



# Te Karere

COLLEGE NEWSLETTER

Friday  
10 April, 2026

## BRANCH HIGHLIGHTS

Updates from the Addiction Nurses Branch, including work that strengthens specialist practice and professional standards, alongside insights from the National Disability Nurses Branch.

## RESEARCH INSIGHTS

This issue shares highlights from current research and evidence-informed practice, offering perspectives that support learning and reflection across mental health nursing.

## MEMBER REFLECTIONS

Reflections from members explore everyday nursing practice, professional values, and the experiences that shape how we support tangata whaiora and whānau.

## UPHOLDING MANA, SHAPING OUR FUTURE

Leadership reflections from our president

### Kia ora Koutou!

It really has been an honor for me to step in to the role of President, alongside **Menetta** as Kaiwhakahaere and **Sarah-Jane** as Vice President, and to be able to stand alongside you all, our committed MHAIDS nurses. Every day you bring skill, compassion, and unwavering dedication to whaiora/whaikaha and whanau, often in moments that are complex, challenging and deeply human. Your mahi is courageous, grounded and profoundly impactful. It is a privilege to serve our college in support of our profession.

As we continue the refresh of our Standards of Practice, we are taking an important step in honouring who we are as specialist nurses – our values, our expertise, and our collective identify. This work reaffirms our commitment to excellence and helps ensure our profession is recognised across the health sector for the leadership and specialist knowledge we bring to the care of people and communities throughout Aotearoa.

Equally significant is our ongoing responsibility to acknowledge the harm experienced by those abused in care. Facing this history with honest, humility and a commitment to do better strengthens our integrity as a profession and reinforces our promise to provide safe, compassionate and respectful care for all.

I am genuinely excited about our conference in November – a chance for us to reconnect, reflect and look ahead together. It will be a time to celebrate the depth of our practice, share new insights and continue shaping a future where our profession is valued and our collective voice is strong.

**Nga mihi nui ki a kotou** for everything you bring to this mahi. Together we will continue to uphold the mana of our profession, support each other and champion the wellbeing of the people and whanau we serve.

**Kym Park**

## UPCOMING EVENTS

### ▶ [Webinar](#)

15 April, 2026  
7pm – 8pm

**Topic:** Mental health assessment and Intellectual Disabilities

### ▶ [Conference 2026](#)

[Early Bird Registrations Open Friday 17 April!](#)

19–20 November, 2026

The Pā, University of Waikato, Kirikiriroa–Hamilton, Aotearoa New Zealand

## RESOURCES

### ▶ [The Aotearoa New Zealand Addiction Nursing Standards](#)

[www.nzcmhn.org.nz](http://www.nzcmhn.org.nz)



## Addiction Nurses Branch

### Richard Jeffcoat (Chair, Addiction Nurses Branch)

#### Publication of the 2025 Aotearoa New Zealand Addiction Nursing Standards

The Aotearoa New Zealand Addiction Nursing Standards (2025) build on The Aotearoa New Zealand Addiction Specialty Nursing Competency Framework (updated 2018) which was initiated and supported by Drug and Alcohol Nurses Australasia (DANA) and Matua Raki. The Standards project was initiated by the Addiction Nurses Branch of Te Ao Māramatanga New Zealand College of Mental Health Nurses Inc in consultation with Te Pou. This resulted in a partnership between Te Pou, the College and DANA. The Standards were then developed by Te Pou with guidance from a reference group that included expertise from Te Ao Māramatanga, DANA, lived experience, and addiction nurses. In addition to the reference group many people contributed through focus groups and individual contributions, including Te Ao Māramatanga Māori Caucus, Pacific input, educators and trainers, and people with lived experience. The Standards are a guide, by nurses for nurses, and provide an exemplar of care that Aotearoa addiction nurses are expected to use. They also inform service users, educators and employers.

The Standards framework is structured on the six pou of the Nursing Council Standards of Competence for Registered Nurses (Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand, 2025). The pou set out the practice and education requirements for addiction nurses. This includes registered nurses, nurse prescribers, and nurse practitioners who work alongside tāngata whai ora, whānau, groups, and communities affected by addiction, reflecting the Aotearoa cultural and health context. The addiction nursing specialty pathway includes three progressive levels: Competent, Proficient, and Expert. The Competent level marks the entry into the addiction specialty, building on the Nursing Council Standards of Competence. Each subsequent level builds on the previous level, reflecting increasing depth and breadth of practice. The Standards are congruent with the College Standards of Practice for Mental Health Nursing and align with the PDRP framework defined by Nurse Executives New Zealand (2017). The Standards also provide a useful reference for nurses who are not addiction nurses who are seeking to develop their knowledge and skills in working with tāngata whai ora and whānau, groups and communities impacted by addiction.

## Quotes from nurses included in the Standards document to reflect the values and competencies of addiction nurses:

“Leadership as an addictions nurse...is about fostering hope and empowering whānau on their recovery journey. It means guiding with empathy, cultural humility, and at the same time respecting the unique strengths of everyone. In my role, I am a believer in a collaborative environment where tāngata whai ora, their whānau, and the team of kaimahi work together to create meaningful change. Upholding the principles of Te Tiriti o Waitangi, I strive to ensure care is equitable, culturally safe, and grounded in the values of tika (truth/ correctness), pono (honest/genuine) and with aroha. Through advocacy, education, and role modelling, I inspire others to lead with compassion and integrity in the pursuit of wellbeing for all.”

**Corey Senelale** Registered nurse Kaihāpai (deputy director) Moana House programme

“Each day, I meet people who are trying to navigate the health system— many facing regular stigma and discrimination because of their substance use. My role is to provide non-judgemental, person-centred care—whether that’s finding a new vein together, accessing naloxone kits, prescribing antibiotics for injecting-related injuries, scripting hepatitis C and STI treatment, providing support letters and referrals, or simply offering a safe space to talk. I advocate for people, challenge stigma, and work to ensure they can access healthcare with fewer barriers. It’s exciting to see improved outcomes when we collaborate with other providers who work with a similar harm reduction and person-centred approach. Trust is everything. At the heart of it all, it’s about really seeing and knowing the person in front of you and meeting them where they’re at—not where the system or others expect them to be.”

**Leah Higgins**, harm reduction nurse prescriber Rodger Wright Community Clinic – DISC Trust.



## National Disability Nurses Branch

### Shirley Murdoch (RN) & John Young (RN)

Disability Equity Nurse Role Waikato Hospital

### Disability Support Link - He Ara Whakamana mo te hunga hauā, Waikato Hospital District

As Disability Equity Nurses, our job is about walking alongside people with a disability and tāngata whaikaha Māori to make the hospital journey easier, safer and more respectful. This role was created to ensure disabled people experience equity within the health system and to improve health outcomes for people with a disability. We are part of the Disability Support Link NASC – Disability Support Services team, which is funded through MSD Disability Support Services. We start with one question: “How can we add value to this person’s experience?” From there, the work can go in all sorts of directions – because no two people, families, whānau or situations are the same.

A big part of what we do is create early collaborative communication when someone with disability comes into hospital, getting to know what matters to them, and helping staff understand their communication style, sensory needs, routines and the things that help them feel safe. Some days that means being at the bedside, calming a situation, or helping staff interpret behaviour as communication. Other days it’s supporting or leading family/whānau meetings, sorting out discharge plans, or making sure residential providers, hospital teams and community services are all talking to each other.

We both bring backgrounds across intellectual disability, complex care, mental health and older persons’ health, which means we’re often involved when things are layered or tricky. We work closely with Adult Mental Health including the Intellectual Disability Dual Diagnosis Service (IDDD) when people with disabilities, including tāngata whaikaha Māori have mental health needs on top of everything else; helping teams take a trauma-informed, rights-based approach. We also support paediatric patients and their whānau – making sure families feel heard and supported through what can be a stressful time.

Whilst most of our work is in the hospital, we will head out into the community when needed, and we sometimes support people outside DSS when a disability-equity lens will genuinely help. At the heart of it, our role is about relationships, communication, and making sure people feel seen, safe and supported – wherever they are in their health care journey.

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## National Disability Nurses Branch

Judy Garriock

### Medicines Care Guides Review – Your Feedback Made a Real Difference

Many of us are regularly asked to provide feedback on changes to official documentation that directly or indirectly affects our practice and the health and wellbeing of the people we support. Too often, that feedback disappears into a void with little or no acknowledgement.

Last year, HealthCERT undertook a review of the Medicines Care Guides for both Aged Residential Care and Community Residential and Facility-based Services (Disability, Mental Health, and Addiction). The aim was to produce a single, unified guide that reflects current best practice and supports consistency across care settings.

A cross-sector working group was established, with representatives from:

- Ministry of Health
- Ministry of Social Development – Disability Support Services
- New Zealand Nurses Organisation
- Health Quality & Safety Commission – Te Tāhū Hauora
- Aged Care Association New Zealand
- Enliven Presbyterian Support
- Radius Care

The two existing guides were merged, and feedback was sought on the draft. For many of us, the first we saw of the draft was when someone in our networks stumbled across the consultation link and shared it widely. What was particularly disappointing was the absence of disability and mental health nursing representation on the working group as the proposed changes would have had significant consequences for these sectors and would have fundamentally alter how people are supported in the community.

With less than four weeks to respond—and limited opportunity to coordinate a collective position—several of us worked quickly and independently to prepare submissions. As is often the case, we did not expect to hear anything further.

This time, however, our feedback was heard. We have since been advised that the draft guide has been taken back to the drawing board. The concerns raised were strong, clear, and consistent, and the risks and unintended consequences identified were significant enough that the guide will not proceed in its current form. This is an excellent outcome. Your voices have prevented what could have been a deeply problematic shift in practice. Thank you for your advocacy, your expertise, and your commitment to protecting the people we care for, partner with, and to whom we are of service.

Given the scale of the proposed changes and the lack of appropriate clinical representation, it is a reminder going forward, that there is value in professional bodies such as Te Ao Māramatanga – New Zealand College of Mental Health Nurses and its members to have a say. This is imperative when legislation, standards, or national guidance with direct impact on our scope of practice is being revised – our profession must be at the table. We leave the last word to the people...

Nothing about us, without us.

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## Spiritual care in mental health nursing, helpful practice or hotbed of debate?

**Patrick White**

Mental health nurses praying with people? What would Seymour say?

In 2024, the associate minister of health, Hon. David Seymour, criticised Te Whatu ora staff for opening hui with karakia (ACT New Zealand, n.d.). Moments like this remind us that spirituality and wairuatanga remain a hotbed of debate in our society. This article discusses spiritual care and manaaki a wairua, in mental health nursing, the topic of my PhD research.

Should mental health nurses, as Seymour suggests, keep activities such as karakia and prayer outside of professional practice? It is intimated that such things should be private, or practised on marae, mosque, synagogue or church. After all, New Zealand is a secular society, right? However, in mental health care situations, my experience has been that people enter our services with deep spiritual and existential needs that are often overlooked. These are medicalised, with treatment focusing heavily on pharmacology. In the twilight of my career, my observation is that mental health nursing care has become little more than medication and behaviour management.

Cultural models such as Te Whare Tapa Whā (Durie, 1985) offer an alternative, holistic way of considering people. Clearly, one of the Pou identifies wairuatanga as an integral strategy of wellbeing. Such models speak of a simple assumption that secular and sacred need not be separated. Te Whare Tapa Whā identifies components of the whole person and their world, not in separate categories, but rather as a holistic, integrated worldview. While wairuatanga may translate as 'spirituality' and manaaki a wairua as 'spiritual care,' the question remains: do these ideas mean the same thing across both Māori and Pakeha worldviews?

It is not only Māori cultural models that support positive engagement with spirituality and wairuatanga. The recovery model has been part of policy in mental health services for many years and includes faith and spirituality as key domains of well-being (O'Hagan, 2006). While this is commendable, how do nurses value tangata whaiora spirituality and actively support them in engaging with it?

There has been little specific training on how to apply the recovery model to support a person's spiritual well-being.

Of further relevance, the recent changes to the Nursing Council's competencies in the form of Pou represent an important shift, challenging nurses to deepen their nursing practice. But where does spiritual care and manaaki a wairua fit in the new Pou? Colleagues have suggested Pou Kawa Whakaruruhau. This Pou clearly outlines cultural safety for Māori, which incorporates wairuatanga and manaaki a wairua, but it is less clear about spirituality and spiritual care for Pākehā and others.

It is noted that Irihapeti Ramsden's excellent definition of cultural safety is now being applied to the updated Code of Conduct (Nursing Council of New Zealand, 2026). Perhaps this provides ongoing support for considering spirituality within the nurse's scope of practice. While these are strong foundations, there is still a practice gap. Where and how do mental health nurses engage in spiritual care that is safe, responsive and grounded in evidence-based practice?

Spirituality and spiritual care have been a continuing theme throughout my nursing career. The most profound moments in my nursing practice have been those in which a person's spiritual need was recognised.



My heart wells with memories of supporting whanau with karakia and prayer, being with them in the passing moments of their loved ones' lives, sharing waiata with tangata whaiora in inpatient morning meetings, and sitting with them as they weep over pain and loss. Many mistakes have been made as well. Yet, like many nurses, I have received little formal preparation for how to do this confidently.

I am grateful to have the opportunity to undertake research on this important topic. The question I am exploring in my research is, "Exploring the value of spiritual care and manaaki a wairua among mental health nurses and people accessing specialist mental health services in Aotearoa New Zealand."

Watch this space e hoa mā! I'm six months into the journey and hope this work will help clarify what spiritual care and manaaki a wairua mean in practice, and contribute to more holistic, culturally grounded care in our profession. Ka nui te mihi kia koutou.

## Whāia te it Kahurangi! Ki te tuohu koe, me he maunga teitei!

*Strive for something of great value. If you must bow your head, let it be to a lofty mountain*

### References:

ACT New Zealand. (n.d.). David vs the media: The "pervasive insanity" of compulsory karakia. YouTube. <https://www.youtube.com/watch?v=SxtzsewypmM>

Durie, M. H. (1985). A Māori perspective of health. *Social Science & Medicine*, 20(5), 483–486. doi: [https://doi.org.ezproxy.auckland.ac.nz/10.1016/0277-9536\(85\)90363-6](https://doi.org.ezproxy.auckland.ac.nz/10.1016/0277-9536(85)90363-6)

Nursing Council of New Zealand (2026). *Code of conduct for nurse: Draft consultation*. [https://www.nursingcouncil.org.nz/NCNZ/publications-section/Consultation/Consultation\\_Revisions-Code-of-Conduct\\_Jan-2026.aspx?WebsiteKey=60ff96d4-9981-4a6f-9e32-8e537523ec0e](https://www.nursingcouncil.org.nz/NCNZ/publications-section/Consultation/Consultation_Revisions-Code-of-Conduct_Jan-2026.aspx?WebsiteKey=60ff96d4-9981-4a6f-9e32-8e537523ec0e) Code of Conduct for nurses

O'Hagan, M. (2006). *The acute crisis: Towards a recovery plan for acute mental health services in New Zealand* (A discussion paper). Mental Health Commission. <https://www.yumpu.com/en/document/view/22201720/the-acute-crisis-mary-ohagan/>

### Bio: Patrick White

Patrick is a current PhD candidate studying at the University of Auckland. He has also completed four years of study with Te Wananga o Aotearoa, achieving a NZQA level 6 qualification in te reo Māori. From 2007 to 2015, he worked in mental health for older people in the Bay of Plenty (BOP). From 2015 to 2025, he worked as a clinical educator for the Mental Health and Addiction Services (MHAS) in the BOP.

Patrick has supported many New Entrants to Specialist Practice (NESP) and the national Safe Practice and Effective Communication (SPEC) training as part of his role as a mental health educator. Completing his master's research in 2022, Patrick's research considered the "Service Users' beliefs and experiences of spirituality in a mental health inpatient unit in Aotearoa New Zealand". In his PhD candidacy, Patrick continues a similar theme, "Exploring spiritual care and manaaki a wairua among people accessing specialist mental health services".

Patrick concurrently works on a casual basis as a Crisis nurse working in Health New Zealand, Te Whatu Ora BOP.



## Sarah-Jane Reweti

**Clare Ariani Barbosa & Deborah Campbell** are Mental Health nurses working in mental health research at Health New Zealand | Te Whatu Ora –Waitematā.

Their research involves both Sponsor funded clinical trials, phase II and phase III as well as grant funded study projects.

The research areas they work in includes depression, bipolar affective disorder, schizophrenia and associated cognitive impairment, as well as providing assistance to colleagues who are undertaking research projects.

The role of the research nurse is extremely varied and for pharmaceutical clinical research it starts with completing a feasibility questionnaire for the Sponsor (pharmaceutical company) answering questions about the potential study and the site abilities and experience in the area of potential study. If the Sponsor selects the site, then the next steps includes site set-up, ethics applications, study specific training, preparing study documents for participants, and then moving to recruitment and enrolling participants and conducting the study in accordance to the Study Protocol and Good Clinical Practice, (GCP).

Mental Health Nursing in the clinical research area requires additional skills and knowledge. Good Clinical Practice is an international ethical and scientific standard for the design, conduct, performance and monitoring and auditing and reporting of clinical trials. This certificate, (GCP) is required to be maintained by all staff involved in the study for the duration of the clinical trial.

Part of working in a specific clinical trial requires training and qualification in using specific assessments, e.g. Positive and Negative Symptom Scale (PANSS), MATRICS Consensus Cognitive Battery (MCCB) as well as reading current literature in the area of specialisation, e.g. Cognitive Impairment Associated with Schizophrenia, (CIAS).

In clinical trials another focus is mitigating the placebo effect. Clinical trials are at risk of having their results impacted by the placebo effect, especially in depression studies. The placebo effect is a fascinating mind-body phenomenon. A person has a placebo effect when they experience benefits of a treatment they expected to receive, even though they haven't received that treatment. Science has shown that various aspects of the clinical study process, from interaction with caring clinical practitioners to the hope that new treatment will work, can psychologically impact a participant to the point that they experience real improvement.

The research nurses work to mitigate placebo response in a variety of ways, establishing modest rapport rather than therapeutic rapport and encouraging the participant to be a research collaborator, sharing what they experience whilst participating in the clinical trial. The role of the mental health research nurse moves from providing treatment to partnering with participants, to test (not prove) if the study medication helps the participant's symptoms more than placebo. This focus is in line with the study outcome which will be based on efficacy and safety.

The research nurses also apply for grants for research projects that are topical and fit within the scope of health research priorities in New Zealand. One current research project that is funded from a HRC (Health Research Council) grant is linked to the previous work on a clinical trial for a potential study medication for CIAS, and invites people with a diagnosis of schizophrenia with an interest in their cognition to attend 5 meetings, 1 of which they complete a cognitive assessment, another meeting is where they give feedback re their experience of the testing and another meeting where they receive feedback about their testing and the final meeting is 3 months later, a check in with what their experience has been and the usefulness of having a cognitive assessment and getting their results.



This research will provide a unique viewpoint of tāngata whaiora's experience in New Zealand and will hopefully highlight the importance of this symptom of schizophrenia.

Mental health research is an exciting and ever changing field of work and importantly the research outcomes or findings can potentially impact the lives of people with mental health conditions. There is also the potential for knowledge gained from clinical research to influence clinical practice.

Anthony O'Brien

## **Limited justification for recommending use of cannabinoids for mental disorder or substance use disorder**

The efficacy and safety of cannabinoids for the treatment of mental disorders and substance use disorders: a systematic review and meta-analysis (Wilson J, Dobson O, Langcake A et al.). *The Lancet Psychiatry*, 2026; 13, 304-315 <https://www.thelancet.com/action/showPdf?pii=S2215-0366%2826%2900015-5>

Cannabinoids are increasingly being prescribed for a range of mental illnesses as well as other help problems such as sleep disturbance and pain. In the case of mental illnesses, the evidence of effectiveness is limited.

In this study the authors reviewed results of 62 randomised controlled trials of use of cannabinoids in mental illness and substance use disorders. Results showed that cannabinoids can reduce symptoms of cannabis use disorder, insomnia, tic or Tourette's syndrome, and autism spectrum disorder, but the quality of this evidence was generally low. There was a low risk of serious adverse events, but an increased risk of adverse events such as headache. Interestingly, there have been no randomised controlled trials of cannabinoids for depression, yet this is one of the common reasons that people use cannabinoids.

The authors concluded that the routine use of cannabinoids for the treatment of mental illness or substance use disorder is rarely justified. The principal investigator of this study was interviewed by [Radio New Zealand's Jim Mora](#).



Anthony O'Brien

## **Peer support provides benefits to consumers but requires robust strategies of implementation.**

Ambord, N., Burr, C., Rühle Andersson, S. and Hegedüs, A. (2026), Implementing Peer Support in Community Mental Health Nursing Teams: Qualitative Evaluation. *Journal of Psychiatric and Mental Health Nursing*, 33: 217–225. <https://doi.org/10.1111/jpm.70076>  
<https://onlinelibrary.wiley.com/doi/epdf/10.1111/jpm.70076>

Peer support is increasingly recommended in mental health care, with consumers reporting that peer support workers foster a sense of hope, are able to validate consumers' experiences of mental distress, and assist consumers to navigate mental health and other services. This Swiss qualitative study reports on the integration of peer support workers into a community mental health service. The research team included a researcher with lived experience of mental illness. Sixteen participants were interviewed, including clinicians, managers and peer support workers. The researchers also made observations of peer workers' visits to consumers. Nurses and peer support workers reported high satisfaction with the peer support service. One participant commented:

"Where (peer support) can supplement the treatment setting, where it can perhaps create a different openness, a different sense of being affected, a different approach it can perhaps influence the recovery process".

Although participants reported positive experiences of peer support there were also problems with implementation of the programme. The authors concluded that successful implementation requires standardised training, adequate financial recognition, team training for the mental health team and good integration within services.

Anthony O'Brien

## **Crisis support units provide an alternative to emergency department admissions for people in mental health crisis.**

Hudson, C., and M.Randall. 2026. Emergency Department Presentations for Mental Health Crisis: Comparing ED-Only Care With Transfer to a Crisis Stabilisation Unit. *International Journal of Mental Health Nursing*, 35, no. 1: e70216. <https://doi.org/10.1111/inm.70216>.

Emergency departments (ED) provide responses to health emergencies arising out of hospital, including mental health crises. However, research suggests that EDs are sometimes experienced as stressful environments for people in mental distress. In addition, consumers can face long waiting times for mental health assessment. The Gold Coast region of Australia established a Crisis Stabilisation Unit (CSU) in an attempt to provide an alternative to ED for crisis assessment and de-escalation.

The CSU was purpose built and designed to better support a recovery focussed model of care. In this evaluation the authors studied 18,240 mental health presentations to ED. 1439 were diverted to the CSU. Consumers referred to CSU had lower triage scores, were more likely to have walked in rather than arrive by ambulance and had shorter lengths of stay.

There was no difference in rates re-presentation between the groups. Consumers transferred to the CSU had on average two hours less time in hospital than those who completed their acute admission in ED. Something that is not clear from the report is whether the CSU group might have had shorter stays even if they'd remained in ED, as they were a less symptomatic group than the ED only group.



7pm – 8pm  
Wednesday 15 April, 2026

[Register Now](#)

We are pleased to announce our next **webinar** that will be held on **Wednesday 15<sup>th</sup> April** from **7 – 8pm**.

Topic: **Mental health assessment and Intellectual Disabilities**

Speaker: **Sandy Smith**

Sandy is a Registered Comprehensive Nurse with a Master of Nursing (2003), specialising in Mental Health and Intellectual Disability. She works with the Regional Intellectual Disability Consultation and Assessment Service for Capital and Coast, covering the Hawke's Bay and Tairāwhiti regions. Over two decades ago, she helped establish this service and continues to support it through key forensic and assessment contracts.

Her work involves supporting people with complex mental health, intellectual disability, physical health, and communication needs. Sandy describes this challenging yet deeply rewarding field as the “sexy end of nursing,” reflecting the breadth and depth of comprehensive practice it requires.

# Conference

19-20 NOVEMBER, 2026

**Whānau in the Hearts and Minds of Nurses** – Ko nga Nehi te pumanawa mo te whānau

**19–20 November 2026**

The Pā, University of Waikato, Kirikiriroa – **Hamilton, Aotearoa NZ**

[Early Bird Registrations Open Friday 17 April!](#)

Join us in Kirikiriroa, Hamilton for two inspiring days dedicated to the future of mental health, addiction and disability nursing in Aotearoa.

**The Te Ao Māramatanga – NZCMHN 9th International Conference** brings together nurses, leaders, researchers, and partners from across the motto for connection, learning, and impactful kōrero.

This year's theme, **Ko nga Nehi te pumanawa mo te whānau – Whānau in the Hearts and Minds of Nurses**, places whānau-centred practice at the heart of every conversation – honouring whaiora, whānau, communities, culture, and identity as essential to wellbeing.

[More info](#)