Service Charter

SRTR Eimaste

Residential Therapeutic and Rehabilitation Facility
for Extended Community-Based Treatment

Vita adolescente

CODESS SOCIALE
Minori

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Dear Service User,

We are pleased to introduce ourselves and, through this "Service Charter", provide you with all the information concerning the "Eimaste" Residential Therapeutic and Rehabilitation Facility for Extended Community-Based Treatment.

The Service Charter is a fundamental communication tool designed to enhance the relationship between service users and service providers.

In accordance with the principle of transparency, the Service Charter provides users with a clear understanding of their rights and, for the service provider, clearly sets out the services offered, including how and when they are delivered.

Finally, the Service Charter recognises service users as active and integral participants in the Quality Management System, with the ability to make informed assessments and choices, with the aim of continuously improving the services provided in line with their expectations.

Thank you for your attention.

Codess Sociale

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1. VISION, MISSION AND SERVICE OBJECTIVES

In the Lazio Region, as observed throughout the rest of Italy, recent years have seen a significant increase in requests for care from Child and Adolescent Neuropsychiatry Services and Mental Health Departments in relation to psychological and psychiatric conditions affecting children and adolescents.

The most recent epidemiological data show an increase in the prevalence of anxiety disorders, mood disorders, self-harming behaviour, eating disorders, social withdrawal, conduct disorders, and problems related to substance use and behavioural addictions.

Available evidence indicates that approximately one in five adolescents experiences clinically significant psychological distress during their development, while a growing proportion require highly intensive, multidisciplinary specialist interventions. Of particular concern is the increase in situations characterised by a high degree of clinical complexity, often involving psychiatric comorbidities, family vulnerability, school-related difficulties, and social marginalisation.

The Lazio Region has identified the protection of mental health in childhood and adolescence as one of its main healthcare priorities, promoting the strengthening of local service networks and therapeutic and rehabilitation pathways dedicated to minors.

However, the growing demand for care continues to place significant pressure on specialist services and residential therapeutic facilities, making it necessary to expand the availability of communities dedicated to adolescents with complex psychiatric disorders.

Particular attention must be paid to adolescents with conduct disorders, emerging personality disorders, antisocial behaviour, cases referred through the juvenile justice system, and dual-diagnosis conditions characterised by the coexistence of psychiatric disorders and substance dependence or behavioural addictions. These conditions require specialist residential interventions capable of ensuring therapeutic containment, continuity of care, personalised rehabilitation pathways, and programmes aimed at developing relational, emotional, educational, and social skills.

The Therapeutic Community for Minors is a high-intensity residential therapeutic and rehabilitation service focused on the comprehensive care of adolescents. Its purpose is to provide treatment, achieve clinical stabilisation, and restore developmental abilities impaired by psychopathological disorders.

The therapeutic intervention is based on a multidisciplinary, integrated, and personalised approach that places the minor at the centre, together with their life history, individual and family resources, and social and local context. A Personalised Therapeutic and Rehabilitation Plan (PTRP) is prepared for each resident in collaboration with the referring services, the family, and the other parties involved in the care pathway.

The Community's general objectives are to:

- ensure clinical stabilisation and reduce psychopathological symptoms through integrated therapeutic, psychological, educational, and rehabilitation interventions;
- foster the development of emotional, behavioural, and relational self-regulation skills, promoting greater self-awareness and understanding of personal experiences;
- support the adolescent's developmental pathway by addressing the risk factors associated with the chronic progression of psychological distress and enhancing remaining abilities and personal resources;
- promote the recovery and strengthening of personal, social, and everyday autonomy, which are essential for the

gradual acquisition of age-appropriate skills;
- improve relational abilities and integration within peer groups through structured experiences of shared living, socialisation, and participation;
- support the continuity of educational, training, and vocational guidance pathways, recognising them as fundamental elements of the therapeutic process and social inclusion;
- strengthen parenting and family skills through support, counselling, and active involvement in the care plan, where compatible with the minor's clinical and legal circumstances;
- prevent self-harming, aggressive, and suicidal behaviour, risk-taking conduct, and social isolation through specific monitoring and intervention programmes;
- encourage the development of a positive personal identity and a realistic, sustainable life plan;
- prepare for and support reintegration into family, educational, and social settings through gradual interventions aimed at assessing and consolidating the skills acquired.

In accordance with the most recent approaches to mental health in childhood and adolescence, the Community adopts a recovery-oriented care perspective. This is understood as a process aimed not only at reducing symptoms, but above all at restoring personal, social, and relational functioning, enhancing individual abilities, and achieving the highest possible level of autonomy and participation in community life

Therapeutic and rehabilitation activities are delivered through individual and group clinical interventions, educational and social rehabilitation activities, school and training support programmes, expressive and occupational workshops, family-focused interventions, and ongoing networking with the relevant local services, in order to ensure continuity of care and the appropriateness of the care pathway.

2. DEFINITION OF THE SERVICE UNIT

2.a Name of the Facility

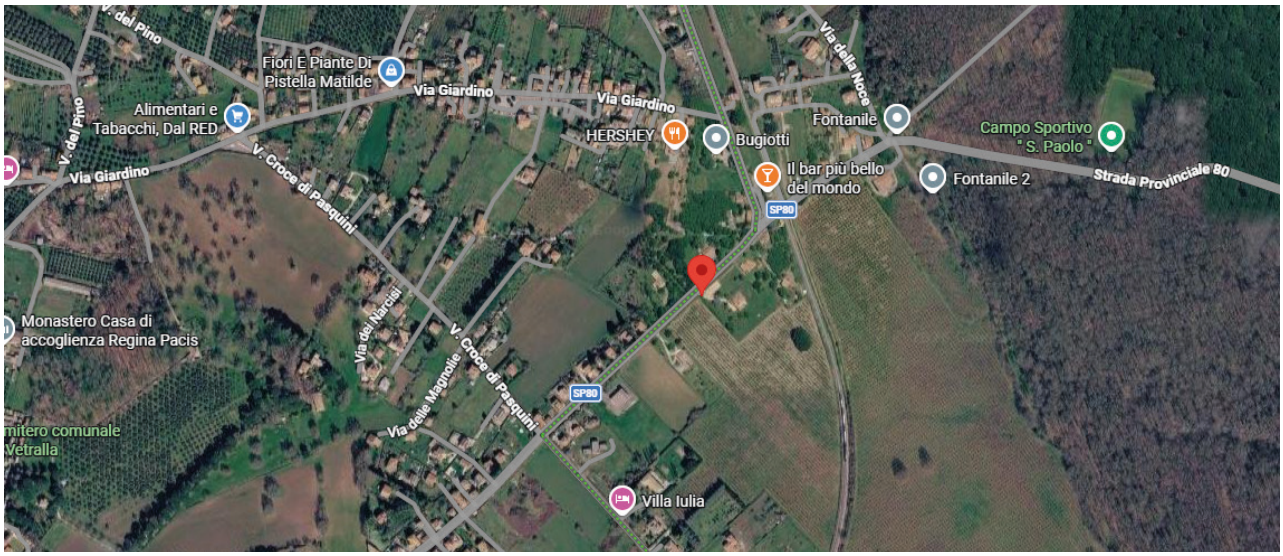
- SRTR "EIMASTE" – Operating Authorisation pursuant to **Determination No. G07087 of 5 June 2026**

2.b.Managing Organisation

- Codess Social Cooperative, 96 Via Boccaccio, Padua (PD)
- Legal Representative: Dr Alberto Ruggeri
- Data Protection Officer (DPO): Dr Lucio Bobbo

2.c Location

- Vetralla (VT), in the Cura district, via Sant'Angelo 128



LOCAL BUS

Cotral bus routes

BY CAR

A1 motorway -> take the Orte exit and follow signs for Viterbo ⊠ take the Vetralla exit, then follow signs for Vetralla and Cura di Vetralla. From Via Cassia Cura, turn left onto Via Sant'Angelo.

BY TRAIN

Regional trains operated by Trenitalia: direct services to Viterbo northbound and direct services to Rome southbound.

2.d Area Served

- Lazio Region – Viterbo Local Health Authority (ASL)
- The Community also admits service users from outside the Region, provided that this is compatible with each patient's individual care plan requirements.

2.e Target Service Users

The facility accommodates 10 service users aged between 12 and 18. The service is intended for minors with neuropsychiatric and neurodevelopmental disorders who require an individualised therapeutic and rehabilitation care programme, where a multidimensional assessment indicates that community-based or semi-residential treatments would be ineffective, including in relation to the family context. All residents' personal data, collected during admission and throughout their stay at the facility, are processed by Codess Sociale, as the data controller, in accordance with the applicable data protection and confidentiality regulations.

2.f Characteristics of the Facility

The Community is located in a semi-rural area, just a few minutes from the town centre, and is easily accessible by public transport.

The building is arranged over three floors.

- **Ground floor:** two spacious living rooms suitable for recreational activities, socialisation — including residents' meetings — and staff meetings; one fully equipped kitchen with pantry; three bedrooms with en-suite bathrooms; one staff room; one room dedicated to healthcare activities and interviews; one staff bathroom; and a bright covered veranda area.
- **First floor:** four bedrooms with en-suite bathrooms.
  Second floor: two rooms for staff use, with an adjoining bathroom.
- **Outdoor areas:** the Facility is surrounded by a large garden and a covered veranda, providing spaces for social gatherings, celebrations, and visits from friends or family members.

The Facility complies with all requirements established by the applicable regulations, including habitability standards, electrical system grounding, compliance of technological installations, and all safety, hygiene, health and environmental conditions required under current legislation.

2.1 Characteristics of Admitted Service Users

In accordance with the regulations of the Lazio Region (Decree No. 00090/2010 and DCA 8/2011, Annex C), the Eimaste Facility admits adolescents on a voluntary basis whose specific clinical and psychological condition involves relational, behavioural, affective and emotional difficulties requiring therapeutic and rehabilitation support within a residential care setting.

The admitted residents present significant psychological and relational difficulties, as well as serious behavioural problems, as a result of:

- psychological and physical trauma resulting from violence experienced or witnessed;
- prolonged exposure to family environments characterised by severely dysfunctional dynamics involving the minor;
- situations of severe relational and material neglect caused by significant deficiencies in the personal and parenting skills of family members;
- psychopathological disorders that have reached a minimum level of emotional stability or an adequate degree of behavioural control, including through pharmacological treatment, particularly with regard to self-directed or other-directed aggressive impulses.

These difficulties are of such severity that they cannot be addressed through outpatient or home-based interventions alone. They therefore require the minor to be placed in a residential setting where intensive, continuous educational and psychological support can be provided in coordination with the interventions delivered by local services.

2.2 Submission of an Admission Request

Admission requests are generally submitted by the Regional Health Service's TSMREE Service to the selected facility, together with a clinical report containing the following information:

- age, expressed in years and months, sex, and relevant medical and family history;
- diagnosis coded according to the criteria established by international diagnostic classification systems;

- description of the complexity and degree of instability of the clinical condition, including the pharmacological and non-pharmacological treatments used and the results achieved;
- description of the impairment of the patient's personal and social functioning within the family, school and peer-group settings; existing resources and potential; strengths and critical issues within the family and the relevant context; and prognostic factors;
- reasons for the admission request, the objectives pursued, and the required level of care intensity;
- estimated duration of the residential pathway and planning of the subsequent care pathway, such as return home, placement in an educational community, or a semi-residential programme;
- any information relating to substance misuse, internet addiction and similar issues, as well as coordination with addiction treatment services;
- any involvement of social services, the Juvenile Court and/or ongoing criminal proceedings.

When identifying an appropriate therapeutic residential placement, the following must be assessed:

- the suitability of the therapeutic and rehabilitation services provided by the contacted Residential Therapeutic Facility in relation to the minor's needs;
- the compatibility between the group of young people already admitted and the minor who is to be appropriately welcomed into the facility.

Given the importance of the environment in therapeutic and rehabilitation interventions, particular care must be taken to maintain the delicate balance among the residents. This balance helps ensure stability within the SRTR and supports the effectiveness of the intervention for each young person.

Upon receiving an admission request, the Eimaste Community carries out an assessment through its internal multidisciplinary team, comprising the Child and Adolescent Neuropsychiatrist, the Clinical Director and the Facility Coordinator. The team contacts the referring organisation as soon as possible to conduct a more detailed assessment, which is essential in determining whether the proposed admission is genuinely feasible.

Whenever possible, the Facility provides an initial response within a few days.

Direct contact between the Facility and the minor and their family, as well as any visit to the Facility, will take place only when admission is considered feasible. This is intended to avoid exposing the minor and their family to potentially frustrating or otherwise unhelpful experiences during the assessment of the service user and their circumstances.

2.3 The Residential Care Pathway

Each service user's therapeutic residential pathway is set out in an Individualised Therapeutic and Rehabilitation Plan (PTRP), specifically defined and developed by the residential therapeutic facility's multidisciplinary team following an initial settling-in period, in close collaboration with the referring service, the family where possible, and the patient.

2.3.1 The Individualised Therapeutic and Rehabilitation Plan (PTRP)

The intervention plan is personalised and individualised, in accordance with the Individual Treatment Plan (PTI) developed by the referring TSMREE Service.

The PTRP must be based on a set of shared information and criteria, including:

- personal details, clinical and functional diagnosis, including relevant medical history;
- reason for referral by the local Child and Adolescent Neuropsychiatry Service;
- assessment of strengths and areas of difficulty relating to:
  - psychopathological area;
  - self-care and environmental management;
  - communication skills;
  - relational skills;
  - school functioning;
  - independence and social skills.
- assessment of the strengths and areas of difficulty relating to the family, school and other relevant settings;
- objectives of the intervention;
- areas of intervention, including a description of the type and combination of interventions planned and the rationale underlying them, with reference to the following categories:
  - psychoeducational interventions;
  - habilitation and rehabilitation interventions;
  - psychotherapy;
  - pharmacological treatment;
  - learning support interventions;
  - interventions involving the family context;
  - resocialisation and networking interventions to support school inclusion;
  - identification of the professionals involved in the interventions, including, where applicable, members of informal support networks and volunteers;
  - indication of the programme duration and periodic reviews, including updates on the progress of the PTRI and the relevant review dates.

The plan must be reviewed periodically and adjusted in response to any new needs arising for the patient and within their living environment.

2.4 Therapeutic and Rehabilitation Pathways and Management of Critical Events

The pathways are differentiated according to the level of therapeutic and rehabilitation intervention required, which is related to the degree of impairment of the patient's functions and abilities — as well as their treatability — and to the intensity of care provided, which in turn is linked to the patient's overall level of autonomy.
The possibility of adapting and diversifying interventions for specific conditions must be ensured on the basis of the relevant scientific evidence, for example in the presence of psychiatric disorders such as conduct disorders, eating disorders, first-episode psychosis, and any associated post-traumatic components. Appropriate adjustments must also be made for service users with specific associated circumstances, including migrants, unaccompanied foreign minors, individuals with unsuccessful adoption experiences, and young people involved in the criminal justice system who are subject to alternatives to detention.

In defining the most appropriate pathways, it is useful to identify the strengths of the patient's family and social environment, both to maintain existing relationships and to rebuild them for the future, or even to create a new family and social support network in collaboration with the relevant social services. Particular attention is paid to maintaining or guiding the young person towards suitable educational pathways, as well as to providing opportunities to assess work-related prerequisites or undertake training placements. As with all other elements of the care pathway, these aspects must also be clearly reflected in the PTRP.

Potentially critical phases of the therapeutic residential pathway — such as admission, discharge, clinical relapse, absconding, and developmental transitions — may, where necessary, involve intensive individual educational and therapeutic interventions and/or home-based interventions during the residential placement. These must always be defined within the individual therapeutic plan agreed with the relevant Child and Adolescent Neuropsychiatry Service. The management of a "crisis" event characterised by behavioural escalation depends on the acquisition and maintenance of specific skills by the professionals working within the residential facility's team.

The PTRP includes the information necessary to address possible problematic behaviours, whether directed towards others or towards the self, including suicidal behaviour, reactivity, and escalation. It also provides for the development of a Crisis Plan and specific guidance on risk assessment and risk management. These measures are monitored, discussed, and updated during periodic reviews. Access to the Emergency Department or hospital admission is sought only when strictly necessary and for appropriate reasons related to an actual clinical deterioration.

2.5 La terapia farmacologica

Before admission to the residential facility, it is advisable for the minor to have already undergone pharmacological treatment and, where possible, for the medication and dosage to have been stabilised. This helps ensure safe continuity of administration within the Community. For patients who are not already known to the services and who begin pharmacological treatment during their therapeutic residential stay, the referring service must arrange more frequent coordination in order to gain a fuller understanding of the patient and assess their response to the prescribed treatment.

Pharmacological treatment must be specifically targeted to the symptoms while limiting sedative effects. For this reason, its objectives, timing, and duration must be clearly defined from the outset. The treatment is agreed and shared between the referring Child and Adolescent Neuropsychiatrist and the team at the residential facility. Where changes are required due to an emergency or are recommended by other healthcare providers, such as the Emergency Department, they must be shared and agreed with the relevant TSMREE Service as soon as possible. Psychopharmacological treatment also requires the involvement and consent of the person holding parental

responsibility for healthcare decisions, as well as the minor's assent, particularly where medicines are used off-label in relation to age or indication. The monitoring and assessment of clinical outcomes are shared with the Child and Adolescent Neuropsychiatrist from the referring local service, the family, and the patient.

2.6 Le attività

During the patient's stay at the Facility, the following are provided in a highly individualised and integrated manner: clinical and pharmacological monitoring, individual psychotherapy, psychoeducation, family interven-tions, daily living skills training, social skills training, resocialisation activities, and occupational activities with ex-pressive, cultural, recreational, and sports-related aims.

The rehabilitation activities offered may be divided into individual activities, carried out with the support and supervision of the Case Manager, and group activities. The latter mainly take place in the Facility's workshops according to a weekly schedule. Based on the PTRP, each patient is invited to participate in a specific selection of group activities.

The group activities offered include bioenergetics groups, psychoeducational groups focusing on needs and rules, art therapy, photography, creative writing, cooking workshops, film discussion groups, and recreational and sports activities.

To support the recovery of basic social and school-related skills, patients are also offered daily self-care training; participation in the everyday activities of the Therapeutic Community — such as setting and clearing the table, laundry, cleaning, gardening, and tending the vegetable garden; resocialisation outings in the local area; volunteering activities with local organisations — including animal shelters, libraries, and parishes; and support with school attendance and individual study.

Below is an example of a typical weekly schedule of rehabilitation activities and how they are organised within the Therapeutic Community:

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6.45 – 7.00	Breakfast for those attending school	Breakfast for those attending school	Breakfast for those attending school	Breakfast for those attending school	Breakfast for those attending school	Breakfast for those attending school	Breakfast for those attending school
8.00 - 8.15	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast
8.15 – 10.30	Personal care and tidying the bedroom	Personal care and tidying the bedroom	Personal care and tidying the bedroom	Personal care and tidying the bedroom	Personal care and tidying the bedroom	Personal care and tidying the bedroom	Personal care and tidying the bedroom
10.30 – 10.45	Morning snack	Morning snack	Morning snack	Morning snack	Morning snack	Morning snack	Morning snack
10.45 – 12.00	School / Recreational activities; Psychological session	School / Recreational activities	School / Recreational activities	School / Recreational activities NPI session / Psychological session	School / Recreational activities; Psychological session	Workshop activities	Recreational activities
13.15 – 13.30	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
14.00 – 14.30	Lunch for those attending school	Lunch for those attending school	Lunch for those attending school	Lunch for those attending school	Lunch for those attending school	Relaxation	Relaxation
14.30 – 15.30	Telephone use	Telephone use	Telephone use	Telephone use	Telephone use	Telephone use	Telephone use
15.30 – 16.45	Study / Homework	Study / Homework	Study / Homework	Study / Homework	Study / Homework	Workshop activities / Community outing	Visit/outing agreed with family members
16.45 – 17.00	Afternoon snack	Afternoon snack	Afternoon snack	Afternoon snack	Afternoon snack	Afternoon snack	Afternoon snack
17.00 – 18.30	Workshop activities Psychological session	Workshop activities Psychological session	Workshop activities NPI session	Workshop activities Colloquio NPI/ Terapia Familiare	Workshop activities NPI session / Family therapy	Workshop activities Family therapy	Visit/outing agreed with family members
18.30 – 19.30	Cura del Sé - Uso del telefono	Cura del Sé - Uso del telefono	Cura del Sé - Uso del telefono	Cura del Sé - Uso del telefono	Cura del Sé - Uso del telefono	Cura del Sé - Uso del telefono	Cura del Sé - Uso del telefono
19.30 –20.00	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner
20.00 - 22.00	Personal care – Relaxation; Tidying one's bedroom	Personal care – Relaxation; Tidying one's bedroom	Personal care – Relaxation; Tidying one's bedroom	Personal care – Relaxation; Tidying one's bedroom	Personal care – Relaxation; Tidying one's bedroom	Personal care – Relaxation; Tidying one's bedroom	Personal care – Relaxation; Tidying one's bedroom

2.7 The Discharge Pathway

Where possible, as already indicated, discharge is generally planned from the time of admission to the Facility, with due caution recommended when communicating this to the service user and their family.
Particular attention must be paid to unaccompanied foreign minors, those who do not have a family context of reference, and young people approaching adulthood.
The identification of the discharge date or period is closely linked to the continuity of the care or life pathway that will support the person at the end of the residential programme.
The discharge process is an integral part of the individual care plan and of the interventions and activities defined within it in relation to the service user's needs. It must be regarded as a particularly critical stage, both because of the ambivalence that often characterises young patients in relation to this transition and because it forms the basis for a positive outcome and the successful continuation of the community-based programme.

As with admission, discharge must be agreed by the extended inter-institutional team following an assessment of the objectives achieved and of the individual, family and environmental circumstances. It must be prepared and managed jointly, allowing adequate time.
Discharge does not take place unilaterally where there are no suitable facilities able to support the young person's subsequent pathway, or without the cooperation of the relevant TSMREE Service and local social services.
Integration between Child and Adolescent Neuropsychiatry Services and Adult Psychiatry Services is of fundamental importance in developing integrated functional and cultural pathways that place the person and their family, rather than service organisations, at the centre. The Department of Mental Health and Addictions is the principal setting through which the relevant services integrate and coordinate their activities.

For minors receiving residential therapeutic care, a joint assessment between the local Child and Adolescent Neuropsychiatry Service and Adult Services is carried out during the young person's seventeenth year and, in any event, no later than six months before they reach the age of majority, in order to agree on the most appropriate care pathway.

Any recommendation to continue the residential pathway within an adult facility must be carefully assessed, both to ensure continuity of care and to prevent the risk of institutionalisation.
On the basis of the joint assessment, when the young person reaches the age of 18, responsibility for the case generally transfers, unless otherwise indicated, to Adult Psychiatry, Addiction or Adult Disability Services.
Where appropriate to the care pathway, a temporary continuation of integrated case management with the Child and Adolescent Neuropsychiatry Service may be arranged.

As indicated in the relevant scientific literature and in the main international experiences, reaching the age of majority should not constitute a rigid bureaucratic break. It may therefore be necessary to provide for continuity of therapeutic care within the residential facility in which the service user is already placed.
Transfer to an adult facility may not be appropriate in certain circumstances, including:

- therapeutic pathways that have only recently begun;
- a therapeutic phase requiring particular stability;
- situations in which the care pathway is expected to conclude in the near future;
- the continuation of administrative measures or involvement in the juvenile justice system;
- the presence, within the adult facility, of a group of service users who are significantly older or whose conditions are not compatible.

In such situations, residential therapeutic treatment within a Community for Minors may be extended on the basis of an appropriate shared plan defining its objectives, methods and duration.

2.8 "Adult Companion"

In agreement with the referring services, a gradual reduction in the level of support may be arranged, thereby ensuring therapeutic continuity. This may include, for example, semi-residential arrangements within the Facility or in other settings, such as the patient's home or through projects similar to the "Adult Companion" programme.
This approach makes it possible to assess and monitor the service user's ability to cope outside the protected environment of the Facility, with the aim of promoting increasing levels of autonomy and responsibility within the social context.

3. ORGANISATION OF THE SERVICE

3.1 Composition of the Multidisciplinary Team

The Community ensures an adequate staffing level to meet the needs of the minors in its care, implement their individual plans, and operate consistently with its organisational document and work plan.
The Facility is managed by a multidisciplinary team comprising healthcare, social care and support professionals, as detailed below in relation to staffing requirements, the professional roles that may form part of the team, and the differing needs of residents.
Staff presence is organised on a daily basis according to the needs of the minors accommodated, their Individualised Therapeutic and Rehabilitation Plans, and the organisational requirements of the Facility.

Within the residential Facility, which has capacity for 10 service users, the scheduled presence—either continuously or during specified time slots—of the following professional roles is ensured:
The multifactorial intervention involves a qualified multidisciplinary team within the Facility, ensuring continuity of care and therapeutic support 24 hours a day. Staffing levels will be adjusted in accordance with the current regulations governing Residential Therapeutic and Rehabilitation Facilities for extended community-based treatment.

a) **Dr. ROBERTO FORNARA** - Consultant Child and Adolescent Neuropsychiatrist and Head of the Facility, also responsible for health and hygiene matters

b) Dr. **ANNA GRAZIA DIMITRI** – Individual Psychotherapist and Facility Coordinator

c) Dr. **STEFANIA NICOTRA** – Family Psychotherapist and Clinical Director

d) **S. CECILI, R.DURANTI** - Professional nurses

e) **F. FAGNANI, E. PIERLORENZI, A. SALVATI, P. PIRAS** – Psychology Technicians / Professional Educators / Psychiatric Rehabilitation Technicians (TERPs)

f) **C. DI MARCO, G. TACCOLI, A. BONCORE** - Healthcare Assistants (OSS)

g) **L. SCOSCIA** - Social Worker

h) **A. SANTINELLI** - Auxiliary staff / **M. PETRUCCI** – Administrative staff

The different professional roles work towards achieving the Community's objectives and implementing the individualised plans developed for each resident:

Child and Adolescent Neuropsychiatrist
They are clinically responsible for the residents accommodated within the Community. They are an essential member of the multidisciplinary team, assess and modify pharmacological treatment plans, intervene in the management of crisis episodes, and conduct regular consultations and meetings with residents. They also participate in scheduled meetings and in drafting the Individual Educational Plan (PEI), ensure continuity of care, and maintain relations with the referring services.

Psychologist and Psychotherapist
They provide both group and individual therapy, participate in weekly multidisciplinary team meetings, and attend review and planning meetings with all professionals and staff involved in the case. They contribute to drafting the Individualised Therapeutic and Rehabilitation Plan and organise and lead psychological support sessions at both individual and group level. They hold weekly meetings, or additional meetings as required, with the minors accommodated within the Facility and implement shared approaches to supporting staff.

Community Educator, Community Psychologist and Psychiatric Rehabilitation Technician (TERP)
The Psychology Technician, Professional Educator and Psychiatric Rehabilitation Technician (TERP) work as part of the multidisciplinary team, contributing to the implementation of the minor's Individualised Therapeutic and Rehabilitation Plan (PTRP). Through educational and therapeutic relationships, they promote psychological well-being, the development of interpersonal skills, personal autonomy and social inclusion. They support the minor in the Community's daily life, encouraging the acquisition of social, emotional and behavioural skills that are conducive to their growth and treatment pathway. They carry out observation, support, rehabilitation and monitoring activities, contributing to the ongoing assessment of therapeutic objectives. They work in collaboration with the family, school and local services to ensure continuity of care and facilitate reintegration into everyday life settings. Their presence provides a stable and meaningful educational point of reference, offering attentive listening, emotional containment and developmental support, in the awareness that, as Donald W. Winnicott stated, *«The foundations of mental health are built through the earliest experiences of being welcomed and supported by a good-enough environment..»*

Nurse

They administer and monitor the pharmacological treatment plans prescribed by the Child and Adolescent Neuropsychiatrist, as well as residents' health conditions. They maintain and manage healthcare documentation and liaise with medical specialists and general practitioners. They also contribute to drafting the Individualised Therapeutic Plan (PTE) and participate in regular multidisciplinary team meetings.

Social and Healthcare Assistants (OSS)

The OSS is a professional member of the multidisciplinary team. They support residents in their daily lives and relationships, help manage communal areas together with the residents, and carry out practical day-to-day tasks, including food management, grocery shopping, menu planning and laundry, in coordination with the educators. They participate in multidisciplinary team meetings and in weekly meetings with residents and the educator.

Social Worker

They liaise with local social services, families, schools, and all formal and informal community stakeholders who can contribute to achieving the objectives of each young person's individual plan. They support pathways towards greater independence and access to employment, in line with the young people's individual characteristics and their family and living circumstances.

3.2 Enhancement of Professional Diversity

As shown in the organisational chart, the Therapeutic Community is structured to encourage the simultaneous involvement of professionals with different technical backgrounds, whose combined expertise helps ensure a more comprehensive approach to care.

3.3 Case management

Within the multidisciplinary team, Professional Educators, Psychiatric Rehabilitation Technicians (TERPs) and psychotherapists may be appointed to act as Case Managers (hereinafter CMs). As a general guideline, each CM is assigned approximately three patients.

Patients are assigned to their CM at a very early stage of admission to the Therapeutic Community, potentially from the preliminary assessment visits before placement. The CM subsequently supports the assigned patient throughout their entire stay at the Facility.

Appointing a CM for each patient is a central element of the rehabilitation plan. It primarily reflects the need to harmonise the different rehabilitation interventions and coordinate the various professionals involved in the individual patient's care. The CM's first responsibility is to establish an effective therapeutic alliance with the patient. This is essential in order to identify, together with the patient, which specific elements of the rehabilitation intervention should be used at each stage, ensuring that the overall plan is effective in achieving its intended outcomes, consistent with the patient's values and harmonised within the group setting.

The CM therefore plays an active and central role in the patient's rehabilitation pathway and oversees their Individualised Rehabilitation Plan. On the one hand, the CM liaises directly with the patient, becoming their designated professional and intermediary; on the other, they coordinate 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 family and the referring service, where they act as the multidisciplinary team's point of reference for the patient's rehabilitation plan.

3.4 Multidisciplinary Teamwork

All decisions concerning the clinical management and Individualised Rehabilitation Plans of patients admitted to the Therapeutic Community are made by the multidisciplinary team.

The team meets weekly and includes professionals from all disciplines. During these meetings, the team discusses both organisational matters concerning the Therapeutic Community as a whole and the rehabilitation plans of individual patients, with the aim of coordinating therapeutic and rehabilitation interventions and addressing any critical issues. The meetings are structured to encourage interactive discussion, with each participant invited to contribute according to their area of expertise.

3.5 Scheduled Staffing and Continuity of Care

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

For general medical needs, patients are cared for by a local general practitioner, to whom they are assigned upon admission. The general practitioner regularly attends the Facility to carry out routine medical examinations.

Staff activities are monitored by the Medical Director, who is also responsible for ensuring that staffing levels comply with the applicable provincial standards.

3.6 Professional Profiles

In keeping with the aim of promoting professional differentiation, clearly defined professional profiles are established for each role within the Community. These are intended to enhance the contribution of each professional and, as far as possible, prevent overlap between the responsibilities of staff with different professional profiles and/or assigned units.

4. NETWORKING AND INTEGRATED

To achieve the objective of effectively reintegrating patients into their social and educational environments, the rehabilitation pathway must combine intensive work within the Facility with equally intensive interaction and integration with the local community and families, on the one hand, and with the referring services, on the other.
The community-based intervention forms part of a broader psychological, social and rehabilitation plan. It represents an intermediate component connecting the various elements of a wider network, including outpatient services, hospital services, social services, educational institutions and schools, socialisation agencies and other relevant organisations. This approach reflects the understanding that adolescents with complex clinical needs require a broad range of responses, solutions and resources, adapted over time to their different developmental and diagnostic needs. These interventions must be strategically planned and capable of moving, in a reciprocal and integrated manner, between healthcare and social support.
The Eimaste Facility is committed to maintaining and strengthening its role as a bridge between the service user and their other care and everyday-life settings. It seeks to provide mediation across the various systems most directly involved in the service user's condition, including the family, social and educational systems in which the problem may manifest itself.
By strengthening the connections between the different parts of the network, the Facility promotes the opening of communication channels and facilitates dialogue between the service user and the various components of the system, preventing relationships and communication from breaking down.

4.1 Interaction with Referring Services

The rehabilitation training period undertaken within the Community should be regarded as one stage of a broader and more complex care pathway managed by the local Child and Adolescent Neuropsychiatry and Psychiatry Services. This highlights the need for effective coordination with these services, both to identify the patients most likely to benefit from a rehabilitation pathway and to integrate the work carried out with the patient during their stay at our Facility with the preceding and subsequent stages of care.

Before admission, the referring service is asked to prepare a detailed clinical report on the patient, specifying in particular the diagnostic assessment, the objectives of the referral and the expected duration of the placement. Ideally, this report should also include information on the patient's personal and family history; recent and past psychiatric history, including any psychiatric hospital admissions; past medical history; social and educational history; pharmacological history, including current and previous treatments and any adverse effects or allergies; substance-use history; the results of any relevant diagnostic investigations, such as ECG, EEG, CT scans, MRI scans and recent laboratory tests; the designated family contact; and the therapist or multidisciplinary team responsible for the patient's care.

We consider this information essential in preventing admissions that are not supported by a clearly defined plan from the referring service. In complex cases where no formal plan has yet been established, staff remain available to work with the referring local multidisciplinary team, contributing their expertise in psychiatric rehabilitation to develop a residential therapeutic and rehabilitation plan during the preparatory stage before the patient's admission.

Similarly, at the end of the rehabilitation pathway, the referring service receives a detailed report on changes in the patient's symptoms and social and occupational functioning, the activities undertaken during their stay at the Centre, the objectives achieved on the basis of clinical and psychometric assessments, and any recommendations regarding therapeutic and rehabilitation strategies that may support the continuation of the recovery process outside the Therapeutic Community.

4.2 Interaction with Families

The care pathway of a patient admitted to the Community necessarily involves their family and, wherever possible, aims to support the patient's timely return to their family environment.
For this reason, in agreement with the referring service, the Community's multidisciplinary team may also provide support to family members in order to facilitate this process.
Family members are also regularly informed and involved in their child's rehabilitation pathway, including through participation in quarterly network meetings held to monitor the progress of the plan.

Understanding the characteristics of each patient's family background is particularly valuable within a psychiatric rehabilitation pathway. It helps the team to better understand the patient's inner world and, consequently, their symptoms, while also supporting the planning of a more effective reintegration into their original living environment at the end of their stay in the Community.

The active participation of the family and the service user in the therapeutic pathway is a crucial aspect of care. They are integral and essential participants in planning, unless otherwise established—for example, in the case of specific orders issued by the Juvenile Court—and their agreement to treatment, together with the family's consent, is essential. Unless otherwise indicated, continuity of contact between the minor residing in the Facility and their family must be preserved and maintained from the time of admission. Any specific restrictions—for example, concerning contact with friends and family, school attendance, outings, the use of mobile phones or electronic devices, smoking, or other matters—must always be set out in the Individualised Therapeutic and Rehabilitation Plan (PTRP) and agreed in advance.
Where specific restrictions are imposed by the Juvenile Court, arise from particular legal proceedings, or are required for clinical reasons, it remains necessary to assess the extent and manner of the information to be provided to the family. The plan also includes support interventions for parents, delivered either individually or in groups and consistent with the minor's individual pathway. These interventions must be agreed upon and detailed in the PTRP, specifying who will provide them and how they will be delivered.
Subject to availability, such pathways may form part of the range of interventions offered by the residential therapeutic Facility to the minor and their family. The availability of these services must be clearly reflected in the organisation's Service Charter.
The referring service nevertheless remains responsible for maintaining follow-up with the parents and ensuring that the minor's therapeutic pathway, together with the expected changes arising from it, is aligned with the family context and the parent–child relationship, so that the results achieved can be maintained.

4.2 Interaction with Local Schools

Patients admitted to the Therapeutic Community who have had to interrupt their studies are promptly supported in contacting local educational institutions so that they can resume their education.
Wherever possible, patients residing in the Community attend school in accordance with their age and personal choices.
The Community promotes inclusion and supports patients in their integration into the school environment by developing tailored pathways in collaboration with local schools. Where possible, specific traineeships are also arranged to support the development of independence and potential entry into employment.

4.3 Interaction with the Local Community and Businesses

As already highlighted elsewhere, in order to complement and integrate the work carried out with each patient and help them reconnect with their social environment, the Therapeutic Community also seeks to promote a cultural process within the local community aimed at reducing mistrust and prejudice towards people affected by psychiatric conditions.
In our view, this objective is so central to the rehabilitation process that it has itself become, alongside the pursuit of each patient's recovery, an integral part of the Therapeutic Community's mission.

Interaction with the local community is promoted in two ways:

- **Volunteering activities:** Anyone interested in volunteering at the Therapeutic Community is first invited to an introductory interview to assess whether their personal characteristics and proposed activity are appropriate for the service users. Where the conditions for collaboration are met, the proposed activity is scheduled and Community staff remain present throughout to support the volunteer. Volunteering activities are planned for the late afternoon or at weekends so that, should they be cancelled, the remainder of the weekly activity programme is not affected.
- **Courses led by external instructors:** The Therapeutic Community organises various courses open to the public,

delivered by external instructors who do not necessarily have a training background in mental health. These include a range of activities, such as exercise, foreign languages and computing, comparable to courses available in the wider community. Interested Community residents may also take part. These activities have two main aims: firstly, to enable participating patients to develop new skills that may support their social or occupational integration; and secondly, to create opportunities for contact and interaction with the local population in an environment that is protected but not medicalised.

4.5 Interaction with Universities

Codess Sociale intends to promote collaboration with universities, both where academic institutions are interested in using our Facility as a setting for clinical research that may contribute to improving the therapeutic and rehabilitation services offered to patients, and for the organisation of training events for Facility staff and/or professionals working in other settings.

Although the Community is an independent Facility, is not directly affiliated with any university and is not primarily intended for research activities, the structure of the rehabilitation intervention offered to patients is suitable for potential research purposes.

In particular, the definition of inclusion and exclusion criteria, the clear planning of rehabilitation activities, the preference for standardised and reproducible interventions, and the practice of measuring predefined outcome indicators demonstrate the intention to align the Centre's working methods with clinical research methodology.

This makes it possible, on the one hand, to compare the outcomes of the work carried out with patients more readily against scientific evidence and, on the other, to adopt an approach based on continuous self-monitoring and ongoing improvement of the rehabilitation programme offered to patients.

Finally, Codess is open to establishing partnerships that would enable the Facility to host training placements for professionals working in the field of mental health.

4.6 Judicial Authorities and the Region

The organisation managing the Community must ensure compliance with all reporting obligations to the Judicial Authorities, as well as with the relevant regional requirements pursuant to Law No. 149/2001.

5. TRAINING AND SUPERVISIONE

Rehabilitation in child and adolescent neuropsychiatry in general, and the rehabilitation of developmental disorders in particular, are fields of medical and psychiatric knowledge that are constantly evolving.
To achieve effective outcomes, a highly specialised rehabilitation pathway such as that offered by the Therapeutic Community must be supported by appropriate training for coordinators and all staff involved. The relevant guidelines require all staff to understand the concept of mental health recovery and its implications for service delivery (Carozza, 2006).
Providing specific and continuously updated training for the various professionals involved is also consistent with an evidence-based medicine (EBM) approach and therefore represents one of the Community's distinctive features.

5.1 Operational Methods for Delivering the Training Programme

The training programme comprises a series of different, mutually integrated training activities.

Initial training. This is an intensive phase conducted before staff begin their duties. It is designed to support the acquisition of basic technical and operational skills, including operating procedures, the organisation of the Facility and familiarisation with the working environment, as well as integration into the team. This includes an introduction to the service-user group and to the vision, mission and objectives underpinning the organisational model.
This training is delivered by the coordinating professionals and is preferably concentrated in the days immediately preceding the start of employment.

Team-Based Training. As previously stated, the Therapeutic Community's organisational approach requires all decisions concerning patients' clinical management and Individualised Rehabilitation Plans to be made by the multidisciplinary team.
During the weekly team meeting, cases are discussed collectively by professionals from different disciplines. This not only enables the various components of the rehabilitation plan to be coordinated, but also creates an important opportunity for mutual, multidisciplinary discussion and professional development.
The team meeting is also the primary setting in which any training needs may be identified and addressed through more specific training activities, as described below.

Specialist Internal and External Continuing Professional Development. This aims to provide staff with specific professional knowledge and support the quality of their work. It is delivered through a range of methods, including lectures, case studies, journal clubs, seminars and conferences.
This type of training may involve all staff or specific professional groups and is managed by the coordinating professionals, who may engage external trainers where necessary.

Mandatory Training. Mandatory training is provided in accordance with Legislative Decree No. 81/2008 and the State–Regions Agreement of 21 December 2011, following the refresher-training intervals established by the applicable legislation.

Good Practice Training Days. Since 2014, Codess Sociale's Quality Department has organised an annual company-wide training and knowledge-sharing event known as the Good Practice Forum.
During this event, different facilities present an intervention or project that has introduced an innovative approach to achieving a specific objective within their service setting—whether educational, rehabilitative, network-based or otherwise—and has produced the expected results. The presentation also includes the specific tools used to measure

the intervention's efficiency and effectiveness.
The aim of the Forum is to promote the exchange of methods and enable multidisciplinary teams working in comparable settings, in terms of service users and service provision, to adopt models that can be replicated more broadly.

The Forum is structured to include all coordinators of the managed services operating within the areas of intervention selected for each event.
Across the three editions of the Good Practice Day held to date, five good-practice projects in the field of psychiatric rehabilitation have been presented.
This initiative is proving to be an effective tool for sharing experiences among service teams, exchanging methodologies, and providing training for professionals with different or comparable roles working across diverse health and social care settings. All activities are guided by an approach that places service users at the centre of educational and rehabilitation plans and interventions.

5.2 Annual Service Training Plan

Each year, an annual training plan is developed, setting out the content, methods and schedule of the planned training activities.
The plan is developed by first identifying the areas in which further training is most needed. The coordinating professionals then determine which of the training methods described in the previous section best meets those needs. Suitable trainers are subsequently selected, either from within or outside the Facility, and a detailed programme for the training event is developed in collaboration with them. The event is then scheduled and offered to all potentially interested staff members.

5.3 Evaluation of the Training Programme

The training delivery procedure includes specific tools for assessing the effectiveness of the training provided in terms of the skills acquired, both for mandatory training and for technical training.

For each individual course, the trainer administers two types of questionnaire:

- **Final training evaluation questionnaire:** designed to assess how closely the course met staff expectations in terms of the relevance and usefulness of the content, the level of detail provided, and the extent to which the content can be applied within their own working environment; it also includes an evaluation of the trainer and the organisation of the course;
- **Learning assessment questionnaire:** a document developed by each trainer based on the specific features of the course, designed to assess its effectiveness in terms of the information learned and acquired.

6. SUGGESTIONS AND COMPLAINTS

Residents, family members, or any other interested persons who wish to express appreciation for the services provided or report any irregularities, inefficiencies or dissatisfaction are invited to inform the Facility. Complaints or written comments may be placed in the Suggestions and Complaints Box. Where requests for improvement or review of the services provided, concerns or complaints are submitted, the Management undertakes to respond as promptly as possible.

To submit a complaint or report to Codess Sociale, the relevant form may be completed and sent using one of the following methods: [1, 2, 3]

- Complaints Box: available at the Facility or at the day centre/service attended.
- Email: Write to direzione@codess.org or qualita@codess.org.
- Fax: Send to the following number: 199 161 911. [1]

Complaints must be submitted in writing and include the complainant's details, the subject of the report and the date or timeframe of the incident. A response will be provided within 30 days. To download the official documents, please visit the following page Codess Sociale Qualità.

Prepared by the Eimaste Team.

The Integrated Management System for Quality, Gender Equality, the Environment, Health and Safety, Social Responsibility and Inclusion, and the Adoption of the Organisational Model pursuant to Legislative Decree No. 231/2001.

Codess Sociale has maintained a management system certified in accordance with UNI EN ISO 9001:2015 since 2005. The organisation pursues its mission through an integrated management system compliant with the ISO 9001:2015, ISO 10881:2013, ISO 11034:2003, ISO 14001:2015, ISO 45001:2018, SA8000:2014, UNI/PdR 125:2022 and UNI 11010:2016 standards.
This system is based on a set of principles and values that guide service provision: a welcoming approach, attention to the individual, enhancement of family and community networks, human-centred care, professionalism, pollution prevention, and the continuous pursuit of innovative reference models in response to emerging needs.
A central role is also played by an organisational model that recognises ethics as one of its fundamental pillars. In this context, on 7 May 2013, the Board of Directors adopted an Organisation, Management and Control Model pursuant to Legislative Decree No. 231/2001.
Integrated with the internal control systems already in place, this model defines the rules and procedures to be followed by all company staff and by the parties with whom the organisation interacts, with the aim of preventing the offences covered by the Decree.