



Case Study Presentation: When Public Health Intervention Requires CPS and Court Involvement

Pamela Salinas, BSN, RN

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Has the following disclosures to make:

- No conflict of interests
- No relevant financial relationships with any commercial companies pertaining to this activity





CORPUS CHRISTI - NUECES COUNTY
**PUBLIC HEALTH
DISTRICT**

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Objectives

By the end of this case study, participants will be able to:

- 1. Recognize** clinical, behavioral, social, and caregiver factors that can contribute to pediatric TB treatment nonadherence.
- 2. Identify** challenges that may interfere with successful directly observed therapy (DOT).
- 3. Describe** interventions used to improve treatment adherence before and after CPS/court involvement.
- 4. Discuss** when persistent nonadherence may warrant escalation to CPS and/or court intervention to protect the child.
- 5. Examine** the importance of multidisciplinary collaboration among public health, healthcare providers, CPS, and the court system.
- 6. Recognize** the importance of balancing child safety, treatment completion, family engagement, and staff safety.
- 7. Discuss** lessons learned that can be applied to future complex pediatric TB cases.



Case History

Two U.S.-born siblings:

Older child: 4 years old at presentation; extrapulmonary TB involving the right knee

Younger child: 2 years old at presentation; pulmonary TB

First health department encounter: **4/14/2025**

Older child in clinic due to persistent right knee pain and swelling since October 2024. Child was unable to walk, loss of appetite, and fatigue. Right knee I/D pathology showed necrotizing granulomas. T-Spot positive.

Younger child had a history of repeated hospitalizations for pneumonia. Gastric aspirates were obtained at a children's hospital and were positive for *Mycobacterium tuberculosis*.

Both children initially began TB treatment on **4/24/2025**



Family & Social Context

Parents were adolescents when the children were born:

- First child born when mother/father were approximately 16 years of age
- Second child born approximately 18 years of age

Very limited health literacy

Difficulty understanding:

- TB disease and transmission
- Importance of completing treatment
- Consequences to children's health if missed doses
- Need for laboratory and imaging monitoring

Repeated difficulty maintaining appointments with multiple healthcare providers

Communication with parents became increasingly inconsistent

Family circumstances significantly affected the children's ability to complete treatment



Initial TB Treatment

RIPE-based treatment initiated in April 2025

Initial medications included:

- Rifampin
- Isoniazid
- Pyrazinamide
- Ethambutol
- Vitamin B6
- Moxifloxacin (4-year-old)

Treatment was adjusted as additional susceptibility information became available

Source case subsequently identified with **high-level isoniazid resistance**

TB specialists were consulted for an alternative regimen

Isoniazid and vitamin B6 were ultimately discontinued

Regimens were individualized for each child



Challenge 1: Treatment Adherence

The first major barrier was inability to consistently administer prescribed treatment.

Parents frequently:

- Did not answer the phone
- Did not answer the door
- Missed appointments
- Failed to bring children for medication administration

Before CPS involvement, treatment adherence was approximately **20% in one phase**

Numerous outreach attempts were unsuccessful

Children initially completed some doses but missed substantial numbers

Treatment interruptions created concern for:

- Treatment failure
- Drug resistance
- Prolonged infectious risk
- Disease progression
- Increased treatment burden



Overcoming Challenge 1: Escalation to CPS & Court

When voluntary interventions failed, the response escalated.

- Multiple attempts were made to work collaboratively with the family
- Home-based directly observed therapy was attempted
- Continued nonadherence ultimately required **CPS involvement**
- **Court order obtained 08/05/2025**
- Court-ordered DOT began **08/06/2025**
- Parents were ordered to bring the children to the health department Monday–Friday
- Medication administration became directly observed
- Adherence subsequently improved substantially, reaching the **mid-80% to >90% range during periods of court-ordered DOT**

Key point:

CPS and court involvement was not the first intervention—it became necessary after repeated less-restrictive interventions failed.



What Changed After Court-Ordered DOT

Before court involvement	After court involvement
Missed doses frequently	Consistent opportunities for DOT
Family difficult to reach	Children brought to clinic
Home visits unsuccessful	Clinic-based administration
Adherence as low as ~20% during one period	Adherence improved substantially
Children's medication refusal	Routine & Discipline
Increasing concern for treatment failure	Improved treatment completion

Important observation:

Court involvement demonstrated that **the children could receive treatment consistently when an enforceable structure was established.**



Challenge 2: Medication Administration Became Increasingly Difficult

- Liquid medications were sometimes spit out
- Multiple administration strategies attempted:
 - Pudding
 - Juice
 - Yogurt
 - Flavoring agents
 - Pill formulations when appropriate
- Older child sometimes:
 - Refused medication
 - Self-gagged
 - Attempted to induce vomiting
 - Vomited after administration
- Antiemetics were attempted
- Younger child was difficult to redirect during administration
- Medication administration became stressful for both children and staff



Overcoming Challenge 2: Individualized Administration Strategies

The team repeatedly adapted rather than simply labeling the children as “noncompliant.”

- Changed formulations when possible
- Tried different vehicles for medication administration
- Used antiemetics
- Increased medication doses as children gained weight
- Consulted pediatric infectious disease specialists
- NG-tube administration was considered as a potential option for the child unable to reliably retain medication

Teaching point:

Medication refusal in young children requires assessment of **formulation, behavior, side effects, environment, developmental stage, and caregiver technique.**



Additional Clinical Challenge: Dental Disease

October 2025:

- Broken front tooth (2-year-old)
- Swollen lips and gums
- Excessive drooling
- Difficulty closing mouth around syringe
- Difficulty swallowing
- Bleeding gums
- Extensive dental caries (4-year-old & 2-year-old)

Parents reported providing soups because eating solids was difficult

Dental surgery appointment arranged for crowns (multiple cancelations caused the dental office to fire the patients)

Dental surgery for both children took place February 2026

Dental disease created an additional barrier to safe medication administration



Court-Ordered Appointments Were Still Not Consistently Followed

The court order required clinic attendance at 2:00 PM.

In practice:

- Family frequently arrived **after 4:00–4:30 PM**
- Clinic medication administration takes approximately **25–40 minutes**
- Late arrival:
 - Limited assessment time
 - Created pressure to administer medications quickly
 - Required staff to remain after clinic hours
 - Increased stress for staff and children

Parents were also frequently unavailable for:

- Laboratory appointments
- Dental appointments
- Routine pediatric care
- CPS meetings

**A court order can establish an obligation,
but it cannot automatically create reliable engagement.**



Establishing a Structured Treatment Environment

- Home DOT was attempted first
- Home environment became increasingly difficult and, at times, hostile
- Staff safety became a concern
- Home visits were therefore no longer considered appropriate
- Court order shifted administration to the health department
- CPS attempted to assist with transportation
- Clinic-based DOT provided:
 - Controlled environment
 - Direct observation
 - Documentation of administration
 - Opportunity for clinical assessment
 - Reduced exposure of staff to an escalating home environment

Staff safety is part of patient safety.



Behavioral & Environmental Barriers

The clinic environment presented additional challenges:

- Children frequently arrived after sleeping much of the day
- Parents reported children staying awake much of the night playing video games
- During visits, children sometimes:
 - Ran through the clinic
 - Pulled items from walls
 - Struck parents
 - Resisted medication
- Parents refused to redirect behavior
- Parents sometimes argued with each other during administration
- The overall environment increased distress for everyone involved



Challenge 3: Medical Monitoring & Follow-Up

- Both children had behavioral challenges that made blood draws difficult
- Laboratory testing required clinic or hospital settings
- Physical therapy was needed for improvement in knee mobility
- Parents frequently agreed to appointments but subsequently:
 - Cancelled
 - Failed to attend
 - Did not provide notice
- Chest imaging was delayed
- MRI of knee was delayed
- Imaging referrals were provided at no cost
- Follow-up reminders were made
- One child subsequently developed a mild cough
- Recommended imaging was still not completed at that time

Treatment is more than medication administration.



Overcoming Challenge #3: Building a Multidisciplinary Network

The health department engaged multiple partners:

- Heartland
- Region 11/PHR11 TB consultation
- Pediatric infectious disease
- DSHS Pharmacy
- Primary care
- Dental services
- Physical therapy
- CPS

The goal was not simply to give medication.

The team attempted to address:

TB + medication adherence + developmental needs + emotional needs + dental health + monitoring + transportation + family engagement + safety



Older Child: Extrapulmonary TB of the Right Knee

Initial disease

- Right knee swelling
- Pain and impaired function

MRI impression:

- Large joint effusion
- Soft-tissue swelling
- New osteopenia/demineralization

April 2025: **15.1 kg**

Ending weight: **25.86 kg**

Approximately **10.8 kg weight gain**

MRI 02/20/2026

- Normal bone marrow signal
- Normal ligaments and menisci
- No joint effusion
- No structural abnormality identified
- Impression: **Normal knee**

Progress

- Knee swelling decreased
- Range of motion improved
- Weight steadily increased
- Continued limp/out-toeing gait
- Pain with jumping or prolonged play
- Concern for long-term musculoskeletal sequelae
- Physical therapy finally initiated by parents

**END OF
TREATMENT
08/21/2026**



Younger Child: Pulmonary TB

Initial disease

- Fever
- Cervical Adenopathy
- Loss of appetite
- Cough
- Shortness of breath

Progress

- History of recurrent pneumonia/hospitalization
- Weight increased substantially during treatment
- Resolution of all symptoms

Imaging over time

April 2025: **13.7 kg**

Ending weight: **22.54 kg**

Approximately **8.8 kg weight gain**

03/02/2025: Bilateral lower-lobe micronodular opacities

01/07/2026: Mild perihilar/peribronchial thickening; no acute infiltrate

03/31/2026: No acute cardiopulmonary process

**END OF
TREATMENT
08/27/2026**



When Was CPS/Court Involvement Necessary?

Escalation occurred after repeated attempts to resolve barriers voluntarily.

Interventions attempted included:

1. Repeated education
2. Telephone outreach
3. Home visits
4. Directly observed therapy
5. Flexible scheduling
6. Medication formulation changes
7. Flavoring/administration strategies
8. Antiemetics
9. Coordination with PCP and specialists
10. Transportation assistance
11. Dental and specialty referrals
12. CPS engagement

Despite these interventions, adherence repeatedly deteriorated.

The central issue became the children's right to receive medically necessary treatment versus the parents' inability or unwillingness to consistently provide it.



Escalation: From Court Order to Removal Consideration

By February 2026, concerns included:

- Missed TB doses
- Missed dental appointments
- Missed pediatric appointments
- Missed CPS meetings
- Increasingly poor communication
- Repeated no-call/no-show pattern
- Deteriorating adherence
- Medication administration becoming emotionally traumatic
- Concerns regarding safe and effective completion of treatment

02/21/2026: Affidavit for removal submitted

02/23/2026: Emergency court hearing

- Children remained in the home pending judicial decision at that point
- CPS continued attempting to facilitate treatment and transportation

Teaching point:

CPS involvement is not synonymous with removal. Its role may include **protecting children while supporting treatment adherence and family engagement.**



Teaching Point

Outcome & Current Perspective

- After 16 months of medication it was determined that the children had received **enough medication to confirm adequate treatment completion**
- Treatment was complicated by:
 - Significant interruptions
 - Drug resistance considerations
 - Behavioral barriers
 - Caregiver nonadherence
 - Missed monitoring
 - Dental disease
 - Multiple court interventions
- Despite the difficult course, clinical outcomes included:
 - Significant weight gain
 - Improvement in knee findings
 - Improved respiratory imaging
 - Increased adherence during structured DOT



Teaching Point

- 1. Start with the least restrictive intervention—but recognize when it is failing.**
- 2. Nonadherence in children is often caregiver-dependent.**
The child may have no ability to independently ensure treatment completion.
- 3. Directly observed therapy can reveal the difference between inability and unwillingness.**
- 4. CPS and court involvement can become necessary when failure to provide treatment places a child at significant risk.**
- 5. Court involvement should follow documented, repeated attempts at less-restrictive interventions whenever feasible.**
- 6. Staff safety matters.**

A home-based intervention is not appropriate when the environment becomes threatening or unsafe.



Key Takeaways

Sometimes Treatment Requires More Than Medication

- Education is essential—but education alone may not be enough.
- Repeated outreach and voluntary interventions should be documented.
- Treatment adherence must be assessed objectively.
- Children depend on caregivers to access lifesaving care.
- CPS can provide an additional layer of protection and support.
- Court orders may be necessary when voluntary measures fail.
- Staff safety must remain a priority.
- A multidisciplinary approach is critical.

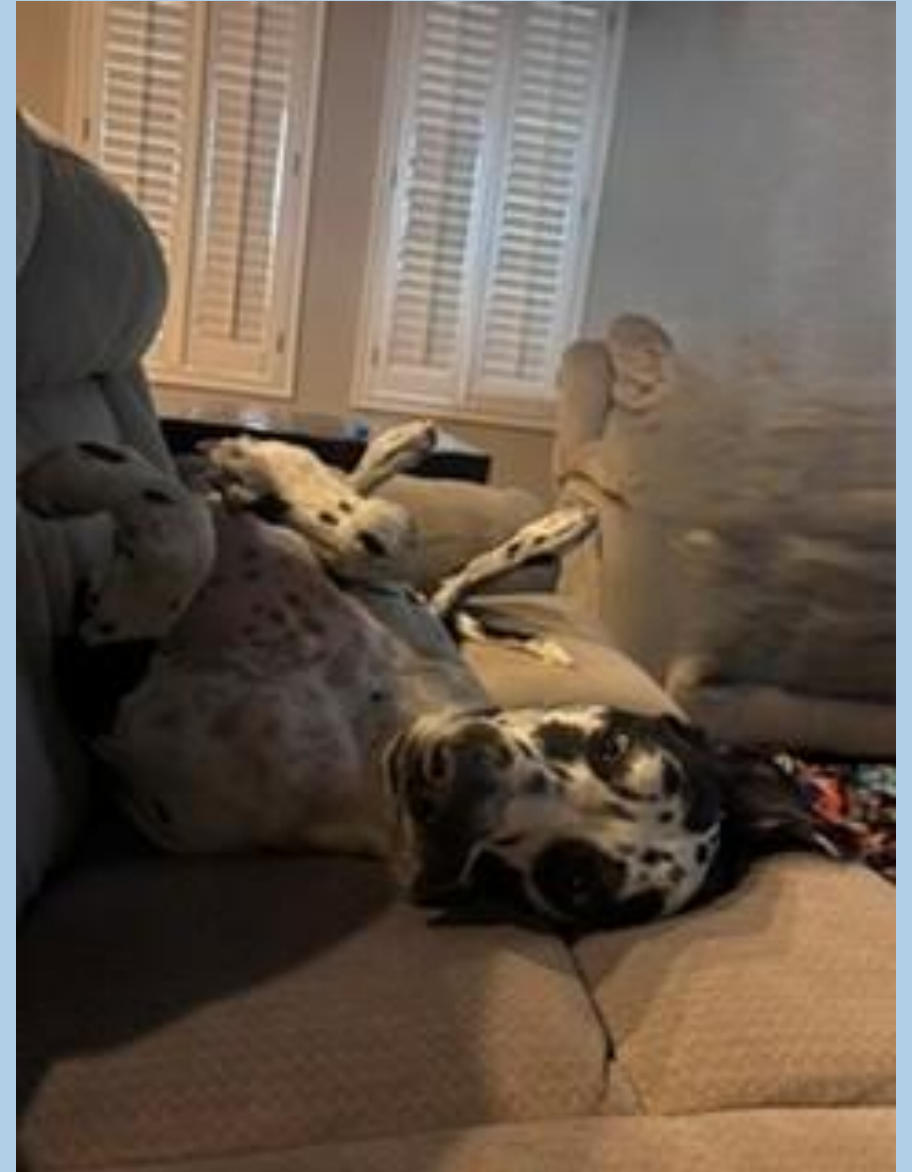
Most importantly:

CPS and court involvement should not be viewed as the first response to nonadherence. In complex pediatric TB cases, however, they may become necessary tools to protect the child when repeated voluntary and supportive interventions have failed.



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Thank you!