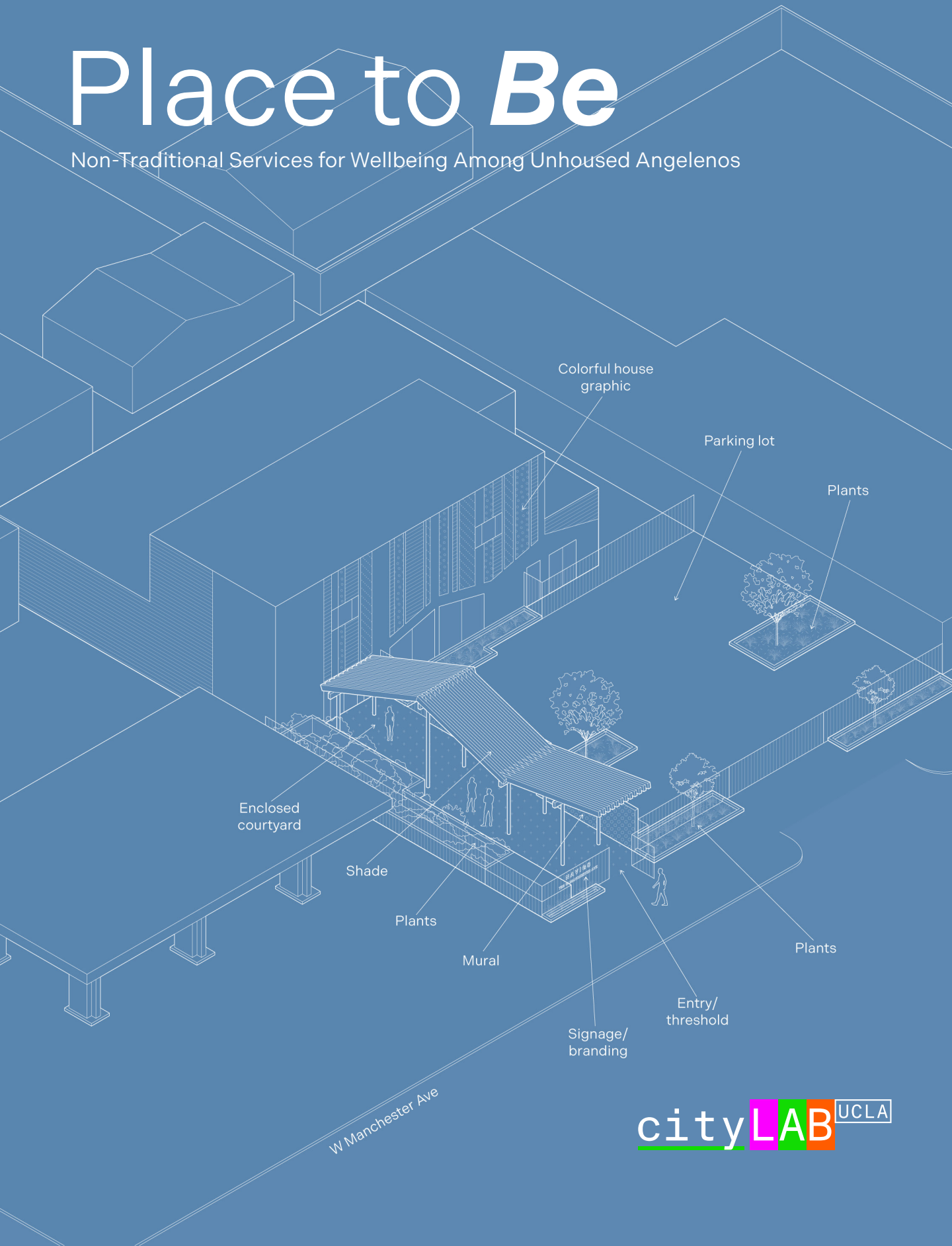# Place to *Be*

Non-Traditional Services for Wellbeing Among Unhoused Angelenos

Colorful house graphic

Parking lot

Plants

Enclosed courtyard

Shade

Plants

Mural

Plants

Entry/ threshold

Signage/ branding

W Manchester Ave

cityLAB UCLA

CREDITS

Dr. Dana Cuff
UCLA cityLAB Director

Dr. Burton Cowgill, PhD, MPH
Associate Professor at the UCLA Kaiser Permanente Center for Health Equity, Department of Health Policy and Management, UCLA Fielding School of Public Health

Wendelin Slusser, MD, MS
Associate Vice Provost at UCLA Semel Healthy Campus Initiative Center

Alejandra Guerrero
UCLA cityLAB Deputy Director

Rayne Laborde Ruiz
UCLA cityLAB contributor

Danielle Paulazzo
UCLA cityLAB Research Associate

Naomi Yama
UCLA cityLAB Research Associate

Jane Wu
UCLA cityLAB Research Associate

Kinamee Rhodes
UCLA cityLAB Research Associate

TABLE OF CONTENTS

INTRODUCTION

For the half-million people experiencing homelessness living in the United States, the "housing first" movement argues homelessness is a housing problem. But this basic truism remains an abstract ideal because housing production is notoriously costly, slow, insufficient, and does not always include needed support services. In the meantime, people experiencing homelessness have a life expectancy of 63, a full 14 years shorter than the average U.S. life expectancy (Fuller, 2023). This one measure is symptomatic of the deep inequities in health outcomes between unhoused and housed people, a gap that is further exaggerated by racial disparities. For those experiencing homelessness, the housing crisis is paired with a health crisis rooted in the ineffectiveness of traditional methods of service delivery in this context. There are myriad means by which the health and quality of life of our unhoused neighbors could be improved, starting with a better understanding of how to define their wellbeing. But those community health workers who practice "street medicine" are not waiting for such definitions. Instead, they move as effectively as possible through the streets, sidewalks, and open spaces where people are living, to bring a range of health services out of the backpacks they stock with medicine and diagnostic tools, vans equipped with supplies, and sophisticated mobile health clinics. Having witnessed the struggles of health providers working in the streets, this research team looks into a basic aspect of service provision to unhoused people to determine whether there are more effective means to respond to community health workers' spatial needs as they labor to improve the wellbeing of those experiencing homelessness.

The research is appropriately situated in Los Angeles, which leads the nation in unsheltered homelessness, with some 70,000 people living outside. This study examines de-institutionalized and open-access case studies of health centers providing services to unhoused Angelenos and examples of hybrid models across the US. Through a transdisciplinary approach recognizing intersections between public health, design, and urban planning, our evaluation assesses perception of key spatial conditions, and asks how to more clearly measure impact on wellbeing.

We organized the research around five research questions:

- *What does wellbeing mean for people living without shelter?*
- *What social science instruments are best suited to measure wellbeing among unhoused people?*
- *What do we know about the linkages between physical spaces of homelessness, service provision, and wellbeing?*
- *What means have been deployed in Los Angeles and elsewhere to deliver healthcare outside conventional bricks-and-mortar clinics?*
- *What alternative kinds of spaces might enhance community health services for unhoused clients and their service providers?*

With an interdisciplinary team of researchers from public health, architecture, and urban planning, as well as an intimate group of providers and unhoused constituents from a non-traditional health program, we undertook analysis of wellbeing metrics, key informant interviews, and participatory design research. In each we sought to better define wellbeing - a sometimes vague term in health - particularly in consideration of how understandings of wellbeing differ for unhoused people. The study goes on to evaluate research instruments for measuring emotional, physical, and social wellbeing in service models. In addition to refining a practical understanding of wellbeing among unhoused people, and a study of methods for its measurement, the researchers surveyed existing practices for de-institutionalized and unconventional healthcare, and discussed such practices in depth at the Venice Family Clinic in Los Angeles. This pilot study offers guidance for public health providers, planners, designers, and policy makers seeking new, open-access ways to understand and serve the needs of unhoused Angelenos.

Before we delve into the report, we would like to address our approach to terminology. The research team acknowledges the language used to refer to individuals experiencing homelessness is imperfect. Newer terms, such as "unhoused," may not be immediately recognizable and often fail to accurately capture the way individuals with lived experience self-identify. On the other hand, the term "homeless" is frequently interpreted as callous, minimizing the underlying factors contributing to homelessness and providing an inaccurate portrayal of people's experiences. While an evaluation of which term is most appropriate is worthwhile, it is beyond the scope of this project.

Out of respect for the terminology most frequently used by our participants with lived experience of homelessness and to maintain consistency with the language employed by our service provider partner, we will predominantly, but not exclusively use the term "people experiencing homelessness" throughout this report.

DEFINING WELLBEING

LITERATURE REVIEW

In the past decade, momentum towards a "culture of health" approach to public health service provision has emphasized the importance of wellbeing as a metric of success (Davies et al., 2014; Trujillo & Plough, 2016). To better understand people experiencing homelessness may define wellbeing we conducted a literature review of 115 studies. In this review of case studies and service evaluation, the concept of wellbeing has been inconsistently invoked, measured, and applied.

Why unhoused Angelenos? Why wellbeing? Why physical space? Why now?

More than half a million people in America experience homelessness (Office of Community Planning and Development, 2022), with nearly 70,000 people unhoused in Los Angeles County and over 41,000 in the City (Los Angeles Homeless Services Authority, 2022). Unhoused Angelenos are disproportionately BIPOC (despite accounting for under 8% of the County population, 34% of unhoused people are Black) and LGBTQA+ (national surveys find that 40% of unhoused youth identify as gay, queer, or gender nonconforming), meaning the discrimination they face due to housing status is often complicated by race, gender, and/or sex-based discrimination (Bauman et al., 2014; S Choi et al., 2015). Similarly, the intersection of identities made vulnerable through discrimination and bias means unhoused people more often experience the negative influence of social determinants of health, "correlat[ing] with individual and community risk factors" (Islam, 2019; Kertesz et al., 2021). These increased risk factors culminate in unhoused people experiencing poorer outcomes across a breadth of measurements, such as physical health, mental health, and quality of life.

The WHO defines wellbeing as a positive state and as "a resource for daily life... determined by social, economic and environmental conditions. Wellbeing encompasses quality of life and the ability of people and societies to contribute to the world with a sense of meaning and purpose" (World Health Organization, 2021). Despite providing this definition, the WHO acknowledges a lack of clarity in deriving a precise interpretation of wellbeing from existing literature (World Health Organization, 2021). The functional definition used in research and service evaluation differs depending on the researcher's goals and which measurement tool the researcher chooses to use.

Wellbeing in particular is identified by the WHO as a critical component of more effective policy, and in its "wellbeing agenda" calls for a shift from narrow measures of health to a more broad, cross-sectoral understanding that can be used to holistically improve lives (World Health Organization, 2021). Similarly, an emerging wave of public health, known as a culture of health, centers the promotion of wellbeing by making the "healthy choice the easy choice," and minimizing the culture and environment which promote unhealthy choices (Davies et al, 2014). This approach recognizes society as a whole influences individual health outcomes, including the passage of policies, structuring of activities that enhance wellbeing, and the focus of this research: the design of care infrastructure and its surroundings.

Architecture and urban planning play a crucial role in preventing and addressing chronic homelessness and its sequelae: housing-first solutions are the most successful means (Padgett et al., 2010). Yet, Los Angeles is decades away from providing an adequate amount of dignified, affordable, and permanent supportive housing (Phillips et al., 2022). In the interim, a robust continuum of service options is necessary to support unhoused individuals not yet on the path to housing in ways that are liveable, dignified, and accessible (Gelberg et al., 2000; Perry, 2013; Wolch et al., 1988). Given Los Angeles County leads the nation in unsheltered homelessness, with roughly 70 percent of its unhoused population

lacking adequate shelter (Adarkar et al., 2023), daily activities and services that impact wellbeing for the majority of unhoused people must be conducted in public space. However, increased pressure to banish unhoused people from public space complicates both the accessibility and effectiveness of service provision. Meanwhile, of these services, few currently use wellbeing as a metric of success and the lack of clarity in defining and measuring wellbeing, especially in hard-to-reach populations, presents a barrier to widespread adoption as a metric for understanding the impact of services (Ahuja et al., 2020).

What are the links between physical space and wellbeing in literature today? Why does this matter?

The literature is further limited when examining how physical space intersects with wellbeing for unhoused people, and in consideration of how space can be optimized in service provision. The challenges unhoused people face by having to conduct private matters in public spaces and how constant upheaval causes distress (Amster, 2003; Reuter, 2017). These studies paint a picture of how physical space is experienced by unhoused people and what facets of life are made more difficult by the spaces unhoused people can or are prohibited from inhabiting. For example, as one unhoused man in Los Angeles' Chinatown put it, "You say I'm dirty, but where am I supposed to shower when you took away my shower? Where am I supposed to go to the bathroom when there are no public restrooms?" (Laborde Ruiz, 2020). Other examples include the detrimental physical and mental health impacts of extreme weather events or how anti-camping laws and policing disrupt people's ability to rest and reside in safe areas (Bauman et al., 2014; Every et al., 2019; Fisher et al., 2015).

The linkages between physical space and wellbeing among unhoused individuals is primarily a matter of suitable locations for services and shelters. While many case studies emphasize shelters, their insights may still be applicable to other spaces specifically providing other services. However, aligning with findings that different subpopulations assign varying importance to specific wellbeing domains, conflicting outcomes emerge when exploring how location choices affect wellbeing.

Frequently, services and shelters are situated in marginal spaces or service hubs where large populations of people experiencing homelessness gather, such as the neighborhood of Skid Row in Los Angeles. This approach can yield positive effects, enhancing accessibility and engagement with services, minimizing resistance and conflicts with housed neighbors, and fostering connections within the community. Nevertheless, siting services in these locations may also carry negative repercussions, particularly for the most vulnerable subpopulations. For instance, it may diminish feelings of safety due to proximity to crime and police encounters or result in residing in areas with inadequate sanitation.

While existing literature contextualizes these experiences, it primarily falls short in measuring the wellbeing outcomes resulting from spatial struggles. The need arises for a more methodical approach to understanding the specific spatial conditions influencing wellbeing, particularly in public spaces, to inform evidence-based service provision.

MEASURING WELLBEING[1]

With the integration of metrics to assess wellbeing among diverse study populations becoming more common, their inclusion in studies among people experiencing homelessness n has also become more frequent. This section presents the findings from an extensive literature review that was conducted to identify and describe the range of metrics related to wellbeing that were included in studies among the homeless population. Among 48 studies selected through the initial search, 28 distinct "scales of wellbeing" were identified ranging from single item questions to scales encompassing 50 or more items. To better focus the search on studies that intentionally integrated wellbeing metrics into studies of the homeless, we selected those that met at least two of the three criteria below for further investigation and analysis:

- Included a study sample closely linked to the homeless or unhoused population
- Assessed wellbeing or a related domain (e.g., quality of life or life satisfaction)
- Incorporated survey-derived measures into the evaluation of the study outcome

We also excluded studies that met two of the three criteria, but included survey items with limited evaluative insights. This process resulted in 35 studies that utilized 20 of the original 28 distinct "scales of wellbeing."

Was it wellbeing they were trying to measure?

Although a consensus has remained elusive in regards to both defining and measuring wellbeing, most can agree that wellbeing is a multidimensional construct and cannot be measured through a single lens. Such constructs as life satisfaction, happiness, or economic stability fall short of assessing overall wellbeing in isolation (Ruggeri, K., Garcia-Garzón, E., Maguire, Á. et al, 2020). "Scales of well being" identified through the search were then assessed for the domains captured through the instrument. Domains included: health status, emotional health, subjective quality of life, life satisfaction, living conditions, housing situation, financial situation, social support, education, income, health insurance status, and demographic information.

Among the "scales of wellbeing" identified through the literature search, no scales focused both on a complete assessment of wellbeing or specifically on people experiencing homelessness. One tool, the Quality of Life for Homeless and Hard-to-House Individuals Inventory, was specifically developed for the unhoused population as part of a dissertation project and is in the early stages of content validation (Russell, 2013). The QoLHHI does assess a broad set of domains, including subjective quality of life, health status, emotional health, living conditions, housing situation, financial situation, and social support. No additional studies were identified that used the QoLHHI (Hubley A., Russell L., Gadermann A., Palepu A., 2009). Four instruments developed with the specific intention of assessing wellbeing were utilized in studies among the homeless. The most frequently used scale was the Personal Well-being Index (3 studies)(International Wellbeing Group, 2013), followed by the Stanford WELL for Life Scale (2 studies) (Ahuja N., Nguyen A., Winter S., et al, 2020), the Index of Well Being (1 study) (Runquist J., Reed P., 2007), and Cantril's Self-Anchoring Scale (1 study) (Kahneman D., Deaton A., 2010) . The "scales of wellbeing" used in the remaining studies utilized instruments that mostly assessed satisfaction with life or self-reported quality of life, with a few measuring happiness or self-esteem. These findings illustrate the limited number of studies that have incorporated complete assessments of wellbeing among studies of people experiencing homelessness.

Even among studies that did utilize established "scales of wellbeing" within their work with people experiencing homelessness, the domains represented by these existing scales vary widely. For example, the Personal Wellbeing Index incorporates a series of scales that address: life as a whole, standard of living, health, achievements in life, personal relationships, safety, community connect, and future security. In contrast, the Stanford WELL for Life Scale includes measures of social connectedness, lifestyle and daily practices, stress and resilience, experience of emotions, physical health, purpose and meaning, sense of self, finances, spirituality and religiosity, and exploration and creativity.

The findings from this literature review bring clear attention to the pressing need for the development and adoption of metrics that can assess the multi-dimensional aspects of wellbeing among people experiencing homelessness. The review suggests social connection and feelings of safety have received the most attention as factors that can be enhanced or damaged through service provision and are, therefore, particularly important. However, the unhoused population is not a monolith and interventions that may improve wellbeing in one subpopulation may have conflicting effects in another. For example, gender has been shown to be one of the largest predictors of wellbeing among unhoused people (Anderson et al., 2021), and people who identify as women in this population seem to emphasize and prioritize safety in service provision, potentially over other factors such as proximity to social networks (McLeod & Walsh, 2014; Walsh et al., 2010). Additionally, the bulk of the literature on wellbeing of unhoused people is based in temporary shelter settings rather than on the experiences of unsheltered unhoused people, so these samples may not accurately represent the needs and priorities of unsheltered people.

Despite these challenges, it is imperative to integrate the daily lives and needs of unhoused individuals into service-based definitions of "success." Services oriented towards unhoused individuals frequently overlook holistic wellbeing as their metric for success. Instead, they more commonly gauge their effectiveness based on their capacity to deliver the service or discrete components of wellbeing. For example, we found case studies measuring how design choices in service spaces impact feelings of connectedness, which while significant, may be missing some of the limitations or successes of programs that may be illuminated by holistically measuring wellbeing. Though there do not yet seem to be established best practices for incorporating wellbeing as a metric for success in service provision for unhoused people, there are active and encouraging discussions. For example, a recent study on intersections of transit utilization and homelessness suggests, "Centering the mobility and wellbeing of unhoused riders when defining success rather than simply the efficient operation of transit vehicles fits within transit's social service role and is an important first step to improving outcomes for them and for all riders" (Loukaitou-Sideris et al, 2020).

Overall conclusions from the literature review can be found at the end of this report.

---

[1] For further information about wellbeing and metrics see Appendix.

SPACE & WELLBEING

The extensive literature review on wellbeing sheds light on the significant struggles of unhoused individuals to access health services. Given the shifting geographies of people experiencing homelessness, not only are the kinds of health services important, but the varied spatial conditions of health provision impacts wellbeing. Two basic bodies of spatial research were undertaken by the study team in order to answer the final two research questions listed above:

- *What means have been deployed in Los Angeles and elsewhere to deliver healthcare outside conventional bricks-and-mortar clinics?*
- *What alternative kinds of spaces might enhance community health services for unhoused clients and their service providers?*

For the first question, we analyzed six contemporary case studies of different kinds of service spaces which we grouped into four different types of facilities below. For each spatial type, we describe one or two representatives of the group in some depth, moving from the least to the most comprehensive in terms of services. Both fixed locations and mobile or temporary facilities are outlined.

For the second question, we conducted two focus groups with service providers at the Venice Family Clinic.

Types of service spaces

- *Access Point:* positioned as a gateway , Access Points serve as primary spaces providing connections to essential services and resources tailored to the unique needs of unhoused communities.

- *Resilience Hubs:* as a means to strengthen community at times of increased need, Resilience Hubs are facilities designed to support and safeguard community members against a spectrum of threats, ranging from climate change to social instability.

- *Commons:* at the grassroots level, Commons area represents community-driven centers that directly respond to locally identified needs through collective efforts, fostering a sense of ownership and empowerment.

- *Magnet:* serving as top-down community spaces, Magnets create opportunities for diverse community engagement while specifically addressing the needs of vulnerable community members.

The four spatial-service types make apparent the range of community health provision opportunities and the kinds of spaces required for each, from the space with the most singular function, the access point, to a magnet where a range of community-centered functions are offered (including some limited health care). By aligning these typologies we aim to not only to contextualize how wellbeing was understood by health providers servicing unhoused communities but also to discern which spatial qualities could impact their success. In addition, we identified a series of programs in each case study that further explain the typologies:

Personal Care/ Hygienic Services	Mobility	Rest	Power	Cooling
Employment Assistance	Legal Services	Mental Health Services	Education	Youth Services/ Outreach
Storage	Technology Access	Gardening	Drinking Water	Emergency Services (Climate)
Food Access	Bathrooms	Art	Recreation	Physical Health Services

This integrative approach to physically analyzing health centers offers an alternative lens for understanding the intricate interplay between physical space and service provision to study how best to support the wellbeing of people experiencing homelessness. Moreover, identifying the impact on unhoused people of typologies and programming allows us to draw conclusions on how alternative spaces function and the means to improve them.

ACCESS POINT

UCLA Mobile Clinic Project

Location: Mobile/temporary, 5941 Hollywood Blvd, Los Angeles, CA
Time: Every Wednesday 6:00 - 8:15pm
Toolkit: Mental Health Services, Mobility, Personal Care / Hygienic Services, Physical Health

The UCLA Mobile Clinic Project (MCP) operates a mobile clinic site in Hollywood serving the unhoused population, with the aim to improve health outcomes and quality of life of individuals experiencing homelessness as well as other vulnerable populations in the greater Los Angeles area by connecting them to the existing continuum of care (Mobile Clinic Project, n.d.). The clinic has operated every Wednesday night for 17 years, providing predictability for its users. When the MCP truck, which contains supplies, clothing items, and medications, arrives at the clinic site, it defines a threshold and sense of place on the street. The mobile clinic site is further spatially defined by folding table stations for triage, data collection, and service referrals. Medical services, which are provided by attending physicians and medical students, do not occur within the truck itself, but are provided at the stations outside.
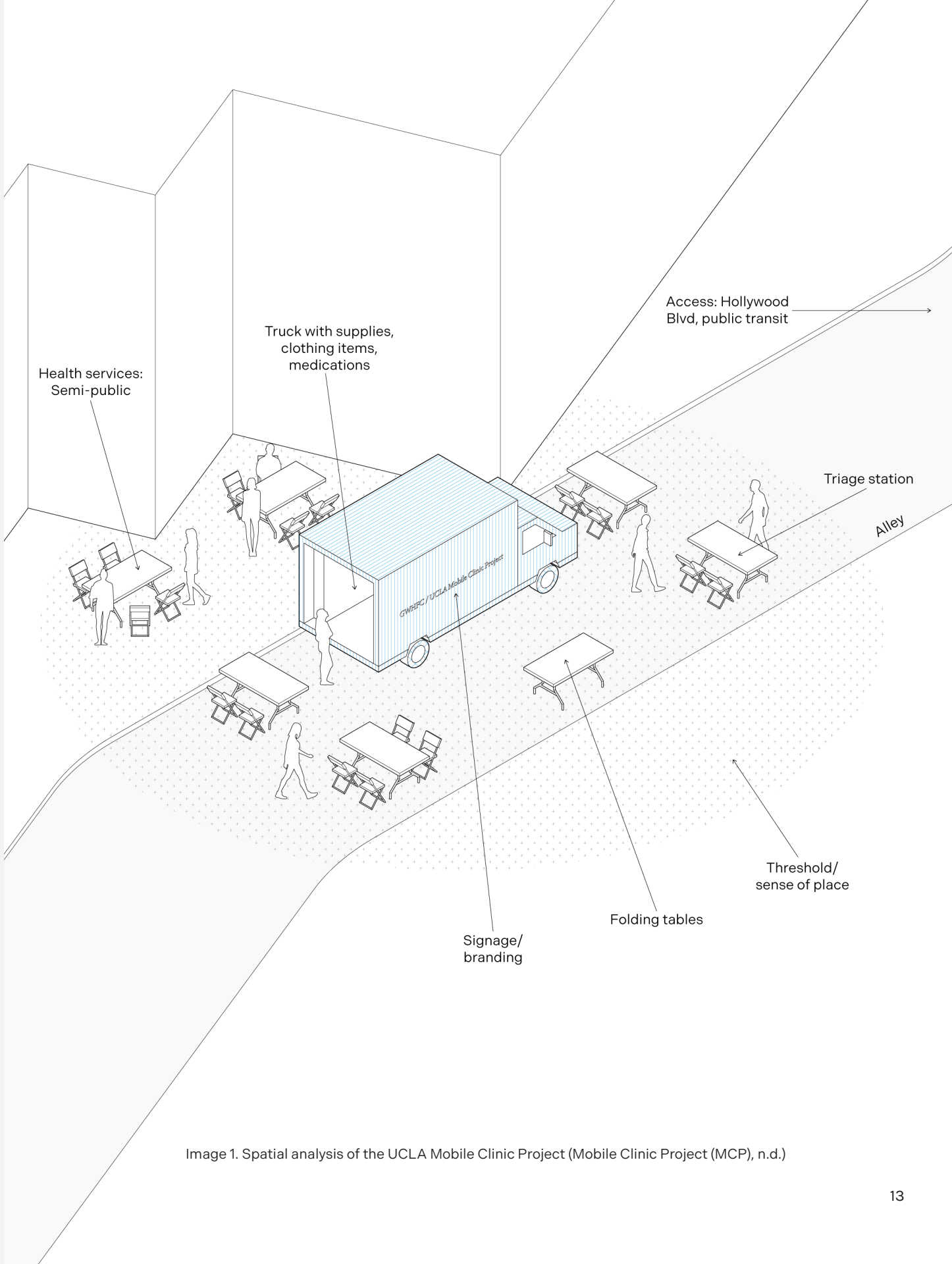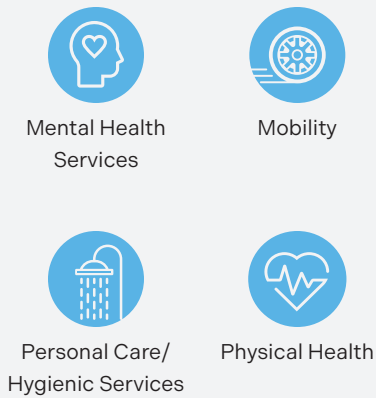
Mental Health Services

Mobility

Personal Care/ Hygienic Services

Physical Health

Access: Hollywood Blvd, public transit

Truck with supplies, clothing items, medications

Health services: Semi-public

Triage station

Alley

Threshold/ sense of place

Folding tables

Signage/ branding

Image 1. Spatial analysis of the UCLA Mobile Clinic Project (Mobile Clinic Project (MCP), n.d.)

Health services: Private

Laundry facilities

Shade

Bathrooms

Showers

Shade

Shade

Enclosed courtyard

Towne Ave

Stanford Ave

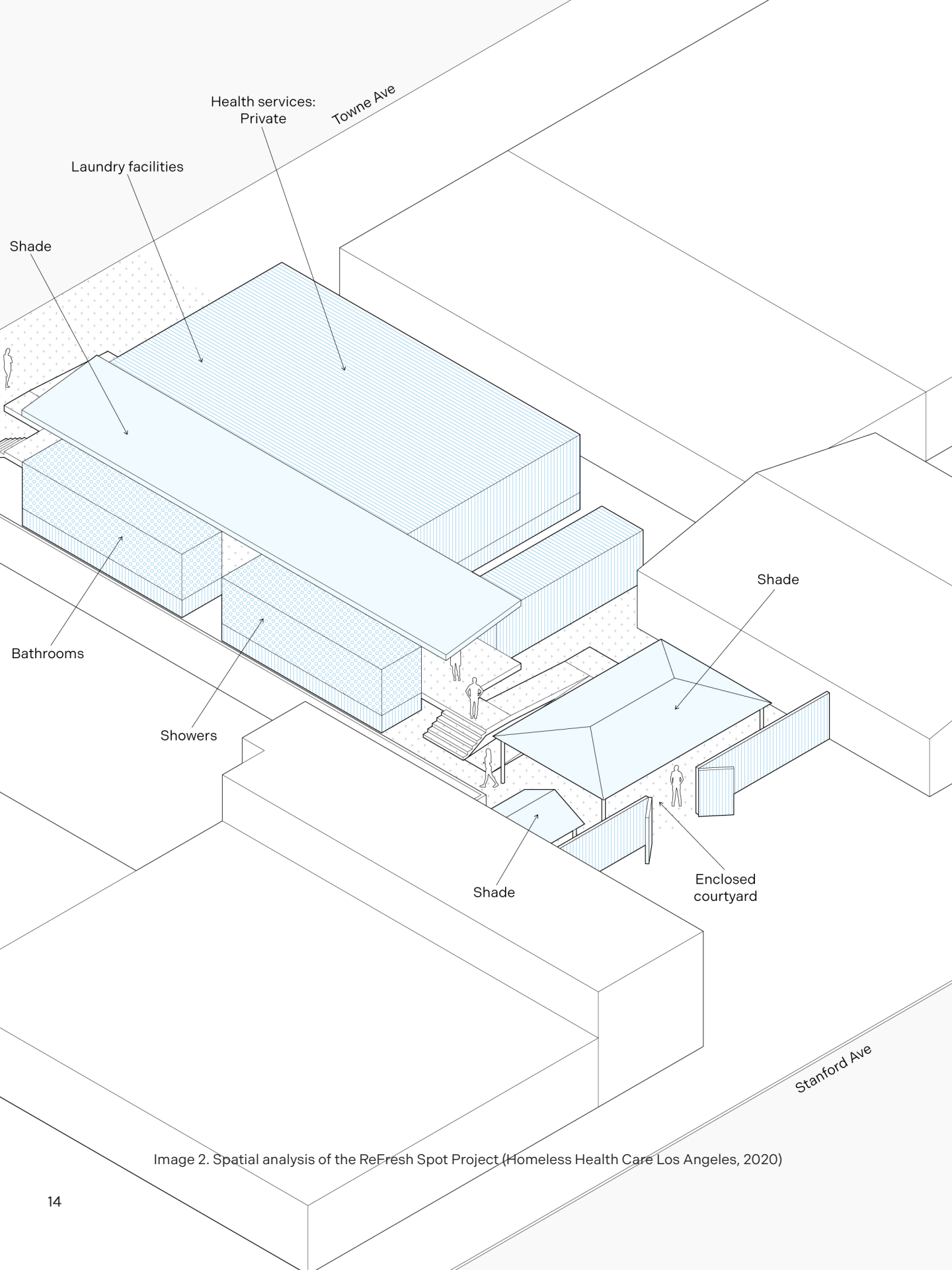Image 2. Spatial analysis of the ReFresh Spot Project (Homeless Health Care Los Angeles, 2020)

ReFresh Spot

Location: Fixed location, 544 Towne Ave, Los Angeles, CA
Time: Open 24/7
Toolkit: Bathrooms, Cooling, Drinking Water, Emergency Services (Climate), Employment Assistance, Food Access, Legal Services, Mental Health Services, Mobility, Personal Care / Hygienic Services, Physical Health Services, Power, Youth Services / Outreach

The ReFresh Spot in Skid Row, Los Angeles, is a public facility providing the community of Skid Row a safe space to meet their basic needs with dignity. The ReFresh Spot offers access to showers, bathrooms, laundry, drinking water, a small library, phone charging, and WiFi connectivity, and is staffed by community members. It is a public space open 24/7 (including holidays) with no discrimination for entry, providing a point of temporal stability and predictability. Supplies including hygiene and wound care kits, socks, undergarments, overdose prevention kits, pet supplies, food, and more are distributed at the ReFresh Spot. Community partners collaborate to provide additional health, housing, legal, and other services (HHCLA, n.d.). The site consists of multiple buildings and trailers for showers, restrooms, laundry, and other services, connected by a covered walkway. At one end of the site, canopies and fences create a shaded enclosed space that can be used for services, gatherings, or events.

Bathrooms

Cooling

Drinking Water

Emergency Services (Climate)

Employment Assistance

Food Access

Legal Services

Mental Health Services

Mobility

Personal Care/ Hygienic Services

Physical Health
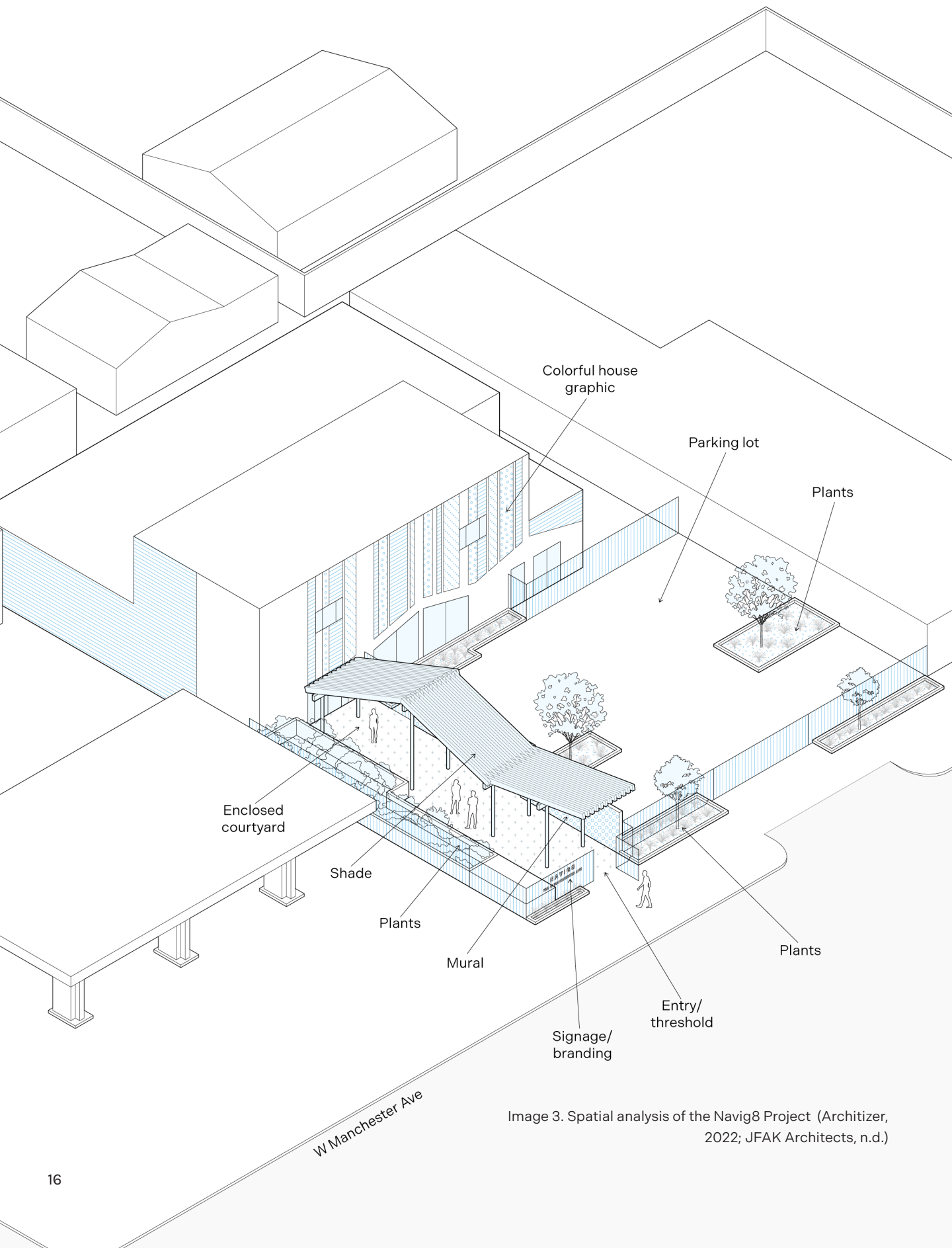
Power

Youth Services/ Outreach

Image 3. Spatial analysis of the Navig8 Project (Architizer, 2022; JFAK Architects, n.d.)

Colorful house graphic

Parking lot

Plants

Enclosed courtyard

Shade

Plants

Mural

Plants

Signage/ branding

Entry/ threshold

W Manchester Ave

Bathrooms

Drinking Water

Employment Assistance

Personal Care/ Hygienic Services

Storage

Navig8

Location: Fixed, permanent location; 729 W. Manchester Ave, Los Angeles, CA
Time: Monday - Friday 7:30am - 5:00pm; Saturday 10:00am - 1:30pm
Toolkit: Bathrooms, Drinking Water, Employment Assistance, Personal Care / Hygienic Services, Storage

With a large multipurpose interior space that can adapt to a range of uses, the Navig8 Center (Council District 8 Navigation Center) supports people experiencing homelessness in South LA by providing shower and laundry facilities, storage for personal belongings (250 individually allocated storage bins), case management, and referral to housing and employment services (Empowerment Congress Southwest Area Neighborhood Development Council, 2023). It serves as an access point for the Coordinated Entry System and can be used at times of need for various purposes. The Center has a strong street presence, as the colorful gable "house" graphics on the building's facade allude to a sense of home (JFAK Architects, n.d.). Its entry from the sidewalk is marked by a colorful shade structure, lockers for storing personal items not allowed in the center, and is decorated with a mural and plants, creating an enclosed shaded queuing area.
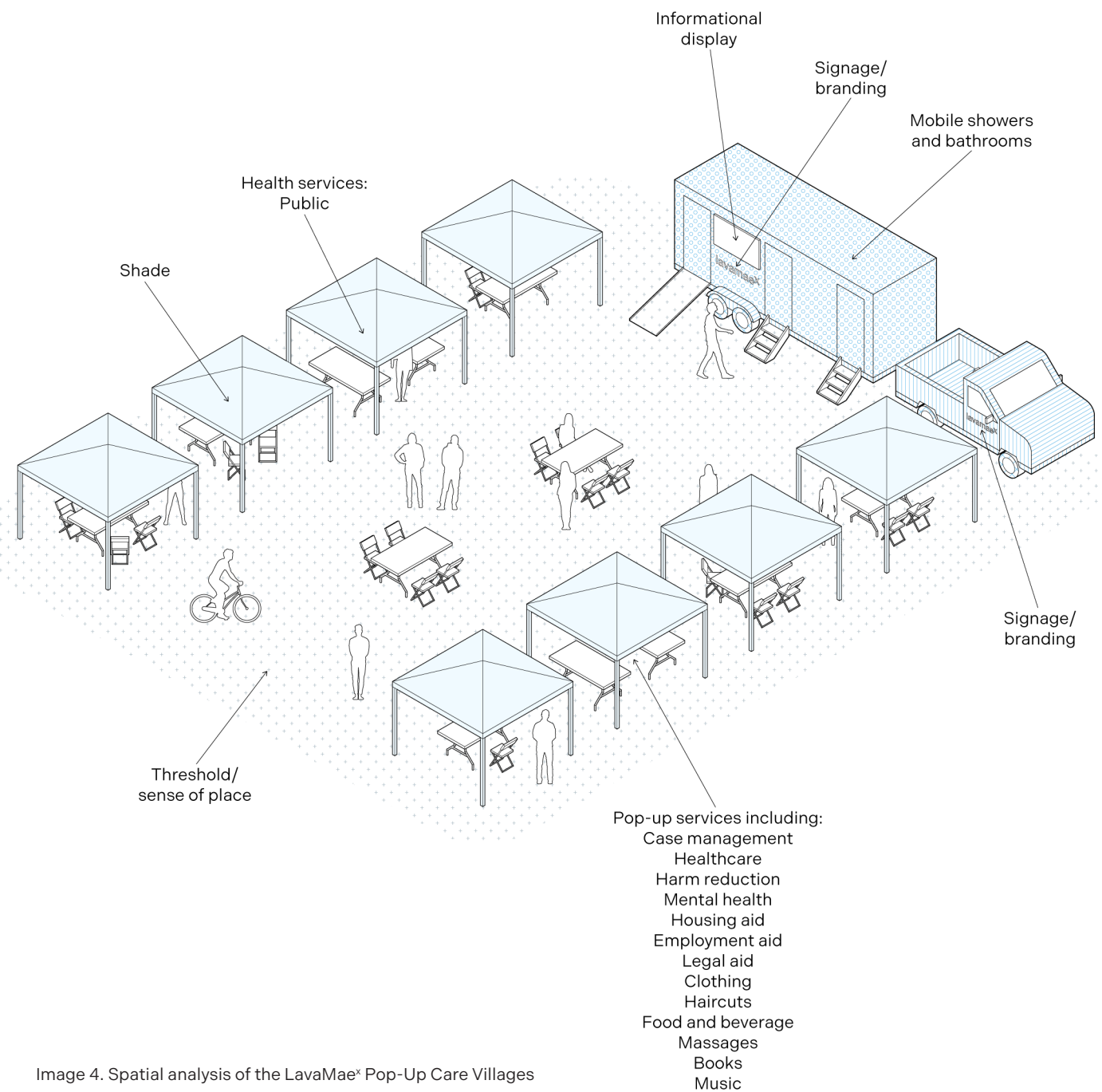
Informational display

Signage/branding

Mobile showers and bathrooms

Health services: Public

Shade

Signage/branding

Threshold/ sense of place

Pop-up services including:
Case management
Healthcare
Harm reduction
Mental health
Housing aid
Employment aid
Legal aid
Clothing
Haircuts
Food and beverage
Massages
Books
Music

Image 4. Spatial analysis of the LavaMae[x] Pop-Up Care Villages Project (LavaMae[x], 2022)

Art

Bathrooms

Drinking Water

Employment Assistance

Food Access

Legal Services

Mental Health Services

Personal Care/ Hygienic Services

Physical Health

LavaMae[x] Pop-Up Care Villages

Location: Temporary; Variable in San Francisco Bay Area and Los Angeles Area
Time: Variable
Toolkit: Art, Bathrooms, Drinking Water, Employment Assistance, Food Access, Legal Services, Mental Health Services, Personal Care/ Hygienic Services, Physical Health Services

LavaMae[x] is a nonprofit organization providing resources and knowledge to promote wellbeing for people experiencing homelessness. The LavaMae[x] Pop-Up Care Villages bring mobile showers and bathrooms to a public space, and provide pop-up services including case management, healthcare, mental health, housing and employment aid, legal aid, clothing, and haircuts (LavaMae[x], 2023b). The Pop-Up Care Villages also aim to create a positive community setting by providing music, food and drinks, books, and massages. Through the Pop-Up Care Villages, public space is transformed into a place of wellbeing by the temporary presence of these services. In June 2023, LavaMae[x] announced the closure of its programs and operations due to an unprecedented budget shortfall (LavaMae[x], 2023a).
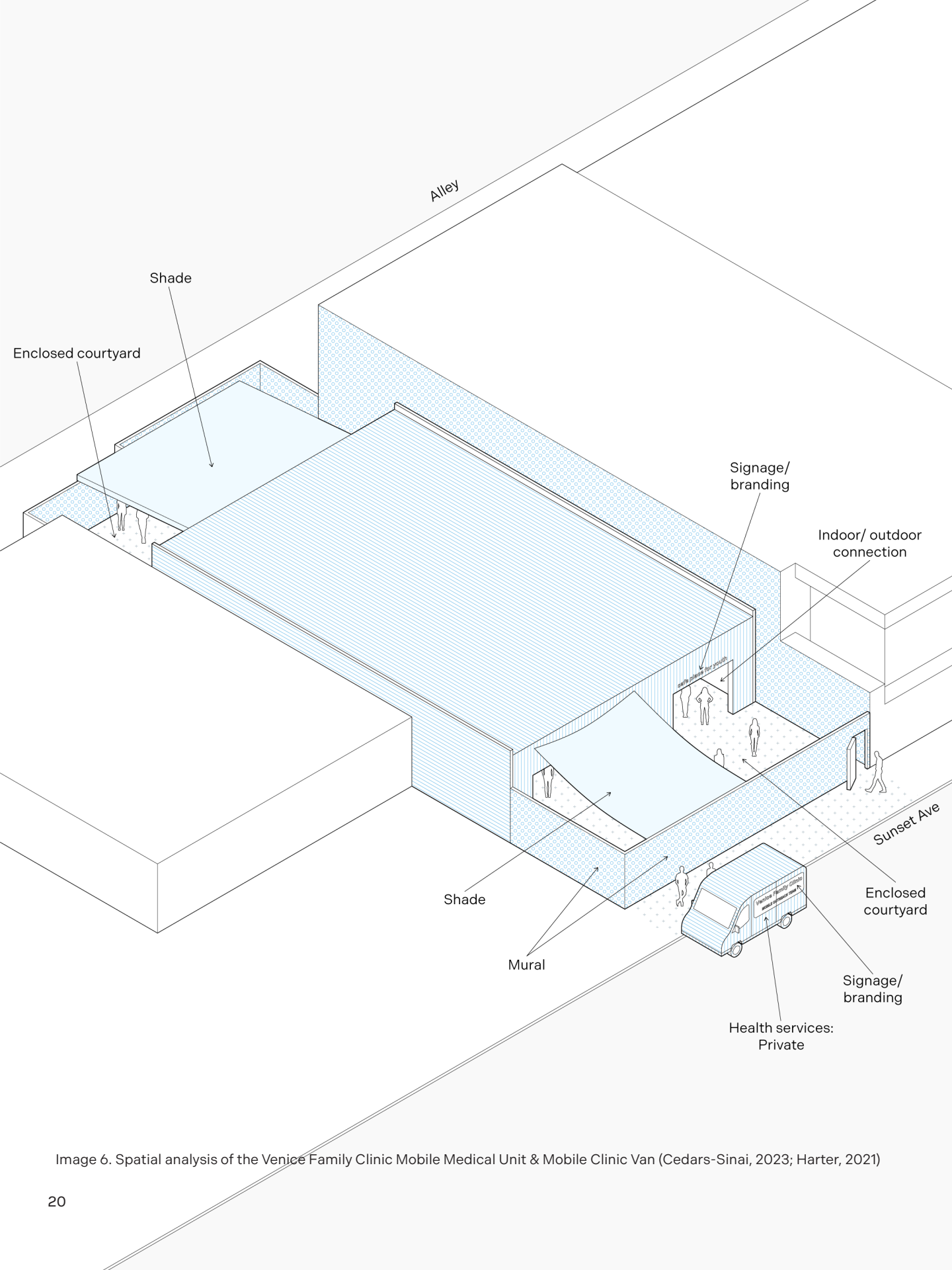
Image 6. Spatial analysis of the Venice Family Clinic Mobile Medical Unit & Mobile Clinic Van (Cedars-Sinai, 2023; Harter, 2021)

Labels on diagram:
Alley
Shade
Enclosed courtyard
Signage/branding
Indoor/outdoor connection
Shade
Enclosed courtyard
Mural
Sunset Ave
Signage/branding
Health services: Private

Icons:
Art
Bathrooms
Education
Employment Assistance
Food Access
Legal Services
Mental Health Services
Mobility
Personal Care/Hygienic Services
Physical Health
Power
Recreation
Technology Access
Youth Services/Outreach

Venice Family Clinic @ Safe Place for Youth Access Center

Location: 340 Sunset Ave, Venice, CA
Time: SPY Access Center: Monday, Tuesday, Thursday, and Fridays 10:00am - 4:30pm, Wednesday: 9:30am - 1:00pm
VFC Mobile Clinic Van @ SPY Access Center: Tuesdays
Toolkit: Art, Bathrooms, Education, Employment Assistance, Food Access, Legal Services, Mental Health Services, Mobility, Personal Care / Hygienic Services, Physical Health Services, Power, Recreation, Technology Access, Youth Services / Outreach

The Safe Place for Youth (SPY) Access Center provides a continuum of services for young people. At the Access Center, SPY provides basic survival needs of food, water, clothing, and other survival essentials (Safe Place for Youth, n.d.). Additional services are available to help young people improve physical and emotional wellbeing, and develop meaningful relationships with peers, staff, and the community. Venice Family Clinic (VFC) partners with SPY to provide onsite services during Access Center hours. VFC's mobile clinic van comes to the Access Center on Tuesdays and provides health services within the private space of the van. The Access Center consists of a building that opens onto two enclosed courtyards with shade canopies, which create a sense of enclosed space while connecting indoor and outdoor spaces. The walls of the courtyards are painted with murals or colorful paint, creating an inviting and welcoming space.

Venice Family Clinic Mobile Medical Unit & Mobile Clinic Van

Location: Variable in Los Angeles Area
Time: Variable
Toolkit: Mental Health Services, Physical Health Services

Venice Family Clinic (VFC) operates mobile medical units as well as mobile clinic vans. The mobile units and vans support a tailored approach to health service access, as they can be stationed on the street or at community organizations. These mobile clinics allow healthcare workers to draw blood, obtain other samples, provide rapid HIV and Hepatitis C testing, and give medically assisted drug and alcohol treatments (Venice Family Clinic, 2021). Depending on the patient's preferences and level of trust, doctors can provide health services outside for visibility and safety, or inside the medical van or unit for privacy. Both the medical units and vans have extendable canopies that provide shade and create a sense of entry, and define a sense of place through their presence and branding. The branding and contact information on the exterior of the mobile clinics also acts as advertising to inform more people of VFC's street medicine services and increase access as they drive around the city.

Mental Health Services

Physical Health
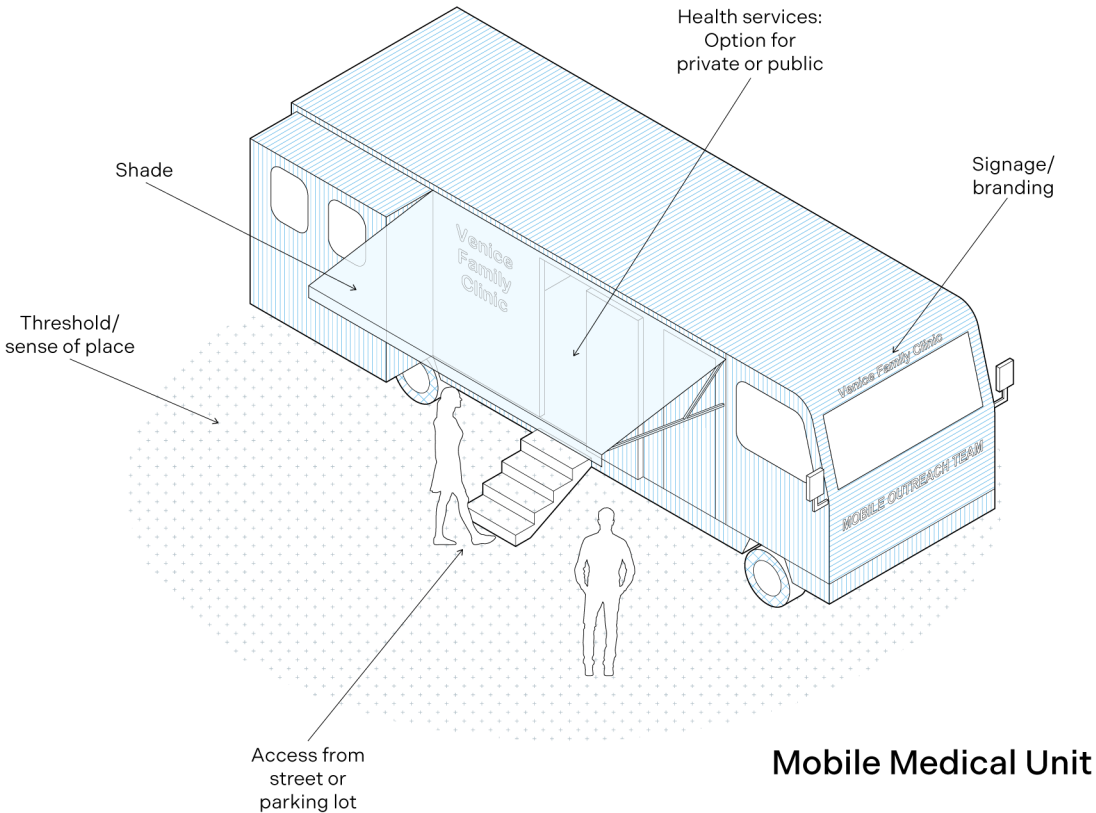
Mobile Medical Unit
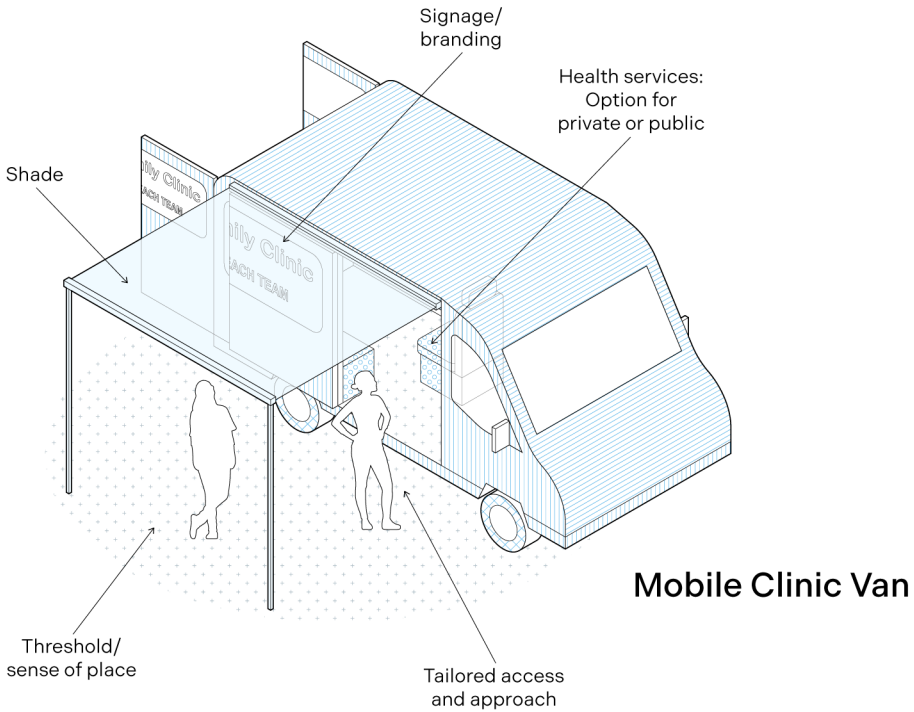
Mobile Clinic Van

Image 6. Spatial analysis of the Venice Family Clinic Mobile Medical Unit & Mobile Clinic Van (Cedars-Sinai, 2023; Harter, 2021)

IN-DEPTH CASE STUDY: THE VENICE FAMILY CLINIC

To gain a deeper understanding of wellbeing concerning service provision spaces, the research team collaborated with the Venice Family Clinic (VFC) to learn more about the function of a comprehensive service "magnet" in both permanent and mobile facilities. With VFC, we conducted a series of in-depth interviews and participatory design workshops. Our analysis focused on VFC's spatial conditions at the Safe Place for Youth Access Center and their Mobile Medical Unit and Mobile Clinic Van. It is situated within one of the largest unhoused population zones in the Los Angeles basin, second only to Skid Row. The area has witnessed the largest increase in its homeless population, reaching a staggering 32%, as reported by the Los Angeles Longitudinal Enumeration and Demographic Survey (Ward et al, 2023). Notably, VFC's health providers are renowned for their extensive and dedicated street medicine team. Serving a diverse range of populations, including 11% of people experiencing homelessness, VFC operates with nine street medicine teams covering West LA in Service Planning Area 5 and Service Planning Area 8. While our research is centered on the Safe Place for Youth Access Center, VFC's brick-and-mortar clinic on Rose Avenue serves as their identified hub for homeless healthcare, according to service providers. Additionally, VFC extends its healthcare services to bridge home sites and Project Roomkey locations. When street medicine teams deploy, they always collaborate with partner homeless services providers and their caseworkers/social workers, leveraging their familiarity with individuals in need of medical care and their locations. This in-depth examination of VFC operations not only offers precise insights into what it entails to deliver healthcare in both traditional brick-and-mortar and mobile clinics but also directly provides insights on potential solutions that could enhance community services for unhoused clients and their service providers.

INTERVIEWS[2]

The research team conducted five interviews to inform this report. The goals of the interviews were twofold: to inform the definition of wellbeing for people experiencing homelessness; and to understand how Venice Family Clinic (VFC), as a successful and innovative provider of a range of services to people experiencing homelessness, operates in de-institutionalized spaces and how those service spaces impact their clients' sense of wellbeing. Understanding the key components of wellbeing for people experiencing homelessness is a critical first step in developing or selecting a valid tool that can be utilized to center wellbeing as a metric for success in service provision. Further, understanding how VFC clients experience service spaces helps indicate what types of provider characteristics, particularly those with a spatial component, should be replicated or considered if improving wellbeing is the goal of a service provider. In the course of these interviews, participants also revealed many other considerations for future study that are beyond the scope of this project but have been documented in our conclusions. From these interviews, we derived the following general findings:

Components of wellbeing

The interviews revealed people's interpretation of the word wellbeing was idiosyncratic, based on life experiences and positionality. Even though respondents differed in terms of what components came to mind first, when expanding on their personal definition of wellbeing many points of overlap were revealed between participants. The concept of wellbeing as multifaceted and as a holistic measure

_____

[2] For further methodology notes see Appendix.

of life experience was shared by all. One participant clearly articulated that for her wellbeing means "how [she is] doing physically, emotionally and mentally. That's wellbeing to me, how [I'm] feeling in all aspects." Interviewees' descriptions of wellbeing generally coalesced around six key components, which are described in detail in our code book (see appendix).

Mental and emotional health

Mental and emotional health was one component of wellbeing that came up quickly and clearly for all clients. Clients talked about day-to-day feelings and mental health conditions that heavily impact their wellbeing and require ongoing treatment such as schizophrenia, substance use disorder, and depression.. However, mental and emotional health was also described as highly intertwined with other aspects of life, implying that it can be affected by various interventions. For example, one client explained the cyclical interaction of clinical depression with her physical health; "I would get sick, or I'd get depressed, and then I would get sick or... I get sick and then I'd be sad... just because it would over-exert my body so much." Clients experiencing homelessness also explained that spatial stressors such as not being able to meet their needs for shelter or to safely store belongings, like medications, negatively impacted their mental and emotional health. Both providers we interviewed also acknowledged the importance of mental and emotional health on wellbeing, particularly of diagnosable mental health disorders. However, they simultaneously emphasized the need to meet patients "where they are at" in terms of their physical location and the importance of not forcing mental health treatments on people who may not desire them.

Social health

All clients also freely provided anecdotes of social interactions that indicated either positive or negative social health impacts on their wellbeing. On one hand, a positive social interaction could contribute towards having a good day or to feeling "like a normal person," as one participant put it. On the other hand, a negative interaction could damage one's sense of self esteem. Clients shared examples of how social interactions within their own community – such as with family, housemates, or trusted providers – influenced how they felt about the quality of their day. For example, one client expressed that waking up to his mother singing him happy birthday contributed to making a recent day good for him. In contrast, two clients shared stories that stressed the impact that stigma towards people experiencing homelessness plays on self esteem during interactions with the wider local community. Providers also discussed the importance of social health and focused on the benefits of being surrounded by a supportive and safe community. One provider was particularly focused on the importance of psychological safety on wellbeing stemming from social environments that "allow people to not feel othered and feel integrated within the community."

Physical health

Physical health was one of the components of wellbeing where clients had the most consensus. All clients shared the sentiment that their physical health is central to wellbeing and that poor health can have ripple effects across their lives. Clients also felt the need to actively take care of their physical health and that staying healthy while homeless is especially worrisome. One client in describing her stress around staying healthy said "I'm always trying to go to the doctor because I'm scared... Anytime that you have any issues with your body it really screws everything up and especially when you're on the streets [your health is] all you have." Interestingly, although the medical provider we spoke with talked about physical health as incredibly important, he framed it as distinct from wellbeing. While supporting physical health the best he can for clients experiencing homelessness, he also acknowledges that it may not be his clients' highest priority when it comes to improving their wellbeing. He also noted that physical health

markers such as sleep or stress hormone levels may help approximate wellbeing. However, it must be acknowledged that these markers are inextricably tied with other components of wellbeing, such as being able to meet one's needs for a safe place to sleep.

Ability to meet needs

When clients were asked to define wellbeing in their own words, none of them explicitly named their ability to meet their basic needs as a component of wellbeing. However, in illustrating t times when their wellbeing was good or bad, their ability to meet their needs was either central to the anecdote or made a large impact on other identified components of wellbeing. For example, after one client identified physical health as critical to her wellbeing, she explained that "if you're only living on food stamps and sleeping outside, it's hard to be healthy." In other examples clients explained that lacking a safe place to sleep caused worry and exhaustion, negatively impacting mental health and triggering social stigma from their housed neighbors; or lacking a safe place to store belongings often leads to losing important medications. Providers, in contrast, explicitly identified the centrality of being able to meet basic needs in order to experience wellbeing. One provider explained that "it's probably the basic parts of Maslow's hierarchy of needs that that would be wellbeing", while the other explained the experience of wellbeing as having "the ability to not only care for myself but... have the means to provide safety for myself and that...I'm not going without." The providers heavily emphasized the element of physical safety provided by shelter.

Sense of accomplishment

Though some clients placed more emphasis on it than others, all clients at least mentioned the importance of having a sense of accomplishment in their lives and playing an active role in self improvement. When asked what well being meant to her, one client immediately noted it meant "handling business, getting things off the checklist, knowing that [I'm] getting closer to what [I'm] trying to achieve, knowing that [I've] got help taking the steps to get what [I] need to get done... just doing whatever [I] can to get [myself] out of this situation." Interestingly and in contrast, neither of the providers directly mentioned that a sense of accomplishment might be impactful to the wellbeing of their clients.

Life Satisfaction

Life satisfaction is the most subjective component of wellbeing that frequently arose in interviews. While life satisfaction is influenced by each other component of wellbeing, it can also be greater or less than the sum of its parts depending on people's values. Clients acknowledge that elements of their lives do not need to be perfect in order to experience wellbeing or to be satisfied with their holistic lot in life. At times the discussion of life satisfaction overlaps with mental and emotional health because the words happiness and feeling are invoked. But life satisfaction transcends simply experiencing emotions towards taking stock of one's life. Additionally, one client explained that wellbeing meant "wanting to do more things that feel good for your soul versus just your body." In support of this, when describing wellbeing clients brought up being able to engage in activities that bring them peace and satisfaction, such as art, yoga, spending time at the beach, and music. One provider in particular stressed the importance of subjective life satisfaction to improving wellbeing which opens the door to providing broad and creative types of support.

Provider Characteristics

Because the clients and providers we interviewed engage with VFC services in various ways and spaces, the interviews resulted in rich information about the characteristics of homeless services are most impactful at both brick-and-mortar locations and mobile treatment spaces. . Participants focused on some spatial and physical characteristics, but since we also asked how VFC supports their wellbeing, we received valuable information about the VFC's practices and operations. Additionally, clients provided helpful information about a range of services and spaces that VFC may not control, but where they cooperated closely and successfully with partners such as Safe Place for Youth. While participant priorities varied depending on where they generally receive or provide care from VFC, discussions centered around seven provider characteristics.

Accessibility and convenience

All clients shared a sentiment that they, and others they know, aren't aware of their resources when their circumstances reach crisis status. They shared finding VFC by stumbling upon it or by a friend introducing them to the provider. The fact that VFC situated its services for people experiencing homelessness in areas where people are likely to be or congregate in order to meet people where they are at helps support this method of access. However, all clients agreed that more outreach and dissemination of information is needed in order for people to quickly get the help they need. Word of mouth alone does not cut it when people are newly unhoused. Clients also noted that efficient processes matter. Slow paperwork, cumbersome check in processes, lack of reliability or predictability, ineffectual communication processes, and confusing triage systems affect people's perceptions of how accessible the space and care provided there is. The diversity of needs from people who rely on these services was evident even in our limited sample size of clients. The interviews revealed how multiple channels for getting connected to care (such as by appointment, walk-in services, and direct outreach via street medicine) significantly support the likelihood that people can and will access care based on their needs and limitations. The VFC providers also recognized their strength lies in their accessibility to this population by creating multiple types of access points for people to receive care in the way that is most comfortable and easy for them. For providers to serve a broad section of unhoused clients with diverse intersectional identities, they cannot just have one entry point to services.

Trust in providers

Behind accessibility and convenience, trust in providers was perhaps the most emphasized characteristic among clients and it seems to impact not only whether people experiencing homelessness choose to access care but also the perceived effectiveness of that care on their wellbeing. All clients mentioned the emotional impact of being able to trust that their provider cares about their wellbeing. For example, one client expressed that "for somebody to really sit down and listen to you and understand what you're going through and try to help you after you've been trying to figure it out... It's like relief." Clients also stressed the importance of trusting that their provider will treat them with high-quality care and that they will do so reliably. Clients shared that heartbreak and false hope are evoked when subpar care is provided or when providers do not follow through on promises. Relatedly, clients emphasized that responsive and easy channels of communication helped foster trust that important follow-up care would not be forgotten. Additionally, every client we interviewed mentioned a specific individual provider who understands their unique circumstances that helped them feel comfortable obtaining services. The VFC providers also understood the centrality of building trust between themselves and the community they are trying to serve to their ability to successfully provide care. They acknowledged that part of building this trust is based on deeply listening to their clients to understand the type of care they want to receive, and on providing care in the places where clients felt most safe and comfortable.

Services offered

When asked to reflect on how VFC has supported their wellbeing, clients shared appreciation for being able to utilize multiple types of services in the same location in addition to the medical support they received. When clients were at their lowest points the services that attended to their immediate basic needs, such as food, showers, clothes, acute medical care, sleeping bags and tents, were particularly impactful. However, they also stressed the importance of providing longer term support as well, including housing case management, mental health and substance use treatment, connection to transportation services, and regular medical visits. However, in relation to the trust in providers characteristic, the quality of services provided matters. If services are offered but the provider does not have adequate capacity to provide them, it can cause delay for the client in getting critical care that they may need to receive elsewhere. Despite this, the VFC provides the broad range of trauma that people experiencing homelessness are exposed to means that safety looks very different depending on individual experiences – to some, safety may require privacy while to others safety is achieved by being out in the open. Overall, the interviews made clear that true safety is only afforded with housing.

Comfort and quality of service spaces

Though the constraints on design vary greatly between mobile versus brick and mortar service locations, all clients expressed appreciation for spaces that feel normal and comfortable despite where they primarily accessed care. As one client noted, she enjoyed receiving services at Safe Place for Youth because "they don't make it feel like you're here for what you're here for," while another noted that the comfortable space reminded her that she was seen as a human being there. Safe Place for Youth achieves this by decorating the rooms with art, plants, activities, and vibrant colors, while the mobile van does so with soft lighting and comfortable chairs for the waiting area. Clients who used brick and mortar locations and the mobile services preferred more expansive open spaces to boxy and constrained rooms. Locating services in a nice neighborhood, such as Venice, also helped the clients feel entitled to a dignified space. Both VFC providers acknowledged that providing care for people experiencing homelessness in comfortable and high quality spaces is something they are continuing to improve upon, as it has not historically been the focus of homeless service provision.

Privacy

Privacy was another characteristic of service provision spaces that was raised less frequently by clients than we anticipated as informed by our literature review. We caution this to not be taken that privacy is unimportant, but that while experiencing homelessness privacy during service provision may not be expected or be the highest priority. Speaking to this lack of expectation of privacy, one client explained that while receiving services at the mobile medical van "you do have to be okay with discussing some things a little bit more in the open, [but] when things get private, [the doctor] does bring people inside [the van]." Separately, the same client expressed how impactful the privacy his new housing affords him has been on his well being. The infrequency of privacy being discussed in the context of service provision may be partially explained by the observations of one VFC provider. She shared they learned a lesson when they launched the mobile vans as a safe place to conduct gynecological exams because the isolation actually triggered traumas of being taken advantage of for many women. Instead, VFC providers try to provide as much privacy as they can to their clients, such as by creating human shields or stepping to the side, while offering, but never forcing, more private options if the client seems comfortable.

Fostering community inclusion and belonging

As indicated by its prevalence in our literature review, designing a service space that fosters a sense of community inclusion and belonging is helpful. For the two clients who accessed services at Safe Place for Youth, the community spaces occupied by other people their age struggling with similar issues helped them feel less stigma around accessing the services they needed. Again the importance of location was raised because clients wanted to feel like they are respected by and belong in the local community. Venice was described as a good place to be because the concentration of service providers in the area has helped to foster a sense of community care and support between housed and homeless neighbors. The providers emphasized that they both draw on and reinforce this community support by cooperating with local residents and community leaders to identify which people are in need of support and where services may be needed. One provider also acknowledged their role in creating "high information spaces" shared by housed and homeless people that allow people to feel integrated within the community. She gave examples of community art projects or exercise classes that bring people together, while service providers provide information that help decrease stigma or biases against people experiencing homelessness.

Overall conclusions from the interviews can be found at the end of this report.

DESIGN WORKSHOPS

As the final research task, we conducted two design workshops with VFC service providers to imagine collectively what open-access, destigmatized service delivery may look like in the future. These final exercises can be described as a concept-based conversation, documented in real-time by researchers.

Design workshop #1: Qualifier Sliders

Date: 11/21/2023
Time: 1:30 PM
Duration: 30 mins
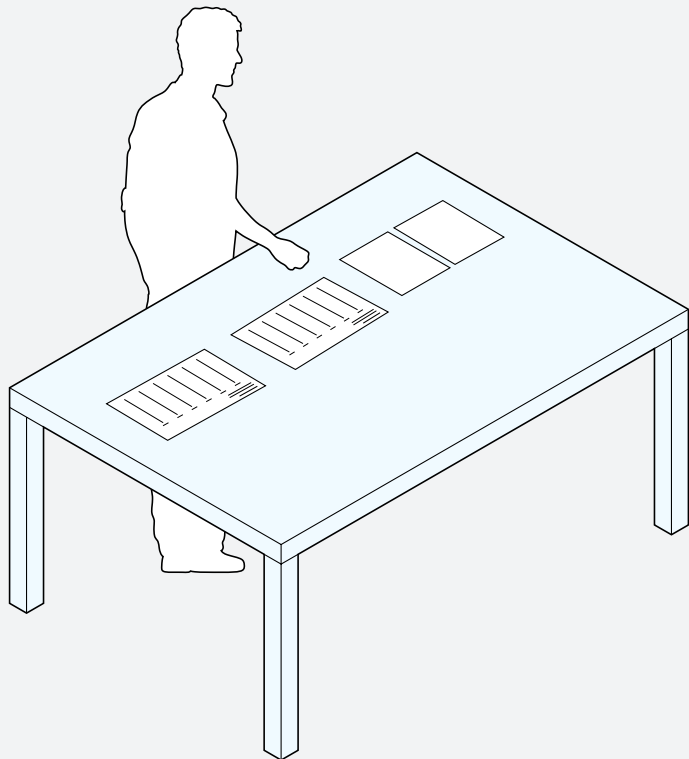**Location:** SPY Access Center at 340 Sunset Ave, Venice, CA

Color	Name	Role	Activities
Pink	Person 1	Site Coordinator Representative	Administrative support & aftercare needs
Yellow	Person 2	Patient Service Representative	Coordination of homeless outreach program
Light Green	Person 3	Site Manager for Homeless Outreach	Enhance patient care divest service
Dark Green	Person 4	Substance Use Counselor	Provide counselor services
Pink (C)	Person 5	Physician Assistant	Primary medical care
Yellow (R)	Person 6	Medical Assistant	Nursing Support

Table 1. Workshop Attendance

Exercise

Service providers from VFC's Mobile Clinic Van were asked to position a color sticker according to their assessment of desired spaces to provide care. The qualifiers, informed by both the literature review and our prior case study analysis included:

- Private — Visible
- Comfortable — Efficient
- Secure — Open-access
- Clinical — Home-like
- Casual, walk-ins — Structure, scheduled
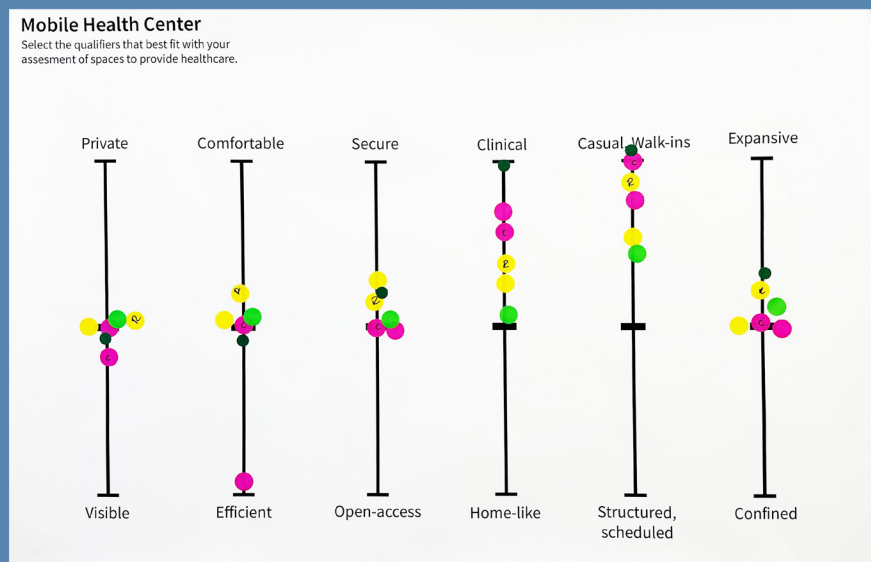- Expansive — Confined

Image 7. Workshop 1
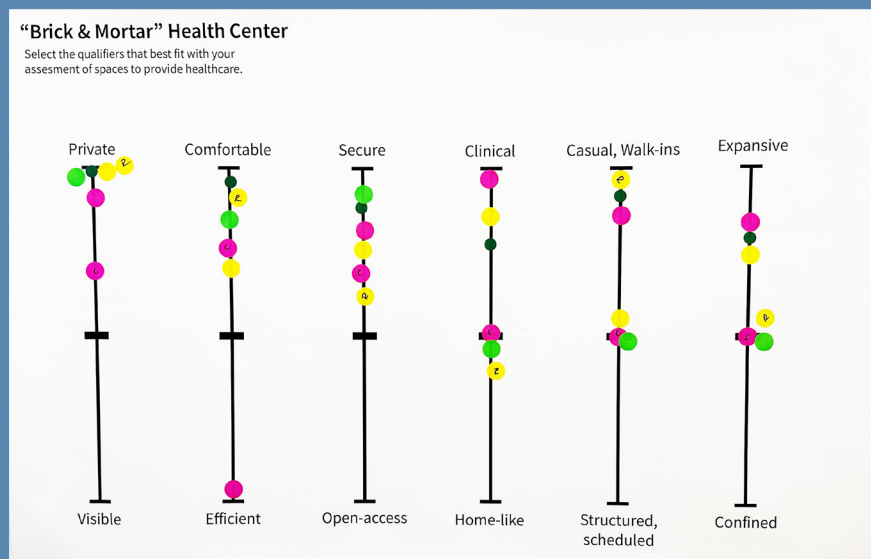
Image 8. Mobile Health Center Qualifiers

Image 9. "Brick and Mortar" Center Qualifiers

Findings

This exercise revealed providers' perceptions of the qualities needed for different types of spaces. For the mobile health center, a clear consensus emerged on the necessity for accessible and visible spaces, along with a focus on comfort and efficiency. However, this consensus began to shift when considering other categories, with an apparent preference for secure spaces that convey a more clinical atmosphere, featuring unstructured processes and the potential for expansiveness.

In contrast, providers exhibited less balanced assessments of the qualifiers for "brick-and-mortar" centers, indicating a belief that these spaces should primarily be more private, comfortable, secure, and clinical. The group displayed divided opinions regarding the clinical feel, and considerations of whether the space should feel expansive or confined. Intriguingly, providers also diverged on how services should be structured, corroborating interviews that emphasized the need to organize care while remaining flexible for individuals seeking services without appointments.

In the exercise, providers commented on their limited time for contemplation regarding the spaces they occupy. However, they emphasized the urgent need to expand investments in brick-and-mortar spaces, allowing for the provision of better services.

Design workshop #1: Qualifier Sliders

Date: 11/28/2023
Time: 1:30 PM
Duration: 30 mins
Location: SPY Access Center at 340 Sunset Ave, Venice, CA
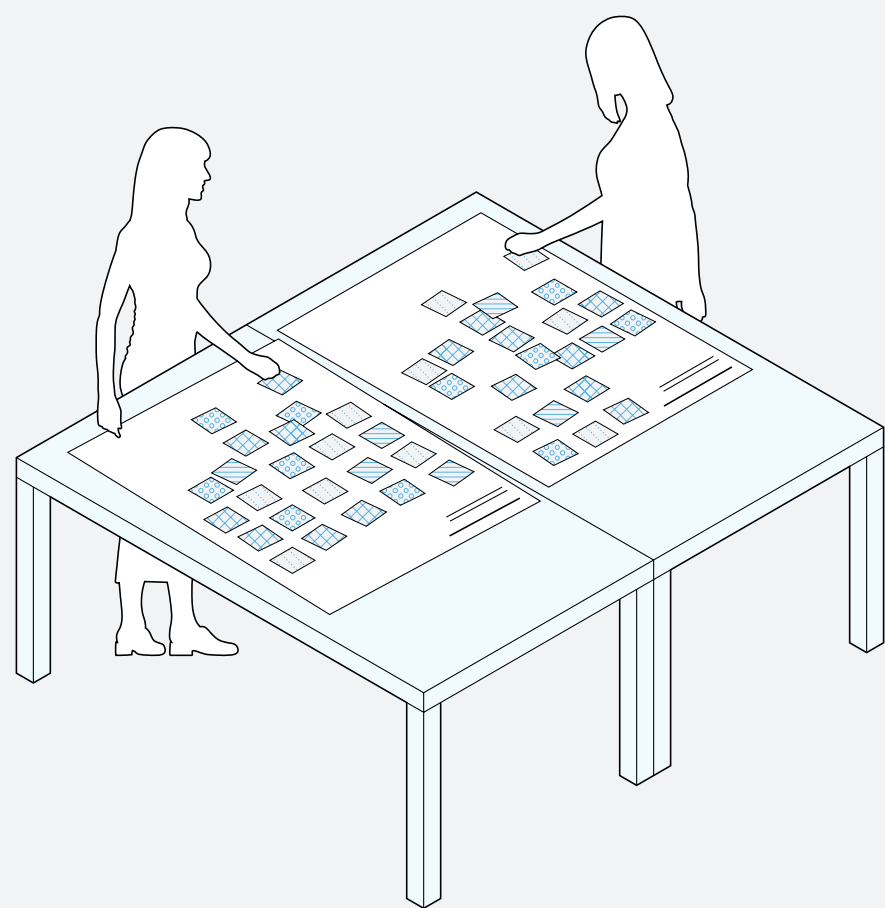
Image 10. Workshop 2

Name	Role	Activities
Person 1	Site Coordinator Representative	Administrative support & aftercare needs
Person 4	Substance Use Counselor	Provide counselor services
Person 5	Physician Assistant	Primary medical care
Person 7	Pre-Physician Assistant	Support medical care
Person 8	Medical Assistant	Support medical care

Table 2. Workshop Attendance

Exercise

Service providers from VFC's Mobile Clinic Van were asked to post on boards the physical elements they felt were needed in the health center. Next, they grouped elements and finally selected which they perceived as necessary(green sticker) or nice to have (purple sticker).

Image 11. Mobile Health Center Elements

Image 12. "Brick and Mortar" Center Elements

Mobile Health Center		"Brick & Mortar" Health Center	
Necessary	**Nice to have**	**Necessary**	**Nice to have**
Diagnostic tools	Toilets	Rooms to sleep/rest	Laundry facilities
Space to register vitals	Laundry	Water fountain access	Preventive care
Hygiene products	Showers	Great internet	Solar Battery charger
Snacks and water	Storage area	Pharmacy	Outdoor space
Tables & chairs	Waiting area	Private exam room	Places to rest
Great internet	Walls/Windows	Full lab access	Paper goods
Transportation access	Lab	Showers	Warm/dry clothes
Motel funds	Mental health provider	Clothes drop-off	Phone giveaway
Socks	In person case manager	Closet	
	Insurance worker	DBT Therapy	
	Access to behavioral health	In person case manager	
	Vaccines	Insurance worker	
	Durable medical equipment	Access to behavioral health	
		Durable medical equipment	
		Ability to do womens exams	

Table 3. Prioritization results

Findings

While some of the service providers focused on actual physical elements, many of them quickly started inputting additional needs for staff and equipment, explaining the challenges they have when caring for people experiencing homelessness. Some   felt incorporating physical elements in the exercises was shortsighted, as there was a more pressing need for support. Although some participants initially questioned the necessity of facilities like laundry and showers in mobile units, in further discussion a consensus emerged around their importance for holistic wellbeing. Overall, the necessary as well as the important ("nice to have") physical components in both mobile and fixed service centers are shown in Table 3. The elements that are related to a physical necessity are black and the ones that identify services are grayed out. Worth noting about brick-and-mortar facilities is the importance assigned to rooms for rest and sleep, water, followed by good internet access. These items would appear to be particularly important to a health facility specializing in a clientele experiencing homelessness. The next three elements (pharmacy, private exam rooms, full lab access) are more conventional parts of any strong health facility. By contrast, in the mobile health context, the most important elements are the more conventional service provision capabilities (diagnostic tools, space to register vitals, hygiene products) while the next four elements are particular to a mobile site for unhoused clientele (snacks and water, tables and chairs, great internet, and transportation access). The reversal in priorities indicates the specificity of spatial and temporal contexts for clients experiencing homelessness.

When asked to reflect upon their experiences during the exercise, participants revealed a spectrum of sentiments, including feelings of resentment of lack of resources, alongside an acknowledgment that the process aided them in exploring viable options for care. Notably, there was a collective desire to replicate the comprehensive services available at brick-and-mortar facilities, albeit on a smaller scale, within the spatial confines of mobile units.. This aspiration is rooted in the belief that integrating such services into mobile units is crucial for building trust, thereby facilitating the transition of clients to more reliable care at brick-and-mortar centers. The study uncovered a symbiotic relationship between enhanced services at brick-and-mortar locations that bolstered the legitimacy of mobile service provision. Despite the vital role of mobile units in garnering trust and initial engagement, participants highlighted the challenges of delivering primary and preventative care in such settings, emphasizing the inherent efficacy of brick-and-mortar settings for acute care.

Overall conclusions from the workshops can be found at the end of this report.

CONCLUSIONS

A set of interrelated conclusions can be drawn from the various studies that comprise this research report: literature review, interviews, case studies, and workshops.

The literature review highlights the pressing need for the development and adoption of metrics that can assess the multi-dimensional aspects of wellbeing among people experiencing homelessness. Based on the key informant interviews with providers serving people experiencing homelessness, we gleaned insight, additional perspectives and the challenges that will help address this gap in wellbeing metrics for the unhoused population. For instance, as part of the key informant interviews conducted with providers, opinions regarding the assessment of wellbeing among the unhoused community varied. One provider felt strongly standard metrics of wellbeing should be used regardless of the population, "I think it is important that it's the same set of factors so we can compare between the two [housed vs. unhoused], and we can have that drastic difference." While the other provider believed it was critical to frame well being in a way that would resonate with people experiencing homelessness, stating "I think...definitely asking and not assuming that we have the same ideas of what this [wellbeing] means is the imperative." Both points are valid and point to the need to collaboratively develop metrics that can both holistically assess wellbeing among the unhoused population and clearly delineate the range of experience between housed and unhoused individuals. These metrics are not only critical for identifying the unique needs of the unhoused population, but to also assess whether interventions tailored to meet the needs of people experiencing homelessness are having the desired effect.

Furthermore, the idea of being able to meet one's basic needs for shelter, food and water, physical safety, a place to rest or sleep, or to maintain hygiene, as described in Maslow's hierarchy of needs, is both fundamental to understanding wellbeing for people experiencing homelessness and also complicates the effort to define distinct components for measurement. Centering the ability to meet basic needs in efforts to improve wellbeing for this population provides a concrete intervention point, but can also disguise the other important components people identified. Examples gleaned from the key informant interviews among the unhoused revealed a general consensus for instance that the concept of wellbeing as multifaceted and a holistic measure of how life was experienced was shared by all. The components that came up quickly and/or consistently were mental and emotional health, social health, physical health, a sense of accomplishment, and life satisfaction.

While our focus during the interviews was on service provision in non-institutional spaces, both clients and providers consistently brought the discussion to housing, reaffirming the housing first approach. They noted despite successes in improving approach to care, need significantly outpaces resources in human, physical, and monetary capital. Moreover, bureaucratic hurdles also limit success in the field. Clients and providers recognize they are doing good work but more of it is needed. Success is in many ways dependent on how well a provider partners with other service providers and agencies. Providers noted being better equipped to serve their clients when they have good relationships with local police, hospitals, and other homeless services to coordinate care. Clients appreciate the expanded services that can be provided as a result of these partnerships.

It is important to note recruiting participants for the interview portions of the study was challenging. We intended to interview participants from multiple service providers and conduct a longer combined participatory design activity, but adjusted our plans accordingly with what was feasible. Challenges like these suggest why data may be sparse in this population, but that is not for lack of necessity. The mixed methods approach taken by the research team may serve as an example for engaging with this hard-to-reach community.

Looking at the case studies, the opportunity to combine spatial-service types is obvious but it is less obvious that the cases also offer differ combinatorial strategies appropriate in different contexts. If wellbeing is more broadly defined by community health measures, creating more comprehensive settings is an appropriate spatial response. For example, in Los Angeles, The Refresh Spot is a long term site where unhoused people's basic needs can be addressed, but it lacks formal health care facilities and must either refer clients elsewhere (perhaps providing transportation) or invite visits from a mobile clinic. The Venice Family Clinic, which we will address further, is a permanent, formal health care provider with alternative community health practices like mobile clinics and basic needs referrals. It does not currently offer a permanent site for basic hygiene like laundry and showers, which might be offered by temporary or pop-up sites if not possible or desired for permanent incorporation. The Navig8 service center could be a stronger gateway to community wellbeing with the addition of missing permanent and/or temporary spatial-services, like a health clinic or regular pop-up food distribution. Comparisons across spatial-service types suggest a number of possible ways to fill gaps in service provision: create a network of links between services that are geographically distinct; add spaces and services where possible to make current spatial-service sites more robust; bring missing components to spaces via temporary spaces (eg pop-ups) and mobile units. This population is incredibly diverse in its needs and what approaches to care work best for them.

The workshops shed light on spatial design choices in service provision that would positively impact unhoused people. Service providers shared the importance of discretion in the design of spaces primarily providing services to unhoused people. Some of these findings were prominently present in the literature review as well. For example, some qualitative studies found that large and imposing buildings used as shelters make it clear that there are large concentrations of local unhoused people, which can reveal stigma in the local housed community and lead to unhoused individuals feeling unwelcome or unsafe. We had several exchanges where it was consistently noted, and supported by findings in the exercises, that privacy is a main focus when providing care for these communities. The importance of considering the appropriateness of confidentiality and privacy when providing services comes up frequently in the literature, in the interviews, and in the workshops. Many unhoused people stress the importance of privacy; however, others report that the physical separation of clients without adequate steps to ensure security can foster dangerous situations, complicating the implementation of design choices that create privacy.

Our conversations with the staff at the VFC Mobile Clinic Van allowed us to conclude that while alternative, mobile means of bringing care to people experiencing homelessness are important, they remain a complementary practice that should support more permanent investments. The positive effects of designing spaces to enhance opportunities for building and engaging with the community, both within the unhoused community and with housed neighbors, are not fully achieved by mobile clinics. Another dimension we have uncovered is the relationship between how the space feels and the impact it can have on people experiencing care. There is a need for places of service provision to feel 'homey,' warm, and welcoming in ways that help normalize the space and create emotional safety. This also sheds light on the common commentary from service providers about the necessity to figure out more permanent models of care and to consider mobile clinics as complementary services that derive from more established and holistic efforts for wellbeing. The Memphis case study was an effort to demonstrate that there are real-life examples of hybrid models of health centers that combine some qualities and elements of both models. It also showcases spatial characteristics that prelude incremental expansion of services and infrastructure.

From our studies, there is a general consensus physical space has a significant impact on the lives and wellbeing of unhoused people. The very fact of being 'unhoused' is itself a matter of physical space, and it is this spatial condition that has health impacts. But what about the spatial conditions of health services? Despite this, there is almost no research formally connecting spatial considerations in service provision with the ultimate goal of improving wellbeing. This pilot study recognizes the need for and

leaves an opportunity to implement better tools to measure wellbeing, aiming to create healthier physical environments for unhoused people not yet on the pathway to permanent supportive housing. We also lay the groundwork for continuing the systematic study of the physical spaces deployed to provide services for people experiencing homelessness.

APPENDIX

I. MEASURING WELLBEING

While a precise definition or form of measurement remains elusive, similarities can be found across emerging and established uses of the term of wellbeing in literature focused on unhoused populations. There is a general agreement that wellbeing includes both objective and subjective components, with acknowledgement of the role of positionality: that wellbeing is experienced and felt differently by each individual depending on their individual resilience, disposition and circumstances. A large range of domains (or components of wellbeing) which are frequently included or combined in measurement tools include:

- Physical health
- Mental health
- Positive sense of self
- Sense of purpose or meaning
- Social connectedness
- Positive emotions
- Positive experiences
- Happiness/overall life satisfaction
- Domain specific life satisfaction, ex:
  - Material resources
  - Ability to meet needs
  - Relationships
  - Health
  - Self-image
  - Income
- Resilience/stress
- Ability to meet needs
- Lifestyle and daily practices, ex:
  - Drug use
  - Sleep
  - Diet
- Finance
- Spirituality

When reviewing how wellbeing has been measured in the literature, we found some recurring inconsistencies which complicate comparisons of case studies aiming to improve wellbeing.

1. *Wellbeing as an umbrella, not silo.* Often, researchers purportedly study wellbeing measures related but more narrow outcomes in isolation (such as health-related quality of life or life satisfaction), while conflating these with wellbeing when discussing findings, conclusions and impact. This can happen either by using the term wellbeing loosely, or by using tools that are now commonly described in the literature as measuring wellbeing despite being originally designed to measure a related concept. For example, the *Short Form 12 item (version 2) Health Survey (SF-12v2)* is often used as a proxy for wellbeing even though it was designed as a health survey. Such silo-ing of what we call "narrow" outcomes defies the tripartite focus on mental, physical, and social health emphasized in the WHO's conceptualization of wellbeing.

2. *Uneven weighting of domains across studies.* Some researchers use measurement tools that have been developed to measure wellbeing holistically, such as the Stanford WELL Survey or the Personal Well-Being Index, while others use a combination of tools that each capture discrete components of wellbeing. While some will combine validated measures, for example the *Psychological Well-Being Scale* with the *Sense of Community Index-2,* others create their own survey questions to capture information on the domains of wellbeing they have determined most relevant.

3. *Well vs. good.* Measurements of "quality of life" particularly complicate wellbeing literature. Historically the more frequently used concept, quality of life is often used synonymously with wellbeing. However, quality of life is now understood by the WHO as a component of wellbeing aiming to capture the ambiguous concept of "a good life" (Barcaccia et al., 2013). Given quality of life contributes to wellbeing and the abundance of its use as an indicator of wellbeing in the literature, some case studies utilizing the quality of life measurement may be useful for the understanding of wellbeing.

We agree with Davies, the field of wellbeing in unhoused populations is "a nascent but important research arena," (Davies et al., 2014); for instance, identifying tools to measure wellbeing, for this population is understudied. Indeed, many questions used to evaluate wellbeing from established metrics, such as the Stanford Well Survey (Ahuja et al., 2020) or Satisfaction with Life Scale (Biswas-Diener & Deiner, 2006), are not clearly adaptable to unhoused populations. Questions include "how many days did you stay in bed this month" and housing-specific inquiries that do not reflect the lived experience of unhoused people. Beyond eliminating or translating irrelevant questions, the long-form questionnaires and qualitative interviews used by researchers in studies to date are not always feasible to implement in settings where unhoused individuals spend their time.

The bulk of the literature involving unhoused people and wellbeing use existing metrics without explicitly debating whether the chosen metric is the appropriate tool, nor are there many investigations into whether measures of wellbeing in this population are valid. Instead, most of the literature either focuses on comparing unhoused people's wellbeing to housed people or demonstrating which life conditions have the greatest impact on wellbeing. Both are valuable questions, but may have less utility than assumed if we cannot be certain the wellbeing measures are valid. While some narrow measures, such as the *Short Form 12 item (version 2) Health Survey (SF-12v2)*, have been validated in subpopulations of unhoused people, we only found one wellbeing-related measurement tool designed specifically for use in unhoused populations – the Quality of Life for Homeless and Hard-to-House Individuals Inventory (Hubley et al., 2009). Though not a perfect equivalent for wellbeing such as ___, the tool informs ways of gathering information on the impact of place and unhoused lived experiences.

Having measures accurately capturing wellbeing in unhoused people is especially important given some literature suggests the experience of being unhoused affects how and to what extent people experience the various domains of wellbeing. For example, while most studies comparing overall wellbeing between housed and unhoused individuals find unhoused people score lower, this does not necessarily hold true across domains. One study found stress, for example, is a domain where unhoused people fare relatively well (Ahuja et al., 2020). Understanding which domains of wellbeing hold the most salience for unhoused people may illuminate opportunities for improvement or protective factors to enhance wellbeing.

However, the literature does not make a clear distinction between what wellbeing is and what impacts wellbeing outcomes. In measuring wellbeing in unhoused people things like privacy, safety, living environment, or autonomy may be measured as components of wellbeing in one study whereas in another they are considered conditions that impact overall wellbeing. Regardless, the literature reveals many factors that impact wellbeing in this population, many of which can be altered and improved by thoughtful service provision and interventions. These factors include:

- Privacy
- Feelings of safety
- Physical/living environment
- Rest/sleep
- Autonomy/control over one's life or circumstances
- Social support
- Social connectedness
- Sense of belonging
- Social and cultural activities
- Shared physical space
- Ability to engage in leisure activities
- Spirituality
- Health status
- Safety
- Gender
- Time of year
- Mobility
- Length of time unhoused
- Physical health

II. CODE BOOK

Components of Wellbeing

- *Mental and emotional health* – Mention of emotional state experienced, including self esteem, or clinical diagnosis of mental health disorder such as anxiety or depression.
- *Social health* – Mentions of social health including social relationships or connections/ connectedness, interactions with others, feelings of belonging, having a social network.
- *Physical health* – Mention of physical health including feeling healthy, strong, absence of presence of pain, health indicators, rested.
- *Ability to meet needs* – Mention of ability to meet basic needs (food, physical and bodily safety, shelter, hygiene, ability to sleep and rest), ability to pay bills.
- *Sense of accomplishment* – Mention of accomplishments, sense of accomplishment, or goal setting such as securing a job or housing, engaging in exercise or a healthy activity for its benefits.
- *Life Satisfaction* – Expresses subjective opinion on their overall life circumstances, self, level of holistic or long term happiness or being content. May also mention engagement in enjoyable activities that support a sense of satisfaction, such as leisure, painting, listening to or playing music, games, gardening.

Provider Characteristics

- *Accessibility and convenience* – Mention of ease of accessing case study, for example physically getting to the space, signing up for services, financial accessibility, or low barriers to entry or to get appointments. This can also include cumbersome processes which lead to difficulties in accessing services efficiently. This can also include how word is spread about the service (without knowing about the service clients cannot access it). Mentions that the location is in a place with other services around or is easy to get to.
- *Trust in providers* – Mention of trust participants felt towards providers they interacted with at case study, trust or faith that they will receive good quality of care, trust that providers will treat patients with respect for their autonomy in choosing their treatment and which needs they deem worthy of focus, with kindness, and with dignity.

- *Services offered* – Mentions the range of services offered by the case study such as medical, food, case working or social support, ability to obtain multiple services in one place, etc., or mentions quality of the services.
- *Safety* – Mentions feeling safe or unsafe in the physical space or in the area immediately surrounding the space where care is provided.
- *Comfort and quality of service space* – Mentions the comfort or discomfort experienced within the design of the physical space or the neighborhood the service is located in, including whether the space is visually welcoming, homey, comfortable, nice or aesthetically pleasing, or has activities to do.
- *Privacy* – Mentions the level of privacy experienced in the space or privacy of the service space from the community.
- *Fostering community inclusion and belonging* – Mentions stigmatization or lack of stigmatization of unhoused people within a community, actions of support from neighbors, ability to connect meaningfully with a community.

III. INTERVIEWS METHODOLOGY

Recruiting and Sample

VFC medical providers referred three clients to us for interviews, one of which was scheduled in advance and two were recruited from walk-ins while our researcher was on site. Since scheduling meetings with people experiencing housing insecurity can be challenging, which was evidenced by our difficulty recruiting interviews from other service spaces, stationing ourselves on site while services were being provided allowed us to successfully recruit interview participants. Client participants were all recently housed, but had experienced homelessness just prior to obtaining housing and had utilized VFC services during that time. The three clients provided insight into experiences utilizing VFC services for people experiencing homelessness at a range of locations. Collectively, the clients utilized VFC's street medicine units, the brick and mortar clinic on Rose Avenue (often referred to as VFC's "homeless healthcare hub", and the VFC's mobile medical van at their partner site, Safe Place for Youth.

We also interviewed two VFC staff members who work on homeless healthcare initiatives. Dr. Coley King is the director of VFC's Homeless Healthcare Services and Evonne Biggs is the program manager for Homeless Services and Health Equity at VFC. Their work focuses heavily on VFC's mobile street medicine program, but they also engage with and coordinate care at other VFC locations as well. All participants that were interviewed received gift card incentives for participation per our Institutional Review Board approval.

Interview Protocol

All interviews were semi-structured to allow for focus on topics that participants offered as significant to them. Client interviews were broken into three main categories of questions: history of their interactions with VFC, how they experience the VFC service spaces and how they impact their wellbeing, and their personal interpretations of the term wellbeing. Provider interviews followed a similar structure but asked providers to consider how the spaces where they provide care impact their clients.

Researchers created a code book informed by our literature review which was refined by the content of the interviews themselves, so that the interviews could be compared and findings could be synthesized. The code book included codes for labeling components of wellbeing and for provider characteristics. Two researchers coded the transcribed interviews independently, then their coding was compared to confirm that the interviews were interpreted with reliability.

WORKS CITED

Adarkar, A., Gjika, T., Ward, T., Woetzel, J., & Wong, Y. (2023). *Finding solutions to Los Angeles' homelessness crisis.* McKinsey & Company. https://www.mckinsey.com/industries/public-and-social-sector/our-insights/homelessness-in-los-angeles-a-unique-crisis-demanding-new-solutions

Ahuja, N. J., Winter, S. J., Freeman, M., Shi, R., Rodriguez Espinosa, P., & Heaney, C. A. (2020). Well-Being without a Roof: Examining Well-Being among Unhoused Individuals Using Mixed Methods and Propensity Score Matching. *International Journal of Environmental Research and Public Health*, 17–19.

Amster, R. (2003). Patterns of Exclusion: Sanitizing Space, Criminalizing Homelessness. *Social Justice,* 30, 1(91) Race, Security & Social Movements, 195–221. https://doi.org/https://www.jstor.org/stable/29768172

Anderson, M.-C., Hazel, A., Perkins, J. M., & Almquist, Z. W. (2021). The Ecology of Unsheltered Homelessness: Environmental and Social-Network Predictors of Well-Being among an Unsheltered Homeless Population. *International Journal of Environmental Research and Public Health*, 18(14), Article 14. https://doi.org/10.3390/ijerph18147328

Architizer. *Council District 8 Navigation Center by John Friedman Alice Kimm Architects (JFAK).* (2022, December 26). https://architizer.com/projects/council-district-8-navigation-center/

Barcaccia, B., Esposito, G., Matarese, M., Bertolaso, M., Elvira, M., & De Marinis, M. G. (2013). Defining Quality of Life: A Wild-Goose Chase? *Europe's Journal of Psychology,* 9(1), 185–203. https://doi.org/10.5964/ejop.v9i1.484

Bauman, T., Rosen, J., Tars, E., Foscarinis, M., Fernandez, J., Robin, C., Sowa, E., Maskin, M., Cortemeglia, C., & Nicholes, H. (2014). *No Safe Place: The Criminalization of Homelessness in U.S. Cities.* National Law Center on Homelessness & Poverty. https://homelesslaw.org/wp-content/uploads/2019/02/No_Safe_Place.pdf

Biswas-Diener, R., & Deiner, E. (2006). The Subjective Well-Being of the Homeless, and Lessons for Happiness. *Social Indicators Research,* 76, 185–205.

Cedars-Sinai. *Cedars-Sinai donates mobile unit to Venice Family Clinic.* (2023, October 19). https://www.cedars-sinai.org/newsroom/cedars-sinai-donates-mobile-medical-unit-to-venice-family-clinic/

Davies, S. C., Winpenny, E., Fowler, T., Rubin, J., & Nolte, E. (2014). For debate: A new wave in public health improvement. *Lancet,* 1889–1895.

Empowerment Congress Southwest Area Neighborhood Development Council. *CD8 Navigation Center.* (2023, May 18). https://southwestnc.org/6788-2/

Every, D., Richardson, J., & Osborn, E. (2019). There's nowhere to go: Counting the costs of extreme weather to the homeless community. *Disasters*, 43(4), 799–817. https://doi.org/10.1111/disa.12400

Fisher, M., Miller, N., Walter, L., & Selbin, J. (2015). California's new vagrancy laws: The growing enactment and enforcement of anti-homeless laws in the golden state. *SSRN Electronic Journal.* https://doi.org/10.2139/ssrn.2558944

Fuller, T. (2023, June 22). A rising tally of lonely deaths on the streets. *The New York Times.* Retrieved December 11, 2023, from https://www.nytimes.com/2022/04/18/us/homeless-deaths-los-angeles.html.

Gelberg, L., Andersen, R. M., & Leake, B. D. (2000). The Behavioral Model for Vulnerable Populations: Application to Medical Care Use and Outcomes for Homeless People. *Health Services Research*, 34(6), 1273–1302.

Harter, C. (2021, January 21). *Venice Family Clinic rolls out new doctor's office on wheels.* Santa Monica Daily Press. http://smdp.com/2021/01/21/venice-family-clinic-rolls-out-new-doctors-office-on-wheels/

HHCLA. *Our programs | Homeless Health Care Los Angeles (HHCLA).* (n.d.). Retrieved November 19, 2023, from https://www.hhcla.org/programs

Homeless Health Care Los Angeles. (2020, August 13). *Refresh Spot Fly Thru* [Video]. YouTube. https://www.youtube.com/watch?v=GRigzgEqDio

Hubley, A. M., Russell, L. B., Gadermann, A. M., & Palepu, A. (2009). *Quality of Life for Homeless and Hard-to-House Individuals (QoLHHI) Inventory.*

International Wellbeing Group (2013). *Personal Wellbeing Index: 5th Edition.* Melbourne: Australian Centre on Quality of Life, Deakin University http://www.acqol.com.au/instruments#measures

Islam, M. M. (2019). Social Determinants of Health and Related Inequalities: Confusion and Implications. *Frontiers in Public Health,* 7(11).

JFAK Architects. *Navig8—Council District 8 Homeless Navigation Center.* (n.d.). Retrieved December 2, 2023, from https://www.jfak.net/work/council-district-8-navigation-center-navig8/

Kahneman D, Deaton A. (2010) High Income Improves Evaluation of Life but Not Emotional Well-Being. *Proceedings of the National Academy of Sciences (PNAS).* 107(38):16482-16493. doi.org/10.1073/pnas.101149210

Kertesz, S. G., DeRussy, A. J., Riggs, K. R., Hoge, A. E., Varley, A. L., Montgomery, A. E., Austin, E. L., Blosnich, J. R., Jones, A. L., Gabrielian, S. E., Gelberg, L., Gordon, A. J., & Richman, J. S. (2021). Characteristics Associated With Unsheltered Status Among Veterans. *American Journal of Preventive Medicine*, 61(3), 357–368. https://doi.org/10.1016/j.amepre.2021.03.017

LavaMae[x]. *Closure of programs & operations*. (2023a, June 6). https://lavamaex.org/blog/closure

LavaMae[x]. *Mobile Hygiene Impact Report, Jan—March 2023.* (2023b, May 11). https://lavamaex.org/blog/mobile-hygiene-impact-report-jan-march-2023

LavaMae[x]. (2022, June 14). *May 2022 Pop-Up Care Village* [Video]. YouTube. https://www.youtube.com/watch?v=0yJDA_muu_Y

Los Angeles Homeless Services Authority. (2022). *2022 Greater Los Angeles Homeless Count—Los Angeles County.* https://www.lahsa.org/documents?id=6515-lacounty-hc22-data-summary

McLeod, H., & Walsh, C. A. (2014). Shelter Design and Service Delivery for Women Who Become Homeless after Age 50. *Canadian Journal of Urban Research,* 23(1), 23–38.

Mobile Clinic Project. *The Mobile Clinic Project at UCLA*. (n.d.). Retrieved November 19, 2023, from https://www.mobileclinicproject.org

Mobile Clinic Project (MCP). [@uclamobileclinic]. (n.d.). *Posts* [Instagram profile]. Instagram. Retrieved November 19, 2023, from https://www.instagram.com/uclamobileclinic/

Office of Community Planning and Development. (2022). *The 2022 Annual Homelessness Assessment Report (AHAR to Congress) Part 1: Point-In-Time Estimates of Homelessness* (p. 11). U.S. Department of Housing and Urban Development. https://www.huduser.gov/portal/sites/default/files/pdf/2022-AHAR-Part-1.pdf

Padgett, D. K., Henwood, B. F., & Tsemberis, S. J. (2010). Housing First: Ending Homelessness, Promoting Recovery, and Reducing Costs. In *How to House the Homeless, ed Ingrid G. Ellen & Brendan O'Flaherty.* Russell Sage Foundation.

Perry, S. L. (2013). Urban Hybrid Space and the Homeless. *Ethnography*, 14(4), 431–451.

Phillips, S., Reid, C., Cuff, D., & Wong, K. (2022). *Housing And Community Development In California: An In-Depth Analysis of the Facts, Origins and Trends of Housing and Community Development in California*. California 100 Initiative. https://escholarship.org/uc/item/32m1g6xk

Reuter, K. (2017). Bodies Made Public: The Homeless Body in 1980s Los Angeles. *New Errands*, 4(2). https://journals.psu.edu/ne/article/view/60345/60307

Ruggeri, K., Garcia-Garzon, E., Maguire, Á. et al (2020). Well-being is more than happiness and life satisfaction: a multidimensional analysis of 21 countries. *Health Qual Life Outcomes* 18, 192. https://doi.org/10.1186/s12955-020-01423-y

Runquist JJ, Reed PG (2007). Self-Transcendence and Well-Being in Homeless Adults. *Journal of Holistic Nursing.* 25(1):5-13. doi:10.1177/0898010106289856

S Choi, Wilson, B. D., Shelton, J., & Gates, G. J. (2015). *Serving Our Youth 2015: The Needs and Experiences of Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Experiencing Homelessness.* The Williams Institute with True Colors Fund. https://escholarship.org/uc/item/1pd9886n

Safe Place for Youth. *Access center—Safe Place for Youth*. (n.d.). Retrieved November 19, 2023, from https://www.safeplaceforyouth.org/access_center

Safe Place for Youth (SPY). [@safeplaceforyouth]. (n.d.). *Posts* [Instagram profile]. Instagram. Retrieved November 19, 2023, from https://www.instagram.com/safeplaceforyouth/

Trujillo, M. D., & Plough, A. (2016). Building a culture of health: A new framework and measures for health and health care in America. *Social Science & Medicine*, 165, 206–213. https://doi.org/10.1016/j.socscimed.2016.06.043

Venice Family Clinic. *Venice Family Clinic launches mobile clinic van to help families at risk of becoming homeless and enhance its street medicine program.* (2021, January 18). https://venicefamilyclinic.org/news/press/venice-family-clinic-launches-mobile-clinic-van/

Walsh, C., Beamer, K., Alexander, C., Shier, M., M, L., & Graham, J. (2010). Listening to the silenced: Informing homeless shelter design for women through investigation of site, situation, and service. *Social Development Issues,* 32, 35–49.

Ward, J., Garvey, R., & Hunter, S. (2023) Recent Trends Among the Unsheltered in Three Los Angeles Neighborhoods: An Annual Report from the Los Angeles Longitudinal Enumeration and Demographic Survey (LA LEADS) Project. *RAND Corporation*. https://www.rand.org/pubs/research_reports/RRA1890-2.html.

Wolch, J., Dear, M., & Akita, A. (1988). Explaining Homelessness. *Journal of American Planning Association,* 54(4), 443–453.

World Health Organization. (2021). *Health Promotion Glossary of Terms 2021.* World Health Organization. https://www.who.int/publications/i/item/9789240038349

World Health Organization. (2021). *Towards Developing WHO's Agenda on Well-being.* World Health Organization. https://www.who.int/publications/i/item/9789240039384