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The Influence of Low-Barrier and Voluntary Service Policies on Survivor Empowerment in a Domestic Violence Housing Organization

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The purpose of community-based domestic violence crisis housing programs (e.g., shelters) is to provide a safe setting that promotes empowerment for survivors of intimate partner violence. For staff to reach this aim, the program must have formal structures and processes in place to support such efforts. This study explored how low-barrier and voluntary service policies influenced staff practices and survivor empowerment. Low-barrier policies require that programs remove barriers that prevent survivors, particularly those who have mental health concerns and/or addictions, from being able to access services. A voluntary service policy states that survivors have the right to choose which services, if any, they would like to engage in during their stay at the program. Survivors' ability to stay at the housing program is not contingent on their participation in program services. This exploratory-sequential (QUAL→ quan) mixed-method study examined how low-barrier and voluntary service policies influenced staff behavior and how these behaviors then related to survivor empowerment. Qualitative results revealed that low-barrier and voluntary service were guided by cultural values of justice and access, encouraged survivor-centered practices among staff, and were believed to promote survivor autonomy. Quantitative results suggested that when survivors perceived they had a choice to engage in program services or meet with an advocate, their empowerment increased. This study has implications for domestic violence organizational practice and provides evidence about the contextual factors that support individual empowerment.

Public Policy Relevance Statement
Abusers engage in multiple tactics to remove power from their intimate partners, which has a significant negative impact on survivors' mental and physical health. Domestic violence crisis housing organizations (e.g., shelters) are designed to restore survivors' interpersonal power. This study suggests that inclusive entry policies (low-barrier) and a flexible program engagement policy (voluntary service) support survivor-centered practices and increase survivors' empowerment.

Intimate partner violence (IPV) is an enduring and prevalent social problem. More than one third of women have reported physical abuse, psychological abuse, sexual abuse, and/or stalking while in an intimate relationship over the course of their lives (Black et al., 2011). Women with abusive partners tend to have greater negative physical and psychological outcomes compared with women who have never experienced violence (Ellsberg et al., 2008). The negative consequences of abuse greatly influence survivors' well-being (Lacey, McPherson, Samuel, Powell Sears, & Head, 2013). For example, abusive partners often isolate women from their social networks, leaving them without access to supportive resources (Stark, 2007), or make it difficult for survivors to obtain and sustain employment (Adams, Tolman, Bybee, Sullivan, & Kennedy, 2012; Showalter, 2016).

Community-based practitioners and researchers have developed numerous responses to promote survivor empowerment, support safety, and help mitigate the negative mental and physical health consequences of abuse (Sullivan, 2017; Zosky,

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2011). Community-based domestic violence (DV[1]) housing programs are an example of these efforts. Housing programs, such as shelters, provide short-term crisis housing and supportive programming such as advocacy, individual therapy, support groups, financial assistance, housing assistance, and children's programs. Shelter services have been reported by those who use them to reduce violence, support psychological well-being, increase access to community resources, and expand social supports (McFarlane, Symes, Maddoux, Gilroy, & Koci, 2014; Messing, O'Sullivan, Cavanaugh, Webster, & Campbell, 2016; Sullivan & Virden, in press; Zosky, 2011).

Empowerment, defined as having personal, interpersonal and social power in one's life, is the primary desired outcome for residents in DV programs (Cattaneo & Goodman, 2015; McGirr & Sullivan, 2017), yet very little evidence exists about the processes that connect program practices to either an increase or decrease in survivors' sense of power over their lives. Some program policies, for example, that include restrictive rules for residents, or limit access to services for survivors who have more complex and compounding concerns (e.g., severe mental health issues) and who occupy stigmatized identities (e.g., sex workers, having criminal histories; Nichols, 2011; Zweig, Schlichter, & Burt, 2002), have been theorized to be oppressive and disempowering (Gengler, 2012; Smyth, Goodman, & Glenn, 2006; VanNatta, 2010). Some studies have found that restrictive housing policies might remove the ability of survivors to make their own decisions and may inadvertently create an environment in which staff engage in practices that disempower rather than empower survivors (Gengler, 2012; Glenn & Goodman, 2015; Moe, 2007). These critiques suggest a misalignment between an organizational mission that aims to be empowering and actual organizational practices that do the opposite.

In response to this disconnect between mission and practice, some practitioners have adopted, or have articulated a desire to adopt, policies that are less restrictive, ensure greater access to program services, and prioritize survivors' autonomy (for one example, see Missouri Coalition Against Domestic and Sexual Violence, 2012). Two policies that theoretically align with the empowerment mission of the field pertain to low-barrier and voluntary services. Although low-barrier policies—those that remove barriers to services—have been examined in the context of organizations that provide services to people with addictions (e.g., Edland-Gryt & Skatvedt, 2013), there is no evidence to date that describes how these policies would translate in the IPV field and whether practices associated with these policies could lead to empowerment for survivors. Similarly, the voluntary service policy—meaning that no services are mandated—has not been studied empirically within DV programs but is a required policy for all programs receiving funding through the Family Violence Prevention and Services Administration (Administration on Children, Youth and Families, 2012). The purpose of this study was to explore how low-barrier and voluntary service policies influence program and staff practices, and how staff practices then relate to survivor empowerment.

Empowerment Theory Guiding Domestic Violence Housing Programs

Abusive partners engage in systematic attempts to remove power and maintain control over their partners (Stark, 2007). This makes it very difficult for survivors to access the resources and supports they need to live full and healthy lives (Helfrich, Fujiura, & Rutkowski-Kmitta, 2008). Therefore, when survivors reach out to services, providers are often interested in implementing processes that acknowledge and restore interpersonal power (McGirr & Sullivan, 2017). An empowerment process involves working with survivors to set and achieve personally meaningful goals by increasing their critical consciousness, enhancing their social and community supports, and building skills and competencies (Cattaneo & Goodman, 2015; McGirr & Sullivan, 2017). Empowerment has been found to mitigate the negative impacts of DV, leading to a decrease in posttraumatic stress disorder (PTSD) symptoms and depression (Goodman, Bennet Cattaneo, et al, 2015; Perez, Johnson, & Wright, 2012).

Numerous approaches have been identified to inform how DV advocates can interact with survivors to promote empowerment (Cattaneo & Goodman, 2015; Sullivan, 2016). These approaches include survivor-defined practices (Kulkarni, Herman-Smith, & Ross, 2015), trauma-informed practices (Goodman, Fauci, et al., 2016; Goodman, Sullivan, et al., 2016), and culturally relevant practices (Gillum, 2009; Whitaker et al., 2007). These approaches emphasize the importance of survivor autonomy, choice, and context. Yet these approaches cannot exist without larger organizational cultural and structural processes to support them. Housing program policies directly influence how organizational values and approaches are being implemented in practice by staff (Nnawulezi, Sullivan, & Hacskaylo (under review)).

Some scholars have argued that the professionalization of DV shelter services has resulted in a misalignment between shelters' mission of empowerment and their organizational policies. This professionalization has included a shift toward a clinical orientation that is decontextualized, privileges the provider as expert, limits survivor autonomy and choice, and disregards survivors who have complex needs (Smyth et al., 2006; Wies, 2008). These misaligned shelter policies, mediated through staff practices, potentially contribute to survivors' disempowerment (D'Enbeau & Kunkel, 2013). Few studies have examined the impact of shelter policies on staff practices and their subsequent influence on survivors. One prior study found that a formal hierarchal organizational structure that emphasized top-down approaches led to shelter practices that were misaligned with the organization's mission of empowerment. This misalignment, coupled with an unclear understanding about what constituted empowerment, contributed to staff practicing empowerment "as a disciplinary tactic in which some behaviors are rewarded over others" (D'Enbeau & Kunkel, 2013, p. 151). This finding suggests that formal shelter policies that are aligned with an empowering mission should increase the use of empowering practices. Two overarching shelter policies that have been theorized to relate to survivor empowerment are (a) removing all barriers to accessing shelter (low-barrier), and (b) letting survivors choose the programming they want to participate in (voluntary service).

[1] IPV and DV are used interchangeably throughout this article to represent the same construct.

Low-Barrier Policies

Low-barrier policies, also referred to as low-threshold policies, are a compilation of specific policies designed to reduce the eligibility requirements that can be barriers to accessing services. These policies derive from the field of harm reduction and have traditionally been implemented in treatment settings that seek to provide supportive options for people who have issues with substance misuse and addiction (e.g., van Ameijden, Langendam, & Coutinho, 1999). Low-barrier policies can involve "the absence of waiting lists, toleration of use and injection of illicit drugs, and relative ease to [allow clients to] leave and re-enter the programs" (van Ameijden et al., 1999, p. 559). This inclusive entry process allows people to still have access to supportive services even if they are not sober or in an abstinence-based drug treatment program.

Implementing eligibility policies that include access for survivors with mental health concerns or addictions is critical, given the established interrelationships among victimization, negative mental health outcomes, and substance misuse (Bonomi et al., 2006; Lacey et al., 2013). Despite the awareness of these intersections, some shelters do not allow survivors to access supportive housing services if they are currently using drugs or if they have a severe mental illness (Macy, Giattina, Montijo, & Ermentrout, 2010). Zweig and colleagues (2002) surveyed employees at 20 domestic violence programs and found that survivors with compounding needs had more difficulty receiving supports from DV programs.

Voluntary Service Policy

Although a low-barrier policy focuses on the entry process, a voluntary service policy focuses on how survivors engage in program services. A voluntary service policy states that survivors can choose what program services they can engage in without this choice being contingent on their ability to stay in the program (Administration on Children, Youth and Families, 2012). Although all domestic violence shelters are required to adopt this policy if they are receiving funds from the Family Violence Prevention and Services Administration, the implementation of this approach varies across shelters.

Current Study

The current study examined how two overarching policies within a DV agency influenced staff practice and survivor empowerment. In the first (qualitative) phase, agency staff members were asked to describe how low-barrier and voluntary service policies influenced their actual practice with survivors. In the subsequent (quantitative) phase, survivors receiving program services reported on staff practices and their feelings of empowerment. We hypothesized that the more choice survivors reported having over their lives within the program, the greater their empowerment was.

Method

Mixed-Methods Overview

This study included an exploratory-sequential (QUAL → quan) mixed-methods design. The purpose of this mixed approach was to understand previously understudied constructs of interest with staff, use this understanding to develop questions for survivors, develop hypotheses about survivor experiences with low-barrier and voluntary service policies, and then test the hypotheses linking organizational practices to survivor outcomes (Onwuegbuzie & Leech, 2006). In the initial phase, we qualitatively explored how staff conceptualized and enacted low-barrier and voluntary service policies. These data were analyzed prior to the implementation of the quantitative phase, and findings from staff were used to create the questions asked of survivors receiving services.

Setting

The study was completed at a large, urban domestic violence organization that provides services to survivors of IPV, sexual assault, torture, and sex trafficking. Data for the current study were collected from the agency's crisis housing program, which includes 42 individual apartments. The agency's guiding mission is to provide services in ways that are "responsive, consistent, empathetic, mutually cooperative and respectful, while also providing tools to promote personal power and support survivors' right to be self-governing" (DASH, 2013).

The low-barrier policy implemented by the agency included the following: survivors were not screened out of services for severe mental illnesses, substance use concerns, how long ago abuse occurred, or family size. They also did not have to provide proof of abuse or citizenship. The agency's voluntary service policy states that survivors choose what services they want to engage in while in the program.

Phase I

Sample and Procedures

We contacted eligible staff through e-mail to invite them to participate in a one-time, face-to-face, individual interview about their work. Staff members were familiar with the investigators and overall study from prior meetings and conversations, and had expressed strong interest in having the research conducted. Staff members were invited to participate if they (a) had provided direct services to survivors, or provided direct supervision to advocates who provided direct services; (b) had been employed for at least 2 weeks; and (c) were currently employed at the time of data collection. Staff members who worked in administration (with no direct service), maintenance, or building management positions were excluded. Of the agency's 26 paid staff members, 13 were eligible for the study, and 12 agreed to participate. Six were direct service providers and six were direct supervisors. Informed consent took place at the start of the interview, and interviews lasted an average of 2.5 hr. Participants had the option to be interviewed in a location of their choice. Eight chose to be interviewed on site, and four interviews took place at local coffee shops or restaurants. All interviews were confidential and conducted by the first author. The study was approved by the Michigan State University Institutional Review Board.

Measures

The first author used a semistructured interview guide to examine staff understanding of the organizational context, including the program mission, theory, structure, and culture. The guide was informed by a systematic review of the agency's written documents (e.g., bylaws, employee handbook, personnel policies) and developed in collaboration with the agency's leadership team. Guiding questions included "What does it mean that [agency name] utilizes a [voluntary service/low-barrier] approach?"; "In what ways, if any, does this organizational service approach impact what you do when providing services to survivors?"; and "Could you tell me how this service delivery approach aligns, or does not align, with your personal values?"

Analysis

Data were analyzed using an inductive thematic analysis, a data-driven analytic approach that explores a phenomenon without using a preexisting coding scheme (Braun & Clarke, 2006). The first and second authors completed the analyses, which were confirmed by the third author. We began by reading the transcripts multiple times to get familiar with the data. Then, we completed first cycle descriptive and process coding on four interviews to generate an inductive coding framework (Miles, Huberman, & Saldana, 2014). Using the framework, we completed coding for the remaining interviews and refined the coding framework accordingly. We grouped codes from the refined framework into themes. The themes were revised through a process of rereading the transcripts, adding new data, and rewording specific concepts. Then, a thematic map and descriptions for each theme were created.

Multiple methods were employed to establish trustworthiness of interpretation. The first and second authors coded data separately and discussed the coding framework together to establish an inductive framework. Themes were created through multiple discussions between the first and second authors. All themes were written with a thick description to allow for transparency. The third author confirmed the framework and themes generated. The thematic map and respective theme descriptions were provided to the executive director and training director as a form of member checking.

Results

Five themes emerged from staff descriptions of the organization's policies and practices and how they believed they impacted survivors. The first theme pertained to how organizational norms and values guided low-barrier and voluntary policies. The second theme centered on how policies impacted staff practice, and the third focused on staff capacity needed to enact policies. The final themes related to how staff understood low-barrier and voluntary service policies and practices to impact survivors (Theme 4) as well as at the organization (Theme 5). An overview of the themes is available in Table 1.

Theme 1: Organizational values guide the enactment of low-barrier and voluntary service polices.

All staff described how the agency's low-barrier and voluntary service policies were guided by organizational cultural norms, such as (a) providing equal access, inclusivity, and justice; (b) trusting survivors; and (c) promoting survivor autonomy and self-determination.

Providing equal access, inclusivity, and justice. All participants passionately and consistently stated that survivors have the right to access and sustain safe housing. Many described how some subpopulations of survivors are fundamentally underserved by the DV shelter system because of restrictive screening policies. Low-barrier policies helped to correct this injustice. These values applied to both entry into and experiences in the housing program. All participants also affirmed that survivors, no matter how engaged or disengaged they were in services, had the right to generative opportunities and access to resources.

Trusting survivors. Every participant agreed that implementing low-barrier and voluntary service policies rested on the assumption that survivors are trustworthy. Participants consistently remarked, "We take people at their word." Patricia[2] highlighted this value when she described what it meant to implement low-barrier policies.

> So because we are low-barrier, we do not ask to see your protection orders. We do not ask for any of that. We do not even ask you for ID. 'Cause we're gonna trust that what you're sayin' to me is the truth and we're gonna roll from there. (Advocate)

This value was related to the value of equal access to shelter and housing. Some participants commented that even if some survivors did not provide the entire truth when they first entered the organization, they should still be able to access quality services and safe housing.

Promoting survivor autonomy and self-determination. Staff members believed that survivors have the right to define their own needs and to make their own choices about how to meet those needs. They described that the voluntary service policy assumes that survivors are competent, capable, and should not be penalized for making decisions that may be different from those staff would make. Some felt that mandates forcing survivors to engage in programming were disempowering, dehumanizing, shame-inducing, oppressive, and controlling. Joy stated,

> Voluntary service model is . . . [that] services aren't contingent upon your willingness or your ability to meet a requirement. Such as, you know, mandatory meetings and mandatory case management, mandatory documentation. And just allowin' people to be adults and to be self-governin' and to manage their own lives. And knowin' that everybody's not the same, everybody doesn't have the same needs. Allowing survivors to determine what needs they have and how they want to focus on meetin' those goals and needs. (Supervisor)

Theme 2: Low-barrier and voluntary service policies guide staff practices.

Policies were put into practice in a variety of ways. They included empathetic listening, a focus on survivor needs, building trusting relationships, setting bound-

[2]Names used this in manuscript are pseudonyms.

Table 1. *Values, Practices, and Impact of Low-Barrier and Voluntary Service Policies*

Themes	Description
Theme 1: Guiding organizational values	Inclusivity; access to resources; justice; autonomy; self-determination
Theme 2: Employee practices	Survivor-centered; relationship-building; trust-building
Theme 3: Employee characteristics	Believe the guiding values; build training capacities; provide supports to diverse groups; innovate; create; think critically; stay present; have vision; do not take things personally
Theme 4: Survivor impact	Easy access to services; increase comfort; more transparent; greater autonomy over life; sense of freedom
Theme 5: Organizational impact	Outside organizations misunderstand, negotiate funding opportunities, survivors not communicated information

aries, and providing intensive, focused support. Each is discussed next.

Engage in empathetic and nonjudgmental listening. Listening deeply to survivors' needs was an imperative part of practice when implementing both policies. Participants listened to make sure that organizational programming aligned to what survivors wanted at entry and during their stay. Participants described having to listen without judgment because they could not (and did not want to) make assertions that would screen survivors out of services.

Prioritize survivors' individual needs. Many participants engaged in survivor-centered practices with residents, meaning that the resident decided who and what should be prioritized in their own healing. Low-barrier and voluntary service policies encouraged honoring the individuality of survivors in practice. Joy exemplified this when she said,

> Low-barrier for me would mean allowing people to come as they are without requiring other things to be a prerequisite to receiving services. Meetin' people where they are and not expecting them to be, like, the last person, [or] like the first. And makin' their own decisions of how they move forward with their own lives. (Supervisor)

Build collaborative relationships. Within survivor-centered practices, the relationship quality between the advocate and survivor is vital. The absence of mandatory programming made it imperative for advocates to build collaborative and trusting relationships with survivors to appropriately assess their needs, and to provide resources that aligned with their needs. Participants built relationships with survivors by asking questions, being patient, and remaining flexible.

Staff described difficulties in engaging in survivor-centered practices. Some struggled with having to support survivors' full autonomy and control within legal and program constraints. For example, one staff member discussed that a survivor can choose to do something opposite than what the staff person thought would be best. Others described the difficulty in talking with survivors who were frustrated about their lack of progress when the program ended even though they had not engaged in programming. Temple explained,

> So sometimes participants come to us and be like, "Y'all didn't help me do anything. Y'all didn't help me get my GED. Y'all didn't . . ." and we're like, "No, you were the leader of this process. You know, we've offered this, we've offered that, but it was really up to you to make that decision." So sometimes I can see where partnerships can be strained when working with participants. (Supervisor)

Staff members often wondered how to ensure that people get what they need if their choice to engage in programming is optional. Although many staff members were grateful that they did not have to force survivors to engage in services, some did admit that mandating certain things, such as resident meetings, would make their own work easier.

Set boundaries. Given the flexibility of low-barrier and voluntary service policies, staff members stated that they often had to practice setting boundaries with survivors, particularly around what they (and the program) had the capacity to do and what they were not able to do. Although participants spoke consistently about respecting survivors' ability to freely choose what they wanted, there were times when staff felt they had to place constraints on survivors' autonomy. For example, some staff noted these tensions were related to having to ensure someone's unit was clean for governmental inspection, even if it was contrary to the survivor's desire to do so. Other participants reminded survivors that there were policies that they still had to abide by to maintain their housing, such as not using physical violence, not abandoning their unit, and not using drugs on-site.

Provide intensive support and care. Participants stated that given the diverse set of survivors' needs, staff members require intensive support, time, and resources. Some described that the complexity of these needs could make advocacy and service provision particularly difficult, yet there was a collective understanding among participants that they must work through the complexity; otherwise, survivors would not be able to access, or have a more difficult time at, higher barrier shelters. Karen states,

> It means that we do not weed people out to get the most perfect victim that will be easy to help and to make successful to look good in our statistics. We do not shy away from folks who are struggling with mental illness and are not in treatment. Who are using substances and who are not in treatment. Who are engaged in sex-work. Who are still with their abuser. Who are coming out of prison. All those folks have traditionally been kept out of the domestic violence housing system because they're complicated. Because they're not necessarily willing or able to follow all the rules that are created around those programs. (Supervisor)

Theme 3: Staff members need tools to engage in low-barrier and voluntary service policies. Participants believed that there were certain cognitive, emotional, and behavioral capacities that advocates must have to effectively work in an organization with low-barrier policies. *Cognitively*, staff should want to provide services in a way that is free of most restrictions. They should be able to critically plan and brainstorm with survivors to help them deal with unexpected issues. *Emotional capacity* involves being comfortable with uncertainty and the need for flexibility. It is also important to feel connected to survivors, and want to be present in their

lives. *Behaviorally*, staff must have the skills necessary to act in ways to develop and sustain strong relationships.

Theme 4: Low-barrier and voluntary service policies positively affect survivors. Staff believed that the agency's low-barrier and voluntary service policies resulted in easier entry into their program as well as increased survivor autonomy. They believed that survivors could access their services more easily because screening policies that did not require "proof," such as an ID or a personal protection order. Some even noted that survivors seemed more comfortable being transparent about their experiences when they knew such openness would not result in losing services.

All participants described that the primary reason for using a voluntary service policy was to support survivors' autonomy. Staff described how survivors could define their own needs, and use services in accordance to their self-defined needs. For example, Temples says,

> [Agency name] values survivors in a way that basically says, you know, you can live life as you choose, whatever that looks like—good, bad, ugly—but whatever it looks like for you have the autonomy to do that. And that we will not hold housing over your head or jeopardize your housing for the sake of you operating from a space of a human. (Temple, Supervisor)

Interestingly, although clients were not required to participate in programming, participants stated that many chose to engage in the programming offered to them.

Theme 5: Low-barrier and voluntary service policies have organizational impacts. Low-barrier and voluntary service policies impacted the organization in a few ways. First, many participants felt that the low-barrier policies were misunderstood by outside community programs, which sometimes resulted in misinformation communicated to survivors about the program. Other staff described having to constantly negotiate whether funding opportunities would be a good fit for their organization and/or whether funder requirements differed from the values that are foundational to low-barrier and voluntary service policies. One person stated that voluntary service policies made it difficult to keep volunteers because they did not want to continue to provide services if few or no survivors showed up to an event.

Using Phase 1 Findings to Inform Phase 2

Given the nature of this sequential design, all procedures from the first qualitative phase, including data analyses and interpretation, were completed prior to the start of the second phase. Findings from the first phase suggested that, according to staff, low-barrier and voluntary service policies promoted an organizational context that valued and promoted survivors' autonomy and empowerment. In the next phase, we examined whether the experiences of survivors met this expectation of staff.

Phase 2

Sample and Procedures

Two strategies were used to recruit shelter residents into the study. First, flyers describing the study were attached to every resident's door. Second, recruiters spent time in common areas of the apartment building and approached survivors to describe the study. Shelter residents were invited to participate if they were over the age of 18 and if they had been receiving services for at least 2 weeks. Of 41 eligible survivors, 37 initially agreed to participate in the study, and 33 (80% of the eligible sample of 41) completed the interview. Survivors chose where they wanted to be interviewed, and all decided to be interviewed either in their own apartment or in a confidential room on-site. Every survivor was compensated $25 in cash for their participation. The length of interviews ranged from 34 to 160 min (average = 72 min). Thirty-two survivors gave permission to audio record the interview.

Participant ages ranged from 19 to 63 years, with a mean age of 33.3 years (SD = 10.8). Eighty-eight percent of the sample identified as Black, African American, or African, and 12% identified as Latina or some other race. About one fourth of the sample did not complete high school. Twenty percent had earned a high school diploma, and a majority of the sample (53%, n = 17) had a college degree or had completed some college. Fewer than one third of the sample (29%) were employed at least part time, almost one third were enrolled in school or in a training program (32%), and 29% were unemployed. Survivors' demographic information is summarized in Table 2.

Measures

The research team conducted all face-to-face interviews with survivors, using a combination of quantitative measures and open-ended, qualitative questions. The entire structured interview guide was developed and refined in collaboration with staff, and piloted with a survivor who had recently left the housing program. The empirical literature also informed the content of the indicators. Collectively, these multiple methods support the validity of the study instruments.

Level of participation in services. To assess how often residents engaged in agency programming, each was asked, "How frequently do you participate in the services that happen

Table 2. *Survivor Demographics*

Demographic Variables	Mean (*SD*)	Range
Age	33.3 (10.78)	19–63
Cornerstone stay (in days)	354 (1.89)	20–678
	# of residents	%
Race		
African American/African	29	88
Hispanic/Latino/Other	4	12
Employment		
Employed full time	4	13
Employed part time	5	16
Unemployed	9	29
Student	10	32
Other	3	10
Mental health concerns (Yes)	16	49
Physical health concerns (Yes)	5	15
Parenting children under the age of 18 (Yes)	25	76

here at [agency name]?" The response scale ranged from 1 (*rarely or never*) to 5 (*always*).

Low-barrier policy. Six questions were used to assess participants' understanding of the agency's low-barrier policies. Survivors were asked to state their level of agreement with the following statements: "When applying to this program, staff trusted that I was telling the truth" and "I was able to access housing here despite barriers that might come up at other organizations." The response items for the first two questions were on a Likert scale from 0 (*not at all true*) to 4 (*very true*). Participants were then asked if the following four items were true or false: "I had to provide photo identification to receive services from this organization"; "Staff asked whether I used substance or alcohol during my intake interview"; "Staff force people to get sober in order to receive housing"; and "I needed proof of my abuse in order to access housing."

Voluntary engagement. Two questions were used to assess the extent to which survivors perceived their ability to participate in programming was voluntary: "I chose what [agency name] program and services I wanted to participate in" and "Staff made me feel like I had to meet with them whether I wanted to or not" (reverse-coded). Response options ranged from 0 (*not at all true*) to 4 (*very true*).

Survivor empowerment. The 19-item Survivor Empowerment scale assessed the extent to which survivors reported increases in competencies and skills, community connections, and IPV awareness (Sullivan et al., 2013). Response options ranged from 0 (*not at all true*) to 4 (*very true*). The Confidence subscale contained nine items ($M = 3.26$, $SD = 0.96$, $\alpha = .95$), and a sample item was "I have a greater understanding that I have the ability to make changes in my own life." The Connections subscale (four items; $M = 3.07$, $SD = 1.06$, $\alpha = .85$) included items pertaining to the extent residents felt connected to the people and/or resources in the larger community. An item within this subscale included "I know more about the community resources that I need." The final subscale, Consciousness, assessed participants' knowledge of intimate partner violence ($M = 3.11$, $SD = 0.96$, $\alpha = .90$). This eight-item subscale included question such as "I have a greater understanding that I have the right to be angry about what I've experienced."

Empowerment-related safety. The Measure of Victim Empowerment Related Safety (MOVERS) measured survivors' empowerment as it related to their ability to keep themselves and their families safe from abuse (Goodman, Bennet Cattaneo, et al., 2015). Response options ranged from 1 (*never true*) to 5 (*always true*), and the 13-item measure includes three subscales. The first subscale, Internal Tools ($M = 4.30$, $SD = 0.70$, $\alpha = .86$), measured the extent to which survivors believed they had the internal resources to support their safety. A sample item from this subscale is "I can cope with whatever challenges come at me as I work to keep safe." The second subscale was Expectations of Support ($M = 3.95$, $SD = 0.97$, $\alpha = .79$), and it assessed the extent to which survivors believed they had accessible and effective support networks ("I have a good idea about what kinds of support for safety I can get form community programs and services"). Trade-Offs ($M = 2.28$, $SD = 1.06$, $\alpha = .57$) assessed the extent to which survivors perceived that choices they made to keep safe would present new problems for them (e.g., "I have to give up too much to keep safe"). Previous studies have reported acceptable alphas for these subscales, ranging from 0.74 to 0.88 (Goodman, Bennet Cattaneo, et al., 2015; Goodman, Thomas, et al., 2016).

Analysis

Data were analyzed using SPSS Version 21. We used descriptive and correlational analyses to examine the relationships among voluntary service policies, survivor empowerment, and empowerment-related safety. The first set of analyses explored survivors' perspectives about low-barrier and voluntary service policies. In the second set of analyses, significant Pearson product–moment correlations were followed with bivariate regression analyses to examine the relationship between survivor engagement and their empowerment.

Results

Overall, survivors agreed that the agency employed low-barrier policies to gain enter housing services. The vast majority of survivors (91%; $n = 28$) reported that it was "generally" or "very" true that staff trusted that they were telling the truth upon intake ($M = 3.79$, $SD = 0.60$). Eighty-five percent ($n = 28$) believed it was "generally" or "very" true that they could access housing at the agency, despite barriers that might come up at other organizations ($M = 3.58$, $SD = 0.75$). Further, 89% of participants ($n = 25$) reported that staff did not force people to get sober to receive shelter ($M = 0.11$, $SD = 0.31$). However, 69% ($n = 22$) stated that they had to provide photo identification to receive services, 50% ($n = 14$) reported that they were asked whether they used substances or alcohol during their intake interview, and 54% ($n = 15$) stated that they needed proof to access the housing program.

Overall, 85% ($n = 28$) of survivors reported that it was "generally" or "very" true that they could choose what services they wanted to participate in ($M = 3.45$, $SD = 1.09$), and 77% ($n = 24$) participated in programming or services at least sometimes ($M = 2.42$, $SD = 1.15$). However, survivors reported less choice about meeting with staff. Thirty-nine percent ($n = 13$) reported that it was "generally" or "very" true that staff made them feel like they had to meet with them whether they wanted to or not ($M = 1.82$, $SD = 1.70$).

Survivors reported relatively high levels of empowerment as well as safety-related empowerment. Women reported high levels of Confidence ($M = 3.26$, $SD = 0.96$), Community connections ($M = 3.07$ $SD = 1.06$), and Consciousness ($M = 3.12$, $SD = 0$ .96). Survivors also reported higher levels of Internal tools needed to stay safe ($M = 4.33$, $SD = 0.73$), high Expectations of Support ($M = 3.94$, $SD = 0.97$), and low levels of Trade-offs for staying safe ($M = 2.24$, $SD = 1.33$).

The extent to which survivors voluntarily engaged in services was significantly positively associated with their empowerment, as measured by the three subscales of the Survivor Empowerment scale (see Table 3). "I choose what [agency name] programs or services I want to participate in" was positively associated with increased Confidence, $r = .38$, $p < 0.05$. "Staff made me feel like I had to meet with them whether I wanted to or not" was negatively associated with one subscale of MOVERS: Expectations of Sup-

Table 3. *Intercorrelations Among Voluntary Engagement, Survivor Empowerment, and Empowerment-Related Safety*

Study Variables	1	2	3	4	5	6	7	8
1. I choose what program and services I want to participate in	—	−.16	.16	−.26	.08	.38*	.22	.21
2. Staff made me feel like I had to meet with them whether I wanted to or not		—	−.30	.25	−.37*	−.36*	−.44*	−.46**
3. Internal Tools			—	−.17	.79**	.41*	.62**	.65**
4. Trade-offs				—	−.21	−.10	−.34	−.08
5. Expectations of support					—	.29	.58**	.48**
6. Confidence						—	.64**	.78**
7. Connections							—	.54**
8. Consciousness								—

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

port ($r = -0.37$, $p < 0.05$) and all three subscales of the Survivor Empowerment measure: Confidence ($r = -0.36$, $p < 0.05$), Connections ($r = -0.44$, $p < 0.05$), and Consciousness ($r = -0.46$, $p < 0.05$).

There were small but significant effects on survivors' voluntary engagement when regressed on survivor empowerment and empowerment-related safety. Choosing to participate in programming significantly accounted for 14% of the variance, positively associated with increased Confidence ($r^2 = 0.14$, $p < 0.05$; see Table 4). The more survivors felt required to meet with staff, the lower their reported Confidence ($r^2 = 0.13$, $p < 0.05$), Connections ($r^2 = 0.19$, $p < 0.05$), and Consciousness ($r^2 = 0.21$, $p < 0.05$), accounting for 13%, 19%, and 21% of the variance, respectively. Feeling required to engage with staff accounted for 14% of the variance, negatively associated with decreased Expectations of Support ($r^2 = 0.14$, $p < 0.05$). The more survivors felt required to meet with staff, the less they reported feeling like they had supportive networks available to them (see Table 5).

General Discussion

The goal of this exploratory-sequential (QUAL→ quan) mixed-methods study was to better understand how low-barrier and voluntary service policies may influence organizational and advocate practices, and whether those practices then relate to survivor empowerment. In the first phase, findings demonstrated that policies were value-laden, fueled by beliefs about rights for survivors to be autonomous and able to freely access resources. Staff members put these policies into practice by building deep partnerships with survivors that were grounded in survivors' individual needs and supported the complexity of their lives.

Low-barrier and voluntary service policies were perceived by staff as supporting relationship building with survivors. Staff members worked to develop trusting, sustainable relationships that centered survivors' needs and were not predicated by perceptions or assumptions about survivors' past experiences and current or future choices (Kulkarni et al., 2015; Nichols, 2013). This was evident when staff described that the voluntary service policy required them to relinquish any attempts to fix and/or control survivor behaviors through mandates. Instead, advocates focused on listening to and supporting survivors to gain whatever services and resources they desired. Other studies have also identified the importance of relationship building as being vital to survivor-centered practices (Goodman, Thomas, et al., 2016; Sullivan & Virden, in press).

Staff further stated that an increase in autonomy—which subsequently increases empowerment—was the primary expected outcome of low-barrier and voluntary service for survivors. Previous research has shown that empowerment-oriented organizational policies influence the ways that advocate practices support or hinder survivors' ability to have control over their decisions and lives (D'Enbeau & Kunkel, 2013). The theory of empowerment also supports this notion, suggesting that increasing individuals' autonomy is a key component of increasing their power (Cattaneo & Goodman, 2015). Survivors in previous studies have stated that the use of empowering practices supported their overall self-efficacy (Kulkarni, Bell, & Rhodes, 2012). Future research should continue to examine the underlying processes that link policies which promote survivor autonomy to empowerment.

It is important to note that enacting low-barrier and voluntary policies was not always easy or straightforward, and required a great deal of skill, patience, and support. Low-barrier and voluntary service policies required that staff be creative, flexible, and utilize strong relational skills. Although this flexibility is necessary to support survivor's complex needs, some staff reported that it can

Table 4. *Regression Analysis Predicting Survivor Empowerment and Empowerment-Related Safety*

Dependent variable	*B*	*SE B*	β	r^2
Confidence	−.33	.15	−.38*	.14*

Note. The independent variable is the item "I choose what programs or services I want to participate in." *SE* = standard error.
* $p < .05$.

Table 5. *Regression Analysis Predicting Survivor Empowerment and Empowerment-Related Safety*

Dependent variable	*B*	*SE B*	β	r^2
Confidence	−.20	.10	−.36*	.13*
Connections	−.27	.10	−.44**	.19**
Consciousness	−.26	.90	−.46**	.21**
Expectations of support	−.21	.10	−.37*	.14*

Note. The independent variable is the item "Staff made me feel like I had to meet with them whether I wanted to or not."
* $p < .05$. ** $p < .01$.

be both difficult and draining. An individual commitment to the values that supported these policies may be a critical component to staying motivated and ensuring successful implementation of low-barrier and voluntary service policies. Flexibility is also necessary because not every survivor will be empowered in similar ways. Research has demonstrated how empowerment varies by context and need. For example, Perez et al. (2012) found no attenuating impact of empowerment on PTSD symptoms for survivors who experienced the highest levels of IPV severity. A study by Goodman, Sullivan, and colleagues (2016) also showed how advocates might be limited in their ability to promote empowerment among survivors who lack basic resources. In general, more evidence is needed to explore the ways in which an empowerment approach may benefit, have no effect, or cause harm to survivors (Kasturirangan, 2008).

Overall, the survivors in this study echoed the staff perspectives that the organization was low-barrier, survivor-centered, and empowering. Most survivors reported experiencing few or no barriers to getting into the program, felt trusted by staff, and noted that they were not forced to be sober or engage in services they did not want. Some, however, described practices that ran counter to the program's low-barrier policies. For example, some reported needing identification upon entry into the program, and others reporting being asked about their alcohol and substance use. About half of the sample also reported needing proof of abuse to access services. These findings greatly surprised staff, who insisted that these were not practices of the agency. When asked for their interpretation, numerous staff stated that the community-based clinic through which many survivors entered the program shares space with other organizations that operate higher-barrier shelters. Survivors might have confused the eligibility requirements of the other agencies with this program's requirements. Additionally, the length of time between program entry and participating in this interview varied for survivors. Time of entry could be a confounder in the results, meaning that those who were interviewed more closely to their entry point might remember entering the program more accurately than those who had been at the organization for a year or more.

Findings further suggested that, despite services being voluntary, over three quarters of survivors engaged in services, at least sometimes. The hypothesis that survivors would report higher levels of empowerment when they perceived having greater autonomy with their program involvement was partially confirmed. When survivors made their own choices, it increased their confidence. Those who felt required to meet with advocates were less confident, felt less connected to community, and reported lower domestic violence consciousness.

Limitations

Although these findings help us to understand the ways in which low-barrier and voluntary service policies impact advocate practice and survivor outcomes, they must be considered in light of study limitations. The quantitative component of this mixed-methods study was small and confined to one organization, which impacts generalizability of the results. Because this was a cross-sectional study, care must also be taken in presuming causality among any of the constructs measured in the study. For example, it is possible that those who felt more empowered when entering the program engaged more in services, whereas those who felt less empowered at program entry might have perceived more pressure to engage in activities. Longitudinal studies with multiple programs are needed to further examine the relationships noted herein. Measurement limitations must be noted as well. The study did not measure all possible factors that may contribute to advocate practice and survivor empowerment, such as individual level factors (mental health, SES, etc.), advocates' level of training, organizational leadership, and funder requirements, among others. Further, the voluntary engagement indicators were two single items instead of a scale. Finally, the measures of empowerment focused primarily on psychological empowerment and not on whether survivors' actual power within their lives was increased (Riger, 1993). Standardized measures need to be developed to accurately gauge these important constructs.

Practice and Research Implications

The study findings have numerous implications for staff practice. Results suggest that low-barrier and voluntary service policies provide a strong framework through which staff can engage in empowering and survivor-centered practices. For instance, staff members described how implementing voluntary service policies allowed them to focus on their jobs as opposed to having to police survivors' behaviors. In practice, this can contribute to a more viable and enjoyable workplace for advocates, who can then have stronger relationships with survivors and want to remain in the field longer.

One barrier to implementing this model, however, can be some advocates' own "buy-in" to the notion of an empowerment approach. In the current study, advocates' own values of empowerment aligned strongly with the values of the organization, which influenced their work with survivors. Staff members who have worked in more rule-bound and disempowering organizations may have difficulty shifting their perspectives and practices to this more flexible model.

This study also demonstrated that, when given the choice, survivors generally engaged in programming offered at the housing organization. Having a voluntary services model requires staff to continually work with survivors to provide the supports and services they were looking for, and to interpret lack of engagement as a sign that the services being offered may not be what is needed. At the same time, some advocates felt internal pressure when they believed a survivor could benefit from a specific service or program but the survivor decided against it. This struggle was especially salient for staff when working with survivors suffering from complex trauma. Staff sometimes thought that particular survivors might benefit from more structured services, and this must continually be addressed within agencies.

There are also contextual constraints that make fully implementing low-barrier and voluntary service policies difficult to put into practice. These tensions are inherent in balancing meeting individual survivor needs while also meeting the needs of the community. For example, staff must ensure that buildings remain safe and habitable for all residents. Safety, in the context of this housing program, is defined as being free of health hazards, fire hazards, and safety hazards, such as allowing vermin, accumulation of trash and flammable materials, and improper disposal of waste, such as diapers. Attempting to maintain a safe environment while implementing these two policies may also be complicated by the phys-

ical structure of the housing program. Communal living situations might increase the difficulty of upholding these policies compared with apartment-style individual living situations. As a result, one challenge in practice for organizations that seek to implement these policies is to determine ways to communicate to survivors the instances when options to engage in specific activities are no longer voluntary, and to further think about whether impeding on survivors' autonomy could lead to better or worse outcomes. Future research should focus on exploring the ways in which low- and high-barrier policies influence a range of staff and survivor outcomes, as well as investigate the direct or indirect impact of the broader context (funding, political, social, legal) on individual outcomes.

This was the first study to examine the impact of low-barrier and voluntary service policies on DV housing staff and survivors. As a result, we gained insight into the ways in which low-barrier and voluntary service policies influence advocate practice and impact survivor empowerment. The low-barrier and voluntary service models appear to promote empowering, survivor-centered practices. However, these approaches require that staff have particular skills and supports. Further, for at least some organizations, staff will need to grapple with the conflict between using an empowerment approach which favors survivor self-determination, and satisfying funders who may mandate more restrictive policies. Moving forward, we should more deeply and broadly consider the ways in which policies govern and guide advocate practice and survivor outcomes. Moreover, we must consider the impact of punitive versus empowering service delivery approaches on both advocate and survivor well-being over time.

Keywords: shelter; domestic violence; intimate partner violence; voluntary service; low-barrier; low-threshold; empowerment

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