



## THINK PIECE: Reflecting on Medical Anthropology in Aotearoa New Zealand

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# THINK PIECE: Reflecting on Medical Anthropology in Aotearoa New Zealand

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## I. Introduction

Over the last forty years medical anthropology have put down strong local roots in New Zealand. Today it is arguably one of the largest and most distinctive sub-disciplines within New Zealand anthropology. Two founding scholars of the discipline in Aotearoa<sup>1</sup>, Ruth Fitzgerald and Julie Park, claimed over a decade ago that much work remains for medical anthropology in and of New Zealand. Settler societies such as New Zealand, they argued, “offer dizzyingly large numbers of processes and sites suitable for study by medical anthropologists and the continued collection of contemporary research of this kind is invaluable for those of us attempting to document the wider cultural meaning of health” (2003: 15). Despite an increasing number of medical anthropologists working within and outside of academia, Fitzgerald and Park’s call to action remains prescient, and in early 2017 a group of scholars from across New Zealand responded by establishing the Society of Medical Anthropology in Aotearoa (SOMAA). The Society reflects a growing intellectual and public interest in the discipline and an increasing desire among scholars to expand medical anthropology’s engagement with public debates about health and wellbeing.

The opportunities available for medical anthropologists to engage with major health issues and research in New Zealand are, as Fitzgerald and Park note, sometimes challenging. That medical anthropological research is socially contextualized, people-centered, qualitatively rich, inductively open, and longitudinal make it an ideal tool for the study of complex, often-intractable health problems. Yet it also remains an odd fit with dominant approaches to health research in New Zealand, which often require short timeframes, a focus on quantitative measures, and carefully circumscribed questions and results (2003). Yet this friction is precisely why medical anthropologists are valuable to these debates, bringing perspectives that call into question dominant assumptions about the body, community, suffering, agency and illness, and foregrounding diverse human experiences and systems of meaning.

In considering what makes Aotearoa unique for medical anthropological focus, this think piece sets out four themes. These reflect New Zealand’s particular historical, political, social and cultural landscape, and reveal the relevance of local scholarship for wider global debates about health. By tracing the neoliberal reform of state healthcare, indigenous approaches to wellbeing, local cultural practices of health, and the complex ethics involved in health and illness, this paper spotlights the opportunities that New Zealand medical anthropology affords us for addressing the important health and wellbeing challenges that we face.

## II. Neoliberal Frontiers of Health

New Zealand represents a fascinating case study for understanding how the rise of the neoliberal state affects healthcare. New Zealand has always been at the forefront of neoliberal reform globally. In 1984 the Labour government instituted a radical programme of privatization and economic liberalization, shifting the country from one of the most protected, state-regulated economies in the world to one of the most unregulated free market systems in existence. So abrupt and deep did this political transformation run that it became a model held up around the world by free market proponents (Kelsey 1997). Locally, this watershed moment remains the topic of strong and often

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<sup>1</sup> Aotearoa is the indigenous Māori name for New Zealand. The literal translation is ‘Land of the long white cloud’.

emotionally charged debate, particularly for those who experienced firsthand the rapidly shifting social contract and its effects on their own lives and opportunities. New Zealand society has thus been reckoning with the social consequence of radical market restructuring, and its consequences for health, for nearly four decades.

In line with such reforms, from the 1990s the government began to transform public hospitals to be run according to more commercial principles by competitively-salaried corporate managers. Today New Zealand remains a hybrid mix of public and private systems of care. The country retains a broadly universal public healthcare system. Hospitals are run on a not-for-profit basis, but on an ever-shrinking percentage of government spending, requiring health boards to operate with tight fiscal discipline. Visits to doctors are subsidized but require a co-payment. And while these visits are further subsidized for low income people, research reveals doctors' fees remains a significant barrier and deterrent to many, who consequently tend to utilize hospital emergency rooms when illnesses become acute, worsening health outcomes for marginalized families and communities (Jatrana and Crampton 2009).

Seeking to support a diversified healthcare 'market', subsequent governments have supported the growth of various non-state healthcare actors over the last three decades. Not-for-profit non-governmental organizations, community groups and voluntary groups are now key providers of certain health and disability services, often having to raise money from charity drives, or through competitive tenders for government funding. And the private healthcare market continues to grow, with around 35 percent of the adult population now voluntarily paying for private health insurance. Many medical professionals and health advocates argue that a public-private split in New Zealand does not ease the burden on public healthcare, but instead creates staffing shortages in the public healthcare sector, and weakens support from wealthy, well-resourced people prepared to fight for good public healthcare and publically demand its improvement. This in turn is creating a real risk that public healthcare will become a neglected, substandard system for those too poor to afford health insurance (Wagstaff 2010). One estimate also suggests that the private healthcare system in New Zealand costs the public health care system between \$40-100 million a year (Blumberg 2006).

Globally, New Zealand thus represents a microcosm through which to track and examine the rise of a neoliberal model of health that encourages for-profit and third sector healthcare services, within a society built upon a state-run universal healthcare system. At a time when many are debating the reforms needed to improve healthcare, such as is currently occurring in the US and UK, New Zealand provides a potent case study to explore in real time the ways in which private care undermines, corrodes, transforms or supports state-run models of healthcare.

Beyond the primary healthcare system, New Zealand also offers an optic to understand the effects of neoliberal reforms on preventative medicine and health promotion. Recent public health initiatives and policies have increasingly promoted an ethic of personal responsibility towards health, an ethos that is becoming deeply engrained within public debates and social life. Despite community groups and medical researchers calling upon the state to intervene, the government has resisted using legislative measures to encourage healthy practices, such as removing tax on fruit and vegetable, restricting the clustering of fast food stores in poor neighborhoods, limiting the advertising of junk foods to children, or regulating the food sold in schools. By refusing to foreground or acknowledge the structural determinants of health that make certain choices possible or probable, and by claiming that New Zealand does not need a 'nanny state', they argue for a greater ethos of personal responsibility towards one's health (Trnka and Trundle 2014). While promising freedom, choice and autonomy, such an approach has resulted in a new culture of individual blame when health fails.

This new ethos of blame has emerged at the same time that political reforms have increased social inequality across New Zealand. These new levels of inequality reveal themselves nowhere more starkly than in recent disease and illness trends. These trends crosscut class and ethnicity, with the wellbeing of lower income Māori and Pasifika families hit hardest. Thus, cases of rheumatic fever and respiratory illness among children remain at high rates not normally seen in developed countries that have New Zealand's levels of overall wealth. Linked to overcrowding, poor

housing, poverty, and insufficient public investment in illnesses not deemed a high public priority, these diseases have particularly affected low income Pasifika and Māori neighborhoods.

Reflecting in part the stresses of poverty and racism, increasing rates of mental illness and suicide also track closely with rising social inequity, with Māori, Pasifika and young people faring the worst. Indeed, youth suicide rates are among the highest in the developed world, and combined with high rates of child poverty, mean New Zealand ranks close to last within the OECD and Europe for youth wellbeing (Frykberg 2017). Such statistics act as a barometer revealing how enduring structural racism and deepening social marginalization intersect, and indeed how New Zealand's political reforms have over time become deeply embodied by the population (Harris et al 2006, Jansen et al 2009).

### III. Indigenous Health in a Settler Society

In contrast to these themes of sickness and inequality, New Zealand also presents a hopeful example of how health can become a site for indigenous resistance, political participation and expanded conceptions of individual and community wellbeing. This is particularly the case where Māori community leaders, activists, health specialists and politicians have sought to create Māori models of health, and Māori-centered healthcare systems. Particularly significant has been a refusal to simply frame Māori health concerns within biomedical models of the body and illness, and instead insist upon a more holistic frame for understanding individual, familial and community suffering.

As the eminent Māori scholar Mason Durie has argued, “You don't say, 'How do I adapt this approach to Māori?' You start from the premise 'What is important to Māori' and build round it” (2003). In this vein, Māori scholars have developed models of health that place spiritual and relational wellbeing at the heart of health, and focus on the role of cultural connectedness within a more integrated conceptualization of mental and physical wellbeing. Such an approach draws factors that biomedicine does not traditionally associate with health into the conversation, such as access to and respect for one's language, familiarity with indigenous knowledge and custom (*tikanga*) and connection to tribal communities (*iwi*) and ancestral land (Durie 2004: 10). Māori scholars have also incorporated indigenous concepts into the practices of healthcare. Understanding, for example, how the body is *tapu* (sacred) or how a person has dignity and *mana* (authority and power), reorients healthcare towards considering how illness and medical treatment stem from or result in a person feeling disrespected or disempowered (Radio New Zealand 2017).

Māori anthropologists Lily George and Tarapuhi Bryers-Brown have been central to developing the concept of historical trauma in a New Zealand setting. This framework charts how the traumas of colonization become enduring legacies within Māori family histories, and how the contemporary state and society creates spaces for re-traumatization to occur (George et al. 2014, Bryers-Brown 2015, Wirihana and Smith 2014). As George and her colleagues demonstrate (2014), historical trauma in New Zealand intersects with contemporary forms of institutional racism and structural violence, particularly in the policing, justice and prison systems, which incarcerates Māori at record high rates. This system often casts accusations of criminally widely within networks of kinship and community. Women who are married to, related to and associated with ‘criminals’ thus can unjustly get targeted by the police for suspected criminal behavior, creating ongoing cycles of imprisonment, poverty, stigma and social marginalization for whole family groups (2014: 189). George and her colleagues' task, they argue, has been to humanize “existing stereotypes by telling the stories beneath them” (2014: 191).

Despite the suffering that George and her colleagues carefully acknowledge, embedded within such studies is a future focused politics of hope, an approach that rejects a deficit model attentive only to the ‘bad statistics’ of Māori health. Instead, scholars examine the strategies of resilience and protection that Māori have developed in the face of colonization in order to ensure self-determination and survival. How Māori “make use of individual and community strengths to protect themselves against adverse health outcomes and enhance their health and wellbeing” (Penehira 2011:4) has become the basis for powerful new models of healing that subvert the legacies of historical suffering in the present (e.g. George et al. 2014, Bryers-Brown 2015). As George and her colleagues argue, “Historical

trauma theory is about having the ability to name our pain, and create our own pathways to hope and healing” (2014: 192) and about “finding self-determined solutions to the ills which challenge our lives, while also critiquing societal ideologies and policies which contribute to the continuation of such challenges” (2014: 194).

This research is particularly powerful because it is produced by Māori scholars and communities themselves, and emerges out of a distinctly Kaupapa Māori methodological framework. As the Māori scholar Linda Tuhiwai Smith argued in her groundbreaking book, *Indigenizing Methodologies* (1999), this allows Māori communities to themselves lead the design, prioritization, interpretation, and dissemination of research, and to influence the policy formulations that follow. Such a vibrant indigenous research environment challenges the New Zealand medical anthropology community to further support and acknowledge the work and contributions of Māori medical anthropologists. Moreover, it calls upon us to work broadly and in interdisciplinary partnerships with Māori scholars and communities in ways that meaningfully involve collaborative processes, and which prioritize tangible goals aimed at improving Māori wellbeing.

#### IV. Local Cultures, Local Biologies

Medical anthropology’s focus upon localized and diverse cultural worlds has been crucial in revealing how diseases and pandemics are ‘done’ differently depending on social context. Julie Park’s work has been particularly deft in mapping out the specifically local cultural traits that shape the trajectory and treatment of illness. In relation to the question of how New Zealand families deal with hemophilia, for example, she charts the impact of an enduring pioneer mentality that values a “particular stoicism in the face of pain.” She explains, “Stoicism is an orientation to the world which mutes the expression and downplays the sense of pain, emphasizing the importance of perseverance...without making a fuss, finding ingenious ways to work around difficulties, and even better, doing so with a laconic sense of humor” (2013: 223-4). Correspondingly, hegemonic modes of masculinity and masculine identity limit the discursive possibilities for expressing suffering. Many men thus articulate the distress of living with hemophilia through discussing thwarted physical prowess and strength, specifically in not being able to play rugby, a nationally cherished sport (2000).

Susan Wardell (2013) has also explored how local ideals of gender shape disease, specifically in the area of mental health. Unlike many countries where the pharmaceutical and medical spheres has tended to feminize depression, the promotion of depression treatment in New Zealand has involved a particularly masculine mode of gendering illness. Her research thus shows that pharmaceutical advertisements to doctors could push back against the stoic man-alone attitude that “discourages men from seeking emotional and physical care or treatment” (2013: 67). At the same time, that they could also reinscribe “gendered stereotypes of the tough DIY [do it yourself] man” by promoting a self-management and self-help approach to the treatment of depression (2013: 76).

New Zealand scholars show that local cultural worlds not only provide the empirical material or raw data for analysis, but local epistemological frameworks can provide new theoretical tools for understanding the social and cultural dimension of health. Julie Park, Judith Littleton, Anne Chambers and Keith Chambers offer a powerful example of the value of such an approach. They demonstrate how the Māori concept of *whakapapa*, meaning genealogy or “placing in layers a range of relationships over time” (2011: 70), which can include spiritual, human and non-human entities, offers a sophisticated framework for understanding tuberculosis (TB) in New Zealand and the Pacific.

Tracing the whakapapa involved in a recent TB outbreak in Auckland among the Tuvaluan community thus meant linking historical TB epidemics in the Pacific to the present. This entailed highlighting the colonial history of the Ellice Islands, particularly the migratory labor patterns to phosphate mines on Ocean Island, an exploitative

industry that enriched New Zealand's agricultural sector greatly. It also involved tracing the resulting flow of people, food and water insecurities, and the substandard colonial health services and living conditions that allowed particular vectors of infection to occur and endure over the twentieth century.

Using a whakapapa model does not simply explain disease as a rich spatial and temporal weave of connections, but offers a way to think about obligations across difference. Along with whakapapa, the authors argue that the Māori principle of *utu*, or “reciprocity, repayment, retribution” (2011: 7), is helpful. They thus argue that,

As a better off neighbor and beneficiary of economic colonization in Tuvalu, with an advanced economy, which contributes more than our share to global climate change, New Zealand could use the whakapapa model to find ways to reciprocate for the benefits received and harms done. The principle of *utu* would support being more hospitable to people from this second smallest nation in the world (by population) who want – or seriously need – to include New Zealand in part of their transnational lives. In a whakapapa model, Tuvalu and New Zealand are part of the same environmental realm with mutual kinship obligations (2011: 23-4).

As these varied examples illustrate, medical anthropology has contributed to local conversations about health by foregrounding the culturally specific ways that illnesses become localized and rendered meaningful in a New Zealand context. Such studies reveal the unique cultural landscape of Aotearoa, from its gender norms and its settler identity, to its indigenous systems of knowledge and its distinctly Pacific location.

## V. Alternative Ethics

New Zealand is also a useful location for studying the complex and sometimes competing ethical practices that underpin healthcare. As New Zealand scholars have revealed, health frameworks often hinge upon a set of ethical tensions that practitioners and patients must continually navigate. Ruth Fitzgerald, for example, charts the hybrid forms of care that exist across the New Zealand medical system. Recent work has thus examined scientists within fertility clinics who must merge the precise technical care of embryos with emotional care, which entails “managing difficult patients, ‘talking up’ bad news, finding strategies to sustain hope and meaning, and ‘clicking’ or ‘not clicking’ with individual patients” (Fitzgerald et al. 2013: 1289). Correspondingly, Fitzgerald’s work on hospital care exposes the tensions between the ethics of *clinical care* and *managerial care*. The ethos of clinical care involves deeply embodied knowledge of medical practices that ensure that medical staff deliver medical care of an optimal kind and at the necessary speed to ensure the best outcomes for each individual patient. Managerial care, by contrast, focuses on the optimization of organizational efficiency, and is based on an abstracted vision of patients that blends the idea of good customer service with attempts to standardize care and reduce deviations from established norms (2004).

Other scholars have examined the double-edged nature of ethical practices within healthcare, which sees patients and health professionals navigate between the promises and problems of particular ethical orientations. In this vein, Catherine Trundle, Hannah Gibson and Lara Bell (forthcoming) have explored the diverse dimensions of vulnerability, challenging the pejorative analytical use of the term within medical anthropology by highlighting the interlinked positive and negative vulnerabilities that exist within experiences of illness and healing. Their framework of *articulated vulnerabilities* shows how illness and recovery involve multiple interconnected vulnerabilities at the somatic, social and political level, some of them deleterious to health and some of them supportive and desired. Regaining wellbeing often involves harnessing positive vulnerabilities in order to lessen the effects of harmful vulnerabilities. Thus positive forms of vulnerability exist alongside, and are often intimately interlinked with or emergent out of, forms of vulnerability that threatens health and cause sickness (forthcoming).

The multidimensional nature of ethical practice is also evident in Susanna Trnka’s recent study of childhood asthma, which explores the rise of “patient-centered care” in New Zealand, a model that encourages self-sufficiency, self-responsibility and autonomy among patients. Yet as Trnka reveals in her close analysis of family care regimes, such responsibilization ethics “are realizable only within the context of interrelationality. Autonomy and self-

realization can occur only in a framework that includes support and nurturance from others [...] personal autonomy and knowledge are underpinned and supported by social relations of care and structures of obligation that are inherent within families, communities, institutions, and state–citizen relations.” (Trnka 2017). Despite the important critique of responsabilization regimes that she offers, Trnka makes clear that the new rhetoric of patient autonomy also promises new democratic models of healthcare and patient experience. Such a nuanced approach refuses to take ethics as a normative regime that is simplified or schematized, but rather as a multifaceted, sometimes contradictory, set of social and political practices through which patients and sufferers must navigate and which they creatively remake according to their own concerns and priorities (see also Trnka and Trundle 2014).

Another strong focus by New Zealand scholars has involved exploring the ethical dissonances between patients’ lives and medical systems. This approach is exemplified in the work on d/Deafness by Julie Park, Ruth Fitzgerald and Mike Legge (2015). Exploring if and when d/Deafness is classified or experienced as a disability, they reveal the predicament d/Deaf people face in accessing disability services and assuming disabled identities while feeling able-bodied and well. They thus consider how support services for d/Deaf individuals and communities might be constituted differently, premised upon notions of “citizenship, participation, communication, and care” rather than disability (2015: 154).

In these studies, scholars critique and destabilize the taken-for-granted ethical categories of care, disability, responsibility and vulnerability, allowing us to see both their situatedness within wider political projects, and the opportunities for wellbeing, identity and action that they allow or foreclose. Medical anthropology thus encourages us to challenge what culturally undergirds the mundane practices of health, opening a space for emergent and alternative ethical possibilities for obtaining wellbeing.

This piece has provided only a small snapshot of medical anthropology in New Zealand. If I could describe all of the current research and interventions produced by the students, scholars and activists of the discipline, it would be a far richer and deeper picture. Yet even this narrow glimpse provides many examples of what a perspective from Aotearoa has to offer. Medical anthropology practiced in this particular place provides the vantage point of the neoliberal frontier, the perspective of indigenous approaches to health, the cultural viewpoint of a settler society in the Pacific, and a complex portrayal of the ethical dilemmas involved in sickness and healing. These themes will no doubt continue to occupy medical anthropologists as we carry on the work of understanding health in Aotearoa. At the same time, current and future scholars will reveal newly emergent and unexpected social and cultural practices of health, complementing, challenging and expanding the scholarship and ideas mapped out here, and growing the discipline’s roots even further into local ground.

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