

Equally Well – Promotion Prevention and Early Intervention

Presenter Russell Roberts

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The Paradox - Dying for a Life Worth Living...

*“Many people are spending years living with undetected but **treatable** physical health problems and people are losing their lives because things have been picked up too late”*



Physical health of people living with SMI

<https://equallywell.org.au/>



Six times more likely to die from cardiovascular disease.



Five times more likely to smoke.



Four times more likely to die from respiratory disease,



Likely to die between 14 and 23 years earlier than the general population.

The highest elevated risk of early death is from

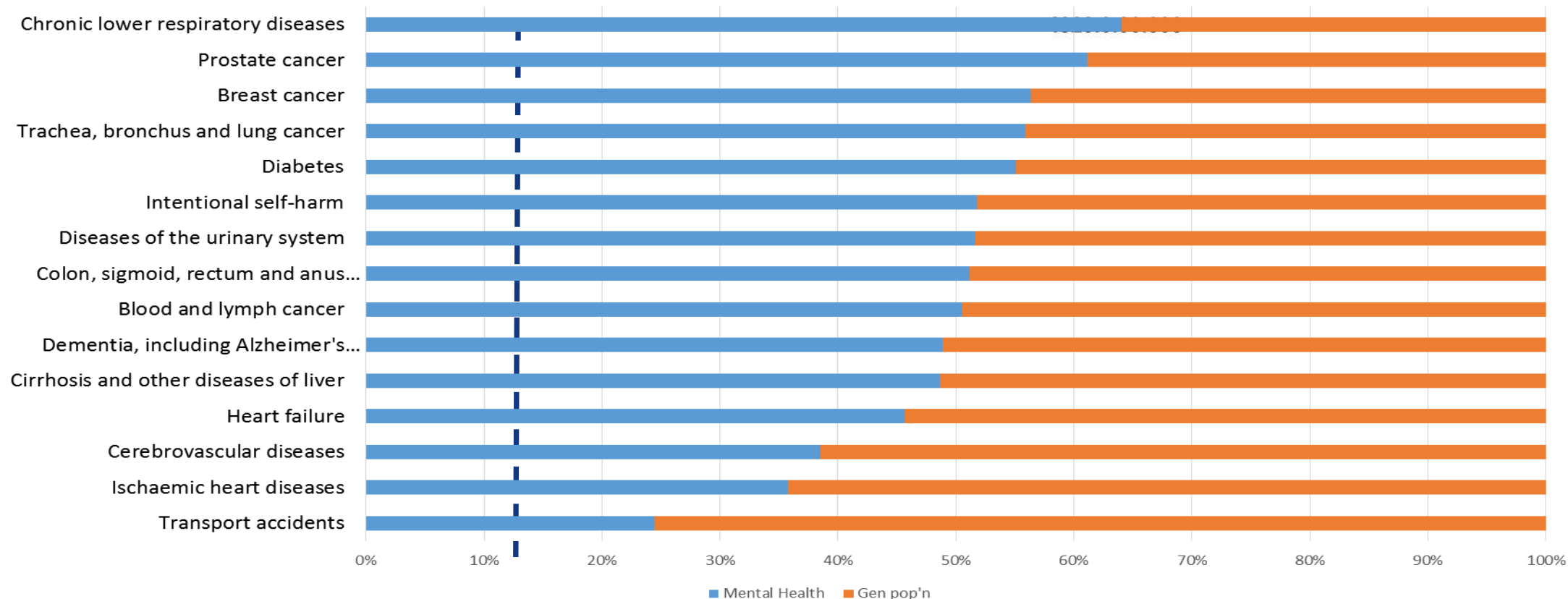
Respiratory disease Prostate cancer and Breast cancer



Mortality of People Using Mental Health Services and Prescription Medications

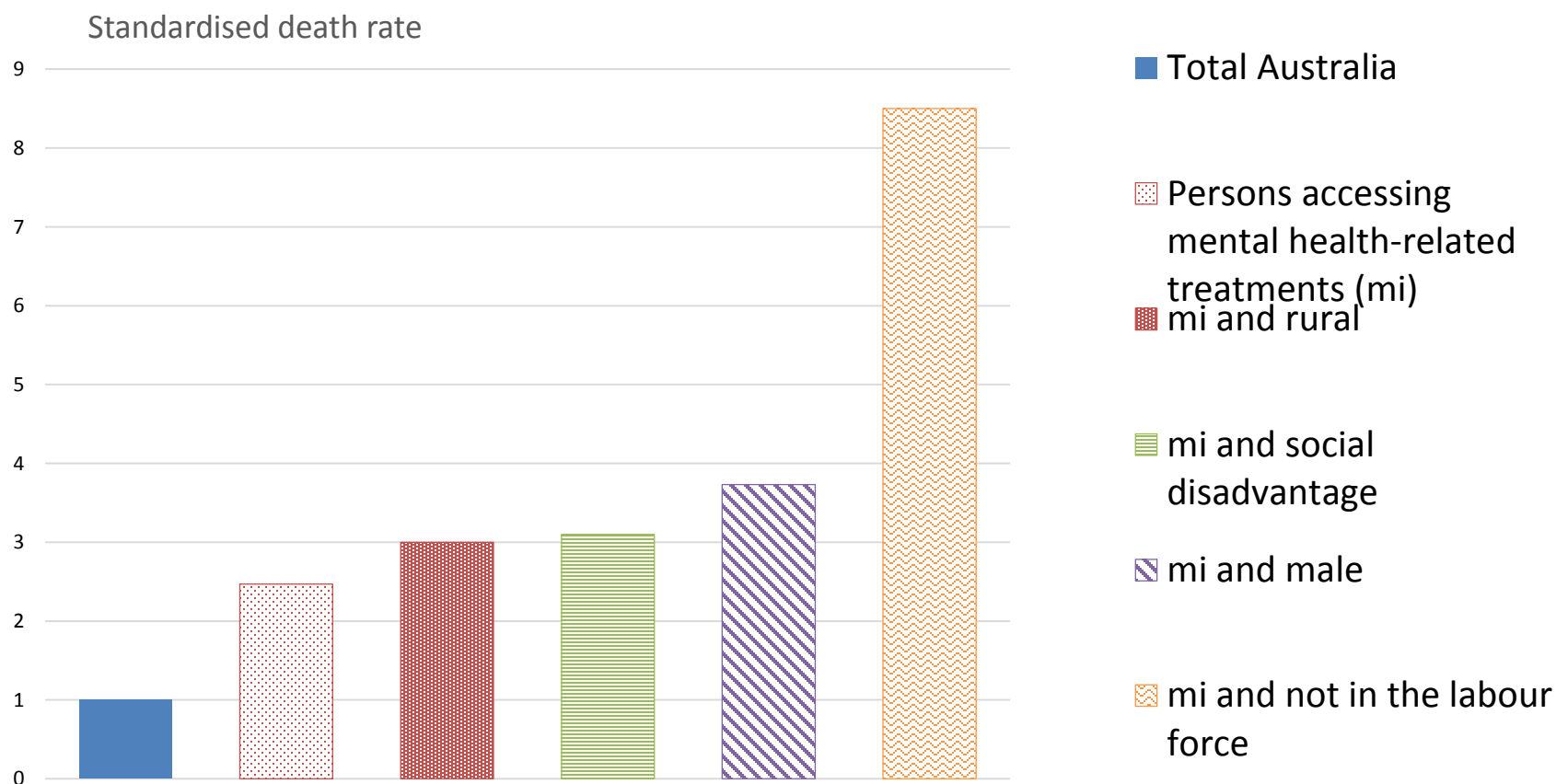
Analysis of 2011 data

Percentage of total population who
accessed
mental health mbs and/or pbs



Relative risk of early death

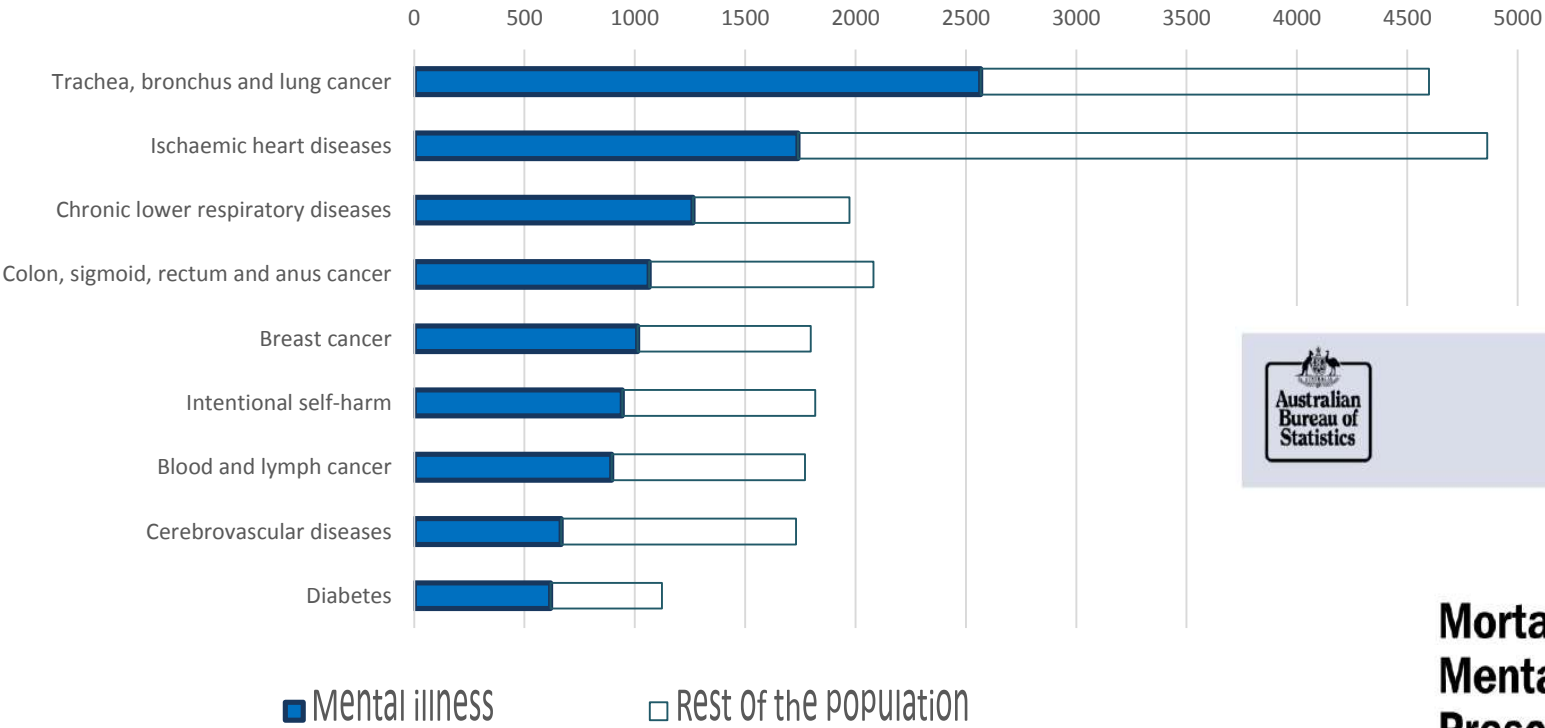
ABS, September, 2017



For every person with mental illness who dies of suicide, 10 die early of heart disease, respiratory disease and cancer!

Every hour, of every day one person with a mental illness dies EARLY due to cancer, heart disease or respiratory disease

Annual number of premature deaths of persons with mental illness in Australia by cause



Mortality of People Using Mental Health Services and Prescription Medications

But its clear that poor physical health is the largest contributor to poor mental health (Lorem et al, 2017)

“...mental health symptoms caused by physical illness is an increasing public health problem”

- 40,000 participants over 65.
- Waves of research at 7 year intervals from 1974 to 2008.
- Age has a protective effect on mental health (17%)
- **Physical illness has major impact: 42% of total effect**

Downloaded from <http://bmjopen.bmj.com/> on November 16, 2017 - Published by group.bmj.com

Open Access Research

BMJ Open Ageing and mental health: changes in self-reported health due to physical illness and mental health status with consecutive cross-sectional analyses

Geir Fagerjord Lorem,¹ Henrik Schirmer,^{2,3} Catharina E A Wang,^{4,5} Nina Emaus¹

ABSTRACT
Objectives: It is known that self-reported health (SRH) declines with increasing age and that comorbidity increases with age. We wished to examine how age transfers its effect to SRH through comorbid disease and mental illness and whether these processes remained stable from 1994 until 2008. The hypothesis is that ageing and/or the increased age-related burden of pathology explains the declining SRH.
Setting: The Tromsø Study (TS) is a cohort study using a survey approach with repeated physical examinations. It was conducted in the municipality of Tromsø, Norway, from 1974 to 2008.
Participants: A total of 21 199 women and 19 229 men participated.
Primary and secondary outcome measures: SRH is the outcome of interest. We calculated and compared the effect sizes of age, comorbidity and mental health symptoms using multilevel analysis based on OLS regression.
Results: Ageing had a negative impact on SRH, but the total effect of age decreased from 1994 to 2007. We assessed the direct effect of age and then the proportion of indirect age-related effects through physical illness and mental health symptoms on the total effect. The direct effect of age represented 79.3% of the total effect in 1994 and decreased to 58.8% in 2007. Physical illness emerged as an increasingly important factor and increased its influence from 15.7% to 41.2% of the total effect. Age alone had a protective effect on mental health symptoms and this increased (2.5% to 17.3%), but we found a stronger association between mental health symptoms and physical disease in the later waves of the study (increasing from 3.7% to 14.8%).
Conclusions: The results suggest that the effect on SRH of mental health symptoms caused by physical illness is an increasing public health problem. Treatment and care for specific medical conditions must therefore focus more strongly on how these conditions affect the patient's mental health and address these concerns accordingly.

Strengths and limitations of this study
• The sample comprises large, representative samples of a general population with repeated measures at ~7-year intervals.
• Multilevel analysis allows for the interpretation of the joint effect of age, comorbid disease and mental health on self-reported health.
• We used the repeated measures as separate cross-sectional data in the analysis.
• The first three panels (1974–1986) did not include any adequate measurement of mental health symptoms and were excluded, but the CONOR-MHI (1994) was validated against the Hopkins Symptom Checklist and showed good agreement.

the patient or participant. It is well known that a whole range of biological, psychological and socioeconomic factors affect SRH, and also that these factors interact.^{1–5} The research literature suggests that SRH is produced in a cognitive process that is inherently subjective and contextual, and also that SRH predicts mortality and other health outcomes; this shows that the basis of self-rated health lies in the biological and physiological state of the individual organism.⁶ Well-known crucial biological factors that independently affect SRH are specific medical conditions (eg, cardiovascular diseases, diabetes and asthma) and health risk factors (eg, resting heart rate, blood pressure, cholesterol, BMI and endocrine measures). Although the effect of SRH attenuates when such variables are controlled for, SRH still remains as an independent variable for all-cause death and other future health outcomes.^{7–11} Mental health symptoms affect SRH, but mental health is also affected by physical disease. The literature suggests that severity of mental health symptoms correlates with many specific medical conditions, and consequently with impaired well-being. Comorbid strain increases with increasing age, and older

INTRODUCTION
Self-reported health (SRH) is a subjective assessment of current health status as seen by

Te dte: Lorem GF, Schirmer H, Wang CE, et al. Ageing and mental health: changes in self-reported health due to physical illness and mental health status with consecutive cross-sectional analyses. *BMJ Open* 2017;7:e013629. doi:10.1136/bmjopen-2016-013629

► Prepublication history and editorial material is available. To view please visit the journal (<http://dx.doi.org/10.1136/bmjopen-2016-013629>).

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BMJ

Lorem GF, et al. *BMJ Open* 2017;7:e013629. doi:10.1136/bmjopen-2016-013629

Physical health has the strongest associations with psychological distress

- 1,633 Aboriginal and 233,405 Non-Aboriginal in NSW
- High distress in 44% of Aboriginal people with severe physical limitations
- And in 21% of Non-Aboriginal

Factors relating to high psychological distress in Indigenous Australians and their contribution to Indigenous–non-Indigenous disparities

Bridgette J. McNamara,¹ Emily Banks,^{2,3} Lina Gubhaju,¹ Grace Joshy,² Anna Williamson,² Beverley Raphael,⁴ Sandra Eades¹

Despite tremendous resilience shown in the face of extreme adversity, First Peoples of high-income countries such as Australia, Canada, New Zealand and the US continue to have poorer mental health and wellbeing than their non-Indigenous counterparts.^{1,3} Self-harm and suicide rates among Aboriginal Australians, First Nations Canadians, Native Americans/Alaskan Natives and Maori are between 1.4 and 7 times the respective national rates.^{4,6} Similarly, psychological distress rates are consistently higher among Indigenous peoples in these countries.^{7,9}

Addressing disparities in mental wellbeing of marginalised groups, including Indigenous Peoples, is a stated World Health Organization priority.¹⁰ Despite this, the factors underlying them have not been quantified. It has been suggested that discrimination, poverty, marginalisation and other effects of colonisation are responsible.² However, it is not known whether there are factors specific to First Peoples that are driving higher distress levels, or whether distress levels can be explained by variation in known risk factors.

Objectives

In this study, we investigate factors relating to high psychological distress among Aboriginal and Torres Strait Islander and non-Aboriginal older Australians, and present

Abstract

Objective: To explore factors associated with high psychological distress among Aboriginal and non-Aboriginal Australians and their contribution to the elevated distress prevalence among Aboriginal people.

Methods: Questionnaire data from 1,631 Aboriginal and 233,405 non-Aboriginal 45 and Up Study (NSW, Australia) participants aged ≥45 years were used to calculate adjusted prevalence ratios for high psychological distress (Kessler-10 score ≥22) for socio-demographic, health and disability-related factors, and to quantify contributions to differences in distress prevalence.

Results: While high-distress prevalence was increased around three-fold in Aboriginal versus non-Aboriginal participants, distress-related risk factors were similar. Morbidity and physical disability had the strongest associations; high distress affected 43.8% of Aboriginal and 20.9% of non-Aboriginal participants with severe physical limitations and 9.5% and 3.9% of those without limitations, respectively. Differences in distress prevalence between Aboriginal and non-Aboriginal participants were essentially attributable to differences in SES, morbidity, disability/functional limitations and social support (fully-adjusted PR 1.19 [95% 1.08, 1.30]); physical morbidity and disability explained the bulk.

Conclusions: The markedly elevated prevalence of high distress among older Aboriginal Australians appears largely attributable to greater physical morbidity and disability.

Implications for public health: Addressing upstream determinants of physical morbidity and improved integration of social and emotional wellbeing care into primary care and chronic disease management are essential.

Key words: psychological distress, social and emotional wellbeing, disability, mental health, Aboriginal and Torres Strait Islander Australians

the findings as an example relevant to other First Peoples in similar circumstances. Our aims were: 1) to examine the relationship of psychological distress to socio-demographic factors, health risk factors, illness, physical disability and functional capacity among Aboriginal and Torres Strait Islander and non-

Aboriginal older Australians; and 2) to identify contributors to the difference in the observed prevalence of psychological distress between the two groups. This study is unique in having large-scale data on both Aboriginal and non-Aboriginal participants within the same population-based cohort study.

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The authors have stated they have no conflict of interest.

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Diagnostic overshadowing and Comorbidities

- 80% of people living with a mental illness have a chronic physical illness (ABS, 2017)
- 55% have two or more co-existing conditions (AIHW, 2017)
- 20% of people with a physical illness have a co-existing mental illness (ABS, 2015)

 The Australian Journal of Rural Health
Aust. J. Rural Health (2017) 25, 4

Editorial
Integrating rural health care

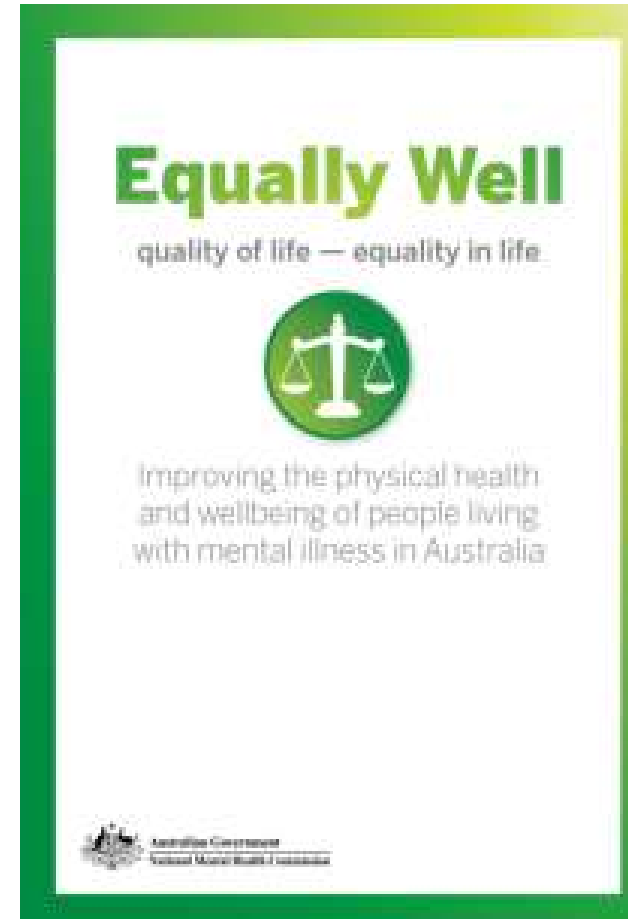
There is a high likelihood that someone visiting a rural health professional for a specific health issue will also have another health-related condition. The Australian Institute of Health and Welfare's report on chronic disease co-morbidity indicates that 75% of people experiencing a chronic health condition also have another long-term health condition, and 55% have three or more co-existing conditions.¹ These data indicate that every professional should be attuned to health issues their client may be experiencing in addition to the 'presenting problem'. This is especially the case for mental health conditions. The Australian Bureau of Statistics (ABS) National Health Survey² shows that over 20% of people with a long-term physical illness also have a mental health condition. The recent ABS survey of mental health and co-existing conditions found that 80% of people living with mental illness have a co-existing, mortality-related physical illness.³ This speaks to the need for routine physical health screening for people experiencing mental illness, and the consideration of general health screening for those with a physical health condition. Taken together, these findings underscore the importance of integrating care for rural Australians.
Having established a helping relationship, the rural health worker is in a prime position to connect clients to other professionals and services. This does, however, require the rural health worker to actively explore the possibility of the existence of other health issues, to be aware of ways to access other services, to take responsibility for the next steps necessary to secure appropriate assessment and treatment, and to be willing to work in partnership with other professionals. This includes not only local health workers and services but also those based in regional or major cities.
Rural health care naturally lends itself to integrated care. Living, working and socialising in the same community helps. So does working in co-located offices and the imperative to work together creatively and collaboratively due to the scarcity of health resources and the tyranny of distance. Integrating care also provides an opportunity for collegiate support. Integrated care is even more important in rural Australia as people living in regional and remote areas are 33% more likely to experience co-morbidity compared to those living in major cities.⁴
The case for integrated care is so strong, and its advantages so clear, it is difficult to understand why so many people continue to live with undiagnosed co-morbid conditions. People living with serious mental illness have a life expectancy approximately 20 years less than the general population,^{4,5} and this life expectancy gap is mostly due to undiagnosed and untreated co-existing physical health conditions. Addressing physical health has a demonstrated positive effect on mental health. Likewise, addressing mental health issues has a positive effect on physical health.
The *Australian Journal of Rural Health* exemplifies and contributes to an integrated approach to rural health. It shares knowledge across professions, issues, regions and research methodologies. By providing the rural health community with the latest in research, policy and practice across a wide range of health professions, it increases the awareness of the contribution and practices of these professions. It also addresses underlying key issues in rural health such as workforce development, training, models of care and the effective use of technology. Finally, it looks to integrate insights from different types of research – clinical and non-clinical, and qualitative and quantitative. Most of all, it seeks to work in partnership to promote and advance the health of rural Australians.

References
1 Australian Institute of Health and Welfare. Chronic Disease Comorbidity. 2017. [Cited 5 Jan 2017]. Available from URL: <http://www.aihw.gov.au/chronic-diseases/comorbidity/>
2 Australian Bureau of Statistics. National Health Survey: First Results, 2014-15. Canberra: ABS, 2015.
3 Australian Bureau of Statistics. National Health Survey, Mental Health and co-existing physical health conditions, Australia, 2014-15. Canberra: ABS, 2015.
4 Thornicroft G. Premature death among people with mental illness. At best a failure to act on evidence; at worst a form of lethal discrimination. *British Medical Journal* 2013; 346: f2969. doi:10.1136/bmj.f2969.
5 Lawrence D, Kisely S, Pais J. The epidemiology of excess mortality in people with mental illness. *Canadian Journal of Psychiatry* 2010; 55: 752-760.

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Equally Well Consensus Statement – *Improving the physical health and wellbeing of people living with mental illness*

- ▶ Launched in July 2017 by Inaugural National Mental Health Commission Chair, Allan Fels.
- ▶ Committed to putting health care for people living with mental illness on an equal footing.
- ▶ We will improve the physical health of people living with mental illness by acting to deliver:
 - ❑ a holistic, person centred approach to physical and mental health and wellbeing
 - ❑ **effective promotion, prevention and early intervention**
 - ❑ equity of access to all services
 - ❑ improved quality of health care
 - ❑ care coordination and regional integration across health, mental health and other services and sectors which enable a contributing life
 - ❑ the monitoring of progress towards improved physical health and wellbeing.

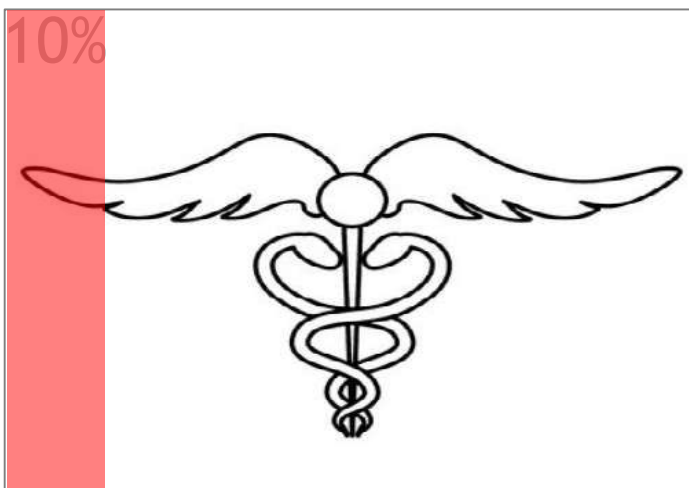


But...comorbidity rises dramatically!!

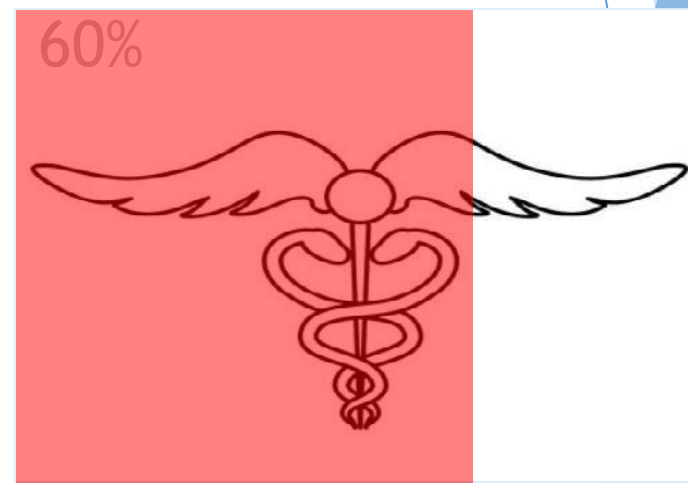


National Health Survey: Mental Health
and co-existing physical health conditions,
Australia, 2014 - 15.
(Feb, 2016)

Under 45s

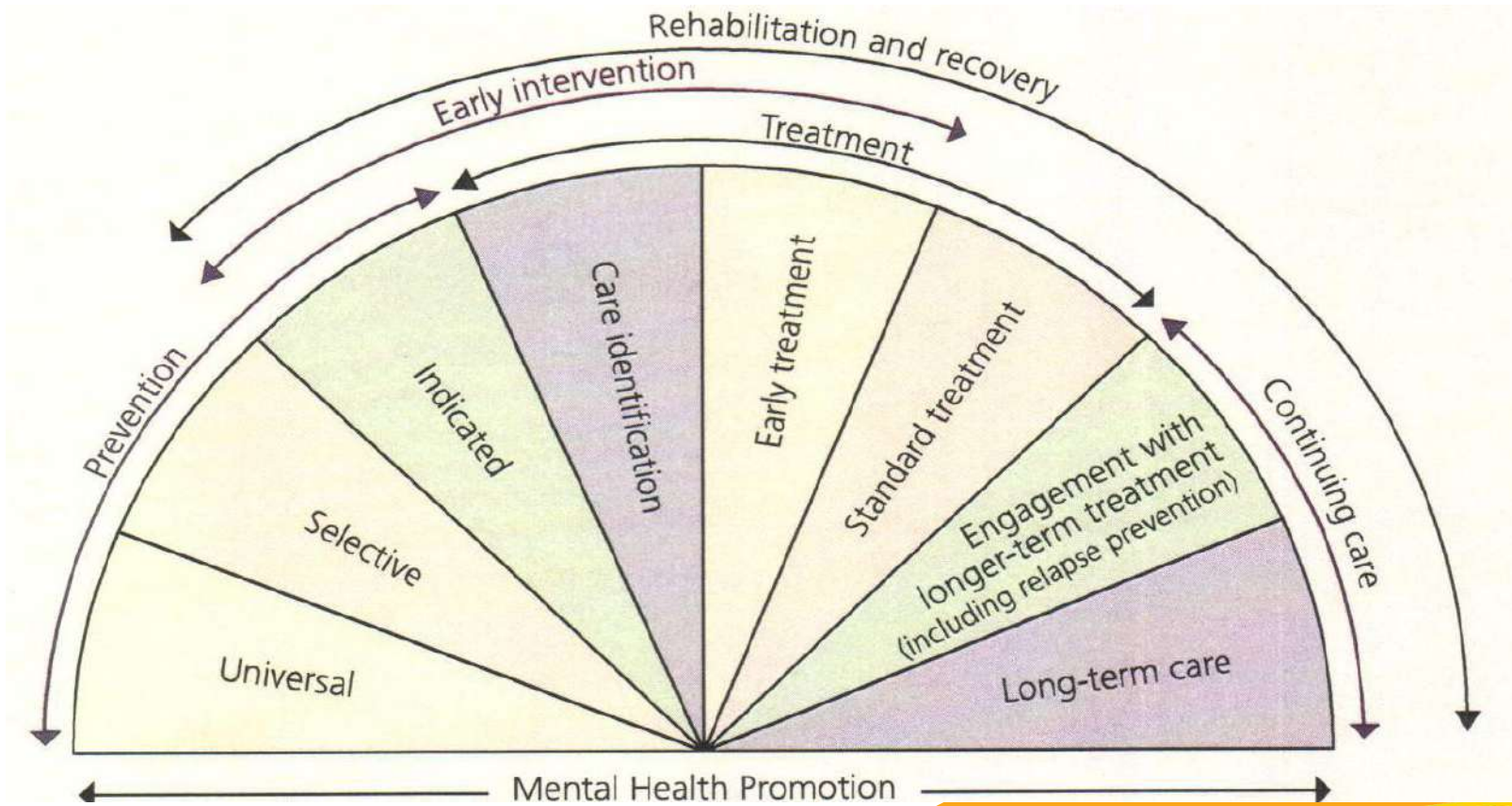


Over 65s



...and co-morbidity is 33% higher for older
persons living in rural communities

The old model



Need for a new framework

Existing models –

- overlooked social determinants and biological antecedents of mental illness
- did not inform action
- did not clearly inform PPEI across the spectrum of illness

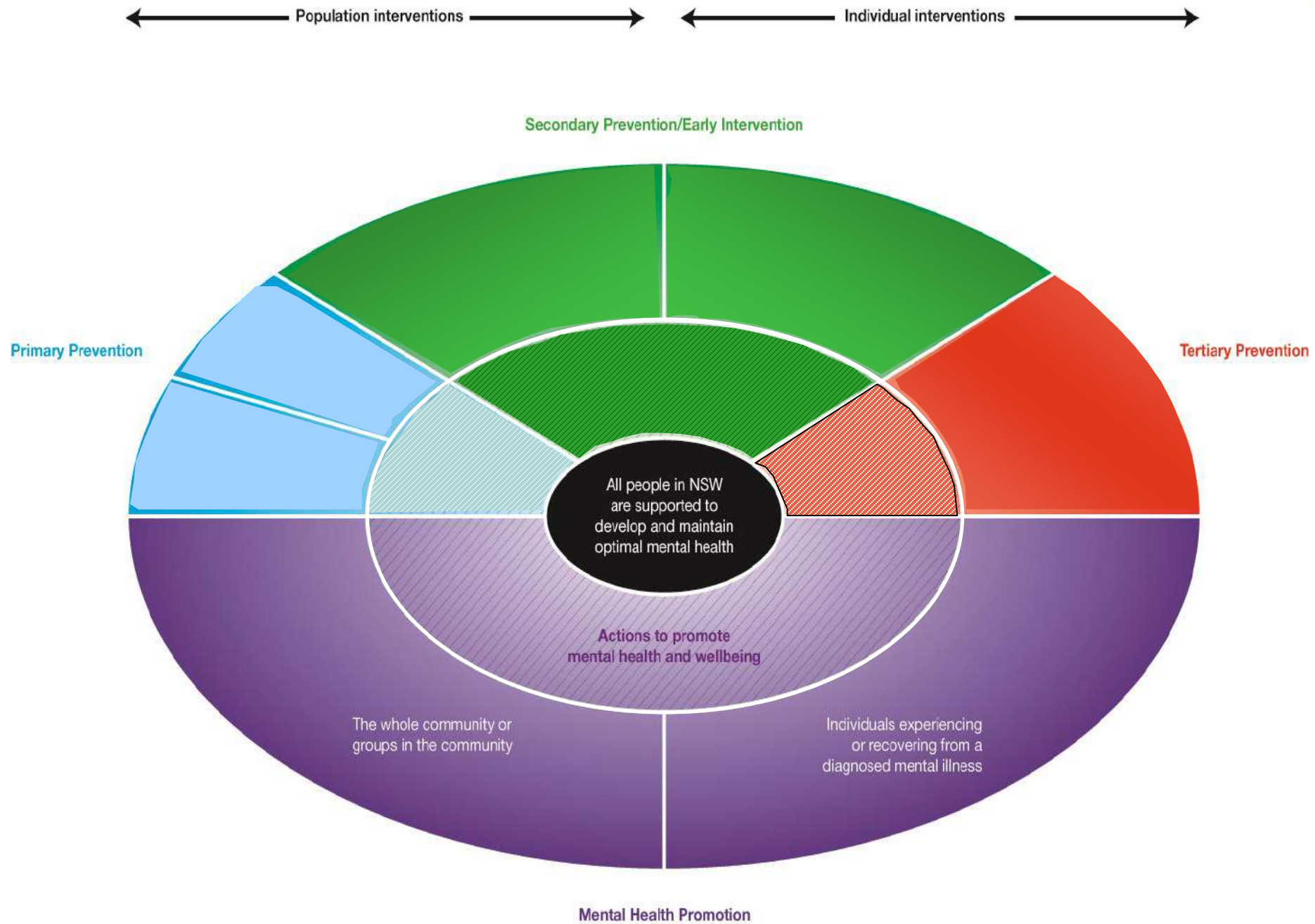
Not quite right

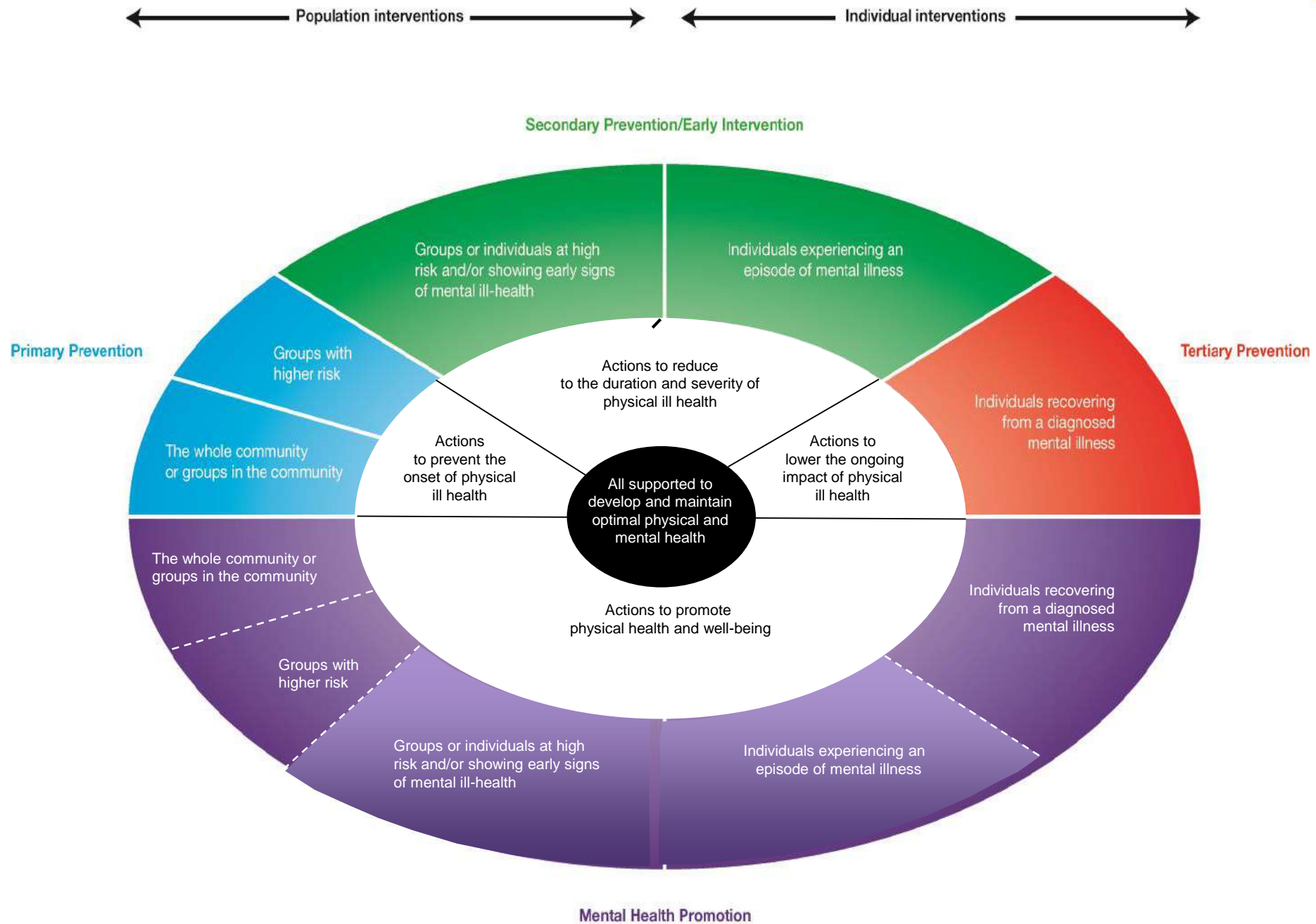
The slide features decorative geometric patterns. The top-left corner has a blue and white triangular mosaic. The bottom-right corner has a yellow and orange hexagonal mosaic. A large, solid yellow shape, resembling a stylized 'S' or a wave, curves across the bottom of the slide.

Need for plain language

- Primary, secondary, tertiary health?
- What is primary?
- Primary secondary tertiary prevention?
- Health Promotion?
- Early intervention?
- Selected, targeted, universal?

Focus	Domain	Target groups	Definition	Terms from the literature
Actions to promote mental health and wellbeing.	Mental Health Promotion	Individuals experiencing or recovering from a diagnosed mental illness.	Interventions to enhance social, emotional and spiritual wellbeing and quality of life for people with diagnosed mental illness. Initiatives can occur within mental health services or in the community and include recovery as a key component.	Mental Health Promotion; Recover
		The whole community or groups in the community.	Interventions to enhance social, emotional and spiritual wellbeing and quality of life. Initiatives can occur with the whole population or selected groups and can occur in any setting (including schools, workplaces, the home).	Mental Health Promotion.
Actions to prevent the onset of illness.	Primary Prevention	The whole community or groups in the community.	Interventions work by focussing on reducing risk factors and enhancing protective factors in whole communities regardless of their level of risk.	Universal Prevention Primary Prevention
		Groups at higher risk.	Interventions work by focussing on reducing risk factors and enhancing protective factors to prevent the onset of a problem or illness in groups known to be at increased risk.	Targeted Prevention Primary Prevention
Actions to intervene early to reduce the duration and severity mental ill-health.	Secondary Prevention	Groups or individuals at high risk and/or showing early signs of mental ill-health.	Early identification of individuals showing signs of mental health problems or illnesses and clear pathways to appropriate services.	Indicated Prevention Early Intervention (prevention focussed) Case identification.
		Individuals experiencing an episode of mental illness.	Interventions work by focussing on reducing risk factors and enhancing protective factors to lower the severity and duration of an illness through early evidence-based treatment.	Early Intervention (treatment focussed) Secondary Prevention Early Treatment.
Actions to reduce the ongoing impact of mental ill-health.	Tertiary Prevention	Individuals recovering from a diagnosed mental illness.	Interventions work by focussing on reducing risk factors and enhancing protective factors to reduce the impact of an illness through rehabilitation and relapse prevention.	Tertiary Prevention, Rehabilitation; Relapse Prevention; Longer-term Care.





Using a PPEI approach to physical health: Diabetes

Focus	Domain	Target group	Description
Actions to promote health and wellbeing	Health promotion	The whole population of people living with mental illness	Interventions to enhance physical health and wellbeing
Actions to prevent the onset of illness	Primary prevention	Whole community. Groups at risk of developing physical ill health	Interventions that focus on reducing risk factors or increasing protective factors
Actions to intervene early to reduce the severity or duration of ill health	Secondary prevention	Groups showing early signs of ill health Individuals experiencing ill health	Early identification of signs of ill health and clear pathways to health services Interventions focussing on reducing risk factors and increasing protective factors
Actions to reduce the ongoing impact	Tertiary prevention	Individuals recovering from physical illness	Interventions focussing on reducing risk factors and increasing protective factors through

Health Prompt

Thank you for agreeing to take part in this brief prompt about your health. I am going to ask you some questions to help establish whether your health needs are being met and identify areas you may like support with. Whilst we are interested in knowing about your health, please be assured that this information will be treated as strictly confidential.

Consumer Name:		Service Site:	
Gender:		Age:	
Date Completed:		Review Date:	

Questions	Yes	No
Do you have a regular GP?		
Are you satisfied with the relationship you have with your GP?		
Have you had your blood pressure checked in the last 6 months?		
Have you had your cholesterol checked in the last year?		
Have you had your blood sugar levels checked in the last year?		
Do you do 30 minutes of moderate exercise 5 days per week?		
Do you have at least 2 alcohol free days per week?		
Do you eat 2 serves of fruit per day? Example of 1 serve of Fruit: 1 medium apple/banana or a handful of grapes		
Do you eat 5 or more servings of vegetables per day? Example of 1 serve of Vegetables: ½ cup of cooked vegetables or 1 cup of salad		
Do you feel you drink enough water? 2L or 8 glasses is the average recommendation		
Is your waist measurement below 88cm (women) or 100cm (men)?		
Have you had your skin checked in the last year?		
Have you had your eyes checked in the past two years?		
Can you hear and understand things easily?		
Are you a non-smoker?		
Have you had a dental check-up in the last 6 months?		
Are you able to keep your balance and have not fallen recently?		
Are your feet free from sores, blisters and swelling?		
Are you satisfied with the quality of your sleep?		
Do you feel you have enough information about the medications you are currently taking?		

Level Health



Image: Neami

1 Do you have a regular GP?

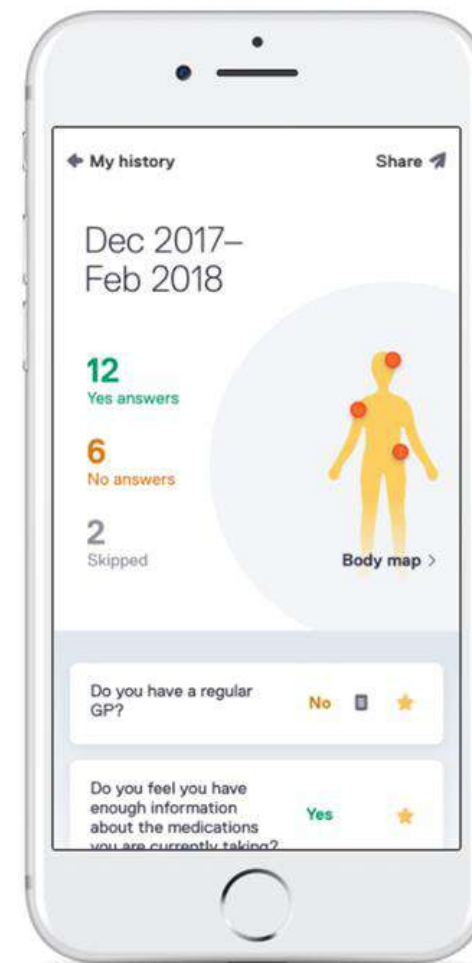
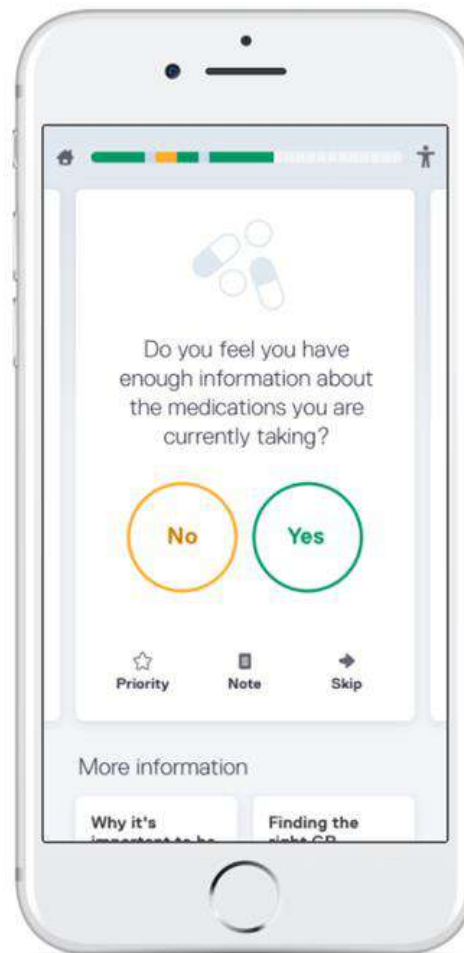
Do you see the same doctor all the time?
Do you feel you see them enough?



My Health Prompt – the app



Level Health



WHO Multilevel Model

Liu et al. (2017) Roberts, Locket, Bagnall, Maylea, Hopwood (2018)

Individual-focused interventions

Mental health disorder management

- Early detection and appropriate treatment
- Interventions delivered at critical time points (e.g., within first year of discharge from hospital)
- Recovery-oriented treatment (e.g., service-user involvement, informed choice)

Physical health treatment

- Early detection and appropriate treatment

Lifestyle behaviour interventions

- Tobacco cessation
- Behavioural weight management programmes, including healthy diet, physical activity
- Interventions addressing substance abuse and risky sexual behaviour

Health system-focused interventions

Service delivery

- Screening for medical conditions
- Care coordination or collaborative care strategies (e.g., nurse care manager)
- Guidelines for integrated delivery of mental and physical health care

Community level and policy-focused interventions

Social support

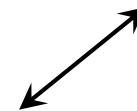
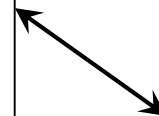
- Peer support programmes
- Family support programmes
- Mental health and consumer advocacy groups

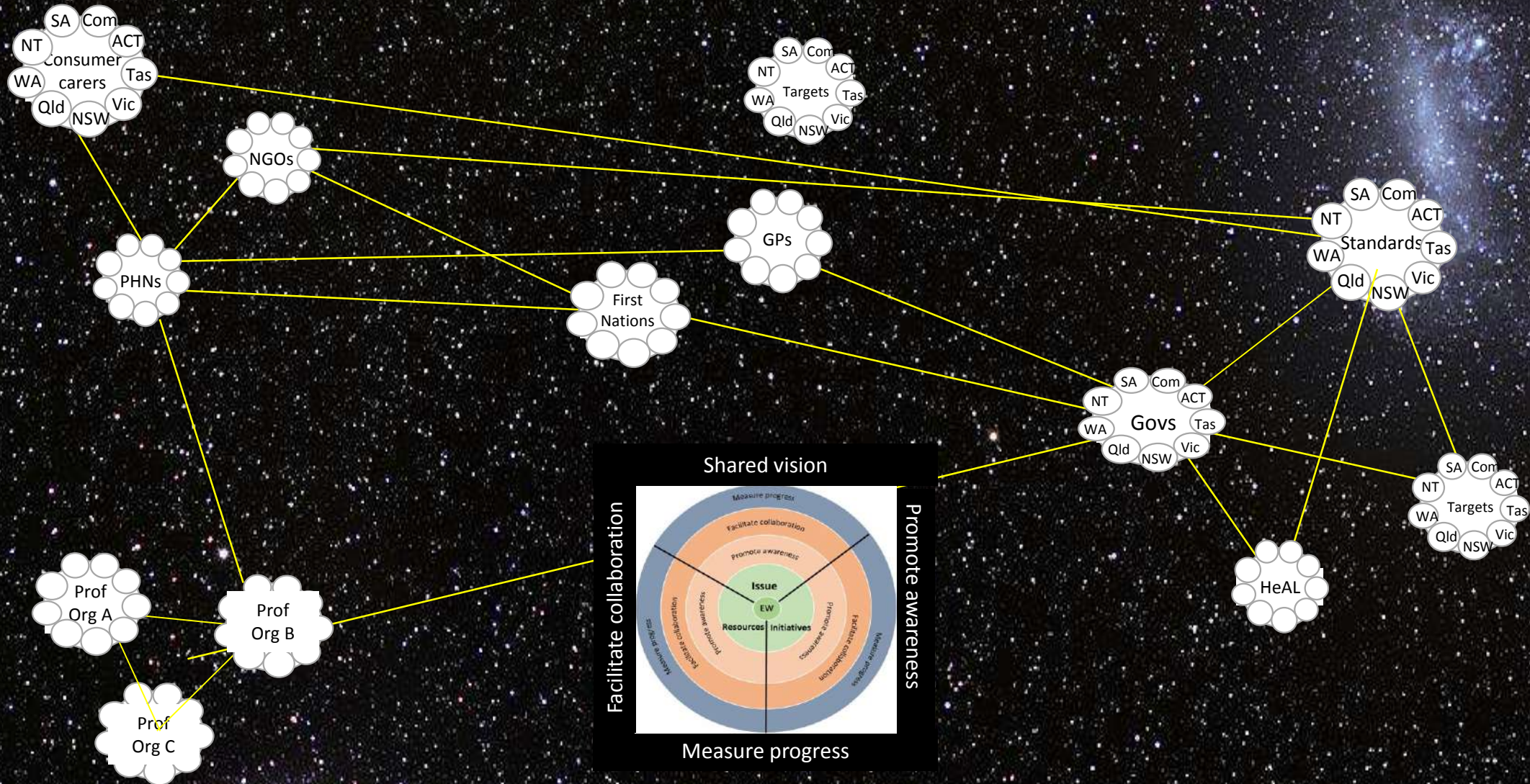
Sigma reduction interventions

- Directed toward communities with SMD and general public

Lifestyle behaviour interventions

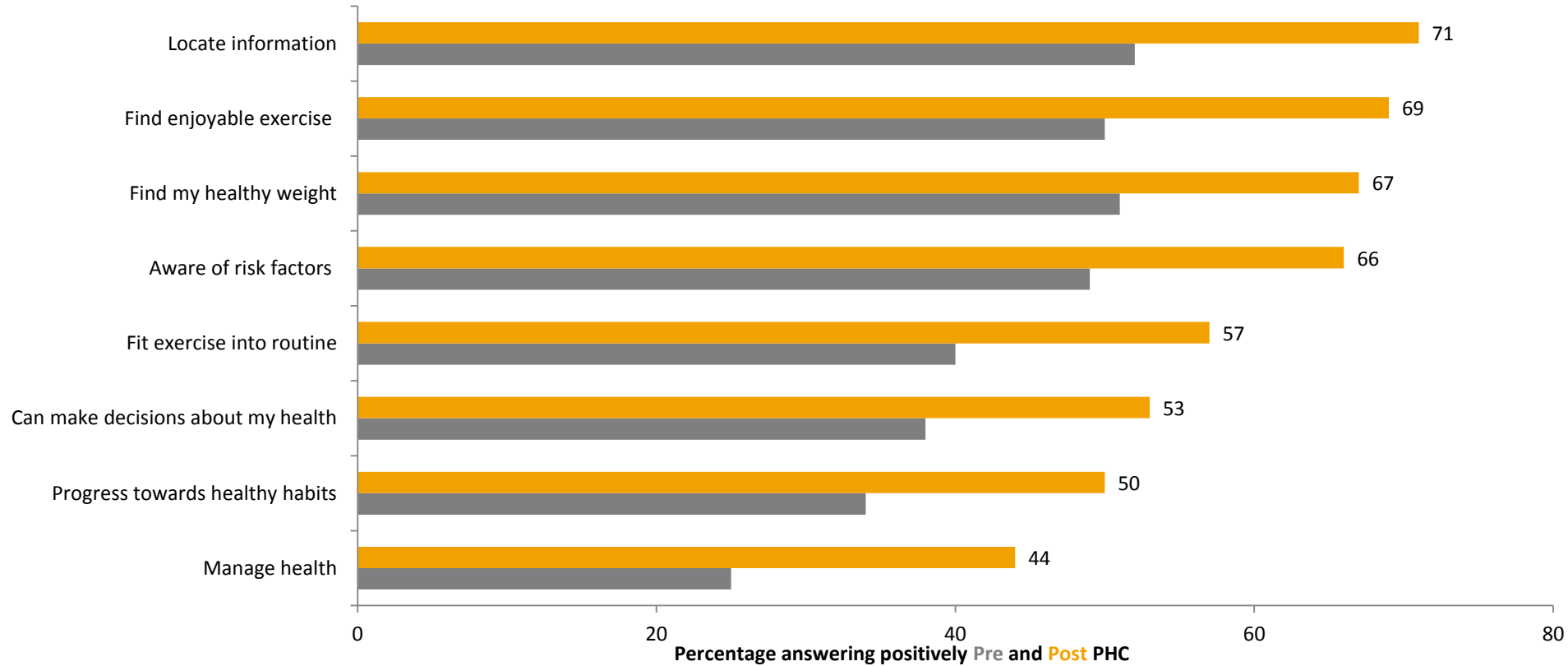
- Comprehensive health care packages, insurance parity and quality
- Public health programmes (tobacco cessation, HIV prevention, suicide prevention)
- Employment, housing, and social welfare sector involvement





Peer Health Coaching

Health Literacy Significantly Increased After PHC





EQUALLYWELL

Smokefree Inpatient Mental Health Services



Aim

Screen smoking behaviour
for all inpatient acute
mental health consumers

AND

provide brief intervention
to identified smokers.

Queensland Government
Smoking Cessation Clinical Pathway

URN: _____
Family name: _____
Given name(s): _____
Address: _____
Date of birth: _____ Sex: ☐ M ☐ F ☐ I

This tool is for screening smoking behaviour and to guide support for those who temporarily cannot smoke or wish to reduce/quit smoking.
Clinical pathways never replace clinical judgement. Care outlined in this pathway must be altered if it is not clinically appropriate for the individual patient.

Category: _____ Date: ____/____/____

Ask
(all patients)
1. Have you smoked tobacco in the last 30 days?
☐ Yes (continue with pathway) ☐ No (congratulate, sign and file)
☐ Electronic cigarettes (may require nicotine replacement therapy (NRT) in hospital)
If you are unable to complete this pathway, document the reason in the comments section below: ☐ See comment

2. Do you want to quit smoking? ☐ Yes ☐ No (still offer NRT for inpatients to manage withdrawal)

Assess
3. Nicotine dependence:
a. How many cigarettes do you smoke in a typical day? ____ Is this more than 10 cigarettes? ☐ Yes ☐ No
b. Do you smoke your first cigarette within 60 minutes of waking? ☐ Yes ☐ No
c. Do you have a history of withdrawal symptoms/cravings from quitting smoking? ☐ Yes ☐ No
If yes to one or more of the above, then the patient is considered nicotine dependent and should be offered NRT.

4. Is the patient nicotine dependent? ☐ Yes ☐ No

5. Are you currently using any of the following?
☐ NRT (continue regimen referring to algorithm on page 2) ☐ Varenicline (Champix®) ☐ Bupropion (Zyban®)
*Advise treating team to prescribe Champix®/Zyban® OR if not available offer NRT (for inpatients only).

Advise
6. Advise all smokers to quit using clear but non-confrontational language:
• "As a health professional the best advice that I can give you is to try to stop smoking"
• "Giving up smoking is hard, but it will help with (e.g. surgery, healing, medication, finances, health and fitness)"
• "Using NRT and behavioural support considerably increases your long term success in quitting"
• "NRT is available from most retail stores, however patches and medications (Champix® and Zyban®) are cheaper on PBS"

Assist
(discuss treatment and other options)
7. Special considerations (medical approval may be required prior to initiating NRT depending on unit preference):
☐ Any local precautions/protocols (e.g. microvascular surgery, skin grafts etc) ☐ Children <12 years of age
☐ Pregnant/lactating ☐ Recent cardiovascular event <48 hours ☐ Clozapine
Note: Patients who stop smoking with or without NRT may require a medication dose change (e.g. opiods, antipsychotics, benzodiazepines, insulin and warfarin). Seek Medical Officer advice if any of the above are ticked.

INPATIENT ONLY
8. Offer NRT to relieve nicotine withdrawal and/or assist with quitting. If smoking/withdrawals persist, NRT should be titrated to achieve effect (see flow chart page 2)
NRT can be initiated by a medical officer, nurse or pharmacist according to your local policy
☐ Patient offered NRT and accepted treatment (ensure discharge script is written for ongoing treatment)
☐ Patient offered NRT and declined treatment (ask again during stay as needed)
☐ Patient unable to be offered NRT. Refer to Medical Officer (see Q7) or reason: _____

PBS
9. Prescribed pharmacotherapy (NRT patches/Champix®/Zyban®) ☐ Yes ☐ No
If no, document reason: _____

Arrange follow-up
10. Patient provided with a copy of "self-help" resource (e.g. 'Quit Because You Can' booklet) ☐ Yes ☐ No
11. Did patient consent to referral to any of these services? (tick all that apply)
a. Quitline Service (13QUIT@health.qld.gov.au Fax: 07 3259 8217 Patient phone: _____) ☐ Yes ☐ No
b. Local smoking cessation support/tobacco treatment specialist services in the HHS ☐ Yes ☐ No
c. GP follow up (remind patients of subsidised PBS products - see page 2) ☐ Yes ☐ No
Fax (with cover sheet) or post copy with discharge summary after completion to the service(s) above.

Comments: _____

Assessment completed by - Name: _____ Designation: _____ Signature: _____ Date: _____ ☐ Tick if you would like outline to send a report on the patient's progress
Assessment review completed by (if required) - Name: _____ Designation: _____ Signature: _____ Date: _____ Initial: _____

Page 1 of 2

www.equallywell.org.au

“Contact us” - Get involved!

Sign up

signup@equallywell.org.au

Commit

lcobb@csu.edu.au

Get updates/newsletters

<https://equallywell.org.au/>

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