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A Relational Ecology for Crisis Prevention Among Unhoused Indigenous Peoples in Albuquerque

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The purpose of this study was to inform the development of a crisis prevention process model focusing on the qualities present in relationships among unhoused Indigenous peoples and integrated healthcare providers when crisis is prevented. The scope of the study is on multidisciplinary healthcare teams (MHT) and removing barriers for clients to access the resources they need. This key-informant study conducted 24 semistructured interviews including (14) unhoused Indigenous people and (10) members of their MHT in 2021. The study consisted of two phases beginning with identifying study and interview questions through a participatory evaluation process. During the second phase, interviews were conducted and recorded by researcher. Coding assistance by the research team supported heuristic content analysis. An integrated healthcare provider's cultural understanding of a client emerged as a fundamental tenant for a client to experience a sense of belonging on their MHT. Seventy-two significant statements were identified, two themes were acquired, structured into three categories, and synthesized into eight codes: cultural understanding, sense of belonging, focusing, strengths, listen, communication, informed, and intraorganizational systems. Ethical distress contributed to escalated crises and prevention barriers while MHT cohesion enhanced the capacity to support a client's success. Participant experiences shaped theoretical integration of the relational–cultural theory, motivational interviewing, and the Community Resiliency Model prevention process model to improve MHT safety planning. The implications for integrated healthcare and housing policy are to increase multilevel support for organizations to sustain MHT cohesion and maintain intraorganizational systems.

Public Health Significance Statement
This study addresses the problem of health disparities among unhoused Indigenous peoples with focus on reducing safety incidents in community behavioral health settings. The integration of relational and somatic clinical models expands on trauma-informed care to further the paradigm shift from a deficit model to an emphasis on resilience and healing in recovery. Public health implications are identified on the interpersonal, multidisciplinary, organizational, and structural policy and practice levels.

Keywords: Community Resiliency Model, crisis prevention, motivational interviewing, relational–cultural therapy, theoretical integration

Supplemental materials: https://doi.org/10.1037/int0000308.supp

Addressing the problem of health disparities among unhoused Indigenous peoples in the Unites States begins with understanding seven out of 10 people who self-identified as Native during the 2010 census lived off the reservation (Estes et al., 2021). Rez/urban is an example of a dichotomous category created by the U.S. Bureau of Indian Affairs urban relocation policies from the 1950s to 1980s when 750,000 Native people

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who were forced onto reservations, beginning with the Indian Removal Act of 1830, were then relocated to cities (Estes et al., 2021). The trend is a continuation of colonization wherein the "urban" individual is seen as being more modern and less traditional which serves to place indigeneity as a thing of the past resulting in Indigenous peoples being seen as outsiders in their homelands (Denetdale, 2016). While *Urban Indian* is a category developed by the state it is essential to recognize how the traditional/assimilated (Estes et al., 2021) dichotomous category perpetuates harm toward both Tribal citizens and people of Native American ancestry living in cities and urban areas who are connected by cultural practices, identity, Inter-Tribal heritage, and resistance to the underlying structural causes of health injustices (Clarke & Yellow Bird, 2020).

In 2020, unhoused Native American and Alaska Native people in New Mexico faced the greatest racial disparity for an all too common trend of houselessness resulting in death with the highest homeless-related mortality rates at 26% increased from 22% of the estimated 419 deaths from 2014 to 2018 (Briggs et al., 2022; Davis, 2022; Henry et al., 2017). In Albuquerque, 44% of people living on the streets self-identified as Native while only being 4% of the total city population (New Mexico Coalition to End Homelessness, 2017; Worth, 2019). Being unhoused increases the likelihood for a person to meet the criteria for *co-occurring* mental health and substance use conditions; and *multi-morbidity* of two or more chronic health conditions (Bowen et al., 2019; Padgett et al., 2011; Zlotnick et al., 2013; Zlotnick & Zerger, 2009). Housing security and recovery services are key social determinants of health objectives (Bowen et al., 2019; Healthy People 2030, 2022). Having a place to live is the first step to housing security. Housing first then the attainment of housing stability (Pearson et al., 2009). This is an important point because services cannot end with just getting folks off the street. Receiving ongoing comprehensive, integrated healthcare services is important to prevent eviction or loss of housing among people who meet the diagnostic criteria for a serious mental illness and a moderate to severe alcohol and substance use disorder. It is important to address the social needs related to the housing barriers someone is facing such as issues related to education, income, employment, disability status, family cohesion, substance abuse, history of conviction, incarceration, or eviction (Braciszewski et al., 2016; Frederick et al., 2014; Padgett et al., 2016). Recovery services are life-saving, increase housing stability, and decrease the use of emergency and hospital services (Kushel et al., 2008).

A Comprehensive Safety Strategy

Social support including family and community is key to breaking cycles of houselessness and is necessary for successful development and implementation of a prevention intervention to effectively address barriers to receive necessary services at community health centers (CHC; Johnstone et al., 2016). First Nations Community HealthSource (FNCH) is a CHC in the state of New Mexico, focusing on unserved and underserved communities in Albuquerque. The homeless outreach program safety subcommittee (HOPSS) is a part of trauma-informed care (TIC) initiative at FNCH to develop a *Comprehensive Safety Strategy* (CSS) to address the issue of more unhoused clients being involved in a safety incident when compared to the general primary care population. HOPSS multidisciplinary healthcare team (MHT) members were cognizant of staff TIC training needs to support a flexible approach that can be individualized to each unhoused client's level of functioning to improve the de-escalation effectiveness of existing interventions. This is consistent with a nationwide study on safety incidents involving unhoused clients who were activated and agitated in clinic resulting in the use of preventable security force, being told to leave the property, and being temporarily or permanently banned from receiving essential preventative services (Health Care for the Homeless Clinicians' Network [HCHCN], 1996, 2011). A critical component of the FNCH CSS is the collective responsibility of the MHT to increase the understanding and the knowledge level of staff on the contexts of clients' safety needs (National Health Care for the Homeless Council [NHCHC], 2016). TIC recognizes that 90% of the people who receive homeless services report a history of childhood trauma (Larkin & Park, 2012; Substance Abuse and Mental Health Services Administration, 2016). For people who have a history of trauma, are living with the impacts of historical trauma, and health issues, stable housing provides the conditions necessary for long-term emotional and social well-being (Mental Health Commission of Canada, 2012).

A CSS is an essential action step for the MHT to minimize barriers to care for recovery from historical trauma particularly destigmatizing behavioral health disparities, understanding colonial contexts of urban houselessness, ending self-blame, and restoring purpose and identity (Kirmayer et al., 2014).

In a nationwide study, reflective listening and therapeutic communication were the strategies emphasized for de-escalation (HCHCN, 2011). The most effective prevention measure identified for unhoused people in different homeless service settings is to know your clients, specifically their risks and the resources to support them (HCHCN, 2011). The interpersonal contexts of crisis incidents highlight the need for an intervention that addresses client and integrated healthcare provider safety needs. A relational approach is necessary for integrated healthcare to prevent safety incidents and remove barriers to care for unhoused people (Henry et al., 2017; Miller-Karas, 2015; NHCHC, 2016; Substance Abuse and Mental Health Services Administration [SAMHSA], 2018). A systematic response away from damage-centered and deficit frameworks is necessary because this escalates crises (Calderon, 2016). A resiliency-oriented approach to crisis prevention understands historical trauma and the social determinants needed to nurture hope and recovery as a compassionate, nonviolent response to connect and build on people's strengths (Miller-Karas, 2015).

Community Resiliency Model

Community Resiliency Model (CRM) understands resilience to be, "[A]n individual's and community's ability to identify and use individual and collective strengths in living fully with compassion in the present moment, and to thrive while managing the activities of daily living" (Miller-Karas, 2020). CRM understands resilience in the context of restoring balance and widening the resilient zone (RZ) for individuals and communities. "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, 2021, p. 7). When we are in our RZ, we can learn to manage activated body sensations, negative or overwhelming emotions, think with more clarity, and safely co-regulate with members of our MHT. In this study, community was defined in context to a client's MHT; their integrated health care providers (e.g., primary care providers, nurses, case managers, cultural mentors, behavioral health clinicians, traditional healers), family, friends, and additional social–cultural–spiritual supports preferred by the client.

CRM is a public health intervention that supports people and their communities through recovery by reconnecting with the body and each other after a crisis and disaster (Leitch, 2007; Leitch et al., 2009; Leitch & Miller-Karas, 2009; Miller-Karas, 2015; Parker et al., 2008). Recovery is supported by strengthening mind–body connection, increasing understanding of emotions as biological responses, and teaching communities the six wellness skills for complex, cumulative, and traumatic stress responses (Freeman et al., 2021; Table 1).

A study with San Bernardino County Mental Health demonstrated communal learning of the wellness skills destigmatized behavioral health services for urban communities impacted by structural poverty and violence by emphasizing helping others, self-care, and resilience (Freeman et al., 2021; Grabbe, Higgins, Jordan, et al., 2021). Disconnection is caused by pathologizing symptoms and implicating mental weakness; traumatic stress activation is about biology not weakness (Miller-Karas, 2015). In a randomized control trial, the wellness skills were demonstrated to improve well-being, resiliency, and secondary stress among nurses in a hospital setting with high rates of poor mental health, secondary stress, and burnout (Grabbe, Higgins, Baird, & Pfeiffer, 2021). In a pilot study, a 5-hr wellness skills class provided promising evidence with a significant decrease in somatic complaints, anger, and anxiety and an increase in well-being among 20 women with histories of trauma in addiction treatment (Grabbe, Higgins, Jordan, et al., 2021). The six CRM wellness skills provide a pathway to wellness for clients and members of their MHTs by embracing the elegant design of the human nervous system to return to balance, our intrinsic ability to heal (Table 2).

Motivational Interviewing

The motivational interviewing (MI) manual for Native American communities emphasizes within each person are the solutions and motivation for change, a core tenant of MI, which is in

Table 1
Participant Demographics and Houselessness

Total participants $N = 24$			
	Clients		Integrated healthcare providers
Description	$N = 14$	Description	$N = 10$
Gender		Gender	
Transgender woman	1	Cisgender women	6
Cisgender woman	8	Cisgender men	4
Cisgender man	5		
Self-identified race		Self-identified race	
Native American	11	Dine' (Navajo)	3
Native American and Black	1	Hispanic	2
Native American and Mexican	1	White	3
Native American and White	1	White and Chippewa	1
		Dine'/Zuni/Apache	1
Tribal affiliation		Role	
Apache	1	Behavioral health	1
Cherokee	1	Clinician	
Dine' (Navajo)	5	Case manager	3
Laguna Pueblo	2	Physician assistant intern	1
San Juan Pueblo	1	Outreach	1
Shoshone	1	Primary care provider	2
Zuni Pueblo	2	Program supervisor	2
Zuni/Hopi/Dine'	1		
Where did you sleep last night?			
Outside	3		
Good Shepherd (men's shelter)	2		
Motel	1		
CARE detox (county)	1		
WEHC (city shelter)	7		

line with honoring each individual within the community, a belief held among multiple tribes of origin to Albuquerque and the surrounding region (Venner et al., 2006). The scaffolding of the wellness skills to develop the crisis prevention process model began initially by observing how *compassion*, a relational element of MI, not only is fundamental to the engagement phase but also is congruent with the relational–cultural therapy (RCT) qualities of *zest* and *calm* described in more detail below (Banks, 2015; Jordan, 2018a; W. R. Miller & Rollnick, 2013). The four processes of MI (e.g., *engage*, *focus*, *evoke*, and *plan*) shaped integration of

Table 2
The Trauma Resource Institute Six Wellness Skills (Miller-Karas, 2021)

The Basic 3	
The Six Wellness Skills	
Tracking (interoception)	Paying attention to sensations of trauma/stress, resilience, and release inside the body
Resourcing	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
Grounding	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
Gesturing	Conscious awareness is brought to spontaneous movements of the body or limbs that are self-calming, universal, joyous, confident, and releasing gestures
Rest Now!	10 actions that can be taken to come back into the Resilient Zone when stuck in the High or Low Zones
Shift and Stay	Shifting awareness from an unpleasant experience or distressing sensation to neutral or pleasant sensations, using the skills to stay with sensations of well-being

the wellness skills using the other relational elements of MI—*acceptance*, *evocation*, and *collaboration* (W. R. Miller & Rollnick, 2013).

Evocation is to draw out the client's own intrinsic reasons and motivation for change, including their values rather than assuming a lack of wisdom and instilling education. Resistance is a sign that there is discord in the relationship and a cue for the helper to move away from pushing too hard for something and instead toward evoking in a respectful warm manner to convey acceptance for where the client is at and respect for their point of view. MI provides an empowering "way of being" with a client that recognizes their strengths and wisdom using a guiding style in the relationship (W. R. Miller & Rollnick, 2013; Venner et al., 2006, p. 8). The spirit of MI is critical for crisis prevention, response, and intervention. The process model's theoretical framework was developed by integrating sound neurobiologically informed knowledge on resilience with collaborative relationship skills grounded in empowerment of people rather than coercion and control.

Relational–Cultural Theory

Relational–cultural theory (RCT) understands resilience in context to our ability to grow and heal through relationships (Banks, 2015; Jordan, 2018a). The Five Good Things of growth-fostering relationships (e.g., *zest*, *sense of worth*, *desire for connection*, *clarity*, and *productivity*) are qualities that can be used to access the effectiveness of multilevel interventions as these qualities have integrity on the interpersonal, organizational, and environmental levels (Banks, 2015; Jordan, 2018a). The C. A. R. E. Program, in bold, further builds on the Five Good Things, in italics, informed by the neuroscience of RCT where C. A. R. E. reflects the first four of the Five Good Things (Banks, 2015). **Calming** occurs when there is this quality of calm in the vagus nerve, when in a safe relationship, then there is *zest* or warmth that can be felt on the inside of the body through interoception. **Accepted** is understood to be a bottom-up biological experience sending messages of physical awareness of an emotion up to the dorsal anterior cingulate cortex (dACC), the alarm system of the brain. When the emotion of accepted is present in the nervous system a *sense of worth* can be felt. **Resonant** is 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. When safety and understanding are communicated nonverbally in a relationship, there is a resonance present, then the *desire to connect* with more people can grow. **Energetic** increases when the dopamine reward system gives the effect of cognitive focus bringing mental *clarity*. When all these qualities are present and experienced in a relationship then there is *productivity*, that we can do what is mutually needed together (Banks, 2015; Jordan, 2018a). The quality of productivity, as described by RCT, is critical for the interpersonal and multidisciplinary determinants necessary for crisis prevention.

Relational Ecology

At the intersections of Indigenous Knowledge and Relational–Cultural Theory (RCT), *relational ecology* is an invitation to move into relationship by recovering our collective health as collaborators toward environmental justice (Gunderson et al., 2021; Prussia, 2019). RCT has centered relationships as a principal need for the well-being of humans and the relational dynamics on healing as an alternative to a dominant Western lens overemphasizing Eurocentric ways of knowing that prioritize the self as separate (J. B. Miller, 1976; Prussia, 2018). Expanding the scope of the RCT explanatory model to understand connections that are more-than-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 (Abrams, 1996; Gunderson et al., 2021). Indigenous feminisms on ecology provide an essential framework for theoretical integration of the RCT C.A.R.E. Program with the CRM's six wellness skills for crisis prevention among unhoused Indigenous peoples in Albuquerque. Relational ecology is necessary for policy and practice to center a paradigm shift away from a deficit orientation toward resilience and healing.

Purpose and Research Question

There is a gap in knowledge on specific, culturally relevant, crisis prevention interventions for unhoused Indigenous peoples in integrated healthcare settings (HCHCN, 1996, 2011; NHCHC, 2016). The development of this key-informant qualitative study was built on a first phase,

participatory evaluation process tracking, investigating, and analyzing safety incident trends. Previous studies have concentrated on responding to workplace violence in homeless healthcare settings with emphasis on identifying aggressive behavior, verbal de-escalation, managing violent behavior, and debriefing a safety incident (HCHCN, 1996, 2011). An essential component of a CSS is to enhance integrated healthcare providers' understanding of the cultural realities of unhoused people living in Albuquerque who are from dozens of Indigenous Nations. Shifting paradigms from colonial frames toward Indigenous ways of knowing asks for MHTs to engage in critical reflection on how relational discord in clinic continues to be shaped by the impact of racist medical ideologies about alcohol genes and racialized stigma as well as portrayals of Native Americans as violent and aggressive (Clarke & Yellow Bird, 2020; Gray et al., 2018).

The purpose of this study was to inform the development of a crisis prevention process model focusing on the relationship among unhoused Indigenous people and integrated healthcare providers when crisis is prevented. Using key-informant perspectives, a resiliency-oriented approach identifies facilitative factors that are needed for a CSS to be successful moving beyond crisis response to prevention.

Methodology

Study Design

This qualitative content analysis study used key-informant interviews to guide theoretical integration with perspectives from unhoused Indigenous people and members of their MHT for development of a crisis prevention process model to be applied in Albuquerque, New Mexico.

Participants

The setting for this study was initiated at the FNCH, an urban Indian health center and federally qualified 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) administered by 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.

A total of 24 participants engaged in semi-structured interviews for this study (Table 1).

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 reported experiencing houselessness for periods ranging from 1 month (i.e., minimum inclusion criteria) to 12 years with a mean of 2.68 years. Ten out of 14 client participants reported having experienced houselessness for more than 1 year. Two years were 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. 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 reasons to sleep outside. Clients who reported staying at the Good Shepard were on probation and identified as cisgender men. All city shelter participants were cisgender women who reported feeling safer in shelter than sleeping outside.

Data Collection

Key-informant interview questions for this study were developed with HOPSS participants. Semistructured interviews consisted of one 90-min meeting, a follow-up session (i.e., one or two) for clarification as needed. 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 informed

the development of the process model grounded in the experiences of participants for the implementation of a CSS to effectively respond to local culture, practices, and policies among member agencies.

Data Analysis

The primary researcher brought radical empathetic attention and a nonjudgmental stance to support participants to engage with difficult content regarding contexts of being unhoused 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)

Memo-writing was used to build interactive theoretical analysis into the research process early on. All interviews were recorded in the field, saved to a secure digital cloud system, and transcribed into documents in order for coders to collaborate. Audio recordings of interviews and qualitative content analysis began first with the research team reflecting on the impact of social determinants in interpersonal, organizational, and environmental contexts of client/provider relationships to better understand resilience factors that facilitated crisis prevention (Padgett, 2016).

Ethical Considerations and Validation

In context to the ongoing history of Indigenous peoples being overly pathologized and reduced to traumatized subjects of research, this study is explicitly aligned with an ecological lens on resilience, community, and prevention to resist perpetuating colonial narratives. A participatory process was used to identify the research focus, develop an interview tool, and generate frames for measuring the effectiveness of a CSS. The literature review occurred before data analysis in order to understand enough to justify the research proposal. Specifically, the historical and sociopolitical contexts of housing security disparities in Albuquerque among people who self-identify as Native American, crisis de-escalation in community-based homeless services, and CRM. Proceeding data analysis, the literature review expanded to include the MI, RCT, relational ecology, and SAMHSA TIP 61 to inform crisis prevention model development. To reduce the influence of foreknowledge and the researcher's experiences on the interpretation process the primary researcher engaged in ongoing self-reflection through journaling and dialog with the research team. This aspect of bracketing promoted humility to learn from participants' perspectives and experiences. Particularly, during relational analysis, going below the surface of what was being said by clients about the quality of integrated health provider *relationship* and *attention* to understanding the dynamic undercurrent of MHT *cohesion*.

More details on the study methodology can be located in the online supplemental materials.

Findings

The constant comparative method of thematic analysis was applied to participant interview content across question domains, 72 significant statements were identified. They were then synthesized into eight codes, structured into three categories, and two themes were acquired (Table 3).

Belonging in Relationship Through Crisis

Participants described the theme of the sensory connections of belonging as a process grounded by a stabilizing relationship for the client, during the crisis of being unhoused, where an integrated healthcare provider has the quality of "patience" when "being present" in order to "connect with heart" to "see where I come from" and "keep my thoughts positive." The dynamics of presence and awareness were perceived by participants to be fundamental for providers to understand the safety needs of clients for crisis pre-vention more broadly categorized as relationship and attention.

Relationship

Client participants identified *cultural understanding* to be fundamental for a quality relationship with an integrated healthcare provider who

Table 3
Participant Themes on Crisis Prevention

Codes	Category	Theme
Cultural understanding	*Relationship*	Belonging in relationship through crisis
Sense of belonging		
Focusing		
Strengths	*Attention*	
Listen		
Communication	*Cohesion*	Communities for integrated health care
Informed		
Interorganizational systems		

was "Native like me," "from my pueblo," "Navajo too," had lived experience with addiction and/or houselessness, was from a shared culture, spoke the same language, engaged in a shared religious or spiritual practice, and was informed about skills that can bring relief to emotional and physical pain. Together a calming and accepting presence supported unhoused clients to have the *sense of belonging* needed in order to connect. An interpersonal dynamic was reported involving the integrated healthcare provider taking compassionate actions and the client's experience of receiving kindness. Participants described a warmth in connection as part of the experience of belonging in the relationship. Participants perceived being attuned to what were the relevant safety needs of a client as fundamental for a provider's actions to alleviate the suffering related to the disconnection of houselessness. Participants who shared the experience of feeling heard emphasized how the provider was *focusing* on what change was possible.

Cultural Understanding. The process of building trust was described to be ongoing and understood by participants to begin with a culturally responsive welcoming as a way to consistently expressing respect. Taking a moment to calmly acknowledge a client in a warm and respectful manner is a culturally responsive practice of hospitality identified as particularly important when unhoused. Additionally, space in common areas for clients to rest and talk with each other meet clients cultural safety needs. When a provider shared relevant lived experience, to show how they walk the talk in recovery there was increased trustworthiness. Providers who spoke the same language and offered relevant options for each client's recovery journey were important for a client to experience understanding. *Cultural understanding* was identified to be present when working with Indigenous providers and also with non-Indigenous providers.

Clients

> 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?

Integrated Healthcare Providers

> You 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.

Sense of Belonging. When an integrated healthcare provider was present and open to learn more about what was going on for the client then the client described having a *sense of belonging*. Belonging was observed by both provider explicit compassionate actions and client implicit emotion "brings that warm feeling." It is important to distinguish the differences between the clients' experience of receiving kindness and compassionate care toward housing stability. Compassion is a source of warmth but not the warmth itself. Compassion is explicit by taking relevant actions and implicit warmth is in connection with an accepting provider. A client's felt sense of belonging is the warmth experienced with a shift in awareness from the pain of disconnection to connection. When an integrated healthcare provider was able to access the resources they needed themself to feel grounded and could maintain presence then client safety needs were better met, the client's distress was

lowered, and their sense of belonging was strengthened.

Clients

> 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.

Integrated Healthcare Providers

> 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.

Focusing. Participants described how clarifying together what can be addressed offered an opportunity to center the client's agency and move forward in their recovery process. *Focusing* on what was important to the client and the provider matching support and resources to meet their needs was perceived to be critical for success.

Clients

> 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.

Integrated Healthcare Provider

> 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…and then eventually, you know, work her way into housing, not that that's the whole solution, but that she had.

Attention

Participants identified key recovery domains integrated healthcare providers focused on together during safety planning for crisis prevention. Participants shared about the dependable, continuity of care needed for stabilization. Participants emphasized that clients "have their basic needs met in order to focus" because "you need an action plan" and a helpful provider will "always try to find a solution no matter what" and support a client to "keep my thoughts positive." Participants recalled client *strengths* being drawn out and their stories remembered by providers who *listen*.

Strengths. A strengths-based approach facilitated connection when an integrated healthcare provider learned more about how a client understood what they needed. Prayer, family, spiritual community, ancestors, creator, music, culture, laughter, and integrated healthcare providers were healthy relationships identified among client participants as motivation. Recalling healthy relationships that bring up a sense of worth and validation strengthened hope.

Clients

> I started to think about my family, my daughters, and my grandkids that I'm not alone in what I'm going through.

Integrated Healthcare Provider

> 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.

Listen. Participants identified the importance for an integrated healthcare provider to be knowledgeable about both the clients and their colleagues with information shared among members of an MHT. A pattern of ethical distress emerged among integrated healthcare providers due to barriers to care and crises escalated due in part to limited available staff. This contributed to barriers to listening. Clients expressed ambivalence about making a change when there was a good deal of uncertainty about how to best move forward. The role of listening during stabilization and crisis prevention was to hear not just each other's words, also the nonverbal, values, and perspectives.

Client

> 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.

Integrated Healthcare Provider

> 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.
>
> 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.

Communities for Integrated Health Care

Participants identified how overemphasis on behavior change during an activating event brought up discord in the relationship if the resources needed for stable housing and culturally relevant recovery options were not being effectively addressed by the MHT and interorganizational systems.

Cohesion

Cohesion was described by participants to be about the group dynamics among multidisciplinary team members when responding to an activating event and, over time, together preventing crisis working toward the client's housing and recovery goals. The importance of "safety" for clients and providers was perceived to be enhanced by "open communication" among "competent" MHT members who could "walk your talk" to help clients achieve their goals. A cohesive MHT consistently walks their talk together.

Communication. Open communication among participants was the most significant facilitator of cohesion for a MHT. Open communication was described to be necessary to a client's experience of having a reliable team and safe relationships or not. Integrated healthcare providers described the importance of prioritizing warmth with clients during stabilization to help the client be successful with the next steps of their safety plan.

Clients

> 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.

Integrated Healthcare Provider

> 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.
>
> 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.

Informed. Open communication among MHT members was identified as necessary to solve problems and support stabilization together by shifting tasks and roles as needed in a busy setting. Then the team could communicate in an informed manner, people knew about available options and each other's roles. Participants perceived how informed providers were dependable over time. Members of the MHT needed to be able to recall what was the most important and brought meaning in the life of each client in order to be helpful when clients were struggling the most. Client's strengths and reasons for living were described by participants to include family, desired futures (e.g., occupation and education), recovery, and faith. Integrated healthcare providers emphasized they needed to be self-aware of their own state of wellness to ensure they could be present with a client, recall their story, and support their team from a grounded place.

Clients

> 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.

Integrated Healthcare Provider

> 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.

Interorganizational Systems. Interorganizational 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 resilience factor contributing to the client's experience of moving toward their recovery goals.

Clients

> 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 what not. Also, I get medication for my depression, my anxiety, and PTSD. I don't know it' a plus that the locations are right in the heart of the neighborhood. Every other place is like too far to walk.

Integrated Healthcare Provider

> She was referred to CARES and they got her in her safe house and I basically stayed with her the entire time just letting her know like giving her food and water, making small talk, letting her know like you know, we're not going to put you back out on the streets we're going to make sure they stay somewhere safe and and we work this through and she got a housing voucher.

More details on the study findings can be located in the online supplemental materials.

Discussion and Implications for Policy

Humans are social beings who thrive in connection and resist marginalization (Clarke & Yellow Bird, 2020; Craddock & Banks, 2018; Jordan, 2018b). RCT 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).

The metaphor of a compass emerged analyzing how the codes: *cultural understanding* and *sense of belonging*, reflected the grounding and tracking skills from CRM, the **calm** and **resonant** concepts from RCT, and paths to culturally responsive care (W. R. Miller & Rollnick, 2013; SAMHSA, 2018; Venner et al., 2006; Table 2).

The compass is a circle and guide toward connection, using the earth's cardinal directions (e.g., north, east, south, and west) visually to describe how the axis of the categories of *relationship*, *attention*, and *cohesion* correspond to the neurobiological, relational–cultural C. A. R. E. program (Banks, 2015). Participant experiences and culturally relevant MI practices, including the four phases of MI, are integrated in the direction of the process model with focus on building resilience from the relational foundation during crisis prevention (Venner et al., 2006).

With *relationship* on the east–west horizontal axis connecting **calm** and **resonant**, then *attention* on the south-north longitudinal axis connecting **accepted** and **energetic**; all surrounded by the essential element of *cohesion*. 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 as a whole within an organization and in connection with *interorganizational systems*. Participants shared an understanding on clarity in context to **energetic** both RCT concepts illuminating the development of *being in relationship through crisis* at the foundation necessary to arrive to safety and recovery planning together (e.g., client and provider). The integration of the RCT concepts, sense of worth and accepted, contribute to understanding why the category *cohesion* is in part determined by clients having confidence they can depend on their MHT. When a team is cohesive, they are productive together and can get things done like safety planning for crisis prevention. The participants' understanding of the multilevel interpersonal, multidisciplinary, and organizational resilience factors for crisis stabilization and prevention provides a knowledge base to develop a prevention strategy for unhoused people.

A Process Model for Integrated Healthcare Providers

The process model developed for implementation is a C. A. R. E. program for MHTs to scaffold The Five Good Things of growth-fostering relationships, The Basic Three CRM 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 intervention 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 1 is a visual to understand the elements of relational ecology for crisis prevention by applying a C. A. R. E. model for MHTs.

Grounding

Interpersonal resilience emerged as a sense of belonging, grounded in compassion, for a client in 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 (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.

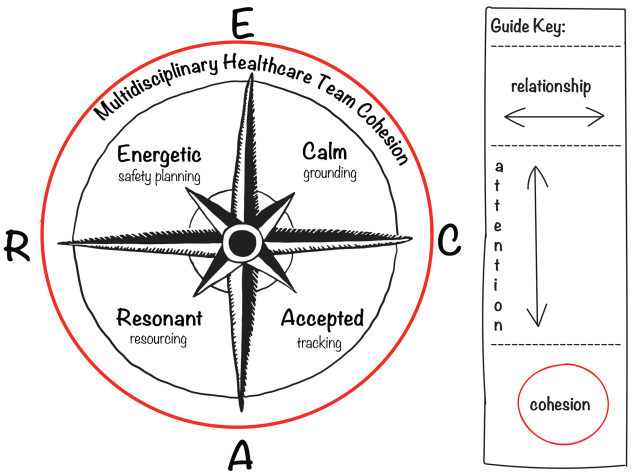
A calm and present integrated healthcare provider can be grounding for a client struggling with a low sense of belonging due to disconnection from marginalization (Jordan, 2018b; O'Keefe et al., 2014; Thistle, 2017; Van Orden et al., 2006). Compassion was understood as a warmth experienced with a quality of presence congruent with the relational component of MI (W. R. Miller & Rollnick, 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; O'Keefe et al., 2014).

Tracking

The resilience designed within the nervous system supports a client's interoceptive, biological awareness of belonging established through compassionate, grounded connection (Banks, 2015;

Figure 1

Crisis Prevention C. A. R. E Model for Multidisciplinary Care Teams



Note. See the online article for the color version of this figure.

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 & 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 & 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, whom 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 in the body. Tracking strengthens the mind-body connection and the capacity for clients to move forward in 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 expand and connect outside of themselves. Nourishment and water are important parts 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, is strengthened in a resonant relationship. Emotional self-awareness enhances the capacity for a client to begin to focus 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, and spirituality) can also be brought in using conversational resourcing and/or imagination to enhance the 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 must 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 to clarify 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 to center client autonomy in shaping their care.

Multidisciplinary Healthcare Teams

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 CSS. The work environment is a social determinant of health (Bransford & Cole, 2019; Healthy People 2030, 2022). 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 of 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 and prevent provider burnout and compassion fatigue (Bloom et al., 2003; 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 (Rosen et al., 2018).

Practice and Policy Implications for a CSS

Community-based prevention to address health disparities related to houselessness requires significant structural changes to bring together integrated healthcare and housing policy at the federal, state, tribal, 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. Integrating somatic literacy and the CRM 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 interagency strategies an organization can take to implement Wellness Skills, bring immediate relief to clients, and provide mutual support for colleagues (Miller-Karas, 2015; Prussia, 2019). 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 practices 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 that understands cohesion enhances the capacity for an MHT to uphold client self-determination toward their fullest potential as a central tenet of a successful CSS (Bowen & Murshid, 2016; Substance Abuse and Mental Health Services Administration, 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.

Conclusion

This study emphasized the importance of grounding a relational ecological model in

participant experiences to more effectively 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 CSS. 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 is important for effective response, de-escalation, and stabilization of crises. CRM provides essential wellness skills to scaffold from a relational foundation using a culturally responsive implementation process to increase the capacity for the CSS to succeed.

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