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The Tidal Model of Mental Health Recovery and Reclamation: Application in Acute Care Settings

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The development, over the last decade, of the Tidal Model of Mental Health Recovery and Reclamation is described, and a summary of the application of the various Tidal processes of care is provided. Studies of evaluations of the Tidal Model within acute care settings are summarised and the potential contribution that the model makes to the development of person-centred care, within acute settings, is discussed.

RECOVERY AND MENTAL HEALTH

First developed in England in the late 1990s (Barker, 1998), as a model for acute mental health nursing care, the Tidal Model of Mental Health Recovery and Reclamation (Barker & Buchanan-Barker, 2005) is increasingly recognised as an important mid-range nursing theory (Brookes, 2005, in press; Cutcliffe, H yrkas, & McKenna, 2009) and is now practised by a range of disciplines across the mental health care spectrum (Barker & Buchanan-Barker, 2008a). Over 100 discrete Tidal projects have been established in Australia, Canada, England, Ireland, Japan, New Zealand, Scotland, and Wales, serving people in youth, acute psychiatric, rehabilitation, autistic-spectrum, learning disability, and elder care services, across the community-hospital care divide.

The Tidal Model focuses on helping people who have experienced some metaphorical “breakdown” recover their lives as fully as possible, by reclaiming the personal story of their distress and difficulty. Given the multifarious nature of existing definitions (Craig, 2008), the Tidal definition of recovery is framed so that persons in care are enabled to clarify their own understanding of the concept.

In the Tidal Model, recovery means “getting going again.” The myriad human problems and experiences described as different forms of mental illness or psychiatric disorder, all involve some slowing down, disruption, or arrest of personal, interpersonal, or social development, or some other interference with the conduct of everyday life. By trying to help an individual “get going again,” the Tidal practitioner, of necessity, helps others identify, describe, and begin to address the issues, problems, or difficulties, that brought them to this particular point in their life and, thus, begin to rejoin the flow of life.

Tidal assumes that the primary aim of acute care is to provide a safe haven within which support is provided to enable repair and recuperation work to be undertaken. This is the necessary precursor to returning to everyday living in the natural community. The experience of acute care is, therefore, recast as a rehearsal space for addressing the problems in living that made this form of care necessary in the first place.

GENESIS AND INFLUENCE

The origins of Tidal lie in our work with people with multiple disabilities from the early 1980s and our early attempts to develop an alternative model of nursing for working with people with a diagnosis of manic depression (Barker, 1984; Barker & Buchanan-Barker, 2008b; Barker, Hume, & Robertson, 1984; Hume et al., 1988). Those experiences led us to question the appropriateness of trying to help people change through some form of therapy or active form of professional intervention (Masson, 1989). Over time we concluded that the most important consideration involved the question: How might we help people live more personally meaningful lives by using the personal and interpersonal resources they already possess (Barker, 1990)?

In the 1980s we also discovered the work of Morita (1874–1938) who had developed a highly original form of psychotherapy in 1920s Japan (Reynolds, 1984). Morita addressed his patients as students, affirming that his role was not to change them (or rid them of mental illness), but rather to help them learn something directly from life, about their experience of living with such problems. Morita reminded us that life cannot...
be controlled, but we can do something to respond to the challenges that life puts before us (Morita et al., 1998). Morita’s Zen-influenced perspective resonates with other, pragmatic, approaches to addressing the lived experience of mental illness, which have influenced the development of the Tidal Model (e.g., Epston & White, 1990; Vaughn, Webster, Oralhood, & Young, 1995).

The formal development of Tidal began in 1996 and drew heavily on an international study of the need for psychiatric nursing (Barker, Jackson, & Stevenson, 1999) and a model of empowering interactions, which were developed from a study of the support perceived necessary by persons with a diagnosis of psychosis (Barker et al., 2000). All Tidal processes reflect the influence of our 25-year long interest in empowerment, needs-based care, and the enabling of learning through direct experience espoused originally by Morita, almost 90 years ago.

**DISTINGUISHING FEATURES**

Although the concept of “recovery” has become more widely accepted within mental health nursing (e.g., Jensen & Wadkins, 2007; Jones et al., 2008), the Tidal Model has some distinctive features and is probably the first mental health recovery-focused model that is:

- Developed by mental health nurses specifically for mental health nursing practice;
- Developed conjointly by mental health professionals and sample groups of people in their care (consumer-advisors);
- Developed for use in the most challenging situations: e.g., acute care settings, where people are at their lowest ebb;
- Evaluated rigorously in mainstream public sector practice; and
- Used as the basis of recovery-focused care across the hospital-community spectrum—from child and adolescent services to older persons (See Barker & Buchanan-Barker, 2005, 2008b; Buchanan-Barker & Barker, 2008; Fletcher & Stevenson, 2001; Stevenson & Fletcher, 2002).

**PHILOSOPHY FOR PRACTICE**

The theoretical and practical development of the Tidal Model (Barker, 2000a, 2001a; Buchanan-Barker, 2004; Fletcher & Stevenson, 2001; Stevenson & Fletcher, 2002) was built on the Model’s emphasis on the lived experience and the critical role of narrative (Barker, 2000b, 2001b; Barker & Buchanan-Barker, 2004a). The Model’s underpinning importance of empowerment (Barker, 2001c) and the importance of metaphor (Barker, 2002; 2004; Barker & Buchanan-Barker, 2005) have been described at length in the international literature.

Since 2002 the value base of the Tidal Model has been clarified further through articulation of the “Ten Commitments” (Buchanan-Barker & Barker, 2006, 2008), which are augmented by 20 Tidal competencies to support audits of Tidal practice (Barker & Buchanan-Barker, 2007).

Although described as both a theory and a model (Brookes, 2005; Cutcliffe, Hyrkas, & McKenna, 2009), Tidal is primarily a pragmatic philosophy for practice: a way of thinking about what needs to be done to enable the process of recovery. In our writings we have provided illustrations of how this enabling might take place (Barker & Buchanan-Barker, 2005, 2007), all of which were developed in mainstream clinical practice settings. However, these serve only as templates for the specific individual and group processes (described later) and are illustrative, rather than prescriptive. Practitioners need to tailor all interactions to suit the changing nature of the person’s life situation.

**Narrative and the Mystery of My-Story**

In Goatley’s (1997) view: “Language is more metaphorical, less literal than we are accustomed to think” (p. 336). The English language, in particular, is awash with metaphors, especially with metaphors of nautical origin. However, many non-European cultures with which we have had contact (e.g., indigenous Australians, the Maori and Pacific Islanders of New Zealand) also embrace water-related metaphors as a way of articulating indefinable aspects of human experience. When people have unusual or extreme experiences that they find difficult to express, frequently they invoke metaphors, standard or personal, as a way of articulating their experience. One person, who found it difficult to tell us about what was happening in her life said, “It’s the mystery of my story.” This reminded us that, commonly, health and social care professionals reduce the complexity of this “mystery” to a most rudimentary history.

People often find it difficult to find the words to express fully their unusual or challenging experiences. For this reason, Tidal emphasises the experience of persons—rather than the behaviour of patients (or clients, consumers, etc.)—and far less the illnesses or disorders that affect them. As a result, the Tidal Model favours talk about persons-in-care. Tidal is concerned not to unravel (or attribute) the cause of the person’s problems of living, but aims instead to explore the person’s experience and its associated meanings, as a means of charting the next step that might need to be taken on the person’s recovery voyage.

**Recording the Narrative**

As part of this conjoint exploration of the person’s world of experience (Barker & Whitehill, 1997) all records of the Tidal conversations are written in the person’s own voice, rather than translated into a third person account, or professional language. The nurse and the person-in-care co-create a narrative account of the person’s lived experience. This includes the identification of what the person believes is needed at that moment, in terms of nursing care, and holds the promise of what needs to happen to meet that need.
Our professional experience and research studies (e.g., Barker et al., 1999) suggest that people often retain only the vaguest memories of their stay in hospital. Such memories often are dominated by critical incidents or aspects of routine medical and nursing care. When discharged, a large body of professional records may be left behind, but the person may take little by way of an account of their experience of care, for reference.

In Tidal the person is encouraged to retain copies of all the assessments and care plans developed during their stay; for personal reference and discussion with family and friends where appropriate. On discharge, the person takes home these records as documentary evidence of the whole process of care. It is hoped that this will provide a basis for the continuation of the person’s recovery in the natural community. One Tidal consumer-advisor described this as the first step in self-management (Whitehill, 2005).

THE TIDAL MODEL IN ACTION

Philosophical Approach

Originally described as a philosophical approach to the development of practice-based-evidence in mental health care (Barker, 2000b), Tidal invites practitioners to ask:

- How do we tailor care to fit the specific needs of the person and the person’s story and unique lived experience, so that the person might begin, or advance further on, the voyage of recovery?

Tidal theory asserts that the unfolding drama of breakdown and recovery is experienced originally within the person’s whole lived experience, or lifeworld (McCann, 1993). The story of this unfolding drama emerges from three distinct but interrelated domains (or living spaces): Self, World, and Others (see Figure 1). These domains represent dimensions of the person’s overall relationship to the theatre of human experience and are the metaphorical settings for the enactment of the person’s story.

Discrete Tidal processes have been developed in an effort to explore the person’s ongoing experience, within each of these three domains.

The Key Tidal Processes

Overview

Tidal assumes that the necessary work of recovery should begin as soon as possible; Preferably as soon as the person connects with the service. Traditionally, a person referred to a service is accompanied by a referral letter or lengthy case notes describing past experiences of care and treatment. Historically, at least, the focus has often been on the illness rather than the person.

- The nurse’s first task is to find out who the person is behind all these histories, and what problems in living have brought him or her into care.

- Next, the nurse must negotiate with the person the kind of support needed to help begin to address these problems in living
- Finally, the nurse must negotiate the conditions that will promote the person’s sense of personal security. What will help him or her feel more secure? Less at risk of harm from self or others?

All the Tidal processes used to address these issues seek to keep the person in the driver’s seat, maintaining her or his autonomy, as much as possible. All Tidal care is seen as a rehearsal for the self-management that will be necessary when the person is discharged from care and expected to fend for him/herself.

The overall Tidal process—from entry to exit—is illustrated in Figure 2. This process is, of necessity, highly flexible and is dependent on the person’s presentation. Tidal work may begin in any of the three domains.

- If the person is in a highly disturbed (or disturbing) state, the initial focus may need to be on developing a Personal Security Plan, exploring the threats that lie deep within the person’s private world (Self domain);
- If the person is not a major risk to themselves or others, the team may encourage the person to begin to tell their story, through the Holistic Assessment, following this up with dedicated One-to-One sessions, in which the hot issues of the day can be addressed (World domain);
- If people are reluctant to engage in individual work, they may be encouraged to sit in on one of the groups, to become acclimated to the Tidal philosophy. Here the
The person may gain confidence in the team members or other persons in care (Others domain).

The Self Domain

The Personal Security Plan

The first priority of all care settings is to help the person feel as safe and secure as possible. Commonly, acute services provide close supervision (observation), often in conjunction with medication, as a means of containing anyone deemed to be at risk to self or others. Such interventions may limit the risk of physical harm, but often fail to address the person’s underlying emotional insecurity (Barker & Cutcliffe, 1999).

In the early stages the key Tidal focus is to develop a provisional Personal Security Plan, which will be developed further as the nurse-person relationship becomes more established. The Personal Security Plan is focused on helping the team, and the person, appreciate what the person might be able to do to help her- or himself feel more secure, and what the professional team might do to augment this.

This conversation begins to rehearse the collaborative relationship, which will be threaded through all the other Tidal interactions involving the nursing team. For many persons in care used to standard psychiatric practice, such openness can often feel threatening. However, our research (Barker et al., 1999) and ongoing professional experience confirm that persons in care find processes such as continuous/special observation oppressive (Rose, 2000). More importantly, containment alone does nothing to address the person’s underlying problems or to involve the person in her or his own care and self-management.

Bridging

The Tidal bridging metaphor (Barker & Buchanan-Barker, 2004b) suggests the necessary work of this stage in the caring process. The team must attempt to reach out toward the person in its care, but must also encourage the person to reciprocate, so that a connection might be made. Without such a mutual connection the bridge to recovery may be impeded. Regrettably, much mainstream acute psychiatric facilities across different countries worldwide, still maintains a unidirectional focus on physical safety, where the person in care is rendered relatively passive.

The Personal Security Plan is developed from conversations about the kind of things the person already does, or might do, to help him- or herself feel more safe and secure, and what others might do to augment this sense of security. As this discussion develops, notes are made (in the person’s own words) of the points discussed and, finally, the nurse makes a copy of the Plan for the person’s reference, as an aide memoire. The original is placed in the person’s notes for reference by the team. The person is encouraged to try out the plan as part of his or her everyday routine and the plan will be revised and adapted over the succeeding days, as useful things are maintained or developed further, and ineffective things are dropped and replaced by alternatives. Initially, the writing of this plan is undertaken by the nurse, who acts as secretary, but this responsibility is handed over to person (wherever possible) as quickly as possible, since the Personal Security Plan, like all other Tidal processes, belongs primarily to the person in care, and must always be regarded as such.

The Monitoring Assessment

As the relationship develops the team introduce the Monitoring Assessment as a means of helping person reflect further on him- or herself, his or her feelings, and the developing relationship with the nursing team. This process focuses on helping the person:

- Articulate his or her own thought/feelings/experience in his or her own words;
- Talk about how these thoughts, feelings, or other experiences affect the person, especially in terms of being safe or vulnerable;
- Externalise these personal states by scaling them with numbers or representing them graphically with pen and paper;
- Discuss the emerging relationship with the nursing team, especially in relation to current or potential helpfulness;
- Discuss what the person can or might do to help begin to develop a better sense of personal security; and
- Discuss what action the team might take to support the person’s personal security.

At the end of this session the person is asked to rate the degree to which he or she thinks he or she can keep him- or herself safe until the next session. The nurse does likewise, after which the two ratings are compared and discussed. Where there is agreement, this can serve as an illustration of the development of the bridging relationship. Where discrepancy exists, this provides...
an opportunity for further discussion of the differing perspectives, affording each party a chance to see themselves through the other’s eyes, thus enabling mutual empathy.

Finally, as in all Tidal sessions, a copy is made of the Monitoring Assessment record—which has been written in the person’s own words—for the person’s own reference; the original retained for reference by the team.

The World Domain

The Holistic Assessment

The Holistic Assessment is a five-page template for exploring, in more detail, the person’s lifeworld and the problems in living that generated the admission. After providing a simple rationale for the session, the nurse invites the person to talk about “what has brought you here?” or “how have you come to be here, now.” The person is, intentionally, not asked to talk about his problems, illness, or a particular disorder, since many people believe that they have no such problems, illness, or disorders.

Once the person has identified an issue, difficulty, or other problem in living (something he either wishes or needs to talk about), the nurse explores the circumstances under which the person became aware of this problem in living; the effect it had in the past and presently; how it has changed or developed over time; and the influence it has had on the person’s relations with others.

Although people often find it difficult to articulate meanings, the person is encouraged, however speculatively, to talk about the perceived meanings of particular events and what they believe this might say about them, as persons. This provides an opening to begin to discuss the person’s hopes and dreams regarding what might be done to begin to address the situation, especially the role the team—or other people—might play in this.

In the second stage, emphasis is focused on helping the person appreciate that the problem under discussion is the problem, and not the person him or herself. To this end, the person is encouraged to stand back from, or externalise (Abels & Abels, 2001), the problem—viewing it, as if from a distance.

- How much distress does it cause the person?
- To what extent does it disrupt the everyday living of the person’s life?
- How much control, if any, does the person have over this?

In the third stage, the person is encouraged to explore her or his personal (and interpersonal) resources. On discharge, the person will spend most of her or his time alone with his problems. (Even within 24-hour nurse care, the person may be alone, existentially, for most of the time). In anticipation of this situation, the person is encouraged to discuss in detail, the people, things, ideas, beliefs, and values, that are important, and the reasons why they are important. For most persons in care, this involves a process of re-discovery, where aspects of their life, which are taken for granted, are brought into sharp focus.

In the final phase, the nurse prepares the person for the One-to-One Sessions by exploring the person’s perception of what might constitute a resolution of a problem or fulfillment of some discrete need, and what the person believes might need to change, to begin such a process of change.

Again, on conclusion, a copy of the record of this conversation is made for the person and the original is stored for reference by the team.

One-to-One Sessions

Dedicated time is negotiated daily to explore issues that are important to the person at that moment in time. The person is encouraged to generate the agenda, and the session focuses on discussing how the person presently deals with (or lives with) this problem; or exploring, through imagination, how the person might address the situation.

To further help illustrate the collaborative nature of Tidal care, the recording format has two columns: one for the person in care and one for the team. All the questions are framed to enable the person to internalise the process—“What did I notice?; What have we discussed? In time, this becomes a routine means of self-examination.

Using Morita’s original awareness method (Morita 1998), the person is encouraged to notice how she or he has (or might have) dealt with a particular situation, and then is encouraged to discuss how she or he might use this personal knowledge and how the team members (or others) might help with this on an everyday basis. The person is also invited to comment on the kind of support being received in general and how this might be improved or adapted. Before concluding, the person is asked to summarise, in her or his own words, what the session has addressed and is invited to comment on how she or he felt about this particular session.

The resulting record provides a detailed—if pithy—summary of the One-to-One Session, in the person’s voice, rather than that of the team member. (See Figure 3.)

The Others Domain

Groupwork

Tidal groupwork uses a variety of formats to encourage members to talk about themselves as people, rather than as patients. Many popular forms of groupwork emphasise psychoeducation (Pekkala & Merinder, 2002) where the person is often encouraged to adopt professional constructs as a means of understanding personal problems: a form of professional colonisation (Barker, 2003a). Tidal groups seek to maintain each person’s identity, empowering the group to support one another and help each person to have a genuine educational experience—by drawing on their existing self-knowledge and developing this through the medium of the group.

The Discovery Group is facilitated by two team members, who enable the group to tell stories about their experience of diverse aspects of everyday living. All talk about illness or problems is off limits. The facilitators also participate, and through the
judicious use of self-disclosure, the persons in care are helped to see the nurse as a person, with a life, beliefs, and feelings of his or her own (Cook, Phillips, & Sadler, 2005). The Discovery group is highly supportive and serves as one kind of model for the natural supportive community, which most people value. This group also rehearses membership of mutual-support groups, which many participants go on to join in the community, after discharge.

The Solution-Finding Group has a single nurse facilitator, who steers the group conversation, rather than leading in the traditional manner. Group members are encouraged to explore problems brought by other members by asking questions. The volunteer is in the driver’s seat at all times, and is under no pressure to answer. After, several rounds of questions, if the volunteer allows, the group is encouraged to make comments, suggestions, or otherwise bear witness to the problem under discussion. Before concluding, the facilitator, summarises the discussion and invites the volunteer to comment on differences experienced as a consequence of the discussion.

The Solutions Group helps participants develop their awareness that the beginnings of many of the answers they seek lie either in their own hands or may be found among friends, family, or others who are in the same boat.

In the Information-Sharing Group, group members identify topics about which they would like to know more. Medication, housing, community support, alternative therapies, are all popular topics. These groups are hosted by an expert on the listed topic, rather than one of the clinical team.

All the Tidal groups rehearse the kind of self-determination necessary for exploring options and alternatives on return to community living, and represent distinct alternatives to the therapy groups provided by professional team members.

**RESEARCH AND EVALUATION**

**Audit and Quantitative Evaluations**

Given that recovery is highly individual, most of the evaluations of the Tidal Model in practice have relied on anecdotal accounts from persons in care or measures of personal satisfaction with the service delivered.

However, Berger (2006) has described how the Tidal Model could be integrated into a broad-based interdisciplinary clinical programme. Brookes, Murata, and Tansey (2006) described how they had introduced the model across several programmes within hospital, in a series of waves. Lafferty and Davidson (2006) described how the Tidal Model resonated with new developments in the rights-based principles of recent mental health legislation in Scotland.

In the original pilot of the Tidal Model (1997–1999), efforts were made to evaluate, in a more controlled manner, the effect of introducing the Model on a range of factors, perceived by the clinical and managerial team as of critical of importance (Stevenson, Barker, & Fletcher, 2002). The evaluation protocol focused on the frequency of a range critical incidents (e.g., suicide and self-harm attempts; episodes of aggression; changes in legal status; length of stay; the length of time between admission and commencement of formal assessment and care planning). Data were collected over the year prior (pre) and the year following (post) the introduction of the Tidal Model. This protocol has been used, with minor modifications, in a range of studies in acute care within the UK, Canada, Japan, and Ireland (e.g., Gordon, Morton, & Brooks, 2004, 2005; Lafferty & Davidson, 2006) and incorporated an evaluation of nursing staff attitudes towards nursing care, recovery, and the Tidal Model.

Despite significant national and cultural differences, and variations in the use of the various Tidal processes, these studies have shown remarkably similar results, with no reports of negative outcomes or significant negative responses from staff.

Six studies of acute care in Scotland, England, and Ireland used the original evaluation protocol and all have demonstrated reductions in the number of (a) self-harm and suicide attempts; (b) aggressive verbal and physical events toward staff; (c) incidents needing physical control and restraint procedures; and
Qualitative Evaluation

The phenomenological study conducted by Cook, Phillips, and Sadler (2005) in a regional secure unit in New Zealand provided an interesting five-theme overview of the perceived changes in the unit culture, following the introduction of the Tidal Model.

- Nurses were more hopeful, and felt they were making more of a difference. Similarly, patients felt able to communicate in their own words their feelings of hope and optimism.
- A levelling of the power relationship emerged between staff and patients.
- An enhanced sense of self and interpersonal connectedness.
- A sense of collaboration, expressed simply as working together.
- A feeling of humanity: the potentially objectifying forensic setting now had a human face.

The authors concluded that the use of the Tidal Model enabled a “synergistic interpersonal process wherein nurses are professionally satisfied and patients are validated in their experience” (Cook, Phillips, & Sadler, 2005, p. 539).

Many similar findings are reported in the anecdotal evaluations of the outcome of the Tidal process either on discharge or following return to the community. The following account from someone on an acute care unit is typical of the mixed feelings experienced when persons encounter a change in the kind of nursing care to which they have become used.

When my nurse first introduced me to the Tidal Model I didn’t like it at all. I thought it was too formal and didn’t like her writing down the things I said. I saw her a week ago and we were remembering that time. I recognized that my thoughts toward the Tidal Model have changed. And if I look honestly, I have accomplished more since starting with the Tidal Model than I have in my entire life . . . it’s more about what has changed “inside.” I almost can’t believe that this thing I despised is one of the things that helped me the most.

I feel like my own voice is heard. I feel empowered and that we work as a team. I feel like she is interested in things I have to say and she helps me see the change and work that has taken place. I am aided in taking the actions necessary to make those changes and my experience is never argued against. We look at what has worked and when I can’t see things, she is able to point them out to me.

I feel like the Tidal model has made room for my voice. I’m not just another patient who is mentally ill. I am a person with goals and dreams and a life worth living. I get to discover and learn and make changes all the time. Now I know that I can think, decide, and act for myself. I don’t need someone else to save me anymore, because [now] I have been given me the opportunity to save myself.

THE CONTINUUM OF CARE

Historically, the asylum was set apart (conceptually) from society. Modern hospital units also appear divorced from the cycles of care and treatment found in the natural community.
Any model for acute (crisis) care should recognise that crises always occur in the person’s everyday world. An integrated model of mental health care would embrace crisis (acute) care as part of its wider mission (see Figure 4).

The Tidal Model recognises that the care needs of the person will differ, depending on where the person stands on the continuum of care, the stages of which are fluid and invisible (see Figure 5).

Immediate Care

When people enter a crisis they need immediate care, focused on finding a solution quickly. The person who requires the safe haven of acute care needs emotional rescue, needs to be helped to feel emotionally secure, and needs to begin to understand what must be done to help her or him return to everyday living. By definition, this work is focused and short-term, dealing largely with surface issues, in the same way that actual lifesavers and fire-fighters focus first on reducing the crisis. Although drugs have traditionally been used to reduce distress, clearly there are many other non-invasive ways of achieving this, not the least by providing empathic, supportive care.

Transitional Care

Once the person has begun to work on the solutions to the immediate problems the process of transition begins. This involves either the negotiation of discharge to home or delving deeper into the problem that generated the crisis in the first place. This transitional phase focuses on providing the smoothest passage into community care, or into more specialised forms of support.

Developmental Care

For those persons who find it difficult to make this transition, more intensive, longer-term support may be needed. This focuses on developing the person’s understanding of the factors (personal, historical, social) that might have given rise to the crisis. Although not necessarily psychotherapeutic in orientation, this kind of care aims to help the person learn more about the meanings of the crisis experience, so that he or she might face the future with greater confidence.

The Need for Planned Admissions

The work of the community based crisis team and the acute ward team should be similar: focused on immediate and transitional care. The most common reason for a hospital admission is fear for the person’s safety or the safety of others. Community services often become resigned to this after a protracted period of trying to help the person at home or through various community based services. Their resignation is often dramatic, and can add to the experience of crisis felt by the person. A planned admission, where the person is offered specialised supportive care before the crisis peaks, should (in principle) be a logical extension of primary care. This provides the person with an opportunity to deal, constructively, with problems of living before they get out of control. The admission might be into an acute care ward, or into the support of a crisis team, or into any one of a number of alternative services that might help prevent the person from descending completely into the depths of a full-blown crisis.

DISCUSSION

Over the past decade, mental health services in many countries, especially within Europe and Australia, have felt the need to re-focus attention on acute psychiatric care, believing that the quality of these services had diminished following the shift towards community care in the 1980s and 1990s (Barker, 2003b). Concerns have repeatedly been expressed regarding the development of an observation culture within acute care settings, where people presenting as at risk of suicide, self-harm, or a danger to others may be contained physically, but in a manner that many view as less than therapeutic (Barker & Cutcliffe, 1999, 2000; Bowles et al., 2002; Bowers et al., 2002; Cutcliffe
& Barker, 2002; Dodds & Bowles, 2001). Arguably, much of the disenchantment with acute care derives from the lack of clarity, if not an actual loss of purpose within such services.

The Tidal Model locates acute services (like other secondary and tertiary health services) within the community, rather than as something separate. As noted earlier, many contemporary problems with acute care provision appear to be, at least in part, a function of the institutional legacy, which represented hospital and community as distinct entities, rather than points on the continuum of care (Barker & Buchanan-Barker, 2005, 2007).

If the purpose of acute services appears uncertain then the purpose of psychiatric-mental health nursing may, especially in acute care settings, be even less clear. Many authors (e.g., Campbell, 2006) have noted that dispensing medication and preventing people from harming themselves or others through containment protocols is more suggestive of a caretaker (or policing) function, than the sophisticated, interpersonal therapeutic interaction described, for over 50 years in the psychiatric nursing literature (Peplau, 1952). Regrettably, mechanised forms of containment—whether through use of medication, seclusion, or observation—often becomes the preserve of low ranking, untrained staff or students who, as Rose (2000) reported from personal experience, “have no interaction whatever with the patient during an eight hour shift. They read magazines (p. 8).”

Tidal assumes that any reflexive definition of nursing must involve nurturing or the promotion of growth and development. Barker (1989) reframed this process as trephotaxis: “the provision of the necessary conditions for the promotion of growth and development” (p. 132). The original development of the Tidal Model in England in the mid 1990s involved an attempt to refocus attention on the person in need of acute mental health care. However, many of the nurses who became involved in subsequent Tidal projects, both within the UK and abroad, were as keen to recover their nursing purpose as those in their care were to recover their lives. After years of working within systems, governed by policies, written by remote health care bureaucrats (Ward & Jones, 2006), many nurses are now trying to reclaim the proper focus of nursing (Barker, Reynolds, & Stevenson, 1998). The Tidal Model may be one approach to enabling recovery and reclamation, for both nurses and the persons in their care.

CONCLUSION

The Tidal Model was developed originally to address a felt sense of loss of purpose, or focus within nursing in acute psychiatric care settings. Over the past decade, the model has been developed across the whole hospital-community spectrum, but continues to hold particular relevance for the acute care setting. The single most original feature of the Tidal Model is the approach adopted for exploring and documenting the personal story of the flow of the lived experience. As far as we are aware, no other model—nursing or otherwise—has focused all its attention on developing, conjointly, accounts of the person’s experience, recorded in the person’s own words, which subsequently become the primary means for enabling the person’s recovery. This represents one example of the “craft of caring” (Barker & Whitehill 1997, p. 26).

Tidal assumes that the primary purpose of acute care is to enable persons to return to the natural community, as quickly as possible, by helping them to be able to deal better with the problems of living that made the admission necessary. In most acute care settings the Tidal Model is implemented alongside a range of other health and social care interventions, considered desirable (Berger, 2006). Although the provisional strategies developed for dealing with particular problems in living, and the personal knowledge on which they are based, is used to guide the professional team, this body of knowledge and information belongs primarily to the person in care. The idea that patients should be able to read their medical records and have access to copies of their care plans, is gaining credence around the world. The Tidal Model takes this philosophy of patient involvement to its obvious conclusion by building the process of care around the person’s own records of the lived experience of mental health care.

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REFERENCES


