Integrated Health and Social Service Delivery: A Needs Assessment Among Clients of Homeless Services in Central and Eastern Europe

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Acknowledgements

The SOLACE-CEE partners and their clients

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A bold new approach to chronic homelessness across Central and Eastern Europe

Solutions for Overcoming Homelessness through Integrated Care in the CEE region

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The Problem

PROBLEM	Urgent need for a solution for the chronically homeless individuals with more complex challenges and higher- intensity service needs, including support for mental health issues or substance abuse, typically with homeless spell over 1+ year
NEED	Chronic homelessness requires radical, compassionate and complex solutions
SOLACE	A bold new approach to chronic homelessness across Central and Eastern Europe

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What is our solution?

HOLISTIC CONTINUUM OF CARE

Integration of housing, **healthcare**, social support and employability services.

TARGETED HEALTH SERVICES

Implementation of specialist health services, including telemedicine and remote monitoring.

EFFECTIVE OUTREACH

Expanding outreach to non-traditional areas and providing telecare services in shelters.

TRAUMA-INFORMED CARE

Ensuring services are respectful and adapted to the emotional needs of homeless individuals.

DATA COLLECTION AND EVALUATION

CAPACITY BUILDING

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Intervention logic

1. **Build a multidisciplinary outreach team** to engage with homeless people using a trauma-informed, trust-building approach.

2. **Conduct comprehensive research** to assess needs and design an Integrated Health and Social Care program, including TeleMedicine and existing services.

3. **Launch a pilot phase** in selected cities to test services and establish HUBs supporting the integration of homeless individuals.

4. **Engage stakeholders** through awareness and partnerships, while providing training to improve staff capacity and sensitivity.

5. **Evaluate impact and gather feedback** to develop a scaling tool estimating health sector cost savings.

6. **Organize advocacy events** to share findings and promote evidence-based homelessness policies.

7. **Launch a joint campaign** and share key results to raise awareness and highlight the project's impact.

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Pilots

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Diversity of the settings

- Countries: RO, HU, PL, BG (capital cities), SK (two other cities)
- Services on board: shelter for families, large service + shelter provider with health capacities, HF provider, social inclusion work and health counselling focused NGO
- Target groups: ghetto population / unsheltered PEH / sheltered PEH / families in precarious housing (ETHOS 5)
- Welfare systems, health systems, insurance systems and therefore barriers to services are different, too
- Respondents: in-house clients and potential clients

COMMON NEED: TACKLING CAVEATS OF HEALTH AND SOCIAL SERVICE ACCESS

Methods of the data collection and analysis (1)

Multiple purposes of the data collection:

- creating evidence to support program design (client level, organisation level)
- creating the baseline database for the program evaluation (client level)
- feed the monitoring framework (organisation level)

Phases (2025):

- January-March: co-creation of the data collection tools (local variance of target client group)
- April - May: quantitative and qualitative data collection (standardized questionnaire in 5 languages, interview/focus group outline)
- June: data analysis

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Methods of the data collection and analysis (2)

Triangulation:

- quantitative - clients of own and partner services; descriptive analysis of the data (N=265, data on altogether 655 persons)
- qualitative - health and social professional respondents and within the network & clients within own and / or partner services (20+ interviews)
- contextual and service design information within the given countries/cities

RESPONDENTS' NUMBER - QNT	
CASA IOANA	15
DEDO/VPR	128
HESED	40
MÁLTAI	53
HF POLAND	29
TOTAL	265

Caveats: some partners were already running select services, others not yet; data are NOT representative of the whole sector/city/country; in some cases not even for the participating organisation' views (esp. small PL organisation)

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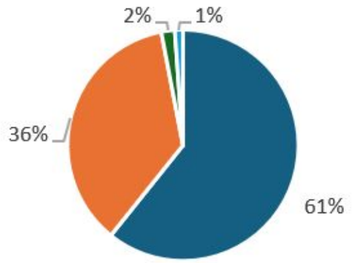
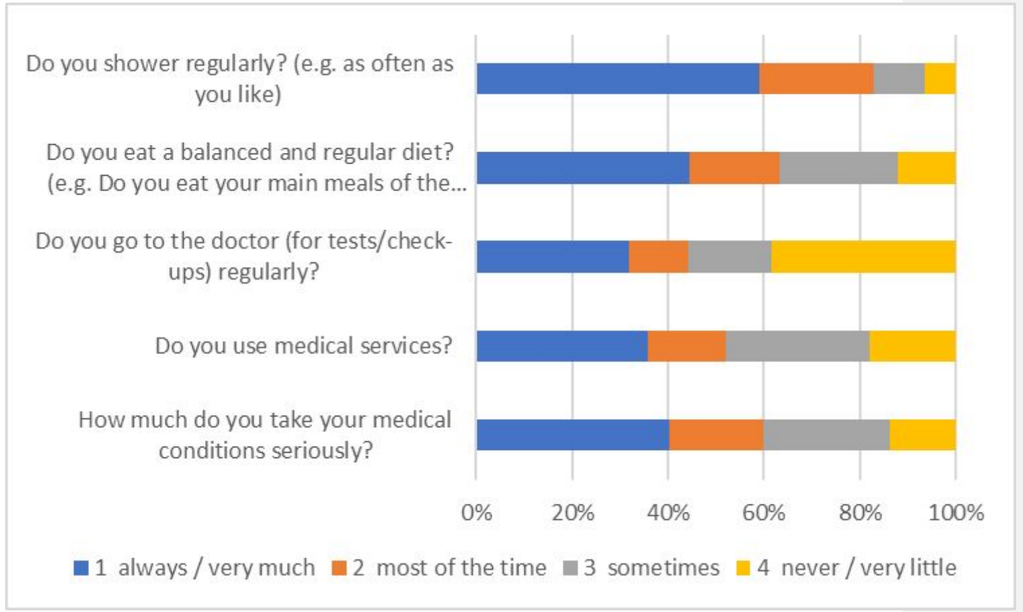
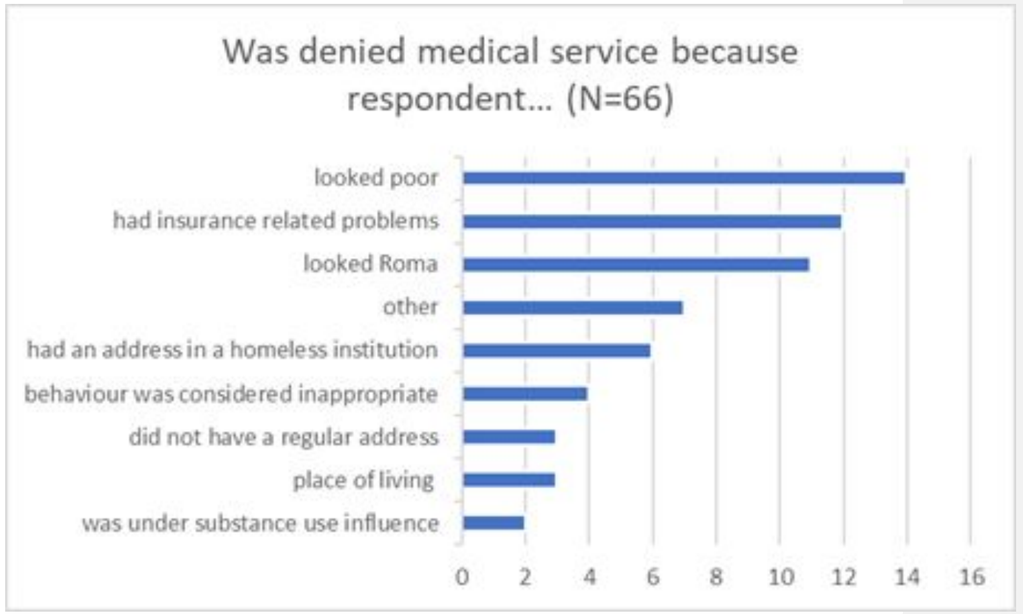
GENERAL OBSERVATIONS

1 - heterogeneous target groups of partners / services
2 - very low incomes and great dependence on transfers
3 - housing vulnerabilities + shelter population
4 - scarce social & formal resources but great needs
5 - low health use but high emergency levels
6 - access to health care: public service use prioritised
7 - very strong barriers to service use due to refusal and disrespect
8 - low HL + TM unfamiliar for most respondents



61% of respondents reported having at least one health issue





Trauma related experiences

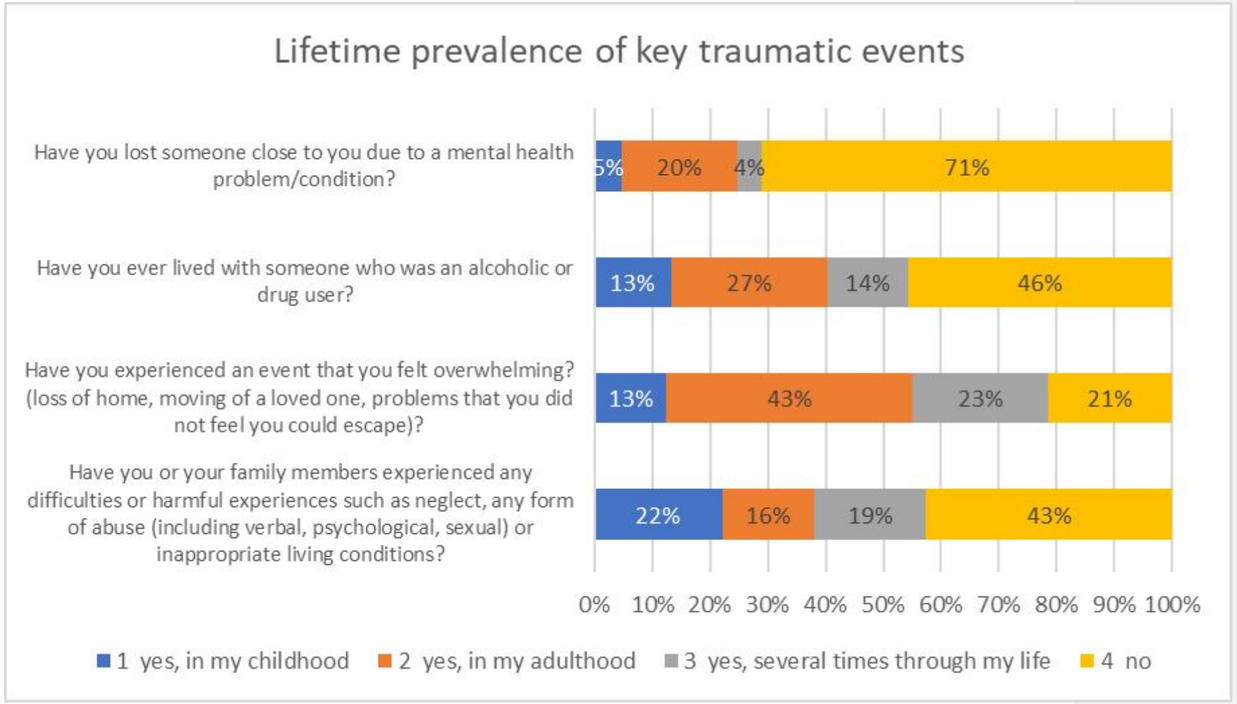
Traumatic life events have hit 80% of our respondents.

One in every 10 persons did not have any loving person in their childhood.

Every one in three persons lost a loved one due to mental health issues of that person.

More than half of the respondents had episodes of living together with a person having addictions.

Every second client has faced abuse either in their childhood, adulthood or both.



TIC is a relevant approach

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NEEDS ASSESSMENT
SLOVAK SAMPLE - SEVERAL INSIGHTS

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Slovak sample: Client characteristics

Number of respondents (individuals and household representatives):

128

4,6%
SLEEPING ROUGH
(ETHOS LIGHT 1)

12,5 %
NIGHT SHELTER
(ETHOS LIGHT 2)

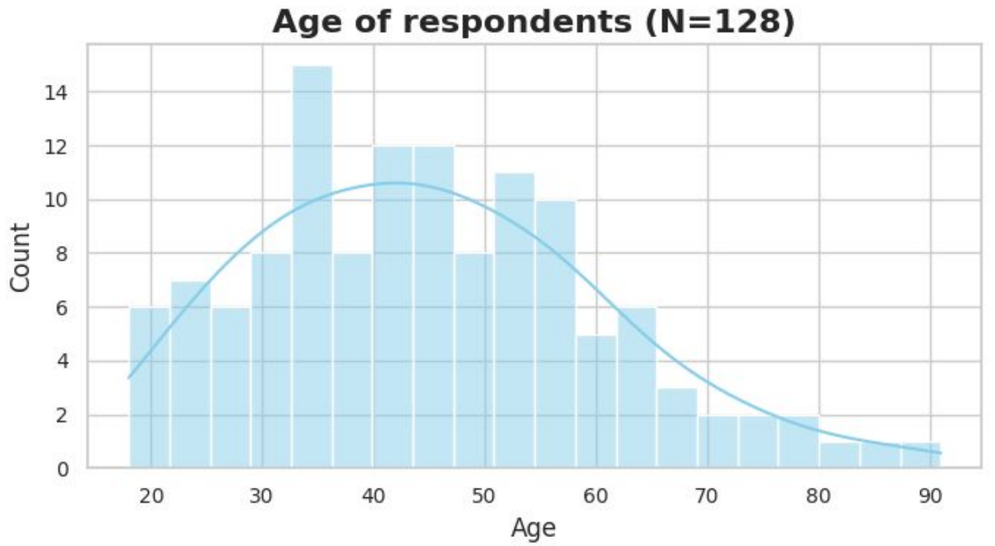
50 %
SHELTER
(ETHOS LIGHT 3)

23 %
SHACK, INFORMAL HOUSING
(ETHOS LIGHT 5)

10 %
HOUSING FIRST PROGRAMS
OR SOCIAL HOUSING
< 1 YEAR: 10%

Number of all household members including children:

375



Average age of respondents (N=128):

45

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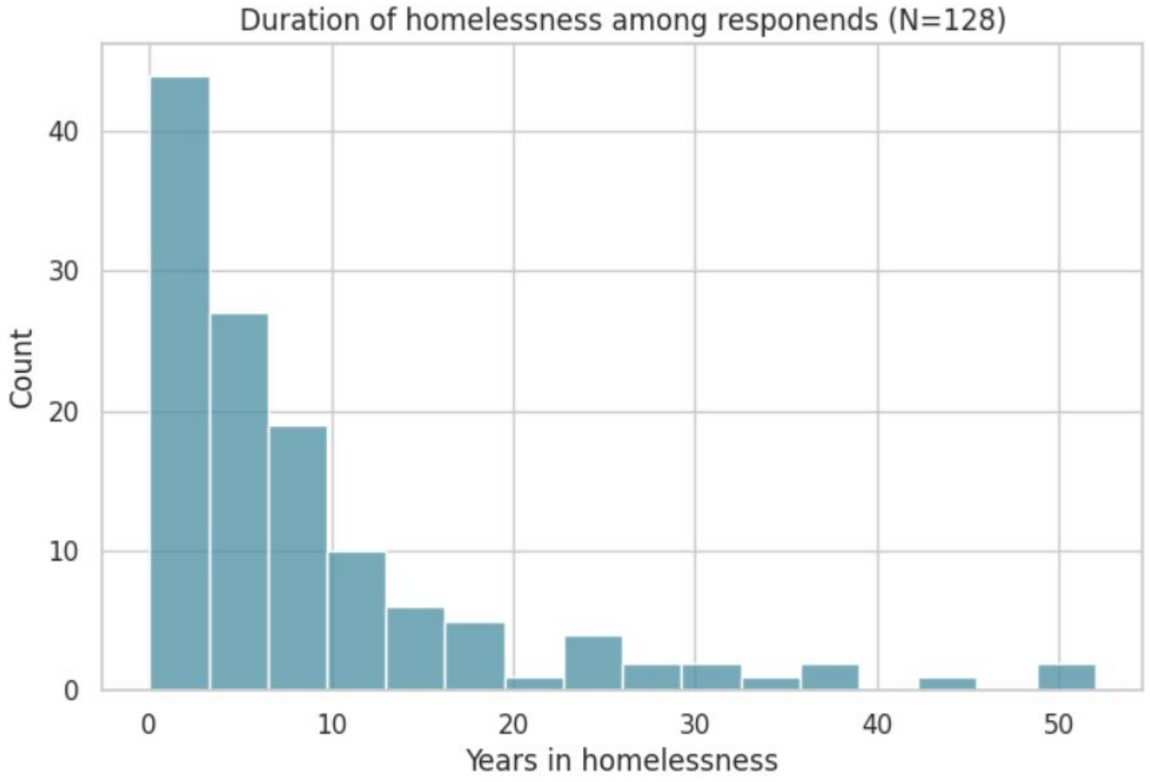
SK: Duration of homelessness

Average duration of homelessness among respondents (N=128):

8,9 years

Median:

5 years



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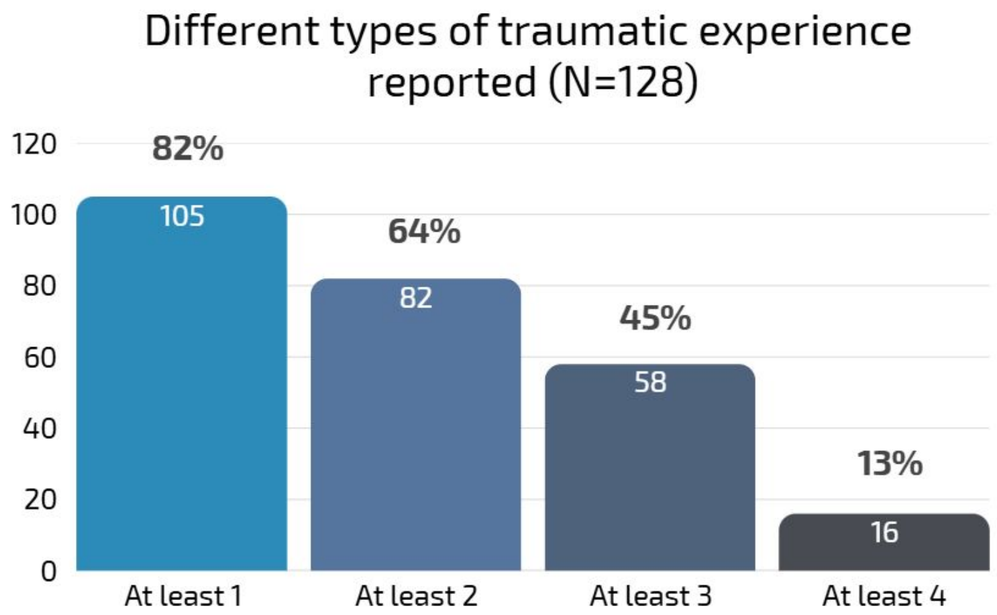
SK: Traumatic experiences



- ❑ Not having a loving person in childhood
- ❑ Lost someone due to their mental health
- ❑ Have lived with a person with addiction
- ❑ Having experienced an overwhelming event
- ❑ Neglect or abuse

Only 1 of the 7 interviewed local service providers uses **Trauma-Informed Care**.

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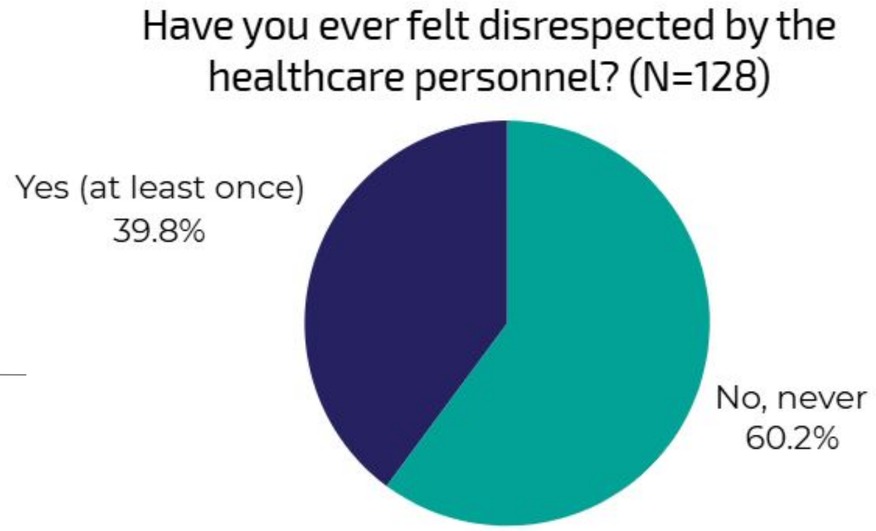
Slovak Sample: Impact of homelessness on healthcare utilization

4,1x higher use of **emergency** healthcare services than general population[1]

3,5x more often are clients **hospitalized** than the general population[1]

50% respondents have chronic diseases[2]



[1] *Source of Slovak official data: National health information centre (https://www.nczisk.sk/)*

[2] *Diseases were classified by our general practitioner based on her clinical judgement and the clients' reported health problems*

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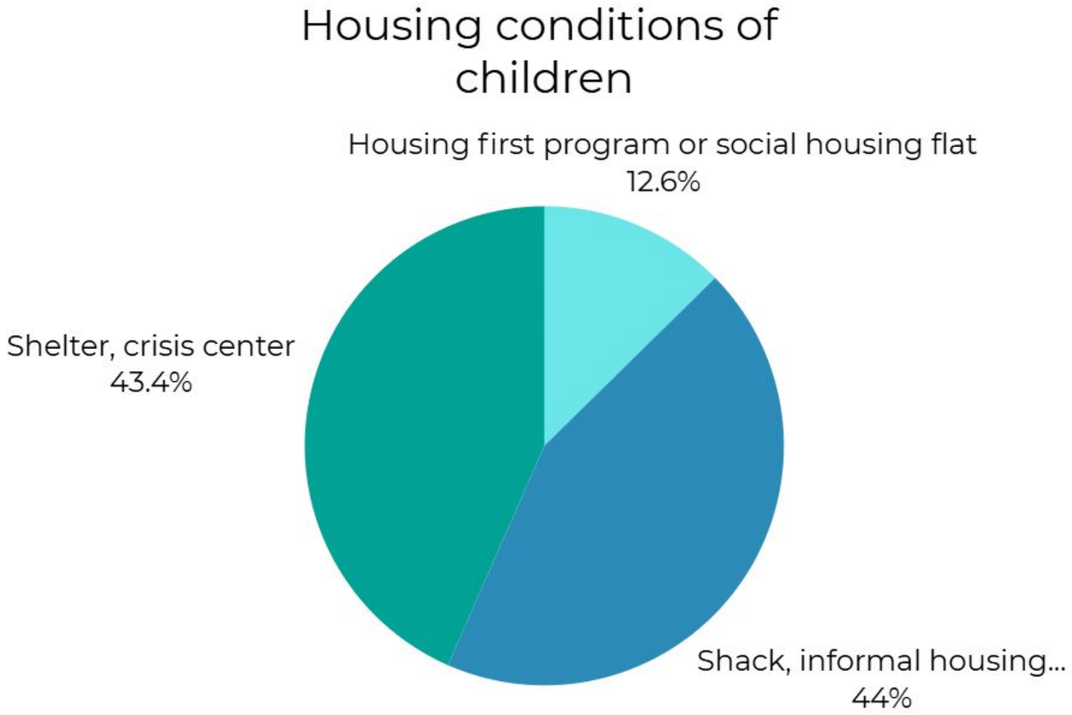
SK: Children

Information reported by adult household representatives

Number of children in SK sample: **182**

Average age: **~9 years**



Housing conditions

65.5% live in a household without their own shower and warm water

43.1% live in households without access to tap water

Health

24% were reported to have at least one health issue

10% has at least one chronic disease

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NEEDS ASSESSMENT
QUALITATIVE PART OF THE RESEARCH

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Challenges

Reported by both clients and providers

ACCESS TO HEALTHCARE	• Access to services for insured and uninsured • Better health literacy and awareness • Care for people with psychiatric or physical disabilities • Nutrition and prevention of major diseases • Cardiovascular screening in men, early diagnosis & treatment • Maternal and female health (including mental health) • Early childhood development support
ACCESS TO HOUSING	• Lack of appropriate housing options/transitional housing/affordable rental options • Improving living conditions and housing
ACCESS TO EMPLOYMENT	• Systems that support people in finding work
CAPACITY DEVELOPMENT	• Shortage of professionals • Low salaries

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Reasons behind the unmet needs

Reported by providers

1. Legal and Administrative Barriers

- Annual renewal requirement for permanent disability certificates
- Bureaucratic inefficiencies and weak support from the Employment Office

2. Healthcare Challenges

- Long waiting times, poor accessibility, and general distrust in public healthcare
- Delays in medical care and prosthetic services

3. Social Services and Accessibility

- Frequent staff turnover in social services
- Lack of public transport support

4. Discrimination and Stigma

- Experiences of disrespect and stigmatization in state institutions, especially for vulnerable groups

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Challenges of shifting service delivery
(to address needs and barriers, as reported by service providers)

Funding & services	Need for stable, predictable, flexible funding and pooled resources Covering integrated care, housing, long-term support for vulnerable groups
Administration	Regulatory gaps, complex bureaucracy, and insufficient resources Services often misaligned with family expectations
Organization & Coordination	Limited integration between health, social, and psychological services Need for better collaboration, clear roles, and stronger systems
Service Delivery	More capacity for integrated case management Flexible funding, staff training, and expanded therapeutic services
Clinical Settings	Gaps in standardized procedures, planning, and monitoring Need for continuous and coordinated care
Staffing	Shortages of staff and specialist support Greater need for training and supervision
Clients' Expectations	Mixed satisfaction; demand for more personal, accessible care Better communication, mental health, housing and financial help, less bureaucracy

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Introduction to planned services -
Models of Integrated Health & Social Care in partner organizations based on their target groups

Country	Model	Target Group
Slovakia (DEDO & Všetci pre rodinu)	Integrated Health & Social Care HUBs (GP, psychiatry, psychology, social & legal counselling, work integration) + outreach teams + telemedicine	Chronically homeless individuals & families in Housing First, incl. multimorbidity & mental health needs
Hungary (MALTAI)	Hybrid medical model (mobile clinics, digital health, telemedicine, community-based support)	Rough sleepers & long-term homeless with chronic diseases and low digital literacy
Bulgaria (HESED)	Community-based integrated centres in marginalized neighbourhoods with outreach, health & psychosocial support	Homeless people & marginalized Roma communities facing health & social exclusion
Poland (Housing First Poland – NMP)	Specialist mobile support teams linked with Housing First, focusing on mental health & trauma-informed care	Individuals with long-term homelessness, now in municipal flats, with complex mental health challenges
Romania (Casa Ioana)	Integrated services for families & women (psychosocial support, employment counselling, linkage to health)	Women & children experiencing family homelessness or domestic abuse

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Addressed Needs and Remaining Systems Gaps I.

Identified Health and Social Needs / Barriers	Planned SOLACE Response (DEDO/VPR)	Remaining Systems Gaps
Healthcare Access & Trust • Difficult access to healthcare • Lack of insurance • Distrust & fear of doctors / rejection • Being refused services • Health care seen as low priority	**HUB with GP & basic specialists** • Adult screenings • Social support to encourage participation	• Insurance & entitlement reform • Reduction of refusals & waiting times
Need for accompaniment & transport • Immobility • Inaccessibility of specialists	**Outreach & peer workers** • Accompaniment to appointments • Referrals to specialists	• Long-term transport subsidies • Respite / rehab care
Psychological & Emotional Support • Lack of psychological support • Lack of social & emotional support • Stressful environments	• **HUB psychologist** • Peer support & group activities • Trauma-informed care approach	• Wider psychiatric services • Culture change in public institutions
Coordination & Flexible Support • Poor coordination between health & social services • Need for flexible support • Support limited to administrative help	• **Case management in HUB** • Social support embedded in health services • Linkage to NGOs	• Systemic inter-agency reforms • Stable funding for flexibility
Employment & Legal Support • Limited employment opportunities • Debt enforcement / legal issues	• Legal counselling in HUB • Job-related support services	• National labour market measures • Job & transport subsidies

Needs Addressed by SOLACE (DEDO/VPR)

Key Messages:

- **HUB + outreach** = easier access to health & psychological care
- **Social, legal & peer support** to overcome barriers
- **Safe environment with trauma-informed approach**

Addressed Needs and Remaining Systems Gaps II.

Identified Housing and other needs/barriers:	Remaining Gap:
Housing & Continuity of Care • Lack of external housing facilities • Lack of transitional housing • Absence of follow-up after hospital discharge	• **Transitional & medical respite housing** • **Structural reform of shelter/housing system**
Shelter Conditions & Daily Life • No day access to shelters • Need for hygiene facilities	• Day centres with hygiene • Shelter system reform
Human Dignity & Rights • Discrimination & shame • Lack of privacy • Need for humane, less bureaucratic approach	• Anti-discrimination reforms • Administrative simplification
Basic & Family Needs • Food access priority • Babysitting problems • Lack of finances	• Broader welfare & childcare support • Financial assistance
Transport (structural) • Limited transport opportunities	• Subsidized or systemic transport support

Key Messages:

- Housing & shelter conditions remain unresolved
- Structural gaps: transport, finances, discrimination
- Require systemic & legislative reforms beyond project scope

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Integrated HUBs - Košice & Prešov

Core Functions (WHAT)

One-stop access: GP, psychiatry, psychology, social, employment & legal counselling

Outreach teams: MD+ nurse + social worker + peer support

Case management: integrated health & social plans

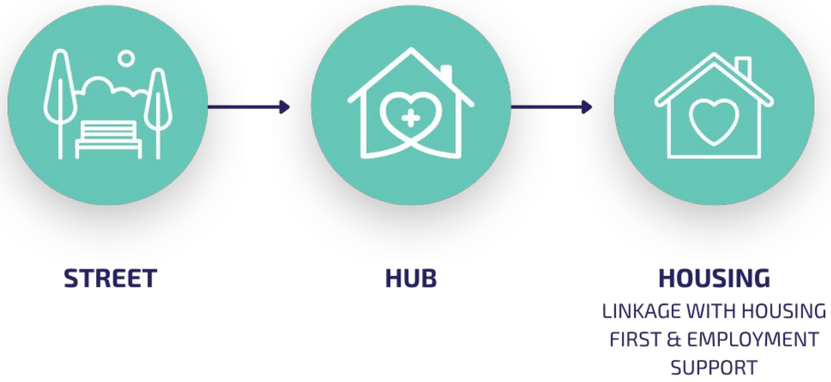
Telemedicine & digital health consultations

Referrals to specialists & hospitals

Principles (HOW)

- Low-threshold, inclusive, no insurance required
- Trauma-informed, safe & respectful environment
- Person-centred, voluntary, dignity-driven care
- Integrated multidisciplinary teamwork

Continuity of care:



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