Inclusion & Exclusion Criteria

**Shelters save lives.** At a fundamental level, emergency shelters exist to provide “**harm reduction**” in that they reduce the harms associated with sleeping outside, staying with strangers, or remaining in an unsafe home. These harms may be environmental (extreme heat, cold weather, rain or wet conditions, staying in places not fit for human habitation) or interpersonal (attacks, sexual assaults, exploitation).[[1]](#footnote-1) Given the role that shelters can play in meeting basic needs and protecting people from serious harms, The Salvation Army is committed to ensuring that our shelters are as accessible and welcoming as possible.

Emergency shelters serve people who are deeply dependent on alcohol or drugs, people who are struggling to maintain their sobriety, and people who may drink or take drugs occasionally but are not addicted. At the same time, shelters must also manage their own risks and liabilities. Balancing these various needs is not easy and there is no perfect solution. The Salvation Army works to maximize access to shelter while maintaining a safe environment. Emergency shelter **intake and discharge criteria are** **based on people’s behaviours**:

* In communities where there are few emergency shelter options available, The Salvation Army places as few limits as possible on client behaviours to ensure that anyone who needs shelter has access. In these cases, people may be turned away or discharged from emergency shelter only if they pose a health or safety risk to themselves or to others.
* In communities where people have access to no-barrier or low-barrier emergency shelters, The Salvation Army may set higher expectations for client behaviours. In these cases, people may be turned away or discharged from shelter for actively disturbing others and not responding to staff interventions. However, in cold, rainy, or extreme heat weather conditions, restrictions on access to shelter are lowered as needed to encourage people to come inside and reduce their risk of injury, illness, or death.
* In all cases, restrictions on admission are based on behavioral standards, and not on absolute sobriety. When applying the rules, Salvation Army staff (in their own words) “err on the side of compassion,” “think in the grey” (as opposed to black and white), “put relationships over rules,” and “listen with ears of learning, not ears of judgment.”[[2]](#footnote-2)
* Where possible, staff ensure that clients who are discharged or turned away have a bed at another shelter or another place to stay.

If a client is worried that admitting to using substances will lead to discharge from emergency shelter, the client is likely to hide and lie about substance use to staff. This reduces staff opportunities to provide meaningful supports. Using a person-centred, harm reduction–based, non-judgmental approach has been established as a key best practice for developing the kind of honest, trusting relationship with clients that can lead to positive life change.[[3]](#footnote-3)

Salvation Army shelters should be clear and upfront about their inclusion and exclusion criteria, as well as their expectations for client behaviour. Rather than a culture of authoritarianism and rules, we prefer that a set of mutual rights and responsibilities be agreed to by both the client and the shelter, upon admission.

⇨Please see the Sample Emergency Shelter Occupancy Handbook attached, especially for a sample Rights and Responsibilities statement and the Behaviour-Based Follow-Up Table which outlines how dangerous client behaviours will be addressed, up to and including discharge from the program.

1. (Austen & Pauly, 2012; Baggett et al., 2013; BC Coroners Service, 2014; Davidson et al., 2014; Davis et al., 2012; Golden et al., 1999; Goodman, Fels, & Glenn, 2006; Holton, Gogosis, & Hwang, 2010; James Pratt Consulting, 2009; Paradis, Novac, Sarty, & Migrant, 2009; B. M. Pauly, 2005; Bernie Pauly et al., 2013; Sam Tsemberis, Gulcur, & Nakae, 2004; Tutty, Weaver, & Rothery, 1999; USICH, 2010; YWCA Canada, 2014) [↑](#footnote-ref-1)
2. (Homelessness Task Team & Kooistra, 2014b) [↑](#footnote-ref-2)
3. (Baker Collins, 2013; Davis et al., 2012; Elliott et al., 2005; Gates et al., 2013; Goering et al., 2014; Goodman et al., 2006; Guarino, Soares, Konnath, Clervil, & Bassuk, n.d.; Hopper et al., 2010; Hwang, Stergiopoulos, O’Campo, & Gozdzik, 2012; Hwang et al., 2005; Jennings, 2008; Mental Health Commission of Canada, 2014a; Najavits & Hien, 2013; National Alliance to End Homelessness, 2012). [↑](#footnote-ref-3)