Psychological interventions in the Italian national health system: appropriateness and accountability

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ABSTRACT

In the field of clinical governance, the search for progressive high-quality health interventions is accompanied by the different health values they assume for the different stakeholders involved. With increasing frequency, the value of clinical psychology and psychotherapy interventions in the public service is also supported by their ability to be appropriate and measurable in terms of their effectiveness. As such, their expected future is one of systematic inclusion within increasingly defined and specific care pathways. The challenge that this evolution poses is complex from an epistemological-methodological point of view because it must include the various perspectives from which one looks at the nature of these interventions. Clinical appropriateness, as a meta-level variable, and accountability go beyond the simplistic/generic cost-benefit assessment of services and are proposed as a necessary conceptual framework for an adequate determination of outcomes.

Key words: psychological interventions, accountability, appropriateness, health value, clinical governance.

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Introduction

The main objective of this work is to explain an *epistemological positioning* of psychology in the field of health promotion. Specifically, the contribution aims to respond to new health needs while maintaining an epistemic position that recognizes the peculiarities and the value of the psychological perspective in health institution.

It is consequently important to encourage psychologists in the Italian National Health Service (NHS) who are healthcare managers to avoid devoting themselves exclusively to clinical care and to leave to *others* the analysis of these care processes that represent the conceptual framework within which an intervention takes place.

The complexity of the context of intervention in the NHS makes it inappropriate to analyze and evaluate these processes in a manner unrelated to organizational and management aspects. Relegating these *challenges* in the background of one's operation implies a high assumption of responsibility from the clinic-therapeutic point of view, even in the presence of low accountability at the level of organizational and managerial processes. This is a perspective that appears to be losing out in terms of institutional and social recognition. Indeed, it is clearly anachronistic at this time to maintain an attitude of avoidance in the face of the challenge of appropriateness, which is an issue of utmost importance to all stakeholders.

The present contribution to the literature presents the key concepts of Clinical Governance (CG) and accountability as privileged references for improving the appropriateness of psychological interventions within the Italian NHS.

Despite several legislative changes, the following initial

reference principles of the NHS, which originated with law no. 833 of 1978, remain valid today: uniformity, universality, and equity of care for all citizens. Increasingly systematically, the quest for continuous improvement in the quality of public health has been the most important driver of service transformation. Through CG actions, this search has involved the development of interventions, in the form of care pathways, characterized by their progressive appropriateness and accountability. This process of planning, organizing, and managing intervention models has involved all the actors of the health system, additionally taking on board, in more recent years, the perspectives of the different stakeholders (*e.g.*, citizens' associations) in order to take into account their different health values (Teisberg, Wallace & O'Hara, 2020).

Psychologists must also respond to the theoretical and methodological challenges of implementing interventions delivered in the real-world context that remain characterized by appropriateness and accountability (Brinkeroff, 2004; Frank & Shim, 2022; Rock & Cross, 2020).

This development goes beyond the application of interventions delivered solely on the basis of clinical trials (Sculpher, 2015); it also applies to clinical psychology interventions, especially to psychotherapy interventions, even if they refer to gold standards (Baker, McFall & Shoham, 2008). It is worth pointing out that psychologists should be systematically involved in teams focused on the cost–benefit assessment of interventions so that they may contribute to the construction of an evaluative theoretical model in a comprehensive formulation that includes accurate references to the bio-psycho-social model. The economic cost–benefit evaluation in the bio-psycho-social model, even more so than in the bio-medical model, typically requires the presence of multi-professional teams to ensure the analysis of appropriateness is adequate for the health needs and compatible with the complexity of the value references coming from the various stakeholders.

Clinical governance, economic evaluations, and value in healthcare

Numerous institutional documents of the Italian Ministry of Health (MoH) refer to the concept of CG, under which the basic theoretico-methodological assumptions of the entire healthcare governance activity systematically fall. CG aims to increase work ethics by promoting: i) greater transparency in operational choices to support appropriate clinical decision-making and ii) increased accountability and participation of all stakeholders.

The core of the CG is good patient safety practices and clinical practice guidelines. Good practices for patient safety are sustainable over time and potentially reproducible/transferable to other contexts (*e.g.*, implemented at regional, corporate, or unit levels). Furthermore, they are based on literature evidence and implemented according to the principles of continuous quality improvement. Finally, they are attentive to effectiveness and cost-evaluation methodology.

Clinical practice guidelines are recommendations aimed at optimizing patient care that are based on a systematic review of evidence and an assessment of the benefits and harms of alternative treatment options.

Measuring health outcomes is a daunting challenge because of the complexity of the concept of health itself, which is a basic tenet of human experience to which fears, expectations, and needs correspond. Everyone wants to improve health outcomes as efficiently as possible, albeit sometimes starting from very different value premises.

Large-scale studies have paid particular attention to the criteria for choosing interventions and monitoring indicators, which, under conditions of limited resources, should be as selective as possible (Arah *et al*., 2006; Layard, 2006; Layard & Clark, 2015). In this way, *targeted choices* improve performance while avoiding the use of *generic interventions* (Barrett & Byford, 2009).

The optimal cost-benefit ratio can be represented as the difference between the maximum achievable health expectancy and the cost of achieving it. The better the ratio between the effectiveness of an intervention and the expenditures incurred to obtain it, the greater its appropriateness (Donabedian, 1988).

A *maximalist* approach to health (ideal from the point of view of those requiring care) promotes the search for and the delivery of the most effective interventions possible, regardless of their cost. A *minimalist* approach, on the other hand, is oriented toward providing interventions that are as inexpensive as possible. Different stakeholders have different points of view through which they interpret the health value of an intervention. It is evident that the same citizen, under different health conditions, may view their criteria for accepting an intervention differently.

Different viewpoints require constant reformulation of the overall value judgment given to the delivery of certain treatments (drug, surgery, *etc*.) as well as to the entire care pathway.

Traditional approaches to health expenditure assume that the entire amount of health expenditure leads to an improvement in individual and collective health. However, the returns (in terms of patient health) of resources invested in healthcare often vary. Except for no-value healthcare spending, it is impossible to draw clear and rigid boundaries between low, medium or high health value categories.

These macro-categories of health spending (*e.g.*, low-value or high-value) can be placed on a continuum. On the one hand, there are health expenditures with no value to or impact on health outcomes; on the other hand, there are health expenditures with a high value that have (more or fewer) significant health benefits. It is clear that this *complexity* makes reductive a rigid quantitative identification of the macro-categories depicted.

Health services and benefits may demonstrate varying economic value among different patient populations and subgroups according to appropriateness criteria based on scientific evidence or, in their absence, on a formal consensus process among experts.

In summary, the CG views appropriateness as a meta-level variable that increases the following:

- The selection of needs and related care responses (effectiveness and treatability)
- The specificity of interventions in care pathways (treatability and efficiency)
- The accountability of clinical care processes (effectiveness and efficiency)

Accountability and (mental) health

Although the NHS in Italy is composed of a group of healthcare companies, an industrial business model cannot be used to describe its development or to prove its efficiency. In the case of a public health company, which is an extremely complex organization, the volume of decisions to be made during the

course of healthcare activities depends on the heterogeneity of the processes and functions performed, their variability and interdependence, and the external and internal pressures on the results. Large health companies cannot take advantage of economies of scale, as is the case in the industrial model, which is characterized by simple, highly standardized processes. It is precisely the complexity of the organization of public health companies that multiplies governance requirements. In fact, a large portion of the *internal* stakeholders maintain strong behavioral discretion and job tenure with high degrees of protection; in the face of health demand, for example, turf wars between professional families are, at the same time, a differentiating factor for product and service lines and a driving force behind making accountability widespread and *liquid*.

The term *accountability* can be translated into Italian in different ways. Broadly, however, it refers to the quality of one who is accountable step by step, in the sense of being, from the outset, ready to provide explanations for every aspect that makes up one's overall actions.

This composite sense applies well to complex situations where accountability does not concern just a simple event but rather an articulated and organized process.

In Western countries, accountability, *i.e.,* the responsibility for processes and care pathways (Clement, 2023), is among the topics mainly treated as a parameter for organizational improvement in healthcare. Large-scale studies with these characteristics refer to international institutional organizations like the World Health Organization or the Organization for Economic Cooperation and Development (Arah *et al*., 2006).

Even in the past, albeit in a more implicit way, accountability has been a necessary reference to set up pathways consistent with the objective of responding to demands for healthcare from people seeking help, offering them appropriate and, therefore, effective care models. Brinkerhoff (2004), for example, illustrates a model that stratifies different levels of accountability, starting with the financial level before moving on to the level of intervention delivery and ending with the political level.

In clinical psychology and psychotherapy, accountability encompasses, in the context of specific care pathways, the outcome assessment of change processes both during the intervention (process) and either immediately after it (short-term outcome) or long afterward (follow-up or long-term outcome). In terms of clinico-therapeutic accountability, accountability is to be thought of above all as an effort to implement guidelines, if any, or good practices so as to operate according to the most established knowledge. This is a conceptual and value-based model in which all stakeholders, including the recipients of interventions, develop *know-how* and share decisions.

The concept of value is the main reference for addressing the present state of public health and imagining its future (Gray, 2007; Porter, 2010; Porter & Lee, 2016; Teisberg, Wallace & O'Hara, 2020). This conceptual shift has helped to alter the perspective of all stakeholders from volume-based care to value-based care (Gray, 2017).

In line with the most recent developments concerning the quality of healthcare and the progressive importance assumed by the concept of health value, accountability also makes it necessary to address the question of its determination at an epistemological and methodological level under a more comprehensive view, with a change in attitude toward the importance of evaluation and traceability of interventions.

For example, the promotion of psychotherapy interventions in groups is not sufficient in itself to improve the quality of care merely because it reduces the costs of healthcare, unless there are specific indications that such an intervention can be effective and specific. Thus, accountability favors the articulation of interventions into specific Clinical Pathways (CPs) on the basis of scientific evidence.

Therefore, accountability cannot only be conceived as a simplistic account of efficient performance. This is particularly true for psychologists since the clinical care processes they deal with are extremely complex. As a consequence, accountability does not refer to a cost-benefit analysis of interventions, nor can it be summarized in a clinico-therapeutic evaluation alone.

The observation of countries with a greater capacity to support applied research in the field of mental health promotion, such as Canada, Australia, and the United States, reveals how economic investment is increasingly tied to results. Economic constraints derive from the need to invest in projects and activities that are able to yield a good outcome combined with savings, even considering the absolute peculiarity of the mental health area, which is characterized by great heterogeneity when compared to major other medical specialties that boast the advantage - which, in a certain sense, they have earned - of being able to make more direct use of cost–benefit matrices conceived on quantitative rationales.

Especially in mental health, the accountability deficit contributes to a widening of the gap between best practices and actual treatment, affecting all those involved in care (Boden, 2020; Frank & Shim, 2023).

Patients, care providers, and health systems are all, at different times and in different situations, in a position to change their value hierarchies, and they can all contribute to improving accountability.

Several actions can be taken by care providers to facilitate improvement from a management point of view, as follows:

- Identify benchmarks to monitor progress and performance parameters through a clear articulation of specific health objectives to be achieved and intervention standards to be improved
- Target payment/budget incentives to support practices recognized as effective on the basis of scientific evidence
- Set regulatory standards, *i.e.,* consequences for insurers, care providers, and practitioners, in the event of attainment or non-attainment of targets

It is clear that psychologists also need to increase their responsibility from the health point of view, by placing continuity of care and monitoring of interventions at the center of their attention. Several activities can help to achieve this goal, such as i) facilitating access to the service that provides care; ii) guaranteeing a timely diagnostic evaluation to identify priority groups (*e.g*., triage), especially in the presence of long waiting lists; and iii) acting promptly by adapting to the health problems that the person presents. Finally, one should always keep in mind the efforts required to achieve change according to a progressive criterion (*e.g*., the *stepped* model for anxiety disorders).

In short, the fundamental principle of the process of identifying indicators and that of accountability require ensuring an answer to what is done and why it is done and also imply success in overcoming a deterministic conception, bound by reductive cause–effect nexuses with a high degree of predictability, in favor of developing knowledge based on a global and shared vision of care processes. The matter is, of course, still open because of the increasing attention given to the concept of value in health and because of the centrality that patients are

acquiring in self-determining health. Consequently, taken out of context, the model of outcome evaluation, which has been used for decades in psychotherapy research, is not sufficient to capture the totality of variables that come into play in psychological care in the NHS (Brinkeroff, 2004; Rebecchi, 2023; Rock & Cross, 2020; Rosenberg & Salvador-Carulla, 2017).

Accountability: document flow and the care process

Although an outcome evaluation of results is the main parameter through which interventions are monitored (it is strongly related to accountability), it is also important to pay attention to document flows and logical and empirical validation of interventions (in the form of application of guidelines, CPs, *etc*.).

The guidelines for the function of psychology in the NHS of the Italian MoH specify a series of actions and procedures necessary to improve the quality of care. They give particular attention to the correct management of the document flow to favor the traceability of the care process and the exchange of information in settings, which are both strategic aspects for the development of accountability. Introducing a systematization of organizational, management, and clinical processes highlights the need for indicators to meet the accountability needs of various stakeholders (Ridolfi, 2024). Procedures for receiving referrals with the definition of possible priorities and waiting times are an example of organizational processes that clarify which entry channels facilitate access to the service. Some indicators can be adapted for this purpose, such as direct access with or without referral by the treating physician/pediatrician or internal referral by other care/service providers (*e.g*., hospital discharge, psychiatric ward, *etc*.).

Another example of an action that improves accountability from a clinical perspective is the routine adoption of diagnostic tools/checklists at entry. These tools can help to identify priorities of needs, specificity of problems and appropriateness of interventions, making available indicators/measures of the service provided (at management and clinical level).

In relation to performance reporting and document flows, it is worth emphasizing that accountability improves as the ability to record clinic-therapeutic activity increases, rather than the other way around, *i.e*., forcing an activity to enter into a state of bureaucratic reporting, which distorts not only its clinical description but also, above all, its epistemological and methodological content.

In psychological interventions, the more complex the intervention project, the greater the required variety in types of performance, in combination with so-called *specialist services*, which are usually assumed to be the sole benchmark of the activity provided (Table 1). Clearly, the accountability of specialist services, taken alone as the sole benchmark, becomes a total paradox. This accountability model collects reliable data that express only the inappropriate way of proceeding to help the patient, particularly in the most complex cases, which require the construction of a network of multi-professional actions.

Appropriateness as a framework in clinical psychology and psychotherapy

The MoH has attached strategic importance to measuring the appropriateness of healthcare services, in that the MoH is particularly interested in the development of these models for measuring and promoting quality healthcare interventions. «Appropriateness, as a performance dimension, is the degree to which provided healthcare is relevant to the clinical needs, given the current best evidence» (Arah *et al*., 2006, p. 8). Appropriateness therefore refers to effective interventions based on scientific evidence and good practice.

In Italy, MoH has provided several definitions of the concept of appropriateness in terms of:

- Benefit: a decision-making process that ensures the maximum benefit for the patient's health, within the resources that society makes available
- Context: complex, context-dependent conditions, measured by specific methods, which must be placed in their respective domain and defined and articulated in operational terms, referring to different stakeholders
- Path: maximizing benefit and minimizing risk
- Timing: interventions delivered before or after which point it is inappropriate to act or provide a service

In psychology practice in the NHS, the assessment of appropriateness concerns epistemologically, paradigms, methods, and tools of both clinical psychology and the applied disciplines it borders and with which it partly overlaps, which are clinical health psychology, health psychology, and community psychology. The evaluation of appropriateness also includes

Table 1. Appropriateness and complexity of psychological care in mental health.

Complexity of intervention	Recipients/users	Appropriateness (CP *vs.* PS)	Monitoring	Outcome measures	Accountability
High Team members ≥4	Patient Family	CP	EM, GPs, CC	Assessment of symptoms Adaptation profile	Low
Medium-high Team members ≤3	Patient (often family members as well)	CP or PS	GLs, GPs, CC	Assessment of symptoms Adaptation profile Therapy process indicators	Medium-low
Medium-low Team members =2	Patient	PS	GLs, CC, GS	Adherence to pharmacological and psychotherapeutic treatments	Medium-high
Low Mono-professional care =1	Patient	PS	GLs, CC, GS	Adherence to psychotherapeutic treatment Therapy process indicators	High

CP, clinical psychology; PS, psychotherapy; CC, consensus conference; GL, guideline; GP, good practice; EM, equipment monitoring. High complexity team members: *e.g.*, MD, Psy., Soc. Work., Rehab.; medium-high complexity team members: *e.g.*, MD, Psy., Rehab.; medium-low complexity team members: *e.g.*, Psy., MD; mono-professional care: *e.g.*, Psy.

Table 2. Clinical psychology and psychotherapy appropriateness of interventions: a possible matrix.

	Appropriateness (meta-level)			
	Knowledge	Explanation/comprehension	Intervention	Evaluation
Treatability	Role of known variables	Psychopathological theory	Setting flexibility Best practices	Modifiability (of symptoms/disorders)
Effectiveness	Consensus conference Guidelines	Clinico-therapeutic methodology	Gold standard Best practices	Outcome
Efficiency	Cost-benefit Cost-effectiveness	Indicators of the treatment choices	Clinico-therapeutic expertise	Sustainability
Specificity	Target identification	Clinico-therapeutic processes	Setting stability Best practices	Process

psychotherapy interventions, which account for a massive slice of all psychological interventions in the NHS.

Dealing with improving the appropriateness of interventions also makes it necessary to take a stand on the strategic importance of paving the way for an ongoing exchange between research and clinical practice in context.

Clinical appropriateness, conceived as a meta-level variable, increases with treatment specificity and treatability: the greater the appropriateness, the better the effectiveness and efficiency will be. Effectiveness and efficiency are key parameters by which the sustainability of interventions can be determined in the public service. It is clear that the obvious areas of conceptual overlap between such complex variables require a *network* representation of the various interactions. Table 2 shows a schematic representation of the interactions between complex variables.

Conclusions

There are numerous external factors that impact health and co-determine it. In the Italian NHS, the response to incoming health needs can be addressed through the development of organizational and management processes. These processes must be consistent with the idea of building the care pathway through the input of values from various stakeholders, and they must also allow for the evaluation of the *health system* through models capable of grasping epistemological, methodological, and applicative details, with the aim of increasing the quality of services and better tailoring the care provided.

The challenge of guaranteeing quality and valuable healthcare (Scally & Donaldson, 1998) is even more lofty, if possible, in the field of clinical psychology and mental health, where a range of other intervening factors are at work, alongside more easily measurable parameters, to which significant indirect costs (off-set costs) of a much more complex evaluation correspond (Wiktorowicz *et al*., 2020).

Lack of economic resources, staff shortages, *etc*., may contribute to delays in action and postponement of the resolution of the health problem. Each such *postponement* implies that the problem will, at a later date, inevitably return to the health institution and likely under conditions that will result in a much higher cost of care for everyone.

Appropriateness, accountability, and value in health can thus be framed as concepts to which concrete actions of ethical management of institutional resources correspond.

For health system operators, the path that guides their evolution passes both through the acquisition of expertise in the field and through different knowledge processes that are continuously interrelated, such as residential and field training, clinical risk (*e.g*., clinical audits and mortality and morbidity reviews), and applied clinical research. This pathway, as a whole, fosters a culture of accountability and not so much a culture of performance audit and control. This trend results in both a challenge and an opportunity for psychologists, as it lends itself well to stimulating the planning, organization, and management of interventions by encouraging their verification, in order to improve the overall quality of care.

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