Illegal Homeless Encampments In California: Using The COM-B Framework to Transform A Public Health Nuisance Into A New Housing Development Model

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Illegal Homeless Encampments In California:
Using The COM-B Framework to Transform A Public Health Nuisance
Into A New Housing Development Model

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Abstract

California has the highest homeless population, with over 161,000 people experiencing homelessness. Despite approving a billion dollars in grants for the 2018-2019 budget, The 2021 Annual Homeless Assessment Report (AHAR) to Congress revealed California had an increase of over 3,500 individuals staying in shelters between 2020-2021. The multi-faceted and multi-dimensional issues of homelessness and policies make it difficult to prevent individuals experiencing homelessness from living in illegal encampments. Therefore, the author proposes a multi-prong approach to homelessness in California grounded in theories of the Socio-Ecological Model (SEM) and COM-B model and informed by housing first and permanent supportive housing practices. There are two objectives for the recommendations discussed in this paper. The primary aim is to provide alternative permanent supportive housing options for the homeless population, thus reducing illegal encampments. The secondary objective is to create a space for researchers to collect necessary data to fill the gaps discovered in the literature, thus equipping policymakers with enough data to make informed decisions on policies affecting the homeless population. Achieving the two objectives require innovative permanent supportive housing options for individuals experiencing homelessness. The author proposes California develop state-ran authorized homeless camps as an innovative permanent supportive housing option—a whole system approach with intensive targeted health and social interventions to support the whole person care model.

Keywords: Homeless, unhoused, unsheltered, sheltered, homeless encampments, houseless, low housing supply, whole-person care, whole system approach, housing first, permanent supportive housing, social determinants of health
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California prides itself on being the leader of progressive and innovative initiatives compared to other states. However, growing concerns about homelessness leave many leaders and stakeholders at all systematic, intergovernmental, and market economy levels scrambling to contain and reduce the expansion of homeless populations (Kendall, 2022; National Academies of Sciences, Engineering, and Medicine et al., 2018). Piecemeal approaches are regularly undermined by the structural barriers—giving rise to individuals living in illegal encampments throughout California. For example, a 2019 federal court ruling, Martin v. Boise (Martin V. City of Boise, 2018), prevents officials from removing individuals camping on public property unless they offer alternatives, such as availability at a shelter or a legal campground. However, there’s a lack of affordable housing and shelter inventory to provide for homeless individuals (Allegrante & Sleet, 2021). Following the Socio-Ecological Model (SEM) (see Figure 2) and the housing first approach, this paper will focus on systematic housing barriers at the community and societal level, which are contributing factors to individuals experiencing homelessness living in illegal encampments.

The web of complexities within the homeless population traps funding efforts to mitigate the issue. California is investing considerable money into programs serving the homeless population and not improving outcomes. For example, California reported an increase of 3,541 individuals staying in shelters between 2020-2021 (Henry et al., 2022, p.9) even though the state approved $1 billion in grants two years prior to the publication of the report (Petek, 2020). Over the next two years, California will invest $2.2 billion to address the homeless crisis; the plan is short-term, and the authors of the report acknowledge long-term planning and increased priority for homelessness is an objective (Petek, 2022). Therefore, there is no better time than now to start reimagining, redefining, and redesigning housing developments for the homeless population.
Background and Literature Review

Illegal homeless encampments are a public health threat and have increased in response to the surge of unsheltered individuals. Illegal homeless encampments are where unsheltered individuals set up illegal camping, which Olson and Pauly (2021) describe as *visible homelessness* (Olson & Pauly, 2021). According to the US Department of Housing and Urban Development (HUD), people living in places not meant for human habitation, such as cars, abandoned buildings, or public areas, are considered *unsheltered* (Abt Associates Inc., 2004). People living in either an emergency shelter, transitional housing, or supportive housing are considered *sheltered*.

HUD requires Continuum of Care (CoC) agencies (regional or local planning bodies) to conduct an annual Point-In-Time (PIT) count. CoC agencies are charged with coordinating housing and program funding for individuals experiencing homelessness. A PIT is a count of sheltered and unsheltered individuals experiencing homelessness on a single night in January. The 2018-2019 PIT report shows a 12% increase (see Appendix B) in the unsheltered homeless populations (Petek, 2020). Due to the pandemic, the 2021 PIT data does not include unsheltered homeless people (Petek, 2022). The data from the PIT count in January of 2022 was not yet available. There is no specific data on how many individuals live in illegal encampments or how many unlawful encampments exist throughout California.

While this paper focuses on California, it’s important to understand homelessness and the magnitude of the problem at the National level. Over half a million people experience homelessness in the United States (World Population Review, n.d). According to the U.S. Interagency Council on Homelessness (USICH), California has the highest homeless population, with over 161,000 people experiencing homelessness which means 40 out of every 10,000 Californians experience homelessness (USICH, 2015)—comparing this to North Dakota, which has a minuscule homeless population of over 500 (7 out of 10,000). In addition, Texas and Florida, which have populations closer to California, have more than 27,000 persons experiencing homelessness, which means 9 out of 10,000 of Texas’s population and 10 out of
10,000 of Florida's population are experiencing homelessness. Each state has its unique drivers of homelessness, some of which are individual factors and some of which are structural factors. This paper does not go into depth about individual elements; however, they are considered in the recommendations. Likewise, while income inequality is a critical structural factor affecting homelessness (Byrne et al., 2021; Fazel et al., 2014), this paper focuses on the unavailability of affordable housing in California and its impact on the homeless population's health.

**Homelessness a Social Determinant of Health (SDOH)**

The literature establishes that homelessness is a Social Determinants of Health (SDOH). According to Healthy People 2020, homelessness falls under the economic stability domain and is the most severe form of housing deprivation (Healthy People 2020, n.d.). SDOH are economic and social conditions influencing an individual's health. Healthy People 2030 defines SDOH as conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2030, n.d.). There are five domains of SDOH (see Figure 1).

![Social Determinants of Health](image)

**Figure 1:** Social Determinants of Health (SDOH)

Source: Healthy People 2030
According to the National Academies of Science (2018), people experiencing homelessness have a high prevalence of poor health outcomes; the following are three types of interactions between homelessness and health:

1. Health problems, such as mental health and substance abuse, lead to homelessness.
2. There are poor health outcomes in response to experiencing homelessness, such as diseases of extremities, skin disorders, and the possibility of trauma.
3. Treatment of chronic illnesses, such as asthma, HIV/AIDS, tuberculosis, hypertension, diabetes, and chronic obstructive pulmonary disease (COPD), are further complicated by the experience of being homeless.

These interactions between homelessness and health require a multi-prong approach to improving health outcomes within the homeless population. While the Affordable Care Act (ACA) expanded medical coverage and access to care for the homeless population, it alone cannot improve health outcomes for the homeless population. Therefore, a housing-first approach is essential in improving health outcomes for individuals experiencing homelessness.

**Housing First Approach (HF)**

The housing first approach, according to Baxter et al. (2019), emphasizes providing rapid housing without substance abuse restrictions. Innovative interventions should integrate income stabilization, housing, and health as a multidimensional pathway to recovery (Elder & King, 2019). Studies show HF approaches, as opposed to treatment-first approaches, effectively achieve and maintain housing stability, thus improving health outcomes (Baxter et al., 2019; Perkins, 2016). On September 29, 2016, Governor Jerry Brown signed Senate Bill No. 1380, which adopts the housing first approach for any state program funding housing for people experiencing homelessness or at risk of homelessness (Senate Bill No. 1380 Adopting Housing First, 2016). California Advancing and Innovating Medi-Cal (CalAIM) (see Appendix D) attempts to bridge the gap between housing and healthcare by offering a Community Supports component, which is designed to address health-related social needs, such as food and housing
security (Crumley et al., 2022). However, it is unable to bear the entire burden of housing issues. This paper argues health coverage alone is not sufficient in improving health outcomes for individuals experiencing homelessness. Therefore access to stable housing in addition to access to healthcare is imperative. According to Baxter (2019), a systematic review found improvements in housing stability with HF interventions; however, the short-term impact on health outcomes was unclear due to how outcome measurements were grouped. Additionally, the researchers note further investigations into the long-term consequences are required. While long-term effects were not established, a meta-analysis of randomized controlled trials concluded HF approach improved hospitalization and emergency department visits, which the researchers note could be an indicator of improved health outcomes (Baxter, 2019).

**Permanent Supportive Housing Model (PSH)**

As stated earlier, access to stable housing in addition to access to healthcare is imperative, so this paper explores the Permanent Supportive Housing (PSH) model to complement the HF approach for improved health outcomes amongst the homeless population.

Permanent Supportive Housing (PSH) is an evidence-based housing intervention combining various supportive services and housing for individuals experiencing homelessness (Henwood et al., 2018). Supportive services include any combination of low-intensity or high-intensity services such as case management, assertive community treatment, primary health care, psychosocial interventions, substance abuse counseling, mental health, education and prevention programs (relevant to individual needs), and job and legal services (Henwood et al., 2018; National Academies of Sciences, Engineering, and Medicine 2018). A study found homeless individuals have a mortality rate 1.6 times higher than local non-homeless residents, implying a need for intensive targeted health and social interventions for the homeless population (Morrison, 2009). Moreover, observational studies indicated individuals who formally experienced homelessness were off the streets for a significant period due to PSH programs (National Academies of Sciences, Engineering, and Medicine, 2018, p.41). For example, a study in Seattle found only 23 percent of the participants returned to homelessness, and
another study in New York found a retention rate of 84 percent. Suggesting centralized PSH for the homeless population benefits individuals experiencing homelessness (National Academies of Sciences, Engineering, and Medicine, 2018). This paper argues that PSH is also beneficial for the public because of the economic, public health, and safety implications of homelessness.

**Socio-Ecological Model (SEM)**

The socioeconomic, public health, and safety implications of homelessness are analyzed under the Socio-Ecological Model (SEM) to understand better the complex interplay between individual and systematic housing barriers. According to McKenzie et al. (2017, p.155), the socio-ecological approach was developed by psychologist Urie Bronfenbrenner in 1979 and has been applied to various public health issues. SEM recognizes that human behavior shapes and are shaped by multiple levels of influence (McKenzie et al., 2017, p.431).

**TABLE 1 An Ecological Approach: Levels of Influence**

<table>
<thead>
<tr>
<th>Concept</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrapersonal [Individual] Level</td>
<td>Individual characteristics that influence behavior, such as knowledge, attitudes, beliefs, and personal traits</td>
</tr>
<tr>
<td>Interpersonal Level</td>
<td>Interpersonal processes and primary groups, including family, friends, and peers that provide social identity, support, and role definition</td>
</tr>
<tr>
<td><strong>Community Level</strong></td>
<td></td>
</tr>
<tr>
<td>Institutional Factors</td>
<td>Rules, regulations, policies, and informal structures that may contain strain or promote recommended behaviors</td>
</tr>
<tr>
<td>Community Factors</td>
<td>Social networks and norms, or standards, that exist as formal or informal among individuals, groups, and organizations</td>
</tr>
<tr>
<td>Public policy</td>
<td>Local, state, and federal policies and laws that regulate or support healthy actions and practices for disease prevention, early detection, control, and management</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>Natural and built environment</td>
</tr>
<tr>
<td>Culture</td>
<td>Shared beliefs, values, behaviors, and practices of a population</td>
</tr>
</tbody>
</table>

Source: McKenzie et al. (2017)
Implications

**Economic**

There are several economic implications of homelessness throughout several levels of the SEM, from the individual to the organizational level and vice versa. Economic areas affected by homelessness to consider are employment rates; utilization of social, public, or healthcare services; and solid waste services. All areas are interrelated, adding to the web of complexities in the homeless population.

**Employment**

As discussed earlier, economic stability is a key area of the SDOH, and housing instability is a key issue that significantly impacts individuals experiencing homelessness. As a result, individual economic instability has economic implications at the societal level. For example, individuals experiencing homelessness provide little to no revenue streams but utilize one or more social or public services. There is a gap in data pertinent to employment rates amongst the homeless population in California; however, a few cities have captured and reported data. The following summary of the data (Wagner, 2018) gives some insight into the employment rates of specific homeless populations:

- In 2017, 13% of San Francisco’s homeless population had part or full-time employment
- In 2017, 8% of Los Angeles’s homeless population had part or full-time employment
- In 2018, 10% of San Diego’s homeless population had part or full-time employment

Similar research throughout California would close the data gap of employment rates amongst the homeless population and provide data for an accurate cost-benefit analysis to estimate the strengths and weaknesses of various intervention programs. As a result of little or no income sources, individuals experiencing homelessness may utilize one or more social services. There is a gap in data on how many individuals experiencing homelessness receive social services; however, they are eligible for programs such as CalFresh, CalWorks, Medi-Cal, and housing assistance. Therefore, further research for an accurate cost-benefit analysis is required. Regardless of the gap in data, it is crucial to understand systemic barriers prevent
individuals experiencing homelessness from receiving social services, intensifying their economic stability.

**Healthcare System**

The healthcare system is another area affected by the economic implications of homelessness. Individuals experiencing homelessness are more likely to use emergency department services due to a lack of adequate housing and regular, uninterrupted treatment (Sadowski et al., 2009). One study reported that 45% of frequent users of the emergency department population were individuals experiencing homelessness, and of the 15 “super frequent users,” 11 were individuals experiencing homelessness (Linkins, Ph.D. et al., 2008). Frequent users were identified by case managers from six different counties using databases of participating emergency departments. The study showed being linked to permanent housing (PH) was protective. There were 166 individuals experiencing homelessness in the sample; 67 were connected to PH, and 99 were not connected to PH. The sum of emergency department charges for pre-program interventions for those connected to PH was over $813,000 and over $1.5 million for those not connected to PH (Linkins, Ph.D. et al., 2008). The sum of emergency department charges for post-program interventions for those connected to PH was over $553,000 and over $1.4 million for those not connected to PH (see Appendix C).

The interventions included a range of models developed within six programs funded through the *Frequent Users of Health Service Initiative (Initiative)*. The *Initiative* revealed individuals experiencing homelessness are high utilizers of emergency department visits, and the costs significantly impact the healthcare system. The six programs funded by the *Initiative* provided evidence of reducing the use of emergency department services, reducing inpatient hospital utilization, and connecting individuals with medical and social service benefits, including housing. These findings established a valuable connection between housing and healthcare. An economic analysis for helping individuals experiencing homelessness in Sacramento suggests investments in integrated care interventions (housing, wraparound service, and healthcare) for the homeless population may be a better option than the status quo (Hoch & Trenaman, 2020).
The Hoch et al. (2020) analysis found cost offsets associated with integrated care options were reductions in ED visits, inpatient days, criminal justice, victimization, and costs associated with deaths.

**Solid Waste Services**

Another economic implication is the cost of solid waste services needed to clean illegal encampments. The Encampment Resolution Funding (ERF) Program is a $50 million grant to assist local jurisdictions in providing intentional pathways to safe and stable housing for individuals living in illegal encampments (California Business, Consumer Services, and Housing Agency, n.d.). The project goal was to focus on a sustainable restoration of public spaces to their intended uses while being mindful of the homeless population’s needs. The 2021-22 budget encampment resolution effort allocated (1) $2.7 million from the General Fund for encampment relocation coordination and homeless services liaisons, (2) $20.6 million in special funds for the removal of hazardous material at encampments, and (3) $25 million from the General Fund is set aside from the more extensive Clean California budget action to clean up encampments, to the California Department of Transportation (Caltrans) to address illegal encampments (Morales, 2021).

**Health and Safety**

Besides the health and safety implications at the individual level, there are health and safety implications at the community and societal levels. For example, in 2013, the Illegal Dumping Technical Advisory Committee (IDTAC) developed a Homeless Encampment Reference Guide to add to the Illegal Dumping Toolbox and posted it on the CalRecycle website (CalRecycle, n.d.). According to the CalRecycle, website:

> [individuals experiencing homelessness] generate solid waste during their daily activities of food preparation and consumption, shelter building and maintenance, storing their possessions, eliminating unwanted materials, and gathering recyclable materials of value. The resulting piles of trash become harborages and food sources for vectors and related pathogens, sources of odors, fuel for fires, unattractive nuisances to the public, an attractive nuisance for salvagers, and potential sites that can cause bodily injuries.
The decision and subsequent process to close and abate homeless encampments is time consuming and labor intensive. Local government needs to address the management of solid waste in encampments that will continue to be generated while the encampment is in the closure process as well as the abatement of solid waste that remains in the encampment subsequent to its closure.

Until local governments close illegal encampments and restore public spaces to their intended use, individuals living in illegal encampments and nearby neighbors are at risk of exposure to vectors, pathogens, and hazardous odors. For example, due to no access to restrooms, homeless encampment individuals are exposed to fecal bacteria. Additionally, inaccessibility to indoor central air conditioning systems leaves individuals exposed to poor air quality during fire seasons; in some cases, fires start as a result of illegal encampment conditions. Therefore, the community benefit of housing individuals is avoiding the hazards and nuisances of illegal encampments.

Moreover, solid waste accumulated is highly and unpleasantly visible. Items commonly found in encampments include garbage, feces (human and animal), combustibles, recyclables, tires, e-waste, hazardous material, medical waste, pharmaceutical waste, used oil, abandoned vehicles, and dead animals.

**Current Interventions**

As with the implications, this paper will discuss current interventions following the Socio-Ecological Model (SEM).
**Policy Level**

A 2019 federal court ruling, Martin v. Boise, prevents officials from removing individuals camping on public property unless alternatives, such as availability at a shelter or a legal campground, are offered. As discussed earlier, there is a shortage in housing and shelter stock, so local officials have nowhere to place individuals or a way of tapping into community resources.

**Community Level**

There are community-based organizations offering services for individuals experiencing homelessness, such as shelters or soup kitchens. For example, St. Vincent de Paul, Roseville Conference, located in Roseville, California, carries out their mission of providing essential human services and programs to prevent hunger and homelessness by offering rental assistance to clients from becoming homeless. Also, St. Vincent de Paul’s TO GO program serves nutritious meals to individuals experiencing homelessness and low-income individuals and families. Lastly, the Food Locker program provides supplemental groceries to low-income individuals and families. The Gathering Inn in Roseville, California, offers emergency shelter and permanent supportive housing services to the homeless population.

**Interpersonal Level**

While individuals living in illegal encampments are part of a close-knit peer group, case managers from community-based organizations provide professional support. Case managers assist individuals experiencing homelessness by coordinating care and rapid rehousing. For many individuals experiencing homelessness, case managers are their primary point of contact for local resources. For example, The Ritter Center, located in San Rafael, California, provides case management services to those experiencing homelessness by offering rental assistance, security deposits, utility payments, and moving assistance. Additionally, case managers assist individuals budget and managing their fixed incomes. Father Joe’s Village, located in San Diego, California, provides an array of services to its homeless population, such as emergency shelter, transitional shelter, supportive housing, case management, and therapeutic childcare service.
**Individual Level**

Case managers at community-based organizations help place individuals experiencing homelessness who also experience cognitive impairment into substance abuse programs or therapy to address mental health issues. For example, Turning Point Alcohol & Drug Education Inc., located in Los Angeles, California, employs therapists, substance abuse counselors, community health workers, and intensive case managers. The team of professionals provides culturally appropriate counseling to clients struggling with substance abuse or managing mental health.

There is ample evidence highlighting the complexities of homelessness, one of which is the interconnectedness of health and housing. Much research has also been devoted to housing first models and permanent supportive housing interventions (Baxter et al., 2019; Henwood et al., 2018; Latimer et al., 2019; National Academies of Sciences, Engineering, and Medicine et al., 2018; Perkins, 2016; Piat et al., 2015). However, very little data or literature related to illegal encampments and health. There was difficulty locating state data on employment and social service utilization rates for individuals experiencing homelessness. Factoring in data gaps, literature gaps, and systematic barriers, the recommendations discussed below are guided by the housing first model, combining the COM-B (see Figure 4) multilevel theoretical system (a framework for understanding behavior) and the permanent supportive housing intervention model. The aim is to transform a Public Health nuisance into a new housing model for individuals experiencing homelessness. Thus, eliminating illegal encampments and providing a safe living environment with healthy recreational activities where people can heal and recover.
Methods

The author of this paper conducted a literature review guided by a key area identified as a systematic barrier for individuals experiencing homelessness living in illegal encampments at the community and societal/policy levels. In the spring of 2021, under the “Policies and Practices Perpetuating the Gaps between Housing and Health Access for Vulnerable Populations” project, qualitative data was collected, and several key areas were identified; however, this paper will only focus on limited resources—low housing and shelter stock.

The search strategy was in collaboration with Claire Sharifi, a University of San Francisco Librarian. The literature review began with three searches, one in PubMed, APA PsycInfo, and SocINDEX combined, and one in CINAHL Complete. Later searches utilized Google Scholar and Google search engines. All searches included combinations of the following: unhoused, homeless*, houseless*, housing shortage, camp*, encamp*. PubMed yielded five results, CINAHL Complete, APA PsycInfo, and SocINDEX combined yielded seven articles and two ebooks, and Google Scholar search yielded nine articles. After skimming titles and abstracts, ten articles and one ebook were selected for full-text review and data usage; individually, they tell part of the story; however, the problem and possible solutions collectively bring the story into focus. The Google search engine was used to fill any data missing from the articles. Additional relevant reports and articles were shared from professors and colleagues or obtained while searching for additional information to fill in the gaps from the original database searches. Initial searches were restricted to studies published from 2012 to the year of the search (2021). Articles were chosen for their content relevant to four themes: homelessness is a social determinant of health, permanent supportive housing, housing first, and complexities of homelessness. Gaps in the literature suggest an emphasis on research and needs assessments specific to the encampment populations are needed.
**Recommendations**

The following recommendations are intended to create a *whole system approach* (Sharpe et al., 2018) to provide *whole-person care* to individuals experiencing homelessness. As discussed, the web of complexities within the homeless population makes it difficult to close the gap between health and housing for individuals living in illegal encampments. The Behaviour Change Wheel (BCW) framework (Figure 3) provides a theoretically based approach to mitigating the complexities and understanding behavior (Michie et al., 2011).

**Figure 3: The Behaviour Change Wheel**
Michie S et al, 2011

Establishing a comprehensive *whole-person care* intervention for individuals experiencing homelessness requires a *whole systems approach*. The whole system care intervention is accomplished by melding the Socio-Ecological Model (SEM) and the housing first approach with permanent supportive housing services (Policy and community level interventions) and the COM-B model (interpersonal and individual level). The aim is to create state-authorized homeless camps throughout California which provide innovative, supportive housing alternatives for individuals living in illegal encampments. Moreover, the state-authorized homeless camps create a space and opportunity for researchers to collect necessary data that
support policymakers and public health leaders in making informed decisions. As discussed earlier, PIT counts of sheltered and unsheltered individuals experiencing homelessness are conducted on a single night every January. Unfortunately, PIT counts only consider sheltered and visible street homelessness creating unstable data. State-authorized homeless camps will provide stable access for data collection.

**Primary Objective: State Authorized Homeless Camps**

The author proposes the state create a pilot program (policy level intervention) of authorized homeless camps throughout California as an alternative to living on the streets while waiting for permanent housing placement; no time limit will be imposed. The authorized homeless camps are designed modeling Catholic Youth Organization (CYO) Camp Armstrong, Kampgrounds of America (KOA), and Coloma Resort (see Appendix E). These organizations manage camping facilities; each community has unique camping options, amenities, and activities. The proposed state-authorized homeless camps would meld together everything each of these has to offer:

**Catholic Youth Organization (CYO) Camp Armstrong**, located in Sonoma County, is a Catholic community where children of all religious backgrounds participate in youth-centered programs with the aim to:

- Build a community of strong relationships
- Give all participants a sense of belonging and responsibility to the camp community
- Foster an environment where positive attitudes build an overall positive community
- Provide a structure within which participants will excel, be held accountable, and have onsite support services
- Provide meals through the Lodge, a 6000 sq. ft. building that serves as the dining area.
Kampgrounds of America (KOA) is the world's most extensive system of privately held campgrounds, with more than 500 locations across the United States and Canada. Every campground offers:

- Tent, cabin, or RV living options
- Community restrooms and showers
- Organized community activities
- An outdoor amphitheater, picnic areas, and group campfire area
- Camp store

**Coloma Resort**, located in El Dorado County, is a family-owned and operated camping resort and educational facility that has:

- Similar camping options and amenities as KOA, but offers family bunkhouses (2 rooms and a private bathroom)

Aligning with California’s Housing First approach, the proposed authorized homeless camps would provide centralized shelter with various living options and wrap-around services for individuals experiencing homelessness. The proposed authorized homeless camps would provide a central location for service providers to serve individuals experiencing homelessness in a controlled environment, allowing public health officials to quickly assess and monitor the unhoused population. Additionally, the proposed authorized homeless camps empower local jurisdictions to disband illegal encampments humanely and dignifiedly, reduce public waste management services, and increase employment opportunities for individuals in the program.

Following the COM-B model, a team of service and medical providers (organizational level) from local community-based organizations and hospitals would be required to collaborate in creating a support system (whole system) within the authorized homeless camps. According to Michie et al. (2011), capability, opportunity, and motivation produce behaviors that will influence the intended behavioral change in the COM-B system. Therefore, the whole system will include components of the COM-B system to promote whole person care for individuals living in the authorized homeless camps. This intervention, guided by professionals, aims to
provide a safe, supportive environment and tools to help change individual behaviors that perpetuate homelessness.

A team of case managers and service providers would be required to coordinate care following the COM-B system (Figure 4) for individuals living within the authorized camps to change behaviors that contribute to homelessness at the individual level. For example, increase personal capability by providing educational and training interventions to obtain or maintain employment and manage their health. An innovative camp offers various living arrangements (tent, cabin, family bunkhouses, or RV spaces) with layered supportive interventions (medical, mental health, or vocational education). A safe living environment with healthy recreational activities provide opportunities for recovery and healing. Providing a sense of belonging and hope could motivate people and increase their chances of becoming self-sufficient and successful transition back into permanent housing and employment on or off the campgrounds. Building a community that embraces love, hope, and support encourages members to participate in community events and self-care programs.

Figure 4: COM-B System
Michie S et al, 2011
Secondary Objective: Further Research to Close Gaps

In addition to providing centralized housing and wraparound services for individuals experiencing homelessness, the authorized homeless camps create a space for researchers to collect necessary data to fill in the gaps discovered in the literature. Policymakers and public health leaders rely on evidence-based research to make informed decisions on future interventions, budgetary allocations, and preventative initiatives involving the homeless population.

In a controlled environment absent of structural barriers, such as lack of rent subsidies, affordable housing or shelter stock, and lack of access to support services due to restrictive qualifications and eligibility criteria (Piat et al., 2015), public health officials would have more control over addressing the root causes of homelessness as they present themselves. State homeless camps will create an environment where service providers regularly complete needs assessments and work with public health officials and community-based organizations to report data to policymakers keeping intervention efforts moving forward.

Implementation Strategy

Following the MAP-IT Model (see Figure 5), the state-authorized camps would be implemented as a state-ran program in collaboration with local governments, community-based organizations, and community members.

![MAP-IT Whole System Approach](image)

Figure 5: MAP-IT Model
Source: perinatalqi.org/page/MAPITWorksheet
The MAP-IT Model was an adaptation of *Healthy People 2020* as a framework to plan and evaluate community public health interventions (McKenzie et al., 2017, p.46). MAP-IT consists of five phases; 1) Mobilize, 2) Assess, 3) Plan, 4) Implement, and 5) Track. To successfully address the complexities discussed earlier, there must be several cycles of MAP-IT through the planning, implementation, and evaluation process.

The first cycle would be implemented during the planning phase and would include the following phases:

1. **Mobilize**: A task force would be charged with mobilizing key community stakeholders to form a coalition
2. **Assess**: The coalition would assess what resources are already available in the community and any additional resources required.
3. **Plan**: The coalition would set goals, objectives, measures, baselines, and targets.
4. **Implement**: The coalition will set clear action steps, timelines, and responsibilities to assign to program partners.
5. **Track**: Setting baselines are essential to collect and set for adequate program evaluation, as discussed below. Establish baselines for data collection by the following questions should be considered and tracked by the coalition:
   a. How many encampments will be disbanded in the communities running the authorized homeless camps?
   b. How many individuals will be placed in the authorized homeless camps?

Subsequent program intervention cycles would be implemented and repeated for adjustments throughout the length of the program. State homeless camp interventions (housing options, healthcare, substance abuse, behavioral issues treatment, educational workshops, and employment training, etc.) are designed to bridge gaps between community-based organizations and hospitals, allowing them to serve the homeless community as a whole system. The MAP-IT systems approach helps facilitate the mechanism of coordinating resources.
Evaluation Strategy

The task force team will need to develop several evaluation strategies for the multi-level services operating simultaneously to create a whole system approach to meet the needs of each individual. Each evaluation strategy would follow the CDC framework (Figure 6) as part of the Track phase of the MAP-IT model. Every evaluation timeframe would be conducted depending on each program’s goals and targets. Local stakeholders would meet quarterly to evaluate each program using the Logic Model (see Appendix F) to present and share an understanding of the relationship between program resources and planned activities. To fill some of the gaps in data from the literature, credible data will be collected, such as health assessments, employment rates, social service utilization, and permanent housing placement. The task force and coalitions will receive reports of all information and lessons learned.

Funding Options

California owns quite a bit of land (The Bureau of Land Management) and has a surplus budget. Therefore, it is feasible this proposal can receive funding from various sources, such as state, federal, and private funding. Local hospitals can help fund through their community benefits health programs. Private investors and possible partnerships with local banks, universities, and other large firms committed to humanitarian aid would be considered to expedite the initial project and program development. Centralized supportive housing allows community-based organizations to focus on upstream prevention programs. Preventing
homelessness upstream will contain the expansion of homelessness. Over time, the state can reallocate funds from programs no longer needed because they are integrated into the authorized homeless camp model, such as waste management, shelters, clinics, transportation, housing subsidies, and food kitchens.

Additionally, there are three opportunities for the authorized homeless camps to generate revenue; 1) through sliding scale rental fees, 2) by billing Medi-Cal, and 3) through future camping reservations. Upon becoming stable and receiving income, clients are required to pay rent. The sliding scale rent amount is based on their income and type of living option choice (tent, cabin, family bunkhouses, or RV spaces). The onsite clinics would bill Medi-Cal for any medical services provided. Moreover, once the authorized homeless camps are no longer needed, they will have the infrastructure to convert into a public state campground.
Implications and Discussion

Developing authorized homeless camps as an alternative housing option would reduce and, over time, eliminate illegal encampments. Designing and providing central PSH to the homeless population will allow the *whole system approach* (Sharpe et al., 2018) to support the *whole person care* model adopted by Continuum of Care (CoC) agencies. *Illumination Foundation*, located in Orange, California, accomplishes this by providing targeted, interdisciplinary services to its clients. They offer shelter and navigation centers, respite and recuperative care centers, access to health care, and housing programs.

At the proposed authorized homeless camps, *whole system services* are coordinated both within the camp and external services (for those transitioning). Integrating the whole person care model will increase opportunities for individuals to thrive and become contributing members of their communities. Onsite clinics centralize medical care focused on patient-centered care. All staff and service providers will use the *Homeless Data Integration System (HDIS)* to collect and track data. According to *California Business, Consumer Services and Housing Agency*,

HDIS is a statewide data warehouse that compiles data from the 44 regional homelessness service coordination and planning bodies—each referred to as a Continuum of Care—that provide a full range of services, including homelessness prevention services, street outreach services, permanent housing interventions and a range of other strategies aligned with California’s Housing First objectives. Each CoC collects data about the people it serves and its services according to common federal standards. Integrating this data into HDIS establishes California’s first statewide repository of common homelessness data. It streamlines information and analysis by combining information from 44 separate systems into one single point of access. If staff members identify gaps in HDIS, they will recommend improvements to the system operators to expand and maintain a robust data collection system. The unhoused population in a controlled environment provides a central location for service providers to host informational
sessions for individuals in the program. Likewise, having service providers in a central place offers time and space for collaboration and care coordination. This environment encourages a two-way communication path allowing individuals to inform and educate service providers about their needs. Authorized homeless camps offer health and safety benefits, such as reducing infectious diseases; and eliminating waste accumulation within illegal encampments. Having onsite clinics increase the chances of routine health care visits and treatment management, thus preventing the spread of infectious diseases. Additionally, having access to onsite waste management services would increase opportunities for proper waste disposal, thus reducing illegal dumping in public areas.

Moreover, homeless individuals experiencing mental health and addiction will no longer live on the streets and have access to care. In addition to accessing care, they will have access to food, a safe living environment, and peer-to-peer support. The impacts discussed in this section strengthen the overall public health system by effectively delivering ten essential public health services (see Appendix G) outlined by American Public Health Association (APHA).

Limitations

Policy Level

On the housing side, there are standards in developing housing based on current policy and social norms of what housing ought to look like. It will be difficult to change social norms of housing expectations–traditional housing developments require walls, a roof, and utilities. The authorized homeless camps would offer non-traditional permanent and transitional housing options such as tents, RVs, and log cabins.

Community Level

There are limitations to consider with coordinating care between healthcare systems and social service systems. In one study, qualitative analysis revealed providers perceived various barriers to effective service delivery, such as patchwork service approach, relying on outside agencies, and limited provider capacity (Henwood et al., 2018). According to the article, the patchwork service approach, which is having to contract with multiple outside providers, makes consistent access to services difficult. Relying on outside agencies requires increased
communication with third-party providers who frequently prefer not to communicate with other providers. Limited agency resources and large caseloads make it difficult for providers to perform at maxim capacity. Prioritizing client service needs and program guidelines (frequent contact with every client) becomes more difficult to balance as caseloads increase. The article suggests a caseload of fewer than 36 clients helps balance addressing each client's needs (Henwood et al., 2018). The authorized homeless camp creates a central environment where service and medical providers have the opportunity to communicate in person regularly.

The not in my backyard (NIMBY) mentality also creates a barrier for homeless projects in certain communities. For example, this author attended a town hall meeting about the Gathering Inn Campus of Hope project, similar to the proposed authorized homeless camp, and observed community members oppose the project. They claimed the homeless population would attract drug activity and crime to their neighborhoods. The pressure applied to the county board of supervisors stalls project efforts. The proposed authorized homeless camps are developed on state land, eliminating barriers at the county level. One last limitation is the possibility of stakeholders currently receiving funding not wanting a new program that would eliminate the need for their program, thus losing current funding. The authorized camps are designed to utilize current programs and resources, thus creating opportunities for stakeholders to offer services within the authorized camps.

**Interpersonal Level**

There may not be enough case managers to support the number of clients. The authorized camps create an opportunity to build a robust workforce by creating coalitions within the community and partnerships with local universities to assist with the workload.

**Individual Level**

Some individuals may have behavioral limitations, such as mental health, which could cause them to resist moving off the streets. Additionally, for some, their peers and the encampment are their support system. There will be detachment anxieties about leaving a community they are familiar and comfortable with.
Conclusion

The complexities compounded with housing systematic barriers at the community and societal level make it difficult to adequately address issues contributing to individuals experiencing homelessness living in illegal encampments. The literature gaps regarding illegal encampments suggest we are far from fully understanding the magnitude of the problem. For example, there is no specific data on how many individuals live in illegal encampments or how many unlawful encampments exist throughout California. Likewise, there was no data on the employment rates and service utilization amongst homeless populations living in illegal encampments. Without this data, policymakers are ill-equipped to address the issue at the state level. We need to start thinking differently about our approach to homelessness to make real change.

There isn’t a simple solution due to the complexities of this issue; however it’s simple to understand continuing the status quo is NOT the solution. Pumping billions of dollars into a broken system is nothing more than a band-aid covering a dangerous festering cyst laying deeper beneath the surface. Without a state-driven plan, California counties will continue to see an increase in their homeless populations. It may sound cliche, however, the definition of insanity is doing the same thing over and over and expecting different results—it’s time to try doing something different.

Authorized homeless camps aim to establish an infrastructure that acts as a safety net, providing immediate housing options for those experiencing homelessness. In addition, the proposed authorized homeless camps would set the foundation for future data collection, program evaluation, and policy recommendations. Investing in the development of state-authorized homeless camps provides future revenue opportunities. For example, each living option could potentially become rental revenue. There is no better time than now to start reimagining, redefining, and redesigning housing developments for the homeless population (see Appendix H).
References


Among Chronically Ill Homeless Adults: A Randomized Trial. *JAMA*, 301(17), 1771. https://doi.org/10.1001/jama.2009.561


# Appendices

## Appendix A

Table of MPH Foundational Competencies Applied in this ILEX paper

<table>
<thead>
<tr>
<th>Foundational Competency</th>
<th>Description of how used for Capstone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evidence-based Approaches to Public Health</strong></td>
<td></td>
</tr>
<tr>
<td>2. Select quantitative and qualitative data collection methods appropriate for a given public health context</td>
<td>Critically analyzed primary, secondary and tertiary sources to identify the highest quality evidence to use in support of claims and arguments for state-authorized homeless camps.</td>
</tr>
<tr>
<td><strong>Planning &amp; Management to Promote Health</strong></td>
<td></td>
</tr>
<tr>
<td>9. Design a population-based policy, program, project, or intervention</td>
<td>Reviewed the literature to find evidence-based programs on the housing first approach. Designed an intervention drawing on best practices identified in the literature to develop the Authorized Homeless Camp intervention.</td>
</tr>
<tr>
<td><strong>Communication</strong></td>
<td></td>
</tr>
<tr>
<td>19. Communicate audience-appropriate public health content, both in writing and through oral presentation</td>
<td>Outlined, drafted, and finalized Capstone paper, including a literature review, recommendations, and implications on a current public health problem. Created a slide deck based on the Capstone paper and delivered an oral presentation at Health Professions Day in front of an interprofessional audience.</td>
</tr>
<tr>
<td><strong>Systems Thinking</strong></td>
<td></td>
</tr>
<tr>
<td>22. Apply systems thinking tools to a public health issue</td>
<td>Created a logic model to visually depict the resources and stakeholder engagement needed to improve living conditions for homeless individuals living on the streets within the homeless population.</td>
</tr>
</tbody>
</table>

## Health Policy Leadership Concentration Competencies

<table>
<thead>
<tr>
<th>Competency</th>
<th>Anticipated APEX Activity</th>
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</thead>
<tbody>
<tr>
<td>4. Develop recommendations to improve organizational strategies and capacity to implement health policy</td>
<td>Reviewed the literature to identify best practices and gaps in existing strategies for homelessness. Made recommendations at community and societal policy levels.</td>
</tr>
</tbody>
</table>
Appendix B
Chart of Homelessness Growth in California 2010-2020

California's homeless tally is growing

Source: CalMatters, 2022
### Appendix C

**Table of Homeless at Enrollment**

**Comparison of Emergency Department Charges for Clients**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Connected to Permanent Housing</th>
<th>Not Connected to Permanent Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=67</td>
<td>N=99</td>
</tr>
<tr>
<td>Sum of ED Charges Pre</td>
<td>$813,298</td>
<td>$1,491,478</td>
</tr>
<tr>
<td>Sum of ED Charges Post</td>
<td>$553,309</td>
<td>$1,456,732</td>
</tr>
<tr>
<td>Mean Charges Pre</td>
<td>$12,138</td>
<td>$15,065</td>
</tr>
<tr>
<td>Mean Charges Post</td>
<td>$8,258</td>
<td>$14,714</td>
</tr>
<tr>
<td>Pre-Post Difference in Mean Charges</td>
<td>-$3,880</td>
<td>-$351</td>
</tr>
<tr>
<td>Pre-Post % Difference</td>
<td>-32%*</td>
<td>-2%</td>
</tr>
</tbody>
</table>

*Statistically significant

**Table of Homeless at Enrollment**

**Comparison of Emergency Department Utilization for Clients**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Connected to Permanent Housing</th>
<th>Not Connected to Permanent Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=67</td>
<td>N=99</td>
</tr>
<tr>
<td>Sum of ED visits Pre</td>
<td>770</td>
<td>649</td>
</tr>
<tr>
<td>Sum of ED visits Post</td>
<td>510</td>
<td>576</td>
</tr>
<tr>
<td>Mean visits Pre-Enrollment</td>
<td>11.5</td>
<td>6.6</td>
</tr>
<tr>
<td>Mean visits Post-Enrollment</td>
<td>7.6</td>
<td>5.8</td>
</tr>
<tr>
<td>Pre-Post Difference</td>
<td>-3.8</td>
<td>-0.8</td>
</tr>
<tr>
<td>Pre-Post % Difference (Mean)</td>
<td>-34%*</td>
<td>-12%*</td>
</tr>
</tbody>
</table>

*Statistically significant

Source: Linkins Ph.D. et al., 2008
Appendix D

CalAIM Housing-related Community Support Graphic

Source: CalAIM
Appendix E
Models for Authorized Homeless Camps

Catholic Youth Organization (CYO) Camp Armstrong
- Build a community of strong relationships
- Give all participants a sense of belonging and responsibility to the camp community
- Foster an environment where positive attitudes build an overall positive community
- Provide a structure within which participants will excel, be held accountable, and have onsite support services
- Provide meals through the Lodge, a 6000 sq. ft. building that serves as the dining area

KOA
- Tent, cabin, or RV living options
- Community restrooms and showers
- Organized community activities
- An outdoor amphitheater, picnic areas, and group campfire area

Coloma Resort
- Same as KOA, but with family bunkhouses (2 rooms and a private bathroom)
Authorized Homeless Camp—Logic Model

**Inputs**
- Participants
- Activities
- Direct Products

**Outputs—Impact**
- Short term
- Intermediate
- Long-term

**Who we invest**
- Staff Time
- Multi-agency Knowledge
- Community Engagement
- Funding

**What we reach**
- Stakeholders
  - Local
  - State
  - Federal
- Unhoused Population

**What we do**
- Design authorized homeless camps
- Provide on-site wraparound services
- Collect data

**What we create**
- Safe living environment for unhoused population
- Patient-centered programs
- Centralized access to programs

**Results in terms of Authorized Encampments**
- Unhoused population no longer living on street/highways
- Individual needs are being assessed and addressed
- Collecting data for policy makers

**Results in terms of Changing Status Quo**
- Authorized camps become a home until a house is available
- Shelters are reevaluated for effectiveness
- Housing policy reform initiated guided by data collection

**Results in terms of change to the Problem**
- Eliminate unauthorized encampments and traditional shelters
- Reduce communicable diseases
- Increase health outcomes for individuals

**Assumptions**
- COM-B Behavior Theory
- The [Behavior] Change Wheel (BCW) framework

**External Factors**
- Individual behavior
- Stakeholder/community buy in
- Funding

**Evaluation**
Identification—Design—Implementation—Completion/Follow-up
Appendix G
Ten essential public health services American Public Health Association (APHA)

1. Assess and monitor population health
2. Investigate, diagnose and address health hazards and root causes.
3. Communicate effectively to inform and educate.
4. Strengthen, support, and mobilize communities and partnerships.
5. Create, champion, and implement policies, plans, and laws.
6. Utilize legal and regulatory actions.
7. Enable equitable access.
8. Build a diverse and skilled workforce.
9. Improve and innovate through evaluation, research, and quality improvement.
10. Build and maintain a strong organizational infrastructure for public health

Source: American Public Health Association (APHA)
Appendix H

REIMAGINING HOUSING OPTIONS