Abstract

As ‘access brokers’ to resources for their clients, homeless shelter workers are often in a position to aid victimized homeless women in securing medical and psychological services post-victimization. Given high rates of victimization within this population, we would expect that a routine part of a shelter’s case management process would involve queries regarding victimization. Through in-depth qualitative interviews with 42 victimized homeless women in Chicago and Detroit, we sought to discover the extent to which such queries were pursued by staff at their current shelter. What we found is that women are seldom asked to provide a complete history that includes experiences of violent victimization and its effects. From these results, we make a number of recommendations aimed at improving homeless victims’ access to services.

Keywords: homeless; women; victimization; case management; shelter

Within the research literature it has been well documented that homeless women experience high rates of physical and sexual violence (D’Ercole & Struening, 1990; Wenzel, Leake, & Gelberg, 2001; Weseley & Wright, 2009). The physical, mental and emotional effects of violent criminal victimization on members of this group are also well known (Stewart, Steiman, Cauce, Cochran, Whitbeck & Hoyt 2004; Whitbeck, Hoyt, Johnson, & Chen, 2007). Given these facts, the issue of homeless women’s access to medical and mental health services post-victimization would appear to be a critical one.

Unfortunately, the issue of how marginalized women might access services post-victimization has yet to be substantially addressed. Of research conducted in the area of healthcare provision more generally, studies consistently demonstrate that homeless women face significant systemic and situational barriers (Hatton, 1997; Gelberg, Browner, Lejano, & Arangua, 2004; Jasinski, Wesley, Wright, & Mustaine, 2010), which clearly affect those women who are also victims of violence. Within the present paper we identify yet another factor that can play a key role in blocking homeless women's ability to access healthcare services post-victimization: the failure of community service agencies to ask about violent victimization as a first step to referring clients to appropriate services.

Drawing on an analysis of data collected from in-depth qualitative interviews conducted with 42 women in Chicago- and Detroit-area shelters, we found that the majority of homeless women in our study (n=30) were never asked about experiences of violent victimization by workers at their present shelter. Thus, staff members lacked vital information concerning any resulting physical injuries or other traumatic effects that might require healthcare services. When women reported having been asked about violent victimization by shelter staff (n=9), most were asked about experiences of intimate partner violence (IPV) only (n=5)[1]. To the extent that many of these women lack knowledge of existing programs and services to help them deal with the physical and mental effects of violence, in addition to other barriers faced by homeless women, failure by shelter workers to ask about victimization means that one of the best opportunities for assisting victims of violence into securing needed services is being lost. In our concluding section, we draw on our findings to make a number of recommendations aimed at helping service providers better help victimized women access healthcare.

Previous Research on Barriers to Medical and Counseling Services Post-Victimization

In numerous studies, homeless women have reported having been stabbed with knives and syringes, burned, shot, strangled, cut with knives and glass, and beaten with hands, feet and objects (Jasinski et al., 2010; Huey, Fthenos and Hryniewicz, 2012). Each of these forms of

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[1] The remaining three women could not recall whether they had been asked about their victimization experiences.

violence produces physical injuries, most requiring medical treatment and follow-up care. Sexual assaults produce not only physical injuries, but also sexually transmitted infections. Added to the immediate physical effects of violence – the fractures, broken bones, torn tissues, bruises, stab wounds and other cuts – homeless female victims of violence also frequently experience diminished health over the longer term, which has been directly attributed to their exposure to violence (Wenzel, Leake, & Gelberg, 2000).

Violent victimization also produces mental and emotional trauma. Victimized homeless women have reported anxiety disorders, major depression, and post-traumatic stress disorder post-victimization (D’Ercole & Struening, 1990; Stewart et al., 2004). Experiences of physical and sexual assault have been strongly associated with substance abuse problems (Tucker, Wenzel, Straus, Ryan, and Golinelli, 2005) and the worsening of psychotic symptoms among those with pre-existing delusional disorders (D’Ercole & Streuning, 1990). Suicidal ideation is also greater amongst victims of violence, and victimized homeless women are at an especially high risk to have attempted suicide (Ambrosio, Baker, Crowe, & Hardill, 1992).

To address the physical and mental health effects of violent victimization, homeless women require healthcare that encompasses not only primary assessment and wound care, but also gynecological services, health promotion and disease prevention and comprehensive mental health programs (Finfgeld-Connett, 2010). However, the little research that has been conducted on access to healthcare by victimized homeless women demonstrates that they frequently do not receive needed services (Jasinski et al., 2010; Stermac & Paradis, 2001). Such service gaps are seen as an inevitable consequence of systemic and situational barriers that both victimized and non-victimized homeless women face.

Primary among barriers identified is a lack of financial means. Not having access to financial resources can create barriers in several key ways, such as preventing women from accessing private healthcare providers when they cannot afford private insurance or are deemed ineligible for public programs (Hatton, 1997). The effects of ineligibility were notably demonstrated in a 2003 study of 974 women utilizing shelter and food services in Los Angeles (Heslin, Andersen, & Gelberg, 2003). Researchers found that approximately 46% of their sample “lacked health insurance” and, as a result, “were not receiving key health and social services” (Heslin et al., 2003, p.35). A lack of means is also manifested in issues related to basic subsistence – such as the need to find safe shelter or food – which may have to take priority over waiting at a clinic to see a clinician, nurse or other service provider (Gelberg et al., 2004). A further related concern is lack of transportation. Studies consistently show that those without financial means are often unable to secure transportation to clinics or treatment programs outside of their immediate environments (Gelberg et al., 2004; Heslin et al., 2003).

Some women, particularly mothers with young children who lack child care, simply do not have the luxury of scheduling appointments based on a healthcare provider’s availability (Mikhail and Curry, 1999). For women who utilize comprehensive shelter services, program attendance requirements can lead to scheduling difficulties that make it difficult for them to access free clinics or other healthcare programs (Gelberg et al., 2004). Similarly, homeless women in mandated child custody programs, or who are attending addiction treatment programs, may not have the flexibility to schedule medical appointments at certain times or to tolerate long wait times at a clinic (Gelberg et al., 2004.). In some situations, women cannot readily schedule medical or counseling appointments because of demands placed on them by part-time or casual work employers (Huey et al., 2012).

The ability to access healthcare services can also be hampered by the fact that some women may not even be aware of what programs are available to address their healthcare needs. In one recent study it was found that homeless women who seek access to mental health services to deal with anxiety, depression and other clinical issues post-victimization are often unaware of what resources are available to them (Huey et al., 2012). Similarly, in a study of homeless mothers, Tischler, Rademeyer, and Vostanis (2007) noted that respondents wanted better communication from hostel staff about available programs.

While it is the case that untold numbers of homeless women are unable to access medical and mental health services post-victimization, it is very likely that many of these same women *are* accessing other services, principally shelters. To the extent that many shelters and other housing-related programs offer a range of multi-level services – including facilitating access to medical and psychological counseling services, either on-site or through off-site arrangements – it would be reasonable to expect that such organizations would represent a viable conduit for women whose means of access might otherwise be blocked.

Unfortunately, we could find only two previously published papers on the role that shelter staff might play in facilitating women's access to medical and psychological services. One of these is Hatton's (2001) study of social networks as facilitators to healthcare services, in which she found that shelter staff and other frontline community workers can act as advocates or 'brokers' for their clients, helping them to negotiate access to healthcare programs. The secondpaper is based on the work of Heslin and his colleagues (2003), who similarly examined the roleof case managers at shelters and food programs in Los Angeles in helping homeless womenacquire needed services. What these researchers found is that case management was notassociated with increased access to medical care. They suggest their findings "may indicate aneed for better administrative support to inform case managers about the full range of localprograms and other resources available to their clients” (Heslin et al., 2003, p. 50). Within the pages thatfollow, we offer another explanation for why case management might not necessarily lead togreater access to healthcare services in the case of victimized women: the failure of serviceproviders to routinely ask women about their experiences of violent victimization.

Method of Inquiry

This paper is informed by data from an ongoing study of barriers criminally victimizedhomeless women face in accessing services post-victimization. To explore these issues, weconducted in-depth semi-structured qualitative interviews with 79 homeless women, ofwhom 60 reported experiences of violent victimization. As one of the purposes of the present paper isto assess the extent to which homeless female crime victims had been asked by shelter staffabout violent victimization, we have excluded interviews with women who came to a facilitythrough another program[2], as well as those individuals currently on parole as their case historywould have been available to shelter staff prior to arrival. Thus, of the 60 participants whoreported violent victimization, we draw on interviews with 42 women. Although we briefly examine whether women were asked about their victimization experiences at intake, our primary focus was to understand whether being asked facilitates access to services and whether not being asked hinders access to services, and how his impacts homeless women. Therefore, in-depth interviews were deemed to be the most appropriate research method.

To locate potential research participants, we developed a non-probability sample consisting of the maximum number of service agencies working with homeless women in Detroit

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[2] For example, a couple of participants entered shelter services through a program that assists women seeking to transition out of sex work. As part of that program’s process, a complete client history would have been taken.

and Chicago and asked these organizations if they would facilitate our access to their clients. Intotal, 13 organizations agreed to participate. For the present study, we are drawing onparticipant experiences with nine shelters (four in Detroit and five in Chicago).

Client participation in the study was voluntary with individuals providing active consent after being informed about our study and its aims. No incentives were offered for participation. Eligibility requirements included being at least 18 years of age, being currently homeless and residing in a shelter, and appearing capable ofunderstanding the nature of their consent. With each participant, we explained the nature of thestudy, went through the informed consent forms, and outlined the types of questions we wouldbe asking. Once the interviewer was assured that the woman understood the nature of herparticipation and had voluntarily signed the consent form, the interview was begun. Eachinterview was typically of an hour's duration and was recorded with the knowledge and consentof the participant.

To better understand the nature of our sample, we collected demographic information from each woman, including her race/ethnicity, age and overall length of homelessness. Of the 42 women represented here, the majority were African-American (*n*=37), followed by Caucasian (*n*=3), Latina (*n*=1) and Pacific Islander (*n*=1). The most frequently occurring age group were those in the 18-30 category (*n*=17); however, our sample also included women aged 31-45 (*n*=13) and 46-70 (*n*=12). Lengths of homelessness varied, ranging from one week to several years. Most frequently, women in our sample had been homeless for a period of one month to one year (*n*=18), followed by those with three or more years of homelessness (*n*=9), less than a month of homelessness (*n*=8) and one to three years of homelessness (*n*=7).

For logistical reasons, interviews for this project were conducted over the course of two separate trips to Detroit and Chicago (in June and August 2011, respectively). During the firsttrip, we conducted exploratory interviews using open-ended questions. Questions posed centeredon five key areas: (a) basic demographic information; (b) experiences of victimization over the lifecourse; (c) experiences of, or attitudes toward seeking assistance from (i) police, (ii) medical staffand (iii) mental health services; (d) views as to facilitators and barriers to accessing services post-victimization,and; (e) recommendations for future programs, policies and/or services. In relationto facilitators and barriers to services, we asked each woman a variation of the followingquestion: “At any time during your stay here, has any staff member ever asked if you’ve everbeen a victim of violence?” This question was followed up with more specific queries regarding intake and case management processes at their current shelter.

After each interview, debriefing sessions were held during which team memberscompared notes, identified new themes that had arisen during an interview and developed furtherquestions. For our second set of interviews, we developed an interview checklist based on thefive key areas noted above, as well as themes/topics related to areas of interest identified duringearlier debriefings. The checklist helped to focus our questions and to ensure consistency acrossinterviews.

To code and analyze our data we followed Braun and Clarke’s (2006) method of thematic analysis. According to Braun and Clarke, thematic analysis offers a rich, yet flexible, approach to analyzing qualitative. Braun and Clarke’s approach also offers a systematic five-step methodfor analyzing data. After transcribing interviews, reading the transcripts, and noting important emergent themes, we coded our data using an open-coding process in which we carefully coded each data item line-by-line. These initial codes were then organized into broader global themes. Next, we reviewed these broad themes to ensure they accurately reflected the coded data extracts and the longer interviews. Lastly, the themes were further refined and analyzed by combining some subthemes into larger themes and dropping others as the ‘story’ of the data became clearer. At this point, we also named and defined our themes. This process was iterative and we returned to previous stages as required. A deductive analytic approach was taken with the five key areas of the interview checklist guiding analysis; however, our analytic approach remained flexible enough to accommodate additional important themes as they emerged.

“It Was Hitting, Punching …”: Victimization Experiences

Participants were asked a series of questions about victimization and the specificforms of violent victimization they had experienced over the course of their respective lifetimes. Given that IPV is frequently associated with female homelessness(Williams, 1998), it was not surprising to note the majority of women (*n*=31) reported havingbeen physically assaulted by a partner. One participant, a 53-year-old woman from Chicago told a depressingly familiar story of physical and sexual abuse by her ex-husband: “Once we got married, we was together for a few months and he started the abuse.”She explained that the violent relationship lasted “for eight long years” and, despite attempts torun away, “he’d find me.” A 39-year-old Detroit woman said of her first husband, thateven after he left her for another woman, she would sometimes be woken up by “getting pulledoff the couch by my feet, my head hitting the wall or the floor.” Two participants also reportedattempts made on their lives by former partners. One related how her ex-husband broke into a home with a gun and threatened to kill the occupants before being shot in self-defense. The otherwoman said, “A boyfriend I had, he tried to choke me to death.”

We received the second highest reporting rates for having experienced physical assault in childhood (*n*=28).A Detroit woman who had been homeless for three months said of her childhood, “Any whichway they felt, we got whupped. Extension cords, whatever.” A young woman in Chicagoexplained of her early life, “It was hitting, punching and throwing glasses of pop. It was knives being thrown and guns being put to your head … because you don’t want to do what they want you to do.”

Childhood sexual abuse was the third most frequently occurring victimizationexperienced (*n*=22). Most commonly, women reported having been sexually victimized byfamily members, such as uncles, step-fathers, brothers and cousins. One 26-year-old woman was sexually abused by her step-father for eight years. She said, “I have an eight year oldson from a rape, when I was a child. I was molested and raped all the way from the age of nine toseventeen, when I got pregnant.” Another woman told us, “I was molested at the age of five andthen twelve … by a family member.”

Participants also reported experiences of sexual assault in adulthood (*n*=18) and episodes of physical assault by a non-intimate partner (*n*=16). In both circumstances, womenoften knew the perpetrator as he or she was a friend, acquaintance or family member. In one instance, a 54-year-old Detroit woman revealed that she had been sexually assaulted at theage of 37 by her brother. She said, “I had a brother, he’s passed on, he sexually …[stops speaking].” Another woman was sexually assaulted by her husband’s cousin, and still another by a former friend. Although some individuals did report episodes of physical violence by strangers, they were also more likely to have been physically assaulted (as adults) by a family member. During adulthood, one woman had been living with her mother, who would “punch me in the face and start yelling at me.” On one occasion, she said of her mother, “She bit me.” A 40-year-old woman in Chicago reported being randomly assaulted by heradopted father when she would go to visit him. When initially asked about victimization, she said of him, “Occasionally, he has hit me in the face.” She later related an incident in which she was “talking to him and hit me in the face three of four times. I walked around for weeks with my face just ruined. My eye. My right side and my left side.”

The lowest victimization rates were obtained for robbery (*n*=11) and gang-related violence (*n*=8). Of these, most commonly women stated they had been jumped by a group or otherwise physically attacked for their valuables. One woman warned us that the neighborhood we werein was dangerous and that she and her children had been robbed by a group of young thugs only a few blocks away. For women who reported experiences with gang violence, often their victimization came as a result of participation in a gang, either directly as a member or as a friend to gang members. For example, one woman recalled being physically and sexually assaulted as ‘punishment’ by members of a rival gang.

“Mostly I Just Worry About Surviving”: Barriers to Service for Homeless Women

As discussed above, homeless women face numerous barriers to receiving required services post-victimization. Examples of such barriers include a lack of financial means (e.g., cannot afford doctors, do not have health insurance), not having the flexibility to schedule appointments, work demands, a lack of knowledge about available programs, and, for women with children, demands placed on them by the Department of Child and Family Services (DCFS). The women that we interviewed described experiencing suchbarriers in their own lives.

Most commonly, interviewees described barriers to service related to their lack of financial means. As one woman explained, lack of financial means meant a lack of “decent healthcare.” Another described herself as “falling between the cracks” because of bureaucratic regulations. She worked, but was not able to secure enough employment hours to qualify for certain programs. Although one woman from Detroit was able to see a doctor and receive a prescription for her anxiety, she received no further monitoring and was not referred to counseling, which she attributed to her ability to secure health insurance. According to the woman, not having health insurance represented a significant barrier to her well-being:

A: I don't have health insurance.

Q: So you get the worst care possible?

A: Yeah, if I even get it.

Another financial factor identified by participants was lack of transportation, which was seen as a key barrier to accessing services. For example, a young woman from Detroit, who was six months pregnant stated, "I need transportation. I need a doctor. A hospital so I can have my child." Similarly, a 23-year-old pregnant woman from Detroit noted of barriers to services that her current shelter "don't have no transportation and they don't give you no transportation when you need it." With that being said, the same woman explained that practices vary by shelter – a previous shelter she lived in provided clients with bus tickets. A lack of transportation also represented a significant barrier for a 39-year-old Chicago woman, who simply remarked,"They don't have that much transportation here." At a more macro-level, a Chicago woman suggested that the government cutbacks have negatively affected many homeless women because shelters have had to reduce or eliminate transportation for their clients in response to shrinking budgets. According to this individual, such cutbacks "make it more and more difficult for people that really need services for being victimized."

Lack of knowledge about available services also represented an impediment for many of the women interviewed. For instance, an 18-year-old Detroit woman who became pregnant after being raped was in desperate need of counseling services and pre- and prenatal health care, but she was unaware of available services or how to access them:

Q: Do you know if there's any programs that could give you the services you need?

A: No, I don’t know of any.

A 39-year-old Texan living in a Detroit shelter was similarly unaware of available local programs. She described not knowing what services were available, and having to rely on other clients for information. Given the extent to which women interviewed were unaware of existing programs, it is unlikely that that this particular individual was fully informed as to available options.

Barriers related to childcare were less of an issue for participants. Most of the interviewees with children had open files with the DCFS and their children were in foster care. Ironically, these women also tended to be receiving counseling services from the DCFS, but not for therapeutic purposes. Rather, the women were receiving counseling to assess their suitability to parent. Nevertheless, for these women, cancelling rigidly scheduled DCFS visits to attend another appointment was not an option. According to a 26-year-old Chicago woman who had recently cancelled a DCFS visit to meet with her lawyer, “I got into some trouble with my caseworker … Basically, my caseworker was like, ‘I’m very disappointed in you. I’m going to mark this as a failed visit.’” Aside from the DCFS, other women noted that their schooling was a barrier to accessing services. For instance, a thirty year old Detroit woman who was dealing with the effects of IPV while desperately trying to finish a semester at law school advised that her shelter offers counseling groups, but they are not convenient for her:

> I just don’t have time to participate in them right now. Every day, I’m out there in the world … at the library, applying for work, at interviews, looking for places to stay in my area … I just don’t have time to participate in them … My schedule is just so full right now because it’s really time for me to grind, as they say.

In reference to social supports, a 42-year-old Chicago woman said, “They’re telling me you’re eligible for this, you’re eligible for that, but with me being a full-time student, no, I’m not.”

Notably, these barriers to service – and a general sense that they lacked assistance in accessing available services from shelter staff – were a great source of frustration for many of the women. The case of a young 18-year-old Detroit girl who was six months pregnant as a result of a sexual assaultwas particularly demonstrative. This woman did not have a doctor or other form of prenatal healthcare and did not know where she would go to deliver her baby. Moreover, her caseworker was about to go on vacation and she was not referred to another caseworker in the meantime. Although she was in need of many services, the woman stated, “There’s no point in me being here. I can’t get the right type of help that I need. So, what am I here for? What?” A 34-year-old Chicago woman noted another systemic problem that posed a barrier for her ability to seek support post-victimization: male case workers. This interviewee, who felt that she would benefit from having somebody to talk to about her trauma and related emotional problems, said,

> It would be nice just to have somebody there to talk with, to get it out. It’s good to have a woman to relate to, because they have male caseworkers here. It’s like a lot of things, you can only say so much to them. Because at the same time, who hurt you? A man. So, do you really feel comfortable talking to this man?

The women interviewed for this study reported many of the same barriers to service that have been previously identified in the literature. In the following pages we explore an additional significant barrier to accessing services: the failure of service workers to ask clients about their victimization history.

“They Don’t Ask You”: Are Women Being Asked about Violent Victimization?

We asked each participant whether staff members at her current shelter had inquired about experiences of violent victimization in her history[3]. Three of the women (*n*=3) could notrecall whether they had been asked. However, the majority of women interviewed

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[3] If a woman gave a negative response, we verified the response by asking specifically about case managers, intake workers, senior staff members and other shelter workers.

didremember and responded negatively (*n*=30). Only nine participants (*n*=9) stated they had beenasked about experiences of violent victimization by shelter staff.

Of the women who responded negatively, most offered answers that were variations onthe following response, provided by awoman with a history of childhood abuse and intimate partner violence: “No.” For example, a 34-year-old assault victim in Chicago initially said “no,” then added, “They don’t ask you.” A 27-twenty-seven year old woman residing in one of the Chicago shelters said of her case manager, “He askedabout drug use and stuff like that.” Of victimization, she said, “It’s based on you, if you want totell somebody.”

Q: So they don’t come out and ask?

A: Right.

Other respondents similarly reported failures on the part of shelter workers to take detailed case histories that included questions about violence and resulting physical and mental trauma. For example, a Chicago woman revealed that her case manager was unaware of her history of having been violently assaulted because the focus of discussions had been “mainly like housing and drugs, substances, stuff like that.” Discussions about needs and services were even more cursoryat another Chicago facility, a site with comprehensive on- and off-site medical andcounseling services. When we asked a woman at this organization whether she had been asked aboutvictimization, she replied, “No, they just give you a booklet to fill out and you just check offwhat you want from them.”

Nine of the women in this present study had a different experience: they reported havingbeen asked at their current shelter about experiences of violent victimization. Interestingly, wecould discern no recognizable pattern as to when and where women were asked – that is, the ninewomen were not all staying at one or two particular locations where policies were clearly in placeand being followed. Rather, positive responses came from women at five different locations (three in Detroit and two in Chicago). Further, at each of these sites we also received negativeresponses from other women, indicating that queries about victimization were not routine among staffmembers, but rather at the discretion of individual workers. For example, one woman at a Detroitshelter said that it was routine for a case manager to ask about IPV in order to “assess you to see what best plan fits your needs”. However, we queried another resident at the same shelter – who was also a victim of IPV – whether she had been asked about her victimization she replied, “No.” In order to access services to deal with the traumatic effects of IPV, she said, “I volunteered and gave theinformation.”

“Maybe They Haven’t Gotten To Me Yet?”

When examining the responses of the 30 women who reported failures by shelter staffto raise issues of victimization, two key themes emerged: perceived inadequacies in the casemanagement process and limitations arising from organizational mandates.

Of the two themes identified, the most notable set of responses centered on perceivedinadequacies in shelters’ intake/case management process. One Chicago shelter, inparticular, appeared to have adopted an especially haphazard approach to their intake and casemanagement process. We discovered exactly how disorganized this process was during an interview with a 24-year-old woman who had been at the facility for a week at the timeof the interview. When asked if any staff member had queried her about her history of IPV, she replied, “They haven’t even done my intake here yet. They told me they’d do it in a couple of days. Everything I had to find out, I had to ask people who were already here.” A woman at another Chicago facility said of that facility’s intake process, “They just gave me a bed. The next two days later, put me in a computer class or something and that was it.” She also had yet to be assigned a case manager: "Maybe they haven't got to me yet?" A similar response was received by a client of a Detroit shelter. This woman, who had a history of sexual assault, described her intake process as follows: "They just checked my bags and gave me my bed."

Some women felt they had not been asked about victimization or offered appropriate services to deal with the effects of violence because the mandate of the organization was morefocused on employment and housing issues rather than on adopting a holistic approach to homelessness and related issues. For example, a woman residing in a shelter in Detroit that offers comprehensive housing, addiction and mental health servicessaid of the workers at her shelter, "They're looking at us as pretty much that you're homeless, get up and get a job … They're only here to help find housing." A woman at another Detroit facility,who had an extensive history of IPV and was on her second week utilizing this shelter, said thather caseworker had just pulled her in for a "ten, twelve minute meeting," the focus ofwhich was whether she had made progress in securing government and housing services: "'So what have you accomplished? What's going on with you? Where are you at?'" This progress, she noted, was to have been accomplished without even "a piece of paper" outlining available resources. This participant was greatly amused by the idea that her facility would help her secure resources related to her victimization.

"She Asked Me If I Had Any Domestic Violence."

The fact that nine of the women reported having been asked about experiences ofviolence would appear to be a positive sign that shelter workers at some facilities take thoroughcase histories in order to better facilitate women's access to needed services. However, it became apparent during interviews that this was not necessarily the case. Indeed, five of the nine women subsequently revealed that they had been asked about IPV only and not about other forms of physical and sexual violence. For example, a 36-year-old woman in Chicago, who had been a victim of both IPV and severe physical abuse in childhood, said of staff at her present shelter:

A: Yeah, they ask you if you are a survivor of domestic violence.

Q: Did they ask you about the childhood stuff?

A: No, they didn’t ask me. They just asked me if I’m a survivor of domestic violence.

A 40-year-old woman with a history of depression and suicidal ideation linked to physical andsexual abuse in childhood reported that she was only asked about one form of victimization by the head of the shelter: “She asked me if I had any domestic violence.” The problem with such queries is that by focusing solely on IPV, women who may be suffering from physical and/or psychological issues related to other forms of violent victimization are not likely to be identified and given appropriate services.

We also noted other ways in which discussions about victimization with shelter staff were superficial. For instance, a woman with a history of childhood physical and sexual abuse, IPV and various forms of adult physical and sexual violence stated that she was asked about her history by a case manager. However, she also revealed to the interviewer that thequestioning was “not to the extent you are doing it.” As a result, shelter staff knew “some” of her history, “but not all of it.” In discussing why the case manager did not have as complete a picture of her history as the interviewer did, she said, “They really did not ask.” Similarly, a woman, who was battling depression and had a history of IPV and childhood physical abuse, was only asked about IPV:

Q: [referring to the shelter staff] Do they know about your childhood abuse?

A: No, because they never asked me.

In conversations with shelter workers, we sometimes heard that women are often resistant to disclose victimization, thus there is often no point in asking about previous experiences of violence. The women we interviewed not only disclosed episodes of violence in their past, but were also forthcoming about the extent to which they would be willing to share those experiences with shelter workers. One young woman in Chicago said of the staff members at her shelter, "If they would've asked, I would've only been honest about some questions and not all."A fifty-three year old woman at another Chicago shelter was willing to be open about herhistory, but had not been provided the chance:

Q: Would you have told them if they asked you?

A: Yeah.

In reviewing interviews conducted with women who had been asked about victimization it became obvious as to why some might feel resistant to discussing past traumatic experiences:the topic of victimization was approached by staff in such a way that interviewees felt uncomfortable or unwilling to trust them. For example, a woman in Chicago with a history of physical and sexual assault beginning in childhood said that an intake worker "tried to get" at her history of violent victimization by asking her, "'So what happened to you in yourchildhood?'" This individual chose not to disclose her history to the case manager because she felt the other woman was "sifting" through her past to find out if she would be someone "with a bad attitude," rather than seeking information to help her access resources. This participant was willing to be forthcoming with the interviewer because, she said, "You told me why you wanted to know upfront." In contrast, the shelter worker "didn't even give me a reason."

"They Should've Asked Me."

Participants were also asked whether they felt that shelter workers *should* ask female clients about experiences of violence. Overwhelmingly, respondents felt that such queries would be useful as a means of opening the door to a discussion about relevant services for dealing with physical, emotional and/or mental trauma. For example, a 26-year-old woman in Chicagowith a history of sexual assault and IPV was of the view that “they should’ve asked me.” Interestingly, the facility that she was housed in is one that offers comprehensive counseling, employment and other services, so it was felt that such a query might have facilitated her access into counseling services she was not currently attending. When a 40-year-old woman, who contemplated suicide following a lifetime of physicalabuse, was asked whether questions about violent victimization should be a mandatory component of a case history, she replied, “Yeah, because that would help you in the long run to better yourself. Yup, I believe so. [Referring to counseling] There’s a lot of women that need that.” At another shelter,we interviewed a 53-year-old Chicago woman with a history of physical and sexual abuse beginning in childhood. Although this woman had experienced a lifetime of violence, she wasnot presently in counseling. When asked if she thought it would have been helpful to her abilityto access counseling services – which she wanted – if her case manager had asked about herhistory, she responded simply: “Yeah.”

In interviews, participants were quick to note that a significant consequence of failures toask about victimization and/or to take detailed case histories was that they were forced to findother avenues through which to seek resources. For example, a 36-year-old woman in Chicago said she wished shelter workers would ask clients about violentvictimization because the ensuing discussion about resources “would probably be helpful to me.” This individual was eventually able to access therapeutic services on her own initiative, byasking about available counseling programs at an outside addiction treatment program.

“I Need Help”: Drawing Conclusions

It has been asserted that there is a critical lack of needs assessment research to help homeless service agencies improve the effectiveness of their programs and services (Acosta andToro, 2000). The larger study from which the present paper is drawn represents an attempt to build upon this idea by examining the post-victimization needs of homeless female victims of violence and how these needs could be better met within the framework of existing service provision. To the extent that shelter workers and other homelessness service providers have been portrayed within the research literature as ‘access brokers’ for their clients (Hatton, 2001; Heslin et al., 2003), we would expect that queries about victimization would be a routine part of case management practices. Instead, we found that this was not the case and that, in the words of the woman quoted in the subheading above, many victimsof violence are not receiving the assistance they need. Within this final section, we draw on the findings presented above to introduce a number of suggestions aimed at helping serviceproviders implement policies and practices to improve women’s access to services post-victimization.

Many of the participants in this study identified barriers to service similar to those identified elsewhere, such as a lack of financial means (Hatton, 1997), a lack of transportation (Gelberg et al., 2004; Heslin et al., 2003), difficulties scheduling appointments because of the needs of children (Mikhail & Curry, 1999) or programming mandated by shelters (Gelbert et al., 2004), and being unaware of available services (Huey et al., 2012). However, above and beyond these obstacles, not being asked about past-victimization experiences represented a significant barrier to service for the women in our sample and service providers lost an ideal avenue through which to assist these women. Indeed, several of the women interviewed for the present study stated they had either never undergone an intake process upon arrival at their current shelter or that the intake process had been minimal, mainly requiring them to field basic questions about their identity, drug use ormental health issues. As intake can be a vital part of the case management process signalingpotential issues that clients might be facing, we recommend that upon initial contact with clients, service providers begin to construct a detailed life history of the client. While service provider concerns that some women might be resistant to answering personal questions aboutvictimization at intake are valid, we note that this concern does not prevent many agencies from asking clients equally personal questions about drug use or mental health issues. If a client chooses not to be candid during intake, a thorough case management process will provide other opportunities for revealing such information, which can then be used to provide information andhelp formulate post-victimization healthcare treatment plans.

Given high rates of IPV among homeless women and the significant security risk that IPV perpetrators can represent to women’s safety (Browne and Bassuk, 1997;Williams, 1998), it is of no small concern to note how few women in this study – only five of 42 participants – were asked about IPV at their shelter[4]. We also encourage service providers to develop policies that require all clients be asked about possible past and/or current experiences of IPV, as well as experiences with other forms of violent victimization. In our study we captured the experiences of several women who had no history of IPV, but who had beenbrutally victimized through other forms of physical and sexual assault, as well as by robbery, gang violence and childhood abuse. Each of these forms of violence can result in both physical and/or psychological effects requiring treatment.

When conducting assessments, it is important for caseworkers to explain to clients the rationale surrounding why they pose the questions they do. By explaining to clients that the information gleaned will be used to help provide access to healthcare services, otherwise intrusive questions become recast as part of a beneficial process, rather than as an administrative formality or ‘fishing expedition’ wherein the worker “sifts” through one’s past to

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[4] It will be recalled that sixteen of the women interviewed for this study reported having been a victim of IPV, which means that in eleven positive cases women were not asked about this during intake or as part of their case management.

makejudgments about his or her attitude or behavior. Additionally, when asking clients about their experiences with violent victimization, the assessment questions should be specific and presented in a straightforward manner. For example, a closed-ended question such as, “Have you been violently victimized?” leaves too much scope for interpretation and may engender responses that are not complete because clients have forgotten about a particular episode of victimization. A more direct method would be to ask about specific forms of victimization: “Have you ever been in a romantic relationship where youwere hit, slapped, kicked or punched?” or “Have you ever been forced to have sex?”

Lack of knowledge and training in the various forms of violent victimization and IPV may hamper the ability of service providers to recognize and correctly interpret the experiences of clients. Therefore, we also recommend educating all frontline and supervisory staff on issues related to violence, so they will be able to identify, assess, document and properly assist clients in the management of healthcare issues arising from violent victimization. We further recommend that agencies develop programs and policies that are sensitive to gender issues related to victimization, particularly in relation to the fact that it is very likely that women may become highly uncomfortable being asked to disclose episodes of physical and sexual to male workers and therapists. Similarly, we note the need for caution in asking sensitive questions related to victimization of members of the GLBTQ[5] community, a group that is demonstrably at a significant risk for physical and sexual violence (Cochran, Stewart, Ginzler and Cauce 2002).

Finally, policies centered on screening female clients for violent victimization should be implemented consistently across workers and, to the extent that many agencies operate multiple sites, across facilities. Further, the operation of such policies should be routinely assessed in

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[5] The gay, lesbian, bisexual, transsexual, transgender and queer community.

order to determine their effectiveness in gaining clients access to healthcare programs that address their specific needs. Ideally, such assessments should be part of a larger evaluation aimed at discovering which programs and initiatives are most beneficial for helping clients overcome the negative effects of victimization.

Three limitations of this study should be noted. First, we were unable to access domestic violence shelters. For reasons of safety and confidentiality, many of these facilities do not allow access to researchers. Had we had access to these sites, we may have discovered variations in policies and practices that would have shed more light on the role that service providers can play in facilitating access to medical and psychological services post-victimization. Second, we note that we are drawing on an admittedly small sample size; thus, our findings may only be considered preliminary in nature. Third, although interviewees were open about responding to our questions, as can be seen in the preceding sections, often their responses were relatively brief. One reason for this may be that we did not have enough time to establish sufficient rapport with interviewees that they felt comfortable expanding upon their criticisms of shelter practices. Future research in this area might endeavor to have women elaborate on their thoughts in this area in order to expand upon this and other barriers to service that still may remain hidden. Such research might also consider exploring possible changes in levels and types of barriers, if any, as a result of the introduction of the *Patient Protection and Affordable Care Act* (2010).

Nevertheless, the data presented do clearly indicate a troubling pattern worthy of continued investigation. We hope that our attempt at shedding much needed light on this under-researched subject will act as a catalyst for otherscholars to develop studies that will add further knowledge in this area. Such knowledge will hopefully inform relevant policy and practice aimed at helping homeless women secure the resources they need to address not only past and present victimization but to exit homelessness.

References

Acosta, O.,& Toro, P. (2000). Let’s ask the homeless people themselves: a needs assessmentbased on a probability sample of adults. *American Journal of Community Psychology,28*(3), 343-366.

Ambrosio, E., Baker, D., Crowe, C. &Hardill, K. (1992). The street health report: A study ofthe health status and barriers to health care of homeless women and men in the City ofToronto. Toronto, ON: Street Health.

Braun, V., & Clarke, V. (2006).Using thematic analysis in psychology.*Qualitative Research in Psychology, 3*(2), 77-101.

Browne, A., & Bassuk, S. (1997). Intimate violence in the lives of homeless and poorhoused women: prevalence and patterns in an ethnically diverse sample. *American Journal of Orthopsychiatry*, *67*(2), 261-278.

Cochran, B., Stewart, A., Ginzler, J. & Cauce, A. 2002. Challenges faced by homeless sexual minorities: comparison of gay, lesbian, bisexual, and transgender homeless adolescents with their heterosexual counterparts. *American Journal of Public Health*, 92(5): 773-777.

D’Ercole A., & Struening, E. (1990). Victimization among homeless women: Implications forservice delivery. *Journal of Community Psychology*, *18*(2), 141-152.

Finfgeld-Connett, D. (2010). Becoming homeless, being homeless, and resolving homelessnessamong women. *Issues in Mental Health Nursing, 31*(7), 461–469.

Gelberg, L., Browner, C., Lejano, E., & Arangua, L. (2004). Access to women’s health care:A qualitative study of barriers perceived by homeless women. *Women & Health*, *40*(2),87-100.

Hatton, D. (1997).Managing health problems among homeless women with children ina transitional shelter.*Image: Journal of Nursing Scholarship*, *29*(1), 33-37.

Hatton, D. (2001). Homeless women’s access to health services: A study of social networksand managed care in the US. *Women & Health, 33*(3/4), 167-181.

Heslin, K., Andersen, R., & Gelberg, L. (2003).Case management and access to services for homeless women. *Journal of Health Care for the Poor and Underserved*, *14*(1), 34-51.

Huey, Laura, Georgios Fthenos and Danielle Hryniewicz. 2012. “‘I need help and I know I need help. why won’t nobody listen to me? Homeless women’s experiences with accessing and consuming mental health services.” *Society & Mental Health*, 2(2): 120-134.

Jasinski, J., Wesely, J. Wright, J. & Mustaine, E. (2010).*Hard lives, mean streets: Violence inthe lives of homeless women*. Hanover, MA.: Northeastern University Press.

Mikhail, B.,& Curry, M. (1999).Perceived impediments to prenatal care among low-incomewomen.*Western Journal of Nursing Research, 21*(3), 335-355.

Stermac, L., & Paradis, E. (2001). Homeless women and victimization: Abuse and mentalhealth history among homeless rape survivors. *Resources for Feminist Research*.*28*(3/4), 65-75.

Stewart, A., Steiman, M., Cauce, A., Cochran, B., Whitbeck, L. & Hoyt, D. (2004).Victimization and posttraumatic stress disorder among homeless adolescents.*Journal of the American Academy of Child and Adolescent Psychiatry*, *43*(3), 325-331.

Tischler, V., Rademeyer, A., & Vostanis, P. (2007).Mothers experiencing homelessness:Mental health, support and social care needs. *Health and Social Care in theCommunity*, *15*(3), 246–253.

Tucker, J., Wenzel, S., Straus, J., Ryan, G. & Golinelli, D. (2005).Experiencing interpersonalviolence: Perspectives of sexually active, substance-using women living in sheltersand low-income housing.*Violence Against Women*, *11*(10), 1319-1340.

Wenzel, S. Leake, B.,& Gelberg, L. (2001).Risk factors for major violence among homelesswomen.*Journal of Interpersonal Violence*, *16*(8), 739-752.

Wenzel, S. Leake, B. & Gelberg, L (2000).Health of homeless women with recentexperience of rape.*Journal of General Internal Medicine*, *15*(2), 265-268.

Wesely, J.,& Wright, J. (2009). From the inside out: Efforts by homeless women todisrupt cycles of crime and violence. *Women & Criminal Justice*, *19*(3), 217-234.

Whitbeck, L., Hoyt, D., Johnson, K.,&. Chen, X. (2007).Victimization and posttraumatic stress disorder among runaway and homeless adolescents.*Violence and Victims, 22*(6), 721-734.

Williams, J. (1998). Domestic violence and poverty: The narratives of homeless women. *Frontiers: A Journal of Women’s Studies*, *19*(2), 143-165.