Relational Ecology: Strengthening Community Resilience for Unhoused Indigenous Peoples in Albuquerque

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Relational Ecology: Strengthening Community Resilience for Unhoused Indigenous Peoples in Albuquerque

Abstract

Objective: Housing and Urban Development (HUD) Continuums of Care (COCs) are responsible for providing entry to integrated healthcare for unhoused people toward housing stability. A client's safety is a crucial variable to receive services. A comprehensive safety strategy understands the importance of relationship quality for clients and their multidisciplinary healthcare teams (MHT) to prevent safety incidents. Greater depth of knowledge on participant experiences informs the development of a process model for implementing the Community Resiliency Model (CRM) for crisis prevention response to decrease health disparities among unhoused Indigenous peoples in Albuquerque.

Methods: This qualitative key informant study applied an ecological lens on Relational-Cultural Theory (RCT) and 24 participant interview content analysis. Participants include unhoused people who self-identified with Native American, about accessing and receiving homeless services and members of their MHT across COC agencies.

Findings: Participants shared a congruent understanding of the interpersonal, multidisciplinary, and organizational resilience factors for crisis stabilization and prevention. Integrated healthcare providers identified cohesion when an MHT has the organizational supports needed to consistently provided compassionate care and relevant recovery options. Interpersonal resilience emerged as the sense of belonging experienced in a compassionate and accepting relationship. Relational courage is a key facilitator of interpersonal resilience when an integrated healthcare provider can clarify with a client what is the most important and brings purpose or meaning. Participants emphasized multilevel factors for the cultivation of hope in recovery at the heart of crisis prevention.

Discussion: The findings provide a rationale for a paradigm shift to resilience for housing stability. CRM wellness skills can enhance growth-fostering connection and cultural relevance for safety planning. Significantly, cohesion enhances the capacity of an MHT to support a client's success in recovery. Cohesion correlates with integrated healthcare providers in their OK Zones. Ethical distress escalated crises and contributed to barriers preventing safety incidents. The implications for integrated healthcare and housing policy are to increase multilevel support for organizations to provide workforce training, implementation support, and solutions to sustain MHT cohesion and maintain intra-organizational systems. Cohesion is a key variable to enhance the capacity for a comprehensive safety strategy to be successful.

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RELATIONAL ECOLOGY: STRENGTHENING COMMUNITY RESILIENCE
FOR UNHOUSED INDIGENOUS PEOPLES IN ALBUQUERQUE

Jennifer M. Stanley, MSW, LCSW

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DEDICATION

This study is in loving memory of Stephanie Cleland who inspired in me the value for decolonizing healthcare. I am grateful for our friendship and the seeds you planted. Stephanie, what I remember most about you is your heartfulness and hugs. You never looked down on someone or gave sympathies. You uplifted those fortunate to be in your life, believed in them, and treated them like family. November 17, 1981 - February 11, 2001
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The people I had the privilege to work alongside at First Nations ignited the spark of this study. A spark connected to compassion and solidarity with the unhoused people in our community. This study took place in the occupied Southern Tiwa lands currently known as Albuquerque. The Rio Grande/Bravo delta rivershed is called the Blue River by the Southern Tiwa peoples. The Blue River is a life source and mother. This corridor has been neutral territory for many Indigenous nations from time immemorial, including the Tiwa, Keres, Towa, Diné, and Apache peoples.

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Objective: Housing and Urban Development (HUD) Continuums of Care (COCs) are responsible for providing entry to integrated healthcare for unhoused people toward housing stability. A client’s safety is a crucial variable to receive services. A comprehensive safety strategy understands the importance of relationship quality for clients and their multidisciplinary healthcare teams (MHT) to prevent safety incidents. Greater depth of knowledge on participant experiences informs the development of a process model for implementing the Community Resiliency Model (CRM) for crisis prevention response to decrease health disparities among unhoused Indigenous peoples in Albuquerque.

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*Keywords:* Environmental Justice, Healing, Housing Security, Relational-Cultural, Somatic
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CHAPTER 1

Introduction

In Albuquerque, American Indians and Alaska Natives make up more than two out of five people living on the street (44%) while only making up one out of twenty-five people (4%) in the total city population (NMCEH, 2017; Worth, 2019). Growing practice evidence indicates a more wholistic, relational ecological model is necessary for integrated healthcare to prevent safety incidents during crises and remove barriers to care for unhoused people (Henry et al., 2017; Linklater, 2014; Miller-Karas, 2015; NHCHC, 2016; SAMHSA, 2018). Houselessness is too often a terminal diagnosis (Henry et al., 2017). A resiliency-oriented approach to crisis prevention understands historical trauma and the social determinants needed to cultivate hope and engagement in recovery. A compassionate, non-violent approach is necessary to build on people's strengths (Linklater, 2014; Miller-Karas, 2015).

In a national study, childhood trauma is the leading individual-level risk factor for a person to experience houselessness in their lifetime. Overall, the most significant risk factors are social and economic, poverty, and housing loss (Shelton et al., 2009). Community organizations need safer service environments to provide trauma-informed care across the safety domains of physical, emotional, psychological, spiritual, and cultural safety for unhoused people (Harris & Fallot, 2001; SAMHSA, 2014). Trauma-informed care provides a needed focus on the collective safety of clients and integrated healthcare providers that increases the quality of client care and staff retention (Bloom et al., 2003; HCHCN, 2016; SAMHSA, 2018). Culturally responsive, community-based interventions are vital to learning how to contribute to building a prevention infrastructure for mental health challenges during a public health intervention to promote recovery and prevention within a system of care (Miller-Karas, 2015, p. 148; SAMHSA, 2018).
Homeless healthcare organizations increasingly implement trauma-informed care initiatives to prevent safety incidents from escalating in clinics. Reports indicate that decreased reliance on security or police decreases the number of clients asked to leave the clinic (HCHCN, 2016; NHCHC, 2016). A trauma-informed perspective looks at the contributing factors of a crisis by considering, ‘What has happened to you?’ and a resiliency focus on ‘What is right with you?’ and ‘What are your strengths?’ to build on (Miller-Karas, 2015). An unhoused person experiencing cumulative stress or traumatic stress activation can learn and practice wellness skills to help regulate in relationship with integrated healthcare providers (Miller-Karas, 2015). Calming down an overactive traumatic stress response in the nervous system is necessary for collaborative decision-making (Miller-Karas, 2015; Treleaven, 2018). From a regulated state then, together, a client and integrated healthcare provider can begin to shift focus from crisis response and begin to identify external and internal resources, solutions for de-escalation, and move toward a client’s recovery goals (Herman, 1992; Miller and Rollnick, 2013; Miller-Karas, 2015; Treleaven, 2018).

An ecological approach (e.g., interpersonal, organizational, environmental, and structural) for crisis prevention and intervention is necessary to meet the care needs of unhoused Indigenous peoples (IOM, 2012; Bowen and Murshid, 2016; Prussia, 2017; Gray, Yellow Bird, & Coates, 2018; SAMHSA, 2018). Trauma recovery from an ecological approach emphasizes efficacy rooted in the relevance of multilevel public health designs to utilize the entire system as a vehicle for intervention to enhance the person-community relationship for people across different recovery contexts (DeCandia and Gaurino, 2015; Harvey, 1996). Responses to historical trauma need to address the multigenerational effects on individuals, families, communities, and cultures (Evans-Campbell, 2008). Integrated healthcare providers need to have
a strong understanding of historical trauma to better address the roots causes of the crisis, including housing inequities, health disparities, disconnection from relationships including natural sensory ties, ongoing exposure to violence, and the continued socio-political conditions of colonialism (Miller, 1988; Brave Heart, 1998; Brave Heart, 2003; Evans-Campbell, 2008; Brave Heart et al., 2011; Tuck & Yang, 2013; Mohatt et al., 2014; Darroch et al., 2017; Midgley, 2018; Mkandawire-Valhmu, 2018; Curtis et al., 2019; Thistle & Smylie, 2020). People need social determinants of health and the necessary social and economic conditions for housing security to be on a stable recovery path (Bowen, Savino, & Irish, 2019; Healthy People, 2030).

First Nations Community HealthSource (FNCH), a federally qualified Community Health Center (CHC), serves everyone throughout the state, focusing on unserved and underserved communities in Albuquerque, New Mexico. The initial phase of the comprehensive safety strategy began with a trauma-informed care initiative for crisis prevention. Homeless Outreach Program (HOP) integrated healthcare providers spearheaded the initiative to decrease the number of safety incidents and reoccurrences (Appendix A). The HOP Safety Subcommittee (HOPSS) identified a trend in the number and types of incident reports involving unhoused clients. Compared to the general FNCH primary care population, a disproportionately higher number of HOP clients were involved in a safety incident defined as a crisis that resulted in the use of security force, escort off property, or temporary and permanent service bans. More safety incidents ranging from verbal to physical are disruptive to the client's care. A better understanding of the safety needs of HOP clients, integrated healthcare providers, and multidisciplinary teams can prevent safety incidents. The study aims to use qualitative inquiry to uncover more about the safety needs and responses to prevent safety incidents. The quality improvement efforts of HOPSS that occurred before the onset of the COVID-19 pandemic and
throughout the first year shaped the research questions for this qualitative key informant study (i.e., October 2020 to March 2021).

On the ground, the challenges of prevention can sometimes feel overshadowed by the ongoing crises that being unhoused and marginalized can produce at levels overwhelming to a care system. This study concerns participant experiences in the client/integrated healthcare provider relationship when safety incidents were de-escalated and stabilized to generate knowledge on crisis prevention. The research questions addressed in this study are as follows:

What is the relationship between unhoused Indigenous clients and integrated healthcare providers within community organizations during a time of crisis? How are services accessed during a crisis? What services are received or not received? How is crisis prevention approached from a trauma-informed and resiliency-focused culture? How can relationship support housing stability?

The participants were unhoused clients who self-identified as Native Americans receiving homeless services anywhere in Albuquerque and integrated healthcare providers working at homeless coalition member organizations. FNCH leadership identified the need for a comprehensive safety strategy that is culturally responsive and trauma-informed to decrease safety incidents toward crisis prevention. Recovery from historical trauma centers on destigmatizing health disparities with an understanding of the contexts of colonial struggles to support people to no longer hold self-blame and move toward restoring purpose and identity (Kirmayer, Gone, & Moses, 2014).

A historical trauma lens on hope and recovery deepens understanding of the principles of prevention most relevant to unhoused Indigenous peoples in the Housing and Urban
Development (HUD) Continuum of Care (CoC) of homeless service organizations. Relational-Cultural Theory (RCT) is applied to qualitative content analysis of participants' individual and collective needs and strengths to inform the development of a process model for implementing somatic literacy and community-based prevention intervention. Paradigm shifts away from a deficit model that marginalizes and victimizes unhoused Indigenous people is essential for the success of the comprehensive safety strategy. This study calls for structural policy changes to increase multilevel support for organizations such as FNCH to sustain cohesive MHTs and intra-organizational networks for systems of care.
CHAPTER 2

Review of the Literature

“Despite the health inequities, social disintegration and economic disparities, I realize that Indigenous people have a high degree of resiliency. I feel it is crucial to write this story through a lens that recognizes this fact, as well as the significant contributions made by Indigenous knowledge and experience” (Linklater, 2014, p. 163).

Indigenous Histories of Care and Injustice

Anti-Indian policies aimed at ethnic cleansing and land dispossession continue to shape the designations of tribal lands, urban spaces, and bordertowns for Indigenous peoples (Brave Heart, 2003; Denetdale, 2016; Estes et al., 2021; Gray et al., 2018; Jacobs, 2009; Midgley, 2018; Mohatt et al., 2014; Thistle & Smylie, 2020). Without a public education infrastructure and removal of access to needed material resources, many people are displaced, forced to migrate, and relocate to urban areas as a continuation of colonization (Denetdale, 2016). The ‘urban’ individual as more modern and less traditional places indigeneity as a thing of the past, resulting in Indigenous people as outsiders in their homelands (Denetdale, 2016). Traditional/assimilated and rez/urban are examples deliberately created by U.S. relocation policies from the 1950s to 1980s when 750,000 Native people relocated to cities, with more than 78% of people who self-identified as American Indian during the 2010 census not living on tribal lands, pueblos, or reservations (Estes et al., 2021).

Urban Indigenous issues are a global public health concern with disproportionate unemployment, inadequate housing, discrimination, and barriers to care (UN-Habitat, 2010).
An approach rooted in Indigenous ways of knowing, being in a relationship, and values of equity are necessary for public health interventions not to undermine Indigenous Knowledge or perpetuate historical and ongoing violence experienced among urban Indigenous peoples (Estes et al., 2021; Morton, 2019; Prussia, 2019). The marginalization of Indigenous knowledge systems in response to urban Indigenous issues is a part of the U.S. colonial legacy. The colonial legacy includes a racially stratified society with deadly political and economic implications for people of a lower class in the hierarchy of white supremacy culture (Henry & Tator, 2012; Jacobs, 2009). Race is a colonial construct designed to protect white people and the upper classes (Johnson, 2006).

People in the U.S. use the language of bordertown to describe their experience of moving on or off reservations and in or out of jurisdictions where settler laws enable and justify ‘Indian-rolling’ murders, racist vigilantes, and police violence against unhoused people (Estes et al., 2021). Domestic bordertown boundaries were formed through the Homestead Act of 1863 and Dawes Act of 1887, securing private land ownership for settlers employing methods of violence and massacre (Denetdale, 2016; Estes et al., 2021; TRN, 2021). Dispossession of lands transferred millions of acres to white settlers forcing Indigenous peoples into wage labor—another means of survival was bordertown mercantile stores and trading posts. People receive little for their artworks and family heirlooms from lenders and pawnshops (Denetdale, 2016; Estes et al., 2021; TRN, 2021). It is crucial to remember that prisoner of war or concentration camps were the initial form of many reservations in the U.S.. The origin of the term “off reservation” was a military, political expression that a person is an outlaw to be hunted down (Estes et al., 2021). Police and bordertown vigilantes in many bordertowns would not allow Indigenous people to live there unless they were servants to white people (Denetdale, 2016;
Estes et al., 2021; TRN, 2021). Today, the laws enforced upon urban Indigenous peoples experiencing houselessness are for vagrancy, trespassing, panhandling, and sleeping in public (Estes et al., 2021; TRN, 2021). There are few safer places to be an unhoused Indigenous person, particularly in towns bordering reservations and Pueblos such as Albuquerque or Gallup (Denetdale, 2016; Yazzi e, 2018; Bunn, 2019; Herring et al., 2019).

U.S. Indian removal laws in the 18th and 19th centuries broke Indigenous children’s sensory bonds and intimate connections with their communities to consolidate settler claims to land, ownership of land, and maintaining borders (Jacobs, 2009). U.S government boarding schools enforced the cultural superiority of whiteness and the English language through a government-mandated, militarized education (EagleWoman & Rice, 2016). The U.S. government used Eurocentric biomedical practice to justify assimilation policies. It is unethical to take children from their homelands, force children to live in violent boarding schools, sterilize women, and incarcerate non-compliant families at prisoners of war forts or in maximum-security prisons such as Alcatraz. (Stanley, 2020). The colonial legacy of Eurocentric biomedical ethics involved U.S. imperial force and state-sanctioned violence (Torpy, 2000). Biomedical ethics that do not acknowledge other systems of medicine are colonial Eurocentric approaches biased toward knowledge of European origin over non-Euro-American worldviews (Battiste, 2005; Morton, 2019).

In the 19th and 20th centuries, Indian Health Services (IHS) administered eugenically forced sterilization programs across bordertowns near Reservations and Pueblos with the threat to take custody of their children and revoke welfare benefits for non-compliance (Torpy, 2000; Briggs, 2002). Issues of diversity and inclusion of Indigenous people into colonial systems highlight why Indigenous centering paradigms are imperative for meaningful change to occur on
Indigenous terms. A paradigm shift from postcolonial multiculturalism is necessary to move away from Eurocentric methods that attempt to increase diversity by including Indigenous people in colonial systems and institutions that cause harm (Darroch & Giles, 2014; Morton, 2019). With 1 in 200 Alaska Native and American Indian people compared to 1 in 1,000 of the overall U.S. population experiencing houselessness, a paradigm shift is critical (Pindus et al., 2017).

Colonial violence includes deadly policies and practices that eradicate Indigenous identity and humanity through political erasure, physical violence, and stereotypes. U.S. Indian removal and anti-Indian laws continue to impact peoples’ sovereignty to determine enrollment and define themselves as nations (Brave Heart, 2003; Mohatt et al., 2014). A person experiencing houselessness may have lost, had stolen, or never obtained their Certificate of Indian Blood (CIB), a document of legal enrollment with affiliated tribes in the U.S., to access many urban-specific program funds and housing resources. There are many reasons why some people in urban areas are experiencing houselessness may not feel connected to traditional ceremonies or spirituality and identify with Christianity, Catholicism, Native American Church, non-religious, or as both traditional and religious. There are hundreds of nations in the U.S., and each person will have different preferences on being called Native American, Indian, American Indian, Native, Indigenous, and by their nations. It is essential to ask and listen to how someone wants to be recognized and self-identify because many of these identities are racialized and contribute to stereotypes and bias (Walker, 2019). Community-based prevention is non-clinical community-based wellness strategies and policies that are informed and respectful of different perspectives and non-homogenous views within a community and connect with people about their cultural beliefs and practices (IOM, 2012, p. 2).
It is imperative to enhance integrated healthcare providers’ understanding of unhoused Indigenous peoples' cultural and political realities in bordertowns. Social, cultural, and economic contexts for problematic alcohol use among Indigenous peoples began when settlers in bordertowns pressured people to binge drink to make profits, deliberately took advantage for trade, and with leaders during official negotiations (Frank et al., 2000; Lee et al., 2019). Specifically, when talking about alcohol use among Native people in the U.S., the impact of colonial violence on health disparities cannot be minimized (SAMHSA, 2018). Doctors and public health officials in Gallup, New Mexico, in the 1970s, perpetuated harmful myths as experts on ‘Indian drinking’, citing genetic and cultural deficiencies among Native people as the cause (Estes et al., 2021). Doctors and public health officials need to understand how historical contexts contribute to houselessness, substance use, and trauma to support a person in their recovery and healing processes (SAMHSA, 2018). “Genes that increase the risk of substance use disorder and related factors, such as tolerance and craving for alcohol, are no more common among Native Americans than White Americans” (SAMHSA, 2018, p 26). Dehumanizing and racist medical ideologies about alcohol and ‘drunken Indians’ directly result from medical doctors putting their professional interests first reinforces dominant U. S. colonial paradigms (Gray et al., 2018).

**Health Injustices Fueled by Environmental Colonialism**

The pandemic has compounded ongoing environmental and public health issues. Tribal and rural communities that lack running water due to uranium water contamination have had the highest rates of COVID-19 related deaths in New Mexico (Rangel, 2021). It is essential to raise awareness about communities of color disproportionately exposed to pollution, contaminated water, and toxic waste (Clark, Millet, Marshal, 2017; Garcia, 2010; Lorenzo, 2019).
resources and coal plants burn in the Navajo Nation to power energy for surrounding areas, while many in the community go without running water and electricity (Rangel, 2019). A study published by the National Academy of Sciences highlighted that Latino, Poor, Asian, and Black people continue to express more concern about the environment when compared to white and wealthy people (Pearson et al., 2018). Environmental colonialism perpetuates social myths about people of marginalized races and classes being less concerned about the environment. For generations, communities of color have been the ones who have taken the major impacts of expansion, nuclear testing, illegal dumping, mining, and extraction (Rangel, 2019).

For more than 500 years, environmental colonialism has continued to impact the natural environment. Environmental colonialism perpetuates religious and romanticized Western ideas about the relationship between Indigenous people and the land. Dehumanizing people to being a mere part of a changing landscape was a rationale used to justify genocide and the exploitation of land for profit (Johnson, 2008; Miller, 2008; Wilkins, 2018). A Western romantic view of Indigenous peoples is about settlers minimizing the violent realities of social evolutionism by placing people in a passive role as actors in the natural imagined past (Johnson, 2008). Michael Yellow Bird, MSW, Ph.D., asks social workers to remember how Indigenous people resisted (Clarke and Yellow Bird, 2021). It is vital to end the colonial myths and harmful narratives of savage and uncivilized peoples living on Turtle Island before conquest and colonization. People lived in sophisticated societies connected with established cultural systems across the continent (Clarke and Yellow Bird, 2021). Romanticism is cognitive dissonance, an attempt to psychologically reduce any awareness of social and emotional pain as the movement emerged during the era of justifying the global expansion of western colonization (Festinger, 1957). It is
essential to understand the role romanticism has in the dehumanization of Indigenous people to explicitly address the root causes of crises experienced among unhoused Indigenous peoples.

As written in the papel public decrees, the Doctrine of Discovery established a legal, spiritual, and political justification for Christian European monarchs to seize and colonize lands, waterways, and peoples (Miller, 2008). Pope Nicholas V wrote the Romanus Pontifex decree in 1455 to justify the Portuguese conquering Africa as divine intervention (Miller, 2008). Pope Alexander VI wrote the Inter Caetera decree of 1493 to justify Christian European ‘explorers’ as divine intervention throughout Africa, Asia, Australia, New Zealand, and the Americans (Miller, 2008). Both these papel decrees distinguished those saved by God (e.g., European Christians) and those who have fallen and succumbed to the will of the earth (e.g., Indigenous peoples) (Johnson, 2008). In these documents, the U.S. Supreme Court cited in a ruling that Indigenous people are merely occupants of New World lands (Wilkins, 2018). The manifest destiny U.S. policy of President James Monroe in 1823 asserted U.S. hegemony over the Western hemisphere in the Monroe Doctrine that no other nation could establish a colony from the Atlantic to the Pacific (Wilkins, 2018). Manifest destiny coinciding with European romanticism laid the foundation for an onslaught of white European settlers in the dispossession of lands and genocide. In the romantic era painting American Progress by John Gast in 1872, lady Columbia is an anthropomorphization of western civilization. She is bringing the light of civilized intelligence into the darkness of the frontier. The star of the empire on her head, a residential schoolbook in her arms, and carrying the military telegraph wires across the settler’s imagined landscapes:
Reconciliation is necessary for community behavioral health care not to have cognitive dissonance about the health implications of environmental injustices for Indigenous peoples. Vandana Shiva reminds us how the cognitive dissonance of romanticism is also a disembodied reaction to modern Western bioscience, a deadly patriarchal project, much like the false progress of social evolution. Third world and Indigenous feminisms are explicit about the impacts of colonial violence toward nature and people, “A science that does not respect nature’s needs and a development that does not respect people’s needs inevitably threaten survival” (1998, p. 209).

**Housing Security and Recovery Services are Key Social Determinants of Health Objectives**

Housing security and recovery services are key objectives to improve the health of unhoused people targeting four domains: 1. Economic stability, 2. Neighborhood and built environment, 3. Health care access and quality, 4. Social and community support (Bowen,
Savino, & Irish, 2019; Counsel of Economic Advisors, 2019; Healthy People, 2030). Healthy People 2030 recognizes housing security, not paying more than 30% of income on housing, as a social determinant of health (Healthy People 2030). Housing stability is understood concerning housing security when a client can receive outpatient services to facilitate a decrease in emergency or hospital services, incarceration, and eviction (Kushel et al., 2008). Services received are an essential variable in the process of obtaining stable housing among persons diagnosed with Serious Mental Illness (SMI) and Moderate to Severe Alcohol and Substance Use Disorder (SUD) (Pearson et al., 2009). The need to be housed is an initial step from houselessness to housing stability and then to obtaining housing security. Once a person has obtained housing, then second comes the attainment of housing stability. Receiving ongoing comprehensive healthcare services is essential to address the social needs related to a person’s education, income, employment, disability status, family cohesion, substance use, history of conviction, incarceration, or eviction (Braciszewski, et al., 2016; Padgett et al., 2016; Frederick et al., 2014). Social supports and community (e.g., family, friends, and community members) are foundational “to successfully develop and implement interventions” and are “key to breaking the cycle of houselessness” (Johnstone et al., 2016, p. 14).

An ecological re-thinking is necessary to examine the relationship of community resilience to housing stability in the context of an individual’s dynamic interactions with family, community, and healthcare institutions (Haswell et al., 2010; Kirmayer et al., 2011). Community-based prevention interventions are prevalent in Western health care systems emphasizing multilevel social and physical changes to the environment, community engagement, and empowerment in local contexts (IOM, 2012). Community-based prevention in healthcare settings provides an integrated strategy to end homelessness to move toward change that centers
Indigenous peoples on their terms. Discrimination, stigma, workplace ethical distress, and staff burnout are strategic areas in health care that impact a community’s wellbeing and capacity to support unhoused people (NPC, 2011; IOM, 2012). Community resilience is of particular concern when considering how weathering houselessness during the life course has been shown to significantly decrease a person’s health and result in death too often (Padgett et al., 2012; Paat et al., 2019).

Being unhoused increases the likelihood for a person to meet the criteria for both co-occurring mental health and substance use conditions; and multi-morbidity of two or more chronic health conditions such as diabetes, hepatitis c (Hep C), and human immunodeficiency viruses (HIV) (Zlotnick & Zerger, 2009; Padgett et al., 2011; Zlotnick, Zerger, Wolfe, 2013; Bowen, Savino, & Irish, 2019). More than half of the U.S. people experiencing homelessness meet the diagnostic criteria for a chronic health condition, serious mental illness, and substance use disorder (Padgett et al., 2011). Housing stability as a focus for healthcare intervention builds on housing is healthcare HIV and AIDS political organizing, leadership from the National Healthcare for the Homeless Council (NHCHC), housing first policies, and research on systems-oriented social work intervention (Goldfinger et al., 1999; Tsemberis et al. 2004, Solomon et al., 2009; Fullilove, 2010).

There is no standard definition or reliable and valid instrument to measure housing stability. There are three individual-level factors Burt and Anderson (2005) found to be related to housing stability in Housing First programs: 1.) a history of incarceration, 2.) victim of violence and abuse, and 3.) a diagnosis of a chronic health condition (Kushel et al., 2006; Kushel et al., 2008; Pearson et al., 2009; Fredrick et al., 2014; RIGB, 2015; Diette & Ribar, 2015; Stahre et al., 2015; Cox et al., 2017). A person-in-environment, ecological perspective can support healthcare
systems to understand better how the root causes of health injustices are directly related to the cumulative and compounding consequences of housing instability (Bransford & Cole, 2019).

Barriers to obtaining and sustaining housing have been identified to include evictions, felonies, having more tenants than on the lease (e.g., doubling up), rental cost-burden, overcrowding, foreclosures, frequent moves, housing not intended for more than a year (e.g., transitional housing), and houselessness (Healthy People 2030). Affordability and stability are two primary contributing factors to housing security as a social determinant of health (Healthy People 2030; Cox et al., 2017). The issue of housing affordability includes the acceptance of housing vouchers by landlords and property managers in the rental marketplace. Housing vouchers present an economic structural barrier to housing security because HUD administers voucher programs differently in local economies. Most of the housing is outside of the fair market value for a voucher. Housing instability can predict child separation, “Housing fosters stability in house and home, and creates the environment for families to have a greater chance to remain together” (Rog et al., 2017). Housing security is necessary for the stability of employment, access to services, and a person’s individual and family levels of safety and cohesion (Curtis & Geller, 2010). To understand how accessing comprehensive healthcare is related to a person’s housing stability their history of homelessness must be considered because a person’s length of time and the number of episodes experiencing homelessness contribute to cycles of housing instability (Kushel et al., 2008, p. 1213). Stable housing provides the conditions necessary for long-term emotional and social well-being for people who have a history of trauma, historical trauma, and health issues (MHCC, 2012).

Deadly policies and practices in the broader service system criminalize houselessness (Padgett et al., 2016; Aykanian and Fogel, 2019). Understanding the historical contexts of
Indigenous homelessness begins with how homelessness is defined in service contexts to include different contributing factors from a person’s life and their families’ including geographic displacement, spiritual disconnection, mental disruption, cultural disintegration, overcrowding, relocation, escaping or evading harm, emergency crisis, and climate refugees (Thistle, 2017). Conditions of poverty, for example, the criminalization of houselessness, compound the effects of historical trauma and contribute to the development of chronic health conditions, disability, and death (Ehlers et al., 2013; Conching and Thayer, 2019). The stigma of mental illness and substance use increases barriers to receiving essential prevention and treatment services (Whitley & Campbell, 2014). A person’s history of homelessness, length of homelessness, and the number of homeless episodes they have experienced increase the amount, type, and variety of services needed for housing stability (Goldfinger et al., 1995). Effective interventions to end homelessness build economic and social support for people, their families, and the community. Housing stability targets multiple levels informed by a comprehensive understanding of what it means to be ‘housed’ (Fredrick et al., 2014, p. 965). Systematic rethinking is necessary to examine the relationship of community resilience to housing stability in an individual’s dynamic interactions with family, community, and comprehensive healthcare systems (Haswell et al., 2010; Kirmayer et al., 2011).

The Emergence of Resilience and Trauma in Discussions on Community Care

Trauma-informed care is well documented as a necessary component of homeless healthcare programs (Gaurino et al., 2009; Hopper et al., 2010; SAMHSA, 2014; Bransford and Cole, 2019). Adverse childhood experiences (ACEs) are connected to many health risks and health behaviors that contribute to chronic conditions, psychosocial issues, and cycles of houselessness (Bransford & Cole, 2019). One of the first studies to examine ACEs and lifetime
houselessness demonstrates childhood trauma is a primary risk factor for future houselessness (Roos et al., 2013). HUD uses the SAMHSA definition of serious mental illness (SMI) for housing programs which is any behavioral health diagnosis including substance abuse, depression, generalized anxiety, and PTSD causing “clinically significant impairment” as determined by a state board licensed medical and clinical provider (SAMHSA, 2020). Research on unhoused people who meet the criteria for SMI provides additional information on the connections between housing stability and a person's physical and behavioral health (Pearson et al., 2009; Padgett et al., 2011; Padgett et al., 2012; Paat et al., 2019; Healthy People 2020). A person-in-environment perspective moves beyond naming trauma as a universal experience and the consequences of higher rates of trauma in houselessness to uphold a whole person ecological approach for policy and practice (Bowen and Murshid, 2016). This perspective moves intervention toward preventing re-traumatization to address service contexts of adversity by “also addressing long-standing organizational issues, like high turnover and the chronic overworking of staff” (Bransford & Cole, 2019, p. 271).

Indigenous practitioners advocate a resiliency focus to address barriers more effectively to culturally relevant, life-enhancing services (Brave Heart et al., 2011; Gray et al., 2018; Linklater, 2014; Weaver, 2019; Yellow Bird, 2011). Restorative organizational efforts require a resiliency-focus for integrated healthcare to not pathologize people experiencing houselessness and to recognize that “telling current and future social workers to take care of themselves simply is not a sufficient way to address toxic work environments” (Bransford & Cole, 2019, p. 271; Healthy People, 2030). Supporting mutual respect, empathy, encouragement, and care for all integrated healthcare providers and all clients is an ecological process of change needed to
understand housing stability and provide comprehensive services toward the goal of prevention, recovery, and healing (Gaurino et al., 2009).

A Historical Trauma Lens to Understand Hope and Recovery

Hope and recovery invite integrated healthcare providers and organizations to engage in critical self-reflection on historical and political dynamics to address harmful power dynamics that can occur in relationships because of not addressing blindspots, hotspots, and soft spots (e.g., attitudes, assumptions, biases, prejudices, stereotypes, prejudices) (Curtis et al. 2019; Sandeen, Moore, & Swanda, 2018; SAMHSA, 2018). Historical trauma provides an essential lens for integrated healthcare providers and administrators to prevent harm caused by attributing biological and character deficits as the cause of health disparities among Indigenous peoples and other marginalized people. A historical trauma lens acknowledges that genocide and massive, organized violence have occurred and have significant health effects on Native people, communities of African descent, immigrants, and refugees in the U.S. (Brave Heart, 1998; Mkandawire-Valhmu, 2018). A historical trauma lens enables both a fundamental shift in perspective to understand how cycles of violence continue through intergenerational trauma into present-day experiences, and the lens also supports movement toward being more explicit about the health impacts of colonialism, including that of poverty, abuse by social institutions, anti-Indian laws, and gender-based violence (Brave Heart, 2003; Mohatt et al., 2014). A Continuum of Care (COC) can take a step toward being accountable to address health disparities by increasing awareness to acknowledge historical trauma, the ongoing impacts of colonialism, and oppressive social-political systems rather than continue the harm of approaching inequity as an individual behavior problem with individualized psychosocial interventions as the sole solution (SAMHSA, 2018).
The U.S. Congress enacted violence against Indigenous people with policies to force assimilation, remove Indians from their lands, force family separation, mandate boarding schools, and incarcerate non-compliant families (Geoman, 2008; Koyiyumptewa & Davis, 2009; Jacobs, 2009; EagleWoman, 2016). In a study on the impacts of historical loss experienced by American Indian and Alaska Native people in the U.S., one-third to one-half of Native adults thought about historical loss multiple times a day to weekly (Whitbeck et al., 2004). These thoughts were strongly correlated with emotional distress, including for young adults, as evidenced by self-reports of experiencing anger, avoidance, anxiety, and depression. People have thoughts on the loss of traditional language, spirituality, land, family ties, being treated poorly by U.S. officials, and the effects of alcoholism in their communities (Whitbeck et al., 2004).

The Children’s Defense Fund (2017) reports how the conditions of poverty are a primary contributor to trauma resulting in the highest health inequity in the U.S. for American Indian and Alaska Native children under the age of five, with more than one in three Native children living in poverty. When “acts of violence, lack of safety and security, and loss of home” are experienced in childhood, long-term health effects throughout the lifespan (Duncan et al., 2019, p. 41). Multigenerational poverty and the accumulative effects of historical trauma continue to impact Indigenous peoples’ health in the U.S., with more than a two-thirds prevalence (62.4% - 68.8%) for Post-Traumatic Stress Disorder (PTSD) diagnosis when compared to one in fifteen (6.8%) lifetime prevalence for adults in the general U.S. population (Kesser et al., 2005; Willmon-Haque & Bigfoot, 2008; Beals et al., 2013). The diagnostic criteria for PTSD provide a limited scope to understand the compounding impacts of historical trauma on individual, family, community, and generational levels experienced among Indigenous people enduring multiple
ongoing traumas in a lifetime due to the socio-economic conditions of settler colonialism (Evans-Campbell, 2008).

Settler colonialism operates through “biopolitical and geopolitical management” of Indigenous life (e.g., people, plants, herbs, animals, waters, minerals, and lands) through destruction for profit gained by claiming ownership of resources, including the forceful removal of Indigenous people from their lands resulting in Indigenous people living in urban areas disproportionately experiencing houselessness and incarceration (Tuck & Yang, 2013). There is an urgent need to address and prevent racial health disparities among Indigenous people, including higher rates of depression, substance use, PTSD, complicated grief, alcohol-related deaths, suicide, HIV and AIDS, Hepatitis C, and loss of ancestral ties (Brave Heart et al., 2011).

The importance of a historical trauma lens on health disparities is to reduce stigma for Indigenous peoples and understand trauma as a collective experience “that communities can come together to overcome” (SAMHSA, 2018, p. 23). Involving supportive networks that overcome similar challenges, community, and family is the most effective approach to addressing historical trauma's impacts by connecting clients with cultural practices and beliefs relevant to their recovery (SAMHSA, 2018). An essential component of cultural safety for providers to alleviate emotional suffering among Indigenous clients is knowledge of tribal differences of collective generational experiences, recognizing traditional cultural wisdom, and exploring resilience when acknowledging ongoing racism and oppression (Brave Heart et al., 2011). Cultural safety is rooted in understating how historical and political factors impact health disparities among Indigenous people to transform organizations and systems of community behavioral health care to center Indigenous communities, build hope, honor tribal sovereignty, and address structural challenges (e.g., disproportionate resource allocation) (Darroch et al.,
Indigenous people in recovery deserve acknowledgment of how it is that they have come this far by identifying the resources and strengths in their life and how vital these connections are to see how change is possible (SAMHSA, 2018).

**Hope**

Hope is a choice shaped by an individual’s sense of meaning about what is possible and collective action to reduce barriers and increase access to external opportunities such as housing and recovery services. “Hope from a sociological point of view involves shifting from an individual perspective toward an understanding of hope shaped by social and environmental systems, institutions, and opportunities” (Grinwrigth, 2016, p. 21). Both hopelessness and hope are contagious; therefore, it is essential to understand how social, cultural, and political factors contribute to how a community health center environment can facilitate or constrain hope for clients in recovery (Herman, 1992; Pedersen and Syme, 2009). It is imperative to collaborate with people to work through the barriers they are facing to sustain feelings of hope for their future (Schwartz, 2021). An essential part of the collaboration for an integrated healthcare provider is to listen to a client to understand their story from their perspective, for them to feel heard by acknowledging the agency in their recovery (Miller and Rollnick, 2013; Grey et al., 2018; SAMHSA, 2018). Extensive research on hope has occurred within psychology, contributing to hope often being first understood as an individual psychological phenomenon in the recovery literature (SAMHSA, 2012; Ginwright, 2016). If a person in recovery feels hopeless about their future, substance abuse is more likely because there is less to lose (SAMHSA, 2018).

In 2010 there were significant structural changes at the federal level within the Department of Health and Human Services instituting evidence-based strategies for integrated care emphasizing mental health and addiction treatment in Patient-Centered Medical Homes
(PCMH) as a core component of national policy change to address health disparities (Croghan & Brown, 2010). There has been an evolution in integrated care from the 60s and 70s, emphasizing multidisciplinary care to the top-down efforts in the 80s and 90s with an emphasis on disease and care management. Initial drivers for policy change were efficiency and cost savings. There has been a growing emphasis on alignment of systems, quality of care, patient satisfaction, and well-being by strengthening primary care services (Evans et al., 2013). Also, the Substance Abuse and Mental Health Service Administration (SAMHSA), with the guidance of people in recovery, developed a working definition for recovery bringing together both mental health and substance abuse disorders in one explanation for the first time at a national policy level: “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2012). These two policy changes have shaped current understandings of the catalyst role a sense of hope for a better future has during recovery and how community behavioral health settings can cultivate hope.

Recovery

Hope is a mainspring of safety, a complex issue for someone experiencing houselessness because they are still involved with interlocking social problems of power impacting their living situation (Herman, 1992). A comprehensive understanding of the literature on trauma-informed care can expand our knowledge of safety at the foundation of recovery to take a more holistic approach to change homeless health care systems. Safety is relative to a person's needs across physical, emotional, psychological, spiritual, and cultural domains within the service environment. Hope is what moves a continuum of care toward a culturally responsive, wholistic approach to recovery in community behavioral health. The SAMHSA Treatment Improvement Protocol (TIP) 61 (2018) on behavioral health services for American Indians and Alaska Natives
in recovery offers a comprehensive approach to culturally responsive care for behavioral health service providers, administrators, and supervisors.

The pathway toward culturally responsive behavioral health care begins in the circle in the east with building cultural knowledge; in the south with cultural awareness and competence; in the west with a cultural perspective on behavioral health; and in the north with culturally specific and responsive skills and practices:

![Figure 1: A path to culturally responsive care (SAMHSA, 2018, p. 12)](image)

Within this nonlinear model, a provider would begin with understanding the historical contexts of experiences of trauma and safety for Native clients from the perspective of the client’s cultural values, beliefs, and worldviews. This phase of the learning cycle centers on the awareness of
Native clients as resilient by drawing on “the strength of their cultures, communities, and families to help face these problems” (SAMHSA, 2018, p. 33). The south asks for the provider to begin to apply the knowledge on trauma and resilience to self-reflection on the roots of their culture, assumptions, views, and values concerning their Native clients. Specifically, to know about the cultures of the clients you are working with, recognize the cultural differences cultural similarities between the provider and the client, and be open to learning the effects of these differences. Then in the west, the provider is asked to deepen their view on how a client understands their own needs and barriers to the care they are seeking to approach change by integrating culturally relevant treatment toward the client's self-defined recovery and healing. Lastly, in the north, to implement clinical skills informed by best practices as defined by science and healing traditions. Implementing culturally responsive clinical skills can begin with Indigenous etiquettes for introductions and processes for providing care. For an integrated healthcare provider to move toward being culturally responsive is not an outcome but rather an ongoing process of learning and changing approaches to communication, connection, and opportunities.

**Example: Indigenous Protocols for Community-Based Homeless Services**

In 2017, the Inner-City Health Associates in Toronto, Ontario, provided a grant to Jesse Thistle, Ph.D., and Janet Smylie, M.D. to develop clinical practice guidelines for integrated healthcare providers working with unhoused Indigenous people (Thistle et al., 2019). The Pekiwewin (Coming Home) project builds on Thistle’s seminal writing to define *Indigenous homelessness* for the Canadian Observatory on Homelessness across twelve dimensions differentiating from non-Indigenous experiences of homelessness, emphasizing the concept of “home” to be more than just a place to live; to include relationship and kinship to earth, land,
stories, spirits, plants, animals, and ancestors (Thistle, 2017; Thistle et al., 2019). The clinical practice guidelines integrate the Western human ecology principle that *housing is healthcare* with traditional practices and systems to shape the four Indigenous protocols of situating, visiting, hospitality, and hearing (Thistle and Smylie, 2020).

For non-Indigenous integrated healthcare providers working with unhoused Indigenous peoples, the protocol begins with *situating* oneself as a guest in Indigenous lands because to be a good guest is to be in good relations with the land (Thistle et al., 2019; Thistle and Smylie, 2020; Stewart-Ambo and Yang, 2021). This shift to move toward a relationship of accountability to land and responsibility to forward decolonization as a non-Indigenous person does not mean that settlers now begin claiming themselves as a guest; instead, to ask oneself: If I am, in fact, a visitor on these lands and hope to become a good guest then how can I begin to reimagine human relationships outside of the structures of settler colonialism? (Stewart-Ambo and Yang, 2021). *Visiting* an integrated healthcare provider working with Indigenous people experiencing houselessness also recognizes that clients are living in their homelands unsheltered or unhoused; therefore, the provision of care moves toward taking the time with each client to provide comfort and to listen without rushing as a visitor in their home (Thistle et al., 2019; Thistle and Smylie, 2020). *Hospitality* is the third protocol for guest agencies to provide basic needs for all clients in an environment with Indigenous-specific symbols, art, and staff relevant to the local territories (Thistle et al., 2019; Thistle and Smylie, 2020). Lastly, *hearing* is the protocol of not just actively listening by providing reflections but also treating people with kindness, respect, and dignity with presence as you would your relative (Thistle et al., 2019; Thistle and Smylie, 2020).
Community-Based Prevention Intervention

Multidisciplinary healthcare professionals cause harm by using “marginalized” to describe Indigenous peoples (Gray, Yellow Bird, & Coates, 2018, p. 58). While economies of health inequity marginalize people, integrated healthcare providers do not want to use the same language oppressive structures, and systems do to people to describe actual people because this discourse dismisses how Indigenous people have resisted and are resilient (Gray, Yellow Bird, & Coates, 2018). To not perpetuate harmful portrayals of Indigenous people as traumatized victims in need of outside Western intervention when approaching crisis prevention, the solutions for community-based response need to come from the Indigenous communities being served (SAMHSA, 2018). There are cultural adaptations of mainstream Western evidence-based practices for clinical intervention identified to be effective strategies for treatment with emphasis on an orientation to the present, a guiding approach, relationship-centered, and offering various modalities (i.e., individual, group, family, and community-based) (SAMHSA, 2018). Several examples of successfully adapted clinical treatment models noted in the *Behavioral Health Services for American Indians and Alaska Natives Protocol (TIP) Series 61* include motivational interviewing (MI), family therapy, trauma-informed treatment, community reinforcement approach, mindfulness-based interventions, cognitive-behavioral therapy, matrix model, and behavioral therapy (Venner, Feldstein, Tafoya, 2006; SAMHSA, 2018). In the case of crisis prevention, there are no evidence-based practices. Concerning the local community, use a culturally relevant evidence-based prevention strategy to base decisions on the best available research evidence (HPIO, 2013).

The Indigenous protocols provide a foundation for developing a process model to implement a comprehensive safety strategy across multiple agencies and organizations.
(SAMHSA, 2018; Thistle et al., 2019; Thistle and Smylie, 2020). A review of relevant research suggests an integrative strategy to use culturally connected, relational, and wellness approaches for crisis prevention training, and ongoing guidance can enhance safety within houseless service agencies (Miller & Rollnick, 2013; Miller-Karas, 2015; Darroch et al., 2017; Mkandawire-Valhmu, 2018; Curtis et al., 2019; Grabbe et al., 2019; Thistle and Smylie, 2020; Grabbe et al., 2021). This includes an increase in integrated healthcare provider contextual knowledge on how to be in a relationship as a helper. An integrated healthcare provider has a responsibility to remember, listen to, build trust, and welcome a client because these relational dynamics shape the client’s access to care and impact their whole health—mind, body, emotion, and spirit (Miller-Karas, 2015; Mkandawire-Valhmu, 2018; Thistle and Smylie, 2020).

The use of wellness skills among MHT members reduces ethical distress and fatigue by re-shifting the focus of care from an individual problem orientation to a community resiliency focus that uplifts hospitality, being in good relations, and clients’ strengths (Miller-Karas, 2015; Grabbe et al., 2019; Thistle and Smylie, 2020; Grabbe et al., 2021). Ongoing coaching and support with implementing wellness skills to have whole body presence when hearing clients are necessary. Drifting from using other effective communication skills is consistently documented, such as with MI (Miller & Rollnick, 2013; Miller-Karas, 2015). More often than not, a client being asked to leave a community center or shelter can be prevented when integrated healthcare providers learn The Wellness Skills, practice responding to traumatic stress with compassion, and are supported as a team in a safe working environment that centers the Indigenous protocols (Miller-Karas, 2015; SAMHSA, 2018; Grabbe et al., 2019; Thistle and Smylie, 2020; Grabbe et al., 2021).
This project was conceptualized to understand better how to support a systematic response away from damage-centered and deficit frameworks that escalate crises among unhoused Indigenous peoples disproportionately experiencing homelessness in Albuquerque (Calderon, 2016). During preliminary fieldwork and collaboration with key informants, the issue of safety incidents escalating during various daily crises involving HOP clients was identified as a priority. The problem was identified as clients being disproportionately told to leave the property by security, being told to leave the clinic for the day, or being banned from services for more than one day after a safety incident involving integrated healthcare providers and other clients. In-depth interviews were conducted with participants (i.e., clients and integrated healthcare providers). It was anticipated that clients’ safety experiences would be strongly correlated with the attitudes and practices of integrated healthcare providers. The interview responses inform the development of a process model to implement a crisis prevention intervention to move toward resiliency-focused approaches to enhance hope and safety and support necessary organizational changes. Adopting a comprehensive safety strategy can decrease crises while improving understanding of trauma among integrated healthcare providers and increasing the experiences of safety reported among unhoused Indigenous peoples.
CHAPTER 3

Crisis Response, De-escalation, Stabilization, and Prevention Intervention

Culturally relevant healthcare for clients experiencing houselessness is welcoming and enables clients to feel safe (NHCHC, 2016). A community organization that wants to move toward a trauma-informed system of care to reduce safety incidents is recommended to start with addressing non-violence and safety for both integrated healthcare providers and clients: “Increased focus on resolving issues of emotion management, loss related to trauma or exposure to adversity, and sense of hope for the future rather than overemphasizing client behavioral control in the service of safety as the exclusive priority” (Esaki et al., 2013, p. 93). A relationship-centered, multidisciplinary approach to primary care is an evidenced-informed practice for centers to provide effective integrated behavioral health services, comprehensive services for a person who has a diagnosis for co-occurring and multi-morbid conditions shown to significantly reduce high utilization of emergency and hospitalization services and death (Croghan & Brown, 2010; Rich et al., 2012; HQO, 2016; Hornberger, 2016; Henry et al., 2017).

More than nine out of ten adults (90%) who receive city and county homeless services report a history of childhood trauma, and more than half report surviving four or more compounding experiences (Larkin & Park, 2012; SAMHSA, 2016). The National Health Care for the Homeless Council, and National Consumer Advisory Board, conducted a trauma-informed care consumer survey as part of a research project on ‘Safety’ in Health Care for the Homeless (HCH) settings in the United States (U.S.) (NHCHC, 2016). The study used a convenience sample of 537 HCH clients of a demographic generally consistent with the national houseless population from Atlanta, Chicago, Houston, Los Angeles, Miami, and Worcester (NHCHC, 2016, p. 3). The project explains that safety is a complex experience involving the
physical environment and a person’s emotional and psychological well-being. For people experiencing houselessness, safety is paramount because they are exposed to higher rates of violence, trauma, daily challenges to meet their basic needs, strained relationships, and a higher prevalence to meet the diagnostic criteria for a behavioral health disorder (NHCHC, 2016, p. 2).

In 1996, the Health Care for the Homeless Clinician Network (HCHCN), Nonviolent Crisis Intervention Techniques Planning Committee published a compilation called *Sample Safety Guidelines in Homeless Health Services Programs* (HCHCN, 1996). The guidelines emphasize not using force whenever possible when responding to clients experiencing activation and agitation. Safety incidents with another client or staff member often result in the use of security force, escort off property, or temporary and permanent service bans (HCHCN, 1996). Safety incidents involving high levels of agitation, ranging from verbal threats to physical incidents, can be prevented, de-escalated, and actions are taken to address the underlying safety needs (HCHCN, 1996). Integrated healthcare provider response is encouraged to begin with an informed assessment of the situation grounded in knowing the patient’s history and then using effective strategies to de-escalate threats or acts of physical aggression. Trauma often has a lifelong impact on a client’s sense of self, ability to self-regulate, skills to build healthy relationships, perception of control, and sense of self-efficacy (NHCHC, 2016).

Recommended strategies outlined in the guideline “do’s, don’ts, and how to’s” for effective listening and therapeutic communication to increase integrated healthcare provider competency in agitated clients presenting to the clinic. The guidelines for *Workplace Violence Prevention and Intervention* were updated in 2011 in collaboration with eight Health Care for the Homeless Network programs and agencies, providing practical measures for integrated healthcare providers with different roles on how to identify risk, prevent violence, protect
victims, respond to incidents, do outreach, and work with brain injury survivors (HCHCN, 2011). A primary takeaway is to “know your clients,” specifically their risks and the resources to support them, like this, they conclude, is the most effective prevention measure any member of an MHT can take (HCHCN, 2011, p. 10).

The guidelines for workplace violence prevention and intervention use the language of “risk” to describe how escalating agitated behaviors result from the interaction between an individual and their environment. The HCHCN does not use an at-risk framework to refute a patient’s responsibility for their actions nor to resolve anyone of consequences, to increase understanding among the workforce on what factors may be in a patient’s history that contribute to a higher risk for a patient having challenging behavior when activated or agitated for many different reasons. Essential factors for integrated healthcare providers to be informed about include a history of trauma and historical trauma, violence, threat, and intimidation; additionally, current substance use with any decompensating mental health status. Integrated healthcare providers need to understand why a person struggling with substance use challenges and diagnosed with a psychiatric disability can contribute to a “small but significant” higher rate of aggression than the general population (HCHCN, 2011, p. 30). Specifically, houselessness is a crisis and is traumatic. The process of becoming houseless and what occurs while unhoused contributes to a client’s loss of social bonds that can erode safety, security, trust, and stability in a person’s life (NHCHC, 2016, p. 2). The stigma and attitudes toward an unhoused person further exacerbate barriers for people to find safer places to be daily, further perpetuating social isolation, disrupting safety, and intensifying trauma (NHCHC, 2016).

Integrated healthcare providers’ attitudes are central to a patient’s safety experience in healthcare systems. “Being treated with respect” was considered the most critical factor in
reporting relative safety among clients in homeless healthcare settings nationwide (NHCHC, 2016, p. 4). The core value to be nonjudgmental in response and “the skill sets that express respect, including MI, trauma-informed care, cultural humility, non-violent conflict management, and de-escalation” are the values and skills necessary to prevent ethical distress and burnout and to best serve clients (NHCHC, 2016, p. 9). When a client is angry, it is essential for integrated healthcare providers not to minimize the patient’s anger and not set ineffective limits because these two factors are the primary contributing factors to the escalation of safety incidents at community-based homeless service programs and agencies (HCHCN, 2011). The use of supervision and coaching to sustain ongoing learning can increase the impact of training among integrated healthcare providers.

For integrated healthcare providers to be able to observe and access a situation, effectively listen to a client, and provide therapeutic communication then, members of the organization must continuously assess their feelings in the situation as not to take agitated statements personally or become defensive (Esaki et al., 2013; HCHCN, 2016). In the guidelines, integrated healthcare providers are encouraged to set clear, consistent, enforceable limits for unacceptable behaviors while never responding disrespectfully no matter how threatened an integrated healthcare provider may feel (HCHCN, 2011). Research evidence emphasizes integrated healthcare providers developing their self-care and safety plans with an MHT to prevent disrespect toward clients (Esaki et al., 2013). While the physical and clinical aspects of safety are essential, it is essential not to overlook the emotional, psychological, spiritual, and cultural aspects of well-being for integrated healthcare providers and clients. Ongoing practice reflection is critical to apply creative strategies to implement attention and emotion regulation.
skills for the various underlying needs of clients and staff to prevent safety incidents (Bloom et al., 2003; Prescott et al., 2008; Guarino et al., 2010; Dubay et al., 2018; Treleaven, 2018).

**A Public Health Intervention**

A comprehensive safety strategy recognizes that our health, the health of integrated healthcare providers, and clients are connected on multiple levels. The level of importance and confidence reported among integrated healthcare providers to promote trauma-informed and resiliency-focused integrated care (i.e., primary care and behavioral health together) can be strengthened by MHT talking and relating with one another about their values toward approaches that center on healing, non-violence, and decolonization (Bandura, 1982; Bandura, 1997; Miller & Rollnick, 1991; Rollnick et al., 2008; Thistle and Smylie, 2020). During training and incident reviews, talking about shared values and practicing wellness skills together can support cultural safety in action by creating a space together as a team to learn about the relationship between trauma and safety to help integrated healthcare providers to apply the knowledge and remain grounded and connected when responding to a client in crisis (Baker, 2019; Baker et al., 2010; Harris & Fallot, 2001; Machtinger et al., 2015; Miller-Karas, 2015; Ramsden, 1993; Stanley, 2016). It is important to remember the social and community contexts for an unhoused, urban Indigenous person in Albuquerque specifically and the role colonization has in the dispossession of lands, a means to livelihood, fleeing violence, and murdered and missing relatives. A critical behavioral health component needed to implement a public health model within a CoC is a collaboration with the different communities to integrate strengths by being culturally responsive to various local languages, spiritual practices, ways of understanding resilience, and the causes of traumatic stress (Miller-Karas, 2015).
The Community Resiliency Model (CRM)

Individuals, families, and communities use the lens of their culture to define and understand the impacts of trauma and to understand how cultural trauma is a significant risk factor for developing behavioral health disorders (Garcia, 2010; Clarke and Yellow Bird, 2021). Environmental degradation hinders the intergenerational transmission of culture, inhibiting sustainability and causing trauma (Weaver, 2019). Environmental colonialism continues to control people and their homelands across New Mexico, resulting in overwhelming losses due to extraction, climate change, and the damming of rivers (Garcia, 2010; Gersony, 2021; Lorenzo, 2019; Weaver, 2019). The natural world is intrinsically linked to Indigeneity and is rooted to place with culture and creation stories in reciprocity to lands and waters of origin (Weaver, 2019). Mindfulness and other traditional contemplative practices focus on a deeper connection with the rhythms of daily life in the natural world, spirit, body awareness, movement, ceremony, culture, and creative expression for healing (Miller-Karas, 2015; Clarke and Yellow Bird, 2021).

A biological model for crisis prevention applies ecological concepts from somatic traditions for trauma recovery, such as the resilient zone, neuroplasticity, and resourcing (Gibson, 2008; Ogden, 2009; Levine, 2010; Van Der Kolk, 2014; Miller-Karas, 2015; Ogden, 2020). The biological approach underpinning somatic approaches to trauma recovery is culturally responsive by listening to the stories of the body, beginning with the source, the lived felt knowledge and moving toward new meanings (Gibson, 2008; Million, 2009; Miller-Karas, 2015). In a general sense, body-centered modalities integrate mindfulness, compassion, movement, and expression as ways to be more aware of the felt senses on the inside of the body in a secure authentic connection to the body, relationships, and life (Banks, 2015; Levine, 2010; Gendlin, 1978; Miller-Karas, 2015; Ogden, 2020). Somatics can bring a trauma-informed
approach to mindfulness (i.e., interoception and proprioception) by learning the differences between sensations of distress and well-being and then approach mindfulness with this experiential knowledge to prevent experiential avoidance, which increases the risk to develop PTSD (Treleaven, 2018).

Strengthening mind-body connections is an approach to increasing understanding of emotions as biological responses commonly experienced by anyone impacted by trauma. Body-based exercises are essential to learning to move away from freeze response states like shutting down or dissociation as a strategy of disconnection to evade feeling social harm, abuse, and violence. Pathologizing trauma and implicating mental weakness cause disconnection (Miller-Karas, 2015). The Community Resiliency Model (CRM)® is a public health intervention to teach communities how to both apply the tracking skill internally to themselves and to guide others to connect with the resiliency designed within their nervous systems by placing attention inside the body on sensations and noticing the differences between sensations of distress (e.g., constricted breath, tense muscles, pain, numbness, jittery, rapid heartbeat) and sensations of well-being (e.g., a deeper breath, relaxed muscles, grounded, calmness, flow, a regular heartbeat). Tracking, or interoception, is also generally described as mindfulness of the body (Compson, 2014).

Body awareness can help return the human nervous system to a state of balance and to feel more integrated with the mind and body (Banks, 2015; Karas-Miller, 2015; Ogden, 2020). Learning about the neurobiology of stressful and traumatic human reactions helps to understand the design of the nervous system. This knowledge helps people make sense of the reactions they have experienced because of the stresses and traumas of their lives. (Miller-Kara, 2021, p. 2).
CRM has been implemented in 75 countries in Asia, Africa, North America, Australia, the Mid-East, South America, and Europe supporting people and their communities through recovery by reconnecting with the body after crisis and disaster (Leitch, 2007; Parker et al., 2008; Leitch et al., 2009; Leitch and Miller-Karas, 2009; Miller-Karas, 2015). This includes deepening connection with resources (e.g., persons, places, animals, plants, spiritual beliefs, ancestors, humor, compassion, kindness, characters) that uplift, bring joy, give strength, and are helpful through difficult times by tracking sensations of well-being connected with resources, a skill called resourcing in CRM (Miller-Karas, 2021). Modern research provides evidence for the groundwork neuroscientists wrote more than five centuries ago about how our thoughts and behaviors change the brain's physical structures throughout the human lifespan (Doidge, 2007). The brain’s neuroplasticity informs how to approach post-traumatic growth (Banks, 2015; Miller-Karas, 2015; Van Der Kolk, 2014). Awareness of resources like safe relationships can strengthen mind-body connections by learning, in an optimal stress environment, how to release traumatic associations and meanings that no longer serve survival and growth (Banks, 2015; Miller-Karas, 2020; Siegal, 2018; Van Der Kolk, 2014).

**Communal Learning.** CRM is part of a significant paradigm shift to move away from understanding mindfulness as a practice to cope individually in silence with trauma and stress as if suffering is “self-imposed through a lack of emotional self-regulation” (Clarke and Yellow Bird, 2021, p. 142). Jon Kabat-Zinn, MD, is internationally recognized for founding the Mindfulness-Based Stress Reduction (MBSR) clinic in 1979 at the University of Massachusetts, which has had a significant impact on how Western medicine has shaped the mindfulness movement in the United States (Kabat-Zinn, 2013; Compson, 2014; Treleaven, 2018; Clarke and Yellow Bird, 2021). Kabat-Zinn’s operational definition of the essence of mindfulness is the
most cited definition of mindfulness, “the awareness that arises by paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience, which includes sensations, cognitions, and emotions, moment by moment” (Zabat-Zinn, 2003). An unintended outcome of overemphasizing one understanding of mindfulness is that essential cultural knowledge is removed when something is decontextualized from the coherent body of knowledge it is rooted in (Clarke and Yellow Bird, 2021).

When approaching mindfulness in a cultural context, developing a better understanding of the practice’s origins can be an important place to begin. For example, right mindfulness, called Pāli sammā-sati, is the seventh element of the Noble Eightfold Path from Theravada and Mahayana Buddhist traditions. There are four foundations of applied mindfulness in contemplation of the body, feeling, state of mind, and phenomena toward relieving all sentient beings from suffering (Bodhi, 2000; Compson, 2014). Additionally, it is essential to recognize that there are many contemplative traditions for healing among Indigenous peoples worldwide. The Western-based trend toward the separate self, to progress as a developing person, toward an individuated mindfulness as a practice of solitude to regulate, contain oneself, and be productive for capitalism is also a hard move away from MBSR’s intentional design using a group learning format in line with the cultural foundations to learn and practice mindfulness with guidance in connection with a sangha or spiritual community (Kabat-Zin, 2011). CRM centers on collaborative learning to build resiliency as a personal and collective responsibility by training guides to support others to deepen their sensory experiences, to bring attention to the elegant design of the human body, both within oneself and in relation to other beings (Miller-Karas, 2015). Mutual empathy is a community behavioral health approach to strengthen growth-fostering connections across differences in the community (Jordan, 2018a).
The Resilient Zone. The importance for participants in CRM training to learn wellness skills in a community setting and also to develop a shared language and culturally relevant understanding of the warning signs of distress in oneself and others. With a collective knowledge base about trauma and the impacts of traumatic stress, participants practice together how to be a guide for each other such as bringing awareness to our bodies and tracking sensations, feelings, and thoughts of wellbeing. A key concept of CRM is that everyone has a nervous system and, therefore, a Resiliency Zone (RZ). The RZ is also called an OK Zone or a Zone of Well-being. “When you are in your Resilient Zone, there is a natural rhythm or flow within your nervous system, just like the seasons, the rising and setting of the sun, and the cycles of the moon and the ocean” (Miller-Karas, 2022, p. 7). An optimal stress level, one where we can still learn, is a mild/moderate and short-lived stress response for healthy development across the lifespan. Also positive stress in CRM is congruent with an RZ because this is a natural flow where someone can learn to manage body sensations, better manage feelings, think with more clarity, and connect.

GOAL: TO WIDEN YOUR RESILIENT ZONE

Figure 2: The Resilient Zone - “OK” Zone (Miller-Karas, 2020)
The Zone of Well-being is not about obtaining a state of happiness, calm or not feeling anger and sadness. Experiencing a wide range of tolerable feelings, including unpleasant, neutral, and pleasant, is a part of experiencing what can come and go daily.

Sensations, feelings, and thoughts of distress can let us know if we are bumped out of our RZ into a high zone or a low zone, such as during a crisis or prolonged states of high stress.

Graphic adapted from an original graphic of Peter Levine/Heller, original slide design by Genie Everett/Adapted by Elaine Miller-Karas

*Figure 3: Stuck on High or Low (Miller-Karas, 2020)*

The Wellness Skills can support us to come back into the implicit felt sense of the body in a gentle and compassionate way. Practicing The Wellness Skills can bring us back into our RZ if we get bumped out. The disparities of trauma and resulting disproportionate safety incidents among unhoused people in community care settings make a public health intervention like CRM
with emphasis on building a collective understanding about the high or low zones and how to respond imperative for crisis prevention.

When wellness skills are practiced over time, the Zone of Well-being can be deepened. All of our RZs are different. Someone struggling with traumatic, cumulative, and toxic stress may feel they are spread thin or more easily bumped out of their zone.

![Diagram](image)

**Figure 4**: The goal is to deepen the resilient zone (Miller-Karas, 2020)

The Wellness Skills are one community health defense to support each other and get through the challenges we face. The skills can be integrated into all aspects of clinic flow and patient areas to reinforce ongoing learning as part of a comprehensive safety strategy.

**The Wellness Skills.** There are six skills in the CRM model. The most practical for community healthcare settings are Rest Now! and The Basic Three skills: 1.) Tracking, 2.)
Resourcing, and 3.) Grounding (Freeman et al., 2021; Grabble et al., 2021b; Miller-Karas, 2020). When stuck on high or stuck on low, the Reset Now! skill provides ten strategies to return to the Zone of Well-being, including variations of walking, drinking water, sensory exercises, hearing sounds, using temperature changes, counting, movement, noticing the breath, and orienting to space. The Rest Now! skill strategies have the same effective components of the mental and soothing grounding skills from Seeking Safety and the distress tolerance skills from Dialectical Behavioral Therapy (DBT) (Linehan, 2014; Najavits, 2002). Resourcing is the best place to begin learning to use the tracking skill to begin to experience sensations of well-being in connection to safe inner and outer resources in a person's life. Grounding can be brought in to stabilize the nervous system's rhythm at any point when sitting, standing, lying down, or walking by noticing where the body has contact with a surface focusing on neutral to more comfortable sensations. After a grounding exercise, a guide will prompt the person to notice thoughts and feelings to assess perceived stress levels.

The Wellness Skills are structured during training to begin with the Reset Now! skills because often, participants, especially when working with veterans, want to know how to immediately bring relief to someone in crisis (Miller-Karas, 2020). After learning the Basic Three and Reset Now! then there are two additional wellness skills to learn and practice.
The Six Wellness Skills

The Basic 3

<table>
<thead>
<tr>
<th>Tracking <em>(interoception)</em></th>
<th>Paying attention to sensations of trauma/stress, resilience, and release inside the body.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resourcing</td>
<td>Anything in life that brings joy, comfort, peace, strength, and happiness from the past, present, to the future. It can be external, internal, and imaged.</td>
</tr>
<tr>
<td>Grounding</td>
<td>Present moment awareness of places of direct contact with any part of the body with something providing support when standing, sitting, laying down, and in water.</td>
</tr>
<tr>
<td>Gesturing</td>
<td>Conscious awareness is brought to spontaneous movements of the body or limbs that are self-calming, universal, joyous, confident, and releasing gestures.</td>
</tr>
<tr>
<td>Help Now!</td>
<td>10 actions that can be taken to come back into the RZ when stuck in the High or Low Zones.</td>
</tr>
<tr>
<td>Shift and Stay</td>
<td>Shifting awareness from an unpleasant experience or distressing sensation to neutral or pleasant sensations, staying with the sensations of well-being.</td>
</tr>
</tbody>
</table>

*Table 1: The Six Wellness Skills (Miller-Karas, 2021)*

The *shift and stay* skill is a pivot in awareness away from an overly activated, deactivated, or pendulating nervous system toward a resource and to notice sensations of well-being and to stay with the felt sense of well-being (i.e., awareness of neutral to pleasant sensations). Slowing down the movement of a spontaneous calming gesture, for example, can increase the felt sense of awareness needed for emotional growth beyond a survival response. *Gesturing* can be learned by developing personal self-calming, joy, and courage gestures. Gestures in general, are described as self-soothing, universal, joyous, confident, and releasing. A CRM guide can gently turn attention toward a spontaneous gesture by slowing down to observe sensations: Notice what happens inside now? (Miller-Karas, 2020). The Wellness Skills can be shared with family, and
friends, used for self-care, and are both accessible and effective across beliefs, social systems, cultures, environments, and borders (Miller-Karas, 2015).

The History of The Wellness Skills. Elaine Miller-Karas, LCSW and Geneie Everett, Ph.D. shared an interest in Somatic Experiencing (SE)®, collaborating to adapt SE to provide large-scale, accessible Trauma First Aide training for first responders on a short-term intervention for disaster and humanitarian crisis during the Thailand Tsunami, South Indian Tsunami, Hurricanes Katrina and Rita, the Sichuan Province earthquake in China, and the Haiti earthquake (Leitch, 2007; Parker et al., 2008; Leitch et al., 2009; Leitch and Miller-Karas, 2009; Miller-Karas, 2015). Elaine went on to found the Trauma Resource Institute (TRI) in 2006 with Laurie Leitch, Ph.D., further adapting Trauma First Aide, “dedicated to bringing culturally sensitive interventions to underserved communities worldwide” (Miller-Karas, 2015, p. 146).

TRI developed the Trauma Resiliency Model (TRM)®, an innovative somatic therapy for not only shock trauma also for developmental, trans-generational, and historical trauma by integrating body-based sensory mindfulness (i.e., interoception and proprioception), sensory integration, felt-sense focusing, the natural world, neuroscience, attachment strategies, and solution-focused psychotherapy (Leitch and Miller-Karas, 2009; Grabbe and Miller-Karas, 2018; Miller-Karas, 2015). TRM is a clinical treatment model implemented by a clinician using an invitational approach with the six wellness skills and the three trauma processing skills: titration, pendulation, and completing survival responses (Miller-Karas, 2015). CRM is the community model.

A Resilience-Focus on Behavioral Health from a Public Health Intervention

The Wellness Skills provide an integrated approach to significantly decrease traumatic stress symptoms and strengthen pathways of resilience through mutuality and the wisdom of the
body for recovery (Freeman et al., 2021; Grabble et al., 2021a; Grabble et al., 2021b; Miller-Karas, 2015). The Wellness Skills destigmatize behavioral health services (i.e., mental health and addiction treatment) for urban communities impacted by structural poverty and violence by emphasizing helping others, self-care, and resilience (Freeman et al., 2021; Grabble et al., 2021a). Participants who have received CRM wellness skills training have experienced decreased somatic symptoms, depression, hostility, and anxiety with significant ongoing effects for three months and reduced anxiety for up to six months given ongoing cumulative stressors (Freeman et al., 2021). CRM has also been demonstrated to improve the well-being, resiliency, and secondary stress among nurses in healthcare settings experiencing high rates of poor mental health, secondary stress, and burnout (Grabble et al., 2021b). CRM offers communities an understanding of the neurobiology of trauma and the impacts on behavioral, cognitive, physical, psychological, spiritual, and relational human domains (Freeman et al., 2021). Additionally, CRM strengthens communities with practical skills for intervention to develop resiliency-informed communities (Freeman et al., 2021).

**Biological Lens on Trauma Toward Resiliency Informed Communities**

Understanding trauma from a biological lens is fundamental for a comprehensive safety strategy to decrease and prevent safety incidents. Trauma can impact all living beings and cause suffering when cumulative and toxic stress overwhelms a natural system’s existing adaptations to stay alive, including humans, animals, birds, fish, insects, plants, waters, earth, and all forms of life (Bohdi 2000, Levine, 2010; Clarke and Yellow Bird 2021). There are many different and compounding contexts in which trauma can occur, from interpersonal to developmental, familial, community, intergenerational, social, institutional, historical, environmental, cultural, economic, and political (Haines, 2019; Clarke and Yellow Bird, 2021). The relationship between integrated
healthcare providers and unhoused Indigenous people is understood by the mutual impacts of the social conditions of violence, abuse, neglect, oppression, loss, accidents, injury, shock, and disasters that break trust and betray the social bonds essential to meet fundamental human needs for belonging and safety (Herman, 1992; Haines, 2019; O’Keefe et al., 2014; Van Orden et al., 2006; Van Orden et al., 2008). Trauma mobilizes powerful, inherent protective instincts. When someone cannot protect themselves or escape to safety, the charge of the traumatic stress response remains stored in the body (Haines, 2019). Traumatic embodied memories shape most experiences moving forward for this person who is now overly prepared, hypervigilant, that the worst will occur again well after this response may be protective. The cumulative effect of holding traumatic stress on the nervous system is overwhelming and contributes to health disparities over the life course (Miller-Karas, 2015).

For a person who has experienced trauma, telling their story about the moment they knew it was that they were going to survive can be a meaningful part of a healing process. Importantly, for change to occur, the body must also understand how to live with a present moment awareness and a restored, balanced perception of an imminent life threat (Van Der Kolk, 2014). The biological lens of CRM begins with understanding trauma as “an individual’s perception of an event being threatening to self and others” (Miller-Karas, 2015, p. 2). Events or a series of events are multistoried and experienced differently from one person to another. It is important to note on a societal level the medicalization of trauma contributes to understandings on trauma largely shaped by what meets the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5) definition for a “Criterion A4” event for Post-Traumatic Stress Disorder (PTSD) (American Psychiatric Association, 2013). A traumatic event is therefore most often understood to only be an actual life threat, serious injury, or sexual violence directly experienced, witnessed,
occurred to close family or close friend, or exposure to aversive details (e.g. exposure cannot be through any media or pictures unless this exposure is work-related) (American Psychiatric Association, 2013). This has not included the ongoing embodied impacts of colonialism, racism, homophobia, microaggressions, or social neglect. However, these experiences have cumulative effects activating traumatic stress reactions on a daily basis during repeated interactions of rejection and danger, referred to as cumulative trauma or C-trauma in CRM (Miller-Karas, 2015).

In Judith Herman’s seminal work, Trauma and Recovery (1992), she brings together over 20 years of research and practices with victims of sexual and domestic violence. The guiding principle of trauma recovery is to restore power and control by taking the first steps to establish safety (Herman, 1992, p. 159). It is essential to understand that safety is relative and not subjective because it is different for each person and community based on their story (Gibson, 2008). Perception is shaped through multisensory reminders of a traumatic event (i.e., emotion, sounds, smells, stomachache, heart rate, headache, visuals, and muscle tension) as if they are occurring in the present moment (Miller-Karas, 2020). The biological lens of CRM recognizes the mind-body reactions to attachment trauma and how danger and fear are reactions to their lived experiences as the aggressor, the prey, or the witness (Miller-Karas, 2020). The biological design of resiliency within natural systems provides the capacity to heal and return to balance after traumatic experiences by being in a safe relationship with other people, family, friends, coworkers, communities, social care, and healthcare providers (Miller-Karas, 2015).

CRM is a public health intervention, a strategy that takes a trauma-informed and resiliency-focused approach to prevention for participants to learn wellness skills to benefit the entire community. To implement CRM to contribute to reducing safety incidents and achieving
crisis prevention, all integrated healthcare providers need to receive training. CRM’s prevention program builds community resilience grounded by culturally relevant body-centered skills informed by the biology of the human nervous system to learn how bodies release conditioned patterns and narratives about histories that no longer serve (Miller-Karas, 2015; Menakem, 2017). Indigenous people strengthening themselves through a deeper connection with traditional practices, community, family, and resources is a form of resistance to the trauma narratives of biomedical deficit and neglect.

**Creative Resourcing.** Creativity is a powerful tool to enhance resilience and the possibility of what can be. Creative resourcing is critical to how fruitful The Wellness Skills can be for a person to get unstuck from traumatic stress response traps, including fear, mental inflexibility, apathy, isolation, addiction, and self-destruction (Van Der Kolk, 2014; Miller-Karas, 2015). Engaging in structured experiential activities when learning and practicing wellness skills in a community-integrated healthcare setting can develop pathways to post-traumatic growth by emphasizing the imagination to deepen resilience and visualize a more hopeful future (Van Der Kolk, 2014; Miller-Karas, 2015). Creative expression can include song, writing, art, ritual, music, ceremony, movement, prayer, games, and crafting. An example of artmaking with a wellness skill is a drawing activity using the tracking skill to explore sensations of well-being connected to drawing an interpretation of what the person would like to be different when the challenge they are facing is resolved, asking what will be different. Approaching traumatic stress with a biological lens highlights how transformative processes begin by approaching each unique mind-and-body in the mutual relationship between bottom-up, sensorimotor, body awareness with top-down, cognitive meaning-making, beliefs to restore
balance integral to the individual human nervous system (Levin, 2010; Ogden and Goldstein, 2020). Resilience informed communities’ uplift creativity for healing and growth.

**Interweaving Resilience Through Story.** Conversational resourcing is an example of another strategy to move beyond traumatic stress survival responses to guide someone during or after a crisis. The CRM guide will invite the person in crisis to tell as much or as little of their story about what happened, beginning by using invitational language to ask a few questions. People often feel they need to share every detail no matter how distressing, and this can result in dissociation or re-traumatization: If you would like to tell me what happened, I would like to ask you from time to time to pause, so the story can be shared with me without this being too harsh on your nervous system. Is this ok with you? (Miller-Karas, 2020). CRM is not a replacement for therapy and can also be an effective community defense to respond to crisis and loss. A CRM guide can start by eliciting permission, as demonstrated above, then using open-ended solution-focused questions, gently bringing attention in the present moment to sensations of well-being (e.g., As you are sharing this, what do you notice on the inside? and, Just notice this neutral to pleasant sensation), and then asking if they would like to continue with retelling their story (Miller-Karas, 2020). Questions that a CRM guide might ask during a crisis include:

- What is a source of strength for you to get through this now?
- Who has been the most helpful for you while going through this? Questions that might be asked after a crisis include:
  - Can you tell me about the moment you knew you would survive?
  - Who was the most helpful to you in the beginning?

Questions that might be asked related to the loss of a loved one:
If they were here with us now, what words of encouragement do you think they would share with you during this difficult time?

What did you enjoy the most about the times you spent together?

The purpose of a resiliency pause is to support an optimal stress level for the person to share their story differently, be witnessed with care, and be embodied in the present when telling their story (Miller-Karas, 2020). Interweaving resiliency pauses can foster a compassionate and gentle approach to facilitate balanced communication between the body and mind during or after crisis and loss (Miller-Karas, 2015; Miller-Karas, 2020). Often a person may find a new meaning emerging about their experience during this process. Looking back on what has helped someone, their family, and their community gets through something can be a source of resilience during times of uncertainty. Being present with someone in crisis to support them to reconnect with their body to move beyond survival toward imagining a life where they can fully enjoy being alive is their birthright (Clarke and Yellow Bird, 2021).

**CRM to Interrupt the Progression of Safety Incidents**

In Albuquerque, unhoused Indigenous people must be given culturally safe care to eliminate health disparities (Bereiter & Brave Heart, 2017; Mkandawire-Valhmu, 2018). Historical and cumulative trauma realities are compounded by racism and discrimination in the CoC (Bereiter & Brave Heart, 2017). An understanding of a person and the environment is vital for MHTs to understand the contexts of clients being unhoused in urban communities on their homelands (Garcia, 2010; Gersony, 2021; Lorenzo, 2019; Prussia, 2019). A healthy MHT can be observed by the participation of members to competently meet mutual needs and make needed changes to collectively address the challenges at hand (Bransford and Cole, 2019; Gaurino et al., 2009; Thistle and Smylie, 2020). When an MHT is part of a resiliency-oriented community,
clients are provided with opportunities for connection and emotional support to grow toward their fullest potential to succeed (NHCHC, 2016; SAMHSA, 2018). CRM implementation provides a relational orientation to strengthen growth-fostering connections among integrated healthcare providers and clients as a public health intervention for crisis prevention (Freeman et al., 2021; Grabble et al., 2021a; NHCHC, 2016). CRM encourages prosocial behaviors on an MHT through everyone learning and practicing wellness skills to enhance emotional balance and co-regulation (Banks, 2015; Miller-Karas, 2015; Vicario, 2021). An MHT that upholds the value of non-violence and takes strengths and solution focus can better prevent safety incidents from escalating, including a client being asked to leave a clinic, escorted off the property by security, 911 being called, or receiving a service ban (HCHCN, 1996; HCHCN, 2011; Esaki et al., 2013). CRM can support a relational ecology for housing stability in Albuquerque.
CHAPTER 4

Relational Ecological Theory

An Ecological Lens on Relational-Cultural Theory (RCT)

At the intersections of Indigenous Knowledge and Relational-Cultural Theory (RCT), relational ecology is an invitation to move into a relationship by recovering our collective health, emotional-physical-mental-spiritual, as collaborators toward environmental justice (Prussia, 2019; Gunderson, Prussia, & Larson, 2021). Somatic literacy for reconnection begins with accessing the body's natural rhythms, broadening interoception awareness, elevating mind-body cohesion, and collaborating with the natural world (Prussia, 2019). Wellness occurs in growth-fostering relationships by learning and practicing how to reconnect when disconnected from the body and the natural world (Striver et al., 2001; Prussia, 2017). An ecological lens on RCT deepens our understanding of strengthening the connection to sensations of well-being and the felt sense of body awareness as a pathway to sustain an everyday balance of emotional health. Relational ecology grounds our understanding of our relationship with the natural world by centering the proclamation that we are nature as a life-enhancing strategy to build resilience at the roots of our connections with all that is through somatic literacy (Biggs, Goldtooth, & Orielle Lake, 2017; Gunderson, Prussia, & Larson, 2021; Prussia, 2019).

RCT has centered relationships as a principal need for the well-being of humans for more than fifty years through a Western lens on healing as an alternative to many dominant Eurocentric ways of knowing that prioritize the self as separate (Miller, 1976; Prussia, 2018). Traditional teachings from Indigenous peoples have understood the value of connection in relationships with other humans and with relation to all life in the natural world (Prussia, 2018). Indigenous leaders in the RCT community ask for practitioners “to embrace the natural
environment as a collaborator” as a step to further the relational movement by growing beyond a person-in-environment perspective to *people and the natural environment* (Prussia, 2018; Prussia, 2019). The Ecological Affinity Group of the International Center for Growth and Connection (ICGC) upholds RCTs’ fundamental agreement with the proposition that we are nature to ground public health education by recognizing that natural beings (e.g., legged, winged, crawlers, and swimmers) live-in relationship and interact within ecological communities (Gunderson, Prussia, & Larson, 2021). During a colloquium on human connections with the natural world, Connie Gunderson expanded on Jean Baker Miller’s founding awareness that all development occurs within relationships throughout the lifespan (Gunderson, Prussia, & Larson, 2021):

“As Relational Cultural Theory (RCT) continues to gain global recognition in academia and in medicine, psychology, social work, education, social justice; it is natural for RCT to spread its wings. Many of us who resonate, people involved in global ecological research, feel connected to our brothers and sisters [siblings] who carry sacred Indigenous knowledge and wisdom; and we join organizations and movements to support ecological activism. Similar to the psychological perspective of RCT, ecology grounded in RCT, and I will call this relational ecology, emphasizes relational development through diverse lifespans, neurological and sensory connections, and ecological justice”.

Expanding the scope of the RCT explanatory model for understanding connections that are not just human is a *both-and* approach to understanding relational development through lifespans from both Indigenous and Western; and from qualitative and quantitative ways of knowing (Gunderson, Prussia, & Larson, 2021).
Indigenous Feminisms on Ecology

“As Pueblo Youth, we bear testament that the Pueblo Revolt of 1680 never ended. We acknowledge that as descendants of Pueblo revolutionaries and powerful matriarchs, the resistance and power instilled in our ancestors to sustain our cultural lifeways have been passed down to us” (Pueblo Alliance, 2021).

Rematriation of Waters and Lands. The Pueblo of Sandia is a Southern Tiwa Pueblo located just north of Albuquerque. In the Tiwa language, the traditional homelands are called Tuf Shur Tia, meaning ‘Green Reed Place,’ referring to the Bosque type of forest found along riparian plains of stream and riverbanks, the life sustained by the waters between the mountain and river here in the Rio Grande Bravo delta rivershed, Albuquerque corridor, called the Blue River by the Tiwa speaking peoples of the area. As a result of climate change and the Army Corps of Engineers Dam 58 miles north, many stories are told about plants, herbs, medicine, and animals that once thrived in the creeks and ponds of the floodplains of Tuf Shur Tia (Gersony, 2021). Julia Fey Bernal, an enrolled tribal member of the Sandia Pueblo and Alliance Director of Pueblo Action Alliance, states:

“In my community, we view the river as a mother, having personhood, a living entity. Therefore, there’s a lot of respect and care that we, as stewards of this land and our waterways, have towards ensuring that our river is healthy” (Gersony, 2021).

The Tuf Shur Tia Indigenous peoples’ connection with their homeland and their waters is a significant cultural resource and source of resiliency grounded in the lifeways of knowing how healing the land and water is also healing the people. Julia Fey Bernal reminds us that violence to the people is violence to the land, and violence to the land is violence to the people because settler extractive methods of taking and controlling Indigenous waterways are deadly and cannot
be minimized (Clarke and Yellow Bird, 2021; Gersony, 2021). Culture encompasses nearly every aspect of human life, including how history is embodied and storied through what can or cannot be sensed, felt, and processed (Menakem, 2017).

The social casualties of cultural trauma for unhoused Indigenous people in Albuquerque can be observed by the displacement of people from land, water, and community due to nuclear and extractive colonialism, institutional violence, structural racism, and individual settler bias (Garcia, 2010; Weaver, 2019; Clarke and Yellow Bird, 2021). The ongoing nuclear colonialism of the Los Alamos National Labs (LANL) in the upper Rio Grande has contaminated underground aquifers with radioactive waste among the San Ildefonso and Santa Clara Pueblos (Garcia, 2010). The Jackpile Uranium Mine at the Paguate Village of the Laguna Pueblo has also caused significant environmental destruction, loss of livestock, overwhelming suffering, illness, cancer, unemployment, and gender-based violence across the community (Lorenzo, 2019). To approach understanding the impact of nuclear and extractive colonialism on Pueblos, a deeper understanding of gender justice is necessary:

“... the notion of gender must be expanded to include the feminine, and that furthermore, because men and women at Laguna ascribe to a Laguna epistemology, which holds the feminine as sacred, both women and men are impacted. While not all impacts from the mining project on women would be classified as violence by community members, impacts on the feminine as embodied by human beings and Our Mother, and a central part of the identity of a matriarchal, matrilineal people, constitutes spiritual violence that has resulted in multiple forms of trauma” (Lorenzo, 2019, p. 23).
The importance of Pueblo feminist perspectives is central to decolonizing spirit, body, heart, and mind to restore the balance of power among people of all genders and restoring matrilineal traditions of respect and reciprocity to lands and rivers as mother (Bernal and Trujillo, 2021).

**Urban Indigenous Health Care in Albuquerque, New Mexico**

New Mexico is the second-largest oil-producing state in the U.S., with the least restrictions compared to any other state (Fendt, 2022). Going back to the 1970’s New Mexico has been dependent on the boom or bust cycles of the global extraction economies (NMHSD, 2019). While the gas and oil industry provided 33% of the state's revenue for the fiscal year 2021, they are also the biggest producers of greenhouse gasses in the state (Fendt, 2022). The state's reliance on gas and oil extraction is an insidious example of environmental health disparities. What is making the people and the environment sick is not a resource for recovery and healing.

Unmet care needs and service gaps result from dependence on extraction economies (NMHSD, 2019; NMLFC, 2020). While New Mexico also has the most extensive state Medicaid program, having insurance does not equal good healthcare (NMLFC, 2020; TRN, 2021). 23 sovereign nations, pueblos, and tribes have a border with the state (NMLFC, 2020). The largest population of Native Americans (9%) faces health disparities in access to and use of public health systems (NMHSD, 2019). Urban Indigenous peoples have the poorest healthcare due partly to the state’s reliance on extraction economies and the Department of Health and Human Services not providing the appropriate funds obligated by treaty and federal law (IHS, 2015; TRN, 2021).

New Mexico ranks 50th in poverty, with 50% of children and 20.6% of all New Mexicans living in poverty (NMHSD, 2019). The second leading cause of death among
Indigenous youth is suicide (Fabian, Fernandes, & Esposito, 2020). Suicide rates increased in 2020, with the most losses in Albuquerque, Bernalillo County (NMDOH, 2021). A significant systemic barrier identified by FNCH was not being able to retain staff for longer than two years (Fabian, Fernandes, & Esposito, 2020). Additionally, limited capacity to meet with a client beyond a 15-minute brief intervention (e.g., Screening, Brief Intervention, and Referral for Treatment (SBIRT) and no aftercare capacity for youth who have attempted suicide (Fabian, Fernandes, & Esposito, 2020). Homelessness and incarceration are significant risk factors for suicide. In 2019, the state budget provided 2.3 million for a targeted response to families, transitional aged youth leaving foster care, and other vulnerable groups (Fabian, Fernandes, & Esposito, 2020; NMLFC, 2020). In the wake of the COVID-19 pandemic, the Health and Human Services (HHS) department has proposed a 36% increase, $2.2 billion more for the Fiscal Year (FY) 2022 than 2021, allocating $5.2 billion to Tribal Health Programs (THP) and Urban Indian Organizations (UIO) Clinical Services programs in the U.S. (HHS, 2022).

Indigenous sovereignty and self-determination are the most powerful strengths-based and cultural tools for suicide prevention and health justice (CAIH, 2022). It is not adequate healthcare to merely increase funds in response to increased health disparities without addressing the social conditions underlying the health injustices across health care systems serving Indigenous peoples. A vital pivot toward health justice includes increased HHS accountability to adequately fund IHS Clinical Programs and clean, sustainable energy (NMLFC, 2020; TRN, 2021).

**Understanding Trauma Recovery and Healing from a Relational Ecology Lens**

“What we seek is a world premised on Indigenous values of interspecies responsibility and balance” (TRN, 2021, p. 30).
Marginalization and disconnection are relational traumas that have cumulative long-term health consequences because the neurobiology of our health and well-being was created for interdependent relationships (Marlatt-Murdoch, 2018). Relational ecology is grounded by multiple ways of knowing how life on earth is both vulnerable and interdependent, “therefore our relationship with water and air is primary and mutually relevant” (Gunderson, Prussia, & Larson, 2021). When relational-cultural practitioners talk about ecological responsiveness and environmental justice, the perspective acknowledges how the earth and universe develop, live, and breathe. Akin to plants, “we need connection the way we need air and water” (Jordan, 2018b, p. xiii). The life-enhancing connections humans sustain in relationship with each other are also recognized by science among herbs, scrubs, mosses, grasses, and trees living in their environments. Our nervous systems are supported in a biorhythmic flow when our sensory connections identify interpersonal safety and acceptance (Gunderson, Prussia, & Larson, 2021).

The natural design of the dorsal anterior cingulate cortex (dACC), the alarm system of the brain, reminds us why a connection is a primary need so critical to our well-being because the dACC responds to an injury, physical pain, or the absence of air or water with the same urgency as social exclusion (Banks, 2015; Jordan, 2018b).

A central philosophy to the teachings of the medicine wheel is connectedness from the microcosmic to the macrocosmic with all that is, to all my relations, within the circle (Thistle, 2017). Many medicine wheels, or sacred hoops, are influenced by the different cultures and environments across Indigenous nations, all used to offer various teachings (Gibson, 2018). The medicine wheel is a sacred symbol described as a contemporary tool that integrates ancient Indigenous healing technologies, traditional knowledge, and ways of understanding. On Turtle Island, the medicine wheel is commonly depicted in four colors yellow, red, black, and white.
Additionally, the four directions (north, east, south, west), elements (earth, air, fire, and water), seasons (winter, spring, summer, fall), medicines (sweetgrass, tobacco, cedar, sage), hills of life (elder, infant, youth, adult), and stages of well-being (spirit, mental, physical, emotional) (Gibson, 2018; Thistle, 2017). One of the oldest remaining medicine wheels is more than 10,000 years old in the Big Horn Mountains, where Indigenous people from many nations would gather and share life and culture (Yellow Bird, 2021).

Image 2: The Bighorn Mountain Medicine Wheel (USDA/FS, 2022)

The medicine wheel and mindfulness are integrative practices that inform neurodecolonization of the mind and body shaped by current trauma theory and science on neuroplasticity (Yellow Bird, 2013).

The brain can change its structure, including perceptions, thinking, and consciousness, when new experiences and knowledge are integrated and accommodated (Yellow Bird, 2013). While the mind develops in colonial contexts, the brain is reshaped by engaging with traditional Indigenous contemplative practices such as ceremony, prayer, singing, dancing, and other
cultural expressions to decolonize the mind and body by transforming “colonial trauma, distractions, symbols, language, and systemic racism, sexism, ableism, and homophobia” (Clarke and Yellow Bird, 2021, p. 145). Throughout Indigenous cultural expressions, traditional knowledge has known how humans' emotional, physical, mental, and spiritual well-being are hard-wired with the natural world (Prussia, 2018). Indigenous teachings that water is life and water is living can also be reflected in more recent understandings from western science that identify the human body to be composed of 70% water. Marasu Emoto succinctly concludes that we are water (Prussia, 2018). Disconnection from the natural world disconnects people from their bodies, and reconnection to sensation, the body's language, can reconnect people with the natural world (Gibson, 2008; Prussia, 2018).

Leah Prussia, DSW, LICSW, SEP (2019) has used the medicine wheel as a tool for somatic literacy to teach about personal and planetary healing. Mind-body disconnection has negative health consequences for humans (isolation, depression, addiction, diabetes, obesity) and the earth (polluted waterways, decimation of sacred sites, mining/oil/gas extraction, climate change) (Prussia, 2019). Moving toward relationship is a move away from an ego-mindedness world view with the human mind on the top as the superior being over all other life forms and toward an eco-mindfulness world view centering on the interconnection of all life with humans as a part of the whole (Gunderson, Prussia, & Larson, 2021)
Figure 5: Somatic literacy moves toward a relationship with self, others, and all that lives (Prussia, 2019)

The emotional effects of disconnection from the physical world include dysregulated hyperarousal or hyperarousal biorhythms of distress that have significant health consequences resulting from living in prolonged traumatic stress states outside the bounds of the types of stress that can be healthy or life-enhancing. Disconnection from other people and the body are often a survival strategy in response to trauma, cumulative stress, and marginalization (Jordan, 2018a). Integrated healthcare providers to remain open and curious rather than pathologizing about
strategies of disconnection because we want to understand how it is that someone has survived (Jordan, 2009).

Reconnection through growth-fostering relationships with the natural world can begin by accessing the body's natural rhythms of resilience when placing awareness on sensations of wellbeing through somatic interoceptive practices in connection to inner and outer resources. The elevation of the mind-body connection contributes to cohesion in collaboration with the natural world (Prussia, 2019). Returning to relationships with the natural world is vital for behavioral health (Jordan, 2018b). A person's spiritual well-being is enhanced through connection with the natural world (e.g., body, people, animals, plants, rivers, mountains, universe) by living in accord with cultural knowledge about reverence for the earth through relationality, reciprocity, and mutual respect (Prussia, 2019).

An expanded perspective of interoception and sensory connection reveals how two core somatic skills, interoception, and resourcing, support recovery and growth. The sensory connections of memory are accessed during resourcing when bringing awareness to the felt sense of connection to an emotional support animal, a place by the river, the presence of a creator, the smile of a loved one, home, and safe connections. Human growth occurs through and toward safe relationships over the lifespan (Jordan, 2018a). From an ecological perspective, RCT offers a cross-cultural approach to understanding different biological perspectives on how all of creation is hardwired for connection and why this is important for somatic literacy on crisis prevention (C. Gunderson, personal communication, February 9, 2022). An ecological perspective centers on the interconnectedness of relationships toward justice for people, animals, plants, soil, air, waters, lands, elements, and all life (C. Gunderson, personal communication, February 9, 2022). A central tenet of relational ecology is reflected in Judith Jordan’s words, “We are one, we
belong to one another. We are responsible for one another. The air we breathe in and exhale speaks to the depth of our connection” (Gunderson & Prussia, 2021). From an ecological perspective, the vitality of co-regulated connections between humans and the natural world is understood in behavioral health as a core tenant to well-being. The safeguarding of natural resources is essential for our health.

Toward Housing Stability: The Five Good Things of Growth-Fostering Connection

Participant narratives shape understanding of the relational ecology needed to support growth-fostering relationships in community behavioral health care. Using mixed content analysis methods, understanding RCT emerged as a salient theoretical underpinning from an ecological perspective. A core tenet to emerge from this study is that environmental justice is necessary for Indigenous peoples’ housing security. A relational ecological process model for crisis prevention is designed to have policy integrity from the structural to the interpersonal level. The scope is on resilience to better understand social determinants of health as facilitators or barriers to resilience across interpersonal, organizational, and environmental domains of crisis prevention.

A safe connection established through relating is necessary to stabilize an activated nervous system. Integrated healthcare providers are expected to show up-regulated to provide a secure enough relationship to co-regulate and relate (Vicario, 2021). Safety is relational, and a client can notice when it is present because they can feel sensations of well-being, a calming effect, and trust. Power-with relationship behaviors are action-oriented, as evidenced by taking a step forward to relieve suffering and establish a safe connection (Jordan, 2018b; Vicario, 2012). Safe relationship behaviors are ‘en-couraging,’ supportive, accepting, listening, negotiating differences, and trusting (Vicario, 2012). Unsafe relationship behaviors have a power-over
Dynamic: blaming, criticizing, bribing, complaining, threatening, punishing, rewarding to control, and aggression (Vicario, 2012).

**Integrated Health C.A.R.E. for Interpersonal and Organizational Resilience**

Safe relationship behaviors enhance The Five Good Things of a growth-fostering relationship: zest, sense of worth, desire for more connection, clarity, and productivity (Jordan, 2018a; Miller & Stiver, 1997; Schwartz, 2021; Vicario, 2012). Amy Banks, M.D. (2015) provides a C.A.R.E. program to understand the neuroscience of RCT. The C.A.R.E. program neuroscience was applied to qualitative content analysis processes to understand better The Five Good Things of growth-fostering relationship for crisis prevention. RCT understands interpersonal resilience in context to our ability to grow and heal through relationships. Calm, Accepted, Resonant, Energetic provides a biological perspective to describe interpersonal resilience for a whole person's emotional-physical-mental-spiritual health. Interpersonal awareness has a resonance, letting us know if we feel safe or unsafe concerning another. A biological understanding of fight/flight/freeze distress responses is not that these are wrong responses but rather a hardwired strategy for crisis survival response when something is understood to be unsafe. A critical somatic awareness to develop is distinguishing between sensations of distress, wellbeing, and release (Levine, 2010; Karas-Miller, 2015, Stanley, 2016). Self-awareness in connection like when resourcing, can be described through our felt senses to assist us in distinguishing if there is safety present or not with another person, animal, creator, place, water, culture, and source of energy (Gibson, 2008; Levine, 2010; Karas-Miller, 2015, Stanley, 2016). C.A.R.E. helps describe why knowledge about safety in relationships is at the heart of interpersonal resilience. Community behavioral health care needs us to approach crises with compassion, acceptance, partnership, and evocation (Miller & Rollnick, 2013).
Calming. Zest, one of The Five Good Things, is the stuff the relational components of MI are made of (Jordan, 2018a; Miller & Rollnick, 2013; Miller & Stiver, 1997; Schwartz, 2021; Vicario, 2012). Compassion extends interpersonal resilience through the presence of vagal toning that is not too tight or brittle with a guiding approach. At the core of the body, the smart vagus nerve connects from the amygdala, a part of the alarm system in the brain to alert physical and emotional pain, down to every organ and out across musculoskeletal structures. The smart vagus is an interoceptive system connecting the body up to the amygdala. A person can notice sensations of well-being on the inside. Tracking is a CRM wellness skill used to distinguish the differences in sensations as an initial step to shifting top-down attention from one sensation in a field of awareness to another. Calming is a mind-body spiritual component of recovery as an implicit way to connect with all that is, creator, serenity, silence, deity, the universe, and the natural world. Culturally relevant language to describe calm and well-being are at the core of a person feeling safe to track body awareness together during a crisis.

Accepted. Sense of worth, one of The Five Good Things, is understood as a bottom-up biological experience sending messages of physical awareness of emotion and belonging (Jordan, 2018a; Miller & Stiver, 1997; Schwartz, 2021; Vicario, 2012; Van Orden et al., 2008). The interpersonal-psychological theory of suicide helps to explain the inverse relationship between an increased sense of belonging and decreased suicide risk with a lower perceived burden (O’Keefe et al., 2014). From the body up to the dorsal anterior cingulate cortex (dACC), the alarm system of the brain, the grounding and gesture wellness skills can calm down and soothe an activated nervous system. Grounding is awareness of connection to the earth’s gravity at the points of contact the body is making with any surface when touching, standing, sitting, laying down, or floating. Ways to ground mind-body alerts like perceived burdens are mental,
physical, or soothing grounding (O’Keefe et al., 2014; Najavits, 2002). Belonging is a life-enhancing experience that is calming and described as feeling grounded or accepted (O’Keefe et al., 2014; Najavits, 2002; Van Orden et al., 2006).

**Resonant.** A desire for connection is one of The Five Good Things (Jordan, 2018a; Miller & Stiver, 1997; Schwartz, 2021; Vicario, 2012). A shift to sensations felt in the heart area that is warming, releasing tension and weight, soft, soothing colors, and lightness. Emotional resonance is felt when safety is present and can be trusted. A neuroscience perspective on relationship and social learning is understood through the language of a mirroring system to describe why our nervous systems are hardwired to connect (Banks, 2015). Jean Baker Miller, a founding RCT theorist, described *feeling-thoughts* to be the integration of intellectual and emotional experiences needed for resonance in relationships. “[A] culture that promotes separation as a goal of healthy human development” is a culture that wants to keep emotions separate from thoughts and people disconnected from their feelings (Banks, 2016, p. 231). How someone experiences a relationship has a lot to do with how they feel in the relationship. Feeling-thoughts are strengthened by spending more time in a deep relationship and resourcing.

Resourcing is a wellness skill to enhance the tone and resonance to belonging and safety through growth-fostering connections. When resourcing, we practice bringing our awareness to sensations of wellbeing inside our physical body to learn to notice and trust our discernments if safety is present or not. Our past relationships shape our relational images, the collection of experiences and ideas we have about relationships (Herman, 1992; Jordan, 2018a; Najavits, 2002). In addition to being in more resonant relationships, resourcing allows us to use interoception and imagination to sense ourselves in connection to safe relationships as symbols, metaphors, shape, temperature, vibration, position, muscle, weight, destiny, taste, heart rhythm,
and breath rate. The resourcing somatic wellness skill supports vagal toning through resonance (Miller-Karas, 2021).

Drinking water can activate the energetic response of the smart vagus (Banks, 2018). Water is a vital natural life source; we are 70% water and can feel an energetic resonance throughout our bodily waters throughout our heart, lungs, brain, kidneys, skin, tissue, bones, and muscles. Water is vital to the relational ecology of crisis stabilization as a source of hydration, a place to sit and rest, a shower, laundry, and wound care. Water’s connection with our emotional health reminds us about the many ways we can communicate with compassion to relieve the suffering of another. The research of Masaru Emoto, M.D. suggests that the molecular structure of water is affected by thoughts, words, sounds, intentions, and music (Emoto, 2004; Radin et al., 2006). Photos from frozen water molecules under the microscope provide visual observation of water’s emotional intelligence formations, replicated across double and triple-blind studies (Emoto, 2004; Radin et al., 2006; Radin et al., 2008).
Image 3: Frozen water crystals

**Top left:** Water crystal that appears in water taken from the fountain of Lourdes, France, frozen at 225°C and observed and photographed under a microscope in a room at 25°C. **Top right:** Water crystal that appears after letting the water hear a noisy tune of heavy-metal rock music. **Bottom left:** Water crystal that appears after wrapping the vial of water with the words “Love & Thanks” in Japanese characters for a period of 24 hours. **Bottom center:** Water crystal that appears after wrapping the vial of water with the word “Devil” in Japanese characters for a period of 24 hours. **Bottom right:** Water crystal that appears after letting the water hear a composition by B. Smetana entitled “The Moldau.” (Emoto, 2004).

Water resonance can provide us with a creative way to connect with the natural world to begin to understand and describe how different emotions might take shape, be held, or rest in our bodies (e.g., round, smooth, sharp, prickly, a blob). Like water, our emotions are ever-changing; they can be fluid and can become stagnant, stuck, or frozen. It is essential to find ways to talk about perceived burdens because they have been shown to predict suicidality (O’Keefe, 2014).

Strengthening and establishing connections in relationships that provide a sense of belonging describes participants' perspectives on crisis stabilization and prevention.
**Energetic.** Clarity, one of The Five Good Things, is associated with the dopamine reward system's effects on cognitive focus (Jordan, 2018a; Miller & Stiver, 1997; Schwartz, 2021; Vicario, 2012). Calm and resonance are the relational components needed to collaborate with shared clarity on a safety plan. Belonging is a life-enhancing experience that is calming and described as feeling grounded or accepted (O’Keefe et al., 2014; Najavits, 2002; Van Orden et al., 2006).

**Organizational Resilience.** Productivity, one of The Five Good Things for integrated healthcare providers, is present or not dependent on the work environment (Bransford & Cole, 2019; Healthy People, 2030; Jordan, 2018a; Miller & Stiver, 1997; Schwartz, 2021; Vicario, 2012). A key organizational facilitator of resilience is cohesion on an MHT. A person’s work environment is a social determinant of health (Bransford & Cole, 2019; Healthy People, 2022; Rosen et al., 2018). Without necessary organizational and inter-agency support, people in crisis environments experience less MHT cohesion and are at a higher risk of burnout (Brave Heart, 2017). Crisis activates traumatic stress responses for clients and integrated healthcare providers. Organizational resilience to compassion fatigue requires a comprehensive community of support to provide preventative care (Bloom, 2003; Esaki et al., 2013). Too much ethical distress in a system of care often contributes to diminished clarity, disconnection, crisis escalation, and withdrawal. RCT offers a multidisciplinary skill for embodied ethical decision making, emphasizing the 3 M’s, Movement to mutuality, Mutual empathy, and Mutual empowerment as a strategy for clients, providers, and team members to all work together in an encouraging relationship (Roberts, 2021).

Being unhoused is a crisis and needs a trauma-informed approach to behavioral health care for whole-body safety, nourishment, drinking water, sanitation, warmth, rest, and housing.
MHTs need to discuss together what Reset Now! wellness skills work best for everyone on the team (e.g., client, nurse, case manager, PCP). Somatic literacy for MHTs needs to provide opportunities for mutual support and to discuss together what helps them come back into a sense of feeling calm, safe, neutral, or pleasant. For example, walking around the block with a coworker or having a break to resource and listen to music. When integrated healthcare providers are familiar with tracking, resourcing, grounding, Reset Now!, self-soothing gestures, and the shift & stay wellness skills, there is a foundation to build on to identify creative ways to support clients with learning and practicing these wellness skills together.
CHAPTER 5

Methodology

Self-Reflection

Decolonization requires structural changes that center Indigenous peoples on their terms. I aimed to participate in knowledge development using a healing justice framework in social work research to address the root causes of historical trauma on housing instability among unhoused Indigenous people in Albuquerque (Pyles, 2020). Strategies to build connections between interpersonal healing and systems transformation is an overarching theme of the participatory efforts made toward identifying the appropriate methods, formulation of research questions, and thinking to position the research in relationship with Indigenous community organizers living in the Albuquerque area (Denetdale, 2016; Yazzie, 2018; Bernal and Trujillo, 2021; Estes et al., 202; Gersony, 2021; Pueblo Alliance, 2021). Critical-emancipatory research on resiliency-focused systems and structural change can build practice-based knowledge on ways to provide culturally relevant healthcare for Indigenous people (Tuhiwai Smith, 1995; Pyles & Svistova, 2015). My research interests are radicalized by my lived experiences of incarceration, residential treatment, and psychiatric hospitalization. Participating in community care has been an important part of my recovery and growth.

A critical-emancipatory lineage asks for me to lean into the tensions with the use of self in social work research and asks how to continuously center the people I am studying and researching with by inquiring into the dynamics of race and class clients' experience with integrated healthcare providers and security in community-based integrated healthcare settings. Sofia Villenas (1995), who informs the critical-emancipatory lineage of action research, encourages self-reflection within the complexities of the borderlands, the Indigenous lands, rivers, oceans, bioregions, and migratory life pathways. Divided by the militarized nation-state
borders of Mexico and the U.S. Many people have been torn away from and cut off from sensory ties to their Indigenous languages, cultures, and lands. The Indian removal laws in the U.S. and U.S. territories, boarding schools, tourism, and resource extraction are methods of Indigenous erasure by tribal disenrollment, to no longer be recognized by the federal government for Native Americans, Alaska Native, Native Hawaiian, and Native Pacific Islander peoples. Ongoing self-reflection on decolonization not being a metaphor or intellectual liberal agenda. Colonialism is a structure, and bordertowns are sites of violence. My role as a social work researcher ethically asks me to be explicit about the realities of colonial violence to not perpetuate economies of health inequity that profit off silence (Stanley, 2020).

**Research Setting**

The setting for this study was initiated at the First Nations Community HealthSource (FNCH), a federally qualified Community Health Center and Indian Health Services (IHS) urban Indian health center in Albuquerque. Key informant participants were recruited across community-based agencies that serve Native Americans and are members of the Housing and Urban Development (HUD) Continuum of Care (COC) coordinating organization, the New Mexico Coalition to End Homelessness (NMCEH). Integrated healthcare providers and clients participated from seven different sites: FNCH, NMCEH, the city of Albuquerque, Westside Emergency Housing Center (WESC), Bernalillo County CARE Detox, Good Shepherd, HopeWorks, and Albuquerque Healthcare for the Homeless. Interviews were conducted in person at the participant's preferred community location or over zoom based on participant preferences. Interviews took place on park benches, in a shelter, on cafe patios, and in vehicles.
Initial Field Notes on Social and Economic Barriers to Health Determinants

Collective experiences of crises among integrated healthcare providers on the FNCH Homeless Outreach Program (HOP) MHT shaped this study’s preliminary stages, onset, and course. Escalated crises between unhoused clients and integrated healthcare providers were observed by the HOP Safety Subcommittee (HOPSS) to disproportionately occur with overuse of 911 and security force compared to the overall primary care client population. HOP integrated healthcare providers continued to raise concerns about safety, bias, and the number of safety incidents involving more than 50 clients in the past year. Discussion among HOPSS participants about developing a comprehensive safety strategy began during MHT meetings in October 2019. Before the onset of the pandemic, a collaborative approach was used to facilitate meetings to engage all program staff, including case managers, supervisors, nurses, medical assistants, clinicians, medical office reception, benefits specialists, and medical providers, to obtain consensus on crisis prevention priority areas that needed administrative support for organizational change. After the pandemic onset, team meetings decreased and were not well attended on zoom. Attendance was impacted by increased demand for integrated healthcare providers to cover shifts at city quarantine hotels and shelters, limited access to the technology needed for HIPAA Zoom meetings, increased ethical distress, and staff turnover.

The purpose, strategy, and desired outcomes were detailed; however, with the onset of the pandemic in March 2021 in New Mexico, further implementation of the improvement effort was delayed. Factors compounding crises continued to be observed and escalated during incidents when clients and integrated healthcare providers were under organizational and structural conditions constraining resiliency. Safety incidents increased in the parking lot because clients could not walk into a clinic building as they could before the pandemic. Clients could not
rest indoors by sitting in the lobby due to state-mandated COVID-19 social distancing capacities. The medical observation room in the clinic was at capacity more often. Clients were not permitted to enter the clinic without a scheduled appointment to see an integrated healthcare provider or could not be seen during walk-in hours. Therefore, clients were outdoors in the parking lot facing pandemic-related challenges to receive services, and integrated healthcare providers were trying to find ways to meet client needs under strained conditions.

Several factors contributed to a client not being able to obtain the required COVID-19 test result to stay at a safe house, community shelter, medical detox, or residential treatment program. A client without symptoms for two weeks or more could not obtain proof of negative test result if they had tested positive in the past three months, could not access test records from the Department of Health (DOH) website, could not obtain a rapid test due to lack of symptoms, the shelter or treatment program did not accept a rapid test, or the accepted test did not occur within the designated testing window usually within the past 48 hours. A stressor for everyone involved.

Urgent behavioral healthcare needs were not met in time due to limited provider availability or escalation in the lobby with front office reception when not able to see their primary care provider as a walk-in that day, obtain any medication refills, or obtain a specialist care referral. Clients could not establish case management for chronic health issues as a result of not having a phone, not having cell phone service at the shelter, missing scheduled appointments, transportation barriers with lower capacity regulations for public busses, not arriving for morning walk-in before the capacity for the day, and services not provided out of office. Clients who presented to the clinic seeking medical detox were not able to obtain the prescribed medications needed for the duration of their time in treatment as per detox program rules due to insurance.
refill limitations; when medications were lost or stolen, the client was not able to be seen by a medical provider to obtain a refill due to provider off-site or no availability, and client not being able to get medications refilled in time before detox beds were filled due to pharmacy volume.

**Participatory Processes Toward a Research Focus**

In January 2020, the Chief Executive Officer (CEO) adopted a quality improvement effort as part of the agency's trauma-informed care initiative to develop and implement a comprehensive safety strategy. HOP staff and program administrators were to create and implement a comprehensive safety strategy to decrease the occurrence and recurrence of safety incidents and increase the clients' and integrated healthcare providers' self-reported safety. Meetings to further develop and implement the comprehensive safety strategy were placed on hold to adapt to emerging COVID-related crisis needs. Project specific meetings continued in June 2020. Leadership emphasized that the initiative was to strengthen the program and its staff to address the needs of its clients effectively and efficiently. The comprehensive safety strategy was designed for the program’s integrated healthcare providers and administrators to be responsible for tracking safety incidents that can range from verbal to physical incidents. Nearly all the safety incidents that occurred the year prior involved HOP clients.

Members of the HOP safety team subcommittee conducted investigations into issues around safety needs among its programs, including activating events, escalating factors, the effectiveness of its existing interventions, outcomes of its current interventions, and lessons learned for preventing or decreasing recurrences. Trends were analyzed that could serve as markers for improving the program (e.g., adjusting internal procedures, screening, services). The HOP safety subcommittee made recommendations to increase the safety of its program users and staff. Integrated healthcare providers and program administrators were cognizant of minimizing
barriers to care to ensure clients have access to needed program services and adopt a flexible approach that can be individualized to each client’s level of functioning.

**Desired Outcomes.** The effectiveness of the comprehensive safety strategy was assessed following the agreed-upon guidelines. Fewer preventable safety incidents as measured by the number of incident reports documented with human resources and security involving an unhoused client. A reduced number of clients who are temporarily or permanently banned from program services as measured by the number of clients on bans. As measured by survey response, an increased understanding and knowledge level about the context of the safety needs for unhoused clients and what safety action steps to undertake.

A baseline survey was conducted in March 2021 with 11 relevant staff on well-being, behavioral health, level of preparedness for a crisis, stabilization, and prevention; satisfaction with management; effectiveness of communication; perceived safety, and factors for feeling unsafe or safe. The baseline staff survey identified two key areas of strength: 1.) the importance of behavioral health at an agency, and 2.) management informed on safety procedures. Two key areas for improvement identified during the baseline staff survey were: 1.) communication across programs; and 2.) training preparedness for crisis response, de-escalation, stabilization, and prevention. Two key challenges identified were: 1.) perceived priority of client safety over the safety of staff; and 2.) staff screening HOP clients for COVID-19 (i.e., questions, temperature checks) overall reported feeling the least safe when compared to members of their team.

The stressors of working at a clinic in an unserved and underserved community during the pandemic were observed system wide. The location where crises were increasingly observed moved from lobbies to outside with frontline workers, specifically COVID-19 screeners. The HOP safety team subcommittee identified a preference for trauma and resiliency-informed
approach informed by current research evidence on staff and client well-being. A pilot CRM training was implemented with COVID-19 screeners as an initial response to assess the relevance of The Wellness Skills to enhance frontline worker response and understanding. The training was scheduled for two hours at the request of key stakeholders. The pilot CRM training for eight COVID-19 screeners provided a generative space to identify relevant practice scenarios, and link screener identified challenges to skills to support self-regulation and co-regulation for de-escalation and crisis prevention. The Reset Now! skills were the most relevant for crisis response in the parking lot at screening locations.

Additionally, to increase understanding among frontline workers about different clinic flows and how they can support clients to meet the needs patients present to the clinic (e.g., medication refill, walk-in medical, specialty referral, wound care, labs, behavioral health, COVID test, detox, clothing, mail, hygiene). Training satisfaction with learning objectives, instruction, content, teaching methods, relevancy, and the location was overall a 4.5 on a 1 (poor) to 5(excellent) scale. Feedback from the eight participants emphasized having more time: 1) for additional training and 2) applying skills to different practice scenarios from daily encounters.

**Questions for Research Interview Tools.** An Appreciative Inquiry (AI) approach shaped the topic of the key informant interview guide questions to maintain integrity across phases and levels of intervention by centering a strengths-based understanding on what is working when crises are prevented and what can be learned from these experiences to direct growth. Rather than taking a problem or deficit focus, the poetic principle of AI provides the formative concept that what we focus on grows, “Human systems grow in the direction of their deepest and most frequent inquiries” (Cooperrider et al., 2003, p. 37). The AI strengths-based approach to human systems and organizational change is congruent with the biological resiliency focus of CRM.
informed by research on neuroplasticity, emphasizing that where we put our attention grows, “where attention goes, neural firing flows, and neural connection grows” (Siegal, 2018; Miller-Karas, 2020). FNCH leadership encouraged a focus on what is working. These strengths are already present to support growth from these collective stories and experiences to generate knowledge on how to deepen and expand community resiliency for crisis prevention. The HOP safety subcommittee developed the interview guide questions for integrated healthcare providers and clients to inform a process model further to implement CRM as part of a comprehensive safety strategy. The interview questions were shaped to elicit participant stories, experiences, and reflections on themes of safety, crisis prevention, trauma-informed, and resiliency-focused in ways relevant to their daily lives in community-based homeless services. At the heart of the questions is the CRM ethos to build resilience and awaken hope that can sometimes be lost when a community is experiencing multiple, compounding systemic barriers to housing stability.

**Project Design**

The researcher utilized a qualitative key informant methodology to apply a culturally responsive and resilience-focused framework as a comprehensive strategy to develop a process model to implement CRM within a local COC. Qualitative methods encourage nuance and depth for the socially conscious researcher to distinguish the complexities among social systems, relationship dynamics, and the individual research participants in different contexts (Padgett, 2016). Conventional content analysis during open coding supported the identification of a relevant theory to the use of a directed content approach for the integration of an ecological lens on RCT to build on the framework of the person and environment by identifying key concepts during focused coding toward categories on crisis prevention (Gunderson, Prussia, & Larson, 202; Hsieh & Shannon, 2005; Prussia, 2019). The primary researcher constructed
meaning with volunteer key informants through this project using preliminary field notes and interviews. The semi-structured interview tool allowed for flexibility to explore how each participant experienced different interpersonal dynamics during crisis response when a crisis was de-escalated and stabilized. They also recalled what was present in the relationship when crises were prevented. An emphasis on prevention deepened inquiry into what it is about the relationship between clients and integrated healthcare providers that is crucial for crisis response and de-escalation. Grounding the perspectives on safety, stabilization, and prevention to inform a comprehensive safety strategy. An understanding was gained from participants of the qualities of relationships they experienced to prevent crisis and enhance access to care for Native people in Albuquerque. Analysis of key informant interviews integrates the constant comparative method to thematic coding using an iterative process to weave theoretical sampling simultaneously with the coding process.

**Sampling and Recruitment**

A combination of convenience and maximum variation sampling methods was used to select this study's participants. The sampling strategy for integrated healthcare providers targeted participants in different roles represented on multidisciplinary teams across several member agencies in the COC serving Native people experiencing houselessness. The primary researcher built on established connections from fieldwork to directly recruit participants. The sampling strategy for clients targeted participants who integrated healthcare providers identified to represent diverse demographics and life experiences of the total Native population in the COC. Support from COC member agencies was emphasized during outreach for the recruitment of clients. Integrated healthcare providers also distributed emails and flyers to recruit client participants at program sites. All voluntary participants enrolled in the study initially contacted
the primary researcher by voice message, text, or email as requested on the recruitment flier 
(Appendix B).

**Participant Criteria**

Integrated healthcare providers have worked at an NMCEH COC member agency since 
the onset of the COVID-19 pandemic in March 2020. Integrated healthcare providers completed 
an integrated healthcare provider Questionnaire (Appendix C) and indicated if they met the 
inclusion criteria based on their answers. The initial questionnaire screened to assure the 
participants work or have worked at an NMCEH COC member agency. Their job duties 
emphasize providing direct services to clients experiencing houselessness and serving clients 
who self-identify as Native American.

Clients receive services at a COC member agency in Albuquerque, self-identify as Native 
American, are currently living in Albuquerque, and have experienced houselessness for one night 
in the past month or three times in the 12 months using the HUD definition of “literally 
homeless” (HUD, 2012):

Individual or family who lacks a fixed, regular, and adequate nighttime residence, 
meaning:

(i) Has a primary nighttime residence that is a public or private place not meant for 
human habitation:

(ii) Is living in a publicly or privately operated shelter designated to provide 
temporary living arrangements (including congregate shelters, transitional 
housing, and hotels and motels paid for by charitable organizations or by federal, 
state, and local government programs); or

(iii) Is exiting an institution where (s)he has resided for 90 days or less and who
resided in an emergency shelter or place not meant for human habitation immediately before entering that institution

**Human Subjects Research**

This study required the University of Pennsylvania Institutional Review Board (IRB) approval. Before being interviewed, participants completed an IRB-approved consent form. All participants were voluntarily enrolled in the study by contacting the primary researcher via email or phone (Appendix B). Interested respondents were provided with a copy of the informed consent form (Appendix G), obtaining consent through written informed consent procedures. The primary researcher held sole responsibility for consent procedures and the obtention of consent. After initial contact and obtaining informed consent, participants were screened over telephone or email. They completed one of the two questionnaire forms for study screening (Appendix C and Appendix D) to ensure inclusion criteria were met. During screening phone calls, texts, and emails, the primary researcher answered any questions about consent or participation in the study. Interested participants were scheduled for face-to-face or zoom interviews in 90-minute time blocks. Arrangements were made to obtain written consent signatures using appropriate COVID-19 social distancing measures. Digital data and documentation of completed consents and screening are maintained in secure digital files, and completed forms are located within the primary researcher’s office. Participant hard copy responses on paper forms will be shredded after completing the project.

**Data Collection Methods**

**Semi-Structured Interview**

Interviews consisted of one 90-minute meeting, a follow-up session (i.e., one or two) for clarification as needed, and a semi-structured qualitative design. The purpose of the follow-up
sessions was to discuss theoretical content as it emerged during coding processes. Themes were clarified with participants to ground model development and bend toward dialog with complexity and difference. The focus of the study was to understand what safety and crisis prevention has looked like for Native people experiencing houselessness in Albuquerque. The study looked at the perspectives of both unhoused adults who self-identify as Native American and integrated healthcare providers at community-based organizations serving Native people who are experiencing houselessness. The interviews included gathering information about participants’ experiences:

1. What is the relationship like during a crisis?
2. How are services accessed or not during a crisis?
3. How is crisis prevention best approached?
4. Does the relationship shape housing stability?

The interviews have informed the development of a process model grounded in the experiences of participants from community-based homeless services for the implementation of CRM to effectively respond to local culture, practices, and policies within the New Mexico Coalition to End Homelessness (NMCEH), Continuum of Care (CoC) member agencies in Albuquerque serving Indigenous peoples.

**Data Analysis Methods**

An iterative, recursive approach to data collection, congruent with analysis, has been used. Constant comparison and reflection have supported the researcher and assisted coders in constructing meanings from field notes, interviews, transcripts, and code snippets. The primary researcher brought radical empathetic attention and a non-judgmental stance to support participants to engage with difficult content regarding crisis contexts to allow participants to
have space for shifts in meaning during interviews and for any new awareness to emerge.

Heuristic analysis during the interview process centered on collaboration between the researcher and the participant to assure the researcher understood the narrative (Moustakas, 1990). Moustakas (1990) identified the aim of heuristic methods to be *discovery*:

“A way of self-inquiry and dialogue with others aimed at finding the underlying meanings of important human experiences. The deepest currents of meaning and knowledge take place within the individual through one's senses, perceptions, beliefs, and judgments. This requires a passionate, disciplined commitment to remain with a question intensely and continuously until it is illuminated or answered” (p. 15).

To promote transparency and reduce the impact of implicit bias from the researcher’s own experiences on the interpretation process, the researcher has engaged in self-reflection on experiences of crisis with clients as an integrated healthcare provider. Data analysis included a constant comparative analysis of codes toward identified themes on individual, organization, and structural facilitators and barriers to resiliency in crisis prevention for a COC serving unhoused Indigenous people. Memo-writing was used to build interactive theoretical analysis into the research process early on. Memos were an important method used to move with the narratives during coding toward theoretical categories using initial notes to refine and integrate insights into an emergent analysis informed by the participants’ experiences and theoretical concepts (Padgett, 2016).

**Data Management Methods**

All participant interviews were scheduled and stored on a secure university email cloud drive. Additionally, participants received a call, text, or email reminder for their interview 48 hours before the interview session date through a HIPAA-compliant system. The researcher
tracked the collection and storage of participants’ interview data using a secure electronic database for confidentiality per HIPAA requirements.
CHAPTER 6

Findings

This study aims to generate knowledge on crisis prevention to inform the implementation of a public health model using content analysis of key informant interviews. A total of twenty-four adults, precisely fourteen clients, and ten integrated healthcare providers, consented to participate. All participants completed a semi-structured interview, and pseudonyms were used. These interviews occurred considering the impact of social determinants on interpersonal, organizational, and environmental contexts of relationships looking at resilience factors that prevent a crisis.

Figure 6: MHT factors, in red, are shaped by interpersonal and organizational factors

All fourteen client participants self-identified as Native American because this was an inclusion criterion for client participants. All ten integrated healthcare provider participants had
worked in homeless services for more than a year and during the pandemic at their interview as per study inclusion criteria. They have all been assigned an alias to maintain their confidentiality.

<table>
<thead>
<tr>
<th>Description</th>
<th>Clients N=14</th>
<th>Description</th>
<th>Integrated Healthcare Providers N=10</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL Participants N=24</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th></th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transgender Woman</td>
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<td>Cisgender Women</td>
</tr>
<tr>
<td>Cisgender Woman</td>
<td>8</td>
<td>Cisgender Men</td>
</tr>
<tr>
<td>Cisgender Man</td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Self-Identified Race</th>
<th></th>
<th>Self-Identified Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>Native American</td>
<td>11</td>
<td>Dine' (Navajo)</td>
</tr>
<tr>
<td>Native American and Black</td>
<td>1</td>
<td>Hispanic</td>
</tr>
<tr>
<td>Native American and Mexican</td>
<td>1</td>
<td>White</td>
</tr>
<tr>
<td>Native American and White</td>
<td>1</td>
<td>White and Chippewa</td>
</tr>
<tr>
<td>Dine' / Zuni / Apache</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tribal Affiliation</th>
<th></th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apache</td>
<td>1</td>
<td>Behavioral Health</td>
</tr>
<tr>
<td>Cherokee</td>
<td>1</td>
<td>Clinician</td>
</tr>
<tr>
<td>Dine' (Navajo)</td>
<td>5</td>
<td>Case Manager</td>
</tr>
<tr>
<td>Laguna Pueblo</td>
<td>2</td>
<td>Physician Assistant Intern</td>
</tr>
<tr>
<td>San Juan Pueblo</td>
<td>1</td>
<td>Outreach</td>
</tr>
<tr>
<td>Shoshone</td>
<td>1</td>
<td>Primary Care Provider</td>
</tr>
<tr>
<td>Zuni Pueblo</td>
<td>2</td>
<td>Program Supervisor</td>
</tr>
<tr>
<td>Zuni / Hopi / Dine'</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Table 2: Participant demographics

Several integrated healthcare providers requested to not have the agency they work at be named because disclosure on this detail would raise questions in the workplace. Client participants were interviewed in a public setting preferred by the client including on park benches and in shelter.
Client participants reported experiencing houselessness for periods ranging from one month (i.e., minimum inclusion criteria) to twelve years with a mean of 2.68 years. Ten out of fourteen client participants reported having experienced houselessness for more than one year. Two years was the mode and median. The question, where did you sleep last night also reflected in this group of participants the client's preference given their options.

<table>
<thead>
<tr>
<th>Where did you sleep last night?</th>
<th>Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outside</td>
<td>3</td>
</tr>
<tr>
<td>Good Shepherd Center <em>(men’s shelter)</em></td>
<td>2</td>
</tr>
<tr>
<td>Motel</td>
<td>1</td>
</tr>
<tr>
<td>CARE Detox (county)</td>
<td>1</td>
</tr>
<tr>
<td>Westside Emergency Housing Center WEHC <em>(city shelter)</em></td>
<td>7</td>
</tr>
</tbody>
</table>

*Table 3: Participant houselessness*

Clients who stated they preferred to sleep outside reported issues of safety in the men’s dorm at the city shelter and transphobia in the women’s dorm as a primary reason to sleep outside. Clients who reported staying at the Good Shepard were on probation and identified as cisgender men. All city shelter participants where cis women who reported feeling safer in shelter than sleeping outside.

**Interpersonal Resilience**

Constant comparative analysis occurred throughout the three stages of coding between all participant descriptions of their experiences during crisis prevention. First, analysis of initial line by line coding of interview transcripts occurred on individual, organizational, and systemic facilitators or barriers to resiliency during crisis prevention. Second, focused coding identified the themes of *relationship* and *attention* as individual level facilitators. Third, theoretical coding
was used to understand the core dynamics of crisis prevention in relation to relational-cultural theory (RCT), research on interpersonal neurobiology, wellness skills, somatic literacy, seeking safety, solution-focused, and motivational interviewing (Jordan, 2018; Lutz, 2014; Miller-Karas, 2015; Miller and Rollnick, 2013; Najavits, 2002; Ogden, 2009; Ogden, 2020; Schwartz, 2021; Stanley, 2016).

During interviews four probing questions on the quality of relationship were explored with participants:

1. Can you share about a time when you felt supported during a crisis?
2. Can you share about a time when you felt a crisis was prevented?
3. Can you share what is different when your safety needs are met?
4. What are your safety needs when working with an integrated healthcare provider during a time of crisis?

Figure 7: Qualitative coding terms generalized for descriptive purpose (Hahn, 2008)
These probing questions on the quality of relationship brought up the importance of presence for the integrated healthcare provider in relationship with a client. A crisis was reported to escalate when there were barriers to warmth and listening in the helping relationship.

The question of quality of relationship during crisis is concerned with the facilitators of resiliency to expand the zone of well-being at the center where someone feels a range of positive and negative emotions at a level that is manageable when the sympathetic or parasympathetic responses are activated.

<table>
<thead>
<tr>
<th>Window of Tolerance</th>
<th>Resilience Zone</th>
<th>Polyaugal Theory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperarousal</td>
<td>The High Zone</td>
<td>The Sympathetic Response</td>
</tr>
<tr>
<td>Window of Tolerance</td>
<td>The OK Zone</td>
<td>Ventral Vagal</td>
</tr>
<tr>
<td>Hypoarousal</td>
<td>The Low Zone</td>
<td>Dorsal Vagal</td>
</tr>
</tbody>
</table>

Table 4: The Zone of Well-Being or the OK Zone

The resilience zone or the “OK Zone” in CRM is more generally called “the window of tolerance” by Daniel Siegal or “ventral vagal” by Stephen Porges (Ogden, 2009; Ogden, 2020). Siegel and Porges, respectively, describe what is occurring when traumatic stress activation is in the high zone or the low zone (Ogden, 2009; Miller-Karas, 2015). The OK Zone is when there is manageable to no cumulative stress or traumatic stress activation supportive of growth, learning, and well-being.

Crisis prevention as described by the client and integrated healthcare provider participants involved an interactive dynamic between the quality of the relationship and what the integrated healthcare provider paid attention to. The underlying relational components of (MI) (i.e., compassion, acceptance, collaboration, and evocation) were described in different ways by
integrated healthcare providers during their interviews (Miller and Rollnick, 2013). However, kindness received by clients was reported to be essential to their experiences of de-escalation and safety. Kindness received was described by clients during scenarios which integrated healthcare providers described providing compassion in care. The way of being, as understood in MI, is the relational foundation to engaging before putting attention on the focusing, evoking, and planning phases (Miller and Rollnick, 2013).

**Belonging in Relationship Through Crisis**

Focused coding on *relationship* supported the identification of the initial codes: *warmth*, understanding, belonging, and focusing. Focused coding on *attention* supported the identification of the initial attention codes: remember, listen, strengths, and time. The relationship and attention codes are analyzed and further clarified the interpersonal context to the client and integrated healthcare provider relationship during crisis prevention. Participant perspectives on the interpersonal facilitators of resilience are analyzed below using theoretical sampling on interpersonal neurobiology, seeking safety, CRM, solution-focused, and MI to understand how the qualities of the relationship are described during crisis prevention to feel safe enough to connect and feel resonance in connection to people and the physical world.

**The Sensory Connections of Belonging**

All client participants identified the quality of kindness the most frequently during crisis stabilization and prevention. The quality of kindness has a warmth in presence “the way they talk to you”, “non-judgmentally”, “respectful”, “the way they treat you”, “patience”, “considerate”, “cared for”, “kinship” and “almost love”. Amy Banks (2015) highlights how the mesolimbic dopamine system in the brain begins at the brainstem, connects to emotions and feeling in the amygdala, then is relayed and processed at the thalamus to the orbitomedial prefrontal cortex
where the decision on what to do in response to the incoming sensory information (Banks, 2015). Specifically, when in a growth-fostering relationship there is a dopamine reward response that can give people the feeling of zest like a warmth, sense of motivation, or glow (Banks, 2015).

Kindness is soothing to mobilizing defenses learned from attachment patterns growing up (Lutz, 2014; Miller-Karas, 2015). People are coming from many different experiences and sometimes issues compounding crises can go back to childhood. A client with a history of multiple familial losses had also experienced recent staff turnover on her care team. She recalled several integrated healthcare providers who worked in collaboration with her through a difficult time when she struggled with disconnection and thoughts to kill herself:

I trust them a lot. Because they talk to me in a good way. They don't yell at me or get after me for my drinking. They talk to me calmly. Seems they were the only ones who I trusted mainly more than anybody else. I just felt comfortable with them and I felt safe around them. For them being there for me when I need to talk to somebody or every time I need their help and support with staying positive. I started to think about my family, my daughters, and my grandkids that I'm not alone in what I'm going through. [Jeannette Nez]

Her well-being depends on reciprocal experiences of belonging in safe relationships because this is where the feeling of being worthwhile and valued comes from (Jordan, 2018a). The strategy of suicide to no longer feel the pain of disconnection was addressed in the relationship by supporting her to reconnect to the relational images of family members from a place of worth (Jordan, 2018a; O’Keefe et al., 2014). During crisis response, de-escalation, and stabilization an integrated healthcare provider can be a guide for a client to reconnect when meeting and this is essential to foster the desire for more connection needed for prevention (Jordan, 2018b).
The experience for a client to feel safe in relationship is understood to be an interpersonal process where the connection supports the ventral vagus nerve or the smart vagus with the co-regulation needed for a good tone to calm fight/flight/freeze responses of disconnection learned for survival (Banks, 2011, p. 27; Schwartz, 2021; Stanley, 2016). A client can learn to self-regulate through mutual connectedness and safety in relationship with a trusted integrated healthcare provider (Schwartz, 2021). A client who shared about a diagnosis of PTSD and experience seeking connection at a community health center:

Some, mostly, all of them will actually touch your shoulder, or try to give you a hug, you know, I see that they're trying to connect with my heart. And they see my heart is hurting. They're, like, sympathetic towards me. And, and I like that, you know, because I feel like I'm all alone. And when they try to reach out to me like that, I feel like they actually care and almost love me. And, you know, complete strangers and stuff. And then they actually want to sit down with you and talk to you. They go Hey, what's going on? How can I help you? How can I ease this pain you're going through? And that's why I really like going there. Any other place I’m just an Indian you know? [Liam Chavez]

The connection he describes with Indigenous providers reflects a sense of worth in connection to healthy recovery relationships in the community. A sense of worth is associated with reduced stress response activation, negative consequences of alcohol use, and builds resilience that mitigates the health effects of trauma (Jordan, 2018a). A person living with the impacts of traumatic stress, suffers from intrusive thoughts, memories, changes in cognition, changes in mood, avoidance, and issues with high/low arousal. A sense of worth in a relationship can calm survival responses activated when false alarms go off from perceived threats to acceptance (Banks, 2015).
The relational foundation described between clients and integrated healthcare providers during crisis stabilization reflect experiences of attunement in presence and resonance. A participant reflects on what it is like for her to feel seen and heard by an integrated healthcare provider:

That I do exist and that I am being cared for and not suffering in silence.

[Valencia Yazzie]

Mirroring systems are neural pathways in the brain that support deep nonverbal communication allowing someone to feel sensations of connection on an interpersonal level when taking in another person's facial expressions, changes of skin color, tone of voice, posture, laughter, and the inner felt sensations of another like pain or warmth (Banks, 2015). The mirroring system allows us to functionally mimic another person for social learning and to have the emotional intelligence of empathy to feel what another person is going through (Banks, 2015). Five out of ten participants emphasized the empathic response felt in kinship to integrated healthcare providers who were also Indigenous.

That's really why I like First Nations, because there are native people, they're just like me, maybe not the same tribe, but I kind of feel like a kinship with them. And I go there, and they helped me out a lot. You know, they hear my worries, what I'm going through, my struggles, and I really feel like they're there, honestly, to help me. They want to see me succeed. [Liam Chavez]

The qualities of relationship during crisis stabilization and prevention describe the importance of a safe connection in a growth-fostering relationship before collaborating to identify what actions to take together.
Integrated healthcare providers identify the quality of compassion as their experience of being in relationship during crisis stabilization and prevention: “being present”, “time and attention”, “patience”, “acceptance of where they are at”, “validate”, “holding space”, “assist them in recalling their strengths”, and “talk about available resources”. An integrated healthcare provider shared information about a client who did not arrive during the open walk-in hours to complete a new client intake with an outreach case manager. Even when a program is closed he emphasized how critical it is to take the time to understand why a client is there in order to identify urgent service needs and next steps.

I just think about how I would want to be treated, you know, the empathy part is very important to me. So, I do think about each encounter, and how I talk to somebody.

Because I've been treated pretty badly in life too, so, I know what bad customer service is. [Robert Begay]

In this case, the issue of human trafficking was identified, a specific program was called, and the client was able to complete an intake with them that day. In this example, the integrated healthcare provider effectively communicated to the client that she was accepted.

Compassion toward clients during crisis response and prevention is described by integrated healthcare providers as always acting to alleviate their suffering (Miller and Rollnick, 2013). While the felt sense of connection is interpersonal the two components of kindness received and taking compassionate action are differentiated and interacting. It’s important to distinguish the differences between kindness received and compassion in care. Compassion is a source of warmth but not the warmth itself. A client’s felt sense of connection is the warmth experienced with a shift in awareness from suffering in disconnection to connection with an integrated healthcare provider whom the client feels accepted. Attunement to what are relevant
needs is fundamental to compassion because intentions for an action need to actually alleviate suffering.

An integrated healthcare provider reflects on her experience of the felt sense of connection providing compassionate care during crisis prevention:

Sometimes it's also just being quiet and being the ears without words. Not that nobody signals or vibes aren’t being given off. I believe my higher power gives me a positive energy to give out and that helps me. Everyone's beliefs are different. In god, universe, something good to feel in self and release then that helps to ground the situation somehow. I don’t know sometimes how I have that touch. But I don’t always know how I did but after I’m like oh, I just helped to prevent a suicide, or that person is not going to kill themselves, I’ve helped them to be safe. [Bobbie Montoya]

Without the felt sense of connection then the actions taken can be hurried and center what the integrated healthcare provider thinks is helpful without knowing more about what is going on or what the client is motivated to change. When an integrated healthcare provider can use their inner resources to feel grounded during a crisis then they can help a client to transform states of distress as a guide with their “quality of presence” (Miller-Karas, 2015; Stanley, 2016; Jordan, 2018, p. 99). Acceptance is more than a positive intent during crisis response, stabilization, and prevention. Together a calming and accepting presence supports a client to have a sense of belonging on the interpersonal level. Compassion is explicit by identifying what actions to take and implicit with the sense of connection. We are hardwired to connect, and it is critical to understand the biological underpinnings for a desire to connect as an inherent resilience to cultivate (Banks, 2015). A key facilitator for interpersonal resilience is the quality of presence
and resonance felt when an integrated healthcare provider can offer a compassionate presence for the client to know they are accepted and feel a sense of worth (Banks, 2015).

**A Shared Understanding of Hope in Recovery**

Client participants identified feeling heard during communication as the second most important quality of relationship during crisis stabilization and prevention. Seven out of ten clients expressed feeling heard during communication with an integrated healthcare provider. Clients described feeling heard during culturally relevant, focused conversations about their whole health recovery. Participant clients identified integrated healthcare providers who had a shared understanding of what they were going through when the provider is “Native like me”, “from my pueblo”, “Navajo too”, has lived experience with addiction and/or houselessness, from a shared culture, is engaged in shared religious or spiritual practice, and is informed about skills that can bring relief to social and physical pain. The process of building trust is ongoing and described by clients to begin with a culturally responsive welcoming to consistently express respect.

Generally, a formality of kindness or of being recognized or acknowledged. In Native American terms, where she's saying like, Hello darling, how are you doing? You know, that type of sincerity. If I'm feeling hopeless, if I'm feeling down depressed, you know, I can go there for that comfort. And immediately somebody will greet me and give me a hug. And ask me, are you okay? You know, that type of recognition stuff where people are throwing up their sincerity is about the best feeling that you can receive, especially in the environment that I'm in. [Tamika Baca]

Participants emphasize not jumping right into problem-solving because establishing safety and connection are important to not overlook to collaborate together on building a shared
understanding of what the client is going through and what they need. An integrated healthcare provider describes how he approaches being culturally responsive in this manner:

So, like, for me, growing up, you're always taught, when you introduce yourself, or meet somebody here, you introduce yourself, traditionally, or it's out of respect, you do it respectfully, it's never like, Oh, hi, my name is so and so. And just being straight out friends, culturally, it's brought out with respect. And so, a lot of people that I met when I was working [here], that's how they would interact, they would see that and they would understand that, especially the older population, that's how they connected with people. It’s what they knew. You would say hello and then you would offer them something to drink, something to eat, something so that they feel comfortable. You let them know that this is safe, like, whatever you need, you can come here and then start from there building a relationship or talking to them and start building the connection. [Isaiah Norberto]

The etiquette for welcoming someone, making introductions, informed consent, and establishing or maintaining connections are more than sharing names or job titles. It is also more about who you are than what you have done. For example, an integrated healthcare provider is encouraged to share about their family, birthplace, and where they grew up as well as be mindful about the tone of voice, and pacing, and not impose values (SAMHSA, 2018).

Formalities, greetings, and introductions with clients during a crisis will vary for the initial response, de-escalation, stabilization, and prevention emphasizing what is the most important approach to support an integrated healthcare provider to begin to establish enough connection for the client, “to know who you are before deciding if they should trust you” (SAMHSA, 2018, p. 55). Typically for crisis response and de-escalation, this will include informed consent (Stanley et al., 2018; Stanley & Brown, 2012; Stanley & Brown, 2009).
Trustworthiness is a core principle of trauma-informed care (Harris & Fallot, 2001; Battaglia et al., 2003; Elliot et al., 2005; Fallot & Harris, 2009; Hopper et al. 2014; SAMHSA, 2014; Wolf et al., 2014). Recognizing the impacts of historical trauma is fundamental to integrity of care with Indigenous people (Brave Heart, 2003; Brave Heart et al., 2011; Evans-Campbell, 2008; Goodkind et al., 2010; Goodkind et al., 2012; Mohatt et al., 2014; Kirmayer et al., 2014; Burnette, 2015; Burnette and Figley, 2017). Honesty about the impacts of colonial violence on relationships with institutions, systems of care and providers, specifically mistrust, and strategies toward healthcare systems transformation are all a part of trauma-informed care (Bereiter & Brave Heart, 2017; SAMHSA, 2018). For an integrated healthcare provider, especially in a fast-paced environment, to take a moment to calmly acknowledge a client in a warm and respectful manner is a culturally responsive practice of hospitality (Thistle and Smylie, 2020).

Integrated healthcare providers from multiple disciplines have historically demonstrated an inability to respond to the political and cultural realities facing Indigenous peoples and have not implemented interventions with the understanding of how colonial government policies result in health injustices (Gray et al., 2018). Participants who shared the experience of being heard emphasized two contributing factors including when there was a shared cultural understanding and when the provider shared about their relevant lived experience (e.g., walk the talk in recovery). These qualities were identified to be present when working with Indigenous providers and with non-Indigenous providers. A client participant reflects on her experience of feeling heard with a therapist who spoke her preferred language when she struggled with thoughts of suicide:
Yeah, I love to talk to [my counselor] because I trust her. Because she is Navajo and I am Navajo, so we talk in my language at times that's why I understand what she says, the way she talks with me, and I like her for that. [Jeanette Nez]

Another participant engaged in a traditional wellness program reflects on working with Indigenous providers, from different tribes, who disclosed a history of houselessness or being in recovery themselves and how this contributed to crisis prevention for her:

To communicate with them it's a lot easier for me to put myself out there and inform them of what it is that I need or what the help I'm asking for and they're there to try to extend their help and support as much as they can. [Tamika Baca]

Participants highlight that a collaborative provider is grounded in the point of view and perspective of the client to build rapport and facilitate trust in ways that are relevant to the client’s culture, understanding of the problem, and values.

A participant reflects on her experience with a Psychiatric Mental Health Nurse Practitioner (PMHNP) taking her perspective to understand the issues she had been struggling with regarding concentration, information processing, and dissociation. Particularly, the challenges to access outpatient psychiatric medication management.

She finally saw and started to understand what it is that I'm going through that is because I'm in recovery too and so she knew that it wasn't the drugs that was keeping me like that. [Valencia Yazzie]

The client identified drug user stigma to have been a primary barrier to treatment for her fleeing domestic violence. She shared she was repeatedly offered substance abuse treatment in the community after more than a year of no substance use while she was seeking treatment for her mental health issues.
For a provider, listening is not just hearing words, nonverbals, and being comfortable in silence, it is also being open to allow for what you are hearing to shape your understanding of the problem a client is describing and showing from their perspective. For crisis services received to be helpful then the services need to be relevant to the crisis. When a provider can understand the perspective of a client then a dynamic process can take place in the relationship because the care provided begins to become more relevant with a shared understanding of what recovery means to the client, presently in their life.

Clarifying together what can be addressed, while the client is present and oriented, offers an opportunity to get through a crisis and center the client’s agency to move forward toward the self-determined goals relevant to their recovery process (Grinwrigth, 2016; Miller & Rollnick, 2013; Schwartz, 2021). Hope is shaped by a shared understanding of what is possible. Community health centers have a responsibility to collaborate with a client and evoke their meanings and reasons (Miller & Rollnick). Judith Jordan brings forward a core tenant that, “Hope arises in relationship” and emerges “where change is deemed possible” (Jordan, 2018a, p. 129). A client shares about times when he had presented to a community health center in crisis and left feeling more hopeful:

Pretty much all the time I go there. I feel myself overwhelmed so I'll go there and seek counseling, some type of therapy. I go to the sweat lodge there too, as well, to cleanse myself, my body and my mind. Also, to get some prayer into the Creator, you know. And on top of that there's also other Native peoples who are like me, who go to that establishment. I hang out with them and laugh a little, make jokes with them. [Liam Chavez]
He shared about a way out of disconnection and the limitations of the separate self when supported to reconnect in relationships with integrated healthcare providers, traditional wellness, creator, and peers in a safe environment. Isolation and chronic disconnection are relational-ecological injustices caused by marginalization (Jordan, 2018a; Jordan, 2018b). Relational courage is present in encouraging relationships that facilitate confidence and belonging in recovery. In part, hope develops the courage needed for recovery to face the challenges at hand with community support (Jordan, 2018a; Jordan, 2018b). A key facilitator of interpersonal resilience is relational courage when an integrated healthcare provider can focus on clarifying a shared understanding of belonging in recovery with a client in crisis.

**Where Resonance Flows, Hope Can Grow**

Participants identified key recovery domains integrated healthcare providers focused on together during safety planning for crisis stabilization and prevention. Seven out of ten participants shared about the impact dependable continuity of care had on stabilization and growth in their recovery. These participants recalled their strengths being elicited, built on, and their stories remembered. Clients described their feeling-thoughts in relationships with integrated healthcare providers over a period while addressing challenges and completing tasks together toward housing stability. Clients identified multiple ways providers focused attention during crisis stabilization and prevention including: “encourage me”, “always try to find a solution no matter what”, “focus on the future”, “keep my thoughts positive”, “to see where I came from”, and “helping me learn how to be on my own”. Integrated healthcare providers described actions taken when clients were expressing mild, moderate, or severe signs of distress using a flexible approach to collaborate with clients to address the crisis together. All integrated healthcare providers identified domains to focus attention on throughout crisis stabilization and prevention.
including: “you need an action plan”, “get a sense of somebody's ability to regulate something”, “have their basic needs meet in order to focus”, “do whatever I can”, “be as helpful as possible”, “pulling the other resources in”, “care coordination”, “start rebuilding”, “let me show you how you can meet those needs”, “let's do it now”.

Being unhoused can contribute to chronic and serious issues of disconnection in relationships where clients learn to evade their needs, thoughts, emotions, and sensation (e.g., disconnect) as a survival strategy to have some sense of acceptance and safety (Miller & Stiver, 1997). Risks of connection for a person experiencing marginalization can include another rejection, being sent away, the possibility of being hurt, abuse, or denial (Giller, Vermilyea, & Steele, 2006). This is a central relational paradox. We are wired to connect, we need connections to survive and thrive like we need air and water, but because of trauma it can be hard to feel safe in a relationship and scary to connect (Jordan, 2018a; Jordan, 2018b). Establishing a shared understanding of the challenges of trying to connect when unhoused and in crisis can be an opportunity to build mutual empathy and enhance resilience. Relational resilience in the context of a crisis can support the trust to move toward a relationship when a connection is needed the most. The client can build their sense of relational competence and efficacy with an integrated healthcare provider who understands their strategies of disconnection. The experience of resonance and responsive care in a relationship diminishes isolation. Importantly, resilience is not a quality of character someone possesses within them because it is relational (Jordan, 2018).

Arriving to Safety and Recovery Planning

Regarding client empowerment, sometimes knowing what a client is ready, willing, and able to do can get complicated and distorted by hotspots, blindspots, or soft spots on a multidisciplinary healthcare team (Jordan, 2018a; Miller & Rollnick, 2013; Sandeen, Moore, &
Swanda, 2018). The courage of a client to collaborate together with an integrated healthcare provider and develop a strategy forward through a crisis is a risk for the client and requires a guiding approach (Jordan, 2018a; Miller & Rollnick, 2013). When an integrated healthcare provider can take a power-with, guiding approach, then the collaboration is attuned to the client's needs by finding a balance together between following and directing (e.g., guiding) (Jordan, 2018a; Miller & Rollnick, 2013). Encouraging a client to arrive to a safety plan together occurs through eliciting their desires for more connection (e.g., social network, family, friends, groups) from a place of having a secure base in relation to a trusted integrated healthcare provider. Hope can look like developing positive expectations for the future by making a tangible impact on a person’s life about what is possible and resolving the issue of burdensomeness (Banks, 2015; Davidson et al., 2010).

Learned helplessness has been described as the behavioral component of hopelessness (Jordan, 2018a). When a person feels overwhelmed and others in their environment are not responding with culturally relevant care then isolation, self-blame, shame, and immobilization can occur from the disconnection contributing to chronic disconnection (Jordan, 2018a). An integrated healthcare provider recalls a crisis where he advocated to provide increased support for a client who was struggling with, “significant mental health issues, heavy meth use, and attempting to flee a domestic violence situation”. He shared how she had started to detox herself and was working to get into a shelter, however, could not decide what to leave and what to take with her on the bus of her life belongings. He states she became increasingly overwhelmed feeling out of control thinking she can’t leave her abuser:

I did actually take and drop off some of the other stuff that couldn't go to the shelter somewhere else and then took her partway, you know, to the shelter and I kind of tried to
balance a lot. Okay, you got to choose some stuff, you know. And I couldn't even actually take her all the way to the shelter because they're supposed to enter on their own. But yeah, I allowed her to make the choice of actually getting over there, but I gave her some help along the way. I'm no neuroscientist, or anything, but this person, her ability to regulate the crises was so limited, you know, and so I was like, that's why I think she needed a greater degree of help, you know, to make the plan work. So long story short, there were a lot of ups and downs after that, but it was a significant boost in that she did keep on and then eventually, you know, work her way into housing, not that that's the whole solution, but that she had. I felt like it was a critical point where the situation could have gone on to be very destructive, you know. [Peter Laird]

Would it have been empowering for a provider, in her case, to say, ‘You can do this. All you need to do is just go to the shelter. They are expecting you. You got this’. Specifically, regarding this incident, different providers had different ideas about what she could or could not do independently at the time. The client expressed feeling helpless, experiencing an activated survival response, and trying to figure things out by herself did not feel manageable to her. Crisis prevention requires power-with relationships to create and implement safety plans together.

Discussing the core components of a safety plan enables members of the MHT to identify better what high or low activation can look like for the client and their green, yellow, and red flags (Miller-Karas, 2016; Najavits, 2002). Another essential component of safety planning is for the team to understand, from the client’s experience, what interventions are supportive or not (Bloom, 2003; Esaki et al., 2013; Najavits, 2002). When a client is activated, facing barriers, and/or bumped out of their OK zone, a provider wants to be informed about how they can best respond before, during, or after something has escalated (Bloom, 2003; Esaki et al., 2013;
Miller-Karas, 2015; Najavits, 2002). An integrated healthcare provider will be knowledgeable about the client among members of an MHT or referenced in the electronic health record. A provider shares her perspective from the client's point of view about what can be overlooked during a safety incident:

Something happens when they get there to the center that escalates them. Sometimes they show up anxious and, you know, clearly, like something's really important to them. But they are not, they don't show up, having blown up, they blow up because something happens. And so, I think that prevention piece is like the key. To be aware that people are coming with needs that are important to them. [Ali Duluth]

Co-regulation on an MHT is important. Integrated healthcare providers can walk the talk by supporting each other to show up regulated for a client. When providers can implement their own safety plans with their colleagues, then the provider and their team are better prepared to show up regulated (Bloom, 2003; Esaki et al., 2013; Vicario, 2012). A co-regulated provider is warm, grounded, welcoming, and can support a client to have a sense of safety (e.g., calm, neutral, okay) enough to figure out what options to act on together (Banks, 2015; Miller-Karas, 2015; Thistle, 2017; Vicario, 2021).

The role of listening during crisis stabilization and prevention is to hear not just each other's words, also the non-verbal, values, and perspectives. Paying attention to the non-verbal ways someone might be asking for help include gestures, volume, tone of voice, appearance, body posture, eye contact, and facial expressions. An integrated healthcare provider identifies how she approaches barriers in clinic flow to access a clinician for walk-in counseling:

I found it important to go out and engage clients, physically outside, because there was a barrier between a crisis happening and then me receiving the person or them knowing
that I was available. And then just looking at their appearance compared to how they typically are within their normal range or not. Looking for crying, posture, like hunched over posture, pacing, kind of off to themselves, maybe more animated, like moving their body like, you know, agitated. [Virginia Cross]

Greeting clients, rather they are in the lobby, or the parking lot looks like going to the client, welcoming them by offering basic needs (i.e. water, a seat, the restroom, shower, laundry, snacks), and asking what they need help with today (SAMHSA, 2018; Thistle & Smylie, 2020). A model with integrity also upholds that clients and integrated healthcare providers are doing their best. For an integrated healthcare provider, it is important to remember that ambivalence can arise for us because our values are to uphold an ethical approach, to meet a client’s recovery needs, but there may be very limited options available (Miller & Rollnick, 2013). Therefore, a pattern of ethical distress can emerge among integrated healthcare providers due to barriers to care and crises escalated due in part to limited available staff. Ethical distress is a cue that there are decision points providers are ambivalent about because the best course of action is not clear when there are few available options, such as to come back another day or to schedule an appointment, these options are often not relevant to the client’s needs (Jameton, 2013). The observed pattern among providers reporting too much ethical distress led to a dismissive response among colleagues in response to an escalating crisis. Too much ethical distress is an organizational risk factor for disconnection in turn a barrier to interpersonal resilience.

There are also times when a client’s values are not congruent with the available options. When an integrated healthcare provider is with a client then they can elicit more information about an activating issue and listen to understand what is the most important to them right now by clarifying values and reasons to connect on recovery commitments (Miller and Rollnick,
A person can be ambivalent about making a change when there is a good deal of uncertainty about how to best move forward. On the day of the interview the client follow-up with his case manager after he had put it off for a few months. He shared how his cultural values contributed to ambivalence:

But for me, as a Native American, you know, I tend to think to myself, I can get myself out of this, that housing or whatever services are there, I really don't need to look into it yet. Because there's someone that's older than me, more disabled than me, that can take that. [Liam Chavez]

He shared how his values and concerns of being a burden, a risk factor for suicidality, are the main reasons he had been ambivalent to reach out for help (Van Orden et al., 2006; Van Orden et al. 2008). A low sense of belonging results from marginalization and disconnection from family, friends, and groups (Jordan, 2018b, Thistle, 2017; Van Orden et al., 2006; Van Orden et al., 2008). An integrated healthcare provider can recognize the worth of a client by taking their perspective and connecting to their values (Jordan, 2018a; Miller and Rollnick, 2013). A strengths-based approach can facilitate connection when an integrated healthcare provider learns more about how a client understands what they need. The value of caring for elders reflects how he knows the worth of an elder and the care elders deserve. He stated he had been turned down for interviews and employment because of disability and racial stigma. He recalled how he feels supported by integrated healthcare providers.

Recalling healthy relationships that bring up a sense of worth and validation can strengthen hope. The energy to keep moving forward in recovery amid barriers can be found in healthy relationships (Banks, 2015). Prayer, family, spiritual community, ancestors, creator, place, culture, and integrated healthcare providers are healthy relationships identified among
client participants as motivation. Human brains are designed to release dopamine to encourage
life-enhancing behaviors including drinking water, sex, exercise, eating, and healthy
relationships (Banks, 2015). A client shared how her connection with integrated healthcare
providers helped her to recall reasons for living and recovery:

It was maybe from [my case manager and therapist] who talk to me a lot supporting me
with staying positive. Staying positive and to keep taking my medications that [my
primary care provider] provided for me. And they told me that they really care about me
and what happens to me. That they don't want anything to happen to me. And I need to
start thinking about my family, my daughters, and my grandkids so that I'm not alone in
what I'm going through. [Janette Nez]

Evoking healthy relationships is a way to begin conversational resourcing by asking: What
colorations are the most important, calming, and supportive? What connections bring purpose or
meaning into your day? What are you noticing right now while you are bringing this connection
to mind? Bringing sensory awareness to resources can provide a stabilizing effect and bring
some zest into the room to reinforce healthy dopamine pathways that enhance motivation for
recovery planning (Banks, 2016; Miller-Karas, 2015; Miller & Rollnick, 2013).

Only one resource is needed to evoke a desire to connect. Many people cannot identify a
resource right away. For them, it is especially important to have a provider who is grounded and
prepared to share Reset Now!, soothing gestures, shift and stay skills for recovery planning. An
integrated healthcare provider speaks to seizing the moment to brainstorm options in order to
identify a tangible next step together:

So, doing as much as I can while they're there, because it's really a big opportunity,
because maybe they don't even think about it because they are in survival mode, or they
don't know that it's available. That was pretty common people would be like, Oh, I didn't know you guys did that, or I didn't know that was possible. I think not having your needs met, when you're so used to not having, you know, the hierarchy of needs, any of those. It's like, it probably doesn't seem as possible to have those met. And then if you don't necessarily have that relationship, or awareness of how to meet those needs, you kind of just deem it as impossible. [Virginia Cross]

Integrated healthcare providers say in the moment, with the client, work toward accomplishing something tangible like a phone or ID. Providers emphasized why they identify the next step together and provide a warm handoff if another multidisciplinary healthcare team member will work with them next. A tangible next step can support a client to begin to build hope about change when they see themselves making progress (Miller & Rollnick, 2013).

Participants identified the need to have a mutual understanding of what they are doing together and who the team is. A client speaks to other clients about agency and taking an active role in their recovery:

You have to do your part and continue to show up. When you're supposed to and, you know, give them their part they need from you, you know, you have to do your footwork, you can't just kick back and let them do all the work. [Leah Griego]

An established relationship together is needed for an MHT team to recall together how they have gotten through barriers before and to acknowledge the strengths of the client. Crises can escalate due to multiple factors including when there are barriers to receive needed care or clients are sent away without action taken.

Sometimes an integrated behavioral health provider will have their own strategies of disconnection that are about their own feelings of helplessness or overwhelm (e.g., avoidance,
Embodied ethical decision-making with the 3M’s is important for comprehensive safety to encourage clients, providers, and team members to all work together toward mutual empathy and empowerment (Roberts, 2021). A commonplace for ethical distress to come up is when the client knows what they need to do but they have not done it (e.g., I can’t do it for them). These tensions of client autonomy and provider judgment can cause ethical distress and shape boundaries (e.g., healthy, too close, too distant, inconsistent) when integrated healthcare providers try to connect with a client for recovery planning and crisis prevention (Jordan, 2018a; Miller-Karas, 2015; Miller & Rollnick, 2013; Roberts, 2021).

An integrated healthcare provider reflects on the importance of mutuality in order to build safety and recovery plans together:

Sometimes when you are in a crisis you don’t know how to come out of the crisis because your mind is just overwhelmed. So, if you have the right person to talk with to help you get out of that crisis they will help assist you to come up with a plan. Some people will say, just tell me what to do to make it better. And I’ll provide guidance but still they need to value the plan. Like anything in life, if it is solely somebody else's then you are not going to appreciate it the same as if it’s yours. If it comes from you and through you and you developed and helped to create it then it is like I did this. I can do this. [Bobbie Montoya]

Ethical distress can occur when an integrated healthcare provider feels like their values to collaborate and for empowerment are compromised because there are barriers to take the preferred course of action (Bloom, 2003; Esaki et al, 2013; Roberts, 2021). Ethical decision making is not only a rational process also an embodied regulated process in order to be attuned
with the needs of an MHT (e.g., self, client, colleagues) when identifying what the dilemma is and what options there are (Bloom, 2003; Esaki et al, 2013; Roberts, 2021). Crisis prevention for integrated healthcare providers working with someone who is unhoused, begins with addressing the issue of chronic disconnection at the interpersonal, multidisciplinary, and organizational levels.

**Communities for Integrated Health Care**

Humans are social beings who thrive in connection and resist marginalization (Clarke & Yellow Bird, 2021; Jordan, 2018b; Craddock & Banks, 2018). Psychological resistance theory provides a framework to understand hope as a life source for communities connected through shared values, expectations, and dreams (Craddock & Banks, 2018; Walker, 2016). The social pain felt in response to exclusion is a piece of the violence caused by marginalization affecting whole groups of people and communities (Craddock & Banks, 2018). When there is limited affordable housing, growing houselessness, violence, and barriers to recovery services the combination of harm reduction and Housing First services alone are insufficient to improve health outcomes and reduce health care costs related to chronic health conditions (CEA, 2019). Social and economic resources are necessary for unhoused Indigenous people to have housing security and culturally relevant options in recovery to facilitate safe, encouraging, and healthy connections in the community (Craddock & Banks, 2018; Healthy People 2002; SAMHSA, 2018).

An important organizational facilitator for resilience is strategies to support cohesion on MHT to find ways to use The Wellness Skills as a part of the program structure to help overcome barriers, deescalate, and stabilize crises together (Bloom, 2003; Esaki et al., 2013; HCHCN, 2011; Giller, Vermiyea, Stelle, 2006; Grabble & Miller-Karas, 2018; Grabble et al., 2021;
Grabble et al., 2021a; Grabble et al., 2021b). Organizations have a core role in implementing a comprehensive safety strategy to enhance calming, accepting, resonant, and energetic (C.A.R.E) dynamics among integrated healthcare providers, clients, and the team as a whole. Culturally relevant recovery services are essential to address chronic disconnection and cumulative traumatic stress (Clarke & Brave Heart, 2021; Jordan, 2018a; Miller-Karas, 2015). Integrated healthcare providers need a supportive work environment and a cohesive MHT to consistently connect with clients in a dependable manner that is warm, welcoming, and grounded (Bransford & Cole, 2019; Healthy People, 2030; Thistle, 2017; Thistle et al., 2019; Thistle & Smylie, 2020).

The sensory connections of belonging are encouraged by the presence of compassion and worth in relationships. The Wellness Skills, interoception, and grounding are the spiritual and physical aspects of a relational-cultural intervention for crisis prevention (Miller-Karas, 2015; Najavits, 2002; Prussia, 2019). Clients need a sense of belonging in a relationship with at least one integrated healthcare provider to clarify and begin to think through their preferences and how they want to move forward with any culturally relevant recovery options (Banks, 2015; Jordan, 2018a; Najavits, 2002; O’Keefe et al., 2014). An invitation into a power-with relationship can address the issue of helplessness being a behavior related to feeling hopeless (Banks, 2015). For a client, if confidence is low, then focusing on their agency in recovery can look like recalling strengths and resources to help integrate emotions split off from thoughts to become better known as a whole person what step to take next with a calm mind and body (Banks, 2015; Jordan, 2018a; Miller-Karas, 2015; Miller & Rollnick, 2013; Najavits, 2002).

Taking tangible initial steps can help build self-efficacy (Miller & Rollnick, 2013). Any ambivalence about change, even when the options are less than ideal, is a cue that someone is considering some options (Miller & Rollnick, 2013). If resistance to change comes up, this is a
red flag for discord that there is not a shared understanding about what needs to change.

Resonance in the relationship is essential to help someone get unstuck from avoidance and disconnection (Banks, 2015; Jordan, 2018a). Overemphasis on behavior change can bring up discord in the relationship if the social and economic resources needed to address stable housing and culturally relevant recovery options are not being effectively addressed by the multidisciplinary healthcare team or inter-organizational systems. Clients will feel safe enough to connect when they are reasonably confident the integrated healthcare provider understands their needs. Emotional understanding and resonance are essential for a client to feel safe. Safety is a fundamental first step in recovery planning (Herman, 1992; Najavits, 2002). Asking a client to share what is the most important to them right now and what brings them meaning or purpose in the day to day are essential questions to begin conversational resourcing (Miller-Karas, 2021). Interpersonal resonance is a source of hope to be able to grow. Bringing in and connecting to resonant relationships and resourcing are emotional aspects of recovery planning. Compassion is a presence by nature, and this can help to explain how compassion fatigue can result from social and economic barriers to housing stability, recovery options, and cohesive healthcare (Burnette, 2015; Burnette & Figley, 2017; Grabble et al., 2016; Miller & Rollnick, 2013; NHCHC, 2016).

**Organizational Support for Cohesive Multidisciplinary Healthcare Teams (MHT)**

Participants identified cohesion of care as a primary organizational facilitator for interpersonal resilience. Cohesion on a multidisciplinary healthcare team concerns the health of the whole team, including all members' behavioral health. Productivity is one of The Five Good Things about growth-fostering relationships (Jordan, 2018a; Miller & Striver, 1997; Schwartz, 2021; Vicario, 2012). People can act both within the relationship and outside the relationship when they are in a mutual growth fostering relationship (Jordan, 2018a; Miller & Striver, 1997).
Two questions any member of the multidisciplinary team can ask themselves about the influence of mutuality on the productivity of the team include (Vicario, 2012):

1.) Do I feel like I can be creative and express myself, or do I feel unsafe expressing myself when I am around this person?

2.) Do I feel like I can get things done or feel like I am unable to complete tasks that I usually can when I am around this person or group?

Participants representing various members of MHTs described four codes on the theme of *cohesion*, describing the dynamics of mutuality when the organizational supports are in place for a team to provide crisis stabilization and prevention: informed, dependable, communication, and inter-organizational systems. While the theme of cohesion was present among integrated healthcare providers’ narratives and is the primary source there are several instances when clients describe aspects of cohesion being present, which are also included in the analysis.

The theme of cohesion is described from the participants' perspective about group dynamics among their multidisciplinary team when responding to an activating event and, over time, preventing crisis together toward the client’s recovery goals. The integrated healthcare providers describe the dynamics of a cohesive multidisciplinary team to include “safety,” “open communication,” “coordinating,” “warm handoff,” “competent,” “modeling,” “walk your talk,” “transparency,” “debrief.” Cohesion is a facilitator for productivity on the team for all members. Productivity is the belief that we can do this (Jordan, 2018a; Miller & Striver, 1997). An integrated healthcare provider describes how she talked with clients regarding their concerns, available options, and who else is or needs to be brought into the team.
It's not an us and them. We are a team together and that's the constant conversation, it’s like, let's figure this out. It's not like, I'm gonna figure this out for you. Or, you need to figure this out. It’s like, let's figure this out. We are here as a team. [Ali Duluth]

She elaborated on an ongoing weekly event prior to COVID-19 when multidisciplinary teams would get together for movie day.

We developed movie day, it was like you know a time that I could just go sit with patients watch a movie, pulling back you know anyone that needed to but we can laugh together you know, as watching Walk the Line and everyone's singing, it's one of the best memories I have because it allows them to you know, to just relax and like to recognize me. [Ali Duluth]

Cultivating a cohesive team can begin with integrated healthcare providers at outreach events, so the connections made can contribute to the client’s sense of belonging when they do follow-up or walk-in and see some familiar faces.

Open communication among participants was the most significant facilitator of cohesion in a multidisciplinary team. When the team could communicate in a dependable manner, people were informed about available options. Open communication was described to be necessary to a client’s experience of having a reliable team and safe relationships or not. Dependable relationships are important to have a sense of belonging and build a life worth living. A participant shared how everyone on her team, including her primary care provider, case manager, behavioral health clinician, and shelter staff, knew her children and grandchildren are the most important to her. Prayer is one thing that brings meaning into her day.

When I was in my suicide attempts, staff were here, and I was trying to take an overdose on my prescription pills and they talked me out of it. [Janet Nez]
Strengthening reasons for living using the conversational resourcing and resource intensification skills on one basis for living and what brings worth to living are important initial components of safety planning (Ferguson et al., 2021; Miller-Karas, 2015; Stanley et al., 2018; Stanley & Brown, 2012; Stanley & Brown, 2009).

Reasons for living are described by participants to include family, desired futures (e.g., occupation and education), recovery, and faith. Integrated healthcare providers informed about the historical contexts for poverty and housing loss better understand how social and economic marginalization keep people and their families from obtaining housing stability (Shelton et al., 2009; Thistle, 2017). A participant reflects on an observation he has made among most clients:

It's almost like 100% of the time; it’s just some series of events that lead up to something. And so, that’s part of the conversation to, kind of like, understanding the context of where they're at for this moment. [Peter Laird]

A solution-focused technique called amygdala whispering emphasizes questions to elicit agency and express empathy by assuming the person has the abilities and capacities to get through the challenges they face (Lutz, 2022). Integrated healthcare providers need to be attuned with a safe and reassuring therapeutic understanding so the planning process can help them feel more hopeful, open to collaboration, and consider the most viable options (Ferguson et al., 2021; Lutz, 2022; Stanley and Brown, 2012).

Co-regulation engages interpersonal relationship processes to stabilize cumulative stress and traumatic stress activation. Integrated healthcare providers need to be self-aware of where they are within their zones to ensure they can be present with a client and support their team from a grounded place. An integrated healthcare provider described the importance of prioritizing a warm handoff with a client during crisis de-escalation or stabilization to help the
client to be successful with the next steps in their safety plan. An integrated healthcare provider shared her priority to facilitate a warm handoff for victims of crime in her program:

I will come over to introduce myself and provide a brief orientation, so they are more likely to come to a scheduled appointment. Also, I want to minimize how many times they have to tell their story. [June Chatto]

The role of a warm handoff during safety planning is an effective strategy and gold standard for multidisciplinary teams to navigate internal referrals within an organization (Lundgren and Krull, 2018). The participant further elaborated on the importance of being willing and open to participate in a warm handoff whenever possible because this communicates to the patient that they have a cohesive team working with them. During safety planning, effective communication and collaboration among team members can enhance a sense of belonging by providing the client with psychosocial support to feel calm, grounded, and accepted (O’Keefe et al., 2014; Najavits, 2002; Van Orden et al., 2006).

Integrated healthcare providers consistently described productivity on an MHT during a crisis to be preceded by open communication among members and a willingness to meet the clients' needs together. Open communication among MHT members was identified as a need to solve problems together and shift tasks as needed. For example, an integrated healthcare provider recalls a time he coordinated with his colleagues to assure someone could fill in for his outreach services for some time for him to talk with a client who approached him in crisis. An integrated healthcare provider shared that no clinicians were available at the moment; however, he provided culturally relevant services to enhance the client’s reasons for living by talking about traditional values and what was the most important to the client.
Because we had this shared culture, cultural background, we can make that an establishing connection to were talking about traditional beliefs and talking about family and talking about those connections, that he was able to readjust and focus himself to where he was like, okay, like, so he was able to talk to his family and be able to be uplifted out of that. And so, it helped for a couple months there. For his situation. I know for a little while, he went back to rehab for a bit, and then he moved back with his family after that. And then, after that, I lost connection with him. But because of that situation, and being able to connect with him on that deeper level, I was able to help with this situation, and just having other people, even though we were short staffed on that day, helping other people just step in temporarily to take over what I was doing really did help. Because if not, it could return a lot differently. [Isaiah Norberto]

He described his experience of cohesion when he coordinated with his team so a client considering suicide could have space to talk in privacy. An essential aspect of cohesion during crisis response is awareness to track oneself, the team, and clients. Crisis stabilization was cohesive because the team found a way to support the client's need for someone to listen.

A cohesive MHT consistently walks their talk together. A client is more likely to experience dependable care when members of the MHT are informed about each other’s roles and can effectively coordinate across programs. A client describes his experience with established integrated healthcare providers across three sites near where he lives.

I go to All Nations Wellness and Healing Center (ANWHC) for resume building and daily meals. And I also go to the Truman Center for spiritual help. And First Nations, they help me here at Zuni. They help me with medication for my leg and whatnot. Also, I
get medication for my depression, my anxiety, PTSD. I don't know it's; it’s a plus; that location is right in the heart of the neighborhood. Every other place is like too far to walk.

[Liam Chavez]

He described an aspect of cohesion, knowing who does what and whom to go to for what on his team. He shared how he started thinking about applying for disability after not obtaining employment for more than a year. He disclosed that he worked as a security officer at the airport before the event when the police shot him. He named the resulting physical injury and discrimination holding him back from employment. He emphasized how he wants to be able to work as the source of his ambivalence about not following up with two different case managers to complete a SOAR disability application and COC housing assessment. He conveyed how productivity is present on his team because he is informed about his options, has been active in his recovery, and is talking with his team about the next steps.

Participants remind us how crisis prevention thrives with open, honest communication to bring people into the planning process and coordinate care across providers, programs, family, social and natural supports. Organizational support was present during crisis prevention when staff modeled wellness skills and there was transparency to coordinate logistics to implement a safety plan. Regarding administrative support, specifically, the integrated healthcare providers named staff training to have the ongoing coaching and supervision needed to have a consistent crisis response system wide. Inter-organizational systems for the MHT to coordinate with other organizations, such as referrals to specialty care or appropriate communication with the courts, were identified by participants as a crucial organizational resilience factor contributing to the client’s experience of productivity moving toward their recovery goals.
CHAPTER 7
Discussion and Implications for Policy

The metaphor of the earth's cardinal directions (e.g., north, east, south, and west) is being used to visually describe how the themes of relationship, attention, and cohesion correspond to the C.A.R.E. program to provide a guiding tool to build resilience for crisis prevention in integrated community healthcare settings.

Figure 8: The C. A. R. E compass is a guiding tool for crisis prevention

The three themes were analyzed with practice-based knowledge of CRM, Solution-Focused, and Motivational Interviewing. The relational ecology compass emerged from the findings on the quality of the relationship by integrating theoretical concepts from RCT corresponding to calm
and resonant on the horizontal axis, attention with accepted and energetic on the longitudinal axis, and cohesion encircling the axes.

The quality of relationship present during crisis prevention was described by participants to include warmth, belonging, understanding, and focusing. The focused codes: Warmth and Belonging, together shaped the thematic code *sensory connections of belonging* that led to integrating theoretical concepts from the C. A. R. E. program and The Five Good Things to strengthen the relational ecological model’s understanding of calm and zest. The focused codes: Understanding and Focusing, together shaped the thematic code *where resonance flows; hope can grow* by further integrating the RCT concepts of resonant and a desire for more connection. The relationship, precisely the quality of presence and resonance, was identified as one key facilitator for interpersonal resilience during crisis response, de-escalation, stabilization, and prevention. By following the thread of the process, participants described the relational components of MI were illuminated, specifically the foundational phase of engagement into the focusing phase.

Focusing is a relationship code and an intermediary to the theme of attention between an integrated healthcare provider with a client described by participants to be present when a provider remembered, listened, built on strengths, and gave the time needed for crisis prevention. *A shared understanding of hope in recovery* is a thematic code that integrates the RCT concepts energetic and clarity, while the thematic code *arriving to safety and recovery planning* integrates the RCT concepts of acceptance and a sense of worth. A second key facilitator for interpersonal resilience is relational courage which requires rapport and trust for the client to feel safe enough to take the risk and connect with the integrated behavioral health provider. A shared understanding is gained in the context to an integrated healthcare provider's focused attention on
collaboration to understand what the experience of belonging means to a client in their recovery from the point of view of the client's culture, understanding of the problem, and values.

Cohesion on an MHT is a dynamic of mutuality needed for a team to provide crisis stabilization and prevention. The theme of cohesion was emphasized by integrated healthcare providers describing the presence of colleagues who are informed, dependable, and have open communication with one another and the client together as a whole within an organization and in connection with inter-organizational systems. Participants shared the role of the energetic and clarity RCT concepts must develop a shared understanding of hope in recovery as the foundation needed to arrive to safety and recovery planning together. The integration of the RCT concepts, ‘accepted’ and a ‘sense of worth’, contributes to understanding why cohesion requires clients to be confident they can depend on their MHT. When a team is cohesive, they are productive together to get things done.

The Participants' understanding of the interpersonal, multidisciplinary, and organizational resilience factors for crisis stabilization and prevention provides a multi-level knowledge base to develop a prevention strategy for unhoused Indigenous peoples in Albuquerque COC settings.

The Elements of Relational Ecology for Crisis Prevention

The process model developed for implementation is a C. A. R. E. program for Multidisciplinary Healthcare Teams (MHT) to scaffold The Five Good Things of growth-fostering relationships, The Basic Three wellness skills, and Rest Now! skills for crisis response, de-escalation, stabilization, and prevention. The process model is an interpersonal resiliency tool for MHTs emphasizing strengths-based and culturally responsive care. Crisis response begins with the calm relationship qualities to encourage a sense of belonging using the Grounding and Rest Now! skills. Next, to establish shared clarity in understanding of the clients experience to
encourage acceptance through presence using the tracking skill. Then to connect in relationship with an encouraging, resonant approach to cultivate hope using the resourcing skill. Lastly, arriving to a mutual plan for safety in recovery grounded in building proactive support.

Figure 9: Crisis prevention C. A. R. E. model for Multidisciplinary Healthcare Teams

**Grounding**

Interpersonal resilience emerged as a sense of belonging for a client in the context of crisis prevention grounded in a compassionate relationship with at least one person on their MHT. Kinship and hospitality are culturally relevant components to interpersonal resilience by providing warmth, a formal greeting or acknowledgment of personhood, comfort, and basic needs (e.g., offering a seat, water, a snack) to welcome a client as a relative who deserves to be
treated with kindness in their homelands (Thistle, 2017). At the heart of the grounding skill is supporting people suffering from severe distress to reconnect with themselves and to experience authentic feelings of safety in their Zone of Well-being when orienting with the gravity of the earth when guided by an integrated behavioral health provider. Additionally, the Rest Now! skill can bring immediate relief through more interactive cognitive, physical, and soothing grounding strategies (Najavits, 2002; Miller-Karas, 2021). Culturally relevant language to talk about bodily awareness of sensations that are calming (e.g., pleasant, or neutral) when learning and practicing grounding skills is important for a person to feel safe and connect with what safety means in their recovery.

A calm and present integrated healthcare provider can be grounding for a client struggling with a low sense of belonging due to disconnection from marginalization (Jordan, 2018b, O’Keefe et al., 2014; Najavits, 2002; Thistle, 2017; Van Orden et al., 2006; Van Orden et al., 2008). Compassion was understood as a warmth experienced with a quality of presence congruent with the relational component of MI (Rollnick and Miller, 2013). The presence of compassion in the relationship encouraged clients to remember their intrinsic value and worth. A dependable and consistent relationship is important for the care provided to be trauma-informed. For a client to work with integrated healthcare providers who are calming, and grounding provides a relational foundation to be able to collaborate together and identify viable options for crisis prevention and recovery (Banks, 2015; Jordan, 2018a; Najavits, 2002; O’Keefe et al., 2014).

**Tracking**

The resilience designed within the nervous system supports a client to have an interoceptive, biological awareness of belonging established through compassionate grounded
connection (Banks, 2015; Miller-Karas, 2015). When the dACC alarm system queues a client that they are accepted by an integrated healthcare provider an important outcome is the relational courage to shift out of survival responses to connect with themselves and others (Banks, 2015; Jordan, 2018a). Going slow is fast when establishing trust and building rapport because the alarm system will be tracking for queues to confirm reasons for disconnection based on past interpersonal experiences which are heightened during a crisis (Jordan, 2018a; Rollnick and Miller, 2013).

Participants emphasized the cultivation of hope in recovery at the heart of crisis prevention. Specifically, how hope emerges in relationships where change is understood to be possible emphasizing they are not alone and we are in this together (Jordan, 2018a). The client’s experience and perspective need to be evoked from their intrinsic reasons for change (Rollnick and Miller, 2013). The tracking skill to notice neutral, pleasant, and unpleasant sensations on the inside of the body can enhance a shared understanding of hope in recovery. By tracking sensations of well-being when establishing rapport, a client can build confidence in themselves to know when they are safe, who they can trust, and what is most important to them. When an integrated healthcare provider can deeply listen to the client’s experience then a client can feel safe enough to connect to sensations within their body. Tracking strengthens the mind-body connection and the capacity for a client to move forward in their recovery in the spirit of self-determination.

**Resourcing**

When a person establishes their own sense of being grounded and safe within themselves then fundamental relational needs are met to be able to expand and connect outside of themselves. Nourishment and water are an important part of the process for a person to shift
from being less restrictive and shrinking to opening up to connect. In the same way, a client should be offered water and a snack upon greeting and welcoming an integrated behavioral health provider also needs nourishment and water to show up grounded for clients in crisis. Co-regulation provides a concrete example of what it looks like to walk the talk for integrated healthcare providers because a client cannot stabilize cumulative and traumatic stress activation with a provider who is not in their own Zone of Well-being. The mirroring systems of the brain have an important role in relationships which allow a client to experience felt sensations of emotions in connection to what an integrated healthcare provider is experiencing in context to many of the subtle deep nonverbals that can be communicated (Banks, 2015).

Resonance is a relational, emotional dynamic possible when the qualities of safety and trust are present in the relationship which are important for emotional co-regulation during a crisis. The integration of emotions with cognitions, feeling-thoughts, are strengthened in a resonant relationship. Emotional self-awareness enhances the capacity for a client to begin to focus with an integrated healthcare provider on what is the most important to them and what available options they are motivated toward. Resourcing is an effective skill to introduce to a client when there is some interpersonal resonance established. Safe relationships in a person's inner and outer worlds (e.g., place, people, animals, culture, spirituality) can also be brought in using conversational resourcing and/or imagination to enhance connection to supports and strengths in the present moment. Resonance can occur through resourcing as well. Resonance is an emotional aspect of recovery specifically contributing to the desire for more connection which is critical for safety and recovery planning. Hope can grow when relational resonance is experienced in the present.
Safety Planning

When calm and resonance are both present in a relationship an enhanced energetic quality begins to take place (Banks, 2015). As social beings we are designed to have a dopamine reward as a natural reinforcement for being in a safe and growth-fostering connection (Banks, 2015). The energetic boost can breathe hope into the process to enhance motivation to take recovery-oriented actions. The underlying interpersonal biological process helps to recognize how a shared understanding of hope in recovery is at the foundation of arriving ‘to’ safety planning. Specifically, not arriving ‘at’ safety planning but ‘to’ safety planning because it is a process to get there and a process throughout. The energetic quality acquired through eliciting and focusing provides the clarity needed to get more specific about what it is exactly that we need to do together (e.g., learn wellness skills, increase social support) and to have a plan.

The client’s agency is essential to uplift throughout safety planning by emphasizing choice to minimize hopelessness. Safety is understood in context to what it means to the client in their recovery relating to their mental health, traumatic stress, substance use, healthy relationships, suicide prevention, housing, and culture (Najavits, 2002). Scaffolding in the CRM wellness skills to meet the safety needs of a client needs to be approached in a manner that is relevant to the challenges the client is facing emphasizing their self-determined goals. Practicing wellness skills together increases the capacity for a client to be present and oriented in order to clarify together what needs to be addressed to get through a crisis. A safety plan is important for an MHT to know their clients, for crisis prevention, and importantly to center client autonomy in shaping their care.
**Multidisciplinary Healthcare Teams (MHT)**

Cohesion was a primary theme among integrated healthcare providers. Cohesion on the interpersonal level has been understood in relation to mind-body cohesion in the literature review of this study. In the group context, MHT cohesion is an organizational facilitator for resilience and a key variable for the capacity of a comprehensive safety strategy. The work environment is a social determinant of health (Bransford & Cole, 2019; Healthy People, 2030). When integrated healthcare providers reported they were in their Zones of Well-being this was closely correlated with cohesion. When cohesion was present integrated healthcare providers expressed being better able to consistently provide compassionate care. Cohesion was described to enhance the capacity for an MHT to support client success in recovery. Integrated healthcare providers highlighted how the sentiment that *we can do this together* is important for the productivity of an MHT to accomplish client-centered recovery goals together and to prevent provider burnout and compassion fatigue (Bloom, 2003; Brave Heart, 2017; Esaki et al, 2013). MHT cohesion is an important factor to enable crisis prevention and the well-being of both integrated healthcare providers and clients (Brave Heart, 2017; Rosen et al., 2018).

**Practice and Policy Implications: A Comprehensive Safety Strategy**

Community-based prevention intervention to address health disparities among urban Indigenous peoples requires significant structural changes to bring together integrated healthcare and housing policy at the federal, state, county, and city levels. This study highlights a need for multilevel policy changes to increase training infrastructure, ongoing implementation support, and retention of a culturally responsive workforce at CHCs serving urban Indigenous peoples. Policy should include interpersonal, multidisciplinary, organizational, and structural strategies.
for crisis prevention and housing stability. Structural change will strengthen the system's quality of care, client well-being, and workforce cohesion (Croghan & Brown, 2010; Evans et al., 2013).

Relational ecological practice implications for integrated healthcare services are grounded in participant experiences indicating the importance of flexible interventions to target interpersonal resilience and MHT cohesion for crisis prevention. The findings provide a rationale for an intervention that centers on growth-fostering connection, somatic literacy, wellness skills, and culturally relevant care on the interpersonal level for clients and integrated healthcare provider well-being. A whole person ecological approach understands cohesion enhances the capacity for an MHT to uphold client self-determination toward their fullest potential as a central tenet of a successful comprehensive safety strategy (Bowen & Murshid, 2016; SAMHSA, 2012).

MHT cohesion is a dynamic of mutuality when integrated healthcare providers have effective communication together, collectively know their clients, and clients have confidence in their MHT. Importantly, addressing challenges together and making tangible progress toward the client’s recovery-oriented goals. Hope in recovery is present when change is possible.

Integrating somatic literacy and The Wellness Skills into multidisciplinary practices (e.g., meetings, group supervision, coaching, crisis response, self-care) can increase capacity for open communication among MHT members with more awareness about each other's roles, intra-agency networks, attunement with one another, and approaches for co-regulation. Somatic literacy upholds trauma-informed and resilience-focused perspectives to shape the inter-agency strategies an organization can take for MHTs to implement The Wellness Skills, bring immediate relief for clients in crisis, and provide mutual support for colleagues (Brave Heart, 2017; Jordan, 2018; Miller-Karas, 2015, Prussia, 2019).
Relational ecology is necessary for policy and practice to center a paradigm shift toward resilience and healing. A deficit model normalizes historical trauma, genocide, poor health, and the erasure of Indigenous peoples. Structural accountability for systems of care in New Mexico can be embodied by cutting ties with extraction economies to fund public behavioral and integrated healthcare services. Environmental justice provides a pathway toward an authentic relationship with land with integrity by acknowledgment of roots of health for the person and the environment. The end of reliance on extraction economies that perpetuate health disparities begins with centering the solutions generated among Indigenous peoples who have been leading change toward health justice and continue to. Further key-stakeholder research is indicated for structural policy changes.

Limitations

A limitation of this study is the focus on facilitators of resilience in crisis prevention. Social determinants of health can be both a facilitator or barrier to resilience (Bransford & Cole, 2019; Healthy People, 2030; Rose et al., 2017). Cohesion is an important factor in the workplace that is bidirectional with implications for integrated healthcare providers and the quality of the clients’ care (Bloom, 2003; Brave Heart, 2017; Esaki et al., 2013). Barriers to crisis prevention were not a focus of participant interviews nor a scope of the study. Barriers to crisis prevention were identified initially as reason for this study however, the resilience facilitators cannot be inverted to infer a deeper understanding about barriers. With this said there were consistent points highlighted by participants worth noting. When considering barriers to crisis prevention, from a client’s perspective, interpersonal points for further consideration are not feeling the provider is actually listening or cares, being referred to services that are not relevant, poor communication on the MHT (e.g., being told different things), poor intra-agency communication
(e.g., getting the runaround), limited walk-in hours or availability, and program guidelines or rules not being consistently and flexibly implemented. From an integrated healthcare provider perspective, the organizational points for further consideration are poor fit at hire, low attendance at MHT meetings, limited supervision, burnout, compassion fatigue, mental illness or substance use stigma among staff, and ethical distress for integrated healthcare providers when they are not able to meet the needs of clients. Barriers to crisis prevention are understood by participants to create interpersonal and organizational tensions that frequently resulted in the escalation of an issue.

Conclusion

This study emphasized the importance of a relational ecological model to address health disparities among unhoused Indigenous peoples living in Albuquerque. A paradigm shift away from a deficit model toward resilience informs the implementation of CRM as part of a comprehensive safety strategy. The quality of relationship a client has with integrated healthcare providers on their MHT is fundamental to crisis prevention. The key facilitators of interpersonal resilience are the relational courage for a client to connect in a relationship with members of their MHT when the quality of presence and resonance is felt. A shared understanding of the client’s experience of their culture, the problems they face, and important values shape what choices are the most viable for their recovery and healing process. A client's connection to members of their MHT that offer the five good things about growth-fostering relationships are important for effective response, de-escalation, and stabilization of crises. CRM provides essential wellness skills to scaffold from a relational foundation for a culturally responsive implementation process to increase the capacity for the comprehensive safety strategy to succeed.
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Appendix A

Homeless Outreach Program Safety Subcommittee

**Purpose:** To adopt a comprehensive safety strategy to be implemented by the Homeless Outreach Program (HOP) to decrease the occurrence/recurrence of safety incidents and increase the safety of clients and staff. The adoption of a comprehensive safety strategy will strengthen HOP and its programs in addressing the needs of its clients effectively and efficiently.

**Strategy Summary:** The HOP Safety Subcommittee (HOPSS) will be composed of HOP’s integrated healthcare providers and administrators. HOPSS will be responsible for (1) tracking safety incidents that can range from verbal to physical incidents; (2) conducting investigations into issues around safety needs among its program’s users such as but not limited to triggers, escalating factors, the effectiveness of its existing interventions, outcomes of its existing interventions and lessons learned for preventing or decreasing recurrences; (3) analyzing trends that could serve as markers for improving HOP (e.g., adjust its internal procedures, forms, services, etc.) and (4) making recommendations to increase the safety of its program users and staff. When feasible, HOPSS will make recommendations for staff training and implementing evidence-based practices. HOPSS will be cognizant of minimizing barriers to care to ensure clients have access to needed HOP services and will adopt a flexible approach that can be individualized to each clients’ level of functioning.

**Outcomes:** The effectiveness of HOPSS will be assessed by the following:

1. Decreases in the number and types of safety incidents as measured by the number of safety incident reports
2. Decreases in the number of clients who are temporarily/permanently banned from HOP as measured by the number of clients on bans
3. Increase the understanding and knowledge level of the Safety Committee members about the context of the safety needs of HOP’s clients and the safety action steps undertaken as measured by survey responses by Safety Committee members
4. Survey results by HOP client and staff regarding HOP’s services, safety issues/needs, and levels of satisfaction among clients and staff
Appendix B

<<Date>>

Re: Recruitment for Research Study

Dear Community Member,

I am writing to let you know about an opportunity to participate in a research study to better understand safety and crisis prevention for Native Americans experiencing houselessness in Albuquerque. I live and work in Albuquerque and am a student in the Doctor of Clinical Social Work program at the University of Pennsylvania School of Social Work and Social Policy. The study is designed to better understand safety in the relationship between Native American people experiencing houselessness and the integrated healthcare providers working with them during crisis.

I am conducting this study through the University of Pennsylvania with integrated healthcare providers who are staff at New Mexico Coalition to End Houselessness (NMCEH) Continuum of Care (COC) member agencies located in Albuquerque, New Mexico. The NMCEH is not a sponsor nor affiliated with this research project. However, integrated healthcare providers who are working at COC member agencies are one of the main groups being interviewed for this study.

Your participation will include a 90-min interview at a community location convenient for you or over zoom or telephone based on your preferences. We will schedule a time that is convenient for you. If you are interested in participation, please call or email. I will get back to you to be sure you are eligible to participate in the study. If so, we will schedule your interview at that time. All participants will be provided $30.00 for the initial 90-minute interview and $5 for each follow up 15 to 20-minute session to compensate you for your time. If you do not want a gift card for yourself than it will be donated to NMCEH for client distribution.

If you would like more information about this study, please contact me at (505) 629-5374 or via email at jehaley@upenn.edu. Agreement to be contacted or a request for more information does not obligate you to participate in this study.

Thank you for considering this research opportunity.

Sincerely,

Jennifer M. Stanley, LCSW
Crisis Prevention Study

Are You:

● Native American
● Experiencing Houselessness

Help researchers understand:

● Your experience of safety and resiliency
● The relationship you have with your service providers
● The role crisis prevention has in housing stability

Participation includes a 60 to 90-minute interview.
You will be compensated $30.00 for your time.
Interviewer will meet anywhere you feel comfortable and prefer.
Appendix C

Integrated Healthcare Provider Questionnaire

Date:

Job title: ________________________________________________________________

Highest Level of education:


License:

[ ] N/A [ ] CNA [ ] MA [ ] LVN [ ] RN [ ] APRN [ ] LMHC, LMSW [ ] LPCC, LCSW, LMFT
[ ] PhD, Psy.D, Psychologist [ ] NP, PA [ ] PMHNP [ ] MD, DO

COC Member Organization of Employment:

[ ] A Peaceful Habitation [ ] Goodwill Industries of NM - SSVF Program
[ ] Adelante Development Center [ ] Heading Home
[ ] Albuquerque Health Care for the Homeless [ ] Heroes Walk Among Us
[ ] Amity Foundation/Almas de Amistad [ ] High Desert Housing Corporation
[ ] Archdiocese of Santa Fe, Office of Social Justice [ ] Immaculate Conception Church
[ ] Barrett Foundation, Inc. [ ] Mission to the Displaced
[ ] Casa Q [ ] Mission To The Homeless, Diocese Of The Rio Grande
[ ] Casas de Vida Nueva [ ] NewLife Homes
[ ] Catholic Charities [ ] NMCEH
[ ] Cion Housing Services, Inc [ ] NM Mortgage Finance Authority
[ ] City of Albuquerque [ ] NM Veterans Integration Center
[ ] Crossroads for Women [ ] S.A.F.E. House
[ ] Cuidando Los Niños [ ] Hopeworks

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| [ ] Enlace Comunitario | [ ] Supportive Housing Coalition of New Mexico |
| [ ] Family Promise of Albuquerque | [ ] Tender Love Community Center |
| [ ] First Nations Community Healthsource | [ ] Therapeutic Living Services |
| [ ] Good Shepherd Center | [ ] Other: |

**Do you provide direct services to adult Native American clients?** [ ] Yes  [ ] No
Appendix D

Client Questionnaire

Date:

Where did you sleep last night? ____________________________________________

In the past month have you slept at any of the following (mark all that apply):

[ ] on the streets or outside [ ] in a vehicle [ ] at a shelter – name of shelter(s):

____________________________________________________________________________

[ ] transitional housing – name of program(s):

____________________________________________________________________________

[ ] a hotel or motel paid for by community organization or government program

Have you experienced houselessness before this recent episode? [ ] Yes [ ] No

About how long have you been experiencing houselessness (i.e. this episode)? __________

About how many times have you experienced houselessness before? _________________

Are you fleeing domestic violence? [ ] Yes [ ] No

Are you pregnant? [ ] Yes [ ] No

Are you currently on probation or parole? [ ] Yes [ ] No
Appendix E

Client Interview Guide

Participant Name:
Date of Interview:
Interviewer Name:

Introduction to the Study:

Hello, my name is Jennifer Stanley. I live and work in Albuquerque and am a student in the Doctor of Clinical Social Work program at the University of Pennsylvania School of Social Work and Social Policy. This research is toward my doctoral degree. The study is designed to better understand safety in the relationship between Native American people experiencing houselessness and the integrated healthcare providers working with them during crisis. I have prepared questions; we have flexibility throughout our time together. I invite you to answer questions in any way you would like. You may decline to answer questions or decide to stop the interview at any point. This will not impact anything outside of this interview in any way. I anticipate we will be talking together for 90 minutes today, and we can take breaks as needed. I thank you in advance for your time.

Interview Questions:

I. Define crisis: Share the window of tolerance, resilient zone, and frame a crisis as a something bumping you out of your zone when a stressor or accumulative stress no longer feels manageable.
   a. Tell me about your relationship with different integrated healthcare providers during a time of crisis.
      i. What was the quality of the relationship?
         1. Can you share about a time when you felt supported during a crisis?
         2. Can you share about a time you felt a crisis was prevented?
   b. What services have you received during a time of crisis?

II. Define safety needs: Physical, emotional, social, cultural (i.e. comprehensive)
   a. Can you share what is different when your safety needs are met?
      i. Can you recall a time when you went to clinic in crisis and left feeling better?
   b. What are your safety needs when working with an integrated healthcare provider during a time of crisis?

III. Define trauma-informed care: An awareness of the impact trauma can have on someone, how trauma can compound when experiencing houselessness; asking what are you going through; TIC moving toward not causing harm.
a. How might trauma-informed care prevent crisis?
   i. What is some guidance you would like to share for programs that want to provide trauma-informed care?

IV. Define a resiliency-focused culture: Asking what is right with you? What are your strengths that can be built upon? A resiliency-focused culture is TIC and also builds upon that awareness to act to reduce suffering.
   a. How might a resiliency-focused culture prevent crisis?
      i. What guidance do you want to share with programs that want to provide a resiliency-focused culture?
   b. What kinds of change do you think these two approaches (i.e. III and IV) can move toward for houseless services in Albuquerque?

V. Define housing stability: Not paying more than 50% income on housing, not moving more than 3x in a year, no evictions, no episodes of houselessness, and the type of housing maintained for longer than a year.
   a. How do you understand issues of safety and crisis to be connected to housing instability?
      i. Can you share what issues of safety you have struggled with the most during period of housing instability in your life?
      ii. What is important for integrated healthcare providers to know about what you need for housing stability?
Appendix F

Integrated Healthcare Provider Interview Guide

Participant Name:
Date of Interview:
Interviewer Name:

Introduction to the Study:

Hello, my name is Jennifer Stanley. I live and work in Albuquerque and am an on-line student in the Doctor of Clinical Social Work program at the University of Pennsylvania School of Social Work and Social Policy. This research is toward the completion of my doctoral degree. The study is designed to better understand safety in the relationship between Native American people experiencing houselessness and the integrated healthcare providers working with them during a crisis. I have prepared questions; we have flexibility throughout our time together. I invite you to answer questions in any way you would like. You may decline to answer questions or decide to stop the interview at any point. This will not impact anything outside of this interview in any way. I anticipate we will be talking together for 90 minutes today, and we can take breaks as needed. I thank you in advance for your time.

Interview Questions:

I. Define crisis: Share the window of tolerance, resilient zone, and frame a crisis as a something bumping you out of your zone.
   a. Tell me about your relationship with different clients during a time of crisis.
      i. What was the quality of the relationship?
         1. Can you share about a time when you felt supported during a crisis?
         2. Can you share about a time you felt a crisis was prevented?
   b. What houseless services do your clients receive during a time of crisis?

II. Define safety needs: Physical, emotional, social, cultural (i.e. comprehensive)
   a. Can you share what is different when your safety needs are meet?
      i. Can you recall a time when you a client came to clinic in crisis and left telling you that they were already feeling better?
   b. What are your safety needs when working with a patient in crisis?

III. Define trauma-informed care: An awareness of the impact trauma can have on someone, how trauma can compound when experiencing houselessness; asking what are you going through; TIC moving toward not causing harm.
    a. How might trauma-informed care prevent crisis?
i. What is some guidance you would like to share with programs that want to provide trauma-informed care?

IV. Define a resiliency-focused culture: Asking what is right with you? What are your strengths that can be built upon? A resiliency-focused culture is TIC and also builds upon that awareness to act to reduce suffering.
   a. How might a resiliency-focused culture prevent crisis?
      i. What guidance do you what to share with programs that what to provide a resiliency-focused culture?
   b. What kinds of change do you think these two approaches (i.e. III and IV) can move toward for houseless services in Albuquerque?

V. Define housing stability: Not paying more than 50% income on housing, not moving more than 3x in a year, no evictions, no episodes of houselessness, and the type of housing maintained for longer than a year
   a. How do you understand issues of safety and crisis to be connected to housing instability?
      i. Can you share the issues of safety you have observed your clients to struggle with the most during periods of housing instability, in shelter, and living on the streets?
      ii. What is important for the city of Albuquerque to know about the housing stability care needs of your clients?
Appendix G

UNIVERSITY OF PENNSYLVANIA
RESEARCH SUBJECT INFORMED CONSENT FORM

Protocol Title: Community Resiliency: Safety and Crisis Prevention for Native People Experiencing Houselessness in a Continuum of Care (COC)

Principal Investigator: Jennifer Stanley
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Sponsor Dennis Culhane, PhD

Summary
The purpose of this study is to better understand safety and crisis prevention for Native people experiencing houselessness in Albuquerque. Adults experiencing houselessness who identify as Native American and integrated healthcare providers at community-based organizations serving Native people experiencing houselessness will be invited to participate in this research. The research includes interview questions regarding the relationship between clients and integrated healthcare providers during crisis and explores possible connections to housing stability. The study will include interviews to evaluate crisis prevention in the Albuquerque COC.

Why was I asked to participate in the study?
You are being asked to take part in a research study. Your participation is voluntary which means you can choose whether to participate. You are being asked to join this study because we would like to understand more fully how to best respond during crises related to houselessness. You have stated that you identify as Native American, have experienced houselessness in the past month, and are living in the Albuquerque metropolitan region. We would like to listen to your experiences during an interview to help us expand knowledge on how the quality of the client/integrated healthcare provider relationship relates to safety, crisis prevention, community resiliency, and rather there is a correlation to housing stability.

If you decide to participate or not to participate there will be no loss of benefits to which you are otherwise entitled. Before you decide, you will need to know the purpose of the study, the possible risks and benefits of being in the study and what you will have to do if you decide to participate. The primary researcher is going to talk with you about the study and give you this consent document to read. You do not have to decide now; you can take the consent document

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with you and share it with someone who you trust. If you do not understand what you are reading, do not sign it. Please ask the researcher to explain anything you that you do not understand, including any language in this form. If you decide to participate, you will be asked to sign this form and a copy will be given to you. Keep this form, in it you will find contact information and answers to questions about the study. You may ask to have this form read to you.

This study is being conducted through the School of Social Work and Social Policy (SP2) with participant interviews completed in person, over zoom or telephone based on your preference. If you prefer to meet in the community at a local location convenient for you than we will adhere to proper Department of Health social distancing, hand sanitization, and face masks guidelines to assure COVID-19 related risks are effectively addressed. Data analysis of interviews will also occur in Albuquerque, NM.

What is the purpose of the study?

The purpose of the study is to learn more about:

- The experience of houselessness for Native people in Albuquerque
- How the COC can expand the current understanding of safety and resiliency
- The individual and collective needs for safety among clients and integrated healthcare providers
- The contribution the quality of relationship has on crisis prevention and possible implications toward housing stability
- This study is being conducted for the completion of a dissertation

This is not a form of treatment or therapy. It is not supposed to detect a disease or find something wrong. As an investigator, the researcher is interested both in your well-being and in the conduct of this study.

What will I be asked to do?

- Attend a 90-minute interview. The interview will be recorded and transcribed.
- Complete a questionnaire (History of Houseless Form or Integrated healthcare provider Questionnaire)

How long will I be in the study?

The study will take place over a period of 9 months. This means over the next 1-2 months we will ask you to spend 90 minutes participating in this study. It is possible there may be follow-up questions and you would be contacted by phone or email, depending on your stated preference, if any clarification is needed regarding your interview responses.

Where will the study take place?
You will be asked your preference for a 90-minute interview to occur at a community location, over zoom, or over the phone.

**What are the risks?**

There are potential risks for participation in this research that you should be aware of. These include:

1. **Loss of time.** The time needed to participate includes 90 minutes plus time to respond to any follow-up questions if they arise.
2. **You will be completing an interview about issues of houselessness, safety, and crisis.** This may potentially yield psychological or emotional distress. Recalling traumatic or troubling events may cause some level of distress. This is a short study exploring sensitive topics which in some circumstances may result in, for some participants, flashbacks, nightmares, reactivation of fears, or unhappy rumination. There is a list of community resources available for you and will be provided by the primary researcher should you want to seek further support following this study. The primary researcher holds a graduate degree in social work. The researcher will be available to assist you should you need during the interview and can help you connect to available resources following the interview as needed.
3. **You will be completing a questionnaire; however, these are not diagnostic tools.** The researcher will not be providing a diagnosis at any point during the study. As a result of participation in behavioral research, some participants may falsely (or correctly) come to identify themselves as having a condition for which they might seek treatment.

**How will I benefit from the study?**

There is no direct benefit to you. However, your participation could help integrated healthcare providers better understand issues of safety and crisis prevention in houseless services and contribute to the field of community resiliency and housing within the Albuquerque COC which can benefit you indirectly. In the future, this may help Native Americans in Albuquerque experiencing houselessness to receive trauma responsive and resiliency-oriented services which support housing stability.

**Will I receive the results of research testing?**

The primary researcher is available to continue to collaborate with you regarding your interview and can provide you information on how to connect to the final dissertation upon publication.

**What other choices do I have?**

Your alternative to being in the study is to not be in the study.

**What happens if I do not choose to join the research study?**
You may choose to join the study, or you may choose not to join the study. Your participation is voluntary.

There is no penalty if you choose not to join the research study. You will lose no benefits or advantages that are now coming to you or would come to you in the future.

If you are currently receiving services or employed and you choose not to volunteer in the research study, your services or employment will continue.

**When is the study over? Can I leave the study before it ends?**
The study is expected to end after all participants have completed all visits and all the information has been collected. The study may be stopped without your consent for the following reasons:

- The PI feels it is best for your safety and/or health-you will be informed of the reasons why.
- The PI, the sponsor or the Office of Regulatory Affairs at the University of Pennsylvania can stop the study anytime

You have the right to drop out of the research study at any time during your participation. There is no penalty or loss of benefits to which you are otherwise entitled if you decide to do so. Withdrawal will not interfere with your future care or employment.

If you no longer wish to be in the research study, please contact Jennifer Stanley, at 505-629-5374 or by email: dignityandjustice@gmail.com - and take the following steps:

- Provide the researcher with your name and that you are dropping from the study.
- There are no consequences for dropping out of the study.

**How will my personal information be protected during the study?**

We will do our best to make sure that the personal information obtained during this research study will be kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law.

All files and information collected for this study including enrollment forms and questionnaires will be kept in a secure location. These materials will be in a locked room with a locking file cabinet that only the PI has access to. The institutional review board at the University of Pennsylvania will also have access to the records as needed.

Participants will be de-identified by using a number and coding system. Names, addresses, phone numbers or other identifying information will be removed from all data sets to protect confidentiality. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

**What may happen to my information collected on this study?**
All identifiable information will be coded a unique random identifier (participant record number) that is separately linked to participant identifiers (name). Re-identification is possible.

There is a risk of breach of confidentiality (unintentional release of your information). We will do our best to make sure that this doesn’t happen. However, we cannot guarantee total privacy. We will protect your confidentiality during storage and sharing by using your participant record number and/or pseudonyms within communications or publications.

If you have questions about the storage of your information, or have changed your mind, you can contact Jennifer Stanley at 505-629-5374. If you change your mind, you will not be penalized in any way and your information will not be used and all data collected (forms and interviews) will be destroyed.

The research data will be stored for future use. The private information collected via the interviews will be securely stored and de-identified following the study. The de-identified data could be distributed for future research studies without additional informed consent.

**Records and Research Results**

Your demographic information will be in a secured electronic record. These are encrypted files that follow the standard guidelines to ensure confidentiality is maintained.

**What is the Electronic Record?**

An electronic version of the record will be stored using a secure password protected and encrypted computer in excel format. The purpose of maintaining an electronic file includes having a secure location for entering your demographic information produced from your participation in this research study. The PI will need to obtain basic information about you that would be similar to the information you would provide the first time you visit a community facility (i.e., your name, the name, address, phone number, email or other contact information). Information related to your participation in the study (i.e., appointments for interviews) will be placed in this electronic record to assist in scheduling the study interview sessions and aide in reimbursement procedures for study participation.

Your electronic record may be accessible to appropriate members of the research team. Information within your record may not be accessed by anyone else outside of the research team. The information pertaining to the content of your interview is confidential. The information in the electronic record is to assure scheduling and reimbursement for participation are documented within the study record. All information recorded from your interview will be stored separately in a secure location. These materials will be in a locked room with a locking file cabinet that only the PI has access to. The institutional review board at the University of Pennsylvania will also have access to the records as needed.

**Will I have to pay for anything?**
There are no monetary costs for participating in the study. Every attempt will be made to schedule a time for your interview during a convenient time for you at community location you prefer, over zoom, or the telephone to reduce or prevent additional travel or transportation.

**Will I be paid for being in this study?**

All participants have the option of a $30.00 monthly buss pass for Albuquerque transit or may choose to donate their Gold Pass to a community member experiencing houselessness.

**Who can I call with questions, complaints or if I’m concerned about my rights as a research subject?**

If you have questions, concerns or complaints regarding your participation in this research study or if you have any questions about your rights as a research subject, you should speak with the Principal Investigator listed on page one of this form. If a member of the research team cannot be reached or you want to talk to someone other than those working on the study, you may contact the Office of Regulatory Affairs with any question, concerns or complaints at the University of Pennsylvania by calling 215-898-2614.

When you sign this form, you are agreeing to take part in this research study. If you have any questions or there is something you do not understand, please ask. You will receive a copy of this consent document.

_________________________________  ________________________  __________
Printed Name of Subject                Signature of Subject            Date

You are agreeing to take part in this research study. If you have any questions or there is something you do not understand, please ask. You will receive a copy of this consent document.