An investigation into the quality of services provided by a psychiatric day center in the representations of the actors involved

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Abstract

Objective: This survey aims to explore the quality of social and health services provided by a psychiatric Day Centre according to the representations proposed by the various actors involved. *Methods*: The quality topic was investigated through a mixed research approach, which is useful for acquiring both qualitative and quantitative information, integrating various sources (operators, technicians, and users), and using different survey techniques. A pool of instruments was defined, ranging from measures of association and graduation between variables (Pearson's X^2, Kendall's Tau-c) to lexicometric analysis on narrative-type sources, functional to formulating hypotheses on the actual functioning of the Service. *Results*: An overall set of quality performance indicators of the Day Centre was identified, to suggest specific lines of organizational intervention. *Conclusions*: A vision of Quality as the productive competence of a given health context in providing

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effective and sustainable responses to the health demand of the population served is described. It can be assessed through a survey procedure based on qualitative-quantitative methods of reading and analyzing specific indicators deduced from the social representations of the actors involved.

Keywords: quality, mixed methods, case study, organizational analysis, social representations**.**

Quality in Healthcare

For several decades, quality, efficiency, and equity/accessibility of healthcare services have been central to an extensive and lively technical debate. The need for healthcare systems to respond to the growing demand for health and the evolving needs and expectations of the population served has driven the continuous introduction of clinical and managerial innovations to achieve more efficient spending management and greater effectiveness in outcomes. Starting from Donadebian's classic contribution (1980), a distinction emerges between technical, interpersonal and comfort-related aspects as constitutive elements of the quality of care, which can be investigated along three axes: the process (professional quality), the structure (organizational-managerial quality), and the outcome (perceived quality and evaluation of the outcome). Specifically, quality understood in its technical/professional dimension would primarily refer to the evaluation of the appropriateness of procedures and services provided by healthcare personnel, developing into various approaches (Pagano & Vittadini, 2004; Scrivens, 1997), such as: Clinical audit; Quality Assurance or VRQ; Professional accreditation based on peer review mechanisms; and primarily Evidence-Based Medicine (EBM) concerning practices and gold standards. On the other hand, quality related to the organizational-managerial dimension, on the other hand, would focus on managerial-administrative aspects, structural issues, resource/equipment management, and coordination of information flows. In this area, programs for the accreditation of healthcare facilities for excellence and Quality Management Systems (Total Quality Management and ISO UNI EN 9000 standards) would be of particular importance, based on a slow reconsideration of hierarchical-functional

models according to increasingly process-oriented logics (Costa & Gubitta, 2004; Foddis, 2011). Finally, quality understood in the dimension of the outcome/outcome would show further articulations on two main levels: on the one hand, the models linked to the measurement of the effectiveness/performance of healthcare facilities in specific clinical outcomes (in-hospital mortality, post-operative quality of life, days of hospitalization or presence of specific sentinel events); on the other, the participatory analysis of quality, based on the definition of listening models applicable for the systematic collection of information on the Company's ability to intercept and satisfy the needs of patients (patient satisfaction) and to create favorable working conditions for operators (job satisfaction).

Within this multidimensional framework, the community psychiatry field has addressed the quality issue through various organizational-managerial and technical-professional proposals. For example, the management of waiting lists and service delivery times are key strategic indicators of timeliness, efficiency, and continuity of care (Rebba, 2010; Vaccaro & Barletta, 2003), or the development of models for understanding user needs in choosing clinical pathways to implement (Carli, Paniccia & Lancia, 1988; Gilliéron, 2007; Luborsky & Crits-Christoph, 1992), resulting in the use of standardized procedures to organize, uniformly, interindividual modalities and the standard conditions for implementing interventions (Bateman, Fonagy, 2019; Bolelli, 1996; Clarkin *et al.*, 2006; Linehan, 2014; Luborsky, 1989; Nicolò, 2021). Finally, the dimension of quality related to outcomes references a broad range of contributions (De Coro *et al.*, 2010; Rossi, 2003; Roth & Fonagy, 1998; Timulak, 2009; Westen *et al.*, 2004), aimed not only at identifying valid and reliable indicators/predictors of outcomes in various clinical trajectories (e.g., discharges, dropouts, chronicity) (Carli & Paniccia, 2011; Fava & Masserini, 2002; Lingiardi, 2002; Liotti & Monari, 2003), but also at the empirical verification of the comparative effectiveness of different treatments (Chambless & Hollon, 1998; Dazzi *et al.*, 2006; Sakaluk *et al.*, 2019) in the realm of Empirically Supported Treatments (ESTs). More recently, this has extended to evaluating clinical pathways in real-world situations through naturalistic observational studies mainly conducted within the public healthcare setting (Giordano *et al.*, 2021; Lora *et al.*, 2004; Tarallo *et al.*, 2020). The identification of interesting correla-

tions between levels of satisfaction expressed about healthcare services and therapeutic compliance/adherence (Subeesh *et al.*, 2019) has further contributed to the growing prominence of research on *perceived quality*, in which the attention shifts to the evaluation of the subjective point of view, expressed by the actors involved in the care process, concerning satisfaction and quality of services (Cortese *et al.*, 2010; Hod & Yaron, 2015; Manna & Dicuonzo, 2018). However, listening models for opinions and satisfaction levels in psychiatry present specific challenges, particularly in defining methodologies for collecting an empirical basis that is reliable and sensitive enough to the cognitive and emotional functioning levels of the *target* population, especially in chronic psychiatric conditions. Consequently, these models frequently involve the participation of caregivers in advocacy roles (Buscaglia *et al.*, 2004; Cozza *et al.*, 1997; Chiappelli *et al.*, 2000; Lomonaco *et al.*, 2003; Ruggeri, 1993; Ruggeri *et al.*, 1993) or the integration of data from epidemiological studies and corporate information systems (Barcella *et al.*, 2010; Biggieri, 1994; Pacaloni *et al.*, 2004).

Limits of measurability of the construct in real contexts

In the framework outlined, Quality is a conceptual and methodological tool aimed at producing a more efficient organization of healthcare processes, capable of promoting accessibility, appropriateness, and homogeneity in the delivery of clinical pathways. It also actively responds to the evolving needs and expectations of the served population, generating perceptions of satisfaction within a sustainable system framework. Therefore, multidimensional constructs, whose specific declinations within the various real care contexts, often take on evident critical aspects regarding the performance dimensions of process/outcome and organizational efficiency in the context of the procedures for assessing the levels of user satisfaction.

A frequently encountered fact (Cinotti, 2004), for example, concerns the substantial variability of performances linked to indicators of efficiency of production processes and effectiveness in outcomes, observable independently of the quantity of resources invested and the degree of technological-organizational sophistication present in such

healthcare systems. This issue can be attributed (Grilli & Taroni, 2004), on the one hand, to the usual difficulty in managing high levels of complexity given by the multiplicity of patients' healthcare needs, on the other to the poor integration between organizational-managerial models of quality improvement, borrowed from the entrepreneurial field, and technical-healthcare approaches that tend to focus exclusively on aspects of appropriateness of clinical decisions. These are problems that would have only been partially solved by resorting to more concerted approaches based on the integration of different tools, indicators and systematized operational actions (Foddis *et al.*, 2021, 2023), as in the experience of *clinical governance* (Lega, 2016).

At the same time, observing more carefully the area of perceived quality, it emerges that the majority of user satisfaction evaluation programs appear essentially inspired by logic borrowed, often uncritically, from customer satisfaction and as such, not fully applicable in the healthcare sector, if not at the cost of gross simplifications linked to questionable equivalences between "person who lives a subjective and somatic experience of illness" and "customer of a service". Furthermore, the consideration of the high levels of satisfaction, around 80%, expressed by the subjects participating in customer satisfaction surveys generally proposed in the healthcare sector, seems to pose a serious problem of absolute reliability of such surveys (Carr-Hill, 1992; Voutilainen, *et al.*, 2015; 2016). In fact, a series of conceptual aspects that are all too often not previously clarified during the design phases of the surveys come into play to fuel uncertainty regarding the validity of patient satisfaction surveys: first and foremost, the idea that the judgment of satisfaction with the health services used depends exclusively on the fulfillment of the person's previous expectations (Fitzpatrick & Hopkins, 1983); furthermore, in an even more questionable manner, the failure to consider the profound difference that exists between the expectations of the individual and the needs of the community served and on which, in particular, the Health System should electively organize its healthcare responses (Lerza, 2011).

The model of patient satisfaction understood as correspondence to the expectations of the user of healthcare services, starting from the research of Linder-Pelz (1982), would also show many weaknesses when applied to real healthcare contexts, primely characterized by aspects of uncritical passivity and delegation or by different hierarchies

of priorities, elicited by such healthcare situations in the variously involved subjects.

The evaluation of perceived quality appears, therefore, to be a complex methodological operation (Parasuraman, *et al.*, 1988; Ruggeri, 1996; Zeithaml, *et al.*, 1990) that primarily draws attention to the fact that users generally possess limited information about the management procedures and the regulatory and financial constraints underlying the provision of health services, with the risk of overlapping their desires with the actual priorities of the structure. On the other hand, "giving voice" to the recipients of health services means accessing a multitude of valuable information regarding the relationship models between interviewees and the healthcare institution in terms of needs, experiences, expectations, and requirements. In this perspective, the meaning of the concept of patient satisfaction, rather than referring to previous expectations, would seem to depend primarily on the role in which the user perceives himself or is identified by and in the relationship with the health system to which he belongs (Cipolla *et al.*, 2002; Zastowny, 1995).

The interesting trajectory "patient/user/client/stakeholder/citizen" (Cinotti & Cipolla, 2003) seems, therefore, to tell the changes in the identification of the recipient of the care processes observed in recent decades, making it clear how the very way of defining the person belonging to a Health Service probably represents the most powerful organizer of the clinical relationship model and, indirectly, of the quality/satisfaction evaluation paths that will be consequently implemented in this care context.

Along a dimensional continuum, it is then possible to imagine how the term "patient" (from the Latin *patiĕnte*, he who endures, tolerates, suffers) tends to be associated more closely with the concept of pathology understood as somatic *disease* (Illich, 1976; Good, 1994) while the term "citizen" favors, in a more natural way, the consideration also of the social and affective aspects present in the concept of *illness*, favoring broader readings and articulations of the construct of Quality and its possible assessment.

Method

The critical issues identified have oriented this work towards the definition of an alternative methodological proposal for evaluating the quality of services provided by a specific care context. The perspective adopted, in particular, has: a) tried to anchor the quality construct to the theme of the functionality of the productive coexistence system traceable within a specific context; b) integrated information and representations on the Service produced by the different actors, involved in various capacities in the care process; c) used tools and strategies for data collection and processing differentiated along the qualitative-quantitative continuum, placing itself within a framework of methodological reflections typical of Mixed Methods Research (Amaturo & Punziano, 2016; Mauceri, 2019); d) considering the perceived quality not with marginal functions, as a simple corollary to the technical evaluation of the clinical-operational aspects (process) and managerial-organizational (structure), but as a privileged channel of knowledge access to the relationship between the concrete health action of the operators and the relative representations evoked in the population served; e) finally, understood this method of investigation as potentially applicable, with the same purposes, to the evaluation of different healthcare contexts.

Sample

The investigation was conducted in the context of a Psychiatric Day Center (PDC), a semi-residential structure located in the Italian city area of competence and with therapeutic-rehabilitative functions dedicated to a population of people between 25 and 70 years of age approximately, affected by a variety of psychiatric disorders of a predominantly psychotic type (schizophrenia and affective psychosis), severe/recurrent mood disorders or borderline personality disorders (low-functioning cluster A and B) (American Psychiatric Association, 2013; Lingiardi & McWilliams 2017) with different clinical profiles of autonomy and socio-affective functioning. The integration between a healthcare team and a group of operators belonging to a type B social cooperative (Law 381/1991), involved in the provision of laboratory

activities, allows the pursuit of rehabilitation objectives in patients related to the management of activities and requests of daily life and more functional adhesion to dyadic and group interpersonal relationships.

In particular, the investigation involved: 62 psychiatric users (33 males; mean age 49.1 years; SD = 11.9); 12 laboratory technicians (9 females; mean age 49.5 years; SD = 9.6); 7 healthcare workers (5 females; mean age 43.7 years; SD = 12.1).

The evident heterogeneity of the subjects involved, in terms of roles, levels of knowledge of the organizational context, and different capacities for symbolic representation of their affective-relational experience, suggested, during the research planning phase, the preparation of differentiated tools and strategies for detecting their respective opinions and perceptions on the Quality and functioning of the Service.

Procedure

The data were collected between May and November 2021 following these points: a) the administration of a patient satisfaction questionnaire addressed to users (62 subjects) attending at least one of the laboratory activities offered by the PDC during the chosen time window, and interested in joining the survey by signing the prepared informed consent; b) the administration of a job satisfaction questionnaire addressed to all laboratory technicians (12 subjects) permanently employed in the Service; c) the compilation of an organizational Check-List by healthcare workers (7 subjects) employed by the PDC; d) conducting and audio-recording three plenary *focus groups* dedicated to healthcare personnel and laboratory technicians on topics relating to the evaluation of the organizational functioning of the PDC.

Data analysis

The research involved collecting and processing data from the different information sources following development phases: a) the first objective was to evaluate the levels of satisfaction perceived by

patients with respect to the quality and methods of delivery of social-assistance services used in the PDC. The SPSS software (ver. 19) allowed the analysis of the association and co-gradation relationships of the variables, expressed at nominal and ordinal levels, taken from the questionnaire items dedicated to the users. The Kendall Tau Index, in particular, proved to be statistically suitable for evaluating the relationship between two ordinal quantitative variables on samples of small subjects and for which the normal distribution is not assumed (non-parametric test); b) the second objective, in parallel, concerning the evaluation of the perceptions of laboratory technicians and the functionality and related critical issues of their work experience within the PDC. The analysis of the frequency distributions detected by the questionnaire dedicated to technicians was carried out using the SPSS software (ver. 19); c) the evaluation of the observation vertex proposed by the healthcare workers, with respect to the shared organizational context, represented the third objective of the survey, conducted through an Organizational Check-list and the analysis of the frequency distributions carried out with the support of the SPSS software (ver. 19); the viewpoint of healthcare and laboratory staff regarding the critical issues of the productive coexistence system within the Service and the relationships with the users under care was also explored through a lexicometric analysis of textual material from different sources: three focus groups; open-ended questions from the questionnaire dedicated to laboratory technicians; the descriptions provided by operators and technicians in the Annual Project, submitted to the institutional client, regarding objectives, educational content, and methods of delivering clinical-rehabilitative activities. The T-Lab software (ver. 5.5 PRO), in particular, allowed for identifying relationships between profiles of co-occurrences of lexical units (LU), on the one hand aiming to highlight specificities through Association and Comparison algorithms between pairs of LU, and on the other hand synthesizing the information through ECT (Elementary Context Types) algorithms based on Cluster Analysis and Correspondence Analysis models (Lancia, 2004). This qualitative analysis of the textual corpus was aimed at a clearer specification of the quantitative data expressed by operators and technicians in the respective tools dedicated to the relative perceptions of quality. Unfortunately, in the time window dedicated to the research it was not possible, for organizational reasons and user functionality, to carry out

a similar collection of textual material on the patients involved, an aspect that presumably would have allowed a more articulated construction of hypotheses. Quantitative data obtained from the three specifically designed structured tools, analyzed using the SPSS software (version 19), and qualitative data relating to the narrative corpus obtained, analyzed using the T-Lab software (version 5.5 Pro), were thus understood as hierarchically integrated within the same design.

Measures

The tools used in this survey were created ad hoc according to the objectives outlined. In particular, the questionnaire proposed to users, entitled "Your point of view", is composed of 11 items (rating; forced choices between opposites) and includes a personal data section and the following four thematic areas: 1) *Function/Purpose* of health or professionalizing nature mainly attributed by the subject to the PDC in relation to his/her therapeutic-rehabilitative project; 2) *Methods/Expectations of relationship* with the Service in the context of participation in rehabilitation activities; 3) *Perception of satisfaction/appreciation* expressed on various aspects of the functioning of the Service; 4) *Results/Personal changes* that the patient believes to have achieved following the attendance of the PDC activities.

The perceptions of laboratory technicians were collected through the questionnaire "My work well-being", composed of 11 items in total, the first 8 of which were closed (one response among alternatives or rating scale), aimed at identifying the critical issues relating to the organizational functioning of the Service, followed by three open-discursive questions relating to the methods of relationship with both healthcare workers and patients in charge.

Finally, the description of the representations of healthcare workers with respect to the functional, organizational and interpersonal dimensions of their work experience within the PDC was carried out through an Organizational Checklist. A tool composed of 60 closed items (rating scales) with scores expressed on a Likert scale from 0 to 5 and divided thematically into three macro-areas: a) Structure, 10 items on the characteristics of the work environment; b) Process, 38 items related to 9 sub-areas (Sending/reception methods; User assessment;

Therapeutic interventions; Relationships within the team; Relationships with technicians; Relationships with the population in charge; Stress factors; Problem-solving strategies; Professional updating/ training); c) Outcomes, 12 items distributed in 3 sub-areas (Evaluation of service objectives/performance; Perceived quality; Forward-looking vision).

Results

The following presents the findings from the data analysis based on the empirical data collected through the various investigative methods described. The first subsection is dedicated to the results on patient satisfaction, followed by the descriptions of the results from both quantitative and qualitative analyses performed on the representations provided by laboratory technicians and healthcare operators.

Patient Satisfaction Results. Table 1 below shows the satisfaction levels expressed by users (62 subjects, 33 males; average age 49.1 years, SD = 11.9) across a wide range of service functioning aspects.

A variable percentage, but always less than 20% of the subjects, expresses negative judgments on specific areas of service delivery considered in the study. The user group shows significant gender differences, with higher satisfaction expressed by women (Pearson's χ^2 = 9.09; p = .011), only regarding the aspect of the variety of activities and services offered by the PDC.

This first general survey of the levels of satisfaction expressed by users required further specification through the evaluation of the demand and the expectations of the relationship addressed by users to the Service. In particular, the function/purpose variable attributed to the PDC allowed a group differentiation based on the relative expectations of the relationship with the context. This variable, taken from the dedicated area of the questionnaire, distinguishes the users involved in 53% (n. 33) of subjects who attribute greater weight to the health aspects of their care path and 47% (n. 29) who identify in own participation in the PDC for primarily socio-work purposes. Specifically, in the group whose attribution of professionalizing functions to the PDC prevails, more defined expectations of the relationship with

the context and higher satisfaction levels on a range of services can be identified. This part of the user group shows greater perceived satisfaction regarding: a) the clarity of information provided by operators about the rehabilitative pathway (Tau C value=.632; sign.=.030; X^2 value=7,250; df 2; sign= .027); b) the support/help in managing unexpected issues and problems provided by the operators (Tau C value=.596; sign.=.046; X^2 value=7.035; df 2; sign= .030); c) the quality of knowledge and skills proposed by the laboratories (Tau C value=.674; sign. .023; X^2 value=6.302; df 2; sign= .043); d) the recreational and cultural external activities offered (Tau C value=.687; sign.=.024: X^2 value =5,536; df 2; sign=.039).

Tab. 1. Quality judgments expressed by users with respect to 9 dimensions of functioning of the Day Centre

Dimensions	*Perceived quality judgment*			*Tot*
	Low	*Moderate*	*High*	*%*
Reception/availability of operators	0	32,3% (20)	67,7% (42)	100 (62)
Clarity of information	11,3% (7)	38,7% (24)	50% (31)	100 (62)
Activities/services	9,7% (6)	48,4 % (30)	41,9% (26)	100 (62)
Comfort environments	11,3% (7)	53,2% (33)	35,5% (22)	100 (62)
Laboratory equipment	19,4% (12)	46,8 % (29)	33,9% (21)	100 (62)
Warmth/positive atmosphere	4,8% (3)	40,3% (25)	54,8% (34)	100 (62)
Support in Managing Unexpected Issues	4,8% (3)	46,8% (29)	48,4% (30)	100 (62)
Learning utility	3,2% (2)	51,6% (32)	45,2% (28)	100 (62)
Project sharing	14,5% (9)	43,5% (27)	41,9% (26)	100 (62)

This different perception of PDC present in the group with predominantly work-related expectations also tends to translate into greater levels of: a) active participation/adhesion to the therapeutic project (Tau C value=.681; sign.=.041; X^2 value=4.183: df 2; sign.=.037); b) personal confidence regarding the recognition of crisis signals (Tau C value=.579; sign.= .046; X^2 value= 5,839; df 2; sign=.037); c) ability to ask for help and rely on operators (Tau C value=.654; sign.= .027; X^2 value= 6.705; df 2 ; sign=.033).

The search for associations and co-graduation relationships between variables has thus led to the identification of some specific perceptions regarding the functioning of the PDC, particularly those proposed by users who are able to take a more defined, committed position in their relationship with the Service and the referring operators. On the other hand, the system of perceptions regarding the PDC attributable to the group of individuals with predominantly health-related expectations appears to be less defined.

Job Satisfaction Results

The administration of the "My well-being at work" questionnaire to the laboratory technicians (n. 12) made it possible to identify the phases of the production process considered to be of more significant organizational criticality (low if identified by less than 30% of the technicians; moderate by less than 50%; high from 50% and above) and the consequent risk factors detected (Table 2).

Thus, a first representation of the Service emerges, expressed by the technicians, as difficult with respect to an effective sharing of planning and anamnestic-functional information on the users. The most immediate critical area identified involves redefining inter-functional communication methods between social and healthcare professionals during the planning and delivery of interventions.

At the same time, the organizational checklist proposed to healthcare workers (n.7) introduced a third observational perspective on the productive reality under examination. The scores deduced from the checklist were developed, at a preliminary level, to verify the concordance of the judgments expressed by the different operators. A first graphic representation of the distribution of the scores expressed is proposed in the boxplot of Fig.1 relating to the different scales of the checklist. Observing the extension of the two "whiskers", upper and lower, and the width of the interquartile range (IQR), as indicators of dispersion of values, it emerges that the categories Sending/receiving methods, on the one hand, and Therapeutic interventions, on the other hand, are respectively the areas with the least and more significant variability in the scores attributed by the coders, both relating to the Process dimension (Cf. Figure 1).

Tab. 2. Judgments of critical issues expressed by laboratory technicians with respect to the various phases of the production process

Production process phases	*Judgment of criticality*	*Critical factors encountered*
Initial interview and assessment (healthcare worker/user)	Low	None
Case description to the technician	High	Insufficient information about users for the required technical-relational work
Rehabilitation project planning	High	limited involvement with the healthcare team in defining the rehabilitation project
Presentation of the project and activity chosen to the user	Low	None
User integration into the laboratory	High	Inclusion of users deemed not fully suitable for the planned laboratory activities
Delivery of the socio-rehabilitative laboratory program	Moderate	Need to manage unexpected emotional-relational crises of one or more participants during activities
Periodic monitoring and verification meetings	Low	None

The multidimensional evaluation of the PDC carried out through the checklist highlights, on the other hand, how the scores for two of the three dimensions explored take on values that can be placed below 50% of the respective ranges (Table 3).

In the perception of the 7 healthcare workers, the Structure dimension appears to be the most problematic in terms of comfort and adequacy of environments and equipment, while generally higher average scores concern the *Outcomes* dimension relating to the quality attributed to the outcomes of their activity.

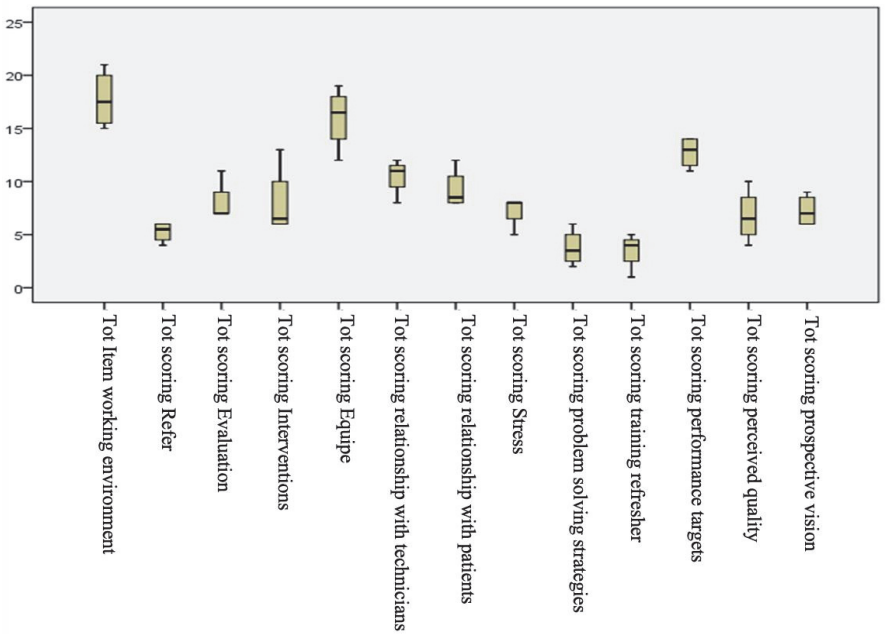

Fig. 1. Box-Plot relating to the distribution of scores of the sub-categories of the Organizational Check-List

Tab. 3. Check-List dimensions and related values attributed by operators

Dimensions	*N*	*Range*	*Min*	*Max*	*Mean*		*Std. Dev.*	*%*
					Statist	*Err.Std*		
Structure	7	0/40	15.00	21,00	17,75	1,376	2,753	44,3
Process	7	0/152	64,00	85,00	71,50	4,734	9,469	47,0
Outcomes	7	0/48	25.00	30,00	26,75	1,108	2,217	55,7
Tot. C-L	7	0/240	109,0	125,0	116,0	3,535	7,071	48,3

Results of lexicometric analysis

Further development of the investigation path concerned the analysis of the dialogic and descriptive narratives proposed by social and healthcare workers regarding their productive coexistence within the Service.

The textual corpus used presents a vocabulary composed of 2925 lemmas, 3395 Hapax, and 5729 graphic forms (type), with a total of

31360 occurrences (token), determining a Lexical Extension Index TTR (Type/Token Ratio) equal to 18.2 %. A text analysis was conducted through the T-Lab *Word Associations* tool. It shows the relationships between a selected keyword and the words that most fre quently co-occur with it in the analyzed text. Figure 2 graphically describes the contextual meaning of the keyword *rehabilitation process* in its clinical, organizational and learning aspects within the PDC.

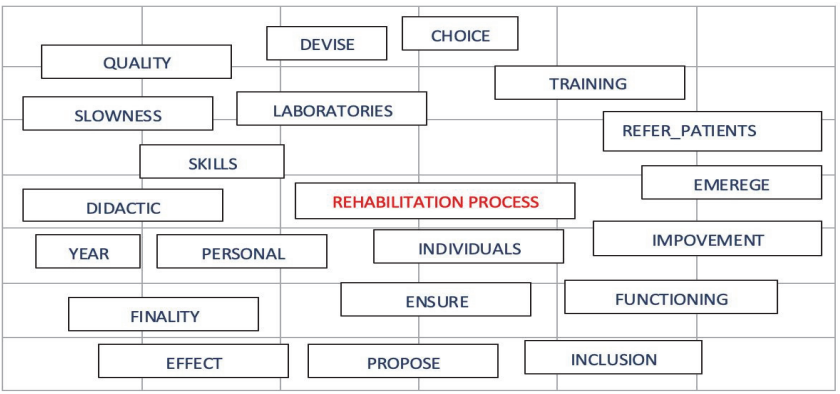

Fig. 2. Map of the keyword "rehabilitation process"

The T-Lab *Keyword Pair Comparisons* tool allows you to continue a detailed analysis of the text by detecting the words that are most frequently and differently associated with a pair of selected keywords. In particular, comparing the key words *patient* and *learner* in Figure 3, it emerges that the former is more frequently associated with *functioning, differentiating*, *improvement*, *psychiatric disorders* and *new crisis*. The key word *learner* is instead associated with words such as *dedicate*, *autonomy*, *support*, *motivation*, *relationships*. Two different modes of representation of the users emerge within the context of the PDC, based on the prevalent healthcare or socio-rehabilitative value attributed to their care pathway.

The transition, in the analysis of the textual corpus, to an overall vision was carried out using ECT algorithms (Elementary Context Types), based on Cluster Analysis and Correspondence Analysis models. In the *Typologies of elementary contexts* T-Lab tool, in particular, each cluster obtained from the analysis can be described using the

sentences, i.e. the elementary contexts and the words (LUs) that most characterize it, selected and ordered through the CHI square test. We opted for a 4-cluster output. The distribution of text segments across the four clusters is illustrated by Figure 4.

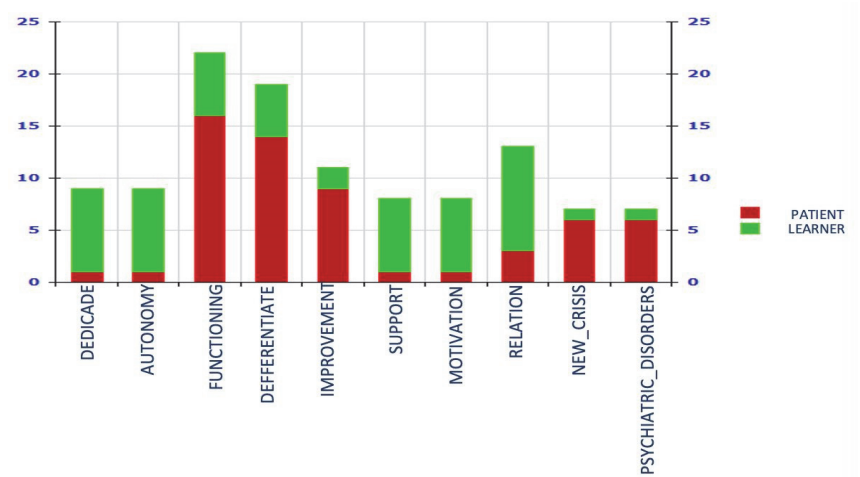

Fig. 3. Patient and Learner Keywords

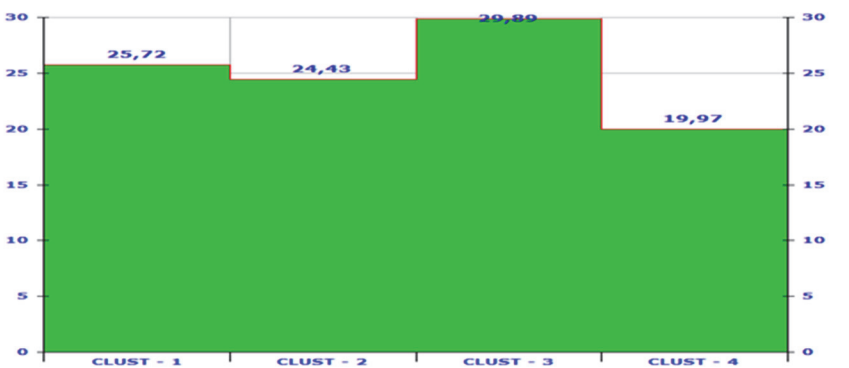

Fig. 4. Inertia explained by the 4 factors

The summary vision obtained through the ECT statistical procedures allows us to outline, through the LU. and the most characteristic phrases of each cluster, a representation of the main cultural

repertoires (Carli & Paniccia, 2003; Foddis & Grasso, 2008) proposed by the staff with respect to the theme of the quality of services within their production context.

Cluster 3, with a higher share of elementary contexts (29.89%), is organized around the following lemmas (Table 4), which seem to reference to the objectives and results expected through the activities of the various professionalizing laboratories.

Tab. 4. Most representative lemmas of Cluster 3

Lemmas	*X²*	*EC in cluster*	*EC in total*
Learning	89,06	36	36
Knowledge	33,10	17	19
Autonomy	29,85	17	20
Group	28,53	42	74
Skills	27,71	30	47
User	27,46	65	134
Reach	26,31	19	25
Practice	25,94	14	16
Working	24,19	62	130
Purpose	24,07	21	30
Use	23,54	43	81
Goals	22,24	36	65

The most characteristic phrases of the above cluster are: "*Specifically, the laboratory aims to provide basic learning by providing for the acquisition of knowledge such as, Basic concepts, Use of the computer and file management, Word processing, Sheets electronic devices, Internet navigation and communication. The laboratory takes place inside a dedicated room equipped with PC stations*" (score 42.445); "*The activity has three types of objectives: acquisition of the ability to use computerized audiovisual technology independently, knowing how to work in a group by developing envious skills and attitudes by sharing a common purpose (producing an audiovisual work)*" (score 41.930); "*The activity of this laboratory, aimed at job placement, involves the acquisition of knowledge useful for the restoration of antique furniture that can be revalued. To achieve this objective, the laboratory is divided into two different lines of intervention which also meet the diversified abilities of the users who take part in it*" (score 35.857).

Cluster 1, following, with a percentage of elementary contexts of 25.72%, is organized around the lemmas reported in Table 5, which seem to describe operational aspects of the relationship between health operators and laboratory technicians in the provision of social-rehabilitation services.

Tab. 5. Most representative lemmas of Cluster 1

Lemmas	X^2	*EC in cluster*	*EC in total*
Healthcare workers	156,14	65	77
Laboratory technicians	100,14	56	77
Improvement	53,03	35	51
Relations	45,67	27	37
Presence	36,07	32	53
Exchange	29,25	14	17
Resources	21,44	15	22
Plenary meetings	21,21	10	12
Clinical condition	20,89	11	14
Quality	19,00	14	21
Situation	15,74	19	35
Dialogue	15,64	8	10

The three Elementary Contexts having the strongest statistical association with Cluster 1 are the following: "*To do this I think that dialogue and discussion between technicians and healthcare workers represent the essential element. It is in the continuous exchange between technicians and healthcare professionals that the path that the user must follow becomes clear and both professional figures are precious and complementary for the user as part of their rehabilitation path*" (score 77.042); "*The dialogue and discussion with the operators is excellent with everyone. I would like it to be possible to think of a noticeboard that contains important information for the various communications between technicians and I hope that events can be organized in which all technicians participate in encourageing aspects of socialization and consequently improveing working relationships*" (score 74.996); "*In the relationship between technicians and healthcare workers, I see as strong points the historicity of the Day Centre, its location within a given territory rich in cultural suggestions and experiences, the fact that the building is owned by ASL Roma 1,*

next door to more relational aspects such as the group nature of the operator staff and the present hospitable climate" (score 65.268).

Cluster 2, with a slightly lower percentage of elementary contexts (24.43%) than the previous, one appears to be mainly composed of the lemmas listed in Tab. 6. This is attributable to the theme of personalized clinical-rehabilitation paths and the assessments of the appropriateness of the relative insertions of the user.

Tab. 6. Most representative lemmas of Cluster 2

Lemmi	X^2	*EC in cluster*	*EC in totale*
Patient	51,67	58	114
Professionalizing	49,36	24	31
Patient referral	34,37	17	22
Complexity	32,02	23	36
Person	29,35	30	55
Reality	28,51	29	53
Operating modes	25,71	19	30
Informatics	25,71	19	30
Choice	22,91	20	34
Understand	21,44	15	23
Support	20,11	12	17
Attention	19,52	15	24

The most characteristic Elementary Contexts of the aforementioned cluster are: "*in fact, the sending methods we are currently thinking about are based on a radical revision of these aspects which have shown in the past to favor uncritical sending, which pay little attention to the evaluation of the real capabilities of the patient and also perhaps a little too compliant towards their unrealistic requests*" (score 32.484); "*whereas in the last two or three years only one person could take the EPDCL exam. We could increase the hours of basic IT by removing them from the EPDCL to organize the offer in a more realistic way or more relevant to the real composition of the group of students belonging to the laboratory, based on actual abilities and motivations*" (score 29.868); *"I only partly understand this discourse on the need to choose and propose professionalizing workshops exclusively because in reality we risk in a choice that is too rigid and*

polarized to lose something, i.e. to do away with a certain type of activity that acts as a glue and allows even the most professionalizing workshops to reap greater rewards" (score 28.587).

Finally, the 4th cluster, with the lowest share of Elementary Contexts (19.97%) is defined by the lemmas reported in Tab. 7:

Tab. 7. Most representative lemmas of Cluster 4

Lemmas	X^2	*EC in cluster*	*EC in totale*
Design	35,95	33	70
Video	34,80	13	17
Audiovisual	32,24	14	20
Embellishment	27,93	12	17
Production	27,89	22	43
Decorate	26,88	10	13
Preparation	24,38	11	16
Outdoor	23,82	13	21
Mosaic	20,32	16	31
Consumables	19,88	13	23
Artistic	19,56	11	18
decorated walls	19,12	6	7

The three Elementary Contexts having the strongest statistical association with Cluster 4 are the following: "*This year's project is included in the more general project of the restyling of the day center. In this regard, the 6 students attending the laboratory with a variable regularity were prepared, 4 themed paintings with the 4 seasons to be set up in the main room of the Day Centre*" (score 29.19); "*The renewal of the design and appearance continued in the wake of the initiatives launched last year aesthetic, restyling of the Day Centre, both in relation to the internal environments, laboratories and common spaces, and the external one, composed of the two gardens, the central one and the perimeter one*" (score 18.53); "*The IT Laboratory and the Photo/Audio Laboratory /Video should in fact occupy the same space while the artistic center of the Mosaic and Recovery Art laboratories should have differentiated and respectively dedicated rooms, but until we find a solution to these problems of space allocation the Mosaic laboratory will always find itself stuck on restricted expressive*

possibilities" (score 17.07). Thus, this cluster essentially proposes themes relating to the organization of spaces and the embellishment of the structure, aspects on which a good part of the ongoing projects in the Service converged at the time of the survey.

Therefore, in the staff's narratives, an overall representation of the functioning of the Day Center emerges polarized around: the choice of specific outputs of the rehabilitation activities (cluster 3); the development of more effective inter-functional relationships between healthcare operator and laboratory technicians (cluster 1); to the definition of targeted insertion paths for patients in care (cluster 2); and finally to the functional adaptation of the Service environments (cluster 4).

Summary

The investigation adopted an integrated method of qualitative-quantitative data collection and analysis, allowing the definition of a measurable set of representations, expressed in various ways by the subjects involved, concerning the functioning of the investigated organizational context. The calculations carried out highlight in particular how: 1) the population in charge of the PDC appears to be widely diversified internally in terms of expectations, objectives and functions attributed to their rehabilitation path; 2) The centrality of outcomes related to the improvement of users' work skills, expressed by operators (Cluster 3), should be interpreted in conjunction with the findings of the patient satisfaction analysis. It is an indicator of prevailing attention aimed at a professionalizing mission of the Service, such as to determine, however, significant current difficulty in grasping and defining in a more detailed way even the demand made by the share (53%) of users with predominantly healthcare expectations; 3) the relationship between healthcare workers and laboratory technicians, as a strategic space in the definition of effective and co-participated inter-functional synergies, is an aspect strongly requested but only partially acquired within the PDC practices. The critical areas outlined therefore seem to represent, to improve the quality of services, the aspects of most immediate intervention within the context investigated.

Discussion

The investigation proposed a reflection on the theme of Quality, with reference to the field of territorial psychiatry, starting from the specific theoretical-operational dimensions present in the literature and the critical issues in the prevalent survey methods. The operational aim was to outline a methodological path useful for exploring the relationship between the system of expectations and needs of the users and the models of operation and provision of services proposed by a given healthcare context. The idea of being able to grasp this connection between the needs/expectations of the users and the organizational-performance structures of a given Service has favored the transition, outlined in this article, from a survey of patient satisfaction according to usual survey methods to a broader, with the integration of quantitative and qualitative data, deduced from different observational perspectives (patients, healthcare and social workers) concerning the functioning of the production context in question. A methodological path that has allowed us to outline a more complex image of the Quality of the Service in question, compared to that obtainable solely through the opinions expressed by a sample of users interviewed on a list of general aspects and with predictable levels of satisfaction attested, such as from literature references, around 80%. From this perspective, improving the quality of a service does not simply mean making specific corrections to individual areas perceived by users as uncomfortable but being able to build a systemic idea of the functioning of the context and a prospective vision of the same.

Quality, understood as knowledge dimension, then becomes a valuable reading model for understanding how competent an organizational context is in intercepting and understanding the requests and needs of the actors involved, translating them into development dimensions and perspectives within the relationship with current and potential service users.

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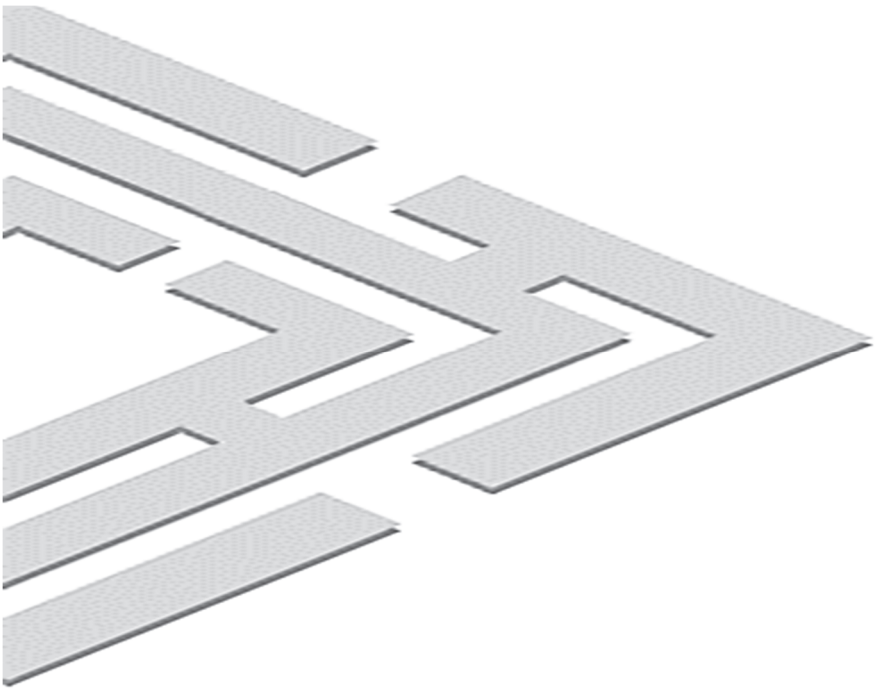
COMMENTARIES*



* Commentary on Castelnuovo *et al.* (2023). Psychology profession, clinical psychology, psychotherapy. Specificities and boundaries. *Rivista di Psicologia Clinica*, 1, 7-25.