VILLA SANTA MARIA SCS

Child Care Center

Neuropsychiatric Rehabilitation Center

LIST OF SERVICES

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VILLA SANTA MARIA SCS
Centro Multiservizi di Neuropsichiatria dell'Infanzia e dell'Adolescenza

Child Care Center
Neuropsychiatric Rehabilitation Center

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INTRODUCTION

The List of Services illustrates Guests, their families and public and private healthcare institutions all relative information on the treatment available, the organization and operations and procedures implemented at Villa Santa Maria SCS.
The publication of this List of Services conforms to the legislative requirements prescribed in the law DGR n° X/2569 dated 31/10/2014.
Further references to the norms are available in the "*Normative references aimed at the adoption of The List of Services within the National Health Service"* published in September 1995, and include:

a. Official Decree of the President of the Council of Ministers dated 19 May 1995: "*General Reference Scheme to The List of Public Health Services*" in The Official Gazette dated 31 May 1995, n. 125
b. Ministry of Health - Guidelines n°2/95: "*Providing the List of Services in the National Health Service"*

See also:

1. The President of the Council of Ministers directive dated 27 January 1994: "*Principles on providing public services"*
2. Ministerial Decree dated 15 October 1996 published in The Official Gazette on 18 January 1997, n. 14 – *Approval of the indicators to be used to evaluate the quality of services offered in terms of personalization, humaneness of the assistance, the right to information, to housing facilities, as well as the activities aimed at prevention of illnesses.*

Villa Santa Maria SCS abides by a Code of Ethics, which clearly sets out the principles and ethical values within which its management, employees, health professionals and all collaborators operate, manage and behave in their rapport with anyone with a relationship with the Institution.
Villa Santa Maria SCS commits to diffusing, updating and verifying its Code of Ethics to all those who interact with the Institution so that any infractions may be duly reported, verified and dealt with in a timely manner.
The Code constitutes a reference in accordance with the law D.Lgs. n. 231/2001 and, as such, an integral part of its organizational, management and control model adopted at Villa Santa Maria SCS.

FUNDAMENTAL PRINCIPLES IN PROVIDING SERVICES

Villa Santa Maria SCS operates daily by respecting the following principles:
Equality of users' rights, assuring that everyone has access to the services provided by the Institution. No distinction is made based on sex, race, language, religion or political orientation. Equality of treatment is guaranteed to everyone with all conditions being equal. This principle implicates not only the right to uniform high quality services and treatment, but also the assurance that nobody is discriminated against in receiving that service.
Impartiality: is a constant commitment by service providers who pledge to operate using criteria of objectivity, justness and impartiality for all users.
Continuity: is a guaranty of regular continuity of treatment. Eventual interruptions are expressly regulated by legal norms of the health sector and include, in any case, the commitment on the part of the Institution to adopt all measures aimed at providing the least amount of discomfort to users as possible. Villa Santa Maria SCS and Villa Colombo operate 24 hours a day, year-round.
Participation: the right to access documentation in accordance to law L.241/90, but also all information, consultations, monitoring records, personal rehabilitative therapeutic projects, that report on the health status, thereby creating a collaborative climate and trust between the user of the service, their friends and families and Villa Santa Maria SCS.
Giving Value to Patient Capabilities: every patient is seen as a person capable of expressing his/her needs and desires.
Innovation: Villa Santa Maria SCS commits to investing in innovative solutions that create new possibilities in its sector to improve the quality of life of patients.
Efficacy & efficiency of services is a constant commitment on the part of the Institute to orient strategies and efforts of its organization to achieve the highest health and wellness objectives.

FUNDAMENTAL USERS RIGHTS

The Right to medical records: everyone has the right to receive all the relative information and documentation necessary as well as to all the official certification that attests to their health conditions
The Right to security: everyone has the right to a safe and secure environment and to remain unharmed by any malfunctioning of any of the facilities while receiving services.
The Right to protection: Villa Santa Maria SCS retains that user protection is of the utmost importance, especially given their health status, whether that be of temporary or permanent weakness, and pledges to never, for whatever reason, leave Guests without the assistance they need.
The Right to certainty: every user has the right to certainty of treatment within the timeline and schedule prescribed and to not become a victim of any professional and organizational conflicts or sudden discretionary changes in the interpretation of the rules and regulations of the institute.
The Right to trust: everyone has the right to be treated as a person worthy of trust.
The Right to quality: everyone has the right to quality professional caregivers oriented towards the sole objective of improving their health condition and quality of life.
The Right to being different: everyone has the right to be recognized according to their specific needs whether those be based on age, sex, nationality, health condition, culture or religion and to receive, as a result, specific differentiated treatment according to these needs.
The Right to decide: everyone has the right to maintain their own sphere of autonomy and responsibility for their own health and life based on the information in their possession and as long as this does not conflict with medical prerogatives.
The Right to privacy: based on the informative document received in compliance with law Dlgs n.81/2008 and their signed consensus declaration, users and their families have the right to privacy regarding the patient's health condition and treatment.

PRESENTATION

PREMISE

The well-being of an infant is one of the main objectives of the Regional Health Plan (RHP); the activities aimed at improving the health of the population during the formative years and their quality of life are particularly relevant to Regional Health providers and the single institutions there within. Regarding the neuropsychic health sector during the formative years, the following points are worthy of note:

1. Some problems of infant and adolescent Neuropsychiatry are becoming increasingly common (please refer to DPCM 12 January 2017, "Definition and updates LEA"):

a) **Psychic and psychopathology illnesses** during the formative years represent an emerging need, for which it is necessary to take charge of by establishing preventative measures and early detection. These interventions assume, in addition to prevention value in terms of psychic illness, a strategy to lessen or treat psychiatric pathologies in adulthood.
b) **Psychiatric and neurological pathologies (infant cerebral palsy, epilepsy, mental retardation, specific learning disorders etc.)** in addition to requiring immediate and continuous therapy over time, these pathologies need to be treated as early as possible so that they do not evolve into serious handicaps that will increase social costs not to mention the detriment to adult lives.
c) **Disabilities during the formative years** present peculiarities that require interventions that are integrated and complex, aimed not only to reduce damage, but above all to prevent interconnected problems.
d) **Rehabilitation** during the formative years can take place only with interventions that respect the whole and uniqueness of the patient; as during the formative years, a strict connection between functional rehabilitation and psychosocial rehabilitation, thus treatment of disabilities must be considered as mental developmental problems and not simply as single function disturbances (neuromotor, sensorial, cognitive).

2. To effectively treat infant neuropsychiatric disorders, a converging plan of action that includes both health and social realms that consider the peculiarities and specificities of the needs in this phase of life must be enacted. Thus, treatment must include:

a) comprehensive treatment that includes prevention and healthcare education;
b) the strict interdependence between development and relational contexts that require an enlarged circle of caregivers including the family and social educational environment;
c) a reciprocal interaction of the various developmental areas: motor, cognitive, psycho-emotional and relational;
d) specific attention (using appropriate instruments and methods) to diverse age groups (infancy & early childhood, period of latency and preadolescence, early and late adolescence), considering adolescence as a milestone of a continuum of growth and development;
e) consideration of the highest indices of comorbidity amongst various disturbances in different and successive age groups.

In accordance with its Articles of Incorporation and planning guidelines, which are integrated with other accredited health services providers (both public and private), Villa Santa Maria SCS provides families with prevention, diagnosis, treatment and rehabilitation services against neurologic, neuropsychiatric and/or psychiatric pathologies in infants and adolescents between the ages of 0-18 who suffer from developmental disorders of various types: - psychomotor, linguistic, cognitive, intellectual and relational .

FOUNDING CHARACTERISTICS AND ASPECTS OF VILLA SANTA MARIA SCS

MISSION

The general objectives are defined based on national and regional norms in vigor and declared in the Institution's mission statement. They include prevention, diagnosis, treatment and rehabilitation of infant and adolescent neurological, psychopathological and neuropsychological disorders that must be guaranteed in a coordinated, appropriate and equal way.
The main objectives of Villa Santa Maria SCS include:
A. Guarantee specialist neurological and psychiatric treatment to patients at its day hospital, semi-residential and fully residential facilities on a regional level according to operational projects that meet the health needs that result from local epidemiologic observation with specific attention to diverse age groups.
B. Recover children with precocious neuromotor, psychological and family based problematic disorders by use of collaborative psychiatric and rehabilitative specialist competences;
C. Treat adolescents afflicted with psychiatric pathologies;
D. Collaborate with scholastic institutions to reinsert and integrate disabled students in all level schools in accordance with the law n.104/92 e D.P.R. 24/2/94;
E. Collaborate with local entities as well as national institutions to reinsert post-school aged adolescents into the work-place and society at large;
F. Collaborate with local entities proposed to the judicial administration within its network to safeguard abused minors, those deprived of basic necessities or yet those undergoing judicial processes;
G. Program and provide training and neuro-psychomotor rehabilitative programs that aim to improve communication and language in collaboration with specifically trained personnel with vast rehabilitation experience. Rehabilitation during the formative years presents certain specific challenges in as much as it is targeted to patients who have suffered precocious damage to their nervous system resulting in mixed deficits (neuromotor, cognitive, communication, emotional-relational, sensorial), therefore requires an integration of various competences
H. Collaborate with patient families using a complete and continuous information flow relating all health and social issues regarding afflicted minors and on the recovery and treatment possibilities aimed at reinsertion back into society.

With these aims, the facility is an Infant Neuropsychiatry structure whose professional operators include:

1. Infant Neuropsychiatrists, pediatric neurologists and pediatricians
2. Physiatrists
3. Clinical Psychologists, psycho-therapists
4. Speech Therapists
5. Physiotherapists and Neuro-psychomotor Therapists for patients during the formative years
6. Psychomotor therapists
7. Special education professionals
8. Specialist Nursing professionals

All the above have specialized training and experience to treat children during the formative years.

Mission

1. Provide the most effective treatment and promote initiatives capable of improving the health and reducing the discomfort and suffering of the patient population during their formative years;
2. Pledge to lower all barriers: economic, political, cultural and social that interfere with the participation and full development of suffering children and adolescents;
3. Favor scholastic and social integration of all disabled users;
4. Favor patient autonomy and social participation;
5. Collaborate with patient families in recognizing the disabled children's rights and towards the most effective way to develop their abilities;
6. Value those factors that protect mental health during the formative years;
7. Guarantee therapeutic continuity with hospitals and other services in the region to raise mental health awareness.

REFERENCE VALUES

1. The centrality of the patient and their family
2. Improve the patient's quality of life as a fundamental prerequisite to a more healthy and harmonious development;
3. Being rooted locally and build working networks;
4. Universalism and Equality;
5. Maximum scholastic and social integration;
6. A community approach;
7. Transfer competencies to real life contexts;
8. Use a participation-based model;
9. Promote clinical trial-based research;
10. Promote interventions based on scientific evidence.

Objectives

Develop the capacity to protect and care for:

1. Minors with or at risk of physical, psychological or sensorial disabilities
2. Minors in situations of abuse or maltreatment
3. Minors in situations of psychological or psycho-social discomfort
4. Minors in a family at risk of social out-casting or broken families

While guaranteeing:

5. Therapeutic continuity and reciprocal involvement of service operators
6. An appropriate and constantly updated rehabilitative neuropsychiatric diagnosis
7. The regular participation of Villa Santa Maria SCS operators at the meetings of all age grouped patients to favor the progression of services from childhood to adulthood
8. Institutional and community integration
9. Organizing services and treatment with district/regional/local health services entities
10. Professional integration

11. The acquisition of a professional multidisciplinary culture in all service areas
12. Updating each skill in all required service areas to guaranty quality and effectiveness of professional treatment
13. Define facilities and methodologies to monitor and verify progress of results
14. Improve professional, organizational and perceived quality
15. Provide timely interventions for prompt diagnosis and rehabilitative treatment
16. Favor the introduction of new proven interventions that reduce waiting times, uncoordinated releases and reduce inappropriate requests for unnecessary services.

CERTIFICATION ISO 9001:2015 AND REGIONAL ACCREDITATION

Institutional accreditation is recognized due to an administrative norm in vigor and released to benefit a legal entity (accredited subject) that is enabled and authorized to provide services on behalf of the regional health service. Certification is therefore a necessary prerequisite to be able to access the contractual obligation and as such to receive remuneration for the services rendered on behalf of the health service.
Accreditation implies improvements and control of quality of the services provided in addition to the assumption of the following obligations on behalf of the regional health service.
Accreditation requisites:

1. ***structural:*** dimension/layout of communal and individual spaces
2. ***managerial:*** assistance specifics standards must be coherent and correctly applied as per the national labor contract for all personnel
3. ***technological:*** equipment, furnishing and facilities must be as per norm
4. ***organizational:*** the list of services, individual therapeutic projects, protocols and procedures, as well as customer satisfaction surveys must be in place.

Villa Santa Maria SCS has developed a quality management system that conforms to the norm ISO 9001:2015 and in 2016 it was awarded its certification as a quality services Center from Swiss Association for Quality and Management Systems (SQS).

REGIONAL NORM FOR THE SECTOR

Admitting a patient for therapeutic, rehabilitative care is differentiated by objectives: sustain and expand autonomy, facilitate behavioral ability or personalize rehabilitative/educational integration.
Rehabilitative projects already under way refer to the personalized integrated approach which is continuously monitored by specialists.
The overall services provided by Villa Santa Maria SCS as well as its organizational model have the social objective to welcome users with the best rehabilitation possible in an effort to improve the quality of life of each patient.
The List of Services describes the types of services offered at the Via IV Novembre, 15 in Tavernerio (Lake Como Area) rehabilitation center and conforms to the structural and organizational requisites prescribed the Lombardy Region as per the following norms NPIA:

1. D.P.R 14.01.1997
2. Lombardy Region:

1. D.G.R. n. VI/38133 del 06.08.1998
2. D.G.R. n. VIII/5743 del 31.10.2007
3. D.G.R. n. VIII/6860 del 19.03.2008

Law DGR n° VIII/007567 dated 27 June 2008 has accredited Villa Santa Maria for the following:

1. THERAPEUTIC REHABILITATION CENTER IN INFANT AND ADOLESCENT NEUROPSYCHIATRY (STRNPIA)
2. DAY HOSPITAL IN INFANT AND ADOLESCENT NEUROPSYCHIATRY (CDNPIA)
3. TERRITORIAL INFANT AND ADOLESCENT NEUROPSYCHIATRY CENTER

The law DGR n°74 dated 23 July 2008 has accredited for the following:

1. RESIDENT HEALTH CENTER PER NEURODEVELOPMENTAL DISORDERS IN DEVELOPING AGED CHILDREN (RSD VSM)

The decree n° 11792 dated 23/12/2015 has accredited VSM's other branch for the following:

1. RSD VILLA SANTA MARIA 2 - RESIDENT HEALTH CENTER FOR REHABILITATION OF NEURODEVELOPMENTAL DISORDERS IN DEVELOPING AGED CHILDREN (RSD VSM2)

ACTIVATION OF THE LEGISLATIVE DECREE 81/2008

Villa Santa Maria SCS satisfies the obligations contained in the decree DG 81/2008 regarding the security and safety of its personnel and patients by having the proper emergency safety plan and the specific training for emergencies of its personnel in place.

All personnel receive general information and training on the risks they may be exposed to and the measures they need to adopt as well as the procedures to follow in case of emergencies.

HISTORICAL NOTES

The history of the institute begins in the 1950s when the Pontifical Opera of Assistance (P.O.A.), Como section, becomes the Opera Diocesan of Assistance (O.D.A.) and acquires the 19th century Villa Bossi in Tavernerio with its surrounding lands and pine forest.
Villa Bossi was a patrician medieval castle used by the military armies of Como and Milan during the times when Communes had their own forces. It was subsequently destroyed because it became the hide out for smugglers, then destroyed and rebuilt several times.
The building was then purchased after World War II by the P.O.A as the highway roadworks company Italstrade, which had used it as its headquarters, became insolvent back in 1942.
At the beginning of the 1950s, the first guests (of all ages) come from a region called Polesine which suffered excessive flooding and for a brief period, by the families of Tavernerio, many of whom lost their homes as they also had to deal with a flood of the river Cosia in 1951.
On 18 November 1952, after a long negotiation with the National Institute of Social Security (INPS), a villa opens under the current name Villa Santa Maria, which served as a quarantine tuberculosis prevention home for children with pulmonary disease complete with a kindergarten and elementary school. The first inhabitants back then were about twenty children sent there to recover by the national health service INPS. The structure was managed and run by the Sisters of the Congregation of the Presentation of Mary to the Temple, whose main branch was in Sestri Levante.
Later in 1962, Mons. Fogliani, until then the head of Villa Santa Maria, becomes the head priest of Sondrio and he is replaced by the general vicar Mons. Carlo Castelli, who confirms the fine work of the Sisters.
In the office of Mother Superior Sister Margherita Dall'Orso enters a certain nun named Sister Maria Pia Terzaghi, who manages the return for Mons. Ambrogio Fogliani, who is ill and spends the remaining days of his life there. He leaves the furnishings and a modest sum of money in his will to the Villa Santa Maria family.
During this period the children remained at Villa Santa Maria uninterruptedly for the whole period of their convalescence, taking in the mountain air and at the end of the school year their improved health was testimony to the effectiveness of the facility. In June of 1966, INPS cancels the agreement with private entities and builds another facility in nearby Erba. Villa Santa Maria was therefore closed and the provincial administration asks to use the villa to house youngsters who showed signs of mental illness. The 10th of October of the same year, the convention with the Research Center of Como which assured the availability of teachers agrees with the Provincial administration to send patients to Villa Santa Maria on the basis of a daily payment contribution for each of the mentally ill youngsters, thereby creating a new entity.
The research center of Como, recognizes the need for a new type of school given the presence of some 60 students with mental challenges and decides to create a special education institute under the guidance of Mons. Castelli. Thus, Villa Santa Maria in collaboration with the provincial administration is founded and denominated as a Medical Psycho-pedagogical Institution.
The expense to run the school is notable as the building required a lot of modification and refurbishment for the classrooms to take shape and for it to be inserted into the local Tavernerio school board. As a result, the Sisters are assisted by social workers since, as the terminology of the day attested to, the children there between the ages of 6 and 12 had an IQ of 050-080 "were recoverable".
Since 1966, the institute takes in minors who are mentally challenged and in part orphans or with parents who were unable to look after them. They required special care since their learning curve was lower than the regular children in frequented the local elementary or middle schools.
Since June 2007, the Center is managed by "Villa Santa Maria SCS a Social Cooperative. Villa Santa Maria SCS represents a reference point for its local community as well as an excellence on a national scale. By developing and promoting its treatment with internationally recognized institutes and some of the major rehabilitation neuropsychiatry centers in the world, it continues to build on its fine reputation.
A large contribution to the modern day VSM activities in Child Neuropsychiatry were made possible by a generous contribution by its benefactor Dr. Alessandro De Orchi.
Alessandro De Orchi1*, was born in Como in 1843, and completed his medical degree and became a doctor and a surgeon. Referring to his professional career shortly thereafter he said, "it will be my purpose to consecrate my life to alleviating all forms of suffering for those who have been disinherited by good fortune". And so, he did. During the third war of Independence he was nominated adjunct medic for the Royal Army in Italy. Afterwards he embarked on a ship called the "Clementina" where during the crossing from Genoa to Buenos Aires, he helped all the*

1 From the website: http://www.fondazione-comasca.it/

immigrants who were travelling in very cramped conditions down below without sufficient light or air. Despite the terribly hard conditions he faced during his lifetime, he always dedicated his life to assisting those in need.

In 1903, now back in Italy, *Dr. De Orchi proposed that the authorities of the city of Como build a seaside recovery facility destined to the sick children from Como in* ***Rimini, the Adriatic seaside city.*** *The proposal was accepted with enthusiasm and some years later they decided to associate the seaside recovery facility to that of the alpine air one which had proven successful in Casasco Intelvi.*

During the end of the 1960s however, families stopped sending their children to the summer camps both at the sea-side or in the mountains as demand for these types of cures waned. Both structures were eventually sold. Since the original scope of these buildings was no longer being respected, the Provincial Administration for Sea-side and Alpine cures for children ***decided to devolve the facilities to entities whose aim was close to that originally willed by the founder****.*

It is for this reason that since 2002, the ***Fund named after Dr. De Orchi within the Province of Como Foundation****, is seen as a guaranty of transparency, trustworthiness and the inalienable purpose of the gift. Thanks to the interests accrued on the generous gift, Dr. De Orchi continues his philanthropic activity directed at helping young Como residents by guaranteeing the sustainability of innovative projects.*

AN ANALYSIS OF SEMI AND FULL RESIDENCY NEEDS (NPIA) IN LOMBARDY

Normative references (Titles in original Italian):

1. SINPIA work group *Residenzialità in Neuropsichiatria dell'infanzia e dell'adolescenza*, 2003;
2. *L'assistenza ai minori con disturbi neuropsichici in Lombardia,* SINPIA 2015;
3. President of the Council of Ministers Unified Regional Conference Act dated 13.11.2014, *Gli interventi residenziali e semiresidenziali terapeutico riabilitativi per i disturbi neuropsichici dell'infanzia e dell'adolescenza.*

PREMISE

Infancy and adolescence are crucial periods for the good health of the body and mind that characterize an individual's entire life. Life expectancy is increasing year after year. Many pathologies can compromise this process with a progressive transformation of pediatric illnesses from acute and infective to chronic, not to mention certain periods where diseases flaring up again.
The major part of chronic illnesses during the developing years are shortcomings of the Central Nervous System (CNS). Neuropsychic disturbances during these formative years are extremely common: overall involving between 10% to 20 % of the infant and adolescent population. These illnesses are diverse and include: intellectual, motor-control, language, speech and learning disorders and those related to the specter of autism, epilepsy, genetic syndromes and neuromuscular diseases, neurogenerative and acquired encephalopathies as well as other complex disabilities and disturbances that range from attention deficit disorder with hyperactivity, to behavioral, psychosis, emotional disorders and many others.

These disturbances occur during a phase of life where the CNS is evolving and the continuous interaction between innate and environmental inputs as well as risk and protective factors are taking place. This has recently brought researchers to define them under one unifying umbrella as neurodevelopmental disturbances. Indeed, this definition helps underlining precisely how the interaction amongst different factors at play here are more dynamic, complex and multifactored in children than they are in adults, and therefore modify the characteristics of these disturbances, their functional consequences and the effect they have on the environment and their eventual treatment. Next to this transversal prospective, it is necessary to have a longitudinal one: how will the child become over time and how will his/her basic developmental and relational functions evolve within these diverse developmental timelines?

The prevalence of neuropsychic disturbances during the developing years is highly variable in the international literature (between 9% to 17%) depending on the methodologies used to measure them. In many cases, they are underestimated as they do not detect light or mild disturbances, and in other cases they are over estimated due to the frequent coexistence of more than one pathology present in the same subject (30% of the cases). This is a lot more stable amongst the different age groups in diverse populations, for those cases with intermediate severity (2% to 2.5%) and those subjects that present multiple problems with serious and complex limits in relevant autonomies in Lombardy 0.5%, corresponds to a little more than 8,000 children and families. This group is very relevant for the Regional Health Service planning and programing.

Psychiatric and neurological pathologies and substance abuse today represent 13% of the *global burden of disease* of the entire population, with cardiovascular ones also on the rise and neuropsychic disturbances in adults rising to a staggering 50%. These pathologies have their origin in children during their formative years and are caused by morbid events that develop over time before the disease is full blown. In the major part of the disturbances under consideration here, precocious treatment and timely interventions during these formative years could change the natural history or evolution of the disease and prevent numerous sequels thereby avoiding a chronic decline that ultimately leads to becoming permanently handicapped.

INCREASED DEMAND

During the last few years, a relevant increase of requests for treatment has manifested itself as the type of patient and the needs of families has evolved. Increased requests for specific developmental disturbances (dyslexia and specific language disturbances), as well as requests for patients with disabilities, neurological or psychiatric disorders of relevant complexity and severity. Parents, pediatricians and teachers are more careful and informed in precociously identifying signals that point to the fact that everything is not alright and that something is not working properly in the neuropsychic development of their children.

Disruptive behavior is also on the rise, at times becoming explosive by the simultaneous occasional substance abuse that is assuming a significant role both in revealing the psychiatric disturbance as well as the resulting complexity in its treatment. New ways of manifesting psychic discomfort, i.e. through internet addiction, home isolation, gang membership and many other forms are also on the rise.
The family and its more traditional environment is increasingly frail, more fragmented and isolated by an aggravated context where professional and economic advancement becomes critical, while at home it becomes necessary to have intensive assistance over prolonged periods of time for a child with serious psychiatric pathologies and/or complex disabilities.

The need for recovery in an NPIA center has also increased during the last few years due to the prolonged life-span of patients with complex disabilities. Increased dependence on new technology provides for greater diagnosis possibilities and targeted therapies in a neurological center equipped to treat the seriousness of the varied psychiatric disturbances.

Being recovered in an NPIA takes place according to the following categories:

1. *children with extreme neurological severity, either at birth or acquired and "Technology dependent" (assisted breathing, etc.), high healthcare, rehabilitative needs where families are unable to care for them at home*
2. *children or adolescents with serious pathologies, either at birth or acquired that are seriously poly-handicapped, high healthcare and rehabilitative needs where families are unable to care for them at home*
3. *adolescents with serious behavioral disturbances associated to mental insufficiency*
4. *adolescents and preadolescents with serious psychopathological disturbances*

1. Children with extreme neurological severity, either at birth or acquired and "Technology dependent"

Extreme neurological severity and Technology dependence can be represented by the following: metabolic encephalopathies and neurodegenerative illnesses in advanced phases, muscular dystrophy, spinal musical atrophy in advanced phase, severe neurological conditions associated to complex malformation syndromes, severe cranial-encephalic and medullary traumas or other acquired acute encephalopathies, at times infant cerebral palsy of the spastic tetraplegic dystonia. They require extremely high levels of continuous healthcare and rehabilitative treatment, with the capacity to manage their ventilators, parenteral nutritional pumps, monitors, ostomy (PEG) etc., and eventual medical emergencies.

They also require specific medical and rehabilitative treatment in neurology, physiotherapy as well as postural, neuro-psychomotor and communication skills.

2. Children or adolescents with severe neurological pathologies, at birth or acquired that are poly-handicapped

These are children during their formative years with neurological and behavioral pathologies tied to cases of infant encephalopathies of the lesion/destructive and/or malformation type. They also suffer from severe impairment in various areas (multiple-motor, neurosensorial, cognitive,

communication, emotional-relational etc. associated to severe cases of epilepsy, dysphagia etc.) that represent a real challenge for any clinical environment due to their fragility, instability and complex and often simultaneous interventions require the utmost attention.
Patients with severe neurological pathologies at birth or acquired need continuous assistance and they particularly require specialized nursing on a low, and often a one-to-one, ratio.
Among the necessary competences, emergency reanimation in cases of episodic asphyxiation or respiration physiotherapy, surveillance and acute epilepsy crisis therapy, nutrition therapy to decrease cases of pneumonia and repeated indigestion not to mention correct postural hygiene and overall "care". The presence of other specific special- education operators are needed to prevent unforeseen complications and to teach, identify and prescribe personalized training in cognitive and communication skills that will be useful for the rest of the patient's life.

Children with neurological pathologies and initially not "technology dependent" may successively become so, or for a period, due to the worsening of their pathologies and the interrelated complications that may result. These include their general increase in morbidity which includes examples such as gastro-esophagus reflux and related complications, to respiratory insufficiency, or yet even orthopedic complications.
Both patient types require systematic interventions by all multi-professional operators on our NPI staff: neuropsychiatrists, psychologists, therapists, rehabilitation specialists, special educators etc. as well as specialized nurses who undergo targeted training and systematic pediatric consultations with hospital staff from intensive therapy departments (intensive surgery, pediatric specialists, local hospital centers of excellence, infant neuropsychiatry, neurosurgery etc.). Should there be a need, Villa Santa Maria SCS is able to quickly and adequately deal with any emergency that may arise at the right specialized facility.

3. Adolescents with severe behavioral disturbances associated to mental insufficiency

The association between behavioral disturbances and mental insufficiency is frequent. It is well known that often mental insufficiency represents the most significant limit in autonomous functioning in adults. Some studies put the percentage at between 10% and 40% of subjects with mental insufficiency or even higher and they underline the fact that the date fluctuates based on the interventions carried out when patients were younger. The percentages rise in the preadolescence and adolescence age groups, when families find themselves in the most compromising period especially in terms of motor skills.
Although very different from one another, these three patient types can partially be managed together since the crucial element is their recovery in situ, or not, depends on their family situation.
Situations of abandonment and loss of custody must be distinguished from situations in which the family is present, but not able to, or no longer able to manage the assistance their children's needs at home. In situations of abandonment, in particular at age 0-3 years and those in the first two more extreme patient types, we try to respond to the solicitations from the Juvenile Court, who may be at a loss for where to house these cases since few facilities are able to take them in during this early age.
Regarding children and adolescents with families, the request for full recovery often arises due to the absence or insufficiency of territorial assistance and/or domiciled assistance that are appropriate to the severity and complexity of the patient's condition.

4. Adolescent and preadolescent serious psychopathological disturbances

This patient type is serious, numerous and requires a precise structural treatment plan that is both complete and flexible. Particularly relevant is the increase of residential patients, 54% of the subjects recovered in therapeutic facilities present behavioral and personality disturbances, 10% present psychotic disturbances and 7% emotional disturbances, while 4% nutritional behavioral disturbances. Furthermore, 60% of users are to some extent in trouble with the Juvenile Court and 75% of these cases present significant difficulties in terms of their family environment.
In the adolescent age group with psychiatric disturbances or at high risk of contracting them, it is fundamental to have an integrated network of treatment centers that are capable of early detection of the most serious pathologies and the flexibility and timeliness to reorient the patient to the most appropriate facility for his or her specific case.
Therapeutic residential rehabilitative treatment for minors with psychiatric pathologies are indicated in the presence of developmental distortions that compromise personal and social autonomy to such a degree that it becomes necessary they are inserted in a physical environment that is ideal to repair their relational skills and retrain their adaptive capacities.
These often regard situations where the disturbances are not single episodes or manifests themselves in a single outburst, but rather affects ordinary family and extra-family existence and thus require targeted interventions that include therapeutic special education to resolve their setbacks.
The acceptance of a residential therapeutic patient is proposed to the territorial Operating Unit of Childhood and Adolescence Neuropsychiatry (NPIA) that has the responsibility for the patient based on his provenance. This institution will have the responsibility to monitor the situation and assume corrective measures should the case warrant them. Intensive rehabilitative therapeutic treatment provides a lot of clinical activity when compared to those regarding social reinsertion.

1. **Neuropsychiatric clinic:** intense and regular monitoring of the psychopathological conditions with the aim to provide the most effective rate of clinical stability and developmental processes by way of regular sessions with NPIA doctors that include both patient and family members;
2. **Psychology department:** short structured interventions (interviews, psychotherapy and group therapies) and psychoeducational (with family members whenever possible);

3. **Rehabilitation department:** interventions that are intense and diversified (individual and in groups) in psychosocial behavior aimed at recuperating the basic interpersonal/social skills to reinsert the patient in their own social context. These interventions may also include inserting the patient in their daily settings as well as at the facility. The aim is to recuperate scholastic activity as soon as possible.
4. **Social reinsertion department:** according to this therapeutic program, interventions are agreed upon with local Social Services and are started up as soon as possible: relational interaction skills, socialization and activities aimed at community participation and other group activities, scholastic and expressive language use, motor skills are practiced both at the facility and out in the community.
5. **Coordination department:** periodic and frequent meetings with the local NPIA network takes the patient and brings them to a local territorial facility (schools and/or Social Services), to monitor the therapeutic rehabilitation project and tweak it if necessary.

1. RESIDENTIAL TREATMENT

This treatment is extensive and encompasses the environment in which the patient lives, the quality of relationships with the clinical-educational staff and with other patients within a multidisciplinary and integrated therapeutic-rehabilitative project. The environmental therapy guarantees a high level of emotional containment and that the relational style is particularly adopted to the patient's clinical needs. Those needs, as well as the needs of his/her family are a focal element in initial evaluation, after which the specifics of the treatment planning take shape. For this reason, Villa Santa Maria SCS is organized into various units that welcome patients per pathology type, age and clinical status:

1. THERAPEUTIC REHABILITATIVE FACILITY IN INFANT AND ADOLESCENT NEUROPSYCHIATRY (STRNPIA)

   1. Therapeutic Community for Pre-adolescents and Adolescents
   2. Dedicated neurodevelopmental disorders unit

3. RSD VILLA SANTA MARIA SCS – RESIDENT HEALTHCARE CENTER FOR THE REHABILITATION OF NEURODEVELOPMENTAL DISTURBANCES IN CHILDREN DURING THE FORMATIVE YEARS (RSD VSM)

   1. Residential measure for severely disabled minors DGR. X/1152/2019

2. RSD VILLA SANTA MARIA 2 - RESIDENT HEALTHCARE CENTER FOR THE REHABILITATION OF NEURODEVELOPMENTAL DISTURBANCES IN CHILDREN DURING THE FORMATIVE YEARS (RSD VSM2)

   1. Residential measure for severely disabled minors DGR. X/1152/2019

2. BOARDING CENTER FOR DISABLED PEOPLE "AGAPE TERZI"

A. THERAPEUTIC REHABILITATIVE FACILITY IN INFANT AND ADOLESCENT NEUROPSYCHIATRY (STRNPIA)

Accredited in accordance to law DGR n° VIII/007567 dated 27 June 2008

The Therapeutic rehabilitative facility in infant and adolescent neuropsychiatry recovers children and adolescents up until the age of 18. Payments are entirely covered by the Regional Health Service with a maximum bed capacity for 32 (thirty-two) patients and is structured as follows:
YELLOW UNIT: 9 BEDS – DEVELOPING AGE PSYCHOPATHOLOGY 1
YELLOW UNIT: 13 BEDS – DEVELOPING AGE PSYCHOPATHOLOGY 2
BLUE UNIT: 10 BEDS – NEURODEVELOPMENT DISORDERS
The health fee includes all the services listed on page 31 to page 38 of this Service Charter, as well as specialized teaching, both carried out by internal teachers and through individualized courses in local schools; sports activities of various disciplines (basketball, rowing, football).

To these are added, according to the guest's needs, other types of services, which still purely by way of example and not exhaustively include the participation of our staff in external school meetings, accompanying the patient for administrative procedures (Photo Cards, Renewal of the ID, hearings at the Legal Protection Offices); preparation for participation in hearings at the Judicial Authority and the Juvenile Court.
Non-convention services are excluded from the health fee, i.e. those not relating to health care services of a therapeutic rehabilitation type.
Examples of non-covered services include but are not limited to, all those peripheral activities that may take place at other local facilities, local schools or by special educators at VSM: the weekly trip and periodic trips / stays in places of culture; cinema on Sundays and holidays; the accesses to the structure rehabilitation pool.
The service is always active all year long 24/7.
In accordance to law DGR X/2189 dated 25/07/2014, also for the year 2018, VSM rendered its availability for elevated cases of assistance in the NPIA type C and B (the most severe cases) in accordance to the procedures prescribed by the ATS Insubria (Local Health Agency).
Patients who have the right to request admittance are given a defined time-period at VSM and therefore accepted for **a 30-day trial period**, to evaluate the capacity of the minor to live within the community context.

1A. THERAPEUTIC COMMUNITY FOR PREADOLESCENTS AND ADOLESCENTS

The therapeutic community for preadolescents and adolescents is a residential facility for short/medium term recoveries with therapeutic, rehabilitative and educational treatment in which a period outside the family nucleus is deemed indispensable.

It is structured as follows:
YELLOW UNIT: 9 BEDS – DEVELOPING AGE PSYCHOPATHOLOGY 1
YELLOW UNIT: 13 BEDS – DEVELOPING AGE PSYCHOPATHOLOGY 2

The therapeutic community for adolescents offers an experience within which a patient can get back on track in their developmental treatment path. It aims to be a coherent structured facility for those patients whose family situation is momentarily dis-functional or undergoing extreme difficulties. By temporarily distancing the patient from his family surrounding and inserting them in a *neutral space community setting,* they can speak with professionals about their fears, anxieties and problems which have been transformed into symptoms.
Adolescence represents a critical period for the psychological growth of a person characterized by constant ambivalence: on one hand, the desire to apprehensively reach adulthood and on the other to leave the benefits of infancy. The task of growing up is difficult under the best of situations and adolescents need to construct their own identities, a sense of self as a distinct person, distinct from others and without entirely losing their ties with infancy. During this time, they establish internal references and the investiture of their first emotional relationships. This is the premise to be able to think about a tomorrow and delineate and construct a project for their future life.
The issue becomes even more problematic if the adolescent does not have a home or lifestyle with solid adult references that they can count on, confront themselves with in a constructive way and use continuous dialogue that allows for their autonomy and liberty to try new things, make their own mistakes all the while relying on a protective environment that safeguards them from the risks and perils of the world outside.
Adolescents inserted into a community facility can greatly benefit in the construction of their identity. This thanks to the possibility to be accompanied by sympathetic people who care and allow them to rethink and give meaning to their existence. Often these adolescents come from a long line of family difficulties that began in their infancy and for which, throughout the years, many attempts to intervene may have gone ire.
Adolescents are often ill-equipped to face the tasks that at their age demographic requires and must begin to come to grips with growing up. They will find that community life can be greatly beneficial due to the synergies of the multidisciplinary team of professionals that temporarily assume a fundamental educational role and promote a new balance that hopefully will improve their rapport within their family of origin.

Objectives
The therapeutic community for adolescents promotes development in young patients by rendering their development years as balanced and positive as possible.

Guiding principles
“Practical orientation to constructing an individual project, the perception of support and clarity of the rules are perceived by adolescents as elements correlated to efficiency. The fact that this period does not depend on the level of their problems, but rather on the possibility to set up treatment projects that are effective even in the most difficult of cases” (Source: website of the Institute of the Minotaur Foundation, Milan).
According to these principles, each patient admitted is given a 30 day Individual Therapeutic and Rehabilitation Plan (PTRI, the Italian: Piano Terapeutico Riabilitativo Individualizzato) with goals and methods to be carried out within the community. Each project is *tailor-made to the individual* based on needs, characteristics and potential by a team of specialists. Each professional involved in the project targets the interventions based on individual and group sessions in rehabilitative, educational and psycho-attitudinal activities. Structuring the treatment plan and its goals

is discussed and monitored over many meetings with the involvement of the Technical Updating Group (the Italian: Gruppo di Approfondimento Tecnico (GAT) and the multidisciplinary team).
The PTRI plan is shared with network operators who will partake in the patient's treatment, starting with the family, Territorial Social Services and when there are legal issues to comply with issued by the Tribunal for Minors, then also a local protection services.
Working in the formative years of a patient implicates that all stakeholders participate in a coordinated way creating a network of relationships and collaborate to creating a support and containment structure within which the patient can grow. The closer and tighter this network is, the more supported and protected the patient will feel.

Service Users
The community can take in preadolescents and adolescents between the ages of 10 and 18 years old.
Acceptance Procedure

Planning and Development of Healthcare Treatment refers to the rapport with the territorial Judicial Protection and Social Services (PSAS) who accept the request via fax or via e-mail and meets with Executive Offices of VSM and its Healthcare Team before proceeding to setting up an appointment to evaluate the case based on the documentation received.
Once the two teams view and discuss the patient's documentation, they decide whether the case is appropriate for VSM treatment. Should the result be negative, then it is the PSAS who formally informs the applicant. In the affirmative, then an evaluation is made with the patient and again it is the PSAS who sets a time for a facility tour and for the preliminary evaluations.

To be able to access the evaluation procedure, the applicant must provide the following information: name, surname, date and place of birth, telephone, address, email, diagnosis and updated medical records.

For STRNPIA recovery patient requests coming from the local territory, then VSM adheres to the ATS INSUBRIA procedure for processing requests.

Evaluation
The following subjects are involved in the evaluation:
1. The Villa Santa Maria SCS Managing Director
2. The Territorial Healthcare Planning and Development Officers who maintain a rapport with the Judicial Protection & Social Services (PSAS)
3. Healthcare Directors and/or Specialist Physicians NPIA - Pediatrics-Neurologist
4. The Applicant
5. The Patient

The PSAS and the Physician meet with the Territorial Services and/or the family based on the characteristics of the patient and evaluate when to meet and in which way.

Following this initial step, the evaluation team and the Managing Director decides whether, or not, to insert the applicant on the waiting list. It is the PSAS that formally communicates the results to the applicant.
As the recovery date approaches, in the affirmative acceptance case, Villa Santa Maria SCS recontacts the Territorial Health Services and/or the family and formally communicates in writing the effective recovery date, as well as the 30-day observation period in which the appropriateness of the patient's acceptance into the community is considered, evaluated (in consideration of the current community at Villa Santa Maria SCS) and ultimately confirmed.
• Confirming Acceptance
If Acceptance is confirmed, the treatment project is planned and shared with the UONPIA sending office, the Territorial Services and the family: types of interventions (clinical, psychotherapeutic, pharmacological and educational) as well as the duration, methodologies and monitoring times of clinical aspects.
• Discharge/Release
This data is shared with the UONPIA sending office and the Territorial Services based on the development of the clinical status and the external conditions, social and family. There is no obligation regarding patients having reached their legal age, but rather on the objectives set by the PTRI which was shared with the entire Villa Santa Maria SCS professional team and referral office and/or the family.
• Rapport with the family.
The regulations that govern the rapport with the family is decided on a case by case basis in accordance with the UONPIA referral office and Territorial Services, (considering and Judicial Authority prescription in force).

Services Offered

Healthcare Treatment

The healthcare director, NPIA specialist participate at evaluating and observing all cases and defining treatment projects in terms of pharmacological treatment and monitoring.

All pediatric-internal treatment, testing and lab analysis and other specialist treatment relative to physiotherapy, cardiology, epileptology, nutritional science are included.

Clinical Activity

1. Interventions in Infant Neuropsychiatry
2. Psychotherapy of psychodynamic treatment
3. Regular clinical status updating for each patient
4. Individual supervision in clinical cases (by way of periodic scheduling and weekly teams of professionals)
5. Meetings with UONPIA, Territorial Services and schools
6. Meetings on a periodic basis with families
7. Clinical status updates on a yearly basis to appropriate Entities involved in the project with the family

Educational Activity

Educational activity is offered as a *space for the senses* that provides adolescents protected and connected places where they can experience positive and stimulating educational experiences, where they challenge themselves and learn how to name their own emotions, to better control them. These educational activities are supervised by competent adult professionals who become a reference point of positive examples for patients; a stark contrast to earlier disorganized or disorienting adult experiences common to problematic families. Targeted to adolescents, the activities cover a wide range of interests and needs:

1. Activities in specialized individual learning if possible in level II secondary schools in their own home territory
2. Activities in socialization with local field trips
3. Activities in athletics: SOCCER, CANOEING, BASKETBALL
4. Activities in self-expression
5. Activities in psychoeducation
6. Activities in special laboratory settings
7. Multi-sensory projects (PET-THERAPY, MINDFULNESS, AWARENESS OF USING THE INTERNET, DRAMMATHERAPY, PHOTOGRAPHY…)

The Team

The multidisciplinary team at the therapeutic community is composed of the following professionals:

1. Infant Neuropsychiatry Specialists
2. Specialist Pediatricians
3. Specialist Nurses
4. Clinical Psychologists
5. Psychotherapists
6. Educational Services Manager
7. Professional Educators
8. Rehabilitation Therapists (in neuro-psychomotor skills in developing years-TNPEE; speech-therapists and physiotherapists)
9. Athletic, sports and aquatics instructors
10. Special Education Professors
11. Specially Qualified Personnel - OSS

These specialized professionals interface with one another to reach the objectives set in the PTRI, as well as collaborate with Villa Santa Maria SCS's professionals. The peculiarity of a multidiscipline team is the possibility to have diverse points of view converge, so that specific competencies can join in having a global systemic view of the patient. The therapeutic plan is constantly updated and tweaked should unforeseen circumstances arrive that create problems or deviations from the original projected treatment.

1B . UNIT FOR NEURODEVELOPMENTAL DISORDERS

The STRNPIA unit, as far as the BLUE UNIT with 10 beds is concerned, has historically been a specialist service for the developmental age (0-18 years) aimed at treating on the one hand acute neurological and psychiatric pathologies and developmental disorders, such as those requiring early intervention aimed at preventing the degeneration of skills and promoting the stabilization of deficits and/or the acquisition of new skills; on the other hand, chronic disorders, often with intense disabling potential, with reduced mental efficiency or relational abilities or physical autonomy and complex multiple needs with a high social and lifelong impact.
This type of neurological and neuropsychological pathology is also characterized by the presence of complex multiple disabilities, whether or not associated with behavioral disorders.
In this regard, without resorting to radical separations, and in the need to identify and state the criterion in use for differentiated therapeutic residential responses for users with neuropsychiatric pathologies and for users with disabilities, appropriate to the type of prevailing needs, in relation also to the different age groups, we intend to emphasize the complex relationship between clinical and mental disabilities and behavioral problems.
Complex organic disability must be necessarily framed and subjected to intensive rehabilitation treatment in the pediatric age, as otherwise it always conditions a behavioral deterioration that can be seen in all areas: irritability, agitation, aggressiveness, sleep and eating disorders.
On the other hand, a great share of our patients in the psychopathology department, better investigated at the clinical-systemic level as in-patients, have often been found to have an organic, neurological basis, and sometimes with varying degrees of intellectual disability, further confirming the inescapable interrelationship between the two areas.
In general, as already pointed out in our meetings, pathways for users with developmental disabilities are differentiated from those for users with neuropsychiatric pathologies, not only assuming the diagnostic category as an important element, but considering also the level of complexity and clinical instability. Pathways are consequently differentiated by type/level of need and consequent need for support, which is determined by the intertwining of clinical characteristics, age, therapeutic-rehabilitation needs, care needs and level of family and environmental hold/support.
The clinical records currently in the charge of the STRNPIA ward at Villa Santa Maria are emblematic in this respect: the 10 subjects as a whole have as many as 45 diagnoses (ICD10 criteria). Severe intellectual disability is constantly present, often accompanied by drug-resistant epilepsy, infantile cerebral palsy, low vision, growth retardation and digestive pathological manifestations of various kinds.
The total number of diagnoses with respect to the DSM 5 criteria is 49, with an average value of almost five concomitant diagnoses per subject. They range from subjects with two diagnoses (there are only two) to subjects with as many as seven (there are two) or even eight diagnoses.

2. RSD VILLA SANTA MARIA – RESIDENT HEALTHCARE CENTER FOR THE REHABILITATION OF NEURODEVELOPMENTAL DISORDERS IN DEVELOPING AGED CHILDREN (RSD VSM)

Accredited in accordance to law DGR n°74 dated 23 July 2008 in the decree n° 11793 dated 23/12/2015

The resident healthcare center for the Rehabilitation of Neurodevelopmental disorders in children (RSD VSM) welcomes patients during their formative years as well as young adults.
The decree n° 11793 dated 23/12/2015 has modified the total capacity to 40 patients (40 beds) with a contract with the Regional Health Service (SSR) and the fee is composed by the SSR portion valued using the SIDI scheme and a portion by social assistance, under their Territorial Services and/or by the family themselves.
The healthcare center is open all year long 24/7.
All the services listed from page 31 to page 38 of this Service Charter are included in the medical fee, as well as specialized teaching, both carried out by in-house teachers and through individualized courses in local schools; sports activities in various disciplines (basketball, rowing, football).
To these are added, according to the needs of the guest, other types of services, which can be listed as follows, purely by way of example and not exhaustively: participation of our staff in external school meetings, accompanying the patient for administrative procedures (passport photos, renewal of identity cards, hearings at the Legal Protection Offices); preparation for hearings at the Judicial Authority and Juvenile Court.
On the other hand, non-convention services, i.e. services not related to rehabilitative healthcare services, are excluded from the healthcare fee.
Only as example, peripheral activities outside the healthcare services provided by the Residential Therapeutic Rehabilitation Facility for Child and Adolescent Neuropsychiatry include: the weekly outing and periodic trips/stays in places of culture; Sunday and holiday cinema; access to the Facility's indoor rehabilitation swimming pool.

Currently the daily social assistance fee is between € 76.19 (seventy-six/19) plus current VAT and € 105.00 (one hundred and five/00) plus current VAT. It may be adjusted according to inflation and to the costs incurred by the organization.
The welfare fee must be paid within 30 days of the End of Month Invoice Date. If the Electronic Invoice is issued to a Public Entity, payment is defined as 30 days from the Invoice Receipt Date.

Expenses not included in this portion include:

1. Tickets for excursions (i.e. stadiums, cinema….);
2. Hotel stays and transport costs during RSD organized trips except when covered by the regional norms in force;
3. Expenses for assistance personnel, etc. as per the norm in force;
4. All transport (including ambulances);
5. External activities not covered in the RSD. (i.e. equestrian sports for the handicapped);
6. Dental care at private external Dentists;
7. Hair-care if done by barbers or hair stylists, pedicure, manicure beyond what is considered normal hygiene;
8. All clothing purchases (i.e. underwear, clothing and shoes);
9. All food and drinks consumed outside principle mealtimes;
10. Consumption of food in external restaurants, personal purchases (i.e. cigarettes, particular toiletries);
11. Use of external laundry services on the part of the guest, products purchased in pharmacies not classified as medicines (i.e. OTC remedies);
12. Private specialist medical consultations not covered by the RSD Health Director.;
13. External therapeutic treatment not covered by the RSD Health Director;
1. During hospitalization, the following are guaranteed: accompaniment to the emergency room; daily change of clothes, personal hygiene and the rapport with Doctors is offered within the limits prescribed by the norm.

Security Deposit: as provided by DGR. 2569/2014 of the Lombardy Region, a Security Deposit equal to the amount of the monthly fee (daily fee for 30 days) must be paid at the time the Shelter Contract is signed.

Voluntary discharge: in the case where the guest and/or their family and/or legal guardian decide to interrupt the RSD recovery, they must give written notice at least 30 days in advance of the voluntary discharge. In the case where 30-day advance notice is not given, the Entity reserves the right to retain the deposit for the said amount or to bill for the corresponding amount despite it not be used.
For whatever has not been expressly indicated above, please refer to the entry contract of each single patient that safeguards, whatever the cause for discharge, the guest's right to receive a Discharge Letter.

3. RSD VILLA SANTA MARIA 2 - RESIDENT HEALTHCARE CENTER FOR THE REHABILITATION OF NEURODEVELOPMENTAL DISORDERS IN DEVELOPING AGED CHILDREN (RSD VSM2)

Accredited according to the decree n° 11792 dated 23/12/2015

The resident healthcare center for the Rehabilitation of Neurodevelopmental disorders in children (RSD VSM2) welcomes patients during their formative years as well as young adults.
The facility has a total capacity for 33 patients (33 beds) subdivided as follows:

1. 22 beds with the SSR contract
2. 11 beds accredited but not subject to an institutional contract per se.

The healthcare center is open all year long 24/7.
Included in the medical fee are all the services listed from page 31 to page 38 of this Service Charter, as well as specialised teaching, both carried out by in-house teachers and through individualized courses in local schools; sports activities in various disciplines (basketball, rowing, football).

To these are added, according to the needs of the guest, other types of services, which can be listed as follows, purely by way of example and not exhaustively: participation of our staff in external school meetings, accompanying the patient for administrative procedures (passport photos, renewal of identity cards, hearings at the Legal Protection Offices); preparation for hearings at the Judicial Authority and Juvenile Court.
On the other hand, non-convention services, i.e. services not related to rehabilitative healthcare services, are excluded from the healthcare fee.
Purely by way of example and without limitation, peripheral activities outside the healthcare services provided by the Residential Therapeutic Rehabilitation Facility for Child and Adolescent Neuropsychiatry include: weekly trips and periodic outings/stays in places of culture; Sunday and holiday cinema; access to the Facility's indoor rehabilitation swimming pool.

1. The fee for contracted places is made up of a health fee, assessed by means of the SIDI form, and a social-welfare fee to be paid by the territorial services and/or the family.

Currently, the daily social-welfare fee is between € 76.19 (seventy-six/19) plus current VAT and € 105.00 (one hundred and five/00) plus current VAT, and may be subject to adjustment based on inflation and the costs sustained by the organization.

The welfare fee must be paid within 30 days of the End of Month Invoice Date. If the Electronic Invoice is issued to a Public Entity, payment is defined as 30 days from the Invoice Receipt Date.

Expenses not included in this portion include:

2. Tickets for excursions (i.e. stadiums, cinema….);
3. Hotel stays and transport costs during RSD organized trips except when covered by the regional norms in force;
4. Expenses for assistance personnel, etc. as per the norm in force;
5. All transport (including ambulances);
6. External activities not covered in the RSD. (i.e. equestrian sports for the handicapped);
7. Dental care at private external Dentists;
8. Hair-care if done by barbers or hair stylists, pedicure, manicure beyond what is considered normal hygiene;
9. All clothing purchases (i.e. underwear, clothing and shoes);
10. All food and drinks consumed outside principle mealtimes;
11. Consumption of food in external restaurants, personal purchases (i.e. cigarettes, particular toiletries);
12. Use of external laundry services on the part of the guest, products purchased in pharmacies not classified as medicines (i.e. OTC remedies);
13. Private specialist medical consultations not covered by the RSD Health Director.;
14. External therapeutic treatment not covered by the RSD Health Director;
15. During hospitalization, the following are guaranteed: accompaniment to the emergency room; daily change of clothes, personal hygiene and the rapport with Doctors is offered within the limits prescribed by the norm.

Security Deposit: as provided by DGR. 2569/2014 of the Lombardy Region, a Security Deposit equal to the amount of the monthly fee (daily fee for 30 days) must be paid at the time the Shelter Contract is signed.

Voluntary discharge: in the case where the guest and/or their family and/or legal guardian decide to interrupt the RSD recovery, they must give written notice at least 30 days in advance of the voluntary discharge. In the case where 30-day advance- notice is not given, the Entity reserves the right to retain the deposit for the said amount or to bill for the corresponding amount despite it not be used.
For whatever has not been expressly indicated above, please refer to the entry contract of each single patient that safeguards, whatever the cause for discharge, the guest's right to receive a Discharge Letter.

16. For the 11 patients (11 beds) accredited but not subject to a social assistance contract, currently the daily fee is between € 200.00 (two hundred/00) plus current VAT and € 300.00 (three hundred/00) plus current VAT and may be subject to adjustment according to inflation and the costs incurred by the organization.

The welfare fee must be paid within 30 days of the End of Month Invoice Date. If the Electronic Invoice is issued to a Public Entity, payment is defined as 30 days from the Invoice Receipt Date.

Expenses not included in this portion include:

c. Tickets for excursions (i.e. stadiums, cinema….);
d. Hotel stays and transport costs during RSD organized trips except when covered by the regional norms in force;
e. Expenses for assistance personnel, etc. as per the norm in force;
f. All transport (including ambulances);
g. Accompanying patients to external appointments, (i.e. administrative tasks like photo ID card renewal)
h. External activities not covered in the RSD. (i.e. equestrian sports for the handicapped);
i. Dental care at private external Dentists;
j. Hair-care if done by barbers or hair stylists, pedicure, manicure beyond what is considered normal hygiene;
k. Pedicures or manicures or any other personal choice care
l. All clothing purchases (i.e. underwear, clothing and shoes);
m. All food and drinks consumed outside principle mealtimes;
n. Consumption of food in external restaurants, personal purchases (i.e. cigarettes, selected toiletries);
o. Internal laundry and wardrobe services requested by the guest
p. External laundry or dry-cleaning services requested by the guest
q. Products purchased in pharmacies not classified as medicines (i.e. OTC remedies);
r. Private specialist medical consultations not covered by the RSD Health Director.;
s. External therapeutic treatment not covered by the RSD Health Director;
t. In the case of hospitalization, assistance to the patient for 24 hours is guaranteed
u. During a case of hospitalization, the following services are guaranteed: guests are accompanied to the emergency room (offered from 7am to 9 pm), daily clothing changes, personal hygiene assistance and the rapport with Doctors and/or hospital is offered within the limits prescribed by the norm.
v. Pharmacological therapy is also guaranteed according to the patient's treatment plan

The Regional Health Fund retains the right provide auxiliaries, principal care-givers and medicines as per the norm in effect relative to places not under contract, and in any case the minor remains in care of their own pediatrician of their own choosing/MMG.
Voluntary discharge: in the case where the guest and/or their family and/or legal guardian decide to interrupt the RSD recovery, they must give written notice at least 30 days in advance of the voluntary discharge. In the case where 30-day advance-notice is not given, the Entity reserves the right to retain the deposit for the said amount or to bill for the corresponding amount despite it not be used.
For whatever has not been expressly indicated above, please refer to the entry contract of each single patient that safeguards, whatever the cause for discharge, the guest's right to receive a Discharge Letter.

2A. AND 3A. RECOVERY FOR MINORS SUFFERING FROM SEVER DISORDERS MEASURE - DGR n° 1152/2019

CRITERIA TO ACCESS TREATMENT

1. Availability of beds
2. Applicants: minors with the most serious disabilities unable to receive homecare and that require 24-hour assistance
3. Access may be granted following a request by:
1. Parents or whomever has legal guardianship after an ATS evaluation accompanied by a UONPIA/pediatrics ward ASST diagnosis;
2. A direct invitation by the ASST once the patient has been released from hospital or an analogous facility, with the aim of moving the patient as little as possible in accordance with the ATS evaluation for full recovery.

HOW SERVICES ARE EROGATED

1. The services are provided in a full recovery regime;
2. The objectives are defined in the PI (Project per Individual) predisposed by the ATS and shared with the patient's signatory;
3. The signatory provides VSM with the voucher upon delivery of the PI;
4. Within 5 days of the recovery date, VSM provides the signatory a PAI (Plan of Assistance per Individual) which contains the objectives, areas of intervention and re-evaluation timetable which must be no greater than six months.

COST OF THE SERVICE

In accordance to DGR N. 1552/2019, and in an effort to provide the most adequate response to the healthcare needs in children with very sever clinical conditions, there are two levels of economic remuneration:

1. Medium intensity: voucher equaling €200,00(two hundred/00)/day
2. High intensity: voucher equaling €270,00 (two hundred and seventy/00) /day

The intensity levels are defined by the ATS according to the norms set out in the law DGR 1152/2019.
The norm provides for an additional cost to be integrated to the medium daily rates that is equal to but not greater than 30% equaling the high intensity profile.
The Regional Health Fund retains the right provide auxiliaries, principal care-givers and medicines as per the norm in effect, the minor remains in care of their own pediatrician of their own choosing/MMG.

4. BOARDING CENTER FOR DISABLED PEOPLE (AGAPE TERZI)

Authorisation to operate CPE submitted to the Municipality of Tavernerio for 10 beds.
Practice Code: 02144390123-13042022-1207
SUAP Protocol: REP_PROV_CO/CO-SUPRO/0053226 of 14/04/202
The service is open 365 days a year, 24/7.

PURPOSE

The "AGAPE TERZI" CAD welcomes adults with medium-severe mental disabilities of both sexes, with different fragility profiles, without family support. It is chosen by the user as his/her usual residence.

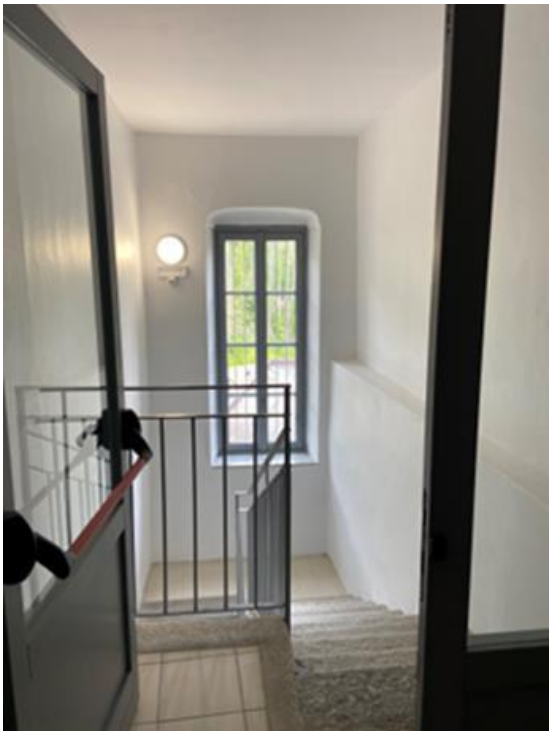
FEE

The daily socio-assistance fee is defined between a minimum amount of euro 100.00 (one hundred/00) plus current VAT and a maximum amount of euro 150.00 (one hundred and thirty/00) plus current VAT.
The hospitalization fee in the CAD will be invoiced on the last day of the relevant month with a due date of 30 days at the end of the month. If the Electronic Invoice is issued to a Public Entity, payment is defined at 30 days from the date of receipt of the Invoice.

Expenses not included in this portion include:

The following costs are not included in tuition fees

a) tickets for admission on outings and trips (e.g. stadium, cinema...)
b) hotel and transport costs incurred during outings or stays organised by the CAD, except as provided for in the relevant regional regulations
c) staff costs for assistance, in excess of what is established and recognised by the regulations
d) any transport (including ambulance) not directly managed by the residence
e) external activities not provided for by the CAD (e.g. horse riding for the disabled...)
f) dental care in private non-hospital settings
g) hair care, if done by barbers or hairdressers; foot and hand care, in addition to what is normally provided for
h) any purchase of clothing (e.g. personal underwear, clothing, shoes, etc.)
i) consumption of drinks and food outside of main meals
j) consumption of meals in external catering facilities; purchase of material for personal use (e.g. cigarettes, special toiletries...)
k) use of external laundry by the guest; purchase of products in pharmacies not classifiable as medicines (e.g. over-the-counter medicines)
l) consultation of specialist doctors in the private sphere not envisaged by the CAD Medical Director
m) therapeutic treatment outside the DAC, not provided for by the Medical Director
n) expenses for medical treatment under the solvency regime or subject to SSN Ticket (e.g. medicines, dentist, ophthalmologist, etc.)
o) monthly contribution for access to the Centre's swimming pool.
p) in the event of hospitalization, 24-hour personal care. During hospitalization, the following are guaranteed: accompaniment to the emergency room during daylight hours (07.00 - 21.00), daily change of clothes, personal hygiene and liaison with doctors, within the limits set by the regulations for the assistance due to the guest according to class.



Health fulfilment management: CAD AGAPE TERZI cooperates with the guarantor, should he deem it necessary and request it, in order to complete the bureaucratic-health practices concerning the guest.

The Regional Health Fund is responsible for the provision of aids, aids and medicines as provided for by current regulations for non-contracted places. Therefore, the guest maintains registration with his or her general practitioner (GP).

VILLA SANTA MARIA SCS
Centro Multiservizi di Neuropsichiatria dell'Infanzia e dell'Adolescenza

Child Care Center
Neuropsychiatric Rehabilitation Center

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Security Deposit: a Security Deposit equal to the amount of the monthly fee (daily fee for 30 days) must be paid at the same time as signing the Hospitalisation Contract.

Voluntary resignation: in the event that the guest and/or his or her family member and/or guarantor decide to terminate the stay in the DAC, prompt written notice must be given, and in any case at least 30 days before the date of the patient's voluntary resignation. In the event of failure to give notice, the Institution reserves the right to retain any security deposit, or to charge the tuition for the corresponding month not used.

For anything not expressly indicated, please refer to the individual patient's admission contract; it is specified that, whatever the cause of discharge, the guest or the person entitled will receive the Letter of Discharge.

Guests' objects: the Management declines all responsibility for objects brought into the residence that are not expressly requested by the residence staff or declared by the guest or his guarantor when he enters the residence.

B. SEMIRESIDENTIAL TREATMENT

DAY HOSPITAL FOR INFANT AND ADOLESCENT NEUROPSYCHIATRY (CDNPIA)

Semi-residential treatment is dedicated to minors suffering from neuropsychic disorders that need specialized didactic, educational, therapeutic and rehabilitative interventions in social support for the wellbeing of the child and constitute an important component in the network of services offered in infant and adolescent Neuropsychiatry.
Minors with neuropsychic disturbances causes difficulties for their proper social and emotional functioning, with complex needs, and correlated problems connected to the somatic comorbidity that necessitate interventions by multi-professionals and are taken under care by the Territorial service in infant and adolescent Neuropsychiatry (UONPIA) who predisposes semi-residential therapeutic-rehabilitative treatment.
Insertion takes place exclusively via the UONPIA's procedure of professional consensus for proper clinical practices based on appropriateness criteria as an "active" and not a "passive" process.
UONPIA's office follows and monitors the progress of the interventions with their own reference (quality control) operators.
SEMIRESIDENTIAL TREATMENT provides a daytime service, accommodating users with care and clinical rehabilitation needs that allow them to remain in the family and socio-educational context of reference.
The service operates Monday to Friday from 8 a.m. to 4 p.m., all year round, including the summer period.

This Neuropsychiatry of Childhood and Adolescence Unit, whose standard services are affiliated with the Regional Health Service and therefore not paid for by families, aims to operate effectively in the integrated service network, contributing to ensuring, in particular for children, pre-adolescents and their families, a global and multidisciplinary rehabilitative approach.

The transport service is guaranteed by the patient's municipality of residence or by the family itself.

FOOD SERVICE

Food Service is provided between 11:45 a.m. and 1:00 p.m., assisted by trained staff.
Special menus for religious observance are provided.
For the provision of Food Service, a daily contribution of 5.00 euros plus 5% current VAT is required, to be paid at the end of the month based on the actual attendance of the child.

Services included in the fees:

REHABILITATION SERVICES
- Cycles of rehabilitation therapy with specialized operators FKT- TNPEE- LOGOPEDIA
- Prescription of aids.....
- Use of aids during stay at the Centre,
- Monitoring of the aid in use;

- Adaptation of customized aids
- Maintenance work on the assistive device, in collaboration with specialized laboratories.

EDUCATIONAL SERVICES

SPECIALIZED EDUCATIONAL SERVICES
In cooperation with the Lombardy Regional School Directorate, for the detached section of the local comprehensive school, activated at our Rehabilitation Presidium, or through parental education, until the completion of compulsory schooling.

C. CLINICAL TREATMENT

INFANT NEUROPSYCHIATRY CHILDCARE CENTER

The Infant Neuropsychiatry Childcare Center deals with:
• simple and complex neurodevelopmental delays, disorders of the autistic and non-autistic spectrum (cognitive delays, developmental delay / language disorder / motor function, communication and relational skills disorder)
• childhood, pre-adolescence and adolescence psychopathology (behavioral disorders, of the oppositional-provocative type, of the disruptive type, of the dissocial type, alterations in eating behaviors, school and / or social withdrawal, disorders of the emotional-affective sphere, ...)
• congenital and acquired cerebropathies, with motor impairment and mental retardation of varying degrees
• neurodegenerative and metabolic diseases on a genetic or dysmetabolic basis
• primary and secondary epilepsies

NEUROPHYSIOLOGY AND NEUROMODULATION DAY HOSPITAL

The Neurophysiology and Neuromodulation day has been active in Villa Santa Maria since October 2019.
The center is equipped with a latest generation Micromed digital EEG for the acquisition of the EEG signal and a Micromed equipment for the acquisition of auditory and visual evoked potentials.
Thanks to the contribution provided by UniCredit through the Carta Etica Project, Villa Santa Maria has acquired an advanced software for the analysis of the EEG signal.
The new equipment makes it possible to carry out appropriate and in-depth analysis, improving the Centre's capacity for diagnostic, therapeutic and rehabilitative intervention.
The electroencephalogram represents indeed a useful tool for reaching a diagnosis as early as possible in the field of pediatric neurology. Having a high-performance and cutting-edge equipment means being able to guarantee the access to a non-invasive and low-cost examination to a higher number of pediatric patients, and subsequently intervene in an accurate and timely manner with the clinical diagnosis and therapy.

HOW DOES THE EXAMINATION WORK?
The EEG signal is collected through the use of a headset that is applied to the patient's head.
The examination can be performed both in wakefulness and in sleep deprivation and may also involve the acquisition of other biological signals (ECG, EMG, Breath).
The test is not painful and is generally tolerated by all children.
Parents can be present during the entire examination and, at the same time, see from the monitor of the recording room the scrolling of the electroencephalographic trace during its acquisition.

DENTAL CLINIC

The Dental Clinic has been active since December 2018 thanks to the contribution of the Fondazione Comasca as part of the project "Improvement of oral health in patients with serious disability, prevention, care of gingival inflammation", achieved in Collaboration with the University of Insubria, Faculty of Medicine and Surgery, Degree Course in Dental Hygiene.
Our dentistry clinic is specialized in the care of patients of pediatric age and / or with little cooperation. In fact, the staff is specialized in welcoming, assistance and care of children with difficulties, activating different strategies in order to get the patient at ease making treatment as possible and effective.

The dental services are accessible on appointment.

The facility offers the following clinical services:
1. With a Regional Health Service SSR convention
2. With private health coverage conventions
3. With a payment scheme.

APPLICATION PROCEDURE AND ACCEPTANCE

The proposal for rehabilitation treatment at the Villa Santa Maria Offices is formulated in writing by e-mail by the territorial UONPIA of reference of the minor.

The Management Secretariat fixes the appointment with the applicant and the multidisciplinary team which will assess the appropriateness of the request by filling in the "Assessment Request" form.

The multi-disciplinary team of reference with the Directorate assesses and verifies the degree of priority in the waiting list through the analysis of form DGM016A (See attachment no. 2), in which the criteria for prioritisation are specified.

The clinical assessment of admissibility of the treatment proposal carried out by the Villa Santa Maria team is aimed at verifying whether the rehabilitation opportunities offered are the most suitable and appropriate to the minor's needs.

If the outcome of the assessment is positive, the name will be placed on the waiting list.

The rehabilitation pathway envisages periodic checks of the project with the sending Service and with the family and continuous monitoring of the clinical aspects through the application of standardised assessment scales.

The average time to complete the assessment procedure is approximately 30 working days.

The average waiting time for admission to the CDNPIA is about 12 months. For residential admission, the average waiting time for placement in the RSD or STRNPIA is also 6 to 12 months.

The rehabilitation project foresees periodic verification by regional health officers and an annual clinical aspects verification which has a standardized evaluation scale upon which progress is measured.

MANAGING THE WAITING LIST

The Villa Santa Maria SCS waiting lists are:
1. Managed separately for each service
2. Instituted and updated each time Villa Santa Maria SCS Executive Management authorizes a new patient on and off the list
3. Managed by the Planning and Development Service through local Healthcare and Villa Santa Maria SCS Executive Management

The assessment of place availability takes into account the clinical type, chronological age and homogeneity of the clinical picture, including the assessment of any clinical and/or social priorities, in cooperation with the sending UONPIA and/or Territorial Service.

The waiting list is structured as follows:

For sociomedical (RSD) and social (CAD) Offer Units

▪ Chronologically according to the date of conclusion of the VSM team's assessment process (ref. Waiting List Confirmation Form);

▪ Waiting List release takes into account the financial coverage for the social assistance quota;
▪ Priority is given to minors who are recipients of judicial orders of removal or abduction, resident in the territory of ATS INSUBRIA.

For the Health Service Units (STRNPIA and CDNPIA)
▪ Upon successful admission assessment, for the STRNPIA and CDNPIA, placement on the waiting list is based on the date requested by the sending Service (UONPIA);
▪ The Waiting List is drawn up taking into account the availability of places in relation to the operating unit;
▪ Priority is given to minors who are the recipients of judicial removal or abduction orders, resident in the ATS INSUBRIA territory.

In the event of confirmation of inclusion on the waiting list, written confirmation is provided to the applicant.

In the event of an assessment of unsuitability, according to the rules on appropriateness, the applicant is formally notified of non-inclusion on the waiting list.

The prerequisites for inclusion on the waiting list are:
1. For places accredited and under contract with the SSR of the Lombardy Region, residence in the Lombardy territory and an age between 0 and 18 years.
2. For accredited places not under contract with the SSR (available only in RSD VSM2), without prejudice to the requirement of being between 0 and 18 years old, the patient's residence may also be outside the Lombardy Region.

Release: The need to undertake a discharge, or not, is evaluated in collaboration with the UONPIA patient referral office and the Center based on the clinical/rehabilitative/social records and is communicated to the family in a joint meeting.
The Center is available to collaborate with the family and Territorial Services to guarantee the continuity of the individual project for each patient.
Discharge can transpire on formal request by the family or when they decide to spontaneously interrupt the rehabilitative project at out Center, according to the conditions prescribed in the admissions contract.
Patients are not required to reach the age of majority.
At the discharge/transfer to another facility or Healthcare Service location the discharge letter releases the reports, the health status, the treatments completed and the necessity for eventual successive treatments and all the information to insure treatment continuity.

CRITERIA FOR DISCHARGE OR RELEASE

Causes for contract resolution or discharge include when:
a) the therapeutic project(PTRI) or rehabilitative individualized project PRI) is not shared with the supporting regional administration by the family
b) the conclusion of the terms for temporary admission
c) when pathological situations arise that require the treatment of specialized services with full-time recovery in such a facility for a period of more than 15 days
d) problematic behavioral issues which were not disclosed at the time of admission and that the center is not able to manage properly
e) when patients reach the age of 18
f) when financial obligations are not met
g) when family administers any type medicines or gives the patient foodstuffs or beverages not authorized by the Health Services Director at the Center.
h) in the case where the Health Services Director retains there has been a fiduciary breech between the family, or the legal guardian of the patient and the Center's professional operators.

Villa Santa Maria SCS does not release any patient without having previously notified the competent UONPIA and the social services of the city of residence as well as of course, the family.

The procedure to follow includes:
1. PATIENT STATUS VERIFICATION (Villa Santa Maria SCS clinical team meets and assesses the treatment plan on a rehabilitative clinical progress point of view and plans the eventual release); to be done 12 months before discharge
2. SOCIAL SUPPORT INTERVENTIONS (Villa Santa Maria SCS clinical team meets with parents/tutors Social Services; updating clinical report on patient status)
3. ACTIVITIES WITH OTHER TERRITORIAL SERVICES (Villa Santa Maria SCS Executive Director meets other facilities, other health structures at the center with the VSM clinical team or at other facilities) prepares clinical files to share

4. RELEASE LETTER: the discharge letter is written by the clinical team, availability to accompany the patient to a new facility if requested). This official letter is delivered to the patient family on the release date.

WORK METHODOLOGIES

ABA (Applied Behavior Analysis)

Behavioral analysis can be defined as the science that studies psychological interactions between an individual and their environment and how that method forms part of the natural sciences.

It includes three main branches:
1. behaviorism (as a philosophy of science)
2. experimental analysis of behavior (research)
3. applied behavioral analysis

The last area of study is designed to apply the data that derive from analysis of behavior aimed at improving the relationship that exist between specific behavior and the external environment. It satisfies diverse functions like describing the interaction between an organism and its environment, explaining how such interactions take place, forecasting their characteristics and the future probability of their reappearance, influencing their form, frequency and function, etc.
One of the fundamental characteristics of the ABA is that is it evidence-based. An expert in behavioral analysis adopts exclusive procedures that scientific research has demonstrated to be effective by applying them to scientific rigor and constantly monitoring the results achieved. Scientific rigor and methodology thus are of fundamental importance.

The attention of ABA is aimed at socially significant behavior (scholastic, social, communicative and adaptive abilities) this renders it apt to be applied to all types of interventions and not, as is commonly and erroneously thought, only to autism. Certainly, and precisely thanks to scientific rigor and methodology, it has obtained numerous successes in the field of general disabilities and autism in particular, thus this is why it is applied in these sectors.

PECS (Picture Exchange Communication System)

Communication is defined in psychological circles as an interactive exchange between two or more participants, equipped with reciprocal intentionality, able to share a specific meaning based on symbolic and conventional systems according to a cultural of reference. Communication permits people to determine their own personality and to implement interactions, with important social consequences and the efficacy of their own actions in their daily life.
Many disabled children, particularly with autism, have difficulty interacting and communicating as they do not possess vocal language, or it is reduced and not very intelligible. Their way of communicating is inefficient, as children tend to isolate themselves or to activate a set of behaviors (often not socially acceptable) to reach their desired goals or, when unsuccessful, to manifest their frustration.
The PECS method permits the use of a social communication instrument that as the advantage of encouraging functional interaction with others by way of adequate behavior, promoting the spontaneity and initiative in the child.
The learning path is subdivided into 6 phases: in the first 2 the child learns how to exchange cards and to look for an interlocutor, successively they learn to discriminate amongst symbols until they can build a sentence to make an articulated request or a comment.
By way of the experience in these years, we have fine-tuned the interventions by moving the therapeutic setting from an individual context to a group one, proposing simultaneous learning to different children that frequent the same class. Teaching to functionally communicate throughout

the school day and in the environment frequented by the child daily, notably favors the successive generalization of the method in other extra-scholastic environments and with different interlocutors. The group context is particularly effective to learning thanks to the presence of peers who serve as a model of imitation.

TEACCH (Treatment and Education of Autistic and related Communication Handicapped Children)

Teacch is a State Service Organization created at the University of North Carolina, USA by Eric Schopler and his collaborators some 30 years ago. It offers autism patients and their families training and consulting services in local schools. The Teacch services continue also for older patients, thereby responding to work related training for autistic people in adulthood.
Therefore, Teacch is not a method, nor is it treatment for children, but an integrated interventions service.
The methods and methodological instruments change based on the experience and the ideas of parents and healthcare operators.
A well planned Teacch program can transpire in all the significant environments for a child: home, school, clinics and is composed of 80% evaluation tasks that have been "completed", that is, already present in the children's repertoire, however which now are promoted for independent use, and 20% new learning that are termed "emerging" abilities. Tasks are simple, necessary and useful in the fundamental areas of autonomy, communication, work and leisure time.
The space must be projected to help the child understand where certain activities are to be taught: a daily plan is defined and communicated to the child with means appropriate to their comprehension. These means are often visual, as in photographic sequences or drawings, or visual-tactile, as a sequence of objects, or yet written words or diaries or schedules.
This methodology permits the management of so-called "behavioral problems", that disturb and preoccupy people around the child. A fair amount of these problems arises from the confusion the environment presents for the autistic children, but are reduced when the child encounters an organized environment according to principles of structured learning.

DIR (Developmental Individual Differences Relationship)

The "DIR Model" represents a rehabilitation treatment approach for children with severe relational and communication disorders.
It was created by Stanley Greenspan and Serena Wieder (Washington DC, 1997) and considers the individual differences in the way each child receives information from the world around them, ow it is elaborated and ow they respond to them, key elements to build relational patterns with the people and environment around them. The model also is centered on the creation of emotive significative relationships as real developmental learning promoters.
The DIR Model is based on an attentive observation of the natural interests of a child, their motivation and peculiar way of interacting with external environments that allows the operators to enter in their world and slowly to bring them towards another universe of sharing. This is impossible if one does not know the individual profile of each child. For this reason, the method leaves the generalities to enter into the world of every single patient, elaborating a made-to-measure treatment in accordance with the child's profile.

The DIR proposes a healthy development model for each child in an appropriate rapport with the capacities that they must mature over time to fully express their intelligence and social skills. These capacities are often absent in children with serious relational and communication disorders.
The DIR Model, referring to the most recent research, proposes an intensive, systematic, and enlarged intervention that involves all the life settings in the life of a child. Keep in mind that to rehabilitate, it is not sufficient "an hour of psychomotor skills" or "two hours of speech therapy" because the complexity of the disorder requires and enlarged program of re-enabling.
This model involves families and schools: together they can develop specific functional capacities that are restricted if not altogether absent in autistic children with developmental disorders.

ACTIVITIES

The Professional staff works in teams to acknowledge the objectives set out for each patient by way of the planning of the Individual Therapeutic Project (PTRI) or the Individual Rehabilitative Project (PRI) with periodic meetings to verify the progress of each patient.
The PTRI or the PRI is the annual plan the specialist physician of the NPIA/pediatric neurology complies after observations of the professional operators at the facility and their treatment, which is analyzed and validated by the Technical Detail Assurance Group GAT, composed by the specialist doctor, a clinical psychologist, head trainer for professional operators, and the head rehabilitation therapists.

PROFESSIONAL STAFF

All the professional staff possess a degree or a technical diploma for their professional profile as per requisites of the norm in vigor on accreditation.
While respecting the provenance of staff members, they are required to have a good working knowledge of Italian for the communication/interpretation of the rapport with guests and their families.

Staff operating on a 24-hour basis:

Medical personnel, which consists of doctors of different specializations:
- paediatrics
- paediatric neurology
- child neuropsychiatry
- cardiology
- epileptology
- pneumology
- gastroenterology
- dentistry
- orthopaedics
- physiatrics
- otorhinolaryngology

➢ Professional nurses: provide nursing care;
➢ OSS staff: ensure personal care and assistance
➢ Clinical psychology service
➢ Psychotherapy service
➢ Neurophysiopathology service
➢ Rehabilitation therapists (physiotherapist, developmental neuropsychomotricity therapist, psychomotor therapist, speech therapist)
➢ Sports Activities Instructor and Swimming Activities Instructor
➢ Health and socio-pedagogical professional educators
➢ Administrative staff

CLINICAL ACTIVITY

Villa Santa Maria SCS provides the following clinical activities:

1. A) Basic medical assistance: At the time of admission, the facility assumes full health responsibility for the guest and the facility's doctors become the guest's primary care doctors.

The medical staff guarantees a daily presence except for Saturdays, Sundays and holidays. During these days and during at night, when the doctor is not present in the structure, an availability expected. A 24/7 presence of qualified nursing assistance is also guaranteed.

During the hospital stay, guests are subjected to basic medical assistance with periodic clinical re-evaluations, verification of therapeutic needs and monitoring of the progress of therapy. These are standard methods of clinical evaluation of general pediatrics, with particular regard to

nutritional balance and regular statural and weight development. Periodic fall risk assessments and pain monitoring are also carried out. In the case of pre-existing chronic diseases, specific checks are carried out as per specialist indications.

The following activities are also guaranteed:
• vaccinations as part of vaccination programs promoted and organized by the Region and / or the ATS
• the health education of the patient and his family, counseling for the management of the disease or disability and the prevention of complications;
• execution of the screening required by national legislation and regional legislation
• certification of suitability to carry out non-competitive sports activities only in schools, following a specific request from the competent school authority
• variable biohumoral tests in relation to the needs of the subject
• routine radiological examinations (in hospitals)
• assistance and management of acute situations with emergency interventions.

In the hospital wards with high health intensity, the management of aids for enteral nutrition (nasogastric tube, PEG) and for respiratory assistance are guaranteed.
If necessary, instrumental investigations and specialist visits are carried out either at the facility by external consultants or at accredited external health bodies:

2. **B) Specialist Activities** including:
1. Epileptology, with an evaluation of the pathological therapy with neuropsychiatric testing instruments (EEG in sleep and while awake) and polysomnography while in bed of the patient, evoked visual and auditive potential.

w. Physiatry
x. Physiotherapy
y. Cardiology with ECG
z. Pneumology
aa. Dentistry with bedside screening
bb. Otolaryngology
cc. Anaesthesia care

2. **C) Infant and Adolescent Neuropsychiatry**: specialist visits, PTRI and PRI planning with a multidisciplinary approach that provides all the neuro-psychomotor, cognitive, behavioral and communication treatments listed below:

1.
2. **I. Neuro-psychomotor reporting**

The study and evaluation of the psychomotor report is based on the following:

1. Maturity and wealth of motor skills with respect to age, chronology of analysis of movements, reason form movement in reaching an object of particular interest or the exploration of the surrounding areas.
2. Orientation and eventual presence of motor stereotipie (i.e. winking, flickering, rocking of the head,) and choreographed movements of the upper limbs.
3. De-ambulation analysis without or with eventual support with particular attention to tiptoe walking to knee or hip jerking to the width of the support base, and the presence of frontal and lateral parachute reflexes
4. Analysis of ability to run, jump, climb stairs, descend stairs, bipodal balance while static or dynamic and with or without support
5. Analysis of postural passages (i.e. from prone to kneeling and from supine to long sitting), from pointing, to reaching towards objects using grasping, to eye hand coordination and more in general the spatial temporal organization

6.
7. **II. Cognitive behavioral reporting**

For the cognitive behavioral report, the focus is represented by the evaluation of the following functions:

1. Attentive ability, eye contact, discontinuous visual following, imitative capacity, comprehension of spatial changes, and the passage of time
2. Possibility to introduce functional table activities with the aid of an adult (consistent attempts at painting and manipulative creating) Such activities are possible for a few minutes at a time due to the pathology
3. Presence or absence of symbolic playing
4. Presence of stereotipie, more or less complex, consistent for example in the flickering of the hands, vocalizing and semi-rotational posturing

5. Presence of aggressive behaviors
6. Acceptance of body contact and other interactions with adults
7. Presence of spontaneous playing with deliberate choice of materials
8. Tolerance to frustrations or negations
9. Ability to discriminate, classify and associate objects or images
10. Recognize persons, rules and family surroundings
11. Graphomotor skills

III. Linguistic communicative reporting

The study of this component considers a series of elements, the most important of which include: communicative intentionality, the richness of verbal and nonverbal language and facial mimicking in situations of discomfort or pleasure, the most used communicative channels with respect to proximity (interpersonal distance) and posture, particularly the comprehension of verbal and non-verbal messages.

IV. Personal autonomy reporting

CLINICAL PSYCHOLOGY SERVICE

1. PSYCHODIAGNOSIS ACTIVITY:

Applying psychological and neuropsychological tests for the functional cognitive assessment of patients with various disorders.

The following testing instruments are used to measure the diagnostic level severity for patients during their formative years:

Intelligence Scales evaluation of verbal ability and overall intellectual capacity.
WIPPSI III: Wechsler for preschool and elementary school aged patients
WAIS-R: Wechsler for adults (from 16-17 years of age and up)
WISC-IV: is the clinical instrument par excellence and administered individually to evaluate cognitive capacity in children from 6 to 16 years of age.
LEITER-R: (Leiter International Performance Scale-Revised): general non-verbal abilities are measured in children and adolescents usually from 2 to 20 years of age (also possible as early as 11 months)
GMDS III: Griffiths Mental Development Scales patients 0-8 years of age
TEST BVS: evaluation of visual and special memory on 6 years old and up
TEST TOL: evaluation of command functions from 4 to 13 years of age
CPM Coloured progressive Matrices: Raven's Progressive Matrices measure non-verbal intelligence throughout intellectual development, from childhood to maturity, regardless of cultural level.

Tests measuring specific learning disorders
MT Cornoldi (reading comprehension): diagnostic instrument for evaluation of dyslexia in primary school (grades 1° and 2°)
MT Cornoldi (reading comprehension): diagnostic instrument for evaluation of dyslexia in primary school (grades 3°, 4° e 5°)
MT Cornoldi (reading comprehension): diagnostic instrument for evaluation of dyslexia in secondary school grades 9 and 10
DDE-2: diagnostic instrument for evaluation of dyslexia and evolutive dysorthography for primary (grades 1, 2, 3) and secondary school (grades 9, 10)
BVSCO-2: battery for evaluation of writing and spelling in primary (grades 1, 2, 3,) and secondary school (grades 9.10)
BIA: battery Italian for ADHD ages 5-13 years old
Test AC-MT 6-11: diagnostic instrument for evaluation of calculation ability, math skills in primary schools
Test AC-MT Cornoldi (11-14): diagnostic instrument for evaluation of calculation ability, math skills in secondary schools
Test AC-MT Cornoldi Advanced (reading) 1: diagnostic instrument for evaluation of reading for grade 11 secondary schools
Test AC-MT Cornoldi Advanced (reading) 2: diagnostic instrument for evaluation of reading for grade 11 secondary schools
Test AC-MT Cornoldi Advanced (mathematics) 1: diagnostic instrument for evaluation of mathematics grade11 secondary schools
Test AC-MT Cornoldi Advanced (mathematics) 2: diagnostic instrument for evaluation of mathematics grade 12 secondary schools
AC-MT 3 Cornoldi Test - 6-14 years new tests to assess calculation and reasoning skills.
Test BDE 2: Battery for Evolutive Dyscalculia (grade 4 and 5 primary)
Test Q1 VATA: battery for evaluation of transversal learning abilities 8-11 years of age

Test Q1 VATA: battery for evaluation of transversal learning abilities 11-14 years of age
Test BVN (5-11): battery for evaluation of neuropsychology in developing years 5-11
Test BVN (12-18): battery for evaluation of neuropsychology for 'adolescents aged 12-18 years
Test PRCR-2: prerequisite tests for preschool and first 2 years of primary school
Test NEPSY-II: battery for neuropsychology evaluation in developing years aged 3-16
Test VAUM eLF: battery for evaluation of aural attention in 4-12 years of age
Test PROMEA: battery for global memory in 5-11 years of age
Test CMF: evaluation of metaphonological skills
BHK scale: for developmental age-quantification of developmental dysgraphia
AMOS test 8-15: 8 - 15 years - assessment of motivation and study skills

Specific Tests for Autism

ADI-R: interview to obtain complete diagnostic information in evaluation of autism spectrum
ADOS 2 (Autism Diagnostic Observation Schedule): measures the spectrum of disorders connected to autism; permits diagnosis criteria according to DSM IV and ICD 10
SCQ: questionnaire that evaluates communication, social and relational skills in children that may be autistic or have signs of the autism spectrum
PEP-III: psycho-educational profile for evaluation of autistic children or those suffering from generalized developmental disturbances from the ages of 2 to 12 years.
TTAP TEACCH- Transition Assessment Profile: evaluates the significant abilities to reach autonomy in daily contexts (home, school, facility centers, residential facilities, etc.) for children suffering from the autism spectrum disorder.
GARS Scale (James E. Gilliam): evaluation scale for autism diagnosis of children aged 3 -22 years

Other evaluation tests

B.A.B.: (Behavior Assessment Battery): development deficit analysis to plan psycho-pedagogic programs for severe/extremely severe cases of all ages
WeeFIM Scale**:** evaluation of autonomy and level of assistance required in caregiving a patient in transfers, communication, relationships from age 3 onwards
Denver Test**:** measures the learning of separate stages of child development from the first month to 6 years of age in the following areas: personal and social behavior, fine and gross motor skills, language and communication
Test PSI-SF: measures family stress levels and the origin of the stress from 1 month to aged 12 in chronic patients
Test SIS: determines emotional needs of a subject with intellectual disorders and defines the necessary support to reach improved functioning beyond the age of 16
Vineland Adaptive Behavior Scales II: evaluate personal autonomy and social responsibility from birth to adulthood. These tests are given to normal developing children as well as those with cognitive disorders to permit planning interventions in terms of individual educational and rehabilitative programs, parental or caregiver interviews for subjects with cognitive disorders from age 6 to 60.
TPV: evaluation of general visual perception – visual perception with reduced motricity, visuomotor integration from ages 4 to 11
TEMA: evaluation of learning memory for ages 5 to 19
VMI: Evaluation of visuomotor integration from ages 3 to 18
SR 4-5 SCHOOL READINESS: evaluation of basic abilities when going from primary to elementary school, 4-5 years
VAP-H: observation scheme for the evaluation of psychopathological handicaps
LAP (Learning Achievement Profile) for pupils with mental retardation from 3 to 10 years of age
TLR: evaluation of receptive language for all ages
ABAS-II (Adaptive Behavior Assessment System – Second Edition): this scale evaluates daily abilities in subjects aged 0 to 89 with pervasive developmental disorders: mental retardation, neuropsychological problems, dementia learning disorders biological risk factors, sensorial and physical disorders.
K- SADS- PL: Diagnostic instrument for psychopathological disturbances in patients aged 6 to 17.
HONOSCA: evaluation scale for global functioning of psychiatric symptomology in children e adolescents
C-GAS/DD-C-GAS: evaluation scale for clinical global functioning for children and adolescents, with or without disabilities
BLACKY PICTURES: Personality Diagnostic Instrument for ages 6 to 11
Linguistic comprehension test - RUSTIONI: to evaluate morphosyntax
PEABODY: to evaluate lexical ability
TAT: for adolescents/adults- Personality diagnostic tool
CAT: for children 3-10- Personality diagnostic tool
Duss Fables: for children- Personality diagnostic tool
Tree Reactive (Koch): from 4 years upwards-Diagnostic tool of psychic evolution

MMPI-A: 14-18 years old- Psychodiagnostic questionnaire

2. INTERVIEWS AND INTERVENTIONS TO SUPPORT PSYCHOLOGICAL & PSYCHOTHERAPEUTIC TREATMENT
children and adolescents with mental retardation and psychiatric disorders

3. INTERVENTIONS OF COGNITIVE REHABILITATION
children affected by diverse levels of intellectual disorders (light, medium or sever mental retardation)

4. EXPERIMENTAL EMPIRICAL RESEARCH
(research protocols, information generation by interviews tests, etc.)

5. OBSERVATIONAL ACTIVITIES
Psychological data collected and elaborated for clinical purposes

6. TRAINING ACTIVITIES
Periodic for educators, inters, trainees in observation ABI, VAP-H and CARS

7. MULTIDISCIPLINARY TEAM PARTICIPATION

PSYCHOTHERAPY SERVICE

Non-pharmacological interventions 2

Multimethod Interventions. With this expression we refer to "multiple" interventions in which many activities are simultaneously provided (with the patient, family, school, life context etc.), which may each have partial but integrated goals to satisfy the personal yet flexible or varying needs of each patient. These are fundamental in complex and multi-problematic cases.

Psychotherapy
Cognitive-behavioral therapy
It is the combination of two treatment types, behavioral therapy and cognitive therapy of brief duration whenever possible. In first-generation therapy, prevalently behavioral the focus is above all on the introduction of behavioral changes by way of techniques like operational and classic conditioning to learn new ways to react. Second generation therapies have included cognitive interventions as key strategies in modifying behavior, with the goal to be able to confront irrational thoughts, dysfunctional, negative or erratic behavior and substitute them with more functional, realistic, rational and positive ones. Third generation therapy (like Acceptance and Commitment Therapy – ACT – and Dialectical Behavioral Therapy – DBT) accentuated the importance of awareness and acceptance of oneself to transform the relationship of the patient with their own thoughts and sensations and to interrupt the existing dysfunctional conflict.
Systemic-relational therapy
Considers the patient as an integral part of the relational system and evaluates the base symptom to the context and its specific characteristics. The patient is seen as a carrier of the symptoms in the family and therefore of dysfunctionality itself. This therapy is geared towards modifying the relational styles within the family nucleus and hence because of the individual rapports of the patient. It acts on the entire system and not on the single member, by way of number of limited sessions with the entire family.

Psychodynamic therapy
This therapy is aimed at learning more of unconscious processes and to rebuilding the past relational dynamics and intrapsychic conflicts to understand the causes and increase the awareness. It originated from psychoanalysis but has its foundation in relational therapy. It is generally a long-term therapy despite that fact that in recent years new short-term models have begun to be used both for adults as well as for children in their developing years and aims to modify the intrapsychic structure that underlie the symptoms.

Psychoeducational Interventions
Psychoeducation is a specific form of education that includes an array of targeted interventions aimed at helping the patient and their families to acquire and maintain those competencies that permit them to optimally manage their lives with the disorder they must bear. This form of therapy is important in mental health treatment as well as in other specialties. Depending on the illness and the age of the patient, this therapy intersects

with increased awareness in an individual as well as a group developing self-control, problem solving, collaboration and thus provides important information to be shared across other treatment branches and competences.

Counseling
Together with other non-structured interventions in which the patient and/or their families and/or their teachers are listened to, supported or guided in the best way to manage their situations and contexts.

Parent Training
Structured interventions of 8-10 meeting cycles, each one specifically themed, in which the parents are supplied with information on their child's disorders. They receive a range of educational strategies appropriate to the characteristics of the illness. Information on their child's condition helps modify the negative interpretation they give to the behaviors. These meeting may be in group formats (a method that permits heightened sharing of experiences and maximizing resources) or individual (referring to the couple or, as the case may be, to the single parent).

Teacher training
These interventions with teachers are an integral part of accepting patients with neuropsychic disorders. The aim of these structured interventions is to learn to recognize the signals of eventual discomfort in students, acquire more awareness, problem solving competences in managing those students with these disturbances and to favor teaching that includes them into the learning process. Periodic meetings with parents helps monitor the overall progress and allows treatment guidelines to be shared.
Information on the illnesses and the instruments to do proper and accurate evaluations of the possible treatments are held. Particularly noteworthy is the information that helps the learning curve of the patient in a classroom setting. These sessions are usually held in groups.

THERAPEUTIC REHABILITATION ACTIVITIES

Physiotherapy

The work begins with a physio-kinesiotherapy evaluation that reveals the global motor skills of the child to identify how able they are to adapt to their environment and to what extent interventions of assistance or auxiliary help from third parties are needed.
Much attention is dedicated to an analysis of autonomous movement, both in terms of quantity (WHAT the child does or could potentially do) as well as in terms of quality (HOW it is done). Therefore, careful attention is paid to: functional level reached, autonomies and eventual transport strategies, manual ability, posture, straightening out needed, the richness of motor schemes used, capacity to adapt and eventual retractions and deformities.

Methodology in treatment
After the evaluation, the therapist defines the individual strategies for the child that sustain their evolution by favoring those which are spontaneously adopted.
An effective rehabilitation must activate each selective movement possible into a functional activity and never allow movements to be an end in and of themselves. By correcting posture, the patient is assisted to prevent a degradation or deformity of their posture. The main elements of treatment are place or setting, games, roles, proposals and interaction.

The setting is a defined, prepared and structured place thought of in advance based on the objectives of the child's treatment and the opportunities it provides. The games played must be accurately selected and, where necessary, modified or adapted to the single needs of the patient while still being stimulating and adequately calibrated to the potential functional goals.
It must not be an absolute therapeutic exercise, nor a technical or methodological solution alone. The therapist must integrate their knowhow and experience to structure a proposal correctly adapted to the child, for a specific function and aim, which in that very moment is interesting and important for the patient.

Respiratory physiotherapy

Respiratory physiotherapy consists of a series of techniques aimed at treating the complications of an acute or chronic respiratory injury. It is aimed at a patient who presents a temporary or permanent handicap attributable to a dysfunction that alters the capacity to adapt to effort, whatever its origin, a capacity where the cardiovascular system, lungs, muscles, control systems and so on are intertwined.

Its main fields of action are: the treatment of acute or chronic respiratory failure, the treatment of an acute dysfunction of the external ventilatory mechanics, the treatment of an obstruction and its consequences on the external ventilatory mechanics, the learning of breathing mastery in the management of a chronic obstructive disease, the treatment of an acute obstruction or the management of chronic obstruction in the case of a hypersecretory disease, rehabilitation to exertion, the reduction of dyspnoea and the improvement of quality of life. In most of these objectives, it incorporates a therapeutic education dimension. The fundamental intellectual process that presides over the exercise of respiratory physiotherapy is based on the pathophysiological analysis of the mechanisms that lead to dysfunction or disability.
Starting from a medical diagnosis and a re-education prescription from the doctor (pulmonologist or internal medicine or health management), the physiotherapist draws up a therapeutic project, specific of treatment objectives and technological choices of which he will carry out periodic checks with the pulmonologist or internal medicine or health management doctor.

Neuropsychomotor treatment

This may be individual or in groups according to the characteristics of the patient.

Individual therapy

Neuropsychomotor individual therapy foresees a 1:1 rapport between therapist and child and takes place in the psychomotor room with frequency that varies between one or two sessions per week.
The general objectives of individual therapy are neuromotor, relational and cognitive–behavioral.
Playing games is the most effective instrument in Neuropsychomotor treatment as it represents the simplest and most effective way to develop harmonious personality traits that stimulate further learning.
The approach is personalized to the potential and difficulties of each patient. The Neuropsychomotor therapist plans, chooses and provides targeted tools in an appropriate setting for the specific child's needs. The setting is both a physical and psychological space for the patient and thus very important. For physical space we mean the psychomotor room (a colorful luminous space, rich with bright colors and building and make-believe games and toys), whereas the metal space refers to the session (frequency on a weekly basis, duration total and the work done within each session). The mental space is a sort of "emotional container" capable of making the patient feel listened to or understood in all their problems. This is possible because the therapist maintains an active listening role welcoming the spontaneous production of the patient by sharing emotions and pleasures, containing their difficulties and fears and favoring the expression of their needs.
Playtime represents an instrument that permits access to the world within the child and the psychomotor treatment is when the child elaborates their personal strategies on how to express themselves with originality and creativity in whatever context of their daily life.

Neuropsychomotor group therapy

Neuropsychomotor therapy in small groups foresees a 1:3/1:4 rapport between therapist and patients and takes place in a large room on a weekly basis.
Choosing participants is based on single characteristics, to have a homogenous group, considering numerous factors in neuropsychomotor group therapy.
The effectiveness of this treatment is due to the possibility of creating a *meaningful context* for children, varying the games played and the activities deciding with the group and thereby permitting them to actively participate in the session's definition. The therapist must reach an active compromise amongst the proposals of the children, so that their behavioral status is respected and above all find and adequate basis to reach the therapeutic goals.
The main elements that make neuropsychomotor groups therapy significant are *comfort amongst peers, imitation, emulation and competition* that are normally created and constitute learning and facilitate experimental behavioral treatment.
Imitation is a learning method that permits children to realize their own mistakes and to modify their behavior to correct them. Furthermore, it permits one child to identify themselves in another one with the same difficulties, thereby favoring the process of becoming conscientious.
Emulation is an instrument that permits the child to assimilate the competences of another to improve and render more efficient their own performance.
Competition pushes children to do better versus their peers by experimenting new strategies.
The connection of these aspects motivates the child to keep up a high level of attention and concentrate on the activity at hand. They also, willingly or not, share their emotions and their state of being with both their peers and the therapist.
Group neuropsychomotor therapy can be considered an effective tool to guide children to improve their performance and resolve the requests that daily life asks of them y confronting challenges in a positive light and dealing with frustrations and failures by looking for new solutions.

Speech therapy

Treatment by speech therapists also revolves around a preliminary evaluation of how effective this type of rehabilitation can become as a response to specific deficiencies in language, communication and learning as an oral-deglutition function. The speech therapist begins treatment after a detailed diagnosis on the part of a team of specialists (Neurologist, Infant Neuropsychiatrists, Physiatrists, etc.).

OBSERVATION EVALUATION

Communicative and cognitive linguistic learning capabilities:

The therapist has a maximum of 3 (three) sessions that last 45 minutes each on average according to the characteristics and the level of patient collaboration.

The therapist verifies:

1. Data collected on anamnesis useful to the clinical documentation by meetings with operators, doctors or family members
2. Testing administration according to age, illness type and clinical status severity
3. *Instruments for the language evaluation*

1. Questionnaire CHILD'S FIRST WORDS - "Gests and words" (8-17 months); "Words and phrases" (18-30 months)
2. TVL – preschool evaluation test
3. PPTV "PEABODY" - test for evaluation of lexical reception
4. Comprehension morpho-syntax "RUSTIONI"
5. TCGB - grammatical test for children
6. TROG-2 – grammar reception test, and language comprehension
7. Exam in articulation, phonetics, orobuccolingual praxis
8. *Instruments for evaluation of prerequisites of learning or scholastic learning*
    1. CMF – metaphonological competences
    2. READING TESTS MT-2
    3. DDE-2 battery for evaluation of dyslexia e evolutive dysorthography
    4. BVSCO-2 battery for evaluation of spelling and writing competences
    5. AC-MT 6-11 calculation ability in 6-11 years age-group
    6. AC-MT 11-14 calculation ability in 11-14 years age-group

Mio-functional and mealtime observation

The therapist does an evaluation at mealtimes to collect:

1. Data collected on anamnesis useful to the clinical documentation by meetings with operators, doctors or family members
2. evaluation of functional morphology
3. evaluation of oral praxis non-phonetical (according to type and clinical status severity)
4. observation at mealtimes: evaluation of chewing, swallowing

TREATMENT

Following an evaluation of therapeutic need, the speech therapist establishes the rehabilitative goals and plans an individualized treatment.
Il speech therapist can, in the cases where the patient is not admitted, offer services on a consulting basis thereby offering advice and suggestions of reference.
Treatment takes place in individual settings once or twice per week.
In relation to the objectives set out, the most appropriate materials are prepared and planned with the aim of creating a therapeutic environment that is positive and stimulation for the child. The speech therapist tries to propose exercises and structured activities that motivate, gratify and often alters structured and unstructured activities.

According to the type and seriousness of the child's clinical status, the therapists work aims to strengthen the relational-communicative competences of the child thereby improving language comprehension, expressive ability and verbal use to favor as much as possible psycho-physical wellness and autonomy.
The scholastic learning activity is aimed at improving and consolidating the basic abilities of reading, writing and mathematical calculations.
IN the management of feeding problems and swallowing, the commitment is aimed at feeding time security with the reduction of eventual risks of dysphagia and a balanced approach of their oral functions.

CAA (Alternative Augmentative Communication)

Augmentative and Alternative Communication (AAC) is an area of research and clinical practice. The aim of AAC is to compensate for communicative disabilities, which lead to limitations in activities of daily living and/or behavioural/social difficulties, characterised by severe impairments in speech and language production (with regard to oral or written modes of communication) and/or comprehension.

The term "augmentative" indicates how CAA techniques, methods, tools are aimed, in the first instance, not at replacing already present modes of communication but at enhancing natural communication through the enhancement of present abilities and the valorisation of natural modes (oral, mimic-gestual, visual, etc.).
The term "alternative" indicates how CAA makes use, when necessary, of special modes and means of communication that replace oral language (modes that may include aids, techniques, strategies, tools such as graphic symbols, writing, gestures).
The aim of AAC is to provide the person with as independent modes of communication as possible and to maximise their abilities and opportunities for participation in living environments.
The recipients of AAC intervention do not have age prerequisites, the common characteristic is that they need special assistance to express themselves - and sometimes also to understand. For this reason, the communication skills and competences of the recipients of this intervention can vary greatly and include motor, cognitive, socio-communicative and speech disabilities of varying degrees.
The AAC intervention is developed in the following phases:

1. Assessment
Assessment in AAC focuses on the characteristics, interests and aptitudes of the person with disabilities and his/her interaction with the environment. It is aimed at identifying communication goals that are important for the person and his/her caregivers.
The assessment involves both the analysis of the person's abilities (global motor skills, fine motor skills, social-communication skills, personal autonomy, cognitive skills) and the investigation of the actual communication opportunities present in the person's daily life and the identification of any barriers to participation.
If necessary, the involvement of a Communication Technician for the identification of an electronic aid and suitable access modes is carried out during the assessment phase.
2. Intervention
The main objective of the intervention is to introduce an AAC system that can meet the child's communication needs. A project is prepared specifying objectives, modalities, environments, times, materials, figures involved and the intervention cycle deadline.
The AAC systems currently used and chosen after evaluation are:
- PECS method
- Communication table (containing photographs, symbols, etc.)
- Electronic aids (low or high-tech), with or without voice output, which allow the selection of symbols or writing using direct selection via a finger of the hand or by means of special devices such as an eye pointer, a joystick or by scanning.
A patient with communicative needs may use different communicative systems at the same time or throughout his or her life, depending on his or her needs and abilities and/or communicative contexts.
If electronic aids are chosen, the initial training, monitoring and adaptation work is carried out by the TNPEE.

Educational rehabilitative treatment

Each patient has goals that form an integral part of the individualized therapeutic plan PTRI.
Educational-rehabilitative treatment is provided everyday by professional educators with a set rapport: the number of guests per operator, in accordance to the norms in vigor by the Lombardy region in accreditation of health services.
Educational and pedagogical interventions are provided in accordance to procedures and clinical conditions and are targeted at helping guests reach their personal autonomy and the adaptive competences that will improve their quality of life.

Music-therapy

Music-therapy has as its primary interest the connection of non-verbal communication and expression through sound. Sound becomes means of self-expression and to establish contact with those around you, to open-up to your environment throughout the entire cycle of one's life.
In the Musicotherapy room, every child has the possibility to express themselves by way of their own sound-musical identikit and to relate to others in the group or through a combination with the Music-therapist. In this way, the group has a musical sound and making music together becomes part of their identity.

Specialized learning

At VSM, it is possible for a patient to fulfill their scholastic obligation by one of the two following proposals:

1. *By way of a convention with the Ministry of Education Universities and Research (MIUR) and the Regional School Board where State recognized curriculums are available to those in a re-enabling facility*: every classroom has a specialized teacher, flanked by professional educators, neuropsychomotor therapists in developing aged children and physiotherapists at Villa Santa Maria SCS who all work together on the courses to guarantee that all the therapeutic and educational goals are assured to be reached.

2. As per the law D.L. n°297 dated 16/04/1994 there is a *private school* active within VSM: small cases also for children aged 0-3 years and 3-6 years, chosen based on their competences and abilities are entrusted to professional educators at Villa Santa Maria who are dedicated to their didactic, scholastic and rehabilitative projects.

Aquatic-Therapy

The facility has a rehabilitative pool with three pools, differing in size, depth and used for their specific therapeutic treatment.

Therapeutic rehabilitation treatment in water can be individual or small group depending on the patient's characteristics.
The privileged instrument of intervention in therapeutic rehabilitation activity in water is play, which represents the most effective means of encouraging the harmonious development of the child's personality in all its aspects to stimulate the formation of new learning.
The therapist implements an individualised and previously planned programme by appropriately preparing the aquatic setting for that specific child or group for its specific needs, choosing the appropriate activities and tools.
Water rehabilitation treatments are different and are adapted, in terms of specific modalities and objectives, to the users according to their age, pathology and degree of disability.

Individualised aquamotricity treatment

Psychomotricity in water can be seen as a valid support to in-room psychomotor therapy as it contributes with it to achieving its general objectives
o Favouring the psychophysical well-being of the child by gradually accompanying him/her on the path of discovery, knowledge and awareness of self, of the other and of the world around him/her.
o To favour the establishment of a relationship of trust between the operator and the child, who will share the pleasure of playing together, collaborating, learning and becoming autonomous.
o Strengthen and expand each child's potential on a motor, cognitive and emotional-relational level.
The aquamotricity activity provides benefits on the cognitive, behavioural and affective-relational level thanks to the direct therapist-child contact, creating a very stimulating sensorial environment; in fact, often an activity can only be softened or reinvigorated through non-verbal communication between child and therapist in the management of typical behavioural expressions. The exercises are planned on the basis of a progression to achieve goals that are continuously adapted to the child's daily needs.

Small-group aquamotricity treatment

Small-group aquamotricity treatment involves a therapist-child ratio of 1:3.
Members are chosen on the basis of individual characteristics in order to have as homogenous a group as possible, taking into account the many factors that come into play in group therapy.
The effectiveness of this treatment modality is based on the possibility of creating a meaningful context for the children by varying play proposals and activities.
The main elements that guarantee the meaningfulness of the therapeutic context in neuropsychomotor group therapy are the peer comparison, imitation, emulation and competitiveness that are normally created: these phenomena constitute the learning modality and facilitate the execution of experimental conduct.
Imitation is a learning modality that enables children to notice their own mistakes and to make changes to their action patterns; it also allows them to identify with a child with the same difficulties, facilitating the process of becoming aware of them. Emulation is the tool that allows the child to assimilate the other's skills in order to improve and make their own performance more efficient.
Competitiveness drives children to try to do better than the other, researching and experimenting with new strategies.

The combination of these aspects motivates the child to maintain a higher level of attention and concentration on activities, sharing his or her emotions and experience with peers and the adult.
The small-group aquaminesitherapy treatment can be considered a good tool for guiding children to seek increasingly effective performance in solving demands, helping them to positively deal with frustration at initial failures, using it as a push to search for new strategies.

Hydrokinesiotherapy treatment
Hydrokinesiotherapy is a rehabilitation tool suitable for orthopaedic, neurological and neuromotor pathologies. Thanks to its physico-biological properties, water is a decisive aid in performing active and passive mobilisation exercises. Water supports a large part of the body's weight, facilitating the execution of movements with correct muscle work even in conditions of reduced tone-trophism and load difficulties. This is why a muscle that has reduced strength and does not allow proper work can perform various movements in water.

Sports activity in water
In this treatment, swimming techniques are implemented and used as a vehicle to achieve goals of psychophysical well-being and subsequently implement the fundamental process of socialisation and integration with the peer group. The rehabilitation team will decide, based on the child's psycho-physical characteristics, which swimming style to start with. This intervention can be carried out in a 1:1 ratio or, right from the start of the course, in a small group, according to the cognitive-behavioural characteristics of the child and any peers.
Water polo is also proposed in small groups: this activity integrates motor, behavioural and relational components and is conducive to achieving various objectives, such as improving global motor coordination, respecting rules and seeking interaction between team members.

WATER PSYCHOMOTRICITY PROJECT
"If there is any magic on this planet, it is contained in water" Loren Eiseley, The Immense Journey, 1957
"In the water, everyone with their own story, in a shared space." Loredana Belloni

To foster a child's psychomotor development, it is important to create opportunities in which he or she can put himself or herself into play in order to get to know each other.
For the child, the best way to learn is to play: so why not do it in water?
Getting active to explore a world of emotions
Get to know yourself and gain confidence in your own abilities
How great it is to play in the water!
Combining one's potential for a common goal
Listen to your body and feel how it moves
The water environment offers greater sensory stimulation than the environment in which we live, as the pressure exerted by water on the skin encourages a better perception of the bodily self than that offered by air.
Water facilitates the perception of one's physical boundaries, delimiting an inside and an outside body, an awareness of the body and its wholeness.
Activity in water represents a very important experience as it involves the child in its entirety, intervening in motor, affective-relational, behavioural and social aspects.
Through play, children reach a state of well-being in the water, learn to control their own bodies and get used to being in a group with other peers.
At the age of 3-5 years, children are not yet mature enough to learn complex swimming techniques of movement. Therefore, motor experiences are proposed that are as varied and fun as possible, enabling them to acquire some fundamental skills: breathing, floating, orientation in the water.

Group USERS:
Group *junior squids 0-24 months*
Group *starfishes 2-3 years*
Group *little fishes 3-4 years*
Group *little squids 4-5 years*
Group *little crabs 5-6 years*
The treatment frequency is every week or once every two weeks based on the number of participants.
Participation is only possible with a Medical certificate granting the permission for the patient to take part in r**ehabilitative athletic-noncompetitive sports in a swimming pool**.
The fee to participate is € 150,00 euros for 10 lessons (to recuperate missed lessons please refer to the regulation).
Payment is to be made IN ADVANCE on the 20th of the month preceding the beginning of the course using one of the two payment methods:
1. Cash, bank card or checks at VSM Center

2. **Bank wire transfer** using the following **IBAN: IT 38 O 08329 50860 000000 113135** – Indicating SWIMMING POOL CONTRIBUTION ON BEHALF OF (INSERT THE SURMANME OF THER PATIENT)

Please bring a copy of the payment receipt to the Center.

GENERAL OBJECTIVES OF THE ACTIVITY

1. Increase awareness of water in children while at play
2. Stimulate the will to "explore" in water in a stimulating way
3. Increase the possibility for interaction through sharing while at play

SPECIFIC LEARNING GOALS

Instill a relationship with the environment

1. Capacity to adapt to new environments and diverse situations
2. Knowledge of the aquatic environment
3. Respect for things, the environment and share spaces with others
4. Respecting the rules

Awareness of self and others

1. Increase the perception of own body and potential
2. Reinforce self-esteem and self-control
3. Acceptance, knowledge and participation in a group activity
4. Respect for others

Aquatic environment

1. Becoming accustomed to being in the water
2. Psychological adapting (anxiety control, fear management)
3. Physical-sensorial adapting (being confident in the water, and managing own body in the water)

Motor-skills in the water

1. Adapting open-air patters to the water (running, jumping, summersault, balance in water)
2. Creating motor aquatic schemes: jumping in, floating, sliding, moving on the surface and underwater

Group junior squids *0-24 months*

We propose a psychomotor activity in the water for children aged 0-24 months so that they can learn to love water by exploring the aquatic environment and experiencing, within it, the body in motion and the emotions related to different experiences.

This experience is proposed in the presence of the caregiver / parent to make the environment as comfortable and familiar as possible for the child, thus favoring the experimentation of the aquatic environment with its own potential and the sharing of spaces and materials with other children and parents. This also represents an opportunity for the adult to share with other parents who live the same experience and adventure in accompanying their children in their growth.

The course offers an opportunity for the mother-child couple to share a privileged time in an environment conducive to relationship and body contact. In fact, the child re-experiences the initial attachment with the mother (bonding) through close skin-to-skin contact.

Furthermore, no less important, the experience in the pool represents a relational and symbolic continuity between fetal and neonatal life.

Methodology:

Gradual entry into the water with provision of a poolside play area.

Proposal of playful activities that allow the child to experience water in a pleasant way

Aims

3. Provide pleasure, joy, relaxation, enjoyment
4. Consolidate the mother-baby relationship
1. Adaptation to the aquatic environment

Specific learning objectives

SENSORY EXPERIENCE

Water, with its physical characteristics and properties, represents a sensory experience that involves all the senses; the sounds are amplified and transformed, the light and reflections that water generates, the smell of chlorine and the environment, the taste of water that children inevitably experience, the touch of water as a unique experience as it is formless and apparently intangible.

Furthermore, the large sensory component is represented by the effects that water produces on the body itself: water supports, contains, massages, relaxes, activates reflections and unifies the body perception.
MOTOR EXPERIENCE
In the water, the child can experiment with different positions and movements, enjoy the effects of buoyancy and propulsion thrusts they already have when they are very young. Some of these are:
- prone / supine and vertical floats
- circular, supine, forward in an upright or oblique position
- use of aids, diving, arm-leg coordination gradual reduction of support
In addition, the experience itself allows the child to adapt breathing to the movement and maintain or reactivate the apnea reflex.

Group STARFISHES *2-3 YEARS*
Children in this age group have very rough movement patterns and others that are barely sketched, and there is a profound variability in individual maturation.
We propose a psychomotor activity in water for 2-3 year old children so that they can learn to love water by exploring the aquatic environment and experimenting, within it, the body in motion and the emotions related to different experiences; this experience is proposed in the presence of the caregiver / parent to make the environment as comfortable and familiar as possible for the child, thus favoring the experimentation of the aquatic environment with his own potential and fantasies, he will be able to share spaces and materials and play activities within a game frame (story), mediated by the operators and the parent who will accompany the child along the way.
The primary goal is to create a positive relationship with water together with your caregiver / parent.
Specific goals
In relation to the environment
2. Knowledge and adaptation to the aquatic environment
3. Respect for things, the environment and spaces to share with other people
4. Respect for the rules

Knowledge of oneself and others
5. Experimentation of the perception of one's own body and of one's potential
6. Acceptance, participation and sharing of a common group activity

Aquatic environment
7. Experimentation and acceptance of new postural structures
8. Experimentation of terrestrial motor patterns in the aquatic environment: (running, jumping, rotating, balancing in water)
9. Experimentation of aquatic motor patterns (buoyancy, sliding on the surface of the water, diving, underwater movements)

Methodology:
Activities proposed in a playful form with the creation of routes, stories, relays, team games, etc.

Aims:
10. To bring children closer to water, in a more conscious and playful way
11. Stimulate the desire to "explore" the aquatic environment through exciting and engaging proposals
12. Increase the chances of interaction with others by sharing the game

SPECIFIC LEARNING OBJECTIVES
In relation to the environment
13. Ability to adapt to new environments and different situations
14. Knowledge and adaptation to the aquatic environment
15. Respect for things, the environment and spaces to share with other people
16. Respect for the rules

Knowledge of oneself and others
17. Experimentation and increase in the perception of one's own body and potential
18. Acceptance, participation and sharing of an activity
19. Respect for others

Aquatic environment
20. Ambience understood as adaptation to water
21. Psychological adaptation (anxiety control and overcoming the fear of water)
22. Physical - sensory adaptation (confidence in water and management of one's body in it)

Motor activity in the aquatic environment

23. Experimentation of terrestrial motor patterns in the aquatic environment: (running, jumping, rotating, balancing in water)
24. Experimentation and acceptance of new postural structures
25. Experimentation of aquatic motor patterns: diving, floating, sliding, moving on the surface and underwater

Group LITTLE FISHES *3-4 YEARS*

The children in this group possess very rough movement abilities which vary from patient to patient and help identify maturity.
The activity is psychomotor based until they can learn to love and explore the water and experiment while immersed in it with their body, their emotions, feelings and fantasies in a group setting. Recreational activities within a playful setting with many valuable learning opportunities to be had along this path from their peers and operators.
The main specific goal, in addition to those mentioned above, is to create a positive relationship with the water and their peers.

Group LITTLE SQUIDS *4-5 YEARS*

For this age group, the aim of the treatment not to learn how to swim by developing the necessary skills to successively be able to learn proper swimming technique. The goals are full acquisition of a few basic but essential techniques
i.e. floating, sliding, simple respiratory control.
The abilities are learnt through games, organized in such a way that problem situations and their solutions become key to conquer desired adaptive behavioral results.

Specific goals:

With the environment

26. Completely adapted to being in the water
27. Promote and consolidate the socialization steps
28. Promote respect for rules, taking your turn and small group collaboration

Awareness of self and others

29. Increase self-awareness of own body to favor the body scheme structure;
30. Acceptance, participation, sharing and group activity
31. Respect for others

Aquatic environment

32. Experimentation with all postural positions
33. Adapting of the motor schemes on dry land to those in water (running, jumping, summersault and balancing in water)
1. Experimenting with aquatic motor schemes of floating with pronounced supine position
2. Acquiring confidence to slide on water
3. Experimenting with immersion and underwater movement
4. Acquiring in water propulsion with lower limbs

Methodology:

Activities proposed under recreational activities with progressive planning using, teamplay, small relays etc.

Gruppo *SMALL CRABS 5-6 YEARS*

This age group sees children that can control their bodies in a natural environment and thus can progress in the water with new possibilities and opportunities to play and learn techniques for future swimming capabilities.

Specific objectives:

With the environment

5. Capacity to adapt to new environment and diverse situations
6. Familiarity with the aquatic environment
7. Respect for things, the environment, shared spaces and others
8. Respect for rules

Awareness of self and others

9. Increased perception of their own body and potential
10. Strengthening of their self-confidence and self-control
11. Acceptance know-how and participation in a group activity
12. Respect for others

Aquatic acclimatization

13. Intense acclimatization such as adapting to the water
14. Psychological adaptation (control of anxiety, overcoming fear of water)
15. Physical-sensorial adaptation (confidence with water and managing their bodies while in the water)

Motor-skills in aquatic environment

16. Adapting of the motor schemes on dry land to those in water (running, jumping, summersault and balancing in water)
17. Creating aquatic motor schemes: jumping in, floating, sliding, moving on the surface and underwater

Methodology:

Using diverse plans with specific objectives according to age of the patient, treatment is provided under the "aquatic laboratory" program that by experimenting new situations will permit the creation of new games (of movement, perception and exploration of space).

Adaptive sports

Sporting activities are proposed to patients at their medical request for whom it is deemed appropriate and useful for their psychophysical well-being.
Sporting activities take place all year round and take place both in the indoor spaces of the facility (gyms, swimming pool, outdoor spaces), and in places outside the facility.

Sport activities include:
1. Individual sports activities: rowing, introductory sports, water sports (swimming), sports activities in the weight room
2. Group/team sports activities: five-a-side football, basketball, introduction to sport, water sports activities
3. Individual or small group walks

These activities are carried out by the Sports Activities Instructor (IAS) who has the task of reaching the patient in the activity rooms and accompanying him/her to the designated places, assisting in the administration of the specific intervention.
The therapeutic approach of the sports activity is designed and customised on the basis of the potential and difficulties of the child in front of us after careful assessment and observation.

The sports activity is divided into individual sports (rowing, swimming pool and weight room), team sports (football, basketball, etc.) and walking; the number of children to be included in the groups may vary depending on the needs or the nature of the activity itself. Group composition is manifested in DSM 097 B in the respective IAS timetable.

Individual sports activity

Individual sports activity does not necessarily involve a 1:1 relationship between the child and the instructor, but relates to the nature of the activity itself: these are sports that involve the use of materials and equipment on an individual basis and whose objective is not necessarily common to the rest of the group participating; some examples of individual sports are rowing, swimming and weightlifting. These activities take place at outdoor facilities or within the designated spaces.
The general objectives of individual sports activity concern the psychophysical growth of the child (understood both as the acquisition of awareness of one's own physique and motor skills, and as muscular growth) in the sense of close relational and cognitive-behavioural (especially with regard to the organisation of one's own space and equipment).
The sports activities instructor therefore implements an individualised programme, planned on the basis of the results of certain physical tests that may be administered during observation or during the first training sessions, and trying to meet the needs and requirements of the child, with specific material and equipment.
Individual sports activity has, mostly for users with psychopathological characteristics, the function of channelling their impulsiveness and aggressiveness towards something more functional and purposeful, within well-defined and commonly accepted rules.

Adaptive rowing

The activity is the brainchild of Dr Fausto Panizza, a neuropsychomotricity therapist and coach of the team, and Dr Piero Poli, doctor of the Italian national rowing team - adaptive section, specialist in orthopaedics and gold medallist at the 1988 Olympics.
The initial idea began to materialise in September 2006, thanks to the willingness provided by the presidency and management of Villa Santa Maria SCS, the Italian Rowing Federation, Canottieri Gavirate and Canottieri Lario di Como.
The motivations that gave rise to this initiative, and that still sustain it today, are various: the conviction of the great value that motor-sport activity has in the psychic, physical and socio-behavioural evolution of persons with psychic disabilities and that, thanks to it, these 'special kids' can achieve unimaginable goals (one team member has been called up for the national team).
The activity currently targets boys and girls between the ages of 13 and 16, with pathologies ranging from autism to mental retardation and behavioural disorders.
The team works through individualised projects for each team member. The goals to be achieved, both on an athletic/competitive level and above all on a therapeutic level, are
- increased attention and concentration time
- ability to imitate
- respect for rules
- frustration management
- improvement of basic motor patterns
- improving coordination and conditioning skills, improving proprioception
- channelling any aggression
- improvement of the level of social interaction

Dancing

The dance activity is performed in a group context. The primary goal is to facilitate the manifestation of one's emotions through experience and bodily expression. To this end, space is left for the expression of imagination through movement and control of one's body and, at a later stage, the representation and verbalisation of the emotions experienced is encouraged.
The aim is also to work on respect for rhythm, aspects of general dynamic coordination and spatio-temporal organisation through the proposal of specific exercises, considering the body both in its globality and in its segmentality and thus reinforcing the integration of the body scheme using different types of material.
To support these aspects and encourage the learning of sequentiality of action, a series of steps is gradually proposed, so that a choreography is created on the basis of music that is maintained until the conclusion of the choreography itself.
The music accompanies the treatment throughout, and the proposed tracks are chosen in advance by each member of the group.
This modality is used with the aim of allowing the expression of one's personal tastes, adapting to those of others and, more generally, improving relational skills through the stimulation of listening.

Team sports activity

Team sports activity involves the creation of groups, depending on the type of sport (football and basketball are examples of this), and takes place either in the indoor gymnasium or in facilities outside the centre; the groups created may be composed entirely of users from the centre, or, where possible and useful for fostering socialisation, the children are placed in external contexts, using existing sports clubs.
Members are chosen on the basis of the characteristics of the individuals, in order to have a group that is as homogeneous as possible, considering the many factors that come into play.
Team sports are particularly effective in several respects; firstly, they foster sociability and reinforce the feeling of being part of a group; secondly, phenomena such as peer comparison, imitation, emulation, competitiveness and cooperation are created in a natural way, which form the basis for the creation of one's own learning mode and facilitate the execution of experimental conduct.
Imitation is a learning modality that enables children to notice their own mistakes and to make changes to their own patterns of action; it also allows them to identify with a child or young person with the same difficulties, facilitating the process of becoming aware of them. Emulation is the tool that allows the child to assimilate the other's skills in order to improve and make his or her own performance more efficient.
Competitiveness pushes children to try to do better than the other, researching and experimenting with new strategies.
Finally, team sports encourage participants to set a common goal, facilitating collaboration between peers, creating complicity and fostering sociability.

Team sports activity can therefore be considered a good tool for guiding young people to seek increasingly effective performance in solving the demands placed on them in everyday life, thus helping them to positively deal with frustration at initial failures, using it as a drive to seek new strategies.

Football

Football is a sport that requires good skills in terms of coordination and integration of the various movements. Within this game there are rules that must be respected for both attacking and defensive action.
Furthermore, this activity helps the children to understand the meaning of team play and the different roles within the team; consequently, a further objective is respect for one's teammates and their different strengths.
The objectives of the activity are:
- To foster learning and respect for the rules necessary to carry out the activity
- To improve the quality of the motor gesture of kicking, increasing control and coordination by focusing attention on it
- Stimulate competition during the activity and the frustration tolerance threshold in accepting defeats, in confrontation with the other group members, in respecting waiting times and rules and in the execution of the therapists' deliveries
- Improving relational patterns with caregivers and peers, promoting and reinforcing appropriate behavioural behaviours

Basketball

The general motor objectives of basketball sport are to learn the fundamentals of this sport and, at the same time, to improve general dynamic coordination skills.
Participation in team sports encourages the acquisition and improvement of cooperative behaviour and respect for teammates within the group. Understanding and observing the rules of the game is also an important objective of this sporting activity.
In addition to sharpening motor skills, this activity represents an important moment of aggregation for the children. In fact, in addition to weekly training in the institute's gymnasium, the team participates in a tournament that is organised with other centres in the area; the preparation for the games and the opportunities to go out represent a special moment for the boys, which also encourages improvement from a behavioural and social point of view.

Walking sports activities

Some users are offered an activity that involves going out in the vicinity of the centre, once or twice a week.
The aim of this activity is to help maintain certain motor patterns already acquired or to improve them if the child has particular difficulty walking. Added to this objective is the possibility of coming into contact with, getting to know and exploring environments that are different from the everyday context.
Once the intervention has been carried out, IAS has the task of entering into the system (SYS-RIPOSO) the service provided or possibly the reasons for non-administration.

RESEARCH – THE VSM FOUNDATION

The VSM Foundation of Villa Santa Maria was founded in 2016 to sustain scientific research at Villa Santa Maria SCS, specialized center in the cure of infants and adolescents suffering from Neuropsychiatric pathologies and to be able to enlarge the range of services the center offers. The aim of the foundation is to support excellence in specialized research and treatment that favors the development of Infant Neuropsychiatry projects that involve Villa Santa Maria SCS and its operators.

To reach these objectives, as a non-profit organization, VSM collaborates and establishes relationships with scientific and cultural entities, universities, research institutes both private and public at a national and international level. But VSM continues to support its clinical activities by promoting and organizing seminars, training courses, conventions, meetings cultural events, and promotional activities.

The principal objectives of the treatment are represented in their order of importance as follows:

1. Continuously improving treatment methods and therapeutic assistance for children and their families
2. Deepening of know-how based on data collected at the center (learning from proprietary data)
3. Better understanding the causes of developmental pathologies with particular attention to autism in collaboration with top-tier research groups

To pursue these goals, Villa Santa Maria SCS decides to enter a network of world-class scientific collaborators and centers of excellence, both nationally and internationally, to facilitate exchanging information and sharing experience multicentric research protocols.

Collaborations with national and international entities

1. ASST Fatebenefratelli Sacco e ASST Santi Paolo e Carlo, Milano
2. ASST Lariana
3. ASST Monza
4. ASST Valle Olona
5. ANFASS, Brescia
6. Centro Diagnostico Italiano, Milano
7. Istituto di Ricerche Farmacologiche IRCCS Mario Negri, Milano
8. Centro di Cultura Scientifica Alessandro Volta, Como
9. Università degli Studi di Bergamo
10. Università degli Studi di Roma Tor Vergata
11. Centro Ricerche Semeion, Roma
12. Campus Biomedico, Roma
13. Università Federico II, Napoli
14. IRCCS Fondazione Stella Maris, Pisa
15. Congregazione delle Suore Infermiere dell'Addolorata Ospedale Valduce di Como,
16. Università degli Studi di Milano Bicocca
17. Università degli Studi dell'Insubria, Varese
18. ENAIP Busto Arsizio (Varese)
19. Ospedale pediatrico Bambino Gesù, Roma
20. Università Ebraica di Gerusalemme, Hadassah Medical School, Israele
21. Ospedale di Beer-Sheva, Israele,
22. Centro MIFNE, Rosh Pinah, Israele
23. Università degli Studi dell'Insubria, Como
24. Università degli Studi di Modena e Reggio Emilia
25. Università La Sapienza, Roma
26. Università degli Studi di Trento
27. Università degli Studi dell'Aquila
28. Università Federico II, Napoli
29. Università di Vienna
30. Istituto Nazionale di Fisica Nucleare, Pisa
31. Istituto Italiano di Tecnologia, Genova
32. Istituto Italiano di Tecnologia, Rovereto
33. Azienda Ospedaliera Universitaria Policlinico Gaetano Martino, Messina

34. Consiglio Nazionale delle Ricerche, Messina
35. Centro Riferimento Regionale Autismo, Regione Abruzzo

INFORMATION

The Executive Management along with the clinical-rehabilitative team periodically inform the families in regular, programmed meetings throughout the year. As far as the personnel is concerned, all the observations/decisions that emerge from these meetings are reported in writing and catalogued in files to better track patient progress.
All the protocols, procedures, and clinical records, individualized treatment plans and work plans are available to the operators in writing and on IT files.
Administrative procedures like work schedules, accounting, purchase order management, administrative statutes and the like are all documented in writing and archived appropriately.
The above is a guaranty of transparency of the Center's operations, its controllers and the verifiability of its results.

REQUESTING ACCESS CLINICAL FILES PROCEDURES

Access to patient healthcare files is granted exclusively by those who have the right by using the appropriate forms available at reception. The facility shall release the documents within 15 days of their request, applying the prescribed fees.

RELEASING FISCAL DOCUMENTATION AND TAX-RECEIPTS

Available upon formal request, the Entity releases all fiscal certifications by the prescribed deadlines in time for tax filings.

A TYPICAL DAY AT VILLA SANTA MARIA SCS

A typical day for resident patients at Villa Santa Maria SCS is as follows:

Morning (07.00-13.00)
07.00-08.00 Wake-up, personal hygiene
08.00-09.00 Breakfast
09.00-12.00 Rehabilitative-therapeutic activity with specialized teaching according to every patient's PTRI
12.00-13.00 Lunch and hygiene

Afternoon (13.00-21.00)
13.00 – 17.00 Rehabilitative-therapeutic activity with specialized teaching resumes.
17.00 - 18.45 Personal hygiene
18.45 - 19.45 Dinner
19.30 - 21.00 Bed-time preparations

Night-time (21.00-07.00)
Night-time surveillance is guaranteed in all wards by nursing staff ASA/OSS.
The typical day for semi-residential patients is as follows:
08.00-09.00 Arrival
09.00-12.00 Rehabilitative-therapeutic activity with specialized teaching according to every patient's PTRI
12.00-13.00 Lunch and hygiene
13.00 – 16.00 Rehabilitative-therapeutic activity with specialized teaching resumes.
16.00 - 17.00 Departure

RECEPTION HOURS OF OPERATION

Reception is open:

1. Monday to Friday: 07.30 to 18.30
2. Saturday and Sunday: 08.30 to 18.30

PARENTAL RAPPORT

1. Continuous updating on the rehabilitative-therapeutic status by referent operators
2. Access to the rehabilitative-therapeutic program along with the operators
1. Possibility to have specialized operators make house calls
2. Continuous educational training programs

FAMILY VISITING HOURS REGULATIONS

To guarantee maximum patient tranquility during the daily rehabilitative activities, family visits within the facility are relegated predominantly on Saturday and Sunday from 09.00 to 12.00 and from 14.00 to 16.00.
For the benefit of everyone, our facility follows the following access rules:

1. Special visits and/or weekend departures must be communicated by 12.00 noon on the Thursday of the same week, to permit for proper organization.

2. Parents must communicate the names of the visitors that will be present during special visits. Anyone not approved for visiting the facility in advance of the date, must wait in the reception waiting area.

3. In the case of visits by a group of people, our on-duty RRSA staff will manage the visit by accompanying the group and deciding how many people can simultaneously visit a patient, etc. Visiting by friends or relatives without the presence of parents must be accompanied by a written consent form on the part of parents. These visitors must provide proper identification. The IDs of special visitors will be retained in exchange for a visitor's badge. The IDs are returned after the visit as the visitors are prepared to exit the facility.

4. In the case of departures and/or visits during holidays, the request for access must be made at least 48 hours in advance by 16:00 to better prepare the patient, the organization of their belongings and eventual therapy.

5. Requests for prolonged assistance must be made 4 weeks in advance of the departure date to ensure patients prepare adequately and all organizational procedures are ready.

6. Visits during the week, from Monday to Friday are only permitted in exceptional cases, so as they do not interfere with clinical, rehabilitative and educational activity. IN such cases the time is from 16.00 to 17.00. Beyond these times, visitors may not remain in the facility.

7. Weekend visits or visits on holidays are possible from 09.00 to 12.00 and from 13.00 to 17.00. Beyond these times, for organizational reasons, visitors may not remain in the facility.

8. At Reception, small lockers are available for those who enter as special visitors, where they must deposit all personal effects including smart phones, bags, etc. which may not be kept during facility visiting.

9. During special visits, the use of smartphones on the part of visitors or patients or any recording devices (sounds or images) is strictly prohibited.

10. It is forbidden to photograph patients at the facility.

11. Visits take place in a room authorized by our RRSA operator, who also may permit visiting the outdoor facilities (park) and/or where automatic refreshment machines are available to have a snack or drink.

12. It is strictly forbidden to loiter in the facility corridors.

13. Introducing foodstuffs of any kind into the facility is permitted only if these are pre-packaged and their expiry date and ingredient lists are clearly visible.

Furthermore, according to the indications for dealing with the COVID19 emergency at the moment the indications are as follows
Reiterating the general recommendations of prudence regarding the behaviour to be adopted during visits and exits in the territory, it is hereby communicated that the Lombardy Region has issued in these days a note regarding the regulation of this activity valid until 31 December 2022.

Despite the end of the state of emergency, visits and outings therefore continue to be regulated as follows:

- GUEST EXITS: at the Territorial Network facilities, guest exits are allowed provided that they have a green Covid-19 certification as per art. 9 of Decree-Law no. 52 of 22 April 2021, converted, with amendments, by Law no. 87 of 17 June 2021.

- VISITOR ACCESS: Visitor access to sociomedical facilities, both for facility visits and for the withdrawal of the guest with an outpatient programme, is permitted exclusively to persons with a Covid-19 green certificate issued following
1. the administration of the booster dose following the primary vaccine cycle or following recovery following the primary vaccine cycle
2. completion of the primary vaccination cycle or following recovery, together with a certificate attesting to the negative result of the rapid antigenic or molecular test performed within forty-eight hours prior to access.

In case of a change in the regulatory indications, families will be duly informed by written communication sent by e-mail.

RELIGIOUS ASSISTANCE

Religious assistance is safeguarded as a guaranteed activity at the facility and naturally is adapted to a context appropriate for infants.
It is also possible to follow any religious dietary restrictions whilst at the facility.

THE MOST BEAUTIFUL SPACES

Gymnasium

A large Gym is available for psychomotor, motor and sports activities.

Another large gym is available for rehabilitative, sensorial-stimulating activities like perception and vestibular activities.

Pools

The facility has rehabilitative pools, with three levels in terms of size, depth and rehabilitative treatment.

Playground

The facility has a large playground dedicated to Mons. Alessandro Maggiolini

GENERAL HOSPITALITY SERVICES

Dining room

The facility has a dining room and kitchen that guarantees the dietary quality which is at times medically prescribed. The elevated quality is in accordance with internationally accepted standards.

Dining Services
Board is available in the dining room at the following times:
Breakfast: 8.00 to 9.00
Lunch: 12.00 to 13.00
Dinner: 18.45 to 19.45
The menu is created monthly with different offerings seven days a week, offering healthy alternatives, special dietary foods and season produce.
Rooms are equipped with two or three beds and all have heir own bathrooms.

Wardrobe and laundry services
Wardrobe and Laundry service is included in the daily fee according to international high-quality standards.
The laundry service is provided by third party suppliers.

Housekeeping and sanitation services
This service also conforms to international high-quality standards provided by third party suppliers.

Administration services
The Executive Management Department manages all administrative services with a highly qualified staff.

AVISMA ASSOCIATION - FRIENDS OF VILLA SANTA MARIA ASSOCIATION

To support Villa Santa Maria SCS, the Friends of Villa Santa Maria Association was founded in 2011 called AVISMA. By promoting human dignity and social values for disabled people and their families as well as the civil rights assistance agencies that pursue social solidarity goals, it fully collaborates with the Entity.

TRAINING PERSONNEL

All the professional staff at Villa Santa Maria SCS possess a degree or a technical diploma for their professional profile as per requisites of the norm in vigor on accreditation.
Personnel participates at regular training sessions promoted by the Entity, to improve professional know-how, abilities and behaviors at the workplace.
Yearly planning is made with leading experts that come to train, share and give talks at targeted meetings, conferences and external conventions on different thematic aspects for each of the profession fields offered at the facility.

INSTRUMENTS USED TO MONITOR SERVICES

To properly monitor the service performance, yearly instruments are used that include:
1. Satisfaction questionnaires with healthcare and treatment questions for patient families.
2. Personnel or staff questionnaire dedicated to workplace environment quality.
Questionnaires are the most complete, simple and effective instrument to involve all staff and patient family members in measuring the service levels with responses being statistically quantified, measured and evaluated by the Executive Directors who are oriented in maintaining the highest quality possible.

1. Appropriate forms to report complaints, suggestions and other useful information available at reception.
The Executive Management pledges to respond to every complaint within 15 days of the date of receipt.

SUPERVISORY BODY

Premise

The law L'art. 6 comma 1 lett. b) del D.Lgs. 231/2001 states that "Administrative responsibility for companies and associations is legally delegated to the officers of the above even if those roles are unfilled for whatever reason" and that the Entity entrusts the supervisory responsibility over the organizational model and management to autonomous, impartial third-party organism who legally execute powers of control.

The Supervisory Body at Villa Santa Maria SCS

The supervisory body is nominated by the Board of Directors for a period of three years. They are re-eligible for a period of three successive mandates.

The Supervisory Body is autonomous, independent and equipped by the regulatory norm to:

1. Verify the efficiency and effectiveness of the organizational model adopted by the Association with respect to all criminal activity as per the law D.Lgs. 231/2001;
2. Verify the respect of The Code of Ethics within the Organizational and Management Model;
3. Formulate proposals to Executive Management for eventual updates and improvements to the organizational model;
4. Signal any violations of the Code of Ethics to Executive Management which may cause any breach of responsibility of the head of the Association.

Reporting violations

All violations or suspected violations may be reported in writing by sending an email to odv.villasmaria@pec.it

Or by mail in writing to the Supervisory Body (Italian: Organismo di Vigilanza – Villa Santa Maria SCS – Via IV Novembre, 15 – 22038 Tavernerio (CO).

The reports should be made anonymously, however, it is understood that the Supervisory Body guarantees anonymity and secrecy. The Body shall respond and ascertain any wrongdoing and take any necessary steps should they deem so.

The Supervisory Board is held to secrecy for all information of any kind in its possession in exercising its function. This obligation requirement is cause for dismissal if not respected. All obligations are in any case prescribed by the law in vigor.

COVID-19 HEALTH EMERGENCY

Since the beginning of the Coronavirus emergency (20 February 2020), Villa Santa Maria has adopted a series of precautions and measures to safeguard the health of its operators, the many children and young people who need assistance and their families.

For this reason, day after day, a structure able to carry on its business has been built and continues to be built even in a strongly changed context. It is also thanks to these measures that it was possible to guarantee the regular opening and functioning of the Day Hospital for Child and Adolescent Neuropsychiatry and Outpatient Services in Tavernerio, and of the CSE in Oggiona con Santo Stefano as indicated by the Lombardy Region and ATS Insubria.

It is emphasized that VSM's activity falls under the ATECO codes:

87.3 - residential care facilities for the elderly and disabled

88.1– non-residential social assistance for the elderly and disabled

Other activities have been reduced or reorganized to respond to a higher level of security by creating paths free from infection and accessible to all. At the same time, dedicated and distinct courses have been set up to cope with any infected child, continuing to guarantee the care and assistance that distinguishes our Center.

Villa Santa Maria maintains its mission of making itself available to patients and their families to improve their state of psychophysical health and quality of life. The families also include ours, made up of all the operators of Villa Santa Maria who are present in the structure or, where possible, at home to work in Smart Working mode.

Villa Santa Maria has reorganized its activities, rationalizing the presence of staff through the adoption, where possible, of the Smart Working tool to reduce contacts, always in compliance with current legislation on the accreditation of structures.
VSM has adopted an emergency protocol that is constantly and promptly updated based on the evolution of the general situation.

CONTACTS (In Italian)

Villa Santa Maria SCS Società Cooperativa Sociale
Sede legale e amministrativa (Legal Administrative Office)
via IV Novembre 15, 22038 Tavernerio (CO)
Email: info@villasmaria.org PEC villasantamariascs@pec.it
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Sede operativa Villa Santa Maria (Facility)
via IV Novembre 15, 22038 Tavernerio (CO)
Email: info@villasmaria.org
tel +39 031-426042 fax +39 031-360549

Sede operativa Villa Colombo (Branch Facility)
via Monte Oliveto, 2, Oggiona con Santo Stefano (VA)
Email: info@villasmaria.org
tel +39 0331-215034 – fax +39 0331-736963

HOW TO REACH US

Our facility is reached by:

1. CAR: motorway A9 exit Como Sud follow direction signs for Lecco/ Bergamo
2. BUS: from Como line C40 Como-Erba-Lecco, C43 Como-Ponzate; from Lecco or from Erba with Bus line C40 Como-Erba-Lecco;
3. TRAIN: FERROVIE NORD: for Como Lago station, then proceed by Bus as in point 2, or FERROVIE FS: Como San Giovanni station, then proceed by taxi
4. AEROPLANE: to Malpensa airport then take the train Milano Nord Cadorna then take a train as in point 3
5. VIA LAKE COMO: take the ferry for the city of Como, then proceed as per point 2