

**Case Study: An Isolated Veteran**

*Related issues: Discharge planning, isolation, anxiety, trauma.*

Mr. G is a 69-year old, African-American, Vietnam War Veteran who lives in a mobile home off the grid in a rural, sparsely populated area. He has lived in his mobile home for the past 15 years since he divorced his wife of 28 years. He has a history of TIAs, COPD, PTSD, and type II diabetes. He currently smokes about one pack of cigarettes a day and says he drinks beer in the evenings, although it is unclear how much he drinks on a regular basis. Mr. G’s income is comprised of a small VA pension and Social Security. He has not had contact with his only son in about 10 years. Their relationship deteriorated following Mr. G’s divorce, after which he became quite isolated and withdrawn.

Mr. G was connected with the VA healthcare system about 20 years ago, but has used services infrequently due to anxiety related to his PTSD. His condition makes it difficult for him to be in loud public spaces for even short periods of time. Recently, he was hospitalized for a right foot, below-the-knee amputation due to diabetic complications. He now uses crutches to get around his home and refused to be fitted for a prosthetic. He spent two months in the hospital and a rehabilitation facility before returning home. He worked with a PTSD counselor throughout his stay to manage his anxiety, but their visits were discontinued when Mr. G was discharged. The social worker at the rehabilitation facility encouraged Mr. G to accept home health primary care through the VA since he is home bound, reluctant to come to the hospital, and has no reliable transportation. He owns a manual truck, but cannot use it due to his amputation. He has no electricity and uses an outhouse on his property, as there is no indoor plumbing.

Mr. G agreed to home health primary care and is visited by a nurse and social worker on a monthly basis. His visiting social worker has a good rapport with Mr. G, but has become concerned that he is showing signs of self-neglect. Mr. G showers infrequently and does not wash his clothing often. He started keeping a hand held urinal by his bed so he does not have to use his outhouse as frequently, and he dumps the contents a few yards from his mobile home when necessary. He is incontinent on occasion, but does not want to use Depends. Mr. G’s home had been cluttered before he came to the hospital and since returning he has had little motivation or energy to clean the small space. He has one neighbor, Mr. H, who buys him groceries on a weekly basis and delivers other toiletries or small items Mr. G needs. Occasionally, Mr. H will also do a load of laundry for him. However, Mr. H works full time and is not available often enough to help around the house and Mr. G is reluctant to have anyone clean or rearrange his space.

Considering this case from a person-centered perspective, what next steps would you suggest to Mr. G’s social worker? What long-term plans might Mr. G require to ensure he is well cared for? What potential complications do you foresee?