INTEGRATED FINDINGS REPORT 2026

Needs Assessment of Homelessness and Housing Stability

MARION AND POLK COUNTIES, OREGON

HOUSING AND HOMELESSNESS COMMUNITY NEEDS ASSESSMENT

PREPARED FOR

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Terms and Acronyms

Homeless services carry a specialized vocabulary, and several of its most common terms mean different things to different organizations. The definitions below establish how each term is used in this report. Program-level and inventory-specific definitions appear in the standalone landscape scan report.

Table 1. Terms and acronyms used in this report

Term	As used in this report
Chronic homelessness	A person with a disabling condition who has lived unsheltered, in a safe haven, or in an emergency shelter for at least 12 months. The 12 months can be continuous, or they can add up across four or more episodes in three years. A family qualifies when its head of household meets these criteria
Continuum of Care (CoC)	The HUD-designated body responsible for coordinating homelessness planning, funding, and policy across a defined geographic area. The CoC for Marion and Polk Counties is led locally by the Mid-Willamette Valley Homeless Alliance.
Coordinated Entry (CE)	The shared regional process intended to assess, prioritize, and refer people to housing resources through common access points and a common assessment.
Diversion	Rapid, flexible problem-solving that resolves a housing crisis without shelter entry, for example a mediated return to family or one-time financial help.
Emergency shelter (ES)	Short-term overnight sheltering intended for immediate crisis. Distinct from transitional housing, which is longer-stay and program-based.
Harm reduction	Harm reduction meets people where they are — reducing the negative consequences of substance use without requiring abstinence as a condition of service.
Homeless Management Information System (HMIS)	Homeless Management Information System, the shared client database used for federal reporting and funding.
Housing and Urban Development (HUD)	The federal agency that administers homeless assistance programs, sets the definitions of homelessness used in this report, and requires the annual Point-in-Time count and Housing Inventory Count.
Housing Inventory Count (HIC)	HUD's annual count of beds and units dedicated to serving people experiencing homelessness, taken the same night as the PIT count.
Household unit	A room or unit occupied by a family or household rather than an individual bed. This report estimates household units at three persons
Literally homeless	HUD's primary homeless category: lacking a fixed, regular, and adequate nighttime residence, including people who are unsheltered, in emergency

Term	As used in this report
	shelter, or in transitional housing. Includes shelter residents. Excludes people doubled up or in self-paid motels.
Low barrier	Minimal preconditions to access services, such as sobriety requirements, ID, or curfews, in order to reach people who might otherwise be precluded from services.
Medication-assisted treatment (MAT)	Medication-assisted treatment for substance use disorder, such as methadone or buprenorphine.
Peer support specialist	A trained staff member whose own lived experience of homelessness, mental health challenges, recovery, or a combination of these is part of their qualification for the role.
Point-in-Time (PIT) count	HUD's one-night census of people experiencing homelessness, conducted in late January. Communities count sheltered people every year and unsheltered people every other year, in odd-numbered years.
Permanent supportive housing (PSH)	Permanent housing paired with ongoing services such as case management, mental health care, and substance use treatment. Generally, for people with long homelessness histories and disabling conditions.
Rapid rehousing (RRH)	Short-term rental assistance plus services intended to move people quickly from homelessness into permanent housing.
Service provider	An organization, or a staff member of an organization, that delivers housing, sheltering, or supportive services to people experiencing or at risk of homelessness in Marion and Polk Counties. In this report, "provider" encompasses individuals in a range of roles, from frontline shelter and outreach staff to program managers and executive directors, working in homeless services and in allied sectors such as behavioral health and food assistance.
Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI)	SSI: A federal needs-based benefit for people who are aged, blind, or disabled and who have limited income and resources. SSDI: A federal benefit for people with disabilities who have a qualifying work history and have paid into Social Security. Standard SSI-level income in this period sits near $994 per month, for an individual and $1,491 for a couple.
Sweep	Enforcement removal of an encampment, often with loss or disposal of belongings.
Transitional housing (TH)	Time-limited housing with program structure, intended as a bridge between shelter and permanent housing. Federal rules set a goal of moving residents into permanent housing within 24 months.
Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT)	The standardized vulnerability assessment tool used at many Coordinated Entry access points to score and prioritize people for housing resources.

Term	As used in this report
Unduplicated count	A count of distinct individuals served across programs.
Unsheltered	Experiencing homelessness while staying in a place not designed for or ordinarily used as regular sleeping accommodation, including streets, sidewalks, parks, vehicles, tents and encampments, and abandoned buildings.
Youth and young adults	People under age 25 who are experiencing homelessness without a parent or guardian. This report groups them by age. Youth are ages 11 to 17. Young adults are ages 18 to 24.

Executive Summary

In 2025, the Point-in-Time Count identified 2,135 people experiencing homelessness across Marion and Polk Counties, up from 1,683 in 2023. **Nearly half of those counted reported that this was the first time in their lives they had lost housing**, while a large share of unsheltered individuals had been homeless for three years or longer. These counts describe the scale of the crisis. However, it does not explain how people got there, what they tried before they lost housing, what happened when they sought help, which parts of the response system are functioning, or what would have changed the outcome. The Mid-Willamette Valley Community Action Agency (MWVCAA) commissioned this assessment to answer those questions.

Woodson Insights Research + Evaluation (WIRE) conducted a mixed-methods needs assessment across both counties between March and August 2026. Eight evaluation questions co-created with MWVCAA guided the design. This report brings together five sources of evidence. The findings from the landscape scan, the community member survey, the service provider survey, and the listening session with community members and service providers are integrated into this report.

Sources of Evidence/Methods at a glance

Table 2. Sources of evidence and methods at a glance

Data source	Scale	Period
Landscape scan and shelter inventory	44 verified sheltering programs operated by 17 organizations	March to May 2026
Community member survey (English and Spanish)	161 complete responses (150 online, 11 phone-assisted)	May 12 to August 12, 2026
Service provider survey (English and Spanish)	90 provider staff across the region's organizations	May 12 to August 12, 2026
Listening sessions (English and Spanish)	8 sessions (7 with people with lived-experience, 1 with service providers); 56 participants with lived-experience and 9 service providers	May to August 2026
Secondary data	2023, 2025 and 2026 Point-in-Time counts,[1] Housing Inventory Count, and housing market indicators	2023 to 2026

Note. Survey figures are reported against the number of respondents answering each item (base number).

[1] The 2023 and 2025 Point-in-Time counts included both sheltered and unsheltered people. The 2026 count included sheltered people only, because HUD requires unsheltered counts every other year, in odd-numbered years.

The five findings to consider

Where providers and community members were asked about the same topics, they ranked the same barriers, needs, and pathways in nearly the same order.

1. Most people experiencing homelessness in the region are long-term residents, and for most, this is not their first episode. Among providers, 84%report that the majority of their clients became homeless in Marion or Polk County, and only 9% point to an origin outside the two counties. Among community member survey respondents, 42% grew up here or have lived here more than ten years, and among those who did move here, family ties outrank service availability as the reason by roughly three to one. Two-thirds of respondents had been homeless before, and 69% of listening session participants reported more than a year of homelessness in total. The dominant movement is intra-regional, toward Salem, along referral pathways the region itself has built.

2. Most people received no prevention support before losing housing. Sixty-nine percent of survey respondents entered homelessness without any prevention assistance at all. Among the 50 respondents who received support, food assistance was the most common form. Rental assistance reached 20 respondents of 161, and case management or a housing advocate reached three. Of those who received support, 40% said it was not enough to prevent the loss. Among respondents currently housed but at risk, rent and deposit assistance was the most cited need.

3. On paper, capacity nearly matches need. In practice, a bed that exists does not equal a bed a person can use. The region's 44 sheltering programs provide a combined capacity of roughly 2,111 sleeping spaces on a typical night, compared against a 2025 Point-in-Time count of 2,135 people. Sixty-four percent of programs carry waitlists. Fifteen of 44 accept walk-ins. More than a quarter of beds sit behind abstinence-with-testing requirements, and rules on pets, partners, records, and identification exclude identifiable groups. Ninety percent of survey respondents named at least one harm from contact with services or enforcement, and four of the five most selected harms describe experiences with services rather than conditions of homelessness itself.

4. Not knowing what exists is a barrier comparable in scale to the shortage of what exists. The most selected barrier among community members was not knowing what services are available or how to find them, at 48%, ahead of waitlists at 42%. This was supported by service providers, 78% of whom reported that clients do not know what services are available. Other barriers selected by community members included waitlists (42%), limited or no internet access (40%), and no working phone (18%). One of the most surprising barriers on the provider side seems to be Coordinated Entry, a system whose goal is facilitating access. **Of the 90 providers surveyed, not one selected the option that Coordinated Entry is working well.**

5. The system is most developed and centered in Salem, and distance remains a barrier. Salem holds roughly two-thirds of the region's sheltering programs and most of its beds. Polk County's seven programs hold about 4.4% of regional capacity, and no day or resource center operates anywhere in the county. Across Polk County, there are 84 individual beds and 3 household units available for 357 people who are experiencing homelessness. Sixty-six percent

of the people counted in Polk County were unsheltered. Rural participants described being directed to Salem for services, and they described services and infrastructure absent from their communities altogether, including no laundromat in Falls City, no day space in Stayton, and a warming center that opens only after three consecutive days at or below 34 degrees if volunteers can be found.

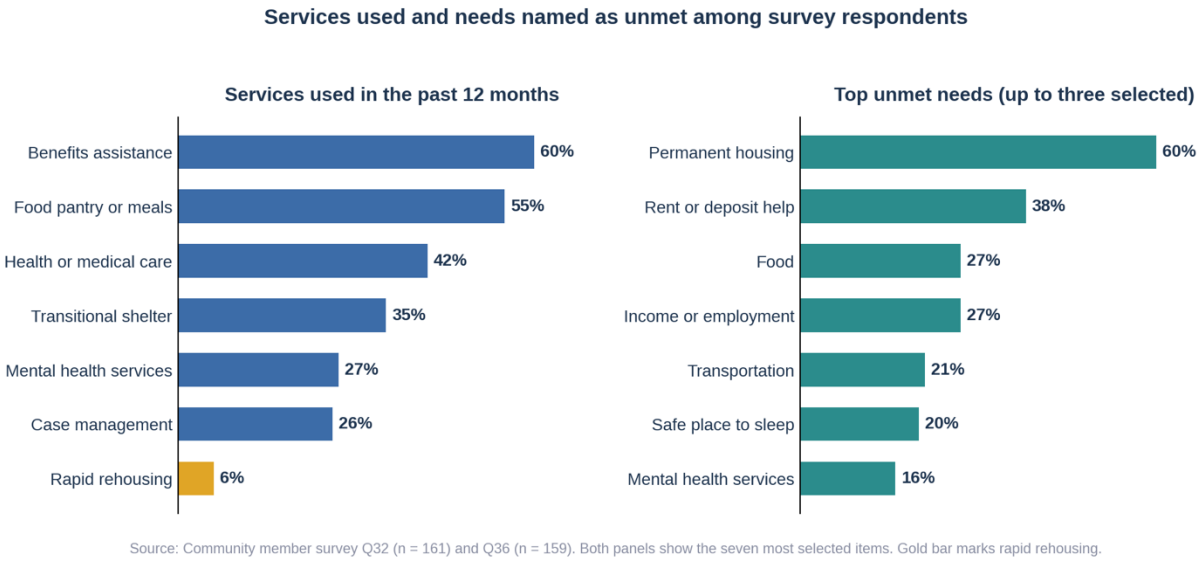

Figure 1. Services respondents used in the past 12 months and needs they named as unmet. The left panel shows the six most used services plus rapid rehousing, marked in gold. The right panel shows the seven most named unmet needs. While permanent housing was cited as the top unmet need, access to services to support permanent housing, rapid rehousing, was only accessed by 6% of the respondents.

Findings by evaluation question

Table 3. Findings by evaluation question

Evaluation question	What the evidence shows
1. Who is experiencing homelessness	The Point-in-Time count identified 2,135 people across the two counties, 953 of them unsheltered. About one in five, 419 people, were in families with children, and the count also identified 108 veterans and 124 people over age 64. Survey respondents and listening session participants describe a population that is largely local and long-term or recurrent. Forty-two percent of survey respondents grew up in the area or had lived here for more than ten years. Of respondents who had moved, 71% came from elsewhere in Marion or Polk County or from another Oregon county. Three-quarters of survey respondents reported a long-term physical or mental health condition. Listening session participants concentrated at both ends of adulthood, young adults who left family and child-serving systems and older adults on fixed incomes. Nearly two-thirds of respondents report an earned income of under $500 per month.
2. Why people become homeless	Housing loss most often followed several events at once. Could not afford rent was the most selected contributing factor at 38%, with mental health, family breakdown, and job loss each near 30%. Providers most often

Evaluation question	What the evidence shows
	reported inability to afford rent, at 87%. Release from jail, hospitals, and foster care appeared among the circumstances providers see most, with few formal connections to those institutions.
3. What services exist	Forty-four sheltering programs run by 18 organizations and concentrated in Salem. Capacity is largest at the emergency and low-barrier end and smaller in transitional housing. Dedicated capacity is smallest for minors, young adults, and survivors of domestic violence. In Polk County, shelter beds equaled 22% of the people counted in 2025, compared with 89% in Marion County. The standalone landscape scan report documents the full inventory.
4. What the gaps are	Permanent housing and rent or deposit assistance were the most named unmet needs. The landscape scan documented gaps in transitional housing, family walk-in access, beds for young adults and survivors of domestic violence, culturally specific and language-accessible services, and capacity in Polk County relative to the people counted here.
5. What the barriers are	Barrers to reaching services and shelter were, in order, not knowing what exists, waitlists, transportation, and program rules, including pet and partner exclusions. Barriers to employment and housing included the cost of replacing identification, criminal and credit records, and receiving notifications by mail only.
6. How well services are meeting needs	The services used most address daily needs. The needs most often named as unmet concern leaving homelessness. Rapid rehousing reached 6% of respondents in the past year. Respondents credited relationships with specific people about as often as services, and the harms they named most often were program rules.
7. Populations needing targeted approaches	Families with children, youth and young adults, older adults, people with disabilities and behavioral health needs, survivors of domestic violence, justice-involved individuals, Latinx and farmworker communities, rural residents, and people excluded by pet and sobriety rules each face distinct circumstances documented in this report.
8. What to do	Fund basic dignity infrastructure, reduce the cost and difficulty of replacing state identification, fix mail-only contact, create a flexible regional housing and diversion fund, repair Coordinated Entry's assessment and communication gaps, expand housing supply priced to actual incomes, and build the shared information layer the system lacks. The recommendations section presents the full set with supporting evidence.

1. Introduction

1.1 Why This Assessment, and Why Now

In 2025, the Point-in-Time Count identified 2,135 people experiencing homelessness across Marion and Polk Counties[2]. This represents an increase of more than 480 people since 2023, when the count identified 1,683 people. Nearly half of those counted, 47%, reported that this was the first time in their lives they had lost housing. At the same time, 618 people, more than one in four, met the federal definition of chronic homelessness[3], and had experienced homelessness for more than three years. These two figures describe two different realities unfolding at once: a significant wave of people entering homelessness for the first time, and a system that has not kept pace in returning people to housing once they lose it.

The conditions producing both are visible in the regional housing market. Rental vacancy across the two counties sits at roughly 4%, and about one in four renter households is severely rent burdened, paying more than half of household income toward housing. In some communities the rate is higher still, reaching 31% in Dallas and 33%in Monmouth. In a housing market with these conditions, a single missed paycheck, a health crisis, or the end of a relationship can move a household from housed to unhoused in a matter of weeks.

Point-in-Time counts and Housing Inventory Counts are designed to measure how many people are homeless on a single night and how many beds exist to serve them. They are not designed to explain how people got there, what they tried before they lost housing, what happened when they sought help, which parts of the response system are functioning and which are not, or what people believe would have changed the outcome. Those questions require asking people directly.

The Mid-Willamette Valley Community Action Agency (MWVCAA) commissioned this assessment to answer those questions. MWVCAA engaged Woodson Insights Research + Evaluation (WIRE) to conduct a mixed-methods needs assessment across both counties, combining a verified inventory of the sheltering services, surveys of community members experiencing homelessness and of the providers who serve them, and listening sessions in communities across the region. The purpose was not to produce another count but instead to understand the lived experiences of community members experiencing homelessness and the service providers that support them in accessing services.

1.2 The Evaluation Questions

Eight evaluation questions guided the design and implementation of this assessment. The questions begin with the foundation: who is experiencing homelessness in Marion and Polk Counties, and what factors contribute to people losing their housing. From there they turn to the response, asking what services exist, where the gaps are, what barriers keep people from

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[2] Mid-Willamette Valley Homeless Alliance, *2025 Point-in-Time Count Summary Report*, April 29, 2025

[3] A person with a disability who has been unsheltered or in emergency shelter for at least 12 months, continuously or across four or more episodes in three years. U.S. Department of Housing and Urban Development, 24 CFR § 578.3

reaching help, and how well current services are meeting people's needs. The questions also focus on which populations carry unique needs that a one-size-fits-all approach would miss. Lastly, these guiding evaluation questions look ahead, asking what high-impact, actionable steps the region can take to improve services and outcomes. Together, the questions move from understanding the problem, to examining the response, to charting what comes next.

Table 4. Evaluation questions that guided the assessment

Evaluation questions
1. Who is experiencing homelessness in Marion and Polk Counties, including demographics, household composition, and geographic distribution?
2. Why are people becoming homeless? What are the root causes and contributing factors?
3. What services currently exist to address homelessness, including inventory, coverage, and capacity?
4. What are the gaps in services, including unmet needs, geographic coverage, and populations underserved?
5. What barriers exist to accessing services or achieving housing stability?
6. How well are current services meeting the needs of people experiencing homelessness?
7. What populations have unique needs requiring targeted approaches?
8. What high-impact, actionable recommendations can improve services and outcomes?

1.3 Guiding Framework

Two frameworks guided this assessment. Culturally Responsive and Equitable Evaluation (CREE) holds that people with lived experience of homelessness are experts on their own circumstances, and it shaped who was invited to speak, how questions were asked, and whose interpretations carried weight in the analysis. Data to Dialogue holds that an assessment should be built around the decisions it will inform, and that delivering findings is part of the research rather than the end of it.

Culturally Responsive and Equitable Evaluation. CREE holds that people with lived experience of a problem hold knowledge that cannot be obtained from administrative data or provider reports alone, and that research relationships carry power dynamics that must be addressed through design rather than disclaimed in a limitations section. In practice this meant compensating participants, holding sessions in trusted community settings, offering multiple ways to participate, asking about strengths and survival strategies rather than only deficits and barriers, and disaggregating findings by identity and geography. It also meant asking whether the system has caused harm, a question most needs assessments do not ask.

Data to Dialogue. WIRE designs assessments backward from decisions rather than forward from available data. Every item in every instrument in this study exists because it informs choices providers, community partners, and policy makers will make. The methodology also treats the delivery of findings as part of the research rather than the end of it, which is why this

report is accompanied by a facilitated sensemaking session in which community members, providers, and partners work through the implications of the findings together, testing and sharpening the recommendations this report sets out.

The two frameworks work in sequence. CREE ensured the evidence was gathered with the community rather than extracted from it. Data to Dialogue ensures the evidence is used to develop actionable insights and strategic recommendations to improve the conditions of the community.

1.4 How to Read This Report

The report moves from context to evidence to action. Section 2 details the methodology, describing each data source and how the components fit together. Sections 3 and 4 set the stage, describing the region and the services that currently exist within it. Sections 5 through 8 turn to the people at the center of this assessment: who is experiencing homelessness, the pathways that led them there, and what happened when housing was lost. Sections 9 through 12 examine the service system from both sides of the counter, first through the experiences of people trying to use it, then through the accounts of the organizations operating it. Sections 13 bring the threads together, addressing populations with distinct needs, where provider and community accounts align or diverge, and the gaps that emerge from the full body of evidence. Section 14 translates the findings into recommendations. Every section closes with a key takeaways box summarizing its central findings.

Findings from the landscape scan are woven throughout this report and summarized in Section 3; the scan is documented in full in its own standalone report, Sheltering Services in Marion and Polk Counties: A Landscape Scan and Gap Analysis (June 2026), which readers should consult for the complete program-level inventory, maps, and appendices.

Quotations from listening sessions and open-ended survey responses appear throughout. They have been lightly edited for readability only, and identifying details have been removed. Every quotation reflects something a participant actually said or wrote.

2. Methodology

2.1 Design Overview

This assessment used a mixed-methods design, which combined qualitative and quantitative data. Quantitative and qualitative data were collected in overlapping periods and analyzed in parallel, then integrated during interpretation. The design pairs two survey instruments, one administered to community members experiencing homelessness or housing instability and one administered to service providers. Focus group listening sessions provided depth and context that survey items cannot capture, and the landscape scan provided an independent, verified account of what sheltering services actually exist. Secondary data from the PIT counts were analyzed as well to understand the regional context regarding housing instability.

Table 5. Data sources, descriptions, and collection periods

Data source	Description	Period
Landscape scan and shelter inventory	A verified inventory of the region's sheltering landscape, documenting capacity, eligibility rules, access requirements, and geographic distribution across 44 programs operated by 17 organizations.	March to May 2026
Community member survey	A survey of people experiencing or recently exiting homelessness, capturing pathways into homelessness, service experiences, barriers, and unmet needs. The survey yielded 161 complete responses.	May 12 to August 12, 2026
Service provider survey	A survey of staff at homeless-serving organizations, capturing capacity constraints, program requirements, referral practices, and perceived system gaps. The survey drew 90 respondents across organizations.	May 12 to August 12, 2026
Community listening sessions	Facilitated group discussions held in trusted community settings across the region, centering the accounts of people with lived experience of homelessness. WIRE held 8 sessions, including 7 sessions with 56 community members with lived experience with homelessness and 1 session with 9 service providers.	May to August 2026
Secondary data	Existing regional data used for context and triangulation, including Point-in-Time counts, and the Housing Inventory Count.	2023 to 2026

Throughout the report, findings from all methods are woven together by topic, so that each section presents survey, listening session, and landscape scan evidence side by side rather than in separate silos.

2.2 Landscape Scan and Shelter Inventory

WIRE conducted a landscape scan of sheltering services for people experiencing homelessness in Marion and Polk Counties from March through May 2026. The scan was

organized around a structured shelter inventory instrument that captured each program's organization and populations served, shelter type, capacity, operating hours, eligibility and access requirements, outreach methods, and funding (for the full instrument, see Appendix E). The scan covers sheltering programs specifically, defined as the emergency, low-barrier, warming and cooling, transitional, permanent supportive, recovery-focused, day-center, and rapid-rehousing programs that make up the region's sheltering continuum. It does not inventory the broader network of food, health, employment, and other non-housing services available to people experiencing homelessness.

Every program's information was verified through a tiered process. Each entry began with internet research, followed where possible by a brief confirmation call with staff, then a more detailed conversation with program leadership by phone or email. In addition, all organizations included in the landscape scan were invited to participate in a feedback session with MWVCAA staff to review a draft of the landscape scan. As a final step, WIRE sent each program a written summary of its recorded details for confirmation and approval before publication. Not every program completed every tier, and the depth of verification varied with each provider's availability. The standalone landscape scan report documents the verification status of every program.

This ground-truthing is a deliberate methodological choice. Published service directories in most regions contain listings that are outdated, duplicated, or describe capacity that no longer exists, and a directory that has not been verified against the programs it describes can misstate what a region actually offers. The full inventory, maps, and gap analysis appear in the standalone landscape scan report, Sheltering Services in Marion and Polk Counties: A Landscape Scan and Gap Analysis (June 2026)

2.3 Community Member Survey

WIRE drafted the community member survey using the eight evaluation questions as the guide. In collaboration with MWVCAA and MWVCAA's Housing and Homeless Services Advisory Council, we conducted two rounds of review and revised the survey instrument. The final instrument contains 50 items across eight sections covering current housing situation, homelessness history, household composition, geography and community connection, pathways into housing loss, economic circumstances, service use and barriers, service experience, and voluntary demographic questions. Extensive skip logic routed respondents past items that did not apply to them. The instrument was made available in English and Spanish. The survey was open and available for community members to complete from May 12 through August 12, 2026. The instrument appears in Appendix A.

The survey was open to adults in Marion or Polk County experiencing homelessness or housing instability, including people sleeping outside, in shelter, in transitional programs, temporarily staying with others, in motels not paid for by a program, or at imminent risk of losing housing. It was hosted on SurveyMonkey. Respondents completed the online survey and if they needed additional assistance they could call a research team member to complete the survey verbally over the phone. Respondents who completed the survey received a $20 e-gift card.

2.4 Service Provider Survey

The service provider survey was developed in parallel with the community member survey. It contained 61 questions covering organizational capacity, populations served, program requirements, harm reduction practice, Coordinated Entry, regional coordination, client barriers, data infrastructure, and open-ended questions. The survey was administered in both Spanish and English and was available for individuals to complete from May 12 through August 12, 2026. Respondents who completed the survey were offered a $15 e-gift card. The full survey appears in Appendix B.

2.5 Community Listening Sessions

WIRE facilitated eight listening sessions between May and August 2026. Seven sessions were with people currently or recently unhoused. The sessions were held in various locations in Marion and Polk County. Participants included Spanish-speaking adults, young adults aged 18 to 24, adults with hearing disabilities, adults with physical and cognitive disabilities, survivors of domestic and family violence, parents separated from their children, older adults, veterans, farmworkers, and people in recovery. All listening session participants received $75 cash.

Sessions with community members were structured around a five-station participatory mapping activity framed by the board game Chutes and Ladders. This is a trauma-informed, liberatory research practice that was developed by Geri Lynn Peak which allows participants to tell their story with dignity and authority[4]. Chutes and Ladders is a board game in which players move along a numbered path toward a finish line, climbing ladders that advance them quickly and sliding down chutes that send them backward, sometimes nearly to the start. Progress depends largely on chance, and a single square can undo many turns of forward movement. When used in the listening sessions, participants marked when their journey into homelessness began. They also identified the first event that precipitated it, plotted setbacks and supports across the intervening period, named rules and requirements that blocked them, and described what they need next and who could provide it. The station format allows everyone to contribute simultaneously, permits drawing or dictation as valid responses, and positions participants as analysts of their own journeys rather than as subjects being interviewed. Facilitated discussion followed, covering topics such as their experience seeking help, avoidance, daily navigation, identity and cultural fit, informal support networks, and what participants would say directly to decision-makers. The provider session followed a separate systems-level guide. Both guides appear in Appendices C and D.

Every session opened with a verbal consent process covering voluntariness, confidentiality, the right to skip any question or leave at any time, and group agreements. Recording occurred only with the permission of everyone present. Recorded sessions were transcribed and reviewed for accuracy; wall sheets and written packets were photographed and transcribed.

[4] Peak, G. L. *Liberatory Fun with Journey Mapping: The Journey Scroll* [eStudy 135]. American Evaluation Association

Table 6. Listening sessions by location and populations reached

Session	Location	Populations reached
Session 1	Woodburn	Latinx community and farmworkers. Session was offered in Spanish.
Session 2	Salem	Adults experiencing homelessness
Session 3	Salem	Youth and young adults 18 to 24
Session 4	Monmouth (Polk County)	Rural homelessness
Session 5	Stayton (Santiam Canyon)	Rural homelessness
Session 6	Virtual online session	Community based organizations and service providers
Session 7	Falls City (Polk County)	Rural homelessness
Session 8	Silverton	Rural homelessness

2.6 Qualitative Analysis

Qualitative data comprised transcripts and notes from eight sessions, more than 50 handwritten participant mapping packets, post-it notes, a service provider Zoom chat log, and open-ended responses from both surveys. Coding proceeded in four phases. First, an open reading of each session established its context. Second, line-level coding identified specific nameable mechanisms, a rule, a deadline, an agency, wherever participants described how something happened rather than only that it happened. Third, cross-session comparison examined where accounts converged and diverged, treating divergence as a finding rather than ignoring it. Fourth, the resulting codebook of 16 codes across six thematic families was applied to the open-ended survey responses, extending the analysis across data sources. The codebook was checked for coverage against every topic in the discussion guides to confirm that no area of inquiry went uncoded.

Written packets were analyzed as a distinct source rather than as annotation to the transcripts. Where a packet and a transcript describe the same event differently, both are reported. Quotations selected for this report represent themes that recurred across participants.

2.7 Quantitative Analysis

Survey data were exported from SurveyMonkey and cleaned before analysis. Survey responses were exported from SurveyMonkey and cleaned before analysis. Cleaning prepared the raw export for accurate counting. This included combining SurveyMonkey's two-row column headers into one row, coding write-in "Other" answers into existing categories where they matched, and flagging possible duplicate responses for review. Responses of "prefer not to answer" were kept in the data. The cleaned file contains 161 responses.

Single-response items are reported as percentages of respondents answering that item. Select-all items are reported as the percentage of respondents selecting each option, which sums to more than 100%, and the report states this wherever such an item appears. Items behind skip

logic are reported against the number of respondents who reached the item, and that base is stated. Respondents who selected "prefer not to answer" are retained in denominators and reported as their own category, because non-response to sensitive items is itself informative.[5]

2.8 Secondary Data Sources

Three categories of secondary data were used. Point-in-Time Count data from 2023, 2025, and 2026 provide trend context and a comparison point for the survey sample. Housing Inventory Count data inform the capacity analysis. Regional housing market indicators inform the context in Section 3.

One feature of the secondary data requires care. The 2026 Point-in-Time Count was sheltered people only. It did not include an unsheltered enumeration, so its totals describe a different population than the 2025 count, which enumerated both sheltered and unsheltered people. Where this report presents both, each is labeled by year and count type.

2.9 Limitations

Neither survey used probability sampling. For this population, that is a strength as much as a limitation. No sampling frame of people experiencing homelessness exists, and the methods that require one, telephone, mail, and online panels, systematically miss unsheltered residents, people without stable contact information, and people disconnected from services. Venue-based recruitment through trusted community settings reached exactly those groups, and it allowed the study to pursue inclusion deliberately by recruiting across languages, geographies, and program types rather than leaving representation to chance. The tradeoff is that the findings in this report describe the people surveyed rather than the full population, and their strength rests on convergence across methods rather than on any single sample's claim to represent the whole.

KEY TAKEAWAYS - METHODOLOGY

Five data sources are reported in this integrated report. These sources consist of the following: **a verified inventory of 44 sheltering programs, surveys of 161 community members and 90 provider staff, 8 listening sessions, and PIT and HIC data for regional context**.

Shelter inventory entries were ground-truth through a tiered verification protocol ending with program approval because published directories routinely list capacity that no longer exists.

Listening sessions positioned participants as authors of their own journeys, using a trauma-informed mapping method that reached Spanish speakers, rural residents, youth, elders, veterans, farmworkers, and survivors of violence.

[5] Community member subgroup differences were tested using the chi-square test of independence, with every reported test stating its p value and effect size as Cramér's V. Provider subgroup comparisons were tested with two-tailed Fisher exact tests, and only differences reaching $p < 0.10$ are described as differences.

Surveys were provided in English and Spanish. Respondents could complete the survey in one of three ways. They could answer by phone with a research team member, complete it online with a team member's help, or independently using the online platform. The research team increased the accessibility of the data collection process by accepting drawings or dictations during the listening sessions, so that neither English, literacy, nor internet access posed a barrier to participation.

3. Regional Context and the Sheltering Landscape

Homelessness in Marion and Polk Counties exists within a particular set of conditions. The housing market offers few vacancies and few units affordable to low-income households. The policy environment is shifting, and the region's geography concentrates services in Salem. This section describes those conditions and presents a verified list of sheltering services in the region that is working to address the issue of homelessness. The inventory covers what exists, what it costs, whom it is built to serve, and how its capacity compares to need.

3.1 Homelessness in Marion and Polk Counties

The most recent complete Point-in-Time (PIT) count, conducted in January 2025, identified 2,135 individuals experiencing homelessness across Marion and Polk Counties. At that time, the count consisted of 953 unsheltered individuals and 1,182 sheltered residents. That total is up from 1,683 homeless individuals in 2023. **At the time of the 2025 count, nearly half, 47%, were experiencing homelessness for the first time[6].**

The 2026 count was conducted differently. It counted only people staying in shelters, transitional housing, and other sheltered settings, and no unsheltered enumeration was conducted that year. The sheltered-only count recorded 953 persons. By coincidence, that is the same number as the 2025 unsheltered count.

The Point-in-Time count is also widely understood to undercount the true scale of homelessness. It misses people doubled up with friends or family, sleeping in vehicles or locations enumerators do not reach, or otherwise out of view on the night of the count. The level of need this report compares capacity against should therefore be read as a conservative floor rather than a complete picture.

[6] McDonald, A. (2025, May 5). Record number of homeless people counted in Marion, Polk counties. *Salem Reporter*. https://www.salemreporter.com/2025/05/05/record-number-of-homeless-people-counted-in-marion-polk-counties/

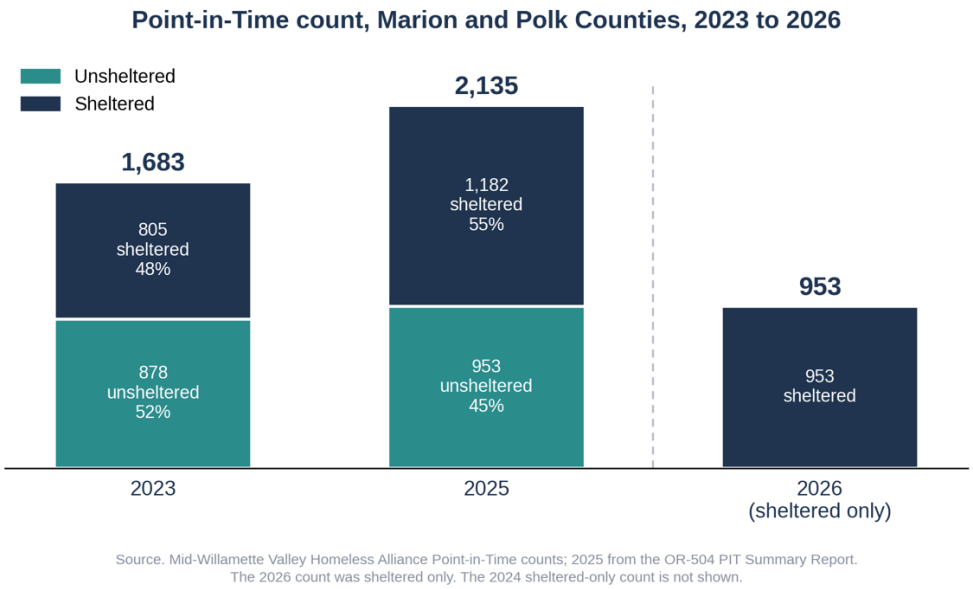

Figure 2. The Point-in-Time trend for 2023, 2025 and 2026. The PIT count for 2026 was a sheltered-only count.

3.2 Housing Market Conditions

Rental vacancy in both Marion and Polk counties sits at roughly 4% . Renter households across the region face significant concerns regarding cost and affordability. **Approximately one in four renter households are severely rent burdened, spending more than half of household income on rent**[7]. Severe rent burden is most concentrated in Polk County's cities, where 33%of renter households in Monmouth, 31%in Dallas, and 28% in Independence are severely rent burdened. The supply side offers little relief. Across the state of Oregon, fewer than 30 affordable and available rental homes exist for every 100 extremely low-income renter households.[8,9]

HUD's fair market rent for a one-bedroom unit in the Salem metro area was $1,198 in fiscal year 2025, and $1,201 in fiscal year 2026, above the 2026 federal SSI payment of $994 a month. The listening sessions described the realities this market produces for people with the lowest incomes. A provider described a newly opened complex where one-bedroom units rent for $998 a month, and where more than 260 families arrived within half an hour on sign-up day. Participants described three-times-rent income requirements, vouchers capped below asking rent with no ability to pay the difference, and rents that doubled over the course of their tenancy.

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[7] Oregon Department of Land Conservation and Development. (2022). *2022 severe rent burden in Oregon (2020 ACS)*. https://www.oregon.gov/lcd/UP/Documents/Annual_Severe_Rent_Burden_Announcement.pdf
[8] National Low Income Housing Coalition. (2026). *The gap: A shortage of affordable rental homes: Oregon*. https://reports.nlihc.org/gap/state/OR
[9] U.S. Census Bureau. (2025). *Selected housing characteristics* (American Community Survey 5-Year Estimates Data Profiles, 2020–2024, Table DP04) [Data set]. U.S. Department of Commerce. https://data.census.gov/table/ACSDP5Y2024.DP04

> *"When I moved in it [the rent] was $895, and when I moved out it [the rent] was increased to $1,800. So I couldn't afford it no more. So here I am."*
>
> Listening session participant, Silverton

Nearly two-thirds of community survey respondents were living on an income of less than $500 per month, including 36% with no income at all. At those incomes levels, no market-rate unit in the region seems affordable. This highlights the fact that there is a supply-and-affordability gap that exists throughout the region.

3.3 Policy Environment

State policy shapes the region's response in three areas: emergency response funding, the laws governing enforcement, and behavioral health financing.

Oregon has operated under a declared homelessness state of emergency since January 2023, and the associated investment has expanded the region's shelter capacity. Governor Kotek extended the declaration for a third time on January 2026 through Executive Order 26-01, which runs through January 2027. While earlier orders targeted shelter capacity broadly, Executive Order 26-01 centers the intersection of homelessness, mental health, and addiction, directing approximately $20 million toward permanent supportive housing and behavioral health programs.[10]

In addition, **two 2021 statutes set the terms under which local governments may regulate and remove unsheltered encampments. House Bill 3115** (ORS 195.530), which has been operative since July 1, 2023, requires that any city or county law regulating sitting, lying, sleeping, or keeping warm and dry outdoors on public property be objectively reasonable as to time, place, and manner with regard to persons experiencing homelessness.[11] This bill also gives a person experiencing homelessness a way to challenge ordinances that fall short of that standard.

House Bill 3124 (ORS 195.505) sets the procedures local governments must follow when removing people from an established camping site.[12] With this bill, officials are required to give a 72-hour notice and that notice must be provided in English and Spanish at all identifiable entrances. Once the 72-hour notice is posted, law enforcement must tell the local agency that provides social services to people experiencing homelessness where the notice was posted. Another stipulation in the bill requires the personal property of those who were removed from the homeless encampment must be stored for at least 30 days within the community from which it was taken. Items with no apparent value or utility, or in an insanitary condition may be discarded immediately upon removal of the homeless individual from the camping site.

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[10] Office of the Governor, State of Oregon. (2026, January 9). *Governor Kotek issues executive order to extend homelessness emergency*. https://apps.oregon.gov/oregon-newsroom/OR/GOV/Posts/Post/governor-kotek-issues-executive-order-to-extend-homelessness-emergency

[11] H.B. 3115, 81st Leg. Assemb., Reg. Sess. (Or. 2021). https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB3115/Enrolled

[12] H.B. 3124, 81st Leg. Assemb., Reg. Sess. (Or. 2021). https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB3124

Weapons, controlled substances other than prescription medication and items that appear to be either stolen or evidence of a crime shall be given to or retained by law enforcement officials. Together these statutes set the minimum standard for how removals must be conducted in the region.

Ballot Measure 110, passed by Oregon voters in 2020, funds recovery-focused capacity in the region, including two recovery-focused housing programs.[13] Now administered by the Oregon Health Authority as the Behavioral Health Resource Network Program, it has been restructured in four legislative sessions since passage. Providers described the effects of those funding changes, including a peer-run recovery center that lost 78% of its funding and reduced their operations from seven days a week to five hours a day, five days a week.

These policies shape the funding structure highlighted in the Sheltering Services in Marion and Polk Counties: A Landscape Scan and Gap Analysis (June 2026). According to the landscape scan, 75% of sheltering programs list the State of Oregon as a primary funding source, and 12 programs are funded by the state alone, with minimal city and county investment. The implication of this finding is that a budget reduction or policy shift could affect the majority of the system's largest programs at once, with little diversification to absorb the loss.

3.4 Sheltering Capacity

In June 2026, MWVCAA commissioned a landscape scan, which is documented in full in the standalone report, Sheltering Services in Marion and Polk Counties: A Landscape Scan and Gap Analysis (June 2026). Readers needing the complete program-level inventory, verification records, maps, and capacity appendices should consult that report.

The Marion and Polk region is home to 44 sheltering programs for people experiencing homelessness and is operated by 17 independent organizations. A handful of operators carry most of the load. MWVCAA operates 15 programs, accounting for 34% of all sheltering programs; Church at the Park operates six; and The Confederated Tribes of Grand Ronde operates three verified shelters, an important Tribal contribution to regional capacity. Together these organizations operate more than half of all sheltering programs in the region.

The continuum of sheltering services spans emergency shelter, low-barrier shelter, warming and cooling sites, transitional housing, permanent supportive housing, recovery-focused shelter, day centers, and rapid rehousing, with many programs self-identifying as more than one type. Program categories should therefore be read as descriptive rather than mutually exclusive.

On a typical night the system offers 1,421 individual beds and 230 family units. Family-serving programs report capacity in households rather than beds; converting at a conservative three individuals per household, typical combined capacity is approximately 2,111 sleeping spaces across 38 programs. During inclement weather an additional 247 warming beds across five programs bring combined capacity to approximately 2,358.

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[13] Oregon Health Authority. (n.d.). *Behavioral Health Resource Network (BHRN) Program*. https://www.oregon.gov/oha/hsd/amh/pages/measure110.aspx

Capacity is concentrated at the edges of the continuum. The largest single pool of individual beds is low-barrier, with 311 beds across the five ARCHES network programs, and a further 529 beds are categorized as emergency shelter across 11 programs that vary widely in size, philosophy, and eligibility. At the long-term end, permanent supportive housing accounts for 65 individual beds with very low turnover. Permanent supportive housing is designed as a long-term home. Most of these programs reported unlimited lengths of stay and run at or near full occupancy, so a unit opens only when a resident leaves. The transitional middle is comparatively thin: transitional housing accounts for 295 beds and 112 households combined, spread across 15 mostly small, population-specific programs. **For a person ready to leave emergency shelter for something more stable, the pipeline forward is narrow, which means people stay in emergency and low-barrier beds longer and those beds turn over more slowly.**

Table 7. Dedicated capacity and the 2025 Point-in-Time count by population among sheltering programs

Population	Programs	Beds	% of beds	Household units	% of units	Sleeping spaces (beds plus units × 3)	People counted, 2025 PIT	% of PIT	Spaces short of or over the count
Adults only	12	683	48%	0	0%	683	1,700	80%	1,017 short
Adults with children	17	453	32%	211	92%	1,086	419	20%	667 over
Survivors of domestic violence	2	130	9%	0	0%	130	420	20%	290 short
Veterans	3	119	8%	0	0%	119	108	5%	11 over
Youth, ages 11 to 17	2	20	1%	0	0%	20	16	1%	4 over
Young adults, ages 18 to 24	2	16	1%	19	8%	73	88	4%	15 short
Total	**38**	**1,421**	**100%**	**230**	**100%**	2,111	2,135		24 short

Note. Capacity from the landscape scan, Table 7. Beds are non-inclement individual sleeping spaces. Household units are converted at three people per unit, the convention used elsewhere in this report, to give sleeping spaces. Day centers and warming-only programs carry no year-round beds and are excluded, which brings 44 programs to 38. People counted from the 2025 HDX summary for OR-504 (count date January 22, 2025). The last column is sleeping spaces minus people counted. PIT groups overlap. Veterans and survivors of domestic violence are also counted among adults, so the rows do not sum and only the total is additive. The domestic violence figure is an optional HUD field that records adult survivors. Percentages are of 2,135 and rounded to whole numbers.

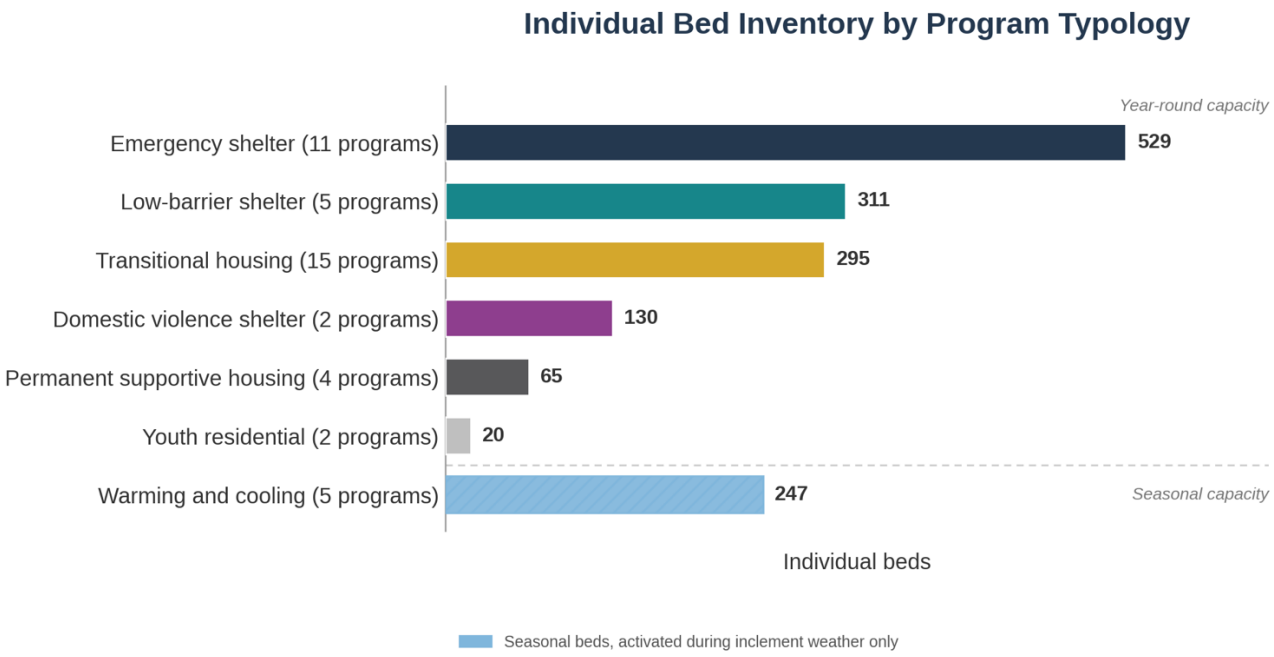

Figure 3. Individual sleeping spaces by program typology. Household units are reported separately and are not included here (1 household unit does not equal 1 bed). Because programs self-identify with more than one shelter type, these categories overlap and are descriptive rather than additive. Bars do not sum to the region's total bed capacity. Warming and cooling beds are activated during inclement weather only and are shown separately from year-round capacity. Transitional housing reflects all programs whose shelter type combination includes transitional housing. Source: Sheltering Services in Marion and Polk Counties: A Landscape Scan and Gap Analysis, Finding 6.

3.5 Verification Findings and Reporting Gaps

The process of confirming each program's details revealed patterns of its own. Different contacts within the same organization sometimes provided different capacity figures, which can be interpreted not as an error but as evidence that these organizations continually adapt to changing needs. Bed counts and availability are a moving target rather than fixed values. Reporting was also uneven on key metrics. Average operating cost per bed was reported by only 15 of 44 programs and reflected different underlying definitions, unique individuals served annually was reported by 28 of 44, and five programs did not report operating hours at all. Two Tribal transitional living centers in each of two Tribal organizations, four total, were excluded from the count because bed data could not be verified.

Cost data were reported unevenly, but what was reported is still informative. Fifteen of 44 programs reported an average operating cost per bed per night, ranging from $12 to $242 with a median of $43. The spread reflects different service models as well as different accounting definitions: a volunteer-staffed seasonal warming shelter and a staffed program with behavioral health supports are not producing the same product. Even with those caveats, a median nightly cost of $43 per bed is a useful reference point for regional planning. This figure sits below the routinely cited costs of institutional settings such as emergency departments and jail beds, where unsheltered people often spend time instead. The highest costs were in small programs

serving youth and survivors of domestic violence. These figures describe the reporting programs only. They are not an estimate of the system's total or average cost.

3.6 Geographic Coverage

Sheltering capacity is concentrated in Salem. The city holds roughly two thirds of the region's 44 programs and most of its beds. Salem is also the only location where the full continuum of shelter types operates together. Polk County accounts for eight programs, offering 84 individual beds and 3 household units, roughly 6% of the region's non-inclement weather capacity. Four programs are in Dallas and three in Monmouth, leaving Independence, Falls City, and rural western Polk County without a dedicated program of their own, and no day or shelter-based resource center operates anywhere in the county. The landscape scan found no shelter-affiliated day center in Polk County. The county has non-shelter resource sites including the Polk Community Resource Center in Monmouth and the ROCC peer drop-in center in Dallas. These sites do not offer overnight shelter.

Capacity can also be compared with the number of people counted in each county. In the 2025 Housing Inventory Count, Polk County reported 79 shelter beds, including seasonal beds, against 357 people in the 2025 Point-in-Time count. That is 22% coverage, compared with 89% in Marion County. Sixty-six percent of the people counted in Polk County were unsheltered, compared with 41% in Marion County.

Capacity in Marion County outside Salem-Keizer area is limited. It consists of two transitional family programs in Mount Angel, a 22-bed program in Silverton, 20 year-round beds in Woodburn, and a seasonal warming site in Mill City. Keizer, adjacent to Salem, hosts the 80-bed Simonka Place. The system's large-capacity resources, including the ARCHES low-barrier network, bilingual staffing, behavioral health services, and around-the-clock access, are located in Salem.

Reaching that core capacity generally requires travel to Salem. For a person in rural Polk County or eastern Marion County the distance is itself a condition of access. Since dedicated capacity outside Salem is small, a single waitlist, closure, or eligibility mismatch can leave a community without a nearby option. Entry pathways compound the pattern in Polk County, where most capacity is not walk-in: two programs require an online application, two accept referrals only, and one maintains a waitlist by default. Three programs report no waitlist, but none functions as a general-population walk-in option.

3.7 Physical Conditions and Operating Access

The physical form of the inventory constrains who can use the various facilities. About 30% of beds are bunks, and roughly a third are in congregate settings. These configurations exclude many older adults and people with mobility disabilities. Top bunks require climbing, which may not be safe for older adults, pregnant people, or people with balance or mobility limitations. Congregate rooms offer little privacy or control over noise and light. Only 25 of 44 programs operate 24 hours a day. The remainder close for some or all of the day, which is why day centers and, in their absence, libraries and parks are among the places people experiencing homelessness most frequently spend their days. Only 15 of 44 programs, about a third, accept

true walk-ins. The rest require referrals, appointments, online forms, or waitlist placement. This converts shelter access into an administrative process for this population. Physical accessibility is affirmatively reported at only 12 programs and unreported at 32, so the region cannot currently state how much of its inventory a wheelchair user can enter.

3.8 Who the System Is Built to Serve

Almost half of all individual beds, 48%, are designated for adults only. The 2025 Point-in-Time count identified 1,700 adults in adult-only households. This capacity is anchored by a small number of large Salem programs. Families are counted primarily in household units, and 92% of household units are dedicated to adults with children. The count identified 122 family households, or 419 people. Only five family units were open at the time of reporting, the thinnest point of open access in the system. Dedicated capacity for minors totals 20 beds across two ten-bed programs, one in Salem and one in Monmouth. The count identified 16 unaccompanied minors, a group single-night counts are likely to undercount. Young adults ages 18 to 24 have 38 beds in dedicated or near-dedicated programs, and the count identified 88n young adults experiencing homelessness. Survivors of domestic violence are served by two dedicated programs totaling 130 beds, one in each county. The count identified 420 adult survivors, a measure that includes survivors who are not seeking domestic violence shelter. Veterans have 119 dedicated beds, and the count identified 108 veterans. For minors, young adults, and survivors, the small number of providers means a single closure, waitlist, or geographic mismatch can leave a person with no dedicated option within reach.

The system's default position towards housing and sheltering is inclusion rather than specialization. Forty-one of 44 programs report serving all races and ethnicities. Programs operate under federal fair housing and civil rights rules that generally bar limiting admission by race, color, national origin, or other protected characteristics. Within those rules, programs can build culturally specific practice through outreach, staffing, language access, and program design. Serving everyone is not the same as being equipped to serve a particular community well. Culturally specific capacity therefore usually means staffing, language, outreach, and practices suited to a community, not restricted eligibility. Only three programs are culturally specific, all serving Tribal members through The Confederated Tribes of Grand Ronde: Warriors of Hope, Village One, and Village Two. One additional program reported Black or African American residents as a primary population it serves. No program indicates that it specifically serves the region’s Latine community, even though the 2025 PIT counts identified Latine residents as disproportionately unsheltered. No program is designated for LGBTQIA+ residents. Language capacity beyond Spanish thins sharply, with Russian at four programs, sign language at three, Marshallese at two, and Chuukese at none.

3.9 Capacity Compared to Estimated Need

At the system's typical capacity of roughly 2,111 combined sleeping spaces, shelter comes up about 24 beds short of the 2,135 people identified in the 2025 Point-in-Time count. That gap closes on paper during inclement weather, when 247 seasonal warming beds bring combined capacity to roughly 2,358. But that near-parity is misleading. The PIT count undercounts actual homelessness, so need is higher than the comparison target. Total bed counts also do not

account for eligibility restrictions, geographic access, real-time availability, or program rules, so usable capacity is lower than the inventory figure. For instance, a women-only or veterans-only bed is not available to someone who does not qualify. Similarly, a bed in Salem does little for someone in rural Polk County without transportation. A bed counted in the inventory may be occupied, waitlisted, or offline on any given night.

The occupancy data confirm how little slack exists. Twenty-eight of 44 programs report maintaining a waitlist. Permanent supportive housing runs at or near 100% occupancy with very low turnover. Transitional housing is nearly as full with 9 of 10 programs at capacity, and 10 of 15 emergency shelters are at capacity. When the back of the system does not move, the front cannot either. The gap between need and usable capacity is therefore wider than a direct comparison of total beds to total need would suggest. The following sections examine the rules, pathways, and information failures that widen it further.

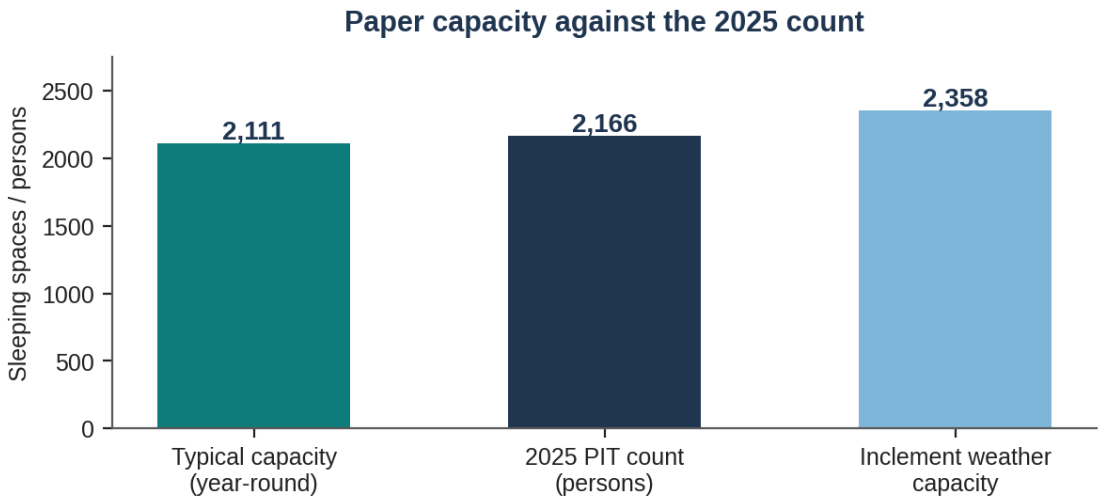

Figure 4. Paper capacity against the 2025 count. Near parity in the totals coexists with waitlists at 64% of programs and full occupancy through the back of the continuum.

KEY TAKEAWAYS – REGIONAL CONTEXT AND THE SHELTERING LANDSCAPE

- **The 2025 Point -in-Time count identified 2,135 people, up from 1,683 in 2023. Forty-seven percent were experiencing homelessness for the first time.** The sheltered count fell from 1,182 in January 2025 to 953 in January 2026. A sheltered count reflects the beds occupied on the count night, so the change can reflect a change in capacity and occupancy as well as need. The 2026 count did not include unsheltered people.
- Housing costs in the region exceed the incomes many people have. HUD's fair market rent for a one-bedroom unit in the Salem metro area was $1,198 in fiscal year 2025 and $1,201 in the

2026 fiscal year.[14] The federal SSI payment for an individual in 2026 is $994 per month. Among survey respondents reporting an income amount, 64% lived on less than $500 per month

- **44 sheltering programs run by 17 organizations provide real scale**, with MWVCAA operating a third of all programs and state funding underwriting **75%** of them, leaving the region exposed to any single funder's shift.
- Typical capacity of roughly 2,111 sleeping spaces sits about 24 beds short of the 2025 PIT count, but near-parity on paper is misleading. The count underscores the need and the inventory overstates what is actually usable.
- Capacity concentrates at the edges of the continuum. Emergency and low-barrier beds are the system's strength. The transitional middle that moves people toward stability is thin and youth and family walk-in capacity are the thinnest points of all.
- This sheltering ecosystem is concentrated in Salem. Polk County holds 4.4% of capacity, and specialized services are almost entirely Salem-based, Openness is not specialization. Nearly every program serves all races and ethnicities, yet culturally specific capacity is limited to three Tribal programs. No program serves the Latine community specifically.
- The region has built real capacity. Forty-four programs across 17 organizations provide roughly 2,111 sleeping spaces on a typical night. Low-barrier shelter anchors the system with 311 beds, and 25 programs operate around the clock. During inclement weather, 247 seasonal beds lift capacity beyond the count of homeless individuals.
- Cost per bed cannot yet be measured across the system. Fifteen of 44 programs reported it, using different definitions.

[14] U.S. Department of Housing and Urban Development, Office of Policy Development and Research, "FY 2026 Fair Market Rents, Salem, OR MSA," HUD USER, effective October 1, 2025, https://www.huduser.gov/portal/datasets/fmr.html.

4. Who Is Experiencing Homelessness

4.1 Where People Were Counted

The 2025 Point-in-Time count describes where people were on one night. Statewide estimates from Portland State University divide the count by county.[15] Marion County accounted for 1,736 people and Polk County for 357. Forty-one percent of those counted in Marion County were unsheltered, compared with 66% in Polk County. Per 1,000 residents, the rates of homelessness were 4.99 in Marion County and 4.02 in Polk County.

Polk County Family and Community Outreach conducted a separate count of rural Polk County, west of Highway 51, on the same night.[16] It counted 135 unsheltered people, 81 sheltered people, and 92 people at risk of homelessness. Dallas recorded 96 people counted as homeless or at risk, Monmouth 75, the Grand Ronde area 62, Independence 45, Falls City 24, and Willamina 6. Independence, Falls City, and Willamina recorded no sheltered people. The rural Polk unsheltered count rose from 5 in 2021 to 135 in 2025.

4.2 Current Living Situations

Survey respondents were distributed across the full spectrum of housing instability. Just under 70% were considered literally homeless:[17] 32% reside in a transitional shelter or a program, 30% unsheltered, and 8% in emergency shelter. The remainder were housed but at risk (14%), recently rehoused after a period of homelessness (11%, or doubled up (4%). Among respondents sleeping outside, encampments and tent communities were the most common location, followed by streets, doorways, and parks, and then vehicles.

Unsheltered homelessness in this sample is not transient. Of the 43 respondents who selected sleeping outside, 12 had been in the same location for more than a year and an additional eight respondents had been in the same location for at least seven months. Across the full sample, 38% of the survey respondents had been in their current housing situation for more than a year. **For a substantial share, homelessness or housing instability is not a brief disruption but a prolonged condition.**

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[15] Cho, M., Greene, J., Spurbeck, F. H., & Zapata, M. (2026). *2025 Oregon statewide homelessness estimates*. Portland State University Homelessness Research & Action Collaborative. https://pdxscholar.library.pdx.edu/hrac_pub/53/

[16] Polk County Family and Community Outreach, "Rural Polk County 2025 Point in Time Count Data," Polk County, Oregon, count conducted January 22, 2025, https://www.polkcountyor.gov/1162/Point-In-Time-PIT-Count

[17] U.S. Department of Housing and Urban Development. (2012). *Criteria and recordkeeping requirements for definition of homeless*. HUD Exchange. https://www.hudexchange.info/resource/1974/criteria-and-recordkeeping-requirements-for-definition-of-homeless/

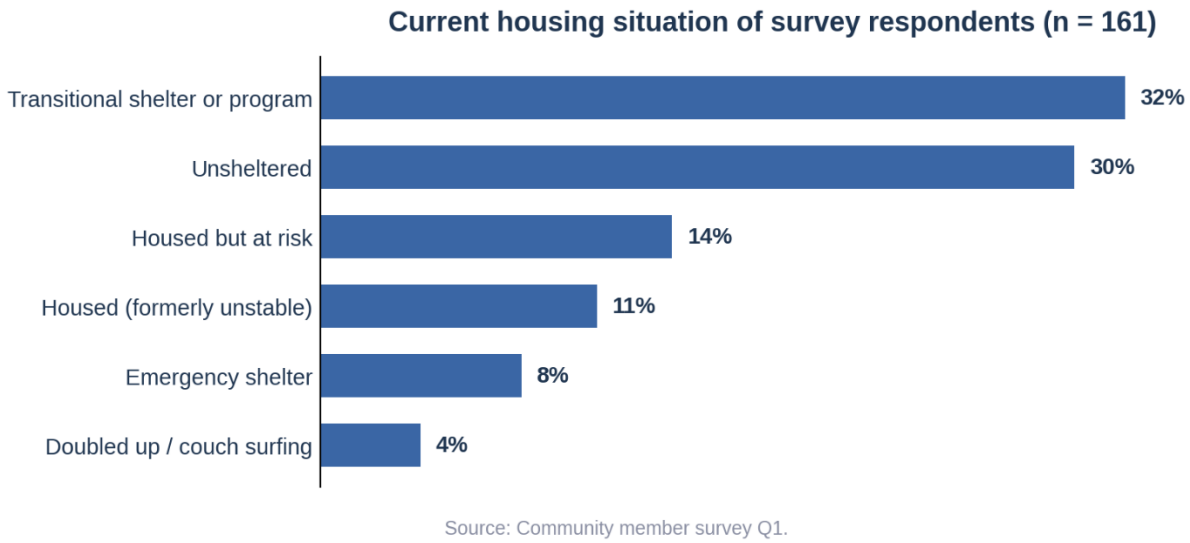


Figure 5. Where respondents were living at the time of the survey.

The survey was distributed largely through service providers and shelter sites, so people connected to services may be overrepresented. Forty percent of respondents were in a shelter or program when they responded. Among respondents who were literally homeless, 57% were sheltered, close to 55% sheltered share in the 2025 Point-in-Time count.

4.3 First-Time and Recurrent Homelessness

In the community member survey, **two-thirds of respondents who answered had experienced homelessness or housing instability before the current episode**. Among the 103 respondents with a prior history, two-thirds had spent 12 months or more homeless within the past three years, and just under a third had experienced four or more separate episodes in that window. Repeated episodes and long duration are related but distinct. Of the 68 respondents who experienced homeless for 12 or more months in three years, 31 had four or more separate episodes of homelessness. This is an indication of a cyclical pattern of gaining and losing housing. In addition, the other 37 respondents experienced fewer episodes of greater length. Both patterns describe homelessness that has persisted, but they imply different responses. Together, these findings indicate that for many people currently experiencing homelessness in the region, the current episode is not their first, and prior episodes either recurred or ran long.

The listening session data shows a similar pattern. **Sixty-nine percent of session participants reported more than a year of homelessness in total**. Only four participants reported experiencing homeless for less than three months. The difference from the PIT's first-time figure is not a contradiction. The count captures everyone on one night, while this assessment reached people connected to services and sessions, who skew long-term. However, it does mean that the population the response system interacts with day to day is substantially a recurrent, long-duration population. As shown later in this report, the longer someone has been homeless, the more critically they tend to describe the system.

4.4 Household Composition

Household composition describes who is navigating homelessness together. The community member survey asked two questions about household composition: how many adults share the respondent's household, and whether children under 18 are in their care. A majority of respondents reported single-person households. Among respondents who were parents of minor children, some had their children with them and others did not. In the 2025 Point-in-Time count, 419 people, about one in five of those counted, were in households with at least one adult and one child. These 122 households included 246 children under 18, and 40 of them were unsheltered. Among community member survey respondents, 25 of 161, or 16%, had children under 18 with them.

The listening session data, described below, add context to this pattern of family separation.

Table 8. Adults in household and children under 18 in care among survey respondents

Adults in household	n	%		Children under 18 in your care	n	%
Just me	89	55%		No	118	73%
2 adults	43	27%		Yes, children with me now	25	16%
5 or more people	16	10%		Yes, but not with me right now	15	9%
3 to 4 adults	13	8%		Prefer not to answer	3	2%

The middle rows of the table's right-hand column show the family separation finding. Fifty-five percent of survey respondents were single-person households. Of the 40 respondents who were parents of minor children, 25 had their children with them and 15 were separated from their children. During the listening session, one mother reported she had been separated from an autistic son because no shelter could accommodate him.

Four respondents were pregnant. Forty-three percent of respondents had a pet. Ownership differed sharply by housing situation: 60% of unsheltered respondents had a pet, compared with 17% of sheltered respondents. Later in this report, we examine one likely reason for this difference, shelter rules that exclude animals, and what pet owners described giving up to keep them.

4.5 Demographics

This section describes who participated in the community needs assessment, drawing on the survey's demographic items and the listening session sign-in data. The survey sample skews toward working-age adults, with 45% aged 25 to 44 and 33%aged 45 to 64. Women outnumbered men, 54% to 42% and 11 respondents identified as transgender, non-binary, gender non-conforming, or self-described. Just over 70% of respondents who reported a race or ethnicity identified as White alone. Hispanic or Latino/a/e/x respondents were the largest group

among respondents of color at 13%, followed by American Indian or Alaska Native respondents at 9%. No respondent identified as Asian or Asian American. All but three respondents preferred English, and one preferred Chuukese. Six respondents identified as veterans and 22 as lesbian, gay, bisexual, queer, or another sexual orientation. The listening session participants show a different age distribution. The two largest age bands were 55 to 64 (27%) and 18 to 24 (25%). The bands in between held smaller shares of participants. Roughly six in ten participants were either under 25 or 55 and older. This distribution partly reflects session design, since one session was convened for young adults and several took place in shelters whose residents skew older. Participants in these two age groups described different pathways into homelessness. Younger participants described family expulsion at or before eighteen, and older participants described rent increases, job loss, divorce, or a medical event late in a working life.

The sessions also differed from the survey in two other respects. Session participants were majority men (52%, compared with 42% of survey respondents), and Hispanic or Latino/a/e/x participants made up 25% of session participants, roughly twice their share of the survey sample, reflecting the Spanish-language session in Woodburn.

Providers were asked whether the mix of households they serve has shifted over the past year. Thirty-six percent reported no change. Among those reporting a shift, the largest single response was an increase in older adults aged 65 and over, at 21%. This exceeded reported increases in families with children, single adults, and youth. Older adults also ranked second among the populations providers identified as falling through the cracks.

> *"We are receiving calls and serving more women who are older and became homeless for the first time ever. The rising rents and rising living expenses are beyond their capacity to make ends meet, especially with fixed incomes."*
>
> Service Provider, Survey write-in

Table 9. Age and race or ethnicity of assessment participants (N = 213)

Age band	n	%		Race and ethnicity	n	%
35 to 44	48	23%		White	161	75%
45 to 54	42	20%		Hispanic or Latino/a/e/x	35	16%
18 to 24	36	17%		American Indian or Alaska Native	19	9%
25 to 34	34	16%		Black or African American	10	5%
55 to 64	34	16%		Native Hawaiian / Pacific Islander	6	3%
65 or older	15	7%		Middle Eastern or North African	1	1%
17 or younger	4	2%		Prefer not to answer / self-describe	11	5%

Combined survey respondents and listening session participants. Age is reported for 213 participants (157 survey respondents and 56 listening session participants). Race and ethnicity is select all that apply, reported against 215 participants who answered (159 survey and 56 listening session); percentages sum to more than 100. Some listening session participants may also have completed the survey, so the two sources may include a small number of the same individuals counted twice.

4.6 Health and Disability

Three-quarters of survey respondents reported a long-term physical or mental health condition affecting daily life, including 29% reporting both a physical and a mental health condition. This was the most prevalent characteristic in the sample. Thirty-five percent of respondents named a disability or health condition as their biggest barrier to employment. Respondents with a condition were seven times more likely to report being denied services because of their identity. In the listening sessions, 43% of participants identified as a person with a disability. Conversations during the listening sessions highlighted accounts of spinal injury, stroke, traumatic brain injury, seizure disorder, deafness, wheelchair use, and disabilities participants described as invisible.

Eighty-six percent of respondents have health insurance, predominantly through the Oregon Health Plan. At the same time, 43% had visited an emergency room in the past 12 months because they could not get care elsewhere, and nine respondents had done so four or more times. **High coverage and high emergency room use appearing together suggests that barriers to care lie beyond insurance status**. In the listening sessions and open-ended responses, participants described the barriers they encountered such as the lack of appointment availability, transportation, provider unwillingness to treat, discriminatory practices and mistreatment due to being homeless, and the practical difficulty of attending scheduled care while homeless.

Table 10. Health insurance coverage among survey respondents (N = 161)

Coverage	n	%
Yes -- Oregon Health Plan (Medicaid)	125	78%
No -- I do not have health insurance	12	8%
Yes -- Medicare	8	5%
I am not sure	7	4%
Prefer not to answer	4	3%
Yes -- employer or private insurance	4	3%
Yes -- Veterans Administration (VA) coverage	1	1%

Note. Community member survey (n = 161). Respondents selected one option. Percentages are rounded to whole numbers and may not sum to 100. Counting all coverage types together, 86% of respondents reported having health insurance.

4.7 Economic Circumstances

Thirty-six percent of respondents reported not receiving any income. Among the 149 respondents who reported an income amount, 64% were living on less than $500 per month. SNAP was the most common benefit reported by community members (56%). Wages from a job followed at 24%.

Many respondents reported health conditions, and far fewer reported receiving disability benefits. Seventy-five percent of respondents who answered the item reported a long-term physical or mental health condition. Forty respondents reported being unable to work because

of disability or health. Twenty-six were receiving SSI or SSDI. In open-ended responses, several respondents described disability benefit applications that had been pending for years, including one pending since 2021.

Twenty-three respondents were working full-time, and another 22 were working part-time or in occasional or temporary jobs, while experiencing homelessness or housing instability. Having a job did not ensure a path out of homelessness. For these 45 respondents, employment and homelessness were occurring together, in a housing market where about one in four renter households is severely rent burdened and few units are affordable at low incomes.

For some respondents, employment problems came before housing loss, and for others, housing loss now stands in the way of employment. Job loss or reduced income had contributed to losing housing for 48 respondents, while 37 of those not working cited the absence of stable housing as a barrier to finding work. Forty-seven respondents were not working and looking for work, and 35 reported applying for jobs without receiving offers. Among those not working, the most common barriers were disability or health (57 respondents), transportation (43), and a criminal record (34). Fourteen respondents had used employment or job training services in the past 12 months, and 43 named income or employment support among their top three unmet needs.

> *"I work 2 jobs but somehow I do not earn enough money to pay for rent, food and bills. A voucher would help and my pay dates do not align with rent due dates."*
>
> Community Member Survey respondent

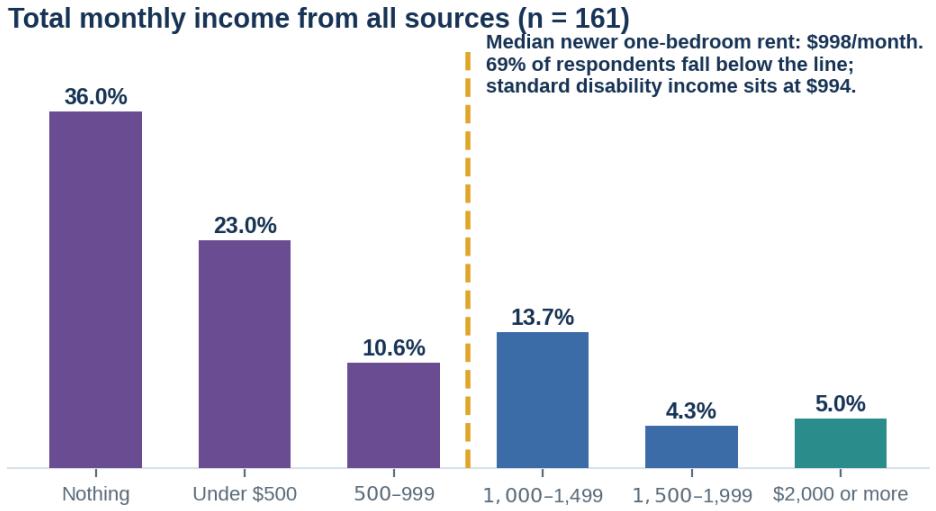


Figure 6. Monthly income among survey respondents. The gold line marks HUD's fiscal year 2025 fair market rent for a one-bedroom unit in the Salem metro area.

Source: Community member survey Q28; 8% of respondents preferred not to answer.

Table 11. Employment status and sources of income and benefits among survey respondents (N = 161)

Employment status	n	%	Sources of income and benefits (select all)	n	%
Not working, looking for work	47	29%	SNAP (food stamps benefits)	90	56%
Unable to work: disability or health	40	25%	Wages or salary from a job	38	24%
Working full-time	23	14%	No income at this time	36	22%
Working part-time	14	9%	Supplemental Security Income (SSI)	15	9%
Not working, not looking	15	9%	General Assistance or state cash	14	9%
Occasional or temporary work	8	5%	Support from family or friends	14	9%
Retired	6	4%	SSDI	12	8%
Prefer not to answer	8	5%	Informal or cash work	11	7%

This table presents respondents' employment status and income sources. The largest employment groups were respondents looking for work (29%) and respondents unable to work due to disability or health (25%), followed by those working full-time (14%). SNAP, a food benefit rather than cash income, was the most commonly reported support, at 56%. Wages were reported at 24%, while 22% reported no income at this time. Cash benefit programs each reached small shares of the sample: SSI at 9%, General Assistance at 9%, and SSDI at 8%.

4.8 Safety and Daily Conditions

Half of respondents (80 of 161) reported feeling safe where they were staying. Seventy-seven respondents reported concerns, including 20 who reported not feeling safe. Safety differed by housing situation: 76% of unsheltered respondents reported safety concerns, compared with 39% of respondents in all other situations, a statistically significant association ($p < 0.001$). Among the 78 respondents describing what made them feel unsafe, 60% cited violence, threats, or fighting around them, and 35% cited being treated unfairly or harassed because of who they are.

Table 12. Perceived safety in current living situation among survey respondents

Do you feel safe where you are currently staying?	n	%
Yes, I feel safe	80	50%
Somewhat, I have some concerns	57	35%
No, I do not feel safe	20	12%
Prefer not to answer	4	3%
Among those with concerns: what makes you feel unsafe? (select all, n = 78)	**n**	**%**

Do you feel safe where you are currently staying?	n	%
People around me: violence, threats, or fighting	47	60%
Being treated unfairly or harassed because of who I am	27	35%
My neighborhood feels unsafe	23	30%
Problems inside the home: mold, pests, or broken heat	17	22%
Something else (weather exposure, theft, and police contact in write-ins)	17	22%
Doors or windows that do not lock	12	15%
Too many people living in the home	8	10%

4.9 Connectivity

Eighteen percent of survey respondents did not have a working phone, and an additional 17% had a phone with very limited minutes or data. Ten percent had no internet access at all, and another 8% reported that access was rare and very limited. Connectivity was lower among unsheltered respondents. Forty percent reported limited or no internet access, compared to 18% of the full sample. Many of the services described in this report involve online applications, phone callbacks, or appointment confirmations. Respondents without reliable phone or internet access face additional steps to complete these processes.

Table 13. Phone and internet access among survey respondents

Working cell phone	%		Regular internet access	%
Yes, with minutes or data	65%		Yes, on my phone	66%
Yes, but minutes or data very limited	17%		Through a library, shelter, or other location	16%
No working phone	18%		Rarely, access is very limited	8%
			No access	10%

KEY TAKEAWAYS – WHO IS EXPERIENCING HOMELESSNESS

- Two-thirds of survey respondents had experienced homelessness or housing instability before the current episode, and among them, two-thirds had spent 12 or more months homeless in the past three years.
- Participant age in the listening sessions was concentrated at both ends of adulthood: roughly six in ten participants were under 25 or 55 and older. The two groups described different pathways into homelessness, family expulsion at or before eighteen for younger participants, and rent increases, job loss, divorce, or medical events for older participants.

- Three-quarters of respondents reported a long-term physical or mental health condition. 86%had health insurance, and 43% had used an emergency room in the past year because care was unavailable elsewhere.

- Among respondents reporting an income amount, 64% lived on less than $500 per month, including 36% of the sample with no income. Forty-five respondents were working while homeless or unstably housed, 23 of them full-time.

- Safety concerns differed sharply by housing situation**:** 76% of unsheltered respondents reported concerns about where they were staying, compared with 39% of respondents in all other situations. Among those describing what made them feel unsafe, violence, threats, or fighting was the most cited concern, followed by being treated unfairly or harassed because of who they are.

- Of 40 surveyed parents of minor children, 15 did not have their children with them, and 53 of 58 session participants reported no children in their household, though many identified as parents. In one documented account, a mother was separated from her son because no shelter could accommodate his disability.

- Thirty-six percent of providers reported no change in the mix of households types they serve over the past year. Among those reporting a shift, an increase in adults 65 and over was the most common response.

5. Migration, Mobility, and Community Connection

5.1 Where Participants Live and What Brought Them Here

Community member survey respondents were concentrated in Salem, which accounts for 122 of 161 respondents. The remainder were distributed across Silverton (7), Keizer (6), Stayton (6), Monmouth (5), and a dozen smaller communities including Independence, Falls City, Woodburn, and Mill City. The listening sessions drew a different geographic profile: 68% of session participants lived outside Salem, across Silverton, Monmouth, Woodburn, Stayton, Falls City, and Dallas, reflecting the placement of sessions in communities across both counties. Most participants at the Spanish-language session in Woodburn lived in Woodburn.

The survey also asked what brought respondents to the area in which they were currently residing. Among the 125 respondents who answered, the most common reason was family or loved ones, selected by 40%. Twenty percent were already living in the area when they lost their housing. Eighteen percent came fleeing an unsafe or dangerous situation, and 11% came for a relationship that has since ended. Service-related reasons were selected less often: 14% selected that sheltering and other services are located here, and 9% selected having heard there were more services or resources here. Two respondents reported being referred or transported to the area by another agency, and three reported being discharged from a hospital, jail, or facility in the area.

Table 14. Reasons community member respondents moved to the region

What brought you to this area? (select all, n = 125 answering)	n	%
Family or loved ones are here	50	40%
Already living here when I lost my housing	25	20%
Fleeing an unsafe or dangerous situation	22	18%
This is where sheltering and other services are located	18	14%
Came for work or a job opportunity	16	13%
Came for a relationship that has since ended	14	11%
Heard there were more services or resources here	11	9%
Cost of living seemed more affordable	5	4%
Discharged from a hospital, jail, or facility in this area	3	2%
Referred or transported here by another agency	2	2%

Note. Community member survey Q14 (n = 125 answering). Select all that apply; percentages sum to more than 100.

Respondents' ties to the area ran deep in most cases. Forty-two percent either grew up in the area or had lived there more than ten years; an additional 19% had been in the area four to ten years and 18% had arrived within the past six months. Among respondents who had moved to the area at some point, the most common origin was another Oregon county (36%), followed by somewhere else within Marion or Polk County (29%) and another state (25%). Write-in responses identify the specific origins. Of the 79 respondents naming a place, 44 came from elsewhere in Oregon, most commonly neighboring Linn, Lincoln, and Clackamas

Counties and the Portland and Eugene areas. Washington State accounted for 10 and California for 7.

The survey also asked whether respondents have family, close friends, or other support people in the area. Sixty-one percent reported connections of some kind: 29% described strong connections and 32% described connections that are not very close. Twenty-two percent reported no connections in the area, and 17% reported that they had connections in the area but that those connections are no longer available. Thirty percent of respondents named family breakdown as a contributing factor to their housing loss. These findings are consistent across the items in this section. Most respondents have longstanding ties to the area, arrived from elsewhere in Oregon when they did move, and came for family more often than for services.

Table 15. Origins and local support connections among survey respondents

Where people came from	%		Support people in this area	%
Another Oregon county	36%		Some connections, not very close	32%
Elsewhere in Marion or Polk County	29%		Strong connections here	29%
Another state	25%		No connections here	22%
Always lived here	6%		Had connections, no longer available	17%

When community member survey respondents were asked where they would ideally live, 52% chose Marion or Polk County, naming it as their community. Twenty-one percent chose elsewhere in Oregon, and 12% chose another state where they have connections. When asked where they feel most at home, respondents mostly commonly answered Salem (44%). **Nineteen percent answered that they do not really feel at home anywhere right now**.

> *"I am not homeless just houseless. Home is where the heart is."*
>
> Community Member survey respondent

5.2 What Providers See

The provider survey asked where the clients they serve are primarily coming from, an item designed to parallel the community member questions about origins. **Eighty-four percent of providers reported that the majority of their clients became homeless in Marion or Polk County. Nine percent identified an origin outside the two counties.**

The provider listening session added a within-region pattern to this picture. Providers described rural residents across both counties being directed to Salem, where most services are located, at volumes Salem's programs described being unable to absorb. This account is consistent with the geographic findings elsewhere in this report, in which services concentrate in Salem while need is distributed across both counties.

Providers also described individual clients arriving from outside the region. These accounts included people arriving by bus from Washington, Grants Pass, and further away, and arrivals

from Eastern Oregon and Southern Washington who, after a year without securing housing, asked for help returning home. **These individual accounts and the aggregate figures describe the same system at different scales. Providers encounter out-of-region arrivals as individual cases, while the survey data, from both providers and community members, indicate that most people experiencing homelessness in the region became homeless here.**

Forty-two percent of surveyed community members grew up here or have lived here more than a decade. Among those who moved here, family ties outrank service availability as the reason for moving by roughly three to one. Only two respondents in the entire sample were transported here by an agency. Eighty-four percent of providers say their clients became homeless locally. The dominant migration pattern the data shows is intra-regional movement toward Salem, produced substantially by the region's own referral practices, which direct people from rural communities to a city whose capacity is already exhausted.

KEY TAKEAWAYS – MIGRATION, MOBILITY, AND COMMUNITY CONNECTION

This population is largely local. Most community member survey respondents had long ties to the region. Forty-two percent grew up here or had lived here more than ten years. In the provider survey, 84% of providers said most of their clients became homeless in Marion or Polk County.

Family, not services, is why movers came. Family ties outrank service availability roughly three to one, and only two respondents reported being transported here by an agency.

The dominant flow is intra-regional, toward Salem, driven by referral practices that tell rural residents the resources are in a city that cannot absorb them.

More than half of respondents want to stay in this region, and one in five do not feel at home anywhere right now.

6. Pathways Into Homelessness

Every person experiencing homelessness in this assessment was once housed. This section examines how that changed. It draws on three sources that each capture a different part of the answer: community member survey respondents described where they were living before the loss, the first event that set it in motion, and the factors that compounded it. In addition, providers described the reasons clients share with them. The section begins with what respondents' histories show about recurrence, then turns to where people were housed before the loss, what happened first, and what else contributed.

Of the 161 community member survey respondents, 103 reported experiencing homelessness or housing instability before the current episode; 51 reported this as their first time, and 7 preferred not to answer. The 103 respondents with prior episodes were asked two follow-up questions covering the past three years. The first asked how many separate times they had experienced homelessness, and the second asked how many total months they had spent homeless.

Table 16. Recurrence and duration of homelessness among respondents with prior episodes

Among the 103 with prior episodes: separate times homeless, past 3 years	%		Total months homeless, past 3 years	%
2 times	52%		12 months or more	66%
4 or more times	32%		Less than 6 months	21 %
3 times	17%		6 to 11 months	13%

Note. Community member survey Q3a and Q3b, asked of the 103 respondents who reported prior homelessness or housing instability. Percentages are of the 103 and are rounded to whole numbers.

6.1 Housing Situation Before Loss

Respondents were also asked where they were living before losing their housing. More than a third, 34%, were renting an apartment or house on their own, and another 8% were renting with roommates. An additional 37% were living with family or a partner, a figure combining the 22% living with family and the 16% living with a partner or spouse. Six respondents had owned a home. Thirteen respondents reported having been homeless or unstably housed for most of their lives.

Table 17. Housing situation and housing assistance before losing housing

Housing situation before losing stable housing	n	%		Voucher or subsidy before housing loss	n	%
Renting on my own	55	34%		No voucher or subsidy	108	67%
Living with family	35	22%		Don't know	16	10%
Living with a partner or spouse	25	16%		On a waiting list, never received	15	9%
Homeless or unstable most of my life	13	8%		Held a Section 8 / HCV	14	9%

Housing situation before losing stable housing	n	%		Voucher or subsidy before housing loss	n	%
Renting with roommates	12	8%		Held another rental subsidy	6	4%
Owning a home	6	4%		Applied, denied or removed	2	1%
Other	15	9%				

Combining the housing categories shows where respondents stood before the loss. Fifty-seven percent of respondents were renting on their own, renting with roommates, or living with a partner or spouse before losing their housing. Most respondents were not receiving housing assistance before the loss. Sixty-seven percent held their housing without a voucher or subsidy. Twelve percent of respondents had held a Section 8 Housing Choice Voucher or another rental subsidy before losing housing. In addition, 9% were on a waiting list that had not yet reached them, and two respondents had applied and had been denied or removed.

The 20 respondents who had held a voucher and lost it were asked what happened. The most common response was a write-in, given by 8 respondents, with one describing a landlord ending a voucher without the tenant knowing. Four had their subsidy terminated by the housing authority, and four left voluntarily. Three were evicted, and three had their voucher expire before finding housing.

When asked about the first thing that started their path to losing housing, respondents most commonly described a relationship ending at 16%, followed by no longer being able to afford rent at 13% and having to leave because of domestic violence or an unsafe situation at 12%. Job loss followed at 11%, eviction at 7%, and a mental health crisis at 6%. The largest single response was a write-in, at 20%, with entries frequently describing a property being sold, a landlord decision, or a compound event that did not fit the offered categories, and ten respondents said it happened gradually with no single event.

Table 18. The first event that started the path to losing housing

The first event that started the path to losing housing (select one)	n	%
Other (write-in, largely coded to employment, family, and health)	32	20%
A relationship ended (divorce, breakup, death of a partner)	25	16%
Could no longer afford rent	21	13%
Had to leave because of domestic violence or an unsafe situation	20	12%
Lost a job or income dropped significantly	17	11%
Evicted	11	7%
A mental health crisis	10	6%
It happened gradually, no single event	10	6%
Substance use	8	5%
A serious physical health problem	4	3%

The first event that started the path to losing housing (select one)	n	%
Fire or disaster, aging out of foster care, or release from custody	3	2%

Note. Community member survey (n = 161). Respondents selected one option. Percentages are rounded and may not sum to 100. Write-in responses coded as Other most often described employment, family, and health circumstances; the full coding crosswalk appears in the component report appendices.

> *"I was doing fine, and suddenly I was left with nothing. I had saved up."*
>
> Community Member Listening Session, Woodburn
>
> *"I have been homeless since 1984. I've gotten on my feet several times, but something would change and I would be homeless again."*
>
> Community Member Listening Session, Stayton

6.2 Contributing Factors

Few respondents described their housing loss as having a single cause. Alongside the first-event item, the survey asked what other factors contributed, and respondents selected an average of between two and three contributing factors. **The responses show housing loss arriving through several circumstances at once, with economic, health, and relationship factors each appearing in a substantial share of accounts.**

The multi-select contributing factors question gives the fuller picture. **Could not afford rent or was priced out was the most selected factor, at 38%.** Mental health challenges followed at 33%. Family breakdown or conflict and job loss were each selected at 30% each. The lack of affordable housing in the area followed at 20%, physical health challenges at 19%, substance use at 18%, domestic violence at 17% , and eviction at 15%. Housing loss in this sample is typically described as several things happening at once.

Domestic violence as a contributing factor differed by gender identity. It was cited by 23% of women and 36% of gender non-binary respondents (e.g., trans, and gender non-confirming respondents) compared with 7% of men.

Table 19. Factors contributing to housing loss among survey respondents

Contributing factors (select all that apply)	n	%
Could not afford rent or was priced out	**61**	**38%**
Mental health challenges	**52**	**33%**
Family breakdown or conflict	**48**	**30%**
Job loss or reduced income	**48**	**30%**
Lack of affordable housing in the area	32	20%
Physical health challenges	30	19%
Substance use	29	18%

Contributing factors (select all that apply)	n	%
Domestic violence or an unsafe situation	27	17%
Eviction	24	15%
Discrimination (race, gender, identity, or background)	11	7%
Release from jail, prison, or detention	9	6%
Disaster or fire, foster care aging-out, or institutional discharge	9	6%

Note. Community member survey Q21, select all that apply (n = 160 answering). Percentages sum to more than 100. Respondents selected an average of 2.5 factors. The disaster, foster care, and institutional discharge row combines three options selected 5, 2, and 2 times respectively.

Taken together, these findings describe housing loss as a compound event. **A first event set the path in motion, most often a relationship ending, unaffordable rent, or an unsafe situation, and additional factors accumulated around it, with respondents selecting between two and three contributing factors on average.** Economic pressure, health challenges, and relationship breakdown each appeared in roughly a third of accounts, and no single factor was selected by more than 38% of respondents. The pattern varied by who was describing it, with domestic violence appearing far more often in the accounts of women and gender non-binary respondents than of men.

6.3 Institutional Pathways

In the community member survey, release from jail, prison, or detention was a contributing factor for 6% of the respondents, and discharge from a hospital or treatment program without housing for 1%. Providers reported encountering these circumstances far more often. **Forty-nine percent of providers cited release from jail or prison without stable housing and 40%cite discharge from a hospital or treatment program among the reasons clients most commonly share as contributing factors to becoming homeless**

Formal data sharing agreements with these institutions were uncommon among provider respondents. Four percent of provider respondents reported an agreement with criminal legal partners, and 9% with hospitals. Providers thus reported institutional discharge among the most common circumstances they see, and reported few formal connections (e.g., data sharing agreement, MOU, or formal agreement) to these discharging institutions. It is unclear why so few formal connections exist.

The provider listening session added foster care and behavioral health facilities to that list. Providers also described a circumstance affecting people under criminal justice supervision. For this group, remaining homeless can violate the terms of their supervision, while their criminal record disqualifies them from many of the housing options that would resolve it. Providers described people held between these two requirements, unable to satisfy one without the other.

> *"The catch-22 with crime, and especially with sexual crime, is that they can break their probation or parole if they are homeless, but nobody's going to rent to them. So, they get*

> *shipped back to jail for a probation violation that they had no control over, and then it just repeats the cycle once they get released."*
>
> Service Provider, Listening session
>
> *"It's not just housing that they'll get denied for. It's also shelter. We have policies at our shelter that certain crimes will disqualify you from entering shelter."*
>
> Service Provider, Listening session
>
> *"I was actually denied one of the housing vouchers that the shelter I was staying at helped signed me up for. I was denied because of me having a felony on my record. I got that felony back in 2016. Ten years ago!"*
>
> Community Member Listening Session, Salem

6.4 What the Journey Mapping Showed

The journey mapping activity during the community member listening sessions showed the structure of these pathways. Across the maps, **housing loss appeared as a cascade rather than a single event.** Almost no participant described a single cause. Instead, the maps showed sequences. A layoff met a rent increase. A car breakdown was followed by a hospitalization. A lost phone was coupled with a missed callback for a job or an important appointment. Participants who could name a first event, such as a mother's death, an eviction, a divorce, being told at fifteen to leave, described everything after it as consequences compounding on one another.

The journey maps also surfaced two distinct pathway archetypes that match the bimodal age profile mentioned earlier in the report. The first pathway belongs to youth. The youth pathway runs through family rupture, expulsion or flight from home at or before eighteen, including at ages as young as 13, 15, and 17 among participants, sometimes tied to identity or safety at home. One participant described it plainly during the session, *“My journey started in the summer of 2022, when I turned 18. My mother decided that I wasn’t her problem anymore, and so I got kicked out.”*

The second pathway belongs to older adults. This pathway runs through economic and medical shock late in a working life, a layoff, a divorce, a stroke, a rent increase against a fixed income. A Salem participant with a forty-two-year career in cabinetry connected his loss in housing to a single termination. *"I used to be the boss. I was the head of 25 people at the shop. Then I got fired four years ago."*

Health, injury, and disability appeared as both trigger and consequence, most often in older participants’ accounts. In some accounts it was the starting point, and in others it arrived mid-sequence, as a coping mechanism for the other traumatic events they were experiencing. Substance use appears in participants' accounts as frequently entangled with grief and loss.

> *"You can't look for work in dirty clothes and no real place to get cleaned up."*
>
> Community Member Listening Session, Monmouth
>
> *“At the age of 13, I ran away from home because I got tired of being a punching bag.”*
>
> Community Member Listening Session, Salem

6.5 Structural Drivers

Providers were asked about the reasons clients most commonly share as the cause of their housing situations. **Inability to afford rent leads decisively at 87%.** Substance use followed at 72% and chronic long-term homelessness at 68%. In the provider listening session, providers described the structural conditions behind these reasons. Service providers described rents set above fixed incomes, income requirements set at multiples no benefit recipient can meet, and funding for services shrinking while demand grows.

The provider data also contain a difference between what providers cited as causes and what they cited as needs. Seventy-two percent of providers included substance use among the reasons clients commonly give for becoming homeless, and 64% cited a mental health crisis as a common cause. These two conditions each run through most providers’ caseloads, and they frequently occur together in the same person. When both conditions occur together, treatment calls for dual diagnosis support. These are services that treat both conditions at once, instead of separate systems that can each turn the same person away. Yet when providers named needed services, substance use treatment was selected by 60% of providers and dual diagnosis support selected by 46%.

6.6 What Has Changed

Providers were also asked how the factors driving homelessness have shifted. The change providers most often described was the aging of the population entering homelessness, with first-time homelessness among older adults on fixed incomes appearing in both the survey write-ins and the provider session. Older adults ranked second among population providers identified as falling through the cracks. Providers and participants also described newly homeless older adults fitting poorly into existing program criteria, which are often built around families with children or around chronic homelessness.

Providers also described funding reductions changing what the system itself can do. One peer-run recovery center lost 78% of its funding. A behavioral health grant was cut by 12%, and the organization removed coordination meetings first, these were meetings the organization established to have consistent touch points with other agencies in the region to stay informed of the various services offered to current and potential clients. Providers connected that loss to less accurate referrals, which participants experience as being sent from agency to agency, a pattern described later in this report.

The accounts from service providers and those experiencing homeless agree on several points. Both groups name affordability as the leading driver of homelessness. Both name release from

jail, prison, hospital, or treatment as a pathway into homelessness. Both describe several causes compounding rather than single causes acting alone. The two accounts differ most in how often they name substance use. Seventy-two percent of providers included substance use among the reasons clients most commonly share, compared with 18% of community members who cited it as a contributing factor. Five percent of community members described substance use as the first event. Release from jail or prison showed a similar gap, named by 49% of providers and 6% of community members. Two circumstances help explain these differences. The first is disclosure. Substance use carries stigma, which can make people less likely to report it. The second is vantage point. Each provider reported on patterns across an entire caseload, while each community member reported on one life, their own. A circumstance can appear often across a caseload and still show up in one person's account as a later consequence, not a starting cause. Participants described substance use following grief, injury, and the conditions of living outside as often as preceding them.

KEY TAKEAWAYS – PATHWAYS INTO HOMELESSNESS

Most respondents had lost housing before. Of the 103 respondents with prior episodes, 66% had spent a year or more of the past three years homeless. Thirty-two percent had experienced four or more separate episodes in that window.

Before the loss, most respondents held conventional housing without assistance. Fifty-seven percent were renting on their own, with roommates, or living with a partner, and 67% had no voucher or subsidy. Fifteen respondents were on a waiting list for assistance when their housing was lost.

No single cause dominated the accounts. Respondents selected an average of between two and three contributing factors, the most selected factor reached only 38%, and the journey maps showed the same structure, with first events followed by compounding consequences.

Affordability appeared at the top of both community member and provider accounts. **Could not afford rent was the most selected contributing factor among community members at 38%**, and 87% of service providers included inability to afford rent among the reasons clients commonly reported.

Two pathways ran through the journey maps, matching the ages of session participants. Younger participants described family rupture at or before eighteen. Older participants described economic and medical shocks late in a working life, arriving against fixed incomes.

Providers reported institutional release as a common circumstance and have few formal connections to the releasing institutions. Forty-nine percent cited release from jail or prison without stable housing, while 4% of providers reported a formal data sharing agreement with criminal legal partners, and 9% with hospitals.

The provider and community accounts differed most on substance use, reported by 72% of providers and cited by 18% of community members. Participants' accounts described substance use following grief, injury, and life outside as often as preceding them.

7. Prevention and Diversion

7.1 What Support Existed Before Housing Loss

Most community member survey respondents entered homelessness without prevention assistance. Sixty-one percent received no support or services at all before losing their housing. Another 8% did not know support was available. Together, 69% of the sample lost housing without any prevention support reaching them.

Fifty respondents (31%) did receive support of some kind. Among this group, food assistance was the most common form, received by 64%. Help from a friend or family member followed at 38%. Rental assistance or help paying rent reached 40% of the group, which is 20 respondents out of the full sample of 161. Case management or a housing advocate, the intervention most closely associated with housing retention, reached three respondents (2%). **The support that reached people most often addressed immediate needs, while the forms of support most directly tied to keeping housing reached far fewer.**

Support that did arrive did not always prevent the loss. **Of the 50 respondents who received support, 40% reported that it was not enough to prevent homelessness.** The remaining 60% reported that it helped for a while. Before the loss, 20 respondents held a voucher or subsidy, and 15 more were on waiting lists that had not yet reached them.

Table 20. Prevention support received before losing housing among survey respondents

Support received before losing housing	n	%
No support at all	98	61%
Had support, and it helped for a while	30	19%
Had support, but it was not enough to prevent homelessness	20	12%
Did not know support was available	13	8%

Note. Community member survey (n = 161). Respondents selected one option. Percentages are rounded and may not sum to 100.

> *"Sometimes the rent is too much, and we have a thousand other utilities to pay. With gas prices going up, we barely get by, living paycheck to paycheck, and sometimes we do not have money to do laundry."*
>
> Community Member Listening Session, Woodburn

7.2 What People Say Would Have Prevented It

One hundred fifty-seven respondents answered an open-ended question about what could have prevented their housing loss. The most common theme was employment, income, or wages, appearing in 23% of responses. Family, relationship, and domestic violence circumstances followed at 20%, and substance use and recovery at 15%. Case

management, navigation, or peer support appeared in 9% of responses. Housing affordability appeared in 8%, and rent or financial assistance in 5%.

Two groups of responses stood apart from the themes above. Fifteen percent of respondents wrote that nothing could have prevented the loss. These answers most often followed a death, a fire, or an exit from violence. One respondent wrote, "There's nothing I could have done. My roommate was arrested for threatening to shoot my son in the face. That led to the eviction and I couldn't afford a place."

Another 7% described the cause in terms of their own choices, using language of self-blame. One person wrote, *"I should have not used any drugs in the first place, kept my job so I could pay rent. There's a long list of wrong turns I took instead of the right ones."* The remaining responses, more than three in four, described circumstances that respondents believed could have been different.

The responses describe prevention in different terms. Some respondents named specific circumstances a program could address, such as waitlist length, income requirements, deposit structures, and document requirements. Others described the loss as unpreventable or as their own doing. Both kinds of account came from people who had lost their housing. Some located the cause in circumstances outside themselves, and others located it in their own choices.

The contrast between response types is important. A substantial group described concrete, addressable system failures, naming waitlist length, income multiples, deposit structures, and document requirements. A separate group described the loss as unpreventable or as their own fault.

> *"Affordable housing options that do not require income equal to 2-3x amount of monthly rent, deposit flexibility to allow it to be divided and paid over time instead of all at once upon moving in."*
>
> Community Member, Survey respondent

7.3 The Provider Perspective of the Prevention Landscape

The service provider survey also asked providers about their prevention and diversion practices. Prevention refers to support that helps households keep housing they are about to lose. Diversion refers to resolving a housing crisis at the point of shelter entry, without the person entering the shelter system. Both practices exist in the region, and the survey asked each provider to characterize where their organization stands.

Among providers, 34% describe housing prevention as a formal or core practice and 33% as informal or limited. **For diversion, 24% described a formal practice, and 36% described an informal or limited one.** The responses show roughly a third of providers practicing prevention and diversion without a formal program behind the work.

Providers described diverting people from shelter entry when they can. This work happens without a formal program or dedicated funding, and program measures do not capture it. An additional 11% of providers reported that they would like to expand diversion.

Table 21. Provider practice of housing prevention and diversion

Practice	Formal or core practice	Informal or limited	Not our focus	Would like to expand
Housing prevention	34%	33%	23%	9%
Housing diversion	24%	36%	29%	11%

Note. Service provider survey (n = 90). Each practice was rated on one scale; percentages are of respondents answering and are rounded, so rows may not sum to 100.

7.4 What Providers Say Would Help Them Expand

Providers were then asked what would most help them expand low-barrier, diversion, and prevention work. Flexible funding not tied to restrictive program requirements was the most selected option at 57%. Additional or specialized staffing followed at 44%, and funder policy changes that allow more flexibility at 34%. Community education to reduce opposition was selected by 30%, and a shared regional diversion fund accessible to multiple providers by 20%. Technical assistance or training on low-barrier models was selected by 17%, and 12% reported that they are already where they need to be.

The pattern across the options is descriptive of what providers identified. The three most selected options concern funding and the conditions attached to it. The least selected option concerns training. Providers most often identified the structure of funding, rather than knowledge of the models, as what stands between their current practice and expanded practice.

Table 22. What providers report would most help expand low-barrier, diversion, and prevention work

What would most help expand low-barrier, diversion, and prevention work	%
Flexible funding not tied to restrictive program requirements	57%
Additional staffing or specialized staff	44%
Funder policy changes that allow more flexibility	34%
Community education to reduce opposition	30%
I don't know	21%
Shared regional diversion fund accessible to multiple providers	20%
Technical assistance or training on low-barrier models	17%
We are already where we need to be	12%

Note. Service provider survey (n = 90 answering). Select all that apply; percentages sum to more than 100.

7.5 The Prevention Gap

The community and provider accounts describe the same circumstance from two sides. Community members described a prevention system that reached few people before their housing loss. Providers described prevention and diversion practiced informally, without dedicated funding or metrics to capture their work in this area. Most providers named flexible funding as what would help them expand it.

The community member survey also identifies the group for whom prevention remains most crucial. Twenty-nine community member survey respondents were housed but at risk or doubled up at the time of the survey. Among this group, rent and deposit assistance was the most named need, selected by 52% of respondents, ahead of permanent housing.

The open-ended responses offer one additional consideration. Roughly one in five respondents named rent, deposit, or income assistance as something that could have prevented their loss, and another one in ten named navigation or case management. Fifteen percent wrote that nothing could have prevented it.

KEY TAKEAWAYS – PREVENTION AND DIVERSION

Most respondents lost housing without prevention support reaching them. Sixty-nine percent received no support or did not know it was available. Rental assistance reached 20 respondents of 161, and case management reached three respondents.

Support that did arrive did not always prevent the loss. Of the 50 respondents who received support, 40% reported it was not enough to keep their housing.

Asked what could have prevented their loss, respondents most often named income, family circumstances, and recovery. Fifteen percent wrote that nothing could have prevented it, and 7% described the loss in terms of their own choices.

Roughly a third of providers practice prevention and diversion informally, without a formal program, dedicated funding, or measurement behind the work.

Asked what would most help them expand this work, providers most often selected flexible funding not tied to restrictive requirements, at 57%. Training ranked near the bottom at 17%.

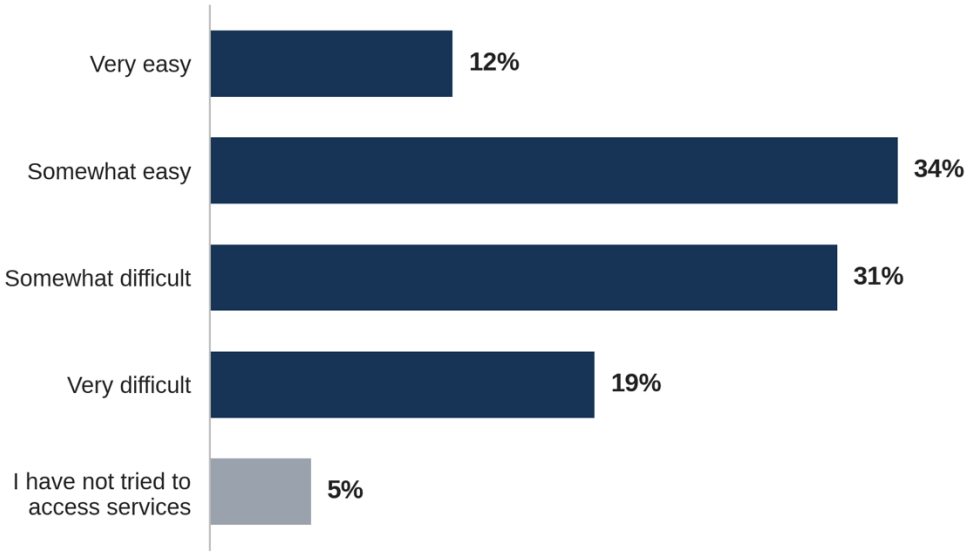
Among the 29 respondents who were housed but at risk or doubled up, rent and deposit assistance was the most named need, at 52%, ahead of permanent housing.

8. Barriers to Services and Housing

This section examines what stands between people and the services or housing they seek. It draws on the community member survey items about barriers, being turned away, and employment. This section also highlights the provider survey items about barriers and program requirements and findings from the listening session that captures participants perspectives on the rules and requirements that blocked them from accessing those services.

8.1 Ease of Access Overall

The community member survey asked respondents how easy or difficult it is to access services when they need them. Responses divided almost evenly. Forty-six percent found services somewhat or very easy to access. Fifty percent found them somewhat or very difficult, including 30 respondents, or 19%, who described access as very difficult. Eight respondents (5%) had not tried to access services. Unsheltered respondents, parents, and people who have been homeless longest reported more difficulty accessing services.



Source. Community member survey (n = 161), single-response item. Percentages sum to more than 100 due to rounding.

Figure 7. Ease of accessing services among survey respondents (N = 161)

8.2 Barriers Reported by Community Members

The survey asked respondents to select the biggest barriers they face in accessing housing and shelter services. Their answers describe several kinds of barriers. Some barriers reflect the supply of services, such as waitlists that form when more people seek a service than it can serve. Some reflect the practical work of reaching services, such as the transportation to get there and the distance to travel, which matter most for people without a vehicle or living outside Salem. Others reflect the rules attached to services, such as pet policies, requirements that separate family members or partners at entry, and sobriety conditions that a person must meet

before being admitted. The most selected barrier falls outside all three groups. It concerns information, meaning respondents did not know what services existed or how to find them.

Not knowing what services are available or how to find them was selected by 48% of respondents. Long waitlists followed at 42% , and lack of transportation at 30%. A second group of barriers was selected by roughly one in five respondents. Being told they do not qualify was selected by 22%. Distance was selected by 18%. Not feeling safe at shelters and being unable to bring a pet were each selected by 17%. Being separated from a family member or partner and having a disability that makes access difficult were each selected by 11%.

The remaining barriers were each selected by fewer than one in ten respondents, among them documentation, a bad past experience with a provider, sobriety requirements, and a criminal history. Ten respondents, 6%, reported facing no barrier. No respondent selected services not available in their language, a result that reflects the survey's largely English-preferring sample rather than the absence of language need in the region.

Table 23. Biggest barriers to accessing housing and shelter services among survey respondents (N = 161)

Biggest barriers to accessing housing and shelter services (select all)	n	%
I don't know what services are available or how to find them	**77**	**48%**
Waitlists are too long	**68**	**42%**
I don't have transportation	49	30%
I was told I don't qualify	36	22%
Services are too far away or hard to get to	29	18%
I don't feel safe at shelters	27	17%
I cannot bring my pet	27	17%
Not allowed to bring a family member or partner	17	11%
A disability makes access difficult	17	11%
I prefer to manage on my own	11	7%
No required ID or documents	11	7%
A bad past experience with a provider	11	7%
No barrier: I can access services when I need them	10	6%
Sobriety requirements I could not meet	9	6%
Outstanding warrant or criminal history	9	6%
Services do not feel culturally welcoming	5	3%
Services not available in my language	0	---

The barriers people face differ with where they are living. The table below shows the ten most selected barriers within each of four housing situations.

The information barrier was the most selected barrier in every group except the unsheltered group, and it was highest among respondents housed but at risk or doubled up, at 62%, and among those currently housed, at 56%. A**mong unsheltered respondents, long waitlists ranked first** at 44%, with the information barrier close behind at 40%. Transportation was selected by about a third of unsheltered and sheltered respondents and by fewer of those housed.

Two barriers separated the unsheltered group from the others. Being unable to bring a pet was selected by 31% of unsheltered respondents, compared with 3% of sheltered respondents. Not being allowed to bring a family member or partner was selected by 15% of unsheltered respondents, compared with 5% of sheltered respondents. These two barriers describe conditions of shelter entry, and they appear most often among the people who have not entered.

Being told they do not qualify was selected at similar rates across all four groups, between 19% and 28% . Distance was selected most often by respondents at risk or doubled up, at 28%. Preferring to manage on their own was selected by 14% of respondents at risk or doubled up, higher than in any other group.

Table 24. Barriers to accessing services by housing situation

Item	Unsheltered (n=48)	Sheltered (n=64)	At risk or doubled up (n=29)	Currently housed (n=18)
I don't know what services are available or how to find them	**40%**	**47%**	**62%**	**56%**
Waitlists are too long	**44%**	**48%**	**38%**	**28%**
I don't have transportation	35%	34%	24%	17%
I was told I don't qualify	25%	19%	24%	28%
Services are too far away or hard to get to	15%	14%	28%	22%
I don't feel safe at shelters	21%	17%	14%	11%
I cannot bring my pet	31%	3%	21%	22%
I was not allowed to bring a family member or partner	15%	5%	7%	17%
I have a disability that makes access difficult	15%	9%	14%	--
I prefer to manage on my own	6%	5%	14%	6%

Note. Community member survey Q34 by recoded housing situation (n = 159; two respondents could not be classified). Percentages are within each group. Select all that apply, so columns sum to more than 100. Sheltered combines emergency and transitional shelter. At risk or doubled up combines respondents housed but at risk of losing it and those staying temporarily with others. Currently housed refers to respondents recently housed after a period of homelessness. Rows shown are the ten most selected barriers overall.

8.3 Being Turned Away

Forty-five percent of respondents had been turned away from a shelter or housing program, and an additional 24% of respondents did not know whether they had been. Among the 73 respondents who had been turned away, a full shelter was the most common reason, reported by 36%. The next two reasons described something other than capacity. **Seventeen respondents (23%) were told they did not qualify without being given a reason. Sixteen respondents (22%) were turned away because of a pet.**

Criminal history followed at 12%. Being unable to bring a partner or family member was reported by 11%, sobriety requirements by 10%, and missing identification by 8%. A refusal without an explanation differs from a refusal because the shelter is full. **When a shelter is full, the person knows the reason and can return or try elsewhere. When no reason is given, the person has no stated condition to meet and no clear next step. This finding pairs with the 48%of respondents who did not know what services were available. Together, the two describe difficulty at both ends of the process, in learning what exists and in understanding why access was denied.**

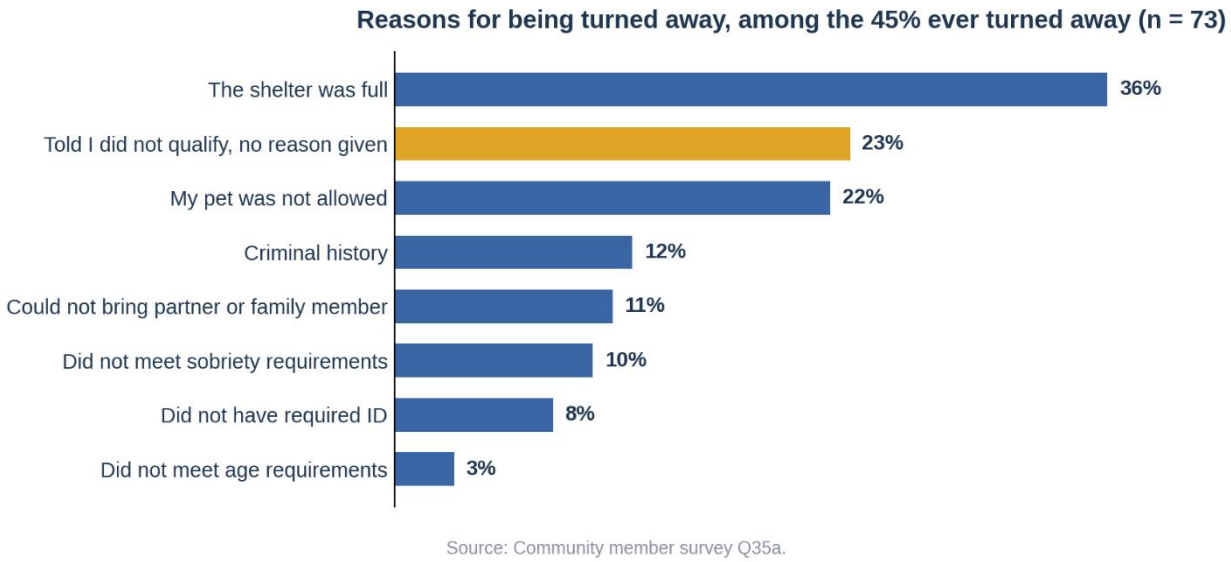


Figure 8. Reasons respondents were turned away from shelter or services. The gold bar marks respondents who were told they did not qualify without being given a reason, the second most common response.

8.4 Barriers to Employment

The survey also asked respondents what barriers stood between them and employment. Disability or a health condition was the most selected barrier, at 35%. The next two barriers describe circumstances that follow from homelessness rather than lead to it. Lack of transportation to get to work was selected by 27%. Lack of stable housing or a safe place to get ready for work was selected by 23%. Applying for jobs without being hired followed at 22%, and a criminal record that limits options at 21%. Needing more training, education, or skills was

selected by 16%. A smaller number of community members cited lacking required identification, at 8%, not finding a job that pays enough, at 6%, and lacking childcare, at 5%. Seventeen percent of respondents reported that employment is not a barrier for them right now.

Two of the most selected barriers, transportation and a place to get ready for work, are conditions that stable housing would resolve. In these responses, the absence of housing appears as an obstacle to the employment that could help secure housing. The same relationship appears in the economic findings earlier in this report, where job loss preceded housing loss for some respondents and housing loss now blocks employment for others. Income or employment support was named among the top three unmet needs by 27% of respondents.

Table 25. Barriers to employment among survey respondents (N = 161)

Employment barrier	n	%
I cannot work due to a disability or health condition	57	35%
I do not have transportation to get to work	43	27%
I do not have stable housing or a safe place to get ready for work	37	23%
I have been applying for jobs but have not been hired	35	22%
I have a criminal record that limits my options	34	21%
Employment is not a barrier for me right now	28	17%
I need more training, education, or skills	26	16%
I do not have the required ID or documents	13	8%
I have not been able to find a job that pays enough	10	6%
I do not have childcare	8	5%

Note. Community member survey, select all that apply (n = 161). Percentages sum to more than 100. The item was introduced as applying to respondents not currently working, but responses were recorded across the full sample, including the 28 respondents who selected that employment is not a barrier; percentages are therefore reported against all 161 respondents. Rows shown are the ten most selected; a further 12 respondents selected Other.

Listening session participants described the daily task of managing their belongings as its own obstacle to appearing anywhere that requires appearing well. Without a secure place to leave possessions, a person carries them, and arriving at an interview with everything they own marks them before a word is spoken. Leaving possessions behind risks losing them. A Salem participant described the situation during the session. *"The reason I mentioned the safe place to keep your stuff is because you can't go to court hauling all these bags, but you can't leave them anywhere either, because people will steal them, and you can't go to a doctor's appointment or a job interview like that."* Having housing or a secure place to place their belongings would help over a common barrier they experience with trying to access employment.

8.5 Structural Access Barriers

Reaching services and work depends on a set of practical conditions. A person needs a way to get there, identification to enroll, and a phone or internet connection to apply, confirm, and follow up. The survey measured each of these, and each was missing for a substantial share of respondents. Thirty percent lacked transportation to services, and 27% lacked transportation to work. Eighteen percent had no working phone, and among unsheltered respondents, 40% had limited or no internet access. Seven percent of respondents lacked the identification or documents required for services, and 8% lacked them for employment.

The listening sessions described how the identification barrier works in practice. A replacement Oregon identification card costs roughly $44. Homelessness declaration vouchers waive the fee, but a person may use only a limited number within a set period. **Participants described identification being stolen, lost during encampment sweeps, and destroyed in flooding, sometimes more than once in a year, so the replacement limit could be reached before the year was out. Participants also described the sequence that follows. Without identification, a person cannot be hired. Without work, there is no money for the replacement fee. Several young adults described this sequence as the barrier standing between them and employment.**

> *"You need your ID to make money, and you need money to get your ID."*
>
> Community Member Listening Session, Salem

8.6 What Providers Identify as Client Barriers

The provider survey asked the parallel question, and the barriers providers identified overlap with the barriers community members identified. **Long waitlists were selected by 81% of providers, transportation by 80%, and clients' lack of awareness about available services by 78%.** No phone or internet access followed at 64%, and inability to bring pets or partners at 59%. **The two sources rank these barriers differently, with community members placing information first and providers placing waitlists first, but the same five barriers appear near the top of both lists**.

The awareness and connectivity findings describe a related circumstance. More than three-quarters of providers reported that clients do not know what services exist. On the community side, 18% of respondents had no working phone, 18% had limited or no internet access, and among unsheltered respondents the internet figure rose to 40%. **Learning what services exist depends in part on the means to search, call, and follow up, and a share of the people the information barrier affects most are also the people with the least connectivity to overcome it.**

In an open-ended response, one provider described a barrier that neither survey had listed among its options. The provider explained that completing an application or intake requires sustained attention, organization, and follow-through, capacities that a person in crisis, without sleep, or managing a health condition may not have available in the moment. The provider also described a second circumstance. The staff who are physically present with clients at high-

traffic sites, such as day centers and meal programs, are often not authorized to complete or submit applications on their behalf, so the person who could help is not the person permitted to. The write-in closed with a proposal. Additional peer and community health worker capacity at those sites, with authorization to assist directly, would let people complete processes where they already are.

> *"Mental capacity, unable to follow directions or follow through, need someone like a peer support specialist or community health worker to lead them through the process. As site assistants, we are unable to help them with paperwork or any other needs they have to find housing."*
>
> Provider Survey Write-in

8.7 Program Requirements and How Participants Experienced Them

Sixty-three percent of shelter and housing programs described themselves as having very few or no restrictive requirements. Among those programs, 52% also reported at least one active requirement. The most common was a curfew (43%), followed by required participation in activities or chose (36%), sobriety (19%), and no pets (15%). Some of these requirements come from funders, licensing, or safety needs. When asked what prevents them from lowering barriers, providers named funder requirements, safety or liability concerns, and staff capacity. A curfew can operate within a low-barrier model when it allows exceptions for work, medical needs, and late arrivals, so that a person does not lose a bed for arriving late. The provider survey did not ask how requirements are enforced. Community members' accounts, described earlier in this section, include some of these same conditions among the barriers they faced.

The landscape scan adds the system-level view of how people enter services. **Of 44 programs, 15, or 34%, accept walk-ins, meaning a person can reach them without a phone, internet access, or a prior relationship with an agency**. Seven programs require an online application. Thirteen require a referral or engagement through Coordinated Entry. Five did not report how people access their services. Referral is the most common access method across the inventory. Most programs are entered by referral, so entry depends on a prior connection to another agency.

8.8 How Access Works Outside Salem

Outside of Salem, access to help works differently. Organizations in rural communities serve people through means other than shelter beds, including hotel and motel vouchers, short-term rental assistance, and other temporary help. This assistance does not appear in a bed inventory, and it depends on the funds and rooms available at a given time. Participants in the four small-town listening sessions also describes services and local infrastructure that did not exist in their communities. Participants in Stayton described no shelter or day space. Participants in Falls City described no laundromat, no grocery store, and no public transit. Showers were improvised through friends or in the river and one resource center recently closed.

Where services did exist, participants described the terms on which they could be used. The Stayton warming center opens only when the temperature holds at or below roughly 34 degrees for three consecutive days. It operates from 6 p.m. to 8 a.m. and is staffed by two volunteers per shift. When volunteers were short, participants described signing up to staff the shelter they needed to sleep in. Food assistance in Stayton reached participants but often could not be used. Participants described four separate obstacles. The volume was insufficient. A 15-pound box had to be carried on foot, with no transportation available. Perishable contents could not be refrigerated. There was no facility for cooking. Together, they meant a person could receive food and still not be able to eat it.

The landscape scan measured the gap these accounts describe. As documented earlier in this report, Polk County holds eight programs with 84 individual beds, about 4% of regional capacity. Its shelter beds equaled 22% of the people counted as experiencing homeless in 2025. Independence, Falls City, and rural western Polk have no dedicated program. There is not any sheltered-affiliated day or resource center anywhere in Polk County, and every Polk sheltering program open to the general population reports a waitlist. Outside the Salem-Keizer area in Marion County, capacity consists of a small number of programs in Mount Angel, Silverton, Woodburn, and Mill City.

Where facilities do not exist, rural communities are not without response. Organizations in these areas serve people through means other than shelter beds, including hotel and motel vouchers, short-term rental assistance, and other forms of temporary help. This assistance does not appear in a bed inventory, and it depends on the funds and the motel rooms available at any given time, but it is the form that sheltering most often takes in communities without a facility.

For rural residents, reaching the system's core capacity generally means traveling to Salem. Providers in the listening session described rural residents across both counties being directed there. The survey shows the same circumstance from the community side. Distance was a barrier for 18%of respondents overall.

8.9 Barriers Named in Listening Sessions

The journey mapping activity asked listening session participants to name the rules that did not work for them, and the discussion that followed asked what seeking help is like. Beyond the identification sequence and the rural absences described above, three barriers appeared in every session.

The first was being sent from one agency to another. The most common phrase across sessions, worded differently in each group, was some version of "they send you somewhere else." Participants described being routed between agencies for weeks, arriving at appointments that had been cancelled without any notice reaching them, and reaching the end of a referral chain with no solution to their problem.

The second was the problem of being contacted. Participants described waitlist notifications sent by postal mail to people with no mailing address. The response

window was 30 days, and it began on the postmark date. Participants described losing waitlist positions built up over several years when a notice never reached them in time.

The third was a record that follows a person. Participants described criminal, credit, and eviction histories closing doors long after the incident, including housing denials tied to convictions more than a decade old. For people under criminal justice supervision, the record produced a bind described earlier in this report. Remaining homeless can violate the terms of supervision, while the record disqualifies the person from many of the housing options that would resolve it. Across sessions, participants asked for ban-the-box protections, which limit when an employer can ask about criminal history, to be extended to rental applications. They described the request as a chance to explain a record to a person rather than be screened out by a form.

KEY TAKEAWAYS – BARRIERS TO SERVICES AND HOUSING

Responses on ease of access divided almost evenly. Fifty percent of respondents found services somewhat or very difficult to access, and 19%described access as very difficult, with more difficulty reported by unsheltered respondents, parents, and people homeless the longest.

Not knowing what services exist was the most selected barrier among community members at 48% and 78% of providers identified the same barrier among their clients. Eighteen percent of respondents had no working phone, and 40% of unsheltered respondents had limited or no internet access.

Forty-five percent of respondents had been turned away from a shelter or housing program. A full shelter was the most common reason. The second most common was being told they did not qualify without a reason given, reported by 23% of those turned away.

Program conditions accounted for a substantial share of barriers and turn-aways. Pet restrictions were a barrier for 31% of unsheltered respondents, compared with 3% of sheltered respondents, and pets were the reason for 22% of turn-aways. Sixty-three percent of programs described themselves as having few or no restrictive requirements, while 52% of the same programs reported at least one active requirement.

Of 44 programs in the landscape scan, 15 accept walk-ins. Most programs are entered by referral, so entry depends on a prior connection to another agency.

Employment barriers and housing barriers overlapped. Lack of transportation and lack of a stable place to get ready for work were the second and third most selected employment barriers, at 27% and 23%.

Listening session participants described three barriers in every session: being sent from one agency to another, waitlist notices sent by postal mail to people without an address, and criminal, credit, and eviction records closing doors years after the underlying event.

Outside Salem, the most common barriers were absences, such as no shelter, day space, laundromat, or transit, with rural communities relying on motel vouchers and other temporary assistance where no facility exists.

In communities without a shelter facility, sheltering most often takes the form of hotel and motel vouchers and short-term rental assistance. This help does not appear in bed inventories, and it depends on the funds and rooms available at any given time.

9. Service Utilization and What Is Working

This section examines how well current services are meeting the needs of people experiencing homelessness. It draws on the community member survey items about which services respondents used, how they experienced them, and what made a positive difference. The provider survey items about exits and program strengths and the listening session material on daily navigation and community assets are also highlighted in this section.. The section begins with what services respondents used in the past year, then turns to how they found them, how they rated them, and what they said helped most.

9.1 Services Used in the Past Twelve Months

The community member survey asked respondents which services they had used in the past 12 months. Their answers describe a pattern of use shaped by immediate need. **The services most respondents had reached were the ones that address the day at hand such as food, benefits, and medical care.** Benefits assistance, covering SNAP, Medicaid, and Social Security, reached 60% of respondents. Food pantries and meal programs reached 55%, and health or medical care reached 42%. A second group of services, those that provide a place to stay and help managing life while homeless, reached between a quarter and a third of respondents. Transitional shelter had been used by 35%, mental health services by 27 %, case management by 26%, and transportation assistance by 24%. Emergency shelter had been used by 18%, peer support by 17%, and substance use treatment by 16%.

Services built to end or prevent homelessness reached fewer respondents. Rapid rehousing, which pairs short-term rental assistance with services to move a person into permanent housing, reached 6%. Services that address specific obstacles to leaving homelessness also reached small shares. Employment or job training reached 9%, and legal assistance 7%. Services for specific populations reached 5% or fewer of the full sample. Domestic violence services reached 5%, child or family services 4%, and youth services 2%. Ten respondents, 6% of the sample, had used no services in the past 12 months.

Several of these figures can be read beside measures of need from the same survey. Forty respondents named domestic violence or an unsafe situation as the first event in their housing loss, a contributing factor, or both. Five of them had used domestic violence services in the past year. Of the 47 respondents looking for work, 7 had used employment services. Of the 34 who cited a criminal record as a barrier to employment, 4 had used legal assistance. Youth services reached 4 of the 26 respondents under 25.

Table 26. Services used in the past 12 months among survey respondents

Services used in the past 12 months (select all)	n	%
Benefits assistance (SNAP, Medicaid, Social Security)	97	60%
Food pantry or meal program	89	55%
Health or medical care	67	42%

Services used in the past 12 months (select all)	n	%
Transitional shelter	56	35%
Mental health services	44	27%
Case management	42	26%
Transportation assistance	39	24%
Emergency shelter	29	18%
Peer support from someone with lived experience	28	17%
Substance use treatment	26	16%
Employment or job training services	14	9%
Legal assistance	12	8%
Rapid rehousing assistance	10	6%
No services in the past 12 months	10	6%
Domestic violence services	8	5%
Child or family services	6	4%
Youth services (under 25)	4	3%

Note. Community member survey Q32, select all that apply (n = 161). Percentages sum to more than 100.

> *"It's [services] not easy to find. They're [service providers are] not always that forthcoming."*
>
> Community Member Listening Session, Salem

9.2 Where People Spend Their Days

The community member survey asked respondents where they spend most of their time during the day. Just over half, 52%, wrote in a location of their own. The most common write-ins were work, followed by home or an apartment, and the shelter. Smaller numbers described a vehicle, a camp, a friend's or family member's place, riding the bus or a bike, or being outside walking, and a few wrote that they were everywhere or nowhere in particular. Among the offered options, parks were selected by 24%, day centers by 20%, and the library by 5%. These results may also reflect that the survey was fielded during the warmer months of the year, May through August. Daytime locations may differ in colder months, when indoor spaces and warming sites are in greater use.

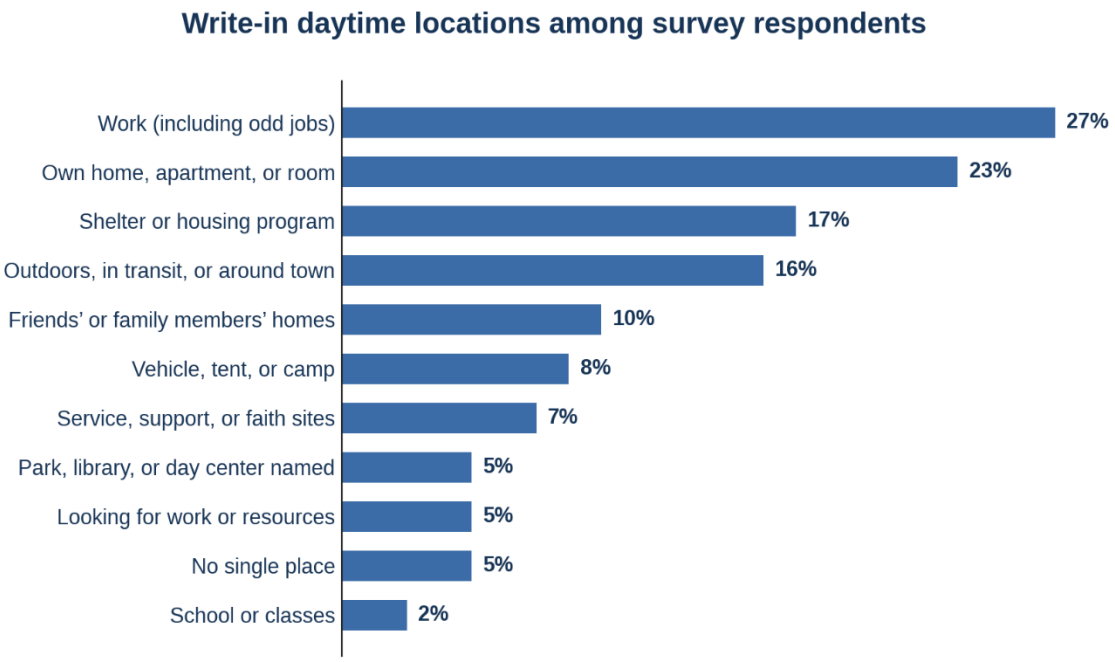


Figure 9. Write-in daytime locations among survey respondents

The write-ins reflect the range of the sample. Respondents who were working, housed, or in a program spent their days at work, at home, or at the shelter. For respondents without those places, the day was spent in public space, with parks as the single most selected location. This finding connects to two others in this report. Only 25 of 44 programs operate around the clock, and day centers are concentrated in Salem, as documented earlier in this report. Therefore, daytime space is limited for people outside those programs and outside Salem. Among respondents who reported safety concerns, 30% cited their neighborhood as feeling unsafe, and participants also describe sweeps and police contact occurring in the same public spaces where people spend the day. Day centers and libraries appear in these responses as daytime places for one in four respondents. In the rural sessions, participants described communities with no day center at all. In Stayton, participants described nowhere to go during the day at all.

9.3 What Has Made the Most Positive Difference

The survey asked respondents what has made the most positive difference for them, with respondents able to select multiple responses. The question responses offered a mix of services, such as food programs and medical care, and relationships, such as a specific worker, family or friends, or a peer with lived experience. **Respondents selected services and relationships alike, with relational supports were among the most frequently chosen.** Figure 10 presents the full distribution, and the table that follows shows how the responses differ by housing situation.

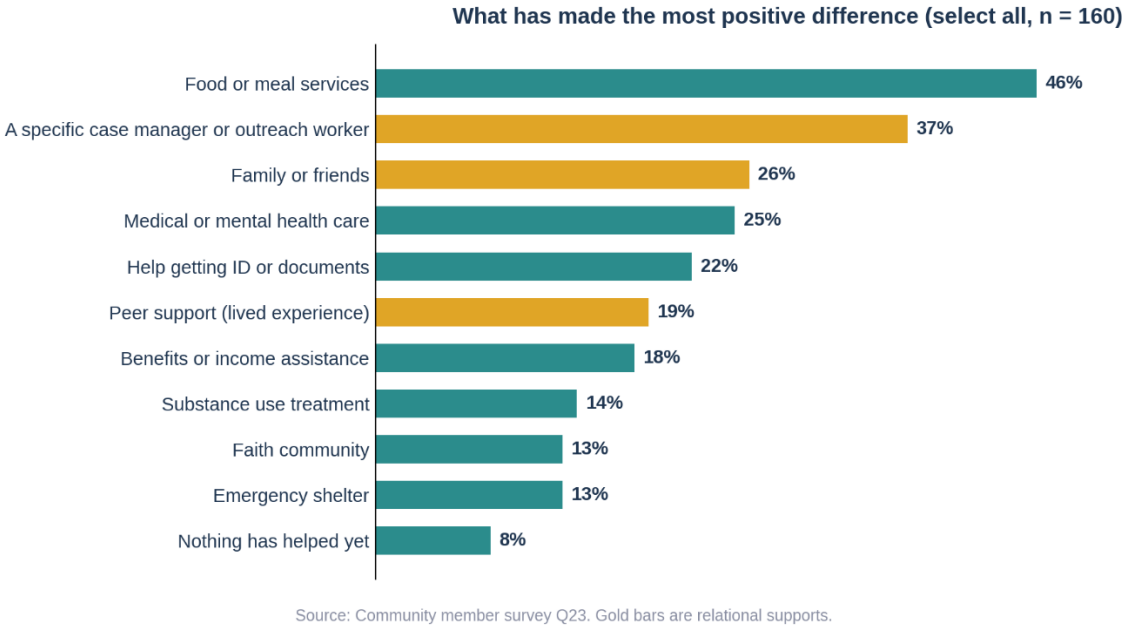


Figure 10. What respondents said has made the most positive difference. The gold bars mark relational supports, a specific case manager or outreach worker, family or friends, and peer support from someone with lived experience.

Food or meal services was the most selected support, at 46%. A specific case manager or outreach worker who helped them was the next most selected, at 37%, ahead of every program category except food. Family or friends was selected by 26%, medical or mental health care by 25%, and help getting identification or documents by 22%. Peer support from someone with lived experience was selected by 19 %, and a faith community by 13%. Thirteen respondents, 8%, reported that nothing has made a positive difference yet. This response was concentrated among unsheltered respondents.

Three of the six most selected supports describe a relationship with an identifiable person rather than a program category. A specific case manager or outreach worker, family or friends, and peer support from someone with lived experience were each selected by between 19% and 37% of respondents. What these three share is that t**he help came from a person the respondent could name, someone who knew their situation and followed it over time.** The remaining supports in the top six categories -, food, medical care, and help with documents - are services a person receives regardless of who provides them. In these responses, the relationship itself was what respondents credited, and it was credited about as often as the services that meet daily needs.

The table below shows the same item by housing situation: unsheltered, sheltered, at risk or doubled-up, and currently housed. Two rows differ most across groups. **A specific case manager or outreach worker was selected by 23% of unsheltered respondents and by 42% to 50% of respondents in the other three groups, rising as housing situations stabilize. Medical or mental health care was selected by 41% of sheltered respondents**

and only by between 11% and 15% by each of the remaining 3 groups. This difference is consistent with shelter programs that provide health services on site or link residents to them. Food or meal services was the most selected support in three of the four groups. Family or friends was selected most often among respondents at risk or doubled up, at 41%, the group most likely to be staying with family or friends.

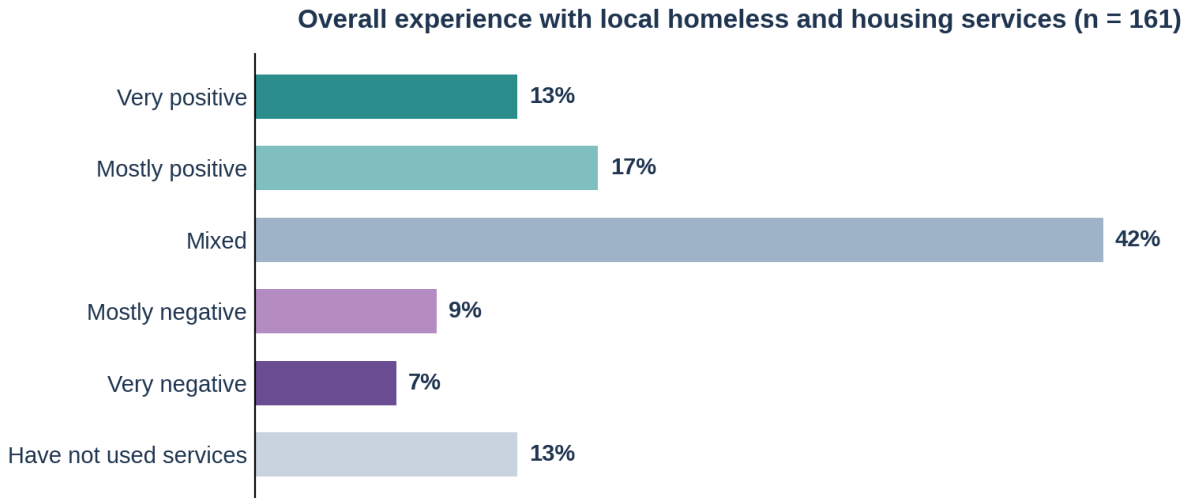
Table 27. What has made the most positive difference, by housing situation

Item	Unsheltered (n=48)	Sheltered (n=64)	At risk or doubled up (n=29)	Currently housed (n=18)
Food or meal services	**48%**	**45%**	**52%**	**33%**
A specific case manager or outreach worker who helped me	**23%**	**42%**	**41%**	**50%**
Family or friends	**25%**	**22%**	**41%**	**22%**
Medical or mental health care	15%	41%	14%	11%
Help getting ID or other documents	25%	23%	14%	22%
Peer support from someone with lived experience of homelessness	13%	23%	17%	22%
Benefits or income assistance	8%	20%	24%	17%
Substance use treatment	13%	9%	17%	22%
Faith community	8%	19%	10%	6%
Emergency shelter (a place where they only allow you to stay for 1 night at a time)	6%	23%	7%	--

Note. Community member survey Q23 by recoded housing situation (n = 159; two respondents could not be classified). Percentages are within each group. Select all that apply, so columns sum to more than 100. Sheltered combines emergency and transitional shelter. At risk or doubled up combines respondents housed but at risk of losing it and those staying temporarily with others. Currently housed refers to respondents recently housed after a period of homelessness. Rows shown are the ten most selected supports overall. A dash indicates no respondents in that group selected the item.

9.4 Overall Experience With Local Services

The community member survey asked respondents to describe their overall experience with local homeless and housing services. **Mixed was the most common response, at 42%**. Thirty percent described their experience as mostly or very positive. Sixteen percent described it as mostly or very negative. Thirteen percent had not used services. **The mixed responses describe experiences that included both help and harm. The same respondents who named specific staff who helped them, described earlier in this section, also named specific staff who mistreated them.** Listening session participants answered a parallel question about how well the system meets their needs. Their answers had the same perspective. Participants expressed gratitude for specific programs and people, and **they described a system that kept them alive without moving them toward housing.**



Source: Community member survey Q39.

Figure 11. Overall experience with local services. Mixed is the median suggesting that most respondents have been both helped and harmed by the same system.

9.5 Peer Support

The survey asked respondents whether they had received support from a peer support specialist, meaning someone with lived experience of homelessness who helps others. Fifty respondents (31%) had received it and found it very helpful. Fifteen (9%) had received it and found it not particularly helpful. Forty-five respondents (28%) had not received it but would like it. Twenty-three (14%) were not sure what peer support is, and 28 (17%) were not interested. **Among respondents who had received peer support, more than three in four found it very helpful.**

The provider survey describes the supply side. **Seventy-three percent of provider organizations employ peer specialists. Seventy percent treat lived experience as a hiring priority or a positive factor.** In the provider listening session, providers with lived experience described peer support as the intervention that changed their own trajectories. They also identified the shortage of peer support specialists as one of the system's primary gaps.

Table 28. Experience with peer support among survey respondents (N= 161)

Experience with peer support (someone with lived experience)	n	%
Received it, and it was very helpful	50	31%
Received it, but it was not particularly helpful	15	9%
Have not received it, but would like it	45	28%
Not interested in this type of support	28	17%
Not sure what peer support is	23	14%

Note. Community member survey Q42 (n = 161). Respondents selected one option. Percentages are rounded and may not sum to 100.

> *"[A provider] having the lived experience really changes these clients' paths and makes them see we can recover."*
>
> Service Provider, Listening Session

9.6 Exit Destinations

The provider survey asked where clients most commonly go when they exit programs**. Fifty-six percent of providers reported that most clients exit to permanent housing, and 28%reported exits to permanent supportive housing.** At the same time, 39% reported that clients most commonly return to streets, encampments, or vehicles. Thirty-one percent reported exits to family or friends, and 24% to emergency shelter. Eighteen percent reported that their organization does not systematically track exit destinations. Write-in responses added two destinations the item did not offer, death and administrative exit after a client stops responding. **Among the providers who do track outcomes, 40% track only short-term or point-in-time status. The system's visibility into whether housing placements hold is therefore limited.**

Table 29. Where clients most commonly went at exit, as reported by providers

Where clients most commonly went at exit (select all)	%
Permanent housing	56%
Return to streets, encampments, or vehicles	39%
Family or friends	31%
Permanent supportive housing	28%
Emergency shelter	24%
We do not systematically track exit destinations	18%

Note. Service provider survey Q7, select all that apply (n = 90). Percentages sum to more than 100. Among the 45 respondents who reported tracking outcomes, 40 percent track only short-term or point-in-time status.

9.7 What Providers Say Is Working and Should Be Protected

Providers were asked, in an open-ended item, what is working well. The most common answer, at 17%, was non-congregate and expanded shelter capacity. Providers described micro-shelters, cabins, safe parking, and specific sites. The second most common answer, at 16%, was that the respondent could not name anything or did not know. The low-barrier, Housing First, and trauma-informed practice model was named by 10%. Street outreach and direct agency-to-agency handoffs were each named by 9%, with several providers describing direct handoffs as something to expand. One culturally specific provider described a model already operating in the region. It combines multilingual, culturally specific outreach with housing navigation, flexible rent and utility assistance, landlord coordination, and continued case management, and it reaches refugee, immigrant, and low-income households that other programs do not. **Taken together, the responses describe a small number of practices that**

providers see working, concentrated in shelter models and direct connections between agencies, alongside a sizable share of providers who could not name one.

9.8 The Daily Journey and Community Assets

The listening sessions revealed that much of what sustains people from one day to next is informal. Kinship networks carry a great deal. A grandmother's address serves as a mailing address, a phone number, and a place to charge a tablet. Siblings drive people to job applications. Faith communities function as infrastructure. Participants described laundry vouchers, free dinners, clothing, hygiene bags, and in one case a place to sleep, and they named specific congregations more readily than public agencies. Peer knowledge serves as a referral system. **People who have been unhoused teach newly unhoused people where to go. In three small towns, participants organized their accounts of survival around one named person - a school district liaison, a shelter director, and an outreach coordinator. These relationships determine whether a resource that exists is a resource that can be reached. They also rest on a single person.**

Participants also arrived with skills. Among them were a welder, a cabinetmaker of forty-two years, a professional cook, a carpenter, a landscaper with a local reputation, a former therapist, and a man taking business coursework so he can build a shelter himself. Participants described self-governance arrangements in camps and a wish to contribute that the system rarely has a channel for.

> *"[Good support is] not too smothering. Nor is it holding your hand, and it's not letting you fall."*
>
> Community Member Listening Session, Silverton

KEY TAKEAWAYS – SERVICE UTILIZATION AND WHAT IS WORKING

The services most respondents used were those that meet immediate needs. Benefits assistance reached 60% of respondents, food programs 55%, and medical care 42%. Rapid rehousing, the service most directly aimed at ending homelessness, reached 6%.

Respondents credited relationships about as often as services. A specific case manager or outreach worker was the second most selected support, at 37%, behind only food.

Peer support drew strong ratings from those who had received it. Of 65 respondents who had, 50 found it very helpful. Another 45 respondents wanted it but had not received it.

Providers reported both exits to permanent housing and returns to the street as common. Fifty-six percent reported that most clients exit to permanent housing, and 39% reported that clients most commonly return to streets, encampments, or vehicles. Eighteen percent do not track exit destinations.

Much of what sustains people from day to day is informal. Participants described kinship networks, congregations, peer knowledge, and in three small towns, a single named person around whom their accounts of survival were organized. Each of these supports rests on individuals rather than on a program.

10. Harm, Exclusion, and Avoidance

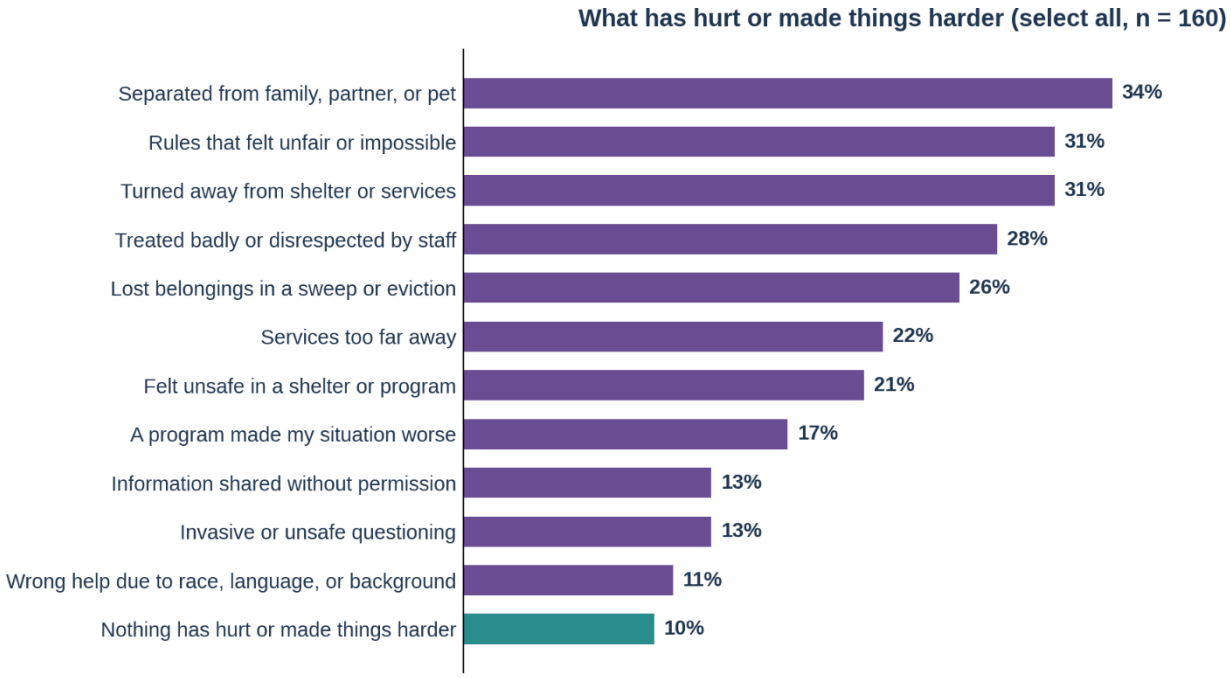
This section examines whether contact with the service system has caused harm. It presents the survey and listening session findings first, then closes with how those findings relate to the positive experiences reported in this assessment.

10.1 What Has Made Things Harder

The community member survey asked respondents what has hurt or made things harder for them. Respondents were instructed to select all that applied. **Ten percent of respondents reported that nothing had harmed them while 90% selected at least one harm.** Four of the five most selected harms describe experiences with services rather than conditions of homelessness itself. These are separation at program entry, rules, being turned away, and treatment by staff. The fifth, losing belongings in a sweep, describes an experience with enforcement.

Overall, the most selected harm was being separated from family, a partner, or a pet upon entry to a shelter (34%). Rules or requirements that felt unfair or impossible to follow and being turned away from shelter or services were each selected by 31%. Being treated badly or disrespected by staff followed at 28%, and losing belongings during a sweep or eviction at 26%. Feeling unsafe in a shelter or program was selected by 21%, and a program or service that made the situation worse by 17%. Having information shared without permission and invasive questioning were each selected by 13%. Not getting the right help because of race, language, or background was selected by 11%.

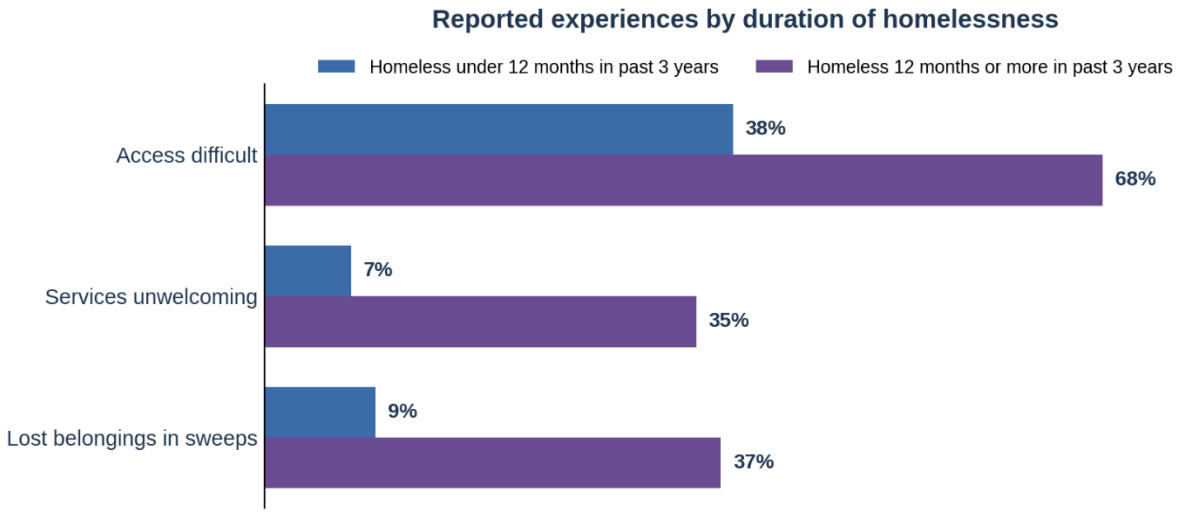
Enforcement actions, especially sweeps, result in compound harms that often make the path out of homelessness more difficult. The listening sessions described the enforcement harms in detail. Participants described tents cut open, belongings taken to the dump before a two-hour deadline had passed, work boots and tools lost in a sweep and never replaced, and a $500 citation for a pallet left at a city-designated camping site. Participants in one session also described a drone purchased to locate camps, which they experienced as surveillance of where they slept. One participant lost the equipment required for the job they were trying to keep. These losses are paid for twice. The person loses what was taken. Programs then spend their own resources replacing it, providing new tents, identification, and work gear so the person can start again. In the survey, 37% of respondents homeless 12 months or more had lost belongings in a sweep or eviction, compared with 9% of those homeless for less time.



Source: Community member survey Q24. Teal bar marks respondents reporting no harm.

Figure 12. What respondents said has hurt or made things harder. The teal bar marks respondents who reported no harm.

> *"Cops came down there, got him out of the bathroom, told him go get the pallet, get it out of there, or get arrested or get a ticket. He ended up getting a ticket because they wouldn't let him go and load his trailer and get the pallet. There were three cops there."*
>
> Community Member Listening Session, Stayton



Source: Community member survey, among respondents with prior homelessness (n = 103).

Figure 13. Reported experiences by duration of homelessness. Respondents homeless 12 or more months in the past three years are compared with respondents homeless for less time on each measure. Longer experiences with homelessness is associated with worse treatment by the system.

10.2 Denial Based on Identity or Disability

Twenty percent of respondents with a long-term health condition reported being denied services because of their gender identity, sexual orientation, or a disability. Among respondents without a condition, 3% reported the same. The difference is statistically significant. In this sample, disability accounts for most of the identity-based denial reported. The open-ended accounts describe a service dog refused despite documentation, no accommodation for seizures, exclusion linked to ADHD and autism, denial tied to mental health history, and a primary care physician declining both to treat and to refer. Other accounts describe denials tied to gender, race, and recovery status. One respondent, a woman, was turned away from a women's shelter without being given a clear explanation as of why. A different respondent, a man, wrote that men do not get help and are expected to manage on their own. One respondent's race was raised negatively at a service before they were turned away. One respondent had help withdrawn after disclosing that they were in recovery. One account described the consequence rather than the event. The experience made the respondent unwilling to reach out for help again.

10.3 Whether Services Feel Welcoming

Whether services feel welcoming differed by duration of homelessness and by housing situation. Thirty-five percent of respondents homeless 12 months or more said services do not feel welcoming to someone like them, compared with 7% of those homeless for less time. **By housing situation, 34% of unsheltered respondents said services do not feel welcoming, compared with 9% of sheltered respondents.** Positive overall experience was reported by 45% of the shorter-duration group and 16% of the longer-duration group. Young adults reported the opposite pattern. Sixty-three percent found services welcoming, compared with 35% of older respondents. These survey responses indicate that prolonged contact with the system may

accumulate harm. Alternatively, people who experience services as unwelcoming may disengage and remain homeless longer.

10.4 Avoidance

The listening sessions describe how avoidance forms. Avoidance is the behavioral consequence and coping strategy used by people who have been harmed by the system. Participants described that they stopped trying after cycles of being sent from agency to agency, after unexplained denials, after property loss undid months of progress, and after treatment that stripped dignity. In the survey, 11 respondents said they prefer to manage on their own and 8 had not tried to access services.

10.5 What Providers Observe About Trust and Dignity

Providers described the same dynamics from the other side. In the listening session, providers described **three patterns. Clients whose behavior or speech reflects an acute mental health condition** are sometimes treated as difficult rather than as having a disability. **People who have been homeless for years** are sometimes excluded from a program after a relapse or a bad day, with nowhere else in the region to go. **Trust erodes when people on waitlists hear nothing,** or in one provider's words, are forgotten. Provider survey write-ins described the assessment process itself as something clients do not want to be involved with. They also described the absence of any channel through which a person in the coordinated entry pool can learn where they stand. **Providers also observed that engagement language can describe a fit problem. A person described as not ready for services may be facing services that were never built to fit them.**

These findings coexist with the positive experiences this assessment documented. **The same respondents who reported harm also named a specific case manager as the second most credited support, described a shelter as giving people worth, and volunteered for further discussion in 83 of 161 cases. Both accounts are true. The harms reported here were frequent, they followed patterns, and they fell most heavily on people with the longest exposure to the system.**

KEY TAKEAWAYS – HARM, EXCLUSIONS, AND AVOIDANCE

Ninety percent of respondents named at least one harm. **Four of the five most selected harms describe experiences with services, separation at program entry, rules, being turned away, and treatment by staff, and the fifth describes enforcement.**

Disability accounted for most identity-based denial in the sample. Twenty percent of respondents with a health condition reported being denied services because of who they are, compared with 3% of those without one.

Duration of homelessness was associated with worse experience on every measure. Respondents homeless 12 months or more reported more difficulty accessing services, less welcome, and four times the rate of property loss in sweeps.

The harms reported here coexist with valued help from the same system. Both accounts came from the same respondents. The harms were frequent, they followed patterns, and they fell most heavily on the people with the longest exposure to the system, which makes them measurable as a feature of the system rather than as isolated accounts.

11. System Capacity, Practice, and Infrastructure

This section examines the service system itself. It draws primarily on the provider survey, the provider listening session, and infrastructure findings from the landscape scan. It begins with demand and capacity, then turns to the workforce, and then to the infrastructure through which programs connect to one another and to the people they serve.

11.1 Demand and Capacity

Eighty-four percent of providers reported that demand for their services increased over the past 12 months, and 52% reported a significant increase. Only one provider reported a decrease. Providers described their capacity to meet that demand in three ways. Thirty-two percent reported that demand exceeds their capacity. Fifty-three percent reported meeting most, but not all, of the demand for their services. Fourteen percent reported fully meeting demand. Seventy-seven percent of providers maintain a waitlist, either a standing list (47%) or one that opens when capacity is reached (30%).

How long people wait cannot currently be measured across the system. Providers were asked, in an open-ended item, what a typical wait time is. Of the 66 who answered, 46% gave a figure that fits a time band, as indicated in the chart below. Twenty-three percent said it varies and gave no figure. Seventeen percent did not know. **Answers ranged from fifteen minutes to more than two years.** One organization reported internal waitlists ranging from 300 to more than 3,000 people across its sites. The responses show no shared understanding across the region of what a wait time is or how it is counted. Without one, the system cannot measure its own performance on waiting, and it cannot tell a person seeking help how long they will wait.

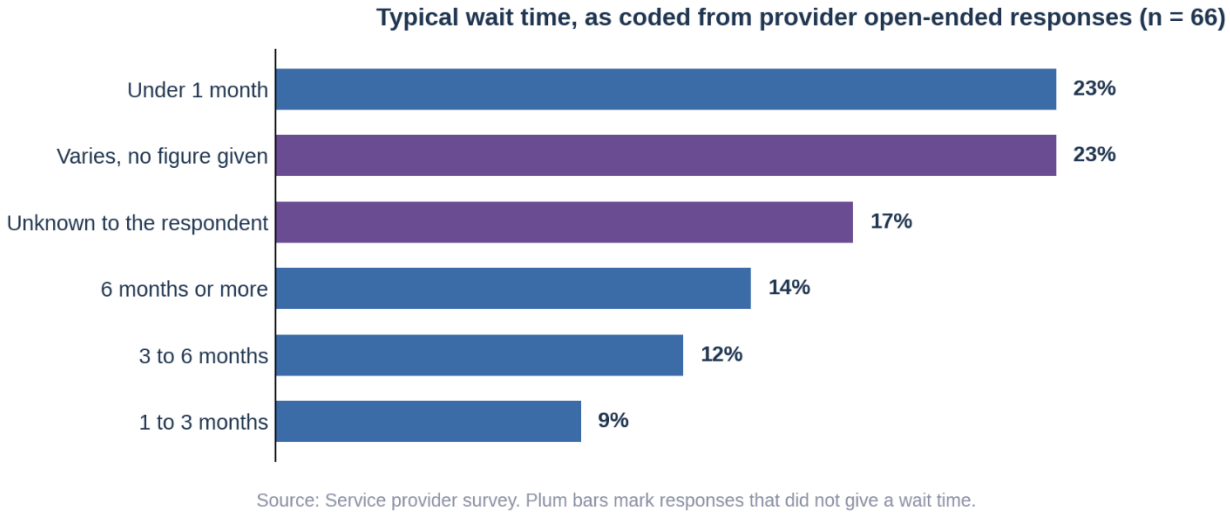


Figure 14. Typical wait time, as coded from provider open-ended responses. The plum bars mark responses that did not give a wait time.

11.2 Workforce

Providers were asked to select their greatest workforce and staffing challenges. **About half of the providers reported funding that does not cover adequate staffing levels.** Among leadership respondents, that share rose to 77%. Forty-four percent named burnout and secondary trauma. Wage competitiveness followed at 30%, and difficulty retaining bilingual or multilingual staff at 20%, in a region with a substantial agricultural and Spanish-speaking population. Nineteen percent reported that staffing is not a significant challenge for them. Difficulty finding qualified employees was named by 16%, and difficulty recruiting staff with lived experience by 13%. In these responses, providers most often described the constraint as the funding and conditions that sustain staff rather than the availability of people to hire.

Table 30. Greatest workforce and staffing challenges reported by providers

Greatest workforce and staffing challenges (select all)	%
Funding does not cover adequate staffing levels	50%
Burnout and secondary trauma	44%
Wage competitiveness	30%
Difficulty retaining bilingual or multilingual staff	20%
Staffing is not a significant challenge for us	19%
Difficulty finding qualified employees	16%
Difficulty recruiting staff with lived experience	13%

Note. Service provider survey, select all that apply (n = 90). Percentages sum to more than 100. Among leadership respondents, the funding item was selected by 77 percent.

> *"Many people who apply to do this work could almost be our clients. Their own stability is often very shaky, health is often poor, and call offs are common, making coverage a challenge, and creating burn out of the staff who can reliably fill in."*
>
> Service Provider, Listening Session

A workforce drawn substantially from people with lived experience of homelessness and housing precarity brings that experience to the work. It also carries staffing consequences. Providers in the listening session described the supports this workforce needs, including coverage depth, supervision, wellness support, and paid self-care time built into scheduled hours. One respondent named the frontline workforce itself as a population falling through the cracks. This hiring practice is otherwise established throughout the region. **Seventy percent of providers treat lived experience as a hiring priority or a positive factor, and 73% employ peer specialists.**

11.3 Language and Interpretation Capacity

The provider survey asked about interpretation capacity. Eighty-six percent of provider respondents reported their organization has some capacity to provide interpretation services for clients. Forty-eight percent reported formal capacity, through in-house or contracted interpreters or remote interpretation services. Twenty-nine percent reported limited and informal arrangements, including bilingual staff and clients' family members. Family-member interpretation raises confidentiality and accuracy concerns, particularly for domestic violence and behavioral health disclosures. Fourteen percent reported no interpreter capacity.

Organizations with formal interpretation capacity reported language as a client barrier about half as often as organizations without it. On a separate item, both groups reported at similar rates that services feel unwelcoming to clients because of their identity or culture. Having interpreters was associated with fewer language barriers, but not with clients feeling more welcome. The two are different problems.

Bilingual capacity was measured twice in this assessment, once in the provider survey and once in the landscape scan, and the two measures ask different questions. The provider survey asked respondents from all organization types about interpretation arrangements. It found 29% with an in-house interpreter on staff and 48% with formal interpretation capacity of any kind. The landscape scan asked the 44 sheltering programs about bilingual staffing. It found about 55% of programs with bilingual Spanish staff or advocates and as many as 75% offering Spanish in some form. Beyond Spanish, coverage thinned. Russian was available at four programs, sign language at three, Marshallese at two, Chinese and Vietnamese at one each, and Chuukese at none.

Table 31. Interpretation capacity among provider respondents (N = 90)

Interpretation capacity (provider survey)	N	%
In-house interpreter on staff	26	29%
Limited and informal arrangements (bilingual staff, family members)	26	29%
Contracted or on-call interpreters	17	19%
No interpreter capacity	13	14%
Telephone or remote interpretation	8	9%

Note. Service provider survey Q3, select all that apply (n = 90). Percentages sum to more than 100. Formal capacity combines in-house, contracted, and remote interpretation.

11.4 Harm Reduction

In this report, harm reduction refers to substance use. It means reducing the negative consequences of substance use without requiring abstinence as a condition of service. Harm reduction is near-universal in principle and narrow in practice. Eighty-three percent of providers reported using harm reduction approaches. Fifty-two percent described it as a core philosophy and formal practice. Four percent reported an abstinence-based program model, meaning a

program that requires clients to abstain from drugs and alcohol as a condition of service. When asked which specific practices they offer, providers reported a narrower set of options. For instance, naloxone distribution was reported by 68% and peer support from people with lived experience of substance use by 54%. Every other practice was reported by roughly a quarter of providers or fewer. Fentanyl test strips were reported by 26%, MAT linkage by 23%, non-judgmental substance use counseling by 23%, overdose prevention education by 22%, wound care without sobriety requirements by 16%, and syringe services by 4%.

Harm reduction in this region largely means naloxone plus a non-judgmental stance. When providers were asked what prevents their organization from implementing or expanding harm reduction practices, the most common answer, at 44%, was that they did not know what was preventing broader implementation. Among those naming a barrier, funder restrictions and lack of staff training were each named by 20%, liability concerns by 19%, and uncertainty about the legal status of harm reduction tools in Oregon by 10%. Two providers wrote in a constraint the item had not offered. Their organizations share a site with a partner agency that operates an abstinence-based program, and the shared location limits the harm reduction practices they can offer there.

The landscape scan adds the bed-level perspective. **Two-thirds of sheltering programs use a behavior-based approach to substance use, meaning they respond to behavior on site rather than requiring sobriety or testing for it. Seven programs, about one in six, take the strictest approach, requiring abstinence from drugs and alcohol and verifying it through drug testing.** A person in these programs must be sober to stay, and a failed test can mean losing the bed. Those seven programs account for roughly 391 beds, about 27% of the system's total, because they include the region's two largest single-gender congregate shelters. The beds behind the strictest requirement are also among the most congregate and least private, with large shared sleeping areas rather than rooms. For a person who cannot or will not meet an abstinence requirement, more than a quarter of the beds counted in the region's capacity are not usable, and a count of total beds overstates what is available to them.

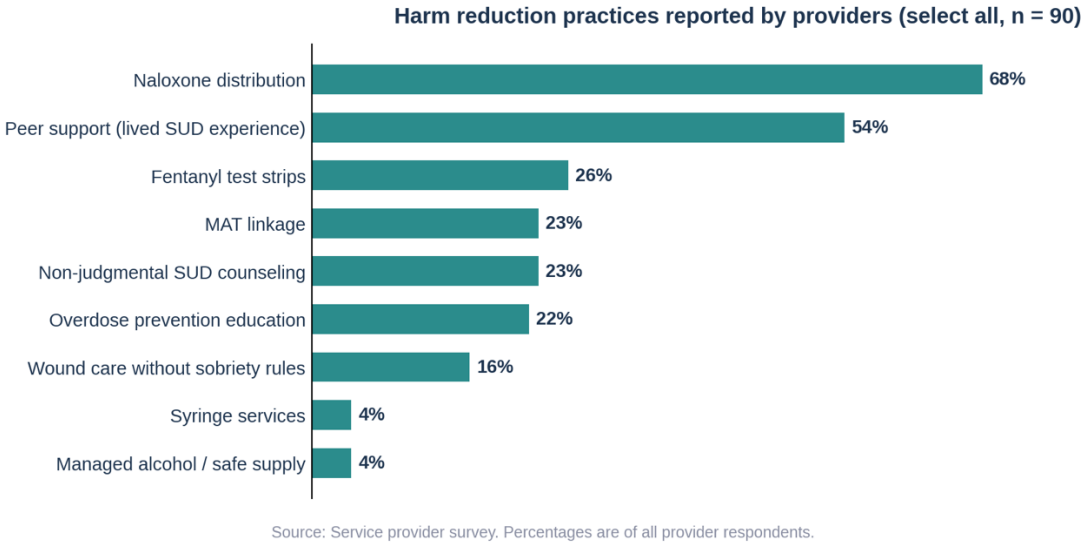


Figure 15. Harm reduction practices reported by providers.

11.5 Coordinated Entry

Coordinated Entry is the process through which people are assessed, prioritized, and referred to housing and homeless assistance across the region.[18] Federal rules require each Continuum of Care to operate one. Programs funded through the Continuum of Care and through Emergency Solutions Grants must use it. Victim service providers may choose not to, to protect survivors' confidentiality. Other programs may take part voluntarily. Coordinated Entry does not work as a first-come, first-served list. People who are assessed enter a pool and are prioritized for openings by need and vulnerability, under the Continuum of Care's written standards. HUD requires a standardized assessment but does not name a specific tool. The landscape scan found Coordinated Entry in use at 18 of 44 sheltering programs, most of them low-barrier. The provider survey asked about participation in it, its effectiveness, and its gaps.

Overall, provider participation in coordinated entry is high. Seventy-nine percent of providers participate in some capacity, and 69% conduct assessments as an access point. Not one of the 90 provider respondents selected the option that Coordinated Entry is working well. The single largest response, at 38%, was that the respondent does not have enough visibility into the system to assess it. Among providers who participate, 68% identified insufficient housing and programs to refer to as the biggest gap. Poor communication about referral status followed at 39%, prioritization criteria that exclude high-need individuals at 31%, and a system not well understood by providers or clients at 30%. On assessment tools, 37% reported using the Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT).[19] Twenty-three percent reported using an assessment tool without knowing which one. The Coordinated Entry assessment is the one that places a person in a regional pool. Other tools may be used by individual program for their own intake.

Write-in responses described four gaps. The assessment relies on client self-report, with no way for a worker's observation to inform the score. Clients placed in the Coordinated Entry pool have no channel to check where they stand. And some clients do not want to be involved with the system at all. Providers in the listening session described Coordinated Entry as a labyrinth and described assessments that never appear in the system. The missing status channel adds to the communication finding. The communication gaps providers described run not only among agencies but between the system and clients, who are told to wait and then have no way to ask where they stand.

Overall, the findings describe two kinds of gaps at once. Sixty-eight percent of participating providers selected insufficient housing and programs to refer to. The item did not distinguish programs that do not exist from programs that exist but cannot be reached through Coordinated Entry. The landscape scan found Coordinated Entry in use at 18 of 44 sheltering programs, and the region's two domestic violence shelters operate outside HMIS. A shortage of programs to

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[18] U.S. Department of Housing and Urban Development. (2017). Notice establishing additional requirements for a Continuum of Care centralized or coordinated assessment system (CPD-17-01). 24 CFR § 578.7(a)(8). 24 CFR § 576.400(d).

[19] Brown, M., Cummings, C., Lyons, J., Carrión, A., & Watson, D. P. (2018). Reliability and validity of the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) in real-world implementation. *Journal of Social Distress and the Homeless, 27*(2), 110–117. https://doi.org/10.1080/10530789.2018.1482991

refer to can therefore reflect limited inventory, limited inventory connected to Coordinated Entry, or both. Providers also identified gaps in the process itself, in how assessments are conducted, whether they reach the system, and how clients learn where they stand.

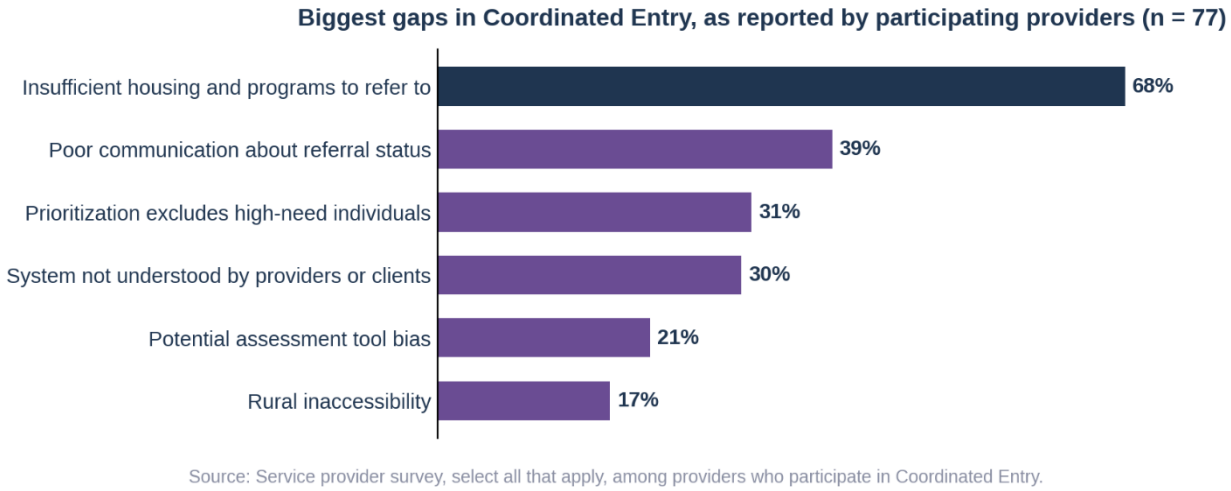

Figure 16. Biggest gaps in Coordinated Entry, as reported by providers who participate in it. The navy bar marks insufficient housing and programs to refer to, the most selected gap.

The findings describe two distinct gaps. Providers identified a shortage of housing and programs to refer to, and they identified gaps in the process itself, in how assessments are conducted, how reliably they enter the system, and how clients learn where they stand. The two kinds of gaps are distinct. A referral process routes people to what exists, so more inventory would not by itself repair the process gaps, and a repaired process would still be routing people toward the same limited inventory. The provider responses locate the larger gap in inventory, selected by 68%, while the process gaps together were named by substantial shares.

11.6 Referral Practice

Sixty-six percent of providers maintain an active referral network and regularly connect clients to organizations beyond their own. The listening sessions described what happens when the work of coordination loses funding. Providers described an organization that, after a grant cut, eliminated the meetings where agencies exchanged information about programs and openings. Without those meetings, staff knowledge of other programs went out of date. Clients were sent to programs that could not serve them, which cost the client's time and the receiving agency's time. Providers described calling shelters listed online as having open beds and being told the beds had been full for four months.

11.7 Coordination

The provider survey asked two questions about coordination, how well organizations currently work together and what stands in the way of working together more effectively. On the first, ratings fell mostly in the middle of the scale. Forty-six percent of providers rated coordination as working fairly well with gaps. Thirty-two percent rated it inconsistent. Twelve percent rated it very well, and 10% rated it poorly.

On the second, the most named barriers concern the structures through which coordination happens. **Inadequate communication structures were named by 51% of providers. Insufficient staffing capacity to coordinate followed at 47%, lack of shared data systems or agreements at 46%, and unclear roles across agencies at 40%. The barriers that describe relationships between organizations were named least often.** Turf conflicts were named by 21%, geography by 19%, and lack of trust between organizations by 13%.

Table 32. Barriers to more effective coordination reported by providers (N = 90)

Barriers to more effective coordination (select all)	%
Inadequate communication structures	51%
Insufficient staffing capacity to coordinate	48%
Lack of shared data systems or agreements	46%
Unclear roles across agencies	40%
Competing funding requirements	32%
Turf conflicts	21%
Geography	19%
Lack of trust between organizations	13%

Note. Service provider survey, select all that apply (n = 90). Percentages sum to more than 100.

Providers also reported that they do not know what services and support their peer organizations actually offer, how similar providers differ, or when program offerings change. On formal data sharing, 47% of providers did not know whether their organization has agreements at all. Among those who knew, the most common partners were MWVCAA and ARCHES, at 31%, and the Continuum of Care, at 28%. Agreements with hospitals were reported by 9%, with county government by 8%, and with criminal legal partners by 4%. Providers named release from jail or prison among the most common circumstances their clients share, and few reported formal agreements with the institutions involved. In these responses, providers located the barriers to coordination in structures, staffing, and shared information rather than in the relationships between organizations.

11.8 Discharge Planning

A third of providers reported a formal discharge planning protocol of their own. In the listening session, providers described warm handoffs that happen informally, between individual staff who know one another. They described discharges from hospitals, jails, foster care, and behavioral health facilities arriving without housing in place, and no formal handoff agreements with the discharging institutions. Nearly half of providers named institutional release among the circumstances clients most commonly share. Four percent reported data-sharing agreements with criminal legal partners, and 9% with hospitals. The system currently identified institutional discharge as a major inflow while holding almost no formal relationship with the institutions producing it.

11.9 Data Infrastructure and Learning Systems

Seventy-three percent of provider respondents use HMIS. Write-in responses identified at least nine distinct platforms in active use alongside it, including spreadsheets at 42%, custom databases, electronic health records, and named systems such as Activate Care and Need Navigator. The landscape scan shows the inventory side. Thirty-one of 44 sheltering programs participate in HMIS and 13 do not. Two of those 13 programs are outside HMIS by design. Federal confidentiality rules prohibit victim service providers from entering client data into HMIS, so the region's two domestic violence shelters record required data in a separate comparable database. HMIS deduplicates at the county level but not the program level. The region therefore cannot produce an unduplicated count of who its shelter system reaches each year. The sum of program-reported unique individuals served, 8,345 across the 28 programs reporting, measures scale rather than distinct people.

Providers rated their own data quality fairly positively, and the data they collect covers a narrow range. Basic demographics are collected by 83% and housing status at intake and exit by 72%. Client satisfaction or feedback is collected by 23%. Disaggregated outcome data by race is collected by 13%. Fifty-one percent of providers did not know whether their organization has ever reviewed outcomes by race or ethnicity, and among frontline staff the figure was 57%. Training on racial equity analysis was the least selected infrastructure request, at 14%. One respondent described what such analysis produced at their organization. The respondent compared guest demographics against county census figures, found under-service of Hispanic residents and over-representation of Native American, Black, and Pacific Islander guests, and documented that older women were referred away because the shelter lacked lower bunks and 24-hour operation.

11.10 Organizational Capacity Constraints

The provider session described funding losses in concrete terms. A peer-run recovery center reported a 78% loss in funding. It is no longer open seven days a week, and its hours dropped from 10 a.m. to 5 p.m. to 11 a.m. to 4 p.m. Another provider whose position is funded through the Behavioral Health Resource Network, the Measure 110 program, reported a 12% cut to that grant in the past year. That provider described quarterly meetings among the network's 11 grant partners in the community. Because of funding, those meetings have been cut back to once a year. Providers connected that sequence to referral knowledge going out of date.

The survey shows differences between leadership and frontline staff on several measures. Leadership and frontline staff see different systems. Leadership respondents track client outcomes at 68%, compared with 21% of frontline staff. Leadership rated Coordinated Entry negatively at 55%, compared with 16% of frontline staff, and 46% of frontline staff reported that they cannot see the system well enough to rate it. Leadership named funding as the staffing constraint at 77%, compared with 41% of frontline staff.

Frontline staff are not more positive about the system. **Within the frontline group, 90% of outreach workers did not know whether their own organization employs peer specialists, and more than 80% of peer and community health workers do not track outcomes. These are the staff with the most direct contact with unsheltered people and the least**

connection to the system's information. Organizations outside Coordinated Entry were roughly twice as likely to name single women as a population falling through the cracks, and more likely to identify geographic distance and shelter safety as barriers.

Program type divides the sample a third way, between shelter and housing programs, which provide places to stay, and non-housing programs, such as day centers, outreach, behavioral health services, and food programs, which serve people without providing housing. Shelter and housing programs carry waitlists at 54%, compared with 26% of non-housing programs. Non-housing programs reported less visibility into Coordinated Entry, at 57% lacking it compared with 31%, and no non-housing respondent rated regional coordination as working very well.

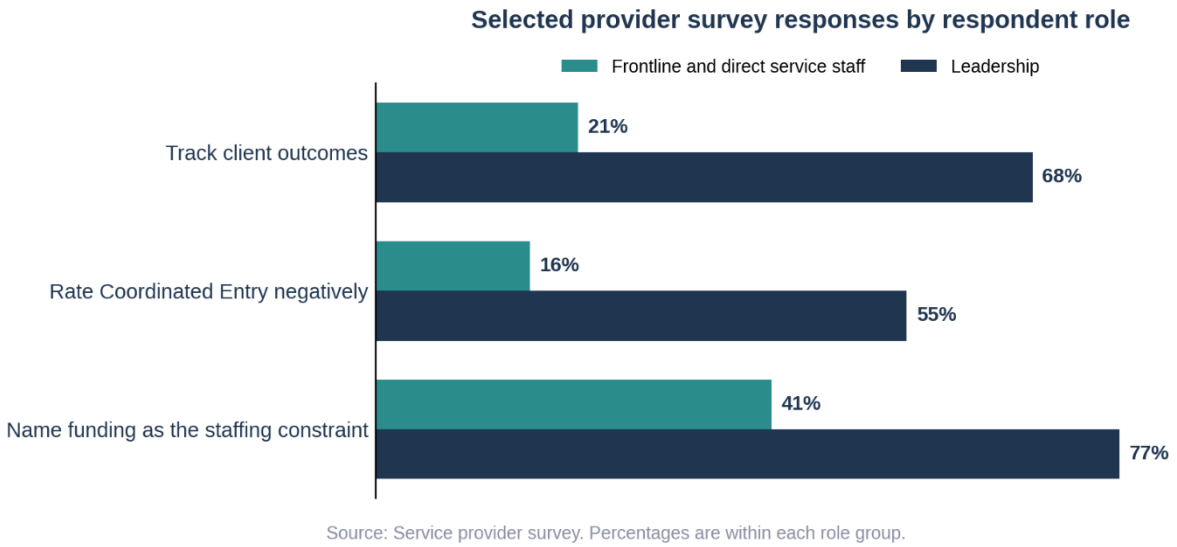

Figure 17. Selected provider survey responses by respondent role. Leadership and frontline staff differ on each measure shown.

11.11 What a Functioning Regional System Would Require

Across this section, provider responses converge on five kinds of infrastructure that the region does not currently have. The **first is shared definitions,** beginning with what counts as a wait time and what low barrier means in operation. Without shared definitions, measures cannot be compared across providers. The **second is a shared and current information layer, a directory of capacity and eligibility that records changes, visible to providers** and in simpler form to the public. **Both surveys found not knowing what exists to be among the largest barriers.** The **third is communication channels that reach clients**, including a way for a person on the Coordinated Entry list to learn where they stand and notification by more than postal mail. The **fourth is analytic capacity that organizations can share**, enough to produce an unduplicated count and to analyze outcomes by race, since thirteen programs sit outside HMIS and nine platforms are in use. The **fifth is funding structured for the work, as providers described it -** covering staffing, coordination time, and flexible assistance. The recommendations in this report return to each.

KEY TAKEAWAYS – SYSTEMS CAPACITY, PRACTICE, AND INFRASTRUCTURE

Demand for services is rising. Eighty-four percent of providers reported increased demand and 77% carry a waitlist, and fewer than half of providers answering could state a typical wait time.

Funding is the workforce constraint, and the lived-experience workforce that is one of the region's genuine strengths needs coverage depth and paid self-care.

Coordinated Entry received zero endorsements from 90 respondents. Two-thirds of participants say the core problem is nothing to refer to; assessment validity, fidelity, and a missing client status channel are the process defects that would persist even with inventory.

H**arm reduction is broad but shallow, and more than a quarter of the region's beds sit behind the strictest sobriety requirements**

Race is recorded at intake at six times the rate it is analyzed against outcomes, and 51% of providers did not know whether their organization has ever reviewed outcomes by race or ethnicity.

Leadership and frontline staff answered differently on outcomes tracking, Coordinated Entry, and staffing constraints, and the **staff with the most direct contact with unsheltered people reported the least connection to the system's information.**

12. Populations Requiring Targeted Approaches

The findings in this report so far describe the population as a whole. This section examines the groups within it whose circumstances, pathways, or service needs differ. Each subsection follows the same structure. It presents what the survey data show where sample sizes permit, what listening sessions and providers described, and what the services the landscape reported for that population.

12.1 Families With Children

Parents of minor children reported more difficulty than other respondents on several measures. Sixty-five percent cited long waitlists, compared with 35% of respondents not parenting. Sixty-three percent did not know what services were available, compared with 42%. **Fifteen percent described their overall service experience as positive, compared with 40%.** Parents also reported feeling unsafe in shelter at higher rates. **Eighty percent of parents named permanent housing as a top need, the highest share for any subgroup on any needs item in the survey.** Childcare appeared both as an unmet need and as an employment barrier. Fifteen surveyed parents did not have their children with them.

The landscape scan describes the family capacity behind these figures. Family capacity is weighted toward longer-term programs with low turnover. Dedicated emergency family shelter holds seven household units, and five family units were open at the time of the scan. Family intake often runs through appointment-only or business-hours processes, so a family in crisis on a Friday evening has limited pathways until the next business day. Providers described two design gaps. Few shelters serve fathers with children. The ARCHES Nest is the only family shelter in the region that accepts fathers with children. Few facilities serve two-parent families.

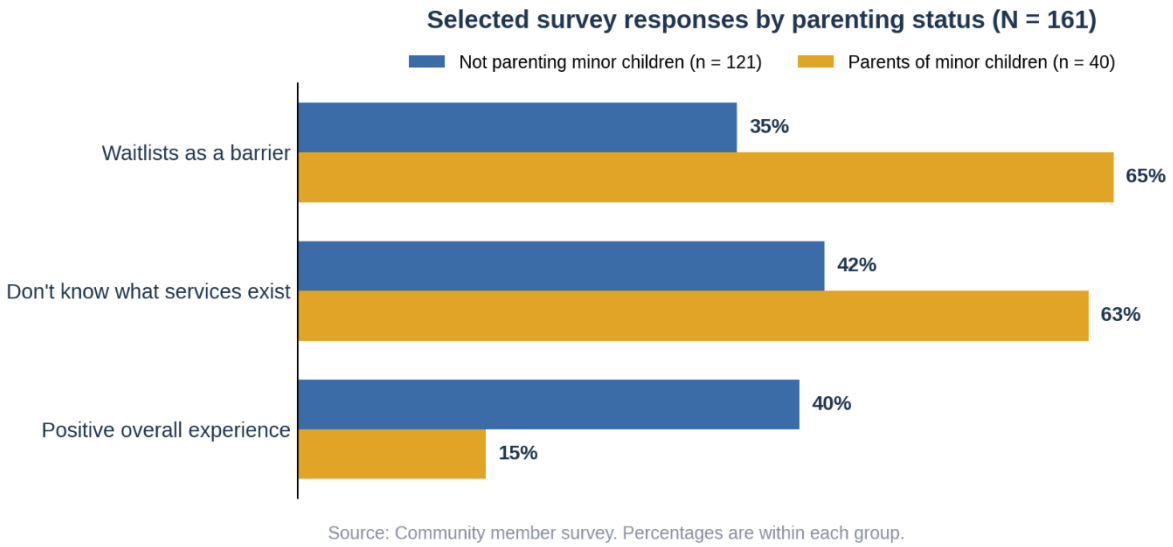

Figure 18. Selected survey responses by parenting status.

12.2 Youth and Young Adults Under 25

Young adults reported easier access and more welcome than older respondents, with 72% finding services easy to access. They were also the lowest-income group in the sample, with 87% living on under $500 per month. Youth programming may be more relational and less rule-bound, or younger respondents may simply have had less exposure to the system, since reported experience worsens with duration. The listening sessions described the youth pathway as family rupture, with participants entering homelessness at 13, 15, and 17 years of age, sometimes tied to issues with their identity or safety at home. One young survivor of family violence was refused by multiple domestic violence shelters because his abuse was not intimate-partner violence.

In addition, the dedicated infrastructure to support youth and young adults is limited. The region holds 20 dedicated youth beds, about 1.4% of all beds. These beds are located in two ten-bed houses. A Salem day center serves youth during daytime hours only. All three facilities are in or near Salem, and none is in rural Marion County. Young adults 18 to 24 are generally served within adult programs. In the youth session, young adults described the cost of replacing identification as the barrier standing between them and work. A replacement identification card costs money, employment requires the card, and without work there is no money to replace it. Several young adults described this loop as what kept them from working.

12.3 Older Adults 55 and Over

Older adults were the population providers most often described as growing and falling through the cracks in the system. The shift toward adults 65 and over was the most common household-mix change providers reported, at 21%, and older adults ranked second among populations providers identified as falling through the cracks, at 59%. A third of listening session participants were 55 or older. These participants described rent increases, layoffs, divorce, and medical events late in a working life, and the physical cost of years outside.

In the survey, 29 respondents were aged 55 or older. Among them, 12 were staying in shelter or transitional programs and 6 were unsheltered, with the remainder in other situations including housed but at risk. Sheltered or not, older participants described the physical toll of homelessness accumulating faster for them than for younger people. Sleeping outside or in a vehicle, walking between services, carrying belongings, and going without consistent medical care wear on bodies already managing the conditions of later life, and participants described injuries and illnesses that did not heal as they once had. One Monmouth participant described years of living outside had on his health.

> *"Two years ago I was a hundred times healthier than I am now."*
>
> Community Member Listening Session, Monmouth

12.4 Latinx Community Members and Farmworkers

Nearly half of provider respondents serve Latinx community members, and a third serve farmworkers. No sheltering program in the region is designed specifically for the Latino

community. Culturally specific and language services ranked near the bottom of provider-observed needs. One case manager wrote that the Latino community is struggling because of fear of immigration enforcement and lack of cultural understanding.

12.5 Rural Residents

The landscape scan shows Polk County holding 4.4% of regional capacity with no day or resource center anywhere in the county, and rural Marion holding scattered single programs. The listening sessions described services and infrastructure absent altogether, no laundromat or grocery store in Falls City, no day space or shower in Stayton, a warming center that opens only at 34 degrees or below for three consecutive days with volunteer staffing, and mail-dependent paperwork in communities with unreliable delivery. The survey shows respondents outside Salem less likely to have been turned away, consistent with fewer programs to approach. Participants described the rural service delivery they sought. They asked for mobile services on a scheduled and publicized route, day space in their own communities, laundry access, and transportation. They described these as alternatives to being directed to Salem.

Rural participants also described the impact of living in a small town and being known for being homeless. In a town where six people sleep outside, residents know who they are. Participants described what this brings them and what it costs. Neighbors and congregations help because they know you. At the same time, there is no anonymity, and a person's circumstances are visible to everyone.

> *"There's so few of us that it's easy to get to know us and put our picture on Facebook."*
>
> Community Member Listening Session, Stayton
>
> *"This is a perfect example of why some of us are uncomfortable admitting that we're homeless, because the homeless are getting blamed for everything. Some of us are flat out lying about having an apartment when we don't, just because we understand the struggle, how real it is, and the harassment that comes associated with the stigma."*
>
> Community Member Listening Session, Monmouth

The concealment participants described has a consequence for the numbers reported on the level of homelessness in the region. **People concealing their homelessness to avoid stigma are undercounted by every enumeration method this assessment draws on, so rural prevalence figures are best read as minimums. Concealment also bears on engagement. A person concealing the circumstance is unlikely to approach a service labeled as serving that population.**

Participants also described the label itself as something they did not accept. Some preferred "houseless," a term with real currency in the region, describing their circumstance as being without a house rather than without a home. Others rejected any category term. One Stayton participant, unhoused on and off since 1984, asked to be rid of the word altogether.

"I'd like to get rid of the name homeless. I don't want to own it. I am just want [his name]. I'm not homeless. I don't want to be known by that."

Community Member Listening Session, Stayton

A provider at a day resource center described encountering the same distinction from the other side, clients who told him they were not "these kinds of homeless." **The distinction people draw between being homeless and being without a house is not wordplay. "Homeless" arrives carrying an identity, with the stigma participants described attached to it. "Without a house" describes a circumstance, something a person is experiencing rather than something a person is. Participants who drew the distinction were declining the identity while acknowledging the circumstance.** For services, the two framings behave differently. **A service framed around the identity asks a person to accept the label as a condition for receiving services. A service framed around the need, such as laundry, mail, a shower, help with rent, asks nothing about identity at all.**

12.6 People With Disabilities and Chronic Health Conditions

This is the largest population in the assessment by any measure. Three-quarters of survey respondents reported a long-term condition. Forty-three percent of listening session participants identified as a person with a disability. Providers ranked people with disabilities third among populations falling through the cracks, at 56%. Respondents with a condition were seven times more likely to report identity-based denial, with accounts including a refused service dog and absent seizure accommodation. Forty respondents were unable to work due to disability or health, and 26 received SSI or SSDI, with open-ended accounts describing multi-year application backlogs. The landscape scan found physical accessibility affirmatively reported at 12 of 44 programs, with 32 not reporting, so the system cannot say how many beds a person with a mobility disability can use. Deaf participants described a further layer, services and community spaces without interpretation, and communication disability being conflated with cognitive capacity.

12.7 People With Behavioral Health Needs and Substance Use Disorders

Serious mental illness led the populations providers identified as falling through the cracks, at 71%, with substance use disorders at 56% and dual diagnoses at 49%. Frontline staff named substance use disorders more often than leadership. Mental health services topped provider-observed needs at 80%. More than a quarter of the region's beds sit behind abstinence-with-testing requirements. Providers named congregate settings as a relapse risk. Providers described people in acute mental health crisis whose symptoms, such as agitation, loud or rapid speech, or difficulty following a conversation, are interpreted by staff as aggression rather than as signs of illness. Providers also described chronically homeless people excluded after a relapse or a bad day with nowhere else in the region to go. In the provider needs data, substance use treatment and dual diagnosis support were each named less often than

substance use. The provider needs data show a related pattern. Providers reported mental health and substance use conditions occurring together across their caseloads, and they named dual diagnosis support, the service built to treat both at once, less often than they named treatment for either condition alone.

12.8 Gender: Two Different Poverties

The community survey shows differences by gender. Fifty-one percent of men reported no income at all, compared with 30% of women. Women were more likely to have some income, consistent with the benefit receipt that accompanies having children in care. The journey and pathway to becoming homeless differed by gender. Women identified domestic violence or an unsafe situation as a contributing factor at 23%, compared with 7% of men. Women cited mental health challenges at 39% compared with 21%, physical health at 25% compared with 10%, and rent unaffordability at 45% compared with 27%. Women were more likely to have a pet, at 56% compared with 27% of men, and named rent and deposit assistance as a top need at roughly twice the rate of men.

Men, by contrast, were the sample's lowest-income group and reported the fewest connections to services. In the provider survey data, men appear repeatedly among the populations existing programs do not fit. Providers described shelters for women and children but not for men with children, single adults and single fathers among those falling through the cracks, and the two largest men's congregate facilities carrying the region's strictest sobriety requirements. Individuals who were non-binary cited family breakdown at 64% (7 of 11) and discrimination as a contributing factor at 36% (4 of 11), compared with 6% of women and 3% of men.

12.9 Survivors of Domestic Violence

Domestic violence or an unsafe situation was the first event that started the path to housing loss for 12% of survey respondents and a contributing factor for 17%. Women cited it as a contributing factor at more than three times the rate of men. Among listening session participants, 22% identified as survivors of domestic violence. Findings from the landscape scan indicated that a dedicated infrastructure consists of two programs totaling 130 beds, one in each county, and the Salem program is among the region's few walk-in options. The listening sessions documented two eligibility gaps. One survivor was excluded from a domestic violence grant because no children were in the home. One young survivor of violence in his family of origin was refused because his abuse was not intimate-partner violence. Providers described capacity denials at domestic violence shelters, and they raised the question of whether domestic violence organizations operate in connection with the broader housing response or apart from it

12.10 Justice-Involved Individuals

Criminal history is the fifth most selected employment barrier, at 21%. It was the reason for 12% of shelter turn-aways. Participants described rental screening that excluded them decades after a conviction. For people under supervision, remaining homeless can violate supervision terms while the record disqualifies them from housing. Half of providers named release from jail or

prison without housing among the reasons clients commonly share. Reentry services appear at four sheltering programs and at none as a dedicated focus. Four percent of providers reported formal agreements with criminal legal partners. Providers described people with sex offense histories, barred from most housing, shelter, and subsidy, as a population with almost no options.

12.11 People With Pets or Unable to Meet Sobriety Requirements

People with pets were identified by 42% of providers as falling through the cracks in the system. **Fifty-nine percent of providers cited pets and partners as a client access barrier,** pets were the third most common turn-away reason in the community survey, and pet ownership concentrated among unsheltered respondents, women, and people with health conditions, some of whose animals are service or support animals. Fifteen percent of programs reported an outright no-pets policy, so the barrier as experienced exceeds the stated prohibitions, with kennel space, liability, and service-animal policy likely accounting for the difference. People unable to meet sobriety requirements face the abstinence-with-testing rules that govern roughly a quarter of the region's beds. Each of these exclusions is set by program policy.

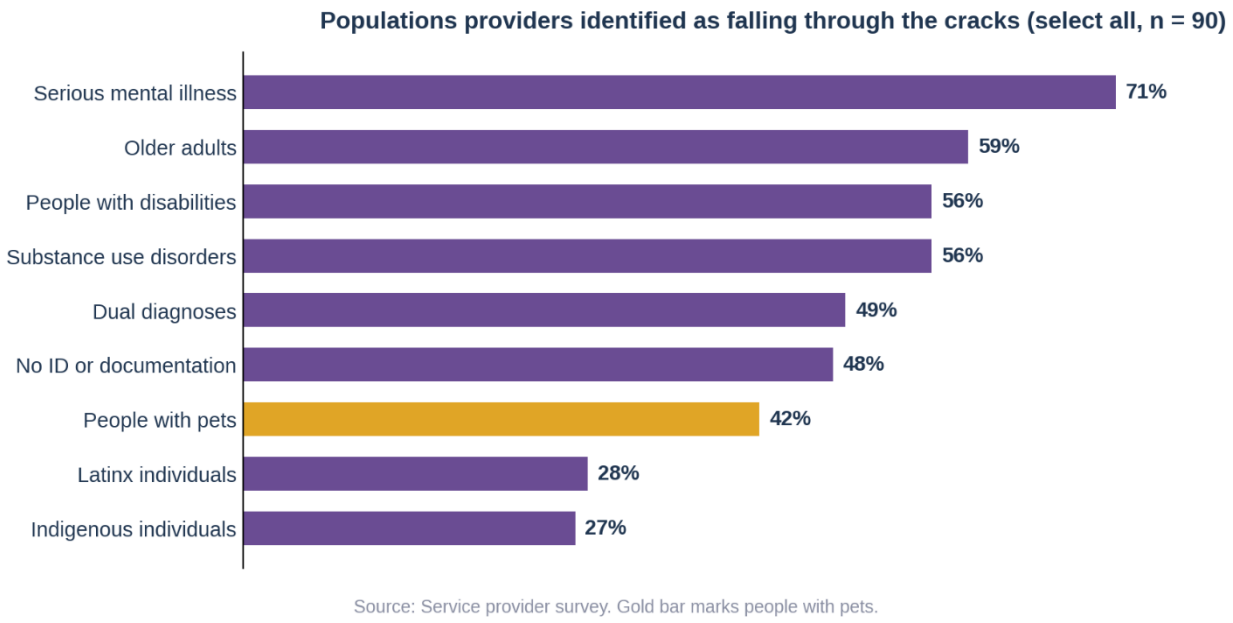

Figure 19. Populations providers identified as falling through the cracks. The gold bar marks people with pets.

Table 33. Populations providers identified as falling through the cracks (N = 90)

Population	%
People with serious mental illness	71%

Population	%
Older adults	59%
People with disabilities	56%
People with substance use disorders	56%
People with dual diagnoses	49%
People without ID or documentation	48%
People with pets	42%
Single women	27% among Coordinated entry provider participants; 53% among non-participants
Latinx individuals	28%
Indigenous individuals	27%

KEY TAKEAWAYS – POPULATIONS REQUIRING TARGETED APPROACHES

Parents of minor children reported more difficulty than other respondents on waitlists, information, and overall experience, with 15% describing their service experience as positive, and the inventory holds seven dedicated emergency family units.

Three-quarters of survey respondents reported a long-term condition. Respondents with a condition were seven times more likely to report identity-based denial.

Youth and older adults occupy the two ends of the age distribution, with 20 dedicated youth beds region-wide and older adults the population providers most often described as growing.

Rural residents described services that did not exist in their communities and the visibility of being known in a small town. Some concealed their homelessness to avoid stigma, and some declined the label itself.

13. Gaps and Unmet Needs

This section brings together what community members said they most need, what providers observe as the most common needs, and what the landscape scan documented as missing. Each source identifies gaps from a different vantage point. Community members describe what they are not getting, providers describe what they cannot offer or refer to, and the landscape scan describes what the current shelter inventory does not contain. The section moves from stated needs to capacity, geography, populations, and infrastructure, and closes with the gaps both community members and providers identified.

13.1 What People Say They Most Need and Are Not Getting

Respondents were asked to select up to three needs they are not currently getting help with. Permanent housing was the most selected, at 60%. Help paying rent or a security deposit followed at 38%. Food and income or employment support were each selected by 27%, transportation by 21%, and a safe place to sleep by 20%. The three most used services community members reported using in the last 12 months consisted of benefits assistance, food, and medical care. **The most selected unmet needs concern leaving homelessness. Rapid rehousing, a service designed to move people from homelessness into permanent housing, reached 6% of respondents in the past 12 months.**

Needs differed by housing situation. **Sheltered respondents need resources and services to help them exit homelessness. Seventy-three** percent of sheltered respondents cited permanent housing as a need. **Among unsheltered respondents, needs were spread across housing, a safe place to sleep, food, and rent help. Among respondents housed but at risk or doubled up, they expressed needing resources to help prevent them from becoming homeless such as help paying rent or a deposit** was the most selected need, ahead of permanent housing. **Among respondents currently housed, they expressed material hardship and needing support with securing food.**

Table 34. Top unmet needs among survey respondents, by housing situation

Top unmet needs	Unsheltered (n=48)	Sheltered (n=64)	At risk or doubled up (n=29)	Housed (n=18)
Permanent housing	65%	73%	41%	22%
Help paying rent or deposit	27%	44%	52%	22%
Food	31%	14%	38%	33%
Income or employment support	27%	30%	28%	17%
Transportation	13%	33%	21%	6%
Safe place to sleep	35%	16%	10%	–
Mental health services	21%	13%	14%	17%
Peer support	2%	6%	17%	6%

Note. Community member survey Q36 by recoded housing situation (n = 159; two respondents did not answer). Respondents selected up to three needs. Percentages are within each group and do not sum to 100. Group definitions follow the earlier subgroup tables. A dash indicates no respondents in that group selected the item.

13.2 What Type of Housing People Say They Need

Respondents were also asked what type of housing they most need right now. A third chose a place of their own with no program requirements attached. A quarter chose supported housing, meaning their own place with services available. Eighteen percent chose any stable housing without specifying a type. Four respondents chose transitional housing with structure and support, while 32% of the sample was living in transitional shelter or a program at the time of the survey. The housing respondents were in and the housing they said they needed differ. In the open-ended responses about what they need, employment and income appeared in 44% of answers and housing affordability in 20%. Given a list, respondents selected housing. Given a blank box, they more often described the income that would make housing attainable.

Table 35. Type of housing respondents said they most need

What type of housing do you most need right now?	n	%
A place of my own with no program requirements attached	53	33%
Supported housing: my own place with services available	41	26%
Other (write-in)	30	19%
Any stable housing, not specific about the type	29	18%
Transitional housing with structure and support	4	3%
Shared housing with others	4	3%

Note. Community member survey Q37 (n = 161). Respondents selected one option. Percentages are rounded and may not sum to 100.

13.3 What Providers Observe as the Most Common Needs

Providers were asked which needs they observe most often among clients. **Mental health services was the most selected, at 80%, followed by permanent affordable housing at 79% and rapid rehousing or rental assistance at 77%**. Transportation followed at 70%, ahead of emergency shelter beds. Culturally specific or language services (32%), childcare (29%), and services for LGBTQ+ individuals (21%) were selected least.

13.4 The Gaps Community Members and Providers Both Name First

Two gaps were named first by both groups. The first is housing that people at the region's actual income levels can occupy. Community members named it first in every format, and providers named it unprompted at more than twice the rate of any other theme. **The second is a working information layer, so that a person in crisis can find what exists, a worker can make a referral that will be impactful, and a family on a list can learn where they stand.**

KEY TAKEAWAYS – GAPS AND UNMET NEEDS

The services community members used most frequently address daily needs, and the needs they most often named as unmet concern surviving being homeless. Rapid rehousing, the service between the two, reached 6% of respondents in the past year.

Community members most often mentioned they need housing of their own, with or without services attached.

The landscape scan documented capacity gaps in transitional housing, family walk-in access, youth beds, and everything outside Salem, with 64% of programs carrying waitlists.

The infrastructure gaps affect every other gap. The system has no shared definitions, no unduplicated count, no client status channel, and no current directory.

14. Recommendations and Action Plan

14.1 The Plan at a Glance

This section answers the assessment's final question, what high-impact, actionable steps can improve services and outcomes in Marion and Polk Counties. It brings together what the assessment found and what community partners added during a sensemaking session in late September 2026. A sensemaking session is a facilitated working meeting where community partners review the findings together, test them against what they see in their own work and lives, and decide what the findings mean for action. During the sensemaking session, participants worked in small groups to review the draft recommendations, name additional needs and root causes, and propose next steps and the organizations that could support the work. That discussion, together with the evidence in this report, shaped the recommendations and action plan in this section.

The plan is organized into 11 priority areas under four themes. The first theme covers keeping people housed and meeting basic needs. The second covers how the system works together. The third covers housing and care for people whom current programs do not fit. The fourth covers place, culture, and public understanding.

Each priority area opens with a goal, a short statement of what the work aims to change. It then describes what the findings show, drawing on the assessment and the sensemaking session. From there, the plan lays out the strategies for that area. Sixty-eight strategies appear across the plan, each numbered by its priority area. An action plan follows each set of strategies. It names the first steps, who could lead them, which partners could join, and when the work could begin. Each priority area closes with milestones that show progress and the groups still to bring into the work.

During the sensemaking session, participants named their own organizations, and others, that could lead or support work in a priority area. **No organization listed in this document has committed to a role. These names are suggestions from session participants and the research team**, for MWVCAA, its partners and the community to use in future conversations.

The table below gives each priority area, its goal, and its strategies. The pages that follow describe each one in full.

Table 36. Priority areas, goals, and strategies at a glance, by theme

Priority	Priority area and goal	Strategies
Theme A. Keeping People Housed and Meeting Basic Needs		
1	**Prevention and Housing Stability** Households at risk of losing housing get help early enough to stay housed, and they stay housed after the help ends.	• Create a flexible regional housing and diversion fund with minimal program conditions. • Treat households at risk of losing housing as a distinct population with a distinct intervention. • Address the barriers that turn a crisis into housing loss. • Fund renter education. • Measure housing stability after assistance ends.
2	**Basic Needs, Identification, and Staying Reachable** People without housing can meet daily needs, keep their documents, and be reached when help becomes available.	• Fund basic dignity infrastructure in every community where people sleep outside. • Extend hygiene access beyond current hours and locations. • Remove the identification barrier. • Fix the contact problem. • Share what exists where people first make contact.
Theme B. How the System Works Together		
3	**Coordination, Coordinated Entry, and Shared Information** People move through one coordinated system, and providers share current information about what is available.	• Repair Coordinated Entry. • Report Coordinated Entry performance alongside housing inventory. • Build a shared, current capacity and eligibility directory, paired with a staffed phone and in-person channel. • Connect outreach, peer, and day center staff to system information. • Convene a quarterly regional resource summit with frontline staff present. • Develop a coordination framework that scales with conditions such as severe weather. • Define what collaborative funding looks like.

Priority	Priority area and goal	Strategies
4	**Program Rules and Access to Housing** Program and screening rules let in the people programs are meant to serve.	• Review program rules separately from program capacity, and publish the results. • Address the pets and partners barrier. • Extend ban-the-box protections to rental applications, and exclude credit history accrued during documented homelessness from screening. • Connect domestic violence organizations to the broader housing response and widen eligibility. • Design for the populations existing programs do not fit. • Bring landlords and property managers into the work. • Pair housing access with longer-term support.
5	**Workforce, Peers, and Data** The workforce is staffed and supported to do the work, and the region learns from shared, unduplicated data.	• Fund staffing rather than programs where possible. • Invest in peer support specialists. • Close the counting gap. • Share data across organizations with consent. • Fund shared equity outcome analysis and return the results to frontline staff. • Collect client feedback routinely, and record the reason for every refusal. • Publish annual reports by agency and program.
Theme C. Housing and Care for People Whom Current Programs Do Not Fit		
6	**Housing Supply and Pathways from Shelter** People in shelter can move into housing they can afford, and people keep the affordable housing they have.	• Expand housing supply priced to the incomes people have. • Add small-unit housing. • Preserve naturally affordable housing. • Create flexible funding for one-time repairs. • Protect and expand what providers identified as working. • Fund transitional and supportive housing steadily. • Connect shelter to coordinated entry and housing referral.
7	**Behavioral Health, Health Care, and Higher-Needs Care** People with behavioral health, medical, and daily-living needs have care and placements that fit those needs.	• Build behavioral health support across the age span. • Add behavioral health stabilization and emergency beds. • Create specialized care beds and medical respite. • Build institutional discharge partnerships. • Close the gap between health coverage and care. • Sustain urgent medical and mental health response. • Provide housing with ongoing support for people with serious mental illness.

Priority	Priority area and goal	Strategies
8	**Youth and Families** Young people and families have shelter and support that fit them, close to their own communities.	• Rebuild transitional and family walk-in capacity. • Establish at least one 24-hour access point for families in each county. • Plan youth services and family services as separate systems. • Keep young people and families in their communities. • Configure family shelter for all family types. • Support young adults leaving youth systems. • Expand services for survivors in families. • Pair early intervention with longer-term follow-up.
Theme D. Place, Culture, and Public Understanding		
9	**Rural Communities** Rural residents can reach shelter and services in or near their own communities.	• Fund rural service delivery as rural service delivery. • Collect town-by-town data and a service inventory. • Identify communities that can host full-service shelter. • Expand rural shelter and housing options. • Increase rural Marion County representation. • Build rural community buy-in.
10	**Culturally Specific Services and Tribal Engagement** Incorporate culturally responsive practices in all aspects of service provision. Establish authentic partnerships, working alongside Tribal nations and culturally specific organizations.	• Establish a Tribal engagement pathway and plan, training staff on Tribal history, practices and respectful engagement and building on existing relationships. • Fund language access and cultural responsiveness as separate investments. • Work alongside culturally specific organizations, honoring their expertise and devoting resources reflective of authentic partnership. • Create culturally safe spaces and outreach. • Work collaboratively to identify service gaps and design effective solutions.
11	**Public Understanding, Community Buy-In, and Policy Advocacy** Residents, elected officials, and funders share an accurate picture of homelessness in the region and act on it.	• Share the findings widely. • Offer ongoing data education for elected officials at every level. • Develop public communications that correct common myths. • Coordinate advocacy at the city, state, and federal levels.

14.2 The Detailed Recommendations and Strategic Plan

This part of the plan sets out each priority in detail. For each one, it gives the goal, what the findings show, and the strategies. The strategies bring together the approaches participants identified at the sensemaking session and the findings of the full assessment. An action plan follows, with first steps, possible leads and partners, and timeframes. Milestones and the voices to bring into the work close each priority.

Theme A. Keeping People Housed and Meeting Basic Needs

The two priorities under this theme address what happens before a household loses housing and what people need each day while they are without it.

Priority 1. Prevention and Housing Stability

Goal. Households at risk of losing housing get help early enough to stay housed, and they stay housed after the help ends.

What the Findings Show

Sixty-nine percent of the sample received no prevention support before losing housing. Of the 50 respondents who received support, 60% reported that it helped for a while and 40% that it was not enough to prevent homelessness. Among the 29 respondents housed but at risk or doubled up, rent and deposit assistance was the most cited need. One-time help with arrears and a month or two of rent addresses a crisis. It does not close a gap between income and rent that continues after the payment.

Flexible funding was the support providers selected most often for expanding diversion, at 57%. Thirty-six percent of providers already practice diversion informally, without funding or measurement.

Participants at the sensemaking session raised prevention in several small groups, and one group formed to work on it alone. They named deposits, emergency rent help, renter education, and budgeting support. They described barriers that turn a crisis into housing loss, including eviction history, rental history, no or low credit, and damage caused by abuse in the home. A former navigation center staff member described people returning to homelessness after rental assistance ended at month 12.

Strategies

1.1 Create a flexible regional housing and diversion fund with minimal program conditions. Place it at the first point of contact, inside the services people already use. Cover deposits, emergency rent, arrears, and one-time costs that would otherwise lead to housing loss. Fund and measure the diversion work providers already do informally.

1.2 Treat households at risk of losing housing as a distinct population with a distinct intervention. Plan, fund, and track prevention for this group separately from services for people already homeless. For households with an ongoing gap between income and rent, pair one-time help with a pathway into longer-term rental assistance or rapid rehousing.

1.3 Address the barriers that turn a crisis into housing loss. Focus on eviction history, rental history, no or low credit, and damage caused by abuse in the home.

1.4 Fund renter education. Include Rent Well and utilize paid instructors.

1.5 Measure housing stability after assistance ends. Track whether households stay housed after rental assistance ends, not only whether they were placed.

Action Plan

Table 37. Action plan for Priority 1, prevention and housing stability

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Map current prevention resources in both counties, with funders, eligibility, and points of access.	MWVCAA	Prevention providers. Housing authorities.	First half of 2027
Convene prevention partners to discuss prevention options and how organizations can collaborate.	Northwest Human Services and MWVCAA	Marion and Polk Counties. City of Salem.	During 2027
Adopt a working definition of households at risk and shared prevention measures, including housing status after assistance ends.	Mid-Willamette Valley Homeless Alliance	Prevention providers. Agency data administrators.	During 2027
Identify funding sources and written rules for the flexible fund.	MWVCAA	City of Salem. Marion and Polk Counties. Oregon Housing and Community Services.	During 2027
Launch or expand renter education classes.	Renter education providers	Housing authorities. Landlords and property managers.	During 2027

Milestones

- A shared definition of households at risk is adopted.
- The flexible fund operates with written, minimal conditions.
- Prevention and diversion results are reported, including housing status after assistance ends.

Voices to bring in. People with lived experience of homelessness. School district McKinney-Vento liaisons. Northwest Senior and Disability Services. Domestic violence service providers.

Priority 2. Basic Needs, Identification, and Staying Reachable

Goal. People without housing can meet daily needs, keep their documents, and be reached when help becomes available.

What the Findings Show

Restrooms, showers, laundry, water, trash service, and secure storage were the most frequently named needs across all seven lived-experience sessions. Community data shared at the

sensemaking session showed no showers available after 10 p.m. One participant described hygiene, waste disposal, and bathrooms as basic government infrastructure that providers keep filling.

Young adults named the cost of replacing their license or state identification as the barrier standing between them and work. Participants described documents lost through sweeps and theft, and a young person who had used up time-limited ID vouchers.

Eighteen percent of respondents have no working phone, and 40% of unsheltered respondents have limited or no internet. Participants said people learn about hygiene and ID resources too late or not at all.

> *"Better sheltering. Some shelters are very strict with rules, some that are very rude, and some that just don't really understand what people go through. We need and deserve a safe space."*
>
> Community Member Listening Session, Salem

Strategies

2.1 Fund basic dignity infrastructure in every community where people sleep outside. Provide restrooms, showers, laundry, potable water, trash service, and secure storage. Start where need is concentrated, such as Marion Square.

2.2 Extend hygiene access beyond current hours and locations. Add mobile showers and laundry in Salem and in rural communities, with staff to maintain them.

2.3 Remove the identification barrier. Subsidize replacement documents, remove the fee-waiver frequency cap, and pair replacement with secure storage. Cover documents lost in sweeps and theft.

2.4 Fix the contact problem. Replace mail-only notification with text, email, and agency-side alerts, and extend response windows for applicants without stable addresses. Expand free phone programs, and extend the ARCHES day center's contact approach to other partner agencies.

2.5 Share what exists where people first make contact. Use outreach teams, day centers, and drop-in sites to share hygiene, identification, and contact resources.

Action Plan

Table 38. Action plan for Priority 2, basic needs, identification, and staying reachable

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Hold conversations among shelters and providers about funding needs and partnerships for hygiene services.	The ARCHES day center (MWVCAA)	Shelters. Day centers. Mobile shower and laundry providers.	By January 2027

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Inventory hygiene, storage, identification, and phone resources, with hours and locations.	MWVCAA	Day centers. Street outreach teams.	First half of 2027
Identify sites and funding for after-hours and mobile hygiene services, including in rural communities.	City and county governments	Shelters and day centers. Mobile hygiene providers.	During 2027
Work with agencies that issue identification documents on fee waivers and replacement frequency.	MWVCAA	State and county agencies that issue documents.	During 2027
Adopt text and email notification across programs, with longer response windows.	Mid-Willamette Valley Homeless Alliance	Program operators.	During 2027
Collect feedback from people who use these services to track whether access grows.	Shelters and day centers	People with lived experience of homelessness.	Multi-year

Milestones

- Hygiene services operate after day center hours in Salem and in rural communities.
- Replacement documents are available without a frequency cap.
- Programs notify applicants by text or email as well as by mail.

Voices to bring in. People with lived experience of homelessness, including people disconnected from services. Police, law enforcement, and code enforcement. Neighborhood associations and the business community.

Theme B. How the System Works Together

The three priorities under this theme address how providers coordinate, which rules decide who gets in, and the staff and data the system runs on.

Priority 3. Coordination, Coordinated Entry, and Shared Information

Goal. People move through one coordinated system, and providers share current information about what is available.

What the Findings Show

None of 90 provider respondents selected the option that Coordinated Entry is working well, and the gaps they named are specific. Sixty-eight percent of participating providers identified insufficient housing and programs to refer to as the biggest gap. Seventy-eight percent reported that clients do not know what exists, and the region has no shared wait-time definition. Inadequate communication structures were the most named coordination barrier, at 51%. The staff with the most direct contact with unsheltered people reported the least connection to system infrastructure.

Participants at the sensemaking session named fragmented funding and accountability, competition for limited resources, organizational silos, and systems designed around programs as root causes. They gave the example of a shelter that lists 25 beds when 15 are available.

Strategies

3.1 Repair Coordinated Entry. Pilot a documented mechanism for worker observation to inform prioritization without overriding client self-determination. Create a status channel clients can use. Audit assessment fidelity across access points and retrain where scores diverge from expected distributions. Organize it as one front door across providers, toward a “no wrong door” approach, and review how it works for young people.

3.2 Report Coordinated Entry performance alongside housing inventory. Publish coordinated entry results, such as how many people are assessed, how long they wait, and how many move into housing, next to the number of housing units and program openings available, so readers can see when delays come from limited housing rather than from the referral process itself.

3.3 Build a shared, current capacity and eligibility directory, paired with a staffed phone and in-person channel. Track available beds, outreach counts, and service disruptions as they change, and set a shared wait-time definition.

3.4 Connect outreach, peer, and day center staff to system information. Include them in CoC communication, referral status updates, and the capacity directory. Set regular communication among street outreach, crisis response, and shelter providers, with communication hours extended to at least 9 p.m.

3.5 Convene a quarterly regional resource summit with frontline staff present. Use it to build communication channels, community among providers, and warm handoffs.

3.6 Develop a coordination framework that scales with conditions such as severe weather. Use emergency management and incident command principles so coordination expands during events and contracts afterward.

3.7 Define what collaborative funding looks like. Share grant information and pursue joint applications among organizations doing complementary work.

Action Plan

Table 39. Action plan for Priority 3, coordination, coordinated entry, and shared information

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Hold a roundtable of agency leaders on shared values, collective decision-making, and collaborative funding.	Mid-Willamette Valley Homeless Alliance and MWVCAA	Agency executive directors. Advocates and frontline staff.	By January 2027

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Schedule and hold the first quarterly regional resource summit.	MWVCAA	Providers and frontline staff.	First half of 2027
Scope the capacity and eligibility directory, starting with shelter beds.	Mid-Willamette Valley Homeless Alliance	211info. Shelter providers.	First half of 2027
Draft a scalable coordination framework with defined roles and decision-making authority.	City and county emergency management	MWVCAA. Northwest Human Services. Mid-Willamette Valley Homeless Alliance. 211info.	During 2027
Begin the coordinated entry fidelity audit and pilot a client status channel.	Mid-Willamette Valley Homeless Alliance	Coordinated entry access points. Youth-serving organizations.	During 2027
Draft interagency coordination protocols and memoranda of understanding.	Mid-Willamette Valley Homeless Alliance	Shelter, housing, outreach, and crisis response providers.	During 2027

Milestones

- The regional resource summit meets each quarter.
- The capacity directory is live, with a shared wait-time definition.
- Coordinated entry performance is reported alongside housing inventory.
- The fidelity audit is complete and retraining is under way where needed.

Voices to bring in. Youth-serving organizations. People with lived experience of homelessness. Criminal justice and law enforcement partners.

Priority 4. Program Rules and Access to Housing

Goal. Program and screening rules let in the people programs are meant to serve.

What the Findings Show

Sixty-three percent of programs described themselves as low barrier, and 52% of those reported at least one active requirement. Pets were named by 42% of providers as a population falling through the cracks and were the third most common turn-away reason. A criminal record was the reason for 12% of turn-aways and an employment barrier for 21% of respondents.

The region holds no dedicated programming for several groups. These include single adults without children, single fathers, two-parent families, fixed-income adults without a substance use diagnosis, people with sex offense histories, Deaf and disabled residents, and LGBTQ+ residents.

Participants at the sensemaking session described screening on credit, rental, and criminal history, and credit damage after domestic violence or a layoff that delays rapid rehousing. They named the costs property managers face for tenants with higher needs. They asked to widen domestic violence eligibility and to serve couples and two-adult households affected by secondary victimization.

Strategies

4.1 Review program rules separately from program capacity, and publish the results. Convene the people who design and administer program rules, starting with mental health programs, and show how specific rules restrict access.

4.2 Address the pets and partners barrier. Fund kenneling, veterinary basics, and facility adaptation.

4.3 Extend ban-the-box protections to rental applications, and exclude credit history accrued during documented homelessness from screening. Address credit damage that follows domestic violence or a layoff.

4.4 Connect domestic violence organizations to the broader housing response and widen eligibility. Establish a confidential referral and follow-up pathway between domestic violence organizations and Coordinated Entry that does not require survivors' information to enter HMIS. Widen domestic violence eligibility to include family-of-origin violence, survivors without children, and couples and two-adult households affected by secondary victimization.

4.5 Design for the populations existing programs do not fit. Start with the groups for whom the region holds no dedicated programming, listed above. Priority 8 addresses family shelter configuration.

4.6 Bring landlords and property managers into the work. Offer incentives tied to the costs of serving tenants with higher needs. Enforce fair housing and ADA protections, including where violations are systemic.

4.7 Pair housing access with longer-term support. Provide deeper, longer-term transitional support and tenant education alongside financial help.

Action Plan

Table 40. Action plan for Priority 4, program rules and access to housing

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Host a conversation on housing access barriers.	Community partners	Landlords and property managers. People with lived experience. Fair housing organizations.	Within 90 days (by December 29, 2026)

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Review program rules across shelter and housing programs and publish the results.	Mid-Willamette Valley Homeless Alliance	Program operators. Funders that set program rules.	During 2027
Design the confidential domestic violence referral pathway into Coordinated Entry.	Domestic violence service providers and Mid-Willamette Valley Homeless Alliance	Coordinated entry access points.	During 2027
Develop landlord incentive options.	Housing authorities	Property managers. Oregon Housing and Community Services.	During 2027
Pursue ban-the-box and credit screening changes for rental applications.	Advocates	City councils. Legislators. Fair housing organizations.	Multi-year

Milestones

- The program rules review is published.
- The confidential domestic violence referral pathway is operating.
- A landlord incentive is in place.

Voices to bring in. Legislators. Criminal justice partners. Recovery services.

Priority 5. Workforce, Peers, and Data

Goal. The workforce is staffed and supported to do the work, and the region learns from shared, unduplicated data.

What the Findings Show

Half of providers named funding that does not cover staffing, rising to 77% among leadership. Of 65 community members who had received peer support, 50 found it very helpful, and 45 more wanted it but had not received it. Three-quarters of organizations already employ peer specialists.

Race is recorded at intake at six times the rate it is analyzed against outcomes, and every organization that analyzes outcomes by race already collects the demographic data. Client feedback is collected by 23% of providers. Among respondents who had been turned away, 23% were told they did not qualify with no reason given. Thirteen sheltering programs operate outside HMIS, so the region has no unduplicated count of system reach.

Participants at the sensemaking session named rural providers among the shelters outside HMIS. They asked for standardized case management documentation, universal releases of information, annual reports by agency and program, and professional training and living wages so staff stay longer.

Strategies

5.1 Fund staffing rather than programs where possible. Build staffing adequacy, supervision, coverage depth, and reflective practice into grant budgets rather than treating them as indirect cost. Design in wellness support and coverage depth for organizations that hire from lived experience, including paid self-care time within scheduled hours, professional training, and living wages.

5.2 Invest in peer support specialists. Increase positions, fund warm handoffs into housing, and add peer and community health worker capacity at high-traffic sites where present staff are not authorized to help with paperwork.

5.3 Close the counting gap. Bring the 13 sheltering programs outside HMIS, including rural providers, into a shared reporting approach designed to fit peer-run and small organizations. Standardize cost-per-bed and waitlist definitions. Produce the region's first unduplicated count of system reach. Pair volume measures with quality measures in grantor expectations.

5.4 Share data across organizations with consent. Adopt a universal release of information and standardize case management documentation.

5.5 Fund shared equity outcome analysis and return the results to frontline staff. Use a regional data coordinator or pooled evaluation support to run disaggregated analysis on data providers already hold, including race and other factors in rapid rehousing follow-up results.

5.6 Collect client feedback routinely, and record the reason for every refusal. Give each person the reason and a next step, so both denials and their causes are visible.

5.7 Publish annual reports by agency and program. Use them to set strategy and to show staff the impact of their work.

Action Plan

Table 41. Action plan for Priority 5, workforce, peers, and data

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Identify the shelters outside HMIS and what each would need to participate.	Mid-Willamette Valley Homeless Alliance	Rural and peer-run providers.	First half of 2027
Build the capacity of governing bodies to create shared data protocols, including a universal release of information.	Mid-Willamette Valley Homeless Alliance board and committees	Agency data administrators.	During 2027
Hold in-person meetings for data administrators and line staff to share practices that do and do not work.	Agency data administrators	Line staff. Peer support specialists.	During 2027

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Agree on shared outcome measures, including breakdowns by race and other factors and recorded refusal reasons.	Mid-Willamette Valley Homeless Alliance	Providers. Culturally specific organizations.	During 2027
Revise grant budget guidance to cover staffing, supervision, wellness, and peer positions.	Funders	Providers.	Multi-year

Milestones

- The region produces its first unduplicated count of system reach.
- A universal release of information is in use.
- Equity outcome results are returned to frontline staff.
- Refusals are recorded with their reasons.

Voices to bring in. People with lived experience of homelessness. Culturally specific organizations.

Theme C. Housing and Care for People Whom Current Programs Do Not Fit

The three priorities under this theme address the supply of housing people can afford, the care some people need to be housed safely, and the specific needs of young people and families.

Priority 6. Housing Supply and Pathways from Shelter

Goal. People in shelter can move into housing they can afford, and people keep the affordable housing they have.

What the Findings Show

Providers recommended expanding supply at 43%, more than twice any other theme. Sixty-four percent of community members who reported an income amount earn less than $500 per month. Providers named non-congregate shelter, street outreach, direct agency-to-agency handoffs, and the culturally specific multilingual navigation model as practices that work well.

Participants at the sensemaking session described too little housing of any type for people in shelter who are ready to move, and shelter turnover as stalled. They named people living on about $994 a month in Social Security, people slightly over program income limits, working people, and older adults as households the current supply misses. They described the loss or rising cost of naturally affordable housing, including mobile home parks, and housing lost to small barriers such as one-time repairs.

Strategies

6.1 Expand housing supply priced to the incomes people have. Include people on fixed incomes, working households, and people just above program income limits.

6.2 Add small-unit housing. Change code and zoning to allow single-room occupancy units, studios, and building up rather than out.

6.3 Preserve naturally affordable housing. Protect mobile home and manufactured housing communities and their space rents, especially for people 55 and older. Expand RV and park capacity with utility hookups and without model-year restrictions.

6.4 Create flexible funding for one-time repairs. Cover repairs such as roofs and weatherization that keep people in the housing they have.

6.5 Protect and expand what providers identified as working. Sustain non-congregate shelter, street outreach, direct agency-to-agency handoffs, and the culturally specific multilingual navigation model. Keep the model in which MWVCAA handles administration and partners provide case management, and ease movement from rapid rehousing to long-term rental assistance.

6.6 Fund transitional and supportive housing steadily. Use Medicaid-funded permanent supportive housing where possible, and review permanent supportive housing outcomes to build shared practice.

6.7 Connect shelter to coordinated entry and housing referral. Operate regional shelter 24 hours a day with a day option, so shelter works as a route into housing.

Action Plan

Table 42. Action plan for Priority 6, housing supply and pathways from shelter

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Compile local code and zoning provisions that limit small units, single-room occupancy, RV parks, and density.	City and county planning offices	Affordable housing developers. MWVCAA.	First half of 2027
Identify mobile home and manufactured housing communities at risk of closure or rising space rents.	MWVCAA	Oregon Housing and Community Services. Community residents.	During 2027
Scope a one-time repair fund with existing home repair and weatherization programs.	MWVCAA	Home repair and weatherization programs.	During 2027
Review rapid rehousing and permanent supportive housing outcomes, including returns to homelessness.	Mid-Willamette Valley Homeless Alliance	Housing providers.	During 2027
Pursue new deeply affordable and small-unit development.	Housing authorities and affordable housing developers	Oregon Housing and Community Services. City and county governments.	Multi-year

Milestones

- Code and zoning changes that allow small units are adopted.
- The one-time repair fund is operating.
- A review of permanent supportive housing outcomes is published.

Voices to bring in. Legislators. Neighborhood associations and the business community. Residents of manufactured home communities.

Priority 7. Behavioral Health, Health Care, and Higher-Needs Care

Goal. People with behavioral health, medical, and daily-living needs have care and placements that fit those needs.

What the Findings Show

Eighty-six percent of respondents have health insurance, and 43% used an emergency room in the past year because they could not get care elsewhere. Respondents described appointment availability, transportation, provider willingness, and the difficulty of attending scheduled care while homeless as the barriers. Half of providers named jail or prison release among the circumstances clients commonly share, and 4% hold a formal criminal legal agreement.

Participants at the sensemaking session described people whose needs exceed what shelters can serve. Low-barrier shelters still exit people when behavior escalates. People discharged from hospitals who cannot manage activities of daily living fall outside what shelters can serve. Seventeen of the needs participants recorded during the session concerned behavioral health, health care, and higher-needs care, from stabilization beds and medical respite to Oregon Health Plan enrollment and longer-term support for people with serious mental illness.

Strategies

7.1 Build behavioral health support across the age span. Serve children in family shelters, parents, adults, and older adults.

7.2 Add behavioral health stabilization and emergency beds. Serve people whose needs exceed what shelters can manage.

7.3 Create specialized care beds and medical respite. Fill the space between regular shelter and permanent supportive housing or assisted living, for people who need help with activities of daily living and for medically fragile older adults.

7.4 Build institutional discharge partnerships. Pursue data sharing and warm-handoff agreements with jails, hospitals, treatment facilities, and child welfare, so people are not discharged to shelters that cannot serve them.

7.5 Close the gap between health coverage and care. Fund delivery models that fit the population the coverage already pays for. These include street medicine and mobile clinics, co-located primary and behavioral health care at day centers and shelters, and a hospital partnership pairing the discharge agreements with emergency-room-based housing navigation. Help people enroll in and keep Oregon Health Plan coverage.

7.6 Sustain urgent medical and mental health response. Fund REACH for the long term and expand it to seven days a week and to Polk County.

7.7 Provide housing with ongoing support for people with serious mental illness. Include people with severe and persistent mental illness, and offer ongoing substance use support so people can stabilize.

Action Plan

Table 43. Action plan for Priority 7, behavioral health, health care, and higher-needs care

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Convene behavioral health, hospital, and shelter partners to map where people go after shelter exits and hospital discharges, and where those paths break.	Marion County and Polk County behavioral health	Hospital systems. Shelter providers. Northwest Senior and Disability Services. Developmental disability services.	First half of 2027
Estimate the need for stabilization, specialized care, and medical respite beds.	Marion County and Polk County behavioral health	Hospital systems. Oregon Health Authority.	During 2027
Draft discharge and warm-handoff agreements.	Hospital systems and Mid-Willamette Valley Homeless Alliance	Jails. Treatment facilities. Child welfare.	During 2027
Identify funding for REACH expansion and long-term operations.	REACH and its funders	Polk County. City and county governments.	During 2027
Offer Oregon Health Plan enrollment support at shelters and day centers.	Oregon Health Authority and the regional coordinated care organization	Shelters. Day centers.	During 2027

Milestones

- Discharge and warm-handoff agreements are signed with hospitals and other institutions.
- REACH operates seven days a week and serves Polk County.
- Enrollment support is available at shelters and day centers.

Voices to bring in. Health care, behavioral health, and recovery services. Families caring for relatives with chronic mental illness.

Priority 8. Youth and Families

Goal. Young people and families have shelter and support that fit them, close to their own communities.

What the Findings Show

Transitional capacity runs through 15 small programs, family walk-in capacity stood at five open units, and dedicated youth capacity is 20 beds.

Participants at the sensemaking session noted that the largest family shelter is in downtown Salem, which pulls children out of their school communities. They described family shelter that has no arrangement for teenage boys ages 14 to 16 or for fathers, and families whose children have high behavioral health or developmental needs. Young adults aging out of youth systems lack rental history and face background check barriers. One participant contrasted the system's focused work on veterans with no comparable focus on youth.

Strategies

8.1 Rebuild transitional and family walk-in capacity. Expand long-term shelter for families and long-term housing for youth in child welfare.

8.2 Establish at least one 24-hour access point for families in each county. Design it as a one-stop point of entry.

8.3 Plan youth services and family services as separate systems. Give each its own goals, outcomes, and infrastructure.

8.4 Keep young people and families in their communities. Add rural youth access points and a small emergency youth shelter in rural Marion County. Develop a rural family shelter model funded jointly by the county, schools, cities, and organizations.

8.5 Configure family shelter for all family types. Include teenage boys, fathers, two-parent families, and families whose children have high behavioral health or developmental needs.

8.6 Support young adults leaving youth systems. Expand independent living, add a day center for ages 18 to 24, and address rental history and background check barriers.

8.7 Expand services for survivors in families. Provide legal representation, childcare, and domestic violence services for youth abused by family members.

8.8 Pair early intervention with longer-term follow-up. Keep to the wraparound model.

Action Plan

Table 44. Action plan for Priority 8, youth and families

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Hold a stakeholder meeting on youth and family services, with data and education, and ask regional organizations to prioritize youth services.	MWVCAA and the Mid-Willamette Valley Homeless Alliance	Youth-serving organizations. Oregon Department of Human Services. McKinney-Vento staff.	By January 2027

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Raise awareness of existing family shelter.	Family shelter providers	Schools. Street outreach teams.	By January 2027
Build and maintain a current catalog of youth and family resources.	MWVCAA	Youth-serving organizations. 211info.	First half of 2027
Gather rural youth and family data and size rural shelter options.	MWVCAA	School districts and McKinney-Vento liaisons.	During 2027
Review how coordinated entry works for young people, as part of the coordinated entry repair in Priority 3.	Mid-Willamette Valley Homeless Alliance	Youth-serving organizations. Young people with lived experience.	During 2027

Milestones

- A 24-hour family access point operates in each county.
- Youth and family services have separate, adopted goals and outcomes.
- A rural youth and family shelter plan is funded.

Voices to bring in. Child welfare offices serving Marion County. Family and youth representation. Young people with lived experience of homelessness.

Theme D. Place, Culture, and Public Understanding

The three priorities under this theme address rural communities, culturally specific and Tribal engagement, and the public and political support the other priorities depend on.

Priority 9. Rural Communities

Goal. Rural residents can reach shelter and services in or near their own communities.

What the Findings Show

Participants at the sensemaking session described rural Marion County as underrepresented at all levels. They described an unwillingness to provide shelter across rural Marion County apart from Woodburn, and named the Santiam Canyon and south county. They said stigma keeps some people from identifying as homeless, such as people living in RVs without hookups, and that rural providers are often outside HMIS.

Groups named limited housing of all types, lack of services and shelter in most communities, transportation and geography, and intergenerational poverty as root causes. They named existing rural resources, including municipalities, schools, faith communities, hospitals, Tribal communities, emergency services, food banks, and day centers in Stayton and Woodburn.

Strategies

9.1 Fund rural service delivery as rural service delivery. Provide scheduled and publicized mobile services, local day space, laundry access, transportation, and warming criteria that open on the first cold night. Add a central basic needs hub in rural Marion County based on the Silverton model, after-hours services, mobile medical care, and transportation to medical care for older adults.

9.2 Collect town-by-town data and a service inventory. Lead it locally, with support, so each small community's needs are visible. Include rural providers outside HMIS.

9.3 Identify communities that can host full-service shelter. Plan for 24-hour access, basic needs, and supportive services, building on practices already working in rural communities.

9.4 Expand rural shelter and housing options. Add rural domestic violence shelter, rural permanent supportive housing, and rural prevention and longer-term rent support.

9.5 Increase rural Marion County representation. Include rural communities in planning and decision-making bodies.

9.6 Build rural community buy-in. Present the data to residents, city councilors, and county commissioners through town halls and stakeholder meetings.

Action Plan

Table 45. Action plan for Priority 9, rural communities

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Hold a rural stakeholder meeting that produces an action plan.	MWVCAA	Center for Hope and Safety. Polk County. Northwest Human Services. City governments.	By January 1, 2027
Present findings at rural town halls and to city councils and county commissions.	MWVCAA regional coordinator	Rural providers. City councilors and county commissioners.	First half of 2027
Begin locally led, town-by-town data collection and a service inventory.	MWVCAA regional coordinator	Rural providers. Cities. Schools.	During 2027
Design and fund local services in communities ready to host them.	Rural providers and city governments	Hospitals, MWVCAA, and the Mid-Willamette Valley Homeless Alliance as funders.	Multi-year

Milestones

- A town-by-town needs and service inventory is complete.
- Warming criteria open on the first cold night across rural communities.

- Rural Marion County has seats on regional planning bodies.

Voices to bring in. Rural Marion County communities. Tribal communities. The business community. People with lived experience of homelessness in rural areas.

Priority 10. Culturally Specific Services and Tribal Engagement

Goal. Incorporate culturally responsive practices in all aspects of service provision. Establish authentic partnerships, working alongside Tribal nations and culturally specific organizations.

What the Findings Show

Sixty-two percent of the workforce is unaware that Tribal nations are present in the region. Culturally specific providers already reach households other programs do not.

Participants at the sensemaking session asked for culturally safe spaces and services that meet cultures where they are rather than expecting people to reach out. They named Tribal representation from The Confederated Tribes of Grand Ronde and The Confederated Tribes of Siletz Indians, and culturally specific organizations, as missing from the session.

Strategies

10.1 Establish a Tribal engagement pathway and plan, training staff on Tribal history, practices, and respectful engagement and building on existing relationships. Approach Tribal partners with respect and awareness of their sovereignty. Develop the pathway with Tribal governments, through each nation's preferred channels.

10.2 Fund language access and cultural responsiveness as separate investments. Fund contracted interpretation to replace family-member interpretation, particularly in domestic violence and behavioral health settings. Invest in the culturally specific providers already reaching households other programs do not. Treat belonging as a distinct, measured outcome.

10.3 Work alongside culturally specific organizations, honoring their expertise and devoting resources reflective of authentic partnership. Create and support authentic collaborations with culturally specific organizations, ensuring timely notification of and open access to funding opportunities and trainings.

10.4 Create culturally safe spaces and outreach. Meet communities where they are rather than waiting for people to reach out.

10.5 Work collaboratively to identify service gaps and design effective solutions. Learn which communities the current system does not reach and why. Employ local community expertise, culturally responsive and best practices to design effective solutions.

Action Plan

Table 46. Action plan for Priority 10, culturally specific services and Tribal engagement

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Develop and implement training on Tribal history, practices, and respectful engagement for staff throughout the provider system.	Mid-Willamette Valley Homeless Alliance	Service providers throughout Marion and Polk counties; Tribal partners, as each nation chooses.	During 2027
Review language access and culturally responsive service availability across shelters and coordinated entry.	Mid-Willamette Valley Homeless Alliance	Shelter providers throughout Marion and Polk counties; Culturally specific organizations and providers.	During 2027
Culturally specific organizations identify the agencies and systems they want to meet with.	Culturally specific organizations	MWVCAA; service providers throughout Marion and Polk Counties	During 2027
Invite The Confederated Tribes of Grand Ronde and The Confederated Tribes of Siletz Indians to shape the Tribal engagement pathway.	MWVCAA	Mid-Willamette Valley Homeless Alliance.	During 2027

Milestones

- Training on Tribal history, practices, and respectful engagement has been selected and implemented at provider organizations throughout the region.
- Tribal engagement pathway and plan are developed.
- Contracted interpretation is in place throughout the system, especially in domestic violence and behavioral health settings.
- Belonging is measured as an outcome.

Voices to bring in. The Confederated Tribes of Grand Ronde; The Confederated Tribes of Siletz Indians; Chemawa Indian School; Culturally specific organizations.

Priority 11. Public Understanding, Community Buy-In, and Policy Advocacy

Goal. Residents, elected officials, and funders share an accurate picture of homelessness in the region and act on it.

What the Findings Show

Participants at the sensemaking session called for town halls and stakeholder meetings that present the data to residents, councilors, and commissioners, and noted the rural political climate. They called for targeted advocacy at the city, state, and federal levels, communications

that correct myths and humanize people, and ongoing data education for elected officials. A group working on health care named state policies that are barriers to actual needs.

The session closed with a request to bring the released reports into existing advisory and coalition spaces. Participants named legislators, the business community, and neighborhood associations as missing from the room.

Strategies

11.1 Share the findings widely. Bring the released report into existing advisory and coalition spaces, and present it at town halls and to city councils and county commissions.

11.2 Offer ongoing data education for elected officials at every level. Brief city councilors, county commissioners, and state legislators on the assessment's findings on a regular schedule, and update them as new count and service data become available, so decisions about funding and policy rest on current local information.

11.3 Develop public communications that correct common myths. Humanize people experiencing homelessness, including people with behavioral health disabilities.

11.4 Coordinate advocacy at the city, state, and federal levels. Focus on the mechanisms this assessment documented, including state policies participants described as barriers.

Action Plan

Table 47. Action plan for Priority 11, public understanding, community buy-in, and policy advocacy

Recommended Action	Suggested Lead	Suggested Partners	Rec. Timeframe
Present the released report in existing advisory and coalition spaces.	MWVCAA	Mid-Willamette Valley Homeless Alliance. Providers.	By January 2027
Prepare a short public summary and a briefing for elected officials.	MWVCAA	Mid-Willamette Valley Homeless Alliance.	First half of 2027
Agree on a shared advocacy agenda among providers before the next state legislative session.	Mid-Willamette Valley Homeless Alliance	Providers. Advocates. People with lived experience.	First half of 2027

Milestones

- Briefings reach city councils, county commissions, and state legislators in both counties.
- Providers adopt a shared advocacy agenda.

Voices to bring in. Legislators. The business community. Neighborhood associations. Police, law enforcement, and code enforcement.

14.3 Implementation Roadmap

The implementation roadmap lists all 53 actions in this plan and arranges them by when they could begin. The first seven actions fall between the release of this report and January 2027. Most are convenings. They include conversations on hygiene services and on housing access barriers, a roundtable of agency leaders, and stakeholder meetings on rural communities and on youth and families. This period also includes sharing the released report in existing advisory and coalition spaces.

The 11 actions in the first half of 2027 focus on mapping what already exists. Partners would inventory prevention, hygiene, and youth and family resources. They would also identify the shelters outside HMIS, compile local zoning barriers, and hold the first quarterly regional resource summit.

Most of the plan, 30 actions, occurs during 2027. These steps turn early conversations into shared tools and agreements, including prevention measures, data protocols, discharge agreements, and a coordinated entry audit. The final five actions are multi-year. They include new affordable housing development, changes to screening rules, and revised grant budget guidance, which take sustained effort beyond a single year.

Table 48. Implementation roadmap and actions by timeframe

Priority	Recommended Action	Suggested Lead	Rec. Timeframe
Now to January 2027			
2	Hold conversations among shelters and providers about funding needs and partnerships for hygiene services.	The ARCHES day center (MWVCAA)	By January 2027
3	Hold a roundtable of agency leaders on shared values, collective decision-making, and collaborative funding.	Mid-Willamette Valley Homeless Alliance and MWVCAA	By January 2027
4	Host a conversation on housing access barriers.	Community partners	Within 90 days (by December 29, 2026)
8	Hold a stakeholder meeting on youth and family services, with data and education, and ask regional organizations to prioritize youth services.	MWVCAA and the Mid-Willamette Valley Homeless Alliance	By January 2027
8	Raise awareness of existing family shelter.	Family shelter providers	By January 2027

Priority	Recommended Action	Suggested Lead	Rec. Timeframe
9	Hold a rural stakeholder meeting that produces an action plan.	MWVCAA	By January 1, 2027
11	Present the released report in existing advisory and coalition spaces.	MWVCAA	By January 2027
First half of 2027			
1	Map current prevention resources in both counties, with funders, eligibility, and points of access.	MWVCAA	First half of 2027
2	Inventory hygiene, storage, identification, and phone resources, with hours and locations.	MWVCAA	First half of 2027
3	Schedule and hold the first quarterly regional resource summit.	MWVCAA	First half of 2027
3	Scope the capacity and eligibility directory, starting with shelter beds.	Mid-Willamette Valley Homeless Alliance	First half of 2027
5	Identify the shelters outside HMIS and what each would need to participate.	Mid-Willamette Valley Homeless Alliance	First half of 2027
6	Compile local code and zoning provisions that limit small units, single-room occupancy, RV parks, and density.	City and county planning offices	First half of 2027
7	Convene behavioral health, hospital, and shelter partners to map where people go after shelter exits and hospital discharges, and where those paths break.	Marion County and Polk County behavioral health	First half of 2027
8	Build and maintain a current catalog of youth and family resources.	MWVCAA	First half of 2027
9	Present findings at rural town halls and to city councils and county commissions.	MWVCAA regional coordinator	First half of 2027
11	Prepare a short public summary and a briefing for elected officials.	MWVCAA	First half of 2027
11	Agree on a shared advocacy agenda among providers before the next state legislative session.	Mid-Willamette Valley Homeless Alliance	First half of 2027

Priority	Recommended Action	Suggested Lead	Rec. Timeframe
During 2027			
1	Convene prevention partners to discuss prevention options and how organizations can collaborate.	Northwest Human Services and MWVCAA	During 2027
1	Adopt a working definition of households at risk and shared prevention measures, including housing status after assistance ends.	Mid-Willamette Valley Homeless Alliance	During 2027
1	Identify funding sources and written rules for the flexible fund.	MWVCAA	During 2027
1	Launch or expand renter education classes.	Renter education providers	During 2027
2	Identify sites and funding for after-hours and mobile hygiene services, including in rural communities.	City and county governments	During 2027
2	Work with agencies that issue identification documents on fee waivers and replacement frequency.	MWVCAA	During 2027
2	Adopt text and email notification across programs, with longer response windows.	Mid-Willamette Valley Homeless Alliance	During 2027
3	Draft a scalable coordination framework with defined roles and decision-making authority.	City and county emergency management	During 2027
3	Begin the coordinated entry fidelity audit and pilot a client status channel.	Mid-Willamette Valley Homeless Alliance	During 2027
3	Draft interagency coordination protocols and memoranda of understanding.	Mid-Willamette Valley Homeless Alliance	During 2027
4	Review program rules across shelter and housing programs and publish the results.	Mid-Willamette Valley Homeless Alliance	During 2027
4	Design the confidential domestic violence referral pathway into Coordinated Entry.	Domestic violence service providers and Mid-Willamette Valley Homeless Alliance	During 2027

Priority	Recommended Action	Suggested Lead	Rec. Timeframe
4	Develop landlord incentive options.	Housing authorities	During 2027
5	Build the capacity of governing bodies to create shared data protocols, including a universal release of information.	Mid-Willamette Valley Homeless Alliance board and committees	During 2027
5	Hold in-person meetings for data administrators and line staff to share practices that do and do not work.	Agency data administrators	During 2027
5	Agree on shared outcome measures, including breakdowns by race and other factors and recorded refusal reasons.	Mid-Willamette Valley Homeless Alliance	During 2027
6	Identify mobile home and manufactured housing communities at risk of closure or rising space rents.	MWVCAA	During 2027
6	Scope a one-time repair fund with existing home repair and weatherization programs.	MWVCAA	During 2027
6	Review rapid rehousing and permanent supportive housing outcomes, including returns to homelessness.	Mid-Willamette Valley Homeless Alliance	During 2027
7	Estimate the need for stabilization, specialized care, and medical respite beds.	Marion County and Polk County behavioral health	During 2027
7	Draft discharge and warm-handoff agreements.	Hospital systems and Mid-Willamette Valley Homeless Alliance	During 2027
7	Identify funding for REACH expansion and long-term operations.	REACH and its funders	During 2027
7	Offer Oregon Health Plan enrollment support at shelters and day centers.	Oregon Health Authority and the regional coordinated care organization	During 2027
8	Gather rural youth and family data and size rural shelter options.	MWVCAA	During 2027

Priority	Recommended Action	Suggested Lead	Rec. Timeframe
8	Review how coordinated entry works for young people, as part of the coordinated entry repair in Priority 3.	Mid-Willamette Valley Homeless Alliance	During 2027
9	Begin locally led, town-by-town data collection and a service inventory.	MWVCAA regional coordinator	During 2027
10	Develop and implement training on Tribal history, practices, and respectful engagement for staff throughout the provider system.	Mid-Willamette Valley Homeless Alliance	During 2027
10	Review language access and culturally responsive service availability across shelters and coordinated entry.	Mid-Willamette Valley Homeless Alliance	During 2027
10	Culturally specific organizations identify the agencies and systems they want to meet with.	Culturally specific organizations	During 2027
10	Invite The Confederated Tribes of Grand Ronde and The Confederated Tribes of Siletz Indians to shape the Tribal engagement pathway.	MWVCAA	During 2027
Multi-year			
2	Collect feedback from people who use these services to track whether access grows.	Shelters and day centers	Multi-year
4	Pursue ban-the-box and credit screening changes for rental applications.	Advocates	Multi-year
5	Revise grant budget guidance to cover staffing, supervision, wellness, and peer positions.	Funders	Multi-year
6	Pursue new deeply affordable and small-unit development.	Housing authorities and affordable housing developers	Multi-year
9	Design and fund local services in communities ready to host them.	Rural providers and city governments	Multi-year

14.4 What Community Members Told Us to Do First

Listening session participants were asked to name one change that would make a difference. Their answers, listed here in order of frequency, describe basic infrastructure more often than programs or services.

- **Public restrooms that are clean and open after 10 p.m.** *"Public restrooms that are clean and decent for you guys to use, and not have a lock on them." "I would like them to put more bathrooms in that are open late, because after 10 o'clock there's no restroom."*
- **Showers.** Participants described improvising through friends, a funeral home, or the river.
- **Laundry.** *"There is no laundromat in this town. Where are we supposed to do laundry?"*
- **Drinking water.** *"There's nowhere to get water. I have to go find a faucet."*
- **Trash disposal.** *"There's not enough trash bins anywhere. I walk for blocks sometimes just to throw something away."* Participants noted that bins are removed after housed residents dump furniture in them.
- **Lockers and storage.** Participants described being unable to attend court, appointments, or interviews while carrying everything they own, and unable to leave belongings anywhere without losing them.
- **Safe, legal places to park or camp.**

Beyond the infrastructure requests, participants asked for three changes to how the system works. They asked for replacement identification and documents to be free and available as often as needed, since documents are lost to sweeps, theft, and weather more than once a year. They asked for the chance to explain a decades-old conviction to a person rather than be screened out by a form. They asked for rent that matches income or income that matches rent. And in every session, in different words, they asked to be treated as a person by clinicians, police, landlords, employers, and front-desk staff.

Table 49. What participants asked for, by listening session

Session	What participants asked for
Session 1, Salem	• Bus passes for people with no income • A laundry assistance program • Cleaner and more frequently serviced public restrooms • Faster unemployment and benefit decisions • Lockers • Help for young people facing barriers
Session 2, Salem	• 24-hour clean public restrooms • Safe legal parking with a shorter application • Lockers and storage • A self-governed pilot community on public land • Places that allow pets and partners • Advocacy and guidance to navigate Section 8 vouchers • Investigation of where funding goes • To be treated "like a human, like any other human"

Session	What participants asked for
Session 3, Salem (youth)	• Free or far cheaper replacement ID, birth certificate, and Social Security card, with no voucher cap • Free or affordable health care • Affordable apartments • Better and safer shelters • Diapers, formula, and period products • Easier access to housing for people with criminal records • Someone trusted to talk to • Better mental health support
Session 4, Monmouth	• Lower rents and more affordable housing • Use of on-site shelter vehicles for resident appointments • Reliable laundry • Better counselors and therapists locally • Use of empty buildings for housing • A community workshop or garage where people can build • An end to judgment and stereotyping • A cleaner river
Session 5, Stayton	• More bathrooms open late • Drinking water • Day work available in short shifts • A legal camping area with a kitchen, bathrooms, and a small nightly fee, self-monitored by residents • Parking permits • An online wish list so the community can donate directly • Ban-the-box on rental applications • Know-your-rights training • Mental health resources • Changes to bottle and can redemption limits
Session 6, Providers (virtual)	• Rental assistance and homelessness prevention funding • Affordable housing for low and fixed incomes • Services for families, particularly single fathers • Animal care resources • Paid self-care time built into staff hours • A quarterly regional resource summit • A shared communication platform that is not HMIS • Live shelter bed availability
Session 7, Falls City	• More affordable housing • A laundromat • A grocery store • Local job opportunities • Electronic rather than mail-only housing paperwork • Reliable mail delivery

Session	What participants asked for
	• SNAP that does not cut off at the first raise
Session 8, Silverton	• Remove or limit background checks for jobs and apartments • Shorter housing voucher waits • Lower rents • Reduce overall cost of living • Disability-accessible service navigation • Qualified ASL interpreters • Affordable cars, bikes, and e-bikes • Help replacing vital documents • Credit history protection during homelessness • Hygiene items covered by SNAP • Job training for entry-level roles • More shelters like this one • Trauma-informed schools, clinics, and police

Note. Requests as recorded in each session's transcript and written packets. Items within each session are listed as raised, not by frequency.

> *"Stop counting us like sheep, and then turn around and go, oh, we've got these many people, we need money, and then take that same money and put it somewhere else."*
>
> Community Member Listening Session, Salem
>
> *"What I need? I need for someone to believe in me."*
>
> Community Member Listening Session, Silverton

15. Conclusion

This community needs assessment set out to describe homelessness in Marion and Polk Counties. Most people experiencing homelessness in the region had lived there for years before losing their housing. Forty-two percent of survey respondents grew up in the area or had lived there more than ten years. For most, the current episode is not their first, and prior episodes recurred or ran long. Housing loss most often followed several events at once, arriving on incomes the regional housing market does not support.

The regional sheltering system holds 44 programs, a workforce drawn substantially from lived experience, peer support capacity in three-quarters of organizations, and near-universal health coverage among the people it serves. The same system's counted capacity exceeds its usable capacity, its rules exclude identifiable groups, its information does not reach the people seeking help or the workers providing it, and the harms it produces fall most heavily on the people exposed to it longest.

Most people who are now homeless received no prevention support before losing housing, and the households now at risk cite that support as what they need. Not knowing what exists is a barrier comparable in scale to the shortage of what exists. The supports people credited most often were relationships with specific people, and the harms they named most often were program rules. The system lacks an unduplicated count, a shared wait-time definition, outcome analysis by race, and any channel through which a waitlisted household can learn where it stands.

The last words are from some of the participants who insights informed this report. When asked what life looks like a year from now if everything works out, participants said the following:

> *"I want to restore my family. I'm working with DHS to get my kids. And I want to give back to those that are in my position."*
>
> Community Member Listening Session, Silverton
>
> *"I'm gonna start taking the business courses for hotel management... The reason I'm taking this is I want to build an RV park... and I want to build myself a campground, and I want to build a homeless shelter to help other people."*
>
> Community Member Listening Session, Woodburn
>
> *"Coming home from work to my kids, my wife."*
>
> Community Member Listening Session, Salem
>
> *"Working, in a house, and a big ol' dog."*
>
> Community Member Listening Session, Salem

> *"This issue is solvable. It's realistic to help people. It's realistic that people can get affordable housing and stay housed. It just needs to be made possible for us to do our jobs."*
>
> Service Provider Listening Session