CAN CO-LOCATION ADDRESS FRAGMENTED RURAL MENTAL HEALTH CARE DELIVERY?—REGIONAL EVIDENCE FROM VICTORIA, AUSTRALIA

Kate L. Clarke
Post-Graduate Student, College of Arts, Social Sciences and Commerce, La Trobe University, Bendigo, Victoria, 3550, Australia.
Email: kl3clarke@students.latrobe.edu.au.

Edgar Burns
Sociology Lecturer, College of Arts, Social Sciences and Commerce, La Trobe University, Bendigo, Victoria, 3550, Australia. Email: e.burns@latrobe.edu.au.

ABSTRACT: The online assessment of co-located mental health services across one Australian rural healthcare district aimed to provide baseline information to address the new federal *Partners in Recovery* program. The resulting website analysis of healthcare, wellbeing, and mental health providers in this rural healthcare district, identified 398 service offerings. City and town centres had a disproportionate share of medical services in general. That is, co-location largely occurred with the administration of hospital facilities and state-level organisations. Current trends creating large-scale administrative units and more contract outsourcing, may exacerbate existing rural mental health issues, given heightened situational factors, and need for change in policy approaches at several levels.

KEY WORDS: Co-location, mental health policy; mental health planning; *Partners in Recovery*; rural mental health

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1. INTRODUCTION

The Australian Federal Government launched the *Partners in Recovery* (PIR) program in 2014, with the aim of providing collaborative and coordinated support to people experiencing prolonged and severe mental illness, with needs requiring assistance from multiple agencies (PIR, 2014). Loddon-Mallee-Murray Medicare Local (LMMML) was one of 61

primary health care providers spread across Australia that were tasked with delivering the PIR program. University-based community planning researchers investigated a baseline measure of the present situation for the development of resources across the LMMML district. It is a largely rural region in the north-central/north-western part of the state of Victoria comprising almost 50 000 square kilometres and approximately 230 000 residents.

At its simplest, co-location can be defined as the placement of "multiple services in the same physical space" (Ginsburg, 2008, p.1). Both Miller *et al*. (2014b, p.443) and Whiteford *et al*. (2014, p.896), writing concurrently in American and Australian contexts, promulgate the central tenet that integration between primary care practitioners and behavioural care practitioners is the most effective method of providing treatment and care for patients. Co-location thus serves as a foundation for a continuum of strategies (Whiteford *et al*., 2014, p.897), under the premise that spatial proximity offers the "potential of collaboration" and practitioner support (Miller *et al*., 2014a, p.368) to facilitate systemic integration.

Whiteford *et al*. (2014, p.897) observed that, "implementation of a strategy does not necessarily ensure that integration has been achieved," noting that the degree of integration and efficacy within co-located or clustered practices is not easily determined. The Whiteford *et al*. (2014) study found that almost half of the forty study cases selected for appraisal used co-location as a linking mechanism with other measures, and the effects reported were positive, notably in "interagency communication, greater mutual understanding of, and empathy for, each other's services, and reduced bureaucracy and improved service efficiency" (p.901). Given LMMML's strategic task of orchestrating individualised services from multiple agencies across a geographically vast area, the potential for co-location to expedite service delivery through such co-location effects was considerable.

2. RURAL FACTORS IN MENTAL HEALTH

Economic issues in the variability of population, land use, and development across the largely rural LMMML region adds particular emphasis to the need for flexible and adaptable non-metropolitan mental health care administrative models. An extensive array of situational factors contributes to a heightened risk of psychological distress (Robinson *et al*., 2012, p.309), culminating in a higher rate of suicide in rural areas than experienced in urbanised areas, notwithstanding potential under-reporting

(Suicide Prevention Australia, 2010a, p.3). Many of these factors are well beyond a level of personal control or influence, adding futility or powerlessness to the inherent challenges of weather fluctuations, consequences of climatic change, decline of rural industries and subsequent devalued sense of purpose, and reduction of communal support through depopulation.

Societal constructions of gender roles (Suicide Prevention Australia, 2010a, p.4) include enduring rural concepts of masculinity, self-efficacy, and a dominating work ethic. These coalesce with the limited nature of available services, reducing the propensity to seek help or support, especially amongst men in the 55+ and under-17 age groups who are most at risk of suicide (Suicide Prevention Australia, 2010a, p.3). These circumstances perpetuate a self-defeating cycle, and further the deniability of mental health problems in rural community culture (Robinson *et al*., 2012, p.312; Stanley *et al*., 2012), even though mental health consequences reverberate outwards through the families and communities of sufferers to inflict pervasive social and economic burdens.

Other constructs of rurality assuming homogeneity may follow one of several traditional idyllic stereotypes, or alternatively reflect 'narratives of decline' (Markey *et al*., 2008). Such views find expression in political and media sources, arising through economic restructuring and deinstitutionalisation occurring since the 1980s. Further, prevailing trends in outward migration to more urbanised coastal areas (Fraser *et al*., 2002, p.289) appear to intensify conventional urban focus in allocating health resources, rather than rural provisioning.

These representations reinforce other allocation determinants such as population density—an indicator at odds with the growing recognition of diversity and consequently something which has become controversial from a land use planning perspective (Mees, 2010). Likewise, urbanised planning factors such as the ubiquity of infrastructure solutions, or deficient public transport, further impact sectors of the population already restricted from access and at high risk of mental health pressures. Through age, infirmity, low socio-economic status, and/or recent immigration; the isolation of distance and absence of proximate work and socialisation opportunities become additional stressors, worsening resilience to mental health problems (Wainer and Chesters, 2000, pp.141, 144).

Robinson *et al*. (2012) analysed barriers to obtaining mental health treatments, their work reinforcing deficient access as a vital factor, and citing "inadequate health insurance coverage… financial constraints, lack of transportation, and difficulty in finding childcare" (p.308) as considerations inhibiting use of mental health services even where they

were co-located. This hints at a more complex view of interrelating causal elements and associations between health and other community activities (Sandercock, 2000; Sartore *et al*., 2008; Heywood, 2011, p.209; Reavley and Jorm, 2012). It states the obvious to affirm these cross-sector issues need cross-sector solutions, more than simple reliance on positivity in inter-professional healthcare relationships.

However, much of the literature on rural conditions is predicated on assessing efficacy from the perspective of health providers, given the relative ease of information collection (Ginsburg, 2008, p.4), and revealing that patterns of resistance towards co-operation are more widespread than examples of cultivated, sustainable integration (Williams *et al*., 2006). The present study was unable to measure integration levels or patient outcomes like other larger scale research programs that have noted inefficiencies and inconsistency in testing, and the absence of specific modelling for complex conduits that act as obstacles to determining associations between integration and patient care (Durbin *et al*., 2006, p.706). However, the practice of co-location of services, as a structural underpinning to systemic integration is considered indicative of the approach taken to address the exigency of a coordinated, multi-vector approach in planning rural mental health solutions.

3. METHOD

In the present project the LMMML request for assistance included selection criteria for relevant data. With only minor adjustment the LMMML list was applied to the therapeutic and support provision for individuals with mental health needs. The main categories were:

- Primary care practitioners—those specialising in general practice, family medicine, and general internal medicine.
- Behavioural care practitioners—including psychiatrists, psychologists, social workers, and counsellors
- Community health and mental health support
- Education and Disability services
- Employment and housing assistance

Systematic webpage content analysis (Kim and Kuljis, 2010) allowed shallow but widespread information collection on mental health service availability in the LMMML health region. Internet and website searches

were run against both geographic location and categories of service providers. Data was collected from all eleven local government municipalities (LGAs) within the LMMML jurisdiction, though data was more readily available from larger towns (Table 1).

Table 1. Urban Centre/Locality (UCL), Populations and Local Government Areas (LGA).

Local Government Area (LGA)	Town (UCL)	Population	LGA Area (ha)
Buloke Shire	Birchip	662	800 040
	Charlton	968	
	Donald	1 355	
	Wycheproof	628	
Campaspe Shire	Echuca	12 613	451 886
	Kyabram	5 642	
	Rochester	2 652	
	Rushworth	981	
	Tongala	1 245	
Greater City of Bendigo	Bendigo	82 794	299 998
	Heathcote	1 688	
Conargo Shire	Conargo	1 540	873 794
Deniliquin	Deniliquin	6 441	14 319
Gannawarrra Shire	Cohuna	11 818	373 534
	Kerang	3 567	
Loddon Shire	Boort	760	669 644
	Inglewood	711	
Mt Alexander Shire	Castlemaine	9 124	152 962
	Maldon	1 236	
Murray Shire	Mathoura	650	434 445
Rural City of Swan Hill	Swan Hill	9 894	611 531
	Nyah West	491	
Wakool Shire	Barham	1 151	752 047
	Moulamein	330	
N=11	N=24	158 941	5 434,200

Source: Australia Bureau of Statistics (2016).

Iterative searches and cross-checking of internet and paper-based sources was followed in recognition of the variety and variability of websites' contents. Because it was a full enumeration of the LMMML mental health offerings, sampling procedures were not required. Within the limits of finding source information and evaluating this data, the investigation

aimed at a complete population count of mental health services offered in the LMML health area. Physical visits to towns were not undertaken. Where multiple practitioners of a single service were associated within a clinic or medical group, they were listed as a single entity unless co-located with different services.

Limitations

In addition to time and resource constraints, the accuracy of counts and nature of service provided depended on sources of variable reliability. Supplementary efforts checked the veracity of website information; however, corroboration was not always available for the following reasons: published address could be the billing or the registered address rather than actual practice location; if street addresses were not provided, practitioners were not included; clarity in describing services offered, varied widely by terminology used or absence of information. The extent of services provided varied between full-time and part-time; lead-time for appointments was not determined. Data sources were restricted to information in the public domain on the internet and from published brochures; ethics approval was not sought because of the public domain provenance of information collected.

4. RESULTS

The study identified 398 facilities or services in the Loddon-Mallee-Murray catchment that met the above criteria. Of the 83 that offered mental health services, 53.0 per cent were concentrated within fifteen kilometres of the central business district of Bendigo, 15.7 per cent in Swan Hill, 10.8 per cent in Echuca, and 8.4 per cent in Castlemaine, placing 87.9 per cent of services in the four most populous centres of the catchment. Twenty instances of co-location between mental health and other services were found, constituting 15.3 per cent of the total facilities identified, with 60.0 per cent (12) occurring in these same rural cities. Co-location largely centred on hospital facilities (50.0 per cent), predominantly under the auspices of multi-locational, public organisations such as East Wimmera Health Services, which operates in the townships of Birchip, Charlton, Donald and Wycheproof. An additional 30.0 per cent (6) of co-locations were allied mental health support with housing and employment services under the management of not-for-profit organisations with geographically widespread responsibility, while 20.0 per cent (4) of co-locations were

with primary care practitioners in private clinics, all situated in Bendigo. A strong tendency was evident for service providers in the LMMML catchment to establish themselves with members of the same stream of medicine rather than combining to achieve diversity in their service offering. Data was mapped onto the LMMML region, Figure 1.

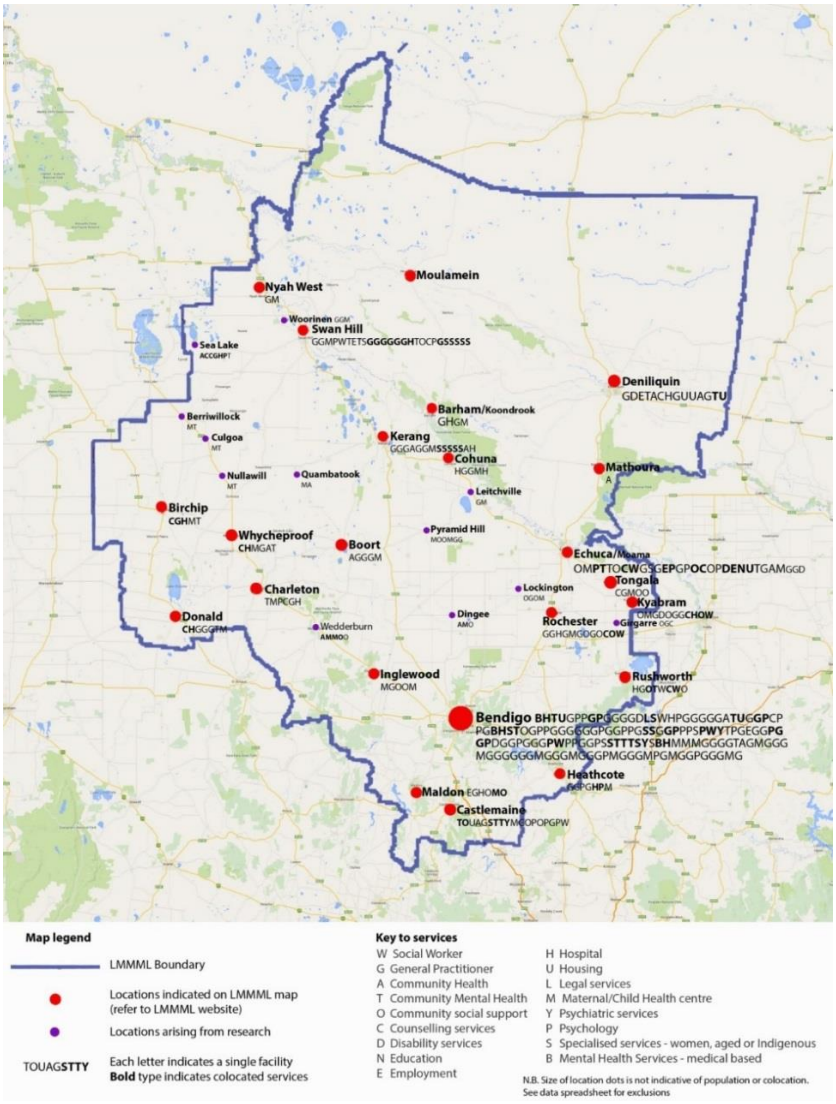

Figure 1. Major Towns and Available Mental Health Services in LMMML. Source: Image from http://www.lmmml.org.au/about/geographic_information.

5. DISCUSSION

The degree to which co-location is absent throughout the largely ruralised LMMML region is of concern, reinforcing Ginsburg's (2008, p.2) contention that co-location, "is one of the least explored of several approaches to care coordination." The frequency of hospital-based co-location identifies more closely to Miller *et al*.'s (2014a, p.369) broader definition of co-location (distances up to one kilometre) than the stricter ten-metre measurement indicating shared premises. This offers the provider benefits of relatively close physical access between services, while retaining the independence of each entity and its delineated purpose, allowing expansion, and reducing friction potential between co-located professionals (Miller *et al*., 2014a, p.367).

Clustering Services

This more expansive gauge is often referred to as clustering in planning contexts, expressed as the "twenty-minute neighbourhood" concept in the Victorian state government's *Plan Melbourne* (Department of Transport, *Planning and Local Infrastructure*, 2014, p.11), whereby people can access services within a twenty-minute walk of their residence. The concept also has a proven basis in economic development, as described in the *Economic Development Strategy* for Portland, Oregon (Portland Development Commission, 2010):

> "*A cluster strategy is the logical organizing principle for growing… sector industries because disparate efforts at retention, expansion, innovation… and workforce development can be concentrated in a manner that makes more efficient use of resources and captures synergies in otherwise unrelated activities… In addition, in-depth knowledge of particular sectors fuels catalytic initiatives that move business development efforts beyond traditional assistance. A cluster strategy is especially critical for a market like Portland, where limited resources require selective investments in the groups of firms that demonstrate the most promise of growth.*"

While Portland's population count and density far exceeds the rural LMMML district, its relevance lies in its position relative to its market, and

its example in requiring shrewd allocation of resources to enable maximal benefits. In planning for mental health services, creating clustered facilities would also ease spatial limitations accommodating diverse elements within a single structure. This would permit flexibility for future changing needs (Ginsburg, 2008, p.6) if used in conjunction with some of Whiteford *et al*.'s (2014) other facilitating elements, discussed below (Friedman, 2011). Assessment of the present data collected on the wider locational criterion, noted above, expanded co-location occurrence to include smaller rural centres such as Kyabram, Rochester, Pyramid Hill, Tongala and Wedderburn.

Clustering within the one kilometre radius assessed by Miller *et al.* (2014a, p.369) raises important possibilities. It could conceivably furnish the possibility of networking, skill development, and increased support amongst providers (slated as a significant advantage of co-location), while distancing the potential for conflict between practitioners over areas of responsibility and appropriate treatments for shared patients (recognised as a corresponding influential detractor) (Ginsburg, 2008, p.5). This assessment of the implications of co-location, however, concluded that "the degree to which a co-located practice succeeds in meeting its patients' needs is determined largely by the way the co-location strategy is designed and implemented" (p.8). Allocating primacy to patients' needs rather than economic efficiency and provider advancement brings other considerations to the fore.

Integrating Levels of Activity

Although providing the potential benefits of clustered services, the predominance of allied services under the auspices of hospital-focused providers is also of concern in the LMMML context, as they concentrate resources in selected locations rather than enabling broad access for a geographically and socially disparate population. Ginsberg (2008) recommended systematic exploration of methodologies, and tailored service application according to circumstances—something not readily apparent in the organisation of large-scale facilities, administered remotely and through established hierarchical structures.

Hospital organisational structures could, however, help incorporate elements of integration identified by Whiteford *et al*. (2014, p.902) as being essential to coherent system functioning in any setting: a shared vision or perspective, communication, strong leadership, especially by a coordinating body or in accordance with a strategic plan, and ongoing monitoring. Mees' (2010, p.72) three levels of activity in relation to

transport planning are equally applicable to structuring of mental health provision:

- Strategic level—over-arching vision and objectives are determined, paralleling federal regulatory perspectives, or the executive management level of a large organisation.
- Tactical level—goals interpreted as comprehensive policies at regional or departmental level, integrating multiple health care initiatives to maximise resources and reduce overlapping.
- Operational level—tactical policy is transformed into the specifics of daily procedure in each separate locale, implemented by practitioners and their communities.

These classifications delineate specific obligations and responsibilities, providing a framework for assessment of the integration indicators above. Although beyond the scope of the current project, the application of such a framework in further research could enable understanding and analysis of the degree of integration within hospital-based mental healthcare systems, such as organisational characteristics, responsibility for patients, co-ordination mechanisms, and data systems and policies (Ginsburg, 2008, pp.2–3).

A Worst-Case Study

Towards facilitating integration, Whiteford *et al.*'s (2014, p.902) most important finding was the recommendation of "a focus on fostering positive organisational climates rather than exclusively directing effort towards top-down service configurations." This suggests templates for future integration through collaboration and consultation between the three planning levels, acknowledging the operational level is ultimately the measure of program success. This principle was exemplified by circumstances in 2009 that saw the imminent loss of the Sea Lake Hospital, on the western edge of the LMMML rural health district. A community-owned, not-for-profit entity, it came within two months of closure after three years of debate between federal and state jurisdictions. Community action led to intervention by the state government with funding, and, more importantly, assistance in restructuring for economic viability within this region. This secured continuing operation, and preservation of its manifold functions in the life and culture of the town (Miller, 2009a; Miller, 2009b).

Jurisdictional conflicts between state-level and federal-level portfolios,

and between public and private entities, constitute two distinct and substantial barriers to effectively integrated service delivery. These compound the inadequacy of resources such as "funding, time, workforce, and technology" (Whiteford *et al*., 2014, p.903). Conflicts between providers illustrating pervasive 'silo' or 'turf' mentalities that inhibit cooperative interaction between stakeholders (Horvitz-Lennon *et al*., 2006; Whiteford *et al*., 2014, pp. 896, 903) are all too readily apparent in healthcare contexts.

Although each tier has a role to play in delivery of services, Ife and Tesoreiro (2006, p.122)—again applying planning rather than medical perspectives—posit that, "it is the members of the community who have the experience of that community, of its needs and problems, its strengths and positives, its unique characteristics." A centralised management, focusing on the strategic and tactical levels, as necessitated by the broad geographical areas found in the LMMML and similar regions, has a strong potential for the proliferation of conflicting and uncoordinated stakeholder positions, undermining local initiatives and resulting in alternative funding 'deliverability' only possible at aggregate scales. Combined with imaginaries of rural homogeneity, such aggregation compounds urban priority, further disregarding rural regions and fostering deterioration of socio-economic capacity in non-urban areas amassed into over-generalised classifications of need (Fraser, 2002, p.291).

Stigma and Mental Health

Beyond the analogy between different complex systems, such aggregation of need is also detrimental to mental health support, given multiple modes of presentation by patients. In the context of the *PIR* program, it is improbable that comprehensive provision and coordination of a diffuse range of housing, employment and other social supports to supplement treatments is possible in hospital contexts, where medical intervention is the primary function. Further, a basic consideration is the nature of mental illness itself, which "can profoundly disrupt a person's thinking, feeling, ability to relate to others, and capacity for coping with the demands of life" (Kilbourne *et al*., 2008, p.337). Navigating complex administrative systems and monolithic physical structures could reasonably be expected to create additional stressors (Durbin *et al*., 2006, p.705), reinforcing patient inhibitions against seeking help. Abbu *et al.* (2007, p.73) study found only 6.0 per cent of respondents would approach a hospital or specific clinic for help, in marked contrast to the 73.0 per cent who would contact their general practitioner, or 43.0 per cent who would

seek counselling from a psychologist or psychiatrist directly.

This reluctance may reflect a more specific institutional interaction problem: potential patients' fear of discrimination and stigmatisation (Hocking, 2013, p.6), which may exacerbate and extend the severity of underlying mental health issues by eroding social support and requiring access in a manner relatively unknown to sufferers of mental health conditions. Abbu *et al*. (2007) found that patients felt repeated admissions to hospital for treatment generated staff perception of them as nuisances, reinforcing prior assumptions and myths that consign mental illness to the category of character weakness. This was accompanied by the notion that mental health problems should be able to be overcome by force of will, and therefore was deserving of contempt or derision rather than empathy and understanding elicited by the 'involuntary' occurrence seen for other diseases (Suicide Prevention Australia, 2010b, p.5; Bos *et al.*, 2013, p.5). The level of stigmatisation of people with mental illness by health professionals was found to be comparable to that of the general community (Stanley *et al.*, 2012; Hocking, 2013, p.7). This suggests that unregulated patient exposure to hospital personnel, or other patients, could lead to unfounded assumptions and the intensification of prejudice (Corrigan and O'Shaunessy, 2007, pp.92,94).

The linking of treatment options with risk factors for potential aggravation of symptoms demonstrates pervasive *structural stigma*, which *Partners in Recovery* (2016, p.3) defines as, "the policies of private and governmental institutions that restrict the opportunities of people with mental illness." This extends the more recognisable *public stigma* attributed to individuals: the "social and psychological reaction reactions to someone they perceive to have a stigmatised condition" (Bos *et al.*, 2013, p.2). The stigmatisation of mental health is the subject of an extensive body of literature beyond this discussion (Smith, 2002; Reavley and Jorm, 2012) but its multiple manifestations constitute a significant part of the barrier to accessing rurally located mental health care services (p.6). This shows once again the importance of policy and design in the implementation of integrated systems emphasising positive patient outcomes: 'normalising' mental health rather than endorsing embedded stereotypes and associated biases that are detrimental to the "quality of life and opportunities" available to sufferers of mental health issues (Corrigan and O'Shaunessy, 2007, p.91).

Emergent 'Desired Paths' Rather than Top-Down Systems

Another planning model is relevant here: accessing mental health services has parallels to 'desired paths,' formed by persistent and repeated use of preferred unpaved routes rather than officially designated literal pathways (Healey, 1996; Kohlstedt, 2016). Essentially, if formally sanctioned treatment delivery modes do not work for people, they will not use them, so a focus on proven means of attaining positive patient outcomes would increase the benefit obtainable from the more than $8 billion (Hocking, 2013; AIHW, 2016) allocated to Australian mental health care funding, particularly as this is decreasing relative to overall national health expenditure. For instance, Sartore *et al*. (2008), found *Mental Health First Aid* training forms an effective strategy to improve care and prevention support in rural and regional locales, especially when based in neighbourhood networks such as those facilitated by co-located premises, with the added benefit of diffusing the dependence and pressure on limited numbers of professionals (Suicide Prevention Australia, 2010a, p.7). Targeting specific, verified measures suggests higher efficacy than government benchmarking aims for increasing access to services "from 6-8 per cent to 12 per cent of the Australian population" (Australian Government National Mental Health Commission, 2014, p.3). The core social reality of rural and other disadvantaged groups is that accessibility is not the same as actually accessing and utilising mental health services. It is a false policy assumption to presume that they are the same.

A variety of other structured programs have clear internet presence. Examples include the American National Alliance for Mental Illness initiative (www.nami.org), *In Our Own Voice* (www.blackrj.org), Australian programs like *beyondblue*'s *Rural Frontline Training Program* (beyondblue.org.au), Family Care's *Coach the Coach* initiative (www.caaretocontinue.co.services/family-care-coaching/), and *Working with Warriors* from Wheatbelt Men's Health (Suicide Prevention Australia, 2010a, p.9). All these and others deliver diverse, individualised messages that enable both presentation of information and discussion of questions arising, enabling the three approaches—protest, education and contact—that together have been found to be efficacious in mitigating stigma as a barrier to care (Corrigan and O'Shaughnessy, 2007, p.90).

With advantages of portability and relative ease of dissemination, education may enhance and diversify the possibilities for cooperation and integration inherent in co-location, creating awareness throughout the community to combat "invisibility" (Robinson *et al*., 2012, p.312). Such 'disappearing' allows problems to be ignored, inhibits the seeking of

treatment and bolsters "the tendency to focus on responding to illness rather than working to improve mental health" (Wainer and Chesters, 2000, p.142). Corrigan and O'Shaunessy (2007, p.92) argue that contact engendering "familiarity", the chief influence for lasting behavioural change, can include prominent individuals, but derives a "greater anti-stigma effect" from "neighbours, co-workers, family members, and other people one regularly associates with and can relate to".

It's the Social, Not Simply the System

From this research it becomes apparent that the community is a fundamental component in empowering mental health treatment and supporting a protective and healing environment. Heywood (2011, p.262) postulated that communities function, "at many scales from local to global [and] are based not only on physical spaces but also on shared interests, prospects and values." This should enable recognition of additional resources that can be integrated into a comprehensive approach to rural mental health, and the implicit value of "community networks, civic engagement, reciprocity and trust" (Suicide Prevention Australia, 2011, p.6), whether virtual or actual, in supporting positive outcomes. Yet the extent to which clustering occurs around these rural hospitals reflects global trends over recent decades that have reconstructed spatial scales towards larger scale regional economic and political imperatives (Aminy, 2002, p.386), relegating human scale to obscurity, and engendering concomitant proliferation of interprofessional and system tensions and conflicts (Gehl, 2010, p.3).

The template is, as Dollery *et al*. (2016) contend for local government, continued development of the vision of a common service model in all areas. Urban planning increasingly embraces cities that prioritise people, recognising health, safety, sustainability and activity as objectives (Gehl, 2010, pp.6–7), similarly mental health issues need to be reframed as an explicable, "part of our shared humanity" (Hocking, 2013, p.24). This involves professional and administrative integration to implement overarching strategy and policy through multi-faceted local means. It would deploy diverse tools inside and outside the formal and practitioner-oriented medical system, to provide accessibility to care using tailored solutions for rural and regional populations within their communities of place.

Co-location and Technology

Technological supports such as online teleconferencing may address impediments of mobility, but are reliant on the availability and working state of appropriate infrastructure and the affordability or availability of internet access. Each of these factors is currently likely to be deficient in many non-metropolitan locales, even before mentioning the degree of comfort or familiarity of users with such options (Suicide Prevention Australia, 2010a, p.9). Notwithstanding these difficulties, improving technology can supply useful tools delivering access for broader cohorts as new solution options through integrated systems (Heywood, 2011, p.259). This can be both within existing arrangements, and as an adjunct to face-to-face modes, whether or not they are co-located (Penn *et al.*, 2005, p.278).

Technology can be read as part of, or one aspect of, the methods and capacity of information access inherent in the convenience of the internet era that are integral factors in accessing services. This enables awareness of available services and the corollary of expeditious measures, such as employment-seeking assistance, a key protective factor in rural mental health risk (Suicide Prevention Australia, 2010a, p.4). A number of government programs subsidise valuable treatment programs to mitigate financial and related burdens of getting help (Australian Government Department of Health, 2014).

6. CONCLUSION

This single health-provider case study triggered a sequence of reflections about the relevance of co-location in addressing government mental health strategies. These wider observations affirm both Ginsburg's and Whitehead *et al.*'s observations that co-location can be an important component of improving mental healthcare delivery. The present results when inspected closely tell a story of larger-scale/urban-centric concentration of services, rather than a uniform or general pattern of rural co-location, which impinges on the availability of services and efficacy of such services in enabling positive patient outcomes. More work is needed unpicking the degree of integration within hospital systems, and exploring professional resistances, (dis)incentives and discomfort working together, and how this could significantly address rural and remote health.

Meanwhile the hospital clustering pattern observed seems inimical to the bottom-up possibilities since it does not address stigma, proximity, the

importance of regional planning, or local initiative in the fundamental community dimensions of mental care and wellbeing. The present worry is that current policy trends imposing ever-larger rural health regions in the name of efficiency is at cross-purposes with the expected outcomes these policies are meant to achieve. Related practices of outsourcing and system funder contracting also apply contradictory commercial logics to rural mental health needs, largely nullifying smaller local innovations energised by local 'ownership' and 'stewardship' in creative responses attempting to address these needs.

In practical, policy and local terms, we need to be clear we are not asserting an inherent or necessary consequence of larger scale in the despoliation of local participation and energies. But it often is associated with such negative effects. Perhaps it is current settings operating with a *one-dimensional* focus on organisational forms and structures or needed efficiency gains, or some combination of these, that is at the heart of the problem. This is a wider matter than just health: co-locating and supporting local energies, sense of ownership, participation, or partnership, does not in our view have to be the opposite/oppositional to emergent local-up components, but it does require a shift in thinking.

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