Volume 3
National Workforce Survey

Women who use force

Final Report of the 2018-2180 – Perpetrators Package – Female Perpetrators Activity: Department of Social Services

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Curtin University

Women Who Use Force in a Family Context

National Workforce Survey Findings

Research Summary

This project addresses the often debated topic of women's use of force in their intimate relationships. It focuses specifically on the Australian community services sector workforce's knowledge and understanding of the issue, their experience in responding to women's use of force, whether and how their agency deliver services to address the issue and seeks their views on what would valuable in responding to this issue in the future. The research involved a national online survey of workers employed in the government and non-government sectors. There were 278 participants from a wide range of areas in community services and all states and territories were represented. The survey was limited to participants whose agencies permitted the research to be conducted with their staff. Some organisations were unwilling to have staff participate and other agencies' approval processes were not able to be met within the timeline and resources available for the project. The sample size and range of agencies represented can therefore be limited.

Key Findings

The findings indicate that the majority of respondents considered that women's use of force generally differed from men's use of force in intimate relationships because it was underpinned by different motivations and dynamics. Women's use of force was seen as often being a situational use of force when threatened and instrumental as a means to an end. Respondents identified male and female partners and children as the most likely targets of women's use of force. The practice experiences of respondents indicated women using force were mostly in the younger age range of 18-35 years. The most commonly reported behaviours of women's use of force were: verbal abuse (86.3%), emotional abuse (73%), protection of self or others (67.3%) and physical abuse (65.5%). It was concerning that almost a third (31.7%) of respondents considered women who withdraw from all sexual activity as a form of force.

In relation to service use, the majority of respondents indicated that women did not access their services frequently to specifically address their use of force. However, family and domestic violence services and alcohol and other drug services reported a higher level of service use by women using force than other service types.

The most common ways in which women's use of force was identified amongst individuals using a service was: self-disclosure, referral information or information obtained during intake or risk assessment. Over half (58.3%) of the respondents reported their agencies did not have intake questions seeking information about women's use of force.

Almost three quarters of respondents (n=207) reported that their agencies would provide a service to women using force, 11 respondents' agencies would exclude women using force and 22% (n=60) reported that there may be some women excluded depending on the agencies' assessments.

The main response of agencies to working with women who use force was providing an individual service (69.1%). The predominance of this response was largely a result of specialist responses for women's use of force not being available and referrals to perpetrator services were unsuitable as women's use of force was not viewed as similar to men's

perpetration of intimate partner violence. The other two main responses were: contacting statutory services and referral to another agency that may be able to assist.

Barriers to agencies working with women using force in intimate relationships was associated with:

- A lack of recognition and understanding of the issue which meant that there was an absence of such considerations in assessment and intake processes of the agency;
- Women may be presenting in crisis with multiple concerns and so other issues were prioritised in the first instance;
- There is limited knowledge, skills and experience within the workforce to address women's use of force;
- The attitudes of workers about the area can result in the issue being overlooked, minimised or responded to inappropriately; and
- Women may be reluctant to disclose their use of force for fear of statutory involvement with child protection/safety or Family Court proceedings associated with child contact.

However, it is important to note that across the survey questions, only a small number of respondents described women's denial of their use of force as a barrier to engagement and responses. Most respondents found that women had disclosed their use of force and would take responsibility for their actions as well as taking responsibility for others actions in some cases. This corroborates the findings of international research (see Larence 2006; 2016; 2017) on this topic that women tend to acknowledge and take responsibility for their use of force. This contrasts with heterosexual men's use of violence in intimate relationships where denial and minimisation are common barriers to engagement. This underlines how a different assessment and intervention approach is required when working with women who use force as it is not the same as men's use of force.

A common theme amongst respondents with knowledge and experience of working with women who use force was the critical role of understanding the context of both the woman's lived experience and the details of the situations where force was reported to be used. Other considerations described about women's use of force were that it can be in self defence or the defence of others (such as children or family members), it can take the form of resistive violence or it may be preemptive in anticipation of a threat or instrumental. The use of alcohol and other drugs was seen to exacerbate women's use of force.

Implications for service and workforce development

A conclusion that can be drawn from the research is that there is not the workforce capacity or services in place to comprehensively respond to women's use of force. Whilst there are a number of practitioners experienced to undertake the work, this is not widespread and there are not assessment and intervention tools being developed and widely used across Australia. The research has found some new insights not previously documented about the community services' workforce knowledge and responses to women's use of force.
To develop a better understanding of the type of workforce required, one section of the survey sought respondents' views about the worker capacities that would be sought to develop this field of practice in the future.

The two aspects identified as most important for workers in this field were: empathy and knowledge about trauma and trauma informed practice. Family and domestic violence knowledge and work experience was also a high priority amongst respondents. Understandings of intersectionality was the other main area identified. Respondents prioritised having a female practitioner over a male, however, this was not as highly ranked as the earlier characteristics. Educational qualifications were not a high priority for the respondents, unless the qualification being undertaken would enhance the characteristics mentioned above.

There is a growing amount of workforce knowledge about working with women who use force. This knowledge has evolved from the work experience of respondents primarily and not from professional development activities or working within services that have interventions and programs for women using force. There is a clear message that existing assessments and interventions are not a key aspect of the majority of agencies but that workers think there is a need to develop expertise and services in this area.

The findings of the survey all point in the direction of needing to take a rigorous and research informed approach to the development of specific interventions in the future from the point of intake through to practice responses. The future priorities ought to focus in the areas of workforce development and systems response or service development.

It is recommended that:

- Consideration be given to the development and implementation of training for the Community service workforce in the area of women's use of force and that training is prioritized for practitioners that meet some of the key characteristics for work in this field as identified in this research.
- As part of the training, a training package is made widely available and includes aspects of online and video conferencing to enable its reach beyond metropolitan areas
- Further research is commissioned, to co-produce with the community services sector, specific assessment items that could be used in a range of agency settings to assist agencies with developing methods to identify women's use of force
- The evaluation findings of the women's use of force programs being piloted in Australia, (Positive shift and others) are examined to identify a model of group practice that may be adopted more widely
- As individual work with women who use force is the most common at present, a model of individual practice is developed based on research and practitioner experience which could be piloted.
- Aboriginal practitioners' and researchers' advice is sought about developing a culturally safe and responsive model for Aboriginal women.

Overview of methodology

This was a mixed methods survey of the Australian community services sector. The survey explored how service providers define, identify and respond to women who use force and consisted of a total of 61 questions. Not all questions were asked of each respondent. This was dependent on the answers given in previous questions. For example, if a respondent stated that they have 'never' encountered a woman who uses force in their work, they were not asked questions about how they respond to women who use force. Respondents were required to answer all questions asked of them to proceed through the survey. Two incomplete responses were incorrectly included with the complete responses during the survey; both were removed from data analysis. Both quantitative and qualitative data was collected. Quantitative data was analysed using SPSS. Due to the large number of responses, qualitative data is still being analysed.

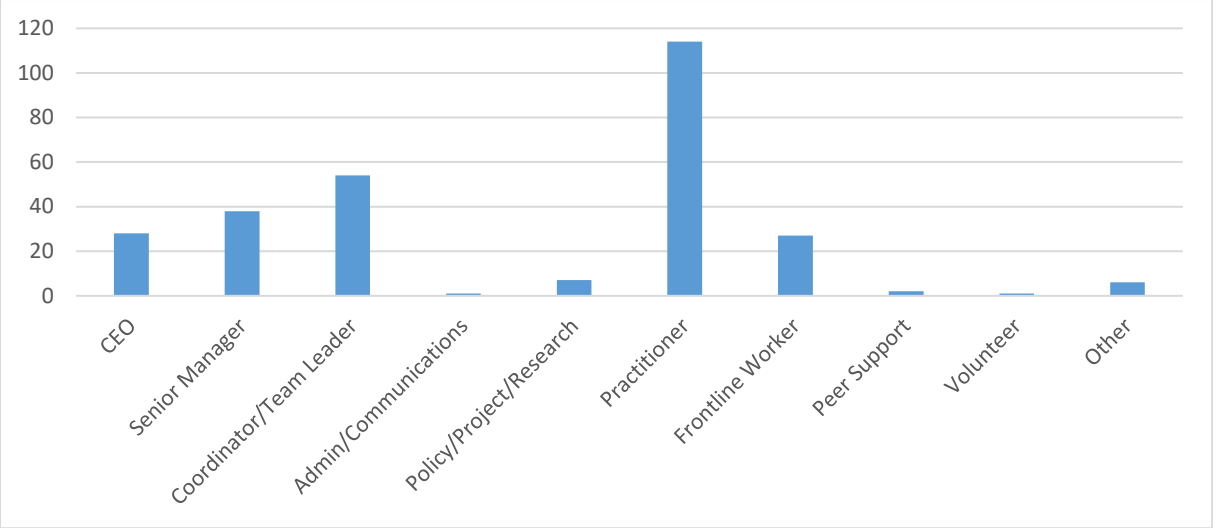
The survey also included a discrete choice experiment (DCE), which was used to explore the characteristics and knowledge practitioners need to effectively respond to women who use force. Due to its complexity, further information about this methodology, including analysis, is included with the DCE results, at the end of this report.

Two limitations of the research should be noted. Firstly, an online survey was used to gather data from across Australia and from as many workers as possible within limited time and resources. However, the trade-off is that surveys cannot gather the depth of information obtained in interviews or focus groups, however, this would have had smaller number of respondents involved. Research involving workforces is largely dependent on organisational approval to involve their employees. This research was limited to those organisations in the sector willing to allow their employees to participate, the sample size and range of agencies represented can therefore be limited.

Findings

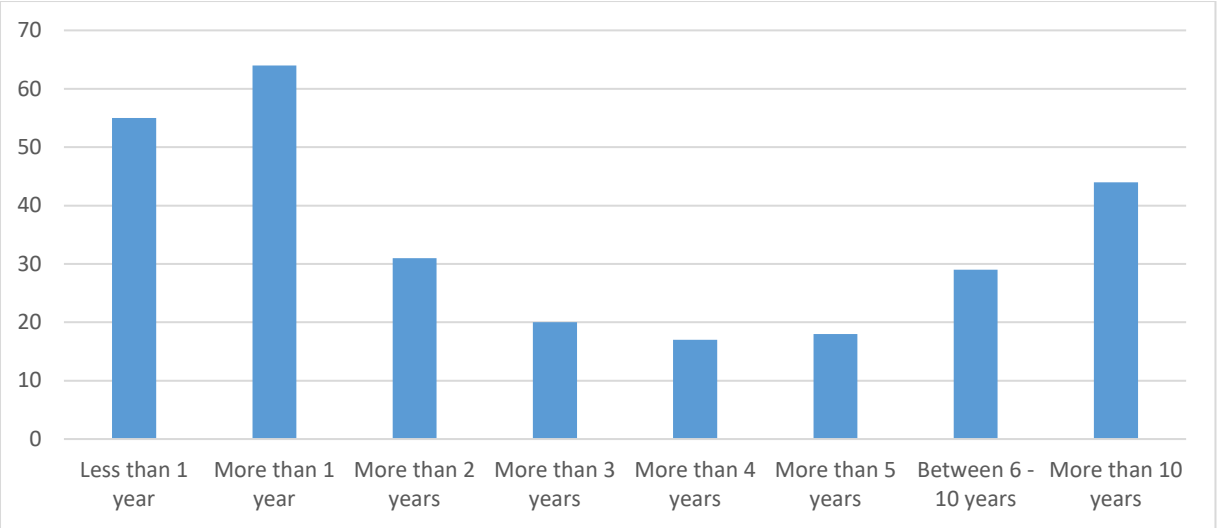
A total of 278 service providers from the community services sector completed the survey. Most of these were practitioners (41%), coordinators or team leaders (19.4%), senior managers (13.7%) or CEOs (10.1%). A full breakdown of the roles of respondents is provided in Figure 1. Six respondents selected 'other' for their current role; five of these were working as lawyers at the time they completed the survey and the sixth declined to specify their role.

Figure 1 – Respondents' current role



In order to gain an understanding of how much experience respondents had in their current role, they were asked how long they have been working in their current role (shown in Figure 2). More than half of participants had less than three years' experience in their current role. Given the high rates of staff turnover within the community services' sector, this was somewhat expected by the research team.

Figure 2 – Length of time in current role



Respondents were also asked to provide the field in which they were working at the time of completing the survey. These were then classified by the researchers. In cases where respondents listed more than one field, information given about their organisation and/or program was used to classify them. Respondents came from a total of 20 fields (as shown in Table 1). The largest group of respondents (34.9%) came from the family and domestic violence field, which included services for both victims and perpetrators of abuse. However, this was to be expected given the topic of the survey.

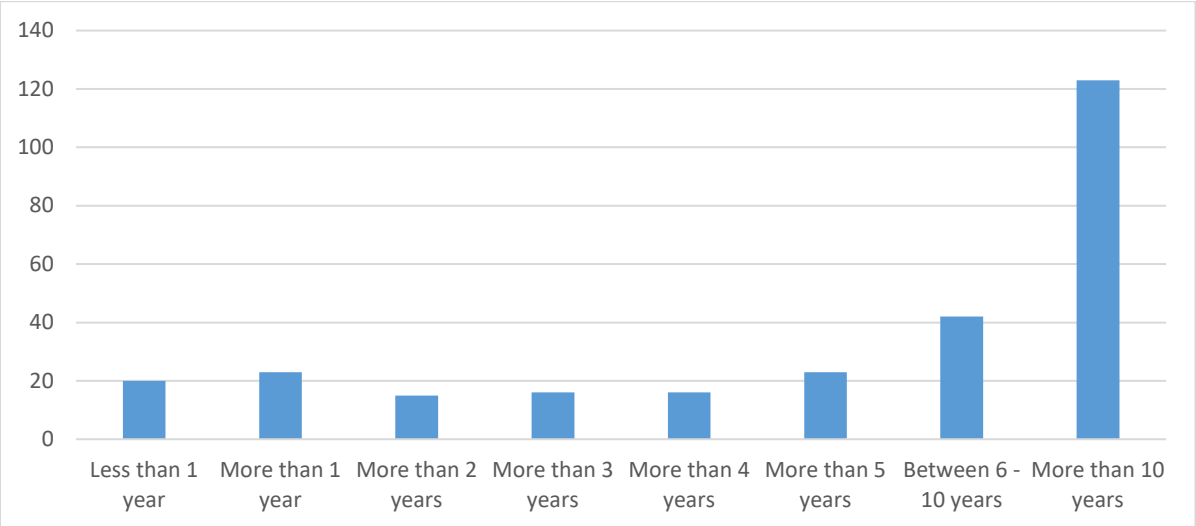
Table 1 – Respondents' current field

Field	Frequency	Percent
Alcohol and other drugs	18	6.5%

Child protection	12	4.3%
Community services	7	2.5%
Disability	3	1.1%
Education	5	1.8%
Employment	1	0.4%
Family services	29	10.4%
Family and domestic violence	97	34.9%
Financial counselling/emergency relief	3	1.1%
Health	14	5%
Housing/homelessness	8	2.9%
Indigenous services	4	1.4%
Justice	9	3.2%
Legal	13	4.7%
Mental health	36	12.9%
Multicultural services	7	2.5%
Research	1	0.4%
Sexual assault	6	2.2%
Social security	2	0.7%
Youth services	3	1.1%
Total	278	100%

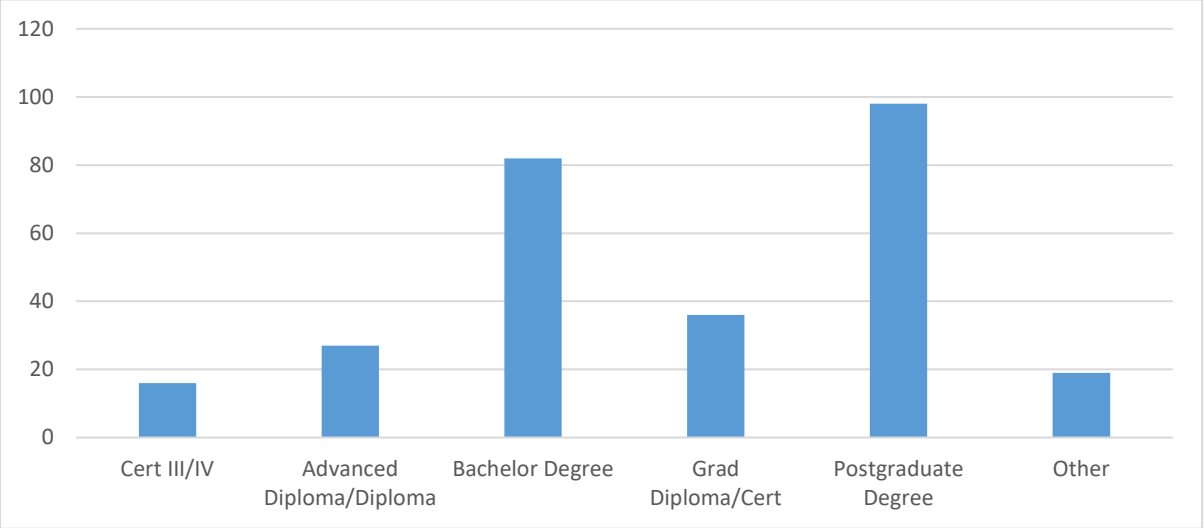
Respondents were then asked how long they had been working in this field, in order to understand their level of experience in the area (shown in Figure 3). Interestingly, almost half (44.2%) had more than ten years' experience, and an additional 15.1% had between six and ten years' experience. Again, this was somewhat expected by the research team, as movement in the community services sector is usually through different roles and organisations, rather than fields.

Figure 3 – Length of time in current field



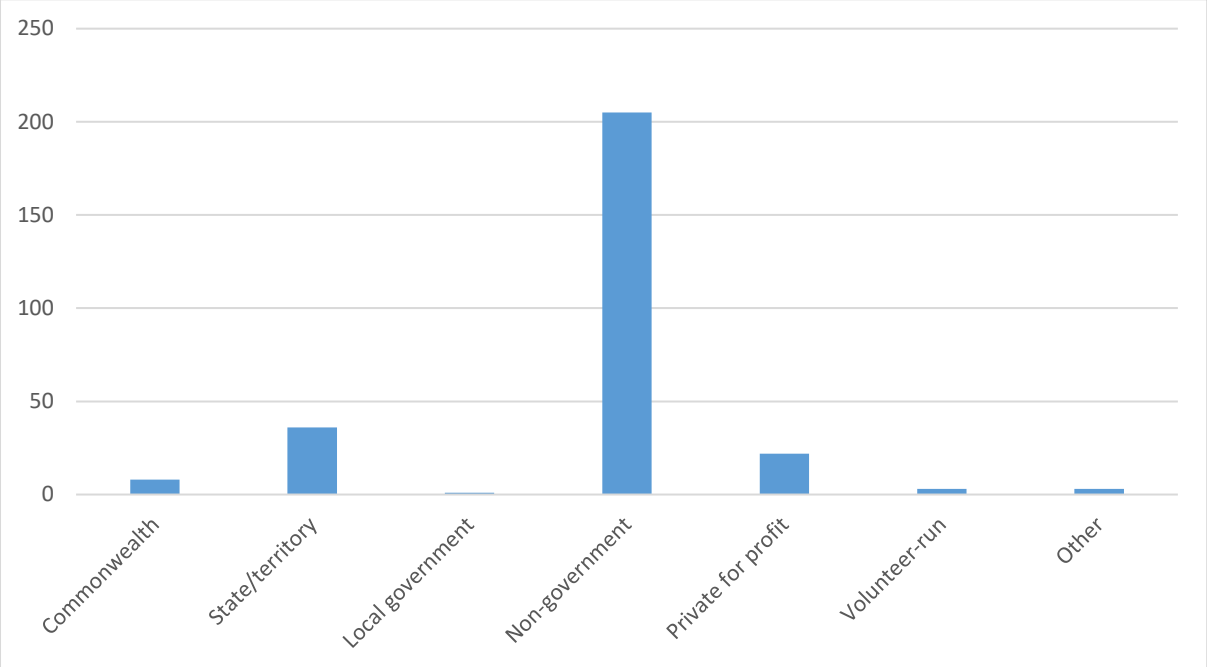
Respondents were asked to provide their highest level of education (shown in Figure 4). Most respondents held either a bachelor's degree (30.2%) or a postgraduate degree (39.6%). Two respondents answered 'other' to this question. Both reported high school as their highest level of education.

Figure 4 – Highest level of education



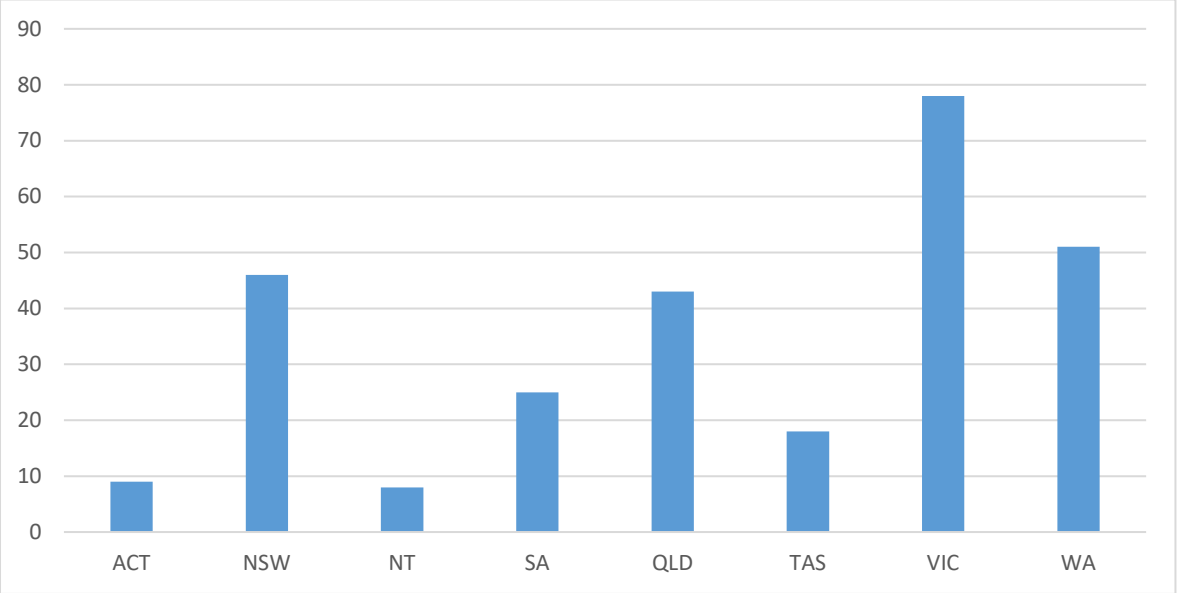
Respondents were also asked some questions about their organisation. The majority came from non-government/not for profit agencies (73.7%) or state/territory government departments (12.9%). A full breakdown of the type of organisations respondents were working in is shown in Figure 5. Three respondents noted coming from 'other' organisations. Two of these were Aboriginal Community Controlled Organisations and the other was a bulk bill medical centre.

Figure 5 – Respondents' organisation type



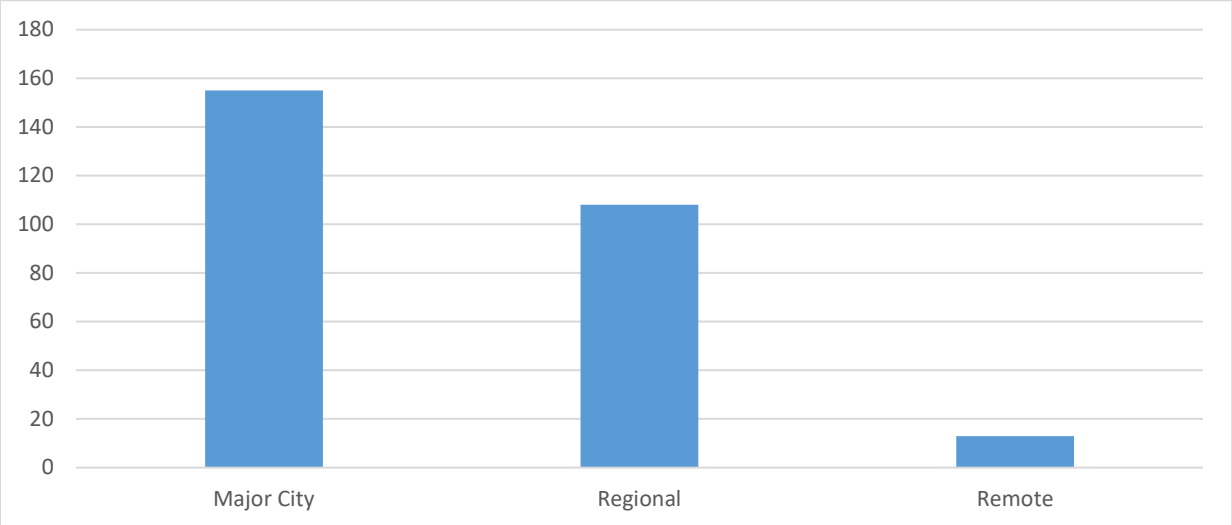
Finally, respondents were also asked about where their organisation is located (shown in Figure 6). Nearly half came from Victoria (28.1%) or Western Australia (18.3%), though this was to be expected given that this is where the two research teams are based. Victoria, as a state, has also placed significant emphasis on addressing family and domestic violence over recent years, which may also explain the large number of respondents from this state.

Figure 6 – Respondents' location by state



Respondents were asked to provide the postcode they work in, so that the researchers could map regionality and determine the extent to which regional and remote communities were represented in the results (shown in Figure 7). As expected, more than half (55.8%) worked out of a major city, and only a small portion of respondents (4.7%) worked in a remote area. It was expected that remote areas would be difficult to reach and have represented in the survey, and as such, this may warrant further consideration in future research.

Figure 7 – Respondents' location by region



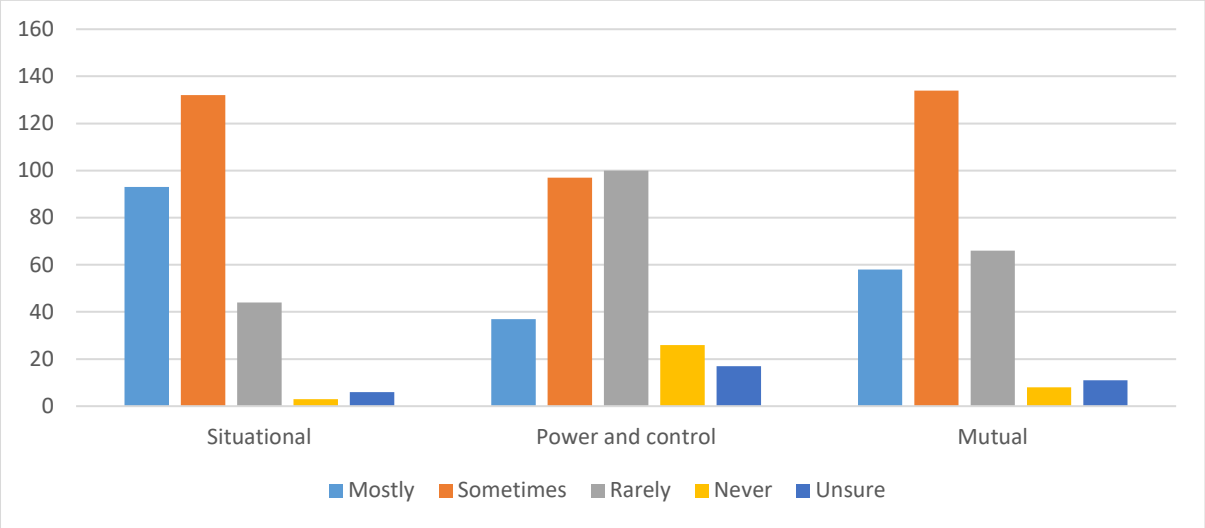
Defining women's use of force

Five respondents commented on the use of the term 'women who use force' throughout the survey. Two respondents did not feel that the term accurately reflected situations in which women have used force or violence in their relationships, while a third respondent said *"it is hard to define as one area only"* (mental health respondent). Another respondent described the term as *"cumbersome and vague"* (family services respondent), though noted that the

survey questions helped to clarify what the term meant. The fifth respondent was supportive of the term 'women who use force' describing it as *"beautifully open to include 'no fault' or mutual blame"* (FDV respondent). This respondent went on to say that this kind of terminology may also be applicable with men who have perpetrated violence, noting that the current language used with men is not quite so forgiving.

Respondents were asked about how they would define women's use of force, based on definitions of male violence against women and literature about women's use of force. Overwhelmingly, women's use of force was seen as being mostly (33.5%, n = 93) or sometimes (47.5%, n = 132) a situational or once-off use of violence, sometimes (34.9%, n = 97) or rarely (36%, n = 100) an ongoing, longer-term pattern of abuse aimed at asserting power and control, and sometimes (48.2%, n = 134) occurring within the context of mutual violence (full results shown in Figure 8).

Figure 8 – Patterns of women's use of force



This was mirrored in respondents' qualitative answers about how they would define women's use of force. Nine respondents noted that women's use of force tends to be situational (i.e. in response to a particular situation or set of circumstances) or instrumental (i.e. to get needs met). As one respondent noted, *"like anyone using force, they are trying to get [their] needs met (e.g. safety, agency or control, sense of peace)"* (child protection respondent). Another stated that women's use of force is *"modelled behaviour where the women [sic] doesn't know any other way to handle a very difficult situations"* (education respondent).

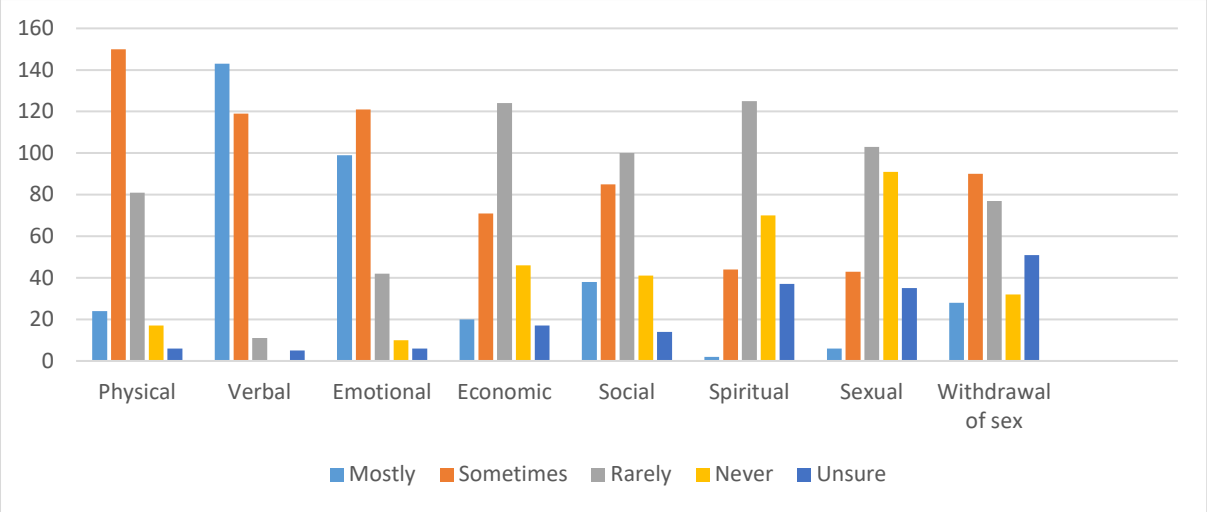
Seventeen respondents referenced power and control in their answer to this question, though it was mixed as to whether they felt women's use of force is characterised by a desire and ability to gain and maintain power and control over the victim. One respondent stated that *"typically when females present with this, the violence and abuse is [a] functional*

and systematic attempt to control the actions of their partner" (AOD respondent). Another noted that, *"where men's violence can usually be situated in a sense of entitlement to a disproportionate amount of control over someone, women's use of force is usually seen in a context of trauma and the attempt to exert back control that they have lost"* (FDV respondent). Several respondents noted that a desire for power and control is more likely to be seen in women using force in same-sex rather than heterosexual relationships, with one respondent noting that they *"work with women who identify as lesbian, bi, trans or queer. The violence they have experienced from the women who are their intimate partners echoes drivers and patterns of violence as a means of gaining power and control used by men"* (FDV respondent).

Six respondents (0.4%), mentioned mutual violence in the context of women's use of force. One FDV respondent noted seeing this during *"heavy drinking sessions"*, while another noted that in *"some same-sex relationships, both partners are using violence in different forms"*. A third FDV respondent noted that the term 'mutual violence' is problematic *"as it suggests the impact is on equal terms. Often the social, financial, psychological impact for women is far greater. Physically, it can often [have a] greater impact for women, and because of the physical inequality, women can often resort to the use of weapons for self-protection or retaliatory violence. Women who use force are often more heavily punished by authorities and their male victims more readily believed than their opposite gender counterparts."*

When asked about the tactics used by women who use force (full results shown in Figure 9), respondents reported that on average women often use verbal force, sometimes use physical and emotional force, and rarely use economic, social and spiritual force, and sexual coercion. In recognition of some of the public discourse around women's use of sex as a weapon against men, respondents were also asked about whether withdrawal of all sexual contact is a form of women's use of force. Though, on average, respondents reported that withdrawal of all sexual contact is rarely a form of use of force, there was a concerning number of respondents that reported that this is mostly (10.1%, n = 28) or sometimes (28.8%, n = 80) a tactic of women who use of force, and few respondents who reported that this is never a form of women's use of force (11.5%, n = 32). This was unexpected and concerning, given current discussions of women's sexual agency and men's obligation, or lack thereof, to sex.

Figure 9 – Types of women's use of force



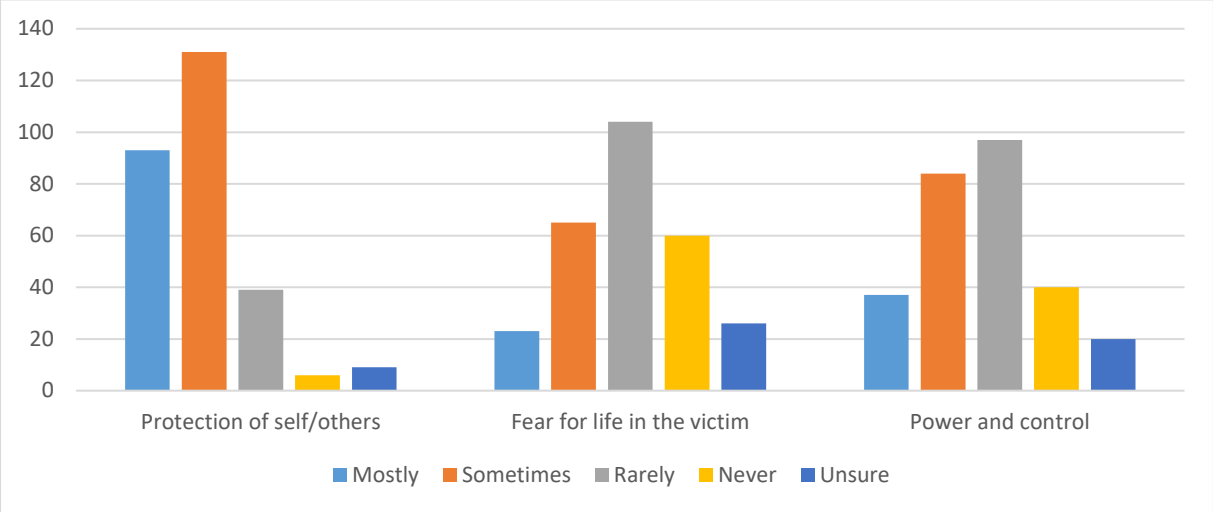
Some respondents felt that the categories included in this question were not exhaustive of the types of behaviours that may be used by women who use force. Manipulation and the use of children were the most commonly named other behaviours. Manipulation included women *"present[ing] themselves as "victim" of another person or circumstances and us[ing] their health issues as a tool to excerpt [sic] sympathy and exert control"* (multicultural services respondent) or *"us[ing] fact of being female/smaller to convince [others] not to report or seek support [as they will] not be believed"* (mental health respondent). Some respondents also considered "using" children to manipulate or control a partner to be a form of women's use of force. Tactics named by women to do this included *"threatening to remove access to children"* (FDV respondent), *"denial of rights to see children and have custody of them"* (mental health respondent), *"accus[ing] intimate partner of abusing their children (physically or sexually) [and] relocat[ing] with their children without consent"* (mental health respondent). Another respondent noted an experience where a client had *"threatened to use force against her children if she was not attended to that day by the practitioner"* (family services respondent).

Other types of behaviours respondents considered to be a form of women's use of force included women using other people, such as family members or other men, to inflict or threaten violence on their behalf, tantrum behaviour aimed at controlling another person, emasculating behaviour, false allegations of abuse, and nagging. One respondent from the family services sector also noted women using 'sex and promiscuity', and using legal systems, as forms of force, though no further explanation of these was given.

Respondents highlighted the importance of considering context when defining women's use of force in practice. This was particularly in regard to who is the primary perpetrator of abuse in the relationship. Respondents also highlighted several factors that may contribute to women's use of force, including alcohol and other drugs, mental health issues, trauma, intergenerational trauma in Indigenous communities, jealousy, frustration, anger issues, narcissistic behaviours, poverty, generational and cultural factors, and poor emotional regulation. A respondent from the mental health field also highlighted the importance of considering *"use of force against animals – the family pet can often be targeted to directly suffer or to intimidate family members"*.

When asked about other characteristics of women's use of force, on average, respondents reported that women's use of force sometimes includes protection of self or others and rarely includes fear for life in the victim or power and control. The full results of this are shown in Figure 10. Similarly, when asked qualitatively about how they define women's use of force, 56 participants noted that it is often a form of self-defence or in response to previous experiences of abuse. As one FDV respondent noted, *"women who have disclosed [that] they have used force has always been in context of self-defence within a violent relationship."* Another FDV respondent stated that they define *"women's use of force as a response mechanism to their partner's violence – self-defence or a pre-emptive 'strike' if they know his modus operandi and something is about to happen… with women who have been abused before but not by their current partner, this use of violence is almost a 'never again' response."*

Figure 10 – Other characteristics of women's use of force

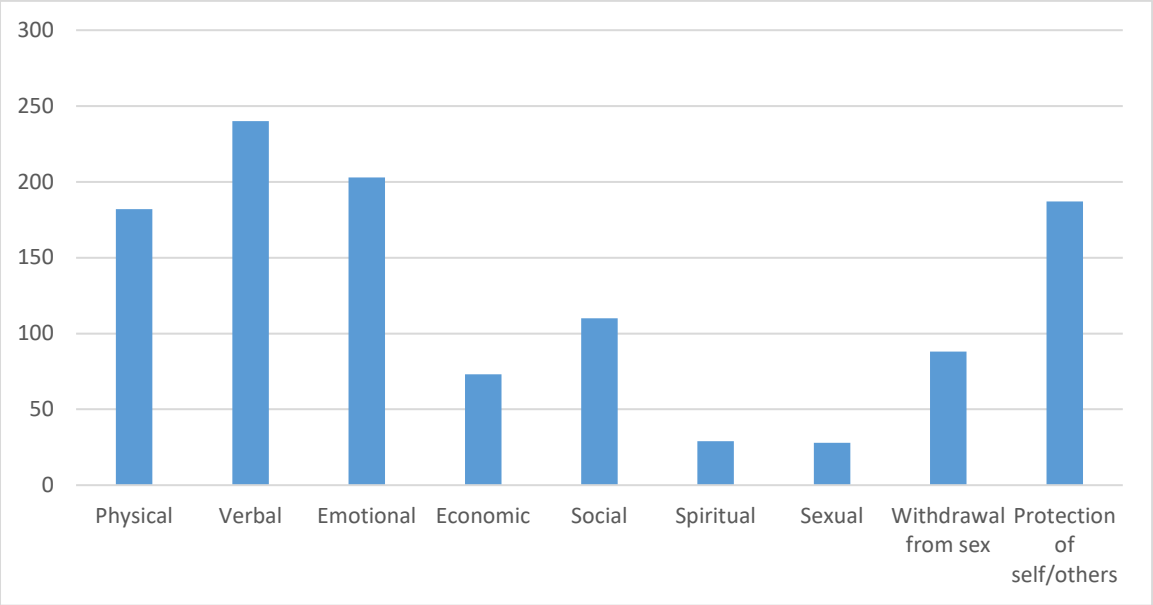


Women's use of force in practice

Respondents were asked a series of questions about the behaviours and characteristics of women who use force they have seen, to see if there were any differences or inconsistencies between their own understanding of women's use of force and what they are seeing in the practice setting. First, respondents were asked about the behaviours they see in women who use force (full results shown in Figure 14). Verbal (86.3%) and emotional abuse (73%) were the most commonly reported, followed by protection of self or others (67.3%) and physical abuse (65.5%). Spiritual abuse (10.4%) and sexual coercion or aggression (10.1%) were the least commonly reported behaviours practitioners were seeing in women who use force.

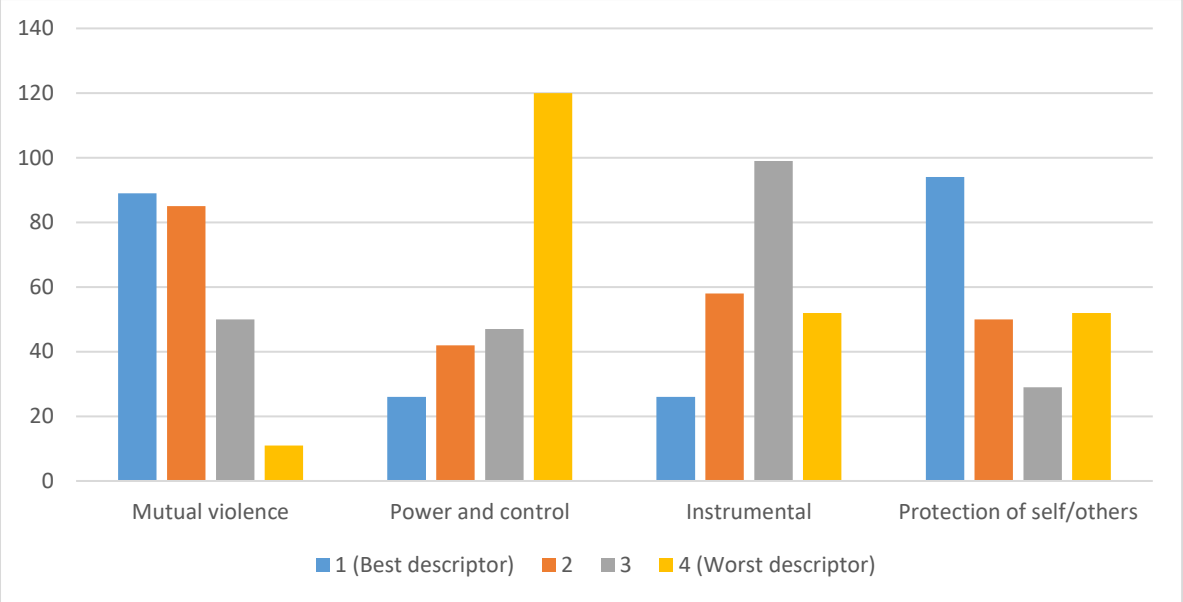
Once again, respondents were asked whether they are seeing women who withdraw from all sexual activity as a form of force. Almost a third (31.7%) reported seeing this behaviour in women who use force presenting to their service. The reasons that this is concerning have been discussed earlier in this report.

Figure 14 – Behaviours of women who use force



Respondents were asked to rank descriptors of women's use of force from 'best descriptor' to 'worst descriptor'. Power and control was seen as the worst descriptor of women's use of force, while mutual violence or protection of self and/or others were seen as the best descriptors. The full results of this are shown in Figure 15.

Figure 15 – Descriptors of women's use of force



Respondents were asked to rank the age groups in which they are seeing women who use force from most common (1) to least common (6). The most common age group was 25-34 year olds, followed by 18-24 and 35-44 year olds. The least common was above 55 year olds. The results of this are shown in Table 2.

Table 2 – Common ages of women who use force

Age groups	Mean
Under 18	3.68
18 – 24	2.52
25 – 34	1.94
35 – 44	2.60
45 – 54	3.99
Above 55	5.27

In order to better understand the context of women's use of force, respondents were asked who the three most common targets of use of force are (see Figure 11). Respondents were then asked who of these was likely to be the main target of women's use of force (see Figure 12). When asked to define women's use of force in the earlier qualitative question, a small number of participants noted that definitions should include women abusing their parents (i.e. elder abuse; 0.72%, n = 2), teenagers using force against their parents (0.4%, n = 1), and mothers using force towards their children (2.5%, n = 7). The quantitative data shows that this is not the majority of cases. Almost half of the respondents (n = 49.3%) reported the main targets of women's use of force are male partners or spouses, and almost a third (n = 32.7%) reported this to be women's children.

Figure 11 – Targets of women's use of force

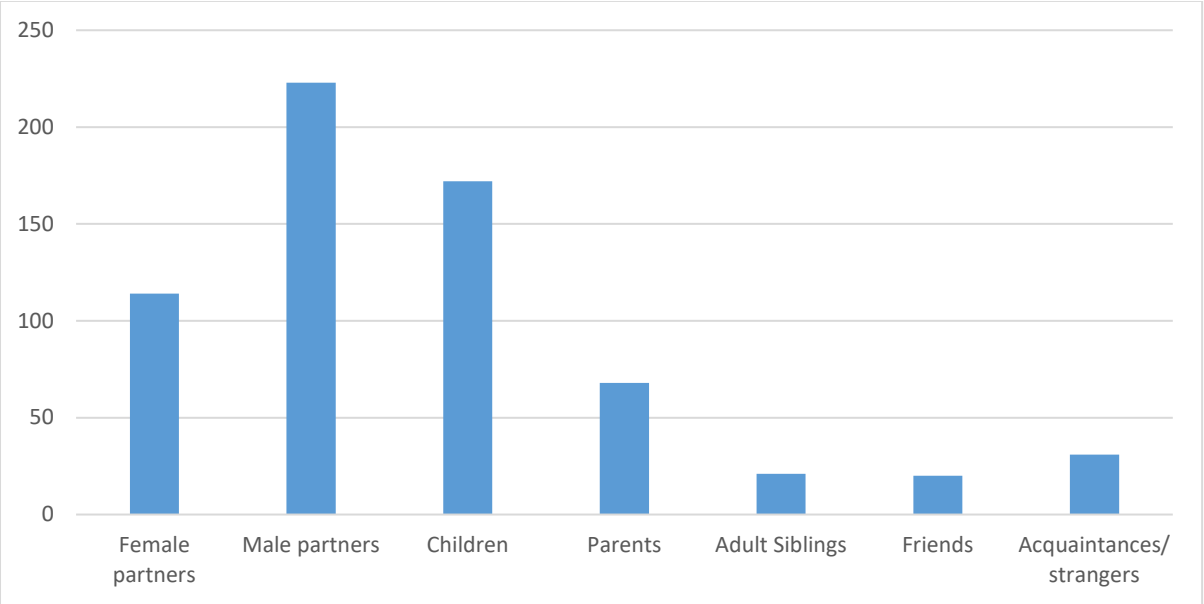
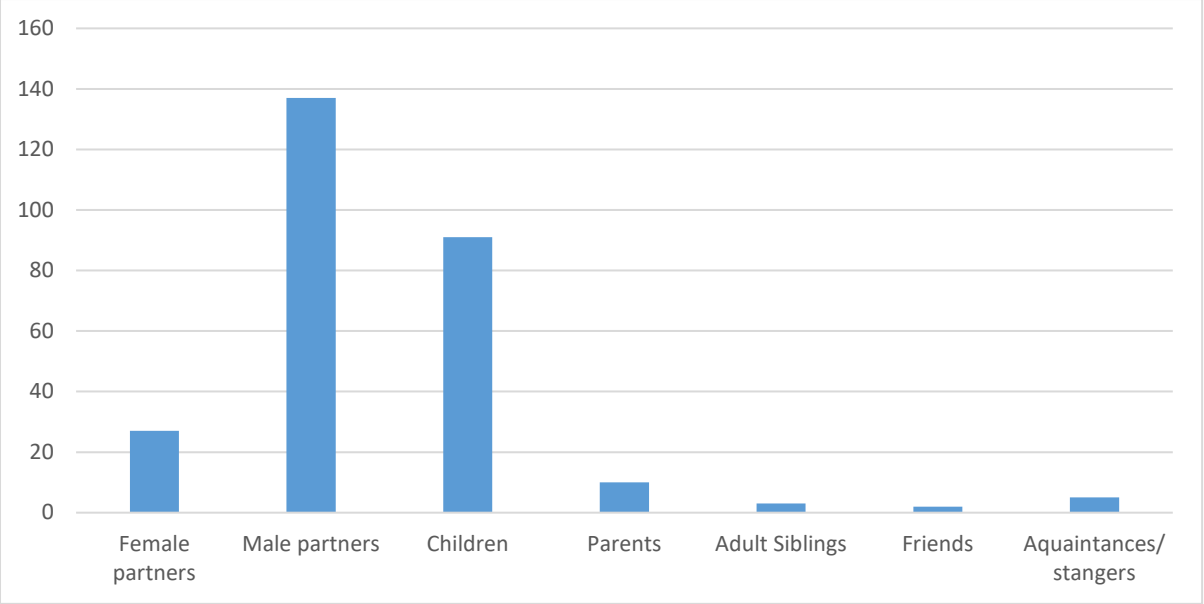


Figure 12 – Main target of women's use of force



Service use of women who use force

Respondents were asked how frequently women who use force access their service. Frequency was broken down into the following categories; frequently (every day), often (weekly or more), sometimes (monthly or more), rarely (less than once a month), and never. Almost a third of respondents (33.1%) reported that women who use force sometimes access their service, and an additional third (32.7%) reported that these women rarely access their service. The full results of this are shown in Figure 13.

These results were broken down by field, to determine which services women who use force are accessing and/or attempting to access. This is shown below in Table 3. Overall, this shows that women who use force access or attempt to access a wide range of services across a number of fields.

Figure 13 – Frequency of service access

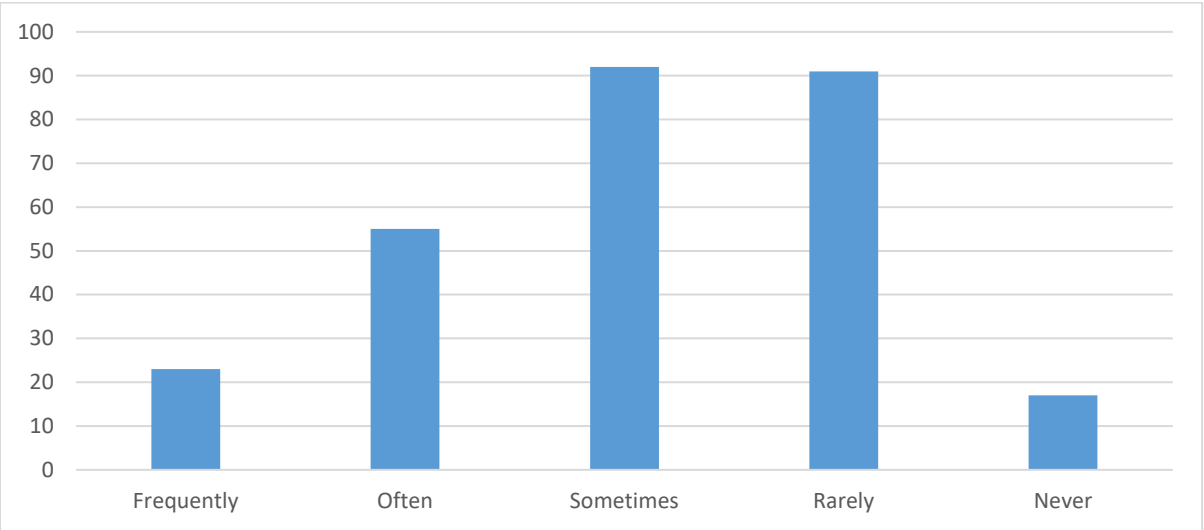


Table 3 – Frequency of service access by field

Field	Frequently	Often	Sometimes	Rarely	Never
Alcohol and Other Drugs	2	7	5	4	0
Child Protection	2	4	2	3	1
Community	0	2	1	3	1
Disability	0	0	2	1	0
Education	0	0	3	2	0
Employment	1	0	0	0	0
Family	1	6	14	8	0
Family and Domestic Violence	8	16	26	41	6
Financial Counselling	0	0	2	1	0
Health	3	1	6	2	2
Housing/ homelessness	0	1	2	4	1
Indigenous	1	0	1	2	0
Justice	1	4	2	2	0
Legal	0	7	6	0	0
Mental health	2	5	16	11	2
Multicultural	0	1	3	3	0
Research	0	0	0	0	1
Sexual assault	1	0	0	3	2
Social security	1	0	1	0	0
Youth	0	1	0	1	1
TOTAL	23 (8.3%)	55 (19.8%)	92 (33.1%)	91 (32.7%)	17 (6.1%)

Respondents were also asked whether women would be excluded from their service for using force. Encouragingly, almost three quarters (74.5%) reported that a woman would not be excluded from their service for using force. Only 11 (4%) respondents reported that women who used force would be excluded from their service, and the remaining 60 (21.6%) noted that exclusion would only occur in some instances. These results were broken down by field, to see whether there are any types of services that women are more likely to be excluded from (shown in Table 4). This showed that women may be excluded from community, family and domestic violence, justice, and legal services, but are unlikely to be.

Reasons for excluding women who use force in some instances included the safety of staff (5.8%, n = 16), other clients (2.9%, n = 8), and children (1.1%, n = 3), services not working with primary aggressors due to organizational mandate or funding (4.7%, n = 13), mental health (1.1%, n = 3) or alcohol or other drug issues (0.8%, n = 2), services only working with male perpetrators (1.1%, n = 3), or because the woman's partner is also a client of the service (1.8%, n = 5). Respondents also emphasized the importance of considering the context of the use of force when determining whether a woman is eligible for services. This was mainly in regard to whether the woman is the primary aggressor in the relationship and if the service is compatible with the behaviours she presents with.

Table 4 – Exclusion from services by field

Field	Yes	No	In some instances
Alcohol and Other Drugs	0	15	3
Child Protection	0	12	0
Community Services	1	3	3

Field	Yes	No	In some instances
Disability	0	3	0
Education	0	5	0
Employment	0	1	0
Family services	0	23	6
Family and Domestic Violence	7	56	34
Financial Counselling	0	2	1
Health	0	11	3
Housing/ homelessness	1	6	1
Indigenous	0	3	1
Justice	1	8	0
Legal	1	11	1
Mental Health	0	31	5
Multicultural	0	7	0
Research	0	1	0
Sexual Assault	0	4	2
Social Security	0	2	0
Youth Services	0	3	0
Total	11	207	60

Identifying and responding to women who use force

Identifying women's use of force

Respondents were asked questions about how they identify women who use force in their practice, respondents could select all items that were applicable. Less than half (41.7%) reported asking specific questions about use of force in their intake or assessment with women. Practitioners most commonly reported identifying women who use force through self-disclosure (68%), referral information (58.6%), and responses provided by the woman during intake (57.9%) or risk assessment (51.8%). The full results of this are shown in Table 5.

Twenty-eight respondents noted other ways in which they identify women who use force in their practice. Other methods included disclosure from the woman's male partner/the victim of the violence (6.5%, n = 18), her children (2.2%, n = 6) or another family or community member (1.1%, n = 3), through collaboration with other service providers (0.4%, n = 1), reports from other staff (0.4%, n = 1), inconsistencies in the woman's story (n = 1), or case notes from previous engagement with the service (0.4%, n = 1).

Table 5 – Methods of identifying women who use force

Method	Frequency	Percent
Observed the woman's behaviour when attending agency	117	42.1%
Information received from other agencies via referral	163	58.6%
Specific questions regarding use of force included in agency intake/assessment	116	41.7%
Responses provided by the woman during agency intake/assessment (though no specific questions regarding use of force are asked)	161	57.9%
Responses provided by the woman during risk assessment	144	51.8%

Method	Frequency	Percent
Reported from others using the service	102	36.7%
Identified during other work with the woman	81	29.1%
Disclosed by the woman herself	189	68%
Other	28	10.1%

Respondents were given space to provide additional, qualitative information about how they identify women who use force. Qualitative responses mostly mirrored the answers provided to the quantitative question about identifying women's use of force, providing more detail on what these look like in practice. Again, the importance of considering context when identifying women's use of force was highlighted. One respondent noted that in their experience *"there is a context for women using force. Often, they are horrified by their actions. Police are quick to judge and assess the situation* [as one of] *the women is* [sic] *using force. Increasing charges of women being convicted without a [family violence] lens of understanding* [the] *circumstances of the force used"* (FDV respondent). A respondent from the health field stated that *"looking at the underlying behaviours of both the perpetrator and the person at the receiving end is important."*

Disclosure

A substantial number of respondents noted that women who use force will often disclose this themselves without prompting. One respondent noted that *"they often readily admit it* [and are] *sometimes even proud of it"* (AOD respondent). Multiple FDV respondents stated that *"it is more common for women to describe themselves as violent than what it is for men",* with one noting that *"women often over-identify as violent; i.e. they identify as abusers despite having no long-standing pattern of coercive or violent behaviours"*. This is consistent with the literature, which suggests that women will more often than not take responsibility for any force or violence being used in the relationship, whether it is their own and their partner's (Larance, 2006, 2017; Larance & Miller, 2017; Larance & Rousson, 2016).

Respondents also reported that women's use of force is commonly disclosed or reported by another person. This was usually the victim of the use of force or the woman's child/ren. A respondent from the family services field noted that information about women's use of force *"usually is disclosed by* [the] *partner or ex-partner. Self-disclosure is reasonably rare"*, though, arguably, the data provided by other respondents refutes this. One respondent noted identifying women's use of force through *"responses from men in the MBCP group"*. This was interesting to the researchers, given that men are known to downplay and/or not take responsibility for their own violence, often trying to shift the blame to their partner (Larance, 2017).

Assessment processes and practices

The use of assessment processes and practices to identify women who are using force seems to differ depending on the type of service being offered. As an FDV respondent explained, their organisation uses *"A detailed pre-group assessment* [that] *asks* [women] *for particular and specific examples of the use of force in their relationships and every day interactions"* for women entering their group program on managing strong emotions like anger. Another FDV respondent stated that their service uses *"a screening tool for both male*

and female clients to identify use of violence." Outside of the FDV field, another respondent noted that *"Family violence questioning is new to the AOD sector within our assessment/risk management. While there are specific questions, questioning is still dependent on the skills of the clinician and therefore may vary client to client/clinician to clinician."* It was also noted by some respondents that the assessment tools and processes they use often illicit information from women about their use of force, though it was unclear whether this was the result of specific questions or women choosing to disclose during the assessment.

Other respondents however, noted gaps in their assessment processes in regard to women's use of force. One FDV respondent noted that screening for women's use of force *"has not been a specific focus of our program and* [and is an area they] *can improve on."* Another stated, *"We have no specific questions other than 'do you have a FVRO against you?"* (FDV respondent). Finally, a respondent from the child protection field explained that *"our intake questions do not sufficiently cover this. We only ask about family violence and don't do enough to differentiate between different dynamics."*

Referral information

Respondents identified receiving referrals for women using force from a range of services. Referrals often come from police or child protection, but also come from legal services or other agencies. Again, the importance of context was highlighted, with respondents explaining that they are often required to undergo a process of discernment to determine whether the referral information is accurate. As one respondent from the FDV sector noted, *"L17s often come to us with the women listed as respondents. We always take this with a grain of salt, as we often uncover (by looking at our history and through conversations with women) that they are actually the victim/survivors of violence, rather than the perpetrators."* Another FDV respondent noted that *"when police arrive at an incident they may witness the woman screaming and yelling abuse and find her difficult to calm or to engage* [and have] *no context or insight into what preceded the woman's response. When service staff sit down and unpack the context and history for that woman, there is usually overwhelming and long history of abuse and manipulation, financial abuse and control."*

Observation

Several respondents provided additional information about how they identify use of force through observation. Strategies for this included observing women's interactions with their partner and/or children, listening to the language the woman uses when describing their own behaviour, and *"looking for specific responses such as her ability to take responsibility for behaviours"* (FDV respondents). One respondent from the mental health field noted that women who use force may be identified by the way that they present to services, explaining that *"The women we see who have experiences of exerting force are generally distinguishable by their high and obvious levels of distress, their self-questioning about what has occurred; their spoken feelings of hopelessness and helplessness to manage a situation in which they feel responsible and are often held by others as being responsible…"*

Barriers to identifying women's use of force

Respondents were also asked about the barriers posed to identifying women's use of force. Six different barriers were noted by respondents, including assessment practices and

procedures, knowledge, skills and attitudes of practitioners, assumptions, beliefs and values about women who use force, lack of services, and responses from both men and women. Each of these is discussed in more detail below.

Assessment practices and procedures

As noted previously, several respondents indicated that there were gaps in their assessment processes that posed challenges to identifying women who use force in their answers to an earlier question. Additional detail was provided in this question, with respondents explaining how their assessment practices and procedures fail to identify women's use of force. Several respondents noted that their intake practices are focused on men's use of violence and thus fail to consider women's use of force, with one family services respondent stating, *"We don't look for it"* and another explaining that *"The fact that family violence is predominantly male perpetrated and most services come from this feminist viewpoint that can fail to identify women as likely perpetrators as easily as men are identified."* A respondent from the mental health sector echoed this, noting that *"Questions are not asked* [in assessments]*, the dominance of the male violence narrative puts women in the role of victim, not perpetrator, and this is rarely questioned."* Other respondents also noted the lack of direct or specific questions about women's use of force in their service's assessment practices and procedures, with one explaining that *"It is not a question on our risk assessment, so we only become aware if the woman discloses this to us during assessment"* (FDV respondent). Another child protection respondent noted that *"The woman is never asked if she has initiated, threatened or hurt anyone as it is deemed too offensive and disengaging."* Respondents noted that the lack of questioning about women's use of force may also be attributable to who is conducting the assessment, with one explaining that *"Workers sometimes avoid difficult questions or conversations, engagement issues, shame and cultural expectations. Sometimes class, Indigenous status, gender etc. impacts on the conversation taking place"* (family services respondent). Another respondent from the health field noted that workers may not ask questions about use of force due to *"Personal perception*[s] *of invasion of privacy. People are hesitant to ask the difficult questions."*

The difficulty of asking women questions about their use of force was highlighted by other respondents, with one noting that women's use of force is *"Hard to ascertain when* [the] *client is in crisis. We do not want to 'victim blame'"* (FDV respondent). A respondent from the AOD sector explained that workers are *"… concerned about being 'wrong' and not supporting women in domestic violence situations."* A mental health respondent noted that the *"complexity of* [a] *victim of violence using violence"* may also pose complicate the identification of women's use of force in assessment.

Assessment practices and guidelines were also criticised by respondents for failing to explore and understand the context of women's use of force. One respondent from the FDV sector noted that those outside of the sector *"don't take into account context. They don't ask about women's lives. They don't see things through a DV lens. They don't see Australian Aboriginal and Torres Strait Islander women as been* [sic] *uniquely disadvantaged and using their own force as a result of colonisation. They don't see CALD women's use of violence in relation to the violence used against them."* Another respondent from the FDV sector explained that *"Reports of women 'using force' are often misrepresented, missing that the women* [sic] *has likely used force to protect herself or however* [sic] *children."*

Several respondents highlighted that cases where both partners are using force or violence can also be difficult to identify through assessment practices and guidelines. One respondent from the FDV sector explained that *"Non-specialist services lacking an understanding of the gendered dynamics of DV and characterising violence as 'mutual' or 'situational' or blaming women for resisting the violence they are experiencing"* can act as a barrier to identifying women's use of force. Another respondent, also from the FDV sector, noted that *"It can be very hard to determine which partner (if any) is the primary aggressor."*

Practitioner knowledge, skills and attitudes

Respondents highlighted that practitioner's knowledge, skills and attitudes of women's use of force poses challenges to identifying this issue. Some respondents noted that practitioners have a limited knowledge of this issue which impacts their ability to identify women who use force. One respondent explained that practitioners need more knowledge *"Not in identifying women who use force, but in understanding why they use force"* (FDV respondent). This lack of knowledge was seen as hindering the development of frameworks or intervention models, with another FDV respondent explaining *"Lack of knowledge as to why women use violence translates to minimal evidence base and lack of assessment tools."* Others highlighted the need for training for practitioners on women's use of force, with one child protection respondent noting that *"More training is required as this area is growing."* However, another respondent noted that *"Staff training that includes simplistic and politicised Duluth Model of FDV and leads to minimising indicators of FDV in women who present to the service"* (AOD respondent) poses a barrier to identification of women who use force, indicating that training for practitioners needs to consider the context of women's use of force to be effective.

Respondents also expressed that not all practitioners understand the potential for women's use of force to be situated within a context of resistive violence. One respondent from the FDV sector explained that *"It is a barrier to 'lump' all women who use force into the same category as a male perpetrator of domestic violence or abuse. Consideration needs to be given to assessment of the corresponding power and control dynamic, historical behaviour patterns, and whether the victim is a risk of coercive control, intimidation, serious injury or death."* Another respondent noted that *"Practitioners who do not have an in-depth understanding of resistive violence and the context of women's use of force in heterosexual relationships, and the points of difference with women who use coercive control in queer relationships… police, child protection and corrections often position women in a heterosexual relationship who use force as a 'perpetrator' – these institutions need a better understanding of FV/IPV and resistive violence."* This was reiterated by another respondent from the FDV sector who stated that practitioners have a *"Lack of understanding of her situation, context to violence. Lack of understanding by police and legal system and other agencies. A strong view that women are responsible for managing children."*

Respondents also noted women not feeling safe or trusting of practitioners as a barrier to identifying use of force. One FDV respondent explained, *"I do not think that at assessment stages one can identify this. I believe that it takes hard work, genuine interest and dedication, prolonged and close contact, impartial approaches, ability to build trust, observation at points of crisis and/or difficulty, home visits, relationship building with children and extended family members, before an assertion that a woman's use of force can be considered as a characteristic of that woman."* Another respondent from the community

services sector noted that shame may prevent women from disclosing use of force to practitioners, explaining that *"women are ashamed to acknowledge violence. In counselling situations this is often disclosed after a period of work when a level of trust has been established."* Additionally, one respondent from the legal sector noted that some women may be unwilling to disclose, stating the *"Single greatest barrier is dishonesty."*

Some respondents felt that practitioners may lack the confidence to ask questions or enquire about women's use of force, particularly if they have not been trained in this. *"Confidence of clinicians untrained in this field* [is a barrier]. *What 'to do' with this information once collected – risk management and safety planning"* (AOD respondent). Others felt that practitioners may not be comfortable exploring this with clients, with one FDV respondent attributing this to *"The service system fearing being accused of mother/woman blaming."*

Assumptions, beliefs and values about women who use force

Respondents noted that assumptions, beliefs and values also pose barriers to identifying women's use of force. Several respondents highlighted that these assumptions are based on gendered understandings and theories of FDV, with men constructed as perpetrators and women as victims. One AOD respondent explained that *"Unfortunately many practitioners assume that only men can abuse and ignore the warning signs when females present as coercing and controlling behaviours* [sic]. *This feeds cowardly and bitter 'men's rights' groups who seek to discredit processes that do effectively identify male perpetrators."* Another respondent from the FDV field noted *"Predominate* [sic] *aggressor paradigm which, though often correct, in many cases can lead to a presumption all violence by women is defensive/resistance, which means abuse by women can be missed."* This was reiterated by a respondent from the mental health field, who felt that *"The social construct of male privilege as the dominant discourse in the domestic violence space"* also posed a barrier to identification. A respondent from the social security field explained that *"Rigid gender roles – expectations that women are the caring sex – make it difficult for people to screen for abusive behaviour."*

Several respondents noted that some practitioners do not believe that women's use of force occurs or believe that it is highly unlike to occur. One respondent from the FDV field described this as *"Prejudice, that women is the innocent party, they are not that bad. Only men does violence* [sic]*."* Another explained that *"Women perpetrators can present as lovely, normal, everyday women and do not disclose any mental health issues, social problems or anger issues. Like any male perpetrator, the dark side comes out behind closed doors"* (family services respondent).

Some respondents also felt that violence or use of force by women can be justified, posing barriers to identifying it in practice. A respondent from the health field explained that women's use of force is *"passed away/excused behaviour due to another external circumstance – unlike male perpetuated* [sic] *violence."* Another respondent from the FDV field noted that there is *"An ongoing belief system that women only commit violence to protect themselves or others… only men commit DFV."*

Lack of services

Respondents noted that a lack of services for women who use force also poses a barrier to identification in practice settings. One respondent from the FDV field noted that *"Women often report that they believe* [disclosing their use of force] *may preclude them from the service."* A respondent from the housing/homelessness field explained that there is a stigma for women who use force resistively that they *"… don't need support or assistance because they can handle themselves, even when they explain they 'fight back' as they are terrified for themselves or their children and literally fight back to survive."*

Barriers to self-disclosures from women

Respondents noted several challenges or barriers to women disclosing their use of force to practitioners. Firstly, that women fear that disclosing their use of force will result in legal and statutory involvement and/or consequences. Child protection and family law court were often mentioned in relation to this. One respondent from the FDV field noted that women have a *"Fear of consequences from Child Safety* [which may cause them to] *be less open in their disclosures…. Uncertainty of what might happen in FLC* [Family Law Court] *with this information."* Another respondent noted that *"DVPO* [Domestic Violence Protection Orders] *on women who use violence (that are actually the victim) create huge distrust in the system for the woman and create multiple barriers in terms of her legal rights, impact on family court proceedings etc."*

Respondents also noted that women often take responsibility for their use of force, even when it is resistive or an act of self-defence. This is consistent with the literature (Larance, 2006, 2017; Larance & Miller, 2017; Larance & Rousson, 2016) and poses difficulties to practitioners situating women's use of force in context. A respondent from the FDV field explained that *"Most of my experience has been that women are forthright with any use of force they have used, and more often than not take more responsibility for the violence that has occurred than their partner who is the primary aggressor."* Another FDV respondent highlighted that *"the primary issue is that it is easy for men who have coercive control over a woman (especially one with trauma presentation) to gaslight both her and those around them into believing that she is responsible for using force, when in reality the situation has arisen almost exclusively from initial male perpetration."* This may be further complicated by *"The criminalization of women who use force, particularly those who do so as a response to DV. Additionally, the lack of understanding of how stereotypes and gender norms contribute to restricting women's access to support which may lead to using force"* (FDV respondent).

Shame and embarrassment may also prevent women from disclosing their use of force to practitioners. One respondent noted that *"Women can feel ashamed in the light of day about their behavior"* (mental health respondent). Another explained that women may feel shame because *"… women who use force are outside the socially contracted gender roles. Using force often impacts their identity as a woman, mother and partner.* [There is an] *expectation that they should be able to control their anger even in the context of family violence"* (FDV respondent). For those women who do wish to disclose their use of force, *"Not knowing where to go"* (family services respondent) may prevent them from doing so.

Some respondents felt that women may normalise or even justify their use of force, particularly if it was directed towards a partner or child/ren. One respondent from the legal field explained that *"Violence is unfortunately fairly normalised in our communities, and users*

of violence are generally known and not especially shy about it." Another mental health respondent noted that some *"women think that they are justified to use force in the circumstances."* Respondents also explained that some women do not see their behaviour as violence or a use of force, with one noting that *"It's often seen as 'tit for tat', or their right to hit a man if they think he is behaving badly"* (mental health respondent).

Barriers to disclosures from men

Several respondents noted barriers to men disclosing or reporting women's use of force. *"Men are less likely to report DV"* (education respondent). Another education respondent noted that men may be *"too shy, embarrassed, ashamed or unable to identify the woman's behaviour as an expression of the use of force"* and therefore may not disclose. Many attributed this to the shame, embarrassment and stigma that is experienced by men who experience violence. One respondent from the FDV field noted that *"In circumstances involving a male domestic partner, it is often shame or embarrassment that will prevent him from ever reporting abuse by his female partner. Sometimes, upon police attendance, he will water-down the seriousness of the incident."* Another respondent from the housing/ homelessness field explained that *"Men are ashamed and feel emasculated to come forward. People with disabilities may have verbal barriers in communication and often the perpetrator will hover over the victim and make private conversations difficult."* It was noted by a respondent from the AOD sector that cultural barriers may also increase shame and embarrassment and/or prevent men from disclosing women's use of force.

Responses to women's use of force

After explaining how they identify women's use of force, respondents were asked to provide information about how they respond to women who use force (results shown in Table 6). The most common response was to offer women individual service (69.1%) and/or to contact statutory services, such as police or child protection (42.4%). In line with the previous question about whether women who use force are excluded from services, the least common response was to exclude women from services and refer them elsewhere (9.4%).

Sixty-nine respondents reported providing another response to women who use force. It was noted by 24 respondents (8.6%) that the response they provide is dependent on the context of the woman's use of force, and is often determined on a case-by-case basis. Other responses included making referrals to other organisations without excluding the woman from accessing services (8.3%, n = 23), group treatment (3.6%, n = 10), family (0.7%, n = 2) or couples therapy (0.4%, n=1), alerting other agencies to the use of force (0.7%, n = 2), provision of a modified service, such as shuttle mediation (0.7%, n = 2), monitoring (0.4%, n = 1), follow up (0.4%, n=1), consideration of legal options (0.4%, n = 1), and being treated as a victim of family and domestic violence (0.4%, n = 1). Two respondents (0.7%), also noted offering support to the woman's male partner as being part of their response to women's use of force.

Table 6 – Responses to women who use force

Response	Frequency	Percent

		(% of agencies)
Excluded and referred to another organisation that is able to provide services	26	9.4%
Offered individual services	192	69.1%
Referred to more appropriate service within your organisation	83	29.9%
Contact statutory responses (e.g. police, child protection)	118	42.4%
No action specifically taken to address the use of force	37	13.3%
Other	69	24.8%

Respondents were then asked to provide additional information about how they respond to women's use of force in practice. This was generally consistent with the quantitative data that had already been collected, though additional detail on what particular responses look like in various practice settings was able to be provided.

Reporting women's use of force

Several respondents noted that they either opt to or are required to report women's use of force to a statutory organisation for further investigation and/or response. These agencies being referred to were mainly child protection, police and corrections. One respondent from the AOD sector wrote that *"We refer to child protection if the woman's child is unsafe, or if* [the] *referral will be supportive of the client."* Respondents noted that police may become involved in situations of women's use of force, even in those cases when the woman is using resistive violence. As one FDV respondent explained, *"In an abusive relationship, particularly long-term abusive relationships, the woman may eventually respond to long-term abuse by using force, which then leads to a police intervention."* This may lead to involvement with the corrections system, with another FDV respondent noting that *"Sadly, women here often end up in prison. There are limited diversion programs."*

Provision of services to women who use force

Respondents identified a range of different services that they are able to offer and provide to women who use force. These include anger and behaviour management (though it is unclear whether this is only in mandated cases), assertiveness training, psycho-educational support, and parenting support. Once again, respondents noted the importance of considering context, particularly in cases where the force is resistive or an act of self-defense. Some respondents noted that, in these cases, their initial or risk assessment formed part of their response. One FDV respondent noted, *"We work with women to identify, assess and respond to if, how and when they are using any force, the context in which that force is understood to be used, undertake risk assessment for herself and others she may be using force against, provide comprehensive referrals if appropriate and make appropriate reports to statutory bodies if appropriate."* Another FDV respondent wrote that *"We have many examples when the police put a protection order (or PPN) against the women, labelling her as the perp. When the women comes to us for help, we explore her own experiences as a victim and provide her with help such as assistance with preparing an order against the perp, contacting the police to see if we can get them to drop the order, or assist with a variation to show her experience as a victim."*

Several respondents noted that they will explore various aspects of a woman's use of force through individual work. A respondent from the justice sector explained that *"Most often we will discuss ways to manage anger, drug use, and therefore abusive behavior. Our women often like to blame other agents for their downfall such as drugs or alcohol - we talk about removing themselves from their kids if they are doing drugs or other substances. We talk about finding safe places for them with extended families."* Another FDV respondent noted that *"We work with women to look at context, effects of behaviour and so on. This assists in identifying causes which, unlike men who use violence, are not rooted in the same conditions of privilege and entitlement."* For one family services respondent, this work includes a *"Discussion of the impact on the woman, her children, and others. Identifying motivation for change. Targeting services and supports to the woman's goals for change."* Another FDV respondent noted that they explore the triggers and antecedents of women's use of force, *"… support*[ing] *the woman to identify why she feels the need to use force, and assist her to find support in regards to these issues."*

Respondents also spoke about working with women to identify alternatives to using force. One mental health respondent explained that they will work with women in individual counselling *"to develop different coping behaviours."* Another wrote that *"If a women is identified as using force, we will work with her to develop alternative behaviours. This can include interpersonal communication skills, positive discipline strategies, identifying and avoiding triggers, CBT techniques and emotional regulation"* (child protection respondent). Two respondents also noted working with women to *"identify resisting responses that keep them safer"* (FDV respondent), but this was only in cases where the woman was not the primary aggressor or perpetrator of abuse.

One respondent highlighted that individual work with women who use force includes challenging their use of force, recalling one case in particular. *"We talked to this woman about the things we observed her doing to her husband, and created a space where we could talk about what was going on. She became very defensive, and it was hard to engage with her after that"* (mental health respondent). Others emphasised the importance of promoting responsibility among women who use force, with a respondent from the FDV field explaining that *"If the woman is identified as using force there may be a discussion about what is underlying the behaviour and talking to the woman about accepting responsibility for her actions and a discussion of what services may be useful for her."* Another mental health respondent noted that they *"Work on people accepting responsibility for own behaviour same as would with anyone using force."*

Several respondents noted that they would provide couple's or family counselling in situations where women are using force. One mental health respondent noted that the use of force *"is worked through with the couple with clear boundaries and realistic expectations for engagement."* Another family services respondent noted that *"We work holistically with the family where possible. We work with both partners towards achieving a more harmonious relationship."* A respondent from the education field explained that in cases of women's use of force *"We may continue to see the couple as a couple and also with another counsellor seeing the woman to work through a range of issues including anger management. Alternatively, we may continue to see the couple but refer the woman to another service that can assist with anger management."*

Service responses

Other service responses to women's use of force identified by participants included exclusion from services, referral to other services, and team consideration of the woman's suitability for service or referral options. Respondents' reasons for excluding women from services were consistent with those discussed previously, primarily focusing on staff safety and whether it is within the organisation or service's mandate to work with perpetrators of violence. In cases where the organisation or service is not able to work with perpetrators, respondents noted that the woman is often referred to another, more suitable service. One child protection respondent noted that *"Generally they are referred to domestic violence services but not specially to services that address their own use of force."* In some cases, respondents noted that the decision of whether to exclude a woman from services is made in a team environment. One FDV respondent explained that *"Where we identify that a woman is using force as the primary perpetrator in a relationship, we would have a team discussion about the appropriateness of our service in assisting (we are not funded to work with perpetrators)."* Another education respondent noted that in these cases, *"The worker provides information about this to their supervisor and consults on the best course of action. Depending on the circumstances, the woman is likely to be referred to another agency for specific support in this area."*

Barriers to responding to women's use of force

Respondents were also asked to identify the barriers to responding to women's use of force. Barriers included factors and characteristics related to these women that make it difficult to respond to their use of force, as well as those factors and characteristics related to practitioners and service delivery. Many of these barriers were also noted as barriers to identifying women's use of force.

Characteristics of women

There were several characteristics of women who use force that were identified as posing barriers to practitioners providing responses. All of these have also been noted as barriers to identifying women who use force. These barriers include a lack of recognition, acknowledgement and/or taking responsibility among women for their use of force, with one AOD respondent noting that *"A lot of people do not like to admit that there is an issue and are not willing to address their use of violence or acknowledge it even. When discussed it is always minimised."* It was also noted that cultural expectations or understandings of violence may also impact this, with one mental health respondent explaining that *"Cultural barriers related to the acceptance of force to get their own way"* may make it difficult to respond.

Respondents also noted that stigma poses difficulties to responding to women's use of force, often leading women not to disclose or be forthcoming. In recognition of this, a respondent from the FDV field highlighted the need for *"A nuanced understanding of why they might be using force in the context of family violence. For women it can be deeply shameful that they have taken on behaviours that they might have experienced themselves, and can validate narratives that are 'bad' people."* A fear of the repercussions, particularly of the child protection or criminal justice systems becoming involved, was also noted by respondents as a barrier to women disclosing their use of force and engaging with the available responses.

Practitioner and service delivery factors

There were also several factors related to practitioners and service delivery that were identified as barriers to responding to women's use of force. Many of these have also been highlighted as barriers to identifying women's use of force. Assessment tools and practices were, again, noted as barriers, primarily because they make it difficult to identify women's use of force, and if the issue is not identified, practitioners are unable to provide any type of response. One respondent from the AOD field noted *"outdated tools that are used for both victims and perpetrators, such as the Dangerousness Assessment Scale"* present a challenge to responding to women's use of force. A lack of understanding about the context of women's use of force was also noted as a barrier to responding. This included not only a lack of understanding among practitioners, but also among women, with one respondent noting that *"Often women pick up on the language of family violence, e.g. 'I was being verbally abusive', 'I was physically violent too', not understanding that in context, this is often what they did to protect themselves, or in context of more violence against them"* (FDV respondent). Related to this, practitioner skills, knowledge and values in relation to women's use of force were also noted as a barrier, with several respondents highlighting that there is a lack of training for both specialist and non-specialist staff in this area.

A considerable number of respondents indicated that the availability, appropriateness and accessibility of services for women who use force is also a barrier to responding. Several respondents noted the lack of services for women who use force, with one attributing this to a *"Lack of government funding which leads to a dearth of programs in the community"* (health respondent). Another respondent from the family services field explained that *"Existing programs that support women are geared toward them being victim survivors rather than aggressors. Only when women are using inappropriate discipline toward their children do CP get involved…"* Others noted that those services that are available for women using force may not be appropriate, with one respondent (FDV) noting that *"Most programs who work with women who use force do not provide a program in the context of trauma and address any of the gendered context for women."* It was also noted that some women who use force have other complex issues as well that may make it difficult for them to access services, with one respondent from the justice field writing *"The women who come to* [my service] *have complex behavioural issues, e.g. substance abuse and mental health or ABI, traumatic history.* [It is] *very difficult for this group to engage with services full stop.* [They are] *Often banned from services."*

Other issues in responding to women's use of force

In order to understand the kinds of issues practitioners are trying to address in their work with women who use force, respondents were asked about the responsibility women take for their use of force and their willingness to seek help (see Table 7). Respondents reported that approximately 42.3% women are willing to acknowledge their use of force and approximately 39% are willing to take responsibility for this. As noted previously, the literature suggests that women who use force often take responsibility for not only their own use of force but any violence that their partner may have perpetrated against them (Larance, 2006, 2017; Larance & Miller, 2017; Larance & Rousson, 2016). In recognition of this, a question asking how many women were likely to take sole responsibility for mutual violence used in the relationship was included in the survey. Respondents reported that, on average, 33.7% of women took responsibility for their own use of force and any violence perpetrated towards

them, which seems to contrast with what has been noted in the literature. When asked about women's help-seeking for their use of force, respondents reported that, on average, only 29.5% of women were likely to do this.

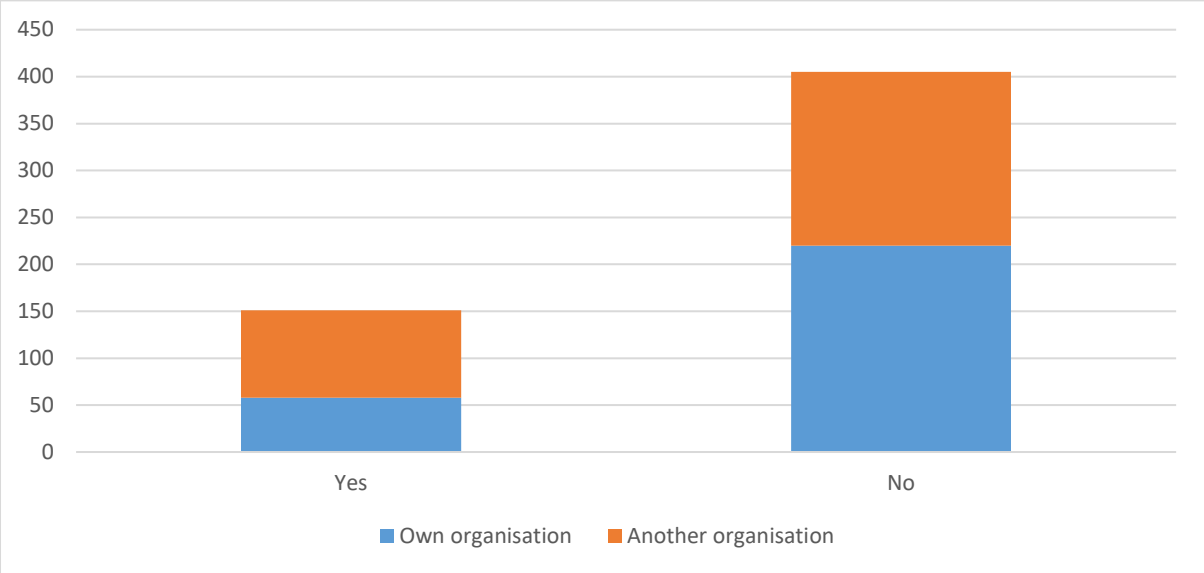
Table 7 – Women's willingness to take responsibility and seek help

Percentage of women likely to:	**Mean**
Acknowledge their use of force	42.3%
Take responsibility for their own use of force	39%
Take sole responsibility for mutual violence used in the relationship	33.7%
Seek support to address their use of force	29.5%

Ability of service system to respond to women's use of force

Given the lack of research and service development in this area in Australia, it was anticipated that there would be few services for women who have used force. Respondents were asked whether they were aware of any programs or services for women who have used force by either their own or another organisation (shown in Figure 16). Only 20.9% of respondents (n = 58), reported a program or service offered for women who use force by their own organisation. Approximately a third of respondents (33.5%, n = 93) reported being aware of programs or services offered by other organisations.

Figure 16 – Participant awareness of programs or services for women who use force



Respondents were then asked if they felt the needs of women who use force are being met within the current service system. As expected, the majority of respondents (72.3%) responded no to this question. Only seven respondents (2.5%) reported that they felt the current service system did meet the needs of women who use force. The remaining respondents (25.2%) reported that the current service system may meet the needs of women who use force.

Motivations of women who use force

Respondents were asked what they believe to be the main reasons or motivations for women's use of force. The primary motivation respondents identified was self-defence or as a form of resistance. One respondent (FDV) saw this as way *"to resist control, rather than to achieve control."* Another wrote that women often use force *"As a way of protecting themselves and their children."* It was noted by another respondent that women may use force as a way of *"fighting back/reclaiming their agency."* One respondent reported seeing women's use of force as *"learn* [sic] *behaviour that has been picked up by the women from the men."*

Resistance also included women responding to feelings of powerlessness. Respondents who reported this expressed that they believed that women who use force in these situations do so as a last resort, stating *"They feel they have no other option"* (youth services respondent). Retaliation was a feature of this as well, with one respondent (FDV) noting that women's use of force *"Seems to manifest as revenge where it is deliberate, with underlying reasons assessed through a spectrum of theoretical perspectives."* It was also noted that women's use of force may be in response to a partner's coercive control, with one FDV respondent explaining that women may be *"Manipulated by partner into using force."*

A small number of respondents noted that women may be motivated by a desire for power and control over their partners and/or children. However, two of these respondents noted that this desire may be more for power and control over a situation than other people, with one explaining that women may use force *"To gain control of a situation through manipulation and fear-based tactics for their own personal gain."*

Trauma was seen as contributing to women's use of force, with respondents noting that many women who use force have a *"long history of survivorship and* [are] *reacting to ongoing abuse"* (FDV respondent). Another noted that women's use of force may be a result of women being *"Unable to regulate emotions due to ongoing abuse, trauma or drug use."*

Respondents noted other reasons for women's use of force, though these may be more accurately described as contributing factors rather than motivations. These included intergenerational influences or learned behaviours, psychological factors, impaired coping, conflict resolution and communication skills, substance use and mental health, and intersections of structural and individual issues. Other reasons for women's use of force, identified by a smaller number of respondents, included mutual relationship dynamics, limited social skills, limited education, financial issues and cultural acceptance of violence. Respondents also noted that different forms of violence or force have different motivations.

Respondents noted that in cases where women had witnessed and/or experienced FDV earlier, the behaviour had been learned and there may have also been some intergenerational influences on their behaviour. One respondent (FDV) explained that women *"Often have grown up in generational DV and have decided that in their perceived choice between perpetrator or victim, they prefer to have the power."* Another noted that women who use force have often *"grown up or been surrounded by an environment in which the use of force is necessary to survive or is normalised"* (child protection respondent).

Other psychological factors were also linked to women's use of force. This may be seen as a response to trauma and included emotional regulation problems, anger, frustration, jealousy,

limited choice, low self-esteem, exhaustion, and grief and loss. One FDV respondent explained that women may be *"Unable to regulate emotions due to ongoing abuse, trauma or drug use."* Another explained that women may use force as a result of being re-triggered by their partners. Additionally, impaired coping, conflict resolution and communication skills were also seen as contributing to women's use of force. This may also be attributed to trauma. One respondent noted that women's use of force is *"likely to be driven by fear of not being able to get what they want and they are not aware of how else to achieve their aims/needs"* (FDV).

Substance use and mental health were commonly cited by respondents as contributing to women's use of force. One FDV respondent described this as *"Lashing out when under the influence of AOD."* Another noted *"Intersectional issues such as housing overcrowding, poverty, gambling issues, alcohol and drug issues, child protection issues, trauma etc."* (FDV) may also trigger or contribute to women's use of force.

Treatment needs of women who use force

The next portion of the survey explored the treatment needs of women who use force. Respondents were asked about how many women who use force also have a history of trauma and/or family and domestic violence victimisation, substance abuse or mental health issues, or a history of violent offending (shown in Table 8). As expected, respondents reported that, on average, more than 70% of women who use force have some experience of trauma and/or domestic violence victimisation, and more than 60% have substance abuse or mental health issues. Also expected was respondents reporting that, on average, less than a third of women who use force have a history of violent offending.

Table 8 – Women who use force common treatment issues

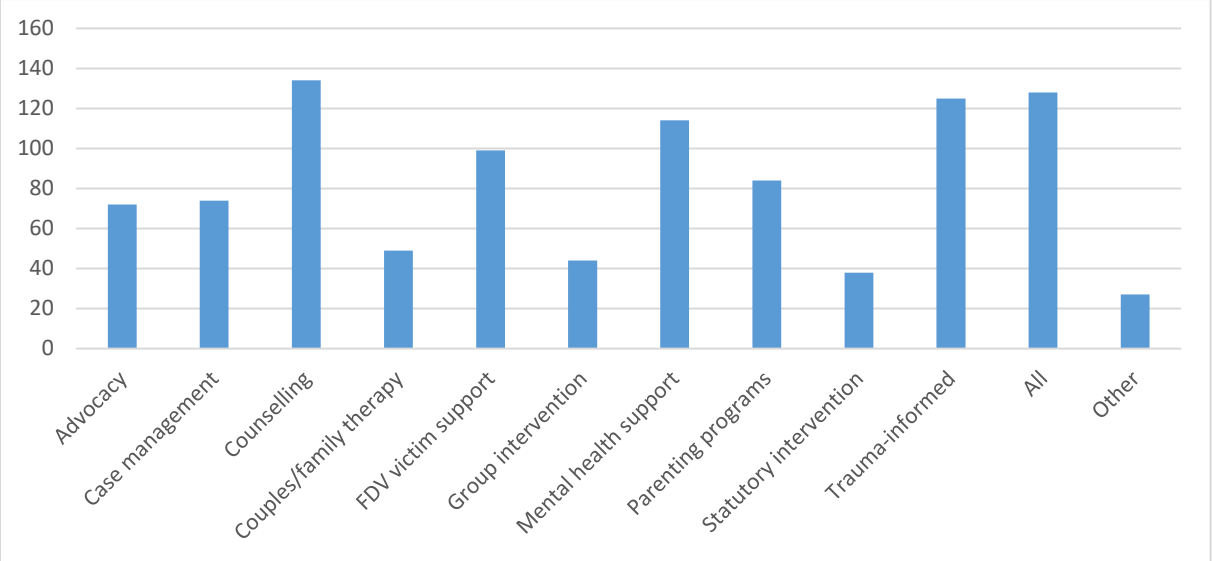
Percentage of women who use force who have:	Mean
Some form of trauma history	78.9%
Been a victim of family and domestic violence	77.9%
Alcohol and other drug use	62.7%
Mental health issues	64.9%
A history of violent offending	32.3%

Respondents were then asked to identify the treatment needs of women who use force (shown in Figure 17). The most frequently identified treatment needs were counselling (48.2%), trauma-informed responses (45%) and mental health support (41%). Statutory intervention (13.7%), group intervention (15.8%), and couples counselling or family therapy (17.6%) were least frequently identified by respondents. In addition, nearly half of respondents (46%) reported that all of the treatment options specified are needed by women who use force.

A small percentage of respondents (9.7%) reported other treatment needs of women who use force. The importance of considering the context of the use of force in determining treatment needs was once again emphasised by respondents (2.9%, n = 8), with one specifying the need for tailored responses for women. Other treatment needs included feminist interventions (0.7%, n = 2), alcohol and other drug support (0.7%, n = 2), culturally

specific responses (0.7%, n = 2), empathy (0.7%, n = 2), legal assistance (0.7%, n = 2), housing and employment assistance (0.4%, n = 1), support as carers (0.4%, n =1), anger management (0.4%, n = 1), and support groups for women with bipolar disorder (0.4%, n = 1).

Figure 17 – Treatment needs of women who use force



Following this, respondents were asked about the three most important knowledge or theories for practitioners to know when working with women who use force (shown in Figure 18). Of these, respondents were then asked to select the most important theory or knowledge for practitioners working in this area (shown in Figure 19). Unsurprisingly, trauma-informed practice emerged as the most important form of knowledge for practitioners (37.8%), followed closely by knowledge of family and domestic violence (22.7%).

In selecting the three most important knowledge or theories for working with women who use force, respondents were given an 'other' option. A small portion (3.6%) selected this option. Other theories or forms of knowledge identified by respondents included lived experience (1.1%, n = 3), cultural knowledge, particularly of Indigenous cultures (0.7%, n = 2), client centred practice (0.4%, n = 1), child development (0.4%, n = 1), mental health (0.4%, n = 1), the risk needs responsivity model (0.4%, n = 1), self-defence (0.4%, n = 1), and systems abuse (0.4%, n = 1). One participant also noted the importance of having knowledge of one's own organisation.

Figure 18 – Important knowledge and theories for practitioners working with women who use force

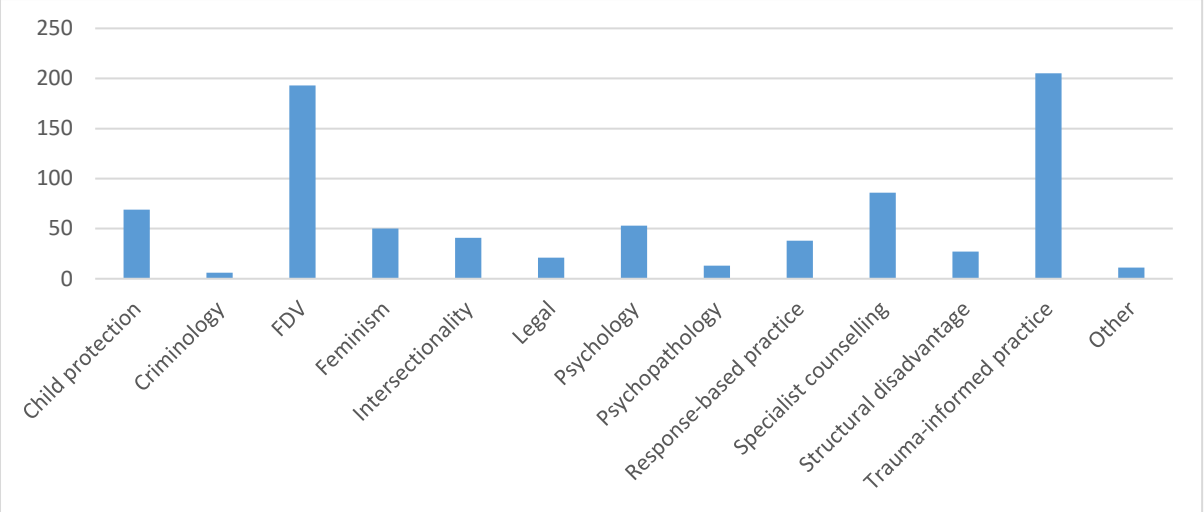
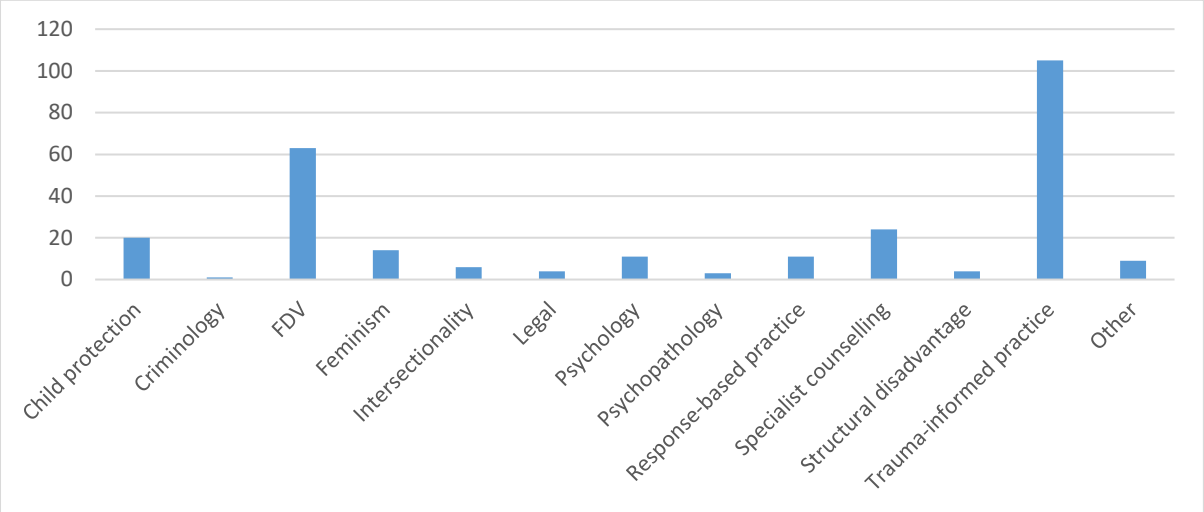


Figure 19 – Most important knowledge or theory for practitioners working with women who use force



The 'ideal' practitioner – the discrete choice experiment

In the final part of the survey, respondents were asked to complete a discrete choice experiment (DCE). This approach presents respondents with a series of hypothetical choices, in this case the choice between referring a female client identified as using force to one of two hypothetical practitioners. The purpose of the DCE is to identify the aspects of a practitioner that make them well-suited to providing appropriate care to that female. For example, do our survey respondents believe that experience is the key driver of whether a practitioner is likely to work well with the female? Or potentially, do respondents believe that formal qualifications are most important? In describing the DCE, we will outline a number of steps in its construction and analysis. First, we will outline how we selected the characteristics (or dimensions) and levels that were used to describe the two hypothetical practitioners. An example dimension might be the gender of the practitioner, and in that case, the levels would be male or female. After defining the dimensions and levels, we will describe how we designed the experiment, and presented the choice sets to survey

participants. We then outline the data analysis, present the results, and describe the key findings from the DCE.

Selecting Levels and Dimensions

The development of dimensions and levels for a DCE is a challenging process and involves a number of considerations that have to be trade off against one another. For example, if there are too few dimensions, then important aspects of a decision are not being captured. However, if there are too many, respondents may face excessive cognitive burden. The Curtin based team developed a large pool of possible dimensions that might be considered within the DCE. These dimensions were traits that might be considered necessary for a practitioner working with a woman who had used force, based on our own experience and the literature. This list was then further refined in consultation with team members at the University of Melbourne and Baptcare. The ultimate intent was to identify a subset of between 8 and 10 dimensions that were potentially important to the choice between practitioners, but that were also as independent of one another as possible (as we did not want to capture the same concept more than once). The final list was then discussed in detail with Lisa Larance, a US based expert in the area whose feedback was used to develop the final list of dimensions and levels.

The final dimensions and levels are presented in Table 9.

Table 9: Final Dimensions and Levels Used in the DCE

Dimension	*Levels*		
Gender	**Male**	**Female**	
Qualification	**On the job or lived experience**	**TAFE qualification**	**University qualification**
Experience	**Experience working with victims of family and domestic violence**	**Experience working with perpetrators of family and domestic violence in a community-based setting**	**Experience working with both victims and perpetrators of family and domestic violence**

Knowledge of Family and Domestic Violence (FDV)	**Basic** – Practitioner has some understanding of FDV, though does not understand or consider the place of FDV in a woman's use of force.	**Good** – Practitioner has a sound understanding of the gendered nature of FDV, the dynamics of power and coercive control, the impact FDV has on the woman, and how an experience of FDV can influence a woman's use of force.	**Advanced** – Practitioner has an in-depth and sophisticated understanding of the gendered nature of FDV, the dynamics of power and coercive control, the impact FDV has on all members of the family, and how an experience of FDV can influence a woman's use of force. Practitioner recognises and is able to challenge minimisation in any form and encourage the woman to take appropriate responsibility (i.e. to only take responsibility for those things that are within her control).
Use of trauma-informed practices	**Occasionally** – Practitioner sometimes recognises symptoms of trauma in clients and therefore practices in a way that, more often than not, does not consider these experiences.	**Most of the time** – Practitioner usually recognises symptoms of trauma and practices in a way is sensitive to these experiences.	**All of the time** – Practitioner is always aware of the possibility of trauma experiences for clients and practices in a way that considers and is sensitive to these experiences.
Levels of empathy and understanding of women's use of force	**Basic** – Practitioner demonstrates limited empathy for the woman and is unfamiliar with the reasons for women's use of force. Practitioner emphasises the woman's accountability and communicates that her use of force is unacceptable.	**Good** – Practitioner has some empathy for the woman and her situation, as well as an understanding of the reason/s she may have used force. Practitioner attempts to balance feelings of empathy towards the woman with a desire to hold her accountable for her use of force.	**Advanced** – Practitioner has a high level of empathy for the woman and her situation, and while assessing her use of force to be inexcusable, the practitioner displays an open and non-judgemental attitude towards the woman that demonstrates an understanding of why force was used and

			makes the woman feel accepted, believed and supported. Practitioner attends to sharing power with the woman and empowers her, rather than exercises power over her.
Understanding of the intersections of violence, age, race, class, gender and disability	**Basic** – Practitioner focusses on one aspect of the woman and pays minimal attention to the other intersecting factors that may impact on her experiences.	**Good** – Practitioner has a good understanding of each of these issues in isolation but not as a set of intersecting and related experiences	**Advanced** – Practitioner has a good understanding of each of these issues and the ways in which they intersect in women's lives
Promotion of a culturally safe environment	**Basic** – Practitioner has given little consideration to culture.	**Good** – Practitioner has some awareness of culture, though this is not consistently evident in practice.	**Advanced** – Practitioner demonstrates cultural humility through a commitment to proactive, ongoing learning about culture and the creation of a culturally safe service response
Identification of risk and monitoring of safety	**Basic** – Practitioner identifies risk at intake and assessment.	**Good** – Practitioner identifies risk at intake and assessment, and regularly reassesses throughout contact with the woman. Practitioner monitors the woman's safety and informs other agencies and practitioners as necessary.	**Advanced** – Practitioner identifies risk at intake and assessment and regularly reassesses risk throughout contact with the woman, monitors the safety of the woman and other relevant parties (e.g. partner and children) and provides supports and additional resources to further enhance safety. Practitioner advises other agencies and practitioners about the

	family's level of risk and safety as necessary.

Design

Deciding which pairs of profiles are seen together is an important aspect of conducting a DCE (Street & Burgess, 2007). Failure to choose the right combinations can cause problems when analysing data, producing estimates that are either wrong or inaccurate. In this work, we used software called Ngene to construct the choice sets (Choice Metrics Pty Ltd, 2018). We pre-specified the design to have 21 possible choice pairs, which ensures that for the three level dimensions, we have an equal number of each level (i.e. 21/3=7). To generate the design, we used a criteria called D-efficiency. This is a standard approach in the literature and identifies the design which allows the most precise estimation of the regression coefficients. As 21 choice sets would be too onerous for most respondents, we instead presented each respondent with eight of these 21 choice sets.

Task Presentation

An example choice set from our survey is presented in Figure 20.

Figure 20 – An example choice pair

Please look at Practitioners A and B described below. If you were referring a female client identified as using force to one of these, who would you prefer to refer them to?

Remember: you can access more information about what is meant by each characteristic by hovering over the text. Both practitioners are equally convenient for the client to access and there is no waiting time or cost to the client for either practitioner.

	Practitioner A	Practitioner B
Gender	Female	Male
Qualification	On the job or lived experience	TAFE Qualification
Experience	Experience working with victims of family and domestic violence	Experience working with both victims and perpetrators of family and domestic violence
Knowledge of Family and Domestic Violence (FDV)	Basic	Advanced
Use of trauma-informed practices	All of the time	Occasionally
Levels of empathy and understanding of women's use of force	Advanced	Basic
Understanding of the intersections of violence, age, race, class, gender, and disability	Good	Advanced
Promotion of a culturally safe environment	Good	Advanced
Identification of risk and monitoring of safety	Good	Basic

Which practitioner would you prefer to refer your client to?

- ○ Practitioner A
- ○ Practitioner B

The nine dimensions in our experiment are the headings presented in the left hand column. In this example, the practitioners differ in all nine dimensions. The respondent is asked to select between the two practitioners. The intuition behind the DCE approach is this: their response will give us some information about each of the levels of each of the dimensions presented in this choice set. If we have enough respondents, regression analysis will provide us with a model assigning a value to each of the levels of each of the dimensions, and hence the practitioner characteristics considered to be most valuable.

Analysis

The purpose of the analysis of DCE data is to identify the dimensions and levels that impact most highly on choice. The assumption is that, if a dimension being at a particular level causes most people to choose that option, that that level is (on average) attractive. The regression analyses we use for analysing DCE data has to reflect the fact that our dependent variable, the thing we are trying to predict, is binary. By this, we mean that options in each choice are either picked as the preferred option (and receive a 1), or are not (and receive a 0). The standard way to analyse such data is with logistic regression. For DCE data, we are talking about analysis of paired data, which is conventionally analysed using a conditional logit model (McFadden, 1974). This method continues to be widely used in health-based analysis of DCE data (Clark, Determann, Petrou, Moro, & de Bekker-Grob, 2014). For a summary of the conditional logit as well as other competing analysis techniques that might be used on DCE data, see Fiebig, Keane, Louviere, and Wasi (2010).

Results

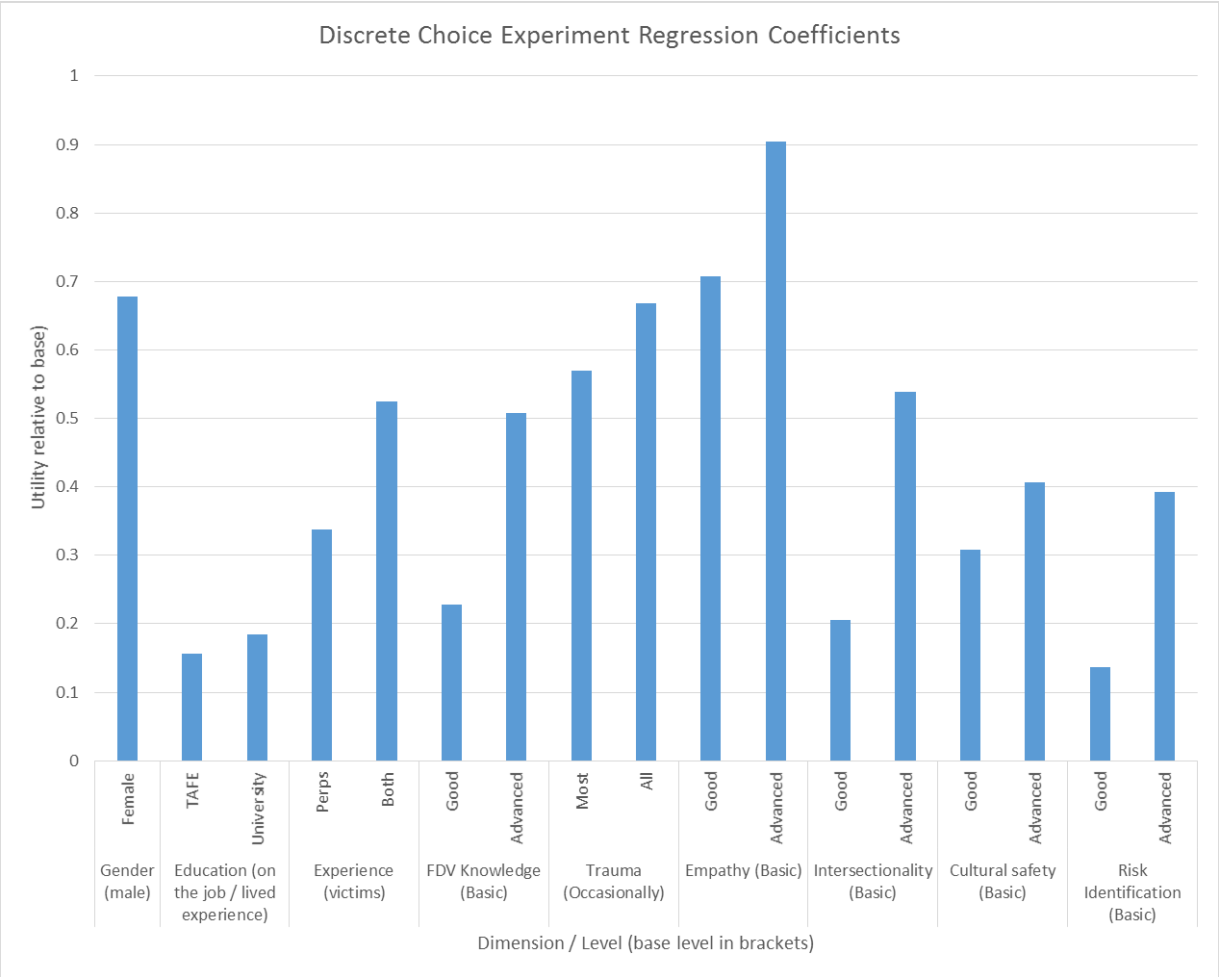
The regression results from the DCE are presented in Table 10, and as a graph in Figure 21. In regression analyses, it is common to dummy code data so all coefficients are reported relative to a base level. So, for example, the coefficient on female is positive (and large relative to the other coefficients). This can be interpreted as showing that the respondents strongly favoured referral to female practitioners relative to referring to male practitioners (which is the base).

Table 10 – Regression Results

Dimension	Level	Coefficient	Standard Error	z-score	P-value	Lower 95% CI	Higher 95% CI
Gender	Female	0.677748	0.060695	11.17	0	0.558788	0.796708
Education	TAFE	0.156945	0.077633	2.02	0.043	0.004786	0.309103
	Uni	0.184073	0.079455	2.32	0.021	0.028344	0.339802
Experience	Perpetrators	0.337624	0.079212	4.26	0	0.182371	0.492876
	Both	0.52521	0.074776	7.02	0	0.378652	0.671768
FDV	Good	0.227397	0.071139	3.2	0.001	0.087967	0.366828
	Advanced	0.50798	0.073431	6.92	0	0.364059	0.651902
Trauma	Most	0.569384	0.075009	7.59	0	0.42237	0.716398
	All	0.668702	0.072318	9.25	0	0.526962	0.810442
Empathy	Good	0.707247	0.081372	8.69	0	0.547761	0.866734
	Advanced	0.90413	0.077709	11.63	0	0.751823	1.056438
Intersectionality	Good	0.20562	0.067193	3.06	0.002	0.073924	0.337316

Dimension	Level	Coefficient	Standard Error	z-score	P-value	Lower 95% CI	Higher 95% CI
	Advanced	0.53838	0.074439	7.23	0	0.392481	0.684278
Culture	Good	0.308305	0.070181	4.39	0	0.170753	0.445857
	Advanced	0.405887	0.075721	5.36	0	0.257476	0.554298
Risk	Good	0.136339	0.074719	1.82	0.068	-0.01011	0.282786
	Advanced	0.391778	0.077439	5.06	0	0.240001	0.543556

Figure 21 – Regression results (graph)



Importantly, the dimensions which had levels which were naturally ordered are reflected in that way in the regression results. So, for example, advanced skills in a level are always preferred to good skills, which in turn are preferred over basic skills. This is an important measure of respondent engagement. Regarding the results across dimensions, the practitioner characteristic that was considered most important was empathy. Relative to having a basic level of empathy, those practitioners with a Good or Advanced level were much preferred by respondents. Other dimensions also drove choice, but by relatively smaller amounts. The dimensions around trauma, experience, FDV knowledge and intersectionality mattered as did gender (with female practitioners preferred to males). The impact of education was relatively small – relative to on the job training/lived experience, TAFE or University qualifications were valued but the effect was modest. This result should be interpreted with caution; these coefficients in each dimension are independent of each

other. So, the model predicts that a respondent seeing two practitioners differing only in qualifications would not strongly favour one over the other. But, if TAFE or University education was assumed to improve the skills in the other dimensions, then those things do matter.

Respondents' explanations of their choices

At the end of the survey, respondents were asked to provide some information on how they approached the DCE. This qualitative data was then compared with the DCE data, to see if respondents' perceptions of their choices were consistent with the choices they made. Twenty-five respondents noted that they found the DCE difficult or confusing, with one explaining that *"The absence of client feedback or reputation/outcomes made the exercise* [feel] *disconnected from actual referral decisions"* (legal respondent). It was also noted by some respondents that client characteristics play as much of a role in their decisions about referrals as practitioner characteristics. Overall, however, qualitative responses were consistent with the DCE data. Respondents reported prioritising empathy, trauma-informed practice, knowledge of FDV, and gender when making decisions about who they would refer their client to. Interestingly, more respondents reported prioritising trauma-informed practice than empathy, which was not reflected in the DCE data. Respondents' reports of how they prioritised gender, experience, and qualification were mixed, and somewhat contradicted the DCE findings. While some respondents felt gender was an important factor in their decision for which practitioner they should refer to, others saw gender as irrelevant. One FDV respondent noted that *"In my experience and feedback from survivors, women feel that they are best supported by women who understand them and their lived experiences."* Another explained that the women they see *"will speak with and trust only women. In addition, women will have an intrinsic and lived experience of the challenges and inequalities gifted to women by society."* Some respondents noted that a female practitioner is ideal, but that they were willing to refer to a male practitioner if they had greater skills and knowledge. One FDV respondent explained that it was *"Preferable to have a female practitioner where possible, but not at the expense of safety or trauma-informed practice".* Some respondents also noted that in the practice setting, they will be guided by clients as to whether they refer them to a practitioner of the same or a different gender.

Experience was similarly mixed, with some respondents preferring practitioners who have experience working with victims and others preferring practitioners who have experience working with perpetrators. One FDV respondent explained that *"Understanding and experience of working with victims of violence is preferable to experience working with perpetrators, as this framework may cloud approach to someone who is likely to be a victim."* On the other hand, a respondent from the AOD field noted that they had prioritised practitioners who had experience working with perpetrators as they felt *"it may be conflicting for someone who only has experience working with victims of violence to then work with a perpetrator."* Some respondents noted a preference for referring women to practitioners who had experience working with both victims and perpetrators, though no reasons for this were given.

There was also some variation among respondents as to the preferred qualification of practitioners working with women who use force. Some respondents preferred to refer to a practitioner who had a formal qualification (i.e. a TAFE certificate or university degree), with

one mental health respondent noting that *"A university degree or TAFE qualification usually means the person is more skilled in critical thinking, analysis* [and] *has* [a] *good grasp of the theory and application of knowledge."* Other respondents stated that it was more important that the practitioner had lived experience to draw on, rather than any formal qualification, with an AOD respondent explaining that in their experience *"clients respond to empathy and lived experience far more than to a response that has been taught."* A small number of respondents indicated that they would have preferred a balance of lived experience and formal qualifications.

Most interestingly, a small number of respondents indicated making their decisions on what they could infer from the practitioner characteristics or combination thereof. Three respondents referred to the relatability of the practitioner as a key factor on their referral decisions in the exercise. One respondent from the youth services field noted this in relation to whether the client would relate to the practitioner, while the other two respondents (family services and justice respondents) noted this as the practitioner's ability to relate to the client. Two respondents noted that it was the practitioner's overall approach, or the combination of skills and knowledge that they used in their work, that influenced their choices in the DCE. An FDV respondent explained, *"… the combination and intersectionality of skills was the most important factor in determining which practitioner was 'most likely' to take the most informed and non-judgmental approach to women."* One respondent from the sexual assault field highlighted the importance of assessment and reflective skills, noting that they chose *"The professional best qualified to conduct an in-depth assessment and maintain reflective practice."* Another respondent from the disability field also noted making decisions based on assessment skills, though described this as determining *"Who would be able to uncover the lies best and get to the truth."*

Summary and Implications

Women's use of force in the context of intimate relationships has been a controversial topic in the light of the men's rights movement as they have claimed that there are far more women using force in intimate relationships than is indicated in official administrative data. In contrast data used to support men's rights claims has often been drawn from research samples where the counting of incidents of violence has been used to determine violence prevalence, which does not offer any explanation of the context in which it occurred, the type of violence or its seriousness. Therefore undertaking a workforce survey of this kind also tended to raise concerns with this controversial area. In contrast this survey was intended to find out directly from the community services workforce how frequently women using force were priesting at services, how did the identify and assess it and what responses were there to the concern.

The findings that emerged suggest that the majority of respondents understand women's use of force through a gendered lens, which is that they do not view the problem as synonymous with male perpetrators use of force in intimate heterosexual relationships. However, there are some respondents who did view the motivations of women using force as much the same as that of men.

However, the majority of respondents view women's use of force as having a fundamentally different purpose dynamic and impact. Indicators of critical differences that were described included that women were largely acknowledging their use of force, accepting responsibility for its use and seeking to gain a better insight into why they force as mostly they were not

content with their situations. Respondents reported that the women they saw often had experiences of multiple forms of abuse by a number of perpetrators and that this had to be addressed as well as their own use of force.

The implications of this research are that there is a need for the development of specific intake and assessment items as well as interventions based on the women and not the same programs that are offered to male perpetrators of intimate partner violence but with female participants instead. Therefore, whilst respondents do not largely turn women away once the use of force is evident or disclosed, the community service systems do not have an organised response to women's use of force, so most workers then offer individual interventions to cater for the woman's needs.

In moving forward it seems that to respond more comprehensively to women's use of force there is training required for the community services workforce, service development from intake to interventions needed to more effectively identify and respond to women's use of force.

References

Choice Metrics Pty Ltd. (2018). Ngene user manual and reference guide (version 1.2).

Clark, M. D., Determann, D., Petrou, S., Moro, D., & de Bekker-Grob, E. W. (2014). Discrete choice experiments in health economics: A review of the literature. *PharmacoEconomics*, *32*(9), 883-902. https://doi.org/10.1007/s40273-014-0170-x

Fiebig, D. G., Keane, M. P., Louviere, J., & Wasi, N. (2010). The generalized multinominal logit model: Accounting for scale and coefficient heterogeneity. *Marketing Science*, *29*(3), 393-421. https://doi.org/10.1287/mksc.1090.0508

Larance, L. Y. (2006). Serving women who use force in their intimate heterosexual relationships: An extended view. *Violence Against Women*, *12*(7), 622-640. https://doi.org/10.1177/1977891206290240

Larance, L. Y. (2017). A practitioner's response to: "Addressing violence by female partners is vital to prevent or stop violence against women: Evidence from the multisite batterer intervention evaluation," by Murray Straus. *Violence Against Women*, *23*(1), NP1-NP2. https://doi.org/10.1177/1077801215575638

Larance, L. Y., & Miller, S. L. (2017). Emergent research and practice trends in contextually addressing the complexity of women's use of force. In C. M. Renzetti, D. Follingstad & A. Coker (Eds.), *Preventing Intimate Partner Violence: Interdisciplinary Perspectives* (pp. 129-158). Bristol, UK: Policy Press. Retrieved from

Larance, L. Y., & Rousson, A. (2016). Facilitating change: A process of renewal for women who have used force in their intimate heterosexual relationships. *Violence Against Women*, *22*(7), 876-891. https://doi.org/10.1177/1077801215610890

McFadden, D. (1974). Conditional logit analysis of qualitative choice behaviour. In P. Zarembka (Ed.), *Frontiers in econometrics*. New York, NY: New York Academic Press. Retrieved from

Street, D. J., & Burgess, L. (2007). *The construction of optimal stated choice experiments: Theory and methods*. Hoboken, NJ: Wiley.