Received: 22 September 2021 | Revised: 1 March 2022 | Accepted: 9 May 2022

DOI: 10.1111/ajr.12887

ORIGINAL RESEARCH

AJRH National Rural Health Alliance WILEY

Examining a rural Victorian community's knowledge and help seeking behaviour for family violence and the role of the local public health service

Peter Kelly BA[1,2] | **Michael Field BMBS**[1,3] | **Ruth Payne GradDip**[1] | **Rebecca Giallo PhD**[4,5]

[1]Colac Area Health, Colac, Victoria, Australia

[2]Strengthening Hospital Responses to Family Violence Initiative, Barwon Health, Geelong, Victoria, Australia

[3]Western Alliance Academic Health Science Centre, South West Healthcare, Warrnambool, Victoria, Australia

[4]Department of Paediatrics, Murdoch Children's Research Institute, Royal Children's Hospital, The University of Melbourne, Parkville, Victoria, Australia

[5]Deakin University, Geelong, Victoria, Australia

Correspondence
Peter Kelly, Strengthening Hospital Responses to Family Violence Initiative, Colac Area Health, 2 – 22 Connor St, Colac, Vic., Australia.
Email: peter.kelly2@barwonhealth.org.au

Funding information
This study was funded by the Barwon Strengthening Hospital Responses to Family Violence Initiative

Abstract

Objective: The rates of family violence within some rural communities are higher than that of metropolitan areas. The extent to which these rural communities know about and access family violence support services is not well understood. Local health services often play a role in providing information and support for community members at risk of, or experiencing family violence. For a rural community in Victoria, the study aimed to: (a) determine community members' knowledge of family violence services, (b) explore community members' help seeking behaviour for family violence, (c) identify perceived barriers and enabling factors to accessing family violence services and (d) explore community members' expectations of, and preferences for, family violence support provided by local health services.

Design: A cross-sectional, anonymous, mixed-methods online survey.

Setting: A rural community in Victoria's Western District, Australia.

Participants: Ninety-nine residents, over 18 years of age.

Results: The majority of respondents had been exposed to family violence. There were varying knowledge levels of family violence support services as well as a number of barriers identified that directly impacted community members seeking help. There were clear expectations about the role of the local health service in family violence identification and response.

Conclusion: There are particular challenges for rural communities in providing support for family violence. Valuable insights can be gained from local communities about their knowledge of services and help seeking behaviours. Evidence generated by this study will inform future strategic planning for family violence services and the local health service.

KEYWORDS

domestic violence, health promotion, primary health care, remote health, rural/remote services

1 | INTRODUCTION

Strengthening responses to family violence in rural, regional and remote communities is a key public health priority in Australia and globally.[1,2] Violence refers to any behaviour that causes harm including physical aggression, psychological abuse, sexual coercion, controlling behaviours, financial deprivation, social and cultural deprivation.[3] Although violence can occur within any family or kinship relationship including against siblings, parents and children,[4] it is important to note that violence used against women by an intimate partner is the most prevalent.[5]

International and Australian research consistently reports that the incidence of family violence, particularly against woman, is higher in rural communities than in more densely populated urban or metropolitan areas.[2,6–8] For example, in the Australian 2016 Personal Safety Survey 23% of women and 6.6% of men living outside major cities reported experiencing partner violence, compared with 15% of women and 5.9% of men living in majority cities.[5] Further, people living in remote areas of Australia were 24 times more likely to be hospitalised for family violence than people living in major cities.[5]

It is widely acknowledged that rural communities face unique challenges in responding to and accessing services for family violence.[4,6] In addition to common barriers to accessing support (e.g. fear of partner, stigma and shame, concern for children, economic difficulties, limited means to leave violent relationships),[9] those living in rural communities can experience specific barriers. Australian research indicates that strong values of family unity and traditional gender roles are barriers for rural women.[10] Research from the US and Canada indicates that 'rural patriarchy' and widespread community norms can reinforce the acceptance of violence against women, protect men who use violence within the justice system, and prevent women from reporting to police and seeking social support.[7,11] In addition, women experiencing family violence can experience social isolation and limited support from family and friends, as well as formal support from health and social services.[12] Even if services are available, there can be concerns about privacy given that health professionals, police and others are likely to know both the offender and person experiencing violence and/or their families.[13,14] Vast geographical distances and lack of transportation are also barriers to accessing services.[15]

Given these challenges, coordinated local responses to family violence are critical to increase the availability of, and improve access to, services in rural, regional and remote communities.[1] For effective local responses, research into the specific needs and help-seeking attitudes and behaviours in different rural communities is needed.[16]

Drawing upon these recommendations, a local rural health service in the township of Colac in Victoria's Western District, Australia, sought to explore community members' knowledge, help-seeking behaviours and preferences for family violence support. The township of Colac is classified as a medium rural/small rural town[17] and has a population of approximately 15 000 people. Family violence is an identified health problem for this community, with a family incident rate in the Colac-Otway municipality of 1746.1 incidents per 100 000 population in 2019–2020 which is higher than the Victorian rate of 1315.4 incidents per 100 000 population over the same period.[18]

What is already known on this subject:

- People living in regional and rural areas experience high levels of family violence
- People experiencing family violence in rural, regional and remove communities face particular challenges in accessing family violence services
- Research is limited on rural help seeking behaviour for family violence

What this study adds:

- Valuable data of how Colac community members seek support for family violence
- Analysis of community members' help seeking behaviours
- Identifies specific actions, tools and practices for the health service to consider in their approach to identifying and responding to family violence

To further inform health service responses to family violence in the Colac community, the study aimed to:

- Determine community members' knowledge of family violence services.
- Explore community members' help seeking behaviours for family violence.
- Identify the perceived barriers and enabling factors to accessing family violence services.
- Explore community members' expectations of, and preferences for, family violence support specifically provided by the local health service.

2 | METHODS

2.1 | Study design and participants

A cross-sectional online survey of residents over 18 years of age living in the rural township of Colac and surrounding area was conducted. The survey was only offered in

English, so participants were required to be proficient in English. A total of 99 adults completed the survey (demographic characteristics are presented in Table 1). The majority were female, born in Australia, and aged between 35 and 54 years. The majority of participants had accessed Colac Area Health services for a health issue, with almost a third doing so in the last 12 months.

2.2 | Measures

An anonymous online survey was designed specifically by the research team with clinical experience in family violence, population and community-based survey research, and research translation. Categorical response options, rating scales and open-ended questions were utilised. At the beginning of the survey, a standard definition of family violence was provided.[19] Exposure to family violence was assessed by asking if participants had ever been afraid of a partner or family member. Similar single item questions have been used in other studies, validated against more comprehensive measures of intimate partner violence such as the Composite Abuse Scale,[20] and has demonstrated good sensitivity and specificity in identifying violence experiences.[21] The survey was reviewed by the Consumer Committee at Colac Area Health as well as a family violence victim survivor. It was also pilot tested by several staff from Colac Area Health. The survey was available on the REDCap online platform for completion.

TABLE 1 Demographic characteristics of the sample ($N = 99$)

Demographic characteristics	*N*	%
Age (in years)		
18–24	6	6.1
25–34	15	15.2
35–44	23	23.2
45–54	34	34.3
55–64	17	17.2
65–74	4	4.0
Gender		
Female	90	90.9
Male	8	8.1
Prefer not to say	1	1.0
Ethnicity[a]		
Australian	94	94.9
Aboriginal or Torres Strait Islander	2	2.0
Indian	1	1.0
European	6	6.1
North American	1	1.0
Other	3	3
Ever accessed Colac Area Health services for a health issue (e.g. hospital, dental and community health clinic)		
Yes	64	64.6
No	17	17.2
Not reported	18	18.2
Time since last accessed Colac Area Health?		
Within the past 12 months	30	30.3
More than 12 months ago	34	34.3
Not reported	35	35.4

[a]Total percentage is >100 as multiple ethnicities were reported.

2.3 | Procedure

The study was advertised extensively in the Colac region via Colac community social media channels, websites, local print and radio media and newsletters. Potential participants were invited to scan the QR code or enter a link into their internet browser, which directed them to a REDCap survey containing the participant information and consent form (PICF). The PICF stated the purpose of the survey, its potentially sensitive content, and details of family violence services were provided.

The anonymous nature of the survey and inability of the research team to provide any follow up to participants was also explained. Participants were required to confirm that they were 18 years of age or older, living in the Colac area and had read the PICF. Once electronic consent was obtained via a checkbox on the PICF, participants were directed to the survey. The survey was open between 22 January and 12 March 2021.

2.4 | Data analysis

Descriptive statistics were used to summarise survey responses related to the research aims. Missing data were minimal, with an average of 16% missing across all survey items. Complete case analyses are presented, with the extent of missing data for each survey item reported in the tables. Thematic analysis of the open-ended responses was conducted using an adapted procedure by Braun and Clarke.[22] This involved (a) familiarisation with the text for each open-ended question, (b) generation of initial codes to summarise the content, (c) search for themes across codes and (d) review, define and name themes.

3 | RESULTS

3.1 | Family violence experiences

Table 2 presents the experience of family violence within the sample, of which 91% identified as female. Given the

small number of male participants, we chose to present descriptive statistics for the entire sample rather than provide a breakdown by gender. Of the 99 participants, 75% had indicated some exposure to family violence, either personally or through another family member or friend. Over half indicated that they had been afraid of a partner or a family member at some point in their lives (54.5%), and almost a third had required police intervention due to safety concerns resulting from family violence (32.3%). Over a third knew a family member who had been afraid of a partner or another family member (36.4%). Finally, nearly half knew a friend who had been afraid of a partner or family member (46.5%). Of the participants who responded to the questions about the timing of their family violence exposure, 10.4% are currently exposed, 18.2% in the past year and 71.3% in the past 5 years or longer.

3.2 | Knowledge of local family violence services and help-seeking

Participants were asked who they would contact if they were experiencing family violence and wanted support.

TABLE 2 Experiences of family violence within the sample ($N = 99$)

Experience of family violence	*N*	%
Ever been afraid of a partner or family member		
Yes	54	54.5
No	33	33.3
Do not know	1	1.0
Not reported	11	11.1
Ever required police intervention due to safety concerns resulting from family violence		
Yes	32	32.3
No	51	51.5
Prefer not to say	5	5.1
Not reported	11	11.1
Family member(s) ever been afraid of a partner or family member		
Yes	36	36.4
No	35	35.4
Do not know	16	16.1
Not reported	12	12.1
Friend (s) ever been afraid of a partner or family member?		
Yes	46	46.5
No	24	24.2
Do not know	16	16.2
Prefer not to say	1	1.0
Not reported	12	12.1

Table 3 shows more than half identified the police, followed by another family member. Over one-third would seek support from a friend, followed by a psychologist, counsellor or family doctor. Almost two-thirds would seek support via the telephone, followed by face-to-face methods and the internet. With respect to specific family violence services in Colac, 59 participants (59.6%) were able to name at least one service, with The Orange Door being most commonly named. It is important to note almost half the sample did not name a family violence service.

3.3 | Perceived effectiveness of family violence services

Forty-nine participants responded to an open-ended question enquiring about their perceptions of the effectiveness of family violence services in the Colac region. Approximately half of the responses ($n = 22$) reflected the helpful and supportive nature of these services:

TABLE 3 Knowledge of local family support services and help-seeking behaviour ($N = 99$)

Knowledge and help-seeking behaviours	*N*	%
If experiencing family violence and wanted to seek support, who would you contact?[a]		
Family member	37	41.6
Friend	35	39.3
GP/family doctor	24	27
Psychologist/counsellor	26	29.2
Police	45	50.6
Other	6	6.7
If experiencing family violence and wanted to seek support, which method(s) would you use to seek that support?[a]		
Phone	57	64
Internet	33	37.1
Face to face	54	60.7
Name any family violence support services in Colac[a,b]		
Orange Door	42	79.2
Colac Area Health	8	15.1
Horizons	2	3.8
Police	4	7.5
SAFV Centre	1	1.9
Safe Steps	1	1.9
Salvation Army	1	1.9

[a]Total per cent greater than 100 as participants could select more than one response.

[b]$n = 53$ participants named at least one service for family violence support.

> These services, have been life changing in helping my family, deal with family violence. As well as giving support to help us move on and heal.

Ten participants shared that these **services had not been helpful or effective:**

> When I eventually got through, the counsellor was condescending and unhelpful.... I did not want the police involved, yet she was forcing me. I hated every minute of it and walked out very disillusioned.

Another 15 participants noted effectiveness was limited by **services being inaccessible** because they are only available business hours with **limited staff resourcing** to manage family violence cases. Two participants specifically noted services were **not helpful for male victims** of family violence:

> Services that I have encountered don't take male victims seriously. Orange Door is terrible and made me feel like a perpetrator.

3.4 | Perceived barriers to using family violence services

Fifty-three participants responded to a question asking about what gets in the way of seeking support for family violence. Seven broad themes were identified (see Figure 1).

Overwhelmingly the strongest theme was fear. Most participants reflected on fear of the perpetrator finding out, repercussions and reprisal for seeking support, and the violence getting worse. There was also fear of not being believed if help was sought:

> Fear of the system as sometimes you feel like, you have to keep proving yourself. In the early stages it can feel as though you aren't getting anywhere. It can take time to realise that you're not in the wrong for seeking help.

The fear of judgement from others and stigma was a concern:

> There is probably a lot that goes unreported because of fear of reporting or embarrassment or fear of judgement and societal pressure and stigma around family violence or abuse.

Fear of not being believed was noted particularly for male victims:

> As a male I feel I won't be believed or treated as a victim.

Fear of the potential impacts of seeking support on the family unit such as family breakdown and homelessness was also perceived as a barrier.

Relatedly, isolation and a lack of support and resources were common barriers. Participants noted 'being alone and not knowing anyone in the area' and 'not wanting to be a burden on others' as barriers in rural towns. Financial difficulties, poor mental health, and not having the time and energy to seek support means that some people delay accessing services.

Barriers related to self-blame, embarrassment and shame were evident in 13 comments:

> Embarrassment in a small community.

> Feeling silly for it to have gotten this far.

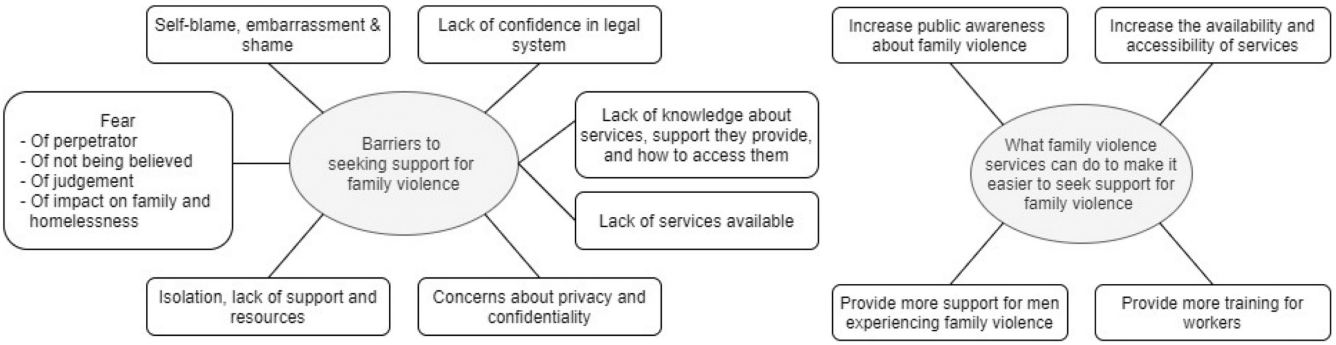

FIGURE 1 Perceived barriers and facilitators to seeking support for family violence

Feeling ashamed to seek help.

Concerns about privacy and confidentiality was viewed as a key barrier to seeking support, reflected in 12 comments such as:

> Small town knowledge, even without names some people may work out who you are if someone shares your story with a family member or friend.

Concern about privacy was a particular barrier for those experiencing family violence and working in the health care system. It was viewed as difficult to disclose family violence to colleagues or others they may see regularly at work, particularly if staff knew their family and the perpetrator. Seven comments reflected a lack of knowledge about services, the support they provide and how to access them. A health care worker noted:

> I don't see information regarding family violence support around our community other then (sic) in the health care facilities. If I wasn't a health care worker I would have no idea how to access family violence support

Relatedly, there was a perceived lack of services, with not enough case workers, long wait times and a lack of emergency accommodation. Finally, a lack of confidence in the legal system was identified in seven comments. There were specific concerns about victim blaming and lack of support for victims by the legal system, and about the lack of consequences for the perpetrator:

> It's actually on police and courts that stop us [from seeking support]. As more times than not perpetrators get off with a warning or a stupid piece of rubbish printed on paper that won't stop them.

3.5 | Enablers to access family violence services

Participants were asked about what family violence services could do to make it easier to seek support for family violence. A total of 55 responses reflected four broad themes (see Figure 1). The strongest theme with 22 responses was increase the availability and accessibility of services. There was recognition that more funding for case workers, crisis support and accommodation services, and mental health services was required. In particular, the availability (i.e. after hours; weekend services) and immediacy of those services deemed critical:

> The most important thing is getting help FAST & ongoing support. I was seeking counselling for a DV situation and was told it would be 4 MONTHS before I could see someone - so I didn't!

Eighteen comments reflected the need for increased public awareness of family violence and promotion of services available:

> Advertise that it's not the victim's fault, that they won't be a burden on others, that the victim is important and their thoughts and feelings are important.

Suggestions to raise awareness of services were offered:

> Making information more accessible in public places may give the person the opportunity to seek the courage to seek help.

> Use a range of mediums to raise awareness of services (e.g. social media, radio, print media) and brochures in commonly visited places (e.g. doctors' offices, MCH, maybe even some shops).

Six comments, offered by both men and women, were specifically about providing more support for men who are experiencing family violence:

> Listen and accept what is said rather than brushing me off because I'm a male.

Finally, five comments were specifically about further training for family violence service workers, ensuring that they 'understand referral pathways and the services available, and understand how to respond to person disclosing family violence'.

3.6 | Expectations of the local health service providing family violence support

Table 4 shows the vast majority of participants indicated it is absolutely essential for a health service such as Colac Area Health to offer support for family violence. The majority indicated that the information on family

TABLE 4 Expectations and preferences for health service family violence support ($N = 99$)

Expectations and preferences for health service family violence support	*n*	%
Level of importance for a health service to offer support around family violence		
Not important at all	1	1.1
Of little importance	–	–
Of average importance	–	–
Very important	20	20.2
Absolutely essential	60	60.6
Not reported	18	18.2
Expectations of a health service to ask about personal/family safety		
Yes	52	52.5
No	16	16.2
Unsure	13	13.1
Not reported	18	18.2
Level of comfort in disclosing experience of family violence to a health worker		
Extremely uncomfortable	20	20.2
Somewhat comfortable	51	51.5
Completely comfortable	9	9.1
Not reported	19	19.2
Perceptions of a health service as a safe place to seek help if experiencing family violence		
Strongly disagree	2	2.0
Disagree	1	1.0
Undecided	27	27.3
Agree	30	30.3
Strongly agree	20	20.2
Not reported	19	19.2
Best method for a health service to provide family violence information[a,b]		
Referral cards	44	55.0
Brochures	58	72.5
Newspaper notice	43	53.8
Other	35	43.8
Best location for a health service to provide family violence information[b,c]		
Hospital waiting room	64	81.0
GP clinic	64	81.0
Library	46	58.2
Other	34	43.0

[a]Total percent greater than 100% as participants could select more than one response.

[b]$n = 80$ participants offered a response.

[c]$n = 79$ participants offered a response.

violence could be provided via brochures in hospital waiting rooms, GP clinics and community venues such as libraries. More than half reported that they expected a health service to ask about personal and family safety as part of regular health appointments. Despite this, only a small proportion indicated that they would be completely comfortable disclosing information about family violence if asked about safety at home. Approximately two-thirds indicated they would be somewhat comfortable. Although the majority agreed that a health service was a safe place to seek help for family violence, it is important to note that a third were undecided whether it would be a safe place.

Participants shared their expectations of health services and health care workers if someone shared that they were experiencing family violence. Figure 2 displays the broad themes. The strongest theme with 18 responses was to provide a private room or space in the health service. This was considered critical for confidentiality and safety:

> A room for people seeking help [this is] not out with everyone else. It's hard enough coming in for help. The last thing you want is people staring at you like you have done something wrong.

Thirteen responses reflected the need for health services to facilitate a discreet way to seek support from health services that would not alert the perpetrator. These included mobile phone applications, a suggestion box in a waiting room, an accessible QR code that requests a call back from a health worker, and small cards with contact numbers that could easily be put in a bag or pocket. The provision of information resources in the form of brochures or online supports and posters was expected by some participants. Finally, four participants expected health services to provide a warm environment and resources for children including fresh water, food, books and toys.

With respect to expectations of health care workers, over 30 responses reflected the need for them to listen, acknowledge and reassure someone who has disclosed family violence:

> Reassure that they have done the right thing by talking to somebody about it. Tell them they are important, their feelings/thoughts are valid

Before discussing options and offering support, it was noted in 12 responses that the person who has disclosed

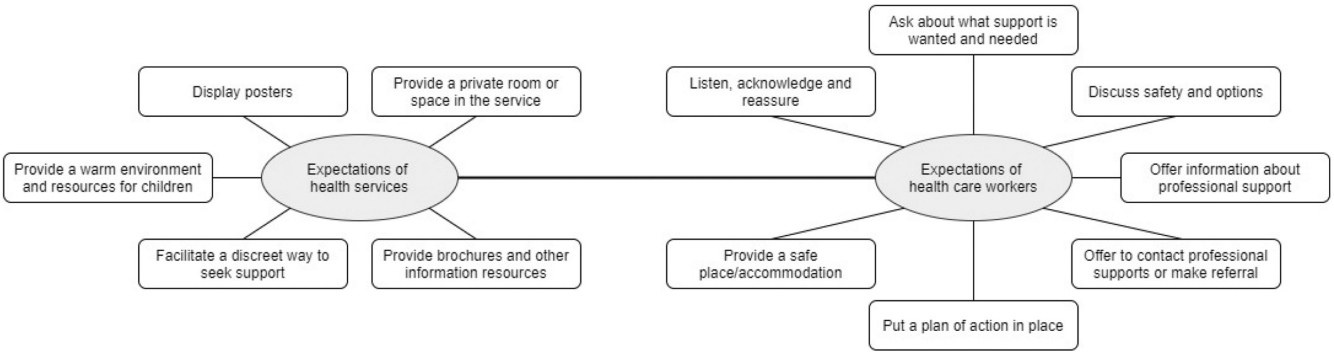

FIGURE 2 Expectations of health services and health care workers

family violence should be asked about what support they want and need:

> Let them choose, help them feel empowered.

Discussing safety and options to ensure immediate safety was reflected in 17 responses. Although few expected a health care worker to provide a safe place or accommodation (9 comments), offering of information about available professional support was considered important (36 responses). It was expected that health care workers would have good knowledge of professional supports and referral pathways, and could help the person put a plan of action in place (7 responses). Although it was viewed as important to let the person experiencing family violence decide what they wanted to do, 38 responses reflected that it was important for the health care worker to offer to contact professional supports (including the police) or to make a referral on their behalf.

4 | DISCUSSION

The vast majority of survey respondents were female, and the findings largely reflect their experiences. This is important given that family violence is more prevalent among women than men,[5] and there are significant barriers to accessing family violence support for women living in rural areas.[10]

4.1 | Experiences of family violence and accessing support

Experience of family violence was common among community members who responded. Three in four participants indicated they had some experience with family violence, either personally or by knowing a family member or friend. Over half indicated they had been afraid of a partner or another family member. Of those who indicated that they had experienced violence, one in 10 were currently experiencing violence in a family relationship and almost one in five had experienced violence in the past 12 months. Clearly recent lived experience of family violence was common. We feel that the voices of people with recent lived experience is important to acknowledge as it will be critical to inform current and future responses to family violence.

Almost half of the study participants knew a family member or friend who had experienced family violence, and that family and friends were identified as an initial point of contact or support for family violence. This underscores the critical role of informal supports for people affected by family violence. A systematic review into disclosure of partner violence to informal supports found the majority of individuals tell at least one informal support about their experience of violence.[23] Disclosure to family and friends can result in opportunities for emotional and practical support, and encourage access to formal support.[24] For some women, however, disclosure to family and friends is a negative experience, particularly if they are not believed, blamed or pressured to leave.[24] These experiences amplify the difficulty for people experiencing violence to access formal support. It raises questions about how health services and specialist family support services can assist family members and friends to respond in helpful ways when someone discloses family violence, or when they observe or suspect family violence. It highlights the need for the broader community to be aware of family violence support options available.

4.2 | Community knowledge of family violence support in Colac

Rural communities often experience a lack of health service funding and shortage of experienced health professionals skilled in supporting people who have experienced family violence.[6,25] Even when services are available, they

can lack visibility and pathways of support are often unclear. Our survey asked community members about their knowledge of support services for family violence in Colac. Many were able to identify potential sources of initial support for family violence including police, doctors, psychologists and counsellors. Approximately half the sample identified at least one specialist family violence service, with The Orange Door most well-known. This is encouraging as The Orange Door is physically located at Colac Area Health, making it more visible to community members accessing the health service.

Despite this, 40% of survey respondents were unable to identify family support services in Colac. This highlights further work is needed to increase the visibility of services in rural areas. Social isolation in these areas continues to be a barrier for women experiencing family violence.[12] In a qualitative study of 49 professionals working in the social care and criminal justice system in rural NSW, the gendered nature of rural communities was identified as a form of social control in which women are often socially and economically dependent on men and are discouraged from seeking support.[13] Therefore, in addition to physically locating family violence services in universal health services to make them more visible and accessible, community-wide campaigns about family violence utilising a broad range of communication methods such as radio (e.g. community radio), print media and social media to reach more isolated members of the community are needed.

4.3 | Barriers to health service use for family violence

Help-seeking and health service use for family violence is complex, and is influenced by a range of factors related to the individual, social and cultural environments they live in.[26] This is especially so for those living in rural communities who often live within communities with strong gender roles and norms that may discourage women from accessing social or formal support for family violence.[10,13] In our study, the most common barriers for seeking support were self-blame, embarrassment, shame and fear. There was fear of retribution by the perpetrator; of not being believed and judged by others; and of consequences such as family breakdown and homelessness.

Whilst such barriers are reported in other studies,[27,28] they are often amplified within a rural context. For example, participants in our study shared concerns about privacy and confidentiality in a small town where 'everyone knows everyone'. It can be difficult to disclose family violence to those who are likely to know the perpetrator and/or their family, or to disclose to those you may see regularly at work or around the community. US research has reported that local police are often friends with the perpetrator of violence and may refuse to arrest or respond appropriately on the grounds of friendship.[29] This same research also noted community norms and a culture of acceptance of 'woman abuse' acted as barriers to victims publically discussing their experiences and seeking social support. It is likely both of these factors create barriers in Australian rural communities.

4.4 | Expectations of the local area health service in providing family violence support

Despite identified barriers to accessing support, the vast majority of participants indicated local health services should offer support for family violence and that it would be a safe place to seek help. There was, however, mixed feedback regarding the effectiveness of current family violence support services in the Colac region. Whilst some participants found it helpful, others shared that services were inaccessible outside of business hours and had limited staff resourcing.

Suggestions about what health services could do to improve accessibility and service quality were offered. For example, safe advertising to increase awareness of family violence support options, as well as the provision of a private room or space that facilitates privacy and confidentiality while attending services. Although this study did not specifically ask about family violence support for children, several participants noted that child-friendly environments were also important.

There were suggestions related to health staff training, with a focus on embedding sensitive enquiry about personal and family safety as part of regular health appointments. If family violence was identified, many participants expected that health care professionals would be empathic and ask what support was wanted before offering referrals and taking action. These themes were also identified in a qualitative meta-synthesis of studies into women's experiences and expectations of disclosing intimate partner violence to a health care provider,[30] which emphasises the need for health professionals to tailor their responses to women's needs and empower them to make choices and to maintain their control and autonomy.

Finally, although there were only six comments offered by both male and female participants, it is worth noting that they expressed that more support for men experiencing family violence was needed. Although there is growing recognition of the need for health professionals to ask men about their own experiences of family violence as well as use of violence,[31] this is rarely done. For example,

in a UK study of 1368 men, only 1.6% of men were asked whether they had been hurt or frightened by a partner.[31]

Given that only 8% of respondents in our study were male, further community-based research focussing on men and their experiences of family violence will be useful to tailor support for this cohort.

4.5 | Study strengths and limitations

Addressing the challenges of conducting research in a rural town, this study used an online anonymous survey to capture community members' feedback on family violence services. The survey was reviewed and pilot tested by consumers at the local health service and a family violence survivor to ensure that it was acceptable and relevant. Open-ended questions yielded rich qualitative responses which complemented survey findings.

Despite these strengths, there are several study limitations. First, the sample was small and not representative of the broader community of Colac. Men were under-represented, along with Aboriginal and/or Torres Strait Islander community members and those from diverse cultural backgrounds. Discussion with the local Ethnic Communities Council about non-English speaking community members completing the survey revealed significant concerns about identification and breaches of confidentiality. The challenges and barriers in accessing support for culturally diverse[32] and Aboriginal and Torres Strait Islander families[33,34] is complex, and likely to be amplified in rural communities with limited resources and access to culturally safe and appropriate care and bicultural workforce. Future work is needed using participatory methods and co-design processes to better understand the family violence support needs and preferences of culturally diverse groups within rural communities.

Second, limited demographic information was collected given concerns about potential to identify individuals within the local community. Collection of employment information may have yielded important insights on experiences, knowledge and perceptions from different workplace sectors. Given the study was advertised in the local health service, it is possible that a substantial proportion of the participants may have been staff or volunteers at Colac Area Health. Research with healthcare workers in a tertiary hospital in metropolitan Victoria found that almost half had experienced family violence.[35] These findings highlight that family violence is common in the health workforce, and that staff working in health care settings in rural towns may experience privacy challenges and barriers to accessing family violence support more acutely than those in metropolitan areas.

Finally, our survey did not ask specifically about family composition such as age and number of children in the family, and preferences for family violence support for community members with children. Despite this, some respondents did share ideas for the health service to improve how welcoming they are for children. Future research is needed to better understand family violence support requirements for rural families and children in rural areas.

4.6 | Conclusions and implications for strengthening health service responses to family violence

Local health services engage with a large cross-section of their communities to provide care for a range of health concerns. They are in a unique position to implement local strategies to prevent and respond to family violence. Consideration of study findings by rural health service providers will be valuable to ensure community expectations are understood and taken into account for future health policy and planning.

Not only did this study identify specific barriers to help-seeking within the Colac region, but it also identified potential community solutions and strategies. It highlighted that a connected community approach is vital to providing effective and safe family violence support.

Further investment in health service capacity building initiatives is essential to ensure health staff have a basic understanding of family violence, are confident to recognise the signs of family violence, sensitively ask patients about their safety and have accessible referral information to specialist family violence services. Any initiatives must be trauma-informed and be mindful that staff in health care settings may also be experiencing family violence at home or experiencing challenges in accessing support. It is critical that health services consider how to provide safe pathways to care that protect privacy and maintain confidentiality for its workforce and community members.

Research in small rural towns can be challenging, but as this study shows, it is critical for informing the development of tailored local responses to address family violence in these communities.

AUTHOR CONTRIBUTIONS

PK: conceptualization; data curation; formal analysis; methodology; project administration; resources; writing – original draft; writing – review and editing. MF: conceptualization; formal analysis; investigation; methodology; project administration; validation; writing – original draft; writing – review and editing. RP: formal analysis; investigation; methodology; writing – original draft; writing – review and editing. RG: conceptualization; formal analysis;

investigation; methodology; writing – original draft; writing – review and editing.

ACKNOWLEDGEMENTS

- Colac Area Health for their on-going support and commitment to this study
- Western Alliance
- Murdoch Children's Research Institute
- Strengthening Hospital Responses to Family Violence Initiative (Barwon region)
- Peer reviewer: Dr. Ali Fogarty, PhD (Clinical Psychology), Research Officer, Intergenerational Health, Murdoch Children's Research Institute
- Dr. Laura Alston, Assoc. Prof. Anna Wong Shee and Prof. Kelsey Hegarty for their assistance with research question formulation and study design

CONFLICT OF INTEREST

The authors declare no conflict of interest related to this research.

ETHICAL APPROVAL

Ethics approval for the study was granted by the Barwon Health Human Research Ethics Committee (HREC/66803/VICBH-2021-247 528(v3)).

ORCID

Peter Kelly https://orcid.org/0000-0001-6054-9167
Michael Field https://orcid.org/0000-0003-3802-7842
Rebecca Giallo https://orcid.org/0000-0002-1065-2921

REFERENCES

1. State of Victoria, Royal Commission into family violence: summary and recommendations, Parl Paper No 132 (2014–16).
2. World Health Organization. WHO multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses. Geneva: World Health Organization; 2005.
3. World Health Organization collaborating Centre for Violence Prevention. *Violence prevention: the evidence*, Briefing No. 5, Page 81. Geneva: World Health Organization; 2013.
4. Phillips J, Vandenbroek P. Domestic, family and sexual violence in Australia: an overview of the issues. Parliamentary Library Research Paper Series No. 2014-15, Parliament of Australia; 2014.
5. Australian Institute of Health and Welfare. Family, domestic and sexual violence in Australia: continuing the national story 2019. Cat. no. FDV 3. Canberra: AIHW; 2019.
6. Campo M, Tayton S. Domestic and family violence in regional, rural and remote communities: an overview of key issues. Melbourne: Australian Institute of Family Studies; 2015.
7. Rennison CM, DeKeseredy WS, Dragiewicz M. Intimate relationship status variations in violence against women: urban, suburban, and rural differences. Violence Against Women. 2013;19(11):1312–30.
8. DuBois KO, Rennison CM, DeKeseredy WS. Intimate partner violence in small towns, dispersed rural areas, and other locations: estimates using a Reconception of settlement type. Rural Sociol. 2019;84(4):826–52.
9. Judicial College of Victoria. Family violence bench book 2014. Melbourne: Judicial College of Victoria; 2014. [cited 2022 Feb 10]. Available from: https://www.judicialcollege.vic.edu.au/eManuals/FVBBWeb/index.htm#34143.htm
10. Wendt S, Hornosty J. Understanding contexts of family violence in rural, farming communities: implications for rural women's health. Rural Soc. 2010;20(1):51–63.
11. Rennison CM, Dragiewicz M, DeKeseredy WS. Context matters: violence against women and reporting to police in rural, suburban and urban areas. Am J Crim Justice. 2013;38(1):141–59.
12. Australian Institute of Health and Welfare. Family, domestic and sexual violence in Australia. Cat. no. FDV 2. Canberra: AIHW; 2018.
13. Owen S, Carrington K. Domestic violence (DV) service provision and the architecture of rural life: an Australian case study. J Rural Stud. 2015;39:229–38.
14. George A, Harris B. Landscapes of violence: women surviving family violence in regional and rural Victoria. Australia: Deakin University; 2014.
15. Mitchell L. Domestic violence in Australia—an overview of the issues. Australia: Department of Parliamentary Services; 2011.
16. Wendt S, Chung D, Elder A, Bryant L. Seeking help for domestic violence: exploring rural women's coping experiences: state of knowledge paper (ANROWS Landscapes, 04/2015). Sydney: ANROWS; 2015.
17. Australian Government Department of Health. Health workforce locator 2019. [cited 2022 Feb 10]. Available from: https://www.health.gov.au/resources/apps-and-tools/health-workforce-locator/health-workforce-locator
18. Crime Statistics Agency. Victoria police data tables 2020. [cited 2022 Feb 10]. Available from: https://www.crimestatistics.vic.gov.au/family-violence-data-portal/download-data-tables2020
19. Parliament of Victoria. Family Violence Protection Act 2008. Melbourne: State Government of Victoria; 2008.
20. Hegarty K, Bush R, Sheehan M. The composite abuse scale: further development and assessment of reliability and validity of a multidimensional partner abuse measure in clinical settings. Violence Vict. 2005;20(5):529–47.
21. Gartland D, Hemphill SA, Hegarty K, Brown SJ. Intimate partner violence during pregnancy and the first year postpartum in an Australian pregnancy cohort study. Matern Child Health J. 2011;15(5):570–8.
22. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77–101.
23. Sylaska KM, Edwards KM. Disclosure of intimate partner violence to informal social support network members: a review of the literature. Trauma Violence Abuse. 2014;15(1):3–21.
24. Fanslow JL, Robinson EM. Help-seeking behaviors and reasons for help seeking reported by a representative sample of women victims of intimate partner violence in New Zealand. J Interpers Violence. 2010;25(5):929–51.
25. The family violence reform implementation monitor. Submission to monitoring the family violence reforms in Victoria. Melbourne: The Australian Association of Social Workers; 2020.
26. Liang B, Goodman L, Tummala-Narra P, Weintraub S. A theoretical framework for understanding help-seeking processes

among survivors of intimate partner violence. Am J Community Psychol. 2005;36(1–2):71–84.
27. New South Wales Law Reform Commission. Family violence – a national legal response. Sydney: New South Wales Government; 2010.
28. Heron RL, Eisma MC. Barriers and facilitators of disclosing domestic violence to the healthcare service: a systematic review of qualitative research. Health Soc Care Community. 2021;29(3):612–30.
29. DeKeseredy WS, Joseph C. Separation and/or divorce sexual assault in rural Ohio: preliminary results of an exploratory study. Violence Against Women. 2006;12(3):301–11.
30. Tarzia L, Bohren MA, Cameron J, Garcia-Moreno C, O'Doherty L, Fiolet R, et al. Women's experiences and expectations after disclosure of intimate partner abuse to a healthcare provider: a qualitative meta-synthesis. BMJ Open. 2020;10(11):e041339.
31. Morgan K, Williamson E, Hester M, Jones S, Feder G. Asking men about domestic violence and abuse in a family medicine context: help seeking and views on the general practitioner role. Aggress Violent Behav. 2014;19(6):637–42.
32. Immigrant Women's Domestic Violence Service. The right to be safe from domestic violence: immigrant and refugee women in rural Victoria. Melbourne: Immigrant Women's Domestic Violence Service; 2006.
33. Fiolet R, Cameron J, Tarzia L, Gallant D, Hameed M, Hooker L, et al. Indigenous People's experiences and expectations of health care professionals when accessing Care for Family Violence: a qualitative evidence synthesis. Trauma Violence Abuse. 2020;23:567–80.
34. Fiolet R, Tarzia L, Hameed M, Hegarty K. Indigenous Peoples' help-seeking behaviors for family violence: a scoping review. Trauma Violence Abuse. 2021;22(2):370–80.
35. McLindon E, Humphreys C, Hegarty K. "it happens to clinicians too": an Australian prevalence study of intimate partner and family violence against health professionals. BMC Womens Health. 2018;18(1):113.

How to cite this article: Kelly P, Field M, Payne R, Giallo R. Examining a rural Victorian community's knowledge and help seeking behaviour for family violence and the role of the local public health service. Aust J Rural Health. 2022;30:631–642. doi:10.1111/ajr.12887