Published in final edited form as:

Soc Sci Med. 2017 November ; 192: 28–29. doi:10.1016/j.socscimed.2017.09.023.

Response to Commentary, “Trauma and the structuring of complex care: Back to the settlements?” by Elizabeth Bowen

Ariana Thompson-Lastad, PhD(c)^a, Irene H. Yen, PhD, MPH^b, Mark D. Fleming, PhD^c, Meredith Van Natta, PhD(c)^a, Sara Rubin, PhD(c)^a, Janet K. Shim, PhD^a, and Nancy Burke, PhD^c

^aUC San Francisco Dept. of Social and Behavioral Sciences, 3333 California St., Suite 455, San Francisco, CA 94118, USA

^bUC San Francisco School of Medicine, 513 Parnassus Ave, San Francisco, CA 94143-0410, USA

^cUC Merced Department of Public Health, School of Social Sciences, Humanities and Arts, Classroom & Office Building, 5200 North Lake Road Merced, CA 95343

In our article, “Defining Trauma in Complex Care Management: Safety-Net Providers’ Perspectives on Structural Vulnerability and Time,” we present an ethnographic portrait of what trauma-informed care may look like in *practice*—even if not in name—in two complex care management (CCM) programs. Though the programs we study did not explicitly claim to provide trauma-informed care, observations of their daily practice highlighted the ways that their work fit with the domains outlined in Machtinger and colleagues’ trauma-informed primary care model (2015). We also illustrated how providers employed the concept of trauma in strategic ways that enabled them to incorporate structural determinants of health into the realm of clinical practice and medical care. In so doing, our ethnography serves, in some ways, as an example of the implementation of structural competency (Hansen et al. 2016) in a complex care setting.

In her commentary on our article, Bowen suggests that health care providers should advocate for action that would address structural causes of trauma. We generally agree with her position, and our article shows why and how, given their particular position and role within healthcare institutions, CCM programs are able to work to address these root causes. We observed that CCM staff not only considered the effects of trauma on patients’ health and health-related behaviors, but attempted to ameliorate some of the underlying causes of patients’ trauma, for instance, by establishing stable housing and accessing adequate, healthy food. Examples of the latter described in the article include a CCM social worker helping a patient apply for food stamps; in other cases, we observed staff waiting in line with patients at food pantries, or even picking up food boxes from such sites and delivering them to patients’ homes.

Bowen argues that health care providers should not only acknowledge connections between housing and health, but be able to prescribe safe and affordable housing. She suggests that “facilitating housing access” should be part of the work of health care providers. Many CCM staff members, including community health workers and social workers, diligently attempted to support patients in finding affordable housing, identifying available rooms and apartments, completing applications with patients, and allowing homeless patients to use a CCM office phone number and address. Though this falls far short of being able to use Medicaid funds for affordable housing, as has been attempted in New York and elsewhere (Bamberger 2016), it is an on-the-ground attempt to increase housing access by utilizing community resources in ways that patients are unable to do on their own. CCM staff saw this as a part of their mission and work, though they were certainly not always successful at helping patients access housing.

Patients enrolled in the CCM programs we observed were rarely well enough to actively participate in advocating for housing prescriptions or other programs that might benefit them. However, we agree that medical institutions could certainly take a leading role in this kind of advocacy. At the same time, our ethnographic examples show how time-consuming, energy-sapping, and bureaucratically challenging such attempts to address structural determinants are. This shows both why such advocacy is so important while also, ironically, why it is often impossible for CCM providers to muster the necessary time, energy, and initiative to undertake it.

Like Bowen, we believe that more empirical research on trauma-informed care is needed in CCM programs and other medical settings. Ethnography is well-suited to answer empirical questions about what trauma-informed care looks like in practice. In addition, ethnographic studies such as ours have the potential to describe the ways programs not specifically named as trauma-informed care employ elements of what is now known as trauma-informed care in order to meet the needs of their patients, thus creating a hybrid or partial implementation model. We observed CCM staff investing more time than most other health care providers are able to, and interacting with patients in ways that were flexible, understanding, and supportive. These styles of interaction fit with Machtinger and colleagues’ (2015) admittedly aspirational model for developing a trauma-informed environment and responding to patients with trauma. CCM staff infused an awareness of social and structural determinants of health into daily care provision, recognizing exposure to trauma and informing their actions with this awareness. They do so within a complex care management model of patient care, thus illustrating the flexibility and compatibility of these care models in practice.

We agree with Bowen that the patients served by CCM would benefit from programs that are more like historic settlement houses and less like the “friendly visiting” of the same era. Given that Bowen writes from a social work perspective, we think it is important to note that in the CCM programs we observed, the entire team took on tasks that are typically carried out by social workers. Though CCM programs generally had social workers as members of their care teams, we also observed periods of time when they were without social workers due to staff turnover and hiring delays. Nurses and community health workers regularly took on case management tasks that would be a part of a social worker role in many other health care programs. One of our team’s previous articles describes how CCM programs seek out

patients who are both in need of their services and willing and able to engage with the programs as they are currently structured (Fleming et al. 2017). We found that the most marginalized patients are less likely to engage successfully in care. For many CCM patients, engagement fluctuated with changes in socioeconomic circumstances. This means that other patients who would benefit from these kinds of services may not be receiving them, whether because of the programs' limited capacity or because they were deemed not to be engaging appropriately with care.

In reflecting on Bowen's commentary on our article, we conclude that it may be more accurate to characterize the work of these CCM programs as striving towards structural competency rather than, or in addition to, trauma-informed care. In many ways, providers in the clinics that are our field sites utilized trauma as a means to legitimate the inclusion of structural and social inequities as 'ills' in need of treatment, alongside other co-morbidities. As we explain in our article, structural competency is a framework for understanding and acting on the social causes of poor health. Such action can take place at a variety of levels, which may include trauma-informed care programs to address the needs of individual patients, collaborations with community organizations to improve neighborhood conditions (Hansen and Metzl 2016), and advocating for changes to social policy. Just as there is a dearth of research on what trauma-informed care looks like in practice in different care settings, there is a need for research that examines the ways that awareness of structural determinants informs clinical decision-making and care, and ethnographic observations of what this awareness means in and for practice. Our research in complex care clinics provides a detailed description of the many ways providers who are attuned to structural determinants work to address these in their care of patients. The providers in our research were not attempting to adhere to the guidelines of trauma-informed care or the framework of structural competency; rather they were redefining care in the safety net from the ground up, and by doing so pushing our understandings of what is needed to provide structurally competent and trauma informed care.

Structural competency — similar to what Bowen and Murshid (2016), have called “trauma-informed social policy,” or social policy that reflects principles of trauma-informed care — infers engagement not only at the level of patient care provision but activism within communities and neighborhoods, and advocating change at the level of social and health policy. Like Bowen, we believe that even the best trauma-informed care is a downstream intervention that cannot address the fundamental causes of trauma and poor health. The institutional pressures that respond to our current health care funding system make CCM programs time-limited and also render it unlikely that health care providers will have time to advocate for such changes. Medically complex patients need committed advocates who are working to change those institutions and policies that make further traumatic experiences more likely. But in the immediate term, socially vulnerable patients also need material, medical and emotional support, according to our patient and provider informants. Changes that CCM staff are making at the clinic level to better address the multiple needs of their socially neglected patients are worthy of note and provide a basis for hope.

References

- Bamberger, Joshua. Reducing Homelessness by Embracing Housing as a Medicaid Benefit. *JAMA Internal Medicine*. 2016; 176(8):1051. [PubMed: 27322820]
- Bowen, Elizabeth A., Nadine, Shaanta Murshid. Trauma-Informed Social Policy: A Conceptual Framework for Policy Analysis and Advocacy. *American Journal of Public Health*. 2016; 106(2): 223–29. [PubMed: 26691122]
- Fleming, Mark D., et al. Patient Engagement at the Margins: Health Care Providers' Assessments of Engagement and the Structural Determinants of Health in the Safety-Net. *Social Science & Medicine* (1982). 2017; 183:11–18. [PubMed: 28445806]
- Hansen H, Metzl J. Structural Competency in the U.S. Healthcare Crisis: Putting Social and Policy Interventions Into Clinical Practice. *Journal of Bioethical Inquiry*. 2016; 13(2):179–83. [PubMed: 27178191]
- Machtinger, Edward L., Cuca, Yvette P., Khanna, Naina, Rose, Carol Dawson, Kimberg, Leigh S. From Treatment to Healing: The Promise of Trauma-Informed Primary Care. *Women's Health Issues*. 2015; 25(3):193–97. [PubMed: 25965151]