Tammy Kremer (00:00):

This episode is coming out a few days after the Supreme Court overturned Roe V. Wade. Whenever you may be listening to this, I want to take a moment to acknowledge this devastating decision, what this might bring up for you, the people you love, the broader country, and the international communities we impact. I hope that listening to this podcast can provide some nourishment for the road ahead. Now we will shift our focus to today's interview on providing trauma-informed care to pregnant people experiencing significant barriers, including homelessness, substance use disorders, and incarceration.

Welcome to Coming Together for Sexual Health, where we talk about enhancing sexual healthcare.

Dr. Ina Park (00:50):

For most of us, having sex is easier than talking about it.

Dr. Rosalyn Plotzker (00:54):

This is not related necessarily to the people who have the infection. It's related to the healthcare system in which they exist.

Duran Rutledge (01:05):

What can I do? What can I learn that impacts change for the people that are in my sphere of influence?

Dr. Rosalyn Plotzker (01:13):

This is so, so, so preventable.

Tammy Kremer (01:16):

These conversations are brought to you by the California Prevention Training Center at the University of California, San Francisco. It's time. Let's come together for sexual health.

My name is Tammy Kremer, and today I'll be speaking with Becca Schwartz. All views expressed are those of the persons speaking and not of the CAPTC or their employer.

Welcome to Coming Together for Sexual Health, Becca Schwartz. I'm so glad you're here to talk to us today about trauma-informed care. Becca Schwartz has been working as a clinical social worker at San Francisco General Hospital since 2004 in the HIV division and in the Department of OB-GYN. In 2018, Becca helped launch Team Lily, a pregnancy care clinic for people experiencing barriers, such as homelessness, substance use disorders, mental illness, and intimate partner violence. As a social worker, Becca provides clinical services in addition to practical help accessing services, such as housing, healthcare, financial, and nutritional benefits to pregnant women and their families. Becca is trained in infant-parent psychotherapy and brings this clinical lens to her work with families. So welcome to the podcast, Becca.

Becca Schwartz (02:28):

Thank you so much for having me.

Tammy Kremer (02:30):

Great. So can you describe your role for us at San Francisco General Hospital?

Becca Schwartz (02:33):

Yeah. So I'm a clinical social worker, as you said, in the outpatient clinical setting. I work in three distinct clinics, though they are partners to each other. One, as you mentioned, is Team Lily. Another is the HIVE clinic, which provides pregnancy care to pregnant people affected by HIV. So living with HIV themselves or living with a partner who has HIV. And finally, in the family health centers, HIV clinic where we care for our whole families affected by HIV. So often on HIV positive adult and their affected family members are followed in our clinic, and there we take care of a lot of the kids born to our HIVE patients. So we stay following families over time.

Tammy Kremer (03:13):

That's great to have that continuity of care for both the patients. I imagine that's also meaningful for you. And I'd love to hear from you what a typical day can look like on the job.

Becca Schwartz (03:23):

Yeah. So since COVID, I have been doing a hybrid model where I go into the hospital on days that I have clinic. And on those days, I will do usually a mix of seeing patients in clinic and then going to visit patients we have who are in the hospital, most of the time on the labor and delivery at the birth center. I also do home visits. Sometimes do outreach, more general kind of street outreach, but more often I'm doing home visits to established clients or seeing them in the clinic setting. And on days that I don't have clinic, I am working from home and doing lots of the follow-up work that is generated in clinic visits. So referrals, follow-up phone calls, meetings with care teams.

Tammy Kremer (04:05):

Great. I could see a lot of different settings, a lot of different moments in people's care, needs also. So different stages that you encounter in your work.

Becca Schwartz (04:14):

Yeah.

Tammy Kremer (04:15):

How did you get into this line of work and what has motivated you to stay in it for so many years?

Becca Schwartz (04:20):

I think the answer is this is the work I've always been doing in different forms. But it was sort of the work I was doing even as early as college, when I was looking at issues of social justice and responses to social injustices by communities. I was doing that work from an academic lens, but kind of knowing I didn't want to be an academic or stay in that lane. And then from early out of college, doing various forms of activist social justice work, such as working in abortion access, working in a women's health street outreach based clinic in San Francisco.

But over time and I think mostly in the context really of doing abortion access work, I came to appreciate that my lane, my kind of interest was in figuring out a way to combine work on the barriers that people experience to their health and wellness and safety, and working in a clinical way with people who are trying to change themselves in some way. And so combining the systemic work with the interpersonal and emotional work of working with individuals was what I wanted to do. And so I went

back to School for Social Work and chose a program that had a real clinical focus. And then came to the General at my first year out of social work school and have been there since.

Tammy Kremer (05:41):

Oh, wow. Just thinking about how social work provides that kind of a lens or a framework to not only see people coming down the pipe with the same issues over and over again, but to also learn about the structures that impact people so that those can be transformed too. I'm curious to know, what's an interaction that you had with a client that became a formative experience in the way you provide care, and maybe there's a structural lens to that story as well.

Becca Schwartz (06:08):

Yeah. And there absolutely is. I feel like it is that intersection of the structural work with the interpersonal work. The kind of internal work and relational work I do with clients that is what, to your last question, about what kind of keeps me in the work, that is what keeps me in the work. Because there is first of all, so much work to do. And there are also so many ways to improve systems to better care for people and so many ways for people to themselves grow in their ability to get what they need and live the lives they want to live, and so I'm a big fan of social work. Social work has been distorted a little bit in my view, and many social work positions at this point in time are really focused in on a clinical lens. Many people from the behavioral health model are really focusing in on doing therapy and not addressing the systemic issues and the structural barriers. And to me, that's the most rewarding part of the work.

So I guess to answer your question about a specific experience, I have an experience that I just think about all the time actually, and it's with a client who I've known and worked with now for close to 10 years. And I have known and worked with her since the day of her HIV diagnosis, which is when I met her. And then through a real long journey, she had with her HIV diagnosis and then through two pregnancies, through two births to HIV negative children who she cares for and is raising. On the day that I met her, she was in our OB-GYN clinic and had just received her HIV diagnosis. And I was called to come meet her to evaluate her for a psychiatric admission for a 5150, which you know is an involuntary hold in the hospital, which is a very intense experience.

Because this person was suffering so intensely, partly about her HIV diagnosis, but it was also a trauma upon trauma, upon trauma. And it was occurring in a clinic setting that was just not prepared to hold her. I think about it so much because I think about how just being asked to come see to evaluate for 5150 was such already, to me reflecting on it, a sign that our clinic setting did not have the tools that it needed to care for this person and hold them and was really scrambling. In a high volume clinic, where lots of people needed to be seen and this person was having a big emotional response and was really traumatized, who could really only go to this very extreme measure of admitting her to the hospital against her will.

Anyway, what this person needed was time. And luckily, in my role, that's what I had. And I was there and could spend time with her and help hold this overwhelming experience she was having. In her case, the HIV was a result of a sexual assault. It was a super triggering experience. And to be in an institution with all the professionals around her was triggering of the sexual assault as well, and her layers of the injustice in the system's response to her sexual assault. So there was a lot of work to be done and it took a lot of hours on that day. And then honestly, a lot of years after for her experience at the healthcare setting to be one that was less traumatizing for her. But it has happened.

Tammy Kremer (09:18):

Can you share anything about her experience now of accessing care?

Becca Schwartz (09:22):

One of the reasons I think about it so much is healing occurred. Like you wouldn't meet this patient now and know any of that to be true. As a mother, she accesses healthcare with ease. She brings her children in for their visits. She gets along with the doctors and the clinic staff. She doesn't miss appointments. She's just totally, I think what our system would consider an easy and straightforward patient. But for years, she either didn't come or she would come but at some point along the journey of checking in, registering, hearing some problem with her insurance, needing to go back to talk to an insurance. Somewhere along the journey that all of our patients go through trying to see a doctor, she would have an event where something would trigger her. Something would be said that felt like it was outing her in some way. And she would leave. She would yell at staff. She would get really upset. It was never without triggers and big responses.

Tammy Kremer (10:17):

Yeah. I just kind of take a moment and like that image of what I might consider a crisis moment of being surrounded by providers and this question of being 5150 or not, how that could really reinforce a lot of the traumatic experiences that you mentioned, and just how many elements are functioning at the same time for a person in that situation. I'd love to hear about how a trauma-informed approach to care could support a patient in that context. And if we can just define what trauma-informed care is. I'm sure it's an infinite definition, but at least a working definition for today, or however you like to use that word would be great. And to talk through some strategies that have come up in interactions like the one you described.

Becca Schwartz (10:59):

Yeah. I think it's kind of ever evolving for me. Understanding the way I see my role in providing trauma-informed care, a lot of it is holding and creating space for patients autonomy. Not overusing the power that we have as healthcare professionals, I think that's the first thing. Including that if a client needs to leave a visit, because they're overwhelmed and they're triggered and they don't feel safe in our setting. Letting that be so inviting them back, making sure that I'm reachable to them when they do feel ready to try again. We try again all the time. And I think there are moments where we can use or choose to not use the power we have as healthcare professionals. And that's where it begins, autonomy and agency in the patients. And full transparency in our role, I feel like is another really important piece to be sharing. What is my role, what confidentiality is, what are the limits to confidentiality. Giving people the opportunity to disclose or not disclose with full knowledge of my role as a healthcare professional.

I think an essential piece of trauma-informed care is willingness to bend and flex the system to be gentler and kinder and more patient and accommodating and to be accessible to people. How they actually need us and not expect all of that bending and fitting in to be done by our patients, which is how I think the healthcare system traditionally is set up. And that's why in the model of Team Lily, it's an open-access clinic. So it doesn't really matter what time you come, on the day you come. It doesn't matter if you miss that day, we try again the next.

It's a clinic in which our patients have access to us by cell phone. And that's I think a significant piece is they have access to all of us by a cell phone. So it's not just me and it's not just our navigator. It's also our physician, which I think is really meaningful. We don't gate keep. And cell phone access is really tricky and not straightforward. And I think that it's difficult to achieve a good balance and what are

traditionally thought of as healthy boundaries when you're really accessible to patients, but also think it's essential to providing trauma-informed care.

I think the other piece for me of providing trauma-informed care is just a willingness to tackle systemic barriers. So just say that that's what's happening when it's happening, to not call something a patient's problem or failing when it's a systemic problem and failing. And to be able to say that out loud to the patient and then to take it to the system, which means that we do a lot of working with all of the systems we interact with which are many. It's like health insurance and healthcare delivery, benefits and benefits delivery. We're talking about the carceral system, and the jails, and the prisons that hold some of our patients. We're talking about the child welfare system. So we are really agreeing in our partnership with our patients to use our voices to help amplify their voices and get a just and fair response from these systems. Housing. I forgot housing. We're doing a lot of advocacy with the housing systems.

Tammy Kremer (14:07):

I'd love to hear from you where the idea for Team Lily came from, how do patients get referred to your care who need the kind of support that you're able to offer?

Becca Schwartz (14:18):

Yeah, so the idea came... There was two things that were happening at the same time. One was my work in the HIVE clinic. And in HIV care in general, I really feel like from the beginning, recognize that social needs need to be at the heart of healthcare delivery. And also, that healthcare is a social justice issue and we need activism and attention all the time in terms of equity and who is who, who has access to what care. So HIV services have long been funded in a way that really have social work integrated, mental health services integrated. So I knew that model really intimately from all my years in the HIV clinic.

And then there was kind of a growing swell of discomfort and disease in the birth center care providers and the in OB-GYN, a recognition that the model of care as it exists which is a fairly high barrier one of getting prenatal care was leaving many people out in the way. This was felt to labor and delivery birth center providers is that patients come in and haven't been able to get prenatal care for one or many barriers reasons. And have their births and child protective services becomes involved because not having prenatal care is a risk factor. And maybe UTOX is done on labor and delivery and substance use is discovered.

Tammy Kremer (15:42):

Can you describe what a UTOX is?

Becca Schwartz (15:43):

Yeah. A UTOX is a urine drug screen. So up until recently, it was our hospital's policy and it is no longer our hospital's policy. But it is still many hospitals policies that someone who presents in labor who has not had prenatal care, or who has not had what's considered adequate prenatal care will just be given a urine toxicology test to check for drugs. Sometimes they're informed. Sometimes they're not informed. And then this becomes the grounds for a child protective services reform.

Tammy Kremer (16:12):

Got it.

Becca Schwartz (16:12):

In so many ways, if you have a high barrier healthcare delivery system and people don't get into care, they are then in this sort of pipeline for scrutiny and policing and then eventually for child welfare involvement. So there just was an increasing sense that this is intolerable, not just to patients obviously, but also to providers who are involved in providing this care and really had no idea of how they could interrupt that pipeline which disproportionately affects women of color. There was a lot momentum and we have this model of care from the HIV realm. And we just wrote a grant basically to try to pilot this idea of providing low barrier care in the model of HIV care delivery with really the social needs at the heart of it. And that was initially an HIV prevention grant. So we were incorporating HIV prevention, counseling, and the offering of prep into care in 2018.

Tammy Kremer (17:05):

Wow. And how has Team Lily grown or evolved since that inception?

Becca Schwartz (17:11):

Yeah, we wrote it way too small. Even in the beginning, our estimates of the numbers we would serve were way off. I think we said it would be 40 patients in the two years of the pilot program. It was 80 the first year and it was a hundred the next year. It's just you don't even know the need until you have something to offer people. So it has grown a ton. I think it has grown because the need is significant. And the need may be growing, but I also think the need has been there and has been underappreciated and undercounted in the city for a long time.

And so because our program is built on partnerships, so right away we were working with the city's substance use treatment programs, methadone clinics, the homelessness services and homeless service providers, street medicine. Right away we were getting referrals from providers who were encountering patients who needed care. And then also increasingly we're getting referrals from our patients themselves, which is something we really celebrate and take great pride in. We have people referring their family members who are pregnant, or their friends. So yeah, it has grown in many directions.

Tammy Kremer (18:20):

Yeah. Some really concrete ways that you can see the impact the clinic is having. People referring their friends is just such a powerful recognition of the kind of support that they received. I'm wondering if you can share with us a bit about what makes Team Lily especially needed or relevant in the context of San Francisco.

Becca Schwartz (18:39):

That's a great question. And I speak not as a data person, just from clinical experience. It has been my experience that women, pregnant women and families in San Francisco have a particularly hard time. There are many, many services. Homelessness services, for example, underappreciate the existence of women and families. I think obviously this is such a very difficult city to make a real [inaudible 00:19:08] financially. And so there are such extremes here of wealth and poverty. Gentrification has made it increasingly hard to just live in a financially vulnerable, but not in crisis. So I think a lot of people who might be making it in another city are in a crisis here.

Tammy Kremer (19:24):

I'm also thinking about historical inequity in terms of racial justice and just the huge gaps in terms of access and ways people get treated in this city.

Becca Schwartz (19:36):

Yeah, it's profound. It takes a reckoning internally, which is I think one of the things we've really been doing at San Francisco General is coming to kind of appreciate the role that San Francisco General has played as an institution in the disruption of families over time. And some of that has led to these efforts to really radically change how we care for families in the hospital. And just a deep commitment across disciplines to interrupt our own processes around engaging CPS specifically.

Tammy Kremer (20:06):

I just want to recognize how powerful that process is to be doing that work of rewriting scripts and changing the way we function from the inside of a system that I sense so badly wants to change. There's such strong commitment to being a source of health and wellness, broadly speaking, for our community. But just the kind of challenges that are inherent in transforming a large system, really humbling how much work that takes. And you mentioned the reflective process around seeing the role that the general hospital has played. And I'm curious to hear more about how that looks in terms of providers and staff, looking at their own experiences of stigma, and how people's understanding of the stigma that impacts the communities that the general hospital serves has evolved in your time there.

Becca Schwartz (20:57):

I think it's evolved so much. There were years for me in my work as an outpatient social worker when I felt like I had no collaboration really with the inpatient care provided. I mean I would try and I would be present. So I'm speaking about the transition of care that goes from the prenatal care we do in our clinics to the birth experience and the postpartum experience and the discharge planning. And I'm speaking specifically about the setting where there is concern about caregivers with substance use disorders and whether there is safety at home to take home a baby.

And for years in my work, I didn't feel like I had any partnership. I felt compelled to show up and be present for the birth admission and after the birth and care planning and to advocate for my patients, but I wasn't doing it in partnership. I wasn't necessarily really listened to. And this is really so foundational to Team Lily and we wouldn't be able to do our work if this wasn't. But the partnership has really grown. It's not just like up to the goodwill of any given provider, whether they stop their workflow to call and talk to me. It's been built into our protocols in some ways that are really, really meaningful.

There are so many people to credit for that work that's been ages in the making. One of whom, Anna Delgado, has done just immense amounts of work on improving the care of patients in the birth center, specifically around the issues of urine toxicology and around child welfare involvement. So what we now have is an actual protocol where there is that's called a timeout where no one provider can act independently, not the inpatient social worker or any care provider on the pediatrics or OB team in making a decision about whether a CPS referral is made. We pause as a system. It's built into the workflow. And an opportunity is given for everyone on a care team to come together. So people taking care of mom in the hospital, people taking care of baby, providers from the outpatient setting.

So Team Lily always is present for these public health nurse. If a public health nurse is working with the family which they often are a community health worker, there's room for people to come to the table and speak on a family's strengths and protective factors in the home, as well as what the risks are, the concerns are. And from there, a collective decision is made about whether a child welfare

referral is made. We have to recognize that is a profound shift in how work is done and it's a real commitment to pausing, to slowing the role, like not being the most efficient. It's really putting patient care and quality care and justice above efficiency because it slows everybody's work, but it's been really meaningful. There's also then a documented process that allows the hospital to go back and look at who in our system is getting child welfare involvement and who is not, which is a really important accountability piece I think we've not always had.

Tammy Kremer (23:47):

Yeah. Are there any other issues around child welfare reporting or child removals that you can share about, maybe from the perspective of supporting a parent who is either concerned about having child welfare notified or has just learned that that has happened?

Becca Schwartz (24:05):

Yeah. That is so much of what we do and so much of what we work on ourselves to do better. I think it begins at the very beginning of care. Engaging pregnant people in care is the recognition that most of our patients have prior negative history, either themselves or in their family systems and communities with the child welfare system. It is an enormous barrier to care. Prior trauma and prior child removals are an enormous barrier to care. And so we have to begin talking about it with our patients from the very beginning because they need to know where we stand. They need to know if we are allies. They need to know if this is going to sneak up on them and they need to know that it's not going to sneak up on them. And so I think I didn't appreciate that as fully as I have come to how much that's a part of our care from the very beginning of engaging a pregnant patient.

And there's so much in my view that we can do and that we do do to make the experience of birth and discharge planning less traumatic to patients. Starting from avoiding child welfare referrals wherever we possibly can, which is our commitment. But then including how we counsel patients, how we prepare them when child welfare is decided by this multidisciplinary team that child welfare is going to be involved. How we set up the interaction, what we ask of child welfare in terms of allowing for an advocate to be at the bedside when they come and meet a family. Attending the meetings that child welfare holds, where they're doing assessments, but then when they're doing also the discharge planning and formulating their decisions about whether they're going to remove or not remove a baby.

I think we have really learned that there is an enormous potential for advocacy. That when a care team, doctor, social worker, nurse use their voice and speak to the full picture of a family and the safety that they have, we can change the outcome. Not always, but we can sometimes. And so we do where we think it's safe and where we think we can left to its own without intervention and advocacy. It's an experience that steamrolls families. It doesn't take into consideration if a woman is just hours postpartum, if she still can't feel the lower half of her body and is disrobed in her bed. It doesn't take into consideration or their dignity. So there's much to be done to improve the experience for patients.

Tammy Kremer (26:29):

And when it comes to decisions by child welfare or to remove a child, is that, in your experience at Team Lily, primarily related to use of substances? Are there other aspects of that that are regular pieces?

Becca Schwartz (26:45):

Use of substances is a significant one. I think the other ones that we see are interpersonal violence. So domestic violence is another reason we see child removals. Mental health issues that are not adequately

treated or where mood disorder is not well-treated in the patients, not stable. Those are kind of the main ones.

Tammy Kremer (27:02):

I'm curious to hear from you about decriminalization or the role of decriminalization of pregnant people who use substances and how that impacts the patients you work with.

Becca Schwartz (27:13):

Yeah. I think criminalization goes hand in hand with stigma and prejudice and then fear of accessing care. It is ignored as a massive barrier. I think that while we are not in a geographic area that incarcerates pregnant women for using drugs during pregnancy, that exists. That fear of that is out in the ether, and then we punish in other ways. We punish by removing children and terminating parental rights. And so I think those are all just massive barriers to care in current pregnancy and future pregnancies.

It has a tremendous impact. And it's why we are talking about it from the very beginning, that what is your goal. And then explicitly and officially and with transparency, we are onboard for your goal. And if your goal is parenting, we are with you for that and we are going to do everything we can to help you get there. And that may include difficult conversations. If we see that your months are passing and substance use is ongoing and we haven't been successful at getting you into treatment or into stable in-housing, we are in this area where we're worried and we're going to talk about it openly because we know what your goal is. And your goal is to avoid child welfare involvement and we are all in for that. So what do we need to do to avoid it?

Tammy Kremer (28:26):

Yeah.

Becca Schwartz (28:27):

And the other thing is to your question about criminalization. While we don't have patients who are incarcerated for drug use in pregnancy, thankfully. We care for many patients who are incarcerated during their pregnancies. And that is another area in which we have really developed our partnerships so that we can be effective advocates for getting pregnant people out of custody and into treatment settings.

Tammy Kremer (28:50):

Mm-hmm. Can you share a bit more about that? How would that look if you were working with a person who's incarcerated, who is pregnant and expecting soon?

Becca Schwartz (28:58):

Yeah. So one of the really great pieces of good fortune we have is the OB on our team who is Nika Seidman, who is a partner in this idea from the beginning, provides OB-GYN care in the county jail, the Suffolk County Jail. She meets all pregnant folks who are incarcerated and provide some with prenatal care if they want to continue, linkage to abortion if they want to terminate their pregnancy. But she cares for them while they're incarcerated and so we're able to really set up good discharges and keep continuity. Our patients meet Nika in the jail and they're able to continue to be cared for. It means that we know of pregnant folks who are in jail and we start working right away with the discharge planning

folks at the jail. We're able to then get access to the patient's attorney and start to advocate on the side of released to the community with appropriate treatment.

Tammy Kremer (29:45):

Mm-hmm. And if somebody doesn't get released to the community and they go into labor, what happens then?

Becca Schwartz (29:51):

It hasn't happened in quite some time, thankfully. But if it happens, child welfare is involved. And if it's known that it's going to happen, then I think patients are talking to their family members, there's work to plan for a discharge of the baby to family. But that doesn't always happen.

Tammy Kremer (30:07):

Mm-hmm.

Becca Schwartz (30:08):

But really, it has been sometimes since we have that outcome.

Tammy Kremer (30:20):

I'm thinking about the kind of context for a provider when working with a patient with such complex needs. And I'm wondering how Team Lily provides ongoing education to folks involved in that program or how you support each other in order to continue to do this work sustainably.

Becca Schwartz (30:39):

It is way deep. I mean there's also a steady infusion of, I would say, victories and joy. So I think one of the things we do is we celebrate with our patients and we spend time with them when they're doing well too, and not just when they're in crisis or struggling. So we get to see them with their babies months out after the birth. And they're still coming to visit clinic and they're still coming to get support from our team and we see them thriving. And that is definitely a sustaining part of the work.

I think we really try to take care of each other in just creating space for what's actually happening, checking in with each other. We're not always working on the same thing at the same time. One of the things about patients leading their care is it often ends up that a patient will have a primary person that they reach out to. So we don't all hold the exact same thing at the same time, but we really create space to listen to each other and support each other. We're really available to each other. So if someone needs to talk through a scenario, or if I really know I need Nika as the physician on our team to advocate in this moment for this patient, I can reach her. And I'm super thankful for that.

Then the other thing, we have built-in consultation which is amazing. It's this reflective listening space that we have with one of the clinicians from the infant-parent program that really is very nurturing and different from any other hour of the month, that hour that we spend with her. We give each other grace. Everybody has complicated lives in addition to our complicated job, and so we give each other the space to take care of our families and do what we need to do. And we trust each other to show up. We also give each other flexibility to also attend to our lives.

Tammy Kremer (32:25):

Yeah. I can feel that kind of humanizing element of the connection in order to also interact with the people that come forward, then to be present and available for what their needs are and what their story is. Would you be able to share maybe an example or two additional patients that you've worked with? I'd love to hear specifically about a patient navigating houselessness in San Francisco. And if you want to speak more broadly to it than a specific case example, that's okay too.

Becca Schwartz (32:55):

Yeah. The majority of our clients come to us unhoused either in one of the city's shelters or navigation centers or outside. It is certainly the minority of our patients who come to us in a stable housing situation. Some of our patients come to us in sheltered, staying with family or friends or partners, but unsafe in that setting and needing to change. So yeah, it's harder to pick one to speak on. I mean so much of what we do is navigate the pathway from unsheltered or unsafely sheltered into safe adequate housing.

I think one of the things that I struggle with the most, because of how our city's homelessness response has been built, it excludes people who are sheltered but unsafe in their setting. And that weighs really heavily. It really prioritizes people who are outside on the streets, and that is obviously an urgent need. But I think my experience is that, particularly for women and for women with children, they are unlikely to be outside and more likely to be inside in unsafe situations and compromising safety or either emotional or psychological or physical safety to be sheltered. And it's really hard to help those clients into housing. I think it's a flaw in our system.

Tammy Kremer (34:24):

Mm-hmm. And when it comes to treatment around substance use disorder, is there anything that makes it different in terms of people's needs when they are pregnant versus when they're not? I'm sure we can't make huge broad statements, but just curious to understand the added complexities if there are.

Becca Schwartz (34:40):

Yeah. I personally am a big advocate for all levels of care being open to pregnant people. It is really important we have three wonderful family residential treatment programs that are specifically for pregnant women and women with kids. And I think that they are invaluable and they're very close partners of ours in the work. But I feel like every program should also be available to pregnant people, because I think pregnancy is just a very different experience for everyone.

Some people are very uncomfortable in a family treatment setting. They don't yet know if parenting is the goal. They don't yet know if they can do parenting. And being immersed in a family treatment setting or parenting classes and are all integrated, is an uncomfortable fit. There are people who are pregnant who have significant mental illness and if they're excluded from the psychiatric stabilization programs we have in the city and forced into family programs, they're at risk for really feeling out of place and uncared for in those settings. I just think all doors need to be open for pregnant people because pregnancy is different for everybody. And it's a journey. For some people, it really changes what it means over time.

Tammy Kremer (35:51):

Yeah, I could see that. I can only imagine that things would evolve very quickly based on parenting decisions.

Coming back to the trauma-informed care lens to this conversation. I'm wondering if there are things that you hear consistently from communities you serve about what they wish providers knew.

Becca Schwartz (36:16):

What I hear most is that how much they don't trust, how much we are not trustworthy. We have not earned the trust of our patients yet, and that is our work to do. I think many of our patients just feel so discouraged themselves so much of the time, have goals that for a certain kind of life they want to live and a certain kind of parent they want to be, and all the dreams that they've had for their lives and how they see as much as any of us see how it doesn't look like what their life currently looks like.

I hear from patients that they want that to be seen, not just like the list of problems and the list of... Which is often really been concretely what, say, a medical chart looks like but all the efforts that they're making. And the full person. Including the person they were before their substance use disorder, before they lost the children in their care, the full person that they are. There's no way to do that other than to spend time and to earn trust and to slowly hear more and more of the picture. But I think our patients really yearn for it.

And the idea that they could just walk into our setting and complete an intake, answer a bunch of questions that they've answered millions of times before to get various services and benefits and not feel, seen as a full person. It's just impossible. It's intolerable for a lot of our folks. And so, one thing we've done as a team is just to eliminate any structured intake. I mean I haven't done an intake in years in the traditional sense because it just feels unreasonable at this point. And when I think back on first meetings I had with patients 10 years ago in the intake questionnaire I would take out, it just feels terrible. It's not reasonable. People should have the opportunity to become known as they are ready for it, as I've established what I can do to actually help them.

Tammy Kremer (38:07):

It just strikes me how much of that is kind of an assumed, taken for granted part of interacting with the medical system and how much of a barrier that would be to so many interactions with care. I'd love to hear what your big picture, rich vision would be for Team Lily and other ways that you're able to support pregnant folks using substances or houseless or encountering any of the other barriers we've discussed today.

Becca Schwartz (38:35):

The first thing that comes to mind is just more. We would have actual treatment on demand, treatment beds available when our patients are ready for it. We would have, in my vision, a unit of the hospital or a part of the birth center that's really dedicated to the admissions that we do to help people stabilize on, for example, medication for opiate use disorder. Those are common admissions now in our patients, but they are unusual admissions for the birth center. They're not a birth event. They're not really related to a birth event. And then we do in our hospital struggles a little bit still to care for folks in this.

Yeah, so in my vision, we would have our own unit. We would have more access to housing. We would be able to... Our system would collectively recognize that safe shelter is an urgent medical issue not just for pregnant people, but for pregnant people. And that we can't even begin our work when people are outside. Their survival is too much at stake and there's too much competing priorities, and we can't get started on any real stabilization work when people are outside. And in my vision, the whole city would recognize this as a health emergency.

And I guess in my vision, we would have a different level of... I think we're building it. We're slowly building it. A partnership that is citywide, that is a commitment to pulling together a safety net for vulnerable families that does not involve child welfare reporting. And where we are working, we are creating it and building it. And in partnership with some of our community partners like Homeless Prenatal and the public health nurses from Maternal Child Health and Team Lily, we are really strengthening that safety net so that we can make alternate safety plans that don't involve child welfare reporting.

And more staff, more of the beds, more flexibility in our system. We have these silos of single adult homelessness in housing services and family homelessness in housing services. The silo doesn't work for our patient population. One of the unintended outcomes of child welfare involvement and child removal is a lot of our patients can become street homeless, can lose their place in housing or treatment if they're in the family system and have a child removal. So it also sets them back tremendously in terms of their efforts to reunify with children, because now they have homelessness in addition.

Tammy Kremer (40:59):

Definitely. And pulling out from the vision for specifically the folks that you work with into a broader social vision. As you know, this podcast is called Coming Together for Sexual Health. And so I like to ask folks, what's one thing you hope we can create by coming together for sexual health?

Becca Schwartz (41:18):

I guess my personal angle on it is just that we all approach the work with continuing deepening appreciation for how systemic barriers impact our patients, how traumatic experiences with healthcare systems and other systems have impacted our patients and just a commitment. We stay in conversation about how to hold that, how to have that knowledge inform our care and our practices and just keep our commitment to getting better, to doing it better, to listening to our patients and hearing that part of their story as well.

Tammy Kremer (41:52):

Well, thank you for sharing that vision and for everything else you shared with us today, Becca. I've really enjoyed getting to hear more about your work and I'm really inspired by the way that Team Lily has been able to serve people that just really need a lot of different types of support than our system has historically been able to offer. So thanks for the work that you do every day.

Becca Schwartz (42:11):

Thank you. Thanks for having me.

Tammy Kremer (42:15):

Thanks for listening and check out the show notes for the resources mentioned in this episode. You'll also find a link to the transcript of the show. Please follow and rate us wherever you get your podcasts. This will help more people find us. Connect with us on Instagram @comingtogetherpod, and learn more about us and get in touch at comingtogetherpod.com. This podcast is brought to you by the California Prevention Training Center, where we build the capacity of healthcare professionals working in sexual health and emerging infectious diseases. Check us out at californiaptc.com and follow us on Twitter @CaliforniaPTC.

This podcast is produced by me, Tammy Kremer, with Laura Marie Lazar and Catalina Macdonalds. It is edited by Layla Mohimani and Isaiah Ashburn, with original music by Layla Mohimani. We're based at the university of California San Francisco. I would like to acknowledge the Ramaytush Ohlone people, the traditional custodians of the land that UCSF sits upon. Thank you for coming together for sexual health.