The 24 Hour Drop-In at Sistering: Women’s Oral Histories

A Community-Based Research Project supported by Sistering – A Woman’s Place & The University of Waterloo Department of English Language and Literature

Funded by a Women’s College Hospital XChange Grant & the Harding/Claxton HSS Endowment Fund at the University of Waterloo

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2020
In participants’ own words...

“Being homeless is a lot more complicated than people think. It’s not just being homeless, being houseless...A lot of the times, I find myself sleeping outside because of people I don’t want to be around, or just wanting to be around just myself in general.”

“I could say this is the first time I’ve not been miserable in a long time...I’m happy here.”

“You look at people and you look them in the eye and you see that they have had experiences in their life that I have had similar to, so, I can...we can relate without words and...it’s a good thing, you know?”

“I stick mainly to Sistering ‘cause I know it so well...Probably, mainly to do with comfortableness...the lifestyle that I live, I’m not really open to new experiences and wanting to experience new things because I’m so insecure about my addiction that I stay to one place where I’m already accepted, and I don’t have to start all over again.”

“Normally, I come to Sistering, and I feel upbeat. I’m in a safe haven. I have a place, not a haven, but a safe place. Sometimes when there are bad days at Sistering, I don’t know if it’s a bad mix or a bad sauce, there are days like this where I’m just like...I have no option. I have no option.”

“I don’t use other shelters. I sleep in my car... sometimes it can get too loud in here, and I suffer from anxiety, severe anxiety. So the noise is a trigger, so I have to leave.”
Acknowledgements

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We are also grateful for the support given to our project by Sistering managers and staff, and for their assistance in building a community-based research team; facilitating two years of meetings, a focus group, and interviews on-site at Sistering; administering peer research payments and catering; and disseminating the research results amongst the participant community at Sistering.

We reserve a special warm thank you to the participants at Sistering who shared their stories and insights with us.
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Executive Summary

Background

The 24 hour drop-in at Sistering began as a pilot project (2015-16) funded by the City of Toronto responding to a need for low-barrier, harm-reduction, trauma-informed overnight services for cisgender women and trans people who do not access shelters. The Feasibility report that led to the pilot project noted the current shelter model regarding curfew, sleeping hours, and intake does not meet the needs of some cisgender women and trans people, leaving them without safe overnight space.¹

Our research question was, “How do participants at Sistering experience the 24 hour drop-in?”² We hoped to learn what participants obtain from Sistering’s 24 hour drop-in that they are not finding elsewhere, and how the drop-in fits into the broader scope of their health, well-being, and quality of life. While conducting this study we also hoped to develop a common language for low barrier service. We hope that a richer perspective on participants’ understanding of the role low barrier service plays in their choices, safety, and well-being, may help policy makers and funders determine where to direct resources to meet this population’s needs.

Team

This was a community-based research (CBR) project. It was important that members of the community who were interviewed and affected by the results also be represented on the research team, and be involved in project planning, conduct of the project, and data analysis. The research team included peer researchers from Sistering (Karen Shaw, Maggie M., J.P., and S.P.); Lindsay Windhager, MSW, former Harm Reduction Coordinator at Sistering; the primary investigator (PI) Dr. Heather Smyth, and two research students from the University of Waterloo, Ashley Irwin (Ph.D. candidate, Department of English Language and Literature) and Shama Saleh (Undergraduate student, Applied Health Sciences).

Methods

We collected primary research data from participants at Sistering through the qualitative research methodology of participant narrative using oral interviews and a focus group. We


² We have chosen to use the word “participants” rather than “clients,” as does Sistering, to designate individuals who use Sistering’s services. This choice of terms reflects Sistering’s view that participants actively participate in many aspects of the agency and its policies, for instance holding Board of Directors memberships, working for pay, and acting as peer mentors. Because “participant” can also mean “research subject,” we try to use the terms “interviewee,” “focus group member,” and “respondent” to indicate research participants.
The 24 Hour Drop-In at Sistering

held a focus group (n=12) in June 2018 and held 43 one-on-one interviews from August to September 2018. Each participant was interviewed by one peer researcher.

Findings

Several broad themes emerged from this project:

1) **Mutual Support:** We learned that the support system at Sistering is grounded in the fact that the participants are at various stages of their journey. Long-term participants, participants who have been in the harm reduction group for some time, or those who have become peer support workers will mentor or look out for other participants who are living through experiences they once had. Healing journeys are not always linear, so participants who reroute to a previous stage of their journey can be supported by friends. There are conflicts, but also durable friendships. Most participants referenced friendship and companionship as a reason to visit Sistering.

Sistering also fosters a common language of mutual care and community. Cis women and trans people at Sistering form support groups that include information-sharing and education—both practical education on safety and harm reduction, and emotional/cognitive education about unlearning stigma and shame. Participants also build community through advocacy and activism work addressing systemic issues such as housing and transit justice, safe supply and use of substances, gendered violence, oppression of undocumented persons, Missing and Murdered Indigenous Women and Girls (MMIWG), etc.

2) **Language for low barrier:** Sistering describes low barrier as ‘meeting people where they’re at.’ Many interviewees reported that these measures are important or very important to them because of substance use, sex work, mental health, and daily routines. When we compared participants’ stories and looked at their descriptions of low barrier service impact in context, we saw that low barrier service measures such as anonymity, no curfew, acceptance of harm reduction approaches to substance use, and non-judgmental treatment of substance consumers may lead participants to feel more comfortable attending the agency and picking up harm reduction supplies, for self or others, which may contribute to better health outcomes and healthier choices.

Participants used words like “accessible,” “freedom,” “autonomy,” “independence,” and “dignity” to describe why it was important for them to be able to come and go at any hour from the drop-in. In context, the word “freedom,” for example, was practical but also indicated the opportunity to make choices, including choices that bring dignity. “Freedom of movement” helped mitigate the trauma and stress of homelessness, where curfews and open/closing hours can amplify the stress of moving possessions and planning safe places to be during day/nighttime. “Dignity” was a critical part of many participants’ healing.

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3 For an example, see Relich, S. (2017, 10 January) ‘Meeting Them Where They Are’: At Sistering, harm reduction means providing more than a space to sleep and the tools to use drugs safely. The Local. https://thelocal.to/sistering-meeting-them-where-they-are-5f5acffe0ad6/ [Accessed 17 October 2019]
3) **Scarcity of options**: A common feature of many interviews was that Sistering is the only option in Toronto for many cisgender women and trans people. Many participants specifically reported that “Sistering is my only option” or “there is no place else for me to go.” When asked what they do when there is too much conflict at the drop-in, or if they are asked to leave, participants said that they would go outside and/or sleep outdoors, and did not have another agency to go to given their circumstances (especially if their respite from Sistering was due to substance use, behaviour, or mental health issues).

Some research team members were part of the advocacy coalitions in 2013-14 that called for new 24/7 low barrier drop-ins for cisgender women and trans people (the activism that led to Sistering becoming a 24/7 drop-in), and noted that the 24/7 drop-in was a response specifically to address the needs of these participants who were at risk of finding no agency or shelter that could accommodate their low barrier needs and mental health complexities.

Our study also revealed the structural context for the scarcity of safe options for individuals in Toronto sharing Sistering’s population demographic. The rising number of overdoses, the need for a safe supply and safe injection sites, increasing homelessness and scarcity of affordable or indexed housing, are overwhelming Toronto’s existing services. Not only are there too few, or no, options in low barrier services, there are often no shelter, housing, or drop-in options at all for too many people in Toronto.

4) **Conflict in low barrier needs**: We learned that the population of cisgender women and trans people at Sistering includes participants at many different stages in their journey, who have a range of housing/shelter needs, relationships with substances, mental health challenges, and resolutions of trauma. Comparing stories, we saw that some conflict at the drop-in is attributable to conflicts in participants’ service needs, where some participants required very low barrier service (see above, as there are no other options available for them), and other participants wanted higher barrier service for their own needs or physical/mental safety.

Many participants reported feeling safe and supported at Sistering. Of the participants who answered “no” to the question “Do you feel safe and supported here? Why or why not?” they gave reasons such as violence in the drop-in, theft, preferential treatment, and client service. It also appeared that some participants’ need for low barrier service—for instance, the possibility of staying inside Sistering overnight while having a mental health crisis—created a barrier for other participants, who were triggered or felt unsafe while in proximity to other participants’ crises or behaviour and in a densely populated space.

We especially noted how often participants answered questions with the needs of both themselves and others in mind. For instance, many participants answered questions about low barrier and harm reduction service by affirming that these services were very important to them and also to the whole community. Some even answered that low barrier options were no longer important to them, but they knew they were important to other participants. In combination with the frequency of participants referring to friendship and companionship, there appears to be a durable and often health-promoting network of relationships at Sistering tied to low barrier service delivery and harm reduction models.
We recommend more study of the intersection of these factors in our study:

1) Sistering as the “only option” for some participants
2) Conflict in low barrier needs
3) Space capacity and crowding

When we compared participants’ stories about those three areas, and looked at their answers in context, it became clear that the three factors are in conflict without a simple solution in the present circumstances. When the drop-in is over capacity, participants are compressed together and conflicts are amplified. Participants may conflict over low barrier needs: one participant may need quiet and feel protective of her possessions, and another participant may be experiencing a mental health crisis and may be agitated and physical. Both need the low barrier space, but one participant’s behaviour may trigger a crisis for the other participant. A participant experiencing trauma and having high needs has nowhere else to go.

It is clear that low barrier and harm reduction policies play an important role in marginalized cis women’s and trans peoples’ health. As we demonstrate in this report, for example, participants’ needs for harm reduction and low barrier service seem to correspond with their feeling safe and supported at Sistering: of the 20 interviewees who said it was “very important” that they could pick up harm reduction supplies, 90% (n=18) said it was also very important that they could come and go at any time of day, and 80% (n=16) reported feeling safe and supported at Sistering. On the other hand, of the 17% (n=6) of interviewees who said they do not feel safe and supported at Sistering, only 17% (n=1) said harm reduction supplies and anonymity were very important, and 67% (n=4) said it was important they could come and go at any time of day. **This cross-referencing of the data suggests that participants’ feelings of being safe and supported at Sistering may correspond to their experiences of, and need for, low barrier and harm reduction policies that do not stigmatize.** We might also conclude that participants who do not feel safe and supported at Sistering are not necessarily those most in need of harm reduction supplies and anonymity, though their need to feel safe and supported at the drop-in must also be addressed.

The team recommends that one solution would be the creation of more low-barrier drop-ins and shelters for cisgender women and trans people, some with particular emphasis on high-need participants and/or those with complex mental health needs and with day and overnight staffing by trained mental health support staff. The overcrowding at Sistering, the high need of Sistering participants for those low barrier services, and the scarcity of other options, makes it urgent that more low barrier drop-ins and shelters be created.

In fact, this study illuminates in general the state of homelessness in Toronto, the lack of affordable housing, subsidized or rent-geared-to-income housing (RGI), supportive housing, and shelter space. It is also clear that this sector needs a range of options and supports to meet the needs of different individuals, including safe/supervised injection sites and harm reduction-focused shelters and drop-ins.
We also recommend further research on specific needs of transgender persons within the shelter and drop-in system in Toronto. Our study recruited two participants to interview who identified as transgender, which was 5% of our interviewees and is higher or comparable to Sistering’s 1% transgender population overall (Ghomeshi, p. 15). We did learn about trans-specific concerns from our interviewees, and believe that a future study with more focused recruitment of trans people across Toronto’s shelter and drop-in system would yield valuable insights about the experiences and needs of this population, especially given the largely binary gender division of shelters and drop-ins and the particular marginalization of trans people within the homeless population (see Mottet & Ohle, 2003; Sakamoto et al., 2010).

Introduction

Background

Sistering is a multiservice agency for marginalized and homeless cisgender women and trans people located on Bloor Street West in Toronto. It has been operating since 1981, but added a 24/7 drop-in program in 2015. This change was a response to events in 2013, when a woman was sexually assaulted twice in one night on the steps of a social service agency at the corner of Dundas and Sherbourne.4 Activists in the shelter and harm reduction community lobbied Toronto City Council to create two 24 hour drop-ins for cis women and trans people whose needs were not met by the existing shelter system, including sex workers, those who use substances, and those with complex mental health issues—groups that may feel stigmatized in the shelter system or who need to come and go from overnight shelters. Sistering and Fred Victor (located in the Adelaide Resource Centre for Women) were chosen for the one year City of Toronto pilot project.

The participants who use Sistering’s services include cis women and trans people who are homeless or precariously housed, socially isolated, and marginalized. For this population, as noted in a 2006 study of women’s homelessness in Toronto, “poverty, housing and social exclusion are primary determinants of health. Homeless women have a higher rate of emergency and chronic health impacts due to living circumstances, poverty and lack of access to preventative services” (Ontario Prevention Clearinghouse et al., p. 5). Sistering is guided by feminist, anti-oppression, and diversity policies, by harm reduction approaches to health and well-being, and by low barrier practices for service delivery. Harm reduction approaches to health “meet people where they’re at”: the focus is on attending to the social determinants of health, including economic and social factors, and reducing the harms associated with substance use, its criminalization, and related factors such as sex work or relationship violence. Harm reduction approaches acknowledge both the benefits

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and risks of substance use and view individuals as active agents. A low barrier drop-in has as few barriers or requirements as possible so that more participants can access services or use the space. Low barrier models might include anonymity, few or no curfew rules, and accommodations about substance use that are built on harm reduction principles.

**Methodology**

“The 24 Hour Drop-In at Sistering: Women’s Oral Histories” is a community-based research project that focuses on the first-person accounts of participants to learn what experiences brought them to Sistering in the first place, and what experiences they had while using the 24 hour drop-in. We hoped to learn in participants’ own words what low barrier 24 hour drop-ins offer them for support, and what ideas they have for improvement within the shelter and drop-in system in Toronto.

Our research question is, “How do Sistering participants experience the 24 hour drop-in?”

We used a focus group and qualitative, semi-structured interviews with open-ended questions to obtain participant narratives. Each participant was interviewed by a peer researcher one-on-one, which permitted trust and affinity and helped interviewees feel comfortable speaking with someone from within their community. We hypothesized that this methodology would permit us to situate participants’ responses and word choices within the rich contexts of their own narratives, and that by comparing these narratives we would begin generating theories and analyses about both common and unique experiences within this population. Our analysis of the qualitative information gained from interviews drew from Grounded Theory and was also informed by research on homelessness and trauma, harm reduction, and feminist intersectionality theory.

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5 Raffi Balian of the Toronto Harm Reduction Alliance writes, “For people using illegal drugs, criminalization creates a whole new dimension – the coping mechanism itself becomes problematic because it’s also a constant source of stress. Poverty, violence, corruption, discrimination and social isolation become probabilities especially when the people using these coping mechanisms come from historically marginalized communities. For these reasons, problems with coping should be called socially constructed stigma (SCS) or coping disruptions rather than addiction. ... The best way to deal with coping disruptions is through human rights, social justice and health promotion schemes. Human rights and social justice create the environment where coping doesn’t become a major issue for the entire population.” See Balian, “Our interpretation of harm reduction.”

6 Our research question initially was “How do participant women and staff at Sistering experience the 24 hour drop-in?” The team decided to refocus the study on participants’ experiences. The research question was edited to reflect Sistering’s updated statement on its inclusive approach to gender. In this report we use they/them as a default gender-neutral singular pronoun.

7 “Grounded theory is an inductive qualitative method that begins with observations and looks for patterns, themes, or common categories...it can also incorporate deductive processes...through the use of constant comparisons” (Rubin & Babbie, p. 244). Grounded theory also situates observations “in a wider environmental context” (p. 245).
Research Team

As a community-based research (CBR) project, from the beginning this project included a research team made up of peer researchers from Sistering who brought interview skills, knowledge, trust within the community, and life experience that shaped the format for interviews, the questions asked, and the interpretation of what we learned. The peer researchers included Maggie M., J.P, S.P., and Karen Shaw, participants at Sistering who also work as peers. In the initial stages of the team collaboration A.H. and J.G. also took part. Lindsay Windhager, MSW, former Harm Reduction Coordinator at Sistering, brought practitioner experience from within the social service, harm reduction, and drop-in sectors. University of Waterloo partners included Principal Investigator Dr. Heather Smyth from the Department of English Language and Literature and research assistants Ashley Irwin (English) and Shama Saleh (Applied Health Sciences).

The team collaborated together on interview format and interview questions and applied for Ethics clearance. The peer researchers determined that the most appropriate interview format was one-on-one peer/participant interviews rather than videotaped interviews involving several research team members, which was the initial tentative plan. The research team underwent Community-Based Research training and interview training, facilitated by Windhager.

The team also decided to add gift bags to the participant compensation of $30 and two TTC tokens, and peer researchers determined that the bags should include comfort objects (stuffed toy, hand cream, chocolate), a Tim Hortons gift card, and a pen and notebook (see Appendix C). Two peer researchers conducted an art session where they decorated the notebook covers with affirmative messages. One rationale for the inclusion of the notebooks and comfort objects was the team’s wish to make a positive contribution to the interviewees during the interview process. The peer researchers felt that the comfort objects, affirmative messages, and opportunity to write reflections would help mitigate potential re-traumatization during interviews and extend care and dignity to their fellow participants. This gesture is another example of the environment of mutual care and whole-person approach to health and harm reduction that distinguishes Sistering’s community, and is consistent with the CBR focus on building capacity.

Process

The research team held a focus group of 12 participants in June 2018 and conducted 43 one-on-one interviews from August to September 2018. All interviews and the focus group were conducted in English. Three one-on-one interviews had audio recording problems and two interviewees withdrew consent, resulting in 38 full interviews. We used the focus group to test our interview questions then added demographic questions when we held the interviews. The interview questions appear in Appendix A at the end of this report.

It is worth noting that as much as possible, our research processes were guided by the same low barrier approaches that guide Sistering. Anonymity is clearly a matter of safety to many participants: the two interviewees who withdrew consent did not feel comfortable or...
safe with the process. Interviews were conducted by peers who were known to the interviewees. After an initial plan to hold interviews in a nearby coffee shop or outdoors, we determined that Sistering was safer for both interviewee and interviewer. And to make the process accessible we tried to schedule interviews for when participants were ready and in a mental/emotional state they were comfortable with, which sometimes took several attempts and needed to be done at a moment’s notice.

Interviews and focus group discussion were recorded on Zoom H1n audio recorders and transcribed by the two research students. Transcriptions were anonymized for names of interviewees, interviewers, staff and other participants, and for unique identifiers like city of origin, incidents, or pet names. They were then lightly edited and uploaded to NVivo qualitative data software.

The Principal Investigator reviewed the transcripts to create an initial concept map and then created coding nodes in NVivo to code the data. Codes were refined and rethought at each stage. Demographic data was separately coded. The research team met to discuss the findings and narrow down the themes and conclusions. We used an art project facilitated by Camille Winchester as part of our discussion and reflection process. This report documents some of our primary findings and analyses from our study. The report was drafted by Heather Smyth with suggestions and edits by Ashley Irwin, Shama Saleh, and Lindsay Windhager.

**Contexts and limitations**

**Missing data**: During some interviews, not all interview questions were asked. In some cases, the interviewer, knowing the interviewee, supplied the answer or skipped the question (e.g. an interviewer might say, “I know you don’t pick up harm reduction supplies, I won’t ask that question”). For the 8 interviews where the participant was not asked about gender identity, the omissions could potentially be substantive (see Figure 6). These omissions were not noted until the interviews were concluded, transcribed, and had begun to be analyzed in NVivo. Attention to this need for full and neutral relaying of the interview questions will be attended to in future research training.

**Confusion about questions**: Some interview questions appeared to be confusing for interviewer or interviewee. Demographic questions, particularly about racial and ethnic identity, sometimes led to requests for clarification during interviews. One set of questions about other agencies in Toronto could have been designed more clearly for the interview guide: it was sometimes difficult for interviewee/interviewer to tell if the questions pertained to Sistering or to other agencies. This ambiguity was attended to carefully during coding.

**Language**: The team was aware that Sistering offers to its participants written and oral translation of communication materials in French, Spanish, Portuguese, and simplified Chinese, but did not feel the team as constituted had the skills or resources to conduct interviews in languages other than English. This created a potential language limitation in
our participant recruitment. Some interviewees noted they spoke multiple languages or stated that English was not their first language (see Figures 2 & 3).

**Population:** Our study hoped to reach some of the most marginalized individuals in Sistering’s participant population. The factors that put these participants at risk also contributed to the difficulty of reaching them for interviews: homelessness, trauma, isolation, substance use, mental health complexities, difficulty with trust, and immediate-need priorities. The peer researchers worked hard to locate participants from our recruitment list, build on prior trust, and interview them at times that presented the least number of barriers to the participants’ inclusion in the study. During the interview period we decided to expand our number of interviewees from 20 to 40. In our effort to protect the anonymity of participants on our recruitment list, the team did not carry printed lists of names, and some participants were recruited for interviews who were not on our initial list or who did not fully meet the recruitment criteria. This may be a significant variable in our results. We sought interviewees who were most in need of low barrier and harm reduction services, for whom the 24/7 drop-in was advocated. Some interviewees’ preference for higher barriers and security measures may be attributed to this sideways shift in recruitment.

**Validation:** A participant needs assessment of programs and services at Sistering was conducted from May-July 2018, at approximately the same time as our group held the focus group and interviews (see *Sistering Participant Survey Findings* [SPSF]). MKG Consulting Services conducted 224 qualitative/quantitative surveys to gather information on participant demographics and experiences. Peers, staff, and caseworkers administered the surveys, which were also translated into simplified Chinese, Spanish, and Portuguese. MKG consultant principal Kimia Ghomeshi read a draft of our report and stated that our findings validated her survey findings.

MKG also reported that their demographic findings showed a change in the population of Sistering’s at-risk participants. Compared with a similar survey conducted in 2009, they note,

“a greater proportion of Sistering participants in 2018:
- Preferred to speak English (+28%)
- Were of White and Black ethno-racial groups (+5-10%), with proportions of Hispanic and East Asian populations declining
- Had Canadian citizenship (+16%)
- Self-identified as bi-sexual and lesbian (+12%)
- Were homeless or under-housed (+12%)
- Had experienced sexual violence (+6%)
- Had attained further education after primary school (+18%)
- Had mental/emotional challenges (+47%) and physical health challenges (+8%)
- Used recreational drugs, including alcohol, marijuana, crack, cocaine, opioids, sedatives, and crystal meth.” (Ghomeshi, pp. 4-5)
MKG’s demographic findings offer important context for the qualitative findings of our Oral History study of the 24 Hour Drop-In. Clearly the population of participants using Sistering’s programs and services has shifted since the agency transitioned to a 24/7 drop-in.

**Results**

**Population Analysis**

Our study conducted a focus group of 12 participants and 41 one-on-one interviews. The focus group participants were not asked demographic questions, but the interviewees were asked questions related to age, language, gender identity, sexual orientation, ethnic and racial identity, and citizenship status.

Figure 1 shows the age ranges of the participants we interviewed for the Oral History project.

*Figure 1: Age ranges of Oral History project interviewees*

![Age Ranges Pie Chart](image)

(Note: all Figures and Charts showing demographic information in this study use data obtained from interviews and analyzed using nVivo)

All interviews were conducted in English, and for the question, “what languages do you prefer to speak?” the first language named was coded: 94% of interview participants said “English” (n=34), 3% reported Ojibwe (n=1) and 3% reported Portuguese (n=1) (see Figure 2). Second and subsequent languages mentioned were also coded (see Figure 3).
When asked about their status in Canada, and reassured that their personal information would not be shared, 74% of interviewees said they were Canadian citizens (n=28), 16% (n=6) said they were permanent residents, 5% (n=2) said they were visitors to Canada, 3% preferred not to answer (n=1), and 5% were unassigned (n=2).
Figures 5 and 6 illustrate interviewees’ answers to the questions, “How would you describe your sexual orientation?” and “What is your gender?”

**Figure 5: Sexual orientation self-identified by interviewees**

![Sexual orientation of interviewees](chart)

**Figure 6: Gender identity self-identified by interviewees**

![Gender identity of Interviewees](chart)

As noted in “Contexts and Limitations,” 21% (n=8) of interviewees were not asked the demographic question about gender identity. This omission could be substantive.

**Participants’ general impressions of Sistering**

Our study revealed some common themes among participant experiences. When asked how they feel when they come to Sistering, respondents used words such as “welcoming,” “peace,” “support,” “safe,” “positive,” “freedom,” and “acceptance” to describe their feelings about Sistering and the things they like most about Sistering.
I feel happy, loved, welcomed. (I-41)

I need some kind of security, some kind of shelter, some kind of support... [At Sistering] I feel at peace. (I-17)

A lot of the times, I’m very nervous. I’m afraid to be around large crowds of people, and I’m scared that somebody might attack me, but when I get here, I feel very welcome and very loved by the women that are here, and it’s... it’s a very positive experience. (I-42)

I feel welcomed. I know that I have a place to be, that at least tonight I know that... I don’t have to worry about where I’m going to be for the night, overnight. (I-13)

Sometimes I’m very happy, it depends on what time... **chuckles** the reasons I’m coming here for. But I’m not coming here because I’m coming down off of drugs. Umm, I’m not so happy but I’m happy to have a place to come to. (I-14)

Gives me a place to go sometimes when I’m feeling isolated. (I-30)

Figure 7 uses the visualization of a word frequency query to show patterns of word choices made by participants in the interviews and focus group.

Figure 7: Word frequency in interviews and focus group

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Source: Data obtained from nVivo text frequency search of top 1000 words using transcripts from interviews and focus groups in "The 24 Hour Drop-In at Sistering: Women’s Oral Histories" research study.

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8 We use I-# to indicate quotations from anonymized Interview respondents and FG-# to indicate anonymized Focus Group members.
Some words, like “comfortable” and “supported,” appear in the questions we asked all focus group participants and interviewees, which may account for their predominance in this visualization. Other words, like “freedom,” “happy,” “friends,” “positive,” and “access,” arose from the participants’ answers.

The first questions we asked interviewees were open-ended, including “what do you like best about coming to Sistering?” Most of their answers reflected on Sistering as a place that shelters them and accepts them. Their answers often included terms like “we” and “everybody,” suggesting that participants are aware of their shared experiences with others and are thinking of Sistering participants as a group.

Seeing everybody alive and well ... because the people here are on the edge so much, whenever I see...as you know by recent deaths ...whenever I see people alive and well, it makes me happy, and I know that they’re well taken care of at Sistering in terms of meals and shelter, you know, even clothing, so that’s good. Like I told [participant name removed] today, stay here, you know? ...I’m glad she’s here. (I-41)

I just love the fact that they take in people, they take in animals, they feed the animals, they feed the people, and like I said they give a roof over their head. And everybody regardless ... is supposed to have a roof over their head. It may not be the best but it’s a roof, instead of being out on the street where you can get raped, mugged. (I-31)

[I like] coming to see friends, coming to see ...recognizable people, like you know? Eating food, feeling comfortable, feeling safe, not worried about anyone after you’re ...just safe...No matter what state it is I arrive in, whether it’s upset, anxious, depressed or whatever or it’s...it’s good. (I-18)

Usually you come here and you’re on your pretty last legs of using or being out there and you come in, you’re fed, you can take a shower. You sit around, talk to other women about their experiences, get a lot of rest here. (I-14)

The little jobs that we can do, and being able to meet with workers and basically helping to put ourselves back together at our own pace. (I-18)

The responses allude to the harm reduction principles of “meeting people where they’re at” (“put ourselves back together at our own pace”), supporting participants’ agency to make their own choices (“I have my freedom”), attending to the linked social/economic/health factors in living with addiction (“people here are on the edge so much”), and the role of acceptance and lack of stigmatization in encouraging participants to make use of harm reduction-oriented services and care.
The lifestyle that I live, I’m not really open to new experiences and wanting to experience new things because I’m so insecure about my addiction that… I really like, stay to one place where I’m already accepted, and I don’t have to start all over again. (I-23)

I feel welcomed. I don’t feel discriminated against. I feel comfortable and just overall welcomed, like no harsh feelings or nothing like that. (I-23)

[I like] That I have my freedom. (I-22)

[Harm reduction] kits, having everything all under one roof, you know. From your doctors to your counsellors to your housing workers to your food supplies to your track what you really need source, right here and make a phone call, done. Yeah, other places don’t take the time to do none of that... And jobs. (I-33)

These interviewees describe how the harm reduction focus, and multi-service approach, of Sistering helped them on their path, and sometimes helps them support others:

I’ve gathered knowledge in doing things that I’m asking for to further my ability to go further in life. Best thing of all is that I have my doctor up above, I have a counselor up above and I have friends below...I’m considering applying for peer jobs in other shelters. But they put me on my feet to do that. They’ve given me the skills to get my resume done so that’s important...the training that they’ve given me [in de-escalating conflict] has put that into my ability when I walk into Sistering, [and] I’ve actually been able to do the same for friends and the Sisters here....It’s been coming to a point where I’ve become very much more enriched with the programs that are available and I take them more seriously, I use the resources better and I talk to the counselors more honestly. I de-escalated my ability to consider using alcohol or what have you. So, so I ended up coming here on just because I want to stay here. I want to actually eventually, maybe work here. (I-25)

I got food. Got clothes. I’ve got great workers that have gone to the limits to make sure that I got my needs. It doesn’t always happen overnight...But eventually...when I look back I actually got a lot of help. (I-11)

I like the low barrier concept. I like the fact that I get a lot of support here. I come up to the third floor and there’s a psychiatrist and psychologists, all the harm reduction. I like the fact that there is a lot of job opportunities at Sistering. There’s a lot of opportunities at Sistering if you really want to move ahead there’s something here for everybody. (I-14)

I don’t have food in the house because my rent is so high. I come to Sistering to have a bite to eat... I have to get some stuff that I don’t have in the house like toothpaste, toothbrush, soap, shampoo that I don’t have. I come and get for help. Sometimes piece of clothes. (I-27)
If I was really hungry, I know I can come get food. If I really needed to do my laundry...I can come do it here. I mean there’s lots of things I can do if I need help, and anything I need help with, I know I can get it here, without fail. (I-43)

Participants describe the impact that Sistering has had for them, noting Sistering’s advocacy work on their behalf.

*Sistering fights for you.* (I-11)

I do feel supported. I’ve felt in this support that caring. I just can’t understand yet but I’m starting to understand it and I don’t know why but maybe it’s because of the lifestyle I lead. And I think maybe people care more than I think. (I-12)

*I could say this is the first time I’ve not been miserable in a long time...I’m happy here.* (I-12)

*I love Sistering because everything here, I’ve got a lot of help and I’m actually getting progress in my life...I’m actually glad I found this place 'cause I’ve never found a women’s place like this.* (I-29)

*I would never stop coming here...If I win the lottery I would give the biggest donation to this place cause I just love it.* (I-30)

*How much they care and how much they...they’re very persistent.* (I-35)

Several respondents stated that **Sistering saved their lives:**

*Sistering saved my life, and I’m very, very grateful to Sistering.* (I-41)

*They saved my life, eh? They took me out from the streets. They got me housing...They’re the ones who initially saved me from like getting killed by my abuser... I was with this guy and they took me into Sistering and it was not at that point in time a drop-in, but they still took me in, you know what I mean? And made sure that I was...wherever I was, I was housed safely for the night.* (I-42)

*Sistering’s done nothing but save my life over the past 12 years and it’s one of the only few places that have...it would be a huge chunk of my life missing ... I would be basically still incarcerated, and nothing would be done with my life. I wouldn’t be employed right now. I wouldn’t be able to see my kids, nothing, you know? I’d be in jail. Gone! Just a loser...dying. Nothing.* (I-42)

*If it wasn’t for this place and the people and the staff, I may not be alive today.* (FG-8)

26% of interviewees (n=10) referred to the work they do at Sistering, and some referred to training, employment counselling, and work skills they developed at Sistering.
Sistering ... gives me opportunities to make money. Sometimes I do kit making ... I feel that my objective originally felt a little hopeless but now I continuously want to be a part of this group hold. So in this sense I’ve put my resume in to a peer counselling group ... Gives me a lot of hopefulness because I did a lot of training. So most of the time when I come to Sistering in the past 4 months it’s been for training. So coming here is just ... is a God bless ... there’s nothing that has been given to me like the opportunity of Sistering. I’m considering applying for peer jobs in other shelters. But they put me on my feet to do that. They’ve given me the skills to get my resume done so that’s important. (I-25)

[Compared with shelters] Sistering is better. Sistering is the best ... Because this place has more ... more things that you can do here. Like you got so much help here compared to other places. Other places they don’t have any help like they do here. Nothing. (I-28)

When asked “what do you like the least?” 54% of the 50 focus group and interview participants (n=27) described fighting amongst participants, noise (for example, yelling), violence, and theft. Some participants noted that conflict is partly due to overcrowding, and many used the word “drama” to describe the environment as a mix of these factors.

The yelling and screaming. There’s nothing you can do about that. It’s uncontrollable. (I-34)

It’s always crowded, always very crowded here, lots of drama. (I-35)

Interviewer: What are your experiences like now when you access the Drop-In?
I-35: Negative other than staff ... I get a lot of negativity because the lifestyle that I live and ... a lot of judgment.

Other answers to “what do you like the least” include wishing more participants got what they needed in terms of counselling or housing, favouritism, rules, and not being paid for work.

This report will return to a discussion of conflict at the drop-in in a later section, “Areas of conflict.”

These respondents’ testimonials attest to the myriad ways that Sistering, the services it offers, the 24 hour overnight space it provides, and the policies that guide it, make a positive difference in participants’ lives. Later sections of this report will offer more detailed analysis of how participants view the role Sistering’s low barrier and harm reduction policies play in their health outcomes, and the criticisms some participants have of the changing atmosphere of the drop-in.
Friendships and mutual care

The next sections of this report will focus more closely on emergent themes from the Oral History research project. A predominant theme in our interviews and focus group was friendship. 12% of the 50 participants in the interviews and focus group (n=6) described without prompting that they first came to Sistering because they were referred by a friend or a friend accompanied them.

I think my first contact with this place was at the first thing I had a friend and she was extremely sick … She has spent I think around a year or so at the hospital. After that she was needing extra support so that’s my first contact. She wasn’t able to do many things by herself and I came with her and I was supporting her! That was my first contact with this place…I didn’t know anything about this place. I didn’t know what was Sistering. Not even the name….My first impression was a very small place from outside. But when you open the door it’s like something different. It’s big, it’s open. It’s a welcoming place. (I-9)

I remember that my best friend brought me up the side stairs and showed me, for the first time, a health medical facility with the Sistering group. The medical, to get a doctor, to get a counsellor, to help me with everyday stuff, and they did, and these counsellors are just incredible, and then when I came back down the stairs, I made friends, and now I come back everyday just to see how everyone is, and it’s just amazing. (FG-3)

I was brought to Sistering …god… almost two years ago by a young woman who had gone through the trenches like we had and was also now a counsellor, and…when I walked in, I kinda smiled and went ah…I’m abnormally normal here. I felt like I belong. (FG-6)

This is the only [agency] I’ve been to. My friend brought me here. I wouldn’t want to go to any other shelter. (I-7)

My best friend had brought me through it very quickly and up to the administration office… And my first impression was that this was an organization that was …very open to help. And I never felt like anybody had to sit there and ask me to wait for, you know, 3 hours in a line. Instead they just said come into the office, ‘What’s going on?’ And immediately I felt like I had family. (I-25)

Comments about friendship appear throughout our focus group responses and interviews. As part of a first-contact story, friendship indicates support and information-sharing, when participants who know about Sistering, or have experienced services there, share their knowledge with other participants.

From the participants’ stories we identified some common themes about friendship that we labelled co-education, community, and steps on a journey:
**Co-education:** the ways that participants share experiences and knowledge to teach each other. It is part of a harm reduction model and peer-support system.

**Community:** the ways cisgender women and trans people build friendships, acquaintanceships, and knowledge or caring about other participants who attend Sistering or other drop-ins, shelters, or respites in Toronto. Community is also built through advocacy and activism work that participants engage in areas of housing and transit justice, overdose prevention and safe supply of substances, resistance to gendered violence, and other systemic issues important to participants.

**Steps on a journey:** the ways that participants who have reached a stage on their journey of health or life circumstances can be an example for participants at an earlier stage on their path, and can offer peer support, knowledge, and hope. As peer researcher Karen Shaw noted in her comments at the end of our project video,

> I’m always telling [other participants] that there’s a light at the end of the tunnel because you’re looking at me. I am living proof that there is a light at the end of the tunnel. You may not walk to that light right now, but it still will be there. It’s just up to you to make that conscious choice, that that’s the path that you want to take.

In their answers to open-ended questions, interviewees and focus group participants reiterated this sentiment.

> Yes I do [feel safe and supported here]...because the people know me for one, but for two, they...it’s just, you look at people and you look them in the eye and you see that they have had experiences in their life that I have had similar to, so, I can...we can relate without words and...it’s a good thing, you know? It’s a nice way to make friends too. (I-42)

We were struck by how often respondents replied that they themselves did not need harm reduction supplies or were not concerned about giving their name, but they knew how important these low barrier options were to other participants. Out of the 38 interviews, 13% (n=5) said access to harm reduction supplies was important for themselves and for others, and 18% (n=7) said they did not use harm reduction supplies but felt they were important for others. 13% (n=5) said anonymity was not important for them, but was important for other participants.

> I don’t pick up harm reduction because I don’t do a choice of drug...So having said that I’m grateful for those who are in need of that to keep safe, caring for them and not spreading needles. I think it’s a wonderful program...Everybody knows my name, but just for them that they are able to come into this place and not say their name for whatever reason and for their privacy and I think it’s an amazing system. (I-11)
This suggested to us that empathy and mutual aid are very strong within the Sistering community. Participants share many experiences, and they recognize and advocate for the support systems other participants need.

We even found that one participant who had moved into housing missed the company of the friends made at Sistering:

_Interviewer: If you moved on and stopped coming to the 24-hour drop-in, what was your outcome like?

_I-24: Umm, I kind of felt like I lost out some people that I like. Yeah, I felt more alone for sure. But I also liked having a home. I like having a home. But I do miss everybody...yeah! You can get to know people.

_Interviewer: Is there like a sisterhood, right?

_I-24: It is a sisterhood. Yeah, it is. ... I feel a little bit sad because other people didn’t have an apartment ... that sometimes bothers me a lot...and I’m finding it difficult to separate from here. So many people to just two people. Like I am to be honest. It seems empty or quieter.

Some interviewees who had moved on to housing continue to come to Sistering for the services and the friendships:

_I-33: Right now I’m at a good place. I’m at home...But I still use this facility because like I said they have works and stuff that you can do. Come visit, like they have a little hobbies stuff or whatever, that they could suggest to you if you’re bored or whatever, you know? So whether you’re here as a place to stay till you get residence, when you do get your residence and you’re comfortable you also have...you don’t lose that connection of like ...I can go see my friends there. I could see if there are any jobs available. It doesn’t...they don’t abandon you. Abandon you and drop your life just like that.

_Interviewer: They’re always there for you like a family kind of thing?

_I-33: Yeah, yeah.

The topic of relationships and friendships often came up during our interviews: the word “friends” appears 50 times and is the ninth most frequently repeated word. Participants credited their friends with telling them about Sistering in the first place, or identifying for them that they needed support. Most participants we interviewed said one of their main purposes in coming to Sistering, and/or the thing that they liked most, was making friends and connecting with their friendship group.

_It is a sisterhood. (I-24)
I get to see all my friends. They support me and I love them. (FG-2)

It empowers me as a woman. It empowers us as a group how we can make changes today, and how we can help each other, and we don’t look at colour, we don’t look at race, we don’t look at look at ... where we come from, but we all share camaraderie. We try and survive. (FG-5)

We also noted that the support system at Sistering is grounded in the fact that the participants are at various stages of their journey. Cis women and trans people who have been in the harm reduction group for awhile or have become peer support workers will mentor or look out for others who are living through experiences they once had. Healing journeys are not always linear, so participants who reroute to a previous stage of their journey can be supported by their friends. There are conflicts, but also durable friendships.

Sistering fosters a discourse of mutual care around the idea of community. Participants at Sistering do paid work making harm reduction kits and take part in groups like KISS (Kicking Isolation, Supporting Sisters) and KAPOW (Knowledge and Power of Women), a “harm reduction-based, sex positive, trans-inclusive, peer-supported drop-in” provided by a partnership between Sistering and Parkdale/Queen West Community Health Centre. Built into these groups is the language of care/support and education. Activities at KAPOW, for example, include “health education workshops, safer sex and drug use information, mindfulness-based stress reduction, bad date reports, safer sex work strategies, and social justice activism.” Participants share knowledge, with the view that knowledge empowers them all. There is a strong feeling of something shared, unique to cis women and trans people:

It’s an open space but at the same time it allows you to as a woman be part of something. It’s something different. Like as a woman you feel like you’re with your people. Like I don’t know, is a feeling like your family, safe. Women feeling...outside it’s a different reality. Here there’s women and it’s very respectful. (I-9)

There’s more help here cause it’s all women based. It’s all about empowering women and it’s amazing. (I-11)

I just love it. I think it’s a beautiful place that us women could go to and it’s an all women place which makes it awesome. Makes it kick-ass. (I-30)

A study conducted with participants at Women’s Information Safe Haven (WISH) in Vancouver’s downtown eastside confirms this aspect of harm reduction: PI Betsy Alkenbrack notes that “Many research participants have told me, in words and actions, that

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9 See, for example, Murray & Ferguson: “progress comes gradually and cyclically” (p. 107).
harm reduction is not only about keeping yourself safe, but also about helping others in the community to stay safe, bringing joy to their lives, and getting involved in Harm Reduction groups” (p. 48).

Our study results revealed that a feeling of community does not prevent conflict and oppression around differences in ethnicity, race, sexual orientation, and gender identity. Two interviewees spoke about racism. Two interviewees spoke about homophobia. One interviewee described transphobia that they experienced at Sistering. It is important to note that Sistering has recently reworded its inclusive approach to gender in its statement of service and advocacy:

Sistering services are available to cis women and trans people, in all their diversity. This includes, but is not limited, to trans feminine and trans women, genderqueer, non-binary, intersex, 2 spirit people, trans-masculine and trans men**. We acknowledge that gender identity and expression is fluid. Sistering works to create a safer space and welcomes self-identified people of diverse trans identities into our communities.

**This is not an exhaustive list of gender identities but highlights communities that are often excluded by gender based violence services**

Participants share many experiences in common related to economic marginalization, precarious housing, complex mental health needs, and substance use, but may experience these forms of marginalization, or the stigmatization that attends them, in different ways depending on other systemic oppressions based in racialization, gender identity, and sexual orientation. As the Coming Together report on homelessness in Toronto states, “transwomen” who are homeless experience severe marginalization and discrimination on the basis of their gender identity and other categories such as race, class, substance use, sexual orientation, ability, and age. ... [examples of transphobia included] being cut off from biological family members, being rejected for housing or a job, or experiencing violence and verbal abuse on the street or in shelters” (Sakamoto et al., 2010, p. 18). Sistering’s gender inclusion statement reflects an awareness of the particular difficulties transgender, nonbinary, genderqueer, 2 spirit people face seeking shelter in a historically sex-segregated shelter and respite system. As the Washington-based report Transitioning our Shelters makes clear, “The need for safe shelters for transgender people is severe. Transgender

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11 From the Sistering Gender Inclusivity Statement 2019. This report uses the shorter identifier “cisgender women and transgender people” in describing Sistering participants but intends it to be a stand-in for the fuller and more inclusive description Sistering has developed.

12 As Sistering’s Gender Inclusivity Statement articulates, gender, and the words we use to describe gender identities, are fluid and changing. The term “transwoman” has become less preferred since the Coming Together report was published, and the phrase “women and transwomen” is avoided for its suggestion that transgender women don’t belong to the category “women.” See https://www.vox.com/2015/2/18/8055691/transgender-transgendered-tnr, https://campusclimate.berkeley.edu/students/ejce/geneq/resources/publications-media-faqs/resources-classrooms-and-groups and https://www.glaad.org/reference/transgender.
people are disproportionately represented in the homeless population because of the frequent discrimination they face at home, in school, and on the job” (Mottet & Ohle, p. 3). The Coming Together report also confirms, “[trans people in Toronto experience] marginalization within the social service system and among providers of shelter, housing, and detox centres” (Sakamoto et al., 2010, p. 18).

**Homelessness is a trauma**

Our interviews and focus group yielded many insights about participants’ experiences of homelessness and precarious housing. Of the 38 interviews, 39% (n=15) of respondents reported being currently homeless, 37% (n=14) reported being currently housed, 11% (n=4) reported being homeless at some point (current status not known), and the housing status of four respondents was undetermined (see Figure 8). It should be noted that housing status was determined from interviewees’ qualitative answers and coding, not from survey responses.

*Figure 8: Housing status of interviewees*

33% (n=5) of unhoused participants noted that they lived at Sistering (one slept on the porch) and others stated that they slept on sidewalks, streets, doorways, park benches, or in a car. Several participants noted that Sistering helped them find housing and praised case workers for their help.

The percentage of participants reporting that they are homeless appears higher in our Oral History study than in the 2018 Sistering Participant Survey Findings, which noted that 20% of survey respondents were homeless and up to 10% were underhoused (Ghomeshi, p. 17). Those who were homeless reported sleeping on the streets or in shelters and drop-ins, and those who were underhoused reported sleeping at someone’s house or using a boarding house or group home. Notably, 17% of the respondents in the 2018 survey who said they were “housed” reported living at shelters, hostels, or drop-ins like Sistering (Ghomeshi, p. 17). Sistering is not intended to be a form of housing and has a policy of limiting consecutive overnight stays to six weeks, but in practice a number of participants attend Sistering “every day, at all times of day,” with 40 respondents during the survey stating that
they were at Sistering overnight every night (Ghomeshi, p. 36). The survey identified an at least 12% increase in homelessness among Sistering’s population since 2009, and notes that “about 20-30% of participants live in sub-par housing conditions with no cooking space, or access to running water, and lack of safety” (Ghomeshi, p. 17).

Studies suggest that cis women and trans people who are homeless or use shelters and drop-in services disproportionately have experienced or continue to experience forms of trauma (Holzhauer et al., 2019; Sullivan et al., 2019; Jean Tweed Centre). Sistering follows a trauma-informed and anti-oppression policy of care. Our Oral History study of the 24/7 Drop-In did not ask detailed questions about participants’ past experiences of trauma, though many participants did describe histories of trauma in their answers to other questions.

However, we did observe that many of the interviewees described homelessness itself as a form of trauma, with multiple factors that impinge on mental and physical health.

I was end of the rope, pretty much. Being homeless is a lot more complicated than people think. It’s not just being homeless, being houseless... A lot of times, I find myself sleeping outside because of people I don’t want to be around, or just wanting to be around just myself in general. (I-35)

I slept out on the porch because I didn’t know how to sleep inside, couldn’t stand being around so many women, and if it wasn’t for this place and the people and the staff, I may not be alive today. (FG-8)

The only thing is with a shelter, it depends on the roommates you get. So you can be shut in with someone, you understand?...someone who wants to beat me up. (I-41)

Homelessness is a real trauma and I have it right now and I don’t know when I’ll ever get over it. (I-41)

The participants we interviewed describe a number of ways they experience trauma while being homeless or in contact with institutions, while visiting shelters, agencies, and drop-ins.

[I need] housing, guidance as to what I’m supposed to... I’m so traumatized here sometimes. I don’t even know what I need to look into, like what I need to do. This has been going on for a year now, and then when I ask people up here what I need to do they’re like “we’ll get back to you.” Okay. No one is getting back to me. It’s a rather frustrating cycle. (I-15)

The one single trait that is so vital to staff to working with the homeless and women who [are in] poverty is that they have a genuine care and you can tell wherever you go the ones that don’t....they’re actually very dangerous people to me because they revictimize people who are already traumatized and
homelessness is a real trauma… I find that there are more genuine staff here that truly care and… then some other places and they’re very… it’s very, very difficult. (I-41)

Sistering offers a respite for participants who are unhoused, and a possible six week stay. For many participants, the cycle they are in is not resolved in those six weeks:

I think that the 6-week thing is problematic for people because it forces people to have to go somewhere. A 6 week stay… as difficult as it is to be down there night after night, I don’t think anybody intends to be here long term or forever. They’re here and they’re doing whatever, whatever pace that they’re dealing with and so that I think Sistering should be a little bit more understanding and then saying, okay fine: under this circumstance or under that circumstance 6 weeks are up and you still feel like, ‘Hey this is going to jeopardize my job, this is going to jeopardize what I’m doing.’ Then they should have a waiver. (I-13)

This quotation demonstrates the need for flexibility in low barrier shelter or drop-in services, given the unpredictable, trauma-framed, and non-linear pathway to stability that people face when they are homeless.

Participants’ understanding of “Low Barrier”

One of our goals for this project was to try and establish a common language for low barrier service. Sistering names its service approach as “low barrier,” but how do the participants who use these services understand that approach? To what extent do they value it? And how do they put that approach into their own words? It is important to understand how participants perceive and experience low barrier service so that a bridge of understanding can be built between service users, service providers, funders, and other stakeholders in the shelter and drop-in network.

It is also important to note that the participants we interviewed often had different preferences and needs when it came to low barrier service. Some wanted lower barrier service and some wanted higher barrier service. Some of the interviewees believed more structure and rules would make the drop in environment more accessible to the participants who found it noisy or violent or who were frustrated with theft. Others believed there needed to be more consistent application of existing rules to make things more fair. Some participants believed too many rules would make the drop-in inaccessible to those with complex mental health needs or substance use. At the end of this study we offer some suggestions for how Sistering might foster a conversation amongst participants about the complexity of offering low barrier service to a wide range of participants’ experiences.

Sistering describes low barrier as “meeting people where they’re at.” The interviews we conducted showed us that participants are at different places on their paths, and that Sistering meets, or does not meet, their present needs in specific ways. For some participants, the curfews and rules required by other shelters or agencies offered them
structure, help with sobriety, or reduced conflict with other shelter users. 21% of interviewees (n=8) stated that they preferred measures that included tougher rules, more security (cameras, security officers, calling police), curfews, or stronger guidelines about violence. 16% of interviewees (n=6) commented that they wished for more consistent application by staff of the current rules, or greater transparency about what seemed inconsistent application.13

For other participants, curfews were difficult to meet, rules about sobriety and/or substance use were experienced as stigmatizing or too high barrier for their present needs, and conflict or mental health complexity was either a part of the respondent’s own present stage on her path, or was a difficult but expected side-effect of low barrier and harm reduction-focused service.

We learned about participants’ experiences of harm reduction and low barrier approaches to service by asking specific questions about the importance of these three policies:

- How important is it that you can come and go as you wish at any hour of the day?
- How important is it that you do not have to give Sistering staff your name?
- How important is it that you can pick up harm reduction supplies?

We drew these questions from the Sistering Participant Survey Findings (2018) report that was shared with us. We chose to leave the question open-ended and qualitative. Participants did not select “very important,” “not important,” “somewhat important,” or “important for others” from distinct survey choices. Rather, their statements were coded and interpreted in context.

Out of the 38 interviewees, 76% of respondents (n=29) stated that it was “very important that they could come and go at any time of day, 13% (n=5) said “somewhat,” 5% said it was “not important” (n=2), and 5% (n=2) did not answer. One interviewee who said it was very important, and one who said it was not important, noted that it was important for others. In the focus group, it appeared 100% of the participants felt it was very important that they could come and go at any time of day: three participants stated why it was very important to them, and the rest of the group chimed in to agree that it was very important. The question addressed the lack of curfew at Sistering, 24 hour/7 day open hours, and ability to leave and return at will, which are not features of all shelters, agencies, and drop-ins.

Our study showed that participants have many reasons for finding a 24 hour drop-in, without curfew, important for the choices they make and the other barriers they

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13 As described in “Contexts and Limitations,” the recruitment process for this project included snowball sampling methods, and some interviewees were recruited who did not fully fit the profile of those most needing low barrier and harm reduction approaches, for whom the 24/7 drop-in was designed. This may explain why some interviewees preferred higher barriers and security measures. The “Executive Summary” and “Discussion” point out that cross-referencing of the data relating to ‘low barrier/harm reduction needs’ and ‘feelings of being safe and supported’ confirmed that those respondents who did not feel safe at Sistering and preferred more security measures did not tend to be those most needing harm reduction supplies and 24 hour access.
experience outside Sistering. Some participants reported finding curfews difficult or impossible to meet because of their daily habits, other obligations, substance use, and sex work. Some participants needed to know that Sistering was there for them any time of day, because crises and needs are unplanned.

It’s very important because I can’t keep a curfew for my darkest day, I couldn’t be in normal vicinity of a regular shelter and keep a 10 o’clock or 9 o’clock curfew. I just couldn’t do it. (I-12)

It’s really important because I’m an addict and my life is really sporadic, and I don’t have any stability, really…I’m just very, very on the go, so that’s really important to me. (I-23)

That is extremely important because in my circumstance with my daughter, a mental disorder, you never know what time of the day I’m gonna need to get her...I’ve had like 20 work assignments in the last year that I’ve lost because of having to take time off. (I-41)

It’s accessible 24/7 and they don’t usually turn anybody away. It’s a little chaotic but what do you do with 100 women in a building, you know? But I like that it’s accessible all the time. (I-34)

I like Sistering because it’s 24 hours, you can come and go. At the other [shelter] there’s a curfew but it’s necessary there. I liked Evangeline’s because you had your own room and your own locker. It’s a little bit more chaotic here, but you have the opportunity to come and go so I do like that…At the time that’s what I needed. Now I need Sistering. (I-34)

Interviewee #34 points out how a participant’s need for low or high barriers can change during their journey: “at the time, that’s [higher barrier] what I needed. Now I need Sistering.”

According to participants’ reports of how they experience the 24 hour, unrestricted access that Sistering offers, this feature of low barrier service appears to support cis women’s and trans peoples’ health and the harm reduction strategies that Sistering follows. Because Sistering is open 24 hours and participants can leave and return, they can get harm reduction kits and also return to a safe place to sleep after sex work.

If I want to jump on the subway at 1:00 in the morning to come get my cheque, I can. … [and it’s] very important [that I can pick up harm reduction kits] because I can get those 24 hours, 24/7. (I-43)

It’s important because if you are destitute, just get away from your house or something’s bad going on in your house or somebody’s like ‘oh you just need food or you just need clothes’. It’s very important that you know that place is available to you. (I-11)
Here it’s 24 hours and it’s great that no matter what time it is I don’t have to wait a couple of hours, you know…just to get the [harm reduction] supplies. (I-33)

This is very important to me because I’m involved in sex work and I’m a practicing addict. So it’s important to me to be able to get myself together from sleep during the day and work at night, maybe use at night. You know the timetables are very…it’s very important to me that I have the freedom and movement. Yes. (I-14)

“Accessible” is another word participants use to describe the fact that the drop-in is open 24 hours a day, 7 days a week.

[I like that] it’s accessible 24/7 and they don’t usually turn anybody away ...I like that it’s accessible all the time. (I-34)

Many interviewees used the words “freedom,” “autonomy,” “independence,” and “dignity” when describing why it was important for them to be able to come and go at any hour from the drop-in. Sometimes the word “freedom” was practical—participants needed to be able to use the drop-in in a way that fit their schedule—but the word “freedom” also seemed to mean a “sense of freedom” and the opportunity to make choices, including choices that bring dignity.

It gives you a sense of freedom, you know? And somewhere to come to, that’s very important. Like if there’s nowhere else, nowhere else to go at least here is a shelter place you can come to and … try to make the best of it. It’s better than being outside. (I-18)

It’s nice to have my freedom and nice not to have any stipulations of having to be somewhere at a specific time. (I-42)

It’s very important [to be able to come and go at any time]. Makes me feel dignified. (I-24)

When I use a shelter it’s because I’ve finally had it with someone or the whole thing all together, and then I get to the shelter, and I go…I miss the freedom...the independence. (I-15)

I can leave for the day, and I have a few trusted people to watch my stuff, and I can leave for 3 or 4 hours, and then I know when I come back. Maybe my chair’s taken, that’s fine, but my stuff will still be there. Whereas with the shelters, walk in downtown Toronto with a suitcase and two bags in downtown Toronto for about several hours. In the winter and the summer, it’s not feasible especially for a woman of my size. I can’t do it, but the shelter says you have to take your stuff with you, otherwise we’re gonna throw it away. (I-15)

Participants reported greater freedom of movement when they could come and go from the drop-in at times that fit their needs. It was also clear that cis women and trans people...
face many practical obstacles when they are homeless and use shelters and drop-ins, such as how to keep possessions safe without trying to transport them everywhere. Combined with the trauma of homelessness that is described elsewhere in this report, trying to move through the city with heavy bags is a significant stress factor in the participants’ lives. Sistering’s 24 hour drop-in offers some participants the option of leaving possessions with friends when they need to leave the site.

Of the 38 interviewees, 32% of respondents (n=12) reported that it was “very important” that they did not have to give their name to use services or pick up harm reduction supplies, 21% (n=8) said it was “not important,” 16% (n=6) said “somewhat,” and 8% (n=3) noted it was important to others. 50% of focus group participants (n=6) answered that it was very important that they not have to give their names. The other focus group participants did not answer the question.

It’s very important…many people have, and even me, have issues and you feel protected. You feel safe. (I-9)

I like people to know who they’re talking to. I like them to address me as a person and as an individual. The anonymity part is more so when it comes to people that are using IV drugs and things like that. I don’t want that to get out in the open because what if they’re trying to seek employment and stuff? There’s a lot of stigma oriented around it. (I-42)

I’ve slept in many women’s shelters, and they…actually breached the confidentiality contract and let people know that I was staying there that were…actually a threat to my safety, so…there’s only two places that I stayed at that have actually kept me safe…and that’s Sistering and that’s their confidentiality and Women’s Rez has helped me a lot. (I-42)

Of the 38 interviewees, 53% of respondents (n=20) stated that it was “very important” that they can pick up harm reduction supplies and kits at Sistering, 29% (n=11) said it was “not important,” 5% (n=2) said it was “somewhat important,” and 13% (n=5) did not answer. 5 participants who said it was very important for themselves, and 7 participants who said it was not, said they knew harm reduction supplies are “important for others.” Three focus group participants said it was very important that they could pick up harm reduction supplies. Interviewees noted that it was important that they not face judgement when they picked up these supplies, for stigmatization and judgement discouraged them from picking up the kits that helped them use substances safely and practice safe sex.

[It’s very important that you can pick up harm reduction supplies so] you can be high and clean. (I-36)

[At other agencies] they have more stigma if you come in and they know that you’re a drug user and they know that you’ve been using drugs, they immediately will blackball you as a drug user and as a waste to society so if you’re in an argument, you instantly lose, okay?...you get the blame and you’re believed to be
the guilty party because you’re an addict, right? But Sistering doesn’t discriminate that way so it’s really really great. (I-42)

They don’t ask questions...they don’t lecture you. (FG-8)

I work at also and volunteer at a couple other community centres. I’ve seen the harm reduction team go out there and actually deliver to different complexes, to different parks, and I think it’s wonderful because it’s acceptance not just from within ourselves but also within the community, our families, and in [other places] it seems to be, let’s kinda close our eyes or ears and maybe it’ll go away, but you know, when it hits home and hits your loved ones... you can’t close your eyes. (FG-6)

Two respondents commented on the need for more safe injection sites to prevent overdoses.

All the shelters now are saying harm reduction, harm reduction. They have special rooms. They have people that are actually using in there and they’re calling the ambulance constantly because people are OD-ing. What they need to have is like an injection or a safe using site on the shelter premise. If you’re a harm reduction shelter you should have a place where people are being monitored, instead of just letting them all over the shelter then you know. (I-14)

I think it would be a really, really great thing...I don’t know how possible or not it is to have a clean shooting site ... And maybe a ... great counselor or sex trade worker right on property. Or both. (I-24)

One interviewee offered a clear description of the connection between stigma and safer substance use:

[When you go to some other agencies] they just...they’re reluctant. Other places are reluctant to give [kits] to you. I find it when I go to [other agency], since you go pick up a kit...I know they’re harm reduction and that and everything. They’re reluctant to give it to you because they think you’re going to leave with it, right? Because there’s no smoking allowed. You’re going to leave outdoor, right? ... They even have security escort you out. (I-12)

The fact that peers and some staff members at Sistering have lived experience contributes to participants’ feelings of being accepted and not being stigmatized.

The staff is also very diverse, there’s a lot of consumer survivors here so I enjoy that. (I-24)

This interviewee went on to point out that they were more likely to obtain harm reduction supplies from a place that offered privacy. When asked, “how important is it that you pick up harm reduction supplies?” they answered, “It’s pretty important. Very important
When asked if these supplies are available at agencies other than Sistering, they responded “yes,” but “I don’t like any other agency because it’s a little bit more...I feel like I’m being monitored and watched, maybe...studied. It’s not as discreet (@-24).

It appears that harm reduction supplies are very important to this participant, and are part of their health, but they are more likely to obtain harm reduction supplies from an agency that offers discretion. By looking at the choice of words—monitored, watched, studied, discreet—we might think this participant feels a lack of privacy or anonymity at other agencies, or perceives judgement because of their use of substances. In the context of the other participants’ answers, low barrier service measures such as anonymity, acceptance of harm reduction approaches to substance use, and non-judgmental treatment of consumers appear to lead participants to feel more comfortable attending the agency and picking up harm reduction supplies, for self or others, which may contribute to better health outcomes.

When cross-referenced with demographic data available for the interviewees (n=38),14 of the group who reported that it was very important they could pick up harm reduction supplies (n=20), 9 respondents identified as white and respondents identified as ethno-racial groups that included Black, Indigenous, Latino/Hispanic, Indian, and Mixed heritage (5 respondents did not answer and 4 respondents did not describe their ethno-racial identity) (See Figure 9).

Figure 9: Importance of harm reduction supplies by ethno-racial group

Figure 10 shows the range of importance of harm reduction supplies within ethno-racial groups.

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14 Demographic data was not obtained for the focus group participants.
Figure 10: Ethno-racial identity and importance of harm reduction supplies

<table>
<thead>
<tr>
<th>Ethno-racial identity</th>
<th>Very important</th>
<th>Somewhat important</th>
<th>Not important</th>
<th>Important for others</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>9</td>
<td>0</td>
<td>6</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mixed heritage</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Black</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Indian/South Asian</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Latino, Hispanic</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Indigenous</td>
<td>3</td>
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<td>0</td>
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<tr>
<td>N/A</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

(Note: answers in Figure 10 will be greater than number of interviewees because some participants gave two answers, including “important for others”)

Figure 11 demonstrates the distribution of low barrier and harm reduction needs across the interviewee population by ethno-racial group, using an answer of “very important” as an indicator of high value placed on 24 hour access, availability of harm reduction supplies, and not needing to give one’s name to receive services. The data represent the number of interviewees in each ethno-racial group who answered “very important” to each question, as well as what percentage of interviewees within each ethno-racial group answered “very important” (presented as # / %).

Figure 11: Need for low barrier and harm reduction services by ethno-racial group

<table>
<thead>
<tr>
<th>Ethno-racial Group</th>
<th>Harm Reduction Supplies Very Important n=20</th>
<th>24 Hour Access Very Important n=30</th>
<th>Anonymity Very Important n=12</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>9 / 56%</td>
<td>14 / 88%</td>
<td>4 / 25%</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>0 / 0%</td>
<td>0 / 0%</td>
<td>0 / 0%</td>
</tr>
<tr>
<td>Mixed Heritage</td>
<td>2 / 100%</td>
<td>2 / 100%</td>
<td>0 / 0%</td>
</tr>
<tr>
<td>Black</td>
<td>3 / 38%</td>
<td>8 / 100%</td>
<td>3 / 38%</td>
</tr>
<tr>
<td>Indian/South Asian</td>
<td>1 / 100%</td>
<td>1 / 100%</td>
<td>1 / 100%</td>
</tr>
<tr>
<td>Latino, Hispanic</td>
<td>1 / 50%</td>
<td>1 / 50%</td>
<td>1 / 50%</td>
</tr>
<tr>
<td>Indigenous</td>
<td>3 / 75%</td>
<td>2 / 50%</td>
<td>2 / 50%</td>
</tr>
<tr>
<td>N/A</td>
<td>1 / 25%</td>
<td>2 / 50%</td>
<td>1 / 25%</td>
</tr>
</tbody>
</table>

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If we take experiences of racialization as a common factor among participants who identified as Black, Indigenous, or People of Colour (BIPOC), this data indicates that white and BIPOC interviewees equally find harm reduction supplies very important, but BIPOC interviewees are about 14% more likely to find anonymity very important, and white interviewees are about 10% more likely to find 24 hour access important (see Figure 12).

Figure 12: Racialization and need for low barrier and harm reduction services

<table>
<thead>
<tr>
<th>Ethno-racial group</th>
<th>Harm Reduction Supplies Very Important</th>
<th>24 Hour Access Very Important</th>
<th>Anonymity Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>White n=16</td>
<td>9 56%</td>
<td>14 88%</td>
<td>4 25%</td>
</tr>
<tr>
<td>BIPOC n=18</td>
<td>10 56%</td>
<td>14 78%</td>
<td>7 39%</td>
</tr>
</tbody>
</table>

Figure 13 shows the distribution of low barrier and harm reduction needs amongst participants by differences in sexual orientation. The chart shows which participants answered “very important” when asked about the importance of 24 hour access, harm reduction supplies, and anonymity.

Figure 13: Sexual orientation and need for low barrier and harm reduction services

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Harm Reduction Supplies Very Important (n=20)</th>
<th>24 Hour Access Very Important (n=30)</th>
<th>Anonymity Very Important (n=12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual/Straight (n=19)</td>
<td>11 58%</td>
<td>14 74%</td>
<td>7 37%</td>
</tr>
<tr>
<td>Homosexual/Lesbian (n=8)</td>
<td>3 38%</td>
<td>6 75%</td>
<td>2 25%</td>
</tr>
<tr>
<td>Bisexual (n=3)</td>
<td>2 67%</td>
<td>3 100%</td>
<td>0 0%</td>
</tr>
<tr>
<td>Asexual (n=1)</td>
<td>1 100%</td>
<td>1 100%</td>
<td>0 0%</td>
</tr>
<tr>
<td>N/A (n=7)</td>
<td>3 43%</td>
<td>6 86%</td>
<td>3 43%</td>
</tr>
</tbody>
</table>

The chart shows what percentage of participants differentiated by sexual orientation find low barrier or harm reduction services very important. For instance, regarding harm reduction supplies, 58% of straight interviewees (n=11) reported that it was very important to them to have access to harm reduction supplies, compared with 38% of

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15 The Toronto Street Needs Assessment 2018 noted that “Racialized individuals are overrepresented in the homeless population in Toronto. Almost two-thirds of all respondents identified as members of racialized groups, with the largest percentage identifying as Black” (p. 5).
lesbian interviewees (n=3), 67% of bisexual interviewees (n=2), and 100% of asexual interviewees (n=1). We can draw from this chart the suggestion that straight and lesbian participants approximately equally value 24 hour access to Sistering, and that straight participants value harm reduction supplies and anonymity slightly more than lesbian participants.

Looking at the data for interviewees overall (n=38), of the 20 respondents who said it was “very important” that they could pick up harm reduction supplies, 90% (n=18) said it was also very important that they could come and go at any time of day, and 80% (n=16) reported feeling safe and supported at Sistering. On the other hand, of the 17% (n=6) of interviewees who said they do not feel safe and supported at Sistering, only 17% (n=1) said harm reduction supplies and anonymity were very important, and 67% (n=4) said it was important they could come and go at any time of day. This cross-referencing of the data suggests that participants’ feelings of being safe and supported at Sistering may correspond to their experiences of, and need for, low barrier and harm reduction policies that do not stigmatize. We might also conclude that the participants who do not feel safe and supported at Sistering are not necessarily those most in need of harm reduction supplies and 24 hour access, though their need to feel safe and supported at the drop-in must also be addressed (see “Areas of conflict”).

Notably, 6 of the 15 respondents in the interviews and focus group who said it was important for others that harm reduction kits be available 24/7, said they themselves did not need or use harm reduction supplies, which supports our finding that participants at Sistering are often aware of their shared experiences with other participants at Sistering and are mindful of the needs of others in their community.

Oh, I think [harm reduction kits] are important to the whole community here! Yeah because there’s nothing, there’s nobody. When I go out and I know I’m going out to use I take about 10 kits with me...because there’s always everybody. Do you have a pipes, do you have a screen, do you have this, do you have that? (I-14)

Not only do I use [harm reduction kits], and it keeps me safe and clean, but I bring them to my friends as well and it keeps them safe and clean, and we don’t have to succumb to using dirty rigs and getting blood infections and all that stuff. (I-23)

[Harm Reduction supplies are] extremely important and extremely needed. My household is a harm reduction ...building and I only was accepted in there because I was a high risk with harm reduction. You have three overdoses within three months to be accepted into the housing that I’m in which is a housing project regeneration, and everybody that is accepted into that housing is a user, so I need to get the supplies to my house when it’s required, so it’s very, very important. (I-42)

As with low barrier service in general, a harm reduction focus is about “meeting people where they’re at.” Participants explained that harm reduction approaches— for example,
not banning participants who arrive at Sistering after using substances—are important and healthy for some, and are detrimental for others who are at a different place on their path. For example, during the focus group, one participant answered the question “what do you like least about coming to Sistering?” by saying,

What I don’t like about Sistering is that there’s basically, there’s no programs such as relapse prevention, or anger management, or ... have an AA every once in a while, or an NA group. (FG-8)

Other participants around the table responded: “If I can intervene, an AA group is against the concept of harm reduction”—“But that’s why we have a KISS group”—“But that doesn’t mean it can’t happen”—“That’s a good point. Because not everybody that comes to Sistering is harm reduction”—“That’s right. There’s people who are sober. But 90 per cent of them are harm reduction.”

Similarly, one interview participant explained why a higher-barrier shelter was the right place to go at a time in their life when they were trying to become sober:

[Evangeline’s] had curfew, you know? 11:00 pm you had to be inside. If you came in high or drunk, you weren’t allowed in. I did it. Seven months...Yeah, it was pretty cool...you have curfew because you want to stay sober, right? ... one of the reasons you go there is to get sober. (I-43)

The 2018 Sistering Participant Survey Findings offered some context for why Sistering participants, comparable to other participants in the same demographic, use substances:

Participants most commonly used substances to cope with emotional challenges (53%) and physical challenges (49%). ... A few participants also used for daily functioning or being able to work through trauma from past abuse. They explained how they used for ‘sanity,’ to ‘exist,’ ‘to sleep,’ ‘to get out of bed, or ‘as a substitute to self-harm.’ (Ghomeshi, p. 23)

Sistering’s harm reduction philosophy is trauma-informed, and accounts for the ways that participants may use substances as coping strategies. As noted earlier, harm reduction approaches acknowledge both the benefits and risks of substance use.

“I have no other option”

For participants who do need very accessible and low barrier drop-ins and shelters, they are very aware that there are no other options: Sistering is the lowest barrier agency that is available to them. If they are not able to go to Sistering (for example, if they are banned), there is nowhere else they can go if they are not able to pass higher barriers.

36 “Kicking Isolation, Supporting Sisters.”
I look forward to coming to Sistering when I stay away from here sometimes because I miss it, and this is the only place I could come to. I got no other place. Yes. (I-10)

I find it to be a positive place mostly, good food, water... and a place to sit down and rest. I am on CPP disability, so I don’t have that extra accoutrement for rent so until I get a job, it’s my next...sidewalk or here. I have no other option. I’m not on ODSP, I’m not on OW so I’m not going to get a supplement, so on $900 plus my savings, I’m using my savings like non-stop, I’m here until I get a job. There’s no government supplement for me, basically. (I-15)

I know how to survive in this environment where **laughs** I couldn’t say that I feel comfortable ... but I still coming because I don’t have other place where to go. (I-5)

Normally, I come to Sistering, and I feel upbeat. I’m in a safe haven. I have a place, not a haven, but a safe place. Sometimes when there are bad days at Sistering, I don’t know if it’s a bad mix or a bad sauce, there are days like this where I’m just like...I have no option. I have no option. (I-15)

Interviewer: So what happens when you’re not comfortable? What do you do?  
I-33: Uh, stay on the street.  
Interviewer: And I guess...attend Sistering.  
I-33: Yup. There you go.

Another respondent says that they feel safe and accepted at Sistering, and notes that their addiction means they are not comfortable trying other agencies and starting over:

I don’t really look for any other agencies, so all I know is Sistering, so I stick mainly to Sistering ‘cause I know it so well ... Probably, mainly to do with comfortableness ... the lifestyle that I live, I’m not really open to new experiences and wanting to experience new things because I’m so insecure about my addiction that I stay to one place where I’m already accepted, and I don’t have to start all over again. (I-23)

The interview with participant I-35 is worth quoting at length for the way it articulates some participants’ perceptions of Sistering’s difference from other agencies and shelters and how it manages its low barrier policies:

Interviewer: Why did you have to go to the shelter?  
I-35: I was end of the rope, pretty much. Being homeless is a lot more complicated than people think. It’s just not being homeless, being houseless...it’s everything comes. A lot of times, I find myself sleeping outside because people I don’t want to be around or just wanting to be around just myself in general.
Interviewer: What’s the same about the other places...agencies or shelters compared to Sistering? Do they have as much patience...

I-35: No.
Interviewer: ...as much supports?

I-35: Not nearly as much

Interviewer: The staff aren’t the same, I guess.

I-35: That’s why I’ve gone to no other shelter but Sistering since I started coming here.

Interviewer: Do you feel comfortable at any other place?

I-35: No. ...

Interviewer: Comfortable with the staff at any other place?

I-35: No.

Interviewer: If you went to one and you didn’t feel comfortable with the staff, like what would you do?

I-35: Leave.

Interviewer: Leave and then go here?

I-35: Pretty much.

Interviewer: At another place, what do the staff usually do if women are not getting along?

I-35: Kick them out.

Interviewer: Umm...do they..

I-35 Call the cops.

Interviewer: Do they do the same here?

I-35. No, they try to control it and try to get in the middle of it here.

Interviewer: And deal with it? Access the issue?

I-35: Yep.
Many interviewees identified Sistering staff as a significant factor in their positive perception of Sistering:

*I don’t find the shelter system supportive. The staff aren’t as in there as they are here at Sistering...the contact is different. It’s either you do as I say or...You don’t get to be as in touch as the staff here. (I-12)*

*I’m very comfortable with the staff and if I’m not comfortable I can talk to them. I feel comfortable talking to them about anything that might have bothered me. And if it doesn’t work out I could take it further up the chain, you know right to the Executive Director. You know that’s how open and available they are to listen to complaints or concerns or whatever. (I-14)*

*[The staff] are very genuine and they’re really, really in this, I feel, to help, and to make you feel better about your circumstances or about where you are in your life at that point in time. (I-23)*

Occasionally, even a low barrier agency like Sistering must ask a participant to temporarily leave. When staff judge that a participant has become a risk to other participants in a way that cannot be managed, or if a participant does not follow the low barrier protocols, they may be asked to take a respite from Sistering or a temporary ban. The participants we interviewed had a variety of opinions on the fairness or usefulness of temporary bans.

*The difference with Sistering is that you guys give a reprieve where you can come back in three days. It’s not a permanent thing but with other shelters it’s 6 months to a year. And it’s just asinine. They need to change their rules and exceptions to the rule. (I-12)*

A brief respite policy is a component of a low barrier approach to service, and recognizes that a participant who is causing risks for other participants is also causing risks for their own health, and that participant’s behaviour (including substance use) may be connected to their own traumas. A minimal respite period attempts to manage the risks to both the participant and to others at the drop-in.

Since Sistering is the only option for many participants in this demographic, as described above, even a minimal respite period may pose risks for this participant. This is one of the reasons that this research project recommends that the shelter/drop-in system in Toronto requires a low barrier shelter or agency where a participant in a mental health or other crisis could go—a further outlet or safety valve in the system to protect her health and safety.
Areas of conflict

An important question from our interviews was, “do you feel safe and supported at Sistering? Why or why not?” We felt this was an important question because it is another way to measure how participants feel about low barrier service and about the services and support systems at Sistering. Of the 38 participants interviewed, 16% (n=6) answered “no,” they did not feel safe and/or supported. They gave reasons such as:

- Violence in the drop-in (interviewee felt supported but not safe)
- Theft
- Preferential treatment
- Client service

A consistent theme in the focus group and interviews was conflict and violence. Some participants felt that there were increasing levels of violence, arguments, and conflict between participants at the drop-in. Some respondents attributed this to higher levels of mental illness and trauma and to overcrowding. Others attributed this to staff not applying rules consistently, or to rules that they felt should be more restrictive or higher barrier.

I find that lately ... since Sistering has come from a day program to an all-night drop-in, the people have no place to go that are with the mental health, and have mental health issues, so they come, and they stay in Sistering, and what’s happening now is it’s become a ... like serious risk to women’s health and safety with mentally ill women and ... they’re counter-reacting with us and it’s an endangerment to us when ... we’re trying to get better from our addictions and trying to integrate into society again, but yet, we have to be backtracked and watch our backs because we’ve got mentally ill people, ya know, basically attacking us sometimes downstairs. It’s pretty wacky then. Something needs to be done ...They need to get a psychiatrist on call on the spot in this place. (I-42)

Because they have the low barrier concept I find they allow a lot of unsafe behaviours to go on that shouldn’t be going on ... So there’s a lot of people ... suffering mental illnesses here that in my mind, in a perfect world would be treated kind of...they would have someone here like a mental health professional to talk to these people when they’re escalating. (I-14)

Other respondents said that they felt staff were doing their best in difficult situations of conflict.

Interviewer: What does staff do to women using the agency who are not getting along?
I-31: That’s a hard one. Because like I said it’s a very volatile situation for the staff. They don’t know what to do and they do the best that they can.
Interviewer: Right.
I-31: Yeah, so I’m not putting the staff down at all. They’re there, they do the best they can to break up fights, and they’re always there! They’re always there. It’s not their fault that people go psycho.

One participant explained their own perspective on de-escalation when they feel angry:

Some staff know how to deal with me when I’m freaking out and angry, and other staff don’t. They think they can just step in and control ... like I said, control the situation and make things all better and calm me down. It doesn’t work that way. (I-35)

The above respondent’s answer suggests that de-escalation tactics, or the use of rules, are more successful when applied with staff knowledge of individual participant’s needs and patterns and when there is an existing rapport and trust.

One topic that did not come up as a theme in the interviews, but that was part of the peer researcher team discussion of this project, was the role of peer workers in the drop-in. Members of the research team who were trained peer workers in the drop-in saw an important role for peer de-escalation of conflict. These team members suggested that one solution to the conflict in the drop-in would be a larger or re-examined role for peer workers in collaboration with staff: more peer workers hired, with greater responsibilities. **The role of peer workers at Sistering would be a productive topic for a future research study.**

We learned during this study that conflict at the drop-in has a number of effects on participants’ experiences there, and has a significant relationship to the issue of barriers. Participants described that when there is yelling and conflict in the drop-in, they can become triggered and stressed.

I-15: It’s bombastic, it’s disturbing, upsetting at times. Other times, it’s friendly and quiet, and I appreciate it, but because I also do have PTSD, every time someone screams, my nerves shake. I start shaking really badly, like...

Interviewer: It’s triggering right?

Some people yelling, screaming. It’s like a torture for me ... if you talk about this with the staff, they say ‘mental health issues,’ but they don’t care about my mental health issues. (I-5)

When asked what they do when there is too much conflict or violence in the drop-in, participants reported many strategies. 18% of interviewees (n=7) answered that they found solutions at Sistering, including speaking with staff (5%), staying away from the triggering person (8%), going to a stairwell or corner at Sistering (5%), or participating in Sistering activities (3%). 34% (n=13) said they would leave Sistering, 16% (n=6) would go for a walk, one would go to the library or listen to music, and 11% (n=4) would sleep outside or in a car or even a streetcar.
[When I’m not comfortable] I sit in the stairwell here or I go for a walk or I go to the library. But I definitely in the heat, when something’s blowing up, I’ll keep quiet. Just in situations where there’s a tailspin, and I can see it from a mile away. I can sense ... all it takes ... I have like this trigger sense, I know, I can, before anyone else, maybe others do, I can tell when things are gonna spin out of control. So just if I’m in a recliner, I’ll shut my eyes, and pretend I’m asleep cuz I know that things are gonna go awry. If it’s during the day, and I’m not in that recliner, I’ll just leave. (I-15)

I don’t use other shelters. I sleep in my car ... And sometimes it can get too loud in here, and I suffer from anxiety, severe anxiety. So the noise is a trigger, so I have to leave. (I-22)

Interviewee #22 (above) articulates how a number of pressures intersect on Sistering’s drop-in and on participants. Many participants are living lives affected by trauma, anxiety, and precarious survival strategies. As we have seen, homelessness is a trauma. Many participants see Sistering as a safe place to feel reduced anxiety. If they face barriers at other agencies or shelters they may also not have anywhere else to go in times of need. If Sistering becomes a place where their anxieties and traumas are triggered, or where they don’t feel safe because of noise and potential violence, they may leave, and not have a safe place to be, because there is no other option.

It becomes a problem without a good solution: participants come to Sistering because of similar traumas and crises, but one participant’s crisis may trigger or initiate a crisis in another participant in close proximity. Because the drop-in is nearly always at or above capacity, there is a great deal of space pressure on the participants, accentuating the effect of noise and conflict. The low barrier and harm reduction model makes it possible for the most marginalized participants to be safe and to seek services, and at the same time a lowered barrier may create new barriers or obstacles for other participants.

**Discussion**

Our most significant findings can be summarized under the following broad themes:

1) Mutual support
2) Language for low barrier
3) Scarcity of options
4) Conflict in low barrier needs.

1) **Mutual Support**: We learned that the support system at Sistering is grounded in the fact that the participants are at various stages of their journey. Participants who have been in the harm reduction group for some time or have become peer support workers will mentor or look out for other participants who are living through experiences they once had. Healing journeys are not always linear, so participants who reroute to a previous stage of
their journey can be supported by friends. There are conflicts, but also durable friendships. Most participants referenced friendship and companionship as a reason to visit Sistering.

Sistering also fosters a discourse of mutual care around the idea of community. Cisgender women and trans people at Sistering form support groups that include information-sharing and education, including both practical education on safety and harm reduction, and emotional/cognitive education about unlearning stigma and shame. Participants build community through advocacy and activism work addressing systemic issues such as housing and transit justice, safe supply and use of substances, gendered violence, justice for undocumented workers, Missing and Murdered Indigenous Women and Girls (MMIWG), etc.

Our findings support other research studies about, and with, homeless and underhoused cis women and trans people in Toronto. The Coming Together community-based research project (Sakamoto et al., 2010) pointed to the “importance of social support networks amongst women and transwomen with experiences of homelessness ... social support networks often evolved as sources for protection, advocacy within the shelter system, information, resources and healing” (p. 6). Furthermore, our findings are validated by research on the centrality of mutual aid practice in harm reduction communities (Smith, 2012; Faulkner-Gerstein, 2017; Ashford et al., 2019, 2018). Bathje et al. (2020), for example, point out that “criminalization, exclusion, and stigma are part of the background context for PWUDs [people who use drugs], though they can simultaneously marginalize individuals and result in a sense of shared identity and community among PWUDs. This sense of community provides a context within which PWUDs can help each other, develop solidarity, reduce harm, and survive” (pp. 128-129). In their study of a harm reduction community in Chicago, Bathje et al. studied “prosocial, altruistic, and communal behaviour” among PWUDs, including the distribution of clean syringes, condoms, and social services information, which they labelled “diffusion of benefits” activities that are “often embedded in social networks, which provide natural opportunities for peer education and the sharing of information and resources” (Bathje et al., p. 4).

2) Language for low barrier: Sistering describes low barrier as “meeting people where they’re at.” Many interviewees reported that these measures are important or very important to them because of substance use, sex work, mental health, and daily routines. When we compared participants’ stories and looked at their descriptions of low barrier service impact in context, we saw that low barrier service measures such as anonymity, no curfew, acceptance of harm reduction approaches to substance use, and non-judgmental treatment of consumers may lead participants to feel more comfortable attending the agency and picking up harm reduction supplies, for self or others, which may contribute to better health outcomes and healthier choices.

Participants used words like “accessible,” “freedom,” “autonomy,” “independence,” and “dignity” to describe why it was important for them to be able to come and go at any hour from the drop-in. In context, the word “freedom,” for example, was practical but also indicated the opportunity to make choices, including choices that bring dignity. “Freedom of movement” helped mitigate the trauma and stress of homelessness, where curfews and
open/closing hours can amplify the stress of moving possessions and planning safe places to be during day/night time. “Dignity” was a critical part of many participants’ healing.

It’s clear that the dignity associated with low barrier and harm reduction policies can have profound impacts on participants’ health choices and health access. In a study on harm reduction policies in Canada, Pauly (2008) points out, “stigma associated with drug use can negatively impact health care interactions and access to health care. In research exploring the experiences of individuals who are homeless and/or using drugs negative attitudes, judgments and perceived discrimination have been identified as primary barriers to accessing health care” (p. 5).

3) **Scarcity of options**: A common feature of many interviews was that Sistering is the only option for many cisgender women and transgender people. Many participants specifically reported that “Sistering is my only option” or “there is no place else for me to go.” When asked what they do when there is too much conflict at the drop-in, or if they are asked to leave, participants said that they would go outside and sleep outside, and did not have another agency to go to given their circumstances (especially if their respite from Sistering was due to substance use, behaviour, or mental health issues).

Some research team members were part of the advocacy teams that called for 24/7 low barrier drop-ins for cisgender women and trans people in 2013-14 (the activism that led to Sistering becoming a 24/7 drop-in), and noted that the 24/7 drop-in was a response specifically to address the needs of these participants who were at risk of finding no agency or shelter that could accommodate their low barrier needs and mental health complexities.

**Our study also revealed the structural context for the scarcity of safe options for individuals in Toronto sharing Sistering’s population demographic.** The rising number of overdoses, the need for a safe supply and safe injection sites, increasing homelessness and scarcity of affordable or indexed housing, are overwhelming Toronto’s existing services. **Not only are there too few, or no, options in low barrier services, there are often no shelter, housing, or drop-in options at all for too many people in Toronto.**

Social service agency Fred Victor confirms that homelessness “is the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual/household’s financial, mental, cognitive, behavioural or physical challenges, and/or racism and discrimination” (“Facts about Homelessness in Toronto”). The report states that over 9200 homeless people in Toronto “are sleeping outdoors, [in] shelters and in emergency respite centres, and in health and correctional facilities every night.” Housing is not affordable for many and “[d]emand for rent-gear ed-to-income (RGI) assistance exceeds the supply” (Romeo-Beehler, p. 2). The Toronto Foundation **Vital Signs Report (2019) notes:**

- “Over the last 12 years, the social housing wait list grew by 68%, while the supply of social housing has remained the same since 1996” (p. 39);

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17 For more analysis of this topic, see Smyth, “A discourse analysis of marginalized participants’ understanding and experience of low barrier and harm reduction service delivery.” Paper under consideration with *Journal of Social Work.*
• “Other critical supports, such as transitional housing to get people off the streets, also have massive wait lists” (p. 35);
• “Since 2013, the number of people using Toronto shelters has increased by 69%. The greatest growth came from refugees, who experienced a 665% increase in homeless [in Toronto]” (p. 41);
• “Shelters (for women, men, youth, and co-ed shelters) are all at least at 97% occupancy, above the target of 90% that was set” (p. 41);
• Indigenous adults are eight times more likely to be homeless in Toronto (p. 40);
• “About 120 of the homeless will die per year” (p. 41)

Marginalization and oppression on the basis of Indigenous and racialized identity and gender identity amplifies these effects. The 2018 Street Needs Assessment reported that Indigenous peoples are “overrepresented in Toronto’s homeless population relative to their share of the general population of Toronto. Indigenous people represent between one and 2.5% of the Toronto population, yet 16% of the overall homeless population” (SNA 2018, p. 14). Migrants and refugees are also overrepresented: “over half (52%) of respondents reported coming to Canada (at some point in their life) as an immigrant, refugee/asylum claimant, or temporary resident” (pp. 18-19). The report found that “almost two-thirds of all respondents identified as members of racialized groups, with the largest percentage identifying as Black. This finding demonstrates that racialized groups are overrepresented in the homeless population relative to their share of the general population in Toronto” (p. 19). The Street Needs Assessment also found that “11% of respondents surveyed identified as LGBTQ2S. This was higher among youth, with 24% of respondents 16 to 24 years of age identifying as LGBTQ2S. Outdoor respondents were also slightly more likely to identify as LGBTQ2S compared to other surveyed groups” (p. 23).

Similar to our study’s findings at Sistering, mental health complexities and substance use across Toronto are connected with homelessness and precarious housing. The Homeless Hub reports that “30-35% of those experiencing homelessness, and up to 75% of women experiencing homelessness, have mental illnesses. 20-25% of people experiencing homelessness suffer from concurrent disorders (severe mental illness and addictions)” (“Mental Health”). The report connects mental health, homelessness, and addiction, noting, “Injection overdoses ... are a public health issue that disproportionally affects marginalized populations, including people experiencing homelessness ... A major concern for the city of Toronto is the 41% jump in overdose deaths from 2004 to 2013 as well as the increase in use of opioids, such as heroin and fentanyl” (“Mental Health”). The 2018 Street Needs Assessment confirms that “almost one third of [homeless] respondents identified having a mental health issue and/or chronic/acute medical condition. 27% reported having an addiction and 23% reporting having a physical disability” (SNA 2018, p. 26).

An increasingly toxic drug supply is another variable in the challenges faced by marginalized individuals and substance users, including Sistering participants. An April 2020 report by the Centre on Drug Policy Evaluation affirmed that opioids in particular are found to be contaminated with benzodiazepines and other unexpected drugs that amplify their overdose potential (p. 6). Safe supply, drug checking, decriminalization, and safe/supervised injection sites are measures that researchers advocate for in order to reduce or mitigate
the risks of overdose (Fleming, 2020; Ivsins, 2020; Bardwell, 2018, 2017; Jesseman & Payer, 2018; Kerr & Tupper, 2017; Fairbairn et al., 2017; Potier et al., 2014). However, overdose prevention sites and supervised consumption sites can be vulnerable to funding cuts and closure notices, as demonstrated in March 2019 when Ontario’s provincial government cut approvals and funding to existing and planned supervised consumption sites (see ‘Unacceptable’).

**Health issues are another systemic factor contributing to, and complicating, homelessness.** As Stephen Hwang notes, “Homeless people have high levels of morbidity and mortality and may experience significant barriers to accessing health care” (p. 229). Hwang’s study points to barriers such as inability to pay for prescriptions or access provincial health insurance: “In Toronto, 7% of homeless individuals report having been refused health care at least once because they lacked a health insurance card” (p. 232). Further, “Homelessness entails a daily struggle for the essentials of life. These competing priorities may impede homeless adults from using health care services, particularly those perceived as discretionary. In addition, many health recommendations regarding rest or dietary changes may be unattainable” (p. 232).

Participants in our study at Sistering referred to their reliance on Ontario Works (OW) and Ontario Disability Support Program (ODSP) as sources of income. The 2018 Street Needs Assessment confirmed that OW and ODSP are primary sources of income for homeless people in Toronto, along with the GST rebate, seasonal work, and panhandling (SNA 2018, p. 26). **These sources of income present barriers, however.** A 2006 Street Health study of ODSP found that “ODSP rates are far from adequate” and identified many barriers faced by eligible people, such as the difficulty of completing applications and navigating the application system without assistance, missing financial and identification documents, lack of a personal physician, and extensive delays within the administrative process (Shartal, pp. 6-7). A 2019 study of social assistance confirmed these barriers to application for OW and ODSP, noting also that “[t]he punitive elements in the system can lead to shame and stigma for clients, an additional psychological barrier to leaving poverty” (Zon & Granofsky). Zon and Granofsky’s policy paper argues that “social assistance has become a less reliable safety net” and it “works very unevenly” because of “systemic barriers and discrimination.” They point out that over the past 20 years the number of Ontarians receiving social assistance has declined, largely because of “changes that made it more difficult to qualify (rather than because fewer Ontarians needed support)... this decline is a result of policy changes rather than a reduction in need.” The result is that “the level of financial support of Ontario’s social assistance programs leaves people far below the poverty line” (Zon & Granofsky). **These analyses confirm the ways that poverty may be an increasing systemic contributor to the conditions of homeless and marginalized people in Toronto, like participants at Sistering.**

4) **Conflict in low barrier needs:** We learned that the population of cisgender women and trans people at Sistering includes participants at many different stages in their pathway, who have a range of housing/shelter needs, relationships with substances, mental health challenges, and resolutions of trauma. Comparing stories, we saw that some conflict at the drop-in is attributable to conflicts in participants’ service needs, where some participants
required very low barrier service (see above, as there are no other options available for them), and other participants wanted higher barrier service for their own needs or physical/mental safety.

Many participants reported feeling safe and supported at Sistering. Of the participants who answered “no” when asked “Do you feel safe and supported here? Why or why not?” they gave reasons such as violence in the drop-in, theft, preferential treatment, and client service. It also appeared that some participants’ needs for low barrier service—for instance, the possibility of staying inside Sistering overnight while having a mental health crisis—created a barrier for other participants, who were triggered or felt unsafe while in proximity to other participants’ crises or behaviour and in a densely populated space.

We especially noted how Sistering participants voiced a commitment to mutual aid. We observed how often participants answered questions with the needs of both themselves and others in mind. For instance, many participants answered questions about low barrier and harm reduction service by affirming that these services were very important to them and also to the whole community. Some even answered that low barrier options were no longer important to them, but they knew they were important to other participants. In combination with the frequency of participants referring to friendship and companionship, there appears to be a durable and often health-promoting network of relationships at Sistering tied to low barrier service delivery and harm reduction models.

We recommend more study of the intersection of these factors in our study:

1) Sistering as the “only option” for some participants
2) Conflict in low barrier needs
3) Space capacity and crowding

When we compared participants’ stories about those three areas, and looked at their answers in context, it became clear that the three factors are in conflict without a simple solution in the present circumstances.

For example, imagine a night when one participant needs a safe low barrier drop-in during a mental health crisis when they are experiencing trauma, may be very loud, and may be agitated and physical. A few feet away another participant needs a safe quiet place to sleep and keep possessions safe, but they are triggered by the noise and witnessing another participants’ trauma and are concerned about theft of possessions. The compressed and crowded space puts the participants in close proximity, and there is not enough space for participants to self-select different areas of the drop-in. Staff may try to de-escalate and assist the participant in crisis in another room, but there are few or no un-used areas in the drop-in. If the participant in crisis is asked to leave because the behaviour breaks a rule, there is no other shelter or drop-in they can go to with similar or lower barrier rules. The open-ended and qualitative nature of the interviews yielded for our team these insights about areas of conflict.
Our research data clearly showed the critical importance of low barrier and harm reduction service to Sistering’s population. We also found that Sistering is perceived as a safe and supportive agency for the majority of participants who need harm reduction supplies and low barriers, such as 24/7 access and anonymity. Overcrowding puts pressure on the agency’s ability to maintain low barrier service, and chips way at participants’ ability to feel safe and manage mental health complexities.

The findings from our project complement other studies on homelessness, violence, and the overdose crisis in Toronto, drawing attention to the systemic causes of marginalization, particularly for cis women and trans people, and the increasing scale of homelessness and poverty. As the Coming Together report states,

[I]ndividual experiences of homelessness are often affected deeply by the historical and current systems of marginalization at the group/structural level … From an empowerment and anti-oppressive perspective, the specific barriers these groups of individuals face must be understood from a structural level, and that services to support those with experiences of homelessness must consider the specific barriers these groups face due to oppression. (Sakamoto et al., 2010, pp. 6-7).

**Participant recommendations for change**

The community of participants at Sistering have many insights about unmet needs and solutions for change based in their lived experiences, contact with many touchpoints in the shelter/housing/drop-in system, and consultations with one another. One participant suggested that Sistering needs separate places for sleeping:

*I was just thinking they could have set up beds and have that whole [basement] area opened up as ... where you sleep, and then upstairs where the recliners are is where for the people who are temporarily needing to rest, not really needing to sleep the whole night away. [Women] can come and go ... Or the ones that are using ‘cause you can’t deny, there are women who use drugs, and they wanna come in and out. They don’t wanna be like stuck in the bedroom. (I-17)*

This participant’s vision for Sistering combines features of a shelter and a 24/7 drop-in. Another participant points out that shelters have much less conflict over sleeping space and have lockers for possessions, which they wish to see at Sistering.

*[At a shelter] it’s much better that you can sleep in a bed ... [here] I see a lot of people fighting before going to sleep ... because they couldn’t find a place to sleep ... [I think] they have to have small lockers for documents, money [in the basement] ... it would be good for a lot of people who are homeless. (I-5)*

Some participants reported a perception that rules are not always applied consistently. Some interviewees feel that when rules are broken—for example, violent behaviour, verbal
abuse, or drinking alcohol—they don’t understand why some participants are given probation and others receive service respites of varying lengths.

I don’t understand how do staff [differentiate] between how one person gets sorta probation and another is kicked out, you know? There ... need to be guidelines, like I would like guidelines as to how staff use discretion when dealing with people who are behaving not well in this space. (I-15)

11% of participants (n=4) suggested an increase in security measures such as cameras or security staff. One participant said:

They should have people dedicated to conflict ‘cause conflict is a reality at Sistering ... not a security guard ... conflict officers or conflict staff that know people really well, know and take the time to understand both sides, and not just listen to the fast-talkers. (I-41)

Participants suggested that programming was very important for mental health and for substance users. They recommended increased programming to help with these needs and advocated for more donations.

What we need is more hands-on in the mentoring for people who are mentally ill ... a program for the ones who are mentally ill where they could learn how to cope. Or the ones who are losing their mind they can learn how to cope and have somebody there to guide them ... through the process because homelessness is not easy ... and especially if you already have an illness it could make you even more lost. So we need more people to help them get on their feet so that they could find a place ... and continue with aftercare. (I-12)

Low-barrier involves a lot of unsolved issues with people that are violent ... I think that [the] approach to the participants should involve more education, more workshops ... how to deal with their violence, extreme violence, the people who are user of illicit drugs and alcohol and others. (I-40)

Sistering is a beautiful and wonderful organization that is really built to helping people and has been doing so for a long time. The only problem is we need to figure out how we’re gonna try to get some more donations and stuff so we can still keep programs running because we don’t need our facilitated programs cut short ... it keeps us outta trouble with the law. It keeps us out of trouble with narcotics abuse. It keeps us busy. (I-42)

Participants suggested that more 24 hour drop-ins are needed, and advocated for safe injection sites on shelter premises to ensure cis women’s and trans people’s safety while consuming drugs.

18 Please see “Contexts and Limitations” and “Participants’ understanding of ‘Low Barrier’” for discussion of the project’s recruitment and interview profile and its effect on results.
[The other shelters] need to have an injection or safe using site on the shelter premise. If you’re a harm reduction shelter you should have a place where people are being monitored. (I-14)

I think it would be a really, really great thing…I don’t know how possible or not it is to have a clean shooting site…. And maybe a great counselor or sex trade worker right on property. Or both. (I-24)

I’m actually glad I found this place cause I’ve never found a women’s place like this … I’m thinking that there should be more 24-hour drop-ins for women, cause women go through crises and addiction and you know they need a lot of support. (I-29)

I feel that Sistering needs a bigger building ‘cause the building we are in now is pretty small and the people … a lot of women are coming more and more. (I-29)

I wish the clothing was more accessible, a lot more than once a week. (I-34)

Research team recommendations for change

The research team members had diverse responses to the interview and focus group results, and differing conclusions to draw about what the interviews revealed.

Sharing Information
A number of interviewees, focus group members, and peer researchers agreed that lack of awareness of programs and activities was a common concern at the drop-in. The 2018 Sistering Participant Survey Findings, in fact, reported that 50% of respondents were “not fully aware of all the services offered at Sistering” (Ghomeshi, p. 40). The peer researchers on the Oral History research team recommended that one product of this research study could be a newsletter for the drop-in, updating participants on the results of the study and serving as a model for a regular newsletter that could be produced within the drop-in (see Appendix B). This newsletter could update participants on past and upcoming activities and events.

Clarity on policies
The interviewee statements about conflict in the drop-in suggested that some participants perceive that rules are not always applied fairly, and that not all participants are clear on what the rules are. A town hall meeting at Sistering focused on what low barrier means, and what code of conduct is in place at the drop-in, might be an opportunity for participants to compare their perspectives on low barrier service and on what they need from the drop-in. It could also be an opportunity for Sistering management to discuss with participants what the drop-in protocols are, and post these in the drop-in, if they are not already.

As this study pointed out, cis women and trans people who use Sistering’s services are at different places on their paths. Many participants are aware of the journeys of the other
participants around them, and remember their own needs at earlier stages of their journey. Because a climate of mutual support and co-education often prevails at Sistering, despite interpersonal conflict, it is possible that participants can have a productive open discussion about what happens when the low barrier needs of different participants are in conflict. One context for that conversation must be the fact that there is no other option in Toronto with lower barriers, which many participants are aware of.

Special purpose low barrier services
Another recommendation from the research group addresses the fact that Sistering is the only option for the most at-risk participants and those with complex mental health needs. If the low barrier of Sistering’s drop-in is too high a barrier for women experiencing a mental health crisis or whose substance use needs cannot be accommodated within Sistering’s harm reduction policies, one solution could be the creation of a separate low barrier, harm reduction-focused facility that does accommodate cis women and trans people with the most challenging mental health complexities. Certainly, the overcrowding at Sistering, the high need of Sistering participants for low barrier services, and the scarcity of other options, makes it urgent that more low barrier drop-ins and shelters be created.

Conclusions
This research study offers a detailed picture of the experiences shared by participants at Sistering’s drop-in. The core themes that emerged from the study—a climate of mutual aid and peer support, a common language for low barrier, the scarcity of options for this demographic, and conflicts in low barrier needs—illuminate the coping skills and very real challenges faced by Sistering participants. Those challenges emerge from and are deepened by the systemic, structural conditions of their lives: marginalization and discrimination, barriers to accessing social assistance, a housing crisis and lack of shelter and drop-in space in Toronto, an increasingly contaminated drug supply, and insecure/underfunded infrastructure of safe/supervised injection sites.

One of our key findings and recommendations brings us full circle to the reason Sistering’s drop-in was first created: in 2013-14, with pressure and insights from advocates, the City of Toronto recognized that low barrier, harm reduction, trauma-informed drop-ins were urgently needed to accommodate cis women and trans people whose needs were not meet by the existing shelter and drop-in network in Toronto: individuals with complex mental health and substance use needs, who required low barrier policies such as 24 hour access and anonymity. Our 2017-19 study confirmed the critical value of these low barrier and harm reduction-focused drop-in spaces, the positive and empowering effects they have on cis women’s and trans peoples’ lives—and the urgent need for more of them.

The team recommends the creation of more low barrier drop-ins and shelters for cisgender women and trans people, some with particular emphasis on high-need participants and/or those with complex mental health needs and with day and night staffing by staff with mental health support training.
We also recommend further research on specific needs of transgender persons within the shelter and drop-in system in Toronto. Our study recruited two participants to interview who identified as transgender, which comprised 5% of our interviewees and is higher or comparable to Sistering’s 1% transgender population overall (Ghomeshi, p. 15). We did learn about trans-specific concerns from our interviewees, and believe that a future study with more focused recruitment of trans people across Toronto’s shelter and drop-in system would yield valuable insights about the experiences and needs of this population, especially given the largely binary gender division of shelters and drop-ins and the particular marginalization of trans people within the homeless population (see Mottet & Ohle, 2003; Sakamoto et al., 2010).

Deliverables for this project thus far include a newsletter, a pamphlet, a small poster for Sistering display, a large research poster, this report, and two research articles and a conference paper drafted by Dr. Heather Smyth. The peer researchers in particular decided information-sharing was an important need amongst Sistering participants, and asked that a newsletter be produced (see Appendix B).

The team produced two videos of the project: “The 24 Hour Drop-In at Sistering: Women's Oral Histories,” which discusses our findings; and “Community-Based Research: 'The 24 Hour Drop-In at Sistering: Women's Oral Histories' Project,” which also discusses the process. Both are filmed by Lucy Drumonde, Luis de Estores, and Heather Smyth, and are edited by Lucy Drumonde. They can be found on YouTube at https://www.youtube.com/watch?v=4-TD9v5I5t5k&t=3s and https://www.youtube.com/watch?v=NFHker5R1s&t=30s.

**Ethics**

Ethics approval for this project was given by the University of Waterloo Research Ethics Committee.

**References**


Relich, S. (2017, January 10). ‘Meeting them where they are’: At Sistering, harm reduction means providing more than a space to sleep and the tools to use drugs safely. The Local. https://thelocal.to/sistering-meeting-them-where-they-are-5f5acffe0ad6/ [Accessed 17 October 2019]


Appendices

Appendix A: Interview Questions

Questions for Oral History Interviews at Sistering

Ice-breaker Questions –

How are you? How was your day? What did you do today?

What do you like most about coming to Sistering?

What do you like least about coming to Sistering?

What time or times of the day did/ do you use Sistering’s Drop-In?

Experiences at Sistering –

What experiences did/ do you have when you came/ come to the 24/7 Drop-In? What does a normal visit to Sistering look like for you?

How do you feel when you come to Sistering?

Do you feel safe and supported here? Why or why not?

How important is it that you can come and go as you wish at any hour of the day?

How important is it that you can pick up harm reduction supplies?
- Do you find these supplies at any other agencies?

How important is it that you do not have to give Sistering staff your name?

Support Services outside of Sistering –

Have you used other agencies in addition to Sistering? Have you ever used shelters? Why or why not?

What is the same about them when compared with Sistering? What is different?

Do you feel comfortable there?

Are you comfortable with the staff?
- With other women that also use that agency (or shelter)?

What happens if you are not comfortable? What do you do?
What does staff do if women using the agency (or shelter) are not getting along?

Is there anything you need from Sistering that you are not getting here?

Current Situation-

If you moved on and stopped coming to the 24 / 7 Drop-In, what was your outcome like?

Where are you at now?

If you are still coming to the 24 / 7 Drop-In, what are you experiences like now?

Is there anything else you would like to tell me about using the 24 / 7 Drop-in at Sistering?

Questions about how the participant identifies herself

We have some questions that we’re asking participants about their age, ethnic background, and how they describe their sexual orientation and gender, so that we have a sense of the background and life experiences of the women we interview. If you’re not comfortable answering these questions that’s ok, and it’s ok if you want to answer some of them but not all.

What is your age range?

- Less than 20 years old
- 21 - 30 years
- 31 - 45 years
- 46 - 60 years
- 61 - 74 years
- 75 and over

How do you describe your ethno-racial group? Here are some common descriptions to choose from, or you can use your own words to describe your ethno-racial background.

- Black, African
- Black, Caribbean
- Black, North American
- White, North American
- White, European
- East Asian (e.g. Chinese, Korean, Japanese)
- Indian, Caribbean
• Indigenous/Aboriginal - First Nations
• Indigenous/Aboriginal - Métis
• Indigenous/Aboriginal - Inuit
• Latino, Hispanic
• Middle Eastern (e.g. Syria, Iraq, Iran, Afghanistan)
• South Asian (e.g. East Indian, Pakistani, Sri Lankan)
• Southeast Asian (e.g. Filipino, Vietnamese, Cambodian, Laotian)
• Mixed heritage
• Don’t Know
• Prefer not to answer
• Other (please specify): ______________________

What language(s) do you prefer to speak? (Check all that apply)

• English
• Cantonese
• Cree
• Farsi
• French
• Mandarin
• Ojibwe
• Portuguese
• Spanish
• Other (please specify) ______________________

What is your status in Canada? (Your personal information will not be shared)
• Refugee
• No status
• Permanent resident
• Canadian citizen
• Temporary worker in Canada
• Visitor to Canada
• Prefer not to answer
• Other (please specify): ______________________

How would you describe your sexual orientation?

• Bisexual
• Heterosexual/straight
• Homosexual/lesbian/gay
• Queer
• 2 spirit
• Prefer not to answer
• Other (please specify): ______________________
What is your gender?

- Female
- Trans – Female to Male
- Trans – Male to Female
- Non-binary
- Genderqueer
- 2 spirit
- Prefer not to answer
- Other (please specify): ______________________________

Thank you very much for speaking with me today!
The 24 Hour Drop-In at Sistering: Women’s Oral Histories

Project Update

Background

Sistering’s Drop-In converted to 24/7 in 2015 after activists lobbied City Hall to demand low barrier drop-in centres for women, including transgender women, whose needs were not met by existing shelters and agencies. We wanted to find out if the women who needed a 24/7 drop-in are being helped, and what things are like now that Sistering is open 24 hours.

The Project

We formed a collaborative research team of four participant women peer researchers, one former Sistering staff member, and a professor and two students from the University of Waterloo, using funding from Women's College Hospital and the Harding/Claxton HSS Endowment Fund. We wanted to hear in women’s own words what their experiences are like when they use the 24 Hour Drop-In. We held a focus group of 12 women and interviewed 43 women from June-Sept 2018.

What we learned

We learned a lot from the women who generously shared their stories with us. We learned that Sistering is the only option for many women: for these women, the rules that some agencies have about curfew, substance consumption, and providing one’s name create too high a barrier for them. Many women said they would be sleeping outside if Sistering did not have a 24 hour drop-in where they could sleep. Women described what low barrier service means to them, and used words like freedom, dignity, independence, and choice to explain why they needed to come and go when they wish, why they needed harm reduction supplies for themselves or for friends, and why they felt safer when they did not have to give their name. The women we interviewed also appreciated that they did not feel judged or stigmatized at Sistering when they picked up harm reduction kits. Some women said that this helped them find dignity, and it also helped them make healthy choices.

We also learned that women are concerned about violence and conflict in the drop-in. Many women described drama, yelling, theft,
Our conclusions

Homelessness is a trauma, and has physical, emotional, and mental effects. Many participants at Sistering are experiencing forms of trauma, and many have complex mental health needs and consumption needs. Participants at Sistering are at different places on their paths, and Sistering plays a different role in their well-being over time. Women may have different needs when it comes to low barrier: some women need low or no barriers to get access to drop-ins and shelters, and some women want higher barriers and more rules to feel safe and feel that things are fair. Members of our research team had different ideas about best solutions. A low-barrier drop-in like Sistering seems to be the only option for many women, who would otherwise not have a safe place to find shelter and sleep. Since the drop-in spaces at Sistering are always full, this means that more low-barrier spaces, or drop-ins, should be made available to meet the needs of a diverse group of women with a range of needs.

Next steps

- Share the project findings and conclusions with the Board of Directors at Sistering, the Sistering community, local media, and the City of Toronto
- Plan for discussions with Sistering participants about possible project ideas for 2020

The team

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and fighting at the drop-in. Some women are triggered by the noise and conflict and choose to leave for awhile. Some women know that they have moments of drama or anger and appreciate when staff and peers know how to support and calm them. Some interviewees spoke about de-escalation, and how rules are applied. They talked about complex mental health needs and how to get along with so many women in a small space.

We also noticed how many women talked about friendship. Many women are brought to Sistering for the first time by a friend. Participant women support each other, share knowledge and information about safe practices and the resources available in Toronto, and advocate for each other. The peer system lets women reach out to others who are at a different place on their path and offer them hope and advice. Women pick up harm reduction supplies to hand out to friends. And many women said how important it is that Sistering is for women and trans people only and is about empowerment.

The team wants to thank all the participants who shared their stories with us, and all the staff who helped facilitate the interviews and let us use Sistering space for the project.
Appendix C: Interviewee gift bag contents