SERVICE CHARTER

This Service Charter has been drawn up to ensure accessibility to services and the protection of users' rights and legitimate interests, pursuant to Article 20, paragraph 5, of Provincial Law No. 13 of 27 July 2007.

Welcome

This document is the result of the active involvement of the Managers, Staff Members, Young Adults and Family Members who, before you, have experienced the services provided by our facility.

We would therefore be grateful if you too would engage with our organisation by providing helpful suggestions or feedback. Your contribution can help us identify possible areas for improvement in the delivery of our services, enabling us to respond more effectively to your needs and, whenever possible, to your wishes as well.

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1. Introduction

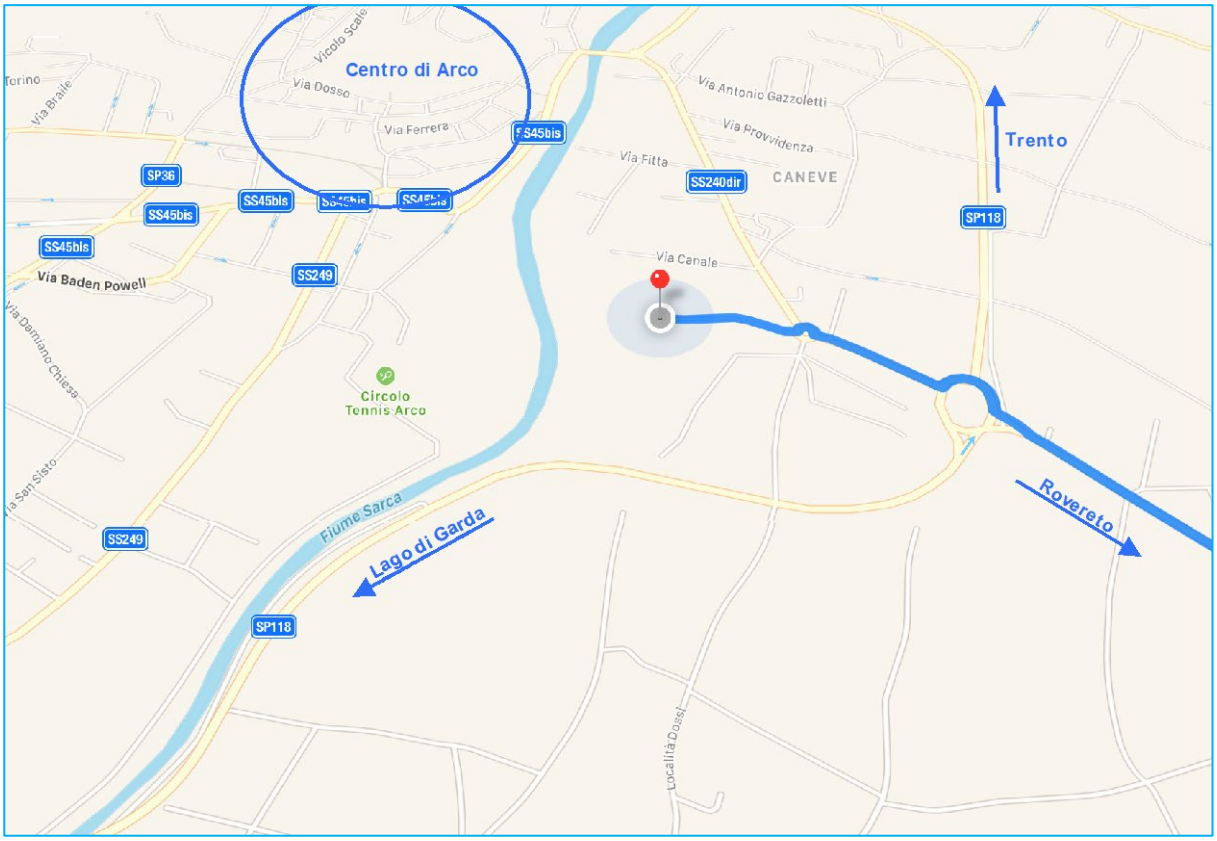
Villa San Pietro is an integrated facility comprising the “Villa San Pietro” Rehabilitation Centre and the high-intensity therapeutic community for minors and young adults, “Il Soffio”.

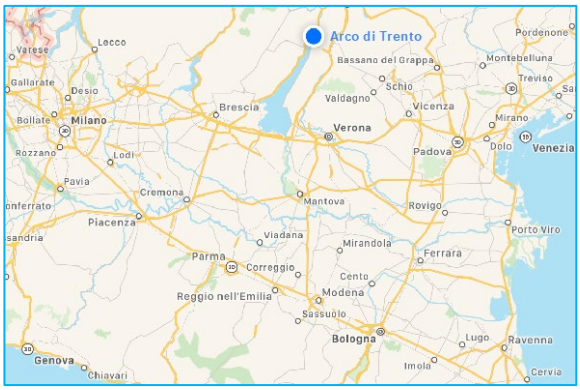
These are two fully independent Operational Units, each with its own specific methodological, organisational and human resources management approaches.

The “Il Soffio” Therapeutic Community is accredited to accommodate up to 10 adolescents or young adults aged between 13 and 22 with behavioural disorders and psychological vulnerabilities, under the accreditation and authorisation of the Autonomous Province of Trento and ASUIT. Of these, 5 places are covered by an agreement with the Autonomous Province of Trento, while a further 5 are available to patients from outside the Province.

The “Il Soffio” Therapeutic Community forms part of the network of healthcare services provided to local patients by the Provincial Health Services Authority.

2. Where We Are and How to Contact Us





Villa San Pietro is located just outside the centre of Arco, which can be reached in about 10 minutes via a pedestrian and cycle path.

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3. About Us

3.1 Codess Sociale

Codess Sociale is a Type A Social Cooperative, founded in Venice in 1979, operating throughout Italy in the social care, health and social care, and socio-educational sectors.
As a mutual, non-profit organisation, its purpose is to pursue the general interest of the community by promoting personal development and the social inclusion of citizens through the management of social care, healthcare and educational services.
In accordance with the provisions of Law No. 381/91, Codess Sociale also promotes the social inclusion of disadvantaged people by supporting their integration into the labour market.
With experience gained through partnerships with more than 300 Public Authorities, Codess Sociale employs over 3,500 people throughout Italy.

3.2 The History of Villa San Pietro

Villa San Pietro has been providing care for people experiencing psychological distress since 1993, initially through the work of the Associazione Silenziosi Operai della Croce.
In 2003, management of the facility was transferred to Villa San Pietro S.r.l., which was subsequently succeeded by Codess Social Cooperative in 2010.
In the summer of 2016, Villa San Pietro moved to its current, newly built facility. This structural change was soon followed by an extensive internal reorganisation process, culminating in the official opening of the new premises in January 2017.
In 2019, the Therapeutic Community for adolescents and young adults, known as "Il Soffio", was established pursuant to Provincial Resolution No. 363 of 15 March 2019.
The same year also saw an increase in the number of accredited places at Villa San Pietro, with some of these places becoming subject to an agreement with the Autonomous Province of Trento.

3.3 Our *Vision*

*"**Providing care during the developmental years to reduce distress in adulthood**"*

The most recent data from the international literature show that:

- approximately 75% of psychiatric disorders in adults are preceded by disorders with an onset before the age of 18 (50% before the age of 15);
- childhood psychopathology often differs from that observed in adulthood (heterotypic development);
- identifying the developmental trajectories of the most significant psychiatric disorders plays an important preventive role in safeguarding the mental health of the population.

The most recent epidemiological data also highlight a marked increase in psychiatric disorders during the developmental years. This applies both to "externalising" disorders (ADHD, Oppositional Defiant Disorder and Conduct Disorders) and to "internalising" disorders (mood disorders) (SINPIA, 2016).

These difficulties are often associated with social and family-related issues. Moreover, outpatient or semi-residential care, or hospitalisation during acute phases, is increasingly insufficient for managing these conditions. Residential settings are therefore needed to provide a more stable environment in which the most disruptive symptoms can subside and to support pathways aimed at helping these young patients develop greater self-regulation and autonomy, preparing them for reintegration into their usual living environments.
It is from this perspective that the "Il Soffio" Therapeutic Community was established: a residential rehabilitation facility with ten places specifically dedicated to adolescent and young adult patients.

3.4 Our *Mission*

The *mission* of the "Il Soffio" Therapeutic Community can be summarised through the pursuit of the following objectives:

- **Resilience**: to foster the development of the ability to cope positively with difficulties arising from one's environment;
- **Recovery**: to enable patients to regain a level of social, educational and/or occupational functioning that allows them to resume an active, meaningful and personally rewarding role upon returning to their social environment, regardless of whether full symptomatic remission has been achieved. This aspect of the mission is supported by a recovery-oriented approach that explores the emotional and connotative meaning of the different elements of the patient's life in order to strengthen motivation throughout the therapeutic pathway;
- **Reducing stigma**: to overcome the cultural barriers that contribute to mistrust and prejudice towards people affected by psychiatric disorders.

The concepts of "resilience" and "recovery" have profoundly influenced approaches in the fields of neuropsychiatry and psychiatry, offering an innovative theoretical framework.
This framework goes beyond a one-dimensional clinical perspective and broadens the understanding of adolescent and young adult development through a multidisciplinary approach. The adolescent or young adult is viewed as a dynamic and active individual whose development takes place within a complex network of life experiences. This includes not only personal characteristics, but also relationships with the wider community and the social structures that provide support.
Within this perspective, the education system and opportunities for social participation play a fundamental role in promoting resilience.

3.5 Our Team

As shown in the organisational chart, the structure of the Community for Minors and Young Adults is designed to promote the involvement of professionals with different technical backgrounds, whose integrated expertise helps ensure a more comprehensive approach to care.
Within each unit, integration is encouraged among at least five different professional roles: a neuropsychiatrist, a psychologist, an Educator/Psychiatric Rehabilitation Technician (TeRP), a nurse and a social and healthcare worker.

Medical Director of Child and Adolescent Neuropsychiatry
Community Coordinator
Educator / Rehabilitation Therapist / Occupational Therapist
Psychologist
Care Assistant
Nurses
Support Staff
Maintenance

3.5.1 Professional Roles and Main Responsibilities

Medical Director – Child and Adolescent Neuropsychiatrist

The Medical Director is responsible for healthcare safety and the prevention of clinical risk. Together with the Coordinator, they assess new admissions and discharges and lead the multidisciplinary team.

In collaboration with the Coordinator, Case Manager and Psychologist, they contribute to the drafting and review of the Individualised Therapeutic and Rehabilitation Plan (PTRI) and liaise with the referring care network.

They conduct clinical interviews and neuropsychiatric assessments and are responsible for the aspects relating to pharmacological treatment and the therapeutic plan within their area of competence.

Coordinator

The Coordinator is responsible for the organisation of the service and staff shift coverage. Together with the Medical Director, they assess admissions and discharges, lead the multidisciplinary team, and contribute to the drafting and review of the Individualised Therapeutic and Rehabilitation Plans (PTRIs), as well as to liaison with the care network.

They coordinate crisis management and debriefing activities, prevention measures, internal training, and actions aimed at improving the organisation of the service.

Psychologist and Psychotherapist

The Psychologist and Psychotherapist contributes to the assessment of new admissions and to the development of the Individualised Therapeutic and Rehabilitation Plan (PTRI).

They provide individualised psychotherapy programmes, contribute to care strategies, carry out participant observation, counselling and psychological rehabilitation, provide support during crises, facilitate psychoeducational groups and, where appropriate, parent training.

Psychiatric Rehabilitation Technician (TeRP) / Occupational Therapist / Healthcare Professional Educator – Case Manager

They perform educational and rehabilitation functions and, for the service users assigned to them, act as Case Manager.

They maintain relationships with the service user, the family and the care network, keep documentation up to date and participate in multidisciplinary team meetings.

During the initial observation period, they prepare the draft CANS assessment, contribute to defining the objectives and activities of the Individualised Therapeutic and Rehabilitation Plan (PTRI), continuously monitor its implementation and promote its review at least every six months.

Registered Nurse

The Registered Nurse participates in multidisciplinary team meetings and carries out all healthcare activities within their area of competence, including clinical monitoring and vital signs assessment, management of medical records and pharmacological treatment, wound care, coordination of specialist appointments, preparation of medication for authorised leave and home visits, and management of medical emergencies.

Social and Healthcare Worker (OSS)

The Social and Healthcare Worker ensures continuity of care and supervision, supports the development and maintenance of basic personal autonomy, and contributes to rehabilitation activities.

They participate in multidisciplinary team activities and support the Case Manager in achieving the objectives set out in the Individualised Therapeutic and Rehabilitation Plan (PTRI) relating to personal independence and everyday living skills.

4. How We Work

4.1 Guiding Principles

The "Il Soffio" Therapeutic Community, in pursuing its *mission*, is guided by a number of core principles that it also seeks to convey to its service users:

- **Equality:** the same services are guaranteed to everyone, without discrimination on the grounds of gender, race, religion or political views;
- **Impartiality:** staff attitudes and conduct are guided by principles of impartiality and objectivity;
- **Responsibility and participation:** each person is regarded as an active participant in the planning and evaluation of their own care pathway;
- **Respect for oneself and others:** the needs of each individual are considered a priority within the wider group context;
- **Continuity:** continuity of care and ongoing support are guaranteed for all residents;
- **Effectiveness and efficiency:** services are delivered with constant attention to achieving the defined objectives and expected outcomes, while seeking the highest possible level of satisfaction for service users and their families.

The "Il Soffio" Therapeutic Community welcomes each service user into a family-like environment, where the distinctive atmosphere of domestic life and everyday routines provides the setting for highly specialised therapeutic and rehabilitation interventions.

The combination of a familiar environment with therapeutic and rehabilitation activities enables the Therapeutic Community to become a place where reparative relationships can develop: meaningful interpersonal relationships in which adaptive forms of communication can be experienced, learned and gradually replace dysfunctional ones.

This setting gives patients the opportunity to experience meaningful emotional moments and to rediscover the symbolic, emotional and relational value of living together, sharing spaces and everyday life. All of this takes place within a supportive and structured environment that,

through interpretation and the attribution of meaning, helps give these experiences a coherent and intentionally reparative purpose.

4.2 Residents' Rights

Right to self-determination
Right to care and assistance
Right to prevention and protection
Right to speak and be heard
Right to information and participation
Right to express opinions and criticism
Right to respect for personal dignity and privacy
Right to freedom of thought and religion

4.3 Methodological Aspects

To fulfil its mission, the "Il Soffio" Therapeutic Community organises its activities according to highly specific clinical and organisational strategies, consistent with the most recent scientific evidence available in the literature and aligned with the organisational models adopted by leading centres specialising in the rehabilitation of young people with behavioural disorders and psychological vulnerabilities.

The general working methodology is primarily inspired by the principles of evidence-based medicine (*EBM*). This has been defined as "the integration of the best available scientific evidence, clinical expertise and patient preferences" in clinical decision-making (Straus, 2011).

In practical terms, applying this approach within the Therapeutic Community results in the following working methodology:

- selection of the main rehabilitation activities on the basis of scientific evidence demonstrating their effectiveness;
- delivery of these activities according to standardised, manual-based and reproducible models;
- continuous staff training in the implementation of the planned activities;
- ongoing updating of working methods in line with newly available scientific evidence;
- measurement of treatment outcome indicators at the beginning, during and at the end of the rehabilitation programme.

To complement and further develop the evidence-based approach, the Therapeutic Community project seeks to take an additional step forward by drawing on the principles of so-called values-based medicine (*VBM*).

Values-based medicine has been defined as a medical practice that, while grounded in EBM, broadens its approach by incorporating, firstly, the *value* of interventions as perceived by the patient and, secondly, the cost-effectiveness of those interventions (Brown, 2005).

This means, first and foremost, placing greater importance on the patient's choices, aspirations and needs. In practical terms, this involves being willing to integrate the goals considered "priorities" by clinicians with those that the individual patient perceives as most important for their own well-being (Fulford, 2011).
Applying this "philosophy" to the working methodology of the Therapeutic Community means enabling each patient to play an active role in defining their own rehabilitation plan. This is an essential prerequisite for greater engagement in the care pathway and for achieving goals that are also personally meaningful from the patient's perspective.

4.3.1 CANS Method – Child and Adolescent Needs and Strengths

The Community uses the CANS (Child and Adolescent Needs and Strengths) as a structured methodology for multidimensional assessment and as a tool to support clinical, care and rehabilitation decision-making. The CANS systematically organises information relating to the functioning of the minor or young adult, the needs requiring intervention, risk factors, and individual, family and environmental strengths.

The CANS is not used as a stand-alone diagnostic test and does not replace assessments carried out by individual professional disciplines. Rather, it provides a shared framework within which clinical and social documentation, interviews, observations of daily life, neuropsychiatric and psychological assessments, care and rehabilitation elements, and information provided by referring Services can be integrated.

Its approach is action-oriented: it makes it possible to distinguish areas requiring priority intervention, areas that need to be monitored, and resources that can be used as strengths within the care pathway. The assessment is therefore directly linked to the definition of objectives, the selection of activities and the evaluation of outcomes.

During the initial observation period, and within a maximum of two months, the Case Manager gathers the available information and prepares an initial draft CANS assessment. The assessment is discussed by the multidisciplinary team and integrated with contributions from the different professional disciplines, while also taking into account, wherever possible, the perspective of the service user, the family or legal guardian, and the referring care network.

A specific objective of using the CANS at Il Soffio is to establish a shared language with referring Services. The adoption of common assessment domains and criteria facilitates dialogue between professionals working across different services, makes priority needs, available strengths and expected changes more explicit, and allows the development of the individual care plan to be monitored over time using more consistent and comparable reference points.

During care network meetings, the Community therefore promotes the sharing of the CANS assessment and its updates, so that the evaluation process can support continuity between residential care, community-based services, work with the family, and discharge planning.

4.4 Case management

Within the multidisciplinary team, Educators and Psychiatric Rehabilitation Technicians (TeRP) are assigned the role of *Case Manager* (hereinafter *CM*). As a general guideline, each CM is assigned approximately two patients.

The patient is assigned to their CM at a very early stage of admission to the Community, potentially as early as the preliminary visits prior to placement. The CM then follows the patient throughout their entire stay at the facility.

Assigning a dedicated CM to each patient is a central element of the rehabilitation plan and stems primarily from the need to coordinate the various rehabilitation interventions and the different professionals involved in the patient's care. One of the CM's primary responsibilities is to establish an effective therapeutic alliance with the patient. This is essential in order to identify, together with the patient, which specific components of the rehabilitation intervention should be used at each stage, ensuring that the rehabilitation plan as a whole is effective in terms of outcomes, consistent with the patient's values and appropriately integrated within the group setting.

The CM therefore plays an active and central role throughout the patient's rehabilitation pathway and oversees their individualised rehabilitation plan. On the one hand, the CM acts as the patient's key professional and point of reference; on the other, they liaise with the various professionals involved in the rehabilitation process.

The central role of the CM is further reflected in their participation in meetings with the patient's family and the referring Service, where they act as the multidisciplinary team's point of reference for the patient's rehabilitation plan.

4.5 Role of the Interprofessional Team

All decisions concerning the clinical management and individualised rehabilitation plans of patients admitted to the Villa San Pietro Therapeutic Community are made by the multidisciplinary team. The team is responsible for ensuring and safeguarding the continuity, appropriateness and traceability of individualised therapeutic and rehabilitation pathways.
The team meets weekly and has a multidisciplinary composition, involving all professional roles.
During team meetings, both organisational matters concerning the Therapeutic Community as a whole and the rehabilitation plans of individual patients are discussed, with the aim of coordinating therapeutic and rehabilitation interventions and addressing any critical issues.
The team is organised in a way that encourages interactive discussion, with each participant invited to contribute according to their specific area of expertise.

4.6 General Principles of Therapeutic and Rehabilitation Work at Il Soffio

4.6.1 Sharing Goals with the Service User

Being welcomed means being listened to, being seen and being included in the entirety of one's feelings, thoughts and actions, as well as in the uniqueness of one's way of expressing oneself.
The multidisciplinary team is responsible for developing an understanding of the service user's personal history, skills, abilities and difficulties, relational dynamics, and relationship with themselves and with others.
The team adopts internal listening and discussion practices designed to encourage each professional to contribute observations, experiences and strategies.
This internal exchange leads to the shared definition of therapeutic and rehabilitation goals and of the methods to be used to pursue them.
The service user and their family members or legal guardians are involved in defining these goals and are given the opportunity to express their preferences. They agree to a shared care plan, which is formally confirmed during care network meetings through acceptance of the objectives set out in the Individualised Therapeutic and Rehabilitation Plan (PTRI).
Family members may also be involved in parent training programmes.

4.6.2 Functional Integration

The pursuit of therapeutic and rehabilitation goals is not limited to the definition of rigidly established procedures. Rather, it is aimed at modulating, mobilising and harmonising the effective processes and flows of the "community organism".
Within this context, each technical professional — whether working in a therapeutic, clinical or rehabilitation role — places their expertise at the service of the "community organism", supporting both the "competence of the system", understood as the capacity for therapeutic and rehabilitation action inherent in the dynamics of the Community, and the "courage of the system", understood as the capacity to envision change that emerges from the vitality of community life: not remaining trapped in fear of difficulties, but focusing on what can work.
At Il Soffio, every professional strives towards the ideal of the "integrated professional": someone who is attuned to, contributes to harmonising, and brings vitality to the dynamic flow of interactions within the community organism.
The way procedures and interventions are adapted within the "community organism" naturally takes into account the individual circumstances of each service user, embracing their specific socio-economic situation, health conditions, physical or psychological vulnerabilities, dietary needs, spiritual needs, ethnic background and other individual characteristics.

4.6.3 Individualised Rules

The young person admitted to the Community is not expected simply to "fit within the rules", but rather to contribute to their evolution and to the development of the Community as a whole.
Each individual identity — whether that of a team member or of a young person admitted to the Community — may seek to defend and assert itself, at times in a confrontational or narcissistic way, thereby becoming less open to trusting relationships with others and to personal growth. These dynamics are closely connected to the way rules are negotiated and experienced.
The dynamics of power and control often revolve around the possibility of applying rigid rules that are the same for everyone. While this may sometimes appear necessary and may provide an apparent sense of security, excessive rigidity and the indiscriminate application of rules can hinder the organic functioning of the Community. They may also foster mechanisms such as labelling,

stigmatisation, exclusionary attitudes, unconscious provocation, and rigid complementary roles — those who impose the rules and those who break them — ultimately blocking developmental processes and replacing them with a sterile form of supervision.
Il Soffio addresses this issue by adopting an individualised approach to rules.
Each young person admitted to Il Soffio receives an individualised set of rules, formally documented and developed on the basis of careful observation and an understanding of their dynamics and needs at that specific stage of their life. Rules, like life itself, are therefore subject to change and evolution and are unique to each individual.
At Il Soffio, the rules are **NOT the same for everyone**.

4.6.4 Mutual Adaptation Between the Community and the Service User – Sharing Goals with the Service User

Rules exist, they are important, and they are assigned to each young person, but without expecting immediate, measurable or tangible results. This might appear to be a weakness of the system, but in reality it forms the basis for mutual adaptation between the young person and the Community.
Each young person helps create a new Community: through the process of adaptation, they change it and contribute to its evolution. In turn, the Community reshapes itself to welcome the young person and provides adaptation even when the young person is not yet able to do so. In this way, the Community communicates flexibility and modulation in response to the maladjustment and dysregulation expressed through the difficulties experienced by the young people in its care.
Each young person is expected to contribute, including in terms of adaptation, only what they are capable of contributing at that particular stage. If, over time, there is no development in the person's ability to accept and follow the rules, new possible forms of mutual adaptation are identified through continued observation and understanding.

4.6.5 Co-Evolution

By removing the tendency for rules to rigidify interactions and individual positions, all members of the team, as well as the young people welcomed into the Community, are free to engage personally and professionally in a process of growth and improvement.
The therapeutic relationship is neither rigid nor prescriptive, nor is it aimed at simply "teaching". Instead, it seeks to generate questions and opportunities: where are we now, together, within our relationship? Where do we want to go?
This open and non-defining perspective fully recognises the expertise that each service user has regarding themselves and legitimises their active participation in the therapeutic and rehabilitation process as an expert in their own situation.
The entire setting is exploratory; every therapeutic intervention is a form of exploration; the whole context is therapeutic, for everyone.
It is a journey of shared evolution and discovery of meaning: a human and existential journey.

4.7 Training and Supervision

To be effective in terms of outcomes, a highly specialised rehabilitation programme such as that offered by Villa San Pietro requires appropriate staff training.

Ensuring specific and up-to-date training for the different professional roles involved is an ongoing commitment undertaken by CODESS Social Cooperative towards its staff. This commitment is currently reflected in the organisation of weekly training events for Villa San Pietro personnel, which are sometimes also open to external participants.
This initiative, which is particularly ambitious in terms of both the frequency and quality of the training sessions, reflects our aim to make Villa San Pietro a centre of excellence in the rehabilitation of psychiatric patients and is a source of particular pride for us.

4.8 Working with Others: Networking

To achieve the goal of effectively reintegrating patients into their social, educational and working environments, the rehabilitation pathway must combine the work carried out within the facility with equally intensive interaction and integration with the local community, families and referring Services.
This is complemented by the commitment to maintaining active links with university centres, through collaborations aimed at staff training and professional development, as well as at ensuring that clinical and rehabilitation practices evolve in line with advances in technical and scientific knowledge in the field.

5. How to Access Our Services

5.1 Who Our Services Are For

The period spent at the “Il Soffio” Community should be understood as one stage within a broader and more complex care pathway managed by local Neuropsychiatric and Psychiatric Services. Effective coordination with these Services is therefore essential, both to identify the patients who are most likely to benefit from the programme and to ensure continuity between the period spent at “Il Soffio” and the phases of care that precede and follow it.

The length of stay varies according to the individual case, up to a maximum of 12 months, with the possibility of extension where appropriate.

Admission to the Therapeutic Community always takes place following a referral by a local Neuropsychiatric or Psychiatric Service, subject to approval of the residential care plan by the Multidisciplinary Assessment Unit (UVM).

Admission to the facility may take place following discharge from a hospital ward, such as a Child and Adolescent Neuropsychiatry Unit (NPI) or Psychiatric Diagnosis and Treatment Service (SPDC), through transfer from another residential facility, or as a new admission directly from the patient’s home environment.

Since the rehabilitation treatment provided at our facility is highly specialised and intended for a specific patient population, a set of inclusion and exclusion criteria has been established in order to ensure clinical consistency among the patients admitted to the programme.

These criteria are shared with the referring Service when collaboration with our facility is initiated and are subsequently reviewed before each admission during preliminary meetings with the patient and the professionals responsible for their case.

Inclusion Criteria:

- age between 13 and 22 years;
- psychiatric disorder in a sub-acute or otherwise stabilised phase;
- significant loss of social and/or educational or occupational skills due to the psychiatric condition;
- a reasonable likelihood of recovering these skills through a rehabilitation programme;
- acceptance by the patient of admission to the facility;
- willingness of the referring Service to maintain ongoing collaboration and to take responsibility for the management of any acute relapses.

Exclusion Criteria:

- psychiatric disorder in an acute phase;
- high risk of breaching any security measures imposed by the judicial authorities;
- primary diagnosis of an active alcohol or substance use disorder;
- disability resulting from intellectual disability or a pervasive developmental disorder;
- insufficient knowledge of the Italian language.

5.2 How to Start a Programme at Il Soffio

PHASE 1 – Referral for Admission by a Local Psychiatric Service

Once it has been confirmed that the patient meets the criteria described above, the referring Service is asked to provide a detailed report including, in addition to the relevant clinical information, the objectives of the referral and the expected duration of the placement.

PHASE 2 – Assessment of the Appropriateness of the Admission Request

Once the detailed case report has been received, it is discussed by the multidisciplinary team in the presence of the Medical Director, Unit Coordinator and Psychologist.

PHASE 3 – Direct Patient Assessment

If, following review of the documentation provided, our facility is considered appropriate for the proposed service user, an in-person meeting is generally arranged at our premises.

The patient is invited to visit the facility accompanied by a professional from the referring Service and, where possible, by a family member or other significant person of reference.

PHASE 4 – Placement on the Waiting List

If there are no factors preventing admission, the patient is placed on the waiting list.

Priority for admission is determined according to predefined criteria, in the following order: urgency related to clinical factors, urgency related to judicial factors, urgency related to social factors, length of time spent on the waiting list (with priority given to patients who have been waiting longer), and age (with priority given to younger patients).

PHASE 5 – Notification of Availability for Admission

Once a place becomes available, the Medical Director and Unit Coordinator contact the referring Service to agree on the admission date and provide a list of the items the patient will need to bring upon arrival at the facility.

6. What We Offer

6.1 (PTRI) Individualised Therapeutic and Rehabilitation Plans (PTRI)

At an early stage following admission to the facility, an Individualised Therapeutic and Rehabilitation Plan (PTRI) is developed for each patient in agreement with the referring Service.
The PTRI first sets out the objectives of the rehabilitation pathway and, by identifying the areas of functioning that require rehabilitation training, determines which specific rehabilitation activities are most appropriate for the patient in order to achieve the agreed goals.
The guiding principle adopted by the Therapeutic Community in defining the PTRI is that of **"co-production"**, meaning the active participation of both the professional and the service user in identifying the objectives to be pursued and the strategies to be implemented in order to achieve them.
ACTIONS: for each objective, the intervention strategy to be implemented in order to support the process of change must be clearly defined and described in detail.
RESPONSIBLE PROFESSIONALS: for each objective, the person primarily responsible for carrying out the planned actions must be clearly identified. This is usually the Case Manager.
TIMEFRAME: for each objective, the estimated period required for the expected change to occur must be clearly specified, also in order to schedule the date on which the outcome will be reassessed. Objectives may generally be divided into short-term goals (1–3 months), medium-term goals (3–6 months) and long-term goals (6–24 months).
Once defined, the PTRI is, wherever possible, presented to the multidisciplinary team by the patient themselves, with the support of their Case Manager.
It is subsequently sent, together with the follow-up assessment and the chart relating to the operational assessment tools, to the referring Neuropsychiatric Service and, where applicable, to the patient's family member of reference.

6.1.1 Application of CANS to Individualised Therapeutic and Rehabilitation Plans (PTRI)

The CANS provides one of the structured foundations for developing the Individualised Therapeutic and Rehabilitation Plan (PTRI): the needs identified contribute to defining therapeutic and rehabilitation priorities, while strengths and available resources are used as a basis for setting realistic and meaningful goals.

These goals are translated within the PTRI into concrete actions, clearly assigned professional responsibilities, implementation timeframes and evaluation criteria. The development of the plan continues to follow the principle of co-production with the service user and integrates clinical, psychological, educational-rehabilitation and care-related contributions.

The Case Manager continuously monitors the PTRI. During plan reviews, the CANS is revisited in order to document changes in needs and strengths, assess progress towards the agreed goals and, where necessary, redefine priorities, activities and strategies.

The PTRI is updated at least every six months and earlier whenever changes in the patient's clinical, functional, family or contextual circumstances make this necessary.

The CANS summary and PTRI updates are used in discussions with the referring Service with the aim of strengthening a shared language between the Community and the local care network, and of making the continuity between assessment, intervention, outcomes and discharge more clearly understandable.

6.2 Rehabilitation Activities

During the patient's stay at the facility, a highly individualised and integrated range of interventions is offered, including: clinical and pharmacological monitoring, individual psychotherapy, rehabilitation, occupational therapy, family interventions (when agreed with the referring care network), daily living skills training, social skills training, and activities aimed at resocialisation, self-expression, cultural development, recreation and sport.

The activities provided are planned in their general structure on an annual basis as part of the activity review process, then reviewed every six months and organised into a weekly schedule.

The rehabilitation activities offered can be divided into individual activities, carried out with the support and supervision of the Case Manager, and group activities. Group activities are mainly carried out within the facility's workshops according to a weekly programme. Based on the PTRI, each patient is offered a specific selection of group activities following an assessment by the multidisciplinary team, taking into account all therapeutic and rehabilitation goals and the types of intervention considered most appropriate and effective.

To ensure the highest possible level of individualisation, activities are divided into three groups or categories:

- **ADAPTIVE SKILLS:** activities aimed at developing basic independence and daily living skills;
- **LIFE SKILLS:** activities aimed at socialisation and at developing skills useful for functioning within the complexity of the bio-psycho-social environment;
- **BODILY SKILLS:** activities aimed at promoting well-being and a positive relationship with one's own body.

The number of participants in each activity varies according to decisions shared between the multidisciplinary team and the patient, seeking to achieve a balance between the patient's wishes and motivation and the rehabilitation purpose of the activity.

The table below lists the main activities provided from June 2022 onwards. The list is not exhaustive, as individualised activities may also be designed and introduced on an ad hoc basis whenever specific therapeutic or rehabilitation needs are identified.

ADAPTIVE SKILLS	LIFE SKILLS	BODILY SKILLS
Cooking Workshop Held weekly	**Life Skills Training Group**, led by TeRP Alessia and psychotherapist Daniele since October 2022. The main objective of the activity is to promote the development and strengthening of the young people's personal, relational and emotional skills, with the aim of improving their adaptive functioning, fostering greater independence, and supporting their growth towards more stable psychological and social well-being. The programme uses the following manual as a reference guide: *"Educare le Life Skills – Come promuovere le abilità psico-sociali e affettive secondo l'OMS"* by P. Marmocchi, C. Dall'Aglio and M. Zannini. **Held weekly**	***"Veleggiando – Diversamente vela"***, a sailing activity held at Fraglia Vela in Riva del Garda from June to September 2025. The project aims to promote the social inclusion of people with mental health vulnerabilities by making use of the therapeutic and relational potential of water-based activities. Experience gained by other organisations has shown that sport — particularly activities linked to water and sailing — can be an effective tool for social integration, helping to improve participation and quality of life. **Weekly sailing sessions, weather permitting.**
Pastry-Making Workshop Held weekly	**EmozionAbile Group**, led by TeRP Laura, TeRP Roberta and TeRP Teresa from May to October 2025. The group's main objectives were to support the management of emotions and related behaviours. The following manuals were used as reference guides: *"The ABC of Emotions: A Social and Emotional Literacy Programme Based on the REBT Model" and "A Guide to Emotion-Focused Individual Therapy".* **Held weekly**	**Swimming activities** at the municipal swimming pool in Arco – Prabi Aqua Park. **Held weekly** **Active agreement in place**
Supervision of Personal Hygiene and Clothing Daily	**Atelier**, led by TeRP Anna Rita since August 2025. The group's primary objective is to support self-exploration, helping participants develop greater self-awareness and achieve improved psychological and physical well-being by working with their feelings and emotions through artistic materials and creative media. In this way, the activity also promotes the development of empowerment. ***Held weekly***	Snow outing to **NEVELAND Park** in Lavarone (snow tubing and sledding) – 18 January 2025 and 16 February 2025. Snow outing to the **Folgaria ski area** (skiing and snowboarding) and the **Palaghiaccio ice rink** (ice skating).

	Non solo social, led by Educator Orietta, TeRP Sofia, TeRP Anna Rita and psychotherapist Daniele from March to May 2025. The project's general objective was to develop logical skills as well as cognitive and artistic abilities by encouraging young people to use their mobile phones in a more varied and purposeful way, beyond their often predominant use of social media platforms.	***Local Walks and Excursions*** – Arco Castle, the Busatte–Tempesta trail, and San Pietro Mountain Hut
Supervision of Room Management (cleaning, tidying and laundry management) **Daily**	***Le Vie degli Asini***, held in Ballino (TN) from June to August 2025, with 6 sessions taking place every two weeks. The project has been active since summer 2022. The primary objective of this Animal-Assisted Intervention (AAI) project is to create an alternative social and emotional space in which participants can strengthen empathic relationships between themselves and others, rediscover enjoyment in being and doing, connect the different moments of their own experience, and integrate the vulnerabilities associated with their condition. One of the project's main goals is to encourage positive contact with animals and with the atmosphere of the rural environment, creating a setting in which each person can experience well-being and express their own individual characteristics. A further key objective is to use the relationship with the animal to consolidate existing skills, gain new experiences and develop new abilities, with the aim of broadening each participant's perception of themselves and of themselves in relation to others. **Project sponsored by the Rotary Club of Riva del Garda since 2023.**	***Sports Activities*** chosen by individual service users (kickboxing, classical and modern dance, horse riding, judo, cycling, etc.)
Daily Tasks involving cleaning and tidying the dining room, setting and clearing the table, tidying the communal area, and waste management.	**Weekend Recreational Outings** (markets, trips to the lake, shopping, etc.)	

Daily, on a weekly rotation basis		
Horticultural Therapy Activities in the Community garden	**Afternoon and Evening Outings** to attend local events (Festa dello Sport, Festa di S. Anna, Arco Slow, etc.)	
	Collaboration with the **"I Lari" Association** – reception hostess activities during the *Festival Atipicamente* event (April 2025). The project was designed for three residents of the Community who were interested in gaining practical training experience and in consolidating and developing new skills useful for their gradual integration into social and working life.	
	Attendance at the theatre performance *"Come nasce una storia d'amore?"* ("How Does a Love Story Begin?"), an educational and gender-based violence prevention event held at PalaVela in Riva del Garda on 7 March 2025.	
	Participation in activities and evening events organised at **Cantiere 26** (screening of the documentary film *"No Other Land"*, Cantiere Arcade).	
	Participation in the presentation of the book *"Ero un bullo"* by Andrea Franzoso, held at Palazzo dei Panni in Arco on 22 October 2025, followed by a **weekly reading and discussion activity** based on the book, starting in November 2025.	
	Bowling outings at **Affi Playcenter** – 26 September 2025, 25 October 2025 and 21 November 2025.	
	Trip to **Gardaland** – 5 June 2025.	
	Participation in the municipal active citizenship project **"Ci Sto? Affare fatica!"** – summer 2025	

6.3 Therapeutic Activities

A neuropsychiatrist and a psychologist-psychotherapist are present at the facility according to a scheduled weekly attendance programme. The frequency of their visits ensures that patients can have at least one individual session per week with each professional.

This makes it possible to provide regular monitoring of the patient's clinical condition and pharmacological treatment. In addition, where indicated in the Individualised Therapeutic and Rehabilitation Plan (PTRI), the patient may be offered individual psychotherapy.

6.4 Other Services

In addition to rehabilitation activities, Villa San Pietro provides a range of complementary services that contribute to the overall care and support offered.

In particular:

- **Catering:** a meal service tailored to residents' nutritional needs.
- **Laundry, ironing and wardrobe services:** household linen is washed, changed and ironed by an external service provider. Laundry activities for patients are instead carried out within the facility as an integral part of the rehabilitation programme.
- **Cleaning and sanitisation:** thorough daily cleaning is carried out, together with periodic deep-cleaning and sanitisation procedures.
- **Gym:** Villa San Pietro has a spacious gym equipped for bodyweight exercise, where various types of classes are regularly held, some of which are also open to the local community.
- **Garden:** the facility is surrounded on three sides by a large private garden available for residents' use.
- **Money deposit service:** safekeeping and management of small amounts of money in accordance with arrangements agreed with the resident and, where applicable, their legal support administrator.
- **Transport:** residents are provided with transport to the nearest healthcare facilities whenever specialist medical appointments are required.
- **Safety system:** every bed space and bathroom is equipped with an audible and visual call system that can be activated by pressing a button, connecting residents with staffed areas.
- **Reception and administrative office:** manages incoming calls and welcomes visitors. It also provides minor administrative support to patients upon request and ensures the delivery of correspondence addressed to residents.
- **Medication:** the cost of pharmacological treatment is largely covered by Villa San Pietro, except in rare cases where the patient is required to contribute to prescription charges.

6.5 Continuity of Care

Continuity of care is guaranteed to residents 24 hours a day, 7 days a week.

During daytime shifts, staffing includes one Social and Healthcare Worker (OSS) and two Educators/Psychiatric Rehabilitation Technicians (TeRP). During the night, one OSS is present on site, with one Educator/TeRP available on an on-call basis. Appropriate staffing is also ensured on public holidays.

In the event of a clinical emergency, staff follow a predefined operational protocol and may also rely on the support of personnel assigned to the other Villa San Pietro teams.

During the daytime, from Monday to Friday, the following professionals are present on a daily basis during scheduled time slots: the Team Coordinator, Team Nurse and Psychologist.

The Child and Adolescent Neuropsychiatrist, who also serves as Medical Director, is generally present at the facility on three separate occasions each week. The Facility Coordinator is usually present every working day, while the Psychologist is generally present on four separate occasions each week.

In addition to the professionals listed above, the facility also relies on external collaborators and staff responsible for administrative, catering and cleaning services.

For general medical needs, patients are cared for by a local General Practitioner (GP), to whom they are assigned upon admission. The GP regularly visits the facility to carry out routine medical examinations.

7 Quality, Environmental and Social Responsibility Management Systems

Codess Sociale adopted its own quality management system in 2004 and, in February 2005, obtained UNI EN ISO 9001:2008 certification from the certification body UNITER.

In 2018, the organisation adopted the new edition of the standard, obtaining UNI EN ISO 9001:2015 certification from the same certification body (Certificate No. 584).

Over the years, the adoption of different standards has led Codess Sociale towards an integrated management systems policy, together with the progressive updating of the applicable standards and related certifications. Its current certifications include:

- **SA 8000:2014** (Certificate No. SA-184), issued by RINA, relating to social responsibility management;
- **ISO 14001:2015** (Certificate No. 70), issued by UNITER, relating to environmental management;
- **UNI 10881:2013** (Certificate No. 084), also issued by UNITER, relating to residential care services for older people;
- **UNI 11034:2003** (Certificate No. 085), relating to the management of early childhood educational services.

Codess Sociale has also adopted an organisational and management model in accordance with the provisions of Italian Legislative Decree No. 231/2001.

Codess Sociale has a dedicated Quality Department that works continuously with all management, staff and operational areas, gathering information and providing input to support ongoing improvement and the assessment of the quality of the organisation's work.

The Quality Management System is structured across three different levels:

1. System-level tools: documentation that applies across all Codess Sociale service areas, such as the Quality Manual, general procedures and certain standard forms used throughout the organisation.

2. Area-level tools: documentation specific to the psychiatric services area but applicable across the various Codess Sociale facilities operating within this field. This documentation includes, for example, operating procedures, work instructions, forms, satisfaction questionnaires, job descriptions and any other tools designed to improve service delivery and enhance the quality of the services provided.

3. Service-level tools: documentation developed within each individual facility according to its specific characteristics and needs.

Codess Sociale has also implemented a system for submitting suggestions and complaints, with the aim of reporting service issues or any failure to comply with the quality principles set out in its policy. At the same time, this system provides an overview of progress towards the quality objectives established to improve its services.

To ensure that the effectiveness and efficiency of the services provided by Villa San Pietro can be tangibly assessed, the internal Quality Management System guarantees continuous monitoring of the work carried out. Performance is evaluated through the use of various tools, as shown in the following table.

Process	Quality Factors	Quality Indicators	Quality Standards
Assessment of New Admissions	Appropriateness of Admission	Defined Inclusion and Exclusion Criteria	Individualised Therapeutic and Rehabilitation Plan (PTRI)
	Patient's Acceptance of Admission	Information Materials (Service Charter); Admission Proposal Assessment Form	Provision of information materials; presentation of the facility to the patient during a preliminary meeting prior to admission; joint signing of the Admission Proposal Assessment Form by the patient, family members, the referring Service professional and the Medical Director.
Admission	Dedicated Admission and Welcome Process	Admission Procedure	Accompaniment to the room by a member of the multidisciplinary team; advance preparation of the room with a personalised name label for the service user; introduction to the organisation and functioning of the facility.
	Clinical Assessment upon Admission	Review and Reconciliation Form	Specialist neuropsychiatric assessment within 24 hours of admission; completion of the Review and Reconciliation Form when the medical record is opened.
Stay	Individualised Care	Case Management	Assignment of a **Case Manager within the first week following admission**
		Multidimensional Assessment	CANS: initial assessment during the initial observation period; review by the multidisciplinary team and use in PTRI updates
		Progetto Terapeutico Riabilitativo Individualizzato (PTRI)	Defined on the basis of the multidimensional assessment; continuously monitored and updated at least every six months.

	Traceability of Information Relating to the Progress of the Rehabilitation Pathw	**Electronic Medical Record**	Documentation of Every Rehabilitation Activity Carried Out at Both Group and Individual Service-User Level
	Regular Neuropsychiatric Assessments	Presence of the Neuropsychiatrist	Guaranteed Presence of the Psychiatrist at the Facility, with at Least 2–3 Visits per Week
	Varied Menu	Structured Menu with Variations Available upon Request	Buffet breakfast; four-week rotating meal menu; separate summer and winter menus; variations available upon request; vegetarian menu available.
Discharge	Coordination with the Referring Service and Key Professionals	Integration of the Period Spent at the Facility with the Subsequent Stages of the Care Pathway	Meeting or telephone consultation with representatives of the referring Service and key professionals in the weeks immediately preceding discharge; inclusion in the discharge letter of the factors that may support continuation of the rehabilitation process after discharge.
	Discharge Information	Discharge Letter to the Referring Local Child and Adolescent Neuropsychiatry Service	Provision to the patient, at the time of planned discharge, of a discharge letter summarising the clinical and psychometric findings from the period of stay.
	Possibility of Obtaining a Copy of the Medical Record	Number of Days Between Receipt of the Formal Request and Release of the Medical Record	Provision of a Copy of the Medical Record Within 15 Days of the Request
Adverse Events and Non-Conformities	Recording and Management of Adverse Events (AEs) and Non-Conformities (NCs)	Recording of Adverse Events (AEs) through the Electronic Medical Record; Paper-Based Non-Conformity (NC) Reporting Forms; Quality Improvement Groups	Immediate recording of Adverse Events (AEs) and Non-Conformities (NCs) using the appropriate forms; multidisciplinary discussion of adverse events and related management strategies during the weekly team meeting.
Satisfaction	Assessment of Service User Satisfaction	Weekly Planning Groups; Satisfaction Questionnaire	A weekly group meeting is held between patients and staff to collect any complaints or suggestions; a satisfaction questionnaire is administered to service users annually.
Appropriateness	Service Delivery in Accordance with Principles of Appropriateness and Consistency	System-Level, Area-Level and Service-Level Procedures	Regular review and integration of internal procedures; presentation of the most complex and important procedures during dedicated scheduled training sessions.