Level 5 & 4 Residential Rehabilitation & Recovery Service

Model of Care
MENTAL HEALTH SERVICES

Level 5 & 4 Residential Rehabilitation and Recovery Service (RR&RS)

TASMANIA
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# Table of Content

## Introduction

### General Principles

- Governance ........................................................................................................... 7
- Continuum of Care ............................................................................................... 7
- Definitions ............................................................................................................. 9
- Environmental Considerations ........................................................................... 11
- Care Planning and Implementation ..................................................................... 11
- Transfer of Care .................................................................................................. 12
- Consumer and Carer Rights and Responsibilities ............................................. 12
- Consumer and Carer Participation .................................................................... 12
- Family Care Plan .................................................................................................. 13
- Key Service Tasks ................................................................................................. 13

## Service Provision

- Daytime Services .................................................................................................. 15
- Night-time Services ............................................................................................... 15
- Facility Services ..................................................................................................... 15
- Medico-Legal Issues ............................................................................................. 15
- Training and Staff Development .......................................................................... 16
- Confidentiality ....................................................................................................... 16
- Payments and Accountability ................................................................................ 16
Staffing ........................................................................................................... 16
Case Management .......................................................................................... 16
Complaints ..................................................................................................... 17
Media ................................................................................................................ 17
Performance Reporting .................................................................................. 17
Performance Indicators .................................................................................. 18
Monitoring and Evaluation ............................................................................. 18
Level 5 Transitional Care

SERVICE SPECIFICATIONS

Target Groups ................................................................. 20
Key Objectives .............................................................. 20
Key Service Features ..................................................... 21
Key Service Tasks .......................................................... 22
Continuum of Care ......................................................... 23
Referral Pathway ............................................................ 24
Admission Procedure ..................................................... 25
Catering ........................................................................... 27

Level 4 Residential Rehabilitation & Recovery Service

SERVICE SPECIFICATIONS

Target Groups ................................................................. 29
Key Objectives .............................................................. 29
Key Service Features ..................................................... 30
Key Service Tasks .......................................................... 31
Continuum of Care ......................................................... 32
Referral Pathway ............................................................ 33
Admission Procedure ..................................................... 34
Discharge Pathway ......................................................... 37
Glossary ........................................................................... 38
INTRODUCTION

Mental Health Services (MHS) Tasmania is committed to the provision of a range of services that meet the needs of consumers and those involved in their ongoing care. The following provides the framework for the development of supported accommodation services for people experiencing a mental illness who require residential services. Supported accommodation services are hereafter referred to as Residential Rehabilitation and Recovery Services (RR&RS) and are based on a recovery focused model of care.

Mental Health Services (MHS) Tasmania acknowledge the support of the Victorian Department of Human Services and the heavy reliance on the publication: “Expanding support and treatment options within mental health services. Prevention and recovery care services. Service Guidelines” DHS:2005.

Mental Health Services Tasmania has adopted the Prevention and Recovery Care (PARC) model of care from the Department of Human Services Victoria. The PARC model is conceptually seen as part of the acute end of the service continuum, one level back from adult acute inpatient setting. In this context, ‘prevention’ refers to the capacity to intervene early in the relapse process, while ‘recovery’ refers to maximising persons well-being through providing post-acute support and interventions aimed at laying a foundation for self-management, relapse prevention and rehabilitation.

MHS Tasmania have utilised the PARC model for Level 5 Transitional Care component of the continuum of care for Residential Rehabilitation and Recovery Care Services. Transitional care is for clients stepping down from inpatient care and stepping up from independent community living.

Supporting Documentation

This document is to be read in conjunction with:

- Mental Health Services Strategic Plan 2006-2011
- Mental Health Services Tasmanian Adult Community Mental Health Services (ACMHS) Blueprint.
- Resource Manual Assertive Case Management
- Consumer Carer Participation Framework
- Non Government Organisation Service Blueprint
- COPMI Guidelines
- MHS Data Collection Policy

Language

Throughout the document the person receiving the service is identified as the “person” or “consumer”. These terms are used interchangeably and are an attempt to destigmatise and normalise the person receiving care.

Carer’s – that is a family member, friend or other significant person caring for someone with a mental illness is referred to as either “carer” or “those involved in their on-going care”.

Residential Recovery & Rehabilitation Model of Care
March 2008
GENERAL PRINCIPLES

GOVERNANCE

The Adult Community Mental Health Service (ACMHS) will be the key Mental Health partner in the Residential Recovery and Rehabilitation Service (RR&RS). Mental Health Services will contract a psychosocial rehabilitation provider to manage the residential support component of the program.

The Area Manager and Clinical Director will have overall clinical responsibility for the clinical treatment and care provided to persons in RR&RS. This will include entry and exit from RR&RS. Services will operate consistently within the principles of the Mental Health Act 1996, and relevant Mental Health Service guidelines, protocols and procedures. ACMHS and the contracted psychosocial rehabilitation provider will develop collaborative operational policies and procedures to ensure the effective operation of the program.

ACMHSN will have responsibility for the provision of clinical services and the psychosocial rehabilitation provider the psychosocial component of RR&RS.

CONTINUUM OF CARE

Mental Health Services provides services across the continuum of care for persons experiencing serious mental illness in Tasmania. Services include:

- Acute Care Services
- Transitional Care and Intensive Community Based Services (Level 5) (RR&RS)
- Residential Rehabilitation and Recovery Care (Level 4) (RR&RS)
- Residential Rehabilitation and Recovery Care (Level 3)
- Packages of Care
- Community Based Rehabilitation Services.

Community based residential services are identified on a continuum from Level 3 to Level 5. Level 5 being the highest level of support available to provide clinical services to people receiving mental health services in the community.

The level of service delivery relates to the level of clinical intervention needed by the consumer to safely maintain them in the community and work towards their recovery. Consumers may move between levels of care during the time they are in the Residential Rehabilitation and Recovery Care Services and this will be reflected in the amount of clinical time allocated to the person receiving care. That is, a person in Level 3 accommodation may from time to time require a Level 4, or 5 service which can be provided in their current accommodation with an increase in clinical care. The level of clinical service provision will at all times be informed by on-going assessment of the person’s needs.

Level 3, 4 and 5 Residential Services are staffed 24 hours a day by a psychosocial rehabilitation provider working in partnership with the Adult Community Mental Health Service.

Level 5: In the community setting, intensive community follow-up and Transitional Care Services provide services for consumers who need a level of monitoring and clinical care that does not require admission to an inpatient unit, but who would benefit from more intensive clinical treatment.
and psychosocial support. People receiving intensive community/Transitional Care Services will be seen by member of the ACMHS at a minimum on a daily basis. This level of service will be provided either in the person’s place of residence or in the RR&RS Transitional Care Service.

**Level 4:** Persons in Level 4 RR&RS have higher support needs as identified through the process of a comprehensive assessment which identifies the level of support and assistance required on a day to day basis.

Persons receiving Level 4 services will require more intensive input from the ACMHS with a benchmark of approximately 2 hours clinical time per week. This may be face to face and include liaison and documentation and may decrease on the basis of on-going assessment as the person moves towards transition to community living.

**Level 3:** Persons receiving Level 3 services require less intensive ACMHS service with a benchmark of approximately 2 hours clinical time per fortnight. This may be face to face and include liaison and documentation. This may be decreased on the basis of on going assessment as the person moves towards transition to community living.

**MENTAL HEALTH SERVICES CONTINUUM OF CARE**
DEFINITIONS

Mental Health Services provide the Clinical Component of the RR&RS program. Clinical activities provided by the Adult Community Mental Health Services include:

- Triage
- Assessment
- Assertive Case Management
- Treatment/Interventions
- Family interventions
- Individual Service Plans/Rehabilitation Plan
- Psycho-education
- Relapse prevention
- Medication management
- Psychiatric review
- Symptom management

Psychosocial Rehabilitation (NGO):

Psychosocial rehabilitation is described by the International Association of Psychosocial Rehabilitation Services (IAPRS) as:

“the process of facilitating an individual’s restoration to an optimal level of independent functioning in the community... while the nature of the process and the methods used differ in different settings, psychosocial rehabilitation invariably encourages persons to participate actively with others in the attainment of mental health and social competence goals. … The process emphasises the wholeness and wellness of the individual and seeks a comprehensive approach to the provision of vocational, residential, social/recreational, educational and [spiritual] personal adjustment services.” (Cnaan et al, Psychosocial Rehabilitation Journal, Vol 11, No. 4: April 1988, p.61)

Cnaan et al state that psychosocial rehabilitation is based on a number of assumptions, including the following two essential ones:

1. Persons are motivated by a need for mastery and competence in areas which allow them to feel more independent and self-confident.
2. New behaviour can be learned and persons are capable of adapting their behaviour to meet their basic needs.

Further, Cnaan et al (1988) propose the following 15 principles which underpin effective psychosocial rehabilitation:

1. Maximisation of full human capacity
2. Equipping persons with skills (social, vocational, educational, interpersonal and others)
3. Persons have the right and responsibility for self-determination
4. Services should be provided in as normal an environment as possible
5. Matching individual needs and the care provided
6. Commitment from staff members
7. Care is provided in a caring environment
8. Early intervention
9. Recognising the role the environment plays
10. Making appropriate environmental changes
11. Unlimited participation
12. Encourage and support chosen vocation
13. There is an emphasis on social model of care
14. Emphasis on the client’s strengths
15. Emphasis on the here and now.

The Victorian community-managed sector developed a set of “characteristics” for non-government services providing psychosocial rehabilitation as follows:

1. Flexibility of structure and service models
2. Voluntary participation
3. Support for mobility and choice of service options
4. Active consumer involvement in services
5. Support for consumer decision-making
6. Concentration on quality of relationships and interactions between consumers
7. Encouragement of peer support
8. Responsiveness to consumers’ needs
9. Provision of most “normal” environment
10. Effective psychosocial rehabilitation
11. Community accountability
12. Utilisation of a broad range of skills
13. Active community education function
14. Active advocacy function
15. Cost-effectiveness: both operational and preventative


Community Residential Rehabilitation and Recovery Services work alongside persons with a mental illness. These programs predominantly provide essential support to assist persons with:

- housing,
- activities of daily living,
- social skills,
- community access and participation,
- social and recreational activities,
- counselling and advocacy,
- financial skills and management,
- vocational and employment support as well as general and specialist information-sharing.
- supporting the clinical component and the ISP

These services are delivered through the implementation of Individual Service Plans utilising tailored programs or group activities that assist persons to gain or develop new skills to manage and maintain their mental health, and deal with the impact their mental illness has on their lives. The prime focus in Residential Rehabilitation and Recovery Services is to assist persons to develop/redevelop their skills in as normalised an environment as possible and in a way that assists them to integrate and reconnect with their chosen community.

**ENVIRONMENTAL CONSIDERATIONS**

The residential component of RR&RS will be:

- Acceptable to the person receiving the service and those involved in their on-going care.
- Accessible and safe
- Conducive to the provision of rehabilitation, support and treatment.
- A homely environment for different age groups and for a mixed gender group, with due consideration given to privacy, personal space and individual interests.
- Sensitive to, and work appropriately with, the cultural and linguistic needs of persons in RR&RS.
- Actively involving persons in their own recovery and work towards engaging and maintaining their links with natural supports and participation in community life (e.g. work or study).

**CARE PLANNING AND IMPLEMENTATION**

Care planning is an important strategy providing the consumers and those involved in the delivery of care with a tool that identifies the person’s needs and matching these needs with strategies to assist with their recovery. The care planning and implementation processes utilised in the RR&RS should be consistent with the overall processes and documentation utilised by ACMHS.

To facilitate effective care planning in RR&RS – both ACMHS and the psychosocial service provider will utilise the same processes and documentation where possible. ACMHS will develop an Individual Service Plan in collaboration with the person utilising the service and those involved in their on-going care. This plan will be the basis of all care planning for both service partners.

Persons entering RR&RS will be asked to sign a Release of Information which will allow for the free flow of information across ACMHS and the psychosocial rehabilitation provider for the current episode of care.
TRANSFER OF CARE

Transfer of care is a critical period in the care continuum. In both the Level 5 Transitional Care and Level 4 Residential Rehabilitation and Recovery components, discharge planning will commence upon entry to the program.

Those involved in the person’s on-going care should be involved in the transfer of care and be included in transfer of care plans and discussions. Significant stakeholders identified by the person receiving care should be involved wherever possible to ensure effective information-sharing and an understanding of on-going needs.

ACMHS, jointly with the psychosocial rehabilitation provider, will ensure that appropriate information is given to the services providing on-going care in order to maintain a continuity of care that meets the needs of the person. The most common services providing on-going care will include:

- Case Management ACMHS
- Crisis response function ACMHS
- General Practitioners
- Packages of Care
- Community-based Recovery Services
- Supported residential services
- Families and those involved in the person’s on-going care.

CONSUMER AND CARER RIGHTS AND RESPONSIBILITIES

ACMHS and the psychosocial rehabilitation provider are expected to provide the person receiving care and people involved in their care, with written and verbal information about their rights and responsibilities in plain English. The client’s understanding of current and on-going information must be regularly assessed and addressed in a timely manner.

CONSUMER AND CARER PARTICIPATION

The consumer and their carers need to be acknowledged as the most significant partners in the recovery process; at all times, both ACMHS and the psychosocial recovery service will seek to include them in their on-going care. People may choose to participate to a lesser or greater degree in their recovery and this will be based on their individual preferences and circumstances and may change over time. The recovery model is an active and assertive partnership between the person receiving care and those involved in their on-going care. Mental Health Services and other providers will deliver goal-orientated and assertive care and treatment. Recovery orientation aims to support the person in their own personal development, building self-esteem and identifying and finding a meaningful role in the community to fulfil their potential.
**Family Care Plan**
*(to be read in conjunction with Children Of Parents with Mental Illness package for Mental Health workers (COPMI))*

Mental Health Services is committed to supporting the maintenance of parent/child relationships. Mental Health Services encourages and supports positive contact between children/young people and their parents/carers who are in residential services. This must occur only if it is in the best interests of the child. The safety of the children/young people is of paramount importance in this process.

The interests of the child/young person override all other interests and must be given priority. Visits that are not in the child’s best interests cannot go ahead despite the benefits the consumer may acquire as a result.

Contact cannot ever be forced.

Considerations inherent in how RR&RS work with the persons receiving care and those involved in their on-going care in relation to visits from children/young people include:

- Decision-making about the suitability of child visitation – this will be informed by clinical assessment, the needs of the child/young person and the person receiving care and be a collaborative decision with the treatment team
- Child and family-friendly visiting environments
- Monitoring family contact and providing support where appropriate
- Discharge planning and liaison with community services

**Key Service Tasks**

**ACMHS**

- Provision of comprehensive clinical assessments of persons, in collaboration with the person receiving care and those involved in their on-going care, ensuring the appropriateness and safety of placement with RR&RS.
- Provision of an Individual Service Plan by clinicians to RR&RS psychosocial rehabilitation staff.
- Development of appropriate transition processes, including handover of assessment and treatment details.
- Development and implementation of individualised treatment and support plans with clear goals, timelines with consumer and staff responsibilities.
- Provision of appropriately planned, intensive clinical treatment and provision of crisis intervention in accord with agreed protocols for unplanned treatment and support.
- Provision of supervision and monitoring of consumer well-being supported by open communication between ACMHS and the psychosocial rehabilitation provider of changes in symptoms, behaviours, treatment and needs.
Formulate and implement joint transfer of care plans at the earliest opportunity, and ensure provision of appropriate continuing care arrangements.

Working in partnership with the psychosocial rehabilitation provider to plan and implement the Individual Service Plan.

Develop joint policies and procedures between ACMHS and the psychosocial rehabilitation provider that facilitate entry, management and discharge of persons utilising transitional care.

**Psychosocial rehabilitation provider:**

- Working in partnership with ACMHS to implement the Individual Service Plan.
- Provision of individualised support, and practical assistance with activities of daily life.
- Provision of appropriate individual and group rehabilitation activities.
- Enhance and/or promote links with natural supports, primary care providers, and other relevant support and community options.
- Maintain strong links between services for the benefit of the resident.
- Develop joint policies and procedures between ACMHS and the psychosocial rehabilitation provider that facilitate entry, management and discharge of persons utilising transitional care.
Service Provision

DAYTIME SERVICES

The psychosocial rehabilitation provider will provide an environment for each consumer that is welcoming, calm, safe and private. During the day, consumers will have the opportunity to participate in structured programs designed to help achieve improved outcomes consistent with key service tasks. Essential to the RR&RS model of care is the understanding that the time the person spends in a residential care setting is transitional, with the ultimate aim of the person moving into a more independent environment.

The psychosocial rehabilitation provider will staff the service 24 hours per day, seven days per week.

NIGHT-time SERVICES

The psychosocial rehabilitation provider will promote the development of healthy sleep patterns and address lifestyle issues that may otherwise contribute to a person’s sleep disturbance.

Psychosocial rehabilitation provider will be on site 24 hours per day. Night shift will be an awake shift for the first 12 months of the program and then will be reviewed.

The psychosocial rehabilitation provider will have access to Mental Health Services from 10.00pm – 8.00am through the Mental Health Helpline.

FACILITY SERVICES

The psychosocial rehabilitation provider will ensure the adequate provision of all facility services covering:

- Cleaning (Transitional Care)
- Linen services (Transitional Care)
- Food (Transitional Care)
- Laundry (Transitional Care)
- Property Maintenance, repairs and replacements, &
- Utilities

MEDICO-LEGAL ISSUES

Administration of medication will be the responsibility of the individual person receiving the service. The psychosocial rehabilitation provider will not have direct responsibility for the administration of medications.

The psychosocial rehabilitation provider will provide for the safe-keeping of medications within the residence in accord with agreed protocols.
**TRAINING AND STAFF DEVELOPMENT**

All parties involved in RR&RS will contribute to initial and on-going staff orientation, training and development. Initial staff orientation will be supported by establishment funding.

Staff education and training will be consistent with the National Practice Standards for the Mental Health Workforce.

**CONFIDENTIALITY**

Both ACMHS and the psychosocial rehabilitation provider agree that, at all times, the confidentiality of person’s medical and other records remain confidential and that they are secure. Parties agree that they will, at all times, maintain the confidentiality of members of the other services and meet privacy legislation standards.

**PAYMENTS AND ACCOUNTABILITY**

Refer to the Service Agreement between the Secretary, Department of Health and Human Services and the psychosocial rehabilitation provider.

**STAFFING**

Adult Mental Health Community Services (ACMHS) will provide clinical support to RR&RS residents across the 24-hour period. Clinical staff will provide intensive in-reach to provide assessment, treatment planning and active specialist mental health care between the hours of 8.00am and 10.30pm, seven days a week. Access to MHS staff from 10.30pm – 8.00am will be via the MHS Helpline.

The psychosocial rehabilitation provider will make available an appropriate level of EFT staff positions to ensure the safe and effective day-to-day operations of the RR&RS facility.

Mental Health Services will review staffing arrangements at regular intervals to ensure the effective and on-going management of the facility and the adequate provision of support to RR&RS residents.

**CASE MANAGEMENT**

To maximise continuity of care, existing case managers from ACMHS will maintain active involvement with their clients for the duration of stay at RR&RS. The case manager will maintain single point accountability for the provision of services to the person whilst in RR&RS. Some components of clinical services may be delivered by a range of clinical staff within ACMHS.

Protocols to guide the relationship between ACMHS and between RR&RS and other case managers will be established.
COMPLAINTS

In the event of any dispute between ACMHS and the psychosocial rehabilitation provider, the following process is to be followed:

1) Wherever possible, disputes will be addressed in a timely manner directly between the relevant individuals or organisations at the local level.
2) Any escalation of a complaint will be addressed by the Team Leader of ACMHS and Manager of the psychosocial rehabilitation provider; if unresolved, the complaint goes to the Area Manager Mental Health Services and the appropriate senior Manager of the psychosocial rehabilitation provider.
3) Clinical issues relating to service provision will be referred to the Area Manager/Clinical Director Mental Health Services for resolution.
4) Issues relating to access to services will be referred to the Area Manager/Clinical Director Mental Health Services.

MEDIA

Both ACMHS and the psychosocial rehabilitation provider will ensure that neither it, nor any of its staff or providers shall communicate to, or with, any media organisation or person regarding the RR&RS service without prior written authorisation of its respective public relations structures. Both parties will notify the other when media contact arises and has implications for the other party.

PERFORMANCE REPORTING

RR&RS will operate according to the National Standards for Mental Health Services (1996) and is accountable under the Mental Health Act 1996, and the Health Records Act 2001, and other relevant legislation.

Each party to RR&RS will develop and maintain data management and record systems consistent with service delivery and with the overall program.

Clinical activity will be recorded on OARS in line with existing data collection. A separate sub-centre will be established by ACMHS to record bed day activity.

RR&RS will report in accordance with the guidelines for Quarterly Data Collection (QDC), and maintain other data in line with Tasmanian MHS data collection policy.

Service Agreements are outcome-focussed and key service requirements are based on achieving services for consumers that:

- respond to their individual identified needs and promote recovery
- enhance quality of life, self esteem and sense of well-being
- improve social and daily living skills, capacity for independent living and involvement in community life
- improve consumer participation in the community through volunteering and employment
- build social relationships, including relationships with families and carers
- provide opportunities for the development and maintenance of social and recreational support networks
- promote the integration of people with psychiatric disabilities into the local community
- provide care in the least restrictive setting.

**Performance Indicators**

All MHS funded non-government mental health service providers will deliver services consistent with the National Standards for Mental Health Services. Performance indicators and outcome measures are based on agreed outcomes specific to each Service Agreement. The following performance measures are indicative of the type of information that will be used to support the measurement of Service Agreements:

- Commonwealth minimum data set requirements
- Percentage of consumers with an individual program plan
- Consumer satisfaction survey
- Activities of daily living (ADL) functional assessments
- ‘Referral to service’ priority rating score evaluation
- Separations
- Average length of stay
- Occupancy rate
- Complaints data
- Service utilisation
- Incident report data

**Monitoring and Evaluation**

Evaluation of RR&RS will be undertaken on an agreed basis and will be consistent with the DHHS planned evaluation strategy. All parties to RR&RS will contribute to the evaluation.
Level 5
Transitional Care
LEVEL 5: TRANSITIONAL CARE

SERVICE SPECIFICATIONS

TARGET GROUPS:

- Persons who are eligible for adult mental health services
- Persons who no longer require acute inpatient clinical treatment and intervention but who would benefit from short-term intensive treatment in a residential setting.
- Persons who are living in the community and require short-term residential support with intensive clinical treatment and intervention to prevent risk of further deterioration, without which re-admission to an acute psychiatric inpatient unit would occur.
- One of the intentions of the transitional care service is to assist carers in the long-term care of the person receiving mental health services. Transitional Care offers an important alternative for early intervention with those persons in the early phase of relapse, and for those in need of further stabilisation and recovery, preparatory to returning to their normal place of living following an acute admission.

KEY OBJECTIVES

For the person in transitional care:

- To enable gains from the period in the inpatient setting to be strengthened.
- To fulfil their individual potential.
- To allow time for community transition plans to be consolidated.
- To minimise the trauma and disruption for persons and carers that may arise from a first episode or relapse of mental illness.
- To provide appropriate types and levels of clinical intervention and support to improve the person’s symptom control and to assist recovery.
- To provide an appropriate range, type and level of psychosocial treatments and support to encourage the person’s use of their functional abilities and to facilitate a return to usual or chosen environment.
- To assist the person to remain in the community.
For the Adult Community Mental Health Service:

- To identify people with a severe mental illness in the in-patient setting and in the community, whose treatment and recovery is better suited to intensive, short-term treatment and support in a residential setting.
- To expand the range of options to people in the sub-acute phase of severe mental illness.
- To prevent admission and avoidable re-admissions to the inpatient unit and supplement crisis intervention services.
- To enhance access to in-patient services through the provision of an intensively supported early discharge alternative.

For the psychosocial rehabilitation provider:

- Provide support and practical assistance with activities of daily life.
- Provide appropriate group-based activities.
- Enhance and/or promote links with natural supports, primary care providers, community sector agencies (eg. Drug and Alcohol Services, Community Health, accommodation services).
- Support liaison with the person’s on-going treatment provider(s).

**KEY SERVICE FEATURES**

Level 5 Transitional care will differ from, yet compliment and be integrated with, other components of Mental Health Services. Transitional care will be fully integrated within the continuum of care and within the partnership model between ACMHS and the psychosocial rehabilitation provider. Routine exchange of information, including clinical information in accordance the Mental Health Act 1996, will ensure best outcomes for the person receiving the service and those involved in their ongoing care.

RR&RS services will provide:

- Bio-psychosocial treatment and care
- Active, community mental health intervention, including crisis support and planning and, where necessary, individually tailored recovery care-planning and implementation, which may involve existing treatment teams
- Individualised support and practical assistance
- Short-term accommodation
- Group activities and interventions
- Day to day support, supervision and monitoring
Access to specialist mental health services staff 24 hours a day, seven days a week through the provision of appropriately intensive ‘in-reach’ or ‘facility based’ activities from the ACMHS, through the 1800 332 388 Helpline Number after 10:00pm.

Access to group and individual services including linkage with supports that can be sustained on discharge

The integrated services system will provide prompt, intensive, short-term, bio-psychosocial treatment and support with a focus on:

- Maximising the resilience and protective factors of individuals that avert crises, prevent illness relapse, promote recovery and enable a return to a suitable living environment.
- Minimising the vulnerability and risk factors that contribute to crisis escalation, illness relapse, impede recovery and promote relocation to a suitable living environment.
- Fosters independent living and social skills, enabling a return to the usual residence and/or independent community living.

RR&RS will actively involve persons in their own treatment, work towards maintaining the person’s links with natural supports, and facilitate the person’s participation in community life.

**KEY SERVICE TASKS**

- Develop joint processes between ACMHS and the psychosocial rehabilitation provider that facilitate entry, management and discharge of persons utilising transitional care.
- Perform comprehensive assessments of persons entering the service directly from the community, in liaison with carers and mental health service staff as appropriate.
- Develop appropriate transition processes and protocols, including handover of assessment and treatment details of persons referred to RR&RS via Ward 1E or other community MHS.
- Develop management plans to guide treatment and support with clear goals, timelines as well as staff and person’s responsibilities.
- Provide intensive clinical intervention and treatment involving a minimum of one contact per person per day, provided by the clinical treatment component of the program.
- Provide supervision and monitoring of person’s safety and well-being
- Provide individual treatment, support and practical assistance with activities of daily living.
- Provide appropriate group-based activities and interventions.
- Enhance and promote links with natural supports, primary care providers, community sector agencies.
- Establish liaison with the person’s on-going treatment provider(s).
- Develop discharge processes and plans, ensuring post-discharge continuing care.
- Involve families and carers where appropriate.
CONTINUUM OF CARE

Level 5 Transitional care lies between acute inpatient care and Level 4 Residential Rehabilitation and Recovery programs. Transitional care can be seen as a step-down from inpatient care, or a step-up from community care.

Entry Criteria

Entry to Transitional Care will be managed by ACMHS. ACMHS will maintain constant communication with the psychosocial rehabilitation provider on the current bed state. Entry to Transitional Care will be as planned and organised as possible.

Consideration should be given to the provision of a Level 5 Transitional Care Service in the person’s home where safe to do so and in conjunction with the person’s family and those involved in their ongoing care.

RR&RS will not be gazetted to admit involuntary persons, although persons on a community treatment order (CTO) may be admitted to RR&RS for more intensive community treatment and support.

- Transitional care services are suitable for persons who need a level of monitoring and clinical care that does not require admission to an inpatient unit, but who would benefit from more intensive clinical treatment and psychosocial support.

- Persons discharged from acute in-patient settings must have recovered to the point where that service can demonstrate a low-risk status that does not require clinical care typically provided by an in-patient unit. If an individual is clinically assessed as requiring inpatient care, they should only be admitted to an in-patient unit.

- A residential address to which the person will return upon exit from RR&RS.

- Clinically assessed as low-risk of suicide, self-harm, and harm to others.

- Agreement to reside at RR&RS and comply with all written rules of RR&RS residence and a willingness to participate in recovery-focused psychosocial rehabilitation and clinical interventions.

- A comprehensive assessment of the person’s psychiatric and psychosocial status will have been undertaken and documented by ACMHS.

- Persons will be referred to alternative services where:

  - a more appropriate service /intervention is available within the framework of least restrictive practice;
  - more intensive supervision and /or support is required outside the scope of the RR&RS.
  - the person has an assessed on-going substantial propensity for high-risk behaviours (including violence and self harm) and for which a more acute admission is indicated
  - a person requires acute medical or surgical interventions

If a person is unable to access RR&RS on one occasion, this should not preclude their consideration at a future assessment.
REFERRAL PATHWAY

Referrals are accepted from the following Mental Health Services.

- ACMHS
- Private Psychiatrists
- Approved assessment centres under the Mental Health Act 1996

In cases where the person is referred to Transitional Care and is not currently registered with ACMHS, then that registration should be completed prior to review of the referral, and a case manager from the ACMHS appointed as soon as possible. Interim arrangements for a case manager can be made when a person is admitted outside of ACMHS business hours.

A referral document is to be completed by the case manager or delegate as an appropriate intervention for the person. Prior to making a referral to Transitional Care, the case manager will consult with the person seeking to enter the program and appropriate family and persons involved in their ongoing care and relevant treating practitioners.

The case manager will append a:

- Biopsychosocial assessment
- Current Individual Service Plan (ISP); for urgent admissions, this can be an Interim ISP. All people in the program should have an Individual Service Plan (ISP). The ISP is designed to integrate the standard measures of outcome into the care-planning process; it provides an evidence-based framework from which to construct a collaborative care plan with the consumer and those involved in their on-going care. This plan is used to document the person’s identified needs along with their strengths. Interventions are developed collaboratively and goals identified to meet the person’s needs. The ISP also identifies the person who is responsible to assist in this process and clearly identifies which service is responsible for specific activities/interventions i.e. ACMHS or the psychosocial rehabilitation provider. Every admission to Transitional Care should identify the goals of the admission and specific interventions required during the admission.
- Current HoNOS Scale
- Current Life Skills Profile (LSP – 16)
- Basis 32

A referral should be approved by the ACMHS Team Leader in the first instance. In the event that there are no available beds, referrals should be referred to the Clinical Director for prioritisation.

The ACMHS Team Leader should then discuss the admission with the psychosocial rehabilitation provider Co-ordinator.
When admission is agreed, the case manager should advise the person and family or carers as soon as practical.

Referrals are prioritised based upon clinical presentation.

RR&RS admission requiring a re-admission to the acute ward, the case manager ACMHS and Team Leader will co-ordinate the admission with Ward 1E. ACMHS will liaise with the Department of Emergency Medicine at LGH to facilitate the admission process.

**ADMISSION PROCEDURE**

New admissions to Transitional Care will be accepted 7 days per week between the hours of 8:00am – 9.00pm. The person entering the program is formally advised by the case manager. Where possible, the person entering the program, and those involved in their ongoing care should be present at that discussion.

The case manager will ensure that the Admission Checklist and Client Orientation Checklist are completed for all admissions.

The referring source is contacted and any additional information about the person entering the program is provided if necessary. The referring source should be advised if the person is accepted for admission.

Persons entering Transitional Care and those involved in their on-going care should be informed on admission that Transitional Care services will be provided for the period of time clinically indicated and that transfer of care will happen as soon as the person is able to manage back in their normal living environment – with appropriate support, or transferred to acute care if clinically indicated.

**Review Processes:**

The review process is a daily collaborative process including the person receiving care, those involved in their on-going care, ACMHS and the psychosocial rehabilitation provider. While ACMHS carries out the clinical review tasks, the review process is to be informed by all those involved in the person’s care plan.

People in Transitional Care are to be reviewed on a daily basis by ACMHS. The review will include:

- Risk assessment
- Mental Status Examination
- Review of ISP goals for the admission
- Transfer of care-planning

**Clinical Interventions:**

In Transitional Care the following interventions will be provided by ACMHS:

- Psycho-education
- Symptom management
- Medication management/encouragement to adhere to treatment
- Goal planning
- Structured problem-solving
• Family/carer meetings – during admission to Transitional Care there should be at least one family/carer meeting with the consumer’s consent and where appropriate.
• And any specific interventions identified in the assessment.

**Family Care Plan**

At assessment ACMHS should identify if the person has children in their care and ensure that their needs are considered through the admission process. The Family Care Plan is designed to support children, young people and families where the parent or carer experiences mental illness and is an initiative of the Tasmanian Kids in Mind Project.

This plan aims to help reduce the anxiety if the person becomes unwell and is unable to care for their children. It also aims to facilitate the sharing of information so that the person’s wishes can be followed as closely as possible in the case of a crisis.

With the person’s consent, a copy may be kept in the clinical file so that health service workers have access to the person’s wishes. If the plan is to be kept in the clinical file, identification should be indicated at the top right hand corner of each page.

The case manager will assist the person in developing the Family Care Plan and takes responsibility for organising appropriate interventions as indicated.

Decisions in relation to contact with children and young people should be informed by the COPMI guidelines.

**Transfer of Care**

The target average length of stay in the RR&RS transitional care will be between 7-14 days and, wherever possible, a maximum length of stay of 28 days. Transfer of care should commence at admission and be discussed with the person and those involved in their on-going care on a daily basis.

Transition to the community will be supported by treatment and support planning, and by sound discharge planning. Discharge planning will commence upon entry into the RR&RS program.

Where a person’s condition deteriorates or where the requirement for more intensive treatment and support becomes evident, the person may be transferred to an in-patient facility. Transfer of a person to a psychiatric in-patient facility will be in accordance with agreed protocols aimed at prompt and seamless resolution.

Discharge planning will be incorporated in the Individual Service Plan and will incorporate transfer of care detailing:

• Community options post-discharge
• Transitional arrangements
• Levels of support during the transition phase (who, what, where, when)
• Relapse prevention
• Crisis response
• Some persons may be eligible for Level 3 or 4 accommodation or Level 2 Package of Care to assist with the transition

CATERING

In keeping with the domestic feel of the residence, the psychosocial rehabilitation provider will ensure the following as of key importance in the provision of food and meals:

- Flexibility/availability of food, hot and cold drinks and reasonable access to food preparation facilities outside of meal times.
- A variety of nutritious foods.

Food is a key component of social interaction and group communication. The preparation and provision of food will be a critical feature in creating and maintaining a domestic feel.

The psychosocial rehabilitation provider will involve residents in the planning and preparation of food as a part of their psychosocial program, while ensuring that a range of fall-back options for the provision of meals are available.
Level 4
Residential Rehabilitation
&
Recovery Service
LEVEL 4 RESIDENTIAL REHABILITATION & RECOVERY SERVICE

SERVICE SPECIFICATIONS

TARGET GROUPS

Level 4 Residential Rehabilitation and Recovery clients:

- Persons who need intensive rehabilitation and recovery support and clinical management due to significant impact of their mental illness.
- Persons who would benefit from a focus on returning to maximum levels of independent living in a supportive residential environment.

KEY OBJECTIVES

For the consumer:

- To provide the opportunity for the person to develop and build on skills to assist with independent living in a supported environment.
- To provide a transitional home environment where persons can learn the skills of daily living in a supported environment.
- To provide an appropriate range of types and levels of psychosocial treatments and support to encourage the person’s functional abilities and to facilitate a return to independent living within the community.

For the Adult Community Mental Health Service:

- To provide a longer term option for persons to enhance their psychosocial skills with appropriate mental health and community support.
- To work collaboratively with the client and psychosocial rehabilitation provider in relation to:
  - Developing an individual service plan (ISP)
  - On-going bio-psychosocial assessment
  - Relapse prevention management
  - Crisis responsiveness
  - Family Care Plan
  - Medication management
Clinical interventions

- Development of specific goals and strategies to achieve a greater level of independent living reviewed monthly or as goals/situation changes with ACMHS, the client and the psychosocial rehabilitation provider

**For the psychosocial rehabilitation provider:**

- Provide support and practical assistance with activities of daily life.
- Provide appropriate group-based activities.
- Enhance and/or promote links with natural supports, primary care providers, and community sector agencies (eg. Drug and Alcohol Services, Community Health, accommodation services).
- Support and liaison with the person’s on-going treatment provider(s).
- Involve families and those involved in the person’s on-going care where appropriate.

**Key Service Features**

The clinical and psychosocial rehabilitation services will be fully integrated. Routine exchange of information, including clinical information in accordance the Mental Health Act 1996, will ensure best outcomes for residents.

RR&RS services will provide:

- Bio-psychosocial treatment and care
- Active specialist community mental health treatment and intervention, including crisis support and planning where necessary, individually tailored recovery care planning and implementation, which may involve existing treatment teams
- Individualised support and practical assistance
- Short term accommodation for transitional care
- Medium term accommodation for clients in the 10 independent units of up to 24 months, with 3 monthly reviews of agreed-upon goals
- Group activities and interventions
- Day to day support, supervision and monitoring
  - RR&RS will include access to specialist mental health services staff 24 hours a day, seven days a week through the provision of appropriately intensive ‘in-reach’ or ‘facility based’ activities from the ACMHS, through the 1800 332 388 Helpline Number after 10:00pm.

The integrated services system will provide prompt, intensive, short-term, bio-psychosocial treatment and support with a focus on:

- Maximising the resilience and protective factors of individuals that avert crises, prevent illness relapse, promote recovery, and enable a return to a suitable living environment.
Minimising the vulnerability and risk factors that contribute to crisis escalation, illness relapse, impede recovery, and prevent relocation to a suitable living environment.

Fosters independent living and social skills, enabling a return to the usual residence and/or independent community living.

RR&RS will actively involve persons in their own treatment, work towards maintaining the person’s links with natural supports, and facilitate the person’s participation in community life.

**KEY SERVICE TASKS**

- Develop joint processes between ACMHS and the psychosocial rehabilitation provider that facilitate entry, management and discharge of persons utilising RR&RS.
- Perform comprehensive assessments of persons entering the service directly from the community, in liaison with family or other carers and mental health service staff as appropriate.
- Develop appropriate transition processes and protocols, including handover of assessment and treatment details of persons referred to RR&RS via Ward 1E or other community MHS.
- Develop management plans to guide treatment and support with clear goals, timelines and that includes staff and person’s responsibilities.
- Provide intensive clinical intervention and treatment involving a minimum of one contact per person per day, provided by the clinical treatment component of the program (transitional care); and weekly contact for persons in the intensive residential rehabilitation and recovery care component of the service. This will be monitored over time and contact levels written into the individual service plan; these contacts may be reduced over time as the person works towards transition into independent living.
- Provide supervision and monitoring of person’s safety and well-being
- Provide individual treatment, support and practical assistance with activities of daily living.
- Provide appropriate group-based activities and interventions.
- Enhance and promote links with natural supports, primary care providers, community sector agencies.
- Liaison with the person’s on-going treatment provider(s).
- Develop discharge processes and plans, ensuring post-discharge continuing care.
- Involve families and carers where appropriate.
CONTINUUM OF CARE

Level 4 Residential Rehabilitation and Recovery sits between Level 5 Transitional Care and Level 3 Residential Rehabilitation and Recovery Services.

Entry Criteria

Entry will be facilitated through the Maximising Recovery Panel.

Admission priority is given to individuals -

- Who are consenting to participate in a structured goal-orientated rehabilitation program and agree to abide by the rules of residence of RR&RS.
- Displaying symptomatology of mental illness \(^{(1)}\) according to ICD 10 or DSM IV.
- Who are over the age of 18 years and under the age of 65
- Who require intensive residential rehabilitation and recovery services
- Clinically assessed low risk of suicide, self-harm, and harm to others.
- A comprehensive assessment of the person’s psychiatric and psychosocial status will have been undertaken and documented.
- Persons will be referred to alternative services where:
  - a more appropriate service /intervention is available within the framework of least restrictive practice;
  - more intensive supervision and /or support is required outside the scope of the RR&RS.
  - the person has an assessed, ongoing substantial propensity for high risk behaviours (including violence and self harm) and for which a more acute admission is warranted
  - a person requires acute medical or surgical interventions

If a person is unable to access RR&RS on one occasion, this should not preclude their consideration at a future assessment.
Referral Pathway

Referrals are accepted by the MRP from the following Mental Health Services.

- AMCHS
- Private psychiatrists
- Approved assessment centres under the Mental Health Act 1996

In cases where the client is referred to RR&RS, and is not currently registered with an Adult Community Mental Health Team, then that registration should be completed prior to review of the referral, and a case manager from the ACMHS appointed. This will require a bio-psychosocial assessment by ACMHS.

A referral document is to be completed by the referring agency and/or the case manager as an appropriate intervention for the person. Prior to forwarding the referral form to the MRP, the case manager will consult with the person seeking to enter the program and appropriate family and persons involved in their on-going carer and relevant treating practitioners.

The case manager will append a:

- Bio-psychosocial Assessment
- Current Individual Service Plan (ISP).
- Relapse Prevention Plan
- Family Care Plan
- Current HoNOS Scale
- Current Life Skills Profile (LSP – 16)
- Basis 32
- Current risk assessment
- Any specialist assessments indicated in the bio-psychosocial assessment
- Legal Status, Guardianship, Mental Health Act, Forensic Orders

A referral should be approved by the ACMHS Team Leader in the first instance.

The ACMHS Team Leader should then discuss the admission with the psychosocial rehabilitation provider co-ordinator of RR&RS. If an agreement cannot be reached, then the MHS Clinical Director should be called upon to arbitrate.

When admission is agreed, the case manager should advise the client and family or carers within two working days of the admission decision.

Referrals are prioritised based upon clinical presentation and needs.

RR&RS admission requiring readmission to the Acute Ward, the case manager ACMHS and Team Leader will co-ordinate the admission with Ward 1E.
**ADMISSION PROCEDURE**

The person entering the program is formally advised by the case manager that they have been accepted.

Prior to admission and on admission, the person and those involved in their on-going care should be informed that the length of stay will be informed by clinical needs. Persons entering the program should be advised that RR&RS is a transitional program and that the goal is to work with the person and those involved in their on-going care to assist them towards their goals. Persons entering the program should be advised that their residency will be reviewed on a three monthly basis or as required and the length of stay will be based on the achievement of the goals developed in conjunction with ACMHS, the person and those involved in their on-going care.

An orientation visit to the services provided by RR&RS will be arranged prior to admission wherever possible.

The case manager will ensure that the Admission Checklist and Client Orientation Checklist are completed for all admissions.

The referring source is contacted and any additional information about the person entering the program is provided if necessary. The referring source should be advised if the person is accepted for admission.

**Care Planning and Implementation**

Persons receiving care in Level 4 Residential Rehabilitation and Recovery Care should be reviewed on a minimum three (3) monthly basis consistent with the clinical review process.

The process of review should include:

- Review of Individual Service Plan

All people in the program will have an Individual Service Plan (ISP). The ISP is designed to integrate standard measures of outcome into the care planning process. It provides an evidence-based framework from which to construct a collaborative care plan with the consumer and those involved in their on-going care. This plan is used to document the persons identified needs along with their strengths. Interventions are developed collaboratively and goals identified to meet the person’s needs, both in terms of addressing the symptoms of the mental disorder/illness and the psychosocial consequences of the disorder/illness. The ISP also identifies the person who is responsible to assist in this process and clearly identifies which service is responsible for specific activities/interventions i.e. ACMHS or the psychosocial rehabilitation provider.

Care planning should be commenced following the assessment and completion of outcome measures. Goals or issues are identified based on information collected from the comprehensive assessment and the clinician/consumer-rated outcome measures. The identified goals/issues should be ranked and prioritised.
The case manager will assist in developing the care plan in collaboration with the consumer and those involved in their on-going care, and, where possible, with other health professionals and service providers. The case manager takes overall responsibility for organising appropriate interventions and monitoring progress.

The ISP review should include involvement from all people involved in the person’s care. The review should be a time where achievements are celebrated and new goals are established providing the person with the opportunity to feel successful in achieving goals.

At each review, the need for the person to remain in RR&RS should be examined and the person should be encouraged to consider the possibility of moving into a more independent or less intensive environment.

**Consumer Participation and Recovery Plan**

The Consumer Participation and Recovery Plan has a recovery focus. It should be kept as a prompt and reminder about how to support recovery for the consumer.

This document provides a supportive structure to assist the consumer in:

- Identifying what helps them stay well
- Identifying early warning signs
- Identifying social supports available to them
- Identifying potential triggers for relapse
- Planning strategies to be followed in case of relapse.

With the person’s consent, a copy may be kept in the clinical file so that health service workers have access to the person’s wishes. If the care plan is to be kept in the clinical file, identification should be indicated at the top right hand corner of each page.

The case manager will assist the person and/or those involved in their on-going carer in developing the Consumer Participation and Recovery Plan and takes responsibility for organising appropriate interventions as indicated.

**Family Care Plan**

The Family Care Plan is designed to support children, young people and families where the parent or carer experiences mental illness and is an initiative of the Tasmanian Kids in Mind Project.

The site will make available to staff the Kids in Mind Kit.

This plan aims to help reduce the anxiety if the person becomes unwell and is unable to care for their children. It also aims to facilitate the sharing of information so that the person’s wishes can be followed as closely as possible in the case of a crisis.

With the person’s consent, a copy may be kept in the clinical file so that health service workers have access. If the Plan is to be kept in the clinical file identification should be indicated at the top right hand corner of each page.

The case manager will assist the person in developing the Family Care Plan and takes responsibility for organising appropriate interventions as indicated.
Mental Health Interventions

Whilst in Level 4 Residential Rehabilitation and Recovery Care, the ISP will form the basis of the interventions provided by both ACMHS and the psychosocial rehabilitation provider.

Clinical Interventions:

There are a range of core management skills which can be utilised to form the basis of the clinical intervention which may include the following:

- Education sessions
- Encouraging adherence to treatment/medication
- Motivational interviewing
- Goal planning
- Structured problem solving
- Communication skills training
- Assertiveness training

The above provide a basic set of core interventions which can be utilised. Specific evidence-based interventions can also be utilised, based on the person’s diagnosis and specific psychosocial consequences of the mental health illness/disorder. Clinical reviews should be used to guide the clinical interventions provided.

Psychosocial Rehabilitation Activities:

The psychosocial rehabilitation provider will provide a range of activities for people in the RR&RS including but not limited to:

- Provision of support and practical assistance with activities of daily living.
- Provision of appropriate group-based activities.
- Enhancing and promoting links with natural supports, primary care providers, community sector agencies.
- Supporting liaison with the person’s on-going treatment provider(s).
- Respond to their individual identified needs and promoting recovery
- Enhancing quality of life, self-esteem and sense of well-being
- Improvement of social and daily living skills, capacity for independent living and involvement in community life
- Improving consumer participation in the community through volunteering and employment
- Building social relationships, including relationships with families and carers
- Providing opportunities for the development and maintenance of social and recreational support networks
- Promoting the integration of people with psychiatric disabilities into the local community
Transfer of Care

The maximum length of stay in the Residential Rehabilitation & Recovery Service will be 24 months. Individual Service Plans will be reviewed every three months, and as required, collaboratively with the person, family/carers and the treatment team (ACMHS & psychosocial rehabilitation provider).

Goals for the person will be reviewed every three months, and as required and discharge options discussed at each review. The goal of discharge and reintegration back into the broader community will be a primary goal discussed with the person throughout their stay. ACMHS & psychosocial rehabilitation provider staff will direct activities towards the achievement of specific goals agreed upon by the person and their treatment team.

Discharge planning will be incorporated in the Individual Service Plan and will include a transition strategy detailing:

- Community options post discharge
- Transitional arrangements
- Levels of support during the transition phase (who, what, where, when)
- Relapse prevention
- Crisis response
- Some persons may be eligible for Level 3 accommodation or Level 2 Package of Care to assist with the transition

Discharge Pathway

Discharges from RR&RS occur when:

- An appraisal of the rehabilitation goals has occurred and intervention is no longer required or feasible.
- The client wants to return to the community and is clinically stable and no further gains are expected.
- Follow-up arrangements have been made with an appropriate psychiatric, medical, nursing or ancillary service.
- If the client’s behaviour deteriorates to the extent that they are no longer appropriate for RR&RS.
GLOSSARY

(1) Definition of Serious Mental Illness

"Adults with a serious mental illness are persons: age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioural, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV, that has resulted in functional impairment which substantially interferes with or limits one or more major life activities."

The following is an analysis of this definition:

- SMIs include any mental disorders (including those of biological aetiology) listed in DSM-IV or their ICD-9 equivalent (and subsequent revisions), with the exception of DSM-IV "V" codes, substance use disorders, and developmental disorders, which are excluded unless they co-occur with another diagnosable serious mental illness.

- All SMIs have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects.

- Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in one or more major life activities including the following:
  - Basic daily living skills (e.g., eating, bathing, dressing);
  - Instrumental living skills (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication); and
  - Functioning in social, family, and vocational/educational contexts.

- Adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are considered to have serious mental illnesses.

(Source: United States Department Of Health & Human Services: The Substance Abuse and Mental Health Services Administration (SAMHSA) http://tie.samhsa.gov/Taps/tap22/appe.htm)