PEER REVIEWED

FINAL REPORT NO. 443

Homelessness as a public health emergency: learnings from crisis

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Publication Date June 2025
DOI 10.18408/ahuri7131701

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ISBN

978-1-923325-12-8

Key words

Homelessness; COVID-19; public health, housing assistance and social policy; crisis response; housing system.

Series

AHURI Final Report

Number

443

ISSN

1834-7223

Publisher

Australian Housing and Urban Research Institute Limited
Melbourne, Australia

DOI

10.18408/ahuri7131701

Format

PDF, online only

URL

https://www.ahuri.edu.au/research/final-reports/443

Recommended citation

Hartley, C., Robinson, C., Barnes, E., Batterham, D., Mason, C. and valentine, k. (2025) *Homelessness as a public health emergency: learnings from crisis,* AHURI Final Report No. 443, Australian Housing and Urban Research Institute Limited, Melbourne, https://www.ahuri.edu.au/research/final-reports/443, doi: 10.18408/ahuri7131701.

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Acknowledgements

This material was produced with funding from the Australian Government and state and territory governments. AHURI Limited gratefully acknowledges the financial and other support it has received from these governments, without which this work would not have been possible.

AHURI Limited also gratefully acknowledges the contributions, both financial and in-kind, of its university research partners who have helped make the completion of this material possible.

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Acronyms and abbreviations used in this report

ABS	Australian Bureau of Statistics
AHURI	Australian Housing and Urban Research Institute Limited
AIHW	Australian Institute of Health and Welfare
BHHP	Better Health and Housing Program
BSL	Brotherhood of St Laurence
CIRF	COVID Isolation and Recovery Facility
DCJ	Department of Communities and Justice
DFFH	Department of Families, Fairness and Housing
DHHS	Department of Health and Human Services
ED	Emergency department
H2H	Homeless to Home
HART	Homelessness Assertive Outreach Response Team
HEART	Homelessness Emergency Accommodation Response Teams
HEFs	Housing Establishment Funds
HER	Hotel Emergency Response
HOST	Homelessness Outreach Support Team
HRAR	The High-Risk Accommodation Response
LASN	Local area service networks
MS2H	Melbourne Street to Home program
MHHOST	Mental Health and Homelessness Outreach Support Team
NGO	Non-government organisation
PCR testing	Polymerase chain reaction testing
PPE	Personal protective equipment
SESLHD	South-Eastern Sydney Local Health District
SHS	Specialist Homelessness Services
SLHD	Sydney Local Health District
SVHM	St Vincent's Hospital Melbourne
Taskforce	Sydney Rough Sleeping COVID-19 Taskforce
WHO	World Health Organization

Glossary

A list of definitions for terms commonly used by AHURI is available on the AHURI website ahuri.edu.au/glossary.

Executive summary

Key points

- The COVID-19 emergency period led to new interventions and further collaboration between health and homelessness sectors.
- This project aimed to capture lessons learned from this increased engagement, focussing on New South Wales, Victoria and Tasmania.
- The research revealed key differences and similarities in the barriers and enablers experienced in delivering health services during the COVID-19 emergency period across the three case-study states.
- Guiding principles to shape the future delivery of health services to people experiencing homelessness were also identified.
- These principles included the need to recognise homelessness as a permanent population health emergency; enhanced targeted responses to homelessness; and the importance of cross-agency and cross-sector collaboration between health and homelessness agencies and services.

Key findings

Enablers, barriers, and lessons learned

Across the case studies, several key enablers, barriers and lessons emerged that offer valuable insights for both the homelessness and health sectors.

The importance of pre-existing relationships

In Victoria and New South Wales, the responses of health agencies to people experiencing homelessness during the COVID-19 pandemic were widely regarded as effective. Interview participants from the community service sector, health sector, and relevant government agencies attributed this success to strong, pre-existing partnerships. These well-established relationships between government entities, health services, and homelessness stakeholders enabled rapid coordination, trust-based collaboration, and the swift implementation of tailored responses. Participants consistently highlighted these partnerships as a key enabler of the effective response.

To support future crisis preparedness, it is recommended that such collaborative relationships be actively cultivated and sustained across all regions, providing a solid foundation for coordinated action in public health emergencies.

The importance of engaged outreach-based health services

In inner-city Sydney, Melbourne and across Tasmania, the delivery of health services during the COVID-19 pandemic was enabled by health agencies that were already active in outreach work before the crisis. The established outreach framework allowed these services to quickly adapt to the heightened demand and logistical challenges brought on by the pandemic, ensuring that health interventions were delivered efficiently and effectively to those in need.

A key lesson learned is the critical value of having an engaged and flexible outreach-based health service infrastructure in place before a crisis hits, as it allows for rapid and effective responses in times of emergency.

Government agencies creating an authorising environment

In Victoria and New South Wales, interview participants from the community service sector, health sector, and government agencies overseeing public health services identified the pivotal role of government in enabling effective health responses. Government agencies created an authorising policy environment that was characterised by flexibility and strong support from senior officials. This environment empowered stakeholders to work collaboratively and operate beyond their usual boundaries, allowing for more responsive and innovative approaches during the crisis period of the pandemic.

Importance of collaboration and shared ways of working

Interview participants from the community service sector, health sector, and government agencies in Victoria and New South Wales identified strong communication and coordination between government agencies, health services, and the specialist homelessness services (SHS) sector as key to the successful delivery of health services during the pandemic. This effective collaboration enabled emerging issues to be identified and addressed promptly and efficiently. Participants emphasised that these communication pathways were critical to the responsiveness of the overall system.

To strengthen future crisis responses, it is recommended that such collaborative practices be formalised and replicated in other jurisdictions, with sustained support for inter-agency communication and coordination.

The need for effective resourcing to sustain collaborations

A common barrier across all three case-study sites was the lack of adequate resources. Interview participants consistently reported that insufficient funding, personnel and logistical support hindered their ability to fully meet the demands of the crisis.

Uneven responses for different groups of people

A significant barrier across all three case studies was the uneven delivery of health services to people experiencing homelessness, with notable gaps in coverage for populations outside metropolitan areas and for cohorts other than rough sleepers.

Case studies

New South Wales

The New South Wales case study concentrated on the delivery of health services in the COVID-19 emergency period to people who were rough sleeping in inner-city Sydney.

The delivery of health services during this period was significantly shaped by pre-existing outreach strategies for supporting people experiencing homelessness.

With the emergence of COVID-19, key services and agencies formed the Sydney Rough Sleeping COVID-19 Taskforce (the Taskforce) to coordinate efforts to house and support people experiencing homelessness.

Interview participants identified several enablers in the successful delivery of health services. These included the strong pre-existing relationships and the role of proactive and engaged health services. The New South Wales case study also reveals several policy implications, including the potential to expand and support the establishment of proactive and outreach-focussed health services.

Victoria

The Victorian case study concentrated on the delivery of health services in the COVID-19 emergency period to people experiencing homelessness, including those sleeping rough, in Melbourne.

Existing human-services infrastructure and relationships shaped health service delivery during COVID-19. Partnerships between the SHS sector and health services enabled programs to support people experiencing homelessness, such as the COVID Isolation and Recovery Facilities (CIRFs).

Interview participants also identified the authorising environment of government agencies as a key enabler in the successful delivery of health services. However, several barriers were identified, including misunderstandings stemming from different working cultures and terminology between SHS and health services.

Tasmania

The Tasmanian case study explored how public health measures were navigated in youth and homelessness services working with unaccompanied homeless children during the COVID-19 emergency period. The case study aimed to contribute to work in Tasmania being undertaken to improve policy and practice responses to unaccompanied child homelessness, in particular for those aged under 16 who experience homelessness alone.

Unaccompanied children faced significant challenges with public health measures because of their lack of stable housing and guardianship. Interview participants identified several enablers in the delivery of health services to unaccompanied children in Tasmania, including the key roles played by community sector peaks and specialist mobile health outreach services. However, they also identified several barriers, such as a perceived lack of understanding within Public Health regarding homelessness, and the lack of COVID-19 responses relevant for unaccompanied children.

Policy development options

Several guiding principles are suggested to enhance collaboration between health services and the SHS sector.

Recognition of homelessness as a permanent population health emergency

Our research highlighted the critical and ongoing need to recognise homelessness as a permanent population health emergency. People experiencing homelessness are disproportionately burdened with severe physical and mental health challenges, resulting in nearly double the risk of mortality and significantly reduced life expectancy compared to housed individuals.

Health agencies and services must take on a proactive and sustained role in addressing homelessness as an urgent public health crisis—and not just as a social issue. This involves implementing policies and practices that prioritise the prevention of homelessness, ensuring that vulnerable populations receive the support they need before they fall into homelessness.

Enhancing targeted responses to homelessness during and after emergencies

During the COVID-19 emergency period, targeted, cohort-focussed initiatives significantly improved the delivery of health services to people experiencing homelessness. For instance, mobile health outreach services in all three case-study states—Victoria, New South Wales and Tasmania—played a pivotal role in complementing the efforts of Public Health agencies.

To build on the success of these targeted initiatives, it is essential that such approaches continue beyond the crisis. Ensuring that people experiencing homelessness maintain access to health services in environments that are familiar and trusted is crucial for sustained health improvement.

Mobile and outreach-based services should not be viewed as temporary measures—but as integral components of a comprehensive strategy to address homelessness-related health needs.

The importance of cross-agency and cross-sector collaboration between health and homelessness agencies and services

For health services to be effectively delivered to people experiencing homelessness, robust coordination between health services and homelessness services is essential. To achieve this, several components are necessary.

The involvement of health bodies like New South Wales local health districts is essential to integrate the SHS sector with local health services, as it fosters coordination.

A well-resourced, centrally authorised framework for inter-agency communication is also needed. Such a framework could bring together health, housing, homelessness agencies and non-government organisations (NGOs) to enhance collaboration and information-sharing.

Finally, formal partnerships between health and homelessness services should clearly define roles to strengthen intersectoral relationships.

The study

On 30 January 2020, the World Health Organization (WHO) declared a global public health emergency in response to COVID-19. Recognising the heightened vulnerability of people experiencing homelessness, Australia implemented measures to protect these communities. These included:

- temporarily housing individuals in motels (Leishman, Aminpour et al. 2022; Parsell, Clarke et al. 2020)
- coordinating with the SHS sector to fund deep-cleaning, adjust capacities, and ensure physical distancing (Flatau and Hartley 2020).

Once vaccines became available, these efforts shifted to prioritising vaccine access for people experiencing homelessness (Currie, Stafford et al. 2022; Hollingdrake, Grech et al. 2024; McCosker, El-Heneidy et al. 2022). The rapid evolution of COVID-19 responses in the homelessness sector led to the emergence of novel interventions and collaborations, marked by heightened engagement between the health and housing and homelessness sectors.

This project aims to capture the lessons learned from this unique period of increased interaction between health and homelessness services and to explore opportunities for expanding or enhancing this engagement.

In this context, this study asks three research questions:

1. What were the barriers and enablers in the delivery of health responses to people experiencing homelessness during the COVID-19 emergency period?
2. What have Australian health and homelessness sectors learned about responses to homelessness from their increased collaboration during the COVID-19 emergency period?
3. What are the guiding principles to strengthen ongoing collaboration between public health agencies and specialist homelessness services?

The report focuses on examining initiatives and responses over the course of the COVID-19 emergency period within three key states: New South Wales, Victoria and Tasmania:

- In New South Wales, the study predominantly concentrates on the health responses targeting rough sleepers in inner-city Sydney—a focal point for numerous interventions due to the high visibility and significant number of rough sleepers.
- The second case study focuses on Victoria, examining the state's overall strategy and specific initiatives designed to support homeless populations, particularly in Melbourne.
- Finally, the report explores public health responses in Tasmania, with a focus on unaccompanied homeless children and the services working with them.

By concentrating on these three states, the report aims to provide a detailed analysis of health responses to homelessness, illustrative of both the challenges and successes in collaboration that emerged in response to the pandemic.

This research project consisted of a literature review and stakeholder interviews conducted with representatives from the community service sector, the health sector, and government agencies overseeing public health services in New South Wales, Victorian and Tasmania. The literature review encompasses academic and grey literature on public health responses to people experiencing homelessness.

Qualitative interviews were with key stakeholders from New South Wales, Victoria and Tasmania who were engaged in designing and implementing public health strategies to support people experiencing homelessness during the COVID-19 emergency. These interviews also included frontline service providers involved in delivering health services.

1. Introduction: Public health and homelessness

- **This research was conducted to understand the public health responses to homelessness during the COVID-19 emergency in Australia. It aimed to identify barriers, enablers and lessons learned from increased collaboration between public health and homelessness sectors.**
- **The report focussed on collaborations in New South Wales, Victoria and Tasmania, examining initiatives primarily in inner-city Sydney (New South Wales), Melbourne (Victoria), and across Tasmania.**
- **The research employed a literature review and stakeholder interviews. The literature review identified barriers and enablers in public health responses, while interviews involved stakeholders from public health agencies, homelessness services and health services.**

1.1 Why this research was conducted

For a short time during 2020, concerns about the Australian housing crisis, and most other public concerns, were disrupted by the arrival of COVID-19, the eventual declaration of a public health emergency, and subsequent population-level health controls never seen before in Australia (Hartley, Barnes et al. 2021; Parsell, Clarke et al. 2020). This project seeks to capture what was learned through this unique period of increased engagement between health agencies and homelessness services, and to what extent this engagement could be expanded or improved.

In recognition that people experiencing homelessness were especially vulnerable to COVID-19, they were the specific focus of public health measures, most predominantly emergency accommodation programs (Leishman, Aminpour et al. 2022). These measures were in response to the risks of people experiencing homelessness becoming unwell from COVID, but also the risks of homeless people not complying—or not being able to comply—with social distancing and sanitising measures and so becoming high-volume vectors of transmission (Parsell, Clarke et al. 2020).

Public health agencies and services also collaborated with other types of services to provide tools and techniques to help the management of homelessness services for adults and young people. These included:

- funding for deep-cleaning programs
- advising on capacity reductions and closures
- reducing the number of people in congregate services to ensure physical distancing requirements (Flatau and Hartley 2020).

Once a vaccine for COVID-19 was made available in Australia, states and territories implemented targeted campaigns to ensure people experiencing homelessness were priority groups during the COVID-19 vaccine rollout (Currie, Stafford et al. 2023; Hollingdrake, Grech et al. 2024; McCosker, El-Heneidy et al. 2022). Through the rapid evolution of COVID-19 responses for the homeless sector, novel interventions and collaborations arose through increased engagement between the health and housing and homelessness sectors.

In this context, this study asks:

1. What were the barriers and enablers in the delivery of health responses to people experiencing homelessness during the COVID-19 emergency period?
2. What have Australian health and homelessness sectors learned about responses to homelessness from their increased collaboration during the COVID-19 emergency period?
3. What are the guiding principles to strengthen ongoing collaboration between public health agencies and specialist homelessness services?

For the purposes of this research, the COVID-19 emergency period is defined as the time frame from the WHO's declaration of COVID-19 as a public health emergency of international concern in January 2020 to the conclusion of Australia's emergency lockdowns in October 2021. This period marks a crucial phase in the response to COVID-19 within the SHS sector, and a time of heightened collaboration between public health agencies and services.

1.2 Research scope

1.2.1 Report focus and limitations

The focus of the study is on the collaborations between health and homelessness services and government agencies that developed during the COVID-19 emergency period, how these collaborations were created, and if they can be sustained. This report does not provide an exhaustive overview of all health responses directed toward people experiencing homelessness across Australia. Nor does it attempt to document a historical record of individual interventions.

Specifically, the report narrows its focus to examine initiatives and responses within three key states: New South Wales, Victoria and Tasmania. By concentrating on these states, the report aims to analyse health responses to people experiencing homelessness through case studies of collaborative efforts that emerged in response to the pandemic.

New South Wales

In New South Wales, the study predominantly concentrates on the public health responses targeting rough sleepers in inner-city Sydney. This area was a focal point for numerous interventions because of its high visibility and the significant number of rough sleepers it hosts. Additionally, the New South Wales section integrates insights from interviews conducted with the SHS sector in regional areas.

Victoria

The second case study focuses on Victoria, examining the state's overall strategy and specific initiatives designed to support homeless populations. The report focuses predominantly on the state's capital, Melbourne, which was the focus of public health and homelessness initiatives. Key programs, their implementations and outcomes are highlighted to showcase Victoria's approach to addressing homelessness from a public health perspective.

Tasmania

Finally, the report explores public health responses in Tasmania and the unique statewide challenges these posed for unaccompanied homeless children and the youth and homelessness services working with them.

By concentrating on these three states, the report aims to present an in-depth exploration of varied approaches within Australia, thereby offering valuable insights into the effectiveness of different public health strategies targeting homelessness.

Limitations

A significant challenge faced during this research was the difficulty in recruiting key contacts within government and public health sectors, including additional costly research governance processes specifically required for the participation of Health Department staff. Many individuals we had initially identified as crucial sources of information had moved on from their positions, rendering them unavailable for interviews.

The unavailability of these key contacts impacted the breadth and depth of the research, resulting in a narrative of collaboration predominantly told from the viewpoint of the SHS sector.

1.2.2 Key concepts

Public health

The World Health Organization (WHO) defines public health as *'the art and science of preventing disease, prolonging life, and promoting health through the organized efforts of society'* (WHO 2024). This definition emphasises the collaborative nature of public health initiatives, highlighting the importance of society-wide efforts in achieving health goals.

In the Australian context, in the 1990s, health ministries at both federal and state levels under the National Public Health Partnership agreed on the following definition of public health (National Public Health Partnership, 1998a, as cited in Fawkes, 2014:6). *Public health is the organised response by society to protect and promote health and to prevent illness, injury, and disability.'*

The organisational component of the definition of public health aims *'to encompass both activities undertaken within the formal structure of government and the associated efforts of private and voluntary organisations and individuals'* (Fawkes 2014:6).

In Australia, public health agencies operate at the federal, state and local levels. Each Australian state and territory has its own health department or agency responsible for public health within its jurisdiction. These agencies implement national policies at the local level, develop state-specific health initiatives, and manage public health services (Fawkes 2014). Additionally, public health services are delivered by local health departments, as well as by NGOs, community health centres, hospitals, and other private providers. These organisations and groups contribute to public health efforts through service delivery, advocacy, and community engagement (Fawkes 2014).

Note that throughout this research document, 'public health' (lower case) refers to the broad scope of public health activities mentioned above, while 'Public Health' (capitalised) refers specifically to government structures and departments.

The COVID-19 emergency period

This study aims to investigate public health responses to homelessness in Australia before, during and after the COVID-19 'emergency period', defined as the time from the WHO's declaration of COVID-19 as a public health emergency of international concern in January 2020, to the end of Australia's emergency lockdowns in October 2021.

This period was chosen for the study as it represents a critical phase in the response to COVID-19 within the SHS sector and highlights a period of increased collaboration between health agencies and services.

However, it is important to acknowledge that the impact of COVID-19 in Australia has continued beyond October 2021. From the beginning of the pandemic in January 2020 to the end of 2023, 22,315 people died from or with COVID-19 (Australian Bureau of Statistics [ABS] 2024) with the vast majority of these deaths occurring following the exit of the COVID-19 lockdowns in October 2021 (Barrett 2023).

1.3 Policy context

1.3.1 COVID-19 public health responses in focus states

When COVID-19 escaped quarantine, the National Cabinet, which comprises the Prime Minister, state premiers and territory chief ministers, was established and began introducing measures to restrict non-essential, organised public gatherings starting on 16 March 2020 (Australian Government 2020). Over the following months, Australian states and territories instituted lockdown measures that were often effective at preventing widespread community transmission (Weiss, Boyhan et al. 2023). By the time lockdowns were phased out, state and territory governments had imposed a total of 40 lockdowns in capital cities and regions within their jurisdictions (Hameiri and Chodor 2023).

While all Australian states and territories experienced some form of lockdown between March 2020 and October 2021, the range of measures implemented varied across jurisdictions, and even within regions of those jurisdictions. Additionally, the specific restrictions often changed within the same state or city over the course of a single lockdown (Hameiri and Chodor 2023).

The lockdown experiences across our three case-study sites were notably distinct. In Victoria, Melbourne earned the title of the world's most locked-down city, enduring 262 days across six separate lockdowns between March 2020 and October 2021 (Boaz 2021; Hameiri and Chodor 2023). In contrast, Greater Sydney faced three separate lockdowns totalling 169 days during the same period, while Hobart experienced two separate lockdowns, amounting to 65 days in total (Hameiri and Chodor 2023). These differences in lockdown measures and their duration underscore the varied approaches and challenges each region encountered in managing the pandemic, highlighting the localised nature of public health responses across Australia (Hameiri and Chodor 2023).

1.3.2 COVID-19 and homelessness policy responses

As COVID-19 emerged, it became apparent that it did not pose equal risks to all parts of society, with some groups at an increased risk of exposure and greater likelihood of severe cases and mortality (Lewer, Braithwaite et al. 2020). One group identified as at particular risk of contracting and being severely impacted by the spread of COVID-19 was those experiencing homelessness. People experiencing homelessness—particularly those sleeping rough or 'street sleeping'—were identified to be at increased risk of infection by virtue of their:

- limited capacity to practice social distancing (Perri, Dosani et al. 2020)
- limited access to infection-prevention measures such as hand sanitisers and masks (Culhane, Treglia et al. 2020; Perri, Dosani et al. 2020)
- reduced ability to self-isolate should they be required to do so (Pawson, Parsell et al. 2020).

The vulnerability of people experiencing homelessness to COVID-19 was also heightened by the higher prevalence of chronic health conditions among the homeless population sleeping rough and in supported accommodation (Flatau, Seivwright et al. 2020; Parsell, Clarke et al. 2020).

The identification of people experiencing homelessness as being at particular risk for COVID-19 sharply contrasted with their usual neglect in public health policies, where their health issues and societal inequalities often become an 'invisible burden' (Babando, Quesnel et al. 2022; Parsell, Clarke et al. 2020). Consequently, it has been suggested that COVID-19 interventions were driven by the perceived threat that homeless populations—believed to be at high risk of contracting and transmitting the virus—posed to the health of the non-homeless population (Parsell, Clarke et al. 2020).

When the first cases of COVID-19 were confirmed in Australia, the SHS sector, homelessness peak agencies and public health experts called upon the Australian Government to implement protections for those experiencing homelessness (Flatau and Hartley 2020). Australia was at this time criticised for its inadequate preparations for the impact of COVID-19 on people experiencing homelessness, with Associate Professor Lisa Wood of the University of Western Australia's School of Population and Global Health arguing in March 2020:

> *Those working in the sector, and homeless people themselves, feel abandoned as there has been no guidance at all and a lack of proactive action for this vulnerable high-risk group. Both in our national and state governments, homelessness crosses several government portfolios, and it seems to be falling through the cracks (Lisa Wood cited in Kirby 2020: 449).*

In the absence of a national strategy to respond to homelessness and COVID-19, state and territory governments adopted a variety of policy and practice measures to both provide temporary accommodation to those currently homeless and to prevent further exits into the homelessness system (Hartley, Barnes et al. 2021). Responses providing temporary accommodation in hotels/motels to people who were rough sleeping were implemented in New South Wales, Queensland, South Australia, Western Australia and Victoria (Hartley, Barnes et al. 2021).

In addition to the provision of temporary accommodation, states and territories unveiled a range of measures to address the identified public health risks of COVID-19 and people experiencing homelessness. In keeping with the initial belief that the COVID-19 virus was transmitted mainly via droplets produced when a person coughs, sneezes or speaks (WHO 2020), these public health strategies concentrated on infection control techniques such as social distancing of more than one metre (within which these droplets were thought to fall to the ground), along with hand-washing and surface disinfection to stop transfer of droplets to the eyes, nose and mouth (Lewis 2022). This led to a focus on strategies involving:

- deep cleaning of homelessness services and congregate care facilities
- reducing the number of people in congregate homelessness services to ensure that physical distancing requirements could be met
- providing accommodation to rough sleepers to remove them from situations deemed vulnerable for the spread of the virus (NSW Department of Communities and Justice 2020.

With the recognition by the WHO in late 2020/21 that COVID-19 was airborne, public health responses began to acknowledge the importance of ventilation and indoor masking—key measures that can prevent airborne spread of the virus (Lewis 2022). Responses for people experiencing homelessness likewise changed, with an emphasis placed on the provision of free, reusable masks to people experiencing homelessness and those in social housing who may have limited access or financial means to purchase masks (McCosker, El-Heneidy et al. 2022; Nouri, Ostadtaghizadeh et al. 2022)

With the development of the COVID-19 vaccine in December 2020, large-scale measures in each state and territory were aimed at ensuring people experiencing homelessness had access to vaccines (Currie, Stafford et al. 2023). This included through the development of community-led programs that leveraged the trust and embeddedness of homelessness services to improve vaccine access and uptake (Currie, Stafford et al. 2023; Hollingdrake, Grech et al. 2024; McCosker, El-Heneidy et al. 2022). Examples of this in the Australian context include:

- the Inner City COVID-19 Vaccination Hub: a collaboration between St. Vincent's Hospital Homeless Health Services and the City of Sydney (which is explored further in the NSW case study)
- the Micah Projects COVID-19 vaccination program in Brisbane (Hollingdrake, Grech et al. 2024).

However, despite these measures, the COVID-19 vaccination rate among people experiencing homelessness was significantly lower than that of the general population, with less than 22 per cent of eligible individuals receiving two doses of the vaccine in some areas (Desborough, Wright et al. 2022).

1.4 Research methods

This research project consists of a literature review and stakeholder interviews to answer the research questions.

1.4.1 Literature review

A systematic literature review was chosen to comprehensively examine public health responses to homelessness before and during the COVID-19 emergency period.

The systematic search proceeded in a series of steps—first exploratory, then specific—following an interpretive analysis. The search process followed the preferred reporting items for systematic reviews and meta-analyses (PRISMA) methodology (Moher, Liberati et al. 2009). PRISMA ensures rigour and transparency in the review process, enhancing the reliability of findings (Mason, Moran et al. 2020). This systematic approach was tailored to address the first of the three core research questions: identifying barriers and enablers in public health responses to people experiencing homelessness both before and during the COVID-19 emergency period.

This literature review consisted of a systematic search of literature to identify:

- the health needs of people experiencing homelessness
- the barriers and enablers in the delivery of public health responses to people experiencing homelessness both before and during the COVID-19 emergency period
- a desktop review of collaborations between public health sector and services and homelessness services.

The literature review was conducted to provide a high-level overview of people experiencing homelessness and interaction with health services. The findings of the literature review are detailed in Chapter 2.

1.4.2 Stakeholder interviews

The second phase of the research involved qualitative interviews with key stakeholders in New South Wales, Victoria and Tasmania who were engaged in designing and implementing public health strategies to support people experiencing homelessness during the COVID-19 emergency. The stakeholders included the following:

- Community service sector: housing and homelessness agencies, specialist homelessness services, youth and community services. Participants from this stakeholder group include both Peaks and frontline services.
- Health services involved in delivering services to people experiencing homelessness during the relevant period.
- Government agencies overseeing public health services to the homelessness sector.

In total, 53 stakeholders were interviewed across the three case-study states. Thirty-six participants were interviewed from the community service sector, 10 participants were interviewed from the health service sector and seven from government agencies overseeing public health services (see Table 1). Interviews were conducted over late 2023 and early 2024.

Table 1: Summary of participants

State	Community service sector: number of participants	Health services: number of participants	Government agencies: number of participants
NSW	12	4	3
Victoria	9	2	3
Tasmania	15	4	1
Total	**36**	**10**	**7**

Source: Authors.

Stakeholder interviews were designed to capture participants' perspectives on the following themes:

- the engagement of the specialist homelessness services (SHS) with public health agencies and health services before and during the COVID-19 pandemic emergency period
- the nature of collaboration between the SHS sector and public health agencies and health services
- lessons learned from collaboration between the SHS sector and public health agencies and health services during the COVID-19 emergency period
- guiding principles to strengthen ongoing collaboration.

2. The health needs of people experiencing homelessness

- **People experiencing homelessness face severe physical and mental health challenges.**
- **Common health conditions include asthma, liver disease and heart disease, with significantly higher prevalence rates compared to the general population.**
- **These health issues contribute to a nearly twofold higher risk of mortality and significantly reduced life expectancy compared to housed individuals.**
- **Barriers to accessing health services for people experiencing homelessness include personal, practical and relational barriers.**
- **Strategies to address barriers include embedding specialist homelessness staff in the health system and prioritising outreach approaches.**
- **The COVID-19 emergency period compounded difficulties for people experiencing homelessness to access health services, which presented client-related, organisational and administrative challenges.**

Studies conducted since the 1970s have consistently highlighted the adverse physical and mental health outcomes experienced by people experiencing homelessness (Australian Institute of Health and Welfare [AIHW] 2024a; Davies and Wood 2018; Flatau, Lester et al. 2021; Parsell, Clarke et al. 2020; Wolf and Hrast 2023). Poor health has been found to be both a driver and a consequence of homelessness (Davies and Wood 2018). Housing is thus a foundational concern for public health (Clifford, Wilson et al. 2019).

For people experiencing homelessness, meeting basic physical needs such as food, water and shelter often takes priority over health needs—which are frequently not addressed until an emergency arises (AIHW 2024a). As a result, people experiencing homelessness are overrepresented across various health inequality measures (Parsell, Clarke et al. 2020; Vallesi, Tuson et al. 2021). For example, data from participants in the Australian National Advance to Zero initiative reveal elevated rates of chronic conditions when inquiring about their medical history or diagnoses by healthcare professionals. The most common conditions reported were asthma (32.9%), liver disease (28.1%), heat stroke/exhaustion (22.4%), hepatitis C (20.6%), heart disease (18.4%), diabetes (10.4%) and emphysema (9.7%).

These rates were notably higher compared to those observed in the general population (Flatau, Lester et al. 2021). They are substantiated by international and Australian research, revealing a broad spectrum of physical illnesses among people experiencing homelessness (Onapa, Sharpley et al. 2022). These health issues encompass:

- chronic pain (Hwang 2001)
- asthma and chronic obstructive pulmonary disease (Lewer, Aldridge et al. 2019)
- heart disease (Baggett, Hwang et al. 2013; Fazel, Geddes et al. 2014)
- HIV-related illnesses (Fazel, Geddes et al. 2014).

People experiencing homelessness also face elevated risks to health through disproportionately high rates of substance misuse (Tsai 2018).

Poor physical and mental health outcomes for people experiencing homelessness contribute to significantly higher mortality rates than those in the general population. A 2020 longitudinal study by Seastres, Hutton et al. (2020) found that people experiencing homelessness in Australia face a nearly twofold higher risk of mortality over a 15-year time frame, and an approximate decrease of 12 years in the average age at death, compared to individuals who visit the emergency department but are not homeless.

When compared to the broader population, this translates to an estimated nearly fourfold increase in the risk of mortality (Onapa, Sharpley et al. 2022). People experiencing homelessness have been identified in research as having poor health prior to experiencing homelessness, and homelessness itself contributes to declining health (Parsell, Clarke et al. 2020). People experiencing homelessness are also highly likely to suffer from multi-morbidity—in other words, the coexistence of two or more chronic health conditions (Vallesi, Tuson et al. 2021).

Data from the 2022/23 AIHW Specialist Homelessness Services annual report shows that approximately 27 per cent (31,600) of SHS clients who were homeless when they first sought assistance from an SHS agency cited health-related reasons for seeking support (AIHW 2023).

People experiencing homelessness have been shown to have higher rates of healthcare service usage, particularly through emergency department (ED) presentations, which are often their first point of medical assistance (Currie, Stafford et al. 2023; Doran 2019). Studies indicate that they are more likely to seek medical treatment later in their illness, leading to acute complications with chronic conditions (Currie, Stafford et al. 2023; Moore, Gerdtz et al. 2011). Additionally, they have high rates of re-presentation, with a recent study finding that 43 per cent of homeless patients reattended an ED within 28 days (Lee, Thomas et al. 2019). This has significant capacity and cost implications for hospitals and healthcare systems (Currie, Stafford et al. 2023; Miller, Hutton et al. 2024).

2.1 Barriers to health services for people experiencing homelessness

While people experiencing homelessness have multiple complex health conditions, they typically remain disconnected from primary and preventative healthcare services and any care they access is often inconsistent and a one-off (Bennett-Daly, Maxwell et al. 2022; Davies and Wood 2018).

In their literature review concerning barriers to healthcare access for people experiencing homelessness, Davies and Wood categorised these obstacles into three distinct groups: personal, practical, and relational (Davies and Wood 2018).

Personal: People experiencing homelessness prioritise meeting their fundamental physiological needs as their primary day-to-day concern, such as access to food, water and shelter. Health needs, on the other hand, tend to receive attention only when an emergency arises (Baggett, Hwang et al. 2013; Davies and Wood 2018; Thorndike, Yetman et al. 2022).

Practical: Physical access barriers to health services include:

- limited access to transportation, or the inability to afford it (Davies and Wood 2018; Gültekin, Brush et al. 2014)
- inaccessibility for people with a disability (Thorndike, Yetman et al. 2022)
- difficulties in being contactable for appointment reminders or changes because of having no fixed address or having frequent changes of address (Davies and Wood 2018; Rizzo, Mu et al. 2022)
- challenges related to safely storing medication
- insufficient identification documents required to schedule a medical appointment (Corrigan, Pickett et al. 2015; Davies and Wood 2018).

Relational: Relational barriers can include:

- stigma associated with seeking assistance for mental health and substance abuse issues (Bungay 2013; Corrigan, Pickett et al. 2015; Davies and Wood 2018; Gültekin, Brush et al. 2014; Liu and Hwang 2021)
- previous poor experiences with health providers (Corrigan, Pickett et al. 2015; Liu and Hwang 2021; Purkey and Mackenzie 2019; Thorndike, Yetman et al. 2022)
- the disparity of social status of health professionals compared to people experiencing homelessness—which can lead to people experiencing homelessness feeling inadequate, irrespective of the well-meaning intentions of the healthcare practitioner (Corrigan, Pickett et al. 2015; Davies and Wood 2018).

In their systematic review of homelessness healthcare, Omerov, Craftman et al. (2020) also identified structural and organisational aspects to unmet health needs for people experiencing homelessness, with barriers including:

- the fragmentation of healthcare systems, with various health services having little interface with other services (Corrigan, Pickett et al. 2015)
- the inaccessibility of services because of locations or clinic hours (Kertesz, McNeil et al. 2014).

Specifically addressing the health needs of people experiencing homelessness in regional areas, Bennett-Daly, Maxwell et al. (2022) highlight the difficulties in these areas of accessing GPs that bulk bill—that is, provide free healthcare—or who were willing to take on new clients.

2.2 Barriers to accessing health services during COVID-19

The literature review identified that many barriers to accessing health services for people experiencing homelessness were exacerbated during the COVID-19 pandemic. Several studies highlighted the challenges in securing reliable and safe public health services during this period (Aronowitz, Engel-Rebitzer et al. 2021; Rodriguez, Martinez et al. 2022). These barriers encompassed individual, organisational and administrative challenges, all of which hindered the effective delivery of public health services (Aronowitz, Engel-Rebitzer et al. 2021; Rodriguez, Martinez et al. 2022).

Further, the loss of face-to-face interactions with service delivery and case workers led to increased feelings of disconnection from usual support networks (O'Brien and Rawlings 2020).

Additionally, the inaccessibility of services due to their locations was worsened during COVID-19, as transportation issues had a significant impact on service delivery and operations (Aronowitz, Engel-Rebitzer et al. 2021; Batko, DuBois et al. 2021).

2.3 Improving the accessibility of health services for people experiencing homelessness

Extensive research has been conducted on strategies to improve access to and provide appropriate care for people experiencing homelessness (Bennett-Daly, Maxwell et al. 2022; Davies and Wood 2018; Keogh, O'Brien et al. 2015).

Since emergency departments (EDs) are often the first point of contact with the healthcare system for people experiencing homelessness, considerable research has been conducted into their potential to improve healthcare access and outcomes for this population (Currie, Stafford et al. 2023; Jelinek, Jiwa et al. 2008; Lee, Thomas et al. 2019).

Currie, Stafford et al. (2023) propose four strategies that emergency departments could adopt to enhance their response to homelessness:

1. Improving the triage and waiting environment
2. Identifying homelessness among patients
3. Linking patients to other supports within the hospital and to housing, support and primary care services in the community
4. Incorporating considerations for discharge planning.

Recognising the necessity of treatment options before hospital settings, Davies and Wood (2018) propose core components of a best practice model to improve health outcomes for people experiencing homelessness. This includes recognising that addressing homelessness is an important form of healthcare, not a separate 'non-health' issue. (Davies and Wood 2018; Stafford and Wood 2017).

This model also includes ensuring continuity of care, which involves trained specialist homelessness services staff working across as much of the healthcare system as possible (Davies and Wood 2018). Additional research supports this approach, focussing on the potential role of homelessness services as 'healthcare navigators', where these services coordinate care and facilitate clients' access to health services (Robinson, Trevors Babici et al. 2023).

Davies and Wood's (2018) research supports general health services specialising in addressing homelessness, emphasising strong connections with the homelessness sector. This is reinforced by Strange, Fisher et al. (2018), who evaluated the Freo Street Doctor service—a mobile, open-access general practice aimed at enhancing primary healthcare for homeless and marginalised populations in Fremantle, Western Australia. Their evaluation highlighted the service's crucial role in improving healthcare access for these individuals within the broader healthcare system.

Similarly, a 2019 Melbourne study by Goeman, Howard et al. demonstrated significant benefits from implementing a Community Health Nurse model for individuals at risk of or experiencing homelessness. This model increased client engagement with health services, community resources and social activities, and enhanced care delivery by collaborating with other service providers (Goeman, Howard et al. 2019)

Davies and Wood also promote the use of outreach services to enable health services to be delivered in locations already accessed by people experiencing homelessness (Davies and Wood 2018). Outreach models of health services for people experiencing homelessness have received considerable support from research at both national and international level (Bennett-Daly, Maxwell et al. 2022; Keogh, O'Brien et al. 2015; Roche, Duffield et al. 2018).

Additional components of Davies and Wood's (2018) model include hospital inreach, improved discharge planning, and coordinated care. These elements are designed to ensure a smoother transition for individuals experiencing homelessness as they move between hospital and community settings. Furthermore, Bennett-Daly, Maxwell et al. (2022) identify increasing access to general practitioners (GPs) who offer bulk-billing services and longer consultation times as a key strategy for enhancing healthcare for people experiencing homelessness.

2.4 Collaboration between health and homelessness services

The literature review reveals a significant research gap concerning collaborations between homelessness services and health agencies. While existing research has extensively documented the health challenges faced by people experiencing homelessness (Flatau, Lester et al. 2021) and the need for health involvement (Fransham and Dorling 2018; Sleet and Francescutti 2021), there is limited exploration of how enhanced collaboration between these sectors could improve health outcomes. Moreover, the mechanisms for fostering such collaboration remain understudied. However, the available literature highlights key elements crucial for effective collaboration between health and homelessness services, including shared goals, shared resources, shared authority, a whole-system approach, effective communication and building adaptive capacity.

Shared goals: When partner organisations are able to develop shared goals, it ensures mutual understanding of the issue, and the approach to collaboration to be followed—and it helps to develop a shared understanding of the challenges involved (Campbell and Vainio-Mattila 2003). The development of a shared goal between homelessness and health services as an enabler to delivering public health responses was highlighted in a 2022 study by Currie, Hollingdrake et al. that reviewed a COVID-19 vaccination hub. As the vaccination hub was established to provide health services to people experiencing homelessness following the commencement of COVID-19, the study described the necessity of the collaboration 'joining forces around a common goal' (Currie, Hollingdrake et al. 2022:10) to deliver health outcomes to people experiencing homelessness.

Shared resources: Collaborative efforts are strengthened by the availability of adequate and consistent funding (Emerson, Nabatchi et al. 2012), as well as through the pooling of skills, professional knowledge, and the integration of data systems (Kania and Kramer 2011). Literature on health and homelessness services collaborations highlighted the importance of shared knowledge. A United States study found that partnership between homelessness services and local health services during COVID-19 ensured a consistent and reliable flow of current information, guidance and the provision of available resources—including testing, vaccinations and personal protective equipment (PPE) (Rodriguez, Ziolkowski et al. 2023). Additional studies found that information from health agencies (such as COVID-19 case trends, updated advice in reducing transmission) was shared through hosting webinars or debriefing sessions with homelessness service staff (Currie, Hollingdrake et al. 2022; Mosites, Harrison et al. 2022) which helped to ensure appropriate information was made available to stakeholders.

Australian studies of public health and homelessness collaborations emphasised the importance of shared resources across homelessness and health services to ensure better outcomes for people experiencing homelessness (Currie, Hollingdrake et al. 2022; Smith, Graham et al. 2020). These shared resources include healthcare staff, consent forms, information and a common approach to messaging the health issue (Currie, Hollingdrake et al. 2022).

Shared authority: The literature review revealed several instances where shared authority was a key feature in collaborations between public health agencies and homelessness services. Studies from the United States—such as the 2022 research by Mosites, Harrison et al. on Minnesota's COVID-19 response—highlight the importance of a shared understanding of roles, authority and capacity among participating agencies. Similarly, the Boston Healthcare for the Homeless program demonstrates the effectiveness of a centralised command centre for decision-making and resource distribution (Baggett, Racine et al. 2020). DiPietro's (2021) United States study further emphasises the need for leadership buy-in and executive support to facilitate resource and policy adjustments. Australian research also underscores the significance of shared authority in successful collaborations. The Inner City COVID-19 Vaccine Hub study revealed that stakeholders praised the collaboration for effectively utilising the skills and resources of all partner organisations. The study noted that shared decision-making prevailed, with an absence of egos, and every role within the collaboration was considered significant (Currie, Hollingdrake et al. 2022).

Whole-system engagement: Studies on collaborations between homelessness services and public health agencies during the COVID-19 pandemic highlight the importance of whole-system engagement. A United States study on COVID-19 protocols in congregate shelters found that close collaboration between interdisciplinary clinical and public health teams, shelter leaders, community experts (including those with lived experience of homelessness), and city agencies was critical for implementing crucial public health interventions (Scott, Rowan et al. 2022). Similarly, research on the Minnesota Department of Health's response emphasised the significance of multi-agency partnerships operating both:

- horizontally—among various agencies within the same level of government
- vertically—involving collaboration among local, state and federal government entities, community-based organisations and health departments (Mosites, Harrison et al. 2022).

Such horizontal and vertical partnerships were necessary to address complex challenges within the homeless population (Mosites, Harrison et al. 2022).

Australian research on the Victorian Eastern Homelessness Emergency Accommodation Response Team (HEART) demonstrated the effectiveness of leveraging regional relationships with various health agencies. This collaboration established referral pathways for individuals in temporary accommodation during the pandemic, successfully addressing barriers to accessing services created by COVID-19 protections and providing tailored support to people experiencing homelessness (Smith, Graham et al. 2020).

Effective communication: The literature review confirms that clear and transparent communication is a crucial component of successful collaborations between homelessness and health services (Zufferey, Skovdal et al. 2022). The Boston Healthcare for the Homeless program study highlights the effectiveness of internal communication between leadership and frontline staff, which fostered a shared sense of purpose and provided essential emotional support during COVID-19. The leadership's transparent communication, including daily organisation-wide updates via online platforms, was particularly noteworthy (Baggett, Racine et al. 2020).

Similarly, the Inner City COVID-19 Vaccine Hub study attributes the success of the Sydney program to clear and direct communication lines between decision-makers across all partner organisations (Currie, Hollingdrake et al. 2022). Further research emphasises the importance of regular communication in building trust and rapport with homeless clients and homelessness service staff. Weekly discussions and informal drop-in sessions involving homelessness services and local health departments were found to be key in preventing misinformation and panic (Rodriguez, Ziolkowski et al. 2023).

Building adaptive capacity: Studies on collaborations between homelessness services and health services—particularly during the COVID-19 pandemic—highlight the importance of building adaptive capacity. Adaptive capacity, along with learning and process refinement, are identified as key characteristics of successful collaborations (Salignac, Marjolin et al. 2019).

These elements allow partnerships to respond effectively to complex and evolving challenges. Examples of adaptive capacity in action include the Temporary Medical Respite Shelter program in the USA, which implemented a hybrid model combining onsite healthcare with telehealth to address clients' complex needs (Wang, Palma et al. 2021). Similarly, in Copenhagen, a mobile test unit was introduced to travel to shelters, demonstrating a tailored response strategy that recognised and adapted to the unique circumstances of individuals experiencing homelessness (Zufferey, Skovdal et al. 2022). This approach was also seen in Sydney, Australia, with the Inner City COVID-19 Vaccine Hub (Currie, Hollingdrake et al. 2022).

2.5 Conclusion

The persistent and severe health disparities experienced by people facing homelessness underscore the urgent need for a paradigm shift in addressing their health outcomes. Traditional approaches have often treated homelessness and health issues as separate entities, leading to fragmented care and inadequate support. However, evidence indicates that housing stability is a fundamental determinant of health, and integrating housing solutions with healthcare services is essential for improving health outcomes among this population.

3. New South Wales case study

- **Before COVID-19, strong collaboration existed between health and SHS sectors in some parts of the state, laying a crucial foundation for the pandemic response.**
- **Central to responses in this period was formation of the Sydney Rough Sleeping COVID-19 Taskforce. The Taskforce included government agencies, health services, NGOs and peak bodies in inner Sydney, coordinating efforts to provide safe accommodation and deliver essential health services.**
- **The COVID-19 emergency period highlighted the need to integrate health services into homelessness support frameworks, enabling COVID-19 testing, vaccination clinics, and ongoing healthcare for vulnerable populations in temporary shelters.**

3.1 Introduction: pre-COVID-19 collaboration

The responses of health and other agencies to COVID-19 in inner-city Sydney were strongly influenced by the presence of existing strategies for housing and supporting people sleeping rough.

Prior to the pandemic, rough sleeping in inner-city Sydney was increasingly visible, as reflected in the 2016 ABS Census data, which reported a 37.3 per cent increase in rough sleeping in New South Wales since 2011, compared to a national increase of 13.7 per cent (ABS 2018). In response to this rise, the Department of Communities and Justice (DCJ) and partner agencies had implemented coordinated outreach mechanisms to provide temporary accommodation and support to individuals sleeping rough in inner-city Sydney.

Recognising the significance of assertive outreach, DCJ established the Homelessness Outreach Support Team (HOST) in June 2017. HOST, a team of DCJ workers, is responsible for delivering outreach services to rough sleepers in inner-city Sydney. HOST conducts assertive outreach independently and in collaboration with multi-agency groups through the Homelessness Assertive Outreach Response Team (HART). HART, led by the City of Sydney and DCJ, includes representatives from specialist homelessness services as well as Neami National (City of Sydney 2020). Another vital element was targeted homelessness outreach workers at St Vincent's Homeless Health.

A critical aspect of HART's work is the expedited placement of clients into temporary accommodation before transitioning them into long-term social housing with comprehensive support, including health assistance (Homelessness NSW 2019). St Vincent's Homeless Health's role in HART included providing health support, supporting agencies, and improving access to healthcare for those sleeping rough. This involved direct health assessments, interventions, and referrals, as well as indirect health consultations and advice to the agencies involved (Longbottom 2020).

Also emerging in the pre-pandemic period was the *Intersectoral Homelessness Health Strategy 2020–2025*. The Strategy was jointly developed by the City of Sydney, DCJ, the South-Eastern Sydney Local Health District (SESLHD), the Sydney Local Health District (SLHD) and the St Vincent's Health Network. The Strategy identified joint service priorities for improving health outcomes for people experiencing homelessness, including improving access to care, strengthening prevention and establishing collaborative governance and shared planning (NSW Government 2020).

Another key initiative in place prior to the pandemic was the work of the SESLHD Homelessness Health Program. Under the program, SESLHD workers developed and ran a series of training program for GPs and hospital services in inner-city Sydney, on the health needs of individuals experiencing homelessness (MacFarlane 2020). One interview participant noted:

> *We developed a training module around identifying, addressing and responding to homelessness, particularly in a health context. It was designed to help health services understand the barriers that individuals experiencing homelessness might face in maintaining their health and how we, as health services, can better tailor our interventions. (NSW interview 09)*

These initiatives fostered high levels of collaboration and engagement between health agencies, DCJ, local government and the SHS sector. An interview participant described this collaboration:

> *We've always had strong relationships in the inner city with agencies that work with people who sleep rough and those in crisis and temporary accommodation. These relationships enabled us to enhance our efforts during COVID. (NSW interview 09)*

This comprehensive pre-pandemic framework laid a strong foundation for the public health and government response to the COVID-19 emergency in inner Sydney.

3.2 Emergence of COVID-19

3.2.1 New South Wales COVID-19 policy response

NSW Health confirmed the first recorded cases of COVID-19 in New South Wales on 25 January 2020 (NSW Health 2020). On 2 March 2020, the first person-to-person transmission of COVID-19 occurred (NSW Audit Office 2021).

On 17 March 2020, the New South Wales Government announced a $250 million stimulus package focussed on protecting jobs lost as a result of the pandemic. From this stimulus package, DCJ was allocated $6m to fund the cleaning of over 215 crisis refuges and congregate care facilities (NSW DCJ 2020).

On 23 March 2020, the New South Wales Government increased restrictions, temporarily shutting down *'non-essential activities and businesses'* (NSW Government 2020). However, SHS were deemed essential services, and were not subject to temporary closure (Hartley, Barnes et al. 2021).

3.2.2 Early public health initiatives and collaboration with SHS

Following the emergence of COVID-19 in New South Wales, NSW SESLHD and St Vincent's Health Network initiated webinars with the SHS sector to focus on COVID-safe practices. These webinars addressed risk factors, COVID-19 symptoms, PPE questions and other infection-control measures. Additionally, SESLHD began distributing the *Coronavirus (COVID-19) Bulletin* to SHS providers within the SESLHD/SLHD geographic area to keep them informed about key developments and information regarding COVID-19. Early editions of the *Bulletin* included guidelines for managing the spread of COVID-19, which were initially developed by the Department of Health for aged care and disability settings (Hartley, Barnes et al. 2021). Key agencies, including the Intersectoral Homelessness Health Senior Collaborative Alliance, later agreed that the *Bulletin* would serve as the primary communication tool for the SHS sector regarding COVID-19 updates (Hartley, Barnes et al. 2021).

Central to the efforts to house and support people who were sleeping rough and in congregate care was the establishment of the Sydney Rough Sleeping COVID-19 Taskforce (the Taskforce) on 30 March 2020 (Hartley, Barnes et al. 2021). Participants interviewed for this project emphasised the pivotal role of health services in the development of the Taskforce:

> *We were looking at what was going on in the UK where they set up a taskforce, and so we advocated to DCJ that they replicate the model (NSW interview 06).*

The Taskforce was established by DCJ, with other members including the SLHD, SESLHD, St Vincent's Hospital Network, City of Sydney Council, NSW Police, community housing providers, SHS providers (Neami National, Mission Australia, The Salvation Army, Wesley Mission, St Vincent de Paul Society, The Haymarket Foundation), and peak bodies (Homelessness NSW, Domestic Violence NSW, Yfoundations, Public Interest Advocacy Centre). Lived experience representation on the Taskforce was coordinated by Neami National (Hartley, Barnes et al. 2021).

Figure 1: Sydney Rough Sleeping COVID-19 Taskforce structure

NSW Government (other than health)	Health	SHSs		Peak Bodies/ NGOs
Sydney, South Eastern Sydney and Northern Sydney (SSESNS) District of the Department of Communities and Justice	Central and Eastern Sydney Primary Health Network	Innari Housing (Aboriginal Controlled SHS)	Mission Australia	Homelessness NSW
NSW Police Force	Sydney Local Health District	The Salvation Army	The Haymarket Foundation (SHS)	YFoundation
Minister's Office	St Vincent's Hospital Network	NEAMI National	The Wayside Chapel	End Street Sleeping Collaboration
	South Eastern Sydney Local Health District	Launchpad Youth Community (Inner city SHS)	Wesley Mission	Public Interest Advocacy Centre
Local Government		St Vincent de Paul		
City of Sydney				

Source: Hartley, Barnes et al. (2021).

An interview participant described the Taskforce as:

> *the beginning of what became quite a large-scale and quite a collaborative and multifaceted approach to addressing COVID in people at risk of experiencing homelessness (NSW interview 05).*

The Taskforce's role was to coordinate the engagement of people experiencing homelessness and move them into accommodation with health and welfare support (NSW Government 2020). To facilitate this, the Taskforce established working groups overseeing different components of support for those in temporary accommodation, including:

- outreach
- support and care coordination
- food security
- accommodation exits
- accessing NDIS
- working with Aboriginal people (Hartley, Barnes et al. 2021).

As noted in the New South Wales Auditor-General's Report to Parliament, *Responses to Homelessness* (NSW Audit Office 2021), the Taskforce's working groups facilitated collective efforts to better support people in temporary accommodation (NSW Audit Office 2021). Specifically, public health agencies played a significant role on the Taskforce by supporting twice-weekly assertive outreach efforts through HART, which helped move people into temporary accommodation and ensured they received appropriate support and health services (Hartley, Barnes et al. 2021).

Public health services also supported those already residing in temporary accommodation. Starting in April 2020, the Taskforce initiated 'pop-ups' in the hotel foyers of seven inner-city hotels used for temporary accommodation to coordinate housing assessments and support services for people experiencing homelessness (NSW Audit Office 2021). These pop-ups provided a range of health assistance, including COVID screening, health assessments, referrals to health services, and case management. As an interview participant for the project detailed:

> *One of the advantages of accommodating our rough sleepers during that time was the opportunity to provide health services. We could send in an outreach team who were able to provide primary healthcare and identify and support some of those chronic needs, or identify a particular condition that needed follow-up (NSW interview 04).*

Other early efforts of public health agencies during this period included collaborating with DCJ on its Guidelines for *Homelessness Accommodation and COVID-19*. These guidelines were produced in consultation with NSW Health and the homelessness peak bodies, and provided tools and techniques to help manage homelessness accommodation sites for adults and young people during the COVID-19 pandemic (NSW DCJ 2020).

3.2.3 Later collaboration: vaccination

As noted earlier, as the pandemic progressed and awareness increased about the airborne transmission of COVID-19 (rather than droplet transmission), the public health focus shifted from social distancing and cleaning services to ensuring appropriate access to personal protective equipment (PPE), such as masks (McCosker, El-Heneidy et al. 2022; Nouri, Ostadtaghizadeh et al. 2022). As with previous efforts, the mobilisation of delivery of masks was coordinated by members of the Taskforce, with the City of Sydney and St Vincent's Homeless Health's efforts particularly highlighted by interviewees. As one interview participant recalled:

> *I remember doing a late-night drop-off of masks and other PPE to homeless services and to rough sleepers. Sometimes I would be up at night worrying about whether we had done all that we could to prevent outbreaks; it really was an incredible team effort driven by a strong desire to protect people experiencing homelessness (NSW interview 06).*

With the COVID-19 vaccine rollout beginning in Australia in February and March 2021, attention shifted towards ensuring that as many people experiencing homelessness as possible had access to vaccination. Taskforce stakeholders such as DCJ, the City of Sydney, SESLHD, St Vincent's Health Network and SHS, and community agencies such as Kirketon Road Centre, Matthew Talbot Primary Health Clinic and St Vincent de Paul Society NSW partnered to establish and support a mass vaccination clinic at St Vincent de Paul Society's Ozanam Learning Centre—a community centre located next to the Matthew Talbot Hostel, Woolloomooloo (Currie, Hollingdrake et al. 2022; St Vincent's Hospital Sydney 2021).

The Inner City COVID-19 Vaccine Hub, established in May 2021, featured a diverse team delivering vaccinations to people experiencing homelessness (Currie, Hollingdrake et al. 2022; St Vincent's Hospital Sydney 2021). This team included registered nurses who administered the vaccines, and a general practitioner who provided vaccine information, assisted with consent forms, and managed any potential adverse reactions. Peer support workers and Aboriginal health workers ensured a culturally appropriate environment. Administrative staff handled patient attendance, collated consent forms, and conducted follow-ups via texts and calls during the week. Taskforce members were also present to offer support with housing and access to social services (St Vincent's Hospital Sydney 2021).

The first Vaccine Hub was held on Thursday, 20 May 2021, at the Ozanam Learning Centre and originally operated weekly. By mid-September 2021, over 5,000 people had been vaccinated against COVID-19 through the Hub (Currie, Hollingdrake et al. 2022.). Initially provided at a fixed location, the Vaccine Hub evolved to include outreach services, offering transport to the Vaccine Hub or providing vaccinations at residences or other locations (Currie, Hollingdrake et al. 2022; Hollingdrake, Grech et al. 2024).

Previous reports into the operation of the Vaccine Hub have highlighted it as an:

> *exemplar of teamwork, with multiple organisations combining forces towards a shared goal of protecting some of our most vulnerable members of the community (Currie, Hollingdrake et al. 2022:15).*

Participants interviewed for this project from health, government and the SHS sector shared this perspective and highlighted the Vaccine Hub as one of the key achievements of the collaboration during the COVID-19 emergency period. As one health interviewee detailed:

> *We all came together once a week for several hours and jabbed and jabbed and jabbed. And the uptake of vaccination in that population, I think at some point they were probably the most vaccinated population in the inner city (NSW interview 05).*

As noted earlier, the Vaccine Hub evolved to include outreach services, and other vaccination clinics were established in other SHS sectors and social housing communities. An interview participant emphasised the efficiency in setting up and running these mass vaccination clinics, attributing it to the strengths of pre-existing relationships:

> *There was no fanfare about it. It was just done … Existing relationships meant we were able to coordinate it quite quickly because we've done similar responses during heatwaves for emergency weather. We've already got that sort of framework (NSW interview 09).*

Another participant noted:

> *There were not many people who didn't turn up for their second vaccination, and where possible, we had outreach teams and relationships where we could go out and get people to come in. So, yeah, that was hugely significant, and I think a real win for people and for the sector. I think it was sort of the good news story we all needed, really (NSW interview 05).*

3.2.4 Regional collaboration

While this case study has predominantly focussed on inner-city Sydney, several qualitative interviews were conducted in regional New South Wales to assess the levels of collaboration between public health agencies and the SHS sector outside inner-city Sydney.

Regional interview participants spoke highly of the individual efforts of DCJ and health agencies, but indicated that the high levels of collaboration evident in inner-city Sydney were not seen in regional areas. One interview participant reflected:

> *I think DCJ and [the Health Department] have historically done a really poor job kind of connecting. They're quite separate. So again, even though there's very much a recognition of the fact that homelessness is a health issue and the intersection is there, there was very little formal engagement (NSW interview 08).*

> *I would've hoped that through COVID we would have a closer relationship with NSW Health and therefore been able to have someone to pick up the phone and go, 'Oh yeah, we're looking at doing this thing. Who's the best person to talk to?' But we don't have those kinds of direct contacts (NSW interview 08).*

The lack of these relationships and direct contacts meant that the SHS sector was often unaware of key public health information on how to best support their clients. One interview participant shared their experience:

> *We were trying to guide the organisation about: 'Should we be mandating staff to have vaccinations? How many vaccinations would they need? What do we do about vaccination of the women and children in the services?' All those kinds of things. And the guidance wasn't clear (NSW interview 08).*

This lack of clear guidance and formal engagement between public health agencies and the SHS sector in regional New South Wales highlighted a significant disparity in the collaborative efforts compared to inner-city Sydney. This disparity affected the ability of regional SHS providers to effectively navigate the public health challenges posed by the COVID-19 pandemic.

3.3 Barriers and enablers in the delivery of public health response

3.3.1 Barriers

Insufficient resourcing

Interview participants identified a lack of resourcing as a key barrier to effective collaboration. One interview participant noted:

> *[The Taskforce] was effective, but it was nowhere near what actually the resources that were needed. So, it was not as effective as it could be (NSW interview 09).*

Another interview participant confirmed:

> *But goodness, we could have done more if there had been more people on the ground (NSW interview 04).*

Interview participants were concerned that there would be a 'balancing of the books' where successful aspects of the Taskforce's collaboration could be reduced or dismantled despite their proven effectiveness.

Some continued siloing

Some interview participants noted the persistence of silos despite the collaborative efforts. One interview participant described the challenge:

> *There were a few barriers during that time because people had to work in a different way and sometimes people didn't like that. They had to step out of their lane (NSW interview 04).*

3.3.2 Enablers

Pre-existing relationships

A strong enabler in the delivery of the health response to people experiencing homelessness during the COVID-19 emergency period was the pre-existing relationships between health services, DCJ, SHS and local government groups. One interview participant detailed:

> *We really had some of that incredible coordination, incredible collaborative approach, which had basically been up and going since 2017 … But this was hard won … and getting to that point of trust in those relationships took time (NSW interview 01).*

Another interview participant emphasised the importance of these relationships:

> *I think because we had them pre-established, it made it a lot easier. There were a lot of side conversations. But because you already have those relationships, you could be quite candid and open (NSW interview 09).*

Proactive and engaged health services

All participants highlighted the unique role of the South-Eastern Sydney Local Health District (SESLHD) and the homelessness outreach workers from St Vincent's Hospital Network. The services, which pre-dated COVID and supported the delivery of a range of health services to people experiencing homelessness, were crucial in helping to drive the public health responses of vaccination and transmission-risk management during this period. As one interview participant noted:

> *These services are unique to the inner city, and their dedication and passion drives improved access to healthcare for those who are homeless—both before, during and after the pandemic. These services are unique—but shouldn't be (NSW interview 06).*

An authorising environment

All interview participants highlighted the flexibility of DCJ and NSW Health as key to achieving successful outcomes during the COVID-19 emergency. One interview participant explained that the COVID-19 period enabled them to:

> *step outside our operational boundaries, the things we normally do, and [show] willingness to do something different, to problem-solve (NSW interview 03).*

Another interview participant also emphasised the importance of high-level support:

> *Structural factors such as executive buy-in by Health and also DCJ … had an impact in terms of making sure that the yeses were lined up when the yeses needed to be lined up to progress things. And that allowed for agile collaboration (NSW interview 04).*

> *It allowed us to go, 'Oh, wait a minute, the computer doesn't say no,' because you had to have workaround solutions in the middle of a pandemic for someone who is experiencing homelessness (NSW interview 04).*

Communication

Interview participants highlighted that the establishment of the Taskforce facilitated effective communication between all parties. One interview participant detailed:

> *The Taskforce provided communication and coordination mechanisms to identify and, importantly, address and then escalate, which was the really critical part of its success (NSW interview 04).*

Another interview participant confirmed the effectiveness of communication within the Taskforce:

> *It was like there was amazing communication. We knew exactly what was happening all the time from their perspective, and they knew from ours (NSW interview 06).*

Shared ways of working

The capacity to change practices, to ensure that agencies could work together, was another key enabler of the Taskforce's success. As one interview participant noted:

> *We had shared ways of working. So, we've all got our different cultures, we've all got our different ways of working. But during the pandemic—and this is something that I've been striving to make sure continues—is that shared ways of working [were adopted] (NSW interview 04).*

Working within a collaborative and trauma-informed framework

Interview participants emphasised that operating within person-centred, trauma-informed and collaborative care frameworks was crucial for the success of health efforts during the COVID-19 emergency. Specifically, for the Vaccine Hub, interview participants highlighted the importance of expertise in identifying and responding to trauma to avoid re-traumatisation, which contributed to high vaccine uptake and return rates for second doses. Additionally, it was vital that the Taskforce acknowledged the interdependency between health and housing services and considered the broader context of individuals' lives.

3.4 What was learned through increased interaction

Further linkages established between SHS and public health agencies

Both NSW Health and SHS interview participants identified a key lesson learned as the increased understanding of each other's roles and the identification of key stakeholders. As one interview participant from NSW Health detailed:

> *It opened up a dialogue, and homelessness services knew who was who in the health zoo … it helped strengthen our relationship with the public health because we really relied on them for up-to-date information (NSW interview 05).*

> *I think what it did was help the homelessness services have a better understanding of the health system and what parts of the health system interact with each other. I think what was interesting was, afterwards, quite a lot of additional services popped up and started providing health services (NSW interview 05).*

However, one interview participant highlighted the need for further training in this area:

> *It's not easy for people that work in the system, let alone if you're outside it. So, I think providing education and training to support homelessness services to identify key health issues and pathways to care that are locally designed is probably one way that health and homelessness services could work together (NSW interview 05).*

Further collaboration on emergency processes

Interview participants identified that the collaborations forged during the COVID-19 emergency period laid the groundwork for further collaboration on emergency protocols for people sleeping rough. This includes protocols not only for pandemics but also for other extreme conditions such as heat events. The joint efforts during the pandemic helped to establish strong, reliable partnerships that could be mobilised for other emergencies.

One interview participant highlighted the effectiveness of these partnerships:

> *Then there are new projects. We'd often go to those key partners within those health districts to say, 'This is a good idea. Let's do this.' It's a lot stronger, and I think it's that shared trauma … really strong partnership that came out of it (NSW interview 09).*

Greater recognition of the role of health in responses to homelessness

Interview participants from both SHS and NSW Health indicated that increased collaboration with public health agencies led to a greater awareness of the critical role health plays in responses to homelessness. This collaborative effort highlighted the necessity of integrating health services into the support framework for individuals transitioning from homelessness to temporary and permanent housing.

One interview participant specifically noted the importance of health services in providing essential support during the housing process:

> *COVID showed us that when you do that sort of triage work at that point of entry into the system, you're actually able to hold people and support people for as long as they need. And that's the other thing—for as long as they need. For some people, that won't be very long. And for some people, it will be (NSW interview 01).*

3.5 Policy implications

There are several policy implications from the successful collaboration between public health services, SHS and government agencies in inner-city Sydney during the COVID-19 emergency.

Outreach models to enhance access to health services

Clinicians from SESLHD and homelessness outreach workers from St Vincent's Hospital Network played a crucial role in driving public health responses during this period. Their contributions exemplify the best practices outlined by Davies and Wood (2018) for enhancing health outcomes for people experiencing homelessness—especially through specialised general practice and outreach services. Interview participants highlighted that initiatives like HART and the Inner City COVID-19 Vaccine Hub effectively addressed traditional barriers to accessing health services for this population. They underscored the importance of outreach-focussed models that are trusted and accessible to people experiencing homelessness.

The success of these initiatives underscores the potential to expand and support the establishment of proactive and outreach-focussed health agencies like those in SESLHD and St Vincent's Hospital Network across other regions. However, it's important to acknowledge that the dynamics in inner-city Sydney differ significantly from regional and other areas of Sydney. The concentration of services in inner-city areas is a result of longstanding issues with rough sleeping and infrastructure. Regional areas in particular often face shortages in various health services, which could pose challenges in replicating a homelessness outreach service similar to that of inner Sydney. Implementing such services in regional areas may require tailored approaches that consider local contexts, resources and infrastructure limitations.

Adopting trauma-informed and person-centred frameworks

In addition to its outreach focus, interview participants highlighted that the success of health engagement and collaboration was largely due to implementing a trauma-informed approach. This approach ensured that services were delivered in a way that recognised and addressed trauma, thereby avoiding re-traumatisation, and enhancing engagement and outcomes. Interview participants also emphasised the importance of person-centred care for future homelessness health collaborations, noting that tailoring services to the individual needs and circumstances of those being served is crucial.

Programs or resources to facilitate collaboration between health services, housing agencies and SHS

As outlined earlier, the Taskforce demonstrated a highly effective collaboration that successfully provided housing and health services to people sleeping rough in inner-city Sydney during the COVID-19 pandemic. Key factors contributing to this success included:

- a supportive environment
- flexibility
- effective communication
- a shared approach to working.

An essential aspect of this collaboration was the recognition of the interdependency between housing and health services, which was critical for addressing the complex needs of people experiencing homelessness comprehensively. The Taskforce model during the pandemic emphasised delivering both health and social care in a manner that considered the broader context of the lives of people experiencing homelessness.

Interview participants involved in this research identified these factors as essential not only during 'emergencies' but also as ongoing necessities, recognising that homelessness itself constitutes an ongoing emergency that requires flexible and collaborative approaches to address.

The need to develop effective collaborations between government, public health and SHS in other groups experiencing homelessness

While this case study focuses on responses to rough sleepers, who receive substantial attention and resources because of their high visibility, it is crucial to acknowledge the need for similar services for other groups experiencing homelessness. People in precarious or unstable housing situations—including those couch surfing—often face greater challenges in receiving support and are historically under-recognised. When considering future responses and potential collaborations between government, public health and SHS it is important to ensure these groups are also considered.

4. Victorian case study

- **Pre-existing partnerships between SHS and health services, such as inreach health services at various SHS sites, were foundational in providing rapid, coordinated support for people experiencing homelessness when COVID emerged.**
- **Additional key enablers included an expedited decision-making environment, rapid emergency funding allocation and involvement of local community health providers.**
- **Barriers to the COVID-19 response included misunderstandings due to differing language and practices between health and homelessness services, privacy concerns in information-sharing, and resource limitations in regional areas. All of these hindered effective collaboration and service delivery.**

4.1 Introduction: the pre-COVID context in Victoria

When the COVID-19 pandemic emerged in Victoria, the government response relied heavily on existing human-services infrastructure and relationships to respond to people experiencing homelessness. Below we describe some of this infrastructure.

In Victoria, people experiencing or at risk of homelessness access SHS through centralised access points. Access points are spread across the state with at least one in every department region, with some additional specialist access points for youth, women and Indigenous people. Intake assessment and planning workers serve as the initial contact point, providing emergency accommodation using Housing Establishment Funds (HEFs) and referring individuals to additional services and housing vacancies in the SHS system. However, those sleeping rough can sometimes access crisis accommodation directly through their outreach worker.

Each Department of Families, Fairness and Housing (DFFH) region has a Local Area Service Network (LASN) that coordinates the SHS sector to enhance planning and service delivery. Each LASN has a dedicated Homeless Networker who is responsible for coordinating the LASN, including:

- organising monthly LASN meetings
- mapping local homelessness resources
- managing a small budget to support the activities of the LASN.

These roles are funded directly by the DFFH but are auspiced by an SHS agency within that given region. Furthermore, a resource register exists across the state where access to case management places, crisis accommodation, transitional housing, and permanent supportive housing is organised and allocated. However, the specific way vacancies are prioritised varies across the regions.

The DFFH publishes services guidelines and conditions of funding to ensure minimum standards and consistency in service provision across the state (Department of Health and Human Services [DHHS] 2015; Homes Victoria 2021). These guidelines provide policy context and links to relevant policies that should be read in conjunction with the DFFH human services standards (DFFH 2024). Prior to COVID-19, the 2014 services guidelines and conditions of funding were in effect (DHHS 2015). During COVID-19, these guidelines underwent several updates to include:

- expectations of SHS agencies to develop COVID-safe plans and business continuity plans
- training in infection control for staff
- priority allocation of existing resources so that staff could be redeployed to the highest priority programs (often supporting people in hotels) throughout the pandemic (DHHS 2020a; Homes Victoria 2021).[1]

Victoria has a strong history of assertive outreach programs for people sleeping rough, which was expanded in the years leading up to the COVID-19 pandemic. In early 2017, the Victorian Government released *Victoria's homelessness and rough sleeping action plan*, a two-year emergency funding package to help address increasing levels of rough sleeping in inner Melbourne (Victorian Government 2018). A rough sleeping strategy was developed, followed by a rough sleeping action plan (Victorian Government 2018). This plan increased funding to the existing Melbourne Street to Home program (MS2H) and Rough Sleeper Initiative (RSI) and expanded assertive outreach programs into other inner city, suburban and regional local government areas. These rough sleeper assertive outreach programs have continued into the present with many programs in Greater Melbourne now connected through the Melbourne Zero project (Launch Housing 2024a).

Pre-COVID relationships between SHS and health services

In addition to assertive outreach programs, prior to COVID there were also established relationships between SHS and health services. In acknowledgement of the significant health needs of people experiencing homelessness, several large SHS crisis and supported accommodation services had set up inreach services where primary and allied health services visited their services at regular set times. For example:

- Launch Housing's Southbank and Youth Foyers (Launch Housing 2024b; Foyer Foundation 2024)
- VincentCare's Ozanam House (VincentCare 2024)
- Bolton Clarke homeless person program (Bolton Clarke 2024)
- Homeless Outreach Psychiatric Service (HOPS) run by the Alfred Hospital (Alfred Health Victoria 2024)
- Cohealth (Cohealth 2024)
- Youth Projects' drop-in service, The Living Room (Youth Projects 2024)
- St Vincent's Hospital's step-down facility, The Cottage (St Vincent's Hospital 2024a).

1 Note: The Department of Health and Human Services (DHHS) was restructured and became the Department of Health and the separate Department of Families, Fairness and Housing (DFFH) in February 2021, with Homes Victoria (formerly the housing division within DHHS) sitting within DFFH taking responsibility for oversight of SHS, community and public housing, as well as Victoria's Big Build.

4.2 Emergence of COVID-19

4.2.1 The Victorian COVID context

Victoria had its first confirmed case of COVID-19 on 25 January 2020 and its first death on 26 March 2020. On 16 March 2020 a state of emergency had been declared and restrictions on the size of public gatherings came into effect.

By the end of March 2020, Stage 3 restrictions were in place, which meant the closure of all non-essential services, ending the school term early and allowing people to leave home for one of four reasons: *'food and supplies; medical care; exercise; and work or education'*. Gatherings of no more than two people were banned 'unless they are members of an immediate household and it is for work or education' (Storen and Corrigan 2020).

By August 2020, tougher Stage 4 restrictions were in place, which limited people to travelling only five kilometres from home for essential shopping and exercise, each for only one hour per day, and imposed a curfew from 8pm to 5am (Hurst and Taylor 2020).

Multiple tranches of funding were released by the state government to support those experiencing homelessness including:

- SHS to provide emergency hotel accommodation through additional HEF
- services to increase outreach to those sleeping rough and find them emergency hotel accommodation
- COVID Isolation and Recovery Facilities (CIRFs)
- SHS to provide support services as well as programs for those experiencing or at risk of family violence, and to keep people experiencing homelessness in emergency hotel accommodation (Storen and Corrigan 2020).

The amount of funding was significant:

> *In the first tranche, we got 150 million bucks out of government for that and the most recent previous investment into homeless services was, that was five years before and it was like, I don't know, 18 million or something for the Rough Sleeping Action Plan … But in terms of service system, that paled into insignificance [compared to] what we could achieve during COVID (Victorian interview 09).*

From early March, the Victorian Government activated the State Control Centre (overseen by Emergency Management Victoria) to coordinate the response to COVID-19. Later in 2020 there were also changes within the DHHS with an additional emergency department created, including a dedicated COVID-19 homelessness team involving staff seconded from within DHHS and the SHS sector.

4.2.2 Early collaboration between health and SHS sector

Several dedicated programs for people experiencing homelessness were set up, and rolled out rapidly in response to the COVID-19 pandemic.

As part of the public health response and state of emergency declared in March 2020, SHS providers were instructed to provide emergency accommodation to people sleeping rough or otherwise experiencing homelessness in Victoria. Access points were instructed to purchase emergency accommodation for everyone presenting to an access point, while existing assertive outreach teams were instructed to engage hard-to-reach households with the aim of facilitating access to emergency accommodation (Kelly 2020).

All efforts to support households experiencing homelessness were coordinated through Homelessness Emergency Accommodation Response Teams (HEART), which were established in May 2020. A HEART was established in each DHHS homelessness services area (or LASN), which included:

- the Homelessness Networker for that region
- all access point agencies
- SHS providers
- representatives from local DHHS area offices (Kelly 2020: 4).

All SHS-funded agencies were mandated to participate in the HEARTs as part of the updated funding guidelines released by the DHHS.

The Homelessness Networker role was refocussed during this time to centre on management of the HEARTs, with the networker taking on responsibility in their area for:

- brokering information on policy and guidelines between access points
- convening the working group
- coordinating a priority list working group to ensure consistency in prioritisation of clients for emergency accommodation
- raising priority issues with DHHS.

HEARTs coordinated the Hotel Emergency Response (HER) which, over time, accommodated thousands of Victorians. It was reported that during the intial lockdown period in Victoria (from March to May 2020), approximately 4,500 people were assisted into Emergency Accommodation (EA) (Parliament of Victoria 2021: 229, cited in Pawson, Martin et al.). By August 2021 the number of people who had been placed in EA totalled 19,000. (Booker 2021, cited in Pawson, Martin et al.2021:86) Between March and September 2020, 3,929 rough sleepers and 6,882 people experiencing homelessness were accommodated through the HER. (Pawson, Martin et al. 2021: 86).

As the pandemic continued and many people experiencing homelessness remained in hotels, the Homeless to Home (H2H) program was developed and funded. This program provided 1,845 people with flexible support packages—including property services, case-management support and brokerage households—to assist them to move to long-term housing (which included public and community housing, and headleased private rentals) from emergency hotel accommodation (Homes Victoria 2022).

Although the number of packages provided was fewer than the number of people experiencing homelessness in the HER (Pawson, Martin et al. 2021), it represented a massive investment, and an opportunity for those experiencing chronic homelessness in Melbourne. The program was targeted to those experiencing chronic homelessness across the state who were residing in emergency accommodation prior to 6 December 2020 (Homes Victoria 2022).

The High-Risk Accommodation Response (HRAR) was a statewide program established in 2020 by the then DHHS. HRAR aimed to address the COVID-19-related health and wellbeing needs of people living in high-risk accommodation settings, which included:

- public housing—high-rise, as well as medium-rise and low-rise dwellings
- supported residential services (SRS) and disability residential settings
- rooming houses
- community housing
- caravan parks with long-term residents.

Hotels used by people experiencing homelessness were added to the HRAR program once an outbreak had occurred. Other accommodation settings were included on a case-by-case basis (Victorian Healthcare Association 2022).

The HRAR program relied on existing relationships and networks. It was delivered through health catchment areas in Victoria. Community health organisations worked with local health services to lead each catchment, with monthly meetings to coordinate local responses (Victorian Healthcare Association 2022). Each catchment was divided into four operational divisions (north, south, east and west) covering both metropolitan and regional areas (Victorian Healthcare Association 2022). A central team managed the HRAR program, which addressed outbreaks in high-risk settings by providing information, support, PPE, advice to accommodation providers, and isolation support. The HRAR program focussed on planning, community engagement, prevention and preparedness, vaccinations and referrals, as well as monitoring for COVID-positive individuals.

As the pandemic progressed into 2021, the HRAR program evolved to focus more on the vaccination rollout and supporting residents in high-risk settings to get vaccinated. Despite its successes, funding for the program ceased at the end of June 2022 (Victorian Healthcare Association 2024).

COVID Isolation and Recovery Facilities

Four specialist isolation facilities were rapidly established in Melbourne using disused facilities, such as aged care facilities. They were operating by April 2020 to provide a safe and supported place for people experiencing homelessness to isolate and recover from COVID-19. These COVID Isolation and Recovery Facilities (CIRFs) were 24-hour facilities that provided:

- case coordination by nurses and occupational therapists
- general medical support from medical assistants (graduate paramedics)
- support by housing support workers and lived experience workers to access housing after leaving the facility (DHHS 2020b).

The four facilities were operated by Anglicare Victoria, Brotherhood of St Laurence/Launch Housing, Sacred Heart Mission and VincentCare Victoria, with St Vincent's Hospital Melbourne (SVHM) and the Bolton Clarke Homeless Person's Program providing the clinical healthcare lead (DHHS 2020b).

During the early phase of the pandemic, stays were expected to be approximately two weeks (or longer if needed) to allow full recovery from COVID and to ensure patients were no longer infectious. People were eligible for a CIRF if they were in Victoria, experiencing homelessness and requiring isolation (Premier of Victoria 2020).

The success of prevention activities such as HER and HRAR limited the spread of COVID-19 among people experiencing homelessness in the first 12 months of the pandemic. This led to the four CIRF facilities being underutilised, with some closing. Sumner House (operated by Brotherhood of St Laurence/Launch Housing with Vincent's Health) remained in operation throughout the pandemic. With significant advocacy from the partner agencies, Sumner House evolved its service model from a CIRF to a dedicated health response for people experiencing chronic homelessness with health issues. From April 2020 to June 2021, Sumner House served 207 residents, including 52 COVID-19-positive individuals, with no resident-to-resident or staff transmissions (Brotherhood of St Laurence 2022).

4.2.3 Later collaboration

From CIRF to the Better Health and Housing Program (BHHP)

As the pandemic progressed, Sumner House transitioned from a CIRF to the Better Health and Housing Program (BHHP) where participants are supported *'over a period of three to six months, during which they are expected to experience an improvement to their quality-of-life and reduction in demand on unplanned/emergency health services, welfare, and justice systems'* (SVHM 2024b). The program has been operating since August 2022, and aims to provide stable housing, health management, and improved wellbeing. The care team includes housing and health service staff, with 24-hour support from Launch Housing and SVHM (Pahor 2023).

Mobile Outreach Service and the delivery of vaccinations

In July 2021, the Victorian Government announced the launch of pop-up and mobile vaccination clinics for people experiencing homelessness and disadvantage. The mobile vaccination clinics were introduced as part the community health C-19 network, which included IPC Health, Cohealth, DPV Health, EACH, and StarHealth (Victorian State Government 2021). The rollout of the COVID-19 vaccine statewide in 2021 resulted in high demand for vaccines, with some people having difficulty securing appointments. The vaccination response relied on existing networks and structures, including hospitals and community health services, rather than creating new networks. Conversations occurred between SHS and health services about setting up temporary pop-up vaccination sites to reach people experiencing homelessness. One interview participant recounted that health professionals worked with SHS to identify hotspots and set up vaccination points:

> *They [emergency government department created during the pandemic] had all of the knowledge that they needed. But yeah, we worked together really closely on, you know, 'Where are the hotspots? Where do we need to set up vaccination points? Who do we need to do it?' (Victorian interview 09)*

One interview participant described how the health services organised through the Aboriginal co-ops were operating vaccination buses, with nursing staff delivering to people experiencing homelessness:

> *Their intervention was really very good and very timely, so they were going basically through the community within their bus with a couple of staff, their nursing staff and vaccinating people as they went (Victorian interview 06).*

A mobile outreach service delivered by St Vincent's, initially funded temporarily for vaccination efforts, also provided various vaccinations and health screenings, including for influenza and hepatitis C. Despite its success, the service faced funding challenges and eventually closed, which was seen as a significant loss to the community. As one interview participant described it: 'that service is actually closed, which is a real loss' (Victorian interview 03).

4.3 Barriers and enablers in the delivery of public health response

4.3.1 Barriers

Lack of shared understanding

Several interview participants working in health and homelessness services called out tensions that arose due to perceived different working cultures, and the language used among health and homelessness workers during COVID. These differences created blockages in shared understanding—a critical feature of successful collaboration and a determinant of success in crisis response involving multi-agency work. As interview participants detailed:

> *[SHS] had to kind of put tools down and have a conversation about the language we were using to describe things, such as how we were rostering staff and things like that, because we realised that we were using different language to describe the same thing (Victorian interview 09).*

> *Was really challenging in lots of ways because often [health services] would think we were speaking about the same thing, but actually different words. Different terminology means different things to housing service versus a health service (Victorian interview 03).*

There were differences in initial recognition of infection control practices between the health and homelessness team. One health interview participant noted that this required providing a lot of education to get to a level of compliance across both teams.

> *So, you've got these health people who are probably slightly obsessive about [infection control] and then housing support workers for whom it's a pretty new concept and for most of the population, it was a pretty new concept … At a government level, there was almost hysteria about infection control and quarantine and all that kind of stuff. So, getting to a point where there was a level of compliance that was probably equivalent across both teams, that meant moderating the health service side of things, but also then providing a lot of education. We did get there and then [it was] really regular for all staff, updating and practising and all that kind of thing (Victorian interview 03).*

Sharing information

During the complex unfolding of the crisis, significant strain was placed on service delivery systems, especially the 'intersections' across shared systems to protect vulnerable populations. Barriers emerged around the sharing of key, and often sensitive, information that was required to expedite public safety measures. As one interviewee put it:

> *I would say the sharing of information … was challenging at times, people feeling comfortable that they were able to share the information, or people 'over sharing'. I think privacy is something we really [needed] to be mindful of (Victorian interview 08).*

This quote describes a tension emerging during the health response to protect homelessness cohorts. While a 'business-as-usual' approach was supplanted by the needs of the crisis response, it created ambiguity around how to factor in existing safeguards on information-holding, establishing processes to ensure key information was correctly and sensitively handled while also facilitating the crisis response across system intersections.

The metro-regional divide

A strong focus on containing the spread of COVID-19 in Greater Melbourne meant that sometimes regional areas were not as well supported and faced their own particular challenges.

> *Look, the challenge we have in this area is actually access to relevant health professionals … waitlists tend to blow out considerably. Getting the actual professional services in this area can be challenging … the demand on services is huge and those small services cover large areas (Victorian interview 07).*

The pre-existing lack of SHS-managed crisis accommodation meant that services were dependent on hotels and motels for accommodation—including quarantine:

> *When you're placing a homelessness person … having tested positive to COVID, to try and then put them into a crisis accommodation because it is a hotel [or] motel, the hotel is kind of saying, 'I don't know if I really want to take this individual. If you're telling me they've got COVID, because how do we support?' (Victorian interview 07)*

Transport to services and testing sites was also an issue. As one interview participant summed up:

> *I guess it just highlighted all the issues that we're aware of in the rural areas that are there, that exemplified them. You can't pull resources from an area where you're resource-poor at the best of times (Victorian interview 07).*

Some regional areas did not have pre-existing assertive outreach programs for people sleeping rough or many health outreach services. This created an additional barrier during COVID as there wasn't existing infrastructure that could be expanded.

Recognition of and support for complex health issues for people experiencing homelessness

The implementation of a drug and alcohol abstinence model for people experiencing homelessness in hotels and isolation recovery facilities during the COVID-19 response created significant challenges. The abstinence model led to difficulties in managing withdrawals, increased risks associated with offsite substance use, people experiencing homelessness breaking isolation rules, and challenges in providing appropriate health support. As one SHS interview participant reported:

> *Then we're saying, 'You can't drink onsite.' So where do you drink? You go out back out onto the street and then you've got the element of, like, that being less safe for the person and potentially being criminalised because you're drinking on the street … That was a bit of a barrier in terms of providing the support, then it was having to use an abstinence model (Victorian interview 04).*

4.3.2 Enablers

Authorising environment

The common thread among the key participant interviews was the ability of government and service organisations to organise, coordinate and respond to the crisis rapidly and efficiently. These responses were facilitated in part by the Victorian Government shifting gears to expedite decision-making, removing existing bureaucratic hurdles to allow service providers the best chance of meeting health needs during the crisis. As one interview participant framed the process:

> *Cabinet was sitting every day. And these [funding] submissions were going to Cabinet. And they're in. They're getting through. And so those types of bureaucratic processes, all the barriers around that came down because we had such a sole focus that everybody agreed we all had to do something [about the crisis] (Victorian interview 09).*

The severity of the crisis on homelessness populations brought about this 'sole focus', under which prevailing administrative processes were suspended to expedite the response.

Alternatively, existing processes were also critical in ensuring timely responses during the crisis. For example, significant additional funds were made available through HEF to place people into emergency hotel accommodations. To ensure the rapid allocation of funding, pre-existing service agreements were utilised and updated to clarify the actions SHS providers needed to take in the COVID-19 environment. Additionally, Homelessness Networkers were effectively redeployed to coordinate the local HER through the HEARTs.

That such a complex system was capable of redeploying services and resources amid a highly ambiguous and unstable operating environment says much for the leadership and operational capabilities in this system. As one interview participant put it:

> *One of the magnificent things about [the response] and what made it work from a homelessness perspective was the government just directed us … there was no butting up against the department. It made so much difference to just being clearly directed. There was no time for disagreement … we found agencies that we didn't even engage with before (Victorian interview 02).*

The pressures placed on the system by COVID-19 led to dismantling of existing administrative barriers and boundaries. This was aided by the rapid introduction of an authorising environment.

Pre-existing relationships

In many instances, the health response was strengthened by place-based, pre-existing relationships between health providers and the community. For example, in regional areas, the connections between health providers facilitated the coordination of implementation. Suitable treatment sites were easily identified based on existing knowledge of available facilities in the local area, and services were rolled out to meet basic needs as interim solutions while more stable clinical governance arrangements were established. Local populations were also more likely to be familiar with providers due to their closer proximity to health service delivery in regional areas. These relationships aided both the technical coordination of the public health response and communication with local people. As one interview participant detailed:

> *[The program] worked, it was predominantly delivered by community health providers (CHPs) in their local areas. They've had lots of connections within their local community already. So, lots of services already knew about them. And they also knew about the sites that were considered … within their portfolio (Victorian interview 08).*

The statewide HRAR program relied heavily on existing relationships across health providers to provide information and support to those in high-risk settings, and later with the vaccination rollout. HEARTs were also based on the pre-existing LASNs to map and understand local resources and manager the HER. The Sumner House CIRF, the only one of the four that continued right through the pandemic and has continued in an evolved state post-pandemic, was a product of a strong pre-existing relationship between St Vincent's Hospital Melbourne, Launch Housing and the Brotherhood of St Laurence.

4.4 What was learned through increased interaction

The response to the COVID public health crisis resulted in a series of learnings for the network of agencies and organisations involved in delivering the response. The acute health needs present in homeless cohorts uncovered highly important knowledge that illuminated and exposed features of the service delivery system and the actors involved.

The interviewees often reflected on the impressive capacity of the systems to adapt quickly and accurately to the unfolding health crisis. Despite the intersectional complexity of service environments for homelessness and health, stakeholders found decision-making efficiency improved, and the benefits of removing administrative barriers to deliver services rapidly. In Victoria, the main lessons learned from the coordinated response centred on formalised collaboration and service co-location.

Investing in formalised collaboration

Interview participants identified the need for formalised relationship-building between homelessness services and the health sector. They emphasised that formal relationships, rather than informal ones, are crucial to ensure continuity despite staff turnover. One interview participant highlighted the critical role that service managers play in maintaining robust relationships between SHS and health services, noting that relationship management should be an integral part of the service manager's responsibilities.

Additionally, one interview participant believed formal relationships should be established at all levels to ensure consistent communication pathways between SHS and health staff:

> *From both sectors together regularly, so I think we need the people on the ground meeting and talking and having relationships and pathways. We then need the kind of middle management doing the same, and we then need the kind of exact level doing the same, and I think probably operating at those different levels (Victorian interview 03).*

Interview participants highlighted the need for dedicated funding to support workers skilled in relationship-building to foster effective collaboration. The Homeless Networkers and LASNs who formed HEARTS and HRAR are both strong examples of the benefits of investing in relationship-building and networking. Formalising these collaborative structures and processes in health and homelessness will give staff greater clarity about where intersectional touchpoints are, and how teams can and should work together to effectively meet the health needs of homeless cohorts.

The importance of co-located services

Stakeholders from homelessness services highlighted the importance of integrating health and homelessness services through co-location that delivered better outcomes for people experiencing homelessness. This approach allows for a comprehensive, multidisciplinary response to the complex needs of individuals experiencing homelessness by providing a full health response within the same space as homelessness services, which meant that organisations can achieve better outcomes. One SHS interview participant detailed the outcomes of multidisciplinary response:

> *So, any multidisciplinary response … I think about Bolton Clarke, the programs there. I think about our programs, if there was something like [the COVID-19 pandemic] that happened again, or a relationship we needed to have. It wouldn't just be doing one task, it would need to be an entire health response within that space. Something holistic every time you do it (Victorian interview 01).*

4.5 Policy implications

There are several implications for policy and policy-making systems in Victoria. Stakeholders identified several system components that were illustrated in practice during the crisis, each of which represents an opportunity to strengthen system design and coordination.

Sharing goals, accountability and resources

The presence of shared goals and resources led to the perception of increased efficacy of service delivery and the protection of public health. Many interview participants noted the importance of agreed goals and coordination of efforts: these enabled better outreach to vulnerable populations in both metropolitan and regional contexts in Victoria. The achievement of shared goals requires a commitment to provide shared resources to empower inter-agency service provision.

Authorising environment

There was agreement among Victorian stakeholders that the shift in authorising environment made it more efficient to rollout the health and homelessness response, largely through the reduction in bureaucratic procedures. There remains a significant opportunity for policy actors to evaluate the improved conditions for efficient and effective decision-making created during the crisis response.

Investing in existing relationships

Existing relationships both within the SHS (HEARTs) and community health (HRAR) sectors, as well as between SHS and health services, provided the infrastructure for much of the successful response for people experiencing homelessness during the pandemic. Collaborations between health and SHS helped both parties to learn each other's language and share knowledge to help:

- health providers grow their understanding of homelessness
- SHS providers grow their knowledge of health services and the health system.

Investing in both networking and relationship-building roles, as well as dedicated program-based collaborations between SHS and health services, will lead to better outcomes for people experiencing homelessness.

When funding is available significant things can be achieved

The significant increase in funding available for people experiencing homelessness meant that inroads were made into the health issues experienced by some of this cohort. The CIRFs (and now BHHP) meant that there were (and are) more options for people experiencing homelessness and complex health issues to receive integrated support. The BHHP has seen improved housing outcomes, improved health and wellbeing, and improved community management of health issues (Pahor 2023). Building on the local knowledge of community healthcare providers, the HRAR program and mobile vaccination clinics were able to provide general support and linkages to support the diverse health needs of people experiencing homelessness (Victorian Healthcare Association 2022).

5. Tasmanian case study

- **Unaccompanied children faced significant challenges in complying with public health orders related to COVID-19, such as lockdown directives, stay-at-home orders, social distancing, and isolation requirements.**
- **Community sector advocates played a vital role in addressing the needs of unaccompanied homeless children during COVID-19, establishing forums and using outreach strategies to push for targeted health responses.**
- **There is a specific need for greater cross-agency visibility and accountability for unaccompanied homeless children as key to safeguarding the health and wellbeing of this cohort into the future.**
- **The Tasmanian Department of Health is a key but largely untapped partner for collaborative work to prevent and respond to homelessness.**

5.1 Introduction: Unaccompanied homeless children

Children who experience homelessness unaccompanied by parent or guardian are among those most vulnerable in the Australian community. Unaccompanied homeless children occupy a fundamental gap in the operations of most government agencies, with no explicit federal government recognition of this cohort.

Nationally, only New South Wales and Tasmania have developed policies (see NSW DCJ 2021; Department of Communities Tasmania n.d.-a) and practice guides (Department of Communities Tasmania n.d.-b; Yfoundations 2021). The ACT has an explicit service coordination response specifically targeting this cohort (ACT Government in collaboration with the Youth Coalition of the ACT 2021).

While child protection agencies may theoretically take some responsibility for this cohort, unaccompanied homelessness is not necessarily considered grounds for out-of-home care provision. AIHW data from 2021–22 (2024b) reveals that, nationally, nearly 13,000 children aged 10–17 years old presented to SHS alone, including 372 children in Tasmania.

Although limited in Australia, existing research on unaccompanied child homelessness consistently reveals pathways of extreme adversity from childhood into adolescence with continued risk of harm and self-harm in the context of surviving outside the family home (Chowdry, Barker et al. 2018; Cooper 2018; Flatau, Thielking et al. 2015; Noble-Carr and Trew 2018; Robinson 2022). Unaccompanied child homelessness includes:

- an absence of consistent care from a parent or guardian
- lack of access to SHS or other accommodation options due to young age and lack of finances
- lack of service access knowledge
- fear of youth SHS—which regularly accommodate young adults up to 21 years of age.

Often escaping abuse, neglect and caregiver domestic violence, unaccompanied homeless children struggle with:

- school access and engagement
- very poor physical and mental health
- intimate partner violence in their own relationships
- risk of sexual and physical assault and predatory behaviour
- drug and alcohol misuse
- involvement in criminal activity (Robinson 2017, 2018, 2021).

When COVID-19 arrived in Tasmania in February 2020 it intersected with a unique period of research, advocacy and emerging cross-sector collaboration on reviewing responses to unaccompanied child homelessness in Tasmania. From 2017–2019, sustained research and advocacy—led by Anglicare Tasmania in close collaboration with Youth Network of Tasmania (YNOT, which is Tasmania's youth peak), and the Office of the Commissioner for Children and Young People—drew renewed attention to the longstanding issue of children under 18, and as young as 10 years old, experiencing homelessness alone while not in the care of a parent or guardian(Commissioner for Children and Young People Tasmania 2019).

This work led to the creation of a broader coalition of concern on unaccompanied child homelessness in Tasmania involving multiple community service organisations and eventually an Under 16s Homelessness Taskforce was established. The Taskforce was a cross-sector expert-advisory panel convened to provide ministerial advice on responding to homelessness for unaccompanied under 16s through the Youth at Risk Project Team of the then Department of Communities Tasmania (Commissioner for Children and Young People Tasmania 2019).

5.2 Emergence of COVID-19 and unaccompanied homeless children

The Under 16s Homelessness Taskforce released its Ministerial Advice in December 2019 (Commissioner for Children and Young People Tasmania 2019). However, before implementation could begin, a Public Health Emergency was declared, and Tasmania went into lockdown under a state of emergency from March to May 2020. The timing of COVID-19's arrival was particularly unfortunate, as it came after years of research and advocacy had finally led the Tasmanian Government to recognise unaccompanied homeless children as a distinct and vulnerable group in need of tailored policy and practice—and potentially legislative intervention (Robinson 2020).

In particular, the Under 16s Taskforce Ministerial Advice highlighted the unresolved issue of the lack of authority and accountability for decision-making to support the wellbeing of vulnerable children not in formal care arrangements (Robinson 2020). The pandemic period unfortunately provided an extreme context of health and welfare risk in which the warnings by the Taskforce about the relative invisibility and lack of accountability for unaccompanied homeless children were given heightened clarity and urgency.

The work of the Under 16s Homelessness Taskforce provided valuable context for early decision-making on improving responses to unaccompanied homeless children during the lockdown period. In April 2020, as part of its COVID-19 Housing and Homelessness Support Package, the Tasmanian Government announced an investment of $513,000 to assist unaccompanied homeless children by increasing the capacity of existing youth outreach services (Tasmanian Department of Treasury and Finance 2020). Led by the Department of Education in collaboration with Communities Tasmania, Vulnerable Student Panels were also subsequently developed to offer additional inter-agency oversight of vulnerable children enrolled in government schools.

However, because they were minors without effective guardians or stable housing and care, unaccompanied children faced significant challenges in complying with public health orders related to COVID-19, such as lockdown directives, stay-at-home orders, social distancing, and isolation requirements. Child and youth outreach services, along with SHS sectors working with these children, also struggled to access key public health services involved in the COVID-19 response, including quarantine, polymerase chain reaction (PCR) testing, and vaccination (Robinson 2020).

In Tasmania, there was confusion among child and youth outreach and SHS sectors about how unaccompanied children would be supported to access the state's only quarantine facility in Hobart (Robinson 2020). These services faced difficulties with:

- managing lockdown and isolation in SHS residential facilities with shared bedrooms and amenities
- dealing with young clients unable to comply with lockdown and social distancing directives
- arranging transport to testing sites (which were initially drive-through only)
- accessing quarantine or healthcare services.

Additionally, the services encountered challenges in supporting children's access to vaccination, including managing consent without legal guardianship and coordinating subsequent vaccination doses.[2]

At the conclusion of the major state of emergency lockdown period, the Tasmanian Government convened a new Under 16s Homelessness Working Group in June 2020, led by Children and Youth Services for the Department of Communities Tasmania, to begin implementing the Taskforce recommendations. Following additional advocacy from the community sector—and after the main period of COVID-19 spread was over—the Working Group released practice guidelines in June 2021 for responding to COVID-19 for unaccompanied under 16s in SHS.[3]

While valuable for child and youth-specific SHS, this advice arrived long after the emergency period was over and problematically targeted the needs of residential SHS settings rather than the needs of unaccompanied homelessness children. Some youth SHS sectors reported they did not have access to appropriate resources to implement COVID-19 outbreak management plans, and it was unclear what guidance youth outreach services received to support access to COVID-19 public health responses for their unaccompanied, homeless clients (Robinson 2020).

2 For further detailed discussion on the mismatch between COVID-19 responses and the context, needs and capacities of unaccompanied child homelessness and the services supporting them, see Robinson (2020) https://www.anglicare-tas.org.au/research/stayhome-a-full-report-of-the-impact-of-covid-19-on-unaccompanied-homeless-children-in-tasmania/.

3 These guidelines were subsequently published on the Department of Communities Tasmania website as *COVID-19 Response for Unaccompanied Under 16s in Specialist Homelessness Services: Practice Guidelines*. However, the document is no longer available.

These efforts to grapple with the unique challenges of delivering a public health response to COVID-19 for children experiencing homelessness alone were not specific to Tasmania. However, in New South Wales, residential and support services were both declared essential, and advice on implementing public health responses was provided by NSW DCJ to the Homeless Youth Assistance Program and youth SHS sectors as early as April 2020.[4] The speed of this response was because existing policy and service systems for unaccompanied homeless children and young people were already well-developed.

Despite the promising recognition of the vulnerability of unaccompanied homeless children in Tasmania during the pandemic, rapid monitoring revealed several challenges:

- the reduction of face-to-face service provision by some government and non-government services, including youth outreach services
- an initial lack of guidance on implementing public health measures for children without safe housing or guardianship.

Both situations negatively impacted both the children and the service providers (Robinson 2020).

In response, significant additional resources were committed post-pandemic to strengthen care team and non-statutory residential care responses for unaccompanied homeless children. This effort was part of the Department of Communities Tasmania's (2021) Strong Families, Safe Kids, Next Steps Action Plan 2021–2023. This was followed by the release in April 2022 of two key documents:

- *Under 16s Homelessness: Children and Young People Under 16 Who Are at Risk of or Experiencing Homelessness: A Policy Framework for Tasmania*
- *Under 16s Homelessness: Children Who Are Under 16 and Alone and at Risk of or Experiencing Homelessness. Practice Guidelines for Specialist Homelessness Services* (Department of Communities Tasmania n.d.-b).

However, as discussed below, there remains limited confidence in the effective implementation of these initiatives.

5.3 Barriers and enablers in the delivery of public health response

5.3.1 Barriers

Lack of awareness of homelessness within Public Health

A lack of awareness and understanding of homelessness more broadly within Public Health as a government agency was identified as a fundamental barrier to the provision of a response to COVID-19 to unaccompanied homeless children. This included an observed lack of awareness of the diverse population of Tasmanians experiencing homelessness and of the SHS sector itself.

> *Interviewer: Would it be fair to say that at the beginning at least, there was a lack of Public Health understanding of the homeless sector and the settings that were involved in the sector?*
>
> *Participant: Yes very, very, very, very. Yes, absolutely. They didn't know they existed (Tasmanian interview 10).*

4 This was published by NSW Department of Communities and Justice as *COVID-19: Frequently asked questions for HYAP and Youth SHS Providers, Issue 1: April 2020*, but is no longer available. Note: advocacy on resolving a lack of clarity on public health responses to unaccompanied homeless children and young people was also ongoing in NSW; see for example: https://womensagenda.com.au/latest/where-can-young-homeless-people-self-isolate-urgent-help-needed-for-homelessness-services-facing-covid-19/.

Community sector participants reported frustration with a lack of understanding within Public Health of the nature of SHS residential settings and how clients interacted with and within these settings, including, notably, the freedom of movement of SHS clients as opposed to those in aged care and disability residential settings. Participants argued that this lack of understanding meant that relevant advice was slow to emerge on how best to prevent and manage COVID-19 transmission and outbreaks within a highly mobile and changeable residential client group, and in poorly resourced and thinly staffed residential services, which included shared bedrooms and facilities.

Initial de-prioritisation of children and young people

Participants also noted that the initial de-prioritisation of children and young people, who were perceived as being at lower risk from COVID-19, may have contributed to an overarching focus on adults in the response. This adult-centred approach was further emphasised in Tasmania due to an early outbreak in an aged care setting.

> *I don't think [Public Health] knew [unaccompanied homeless children] existed … I think there was more support to adults who were experiencing primary homelessness and that were physically on the streets and were the visible homeless. But I think the kids that we see, people are quite shocked about, and they don't really know about [them] (Tasmanian interview 07).*

> *There was no thought from Public Health with regards to people who were under 18 (Tasmanian interviewee 09).*

> *There was much more about a response around adults and what we do in those cases … But we needed to act. It was impacting everybody (Tasmanian interview 11).*

Given the population-level risk, the initial focus of Public Health on the general population was understood as necessary. However, this approach exposed the likelihood of overlooking particularly vulnerable cohorts as there were no designated priority leads with subject-matter expertise. It also highlighted the critical need for early and close collaboration with other agencies that could provide specialist input on tailoring generic population responses to reach more vulnerable groups.

The lack of clear responsibility for unaccompanied homeless children as a cohort

Emerging across the interviews were also many observations that the lack of clear responsibility for this cohort was seen as crucial to their lack of visibility for tailored public health responses.[5] The fact that unaccompanied homeless children cross multiple priority cohorts was also seen as a significant barrier. The historical lack of definitional clarity of unaccompanied homeless children as those under 18 versus homeless young people aged up to 24 years old was seen to contribute to their lack of visibility as minors and, in turn, to a lack of understanding of their extreme vulnerability. Likewise, the historical lack of definitional clarity that unaccompanied homeless children who were not in the custody of a parent or guardian versus homeless children who may be accompanied, for example, in the context of family homelessness, was also seen as problematic.

> *I think ultimately that [unaccompanied child homelessness] just needs to be recognised in the first place … Just recognise that a blanket approach to everyone is not going to apply to them (Tasmanian interview 07).*

5 This could be contrasted with the response to vulnerable children in out-of-home care documented by the Tasmanian Commissioner for Children and Young People, https://childcomm.tas.gov.au/resource/covid-19-monitoring-insights-children-and-young-people-in-oohc/.

Interview participants emphasised that when the pandemic arrived, unaccompanied children and the services working with them fell across and between the purview of multiple government agencies with no clear lead. It was also observed that during the pandemic, direct connections between the community sector, including peak organisations, and Public Health were weak, with only government agency to Public Health communication being seen to have any cut through. As such, with no one government agency taking specific responsibility for unaccompanied homeless children, these systemic gaps and vulnerabilities made advocating for targeted responses for unaccompanied homeless children even more difficult during a population-level health emergency.

> *The component of the [SHS] sector who work with that cohort [unaccompanied children] was certainly asking questions [about outbreak management] because that was a massive gap. There was no information. And really, that went on for quite a long time (Tasmanian interview 11).*

> *You'd ring up Public Health for advice, and they didn't have any idea of the homeless sector … Nobody actually understands what goes on in shelters, Public Health doesn't have a clue, and acute services don't really have a clue how things work in shelters either … (Tasmanian interview 03)*

Little relevance of Public Health directives for unaccompanied homeless children

Public Health directives such as 'stay-at-home' orders or responses such as drive-through PCR testing made fundamental assumptions about the presence of a safe home, a guardian and access to transport. This meant that unaccompanied homeless children were largely missed in public health responses to COVID-19, particularly in the context of restricted face-to-face support services more often involved in providing transport and appointment support for their clients.

> *The expectation that everyone had a safe, nice warm home they could see out their COVID isolation in, that was such a huge presumption that just couldn't be fulfilled. Or the presumption that they [unaccompanied homeless children] had access to a face mask readily or antibacterial stuff wherever they happen to have landed that day. And then you've got the [fact that] they couldn't necessarily stay in one place to complete an isolation because they were couch surfing, or it wasn't safe (Tasmanian interview 12).*

Reduced service capacity due to community and government services deemed as non-essential

The pre-existing lack of targeted public health service engagement with people experiencing homelessness, including unaccompanied children, was only worsened by the definition of many community and government services as non-essential during the public health emergency lockdown period. Not only were there few targeted youth health services to surge in an emergency but, overall, there was explicitly reduced capacity and opportunity to reach and engage with children experiencing homelessness alone. Given unaccompanied children's lack of health service access, reduced contact with other support services was understood to disproportionately impact COVID-19 messaging and response for this group.

Limited focus on targeted COVID-19 measures for priority cohorts

A key barrier in the provision of a response to unaccompanied homeless children was a perceived limited focus on developing and targeting realistic COVID-19 prevention and response measures to priority cohorts as the emergency unfolded:

> *I mean, I think you know those mass clinics work for the mass population … If you think about Public Health, you have a universal approach and then you have targeted responses to those that need them. So maybe that's where we went wrong, as we forgot the targeted responses (Tasmanian interview 06).*

> *When COVID first hit and we were looking at going into lockdowns, we had to do all these risk forms and I remember filling them out going, 'Yes, but unaccompanied minors, unaccompanied minors, unaccompanied minors!' Like, that's our biggest risk is that we're sole-worker, unaccompanied minors, shared facilities. And when they were talking about quarantining, it's like, 'Will you take an unaccompanied minor or not?' (Tasmanian interview 03)*

Shame in admission of the existence of unaccompanied children

Additionally, it was suggested that specific public health responses to unaccompanied homeless children may not have been prioritised because of the broader political risks and 'shame' involved in the admission of the existence and unmet needs of this highly vulnerable cohort.

> *Do agencies want to admit the enormous level of need, or the existence of this particular cohort? Because it kind of brings shame doesn't it, to agencies and government and communities, that we've got kids who are unaccompanied and homeless, full stop (Tasmanian interview 12).*

5.3.2 Enablers

Key role of community sector peaks

Research participants focussed on the key role community sector peaks played as advocates for the needs of those experiencing homelessness, including unaccompanied homeless children, during and following the declared public health emergency. In particular, the creation by the Tasmanian Council of Social Services of a Community Services COVID-19 Network.

This Network included a weekly cross-sector forum, and the use of an issues register, both of which were seen as important 'catch-all' mechanisms through which to raise awareness of the needs of unaccompanied homeless children being observed by frontline workers. This was particularly important for organisations and youth outreach programs that were not part of the SHS sector, where strong leadership from Shelter Tasmania was also reported by service providers. This points to the difficulties faced when a highly vulnerable cohort and the challenges they experience do not fit easily or neatly into advocacy, system and service delivery categories, and highlight a lack of pre-existing engagement between Public Health, community sector peaks, organisations and services.

Nonetheless, the combined efforts of all relevant peaks—including TASCOSS, YNOT and Shelter Tasmania—were identified by participants as key in collective efforts to push for clarification of a COVID-19 response for unaccompanied homeless children, along with the efforts of individuals and the use of personal contacts to raise key issues and request specific health responses. The commitment and creativity of frontline staff was also considered crucial to the delivery of COVID-19 responses to unaccompanied homeless children.

Frontline services reported shouldering increased risks of providing client transport to testing and health services—by driving with the windows down. They also managed stay-at-home, isolation and social-distancing public health directives in residential services with young clients requiring additional support during an extraordinary public health event, but with no change to their very low staff to client ratios—usually one worker to anywhere four and nine clients.

Use of specialist mobile health outreach

Participants reported that when the use of specialist mobile health outreach temporarily expanded statewide in the latter stages of the COVID-19 crisis, it was critical to vaccination access for unaccompanied homeless children. This also applies to dedicated 'vulnerable youth' vaccination clinics held in southern Tasmania:

> *One of the really good things that happened, which again was a bit late to the party, but it was around vaccination and the engagement of the mobile team who actually came to supported accommodation services to provide vaccinations. We had a great uptake of that from young people (Tasmanian interview 11).*

5.4 What was learned through increased interaction

The potential positive role Public Health can play for unaccompanied children was revealed

Positively, the COVID-19 emergency led many children and youth outreach and homelessness services to encounter Public Health as a standalone government agency and service provider for the first time. This experience highlighted the need for a stronger connection between the homelessness and public health sectors. Key learnings included:

- the need to address the limited involvement of Public Health and related services in meeting the ongoing health and mental health needs of the homeless community, including unaccompanied homeless children.
- the need for cross-sector, inter-agency forums with consistent Public Health representation.

Such forums would help engage the public health sector in understanding the current and emerging health issues and service barriers faced by unaccompanied children experiencing homelessness, and establish mechanisms for information-sharing across agency and sector silos.

Participants also reported increased awareness of the potential for advocacy that could be undertaken with the health system more broadly. This included addressing the lack of understanding and engagement shared between the homelessness and public health systems.

> *[The COVID-19 emergency] also made me realise there actually is a lot of advocacy we could do for kids in the health system, more than what I've realised I would say would be my key takeaway from it. Because you sort of only … I always thought of public health [as] like a hospital, there wasn't this broader concept of what the health system is because I don't work in health … Yeah, for me it was a bit of eye-opener (Tasmanian interview 12).*

Positive role of Communities Tasmania

Participants reported that response and coordination improved for SHS sectors once Communities Tasmania, in collaboration with Public Health, took the lead in developing tailored responses to COVID-19 for people experiencing homelessness. Responses included:

- the statewide expansion of Safe Space services—night shelters—for people rough sleeping
- the provision of additional funding to a mobile healthcare service
- the creation of a Mental Health and Homelessness Outreach Support Team (MHHOST).

However all of these initiatives were adult-focussed. Responsibility for unaccompanied homeless children went unclarified, potentially leaving them to fall between the cracks until a more developed response could be developed when the crisis was over:

> *There wasn't a dramatic response for young people … there wasn't like the rough sleeper approach … Safe Space—it's not a place for young people. It really is an adult response, as is the MHHOST. So, for young people, I think the effort was really on Child and Youth Services at the time about how they would help people who were in their Out of Home Care [OHC] (Tasmanian interview 10).*

COVID-19 exposed multiple system and service gaps between the homelessness and health sectors, and for unaccompanied homeless children

Participants strongly identified that there was no successful foundation to build on or surge during the COVID-19 crisis, as there were:

- limited base-service provisions in the homelessness sector
- limited homeless healthcare and youth healthcare services
- few mechanisms for connecting the homelessness and public health sectors—if any.

As previously argued by Robinson (2020), the COVID-19 response focus on 'priority settings' led to gaps where these settings—such as residential SHS—were absent, limited or not as commonly accessed, particularly by unaccompanied children who more likely to be couch surfing.

In short, the public health emergency was observed to have foregrounded an already significant, long-term disconnect between the homelessness and government public health sectors, and to have exposed systemic gaps in supports and responsibility for unaccompanied homeless children. This disconnect was understood by some participants to relate in part to a split between:

- the homelessness sector, which was largely community-operated, and
- the health sector, which was largely government operated—and which was further split between federal and state governments.

This resulted in the difficulty faced by community services in commanding health sector engagement at policy and service delivery levels.

The inadequate responses in supporting unaccompanied children in Tasmania emerged strongly from participants:

> *I think that what we learned is that we didn't have an adequate response, and we couldn't respond in a timely way to a highly vulnerable group of children in the community, and that more needed to be done (Tasmanian interview 13).*

> *What we need to be able to do is flex up in emergencies. But what we need is something that we're flexing up from. And if the system response isn't solid and sustainable with current demand, then it's difficult to flex up in those situations. We need to be pre-prepared to respond to specific cohorts. We are not. We are not (Tasmanian interview 10).*

Participants pointed to the need to strengthen the youth and homeless sectors and public health responses to homelessness, including investment in:

- statewide homeless healthcare provision
- statewide youth health-service provision
- adequate disaster preparedness and planning.

Participants also argued that recognition of the need for additional, dedicated funding to provide targeted health and social care responses to vulnerable cohorts is essential during a population-level crisis, as is expanding the scope of practice of health workers to enable and empower a surge health workforce. Finally, it was also strongly argued that unless there was clearer visibility of and responsibility for unaccompanied homeless children, then improving responses to their homelessness, including through collaboration with the public health sector, was unlikely to occur:

> *I think until the government takes responsibility for unaccompanied homeless children, I think we're always going to find ourselves in this position. We have a policy framework that skirts around the issue around responsibility … There needs to be that level of accountability (Tasmanian interview 13).*

> *I think if we were to go into [another] pandemic, we would be in exactly the same boat, and what we need is the government to recognise that we have highly vulnerable children and young people that require a targeted, coordinated response, and that needs to be communicated more broadly to stakeholders (Tasmanian interview 13).*

5.5 Policy implications

Participants discussed the need for dedicated, visible priority cohort leads or liaisons within Public Health during the pandemic—including specifically for vulnerable children and for young people and for people experiencing homelessness. These liaisons were envisaged as key champions for the health needs of these cohorts across the different divisions of the health system, and as a clear point of contact for advocates and organisations external to the health system.

Participants emphasised the importance of ongoing collaboration, communication and information-sharing mechanisms between government agencies, as well as between government agencies and the community sector. This was seen as particularly crucial for the homelessness sector, given the extent of separation between the community-based homelessness sector, government health agencies and public health services. Participants referred to both sector and cross-sector forums that operated in the years pre-COVID or had had sporadic government attendance; they speculated that such forums—appropriately constituted—may have been excellent avenues through which to ensure the needs of vulnerable cohorts, including unaccompanied homeless children, could be raised and discussed directly with health representatives.

Participants also emphasised that experience of direct collaboration between homelessness and health services and agencies, including Public Health, was needed. Except at the level of executive government, participants could report little direct collaboration between homelessness and health sectors in the child and youth space. It was argued that the development of a statewide homeless healthcare service, inclusive of the needs of unaccompanied homeless children, was crucial not only for responding to current acute physical and mental health needs but as a vehicle for further developing agency and policy collaboration and growing a competent workforce and individual practitioner skill.

While the public health response to COVID-19 and unaccompanied child homelessness is just one dimension of the public health emergency response to consider, it has high value in revealing some policy directions for improved responses to homelessness in Tasmania, as well as in other states and territories. Interview reflections on how responses to COVID-19 for unaccompanied homeless children were navigated in Tasmania reveal four key implications for policy development.

Develop mechanisms to ensure targeted responses to priority populations during public health emergencies and beyond

Firstly, the population-level focus of Public Health was identified as both a strength and a weakness during the COVID-19 emergency. Additional consideration could be given into how to balance this universal focus with clear mechanisms for the development of targeted responses to priority populations, including trauma-informed and age-appropriate responses for vulnerable children and young people and people experiencing homelessness, along with clear mechanisms for rapid engagement with subject-matter experts from relevant government and non-government organisations.

Strengthen the provision of healthcare for vulnerable children and young people

Secondly, research participants clearly observed that public primary healthcare accessible to unaccompanied homeless children is critically limited in Tasmania. The growth of specialist youth and homeless healthcare capacity statewide is needed as one crucial element of both preventing and responding to homelessness.

Clarify responsibility and accountability for unaccompanied child homelessness

Thirdly, the advent of a public health emergency further highlighted—with distressing consequences—the lack of clarity about agency responsibility and leadership of responses to unaccompanied child homelessness in Tasmania. This remains an outstanding issue still requiring further policy and practice clarification.

Engage and resource the Tasmanian Department of Health as a key partner in collaborative homelessness prevention

Fourthly, cross-agency and cross-sector collaboration between homelessness and health sectors in Tasmania remains poorly developed. Addressing this could open novel pathways for the provision of accessible, mobile, trauma-informed and child- friendly and youth-friendly healthcare, along with broader, multi-agency engagement with the unique needs of unaccompanied homeless children.

6. Policy development options

The rapid evolution of COVID-19 responses in the homeless sector led to innovative interventions and enhanced collaboration between public health agencies, health services and the community services sector. This project aimed to capture the lessons learned during this period of increased engagement, and to explore ways to expand or improve these collaborations. In this context, the study addresses three policy issues:

1. *Barriers and enablers in health response delivery:* Identifying challenges and facilitators in delivering health responses to people experiencing homelessness during the COVID-19 emergency.
2. *Lessons from increased collaboration:* Assessing what has been learned from the heightened collaboration between the public health agencies, health services and homelessness sectors during the COVID-19 emergency.
3. *Guiding principles for ongoing collaboration:* Developing principles to enhance and sustain collaboration between public health agencies, health services and SHS.

By addressing these policy issues, the study aims to provide actionable insights for improving responses and collaboration during future emergencies, and enhancing health responses to homelessness more broadly.

6.1 Barriers, enablers and lessons learned

The research revealed crucial differences in the barriers, enablers and lessons learned in delivering health services during COVID-19 across the three case-study states. Despite these variations, several key barriers, enablers and lessons emerged that offer valuable insights for both the homelessness and health sectors.

The importance of pre-existing relationships

In Victoria and New South Wales, where health responses during the COVID-19 pandemic were effective, interview participants highlighted the critical role of pre-existing relationships between government entities, health agencies and homelessness stakeholders as one of the key enablers. These well-established connections facilitated a smooth and coordinated response to the crisis. The pre-existing trust and mutual understanding among these parties allowed for open and candid communication, which was essential for effective collaboration. This trust enabled rapid problem-solving and decision-making, both of which were crucial during the pandemic.

To enhance future crisis responses, it is recommended that similar relationships be actively cultivated and maintained across all regions, ensuring a strong foundation for collaboration when facing public health emergencies.

The importance of engaged outreach-based health services

In inner-city Sydney, Melbourne and across Tasmania, the delivery of health services during the COVID-19 pandemic was enabled by health agencies that were already active in outreach work before the crisis. Interview participants noted that these pre-existing outreach efforts positioned mobile services to effectively expand in response to the pandemic. This expansion included deploying mobile vaccination clinics and pop-up hubs, which proved crucial in reaching vulnerable populations, including those experiencing homelessness and First Nations people. The established outreach framework allowed these services to quickly adapt to the heightened demand and logistical challenges brought on by the pandemic, ensuring that health interventions were delivered efficiently and effectively to those in need.

A key lesson learned is the critical value of having an engaged and flexible outreach-based health service infrastructure in place before a crisis hits, as it allows for rapid and effective responses in times of emergency.

6.2 Lessons from increased collaboration

Government agencies creating an authorising environment

Interview participants from Victoria and New South Wales identified that government agencies played a pivotal role in enabling effective health responses by creating an authorising policy environment.

Participants identified that this environment was characterised by flexibility and high-level support from government officials, which empowered stakeholders to operate beyond their usual boundaries. The authorising environment allowed for creative problem-solving and agile collaboration, essential for navigating the complexities of the pandemic. Stakeholders were able to adapt their approaches and coordinate efforts more effectively, thanks to the supportive and enabling role of the government. Relatedly, significant increases in funding enabled responses to be rolled out rapidly within existing funding mechanisms and structures—for example, HEARTs and HRAR in Victoria.

A key lesson from this experience is the importance of an authorising policy environment that encourages flexibility, innovation and well-funded responses, all of which are crucial for effective crisis management.

Importance of collaboration and shared ways of working

Interview participants from both Victoria and New South Wales identified that there was strong communication and coordination between government agencies, health services and the SHS sector, which enabled successful delivery of health services. They also identified that this effective communication was crucial for identifying and addressing emerging issues promptly and efficiently. The adoption of shared ways of working among stakeholders also facilitated seamless collaboration. Despite differences in organisational cultures and operational practices—and a history of competing for funding—agencies were able to work together effectively by aligning their efforts and adapting their practices to meet the urgent demands of the pandemic. This collaborative approach ensured that resources and efforts were optimally utilised to address the health needs of the homeless population.

Moving forward, it is recommended that these collaborative practices be formalised and replicated in other jurisdictions, with ongoing support for inter-agency communication and coordination, to ensure a sustained and effective response in future crises.

The need for effective resourcing to sustain collaborations

A common barrier across all three case-study sites was the lack of adequate resources. Interview participants consistently reported that insufficient funding, personnel and logistical support hindered their ability to fully meet the demands of the crisis. This shortage of resources limited the capacity of health services to expand and adapt their operations in response to the rapidly evolving needs of the pandemic. The strain on resources affected various aspects of service delivery, from the provision of essential medical care to the implementation of emergency measures.

A key lesson from this experience is the critical need for sufficient and flexible resource allocation in crisis planning and response. Ensuring that health services have the necessary funding, personnel and logistical support in place is essential for an effective and adaptive response to future emergencies.

Uneven responses for different groups of people

A significant barrier across all three case studies was the uneven delivery of health services to people experiencing homelessness, with notable gaps in coverage for populations outside metropolitan areas and for cohorts other than rough sleepers. The Tasmanian case study particularly highlighted the challenges in delivering targeted public health responses to unaccompanied homeless children due to the lack of clear responsibility for their care. This lack of comprehensive coverage meant that not all segments of the homeless population received the support they needed during the pandemic.

Moving forward, it is recommended that efforts be made to ensure equitable health service delivery across all homeless populations, with a focus on expanding coverage in rural and regional areas and addressing the needs of vulnerable groups, such as unaccompanied homeless children, through clearly defined responsibilities and targeted interventions.

6.3 Guiding principles to strengthen collaboration

Based on existing literature and the experiences of case studies in New South Wales, Victoria and Tasmania, several guiding principles are suggested to enhance collaboration between health services and the SHS sector.[6]

Recognition of homelessness as a permanent population health emergency

Our research highlights the critical and ongoing need to recognise homelessness as a permanent population health emergency. People experiencing homelessness are disproportionately burdened with severe physical and mental health challenges. These challenges result in nearly double the risk of mortality and significantly reduced life expectancy compared to housed individuals. The conditions associated with homelessness, such as exposure to the elements and lack of access to consistent medical care, exacerbate these health risks, making homelessness both a key determinant and outcome of poor health.

Health agencies and services must take on a proactive and sustained role in addressing homelessness as an urgent public health crisis, not just as a social issue. This involves implementing policies and practices that prioritise the prevention of homelessness, ensuring that vulnerable populations receive the support they need before they fall into homelessness.

Additionally, health services should be equipped to respond to the unique health needs of those already experiencing homelessness, providing comprehensive care that addresses their immediate medical concerns as well as the underlying factors contributing to their homelessness.

6 While consideration is given here to homelessness-specific services, these guidelines are also relevant for allied community services working with homeless and vulnerable populations, including child, youth and family services.

Moreover, recognising homelessness as a health emergency requires a collaborative, multi-sectoral approach that brings together government agencies, healthcare providers, social services and community organisations (further detailed in the next section).

Enhancing targeted responses to homelessness during and after emergencies

During the COVID-19 emergency period, targeted, cohort-focussed initiatives significantly improved the delivery of health services to people experiencing homelessness. For instance, mobile health outreach services in all three case-study states played a pivotal role in complementing the efforts of Public Health agencies. These mobile units provided critical health interventions directly to people experiencing homelessness, and proved to be both practical and effective.

To build on the success of these targeted initiatives, it is essential that such approaches continue beyond the crisis. Ensuring that people experiencing homelessness maintain access to health services in environments that are familiar and trusted is crucial for sustained health improvement. Mobile and outreach-based services should not be viewed as temporary measures, but as integral components of a comprehensive strategy to address homelessness-related health needs.

Maintaining and expanding these outreach efforts will help bridge gaps in care, making essential health services more accessible and tailored to the unique needs of homeless populations. By focussing on continuity and adaptability in these services, we can better address the ongoing challenges faced by these communities. This will ultimately lead to improved health outcomes and a more equitable health system.

The importance of cross-agency and cross-sector collaboration between health and homelessness agencies and services

For health services to be effectively delivered to people experiencing homelessness, robust coordination between health services and homelessness services is essential. To achieve this, several components are necessary.

1. The involvement of overarching health bodies, such as local health districts in New South Wales, is crucial. These bodies ensure that the SHS sector can be seamlessly integrated with local health services, facilitating a coordinated approach.
2. A centrally authorised and well-resourced framework for inter-agency communication needs to be established. This framework should encompass health departments, housing and homelessness agencies, and non-governmental partners, with the aim of promoting effective collaboration and information-sharing among all stakeholders.
3. Formal partnerships between health and homelessness services are necessary. These partnerships should clearly define the roles of representatives from both sectors to manage and enhance intersectoral relationships. To support these responsibilities, adequate resourcing and funding must be allocated. This will facilitate relationship-building activities through clear communication channels, regular meetings, targeted training, capacity building, and the sharing of data and knowledge. Furthermore, the roles dedicated to relationship-building must be supported with resources to implement structures that enable communication across various levels, including frontline staff, middle management and executive leadership. This multi-level engagement is critical to fostering effective collaboration and developing integrated models of service delivery.

In addition, while not explicitly mentioned by interview participants in this research, involving people experiencing homelessness in the design and evaluation of health services is crucial. This inclusion ensures that their perspectives and needs are central to service delivery improvements.

6.4 Final remarks

The COVID-19 period marked a shift in recognising and addressing the health issues faced by people experiencing homelessness as urgent public health concerns. However, the question remains whether this shift will signify a lasting paradigm change or simply be a brief, shining aberration.

During this time, valuable lessons emerged from effective cross-sector collaborations, highlighting the importance of coordinated, prioritised responses. With the COVID-19 risk now reduced, we must resist the urge to revert to 'business as usual' and instead build upon these lessons to ensure sustained attention to the health, housing and support needs of those experiencing homelessness.

This requires strong, centralised leadership to foster an environment of creative problem-solving and agile collaboration across health and homelessness sectors. Without it, the chance to permanently integrate healthcare resources in addressing homelessness may be lost, along with the critical insights gained during the COVID-19 response.

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Appendix 1: Interview guide: Peak agencies and homelessness services

Note: The topic guide covers all areas that will be covered in the interview. It provides sufficient structure to ensure that all areas are covered with consistency, but will be applied flexibly so that the interview participant can raise topics to discuss of their volition. Follow-up and probing questions will be posed as appropriate. The nature of the follow-up and probing questions will be consistent with the questions and topics below.

Introduction:

- Explain the nature and purpose of interview.
- Public health agencies for the purposes of this project includes Department of Health, other agencies contracted by the Department to deliver health services and NGOs who provide health services.
- When we discuss COVID-19, we are primarily speaking of the period encompassing the lockdown responses. Acknowledge that COVID-19 has had impacts outside of this period, which will be the focus of later questions.
- Provide time and information so that participants understand all information outlined in the participant information sheet.
- When participant is fully informed, ask participant to provide informed consent (by signing consent form).

Participant details:

- Job title/role, and length of time in position/organisation, length of time in govt/homelessness industry.

Questions

Overall project question—don't read during interview: What were the barriers and enablers in the delivery of public health responses to people experiencing homelessness during the COVID-19 emergency?

1. Before the pandemic, what engagement, if any, did your organisation have with public health agencies/services?
    - What was the extent of this engagement?
    - How effective was this engagement?
    - Had you identified the need for further engagement or collaboration?
2. Before the pandemic, are you aware of collaborations/engagement between your member organisations and public health agencies/services?
    - To the extent you are aware, what were members' views on this engagement?
    - Had members identified the need for further engagement or collaboration?
3. With the arrival of the COVID-19 pandemic, did engagement/interaction with public health agencies increase?
    - If so, how was this increased engagement/interaction initiated?
    - Were there any barriers in establishing this increased interaction?

4. For the period encompassing the lockdown period of the COVID-19 pandemic:
    - What public health agencies/services were you interacting with most closely with?
    - What was the nature of the interaction/engagement (i.e. lockdown/'stay-at-home' orders, access to testing, requirements for isolation/social distancing, vaccination)?
5. For the period encompassing the lockdown period of the COVID-19 pandemic, what are some of the key 'wins' or achievements or outcomes of your work with public health agencies?
6. For the period encompassing the lockdown period of the COVID-19 pandemic, what blockages/issues did you experience in working with public health agencies?

Overall project question—don't read during interview: What have the Australian public health and homelessness sectors learned about responses to homelessness from their increased collaboration?

7. What have you learned about public health agencies from your collaboration during the lockdown period of the COVID-19 pandemic?
8. To what extent has collaboration between public health and homelessness services continued post the lockdown period of the pandemic?
    - What was the extent of this engagement?
    - How effective has this engagement been?
    - Had you identified the need for further engagement or collaboration?
9. What has been the ongoing impact (if any) of COVID-19 on the delivery of services to people experiencing homelessness (i.e. isolation, testing, staff impacts, provision of PPE in outbreaks)?

Overall project question–don't read during interview: What are the guiding principles to strengthen ongoing collaboration of public health agencies and specialist homelessness services?

10. What do you think ongoing engagement between public health agencies and specialist homelessness services should look like?
11. What do you think should be some of the guiding principles to strengthen ongoing collaboration of public health agencies and specialist homelessness services?
12. Follow up:
    - Any other data/evidence relevant to our research?

Appendix 2: Interview guide: Health, government agencies overseeing public health

Note: The topic guide covers all areas that will be covered in the interview. It provides sufficient structure to ensure that all areas are covered with consistency, but will be applied flexibly so that the interview participants can raise topics to discuss of their volition. Follow-up and probing questions will be posed as appropriate. The nature of the follow-up and probing questions will be consistent with the questions and topics below.

Introduction:

- Explain nature and purpose of interview.
- Public health agencies for the purposes of this project includes Department of Health, other agencies contracted by the Department to deliver health services and NGOs who provide health services.
- When we discuss COVID-19, we are primarily speaking of the period encompassing the lockdown responses. Acknowledge COVID-19 has had impacts outside of this period, which will be the focus of later questions.
- Provide time and information so that participants understand all information outlined in the participant information sheet.
- When participant is fully informed, ask participant to provide informed consent (by signing consent form).

Participant details:

- Job title/role, and length of time in position/organisation, length of time in govt/homelessness industry

Questions

Overall project question—don't read during interview: What were the barriers and enablers in the delivery of public health responses to people experiencing homelessness during the COVID-19 emergency?

1. Before the pandemic, did your agency/service have interaction with housing/homelessness agencies and organisations?
2. With the arrival of the COVID-19 pandemic, did engagement/interaction with homelessness services increase?
    - If so, how was this increased engagement/interaction initiated?
    - Were there any barriers in establishing this increased interaction?
3. For the period encompassing the lockdown period of the COVID-19 pandemic: What was the nature of the interaction/engagement with homeless services (i.e. lockdown/'stay-at-home' orders, access to testing, requirements for isolation/social distancing, vaccination)?
4. For the period encompassing the lockdown period of the COVID-19 pandemic, what were some of the key 'wins' or achievements or outcomes of your work with homelessness services?

5. For the period encompassing the lockdown period of the COVID-19 pandemic, what blockages/issues did you experience in working with homelessness services?

Overall project question–don't read during interview: What have the Australian public health and homelessness sectors learned about responses to homelessness from their increased collaboration?

6. What have you learned about homelessness/homelessness services from your collaboration during the lockdown period of the COVID-19 pandemic?
7. To what extent has collaboration between public health and homelessness services continued post the lockdown period of the pandemic?
    - What was the extent of this engagement?
    - How effective has this engagement been?
    - Had you identified the need for further engagement or collaboration?

Overall project question–don't read during interview: What are the guiding principles to strengthen ongoing collaboration of public health agencies and specialist homelessness services?

8. What do you think ongoing engagement between public health agencies and specialist homelessness services should look like?
9. What do you think should be some of the guiding principles to strengthen ongoing collaboration of public health agencies and specialist homelessness services?
10. Follow up:
    - Any other data/evidence relevant to our research?

Appendix 3: Focus group interview guide: Specialist homelessness services

Note: The topic guide covers all areas that will be covered in the interview. It provides sufficient structure to ensure that all areas are covered with consistency, but will be applied flexibly so that the interview participant can raise topics to discuss of their volition. Follow-up and probing questions will be posed as appropriate. The nature of the follow-up and probing questions will be consistent with the questions and topics below.

Introduction:

- Explain the nature and purpose of the interview.
- Public health agencies for the purposes of this project includes Department of Health, other agencies contracted by the Department to deliver health services, and NGOs who provide health services.
- When we discuss COVID-19, we are primarily speaking of the period encompassing the lockdown responses. Acknowledge that COVID-19 has had impacts outside of this period, which will be the focus of later questions.
- Provide time and information so that participants understand all information outlined in the participant information sheet.
- When participant is fully informed, ask participant to provide informed consent (by signing consent form).

Participant details:

- Job title/role, and length of time in position/organisation, length of time in govt/homelessness industry.

Questions

Overall project question—don't read during interview: What were the barriers and enablers in the delivery of public health responses to people experiencing homelessness during the COVID-19 emergency?

1. Before the pandemic, what engagement, if any, did your organisation have with public health agencies/ services?
    - What was the extent of this engagement?
    - How effective was this engagement?
    - Had you identified the need for further engagement or collaboration?
2. With the arrival of the COVID-19 pandemic, did engagement/interaction with public health agencies increase?
    - If so, how was this increased engagement/interaction initiated?
    - Were there any barriers in establishing this increased interaction?

3. For the period encompassing the lockdown period of the COVID-19 pandemic:
    - What public health agencies/services were you interacting with most closely with?
    - What was the nature of the interaction/engagement (i.e. lockdown/'stay-at-home' orders, access to testing, requirements for isolation/social distancing, vaccination)?
4. For the period encompassing the lockdown period of the COVID-19 pandemic, what were some of the key 'wins' or achievements or outcomes of your work with public health agencies?
5. For the period encompassing the lockdown period of the COVID-19 pandemic, what blockages/issues did you experience in working with public health agencies?

Overall project question—don't read during interview: What have the Australian public health and homelessness sectors learned about responses to homelessness from their increased collaboration?

6. What have you learned about public health agencies from your collaboration during the lockdown period of the COVID-19 pandemic?
7. To what extent has collaboration between public health and homelessness services continued post the lockdown period of the pandemic?
    - What was the extent of this engagement?
    - How effective has this engagement been?
    - Had you identified the need for further engagement or collaboration?
8. What has been the ongoing impact (if any) of COVID-19 on the delivery of services to people experiencing homelessness (i.e. isolation, testing, staff impacts, provision of PPE in outbreaks)?

Overall project question—don't read during interview: What are the guiding principles to strengthen ongoing collaboration of public health agencies and specialist homelessness services?

9. What do you think ongoing engagement between public health agencies and specialist homelessness services should look like?
10. What do you think should be some of the guiding principles to strengthen ongoing collaboration of public health agencies and specialist homelessness services?
11. Follow up:
    - Any other data/evidence relevant to our research?

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