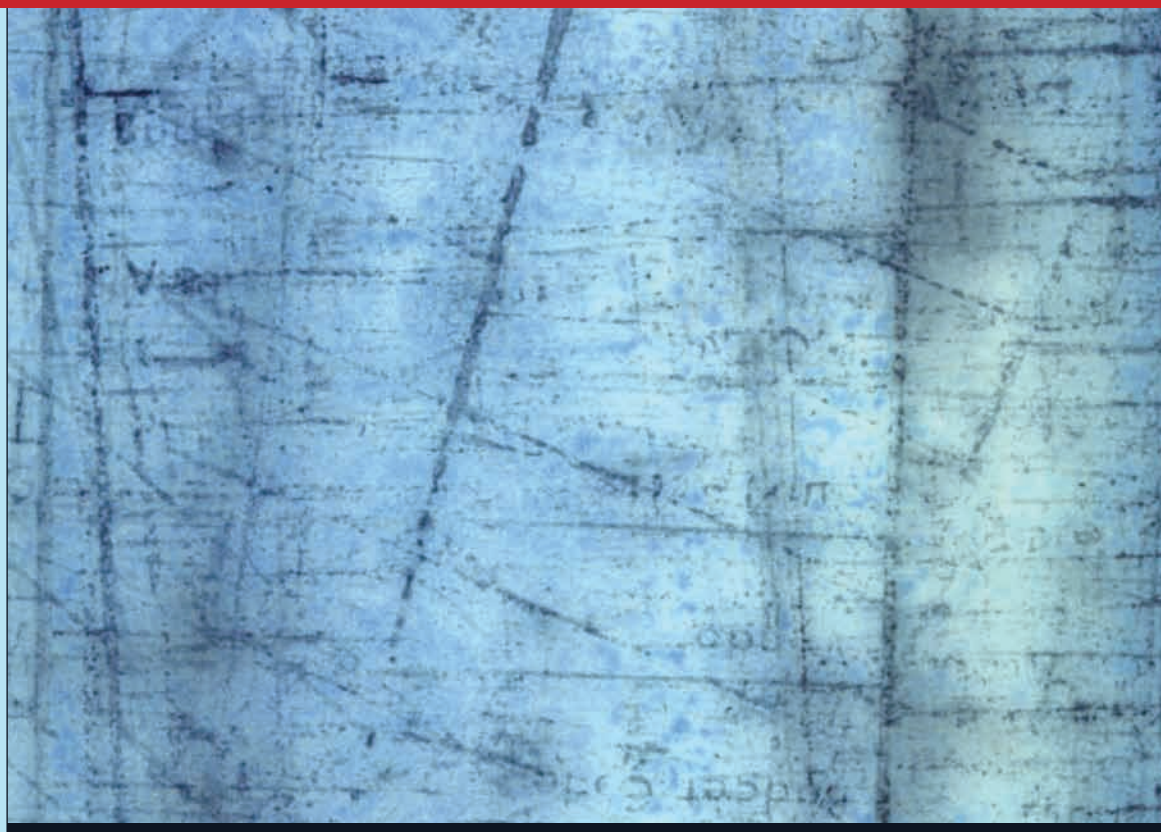
Violence and Victims



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Exploring the Experiences of Violence Among Individuals Who Are Homeless Using a Consumer-Led Approach

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Homelessness increases vulnerability to violence victimization; however, the precise factors associated with victimization and injury are not clearly understood. Thus, this study explores the prevalence of and characteristics associated with violence victimization among homeless individuals by surveying approximately 500 individuals experiencing homelessness in 5 cities across the United States. Our findings reveal that nearly one-half of our sample reported experiencing violence and that prolonged duration of homelessness (greater than 2 years) and being older increased the risk of experiencing a violent attack. In addition, increased length of homelessness and female gender predicted experiencing rape. Women were also significantly more likely to know one's perpetrator and experience continued suffering after a violent attack. We conclude that certain subpopulations within the homeless population are at an increased risk for victimization and, subsequently,

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require added protective services; implications for health care and policy recommendations are also discussed.

Keywords: homeless; homelessness; violence; victimization; rape

Individuals who are homeless have an increased risk of experiencing myriad social problems including victimization and violence (Centers for Disease Control and Prevention, 2010; D'Ercole & Struening, 1990; Fazel, Khosl, Doll, & Geddes, 2008; Fitzpatrick, LaGory, & Ritchey, 1999; Kerker et al., 2011; Kushel, Evans, Perry, Robertson, & Moss, 2003; Lee & Schreck, 2005; Raoult, Foucault, & Brouqui, 2001; Simons, Whitbeck, & Bales, 1989; Tsai & Rosenheck, 2012; Welsh et al., 2012; Wright, 1990). The prevalence of violence victimization in the homeless population has been estimated to range from 14% to 21% and approximately one-third report having witnessed a physical attack on another person who was homeless (Fitzpatrick, LaGory, & Ritchey, 1999; Lee & Schreck, 2005). This rate of violence is highly disparate when compared to the general population in which only 2% report experiencing a violent crime (Truman, 2011). In addition, research has demonstrated that some subpopulations of homeless individuals are at even increased risk of experiencing violence. For instance, those who experience longer bouts of homelessness have increased risk of victimization (Kipke, Montgomery, Simon, & Palmer, 1997; Lee & Schreck, 2005; Simons & Whitbeck, 1991). Those who have been previously turned away from a shelter or reported committing a crime since becoming homeless are also significantly more likely to experience victimization (Garland, Richards, & Clooney, 2010).

Research has also shown that experiencing violence can have serious prolonged effects (Lindhorst & Beadnell, 2011; Sousa, Herrenkohl, & Moylan, 2011). Physical assault on individuals experiencing homelessness has the potential to cause physical and psychological injuries, extend homelessness, and may require considerable medical treatment that most homeless individuals are unable to afford. The aftereffects of violence also include lower levels of perceived safety and an exacerbation of preexisting mental health issues (Kilpatrick & Acierno, 2003; Perron, Alexander-Eitzman, Gillespie, & Pollio, 2008; Sorenson & Golding, 1990).

Given these increased risks of experiencing violence and the understanding that violence can have long-term prolonged consequences, this study specifically aims to (a) describe the experiences of violence among individuals who are homeless, (b) create a sociodemographic profile of individuals who have experienced violence, (c) identify the factors that predict increased risk of experiencing violence and suffering consequences after an attack, and (d) to craft health practice and policy recommendations that illuminate solutions to addressing and stemming the increased rate of violence experienced and the related negative effects both at the macro and micro individual level.

In contrast to previous research, this study takes a consumer-led approach in which currently or formerly homeless individuals were integrally involved in each stage of research (design, administration of the survey, and data analysis and interpretation). This sets our study apart in that the critical perspectives of individuals who have experienced homelessness helped to illuminate not only the issues that are of importance but what the results of this study mean and how they can be incorporated into applied practice and affect relevant policy change.

METHODS

The data used in this study draw on a survey regarding experiences of violence by individuals who were homeless in five cities across the United States (Detroit, Fort Lauderdale, Nashville, Houston, and Worcester). This study was originally conceptualized, designed, and administered by the National Consumer Advisory Board (NCAB) of the National Health Care for the Homeless Council. NCAB comprises individuals who are currently and formerly homeless, many of whom participate in the governance of their local Healthcare for the Homeless (HCH) projects. HCH projects are grantees or subcontractors of the federally funded community health center program. Some are stand-alone sites, whereas others are housed within community health centers, public health departments, or hospitals. Many HCH projects have multiple sites in one community and mobile units or outreach workers travelling to different parts of a community to provide health care services. For example, the HCH project in Nashville is part of a network of primary care clinics with community, school, and mobile clinics. This project provides medical, dental, and behavioral health services to men, women, and children who are homeless through their Downtown Clinic (a brick and mortar clinic located in an impoverished neighborhood), a mobile medical van, evening clinics at a local shelter, and other community health center facilities. NCAB exists to voice the needs of the people who are homeless on a national level, assist new projects in developing local consumer advisory boards, and provide support to individuals who are currently homeless (National Health Care for the Homeless Council, 2009).

Data Collection

The interviewers associated with NCAB recruited individuals at their local HCH projects and sites where health care services relevant to homeless populations are provided. Eligibility to participate in the study was met if individuals were currently homeless, older than the age of 18 years, and self-reported that they were an enrolled patient of the specified HCH project. If an individual met all three eligibility criteria, the interviewer read the informed consent aloud, answered any questions or concerns about the study, and asked for verbal consent from the potential participant. Research interviewers informed individuals that participation in the study was voluntary and that they could discontinue participation at any time.

The institutional review board of the Metro Public Health Department of Nashville and Davidson County approved this study and allowed use of a verbal consent because of the sensitive nature of the survey content and the vulnerable population being surveyed. If an individual did not understand the informed consent for any reason, then interviewers did not continue with the survey and documented the event. If an individual did not wish to participate, interviewers recorded the refusal on a tracking form, including specific reasons why. If a participant knew the interviewer or felt uncomfortable with a specific interviewer, given the sensitivity of the survey questions, attempts were made to find a different individual to administer the survey. All participants were offered a copy of the consent form for future reference. Most surveys were administered in English. However, when non-English, Spanish-speaking individuals were eligible to participate, attempts were made to find a Spanish-speaking interviewer to administer the survey.

Because of the possibility that participants could become emotionally distressed and retraumatized recalling violent experiences, research interviewers provided a list of local

resources after participants completed their surveys. Each site developed a list of resources tailored to the specific services offered by the local community and HCH project (e.g., domestic violence shelters, legal assistance, and mental health services). Interviewers received research training from the National Health Care for the Homeless Council, which included topics such as research with human subjects, informed consent, data collection, and confidentiality. One of the NCAB interviewers was principal investigator of the study and received Collaborative Institutional Training Initiative (CITI) certification as well. Personally identifiable information was not collected through the survey and all responses were anonymous.

The total number of participants in the final sample was 516. This number represents roughly 100 participants from each city. Fifty-eight percent of participants required the assistance of the survey administrator to complete the survey and 89% completed the survey in English.

Analytic Plan

Descriptive statistics were computed on all study variables. Three dependent variables were used: experience of violence, experience of rape, and suffering after an attack. Bivariate analysis was conducted to evaluate the associations between the three dependent variables and myriad sociodemographic characteristics. Because the three dependent variables were dichotomous indicators, four multivariate logistic regressions were conducted to evaluate whether certain characteristics increased the odds of violence, knowing one's perpetrator, and suffering after an attack. A series of logistic regression analyses were then performed using groups of conceptually related independent variables (e.g., regressing experience of violence on gender and race). These exploratory models were used to guide selection of variables for inclusion into the final regression models. The following variables were selected as independent variables: race, sex, length of homelessness, place of attack, and knowing the perpetrator. Evidence of significant predictors (p values) was derived using chi-square. All data analysis was conducted using SPSS 19.0.

RESULTS

Of the total sample, 64% of participants were male, 35% female, and 1% transgender. Nearly one-half (49%) of the participants self-reported as African American, 36% as White, 12% as Hispanic/Latin American, and 3% reported they fell into the category of Other. The median age of participants was 43 years old, with a range of 18–87 years. The median length of homelessness reported by participants was 1.75 years, with a range of 1 day to 47 years.

Witnessing Violence

Participants were asked if they had ever witnessed a violent attack on another homeless individual. For the purpose of this survey, a *violent attack* was defined as an event in which one individual uses force to intentionally harm another individual physically, sexually, or psychologically. Sixty-two percent of respondents reported witnessing an attack. Of those, 32% witnessed an attack in the 30 days prior to the survey and 81% witnessed an attack within the past year. More than half (56%), who responded that they had witnessed a violent attack, reported witnessing an attack on another homeless individual 1–3 times.

TABLE 1. Time Elapsed Since Most Recent Attack and Number of Times Victimized

	Frequency	Percentage (Cumulative)[a]
Most recent attack		
Within past 30 days	71	30%
Within past 6 months	65	27% (56%)
Within past year	39	16% (73%)
More than 1 year ago	60	25% (98%)
Number of times victimized		
1–3 times	179	72%
4–6 times	26	11%
7–9 times	7	3%
10 or more times	14	6%

[a]Percentages do not add up to 100 because response categories were created based on open-ended responses. Responses that could not be categorized are not presented.

Personal Experience of Violent Attack

Participants were also asked if they had ever been the *victim* of a violent attack while homeless. Forty-nine percent of respondents reported being the victim of an attack. When victims were asked about the most recent time they were attacked, 30% reported being attacked within 30 days of the survey and 73% within the past year (this percentage is cumulative and includes those who reported being attacked with 30 days of the survey). Seventy-two percent of victims reported being attacked 1–3 times while homeless (see Table 1).

Males and females experienced violence at virtually the same rate (49% and 48%, respectively), whereas African American participants experienced violence more (51%) than White participants (46%). However, White participants reported experiencing more violence than Hispanic/Latino participants (46% and 44%, respectively). When experience of violence was stratified by age and length of homelessness, the average age for victims was 4 years higher than that for nonvictims (44 vs. 40 years old, respectively) and the average length of homelessness for victims was 1.6 times greater than for nonvictims (4.5 vs. 2.9 years, respectively). In addition, there was a statistically significant difference in median age and length of homelessness between those participants who reported experiencing violence while homeless and those who did not (see Table 2).

Characteristics of Violent Attacks

More than half of victims (58%) reported that they were attacked in a street or alley, whereas 16% reported being attacked in a public park and 13% reported being attacked in a homeless shelter. Victims were also asked to provide the types of injuries they incurred as a result of their most recent attack from a predetermined list of injuries. Although

TABLE 2. Demographic Characteristics of Those Who Have and Have Not Experienced Violence

	Experienced Violence ($n = 253$)	Never Experienced Violence ($n = 287$)	χ^2
Race			3.70
African American	127 (51%)	124 (49%)	
Latino	27 (44%)	34 (56%)	
White	85 (46%)	101 (54%)	
Gender			2.67
Male	161 (49%)	167 (51%)	
Female	87 (48%)	94 (52%)	
Age (years)	Median age: 43		11.09**
≥43 Years	144 (56%)	115 (44%)	
<43 Years	103 (41%)	149 (59%)	
Number of years homeless	Median length of homelessness: 2 years		11.63**
≥2 Years	139 (57%)	107 (43%)	
<2 Years	103 (41%)	147 (59%)	

**$p < .01$.

16% of victims were not injured, more than half of respondents (56%) reported bruising. Approximately 30% were mentally traumatized, 15% were raped or sexually assaulted, and 13% incurred a head or brain injury. Victims also reported broken bones, broken teeth, being stabbed, and being shot (see Table 3). In addition, victims were asked if they were robbed during their most recent attack and, if so, what specific items were stolen. Forty-nine percent of victims reported that they were, in fact, robbed during the attack. Commonly reported items stolen were money (75%), personal identification documents (28%), medication (21%), and clothing (21%).

Victims were also asked to list reasons why they thought they were attacked. Again, the responses came from a predetermined list, which included space for participants to report additional reasons. The top four reasons victims thought they were attacked included the following: robbery (32%), attacker was under the influence of alcohol or drugs (28%), hate crime (15%), attacker had a mental illness (12%), and competition for space (5%). The following explanations were additional qualitative responses provided by victims and each reported by less than 5% of the sample: sexual assault, because of an argument, racially motivated, and to prevent victim from helping another person. Almost a quarter of the victims (24%) were not sure why they were attacked.

In addition, 31% of victims reported that they knew their attackers. Of those, a substantial minority (40%) identified the attacker as a friend; a small minority reported their attacker was an intimate partner; and a very small minority reported that their attacker was a family member (see Table 4). Victims were also asked about the housing status of their

TABLE 3. Locations Where Violent Attacks Occurred and Injuries Incurred as a Result of Attacks

	Frequency	Percentage[a]
Location of attacks		
Street or alley	141	58%
Public park	38	16%
Shelter	32	13%
Abandoned building	18	7%
House[b]	10	4%
Jail	7	3%
Parking lot[b]	6	2%
Bus station[b]	4	2%
Clinic	3	1%
Other	13	5%
Injuries from attacks		
Bruises	137	56%
Mental trauma	76	31%
Raped/sexually assaulted	36	15%
Concussion/head injury	32	13%
Broken bones	32	13%
Tooth/teeth broken	22	9%
Stabbed	20	8%
Scraped or cut[b]	8	3%
Shot[b]	2	1%
Other	12	5%
Not injured	38	16%

[a]Percentages do not add up to 100 because participants could choose more than one response.
[b]These responses arose from themes found in the qualitative data.

TABLE 4. Relationships of Attackers to Victims—Out of Those Who Reported Knowing Their Attackers ($n = 72$)

	Frequency	Percentage
Friend	29	40%
Intimate partner	11	15%
Family member	4	6%
Other	4	6%
No formal relationship[a]	24	33%

[a]This response arose from a theme found in the qualitative data.

TABLE 5. Where Victims Sought Assistance Sought After Attacks ($n = 105$)

	Frequency	Percentage[a]
Emergency room	63	60%
Police	35	33%
Community clinic	11	11%
Friend/family member	10	10%
Health care for the homeless clinic	9	9%
Shelter[b]	3	3%
Other	12	11%

[a]Percentages do not add up to 100 because participants could choose more than one response.
[b]This response arose from themes found in the qualitative data.

attackers. Thirty-two percent reported that the attacker was also homeless and 30% reported the attacker was housed, a quarter of whom were reported to be police officers.

Assistance After the Attack

Forty-six percent of victims sought help after their most recently reported attack. More than half of victims (60%) who sought assistance used the emergency room, more than 30% went to the police, and 30% went to a friend/family member or clinic (see Table 5). Eighty-two percent of those individuals who reported seeking assistance stated that they were successful in receiving assistance.

Sixty-eight percent of those who sought and received help were unable to pay the associated medical bills. We asked victims if they were currently (at the time of the survey) suffering consequences from a violent attack. Half of the victims (49%) reported that they were still suffering. Choosing from a predetermined list, 73% of those reported suffering from psychological trauma, 32% from resultant physical disability, and 28% from burdensome financial debt.

Finally, we asked victims if they were familiar with the Crime Victims Fund, which is a federal program to assist victims of violent crime (and sometimes family members of victims) with resulting medical bills, mental health services, and lost wages. However, only 14% of victims were aware of the Crime Victims Fund—9% of which had actually attempted to receive funds. None were successful.

Multivariate Modeling

Four multivariate logistic regressions were conducted on the study sample to estimate the risk factors for experiencing violence, experiencing rape, knowing the perpetrator, and suffering after an attack. Table 6 shows the results of these multivariate logistic regressions. The results demonstrate that being homeless for a long time (more than 2 years) and older age led to an increased risk of experiencing violence. Moreover, increased length of homelessness and female gender predicted experiencing rape specifically. Finally, only female gender was a significant predictor of knowing one's perpetrator and suffering consequences after an attack.

TABLE 6. Multivariate Logistic Regression Models for Predicting Violence, Experiencing Rape, Knowing the Perpetrator, and Experiencing Suffering After an Attack

	Violent Victimization		Experiencing Rape		Knowing the Perpetrator		Suffering After Attack	
Characteristic	Regression Coefficient	*SE*	Regression Coefficient	*SE*	Regression Coefficient	*SE*	Regression Coefficient	*SE*
African American ($n = 127$)	.994	0.188	.549	0.488	0.870	0.306	1.424	0.287
Female ($n = 87$)	1.131	0.197	89.770***	0.814	2.122*	0.313	2.138*	0.309
≥43 years ($n = 144$)	1.650**	0.194	1.374	0.503	0.841	0.275	1.680	0.317
Homeless ≥2 years ($n = 139$)	1.676**	0.189	3.308*	0.517	1.740	0.325	1.087	0.303
Knowing the attacker ($n = 75$)			0.166**	0.586			−1.796	0.586
Sheltered during attack ($n = 55$)			0.618	0.596	0.370	0.108	1.521	0.354

*$p < .05$. **$p < .01$. ***$p < .001$.

DISCUSSION

The results from this study provide a national picture of the prevalence of violence among individuals who are homeless and the particular characteristics that predict increased risk of experiencing a violent attack, experiencing rape, knowing one's attacker, and suffering consequences after an attack. Half of the participants in this study reported being the victim of a violent attack while homeless. This corroborates findings from previous research demonstrating that homeless individuals may be at increased risk of experiencing violence (Hwang, Orav, O'Connell, Lebow, & Brennan, 1997; National Coalition for the Homeless, 2012). Our results also demonstrate that specific populations within the homeless community are at increased risk to experience violence. Those who have been homeless for a longer time and are older in age were most likely to experience violence. This highlights the importance of targeted outreach and violence prevention efforts for specific populations such as those experiencing chronic homelessness. Thus, our findings indicate that homeless health care providers may need to increase screening for experiences of violence during primary care visits. Screening tools have been developed that can be used during intake assessments by providers or social service agencies that ask about various experiences, health, or social conditions that may be plaguing individuals or families (Helfrich & Beer, 2007; Martinez, Hosek, & Carleton, 2009). The development of a screener that

specifically asks about the incidence of violence and associated characteristics would aid health care practitioners in identifying those who are at increased risk.

Relatedly, research has found that social support is associated with a lower likelihood of victimization (Hwang et al., 2009; McCarthy, Hagan, & Martin, 2002; Wenzel, Tucker, Elliott, Marshall, & Williamson, 2004). This may indicate a need to provide victimization prevention programs and interventions that focus on developing and harnessing social or familial support to aid in a reduction in the rate of violence among individuals who are experiencing homelessness. Social support based interventions have been successful in increasing physical activity, improving diabetes self-management, and bettering health outcomes for domestic violence shelter residents (Constantino, Kim, & Crane, 2005; Kahn et al., 2002; McEwen, Pasvogel, Gallegos, & Barrera, 2010). These interventions can take the form of support groups, risk-factor screening counseling, and group education sessions at community events (Kahn et al., 2002). Based on our results, these types of preventative programs should be aimed at those who have been homeless for a considerable amount of time, those who are older, and women who are at increased risk of experiencing rape, knowing one's attacker, and to suffer consequences after an attack.

Individuals who are chronically homeless are less likely to engage in primary care and mental health services; therefore, clinic directors should ensure dedicated staff time to conduct outreach to identify those individuals who are chronically homeless (Caton, Wilkins, & Anderson, 2007). These outreach workers should be aware of the high likelihood for victimization and use trauma-informed approaches to assess and refer individuals to treatment. Trauma-informed care is a valuable health care delivery technique that can be used to create a safe environment and avoid retraumatization for patients who have been victims to adverse events. This might include first screening for trauma among those who are known to be at increased risk and then providing educational materials, a sense of safety, and support to aid in mobilization and realization of their own strength and resources. In addition, providers can provide guidance to aid in development of positive coping mechanisms for those who report violence victimization. A large portion of the chronically homeless population has mental health issues and previous research has found that persons with severe mental illnesses are more likely to be victimized than the general population (Caton et al., 2007, Teplin, McClelland, Abram, & Weiner, 2005). Although we did not ask about mental health diagnoses, this could explain the higher rate of victimization in our study among those who were chronically homeless.

Our findings also revealed that homeless women should also be targeted by preventive and treatment interventions. The results of this study demonstrate that women are more likely to experience rape. Relatedly, to our knowledge, this is the first study to examine whether rape within homeless populations is related to knowing your attacker. Seventy-nine percent of women who reported a rape in the United States in 2009 indicated that they knew their attacker and only 21% of all rapes and sexual assaults were committed by strangers (Rand & Truman, 2010). This is strikingly different from our findings that 21% of the female victims reported knowing their attacker and 78% of all rapes were committed by strangers, indicating that rape committed by strangers is much more prevalent in homeless populations (Catalano, Smith, Snyder, & Rand, 2009). This difference could be explained by the fact that women who are homeless are unsheltered and lacking a private residence to protect them from perpetrators who otherwise would not have access to them. Thus, management personnel of shelters and clinical providers serving females and families should look for signs that their residents have been victims of sexual assault and be prepared to

connect victims to medical care and mental health services. Mental health consequences of violence victimization include posttraumatic stress disorder (PTSD), depression, anxiety, substance abuse, and panic disorders, with females at a much higher risk for PTSD and depression than males (Kilpatrick & Acierno, 2003). In addition, health care providers should increase access to STD and pregnancy screening for victims of sexual assault and rape. Cross-sector collaboration between public health agencies, homeless service providers, and women and family service entities is needed to address and stem the prevalence of rape against individuals experiencing homelessness. Interdisciplinary partnerships of this kind have been demonstrated to promote health on various levels (individual *and* community) long term (Gillies, 1998). Accordingly, agencies that serve homeless women should provide wraparound, comprehensive services that can help prevent and, if necessary, identify and treat sexual assault and the long-term suffering associated (e.g., resultant mental health issues) with victimization.

Finally, providers and clinics frequented by individuals who are homeless may need to increase support for victims of violence who are seeking medical and wage reimbursement from state victim compensation programs (Office of Justice Programs, Office for Victims of Crime, 2004). This study found that almost 70% of victims who received medical help were unable to pay their medical bills and only 14% were aware of the victim compensation fund and none were successful in receiving funds from it. This indicates a need for education-related outreach that brings awareness to the existence of programs that are available to assist individuals who have experienced violence. The Office for Victims of Crime provides educational materials for providers regarding the Crime Victims Fund and may be a possible resource for providers to increase awareness of violence and victim-related programs and outreach. In addition, many police departments have crime victim advocates whose sole mission is to provide support to victims of crime. Partnerships between homeless service providers may aid in increased awareness of victim financial assistance.

Macro Level Implications

It has long been recognized that providing health insurance and access to health services to individuals in need would aid in the treatment of physical and psychological injuries (Andrulis, 1998; Berstein, Chollet, & Peterson, 2010). Ongoing treatment, appropriate referrals, and appropriate use of medical services without fear of large medical bills would improve access to health care and, subsequently, the health outcomes for victims of violence. The 2014 Medicaid expansion provided for in the Affordable Care Act will result in health insurance eligibility for persons experiencing homelessness, but adequate outreach, education, and benefit design will be required to address the extensive health care needs of victims of violence (Kaiser Commission on Medicaid and the Underinsured, 2011). Treatment for psychological disorders associated with violence, physical therapy, recuperative care, and other services are needed to eliminate extended suffering of those who have experienced violence and should be more widely available for vulnerable and at-risk populations to access.

In the last several decades, laws have been passed that criminalize homelessness. This trend may have led to decreased use of public spaces, forced homeless individuals to the edges of society where they may be more likely to be victimized, and created a more antagonistic relationship between homeless populations and law enforcement. Moreover, previous research reports that individuals who are homeless may be less likely to report

acts of violence because of strained law enforcement relationships or fear of imprisonment (Murray, 1996; Zakrison, Hamel, & Hwang, 2004). Our findings corroborate these findings in that only 33% of victims who sought help after their attacks went to the police, and 30% of those who were attacked by a nonhomeless individual reported being attacked by a police officer. This implies that efforts are needed to strengthen relationships between local law enforcement officers and individuals who are homeless. This could take the shape of organizing around initiatives that attempt to decriminalize homelessness and sensitize law enforcement officers. For instance, Maine and California have implemented police training protocols specifically geared toward ameliorating the strained relationship between law enforcement officials and homeless populations, and Los Angeles has implemented the tracking and reporting of crimes that are specifically aimed toward individuals who are homeless (National Coalition for the Homeless, 2012). More organizing of this kind is needed.

Limitations of the Current Study and Future Research Needed

There are various limitations to this study. All data was self-reported by participants, meaning injuries and suffering could not be verified by clinical diagnosis. Also, we limited eligibility to individuals who were enrolled patients within local Health Care for the Homeless projects. Therefore, we did not get an accurate rate of victimization within the homeless population for each community sampled. Surveying outside of this patient population would provide a better understanding of the experiences of violence of individuals who are homeless and not currently engaged in care. In addition, the survey did not include a follow-up question on why those who reported being victimized did not seek treatment if they reported not doing so. This information could have helped us to better understand the barriers that individuals who are homeless face in trying to seek care when victimized. The biggest strength of this study was that its design and data collection were led by individuals who have experienced homelessness. The NCAB members initiated this project, developed the survey questions, recruited participants, and administered surveys. NCAB strives to provide a voice to those who are marginalized because of their housing status. Leading a study to explore the experiences of violence among those who are homeless has enabled NCAB to teach others about the vulnerability of this population and potentially make an impact on the health care and policy practices that affect it.

Future research is needed to better understand the root causes of violence against individuals who are homeless and to investigate the circumstances and motivators of perpetrators. In addition, the implementation of programs that are targeted toward those who are at increased risk is needed and program efficacy evaluation must be carried out to understand what specific prevention strategies are most effective.

CONCLUSION

In combination, the findings from this study identify that certain individuals are at an increased risk of experiencing violence, knowing one's attacker, and experiencing consequences after an attack. Results from this study should be used to develop health practice and policy recommendations to reduce the incidence of violence against people who are homeless and to promote just and humane recourse for victims of violence. The potential

programmatic, policy, and intervention implications for this study include the need for the following: development of screening tools to aid in the identification of those most at risk of experiencing violence; increased awareness of crime victim funding; creation and maintenance of cross-sector relationships to aid in the prevention of violence; and, finally, amelioration of the relationship between law enforcement agencies and homeless populations.

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