



# Creating Hope by Working Differently

The Power of Collaborative  
Relationships in supporting Complex  
Cases

# Presentation Overview

- Characteristics of a “Complex Case”
- Guiding principles behind “Complex Case” Management
- Case Vignette
- Lessons learned

# A “Complex Case” client:

- Has been assessed by all appropriate government programs (DCS/SPD and/or DoH) and deemed to be “Unclassifiable”
- Does not require hospitalization
- Has significant challenging care needs
- Is consenting

## There is recognition that:

- Front-line clinicians regularly encounter complex and challenging cases, and find solutions in partnership with other service providers, which meet the clients needs.
- Not intended to replace or take away from capacity within usual services to manage challenging cases within existing policies and partnerships.

# If:

Most of the “complex” characteristics are present and,

Two or more government agencies agree to participate in the case; then...

Complex Case designates for the agencies involved could initiate a process to jointly examine the case for potential resolutions and a joint management agreement.

# Complex Case Planning Process is about....

- Bringing together all involved or target services to create a plan of support
- Recognition that services working in isolation of each other do not produce optimum result
- Communication and collaboration between partners

# Complex Case Planning Process is about....

Recognizing that solutions may require adaptation of policy or programs:

- encouraging flexibility in service delivery.
- “best fit” options within existing services based on the individual needs of the client.

# “Complex Case” Demographics 2008

- History of Physical Aggression - 70 %
- SPMI - 52 %
- Significant Physical Health Issues - 44 %
- Elopement or Wandering - 30 %
- Intellectual Disability - 19 %
- Personality Disorder - 18 %
- Dementia - 11 %
- Acquired Brain Injury - 7 %

# Case Vignette

- 25 year old female
- Long standing history of challenging behaviour including parasuicidal and self-injurious behaviour, mood instability, poor impulse control and aggression
- **Diagnosis:** BPD, Borderline Intelligence, Bardet Briedl Syndrome, IDDM, legally blind, poor coping skills
- Using shelter system at time of referral

## History (continued)

- Frequent interactions with Police – which resulted in frequent trips to Emergency Department and involvement from Department of Justice
- Extended hospitalizations - behaviour during hospital admissions or ED visits tended to escalate rather than settle. No benefit seen from extended hospitalizations or pharmacology
- Unstable housing – Family and supported housing arrangements were not able to be sustained due to challenging behaviour

# Process

- Partnerships identified; DCS and CDHA (and DoH CC initially)
- Comprehensive joint Assessment
- Client goals examined
- “Best fit” options explored
- Identified and contacted key stakeholders

## Process (continued)

Case Conference(s) organized to:

- Determine unmet service needs
- Establish involved services
- Collaborate regarding comprehensive support plan including Transition Plan, Care Plan and Crisis Strategy.
- Clarify Roles and Responsibilities of each involved service

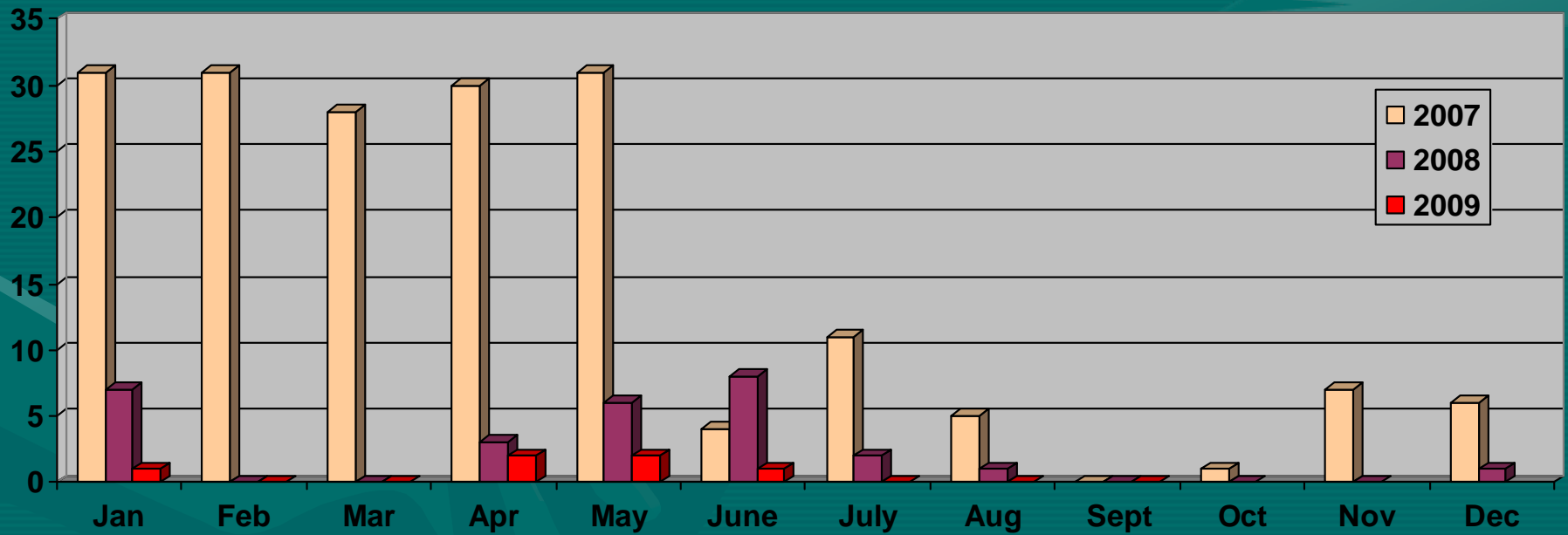
# Process (continued)

- Establish commitment to plan from all involved services
- Signing of MOU between partners
- Implementation of plan
- Frequent assessment of plan to determine changes in level of supports and facilitate problem solving between involved services

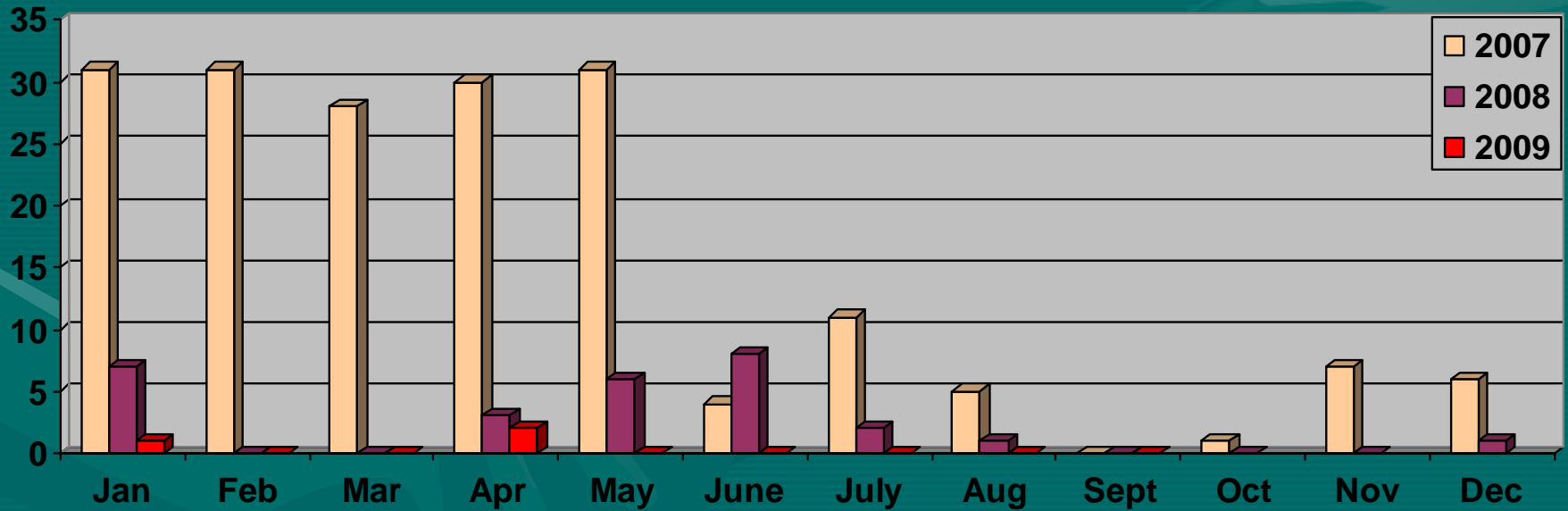
# Services Involved

- Mobile Crisis Team
- DCS Services for Persons with Disabilities
- Mental Health Outpatient Services
- Mental Health Inpatient Services (SSU)
- Emergency Department
- Halifax Regional Police
- DoH Continuing Care / VON
- Community Residential Provider Agency
- Private Psychologist

# Combined Inpatient Days/Days with ED Visit



# Monthly Police Calls



# Client Outcomes

- ↓ in self-harmful behaviours
- Discontinuation of involvement with Justice system
- ↑ self-esteem
- ↑ stability of mood
- Successful vocational pursuits
- Housing stability
- Positive community involvement
- Able to maintain positive family relationships

# Lessons Learned

## Complex Case Resolution requires:

- Flexibility within services/eligibility criteria
- Partnerships /shared responsibility for Plan (including client)
- Willingness to come up with the “best” plan possible – may not be “perfect” plan
- Shared assumption and acknowledgement of risk determined through a consensus process

# Lessons Learned

Case resolution works best when there is:

- Inclusion/education/support of front line staff; goal is to build capacity
- Avoidance of working in “silos”
- Responsiveness to changes in client need
- Flexibility in making changes

# Lessons Learned (continued)

- Shared understanding of agreement –  
MOU
- Clarity of roles and responsibilities of  
involved services
- Timely communication between  
services

# Lessons Learned (continued)

- It takes a multi-service approach to support these cases
- All services/disciplines have equal value
- No one service is able to support these cases... or they would have.

