Section: Violence, Trauma, and Public Health - Original Research Article

Service Providers' Perspectives on Delivering Support for Domestic Violence Victims in Rural New South Wales

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Abstract

Australians living in rural communities are more likely to experience Domestic violence (DV) than those living in urban areas. Service providers (SP) who provide support to victims of DV in these rural settings encounter some structural barriers at a systems and organizational level that may be useful in improving outreach services. However, few studies have explored SP perspectives surrounding these issues. This study aimed to explore service providers' perspectives on delivering support for DV victims in rural New South Wales (NSW), Australia. This qualitative study utilized structured interviews that were audio recorded and evaluated, using inductive thematic analysis. Ten people from the Central West region of NSW, providing support across DV services, legal services, community centers, medical centers, and the police, were interviewed. Half of the interviewees held roles in organizations that provided DV-specific services. Some service providers noted clients presented with other issues first, before disclosing their experiences with DV. Interviewees described key obstacles, including cultural attitudes, comorbid mental health and substance use disorders, and logistical impediments to leaving relationships and accessing services as barriers for victims. They identified the personal toll of their work and a lack of funding for specialized and multidisciplinary services as challenges to providing effective service delivery. Facilitators such as building trust through community services, using technology for remote support, and community support groups were effective. SP cited DV education in schools as an important avenue for primary prevention. This study highlights the significant barriers and facilitators identified by rural DV service providers in the Central West region of NSW, Australia. Despite the personal toll on providers, supportive networks helped mitigate burnout. The study advocates for increased funding, coordinated multidisciplinary services, and educational programs to address structural and cultural issues in rural DV service delivery at both the systems and organizational levels.

Plain Language Summary

Domestic violence (DV) is a serious issue in Australia, particularly in rural communities like Central West New South Wales (NSW), where rates are higher than in urban areas. This study explored the experiences of service providers supporting DV victims in these rural settings. Service providers identified several significant challenges: Victims often face barriers such as ingrained cultural attitudes about DV, co-occurring mental health and substance use issues, and major logistical hurdles like finding transport, accommodation, and new employment to leave abusive relationships. Fear of losing anonymity and existing support networks in small communities also prevents victims from seeking help. Service providers themselves face considerable difficulties, including personal toll and burnout from demanding workloads and exposure to trauma. They also struggle with a lack of adequate funding and human resources, leading to long waiting lists and fragmented services. There's a strong need for coordinated, multidisciplinary services and culturally competent support, especially for Indigenous and male victims, and those with children. Despite these obstacles, providers noted several effective approaches: Building trust through existing community services, which allows victims to disclose DV after addressing other issues. Utilizing technology for remote support (e.g., video counselling) significantly improved access, especially during the COVID-19 pandemic. Community support groups were found to be very empowering for victims, helping them realize they are not alone. The study advocates for increased funding, comprehensive multidisciplinary services, and educational programs, especially DV education in schools, to address both structural and cultural issues and improve support for rural DV victims.

Keywords

domestic violence, service providers, rural, regional, intimate partner violence, family violence

Introduction

Domestic Violence (DV) is a significant public health problem that continues to impact all socio-economic, cultural, and ethnic groups in Australia. Recent statistics from the Australian Institute of Health and Welfare reported that about one woman was killed every 11 days and 1 man was killed every 91 days by an intimate partner in 2022 to 2023 alone.[1] This is even worse in regional Australia.[2] While DV has received growing recognition as a serious societal problem in recent years, national surveys indicate that the rates of DV in Australia have remained consistent between 2005 and 2016.[3] The Australian Institute of Criminology defines DV as "acts of violence that occur between people who have or have had an intimate relationship in domestic settings."[4] Although DV is commonly associated with acts or threats of physical or sexual violence,[5] it may also manifest as verbal, social, emotional, psychological, economic, or spiritual abuse, where the goal is to control the partner's behavior through fear and manipulation.[6] The effects of DV are wide-ranging and can result in physical injury, poorer mental health, issues with reproductive health, substance misuse, financial instability, and homelessness.[7-9] Shame and stigma have been reported among DV victims, and these are prevalent in rural communities.[10,11]

Alarmingly, in Australia, an estimated 4.2 million adults (21%) aged 18 and over, have experienced partner violence, emotional abuse, or economic abuse by a current or previous partner, including 17% (1.7 million) of women and 5.5% (526 600) of men since the age of 15.[3] Australians living in rural and remote communities are also more likely to experience DV than those living in urban areas, with the rate of DV assault in Central West NSW reported to be 1.5 times higher than the State (651.9 vs 441.7 per 100,000 in 2023) and the seventh highest of 13 eight localities in regional NSW.[12-14] Victims of DV in rural settings are 24 times more likely to be hospitalized for DV when compared to people in urban settings.[15] NSW crime statistics from July 2019 until June 2020 found that the incidence of DV in the Bathurst Regional Local Government Area was 544 per 100,000 people, which is 1.37 times more than the average NSW rate.[14]

There are many sociocultural and geographic barriers and facilitators thought to contribute to these higher rates of DV in rural communities, for example, increased prevalence of alcohol and drug use[12,16] and higher rates and acceptability of gun ownership. Australia, is fortunate to have relatively strong gun legislation, compared to places like the USA, as a consequence of the "Port Arthur Massacre" in 1996.[17] However, this differentiation is less marked in rural areas where gun ownership for farming, hunting, and other purposes is more acceptable in rural communities. This has adverse consequences concerning DV and rural suicide.[18]

Rural communities may also tend to adopt a more pervasive patriarchal culture with added elements of self-reliance and stoicism.[12] These characteristics may generate pressure to maintain an image of an intact family unit, which may reduce help-seeking behaviors as victims may fear a loss of anonymity when reporting DV in a small community where people often know each other.[12,19] It may also be difficult for victims to find transport and accommodation to safely leave their abuser, due to the geographic isolation of living in a rural community. The study was undertaken during the COVID-19 pandemic, and it is possible that the pandemic influenced the findings at the time. There is also evidence suggesting that rates of DV increase after a natural disaster[20] due to the stress inherent in these events and, for example, higher consumption of alcohol at these times, which is correlated with DV.[21] These issues are compounded by higher rates of unemployment, lower socioeconomic status, and mobility issues for victims of DV, preventing them from leaving their perpetrators. Thus, rural DV victims are a particularly vulnerable population, and it is important to understand the specific barriers preventing their uptake of DV services.[16]

Although victims of DV living in rural areas face many unique barriers that prevent them from accessing appropriate help, DV service providers in rural settings also encounter structural problems at a systems and organizational level.[16] First, rural DV service providers are relatively scarce in number, face limited resources, and frequently need to cover larger geographic areas.[12,19] Additionally, short-term, competitive, and innovation-driven funding streams contribute to a fragmented service landscape by promoting instability, discouraging collaboration, and prioritizing novel approaches over sustained, core services.[22] As a result, service providers often struggle with inconsistent funding cycles, limited opportunity for coordination, and shifting priorities, all of which can disrupt continuity of care. For clients, particularly in rural areas, this makes it difficult to identify, access, and navigate available services, leading to confusion, frustration, and unmet needs. These problems subsequently manifest in higher costs of service provision, fewer referral pathways, and reduced workforce numbers, particularly those trained in the provision of specific services for Indigenous, culturally,

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and linguistically diverse (CALD), and disabled people.[12,19,23] Reduced workforce numbers mean that service providers often hold multiple roles, from assisting victims to applying for government assistance to educating them about their legal options.[19] This may result in longer wait times for receiving access to other important services, such as legal support and emergency crisis accommodation.[12] These pressures ultimately make it harder to recruit and retain staff long-term, exacerbating the difficulties these workers have in providing continuity of care within their communities.[23] The tight-knit milieu within a rural community also means that service providers must work harder to maintain confidentiality and protect their clients.[23] This means balancing ethical dilemmas that result from being engaged in multiple relationships within the community.[23]

Considering that a growing body of research has explored DV victims' perspectives in an Australian rural context, very few papers have looked at the experiences of service providers.[24] Owen and Carrington[11] interviewed 49 rural service providers in Australia who worked in human services or the criminal justice system. They found that service models were urban-centric, lacked access to criminal justice personnel, and ignored the geographic limitations faced by rural DV providers.[11] More importantly, they emphasized the social and structural barriers for women living in rural settings to come forward and seek help, such as the role of shame, family privacy, and socio-economic dependency on men.[11]

This study will look at rural provider perspectives of DV service delivery in the Central West region of NSW, located west of Sydney and the Blue Mountains. Given the higher rates of DV in rural communities such as the Central West, there is a strong impetus to understand what barriers may exist for service providers to operate in these areas. This research may help identify the appropriate structural and logistical changes needed to support DV service delivery in Central West NSW and improve access for victims.

Methods

Study Context & Setting

This study was conducted in rural and regional townships within the Central West region of NSW, Australia, which encompasses an area of 63 262 km^2. It has a population of 209 810 and consists of large (eg, Bathurst, Orange), medium (eg, Lithgow, Cowra), and small (eg, Blayney, Molong) cities and towns. The 2019 iteration of the Modified Monash Model (MMM) classifies areas within Central West NSW as MM3 to MM5 (MM3 refers to large rural towns – ie, Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas that are not MM2 and are in, or within a 15 km drive of, a town between 15 000 and 50 000 residents, eg, Dubbo, Lismore, Yeppoon, Busselton; MM5 refers to small rural towns: ie, all remaining Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas, eg, Mount Buller, Moruya, Renmark, Condamine). These are categorized by the Australian government as Statistical Area 4, given its population and labor market size. The region reflects varying levels of rurality, impacting service accessibility and socio-economic conditions. It was selected due to its representation of both regional hubs and more isolated rural communities, allowing for an in-depth exploration of domestic violence dynamics, resource availability, and service provision challenges in non-metropolitan settings.

Study Design & Ethics

A qualitative study was conducted using semi-structured interviews. The development of the interview guide was informed by the expert clinical knowledge of the research team, who have extensive experience working in rural health settings, as well as anecdotal evidence drawn from informal discussions with practitioners and observations from practice. This practitioner-led approach, which has been used in previous studies[25,26] was adopted to ensure the guide captured contextually relevant challenges, reflections, and strategies that might not be well represented in the existing literature.

The interview guide was pilot-tested with two rural health professionals who met the inclusion criteria but were not part of the final sample. The purpose of the pilot was to assess the clarity, relevance, and flow of the questions, as well as the appropriateness of the language used. Feedback from the pilot interviews led to minor refinements, including rephrasing some questions for clarity and adjusting the order to create a more natural conversational flow. The pilot also helped ensure that the interview length was manageable and that the guide elicited responses aligned with the study's research objectives. Following the ethical guidelines of the National Health and Medical Research Council of Australia, ethics approval was obtained from the Greater Western Human Research Ethics Committee (HREC; ETH11020) and the Western Sydney University HREC (H14303). This study followed the COREQ (COnsolidated criteria for REporting Qualitative research) guidelines for reporting on qualitative studies (see Supplemental File S1 for the Checklist).[26] Written informed consent was obtained before recruiting the participants, and verbal consent was reaffirmed during the interview.

Recruitment & Data Collection

Eligible participants were individuals with direct or indirect experience in delivering DV-related services in Central West New South Wales (NSW). Participants were included if they had worked in the region for 12 months or more, regardless of whether their primary role was within a DV-specific service. This criterion ensured participants had sufficient exposure to the local context to provide informed insights. Participants were excluded if they had less than 1 year of work experience in the region, as this was deemed an insufficient period to develop a meaningful understanding of service provision in the local community.

Recruitment occurred between July and September 2021. Potential participants were contacted through telephone, Facebook, and email. Additional participants were recruited via word-of-mouth referrals and professional networks. In total, 24 services located in Bathurst and surrounding towns (including Orange, Oberon, Forbes, Parkes, Cowra, Condobolin, Nyngan, and Dubbo) were approached, resulting in 12 participants agreeing to take part in the study. Two individuals who had initially expressed interest but were unavailable for interviews were retained in the sample count, although not interviewed. No other invitees declined participation.

Although saturation was not fully achieved due to time constraints, the interviews yielded rich and meaningful themes. The participating services represented a range of sectors, including domestic violence support services, legal aid, community centers, general medical practices, and police services. While not all were specialist DV providers, they all contributed to DV-related service provision in rural settings and were therefore considered relevant to the study.

Two trained women interviewers conducted structured interviews in qualitative data collection procedures, either face-to-face or via video conferencing, depending on the participant's preference. All interviews were audio-recorded and transcribed, and verbal consent was obtained from all participants before the interview. There were 9 open-ended questions listed in Supplemental File S2, with interviews lasting between 30 and 60 minutes, and no repeat interviews were conducted.

Data Analysis

Each interview was initially auto-transcribed by an online program (Panopto) and later transcribed again verbatim by the Authors to ensure consistency. Transcripts were then cleaned, de-identified, and analyzed by 1 author (R.V.) using NVivo Software (version 1.6) after a close reading before commencing data analysis. Braun and Clarke's[27] inductive thematic analysis approach guided the analysis. The first round of coding created a preliminary codebook, which was discussed and reviewed by all authors. Subsequent rounds of coding allowed refining of the codebook until a group consensus was gained regarding the major themes.

Results

Demographic Data

All 10 participants were women, with experience working in the DV field ranging from 1 year to over 10 years. Five participants had roles specifically relevant to delivering specialized DV services, while the remaining 5 participants (n = 5) had roles that intersected with DV service provision, without being their primary focus. Services ranged from legal aid, housing, counseling, case management, running preventative programs, and facilitating support groups. The participants all provided DV services to Central West NSW. This range of professional roles enriched the findings and reflected the diversity of service delivery contexts.

Thematic Findings

Three key themes were identified, reflecting the journey of DV victims throughout their engagement with DV services from a provider's perspective. The themes encompassed the first steps of DV service engagement (sub-themes: opportunistic avenues for assessing services; barriers to access), rural DV service provision challenges (sub-themes: lack of funding and specialized DV resources; need for multi-disciplinary services; culturally competent and inclusive services; personal toll), and ideal service delivery (sub-themes: current successes; education). Further details are explained below.

Theme 1: First Contact

This theme addresses provider reflections on how DV victims come to engage with their services as well as barriers that hinder their access.

Sub-Theme 1: Opportunistic Avenues for Accessing Services. Out of the 5 participants who held DV-specific service provision (SP) roles, all reflected that most victims of DV in the community make first contact with them through police referrals, child protective services, or self-referral. This pattern of access was also reflected in the non-DV-specific SP group. There was discussion about how victims would engage in these services if not self-referred:

> A lot of the victims don't come until they're mandated to come. So, a lot of our referrals come through child protection services. [Participant 8]

In the non-DV-specific SP group, most victims presented with other issues first before disclosing their struggles with DV, after building enough rapport and trust with the providers.

> The playgroup is seen as something safe, and potential perpetrators are happy for them to go along to something that's for the sake of the kids, a sort of thing. [Participant 8]

Sub-Theme 2: Barriers to Access. Participants identified barriers to seeking help for DV, which included enduring cultural attitudes toward DV, logistics of leaving DV relationships and accessing services, and high rates of comorbid substance use disorders/mental health issues. All participants mentioned that there was no dominant type of DV in the rural communities they serve; however, within these communities, victims often do not seek help until physical violence transpires within the relationship.

> (the) Benchmark is very, very high of what people accept as family and domestic violence. . . People have an acceptance that most families live like this. So why try and change? Why do anything different? [Participant 3]

All participants described logistical difficulties that victims must overcome to access services or to leave their relationships: geographical traveling distance, supporting young children, lack of financial literacy/resources, losing support and friendship networks, loss of community identity, and finding employment or housing.

> And that's what sometimes can stop people (from leaving their relationship); they are going to lose what support networks they do have . . . And for some people, that could be leaving their country as well. [Participant 7]

Five participants described comorbid substance use disorders, by the victim and/or perpetrator, preventing DV victims from accessing services. Often, these issues are linked with financial control exerted by perpetrators or victims perceiving that DV-type behaviors are a result of substance abuse and thus normalizing them.

Theme 2: Challenges of Service Delivery

This theme spoke to the main aspects of service provision that rural SPs identified as challenging and hindered their abilities to provide a positively impactful intervention for their clients.

Sub-Theme 1: Lack of Funding and Specialized DV Resources. All participants explicitly implicated a lack of adequate funding and human resources as a direct barrier to their capacity to support clients, thereby limiting available services. One participant expressed frustration about the lack of funding to facilitate 24-h services, thus forcing service providers to work on-call off-site or leading to long waiting lists and a lack of immediate response. This also contributes to a lack of crisis support and continuity of care.

> There is not enough assistance out here, so we might have gaps in service because somebody must wait a month to *six* weeks to see me. [Participant 9]

> If somebody comes in and sees me, I might get an hour a week or an hour with them a fortnight. And the perpetrators got 24 hours a day, *seven* days a week to undo what I say to them. [Participant 9]

Five participants directly involved in providing DV services expressed the need for more funding to expand service availability. An additional 5 participants, while not stating it explicitly, also implied this need through their responses.

> Better coordination of programs, quicker access to financial resources, and more housing would be on everybody's wish list. [Participant 9]

Sub-Theme 2: Need for Multidisciplinary Care/Services. A salient struggle amongst all participants in this study was the difficulty in coordinating holistic care for the victims who accessed their service. From coordinating safe crisis housing, legal services, childcare, psychological counseling, and financial support, all participants expressed the challenges in providing these essential services to their clients in an integrated way. Two participants specifically emphasized the importance of obtaining holistic case management services.

Sub-Theme 3: Culturally Competent and Inclusive Services. Four participants expressed the need for specialized cultural DV services, such as First Nations-specific DV workers.

> My mistake with my Indigenous client was that I was making so many assumptions; culture plays a huge role in the way we relate, and I can understand how an Indigenous lady would prefer to have an Indigenous counselor. [Participant 1]

Ensuring the provision of culturally safe resources within the community for those victims who were leaving DV relationships impacted the effectiveness of service provision:

> We had people breaching (their apprehended violence orders). I'm talking about eight-, or 10-times repeated breaches. I guess that is one of the things that gets frustrating because then victims lose faith in the system, as well, and start to wonder why, what's the point of even reporting? [Participant 8]

Furthermore, 3 participants commented on the difficulties faced by male DV victims or women who fled DV relationships with adolescent sons, as most DV crisis shelters accommodated strictly women.

> We don't have accommodation options for DV victims. We are a small town. . . even if you help in relocating them from their known communities, everyone's going to know where they live, which still makes them at risk. [Participant 6]

Sub-Theme 3: Personal Toll. Six out of 10 participants discussed experiences of burnout working as DV service providers due to constant exposure to vicarious trauma and coping with demanding workloads and a shortage of resources. However, these participants felt they were well supported by the networks around them or put in place activities to maintain a healthy work-life balance that enabled them to persevere with their work. Struggles to maintain personal boundaries with work and clients were discussed by 3 participants, all of whom worked in rural towns with limited DV services.

> People turn up on my front doorstep. . . having victims turn up on my doorstep at 11 p.m., you know, it was tough for me and tough for the kids. [Participant 8]

Theme 3: Successes and Recommendations

Participants in this study acknowledged the numerous challenges faced in DV service provision but also highlighted key successes and recommendations for improving service delivery. Despite limitations in funding, resources, and specialized services, participants expressed pride in their work and confidence in their ability to support DV victims effectively. Many credited their success to strong collaboration with law enforcement, increased accessibility of services through online and video platforms, and the facilitation of support groups that empower Victims. Additionally, participants emphasized the critical role of early intervention and education, particularly in schools, to challenge harmful behaviors and promote healthy relationships. Community awareness initiatives and tailored resources for minority groups were also identified as essential strategies for enhancing DV prevention and support. The following subthemes explored these successes and recommendations in greater detail.

Sub-Theme 1: Current Successes. Despite the challenges identified in this study, all the participants expressed pride and confidence in how effective their work was with the DV victims they engaged with. Even with limited specialized services, funding, and resources, they felt their work made a positive impact. Participants spoke especially highly of the effectiveness of any support groups they facilitated and the importance of DV prevention programs in schools. Depending on location, participants attributed successes to close working relationships with law enforcement, progressive accessibility of services online or via telephone/video, facilitating victim support groups, and consistent goals and values between workers involved in DV service provision.

> One of the things we found very powerful was group work, where women can see that they're not alone, that there are other women out here, and that can be very empowering. [Participant 9]

> Getting people into counselling was so much easier because everybody was offered all these video counselling. . . previously. . . you're looking at a three to five-month wait. [Participant 8]

Sub-Theme 2: Education. Seven participants described the need to facilitate and invest in early prevention programs aimed at high school children to combat DV. These programs could model healthy relationships with adolescents and challenge the harmful behaviors they may have witnessed.

> Educating these young kids about what's appropriate and what's not, what's acceptable and what's not, what you should expect and what you shouldn't expect. I think that is important in terms of being proactive instead of being reactive to a situation. [Participant 6]

Additionally, 4 participants talked about the need to raise awareness about DV within the community as a crucial strategy in DV prevention. They suggested having programs and community events that challenge current perspectives about DV. All participants expressed the need for educational resources to assist minority groups including victims who are living with disability, those from ethnic minorities, First Nations People, victims with substance use disorders, LGBTQ+ communities, and the elderly.

Discussion

This qualitative study explored the perspectives of 10 rural service providers (SPs) in Central West NSW on DV service provision. Participants identified significant and interrelated challenges to accessing and delivering DV support, including entrenched sociocultural norms, stigma, comorbid mental health issues, limited resources, and systemic underfunding. Many SPs described high workloads and the emotional toll of their work, with several reporting burnout despite the availability of collegial support networks. These factors collectively hindered the effectiveness and sustainability of services. Providers also emphasized the importance of early intervention, with several advocating for DV education in schools as a form of primary prevention. Overall, the findings offer insights into how service provider perspectives align with the lived realities and needs of their communities and suggest areas where structural reforms, such as improved funding, culturally responsive care, and support for frontline staff, are needed to strengthen DV service delivery in rural Australia.

The study findings support the call to increase publicity and awareness of DV services, highlighting the crucial role of media outlets in improving access and visibility. Considering the alarming trend of domestic violence post-COVID-19,[24] and the report that following the identification of DV, most women do not take up a referral to the DV,[28] it is important to inform the public of the need to report any concerns of abuse.[29] Participants in this study highlighted the role of Child Protective Services as the initial point of contact for victims. Recent studies calling for a shift in mainstream DV services toward a more network-oriented approach highlighted the crucial role of informal social support networks.[30] Similar social dynamics in rural communities have also been observed elsewhere.[11] Other major barriers to accessing services identified by participants include geographical isolation, partner obstruction, loss of support networks, financial dependence on abusive partners, lack of accessible housing, and comorbid medical conditions.[11,12,19,23]

These challenges are compounded in rural settings,[10,31] where resources are scarce, and people travel long distances. As noted in a previous study, A meta-analysis[32] on the impact of rurality on women's space for DV actions found that geographical location and social isolation provided women with few opportunities to seek help and aided perpetrators in reducing women's spaces for safety. Similar barriers have been well-documented in previous studies, including the role of social networks and peer support. All of these reflect the systemic issues faced by DV victims in rural settings.[11,12,19,23]

Theme 2 highlighted the obstacles that SPs face in trying to fulfill their roles, including a lack of funding, insufficient specialized DV resources, and the absence of coordinated multidisciplinary services. These challenges, which have been noted elsewhere[22] lead to burnout among SPs, a finding that is consistent with previous research linking resource shortages to difficulties in ensuring victim safety, providing crisis support, and maintaining continuous engagement with DV services.[11,12,19,23] In a study conducted among 24 primary care clinicians from diverse clinical settings across Australia, clinicians felt ill-equipped to identify and respond to similar situations involving abuse of women and suggested they need more training in this area.[31] These difficulties are particularly pronounced for minority groups living in rural communities.[11,12,19,23]

Participants also highlighted the significant disparity between the time victims spend with perpetrators versus the limited time available for engagement with support services, which undermines progress. Similar time concerns were raised regarding after-hours services for domestic violence victims.[33] Previous studies that focus on the experiences of DV victims have reported on the distress experienced by rural DV SPs.[31,34] In this study, practitioners reported experiencing burnout due to the relentless challenges of their work. However, the supportive professional network within which the SPs worked, further training, and effective working relationships with colleagues helped to mitigate some of this distress. This contrasts with the frustrations expressed by SPs in Eastman et al's[19] study, highlighting the variability in support systems for SPs.

The practices that work and potential improvements for effective service delivery were discussed by participants. They spoke about the protective effect of community support groups for DV victims and the use of technology for remote service access. These strategies, especially networking with other rural DV victims, have been shown to reduce feelings of hopelessness and helplessness among victims, better preparing them to address abusive relationships.[19] The use of technology has significantly improved service provision by enabling access to geographically isolated victims and expanding the reach of services. Pfitzner et al[34] emphasized the effectiveness of remote DV service delivery during the COVID-19 pandemic, which remains relevant in rural settings today.

Continuing this, service providers adapted to the challenges posed by the pandemic. Specifically, we now highlight that many of the protective mechanisms discussed under Theme 3, particularly the use of technology for remote service access and the facilitation of community support groups, were direct responses to the disruptions caused by COVID-19. Service providers reported that the shift to remote service delivery not only allowed them to reach geographically isolated DV victims but also increased the number of services able to function during lockdowns and travel restrictions. This aligns with the findings of Pfitzner et al[34] who describe the effectiveness of technology-enabled service provision during COVID-19 when implemented with attention to safety and privacy. Moreover, participants shared that support groups, particularly those held virtually or in small, safely distanced settings, played a critical role in reducing feelings of helplessness and isolation among DV clients, challenges that were intensified during the pandemic. These insights reflect Eastman et al's[19] observations of improved client readiness to address abuse when peer support was accessible.

Participants advocated for increased funding to expand and staff DV services adequately, the implementation of school-based prevention programs, and raising community awareness. These measures are seen as crucial for addressing the cultural status quo and the effects of intergenerational trauma related to DV in rural communities. Other studies also reflect the need to simultaneously address these issues at the individual and community levels to make substantial progress in tackling the DV public health crisis.[11,12,19,35,36]

The broader NSW legislative definition of DV, which includes not only intimate partner violence but also familial and other forms of abuse, may have influenced participants' responses. While most discussions centered on intimate partner violence, some participants acknowledged other manifestations, such as familial violence and coercive control within extended family networks. This was particularly evident in themes related to service access and barriers, where cultural norms and financial control extended beyond intimate partnerships to include family dynamics. Additionally, the challenges of service provision highlighted the need for culturally competent resources, especially for First Nations communities and male victims, suggesting an awareness of domestic violence as a broader societal issue rather than solely an issue between intimate partners.

Service accessibility remains a significant concern. Suggested solutions included expanding mobile outreach, telehealth, and culturally tailored programs to address the needs of marginalized populations. Trust-building efforts, such as maintaining confidentiality and increasing diverse representation in support roles, were seen as essential. These findings align with broader calls for systemic reform to enhance the sustainability, equity, and effectiveness of rural DV service provision.[16]

Strengths and Limitations

The main strength of this study includes the wealth of experience and knowledge of the participants sampled and interviewed. Each participant had a minimum of 1 year of experience in DV service provision, with some reporting significantly longer tenures, up to 10 years, based on information shared during the interviews. Their expertise was enhanced by using models involving collegial support, interdisciplinary care, and senior supervision. Additionally, there was heterogeneity in the SP interviewed, which is representative of the limited services available in rural regions. All interviewees held multiple roles within or besides DV service provision, bringing diverse insights and reliable expertise to the study. Using Braun and Clarke's approach to thematic analysis allowed for a meaningful examination of similarities and differences between each participant's perspective, generating unanticipated insights. To ensure consistency and reliability, we exclusively used extracts from participants' experiences to support findings and maintained continual discussion about the interpretations of their experiences. While the thematic findings, such as access barriers, workforce burnout, and systemic underfunding, may echo challenges identified in other contexts, this study offers novel insights by situating these issues within the unique sociocultural and geographic landscape of Central West New South Wales (NSW), a rural and underresearched region. The perspectives of local service providers show how the cultural norms, professional isolation, and limited resource allocation manifest in distinctive ways within this rural setting. Additionally, the study highlights specific, context-driven recommendations from practitioners, such as the emphasis on DV education in schools and the role of collegial networks in mitigating burnout, which may inform regionally tailored interventions. This study contributes to the limited but growing literature on rural DV service provider perspectives, but it has some limitations.

The fact that saturation was not reached and the inclusion of service sectors geographically clustered in only a few Central West regions, limit the applicability of the results. Only a small portion of the Central West region was represented, and SPs from larger rural towns like Orange were not included. As a larger town, their service provision experiences may have differed from those of the included participants. Future studies would benefit from a more diverse sampling of rural and remote geographical areas. During the time of sampling, some rural DV services were not running or were difficult to access, which may have limited our sample size. Additionally, the sociocultural nature of rurality in NSW and across Australia cannot be homogenized, and the experiences highlighted in this study may not represent other rural or remote Australian regions.

Conclusion

This study highlights the multifaceted challenges faced by rural DV service providers, including access barriers, burnout, and systemic limitations. Despite these challenges, participants demonstrated commitment and a willingness to improve service delivery. Effective strategies must include culturally competent, trauma-informed approaches, targeted mental health support for providers, and improved access through mobile and telehealth services. Addressing these areas is essential for enhancing trust and outcomes for vulnerable populations. Importantly, future policy and research must reflect the diversity of rural Australian communities to ensure reforms are inclusive and impactful. These findings offer valuable insights for strengthening DV service provision in rural settings.

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Ethical Considerations

This research was conducted by the ethical guidelines of the National Health and Medical Research Council of Australia and with ethics approval from the Greater Western Human Research Ethics Committee (HREC; ETH11020) and the Western Sydney University HREC (H14303) on 12 April 2021.

Consent to Participate

Written informed consent was obtained prior to visiting the participants, and verbal consent was reaffirmed during the interview.

Author Contributions

RV; Data collection – RV; Data analysis – RV, ULO; Writing – RV, ULO; all authors contributed to the editing and revisions of the manuscript and approved the submission of the final version.

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Data Availability Statement

The raw interview transcripts contain identifiable and sensitive information and are not publicly available to protect participant confidentiality. However, de-identified coded data (eg, themes or anonymized excerpts) may be made available upon reasonable request, subject to ethical approval and participant consent provisions.

Supplemental Material

Supplemental material for this article is available online.

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