

FEATURE ARTICLE

Crisis engagement in mental health: A New Zealand Māori contribution

Nick Drury and Te Ata Munro

Mental Health & Addiction Services, Hawke's Bay District Health Board, Hastings, New Zealand

ABSTRACT: *The active engagement of clients in mental health services offers far greater chances of successful outcomes. When clients do not actively engage in treatment, their risk of becoming part of the population of 'high users' is greater. The 'high users' consume a disproportionate share of health resources, which may prevent other potential clients from accessing services. Engagement can be particularly challenging in crisis situations, which is how many clients attracting psychotic diagnoses first enter the service. New Zealand Māori bring a transcendent quality to the idea of 'respect for Other', which would make it sacrilegious to overpower Other in most situations. This paper reviews a growing body of literature indicating how we might integrate an enhanced respect or reverence of Other into clinical practice. This includes the idea of engaging more frequently with the social network when building rapport with an individual is particularly challenging. There is some evidence that services adopting this kind of approach are more economical.*

KEY WORDS: *coercion, post-colonial, psychiatric emergency services, spirituality, taboo.*

HIGH USERS AND LESSONS FROM ASSERTIVE OUTREACH

It has long been recognized that a small proportion of mental health clients utilize a disproportionate share of health services. Calculations by Taube *et al.* (1988) indicated that less than 10% of clients were utilizing 50% of mental health service expenditure in 1980. By the mid-90s, the 10% of 'high users' were consuming 70–75% of clinical time (Buck *et al.* 2003; Stuart & Weinrich 1998). Moreover, 'high users' were also consuming a high percentage of non-mental health services (Buck *et al.* 2003). Indications are that this skewed distribution of use is greater in mental health than non-mental health. An economic principle, called Pareto optimality, calls for resources to be shared equitably in a population. Pareto optimality is defined in the following manner: things are

as good for a population as they can get, and one person's gain is no longer another's loss (Daniels 2007). In mental health, this can only be achieved by tackling the problem of the 10% of 'high users', and thereby changing this skewed pattern of health-care provision.

Following deinstitutionalization, by the late 1970s it was recognized that there was a population of 'high users' in mental health (Ellison *et al.* 1995). Amongst adults, these 'high users' tend to attract diagnoses of schizophrenia or major affective disorder. Recently, a growing number of children are joining this 'high user' group also, particularly those with stress-related emotional and adjustment difficulties (Buck *et al.* 2003). Assertive Outreach or Assertive Community Treatment teams (AOTs) were developed in the 1980s to keep these adult 'high users' out of costly hospital beds (Stein & Santos 1998). However, in the past decade, there has been much soul-searching about the ethics of coercive services that pursue and 'offer' services to reluctant and uncooperative people, where the primary emphasis is upon medication compliance (Diamond 1995; Williamson 2002). As Williamson notes, it is difficult not to see assertive outreach as little more than 'social control through the imposition of an

Correspondence: Nick Drury, Mental Health & Addiction Services, Hawke's Bay District Health Board, Hastings, 4120, New Zealand.
Email: Nick.Drury@hawkesbaydhh.govt.nz
Nick Drury, DipClimPsych.
Te Ata Munro, RN.
Accepted March 2008.

oppressive biomedical model' (p. 544). A form of colonization. Some argue that coercive paternalism is justified if there is increased risk of suffering or risk to others (Burns & Firm 2002; Scharfstein 2005). Wikler (1979), however, found that if practitioners themselves were in a similar predicament, they would not want to give up their own freedom to make decisions.

More recently it has become increasingly recognized that most successes Assertive Outreach has obtained in reducing repeated psychiatric hospitalization rates have come from establishing collaborative therapeutic relationships (Addis & Gamble 2004; Fakhoury *et al.* 2007). Success is because of a shift of emphasis from a narrow biomedical focus on medication compliance to an engagement of clients around 'everyday problems' like housing, income, relationships, and other issues of daily life (Falk & Allbeck 2002; Rapp 1998). As Wharne (2005) notes, 'it is perhaps the primary role of AOTs to bring them (clients) to the point of being able to engage successfully' (p. 328). Although medication adherence has been the mantra of the biomedical focus, and non-adherence the alleged cause of relapse and rehospitalization (Thieda *et al.* 2003), on the basis of Assertive Outreach results, a stronger case can be made for the failure of engagement to account for poor outcomes. Wharne (2005) noted that increase in symptoms were usually triggered by relationship conflicts, often with family or friends. When the therapeutic engagement was good, these difficulties could be better navigated. In fact, those diagnosed with schizophrenia and not taking 'antipsychotics', but having good relationships, were found to have a better recovery in a recent 15-year follow-up (Harrow & Jobe 2007).

This shift in focus to the importance of the therapeutic alliance when dealing with this population of 'high users' is in keeping with a growing body of literature attesting to the importance of the therapeutic alliance in most successful psychotherapy (Duncan *et al.* 2004; Wampold 2001). This includes the goal of reduced hospitalizations; for example, with clients attracting a Borderline Personality diagnosis (Comtois *et al.* 2003; Hoch *et al.* 2006). Following a meta-analysis of psychotherapy research, Asay and Lambert (1999) estimated that the strengths and happenstance events that the client brings to therapy account for 40% of the success; and the therapeutic alliance for a further 30% of the success. The particular medication or model of therapy practised by the therapist accounts for only a modest 15% of the success. (The remaining 15% is due to the installation of hope or expectancy that the client will get better.) Wampold's (2001) meta-analysis attributes 54% of the success to the therapeutic alliance, and only 13% to the medication or tech-

nique of the therapist. As Duncan *et al.* (2004) stress, we have been far too preoccupied with the therapeutic technique or pill; our primary focus needs to be on establishing and maintaining the therapeutic alliance, for it is the factor we have the greatest influence on. In the review of this literature by Blow *et al.* (2007), they estimate that *how* we deliver treatment is several times more important than *what* we deliver, for our effectiveness is dependent on creating the therapeutic alliance.

MENTAL HEALTH'S BLIND SPOT

Despite this consistent finding that the therapeutic alliance is the primary key to success in mental health, it has too frequently been relegated to a secondary role or ignored in research and policies regarding practice. Lebow (2006) cites research funding patterns over the past 20 years as being medical model-focused, where the specific ingredients of the treatment are given more importance than *who* provides or *how* interventions are delivered. Indeed, therapist effects are viewed as a 'nuisance' in this type of research; they are 'features to control to ensure that different treatment groups receive comparable interventions' (Lebow 2006; p. 132). Another reason the alliance has been marginalized, is that those developing particular models of treatment (and the institutions funding them), are conducting the majority of research on therapy, and so are naturally focused on *what* is delivered. Much of this research is driven by a political agenda aimed at eliminating human error by developing manualized treatments, where therapist effects are viewed as sources of error rather than variances of effectiveness. However, standardization of treatment has not and cannot eliminate therapist variance (Blow *et al.* 2007; Duncan *et al.* 2004).

A further reason for failure to acknowledge the primacy of therapeutic engagement is that mental health service policies have been focused on stabilizing behaviour, especially crisis behaviours, as rapidly as possible. The sociologist Nikolas Rose (1998) claims that behind the fixation on risk assessment and risk management in mental health lies a more sinister regime; clinical judgement is now less about care and treatment he argues, and much more about the control of those who might pose a threat to the community in which, with the closure of the asylums, they now must live. So individuals are brought to emergency services by crisis teams and the police where hospitalization, costing hundreds of dollars a day, is made available. As noted above and below, ethically questionable coercive practices are also often utilized to

'encourage' the client to take medication as soon as possible (McGorry 2006; Williamson 2002).

Although inpatient hospital staffs hope a therapeutic alliance can be established by the time of discharge, once coercion has occurred it can have a major influence on the treatment relationship. Blanch and Parrish (1993) found loss of trust lasting years after clients were involuntary hospitalized. Calling for a reform of the sociopolitics of treatment in psychosis, McGorry (2006) points to 'the iatrogenic effects of standard care' (p. 19) which is all too frequently characterized by 'crude, typically traumatic, and alienating initial treatment strategies', with 'poor continuity of care and engagement of the patient in treatment' (p. 20). Similarly, Read and Hammersley (2006) argue that the more we privilege models focused on medication compliance over models focused on psychosocial engagement, 'the more frightened, prejudiced, and distancing we become' (p. 274).

Whilst Blow *et al.* (2007) say they are surprised or shocked that greater attention has not been given to therapist variances and the alliance, we say it is a travesty. The failure to engage is all too frequently being attributed to the client, rather than to poor practitioner skills. It should come as no surprise that the greater the cultural and economic gap between practitioner and client, the greater the chance of a 'stronger' diagnosis and hospitalization (Jarvis *et al.* 2005; Minsky *et al.* 2003). As a result of failure to engage, the client is at risk of becoming a 'high user' who will consume a disproportionate share of health resources (and not just mental health). Furthermore, as noted above, this skew in service use because of the growing numbers of 'high users' means that other potential clients are missing out on services.

MANAAKI TANGATA

We would suggest that some indigenous knowledges have much to offer mental health with respect to improving the ability to engage therapeutically with clients who are at risk of becoming 'high users'. Durie (2005) suggests that by focusing on the interface between indigenous knowledge and other knowledge systems, opportunities for employing aspects of both for mutual benefit may arise. This invites us to shift our conversation from a focus on cultural competence as knowledge of another culture, to allowing and acknowledging these ways of being into our ways of being. In particular, Durie (2000) has drawn our attention to the idea that Māori cultural lore of *tapu*, *noa*, and *mana* has potential for risk management in mental health and forensic services. 'Where risk or danger might be encountered, a state of *tapu* was declared, but when

the threat had passed, activities and people involved in them assumed a *noa* status' (Durie 2003). Although the Polynesian words *tapu* (as taboo) and *mana* already found residence in English dictionaries, he suggests that it may be helpful for all to understand the lore or custom (or contextual use) involving these terms better. These ideas lie at the heart of the art of hosting, *manaaki tangata*.

Usually when translated, *tapu* becomes 'sacred', 'dangerous', 'bound', or 'set aside'; *noa* becomes 'secular', 'profane', 'free', 'unbound', or 'safe'; and *mana* becomes 'power' (usually supernatural), 'prestige', or 'standing'. However, anthropologists such as Geertz (2000) and Ricoeur (1994) insist that words are idiomatic and local, and cannot be simply equated with words in another idiomatic and local language. A possible way out of this cultural relativism [so well expressed in Derrida's (1974) famous maxim 'there's nothing outside the text'] is the one offered by Polanyi (1969) and Lakoff and Johnson (1999), and other 'embodied mind' theorists. This approach grounds meaning-making in primitive or simple sensorimotor patterns, many of which are either common to humanity, or can be simply integrated with previous simple sensorimotor experiences. Now, if we consider the common response to an encounter with novelty or *Other*, we note the pause in the flow of our being as we attempt to make sense of it. The generative power or potential of *Other*, what Māori call their *mana*, captures our attention. A wariness is elicited in us. A culturally orchestrated expression of this common sensorimotor response has been suggested by Shore (1991) to be at the root of this concept *tapu*: 'The imposition of *tapu* on people or objects involves experiences of binding, containment, immobilizing and centring in the interest of rendering these people or objects intelligible, and redirecting personal potency for general or cosmic ends'. (p. 17)

Further, Shirres' (1979) analysis from mid-19th century Māori authored manuscripts which offer an even wider perspective of *tapu* than Durie's (2000) suggestion of risk/crisis management. Shirres argues that *tapu* is the recognition of the potentiality for power, either good or evil; and thus is similar to the New Age interpretation of the Chinese character for 'crisis', which incorporates both 'opportunity' and 'danger'. An aesthetic dimension might also be suggested, and we might say it is a situation 'pregnant with possibility'. Because these possibilities are infinite and thus transcend knowing completely, for Māori, *Other* is sacred. Usually, the first translation of *tapu* is 'sacred'. Thus the Māori protocols of *tapu* are deeply concerned with regard to the potential of violence to this 'sacredness' of *Other*.

There is also a relativity in play with *tapu*, for both *Other* and I have *mana*. As a host I need to figure out how we are to go on together in a manner which is beneficial or enhancing to us both, and does not trample on the *mana* of either of us. This is the art of *manaakitanga* (hospitality) – enhancing the *mana* of each of us (Durie 2001; Mead 2003). We may find a way to go on with each other, but it may not be enhancing to the sacredness of one or both of us. Shirres (1982; 1997) describes this as a difference between positive and negative *noa*. Negative *noa* is when the *tapu* of *Other* (or myself) is overpowered – their (or my) intrinsic sacredness or *mana* is trampled upon. This occurs when someone is made a prisoner or slave. Positive *noa* is when the ‘potential for power’ of each can be enhanced.

In the past decade, some Māori educationalists have noted the perceptions of ‘giftedness’ amongst educators are essentially Eurocentric (Mahuika 2007). One such ability is *manaakitanga*, which could be thought of as a performance talent similar to ‘musical intelligence’ or ‘athletic intelligence’. It is a form of social–emotional intelligence, and people with this skill (*kaimanaaki*) have the knack of making others feel relaxed and at ease quickly. As Milne (1993) notes, a student gifted in *manaakitanga* may not be recognized if hospitality is not recognized as a talent in our classrooms; a talent useful not only for tourism and diplomacy, but also for crisis negotiation. This is a performance skill, and although teachable to an extent, just as music can be, those with a ‘talent’ or ‘intelligence’ for it will fare better.

POST-COLONIAL STUDIES

This enhanced sense of respect called for by considerations of New Zealand Māori lore of *tapu* is not, we believe, confined to Māori culture. We see the same call being made by many indigenous people and this is frequently the subject matter of post-colonial studies (Eaglestone 2006). Post-colonial theology is particularly interested in how we might foster a greater perception of the sacred or transcendent quality of *Other* (Rivera 2007). For example, many people from India use the greeting ‘Namaste’, translated as ‘bowing to the divine within you’. Western ethics owes much of its thinking to Kant (1797/1991) who argued that respect does not have to be earned, we cannot put a price on another person and people must be ascribed reverence. However, Kant’s writings suggest that only rational beings warrant respect, which has led to loss of respect or recognition of the transcendent or sacred aspects of *Other*. In mental health, we see the Cartesian–Kantian legacy played out in the

alienating rush to diagnose *Other*, which leads to a failure to engage (Luhmann 2008).

Recently, Levinas’ (1998) ‘Ethics-first’ philosophy has elicited much interest in philosophy and post-colonial studies. For Levinas, *Other* has transcendental qualities, aspects that cannot be fully absorbed within any conceptual scheme. He/she transcends my knowing, and cannot be known completely. The ‘otherness’ of *Other* is for Levinas, ‘beyond being’. Poetically, Levinas says we see the trace of God in the face of *Other*. As such, we are ‘called’ by this transcendent quality of *Other*. Levinas’ philosophy is viewed by some as a much needed antidote to the Cartesian–Kant legacy of Western culture that has restricted respect to the rational and known (Gantt & Williams 2002).

CRISIS ENGAGEMENT SKILLS

Whilst lamenting the paucity of research on the skills mental health practitioners bring to de-escalating potentially violent situations by engaging clients, Flannery and Walker (2003) acknowledge that some practitioners have developed better skills than others. Although leaders in the field (e.g. Mullen 2000) suggest that psychiatric risk is best approached as a therapeutic task, suggesting that engagement is crucial, the language all too frequently used suggests that ‘risk assessment’ is something ‘done to the client’, and can be done in a standardized manner. This practice has arisen, we believe, because risk management has grown out of forensic psychology’s actuarial risk assessment in a political climate of risk aversion. Some writers have attempted to distance themselves from the ‘neutrality’ or ‘passivity’ of actuarial risk assessment by suggesting that clinical risk management is a different activity, as its aim is not to predict risk as much as it is to prevent or reduce the potential of risk manifesting (e.g. Ogloff 2006). This shift calls for a recognition that there is no ‘one size fits all’ consistent method for successfully negotiating crises, for success will depend as much on what the practitioner brings to the table in terms of personal attributes, as well as the relationship, the situational attributes, and the client and their social nexus.

Police crisis negotiation research and literature have highlighted some communication patterns that frequently accompany the development of successful collaborative relationships (Greenstone 2004). For example, Donohue and Roberto (1993) found that when police negotiators and those at the centre of the crisis moved *towards* each other (either psychologically or physically), and *with* each other, in a kind of collaborative dance, resolution of the crisis was more likely. Humour, especially self-

deprecating humour, can also have a positive impact in facilitating this dance (Misino 2004; Strentz 2005). As the Harvard Negotiation Project has noted, successful negotiation calls for the utilization of one's own emotions in a manner which invites respect for all parties (Fisher & Shapiro 2005).

The child welfare literature also provides valuable suggestions for developing our crisis engagement skills in mental health. Influential writers in the child protection field have also noted that there are serious risks of iatrogenic effects in maltreatment cases when a child is placed in foster or institutional care (Parton *et al.* 1997; Pelton 1997). They claim that removal of the child occurs when more important social, cultural, and ideological issues are ignored. This has led to the development of strengths or solution-focused approaches that seek to stabilize and strengthen family situations where there are at-risk children. One of these, the 'Signs of Safety' approach developed by Turnell and Edwards (1999), which builds partnerships with parents and others, could be adapted for crisis management in mental health. This approach engages around three queries: what is worrying, what is working well and what needs to happen.

These writers note that collaborative relationships are more likely to develop when therapists keep a focus on the client's and their family's strengths, on what is working well, whilst being mindful of the problems of concern. In an extremely elegant study of differences between successful therapeutic change and unsuccessful therapy, Gassman and Grawe (2006) found that successful therapists activated the client's resources or strengths from the start, usually, before moving on to activate the client's focus upon the problem. Unsuccessful therapists tended to neglect the strengths, or did so only late in the session. It seems that if one's strengths are not activated, there is a greater chance of taking flight or becoming defensive about the problem. In the formalized New Zealand Māori encounter on the *maraeatea* (meeting house courtyard), we find a similar prescription for the manifestation of *manaakitanga*. In the *powhiri* ceremony of welcome, acknowledging the visitors' *mana* (*waioha tuarua*) occurs from the beginning, and is returned to frequently. This also helps establish a relationship of equals. As Durie (2001) notes 'relationships based on vertical hierarchies take second place to relationships. . . . of mutuality and reciprocal obligations' (p. 78). This also makes good clinical sense, for the most potent contributor to outcome in therapy is the resources the client brings or has available through their relationships. Duncan *et al.* (2004) present evidence that in therapy, when we enlist these client strengths, we both enhance

the alliance and dramatically increase the chances of successful outcomes.

The 'Signs of Safety' approach suggests that this collaborative therapeutic relationship can be furthered by searching for exceptions to the problem behaviour; times when the individual at the centre of the crisis could have acted out in a dangerous manner, but did not. What strengths or resources came into play that reduced the risk? Who noticed, and what does this exception mean? Are there other problems that can be or are being successfully addressed? These exceptions may indicate potential solutions, and allow the therapist to invite reflection on the *mana* of the client and their family/*whanau*. Although some sort of 'invitation to responsibility' is important in many crisis situations, an exclusive focus on achieving this with the individual at the centre of the crisis without an activation of the client's resources can obviously lead to moving *against* rather than *toward* and *with* experience. The more a variety of options can be discovered or offered, such as overnight stay in a nearby motel or crisis home, getting family friends or extended family involved, follow up the next day, etc., so that coercion becomes unnecessary, the greater the chance that engagement will occur. Obviously, once engagement has been achieved, the involvement of other mental health workers should only be transitioned within the context of the engagement that has been achieved.

CASE EXAMPLES

In discussing this paper with a number of colleagues we were surprised by the number of case examples shared with us. We share three of those here.

When Margaret made a home visit to a newly referred client, she suddenly found herself in a situation of having a gun pointed at her head. Recalling her lessons as a dog ranger to avoid allowing her fear to run away with her, she began to talk of her relationship with the gunman's grandmother, whom she knew many years earlier. As she proceeded, she noticed the gunman gradually relaxing, and she was able to establish that they shared a community connection that went back many years. Over the following months, she was able to help the young man at the centre of this drama find a new course in life.

Dave was called to a police crisis where a man stood at the centre of a ring of armed police in a shopping mall car park, brandishing a machete. After getting permission to approach the man, Dave went close enough to be heard speaking softly (but distant enough to be out of reach!) Keeping his head down and looking at the man's bare feet, Dave asked if his feet were cold on this winter

morning. After what seemed like an eternity, Dave says the man allowed him to get socks and shoes for his feet. Dave was then able to ask if the man wanted his help with any other difficulties. Over the next two years, they worked through a number of traumas this war veteran had experienced.

Ripeka and her *kaupapa* mental health team were called to the home of a woman whose husband had walked in on her hanging herself. She had lost an infant to a cot death a few weeks earlier, and it was quickly established that she had serious plans to suicide. The team explained to her husband that although they were more than willing to hospitalize her, less trauma and a better prognosis might be achieved if family resources could be activated to keep her safe. Her husband was issued with a medical certificate to take time off work, two sisters of the woman volunteered their time, and some members of the church brought cooked meals to the home over the next few weeks. The team visited daily at first, coaching the family through interventions they had made to thwart further attempts. The crisis lasted three weeks.

Stories such as these, of human 'horse whispering', appear to be relatively common at the coalface but largely absent from the mental health literature.

WHANAUNGATANGA – FAMILY INVOLVEMENT AND THE MERITS OF PSYCHOSOCIAL INTERVENTION

One place where there is a decline in 'high user' numbers, and greater Pareto optimality has been achieved, is Northern Scandinavia, where network therapy has been developed. Frequently, the call for mental health assistance at the time of crisis is made by family members, and not the individual of concern. If the individual is reluctant to engage in services, coercive interventions may seem attractive. However, superior outcomes for psychosis, both short-term and long-term, are being achieved by Northern Scandinavian teams and engaging the families and their social networks at these times (Seikkula 2002; Seikkula & Arnkil 2006; Seikkula *et al.* 2006). By engaging with the families, utilizing their strengths to contain the situation and commencing with psychosocial treatment from the outset, Seikkula *et al.* (2006) have managed to reduce hospitalization rates to about 25% of other services. They also have more than 80% of their clients either working or studying 5 years later, and 75% showing no residual signs of psychosis. They appear to have all but eliminated psychiatric chronicity in their area.

Because of the widespread belief that the longer the duration of untreated psychosis with neuroleptics, the

greater the degree of brain degeneration will occur, crisis services have rushed to medicate, by coercion if necessary. However, McGlashan (2006) argues that unlike other degenerative disorders, such as dementia, any neurological deterioration in psychosis appears to largely plateau after 3 years. He argues that brain cells are not lost, only their synaptic connections to other brain cells. The preoccupation with delusions and hallucinations leads to a synaptic disuse atrophy. Although neuroleptics may reduce the preoccupation, psychosocial therapies or natural encounters that engage the client will also facilitate reconnection ('re-membering'). This is supported by the findings of de Haan *et al.* (2003) which indicate that delays in intensive psychosocial treatment appear to be a better predictor of poor prognosis than delays in antipsychotic medication. As Seikkula *et al.* (2006) have demonstrated, when the primary focus shifts to social engagement, medication becomes secondary, and in some cases, unnecessary. Bola (2006) notes that the claim that postponement of antipsychotic medication is unethical needs to be reconsidered, as it is not supported by the available evidence.

There is also a growing body of research supporting the position, popularized by Whitaker (2002), that neuroleptics, including the atypicals, cause an abnormal increase in dopamine receptors, thereby rendering people to an increased susceptibility to further psychotic episodes. Their use also leads to an increase in akathisia, which is associated with increased risk of violence. Increasing the use of neuroleptics to deal with these problems seems to be increasing the level of amotivation in these clients and making the chances of 'recovery' slimmer. It is little wonder that the 10% of 'high users' are utilizing increasing amounts of the health services.

Another factor adding to this 'chronicity' problem is Read's (2007) findings that the 'mental illness is an illness like any other' campaign actually fuels fear and prejudice, leading to social distancing and lowered levels of help-seeking. It invites passivity. We have ample evidence that urban living, racism, and other forms of discrimination, child abuse, trauma, early maternal stress, poverty, and other social stresses, including hostile and confusing family milieus, are all possible causes of psychosis (Read & Hammersley 2006). By deliberately ignoring the social causes, especially the family dynamics, services may inadvertently support the power struggles in the dance of 'invisible loyalties' that are occurring in the family (Stierlin *et al.* 1980).

An alternative understanding to the biopsychiatry model, offered by Seikkula and Arnkil (2006), is that an individual, traumatized or wounded in some ways, has

taken refuge in 'an exaggerated state of isolating monologue' (Anderson 2002). In turn, the social network, often inadvertently influenced by the language of biopsychiatry, has also become embedded in a monological position. The result is spiralling and isolating monologues. The social network is in crisis at the time of the referral. It is fragile and engagement with the whole network is crucial. If monologue is the crisis, re-engaging the network and identified client in dialogue is the aim of therapy. At Seikkula's Keropudas Hospital, treatment teams of three or four clinicians meet with the client and their social network within 24 hours. They may meet daily during the first week, depending on the crisis. The same team remain involved throughout treatment. Witnesses to this 'open dialogue' approach report that people, often quite frightened, are soothed when a deliberating atmosphere is generated, and every one is listened to respectfully and responsively, even the acutely psychotic (Trimble 2002). This to us, is what we mean by *manaakitanga* in mental health.

CONCLUSION

Manaakitanga is the skill of hospitality, the art of creating an atmosphere where the *mana* of all participants is enhanced. This is an extreme challenge in some mental health crisis situations; but when the challenge is not met and the client is overpowered by coercive treatments, the long-term cost is high for both the client and society. As there are a number of ethical questions hanging over the practice of assertive outreach, which is often *offered* to clients who have not engaged actively in their treatment, we invite greater reflection on how we might engage clients better at the point of entry into mental health services. By perceiving a sacred quality in our clients, we might begin to share stories of our human 'horse whisperers' more. We are extremely impressed by the outcome figures reported from Northern Scandinavia by Seikkula *et al.* (2006) who appear to have eliminated psychiatric chronicity. We believe we have much to learn, especially, in the act of engagement, so that we may serve our clients better.

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