

# NEEDS ASSESSMENT (Public Version)

Solutions for Overcoming Homelessness through  
Integrated Care in the CEE region

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# 1. Executive summary

The SOLACE-CEE needs assessment was designed with two primary objectives: to understand the support needs of clients for effective intervention design, and to provide initial evidence regarding integration gaps in health and social services across the CEE partner regions (Slovakia, Hungary, Bulgaria, Poland, Romania). The target audience includes policymakers, public health and social service providers, and organizations involved in homelessness provision.

The assessment used a mixed-methods approach, combining **265 standardized client questionnaires** (covering 655 individuals in total) with numerous **qualitative interviews and focus groups** involving clients and institutional stakeholders (social workers, health professionals).

## Key Findings

- **Socioeconomic vulnerability:** Clients demonstrated severe socioeconomic vulnerabilities, characterized by **low educational attainment** (35% of women having primary education or lower), **low formal employment** (only 16% in registered work), and heavy **reliance on social transfers** (53% primary income source). Long-term unemployment, debt, and subsequent disincentives for formal work are widespread issues.
- **Housing instability:** Nearly half of the surveyed households (**45%**) were living in homeless shelters, and another **23% were in non-conventional accommodation** (shacks, tents). Notably, **70% of families with children were single-parent households**, underscoring the severe vulnerability of these groups.
- **Health status and trauma:** Health challenges are endemic and complex. **61% of respondents had at least one chronic or recurrent health condition**, with poor nutrition, mental health conditions, and substance use being highly prevalent. Crucially, **80% of respondents reported a history of traumatic life events**, highlighting the severe and pervasive need for formal Trauma-Informed Care (TIC).
- **Access and behavioural barriers:** Routine healthcare use is limited and reactive. **40% of clients never went for check-ups**, and only 50% reported always looking after basic necessities like personal hygiene and regular meals. **Discrimination is a major barrier: 25% were denied medical services**, and **40% reported experiencing disrespect** during care due to poverty, appearance, or perceived ethnicity (e.g., looking Roma).
- **Health literacy and digital divide:** **Low health literacy** is a major obstacle, with **50% reporting difficulty assessing treatment benefits/risks**. The **digital divide** is significant: **27% have no internet access**, and many express discomfort with potential telemedicine solutions (e.g., 90% in some groups would not use an app for dermatological/dental diagnosis), requiring careful, mediated implementation.

- **Systemic gaps:** Service providers cited common structural obstacles: **fragmented funding** (no integrated mechanism for health and social care), **rigid administration** (complex benefit procedures, poor discharge planning), and **poor formal coordination** between health and social agencies. Unmet needs often stem from staff shortages, burnout, and limited training in specialized areas.

## Conclusion

Significant structural and behavioural gaps exist in housing, healthcare, and service coordination across the CEE region. Addressing these issues requires moving beyond crisis management towards **integrated, client-centred, trauma-informed, and adequately funded services** based on Housing First values. The findings confirm the urgency of the SOLACE-CEE project's focus on service reform and innovative care models.

## 2. Rationale and methodology

The needs assessment activity (March–June 2025) was fundamental to the SOLACE-CEE project's goal of improving Integrated Health and Social Care (IHSC) for people experiencing homelessness (PEH) in the CEE region. It aimed to inform partner-level intervention design and provide baseline evidence of health-social integration gaps.

### Research Tools

#### 1. Quantitative Data Collection:

- **Tool:** Standardized questionnaires (adapted for single clients and households).
- **Sample: 265 main respondents**, covering a total of **655 individuals** (adults and minors) across all partner organizations: Casa Ioana (15), VPR (128), HESED (40), HCSOM (53), and NMP (29).

#### 2. Qualitative Data Collection:

- **Tool:** Semi-structured interviews and focus groups (totalling over 40 sessions).
- **Participants:** Institutional stakeholders (social workers, health professionals) and clients.
- **Purpose:** To explore systemic obstacles (funding, administration, organizational structure) and internal organizational limitations that impede IHSC delivery.

### Target Audience

The primary addressees are partners, policymakers, local authorities, public health service providers, and social care organizations interested in designing and implementing integrated homelessness provision, particularly in the Central and Eastern European context.

## 3. Client characteristics and needs

### 3.1. Demographic and socioeconomic profile

The age range of clients surveyed is broad, predominantly 20–50 years, with significant representation of children (minors account for 43% of the total 655 persons covered by the data) and older adults (especially among NMP clients).

#### Household Composition

Family types are diverse, but single-parent households are highly represented, affecting their resilience and capacity for stability.

- Out of all respondents, **53% were single clients**, and the remainder lived in households with multiple members.
- **41% of all families raising children were single-parent households**, emphasizing the high level of vulnerability for mothers and minors.
- The most common family size was 2-4 persons, but 22 families had 6 or more members (up to 10), indicating the challenge of housing large families.

#### Education and Employment

Low educational attainment is a critical barrier, especially for women in certain regions (HESED, VPR clients).

**Table 1: Highest completed education of the main respondents**

Education Level	Total %	Male %	Female %
No/Incomplete Primary Education	10%	2%	17%
Primary Education	12%	3%	18%
Lower Secondary Education	31%	28%	34%
Lower Secondary & Professional Training	24%	34%	17%
Upper Secondary Education (incl. Post-Secondary)	17%	26%	12%
Tertiary Education (BA, MA or equivalent)	3%	4%	2%

This low educational profile is directly linked to low labour market participation. Only **24% of respondents** were engaged in any form of income-generating activity, and **20% reported no income at all**.

**Table 2: What source of income does the respondent have? (N=260)**

Source of Income	Total %	Notes
<b>Regular Welfare Benefit</b>	24%	Primary source for many.
<b>Old-age/Disability Pension</b>	17%	More common among men, reflecting age differences.
<b>Registered Full/Part-time Job</b>	14%	Only a small minority.
<b>On Maternity/Paternity Leave</b>	8%	Higher among women.
<b>Informal Jobs (Regular/Irregular)</b>	7%	Common but insecure income.
<b>No Income</b>	20%	Highest among Casa Ioana, HESED, and HCSOM clients.

Overall, **53%** relied on social transfers. For those who do work, earnings are extremely low; nearly half of households (47%) report a total monthly household income (including benefits) of **€200 or less**. Debt, often leading to enforcement proceedings, is a frequent barrier that discourages clients from seeking formal employment.

## 3.2. Housing and social conditions

The lack of stable, secure housing is the foundational challenge for nearly all clients across the partner organizations, alongside pervasive social isolation.

### Housing situation

Respondents are predominantly in institutional or precarious housing environments, emphasizing the severe need for Housing First solutions.

**Table 3: Households' housing situation (N=265)**

Housing Situation	Count	%
<b>Shelters (temporary, longer term)</b>	121	45%
<b>Shack / Improvised Housing / Tent / Car</b>	61	23%
Own / Rented Flat (Standard Housing)	39	15%
Public Space / Park / Street (Roofless)	18	7%
Emergency Accommodation (Short Term)	11	4%
With family and friends (Favour-based)	6	2%
Other/Institution	9	4%

Even among the 15% who live in standard housing, only half have a full legal title (own/municipal flat/private rental), indicating precarious legal status for the others. Clients of HESED and VPR disproportionately reside in improvised housing, often lacking basic sanitation, electricity, and running water, which directly impacts health and hygiene.

### Social support

Individual clients reported a poor support network, which hinders their capacity to navigate crises and institutions. Among individual clients surveyed:

- **47% reported having no family, friends, or acquaintances** who could provide financial or emotional support.
- This isolation was more pronounced among men and those who were either very newly or very chronically homeless (over 15 years).
- For many, the staff and fellow clients of the social service provider constitute their only reliable social connection.

### 3.3. Health status and trauma histories

The health profile of PEH is marked by chronicity, complexity, and a profound link to prior trauma.

#### Health status

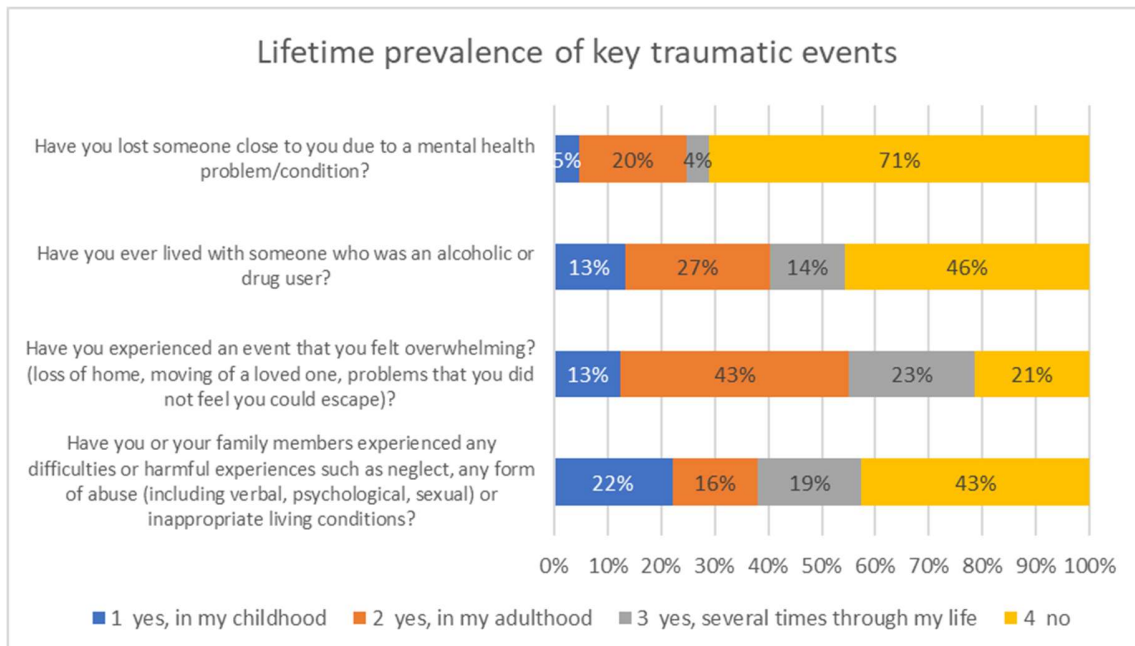
Health problems are pervasive and act as a major barrier to stability, with poor nutrition and neglected chronic conditions being universal issues.

- **55% of respondents** reported having at least one chronic or recurrent physical or mental health problem.
- **34% of respondents** reported that their health condition (mental, physical, or both) **prevents them from working regularly.**
- Chronic conditions (diabetes, cardiovascular, respiratory) are common, often underdiagnosed.
- Among minors, partners reported issues with **neurological developmental challenges** and a severe **lack of preventive healthcare and immunizations.**

#### Trauma exposure

The high lifetime exposure to traumatic events necessitates a system-wide commitment to trauma-informed care.

**Figure 1: Lifetime prevalence of key traumatic events**



- A striking **80% of respondents** reported exposure to significant traumatic life events (abuse, loss, overwhelming events, or living with addiction).
- **52%** reported abuse (verbal, physical, psychological, sexual, neglect) in childhood, adulthood, or both.
- **58%** reported living with someone who was a problem drinker or drug user.
- The prevalence of trauma exposure varies across organizations, with NMP respondents reporting higher exposure to abuse and loss due to mental health problems, confirming the need for tailored, highly supportive services.

Despite this evidence, providers generally reported that formal Trauma-Informed Care (TIC) approaches are absent in most external health and social services, with TIC training being rare among staff.

### 3.4. Healthcare access, behaviours, and barriers

Client interactions with the healthcare system are characterized by avoidance, reactive use, and significant structural barriers, including the digital divide and discrimination.

#### Routine health behaviours

Client self-reported behaviours indicate a generalized avoidance of preventative care.

**Table 4: Use of basic medical services and responding to very basic needs (N=265)**

Health Behaviour	Always/Most of the Time	Never/Very Little
Take medical conditions seriously	68%	15%
Use healthcare services	52%	18%
Go to the doctor for check-ups regularly	41%	<b>40%</b>
Eat well and regularly	59%	15%
Shower regularly	82%	7%

The most critical gap is the **avoidance of check-ups/prevention (40% never go)**. The level of self-care (hygiene, meals) is also concerning for a minority, often linked to the lack of infrastructure in their housing situation.

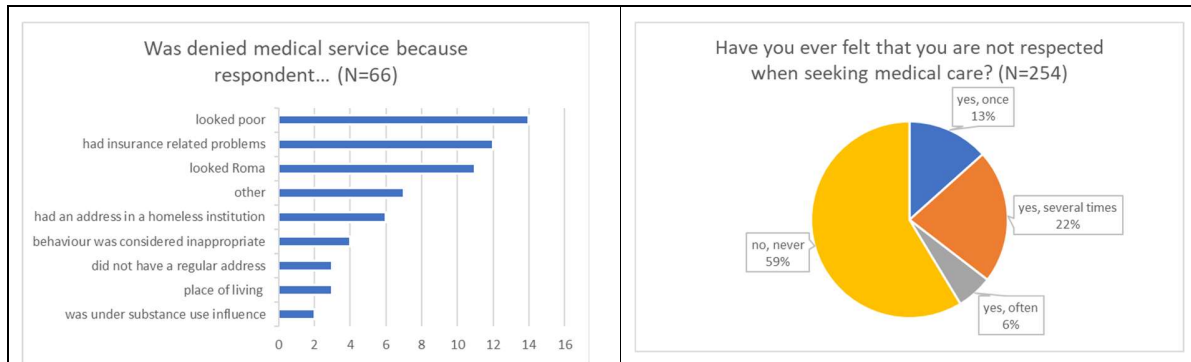
In case of acute sickness, while getting a doctor's appointment is the most common response, **22% would self-medicate** or take complementary remedies, and **23% would do nothing and wait to get better**. This reactive approach drives reliance on emergency services: over half of

main respondents were hospitalized in the last two years, and **one in four household members needed the emergency room in the last year.**

### Discrimination and service denial

Negative experiences fuel clients' mistrust and avoidance of public services.

**Figure 2: Self-reported experiences of service use denial and disrespect during service use**



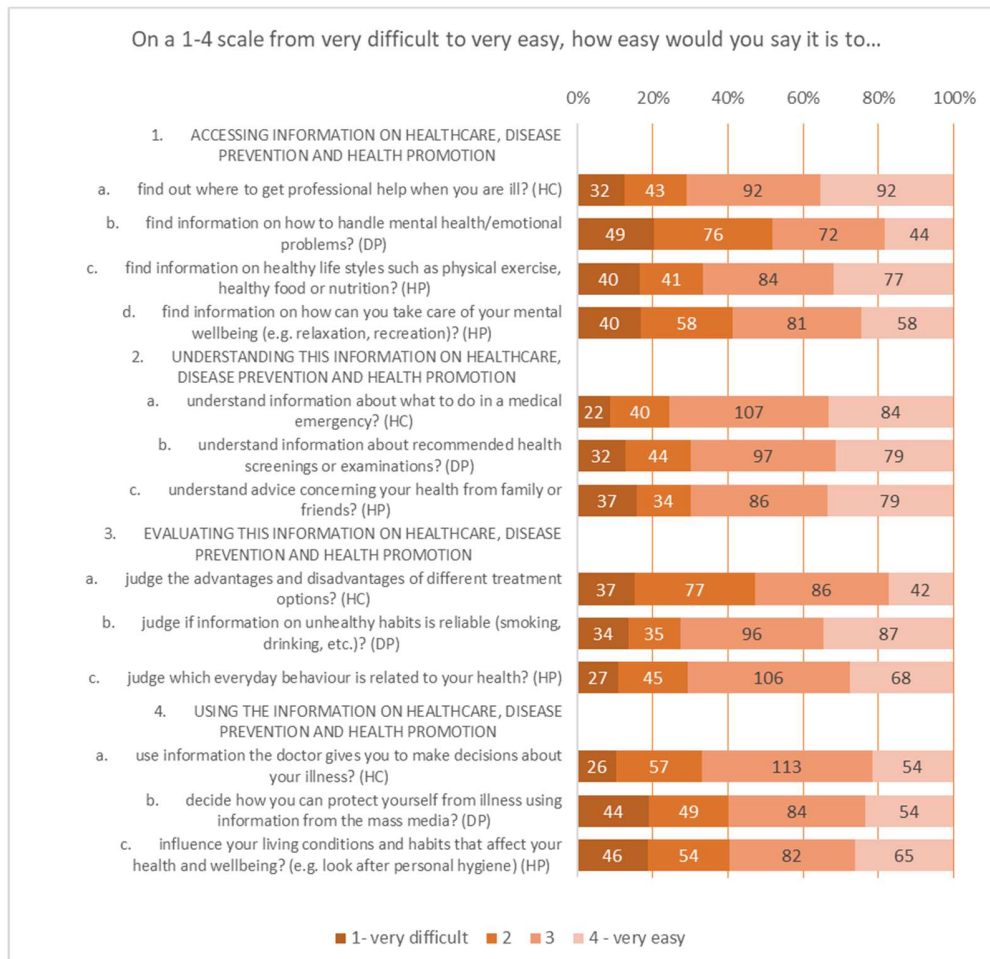
- **25% of respondents were denied medical services.** The leading reasons cited were:
  - **Looked poor (14 cases)**
  - **Insurance-related problems (12 cases)**
  - **Looked Roma (11 cases)**
- **40% of respondents reported feeling disrespected** when seeking medical care (once, several times, or often).

These experiences reflect broader systemic issues, including the reluctance of some medical professionals to work with PEH due to prejudice or concerns over hygiene, as reported by social workers.

## Health and digital literacy

Low literacy forms an underlying obstacle to effective service use and treatment adherence.

**Figure 3: Health literacy of clients (Difficulty to Easy)**



- **50% of clients find it very difficult/difficult to judge the advantages and disadvantages of different treatment options.**
- Finding information on how to handle **mental health/emotional problems** is also difficult for a high proportion of respondents.
- This challenge is most acute among those with lower educational attainment (70% of those with incomplete education report difficulty in evaluating treatment options).

The digital divide further complicates care expansion: **27% of respondents reported having no device to access the internet.** The potential use of telemedicine is treated with caution, with proportional distrust being highest among HESD clients in Bulgaria, who are up to twice as likely to feel uncomfortable using digital solutions for diagnosis (e.g., dental or dermatological problems) compared to the overall average.

## 4. Service gaps and organizational perspectives

Stakeholders consistently pointed to structural and organizational rigidities as the primary barriers to delivering comprehensive, integrated care, far beyond simple resource limitations.

### 4.1. Unmet needs and systemic realities

Organizations identified several pressing, unmet needs, often reflecting systemic failures rather than internal organizational capacity.

- **HESED's seven main challenges:** Improving living conditions/housing; improving access to health services for both insured and uninsured; improving health literacy; better nutrition/early prevention of socially significant diseases; screening for cardiovascular diseases; improving maternal/female mental health; and supporting early childhood development.
- **HCSOM:** Social workers emphasized that those most in need (wheelchair users, severe psychiatric cases) are often denied access to facilities due to being perceived as too aggressive or complex, creating severe gaps in institutional care. They noted the lack of any structured system for trauma processing and psychological support.
- **VPR/DEDO:** Social service providers consistently named **housing** as the biggest problem, noting the lack of transitional housing and affordable rental options. They highlighted **rigid legal and social systems**, including inflexible support models for parents and bureaucratic resistance, as main causes of unmet needs.
- **NMP:** While NMP's own clients in the Housing First program report high satisfaction, interviewees using other external services (shelters, ambulatory clinics) reported long waiting times for medical services and therapy, frequent staff changes, and unhelpful job placement assistance.

Clients appreciated personalized support, but identified the following general unmet needs:

- **Healthcare access:** Lack of affordable dental care, long wait times for specialists (e.g., child psychologists, neurologists).
- **Administrative burden:** Burdensome and complex procedures (e.g., disability certificate renewal, debt paperwork).
- **Respectful treatment:** The need for safety, respect, and non-discriminatory treatment, especially in public institutions.
- **Psychological support:** General lack of professional psychological support across most non-specialized shelters.

## 4.2. Funding, administration, and coordination challenges

### Funding and resource allocation

The core issue is **fragmentation**. There are no dedicated, pooled funding streams for integrated medical and social service provision.

- Providers requested stable, predictable, and flexible funding to sustain long-term interventions.
- HCSOM proposed establishing **additional convalescent, respite, and chronic care accommodations** for clients whose health is deteriorating and who are ineligible for regular services.
- Healthcare providers requested increased funding for **social workers and care coordinators** to help manage patient discharge and basic material needs (clothing, equipment).

### Administration and organization

Administrative rigidities hinder efficient service delivery and client outcomes.

- **Discharge planning:** Health workers noted that discharge procedures lack clear regulation, leading to patients being released without secured accommodation or follow-up plans, immediately undermining their recovery.
- **Bureaucracy:** Interviewed staff across multiple organizations called for simplifying benefit and documentation processes and streamlining referral and entitlement systems.
- **Lack of protocols:** Health providers noted a need for developing **formal methodologies and protocols** for working with and referring homeless patients.

### Coordination and clinical settings

Formal coordination is almost non-existent, leaving gaps in care continuity.

- **Inter-agency isolation:** HESED's respondents emphasized that interaction between social and health institutions functions in "crisis intervention" mode, relying on personal contacts rather than lasting, formal partnerships.
- **Need for a coordinator:** Stakeholders strongly supported creating a **Care Coordinator role** to manage service transitions and referrals, ensuring client-centric care pathways.
- **Standardization gaps:** There is a widespread lack of standardized clinical procedures, shared client records, joint clinical planning, and long-term health monitoring.



## **Staffing and training needs**

The shortage of trained staff exacerbates all other systemic problems. Social workers require regular supervision and specific training in **crisis management, psychological first aid, basic healthcare delivery, and Trauma-Informed Care (TIC)**. Medical staff similarly need training on working respectfully with PEH and understanding the social determinants of health.

## 5. Conclusion and key takeaways

The SOLACE-CEE Needs Assessment provides clear evidence that people experiencing homelessness in the CEE region face complex and reinforcing challenges that stem from individual trauma and systemic neglect.

### Core messages

**1. The primacy of Integrated Care (IHSC):** The system must shift from acute, fragmented crisis intervention to **continuous, integrated, and preventative IHSC** to address the interwoven nature of health and housing instability. This requires breaking down the siloed nature of funding and administrative procedures.

**2. Trauma-Informed Care is essential:** With **80% of clients having severe trauma histories**, the adoption of a pervasive **Trauma-Informed Care approach** must be a mandatory core component of all future service design and staff training, moving beyond in-house counselling to affect all external referrals.

**3. Address systemic barriers, not just symptoms:** Efforts must move beyond individual case management to tackle high-level structural failures:

- Mandating **formalized cooperation and referral pathways** between health and social services.
- Advocating for **flexible, pooled funding streams** for IHSC.
- **Streamlining bureaucracy** and regulating hospital discharge to guarantee follow-up care.

**4. Combatting discrimination and building trust:** High rates of reported discrimination and service denial (40% and 25% respectively) are unacceptable. Training and accountability measures are required within public health institutions to ensure dignified and respectful treatment, simultaneously improving client trust and engagement.

**5. Building foundational resilience:** Future interventions must focus on:

- Providing **Housing First values based solutions** as the necessary platform for stabilization.
- Targeting **low health and digital literacy** through accessible, mediated outreach and education, making digital tools work *for* the clients.

The **SOLACE-CEE project** interventions, focusing on extending and innovating care options through IHSC pilots, are therefore directly aligned with the most urgent needs identified by both clients and service providers across the CEE region.