Learning Report

Advance to Zero in the Country to Coast **Queensland** region

August 2025

the good shift

Contents

This report documents the first phase of work to implement the Advance to Zero in Central Queensland, Wide Bay and the Sunshine Coast. That implementation was funded by Country to Coast Queensland (CCQ) which delivers the Primary Health Network (PHN) program on behalf of the Commonwealth Department of Health, Disability and Ageing. The first phase of implementation was delivered in partnership between Micah Projects, Roseberry Qld (Central Qld) and IFYS (Sunshine Coast and Wide Bay).

The Good Shift has worked as learning partner to support this first phase. We thank the stakeholders from across Central Queensland, the Sunshine Coast, Wide Bay and Brisbane who participated in workshops, interviews, journey mapping sessions and conversations that have informed and helped to refine this report.

This report learns from work to implement, learn about, and iterate Brisbane Zero and Logan Zero. The report reflects an ongoing and evolving learning partnership between Micah Projects and what was the Griffith Centre for Systems Innovation, now, The Good Shift.

Introduction and Process

Intention and overview of report

Advance to Zero (AtoZ) is an international model for ending and preventing homelessness for individuals, young people and families, starting with those who are, or have been sleeping rough. Core elements of the model include collaboration between organisations, a common data set informed by use of the Australian Homelessness Vulnerability Triage Tool (AHVTT) and Known By-Name list. AtoZ also involves service coordination to address people's needs and the use of data to make informed decisions and to stimulate systems change.

Micah Projects has played an active role in supporting the establishment of Brisbane Zero, and now, with the support of CCQ, the establishment of CQ Zero, Sunshine Coast Zero and Wide Bay Zero.

As a long-term learning partner of Micah Projects The Good Shift (formerly The Griffith Centre for Systems Innovation) has prepared this learning report which focuses on:

- how elements of the AtoZ model are being implemented across the three new Zero regions by local partners in Central Queensland with support from Roseberry Qld and on the Sunshine Coast and Wide Bay with support from IFYS
- what is being learnt about the health needs of people experiencing homelessness in the region and about local health systems and
- how AtoZ implementation in these communities might improve integration and coordination between local organisations and services to improve the health and wellbeing of people experienceing homelessness..

The report explores both ***'Zoomed out'*** (whole of region) and, ***'Zoomed in'*** (local community) implementation and learnings. It notes the encouraging progress made in Central Queensland and the Sunshine Coast along with early challenges encountered in Wide Bay. It identifies preliminary patterns and opportunities for continuing to evolve implementation to improve health and housing outcomes for people experiencing homelessness in the region.

Implementation Context

The AtoZ roll-out in the CCQ Region occurred during a time of significant challenges which influenced the circumstances of people experiencing homelessness in the region and the organisations working to support them as is described throughout this report.

Challenges included:

- Councils in Moreton Bay and Brisbane undertaking high profile campaigns to move people who were sleeping in parks and public places on from those places – often with little clarity about where else they might go
- Significant floods and a tropical cyclone
- Ongoing, and arguably worsening pressure with all parts of the housing system failing to meet demand in the face of international, intra-national and intra-regional migration and rising costs of living.

Overview of the learning approach and process of developing this report

The learning approach has involved three Theory of Change workshops with local stakeholders in Rockhampton (CQ),Birtinya (Sunshine Coast) and Hervey Bay (Wide Bay) in October – November 2024. These workshops introduced participants to the Advance to Zero methodology and explored what was known about homelessness and health, the local service system and collaboration arrangements in each region.

CCQ region
Source: https://c2coast.org.au/about/

Particapnts worked together to:

- consider CCQ's learning priorities (see Zooming Out section)
- identify local learning priorities to support Zero implementation and iteration (see Zooming In sections) and
- draft a local Theory of Change (see Appendices).

From January – July 2025 a series of interviews (n=18), focus groups (n=2) and journey mapping sessions (n=2) were held with stakeholders in CQ, Sunshine Coast and Brisbane. Early learnings were also shaped and/or shared via monthly reference group meetings, conversations with implementation staff, and via Zero network and other discussions.

Focused progress discussions were held with key staff from Micah Projects, Roseberry, IFYS and CCQ in July 2025. Thematic analysis was undertaken by The Good Shift and a draft learning report was shared for review and feedback by stakeholders in August 2025.

The learning approach is summarised in Figure 1. A summary of stakeholders engaged across different engagement mechanisms is included in Table 1.

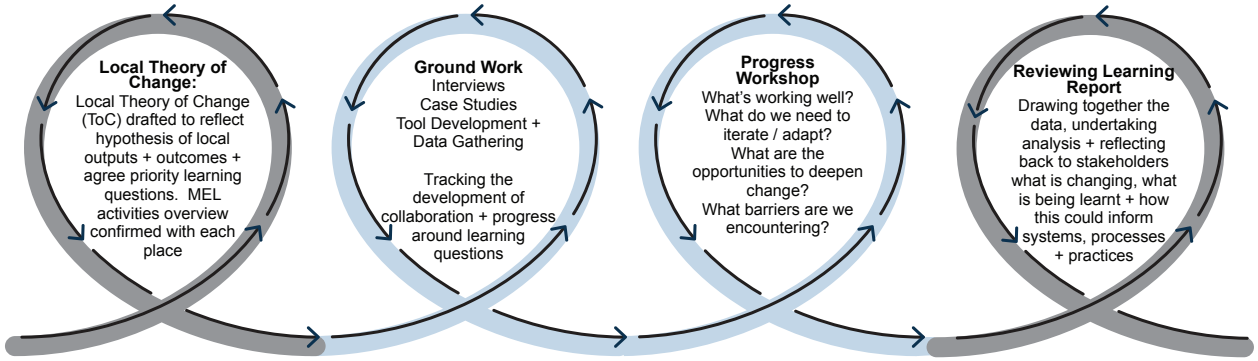


Figure 1: The Learning Approach as a Series of Learning Cycles

Zooming out: County to Coast Regional learnings

The Advance to Zero methodology (or Built for Zero as it is known in the USA) is being implemented in communities around the world with the Australian campaign supported by the Australian Alliance to End Homelessness. In Queensland implementation began in Brisbane and Logan in 2022 and is now being explored in communities across the State. This report focuses on early learnings from implementation in three communities Queensland communities: Central Queensland (particularly Rockhampton, Gladstone, and Biloela), Sunshine Coast and Wide Bay.

Zooming in: Local community learnings

The rollout of the Advance to Zero methodology in Central Queensland (including the development of this report) was funded by Country to Coast Queensland (CCQ). Given homelessness data and health concerns, the rollout focused on three sub-regions: Sunshine Coast, Wide Bay, and Central Queensland. There are multiple communities within each of these regions, multiple local government areas and multiple service sectors and organisations with varying service 'footprints' all of which have influenced roll-out as explored in the descriptions below.

Stakeholders engaged in the ground work phase	Central Queensland Zero	Sunshine Coast Zero	Wide Bay Zero
Theory of Change Workshops	17	7	9
Stakeholders engaged in the ground work phase			
- Homelessness Sector	4	3	0
- Health Sector	3	0	0
- Local + State Govt	1	2	0
- Community Services	3	2	9
Journey Mapping Workshops (people experiencing homelessness)	0	2	0
Learning conversations with Zero Staff (1-3 staff per conversation)	5	3	3
Total = 70	33	19	12

Table 1: Stakeholder engagement by region + method

High level overview of early learnings from first 9 months

People are optimistic about Zero despite timing challenges

Interviewees highlighted that the process of completing and collating Austalian Homelessness Vulnerability Triage Tool (AHVTT) is valuable for people who are homeless and for support staff and advocates. While the Known By-Name lists and Zero Service Coordination arrangements are still evolving, interviewees indicated that they felt that, if integrated within existing multi-agency arrangements, these could provide valuable opportunities to develop wrap-around supports for clients and build and/or strengthen working relationships between organisations.

Access to shared, current, local data via Zero Dashboards to inform planning and funding bids was seen as a major benefit for local communities. Some practical refinements were identified (e.g. to CSNet to improve reliability of data searches) though questions emerged about who would be responsible for negotiating necessary changes. Participants noted that it takes time to build the relationships and trust needed to catalyse participation and the critical mass of AHVTTs needed to grow momentum and stimulate change.

Healthcare is a major priority for people experiencing homelessness but existing services are hard to access

All interviewees indicated that people who are homeless had multiple health needs, many of which were inadequately met by current health systems.

The most commonly identified health issues included:

- mental health;
- addiction-related illnesses;
- acquired brain injuries; and
- wounds and infections.

Major barriers to accessing health care identified by stakeholders included:

- lack of bulk billing GPs;
- lengthy wait times; and
- limited access to mental health services.

Some service gaps are being addressed by community based models such as:

- doctors, nurses and dentists providing regular, voluntary, in-community support;
- community service organisations using Emergency Relief funds to help people meet the cost of medications; and
- staff reaching out to health providers on behalf of homeless clients.

Other new/innovative health models also appear to be helpful and received positive feedback from interviewees including:

- nurse-led clinics (Gladstone);
- walk-in Medicare mental health clinics (Rockhampton, Gladstone); and
- an outreach dental model (Rockhampton).

Continuity of care (health and housing and human) is needed to support people to navigate transitions and treatments

Continuity of care and wrap-around supports were identified as a priority in supporting people to transition from homelessness to housing and to sustain tenancies and social connections. They were also identified as critical to ensuring that people experiencing homelessness were able to gain and attend medical appointments, to receive and comply with treatment and to participate in necessary follow-up appointments.

Delivering this continuity of care often required services to work beyond existing service agreements (and therefore often in an unfunded capacity) e.g. to drive clients to appointments and sit with them for extended wait times, to deliver furniture, to provide food and shower vouchers.

Zero processes are useful for dealing with immediate and operational issues however, processes for tackling systemic change are less clear

Existing AtoZ tools for understanding and supporting people experiencing homelessness (AHVTT, Known By-name lists and Zero Service Coordination) and for improving knowledge about the number and nature of people experiencing homelessness (Zero dashboards) were considered robust and relatively well understood by interviewees.

Interviewees were less clear however, about opportunities and mechanisms for addressing recurring patterns of service gaps or successes locally and/or, addressing more strategic and structural issues which contribute to homelessness. Developing strategies and/or processes for working collectively to tackle systemic issues which emerge in local and/or regional data patterns was seen as a priority.

City-based models need to be adapted for regional implementation and connected to statewide networks

The AtoZ methodology is often described as a Collective Impact approach i.e.. a structured approach to coordinating multi-stakeholder action to a shared goal supported by backbone organisation (Kania & Kramer, 2012). In Queensland, the approach is considered more as a Collaborative Action approach meaning that the focus is on growing collaboration around key action areas that focus on reducing, preventing and ending homelessness (see Brisbane and Logan Learning Report One, 2023). What is consistent however, is a focus on place.

While CQ Zero, Sunshine Coast Zero and Wide Bay Zero are arguably place-based, interviewees identified a range of challenges in implementing the model across relatively large geographic regions with multiple population and service centres. In practice, this has resulted in a narrowing of the initial focus for

CQ Zero from the whole of the region to Rockhampton, Gladstone, and Biloela.

Similar narrowing, either by geography, by cohort as occurred in Brisbane, or some other criterion may emerge in the other two regions given the very different make-up of the towns within those regions. Network arrangements and Communities of Practice across Queensland Zeros and beyond are seen as valuable social infrastructure to support consistent implementation across diverse communities and with valuable, potential to support systemic advocacy and change.

Neighbourhood Centres are helping to meet the needs of people who are homeless and opportunities to explore this role could be expanded

Neighbourhood Centres in all three regions are providing a range of practical supports to people experiencing homelessness including: access to food, medical care, social connection; referrals to health and homelessness services; and practical support such as access to furniture and transport to help people transition to housing. The direct and face-to-face nature of this support enables centres to build trusted relationships with people experiencing homelessness, however these services are often provided in an unfunded capacity and are straining centre staff, resources and at times, relationships with other centre users.

Opportunities exist to engage with Neighbourhood Centres in key communities to identify how services might be expanded/made more reliable with additional investment and/or cross-agency input, capability, and capacity building.

CQ ZERO
Working Together to End Homelessness

100 AHVTTs + Known By-Name List

36% High Health System Users

In the last 12 Months:

- **24% had 5+ ambulance trips to hospital**
- **31% visited ED**
- **19% admitted to hospital for 5+ nights**

WIDE BAY ZERO
ENDING HOMELESSNESS IN OUR REGION

0 AHVTTs collected given implementation delays in this community

SUNSHINE COAST ZERO
ENDING HOMELESSNESS IN OUR REGION

278 AHVTTs+ Known By-Name List

39% High Health System Users

In the last 12 Months:

- **15% had 5+ ambulance trips to hospital**
- **48% visited ED**
- **23% admitted to hospital for 5+ nights**

Zooming out (CCQ Region)

Approach to drawing from data across the region to answer core CCQ Learning Questions

As the funding body, CCQ commenced this phase of implementation, with a degree of familiarity with the AtoZ model and a set of learning questions. These learning questions were streamlined over the course of this first phase and consolidated in the 3 questions listed below. The approach to gathering and making sense of evidence to inform early responses to these questions is summarised above (Overview of learning approach).

We stress that it is early days for Zero implementation in the region with sites having been operational for between 3-8 months. This learning report therefor focusses on progress in implementing the core 'building blocks' of the AtoZ approach and the learnings and patterns which are emerging from this foundational work. Early insights regarding learning questions are also shared.

This' Zooming out' section examines early patterns which appear to be emerging across CQ Zero, Sunshine Coast Zero and Wide Bay Zero. The 'Zooming in' section explores unique issues emerging within each of these Zeros.

LQ 1: How well is data being collated and analysed to enhance understanding of the health needs of people experiencing homelessness?

The primary mechanism within the AtoZ methodology for gathering data about the health needs of people experiencing homelessness is the AHVTT. Summary data from AHVTTs completed between 1 December 2024 and 28 Augst 2025 are summarised below. Following feedback from the

Brisbane and Logan Zero implementation groups, the AHVTT is currently under review and validation processes conducted by the University of Queensland. Due to this process, early in 2025 additional questions regarding health were included.

While still relatively early in the implementation process for all three communities, particularly for Wide Bay Zero, data is emerging via the AHVTTs regarding the health needs of people experiencing homelessness.

Additional health data was also gathered to inform this learning report via initial Theory of Change workshops, interviews and by CCQ staff in liaison with Hospital and Health Service staff. Health data from the AHVTTs and other sources is summarised in Table 2 below.

The majority of interviewees were highly supportive of the AHVTT tool. Interviewees described are range of perceived strengths of using the AHVTT including that it:

- Is a simple and intuitive tool
- Is a useful tool for having potentially deep conversations with people experiencing homelessness about challenging topics such as addictions, criminality, and health needs. Some service users reportedly feel more "….hopeful and relieved …(after the) opportunity to offload things that they have been holding on to for a long time and to help out those around them (by providing information)".
- Can be completed (in some cases) electronically for those who prefer that, or, via paper where this is preferred
- Can be merged to become part of intake and case management in addition to triage processes
- The scoring can be used with clients to highlight the level of challenges they are facing and help to justify their emotional reactions to those cumulative challenges
- When used as an intake tool it helps to understand the range of supports a client might need to

Community	Health needs identified via AHVTTs	Health needs identified via theory of change workshops, interviews HHS data shared byCCQ
Central Queensland	**Substance Use (81 reports) particularly:** • cannabis (38 reports) • methamphetamine (18 reports) and • palatable alcohol (16 reports) **Mental Health (121 issues detailed) particularly:** • anxiety disorders (33 reports) • clinical depression (24 reports) • post-traumatic stress disorder (15 reports) and • neurodevelopmental disorder (14 reports) **Serious ongoing health concern (69 issues detailed) particularly:** • asthma (10 reports) • heart arrythmia (9 reports) • diabetes (7 reports) • dental (6 reports) and • neurological diseases (4 reports)	• Injuries, food insecurity + trauma resulting from domestic + family violence • Poor diet + nutrition • Dental health • Podiatry • Chronic disease • Mental health – particularly depression and anxiety • Diabetes • High blood pressure • Addiction-related health concerns • Suicidality + self-harming in young people • Pregnancy amongst young homeless cohort
Wide Bay	• AHVTT data not yet available	• Suicidality • Acute mental health (particularly for older people) + lack of in-community options to support transition from hospital-based mental health services • Alcohol and other drugs + lack of access to detoxification supports locally • Chronic health conditions • Aging and disability related conditions • Chronic Obstructive Pulmonary Disease
Sunshine Coast	**Mental health particularly:** • anxiety disorder (99 reports) • clinical depression (65 reports) • post-traumatic stress disorder (64 reports) • bi-polar disorder (39 reports) • Obsessive compulsive disorder (22 reports) **Serious ongoing health concern including:** - asthma (32 reports) - heart disease or arrythmia (19 reports) - dental problmens (16 reports) - brain injury or head trauma (14 reports) - neurological diseases (14 reports)	• Dental health • (Multiple) acquired brain injuries • Wounds, skin injuries, infections • Mental health (both a contributor to and consequence of homelessness) • Diabetes • Cognitive impairments • High blood pressure • Heart conditions • Sleep deprivation • Substance disorders (+ resultant denial of care) • Lack of places for post-hospital discharge and recovery (prevents some people from accessing treatment and others from recovering effectively)

Table 2: Health needs of people experiencing homelessness in CCQ identified via AHVTTs and learning processes

support their successful transition into their housing placement and to work to have those supports in place quickly

- Involves a double consent process which supports people experiencing homelessness to have control over what information they share and whether this is shared via Case Coordination processes.

Interviewees also described perceived challenges of using the AHVTT. Issues identified included concerns about:

- The potentially 'triggering' nature of some questions for some people, particularly when people don't know the upcoming questions and may feel trapped to respond. To reduce negative impacts some workers have given the AHVTT to clients to complete some or all items independently and report that clients have been more comfortable with this. Others give people the option not to answer triggering questions. Either way, clients need to be supported through this experience though which creates an additional demand for staff.
- Raising expectations, particularly among younger people, that housing offers will flow quickly from completing an AHVTT
- Why the data is being collated, who will have access to it, whether it is worth doing and whether completing it will result in people experiencing homelessness accessing a house. Sunshine Coast Zero has developed some FAQs which staff indicate have been helpful in answering questions and objections they may encounter when administering the tool.
- The time it takes for already busy and stretched workers to complete the AHVTT in the spirit, with the detail and for the purpose it is intended in the face of significant service demand. A suggestion was made to split the AHVTT so an initial 'urgent' section could be done on intake, and another 'less urgent' section could be dealt with later.
- The risk that providers in smaller communities in the region may make the time and effort to complete and submit AHVTTs but not see any benefit in return if any additional resources flow to the larger centres.
- Duplication with other data collection processes being rolled out within organisations, or by funders
- Answers (particularly those relating to drug use or prior housing incidents) potentially being used to further victimise people
- The clustering of a range of issues into questions with a yes/no response which makes it difficult to capture data on the detail of items within this cluster.
- The wording of some questions which seem to trip up both people administering and responding to the AHVTT and people and
- The lack of sensitivity of the scoring mechanism for some people (e.g. those supported via an immediate housing response).

While the AHVVT is the primary mechanism to gathering data, the process of collating and analysing the data occurs via data dashboards generated from a CSNet database which is shared between Queensland Zero communities to support people as they move around the State. An important principle of the AtoZ approach is that data developed via the local Zero partners is shared data, accessible to any signed-up partner with a CSNet license.

Development of robust and useful dashboards relies on the availability of a reliable and useful number of completed AHVTTs, which in turn, requires a number of organisations completing and submitting AHVTTS. Again, achieving this 'critical mass' takes time however both Central Queensland and Sunshine Coast Zeros have produced data dashboards which have attracted media attention and been well received by stakeholders.

> "I love it. I think it's a fantastic tool"

> "I feel like I'm constantly giving...I never get anything in return...to help my community"

Interviewees all discussed the potential value of both CSNet and the Data Dashboards including their ability to:

- Provide access to more reliable, accurate and current data regarding the true extent of homelessness in the region to inform decision making and grant applications
- Highlight the extent of unmet need in the region as a whole, and within particular communities to stimulate local projects and attract additional resources.

As is common with new and complex initiatives, some challenges were identified by interviewees regarding CSNet and the Data Dashboards including:

- The cost of CSNet licenses (per individual user rather than per organisation) and the time and confidence required to use the platform
- Concerns regarding the reliability of CSNet with some users reporting inconsistencies in data generated via different queries, challenges searching at LGA level both of which had at times resulted in staff resorting to manual spreadsheets.

Some interviewees also expressed uncertainty about mechanisms for addressing issues which are highlighted via the dashboards in a strategic way which is discussed further below.

LQ2: How is data informing strategic investment in primary healthcare and delivering system changes to improve health outcomes for people experiencing homelessness?

A review of the Brisbane and Logan Zeros recognised that a core focus in the first year of implementation was on building interest and capability to implement the model amongst partner organisations with the potential for systemic influence growing significantly in the second year (Griffith Centre for Systems Innovation, 2024). Similarly, in the CCQ Region, much effort has been made to grow participation in the regional AtoZ partnership mechanisms.

Data availability is improving as processes and partnerships evolve however, and early signs of collective advocacy to inform discussions about housing investment decisions are emerging (see Zooming in: CQ Zero and Sunshine Coast Zero). Evidence of the impacts of Zero data on health investment is still to develop however, a range of insights emerged via this review regarding barriers to health services faced by people who are experiencing homelessness and trying to have their health needs met.

69% of people completing AHVTTS in Central Queensland have a serious, ongoing health concern.

41% do NOT seek medical help when unwell.

48% of people completing AHVTTS on the Sunshine Coast have a serious, ongoing health concern.

31% do NOT seek medical help when unwell.

> If you've got an injury it's so hard to focus on other barriers when you're so focused on pain + that ...experience of being unwell

Commonly identified barriers to health services for people experiencing homelessness include:

- Lack of bulk-billing GPs, or, those that bulk bill only after a paid long consultation
- Health workforce shortages and gaps in capability to support people with the most complex needs
- Limited access to mental health services, particularly for young people – some reported they had stopped taking children to the Child Youth and Mental Health Service
- Lengthy waitlist for GPs, specialists, dentists, AOD counsellors, mental health specialists
- Lengthy public transport travel times to and from local/regional hospitals
- Poor continuity of care for people with complex health requirements
- Booking processes typically rely on a person having a consistent phone number and credit to receive updates and reminders about appointments made in the future – once appointments are missed,

people are dropped from the wait lists.

- Significant barriers accessing hospital care, including for mental health services, and very quick discharge processes (including to homelessness)
- Limited access to pregnancy support services for young homeless women unless they are referred by Police
- Slow process to access ACAT assessments for 70+ year olds
- Limited providers of clean needles to support safe injecting
- Vouchers provided to support access to dental care cover basic extractions and /or cleans only
- Lack of specialist services in some smaller communities requiring people to travel to receive medical attention which can be prohibitively expensive
- Limited expectations of health services (based on previous experiences) which deters people from seeking assistance in the future.

> The HOT Teams + Community Mental Health services on the Sunshine Coast provide great advice over the phone

Several early priorities for future health investment were suggested by interviewees:

- Improve access to affordable anti-biotics, bandages, wound care items in community to avoid reliance on hospital
- Improve access to current information about available health services, eligibility criteria, costs and referral processes Continue to provide direct referrals for mental health and other services by phone
- Explore whether current levels of access to local mental health and AODS support meet demand
- Expand investment in nurse walk-in clinics (like the one in Gladstone)
- Foster opportunities for creative expression for people experiencing homelessness
- Invest in a specialist clinic on the Sunshine Coast for people who are homeless or struggling – staff to have an understanding of the barriers people face, appointment/ treatment arrangements to be flexible (like the walk-in Medicare mental health)
- Raise awareness of the size and scale of the issues facing homeless peoples and the organisations working to provide support and solutions to garner greater participation in solving these challenges.

> No one is talking about this - the children experiencing homelessness - sleeping in cars, couch surfing...we are going to be seeing the impacts of this for a long time. Children out of routine, not settled...there'll be a lot of behaviours that are not socially acceptable...we focus on that + not the systems + the structures that have caused this. We blame the victim

In addition to direct investment, several ideas for future service system reform were identified that could be explored further in the future:

- Adjust health booking and billing arrangements so that homeless people can be 'bumped up the waitlist'
- Create pathways for nurses, GPs and others who are treating patients voluntarily, to refer to other medical providers so that patients can transition expeditiously the next level of care
- Learn from and consider opportunities to expand outreach models e.g. outreach dental care (see case study below) and placements for doctors, dentists, medical students and other health professionals to participate in community-based health provision via programs such as OneRoof, Neighbourhood

Centre meal programs and the proposed Nambour Hub

- Strengthen hand-over arrangements for young people being discharged from hospital to homelessness providers to improve the ability of organisations responsible for the care and wellbeing of those young people are able to provide appropriate care
- Explore the costs, benefits and opportunities for more innovative housing and homelessness responses e.g.
    - revisit private sector rental subsidy programs with complementary tenancy maintenance supports if needed
    - strategies to increase investment in social housing to 4% of housing stock
    - opportunities to co-design, women only, long-term housing, particularly for women over 50.

Case Study: Outreach Dental Care

Oral health was nominated as a key priority for people experiencing homelessness in all three regions. Nationally and internationally, many other researchers have also found significant dental health priorities facing people experiencing homelessness (e.g. Durey et al., 2022; Ford et al., 2014; Goode et al., 2018; Stormon et al., 2020).

In our learning conversations people told harrowing stories describing the many ways that poor oral health was negatively impacting their physical and mental health, their housing and job opportunities and their relationships. We heard about lengthy waitlists to see dentists, the prohibitive cost of dental services and of oral health services falling between the gaps of private, public health and hospital systems.

People spoke of being denied dental services due to risks associated with the severity of their health issues, and of hospital admissions for serious illness associated with unmet oral health needs. (see Zooming In Sunshine Coast Additional Insights section).

We also heard about an innovative and inspiring service in Rockhampton that is taking oral health services into the community. Liza Pretorius, Principal Oral Health Therapist for the Central Queensland Hospital and Health Service described how the purchase of some relatively affordable mobile Xray machines, dental chairs and dental units and dedicated training and protocols, enabled oral health staff to provide XRays, examinations and simple fillings, fissure seals and cleans in community settings.

By going to the people, the team was able to:

- increase dental treatment for vulnerable people;
- reduce fear, anxiety, and non-attendance at appointments; and
- provide tailored education about preventative oral hygiene.

While currently focused on people in aged care, residential mental health facilities and schools without access to a dental van this service could potentially be delivered in community-based locations to support people experiencing homelessness in Central Queensland, and/or be tested in other communities.

What would it take?

- Ideally a dedicated outreach dental team involving one dentist, two oral health therapists and four dental assistants OR, internal approvals and adjustment of service targets and metrics to enable an existing dental team to provide outreach services for blocks of time (e.g. one day per week or one week per month)
- Training and safe working arrangements for staff, potentially as part of a multi-service outreach arrangement
- A mobile (folding) dental chair, mobile dental units, a hand-held dental Xray machine and travel case, dental imaging software and laptop, a vehicle for transporting staff and equipment
- Access to a venue where a mobile dental chair could be set up and left for a few weeks
- A place where instruments could be safely locked away
- Access to appropriate power and water supplies
- Promotion of available services and locations to people experiencing homelessness.

Potential benefits for people experiencing homelessness and for the health system

- Improved access to essential oral health services for high-need and under-serviced cohorts
- Reduced anxiety about seeking dental services and reduction in the number of people who ‘fail to attend’ appointments
- Reduction in hospital admissions and other health appointments due to health problems caused by untreated dental needs
- Person-centred education to improve oral hygiene and prevent and reduce the severity of future oral health crises
- Improved access to integrated health and wellbeing services if delivered as part of a multi-agency approach
- Experiences of respect, dignity, care, and inclusion
- Reduced feelings of shame and improved mental health.

LQ 3: To what extent has integration, coordination and collaboration among primary health care, homelessness and housing providers and others been enhanced to improve health outcomes of people experiencing homelessness?

The primary mechanisms within the AtoZ methodology to facilitate integration and coordination to support individuals experiencing homelessness are the Known By-Name List and Zero Service Coordination mechanisms. Both mechanisms take some time to develop and data is only starting to become available in Central Queensland. Arrangements for Case Coordination are being explored on the Sunshine Coast and will be addressed in Wide Bay once staff are in place and AHVTTs are being used to identify people likely to benefit from Service Coordination.

In Central Queensland, Case Coordination commenced in June 2025 (see Zooming In: Central Queensland for details regarding the approach taken) with encouraging results. By 25 July 2025 75 people who had completed an AHVTT had received coordinated support involving at least one other organisation. The CQ Zero multi-agency coordination mechanism had considered 19 people and supported:

- 14 people to transition from homelessness to long-term housing
- 2 people transition from rough sleeping to permanent housing
- 6 people to transition from rough sleeping to crisis or short-term housing
- 30 people to receive medical assistance.

Some local area coordination was also identified between providers within smaller communities not yet serviced by the Zero multi-agency Service Coordination processes.

While Known By-Name Lists and Case Coordination processes are emergent across the CCQ region, interviewees were optimistic that in future these processes would:

- Robustly, consistently, and practically engage health providers in a way that some other interagency processes had not
- Prioritise those with the most complex needs that no one agency can address in isolation, coordinate wrap-around supports and reduce service duplication
- Contribute to reversing existing experiences of hospitals and other health services exiting people into homelessness
- Drive a shared commitment to ‘housing first’ while noting any historical ‘red flags’ to be addressed to maximise housing outcomes
- Provide people with the dignity of being known and engaged with by name and reduce their likelihood of ‘falling off the radar' and reduce the stress associated with having to repeatedly share personal stories with multiple providers without necessarily receiving a service in return
- Provide multiple entry points for people experiencing homelessness who might choose not to engage with one organisation, but be happy to connect with another, or who don’t have a personal phone to receive referral follow-up calls, but who can be contacted via outreach workers
- Connect the range of services needed to support people transitioning into housing to adjust to, and maintain a housing tenancy and their social connections (from the street, Neighbourhood Centres, community meals programs etc.) to help reduce people cycling back in to homelessness
- Help to breach communication and philosophical/ methodological gaps between providers.

> “We need to bring them back from hopelessness to homelessness before we can even start the journey”

> “Once they’re in accommodation, it’s a lot easier for them to address those health barriers”

Interviewees also highlighted a range of potential challenges to the development and use of Known By-Name List and Zero Serivce Coordination processes including:

- The lack of exit points from homelessness to housing across the region
- Challenges for staff in smaller communities deciding whether to nominate someone for consideration via Case Coordination, or to manage the referrals locally
- Changes within the service system that make it difficult to maintain current knowledge about which organisations provide specific services and who might be able to assist
- Examples of Government departments (e.g. Corrections, Youth Justice, and Child Safety) exiting people to homelessness rather than providing appropriate coordination to support successful transitions
- The concerns some people have about the safety and appropriateness of emergency transition social housing (due to prior experiences of sexual assault, drug exposure) that may result in them declining this type of accommodation if offered and be considered a 'black mark' against them
- The negative impacts of insensitive and unsupportive property managers
- A history in some parts of CCQ for cross-agency processes intended to drive strategic change to be 'watered down' via: the non-participation of, or consultation with key actors; the reliance on junior delegates who lack decision-making authority; a focus on micro, operational details rather than structural improvement or strategic prevention
- An absence of collective advocacy in parts of the region to date.

Reviews of the Brisbane and Logan Zeros, noted that the level of collaboration between stakeholders evolved over the first two years of operations as reflected in Figure 2 below. Stakeholders from Central Queensland, Sunshine Coast and Wide Bay were asked to describe the current level of collaboration and their responses are shown on this figure. Explanations relating to these assessments are included in the "Zoomed In" sections.

Additional insights

The impact of move-on arrangements in Brisbane and Moreton Bay

Interviewees on the Sunshine Coast in particular, noted the challenges arising from decisions made by Council's outside of their regions to require rough sleepers to move out of parks and other public places.

People spoke with some confidence of evidence of people from southern communities moving to Nambour which is a direct train ride from the southern cities, as well as to other parts of CCQ. This was considered to be adding a burden to already stretched services. Staff spoke of the emotionally challenging positions they found themselves in, needing to 'ration' services, or, to prioritise 'locals' above other equally vulnerable but more recently arrived people.

Others noted that hearing about move-on arrangements in other cities led some homeless people in the CCQ Region to feel "not valued, illegal…it's trauma on trauma on trauma.".

> "They're not disclosing enough mental health information or medical needs. We don't have the capacity to (support them)...we're not medical staff"

> "A bad property manager impacts more people than a bad tenant"

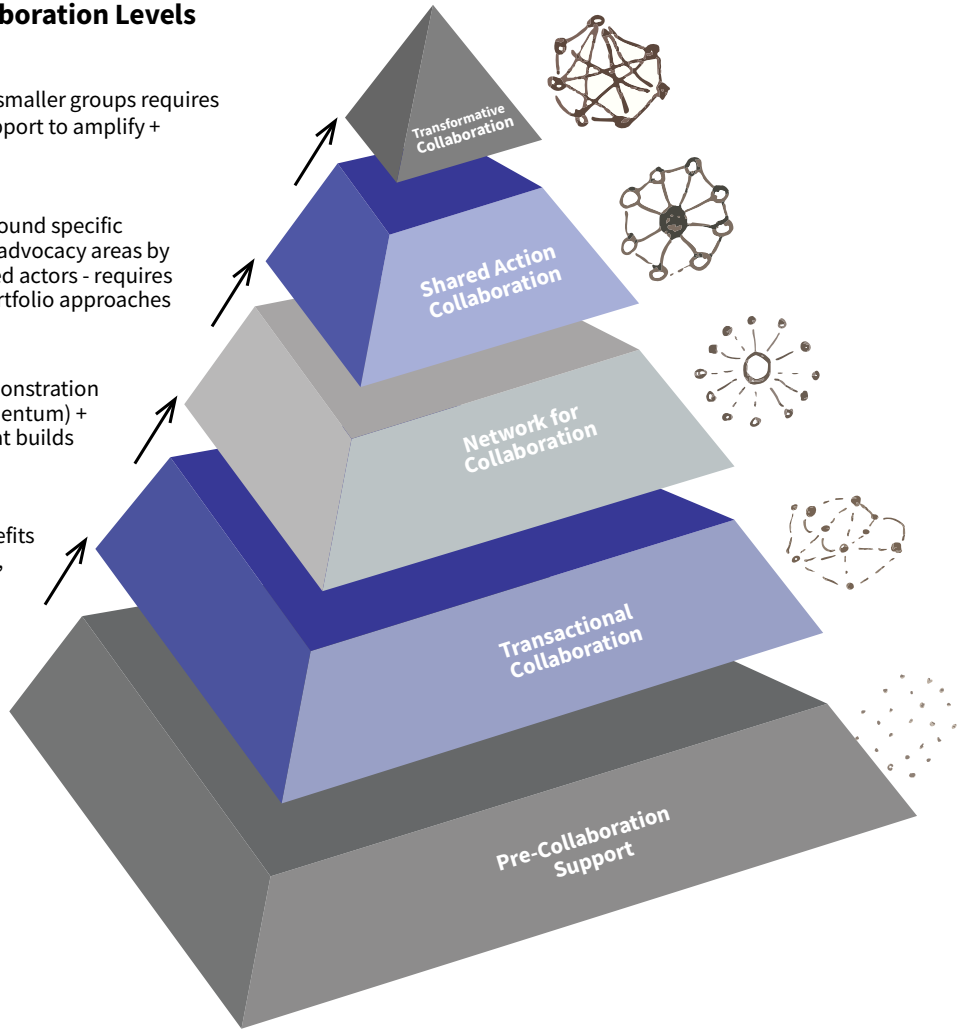
Moving Up the Collaboration Levels

Interconnectivity between smaller groups requires collective governance + support to amplify + elevate results

Stronger focus on action around specific elements - cohorts, issues, advocacy areas by smaller groups of committed actors - requires distributed leadership + portfolio approaches

Stronger trust + action demonstration (eg. evidence of some momentum) + relationalinfrastructure that builds commitment

Addition of some clear benefits to participation (eg. shared, open data) + evidence of changed conditions (eg. commitment to a shared agenda building process)



Defining Features	Defining Processes
Inter-connected tight, close networks with high trust who coordinate clear agenda setting + actions	Commitment to + active participation in systemic advocacy + use of data + collective decision-making to shift systems
Focused groups, tight organisation, open to new engagement but with clear expectations, high trust groups	Active participation in singular action areas that could improve outcomes or shape practice for specific cohorts or in specific contexts
Loose + open groups, but often with strong relationships that encourage participation + attraction of actors with high commitment + capability to contribute	Participation in coordination meetings, analysis of trends in data + broad decision-making around shared use of data, without commitment to joint actions
Loose + open groups, but commitment is generated through signed agreements + some common goals (often supported with training)	Signing on to agreements + fulfilling shared data collection obligations - little engagement beyond collecting + sharing data
Loose, porous groups, shared goals but not always shared agenda about how to achieve those goals	Working in the same sector, supporting the goals but not actively participating the collaboration to achieve those goals

Central Queensland: Moving from Transactional to Networked Collaboration

Sunshine Coast: Moving from Pre-Collaboration to Transactional

Wide-Bay: Pre-Collaboration

Figure 2: Understanding levels of collaboration (and movement between levels) in CQ, Wide Bay and Sunshine Coast Zero

Adapting city-based models for regional implementation

The three CCQ regions are very large comprising multiple cities, towns, and villages. While Brisbane and Logan are very large cities with their own complexities, implementing Zero across diverse and geographically distant communities is posing unique challenges in Central Queensland and the Sunshine Coast and expected to do also so in Wide Bay.

Interviewees highlighted the challenges of servicing the larger cities within their region with the largest numbers of people experiencing homelessness while trying not to neglect smaller, more geographically distant communities where the scale of homelessness might be smaller but still poses challenges. Neighbourhood Centres were identified as having the existing relationships and legitimacy to support Zero in smaller towns (e.g. by encouraging people to complete AHVTTs) though the pressure this placed on centres was also acknowledged (see below).

> I have a lot of compassion for our neighbourhood centres because I think they're definitely on the frontline of the homelessness eipdemic

At the Maroochydore Neighbourhood Centre three nurses volunteer their time to provide health care to homeless people who attend the dinners which are served at the Centre. They report 60-70 contacts each month. They do not recive funds to cover the cost of the basic medical equipment such as bandages, gauze, tapes, blood pressure monitor batteries.

The role of Neighbourhood and Community Centres

In all three communities Neighbourhood and Community Centres were identified as playing key roles in supporting people eexperiencing homelesses including via the provision of:

- cooked meals and opportunities for inter-personal connection
- access to food and other essential health and hygiene products to take away
- access to voluntary services including Orange Sky laundry, hairdressers, doctors, and nurses
- safe spaces to spend time/ sleep / store documents and other valuables
- some counselling or other professional supports
- transport and housing transition supports
- housing referrals and advocacy (including when clients are referred to the Centres by funded NGOs and/or government agencies such as Corrections, Police, Department of Housing.
- emergency funds to purchase medication and other essentials support with pet care.

These findings are consistent with research undertaken by Neighbourhood Centres Queensland (2024) which revealed that 38% of Queensland's Neighbourhood Centres offered homelessness services in 2023-24 while 20% offered housing, rental, or homestay services in that same year and 82% provided food relief to local communities. Centres were estimated to have allocated $162 360 annually to providing tents swags and sleeping bags to people experiencing homelessness, and to have provided 175 320 community meals (not just to rough sleepers).

> The quickest ways that particularly the rough sleeping crowd can get hold of...medical assistance is by attending a couple of the local churches + neighbourhood centres who put on dinners throughout the week

Thirty of Queensland's 155 centres were funded to employ a Community Connect Worker to provide support to community members with complex needs including those experiencing homelessness and with chronic health issues. Only 9% of Neighbourhood Centres receive funding from the Department of Housing and only 4% receive funding from Queensland Health. Twenty-seven centres did not receive any core funding from the Queensland Government (Neighbourhood Centres Queensland, 2024).

Several interviewees also noted the important role that Centres could play, as trusted community organisations, in supporting Zero though noted that most Centres are not explicitly funded to provide these services and expressed concerns regarding staff capability and capacity to provide trauma informed support, to de-escalate complex situations and to manage the interfaces with other centre uses (e.g. playgroups).

In one region it was identified that the Department of Housing had located funded services in local Centres for 1-2 days per week so that they were able to offer some level of homelessness support even though it wasn't considered core business.

Zooming in (sub-regions and towns)

Theory of Change workshops were held in Rockhampton, Hervey Bay and Caloundra between October and November 2024. During these workshops participants identified:

- local health needs of people experiencing homelessness
- potential local partners to contribute to AtoZ in that region
- a local Theory of Change and
- local learning questions.

The sections that follow include the preliminary theories of change generated for each of the three Zero communities. Information gathered to inform this learning report is summarised according to the specific local learning questions developed in each region.

Central Queensland

Overview of approach
Implementation of CQ Zero is being supported by Roseberry. An initial Theory of Change workshop was held in Rockhampton on 25 November 2025. Participants developed a draft Theory of Change which was then refined by Roseberry and is included in Appendix 1.

Local learning questions and progress:
What helps/hinders use of the AHVTT and the creation of a single by-name list in CQ?

- see Zooming Out section (responses to Learning Questions 1 and 3)

What health conditions are prevalent amongst homeless peoples in CQ and what health services are homeless people accessing?

- Health conditions for people experiencing homelessness in CQ are detailed on p 14.
- The services that people were able to access varied across the Region:

> We let people down too often...a huge body of work that has to happen across community...is giving hope back...There's too many people now that think tomorrow's not gonna be better than today...Zero will help in that space too...to destigmatise + work together...+ think tomorrow's gonna be better

- **Rockhampton**
  - AODS and Mental Health services have been responsive in taking clients referred via the Zero multi-agency Case Coordination processes
  - Diversion and detoxification services (though it was noted that many participants were from outside of Rockhampton due to the stigma associated with detoxing in your home community with many hoping to stay in Rockhampton once they completed the program rather than going back to risky environments)
  - Emotional and cultural wellbeing services
  - Medicare mental health centreand Flourish mental health services
  - Better Connect
  - Family re-integration services
  - Hospital social workers and other healthcare professionals.
- **Biloela**
  - Banana Shire Support Centre
  - Hospital-based services including those provided by the Social Workers, Indigenous Health Liaison and Nurse Navigators
  - Outreach AODs and mental health services (a strong desire was expressed for more consistent and frequent services)
  - Telehealth services when necessary (though it was noted that many people experiencing homelessness 'want to see you face to face… there's always so much going on in the background that they're not 100% there with you')
  - Peer support services (though people noted the potential stigma associated with being seen meeting with a health worker in a public place, suggesting that office-based appointments might be more appropriate)
  - Other services were described as 'demand-based' and there was a hope that local AHVTT might help to articulate demand more effectively with Rockhampton and Gladstone-based services

> They're doing it how it should be done + that's local people coming together...it needs to be locally led + ...decisions need to be locally made

- **Gladstone**
  - Nurse-led clinic for wound care, basic scripts, blood pressure monitoring, referrals and more
  - Neighbourhood Centre for referrals and food (distributed courtesy of Foodbank to organisations across the region)
  - Indigenous Health Centre
  - Headspace and childhood mental health
  - Hospital Social Workers
  - Dignity Hub for food, showers, washing

machines and referrals

- A local private dental practice that donates toothbrushes and sometimes supports dental students to provide basic dental clean and care services to young people at the youth homelessness shelter free of charge

What changes between collaborators over time and what helps makes different types of collaborations work?

What changes:

- The release of local Zero dashboards attracted robust local media coverage and supported direct advocacy to visiting political representatives
- Questions emerged about when to formally 'hand over' lead responsibility for representing a client involved in the multi-agency Zero Service Coordination
- Recommissioning of primary health services resulted in significant changes in the local service system during the implementation phase

which disrupted and required the rebuilding of some relationships and delivery arrangements.

> A drop-in clinic doesn't work in Bilo + we've been telling agencies forever that it doesn't work

What helps make different types of collaborations work?

- The partnership between CQ Zero and QShelter/ Integrated Services process. Participants hope that this evolving approach will leverage the strengths and networks of both initiatives and provide an efficient mechanism to support localised service coordination customised to different parts of the region.
- Engaging local health staff who have responsibility for helping to navigate and/or connect across the health system
- Being able to 'plug into' and encourage participation from existing networks
- Long-standing relationships and histories of collaboration and support
- Local 'champions' who encourage other people experiencing homelessness and/or providers to get involved
- In-person visits to meet with providers in distributed communities
- A primary focus on improving outcomes for people experiencing homelessness rather than on organisational targets and budgets
- Streamlining interagency and case-coordination processes to minimise the number of meetings people need to attend and increase the likelihood of effective participation and
- Having key actors participating and encouraging their staff to play a role.

Ecosystem participation

The CQ Zero Team (including a part-time Project Officer, a Data Lead and a Service Coordinator) has worked hard to engage diverse organisations as Zero partners. Those organisations are shown in Figure 4.

> We're relationship builders because if we don't have that (relationships) then it's consumers that miss out on the support they need in community because we have to work very well together to make sure that people stay well in community

The CQ Zero team suggested that the level of collaboration reflected between CQ Zero partners was moving between 'Transactional Collaboration' and 'Network for Collaboration'. This is evidenced with reference to key shifts against indicators of collaboration identified in the reviews of the Brisbane and Logan Zeros in Table 3.

Additional Central Queensland insights

People experiencing homelessness in CQ were often described as being quite transient moving between larger centres like Rockhampton and Gladstone and to smaller towns within the region such as Biloela. The Known By-Name List has potential to support increased continuity of care as people move across the region. Differences in service providers and service options across the different towns in the region however, underscore the importance of sensitive and localised multi-agency Zero Service Coordination processes which enable people moving to a new town to be 'picked up' by a new provider if their original support organisation does not deliver a service within the new location. Consistent with learnings from the Brisbane and Logan Zero experiences, having a small, dedicated team with responsibility for program activation and engagement, data, and servie Coordination supports timely implementation and activation of Zero processes.

Open and Shared Data	Data has been gathered and shared via Data Snaphots which has encouraged participation Organisations have been attracted by the focus on the interaction between health and housing
Shared Leading	CQ Zero and the Service Integration (auspiced by QShelter) staff have agreed to adapt an existing Service Integration meeting to include CQ Zero Service Coordination business to reflect a community-facing and collaborative approach
Support and Infrastructure	CQ Zero have undertaken joint outreach activities with other organisations (eg. CRT)
Collective Momentum	CQ Zero Service Coordination meetings have bossted collaboration and shown that Zero can support hands-on benefits for people experiencing homelessness

Table 3: Elements and contributions to collaboration in CQ Zero

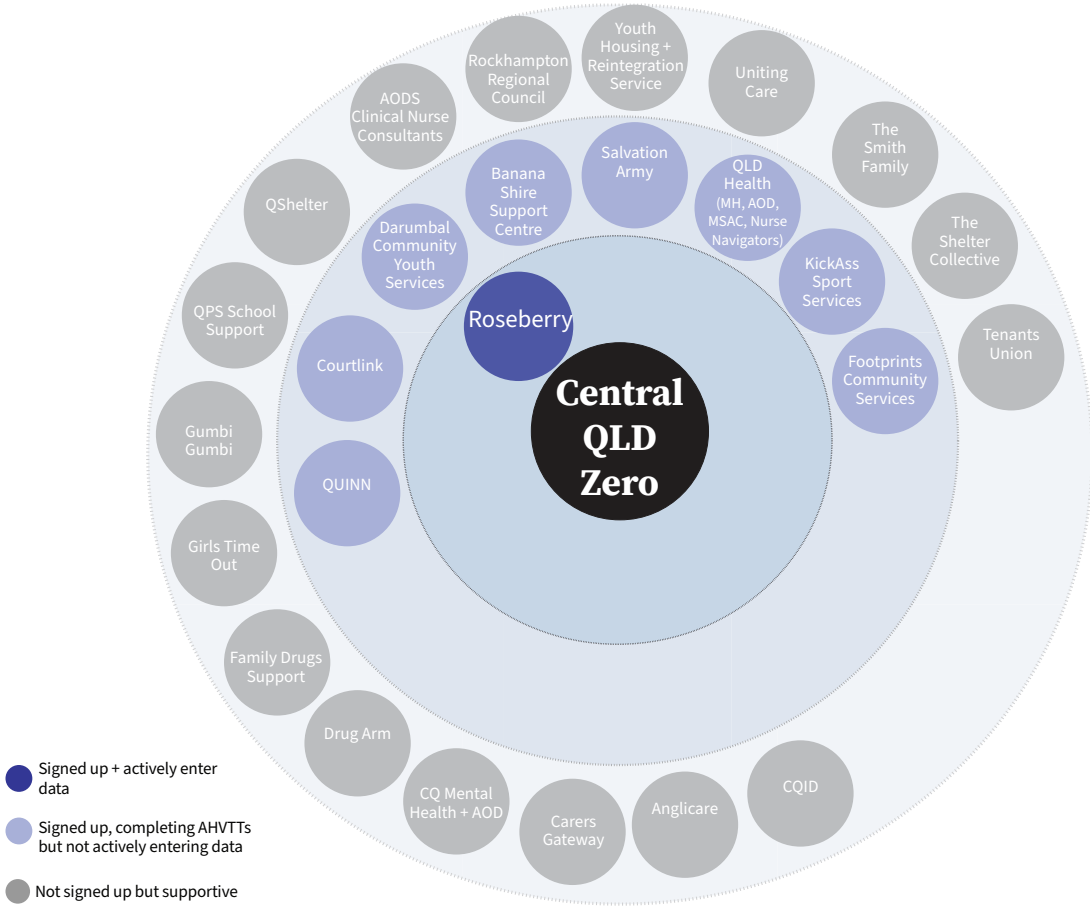


Figure 4: Mapping the collaboration of partners in CQ Zero in Year 1

Sunshine Coast

Implementation of Sunshine Coast Zero is being supported by IFYS. An initial Theory of Change workshop was held in Birtinya on 25 October 2025. Participants developed the draft Theory of Change included in Appendix 2.

Local Learning questions and progress:
Two primary learning questions were developed by participants at the initial Theory of Change workshop. Responses are provided to those initial questions.

1.Can 'super-users' or champions be identified & engaged to support use of the AHVTT?
In addition to supporting the implementation of AtoZ on the Sunshine Coast and in Wide Bay, IFYS Ltd provides a range of direct services to people experiencing, and/or transitioning from homelessness including:

- Immediate Housing Response services
- the Kawana Hub Accommodation
- Homeless Outreach Services
- Care Coordination
- Crisis Accommodation and
- Long-term Accommodation.

To model and expedite collection of AHVTT data in the region, IFYS chose to focus first on completing AHVTTs with existing IFYS clients. This occurred alongside the efforts of the Zero Project Officer to engage other organisations across the Sunshine Coast as AtoZ partners. In this respect, IFYS was the initial 'super-user' though other organisations are now starting to complete and submit AHVTTs.

> "At the moment we're just sort of soldiering through it, doing the best we can + we're not seeing a lot of...positive results as of yet"

2.Does participation in AtoZ processes: improve collaboration; increase trust; improve efficiency and reduce strain on service providers; support fact-based service delivery?

Several pre-existing service coordination and multi-agency collaboration arrangements already exist on the Sunshine Coast. Zero Project staff are reviewing existing arrangements to identify points of connection and avoid duplicating existing arrangements and consolidating staffing arrangements before establishing Sunshine Coast Zero Service Coordination arrangements. As is reflected in the following section, key partners have 'signed up' as Zero partners highlighting promising opportunities for collaboration. Stakeholders interviewed for this learning report revealed:

- their strong support for Sunshine Coast Zero and trust in the methodology and key staff
- a strong desire for a more collaborative and relational approach which improves results for people experiencing homelessness and reduces the strain faced by organisations and their staff
- optimism that the AHVTT data could inform service improvements and local, regional, and broader advocacy and systems change
- a desire to do what they could in their roles to support relationships between Zero and other organisations "…to make sure that it's all kind of tracking as well as it can".

Open and Shared Data	Local organisations have signed up to CS Net and obtained training and licenses to enable local data input and sharing
Shared Leading	Ideas for multi-agency Case Coordination and shared learning are emergent and may focus on health as a point of difference to existing inter-agency arrangement
Support and Infrastructure	Sunshine Coast Zero has developed a website, legal agreements, social media accounts and marketing plans to support consistent and collaborative communication about the intiative Sunshine Coast Council has signed up to Sunshine Coast Zero, has sytems in place to learn from lived experience (see Street Up box below) and a Housing and Homelessness Action Plan. Council is an active contributor to cross-regional decision-making with potential to drive systemic change to reduce homelessness.
Collective Momentum	Sunshine Coast Zero is partnering with the Sunshine Coast Housing and Homelessness Network to galvanise collective advocacy for a Hub to provide a range of supports to people experiencing homelessness in Nambour Engaged with local Counciles (Sunshine Coast, Noosa, and Gympie) to embed AtoZ principles and goals in the new 5 year Housing and Homelessness Action Plan

Table 4: Elements + contributions to collaboration in Sunshine Coast Zero

Ecosystem participation
The Sunshine Coast Zero Project Officer has worked hard to engage diverse organisations as Zero partners. Those organisations are shown in Figure 5.

The Sunshine Coast Zero Project Officer suggested that the level of collaboration reflected between Sunshine Coast Zero partners reflected the 'Transactional Collaboration' set out in Figure 3 .

This is expected to evolve quickly as implementation gains traction as evidenced with reference to key shifts against indicators of collaboration identified in the reviews of the Brisbane and Logan Zeros.

Additional Sunshine Coast insights

While there have been delays in recruiting a small team of staff to support implementation in this region, progress in building towards a critical mass of AHVTTs has been enabled courtesy of access to large groups of people experiencing homelessness via complementary service offerings within IFYS. Participation in local networks and focused engagement has also enabled the Zero Project worker to identify and progress advocacy opportunities. This suggests that while having a small team in place from the beginning is the ideal, progress can be achieved in other ways given the right organisational and staffing capacities.

As noted in the "Zooming Out" section above, access to dental health emerged as a significant priority for people experiencing homelessness on the Sunshine Coast. Two people who were experiencing homelessness while also dealing with significant dental health issues were interviewed as part of this review. Their experiences are mapped in the journey maps below.

> Of the 10-12 AHVTTs I have completed...I think dental would probably be the most common denominator

The Sunshine Coast Council has supported the establishment of Street Up, a group of people with lived or living experience of homelessness who provide fee-for-service consultancy advice, community education, input to poilicy and practice reviews to Government, Non-Government and other organisations to improve outcomes for people experiencing homelessness.

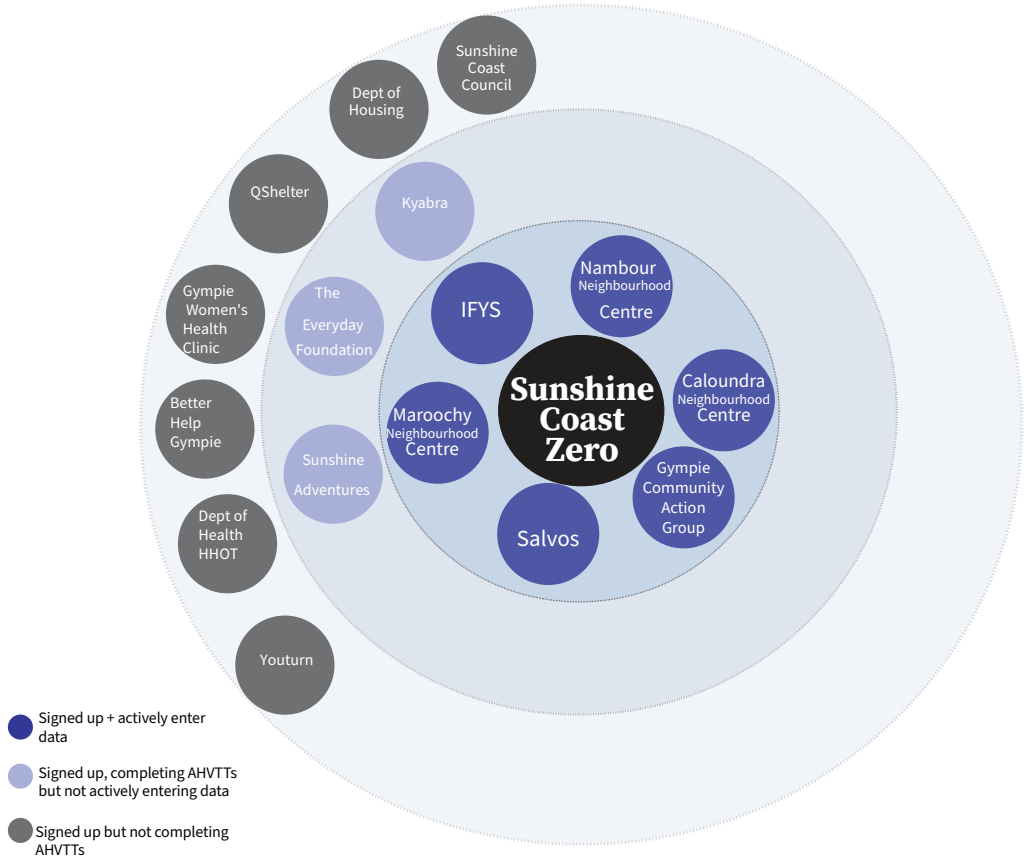


Figure 5: Mapping the collaboration of partners in Sunshine Coast Zero Year 1

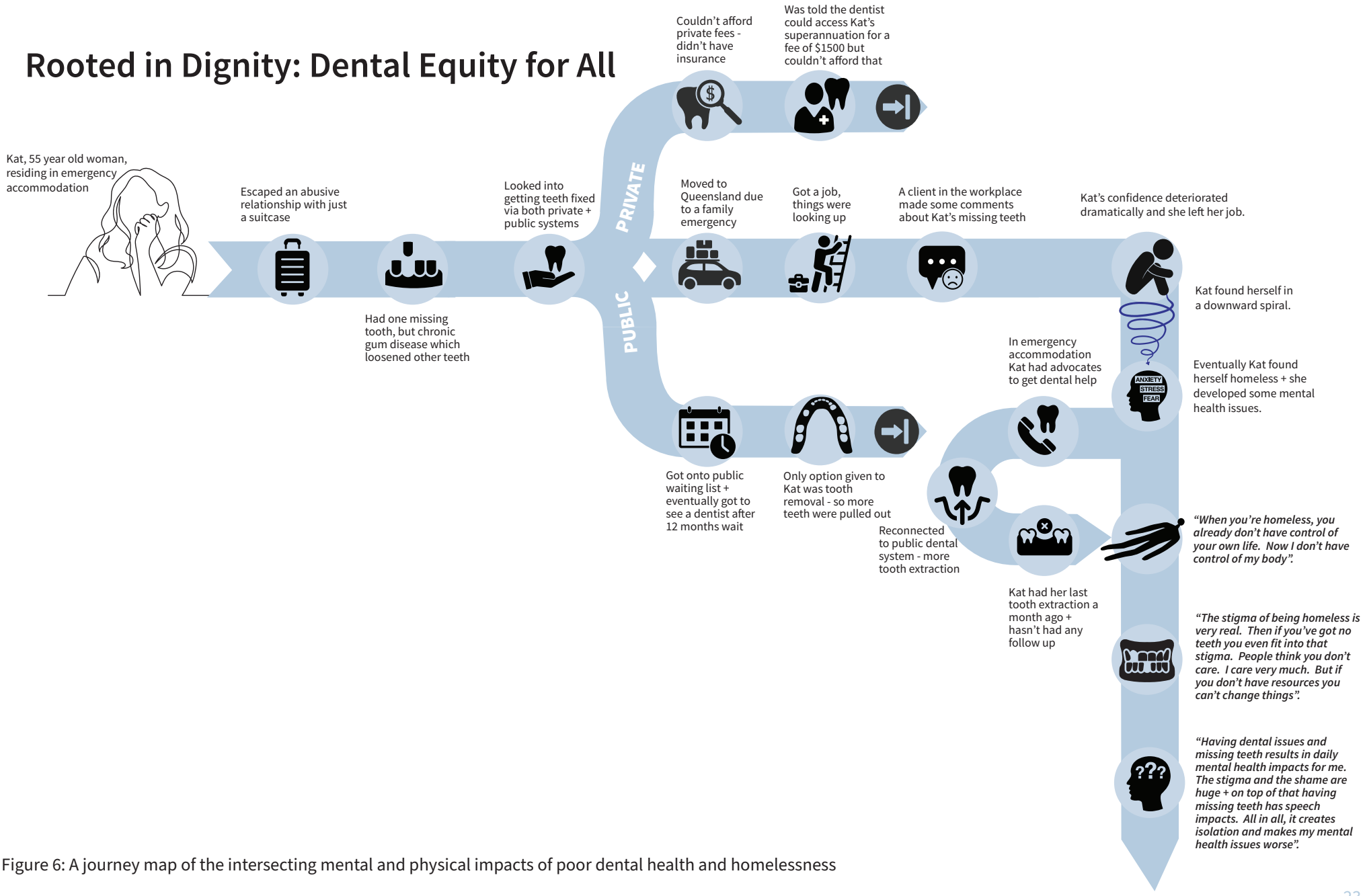


Figure 6: A journey map of the intersecting mental and physical impacts of poor dental health and homelessness

Health Equity Needs Teeth

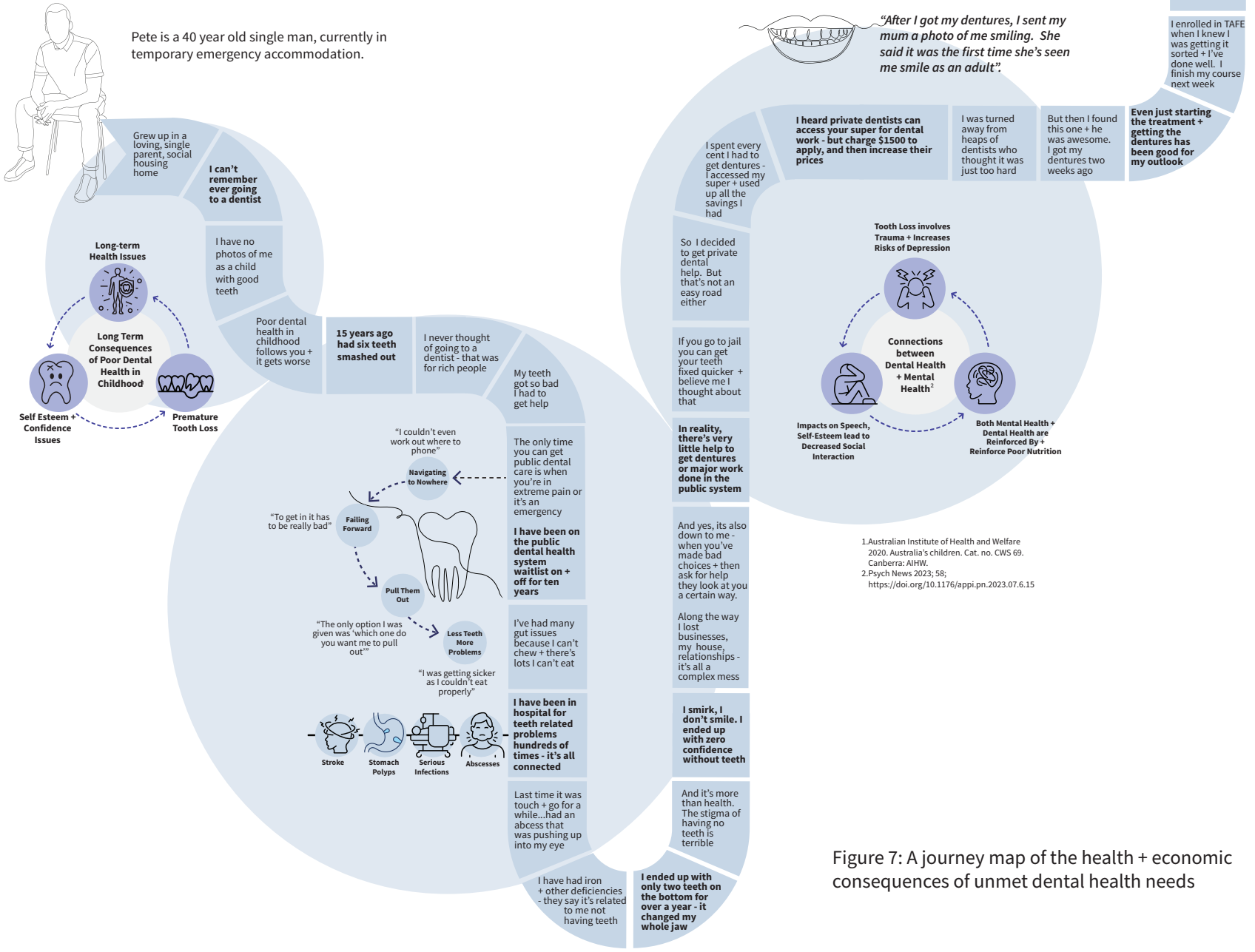


Figure 7: A journey map of the health + economic consequences of unmet dental health needs

Wide Bay

Overview of approach
Implementation of Wide Bay Zero is being supported by IFYS. An initial Theory of Change workshop was held in Hervey Bay on 20 November 2025. Participants developed the draft Theory of Change included in Appendix 3.

Local learning questions and progress
Five primary learning questions were developed by participants at the initial Theory of Change workshop which are listed below:

- What services are/ are not working?
- Who is/isn't collaborating (consistent with available capacity)?
- What services already exist that could help? How is this information kept updated and accessible?
- What mental health issues are caused by homelessness and vice versa?
- What does the intersection between health and homelessness look like in Wide Bay?

Efforts to implement Wide Bay Zero, and to refine and gather data regarding agreed learning questions have been hampered by staffing challenges. As an interim measure, foundational work has been undertaken by the Sunshine Coast Zero Project officer. Steps are being made to recruit a local person to support this region.

Wide Bay Zero was officially launched in June 2025. Several organisations have signed up as Zero partners (see Figure 8) and were expected to complete AHVTT training in July 2025 which is expected to build AHVTT data gathering and momentum in this region. Learning questions will need to be reviewed once partners are signed up and trained. Early partner discussions have highlighted some exciting possibilities such as opportunities to create nursing student placements with Zero partners and to connect Zero with local disaster resilience activities to improve health outcomes for people experiencing homelessness.

Ecosystem participation
A number of organisations are now signed up to Wide Bay Zero as shown in Figure 8. Given the nascent nature of implementation in this region, the level of collaboration within the region is considered to be "Pre-collaboration", with some clusters of organisations moving towards "Transactional Collaboration".

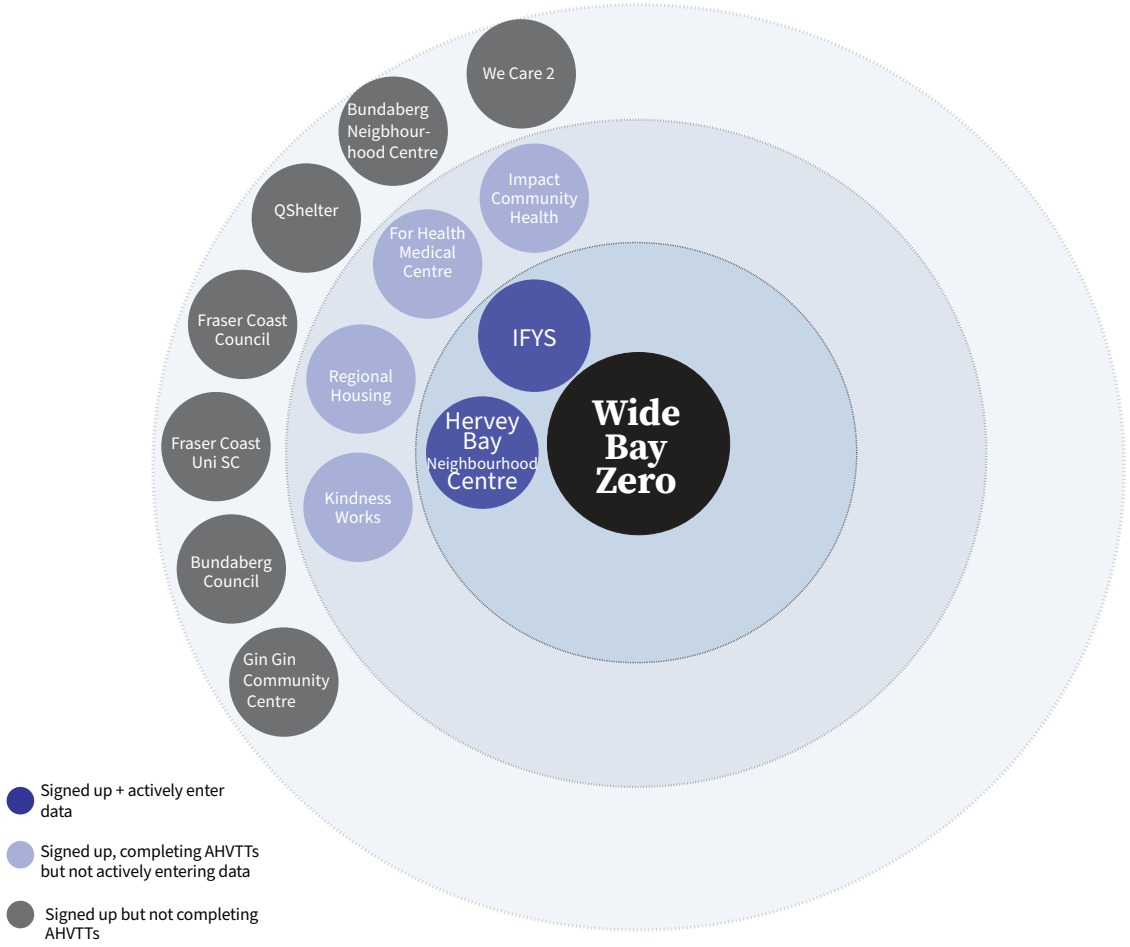


Figure 8: Mapping the collaboartion of partners in Wide Bay Zero Year 1

Recommendations

For the CQ, Wide Bay and Sunshine Coast Zeros
Given valuable but constrained investment, and relatively short implementation windows:

- Consider opportunities to narrow the focus of early implementation efforts (e.g. on specific geographic communities, age cohorts, or other focal characteristics such as health) to support more focused engagement, Case Coordination, solutions development, and outcomes.
- Revisit and refine learning questions in line with insights gained over the initial months of implementation and to reflect the interests of new partners.
- Explore opportunities to consolidate and strengthen local collaborative governance in ways that engage local ecosystem actors in embedding Zero processes within existing processes and help to adjust implementation over time.

For CCQ

- Continue to support CQ, Sunshine Coast and Wide Bay Zeros to identify and respond to the health needs of people experiencing homelessness in those communities
- Continue to learn, and share information about the impact of different operating contexts on the implementation AtoZ across the CCQ region and the different outcomes observed
- Prioritise investment in health services that are accessible to people experiencing homelessness – outreach services (wound care, dental, mental health), nurse-led clinics etc
- Consider opportunities to support primary care providers who are already providing healthcare to people experiencing homelessness (e.g. Doctors and nurses who are volunteering their time) in ways that strengthen existing infrastructure (e.g. Neighbourhood Centres), minimise the financial impacts borne by volunteers and maintain and/or extend existing, trusted services.
- Work with a small number of strategic partners (including potentially people with lived experience) to prototype mechanisms to tackle prioritised systemic issues which emerge within Zero communities and/or across the region. Lessons from the Brisbane and Logan Zeros could provide initial framing for this work.

The two year review of Logan and Brisbane Zeros (Griffith Centre for Systems Innovation, 2024) highlighted that embedding the Zero methodology in those communities required:

- The engagement of senior staff within participating organisations who 'get it'
- Active engagement and problem solving between partners
- Partners experiencing how data connects with better outcomes for people experiencing homelessness
- Collective data sharing and problem solving becoming business as usual.

That review also revealed that as the Brisbane and Logan Zeros matured towards a critical mass of evidence and partners, patterns became clearer and collective action to advance outcomes became increasingly visible and possible which in turn stimulated shifts across actors and systems (Griffith Centre for Systems Innovation, 2024).

Figure 9, drawn from that review reveals the levels at which these systemic shifts emerge and provide a potential framing for systems-focused work in CCQ.

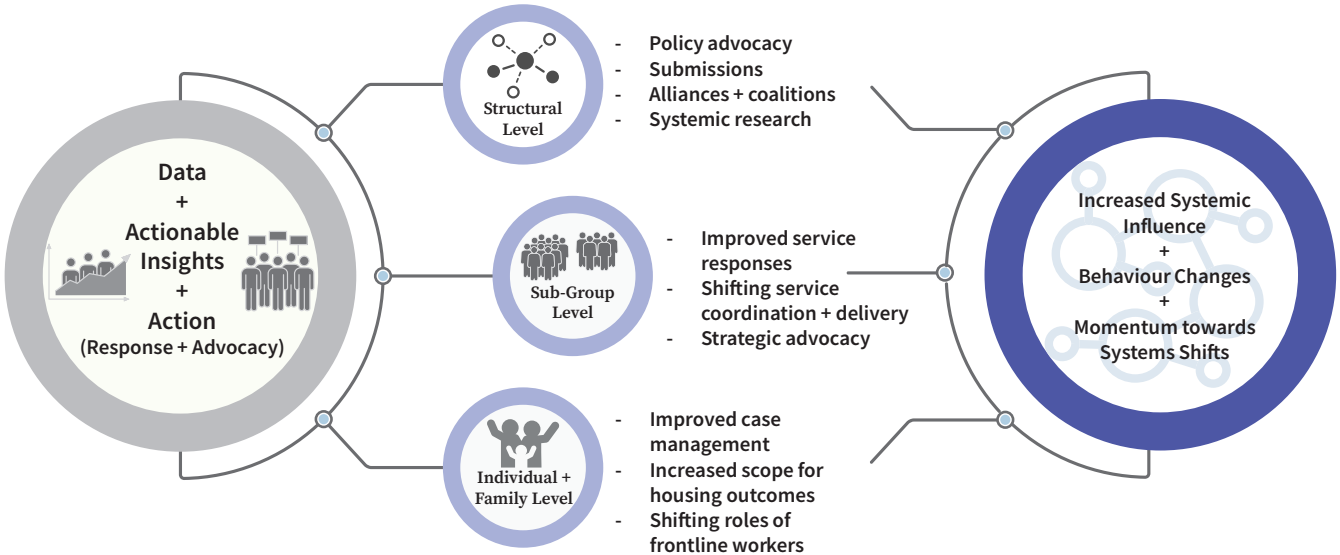


Figure 9: How data informed behavioural and system change in Brisbane and Logan Zero (Griffith Centre for Systems Innovation, 2024, p. 20).

For Micah Projects

Continue to convene, and make visible the cost associated with convening Statewide Zero networks to support:

- training and maintaining methodological rigour of AtoZ in Queensland
- peer support and joined up problem solving
- identification of patterns which emerge across the state to inform advocacy and systems change
- communication of progress across the state.

For other ecosystem investors and decision makers

- Consider opportunities to leverage core funding and resources to strengthen infrastructure that is already providing and or/ connecting primary health services to people experiencing homelessness e.g. Micah facilitation of Statewide Zero networks; existing multi-agency networks; voluntary nurse and doctor community outreach; innovative community and /or free student-provided dental models and nurse-led clinics; and the work of Neighbourhood Centres that are currently providing a range of frontline supports in often unfunded capacities
- Consider the potential to implement Advance to Zero in other communities (e.g. Moreton Bay) to improve the coordination of services to people experiencing homelessness
- Consider opportunities across funding agencies to streamline data dashboards, Known By Name Lists and other shared data tools to improve data consolidation and reduce duplication for service providers and clients
- Consider opportunities to activate housing as health care (Community Solutions, 2024) and to support more and diverse housing options across CCQ and other regions.

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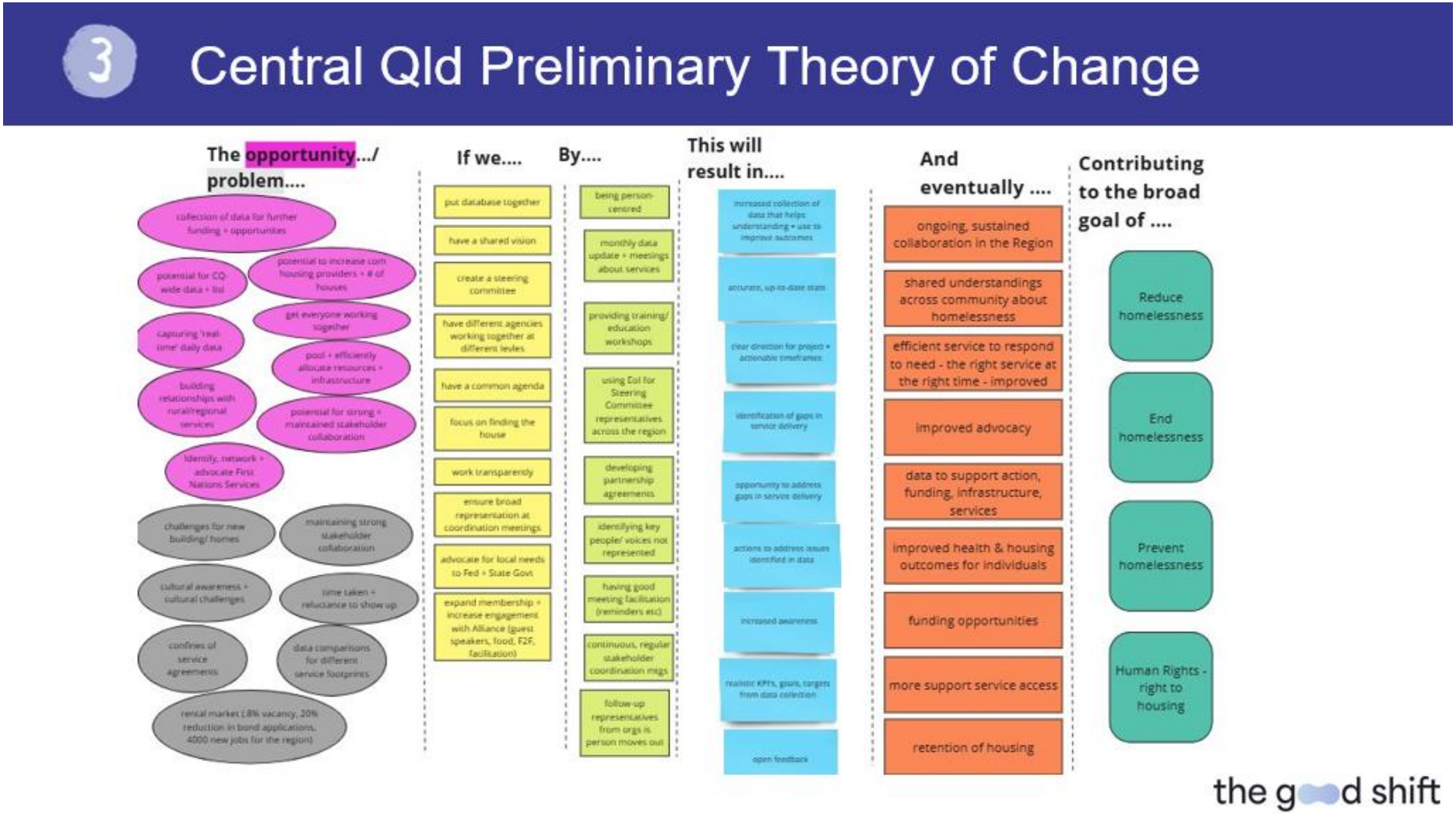
APPENDICES: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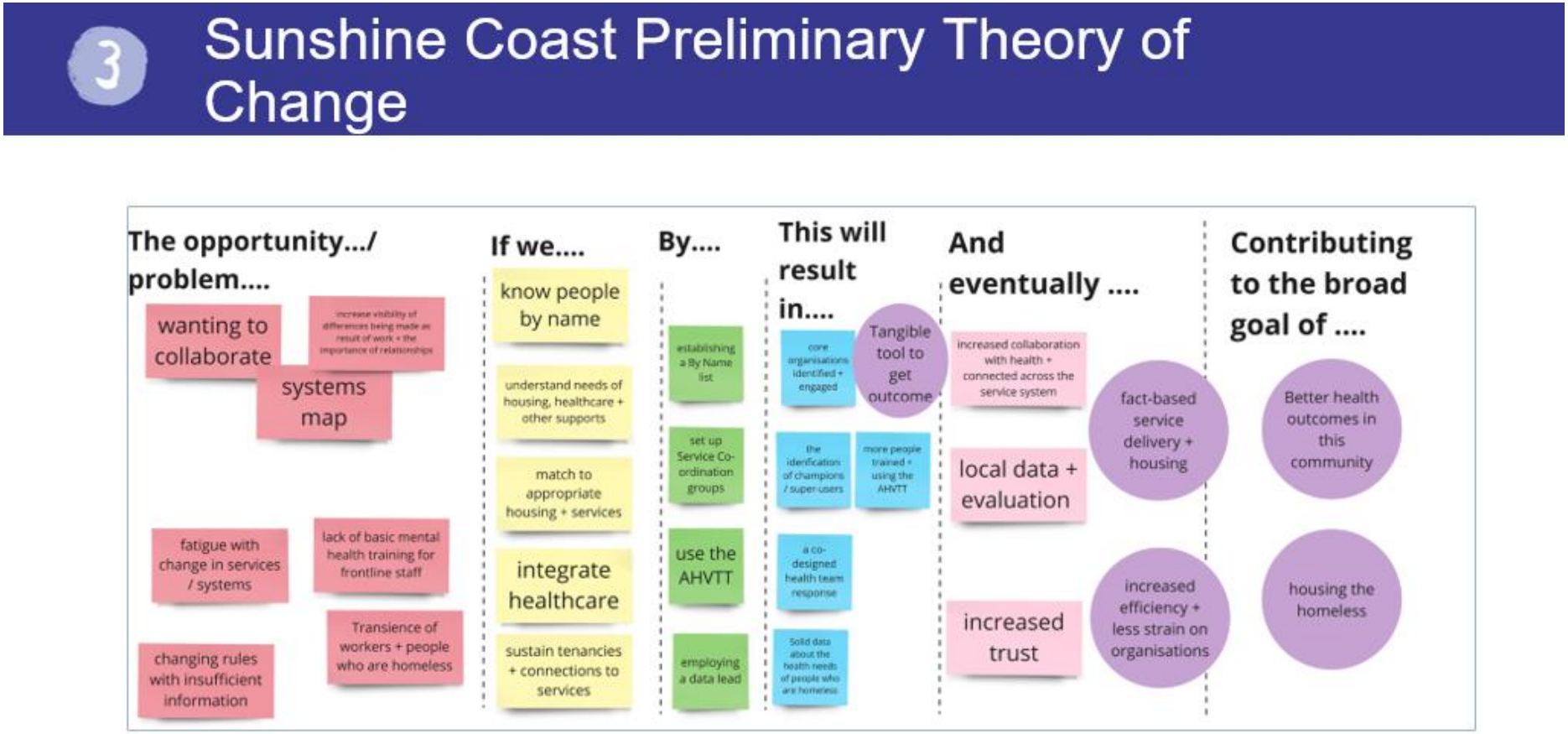
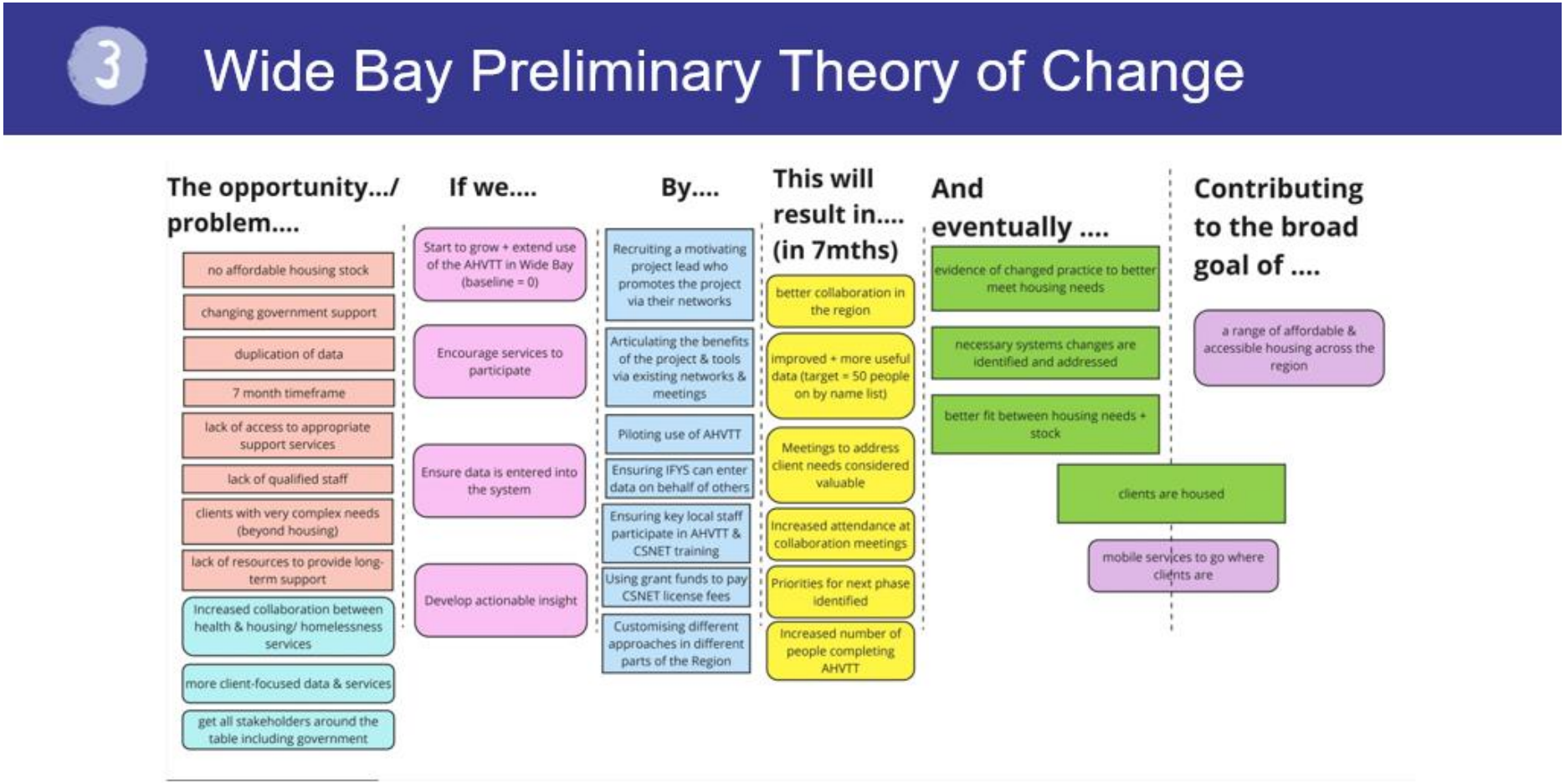
Central Qld Preliminary Theory of Change
The opportunity.../ problem....
collection of data for further funding + opportunities
potential for CQ-wide data + list
potential to increase com housing providers + # of houses
get everyone working together
capturing 'real-time' daily data
pool + efficiently allocate resources + infrastructure
building relationships with rural/regional services
potential for strong + maintained stakeholder collaboration
Identify, network + advocate First Nations Services
challenges for new building/ homes
maintaining strong stakeholder collaboration
cultural awareness + cultural challenges
time taken + reluctance to show up
confines of service agreements
data comparisons for different service footprints
rental market (.8% vacancy, 20% reduction in bond applications, 4000 new jobs for the region)
If we....
put database together
have a shared vision
create a steering committee
have different agencies working together at different levles
have a common agenda
focus on finding the house
work transparently
ensure broad representation at coordination meetings
advocate for local needs to Fed + State Govt
expand membership + increase engagement with Alliance (guest speakers, food, F2F, facilitation)
By....
being person-centred
monthly data update + meetings about services
providing training/ education workshops
using EoI for Steering Committee representatives across the region
developing partnership agreements
identifying key people/ voices not represented
having good meeting facilitation (reminders etc)
continuous, regular stakeholder coordination mtgs
follow-up representatives from orgs is person moves out
This will result in....
increased collection of data that helps understanding + use to improve outcomes
accurate, up-to-date stats
clear direction for project + actionable timeframes
identification of gaps in service delivery
opportunity to address gaps in service delivery
actions to address issues identified in data
increased awareness
realistic KPI's, goals, targets from data collection
open feedback
And eventually ....
ongoing, sustained collaboration in the Region
shared understandings across community about homelessness
efficient service to respond to need - the right service at the right time - improved
improved advocacy
data to support action, funding, infrastructure, services
improved health & housing outcomes for individuals
funding opportunities
more support service access
retention of housing
Contributing to the broad goal of ....
Reduce homelessness
End homelessness
Prevent homelessness
Human Rights - right to housing
the good shift

APPENDICES:



the good shift

APPENDICES:


3
Wide Bay Preliminary Theory of Change
The opportunity.../ problem....
no affordable housing stock
changing government support
duplication of data
7 month timeframe
lack of access to appropriate support services
lack of qualified staff
clients with very complex needs (beyond housing)
lack of resources to provide long-term support
Increased collaboration between health & housing/ homelessness services
more client-focused data & services
get all stakeholders around the table including government
If we....
Start to grow + extend use of the AHVTT in Wide Bay (baseline = 0)
Encourage services to participate
Ensure data is entered into the system
Develop actionable insight
By....
Recruiting a motivating project lead who promotes the project via their networks
Articulating the benefits of the project & tools via existing networks & meetings
Piloting use of AHVTT
Ensuring IFYS can enter data on behalf of others
Ensuring key local staff participate in AHVTT & CSNET training
Using grant funds to pay CSNET license fees
Customising different approaches in different parts of the Region
This will result in.... (in 7mths)
better collaboration in the region
improved + more useful data (target = 50 people on by name list)
Meetings to address client needs considered valuable
Increased attendance at collaboration meetings
Priorities for next phase identified
Increased number of people completing AHVTT
And eventually ....
evidence of changed practice to better meet housing needs
necessary systems changes are identified and addressed
better fit between housing needs + stock
clients are housed
mobile services to go where clients are
Contributing to the broad goal of ....
a range of affordable & accessible housing across the region
the good shift

the good shift