Paula Cortez Single-System Intervention Case Study

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Introduction

Paula Cortez is a forty-three-year-old Latina woman living with HIV whose case includes pregnancy, psychiatric symptoms, trauma, domestic violence, social isolation, physical health concerns, limited resources, and inconsistent treatment engagement. The original essay proposes a single-system evaluation and correctly recognizes that intervention should include open-ended assessment, planning, engagement, community collaboration, repeated measures, and follow-up. It also treats medication withdrawal as an acceptable baseline, describes uncertain outcomes as established facts, uses outdated HIV terminology, and states that Paula was locked in a hospital room for fifteen days. A rigorous and ethical case study must distinguish the clinical intervention from its evaluation. Effective antiretroviral therapy should never be withheld merely to create a baseline, and pregnancy decisions belong to Paula after informed, noncoercive counseling. The evaluation should monitor a small number of meaningful outcomes while an integrated team addresses immediate safety, HIV treatment, prenatal care, mental health, housing, and social support. This design can show whether Paula's functioning changes over time, but it cannot prove that one intervention alone caused every change (Yegidis et al., 2017).

Case Complexity and Person-First Framing

Paula should be described as a woman living with HIV rather than as a person "infected" who is defined by disease. Her needs are interconnected. Trauma and domestic violence may affect safety and trust. Psychiatric symptoms may affect organization, sleep, and adherence. Poverty or unstable housing may make medication storage, transport, nutrition, and appointments difficult. Pregnancy creates additional medical decisions but does not remove autonomy. The social worker should resist reducing the case to compliance. Missed medication or appointments can be behavior to measure, but the assessment must identify the barriers and meanings behind them. A complex case needs coordinated care rather than separate referrals that require Paula to manage the system alone.

Immediate Priorities

Before beginning a research-style evaluation, the team must address urgent safety and health. Priorities include assessment of immediate danger from an abusive partner, suicide or self-harm risk, psychosis or severe mood symptoms, obstetric warning signs, current HIV treatment, medication

access, housing, food, and legal concerns. If imminent danger exists, emergency action follows law and professional duty. Otherwise, planning should preserve Paula's choice and confidentiality. Research measurement must never delay stabilization. The evaluation is secondary to care and should be designed around clinically appropriate actions already justified for Paula.

HIV Care During Pregnancy

Current U.S. perinatal HIV guidance recommends antiretroviral therapy as soon as possible for pregnant people with HIV and continuation of an effective suppressive regimen unless there is a clinical reason to change it. Viral suppression protects Paula's health and reduces perinatal transmission dramatically. With effective therapy and sustained suppression near delivery, the risk of transmission can be reduced to approximately one percent or lower and in some well-managed circumstances to a fraction of one percent. These outcomes are not guaranteed and depend on treatment, viral load, obstetric planning, infant medication, and feeding guidance. Paula needs coordinated HIV and obstetric specialists, laboratory monitoring, and support that avoids blame (National Institutes of Health, 2026).

Pregnancy Decision-Making

The original essay lists deciding whether to keep the pregnancy or obtain an abortion as a problem to be solved by the intervention. The social worker's role is not to choose the outcome. Paula should receive accurate, confidential counseling about pregnancy continuation, abortion where lawful and available, adoption, medical risks, HIV treatment, parenting resources, and safety. Capacity should be assessed only when there is a genuine clinical reason, not because the team disagrees with her decision. Domestic violence, family pressure, clinicians, or financial dependency must not coerce the choice. Respect for reproductive autonomy is central to ethical care.

Domestic-Violence Safety

Domestic violence assessment should be conducted privately, with a qualified interpreter if needed and without a partner or family member present. Questions should cover coercive control, physical and sexual violence, threats, stalking, reproductive coercion, weapons, strangulation, technology monitoring, and risks associated with leaving. A safety plan may include emergency contacts, documents, medication, transport, digital safety, shelter, legal advocacy, and code words. Leaving is not always immediately safe or feasible. The intervention should support Paula's choices and comply with jurisdiction-specific reporting rules while explaining any limits of confidentiality.

Mental-Health Assessment

The case mentions mental illness but does not specify diagnosis, symptoms, timing, or treatment. A qualified clinician should assess mood, anxiety, trauma, psychosis, cognition, sleep, substance use, suicide risk, and medication history. Pregnancy and HIV treatment require coordination when selecting psychiatric medication, but necessary treatment should not be withheld through fear alone. The team should also consider whether apparent disorganization arises from trauma, unstable housing, medication side effects, language barriers, or overwhelming care demands. Psychiatric labels should guide appropriate support rather than justify confinement or exclusion from decisions.

Interdisciplinary Team

Paula's care may involve an HIV clinician, obstetric specialist, psychiatrist or psychiatric prescriber, social worker, nurse, domestic-violence advocate, case manager, pharmacist, housing specialist, and legal or benefits support. One person should coordinate communication with Paula's consent so that she is not required to repeat trauma at every visit. Team roles need definition, and information sharing should be limited to what is necessary. Meetings should include Paula when possible and use language she understands. The team's success is not measured by the number of professionals involved but by whether the plan becomes simpler, safer, and more responsive for her.

Purpose of a Single-System Evaluation

A single-system design uses repeated observations of one client, family, group, or service system to determine whether a target outcome changes across phases. In social work, it can strengthen reflective practice by making goals and progress explicit. It is not identical to a clinical trial and cannot control every outside influence. Paula's evaluation should answer a practical question such as: "Does an integrated, trauma-informed care-coordination intervention improve antiretroviral adherence, appointment attendance, perceived safety, and psychological distress over twelve weeks?" A narrow question is more credible than claiming to evaluate every dimension of her life simultaneously.

Selecting Target Outcomes

Outcomes should be important to Paula, responsive to intervention, measurable without excessive burden, and ethically appropriate. Possible primary outcomes are percentage of prescribed antiretroviral doses taken, scheduled HIV and prenatal visits attended, and a brief weekly distress score. Secondary outcomes may include medication access problems, safety-plan completion, housing stability, and self-rated confidence managing care. Viral load is a clinically important outcome but is measured according to medical guidelines rather than every week for research convenience. A

healthy infant or complete absence of violence is too delayed and influenced by too many factors to function as the only evaluation criterion (Bloom et al., 2009).

Operational Definitions

Each measure needs a precise definition. Medication adherence might be the proportion of expected doses reportedly taken during the previous seven days, supplemented by pharmacy refill data when available. Appointment attendance can be coded as attended, rescheduled in advance, or missed without contact. Distress can be measured through a validated brief scale such as the PHQ-9 for depressive symptoms or GAD-7 for anxiety, administered at appropriate intervals rather than daily. Safety can include whether Paula has a personalized plan and access to agreed resources, but the absence of reported assault should not be interpreted automatically as intervention success because disclosure and exposure may change.

Baseline Phase

A baseline records the target outcome before the new coordinated intervention begins. It should use naturally occurring data and must not remove effective care. For Paula, the team could review the previous four to eight weeks of appointment attendance, pharmacy access, and documented barriers and collect one or more initial symptom measures. If care begins immediately because safety or health requires it, a long baseline is unethical and unnecessary. The evaluator can use a brief prospective baseline or retrospective clinical data with clear limitations. Paula should never be instructed to stop antiretroviral or psychiatric medication so that deterioration can be observed.

Intervention Phase

The intervention phase might include one designated care coordinator, medication access support, weekly contact chosen by Paula, integrated HIV and prenatal scheduling, domestic-violence advocacy, mental-health treatment, and practical assistance with transport, housing, or benefits. The components must be documented so that the evaluator knows what was delivered. Simply saying Paula received “treatment” is too vague. Intervention fidelity can be tracked through contacts completed, referrals connected, barriers resolved, and adaptations made. Flexibility is necessary, but changes should be recorded rather than hidden.

Choosing a Design

A simple A–B design compares baseline with intervention. It is feasible but has weak causal inference because change could reflect pregnancy progression, medication adjustment, a new relationship, housing, or natural fluctuation. An A–B–A withdrawal design would be inappropriate because removing

HIV, safety, or mental-health support could cause harm. A multiple-baseline design across behaviors may be safer: medication support begins first, appointment-navigation support follows, and a structured coping intervention begins later, provided delay is clinically acceptable. In a complex real case, an ethically conducted A–B design with transparent limitations may be preferable to a stronger-looking design that compromises care.

Frequency and Duration

The original essay proposes monthly measures and describes a three- to four-week treatment phase, but frequency should match the behavior. Weekly adherence and distress data can reveal patterns that monthly measurement misses. Appointment attendance is recorded when visits occur. Viral load follows clinical intervals. A twelve- to sixteen-week evaluation may capture early change, while pregnancy and HIV care require longer follow-up. Data collection should be sustainable and should stop or simplify if it increases distress or interferes with care. The one-year-and-two-month period mentioned originally should not be assumed unless supported by the case record.

Reliability

Reliability means that measurement is reasonably consistent. Self-reported adherence can be affected by memory and desire to please the clinician. The social worker should use the same questions and time frame each week, normalize difficulty, and separate support from punishment. Pharmacy data and appointment records can provide additional indicators but also have limits: obtaining medication does not prove ingestion, and attendance does not prove understanding. When observational ratings are used, definitions and training help reduce variation. Data should be recorded promptly and securely.

Validity

Validity concerns whether a measure captures the intended concept. Counting missed appointments may reflect transport failure rather than motivation. A depression score may be influenced by pregnancy, illness, or sleep. “HIV under control” should be operationalized through clinically interpreted viral load and immune measures, not a vague impression. The evaluator should use validated instruments, multiple data sources, and Paula’s account. Construct validity improves when the team asks whether the chosen number genuinely represents the problem Paula wants changed.

Visual and Clinical Analysis

Single-system data are often graphed across time. The evaluator examines level, trend, variability, immediacy of change, overlap between phases, and consistency. Statistical tests may supplement

visual analysis but are not always necessary. A drop in distress after intervention may be meaningful even if data remain variable. Clinical significance asks whether the change improves Paula's daily life, safety, or health—not merely whether a score changes by one point. Paula's interpretation should be included. An outcome that looks positive to the team may not match her priorities.

Confounding Factors

Many events could influence outcomes: change in antiretroviral regimen, pregnancy symptoms, hospitalization, contact with an abusive partner, housing placement, family support, financial assistance, or spontaneous symptom fluctuation. These factors should be recorded on the graph or case timeline. They do not make evaluation impossible; they prevent the team from attributing all improvement to social-work intervention. A complex case benefits from a narrative alongside the numerical series so context is not stripped away.

Ethics and Consent

Paula should understand the purpose of repeated measurement, what data will be collected, who will see them, and that declining evaluation will not remove necessary care. If the activity is research intended to produce generalizable knowledge, institutional review may be required. If it is clinical quality improvement or practice evaluation, professional and privacy obligations still apply. Information about HIV, pregnancy, mental health, immigration concerns, and domestic violence is highly sensitive. Records should be secured, and contact methods should be chosen to avoid alerting an abusive person (Romeiser-Logan et al., 2017).

Avoiding Coercive Hospitalization

The statement that Paula was locked in a hospital room for fifteen days is ethically alarming and unsupported without legal and clinical context. Involuntary treatment or restriction requires jurisdiction-specific criteria, due process, clinical necessity, and the least restrictive setting. Medication nonadherence alone does not generally justify confinement. If Paula lacked capacity or posed imminent danger, the record should state the lawful basis and review process. The revised case should not normalize detention as a technique for ensuring adherence. Engagement, practical support, and shared decisions are safer and more sustainable.

Criteria for Success

Success should be defined in advance and at several levels. Clinical indicators may include sustained antiretroviral access and viral suppression according to medical care. Behavioral indicators may include improved dose-taking and appointment attendance. Psychosocial indicators may include lower

distress, a usable safety plan, stable housing, and stronger support. Process indicators may include successful coordination and fewer repeated referrals. Success does not require perfection, immediate separation from an abusive partner, or one particular pregnancy decision. It means measurable progress toward goals Paula selected while serious risks are reduced.

Follow-Up

Follow-up should continue after the formal intervention phase because relapse, renewed violence, medication barriers, postpartum depression, and infant-care demands may emerge. Contact frequency can decrease gradually while preserving rapid access. Postpartum care includes continued HIV treatment, mental-health screening, contraception or reproductive planning if desired, pediatric follow-up, and support with feeding guidance consistent with current clinical recommendations and shared decision-making. A phone call can be part of follow-up but is not sufficient when complex medical and safety needs remain.

Interpreting Outcomes Honestly

The original essay reports that Paula's HIV became controlled, paralyzed limbs recovered, ulcers remained, and a healthy baby was delivered. Unless those outcomes appear in the actual case record, they should not be presented as observed findings. A proposed evaluation must use future or conditional language. The team may hope to achieve viral suppression, safer pregnancy, improved functioning, and healthy delivery, but it must record what actually occurs. Honest reporting includes nonresponse, setbacks, disengagement, and harms. These outcomes can improve the next intervention and should not be hidden to make the case appear successful.

Conclusion

A single-system evaluation can make Paula Cortez's care more transparent and responsive when it is built around ethical clinical practice. The team should first address safety, HIV treatment, pregnancy, mental health, domestic violence, housing, and practical barriers through coordinated, person-centered care. The evaluation can then track a small set of outcomes such as adherence, attendance, distress, and safety over a brief baseline and intervention phase. Effective antiretroviral therapy must not be withdrawn to create data, and an A–B–A design is inappropriate when removal could cause harm. Measures need operational definitions, reliability, validity, and context. Paula's reproductive choices and priorities remain central, and uncertain outcomes must not be written as facts. The purpose of the design is not to turn a complex life into a graph. It is to use repeated evidence and Paula's own judgment to determine whether the care plan is helping and what should change next (Substance Abuse and Mental Health Services Administration, 2023).

References

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