

Paula Cortez Single-System Intervention Case Study

Posted on June 13, 2018

View this essay online:

<https://academic-master.com/paula-cortez-single-system-intervention-case-study/>

Introduction

Paula Cortez is a forty-three-year-old Latina woman living with HIV whose situation combines pregnancy, psychiatric symptoms, trauma, domestic violence, social isolation, physical-health concerns, limited resources, and inconsistent engagement with treatment. A single-system evaluation can help a social worker examine whether coordinated intervention is improving selected outcomes over time, but the evaluation must remain secondary to safe clinical care. The purpose is not to manipulate treatment in order to create a stronger research design. Effective antiretroviral therapy should not be stopped to establish a baseline, urgent safety needs should never be delayed for measurement, and reproductive decisions belong to Paula after accurate and noncoercive counseling. Current U.S. perinatal HIV guidance recommends prompt initiation or continuation of effective antiretroviral therapy during pregnancy because sustained viral suppression protects maternal health and markedly reduces the risk of perinatal transmission (National Institutes of Health, 2026). An ethical single-system approach should therefore monitor clinically meaningful outcomes while an interdisciplinary team addresses HIV care, pregnancy, domestic violence, mental health, housing, transportation, medication access, and the practical burdens that influence adherence.

Immediate Clinical Priorities and Reproductive Autonomy

Before an evaluation plan is designed, the team must identify urgent threats to Paula's safety and health. Assessment should include current danger from an abusive partner, suicidal or self-harm risk, severe psychiatric symptoms, obstetric warning signs, medication access, food and housing insecurity, legal concerns, and whether she can attend HIV and prenatal appointments safely. Domestic-violence screening should occur privately, without the abusive partner or other controlling people present, and with a qualified interpreter if needed. Questions should include coercive control, physical and sexual violence, stalking, strangulation, weapons, reproductive coercion, and technology monitoring. A safety plan may involve emergency contacts, medication, important documents, transport, digital-security steps, shelter resources, legal advocacy, and a plan for leaving only if and when Paula decides it is safe. Leaving an abusive relationship can increase danger, so the social

worker should avoid treating separation as a simple compliance goal. Any mandatory-reporting or confidentiality limits should be explained clearly rather than discovered by Paula after information has already been disclosed.

Pregnancy creates additional decisions but does not remove Paula's autonomy. She should receive accurate information about continuing the pregnancy, abortion where lawful and available, adoption, HIV treatment, parenting resources, obstetric risks, and available social support. The social worker's role is to support informed decision-making, not select the pregnancy outcome or define one choice as proof of treatment success. HIV itself is not a reason to coerce pregnancy termination. With effective antiretroviral therapy and appropriate obstetric and infant management, perinatal transmission can be reduced to very low levels, although outcomes depend on viral load, adherence, delivery planning, infant prophylaxis, and feeding decisions. Current NIH guidance also emphasizes individualized counseling and continuation of suppressive regimens when they remain appropriate during pregnancy. The same principle applies to psychiatric treatment: necessary medication should not automatically be withheld because of pregnancy, and decisions should weigh maternal psychiatric stability, fetal considerations, drug interactions, and specialist advice.

Designing an Ethical Single-System Evaluation

A single-system design uses repeated observations of one client or service system to determine whether target outcomes change across defined phases. For Paula, a practical evaluation question might ask whether integrated trauma-informed care coordination improves antiretroviral adherence, appointment attendance, perceived safety, and psychological distress over twelve to sixteen weeks. The question should be narrow enough to measure without implying that every dimension of her life can be reduced to one intervention. A simple A-B design is usually more appropriate than an A-B-A withdrawal design. Baseline information can come from recent clinical records, pharmacy access, prior appointment attendance, and initial symptom measures, followed by repeated observations during the intervention. Removing effective HIV, mental-health, or safety support merely to see whether Paula deteriorates would be unethical. If immediate clinical needs require intervention on the first day, a prolonged baseline should be abandoned rather than allowed to delay care. Stronger-looking research methodology is not defensible when it increases risk.

The intervention itself must be described precisely enough to evaluate. One designated care coordinator could help integrate HIV and prenatal appointments, medication access, mental-health treatment, domestic-violence advocacy, transport, housing, benefits, and other practical resources. Paula might choose weekly contact by a method that is safe and convenient, while the team records whether contacts occurred, barriers were resolved, referrals connected successfully, and planned services were actually delivered. An interdisciplinary team may include an HIV clinician, obstetric specialist, psychiatric prescriber, nurse, social worker, pharmacist, domestic-violence advocate, housing specialist, case manager, and legal or benefits support. The number of professionals is not itself evidence of quality. Coordination should reduce the burden on Paula rather than require her to

repeat traumatic experiences to multiple agencies. Information sharing should be limited to what is necessary and should occur with her consent except where law requires otherwise.

Outcomes, Measurement, and Interpretation

Target outcomes should matter to Paula, respond to the intervention, and be measurable without creating excessive burden. Possible primary measures include the proportion of prescribed antiretroviral doses taken over the previous week, attendance at scheduled HIV and prenatal visits, and a validated brief distress measure collected at clinically appropriate intervals. Secondary indicators might include medication-access problems, housing stability, use of an agreed safety plan, confidence in managing care, or connection with social support. Viral load is medically important but should be obtained according to clinical guidance rather than ordered weekly for research convenience. A healthy infant, complete absence of violence, or one particular reproductive choice would be poor sole outcomes because they are delayed, influenced by many factors, and can encourage coercive interpretation. Operational definitions should be established in advance so that “adherence,” “attendance,” “distress,” and “safety” do not change meaning during the evaluation (Bloom et al., 2009).

Reliability and validity require more than collecting numbers repeatedly. Self-reported adherence can be affected by memory and the desire to please clinicians, so the same questions and time frame should be used consistently and difficulty should be normalized rather than punished. Pharmacy-refill information can support interpretation but does not prove medication ingestion. Appointment attendance may reflect transportation or safety barriers rather than motivation. A depression score can be affected by pregnancy, poor sleep, trauma, or physical illness. The evaluator should therefore triangulate measures where possible and include Paula’s own interpretation of change. Graphs can show level, trend, variability, and timing across phases, but clinical significance matters more than a small numerical change that has no effect on daily life. A fall in distress, improved medication access, or fewer missed visits should be interpreted alongside major contextual events such as hospitalization, housing changes, renewed contact with an abusive partner, or medication adjustment.

Ethics, Confounding Factors, and Follow-Up

Many events outside the formal intervention can influence Paula’s outcomes. Pregnancy symptoms, a new antiretroviral regimen, financial assistance, family support, housing placement, psychiatric stabilization, hospitalization, renewed violence, or spontaneous fluctuation in symptoms may improve or worsen the measures being tracked. These influences should be documented rather than ignored because a single-system evaluation cannot prove that one social-work intervention caused every observed change. Transparency is especially important when outcomes are mixed. If Paula disengages, misses visits, remains unsafe, or experiences adverse effects, those findings should be reported rather than edited out to make the intervention appear successful. The evaluation is useful

when it helps the team adapt care, not when it manufactures a persuasive success story. If the activity is intended as generalizable research, institutional review may be required; if it remains clinical practice evaluation or quality improvement, privacy, consent, and professional ethics still apply.

Follow-up should extend beyond the formal measurement phase because postpartum depression, renewed domestic violence, medication barriers, infant-care demands, and housing instability may emerge later. HIV treatment continues after delivery, while postpartum care may also include mental-health screening, contraception or reproductive planning if desired, infant follow-up, and feeding counseling consistent with current shared-decision guidance. Contact frequency can decrease as Paula becomes more stable, but she should retain rapid access when circumstances change. The intervention should never normalize coercive hospitalization or confinement merely because she misses medication or appointments. Involuntary treatment requires specific legal and clinical criteria, due process, and the least restrictive alternative. The more sustainable strategy is engagement, practical support, accurate risk assessment, coordinated treatment, and respect for Paula's choices. Success should therefore be defined as measurable progress toward goals she helped select, accompanied by reduction of serious risk rather than perfect compliance with a clinician-designed plan.

Conclusion

A single-system evaluation can strengthen Paula Cortez's care when repeated measurement is used to support—not control—ethical clinical practice. Immediate priorities include personal safety, antiretroviral access, prenatal care, psychiatric assessment, housing and transportation, and confidential domestic-violence support. The evaluation can then track a small number of outcomes such as adherence, appointment attendance, distress, and safety across a brief baseline and intervention phase. Effective HIV treatment should never be withdrawn to create data, and an A-B-A design is inappropriate when removing services could cause harm. Measures need clear operational definitions, consistent collection, multiple sources where feasible, and contextual interpretation so that barriers are not mislabeled as lack of motivation. Paula's reproductive decisions remain hers after informed counseling, and uncertain future outcomes should never be presented as established facts. The purpose of the design is not to reduce a complex life to a graph; it is to make care more accountable by showing whether coordinated support is helping Paula reach goals she values and where the plan needs to change.

References

National Institutes of Health. (2026). *Recommendations for the use of antiretroviral drugs during pregnancy and interventions to reduce perinatal HIV transmission in the United States*.

Romeiser-Logan, L., Slaughter, R., & Hickman, R. (2017). Single-subject research designs in pediatric

rehabilitation. *Developmental Medicine & Child Neurology*, 59(6), 574–580.

Yegidis, B. L., Weinbach, R. W., & Myers, L. L. (2017). *Research methods for social workers*. Pearson.

Bloom, M., Fischer, J., & Orme, J. G. (2009). *Evaluating practice: Guidelines for the accountable professional*. Pearson.

Substance Abuse and Mental Health Services Administration. (2023). *Practical guide for implementing a trauma-informed approach*.