## Working With Clients With Disabilities: The Case of Lester

Lester is a 59-year-old, African American widower with two adult children. He lives in a medium-sized Midwestern city. Four months ago, he was a driver in a multiple vehicle crash while visiting his daughter in another city and was injured in the accident, although he was not at fault. Prior to the accident he was an electrician and lived on his own in a single-family home. He was an active member in his church and a worship leader. He has a supportive brother and sister-in-law who also live nearby. Both of his children have left the family home, and his son is married and lives in a nearby large metropolitan area.

When he was admitted to the hospital, Lester's CT showed some intracerebral hemorrhaging, and the follow-up scans showed a decrease in bleeding but some midline shift. He seemed to have only limited cognition of his hospitalization. When his children came to visit, he smiled and verbalized in short words but could not communicate in sentences; he winced and moaned to indicate when he was in pain. He had problems with balance and could not stand independently nor walk without assistance. Past medical history includes type 2 diabetes; elevated blood pressure; a long history of smoking, with some emphysema; and a 30-day in-house treatment for binge alcoholism 6 years ago following his wife's long illness with breast cancer and her subsequent death.

One month ago he was discharged from the hospital to a rehabilitation facility, and at his last medical review it was estimated he will need an additional 2 months' minimum treatment and follow-up therapies in the facility.

As the social worker at the rehab center, I conducted a psychosocial assessment after his admission to rehabilitation.

At the time of the assessment, Lester was impulsive and was screened for self-harm, which was deemed low risk. He did not have insight into the extent of his injury or changes resulting from the accident but was frustrated and cried when he could not manipulate his hands. Lester's children jointly hold power of attorney (POA), but had not expressed any interest to date in his status or care. His brother is his shared decision making (SDM) proxy, but his sister-in-law seemed to be the most actively involved in planning for his follow-up care. His son and daughter called but had not visited, but his sister-in-law had visited him almost daily; praying with him at the bedside; and managing his household financials, mail, and house security during this period. His brother kept asking when Lester would be back to "normal" and able to manage on his own and was eager to take him out of the rehabilitation center.

Lester seemed depressed, showed some flat affect, did not exhibit competency or show interest in decision making, and needed ongoing help from his POA and SDM. His medical prognosis for full recovery remains limited, with his Glasgow Coma Scale at less than 9, which means his injury is categorized as catastrophic.

Lester currently has limited mobility and is continent, but he is not yet able to self-feed and cannot self-care for cleanliness; he currently needs assistance washing, shaving, cleaning his teeth, and dressing. He continues with daily occupational therapy (OT) and physical therapy (PT) sessions.

He will also need legal assistance to apply for his professional association pension and benefits and possible long-term disability. He will also need help identifying services for OT and PT after discharge.

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He will need assistance from family members as the determination is made whether he can return to his residence with support or seek housing in a long-term care facility. He will need long-term community care on discharge to help with basic chores of dressing and feeding and self-care if he is not in a residential care setting.

A family conference is indicated to review Lester's current status and short-term goals and to make plans for discharge.