1999). As for the EIP services, there is some evidence that below a certain level of compliance, resources are used inefficiently (Radhakrishnan et al., 2018). Within this framework, several tools have been designed over time to measure whether and to what extent an EIP service is implemented and managed as it was originally designed (Addington et al., 2018).

In recent years, the Italian MHS has undergone some reframing. In 2013, Italy adopted the World Health Organization's Mental Health Action Plan for 2013–2020 (Saxena et al., 2013), and implemented it through an integrated plan of action (Ministero della Salute, 2013). This plan provided for early intervention for severe mental disorders at their onset in young adults (15–21 years old) in the form of a program to be implemented all over the national territory. Another change that occurred in recent years was the reorganization of the catchment area of the Departments of Mental Health (DMHs), the main local structure assigned to the preservation, restoration, and maintenance of mental health in the population. Thus, there is ground for a reconsideration of the current level of the EIP in Italy.

The present study aimed at detailing the current status of EIP services in Italy, illustrating both the structures and the available resources, also offering the first survey about these services' fidelity to the model. This is the third comprehensive, nationwide survey promoted by the Italian Association for early intervention in mental health (Associazione Italiana Intervento Precoce nella Salute Mentale—AIPP) specifically focused on the EIP services operating in Italy since the start of Programma2000. A first, partial survey was promoted in 2011 (Cocchi et al., 2011), followed by a second, more comprehensive, nationwide investigation (Cocchi et al., 2018). The present survey was completed in 2019, but the analysis has been delayed until now because of the COVID pandemic.

## 2 | METHODS

For the purposes of the present survey, a four-part Census form was used including the following sections: (a) a series of questions that inquired whether the DMH had implemented an EIP or was taking steps towards implementing it; (b) a questionnaire about the organization of the EIPs, when established; (c) a questionnaire collecting data about associated general characteristics of the EIPs, such as the size of the catchment-area population, total budget, staffing levels, educational activities; (d) a scale aimed at investigating the fidelity to the EIP model. To investigate the fidelity to the model of EIP, we used the 'First episode psychosis services fidelity scale' (FEPS-FS; Addington et al., 2016). We decided to use the FEPS-FS since it is the most comprehensive tool about the core components of an EIP, it is not based on a specific implementation of the model, and it is one of the most widely used tools to measure fidelity to the EIP model (Addington et al., 2021).

The Census form was mailed to all the directors of all DMHs. Intensive follow-up with e-mail and telephone reminders was applied to support wide participation in the study.

The first three sections of the Census form had already been described (Cocchi et al., 2011; Cocchi et al., 2018). As for the FEPS-FS, it is a 31-item scale that enquires about the core components of an EIP program. Several topics are investigated, including the provision of timely contact with the help-seeker, the provision of evidence-based psychosocial interventions (psychoeducation, family support and intervention, cognitive behaviour therapy for symptoms of psychosis, anxiety, and depression), the provision of evidence-based pharmacological interventions, the delivery of health promotion practices, the monitoring of the key process and outcome measures (Addington et al., 2016). Compilers of the scale are expected to collect data from multiple sources to reach their best estimate for each component. A manual is available for compilation. The FEPS-FS was provided in its Italian version, which was produced with a process of intensive translation and back-translation with the support of the creator of the scale, who approved the final version.

For each item, scores are assigned from 1 (the lowest score, corresponding to the practice most distant from those expected on the basis of the EIP model) to 5 (the highest score, corresponding to the practice most congruent with those expected on the basis of the EIP model). In case of missing data, less than 5% of the total items, a score of 1 was assigned. On the basis of past validation studies of the FEPS-FS, a threshold of 4 was considered indicative of good fidelity to the investigated practice at item level, and a mean overall score of 4 was considered indicative of good fidelity to the model of the centre (Durbin et al., 2019).

## 2.1 | Statistical analysis

Exploratory analysis and descriptive statistics were carried out using the Statistical Package for Social Sciences (SPSS) version 27, and the base statistics and graphical packages running in R (R Core Team, 2020).

As the first measure of reliability, the internal consistency of ratings of the FEPS-FS items across the sites was calculated on the basis of intraclass correlation coefficient (ICC) with a 95% confidence interval (CI). According to a qualitative interpretation (Koo & Li, 2016), ICC values can be interpreted as 'moderate' (0.50–0.75), 'good' (0.75–0.9), and 'excellent' (ICC >0.90).

As a more precise measure of reliability of the FEPS-FS, four EIP centres among those that participated in the survey were visited for an in situ independent investigation of the characteristics of the EIP. Cohen's kappa agreement was calculated between the scores provided by the local compilers and those provided by the independent assessors. Cohen (1960) suggested interpreting values 0.20–0.40 as indicating 'fair', 0.41–0.60 'moderate', and 0.61–0.80 'substantial' agreement. However, these thresholds have been questioned in recent years, and more conservative thresholds have been suggested: 0.40–0.59 would indicate weak agreement, 0.60–0.79–

moderate agreement, values  $\geq 0.80$  indicate strong agreement (McHugh, 2012).

## 3 | RESULTS

Overall, 127 DMHs were invited to take part in the survey, actually less than in the past survey, which included 216 DMHs (Cocchi et al., 2018). The reason for this decrease is the variation in the size of the catchment area of the DMHs, which resulted in uniting previously separated DMH areas. 73 (57%) DMHs accepted the invitation and provided data.

Overall, an active EIP service was reported by 41 DMHs (32% of the total DMHs; 56% of those that took part in the survey). All surveyed EIP services are part of the national MHS. Most operate under the public department of mental health, some are specialist EIP services located within academic (university) mental health centres.

The MH Departments in the north of Italy were not more likely to report having an EIP service ( $n = 21$ ; 35.6%) than those in central Italy ( $n = 12$ ; 34.3%) or in the south ( $n = 8$ ; 24.2%):  $\chi^2 = 1.33$ ,  $p = .51$ . However, when the calculation was limited to the DMHs that effectively took part in the survey, the DMHs in northern Italy were more likely to have an active EIP service (Table 1).

### 3.1 | Characteristics of the public-funded EIP services in Italy

Most EIP services had an autonomous team, which was specifically devoted to service provision. Overall, most centres relied on mental health workers, including psychiatrists, psychologists, and trained nurses. Health educators, social workers, and rehabilitation therapists were less often within the EIP team. No differences were found among geographical areas as far as staff composition was concerned, except for fewer psychiatrists in southern centres.

Most staff involved in the current EIP services lack past training in early intervention. Indeed, the training was based on seminars and clinical supervision after being employed on a team. Most EIP centres reported they used guidelines on early intervention, often more than one (details in Table 1). However, some EIP services used ad-hoc protocols developed by the team.

### 3.2 | Types of interventions provided by the public-funded EIP services in Italy

First contact with the patient was as likely in the outpatient as in the inpatient setting, but in 22% to 35% of cases, the first contact was arranged at the patient's home (Table 2).

The vast majority (90%) of the surveyed EIP services reported the use of validated assessment scales at first contact. For screening purposes and diagnosis, the Comprehensive Assessment of At-Risk Mental States (CAARMS) ( $n = 10$ ; 27%) and the Early Recognition

**TABLE 1** General and structural characteristics of publicly funded EIP services in Italy

	Total	North	Centre	South and islands	
	N (%)	N (%)	N (%)	N (%)	
	73 (100%)	29 (40%)	23 (31%)	21 (29%)	Statistics
Early psychosis services	41 (56%)	21 (72%)	12 (52%)	8 (38%)	$\chi^2 = 6.04, df = 2, p = .049$
	41 (100%)	21 (100%)	12 (100%)	8 (100%)	
Autonomous team	34 (83%)	17 (81%)	10 (83%)	7 (87%)	$\chi^2 = 0.18, df = 2, p = .91$
Focused on FEP only	6 (15%)	3 (25%)	3 (25%)	0 (0%)	$\chi^2 = 2.40, df = 2, p = .30$
Including UHR	29 (85%)	18 (86%)	9 (75%)	8 (100%)	
Team composition	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	
Psychiatrists	3.1 (3.4)	2.6 (1.4)	5.6 (5.5)	1.1 (0.4)	$F(2;32) = 4.48, p = .019$
Psychologists	3.3 (2.3)	3.2 (1.8)	4.5 (3.2)	2.2 (1.3)	$F(2;32) = 2.39, p = .107$
Rehabilitation therapists	0.5 (1.0)	0.5 (1.1)	0.2 (0.4)	1.1 (1.2)	$F(2;32) = 2.07, p = .143$
Health educators	1.1 (1.4)	0.9 (1.1)	1.7 (1.8)	0.9 (1.5)	$F(2;32) = 1.09, p = .347$
Nurses	3.4 (4.6)	2.2 (2.4)	5.8 (7.4)	3.0 (2.9)	$F(2;32) = 2.09, p = .140$
Social workers	0.9 (1.4)	0.7 (1.0)	1.2 (1.7)	0.9 (1.7)	$F(2;32) = 0.38, p = .684$
Other	0.6 (1.3)	0.3 (1.0)	0.7 (1.5)	0.9 (1.7)	$F(2;32) = 0.46, p = .632$
Missing information	6 (14.6%)				
Training	N (%)	N (%)	N (%)	N (%)	
No past training	29 (74%)	17 (85%)	9 (82%)	3 (37%)	$\chi^2 = 7.21, df = 2, p = .027$
Internal seminars	26 (67%)	15 (75%)	9 (82%)	2 (25%)	$\chi^2 = 8.01, df = 2, p = .018$
External seminars	35 (78%)	15 (75%)	7 (64%)	3 (37%)	$\chi^2 = 3.49, df = 2, p = .174$
Clinical supervision	20 (51%)	10 (50%)	7 (64%)	3 (37%)	$\chi^2 = 1.29, df = 2, p = .524$
Use of practice guidelines	N (%)				
NICE (UK)	14 (40%)	7 (39%)	5 (55%)	2 (25%)	$\chi^2 = 1.66, df = 2, p = .435$
Australian guidelines	2 (6%)	1 (6%)	1 (11%)	0 (0%)	$\chi^2 = 0.97, df = 2, p = .615$
Italian national guidelines	13 (37%)	7 (39%)	4 (44%)	2 (25%)	$\chi^2 = 0.73, df = 2, p = .693$
Ad hoc guidelines	7 (19%)	4 (22%)	1 (10%)	2 (25%)	$\chi^2 = 0.81, df = 2, p = .665$
Other, unspecified	14 (41%)	4 (23%)	6 (67%)	4 (50%)	$\chi^2 = 4.86, df = 2, p = .088$

Inventory for the retrospective assessment of the Onset of Schizophrenia (ERlraos) Checklist ( $n = 9$ ; 24%) were used at preference, rather than the Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders ( $n = 5$ ; 13%). The Wechsler Adult Intelligence Scale was used in 40% of Italian EIP centres ( $n = 15$ ).

The majority of the EIP centres used pharmacotherapy in the treatment of FEP and UHR patients. However, less than 50% of the centres used specific guidelines for prescription. Overall, 95% of EIP centres reported that they used low-dose second-generation antipsychotics as a starting treatment for FEP patients. Only 50% of EIP centres reported the same procedure for UHR patients. Anxiolytics were more often used for UHR patients (68% of EIP centres) than for FEP patients (37%). Antidepressants were also more often used for UHR patients (30%) than for FEP patients (20%). The prescription of mood stabilizers was used by about one-third of the Italian EIP centres for both FEP (35%) and UHR (32%).

The majority of the Italian EIP centres provided psychosocial interventions to their patients, principally psychotherapy, family support, and psychoeducation. About two-thirds of EIP services also

offered structured rehabilitative programs, from engagement in sports activities to music or art therapy, support in job-seeking, and computer training. One-third of the surveyed EIP centres involved past beneficiaries—who had achieved recovery—in the organization of therapeutic projects, a meaningful attempt to involve stakeholders in the process of care.

Finally, less than 50% of the EIP centres were involved in awareness campaigns on FEP, which is, indeed, a core component of the early intervention model since its foundation (Joa et al., 2008; Johannessen et al., 2001). The main targets were general practitioners and health workers operating in the same area. The general population was often involved through school initiatives.

### 3.3 | Fidelity to the model on the basis of the FEPS-FS

Among those with an active EIP, 29 DMHs filled in the FEPS-FS. Most participating centres did not fill in item no. 31 about the incidence rate. This was because of the recent change in the catchment area for

**TABLE 2** Characteristics of the intervention in publicly funded EIP services in Italy

	Total	North	Centre	South and islands	Statistics
	N (%)	N (%)	N (%)	N (%)	
	41 (100%)	21 (100%)	12 (100%)	8 (100%)	
First contact with patients					
Outpatient setting	25 (61%)	16 (76%)	6 (50%)	3 (37%)	$\chi^2 = 4.50, df = 2, p = .105$
Inpatient setting	19 (46%)	8 (38%)	8 (67%)	3 (37%)	$\chi^2 = 2.81, df = 2, p = .244$
At the patient's home	9 (22%)	7 (35%)	2 (17%)	0 (0%)	$\chi^2 = 4.35, df = 2, p = .114$
Use of assessment scales	35 (90%)	16 (84%)	11 (92%)	8 (100%)	$\chi^2 = 0.18, df = 2, p = .91$
Pharmacological guidelines	15 (37%)	7 (35%)	6 (50%)	2 (25%)	$\chi^2 = 1.38, df = 2, p = .500$
Psychotherapy	32 (80%)	16 (80%)	10 (83%)	6 (75%)	$\chi^2 = 0.21, df = 2, p = .901$
Family support	31 (77%)	15 (75%)	10 (83%)	6 (75%)	$\chi^2 = 0.33, df = 2, p = .846$
Psychoeducation	38 (93%)	19 (90%)	11 (92%)	8 (100%)	$\chi^2 = 0.80, df = 2, p = .670$
Group rehabilitation activities	26 (63%)	13 (62%)	8 (67%)	5 (62%)	$\chi^2 = 0.08, df = 2, p = .962$
Past beneficiaries' involvement	12 (29%)	6 (28%)	3 (25%)	3 (37%)	$\chi^2 = 0.37, df = 2, p = .830$
External awareness campaigns					
Aimed at GPs	12 (29%)	3 (14%)	6 (50%)	3 (37%)	$\chi^2 = 5.03, df = 2, p = .081$
Aimed at health workers	15 (36%)	7 (33%)	5 (42%)	3 (37%)	$\chi^2 = 0.23, df = 2, p = .890$
Aimed at the general population	13 (32%)	7 (33%)	3 (25%)	3 (37%)	$\chi^2 = 0.45, df = 2, p = .796$

many DMHs, which made it difficult to provide an educated guess on the figure.

The results were satisfactory in terms of internal consistency, when measured as ICC based on the responses provided by the participating centres: 0.863 (95% CI: 0.780–0.926). Cohen's kappa, measured by agreement between independent evaluators in four centres where FEPS-FS was re-applied by observers who were not in the team, was fair to moderate or weak, according to more recent interpretations: 0.571 (95% CI: 0.321–0.774).

Italian EIP centres reported good scoring ( $\geq 4$ ) for core components of the EIP model that are congruent with the standard practice in Italian DMHs, such as having a clear psychiatrist role in the team, the execution of clinical assessment, the design of a treatment plan, the delivery of timely contact, communication with the inpatient team, the use of recommended dosing in prescribing drugs, the involvement of the family in the treatment (Figure 1).

The Italian EIP centres were somehow defective in the provision of interventions that depend on resources (e.g. cognitive-behavioural therapy [CBT], structured [manualized] family support, supported employment) and in the organization of the teamwork (e.g. weekly meeting, annual assessment, coordination of the multi-disciplinary team). They were largely below the expected threshold (scoring 3 or lower, on average) for specialized interventions, such as weight gain prevention, the provision of community living skills, substance use treatment, prescription of clozapine, community and client outreach.

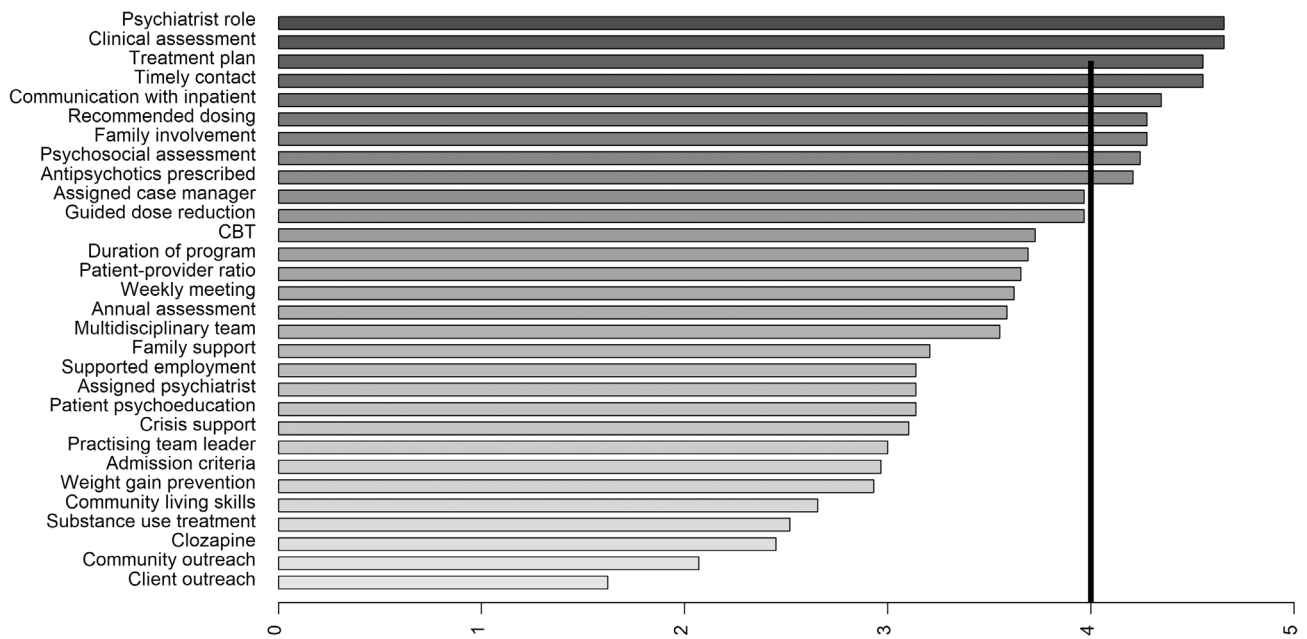
No statistically significant difference was found in the distribution of the total score of the FEPS-FS between EIP services in the north ( $3.5 \pm 0.6$ ), centre ( $3.8 \pm 0.3$ ), or south ( $3.6 \pm 0.5$ ) of Italy.

Overall, five teams only reached the average score for good fidelity to the model (4 or higher on the average global score). Additional eight teams reached an average global score of 3.8 or higher, but still below 4 (Figure 2).

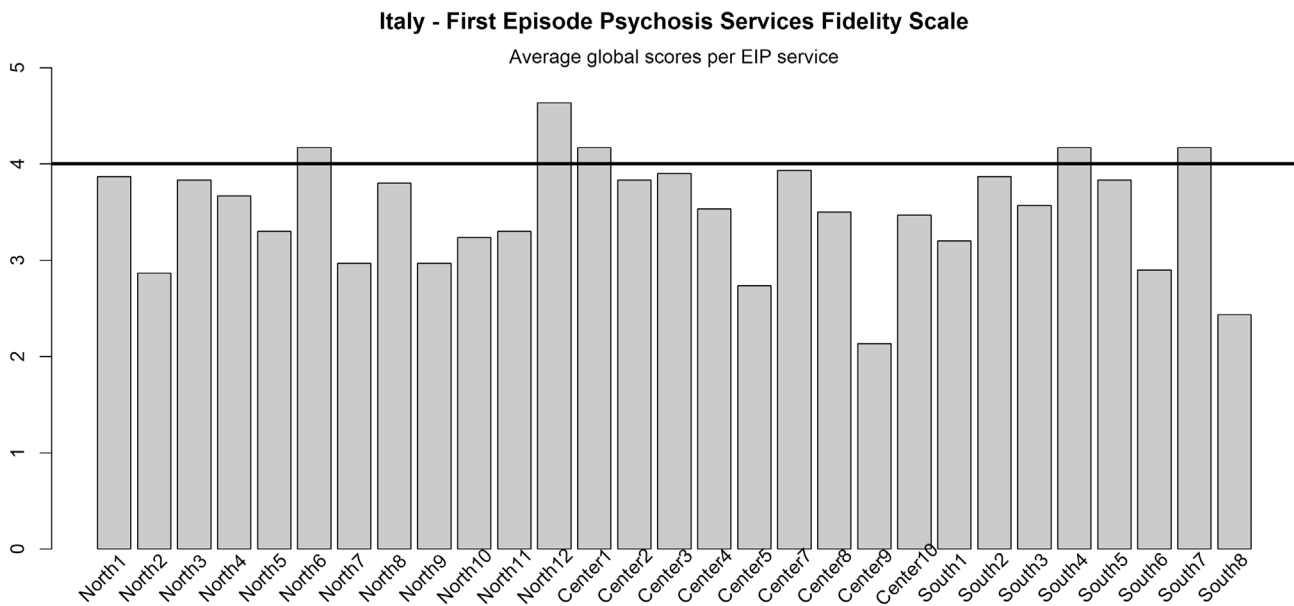
## 4 | DISCUSSION

Compared with initial, partial surveys (Cocchi et al., 2011; Ghio et al., 2012), the participation rate in this study was reasonably large, involving 57% of the DMHs that were invited to take part in the investigation, a slightly higher number than in the previous, most recent survey (103 out of 216 [48%]) (Cocchi et al., 2018). However, as for the past AIPP survey (Cocchi et al., 2018), we cannot exclude that only the interested DMHs took part in the study. We were unable to provide any analysis of the differences between the DMHs that took part in the survey and non-responders because of lack of information on many relevant factors that could have affected the participation rate.

Data suggest that the national diffusion of EIP services can be estimated to vary between 32% and 56%, depending on whether this figure is considered representative of the current status of the EIP in Italy overall or of the interested DMHs only. As observed in the past AIPP survey, EIP services were more likely to be provided in northern and central Italy than in southern Italy and the islands, which might be a reflection of fewer resources being allocated to mental health programs in general, or differences in mental health policy across Italian administrative regions. The regions of southern Italy might have invested more in residential facilities than in preventive interventions.



**FIGURE 1** Distribution of the scores of the FEPS-FS by items—Value is the mean score across centres. The black line indicates the threshold for good fidelity to the investigated practice at the item level.



**FIGURE 2** Distribution of the average global score of the FEPS-FS by EIP centre. The black line indicates the threshold for good fidelity to EIP model.

We observed some lower availability of psychiatrists in the EIP teams in southern Italy, while the types of interventions provided by the public-funded EIP services in Italy did not differ by geographical area. Nevertheless, we have no information about the outcome of the provided interventions in terms of hospital admissions, work outcomes, education, or housing. We are therefore unable to establish whether psychiatric staff shortage in southern Italy affects the effectiveness of the interventions. Overall, additional factors might still affect the heterogeneous diffusion of EIP services across the Italian territory, such

as real geographic barriers to accessibility or the high complexity of users' needs (Catts et al., 2010; Lester et al., 2009). The lack of detailed information about these data is a limitation of the current study.

An important change from the past survey is the growing number of EIP services that rely on an autonomous staff. Indeed in the past AIPP survey, only 10 out of 45 EIP services had an autonomous team (Cocchi et al., 2018), as against 34 out of 41 in the present survey. This is an important innovation since it favours the destigmatization



of the first episode of psychosis. Moreover, it protects FEP and UHR patients from melting with the fraction of chronic and often severely disabled patients who access community mental health services. These patients have different needs than young help-seekers, and the mismatch between these two groups of users might instill confusion in those experiencing their first episode. Another strength of the current public-funded Italian EIP services is the provision of a multimodal package of intervention, which couples standard pharmacotherapy with state-of-the-art psychosocial interventions. This is a clear advantage over the usual treatment provided by non-EIP-oriented psychiatric services where psychosocial treatments are rarely—if ever—provided (Preti et al., 2009).

Several drawbacks should be also considered, such as the scarce compliance with evidence-based guidelines, which resulted also from the application of the FEPS-FS. In Italy as elsewhere, there is still a net separation between child and adolescents psychiatry and adult psychiatry, which makes it difficult to achieve effective continuity of care (Milestone Consortium et al., 2019; Signorini et al., 2017). Some recent experiences within the EIP framework (Poletti et al., 2021) are addressing the issue, which represents a major obstacle to the implementation of effective preventative programs of care (Raballo et al., 2017).

According to the FEPS-FS, the fidelity to the guidelines for early intervention was uneven, with some criteria met by most of the centres, especially those peculiar to the Italian community psychiatry. The most evident deficits concerned specialized treatments, such as client and community outreach, the prescription of clozapine, the use of CBT, crisis support, the provision of manualized family support. The lack of resources, for example in relation to operators trained in the application of CBT, and the differences in the managerial culture of Italian psychiatry that is more willing to invest in structures (communities) than in treatment protocols (crisis units), may explain the differences with guidelines that were tailored to the UK or the US.

It should be noted that the compilers of the FEPS-FS might have been excessively optimistic in replying to the items of the scale. Indeed, when an independent investigation was made, disagreement emerged between the replies of the EIP team and the assessment compiled by the independent raters. The main reasons for the discrepancy concerned the fraction of patients who had achieved the predefined goal, which was often lower in the ascertainment by the independent evaluators than in the global estimates of the local assessors. Nevertheless, only five EIP centres reached the threshold score for good fidelity to the model, suggesting the bias was contained, and the profile of replies was consistent with what can be expected of the Italian NMH system.

#### 4.1 | Strengths and limitations

The use of a standard tool, the application of a validated scale to assess fidelity to the EIP model, and the intensive efforts to reach the largest possible fraction of participants are the major strengths of the study. However, several limitations should be taken into account

when evaluating the findings of the study. First and foremost, the reliance of the survey on self-assessment. We could not check whether all patients received the promised psychosocial interventions, nor could we evaluate the quality of the provided interventions. Data on staff could not be checked, nor was the information on training. Moreover, we had not a chance to control whether the psychosocial interventions, the major strength of the EIP centres, were provided according to current scientific evidence or were implemented based on outdated models and procedures, as per the training received by the staff in the past. We were also unable to investigate how fidelity to the model, as measured by the FEPS-FS, impacted access parameters (patients served, duration of untreated psychosis) or outcome (relapse, hospitalization, work outcomes, education, housing) across the surveyed EIP services, since we lacked such data.

## 5 | CONCLUSIONS

EIP services in Italy are spreading. However, the application of standard guidelines in these services is still limited, and lack of resources might limit the use of specific psychosocial treatments. The further implementation of EIP services in Italy can be supported by an intensive awareness campaign aimed at the stakeholders and the political authorities in charge of regional and national health planning.

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### CONFLICT OF INTEREST

The authors declare no conflicts of interest.

### DATA AVAILABILITY STATEMENT

Research data are not shared since consent to publish was for aggregated data only.

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