SOLACE CEE

Social profile, health literacy, service use and needs of potential clients of integrated services across 5 pilot sites within the SOLACE-CEE project

FEANTSA webinar * 2 November, 2026

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Nr. 101172625

Alena Vachnová | Strategic and Vision Manager

SOLACE-CEE: Introduction to the project and its overall approach

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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 makes us unique?

INTEGRATED HEALTH, HOUSING, AND SOCIAL CARE

IMMEDIATE SUPPORT, NO PRECONDITIONS

FROM STREET TO PERMANENT HOUSING, HEALTH IS AT THE CORE



We Don't Just House People.

We Heal Them.

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What makes us different?



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

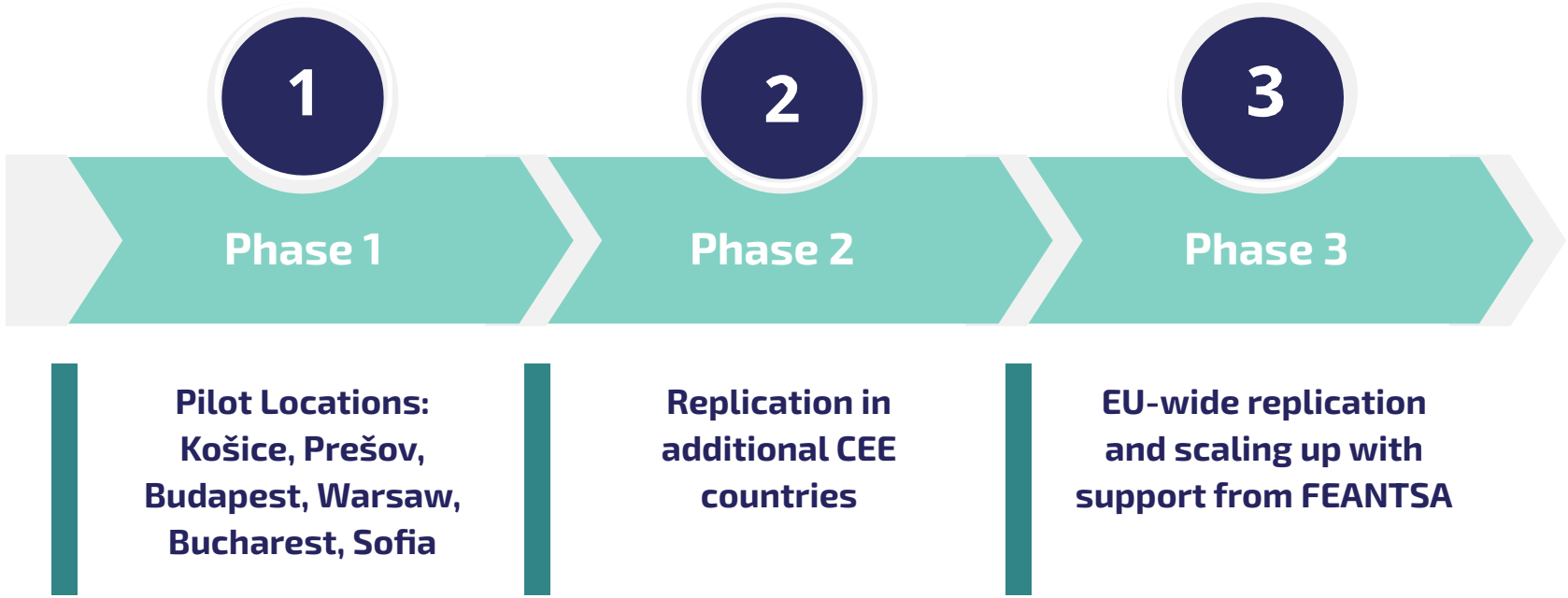
CAPACITY BUILDING

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Why it works (FAST)?

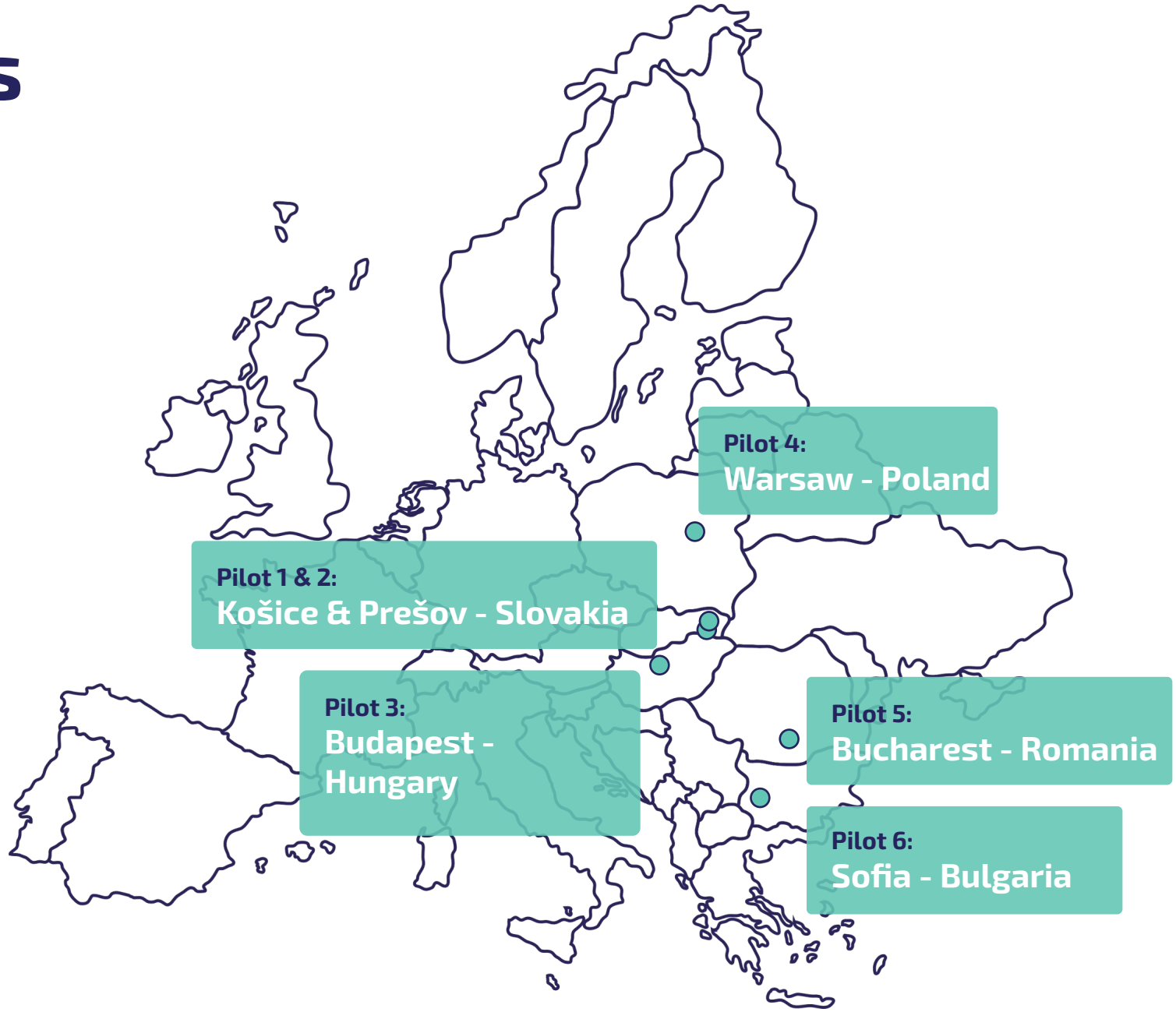
- Pilot locations: 5 countries, 6 cities, 7 partners
- Immediate and complex care
- **Scalable across the EU**



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Pilots



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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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TheFuture

Ending Homelessness by 2030 isn't a Dream - it's a Plan

Ending Homelessness for Chronically Homeless

Creating effective pathways to housing stability and well-being.

Replication Potential

Providing a blueprint for other EU countries.

Policy Advocacy

Contributing to systemic changes across the CEE region and Europe.



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Nóra Teller

MRI - METROPOLITAN RESEARCH INSTITUTE:

Social profile and service needs of potential clients of integrated services across the 5 pilots

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METROPOLITAN RESEARCH INSTITUTE (MRI) - HUNGARY

Research partner in SOLACE-CEE

MRI is an independent research institute based in Budapest with strong expertise in housing, social policy nd urban development. In SOLACE-CEE, MRI provides research, evaluation and evidence to support the development, monitoring and scaling of integrated care responses to homelessness.

WHERE WE WORK?

Lónyay utca 34,
H-1093 Budapest, Hungary

mri@mri.hu

OUR ROLE IN THE PROJECT

NEEDS ASSESSMENT DESIGN

Designs needs assessment surveys and supports analysis of results.

MONITORING & EVALUATION

Leads project monitoring and evluation, including tracking progress and outcomes.

DATA REPOSITORY

Designs the project data repository and supports structured evidence collection.

RESEARCH FINDINGS

Publishes project research findings and translates them into practical learning for the partnership.

DISSEMINATION, REPLICATION & SCALING

Supports dissemination of results and contributes to replication and scaling of the model.

ADVOCACY SUPPORT

Strengthens the project's advocacy efforts through evidence-based recommendations.

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TARGET GROUPS

Five pilots in five CEE countries:

- **Casa Iona (RO):** Women and children fleeing domestic violence, currently staying in shelter (Bucharest)
- **HESED (BG):** Segregated Roma neighbourhood – main clients: children + mothers (Sofia)
- **HCSOM (HU):** Single PEH (in shelters and public spaces) (Budapest)
- **DEDO/VPR (SK):** Families in homelessness / precarious housing and single PEH, current and potential clients (Kosice, Presov)
- **NPM (PL):** Housing First single clients (formerly PEH) (Warsaw)



Needs assessment: understand support needs of the clients and inform integrated service development as input data

Mixed approach:

- **Quantitative** survey with clients

- **Qualitative:** interviews and focus groups with service providers and (potential) clients

Clients - survey respondents by pilots (N=265)

BG	15%	RO	6%
HU	20%	SK	48%
PL	11%		

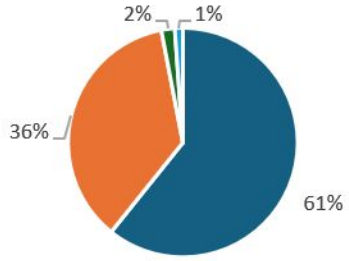
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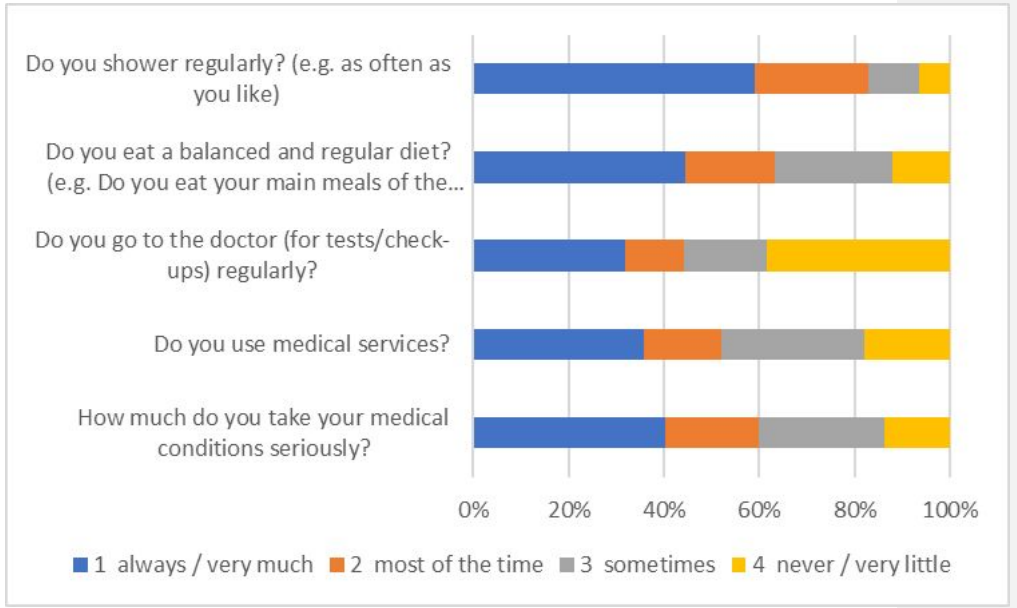
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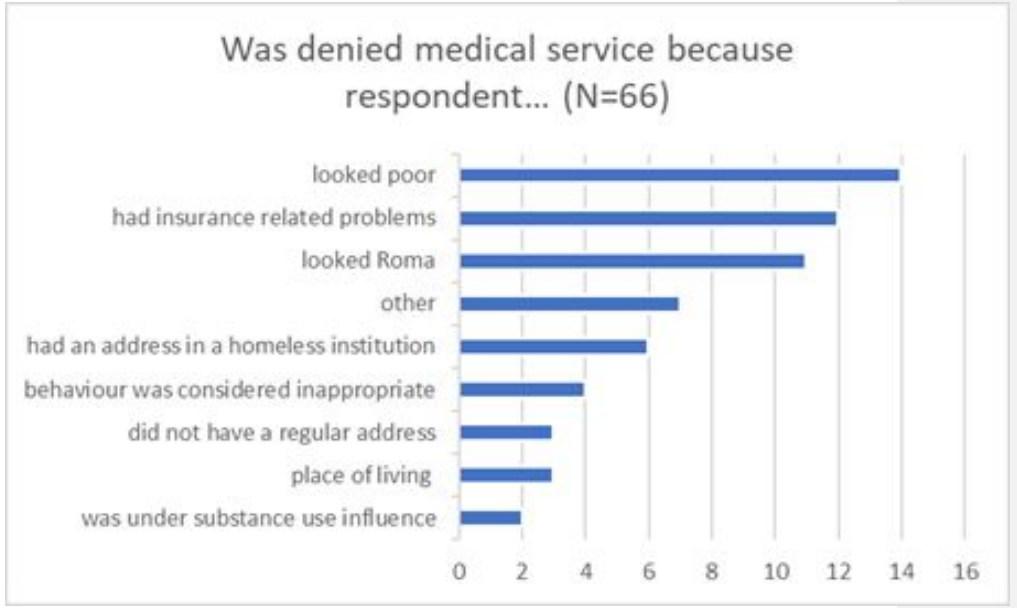
GENERAL OBSERVATIONS

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



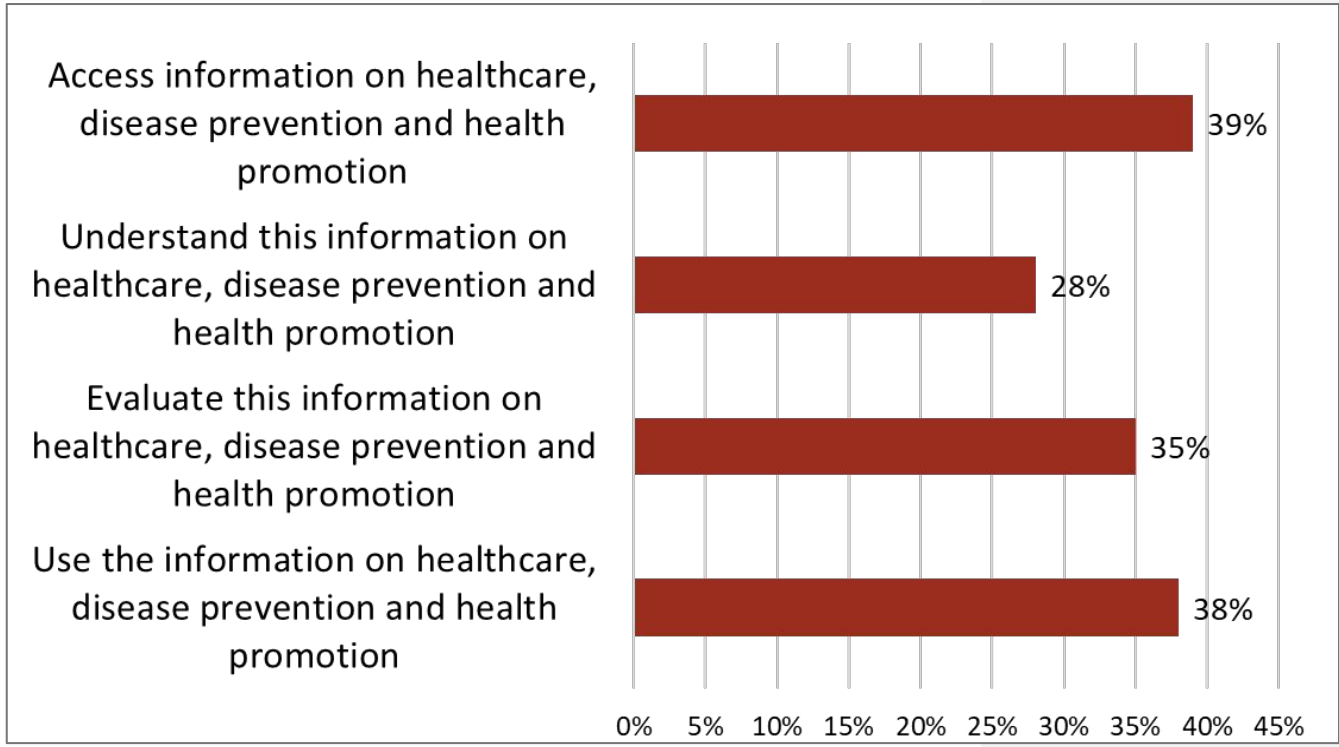


HEALTH LITERACY

Definition: complex ability to access, process and apply information on one's health and use of health services

Measurement: simplified European Health Literacy Population Survey adjusted to the clientele's characteristics

Results: clients answered health literacy related questions grouped into the following 4 dimensions assessing the difficulties on a 1-4 scale (from very difficult to very easy)



Share of those who find it very difficult or difficult to …



Key conclusions and implications for integrated service development

Relations between health literacy and healthcare use:

- Low health literacy is a major barrier to effective use of healthcare
- Health literacy strongly correlates with low level of education attainment
- Gender disparities exist: women have much lower education attainment and low level of reproductive health knowledge
- Healthcare utilization remains low despite worse-than-average overall health condition
- Underutilization is also driven by clients' discomfort during treatment and past experiences of discrimination - representing an extra barrier for our highly trauma-impacted clientele.

Implications for service design:

- Facilitate mediation between clients and healthcare providers, including sensitization of service providers
- Prioritize targeted campaigns to raise health literacy awareness

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Magyar Máltai Szeretetszolgálat

Dr. Sándor Békási

The Hungarian Charity Service of the Order of Malta:

Presentation of the Hungarian pilot, including telemedicine and telepsychiatry.

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MAGYAR MÁLTAI SZERETETSZOLGÁLAT

HCSOM
MAGYAR MÁLTAI SZERETETSZOLGÁLAT

Integrated health and social services for people experiencing homelessness through innovation, telemedicine and strong community partnerships. We serve the most vulnerable - regardless of background - in line with the values of the Order of Malta.

WHERE WE WORK?

28 Bem rkp.,
Budapest, 1011, Hungary
Central Hungarian Region

mmsz@maltai.hu

WHO WE SUPPORT?

People experiencing homelessness - especially those with physical and mental health problems - and people with insecure housing or financial situation.

OUR ROLE IN SOLACE-CEE

- Bringing digital health expertise and piloting telemedicine (including telepsychiatry)
- Delivering training for health workers and outreach teams
- Working with municipalities, ministries, expert groups, labour offices
- Using participatory design to develop meaningful services with clients
- Sharing experience on integrated care approaches

OUR SERVICES & ACTIVITIES

24/7 Health Center, Hostels, Shelters, Night Shelters, Day Centres, Outreach Services
In Budapest and countrywide

HEALTH SERVICES (On-site & Outreach)
- General practice care
- Nursing care
- Health counselling
- Regular health screening

MENTAL HEALTH SERVICES
- Psychiatric assessment
- Telepsychiatry
- Medication management
- Crisis intervention

TELEMEDICINE & TELEPSYCHIATRY
- Remote consultations with specialists
- Access to care for hard-to-reach clients
- On-site telemedicine assistants in shelters help with appointments, technologyn support, and patient engagement

SOCIAL SERVICES
- Case management
- Individual action plans
- Personalized support
- Administrative help

TRAINING & CAPACITY BUILDING
- Telemedicine training for health and social workers
- Training for members of outreach teams
- Train-the-Trainer approach
- Best practice collection and dissemination

REMOTE MONITORING & DEVICE RENTAL
- Remote monitoring for chronic conditions
- Medical device rental (blood pressure monitor, blood glucose meter, pulse oxymeter, thermometer
- Mobile device rental (smartphone, tablet)
- Wearables and digital tools for a better clinical decision
- Devices support telemedicine, self-monitoring and raise health-consciousness

INTEGRATED, PERSON-CENTRED & TRAUMA INFORMED CARE

We connect medical, mental health and social support to address the whole person, empower recovery and promote dignity and inclusion

OUR GUIDING PRINCIPLES

- Trauma-informed and recovery-oriented
- Individualized and participiant-led
- Integrated health, mental health and social support
- Flexible in-person, phone and online support

HOW THE PILOT WORKS

- Remote consultations linked with in-person support
- Patients are encouraged to take an active role in treatment
- Monitoring of chronic medical parameters and any change in health status
- Devices complement telemedicine
- Information is shared (with consent) to ensure continuity of care across services

PILOT FOCUS & SERVICE APPROACH

PILOT FOCUS AREAS

- Working with shelter residents and rough sleepers
- Digital health support through telemedicine and remote monitoring
- Service delivery in homeless sheltersand at the Integrated Homeless Care Centre on Miklós Street, Budpest
- Improved continuity of care for people with complex needs

SERVICE APPROACH

- Person-centred & trauma-informed
- Accessible & easy to reach
- Holistic & integrated
- Collaborative & community-based
- Empowering & respectful
- Low threshold services

OUR GOAL

To ensure that everyone experiencing homelessness in Hungary has access to the right care and support to live a dignified and meaningful life.

HCSOM - HUNGARIAN CHARITY SERVICE OF THE ORDER OF MALTA, HUNGARY

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Digital Health Research & Innovation

Before SOLACE: already existing physical infrastructure

- **Health:** Primary care unit with internal medicine and psychiatry specialist ambulatory care
- **During COVID:** Experiments started with digital health tools and telemedicine
- **Social:** 3 shelters and 2 respite care units, outreach teams

Within SOLACE:

- **Scale-up of telemedicine services:** extension to more shelters, to rough sleepers via outreach teams, inclusion of telepsychiatry
- **Creation of a complex digital health ecosystem:** including the training of telemedicine facilitators for sustainability
- **Additional screening and care activities supported by digital technology**
- **Experts by experience group and co-design**

Why is it important: *Digital health research can reduce the digital exclusion, address a critical evidence gap and inform more equitable access to care.*

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SOLACE / SYSTEMATIC REVIEW

Where the evidence comes from

59 publications · 8 countries



44	United States	**5**	Hungary	**3**	United Kingdom	**2**	Germany
2	Australia	**1**	Canada	**1**	Sweden	**1**	Spain

Circle area is proportional to publication count. Locations are approximate.

Coastlines: Natural Earth

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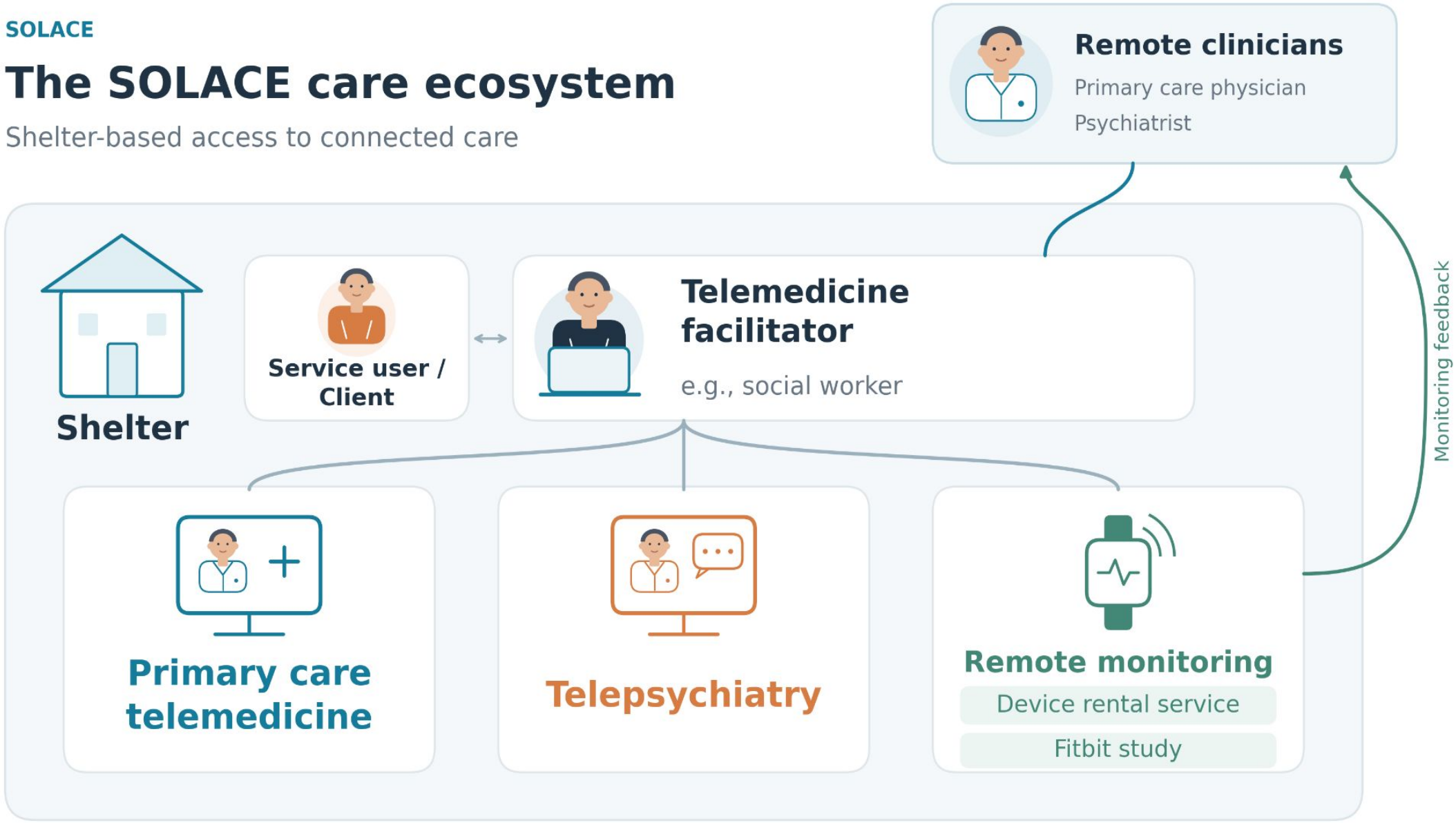
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SOLACE

The SOLACE care ecosystem

Shelter-based access to connected care



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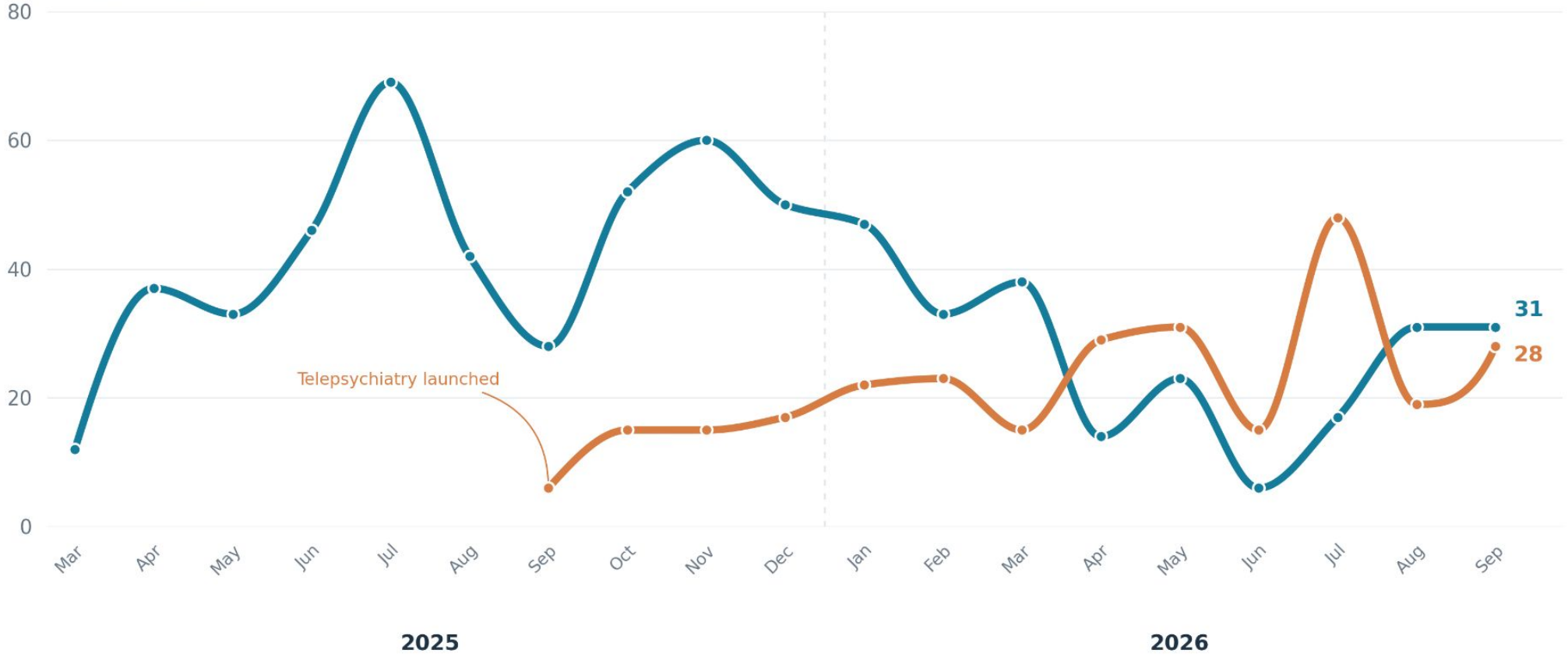
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SOLACE

Monthly participation in remote care

March 2025 – September 2026

	Telemedicine	Telepsychiatry
Part:	305	131
No of OV:	690	278



Source: SOLACE project, monthly statistics. Participation counts do not represent unique patients.

Telepsychiatry launched in September 2025. Dots show observed monthly values; curves are visual guides.

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hesed
health and social development
здраве и социално развитие

Silvia Vassileva

Health and Social Development Foundation

Presentation of HESED's integrated model for support of families in housing insecurity.

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hesed
health and social development
здраве и социално развитие

HESED´S INTERVENTION

We improve the health and well-being of people in housing instability, with a focus on vulnerable Roma communities in Sofia, Bulgaria.

We support women and children experiencing homelessness or domestic violence.

WHERE WE WORK?

Sofia, Bulgaria
mail@hesed.bg

OUR APPROACH

- **Person-centered and empowering**
- **Trauma-informed and gender-sensite**
- **Whole-family and holistic**
- **Partnerships with public services and community**
- **Continuous support and follow-up**

OUR INTEGRATED MODEL: HEALTH + SOCIAL SUPPORT

Deliveres together in the community - through our Social centre and Mobile teams.

WHO WE SUPPORT?

People in housing instability and difficult to reach Roma communities, especially women and children.

We welcome:

- Families and individuals in housing instability
- Women facing multiple vulnerabilities
- Children at risk of poor health and nutrition
- People with chronic health conditions
- Those outside formal health and social systems

HEALTH SERVICES

Primary healthcare
On-site medical cabinet in the social centre

Mental health & psychological support
Counselling and emotional support

Nutrition support
Nutritional assessment and support for children and families

Field outreach & mobile care
Services deliveres in neighbourhoods and at home

SOCIAL SERVICES

Social support
Case managemant help with documentation, benefits and systems

Housing support
Advocacy and support to access adequate housing

Education for children
Support for school enrolment, attendance and development

Support for women
Empowerment rights, protection, safety, employment motivation and consultations

Community engagament
Local partnerships and capacity building

COORDINATED CARE

One team, one plan: regular case conferences ensure seamless coordination between health and social services for each person and family.

OUR PATHWAY TO WELL-BEING

1. Outreach & engagement
2. Health & social assessment
3. Integrated care plan
4. Support & stabilization
5. Empowerment & capacity building
6. Improved health & community inclusion

OUR GOAL & IMPACT

We improve health, strengthen families and communities, and create real opportunities for a better future.

**BETTER HEALTH.
STONGER FAMILIES.
DIGNIFIED LIVES.**

HESED is committed to improving health and social well-being and ensuring that no one is left behind - no matter where they love.

**Health is a right.
Dignity is for everyone.**

We work fo stronger communities and a healthier future for all.

HEALTH AND SOCIAL DEVELOPMENT FOUNDATION

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VERA, 27 YEARS OLD

Single mother of three daughters (3, 6 and 8 years old)

Lives with two of them in a one-room informal dwelling with her brother.

No running water, indoor sanitation or reliable electricity.

Unemployed, illiterate, and financially dependent on social benefits and family support.

Housing insecurity has been a constant factor throughout the family´s life.

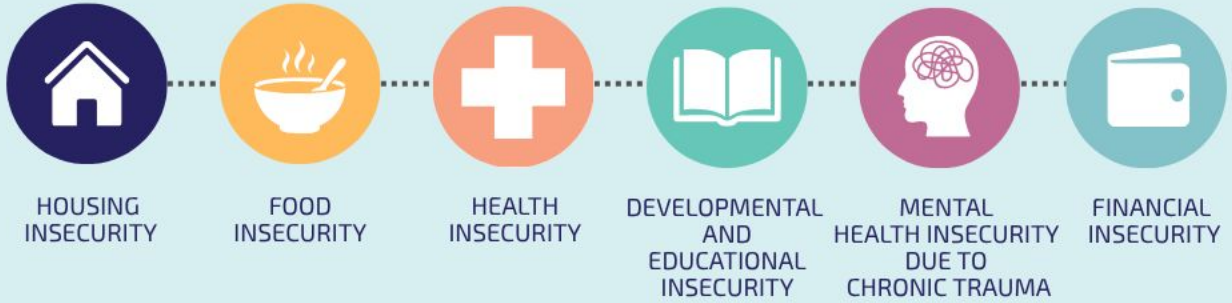
Living conditions that shape





Daily life is organized around **survival.** These are not individual failures - they are the predictable outcomes of specific material conditions: **no stable routine, lack of Infrastructure, overcrowding, constant stress.**

What appears to be a housing problem is, in reality, a chain of interconnected insecurities affecting food, health, child development and education, mental health due to chronic trauma, and finacial stability.



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The cycle of insecurities and the team's response

SYSTEM OF INSECURITIES
HOW HOUSING INSECURITY TRIGGERS A CHAIN OF RISKS

1. **HOUSING INSECURITY**
   Unsafe or inadequate housing, unstable conditions, risk of losing shelter.
2. **FOOD INSECURITY**
   Limited access to enough nutritious food and basic products.
3. **HEALTH INSECURITY**
   Unmet health needs, lack of preventive care, poor health.
4. **DEVELOPMENTAL AND EDUCATIONAL INSECURITY**
   Absences and difficulties at school, limited learning and development, risk of dropping out.
5. **MENTAL HEALTH INSECURITY DUE TO CHRONIC TRAUMA**
   Chronic stress, anxiety, low self-esteem, emotional difficulties for the whole family.
6. **FINANCIAL INSECURITY**
   No stable income, dependence on others and social benefits.

AFFECTS THE SITUATION

THE FAMILY AT THE CENTER

STRENGTHENS THE FAMILY BREAKS THE CYCLE

SYSTEM OF THE TEAM'S RESPONSE
HOW THE TEAM SUPPORTS THE FAMILY

1. **HOUSING SUPPORT**
   Housing advocacy, applications for municipal housing, coordination with institutions.
   — Social Worker
2. **FOOD SUPPORT**
   Food program, food donations, material aid to meet basic needs.
   — Social Worker, Nurse
3. **HEALTH SUPPORT**
   Medical check-ups, tests, vaccinations, dental and gynecological care, health education.
   — Doctor, Nurse
4. **DEVELOPMENTAL AND EDUCATIONAL SUPPORT**
   Coordination with schools, attendance monitoring, learning support, school materials, sensory room.
   — Educational Specialist
5. **PSYCHOLOGICAL SUPPORT AND PARENTAL SKILLS TRAINING**
   Psychological support for mother and children, parental skills training, coordination with child protection services.
   — Psychologist, Social Worker
6. **EMPLOYMENT SUPPORT**
   Job counseling, assistance with job search and labor mediation.
   — Social Worker, Employment Specialist

TEAMWORK – AN INTEGRATED APPROACH

- Regular team meetings and information sharing
- Coordinated actions and a common family plan
- Holistic support and access to services
- Monitoring progress and adjusting the plan

Negative impact (risk increases)

Positive impact (breaks the cycle)

The family – at the center of both systems

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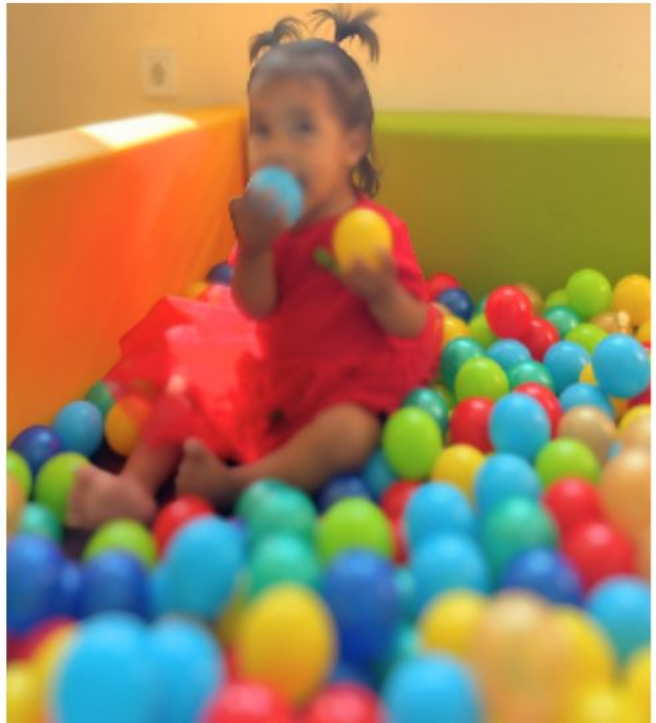






Fakulteta neighbourhood is Roma community with more than 35 000 inhabitants.

People living in extreme poverty and housing insecurity about 3500-4000.



Medical examinations: **670**
People examined: **350**

People receiving intensive social support (case management): **56**

People receiving psycho-social support: **359**

Employment consultations provided: **169**

Children involved in activities in a sensory room and other development activities: **183 children**

People, experiencing housing insecurity, actively using integrated services: 359

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Casa Ioana

Integrated Support for Families in Crisis:

Challenges, system gaps and measurable impact in Romania

Ian Tilling OBE
Founder and President at Casa Ioana

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CASA IOANA'S INTERVENTION

We improve the healt and well-being of people in housing instability, with a focus on vulnerable Roma communities in Sofia, Bulgaria.

Through our partnershop with the Red Cross, we provide integrated social support and healthcare - under one coordinated model.

WHERE WE WORK?

Bucharest, Romania

office@casaioana.org

OUR APPROACH

- **Person-centered and empowering**
- **Trauma-informed and gender-sensite**
- **Whole-family and holistic**
- **Partnerships with public services and community**
- **Continuous support and follow-up**

OUR INTEGRATED MODEL: SOCIAL SUPPORT + HEALTCARE

Casa Ioana coordinates docial services and housing. Red Cross Romania provides healthcare services.

WHO WE SUPPORT?

Women and children experiencing family homelessness, domestic violence or extreme vulnerability.

We welcome:

- Women with or without children
- Survivors of domestic violence
- Families in crisis situations

CASA IOANA - SOCIAL SUPPORT & HOUSING

- **Safe accomodation** — Temporary housing in a safe and supportive environment.
- **Psychosocial support** — Counselling, trauma-informed support, case management.
- **Legal Assistance** — Support with rights documentation and legal issues.
- **Employment & life skills** — Training and support for financial independence.
- **Education for children** — Educational support and activities for children.

RED CROSS ROMANIA - HEALTHCARE SERVICES

- **Medical consultations** — General and specialist consultations.
- **Treatment & Prevention** — Treatment medication and preventive care.
- **Health education** — Information and education on health and wellbeing.
- **Continuous care** — Follow-up and coordination of health needs.

COORDINATED CASE MANAGEMENT

Regular communication and case conferences between Casa Ioana team and Red Cross medical team ensure a holistic, person-centered approach and continuity of support

OUR PATHWAY TO INDEPENDENCE

Crisis & admission → Safety & stabilization → Building skills confidence & health → Independent living → Community inclusion

OUR GOAL & IMPACT

We help women and children rebuild their lives, regain independence and break the cycle of violence and poverty.

FROM CRISIS TO SAFETY, FROM SURVIVAL TO A NEW BEGINNING.

Casa Ioana is committed to ending family homelessness and domestic violence by providing integrated support, hope and real opportunities for a better future.

Every person deserves safety. Every family deserves a home.

In partnership woth Red Cross Romania for accessible healthcare for the most vulnerable.

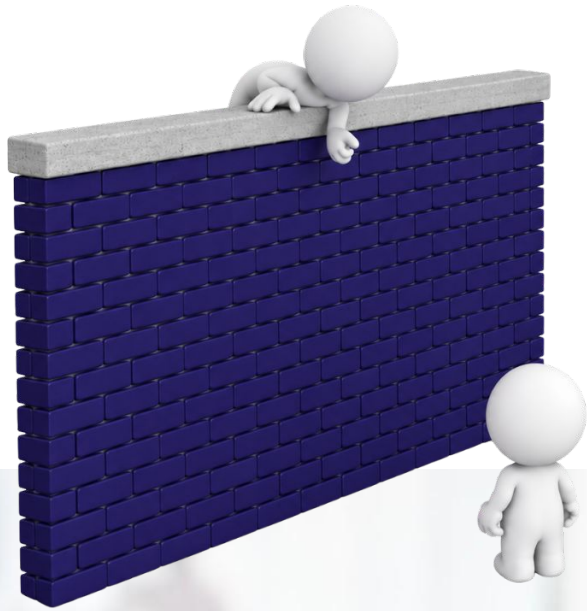
CASA IOANA, ROMANIA

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Major Barriers in Romania

- Fragmented social and healthcare systems
- Lack of identity documents and health insurance
- Institutional stigma
- Lack of safe shelters / temporary accommodation
- No long-term housing pathways





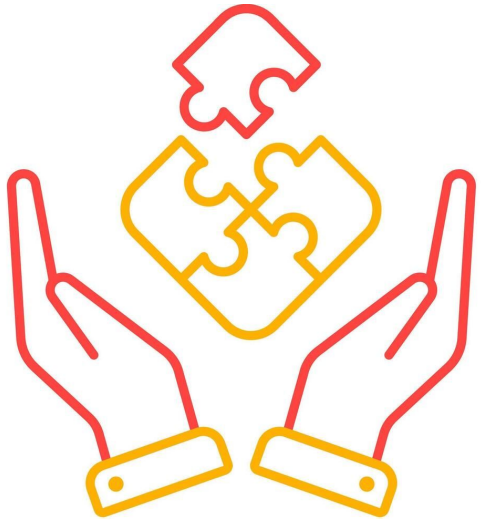
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Focus of the Solution

- Integrated health and social support
- Trauma-informed, value-based care
- System integration and capacity building
- Reintegration and life skills





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Solution Partnership Impact (SOLACE-CEE + Red Cross)

- Coordinated social and medical interventions
- Accessible healthcare
- Reliable pathway to stabilisation



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Measurable Health Impact

77 health assessments

- Integrated monitoring and referrals
- Cardiovascular, metabolic, nutritional and mental-health focus



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Forward Targets

150 free health assessments

- Specialist consultations
- Prevention and risk mitigation
- Continuous support





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Social Services Summary

66 Clients Supported

- Financial and legal support
- Shelter and housing placement
- Medical access and identity
  - documents
- Education and employment pathways





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Counselling Summary

29 Participants

- Adults: family dynamics, communication, self-awareness
- Youth: identity, peer dynamics, motivation, school transitions



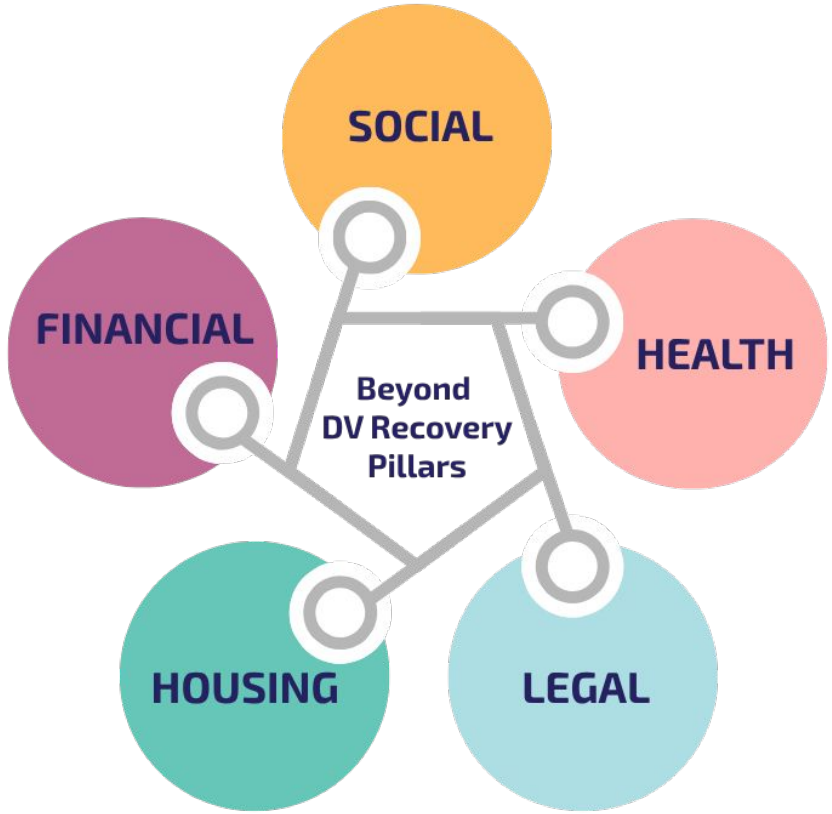
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Closing Message

Integrated care creates stability, dignity, and real opportunities for independence





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POLAND | PROJECT PARTNER

NAJPIERW MIESZKANIE

Julia Wygnańska | President of Housing First Poland Foundation (NMP)

Housing First Poland Foundation

Presentation of the Ambivalence Program - integration of health services to Housing First Value based model

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HOUSING FIRST POLAND FOUNDATION

We promote Housing First values and provide expertise, training and integrated support to end chronic homelessness in Poland.

We believe housing is a human right and the foundation for recovery, dignity and independence.

WHERE WE WORK?

Warsaw and other locations in Poland

fundacja@najpierwmieszkanie.org.pl

OUR APPROACH

- **Housing First values at the core**
- **Trauma-informed practice**
- **Individualized and participant-led**
- **Integrated housing, psychological and social support**
- **Flexible forms of meetings: in-person, phone and online**
- **In the community where people reside: mobile outreach services**
- **Data-informed practice and continuous learning**

WHO WE SUPPORT?

People:

- with experience of long term homelessness
- mental health crises
- in voulnerable housing situations
- predominatly in munical apartments

With us people (re)build trust, make future oriented choices and feel empowered to be leaders of their lives.

OUR INTEGRATED MODEL: HOUSING FIRST VALUES IN PRACTICE

RELATIONSHIP

Safe space for participant and worker to express themselves and receive each others reactions in order to model fullfiling behaviours.

HOUSING

Housing as a right: access to independent private and long term apartment without any preliminary conditions on assumed "readiness".

RECOVERY

The right to full physical, mental and social wellbeing with appreciation for each step towards better health.

SUPPORT

Access to individualised, multidisciplinary and integrated support relevant to health needs and goals.

DECISIONS

The right to take one´s own decisions concerning one´s life and goals, without them neing enforced by support workers, making sure that they develop one´s agency.

COMMUNITY

The right to be treated as equal member of the local community regardless of the housing situation and health needs.

OUR PROGRAMS & ACTIVITIES

Ambivalence program

Mobile specialist team supporting people in municipal apartments with mental health challenges.

Training & Education

Housing First training and fidelity consultation for programs and municipalities across Poland.

Research & Evaluation

Fidelity assessments, research and evaluation to strengthen and improve Housing First programs.

Advocacy & Awareness

Promoting Housing First values and the right to housing among stakeholders and the public.

OUR IMPACT SO FAR

- Ambivalence Program (since late 2021): **26 participants** supported, **12 fully independent.**
- Providing continuos support for as long as 18 to 36 motnhs for each Participant.
- Fidelity consultation and supervision increades across 3-5 programs.
- Increased capacity of services across municipalities to implement Housing First Values.

OUR GOAL

Empowering poeople to act towards ending homelessness and providing evidence based tools.

Housing. Support. Dignity. Together we end homelessness.

We believe in a society where everyone has a home and the change to thrive.

We are committed to international networking, cooperation and partnership to strengthen shared goals.

HOUSING FIRST POLAND FOUNDATION, POLAND

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Participants - target group

- mainly with a history of **long-term homelessness (from 3 to 15 years)**,
- aged between **26 and 70**,
- the majority uses **alcohol and/or other psychoactive substances** in a very harmful way,
- with **mental health issues** (e.g. personality disorders, anxiety disorders, depression, trauma, feeling of hopelessness or suicidal thoughts) and
- **physical health issues** (e.g. hypertension, anaemia, tuberculosis, cancer, organic brain damage, old bone and joint injuries),
- in general housed, majority living in **municipal apartments** from several months to several years (also at the point of engagement to the Ambivalence Programme).



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Barriers:

Systemic:

- limited access to psychiatric services
- no/hardly any dual diagnosis treatments
- low experience and use of harm reduction treatment
- luck of **quick access** to housing and prejudice against new tenants in training of neighbourhood norms
- no communication over one patient between various medical services

Some other:

- **very high support needs** of Participants
- **high emotional pressure** on support workers regardless supervision
- lack of stability for the team due to risk of no continuation of funding
- low awareness of health needs of people with experience of homelessness - homelessness as a welfare rather than health or housing issue



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Solution - Specialist HF Value based

Support profiled by Housing First Values: relationship, housing as a right, decisions, recovery, support adequate to diagnosis and community

Support Team (4 people , 2,25 of full time equivalent) with qualifications including::

- **psychology, psychotherapy** (in various modalities: psychodynamic, existential/logotherapy, solution-focused), motivational interviewing, crisis intervention, streetworking, social work

Support Worker/per Participants ratio: 0,5 work time/4 participants.

Team Meetings every week - 4,5 h each to discuss ongoing work with all Participants.

Group supervision every month - 3 h each to discuss most challenging difficulties and dilemmas we face in our work.



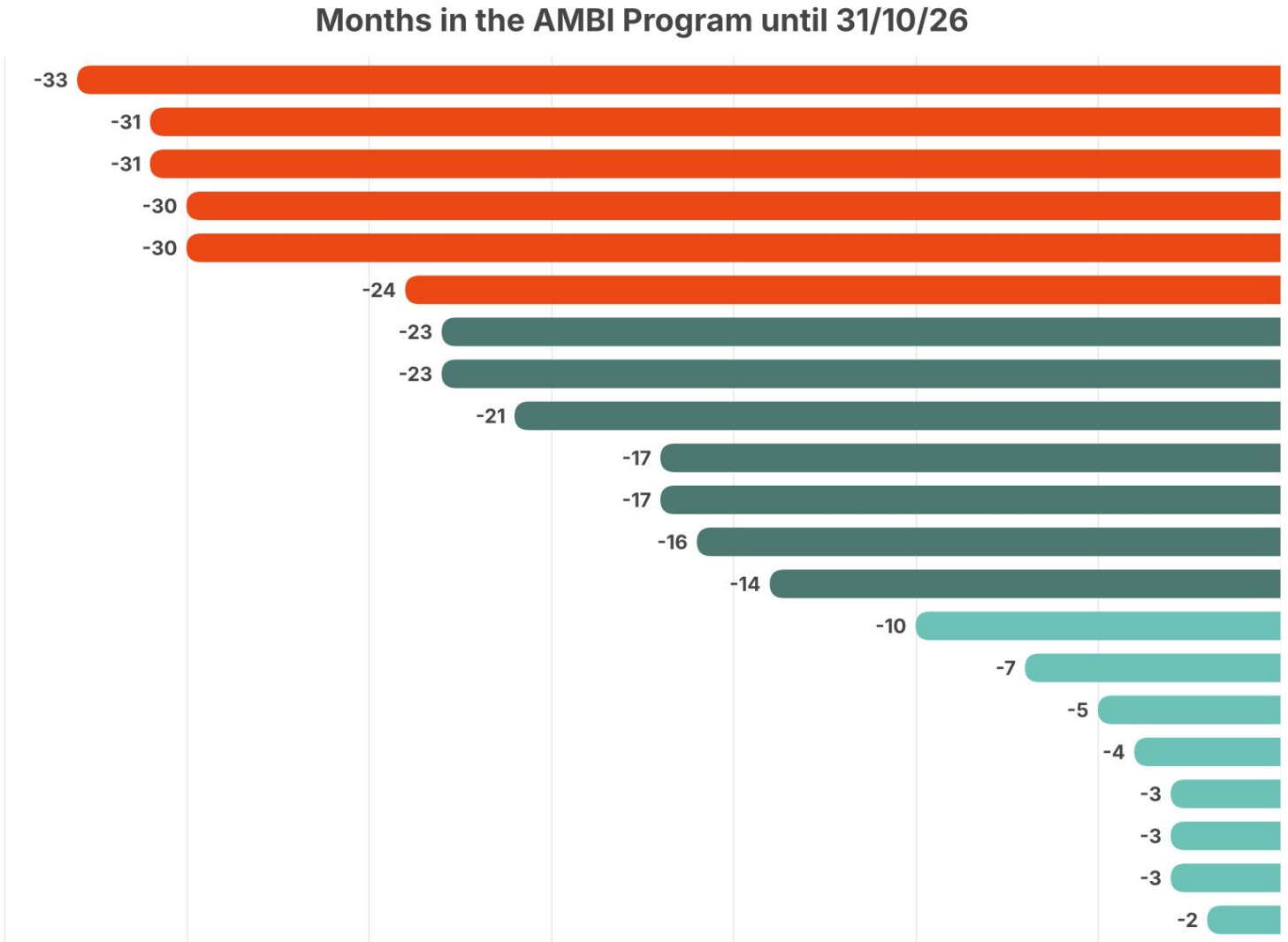
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Solution - long term as long as you need



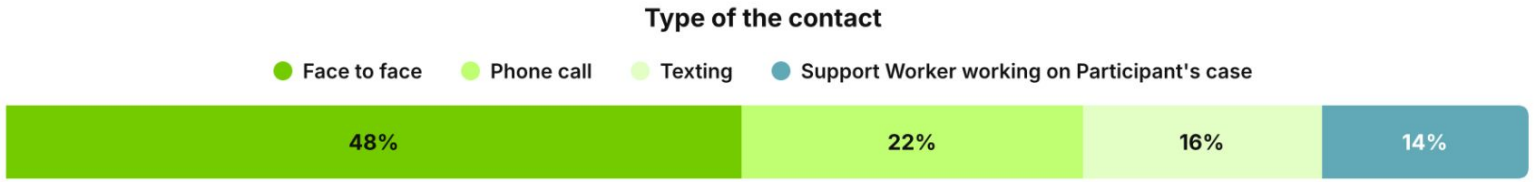
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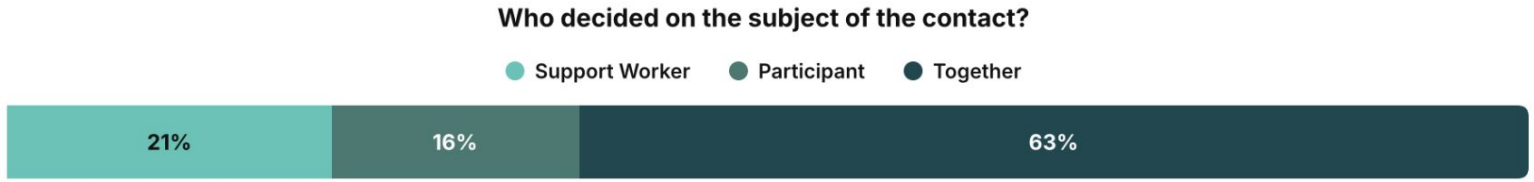
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Solution - intensive









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Všetci pre rodinu

Zuzana Chytilová

All for family

Integrated health and social care in practice, including the development of the Košice and Prešov HUBs.

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Košice & Prešov
Slovakia



TARGET GROUP

KOŠICE - **2300 people experiencing homelessness**

- **63,2 %** are in this situation 5 and more years
- **40,1 %** never had their own stable housing

PREŠOV - **801 people experiencing homelessness**

- **61,8 %** are in this situation 5 and more years
- **35,9 %** never had their own stable housing

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Všetci pre rodinu

ALL FOR FAMILY (VŠETCI PRE RODINU)

Integrated health and social care for people experiencing homelessness.

We connect outreach, outpatient care and housing-based support in Košice and Prešov.

WHO WE SUPPORT?

People experiencing homelessness and housing instability, including families and people who face barriers to healthcare and support.

We welcome:

- Families in housing need
- People experiencing homelessness
- People seeking integrated health and socila support
- People facing barriers to mainstream services

OUR INTEGRATED MODEL

OUTREACH SERVICES
Support reaches people where they are.

→

OUTPATIENT SERVICES
Integrated health and counselling support in care centers.

→

HOUSING-BASED SUPPORT
Long-term support for families in Housing First.

COORDINATED SUPPORT

One team, linked services: health care, psychological support, social counselling and housing-based support are connected to improve access and continuityof care.

CURRENT INTEGRATED SERVICES

Košice HUB

- General practitioner´s office
- Psychiatrist´s office
- Social, labour and legal counselling
- Psychological counselling

Prešov HUB

- General practitioner´s office
- Social, labour and legal counselling
- Psychological counselling

MULTIDISCIPLINARY TEAM

- General practitioner
- Nurses
- Psychiatrist
- Psychologists
- Social workers
- Lawyer
- Job coaches

WHERE WE WORK?

Košice, Prešov
Slovakia

info@vsetciprerodinu.sk

ACCESS PRINCIPLES

- Free of charge
- No health insurance required
- No requirements - open to everyone
- Low-barier access

COMPREHENSIVE | **ACCESSIBLE** | **TRAUMA-INFORMED** | **FOCUSED ON PREVENTION, STABILITY AND QUALITY OF LIFE.**

ALL FOR FAMILY, NGO | SLOVAKIA

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KOŠICE HUB 11/2025

Poliklinika SEVER - 5th floor



GENERAL PRACTITIONER'S OFFICE



PSYCHIATRIST OFFICE



SOCIAL, LABOUR AND LEGAL COUNSELLING



PSYCHOLOGICAL COUNSELLING

PREŠOV 05/2026

Švábska 41/A (Medical Centre Šváby)



GENERAL PRACTITIONER'S OFFICE

Lomnická 30 (DORKA)



SOCIAL AND LABOUR COUNSELLING



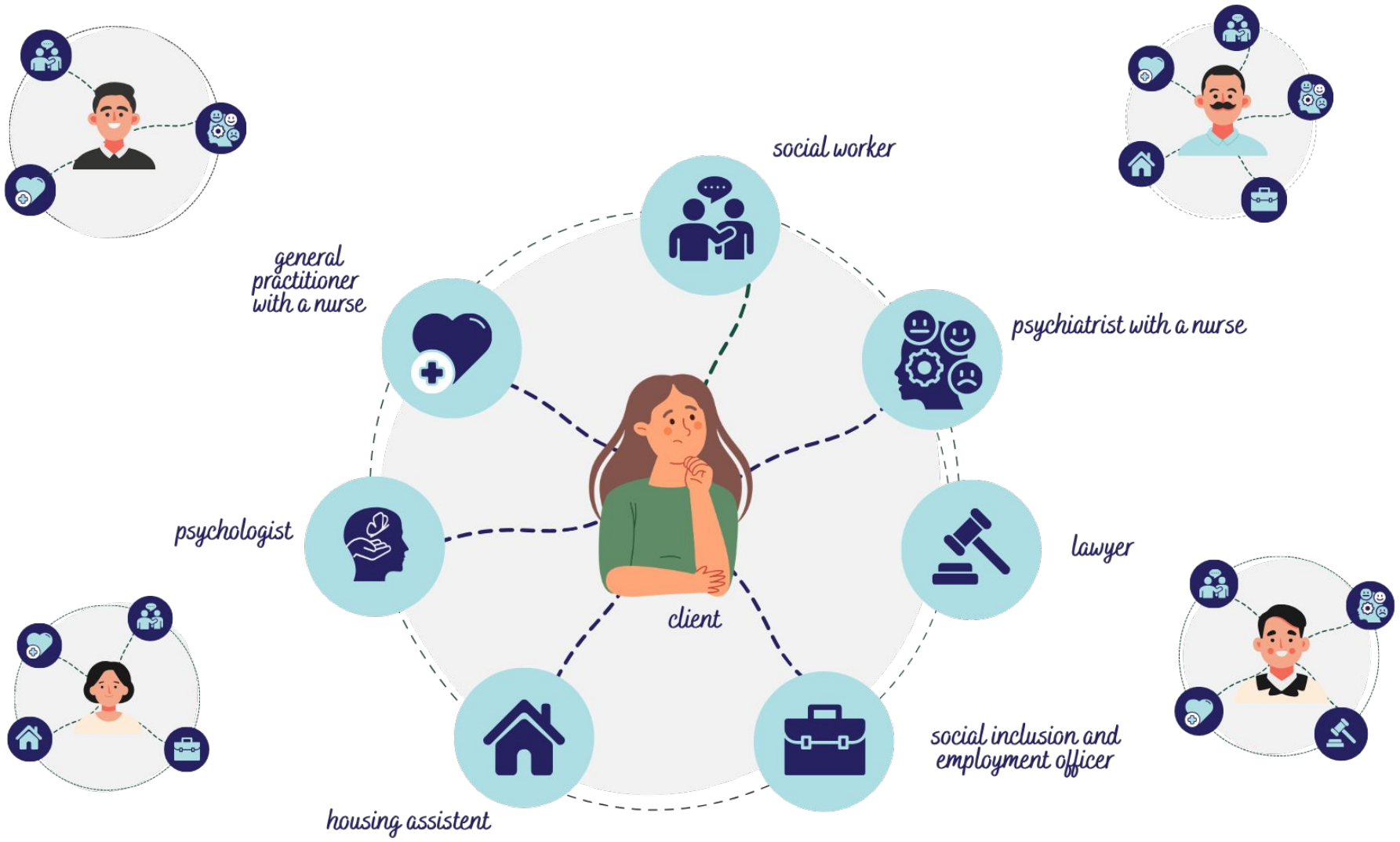
PSYCHOLOGICAL COUNSELLING

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Multidisciplinary team



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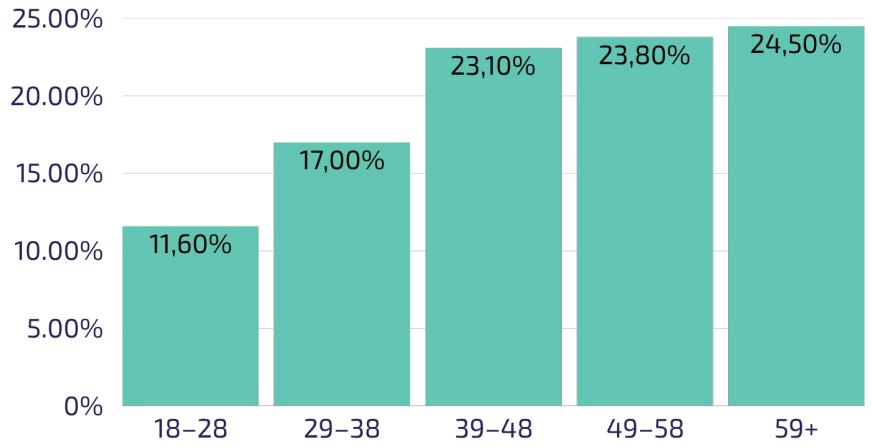
HEALTH | KOŠICE

11/2025

1510 Interactions with patients

130 Registered patients in the doctor's office

Patients by age group









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SUPPORT

KOŠICE | 11/2025

4110+ interactions with clients Košice

1320+ client's visit in Kosice HUB

PREŠOV | 06/2026

490+ interactions with clients Prešov

156+ client's visit in Prešov HUB







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Centre for Health and Social Stabilisation and Support

MEDICAL RESPITE CARE

The service provides temporary accommodation and temporary health, nursing and social assistance to people in vulnerable situations.

WHO IS IT FOR:

- people experiencing homelessness or in need of housing after being discharged from hospital;
- those in need of a safe environment to stabilise their health and support them in addressing their social situation.

GOAL:

To create a safe space for recovery
To prevent: *Deterioration of Health Status, Repeated Hospitalizations*
To support: *Stabilization of life, Return to Community, Obtaining stable housing*



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Nadácia DEDO

Alena Vachnová | COO of SOLACE-CEE

DEDO FOUNDATION

Sustainability and potential for replication.

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Nadácia DEDO

DEDO FOUNDATION

Coordinating organisation in SOLACE-CEE

DEDO Foundation is a coordinating and systems-oriented partner in SOLACE-CEE. Building on its experience in homelessness, housing support, integration and advocacy, DEDO helps connect the project´s service, policy and communication dimenssions across the partnership.

WHERE WE WORK?

Košice, Slovakia

info@nadaciadedo.sk

OUR ROLE IN THE PROJECT

PROJECT COORDINATION

Coordinates the partnership, supports plannong, reporting and smooth cooperation across countries and work package.

INTEGRATED SERVICE DESIGN

Brings expertise in designing integrated responses that connect housing, social support, helath-related pathways and inclusions.

COMMUNICATION STRATEGY

Contributes communication know-how and helos shape clear project visibility, messaging and outreach.

ADVOCACY & NETWORKING

Builds relationships with stakeholders, decision-makers and partner networks to strengthen impact and policy relevance.

HOLISTIC METHODOLOGY

Contributes a holistic approach that links counseling, housing assistance, employment-related support and social inclusion.

DISSEMINATION & SCALING SUPPORT

Helps share results, raise awareness and support replication and scaling of promising practices.

Connecting practice, partnership and systems change.

DEDO FOUNDATION | SLOVAKIA

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E-LEARNING LOADING...

INTEGRATED CARE

TRAUMA-INFORMED CARE

TELEMEDICINE

3 AREAS, 6 MODULES

- **Experts from 5 countries:** Slovakia, Poland, Hungary, Romania, Bulgaria
- **Also available in English, Bulgarian, Hungarian, Polish, Romanian and Slovak**



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SOLACE CEE

SUSTAINABILITY AND POTENTIAL FOR REPLICATION

Needs Assessment research

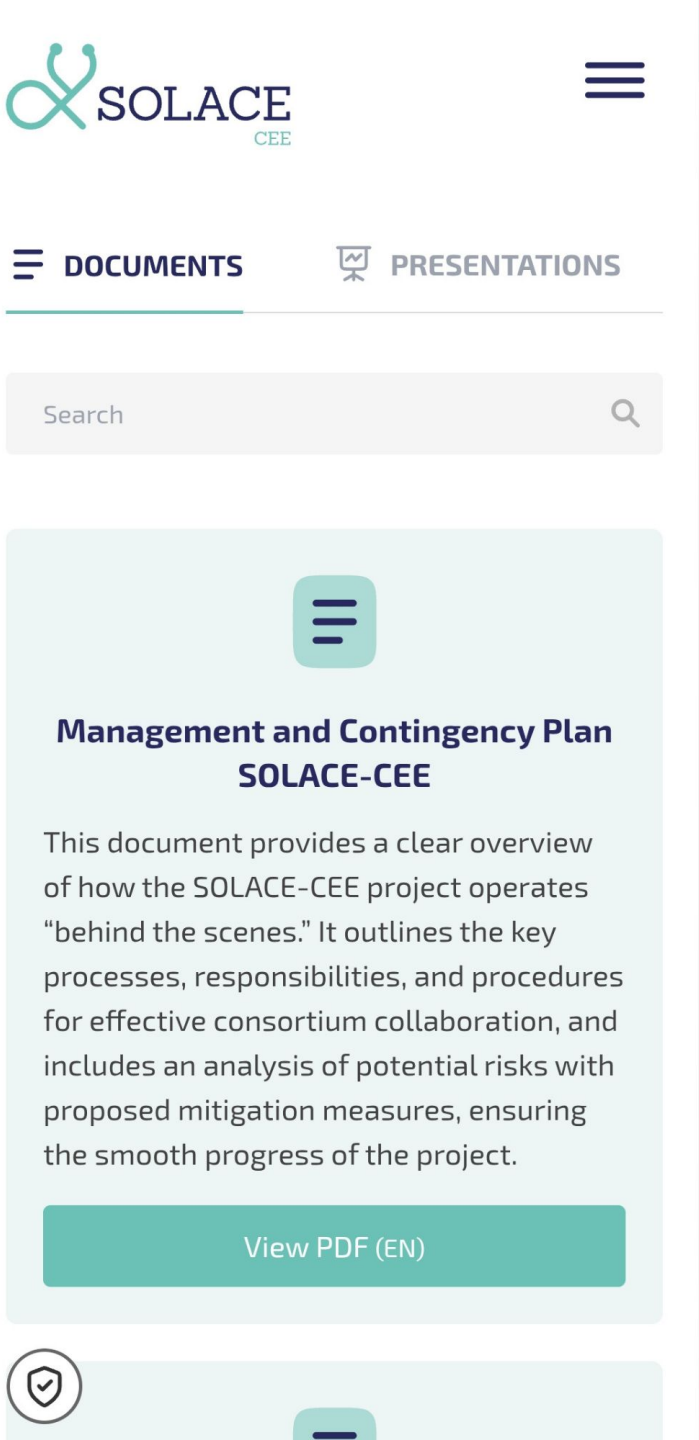
- Research results
- Questionnaires - available in 6 languages

Tools for replication

- Project Methodology Guideline
- Monitoring & Evaluation Plan
- Exploitation and Sustainability Plan
- Action Plan

Communication tools

- Communication manual
- Campaign materials
- Logomanual and press releases



Join us in transforming lives.

Together, we can **end homelessness**.

Follow our journey and latest updates on LinkedIn

Learn more about the project and its impact

Stay informed – subscribe for updates

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