The Tidal Model

Mental Health, Reclamation and Recovery

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Reclamation

The art of the possible

Breakdowns rarely happen overnight. In the same way, recovery does not happen suddenly—but develops at the person’s own pace, depending on their circumstances.

We realise that recovery may take a long time. We are like people mopping up after a great flood. We know that it will need a lot of effort, from ourselves and perhaps from other people. Most of all, we suspect that nothing will ever be the same again.

However, ‘mopping up’ is exactly what needs to be done. We are clearing up and rebuilding the lives that have (almost) been destroyed by the flood. This becomes our most important work.

Through this work we reclaim our human nature. We do what can be done and no more. If we can do that, we may well recover the lives we thought we had lost.
All people are no more than stories. Stories they tell themselves and others, and stories others tell about them.

In the Tidal Model we help people reclaim the stories of their breakdown, their distress and their difficulties, so that, once again, they can own their experience.

By talking about themselves, people become more aware of how they are ‘living’—and perhaps, by ‘doing whatever needs to be done’, they might move beyond their problems, into a new story—of their own making.
Acknowledgement and Dedication

We have worked with many people over the years. They have given generously of themselves, and told us their stories, to help develop the Tidal Model.

These people are too numerous to mention but the success of the Tidal Model belongs to them.

We thank them all. We are forever in their debt.

We dedicate this manual to the thousands of nurses and other professional colleagues who have worked with us, over the years, who inspired us with their commitment to human caring. They know who they are, for we have told them.

May their numbers multiply and may their commitment to caring eventually be recognised.

Poppy and Phil
# CONTENTS

1. Acknowledgements and Dedication ................................................................. 4  
2. Tidal—The first ten years ...................................................................................... 7  
3. What is the Tidal Model? ................................................................................... 9  
4. Introduction ...................................................................................................... 13  
5. The Ten Commitments — Tidal values .............................................................. 24  
6. Overview of the Tidal Model in practice .......................................................... 28  
7. The Three Domains ......................................................................................... 38  
8. The Power of Live Recording ........................................................................... 41  
9. Bridging ........................................................................................................... 43  
10. Monitoring Assessment .................................................................................... 53  
11. Personal Security Plan ..................................................................................... 59  
12. Holistic Assessment ......................................................................................... 66  
13. One to One Session .......................................................................................... 82  
14. Tidal Group Work ............................................................................................ 92  
14. Conclusion ...................................................................................................... 104  
14. The Three Tidal Groups ................................................................................ 105  
15. Appendices .....................................................................................................
The Tidal Model: 1997-2007

The Tidal Model was developed between 1995-1997 and the first formal Tidal trial was conducted in England, between 1997 –1999. This manual represents a fully revised version of the original guide to the practice of the Tidal Model first written in 1997, and published following the completion of the first full trial, in 2000.

Readers who have read the original manual—The Tidal Model: A recovery based approach to mental health care - will appreciate the many developments in Tidal practice over the past decade. A traditional ‘acute in-patient care’ ward provided the setting for the original Tidal trial, and many of the practice templates for the Model were geared towards that setting.

Since 2000, however, the Tidal Model has been used across a wide range of community, hospital and clinic settings, encompassing public and private sector mental health care, as well as voluntary and charitable sector funded services. We have revised many of our practice templates and illustrations, to reflect some of the key developments, which have so impressed us.

This evolution and development of the Model is in keeping with the key principles of Tidal theory. Nothing lasts! We hope that in another 10 years, we shall find that Tidal practice has continued to evolve and develop, as practitioners discover other ways to put Tidal theory into action.

Hospital or Community—Clinical or Home care

The Tidal Model provides a structure for the development of person-centred, collaborative care in any setting. Tidal may be used in a person’s own home, where the focus is to address a crisis in the person’s life, to prevent possible admission to residential
care. **Tidal** may be used as easily in a residential setting, where the focus is on resolving well established problems, as preparation for returning the person home.

In all settings the **purpose** is the same: to **identify the problems of living** that are the source of the person’s distress or disturbance, so that **together**, the person and the professional helpers (and family and friends) can begin to explore what needs to be done, to resolve, or help the person come to terms with them.

**Ordinary Language**
The **Tidal Model** prizes the use of ordinary language, aiming to speak in the same voice as that of the person who is in need of help. This is in stark contrast to typical psychiatric or mental health care, where medical psychological or bureaucratic jargon often ‘muddies the waters’ of the caring relationship.

We believe that by embracing ‘ordinary language’ we show respect for the person and the person’s culture. We also believe that this conveys our willingness to talk with people on their level, showing that we are not trying to bamboozle them with professional jargon, or make life more complicated than is absolutely necessary.

We hope that you, the reader, will agree.

Poppy and Phil

Scotland, 2007
People often ask us to tell them, in very simple terms, ‘what is the Tidal Model?’ Here are our answers.

1. **The Tidal Model** is an internationally accepted theory for the practice of mental health recovery.

Since its launch in the mid 1990’s the Tidal Model has generated over 100 official projects in the UK, Ireland, Canada, Japan, Australia and New Zealand.

These projects range across the complete mental health care spectrum: from home-based care and outpatient addictions, through acute, rehabilitation and forensic units, to the care of older people with early stage dementia. Beyond the mental health field, practitioners in palliative care are exploring the Tidal Model as an alternative philosophy for the care of people who are dying.

2. **The Tidal Model** is a philosophical approach to the discovery of mental health.

Tidal is philosophical in the sense that it is a way of thinking about what people might need in the way of help. Tidal asks: What might need to be done to help people reclaim the story, and eventually recover their lives?

Tidal emphasises the discovery of mental health, as its meaning varies from one person to another. We hope that people will discover what mental health means for them – as unique persons.
3. **The Tidal Model** helps people reclaim the story of their problems of human living, as a first step towards recovering the story of their lives.

**Tidal** aims to help people reclaim the *personal* story of their distress, by recovering their voice. By using their own language, metaphors and personal stories people begin to express something of the meaning of their lives. This is the first step towards helping people recover control over their lives.

As people, all we have is our *story*. All we can ever be is framed by the story of our lives – the events that have occurred, and how we responded to them. This story charts not only the changes that have occurred on our voyage from birth, through childhood and adulthood and eventually into death but also the growth and development that has taken place within us.

4. **The Tidal Model** focuses on helping people deal with their problems of human living.

When people experience *problems of human living* they are described as being ‘mentally ill’ or affected by some ‘psychiatric disorder’ or ‘psychological dysfunction’. Frequently, the person’s story is overshadowed by stories of ‘illness’ or ‘psychological disorder’. People often talk less about the ‘person’ and talk more about the ‘patient’, ‘client’, ‘service user’ or ‘consumer’.

**Tidal** focuses *explicitly* on the person’s story. This is where the person’s problems first appeared. This is where any growth, benefit, or recovery will be found. **Tidal** also focuses on the problems that are affecting the person in living an ordinary, meaningful and fulfilling life.
The key **Tidal** question is:

*What needs to be done to help the person begin to address, resolve or come to terms with this problem, and so begin to recover her or his life?*

5. **The Tidal Model** is a person-friendly approach to mental health recovery.

**Tidal** has no age, class or cultural boundaries and at present is being used to facilitate recovery as easily with younger people, as with adults, or with the older person, across a wide range of societies and cultures.

**Tidal** actively avoids the use of professional or technical jargon, focusing instead on the use of the natural language of the person.

Originally developed as an alternative model of mental health nursing, the **Tidal Model** continues to be practised mainly by nurses, but also finds support within psychiatric medicine, social work, occupational therapy and psychotherapy. Increasingly, **Tidal** is viewed as an important alternative approach to helping people use their natural voices as the key instruments for charting their recovery.

6. **The Tidal Model helps the person to navigate their own way to recovery.**

The concept of ‘recovery’ means many different things to different people. Tidal aims to help people clarify what is distressing or disabling about their problems of human living, as the first step towards clarifying *what needs to be done* to begin to move away from, or overcome those problems.
7. The Tidal Model uses specific human values to guide the helping and enabling practice of mental health recovery.

The Tidal Model has a value base - the Ten Commitments - that guides all the practical process of individual and group work within the Model. These values emphasise the importance of genuine person-centred care that is respectful of culture and creed, and which recognise that belonging and membership are vital to our personal identity as social beings.

8. The Tidal Model is a philosophical and theoretical template upon which to build and develop the practice of mental health recovery.

From Tidal theory we have developed a range of ways of working with people - individually and in groups - that can be adapted to fit the person's changing circumstances. We have developed 'examples' of how practitioners might work with people individually or in groups. These are examples or illustrations —not rules.

“The golden rule is that there are no golden rules” (George Bernard Shaw)

Nurses, and other practitioners, around the world are using the philosophical and theoretical principles of the Tidal Model to develop their own practice to suit the unique needs of the many individuals within their service.
What’s the problem?

People used to suffer from ‘madness’ but now most people talk about the experience of ‘mental health problems’. We may still refer to ‘mental illness’ but, increasingly, it is accepted that people have ‘problems’ with their ‘mental health’, in much the same way they have physical health problems.

However, there is no real agreement as to what, exactly, is ‘mental health’—far less how one might develop this vital state.

If people are not sure of their ‘mental health’ they usually know when they are not ‘feeling too good’, or when they are terrified, emotionally overwrought, cannot concentrate, or wonder if life is worth living. Indeed, most people have had some experience of such problems. What we now call ‘a mental health problem’ and once called ‘mental illness’, may only seriously affect a small proportion of people. However, most people have some understanding of what such problems involve.

People with mental health problems find it difficult to get on with their everyday lives. They have problems in relating—sometimes to themselves and sometimes to other people. They have problems in working, playing and having what most of us would call, a ‘normal life’. Something disturbs their everyday rhythm. Something upsets their sense of equilibrium and personal stability. They experience, what we call, problems of human living.

We prefer to talk about our ‘problems of human living, since this is what people witness, privately, or what is obvious to other people, when they are emotionally over-
wrought, distressed or disturbed. Talking about ‘problems of human living’ also re-
minds us of what we need to be doing: helping people to work out how they might deal with the problems affecting their everyday lives.

Problems of Human Living

For those of us who have never been 'mad', 'mentally ill' or 'seriously mentally dis-
tressed', the best that we can do is to develop our sense of empathy. We try to fit ourselves as much as we can - or as much as we dare - inside the experience of the person who is having such an experience. We try to imagine what such an experi-
ence might be like.

Sally Clay is a woman who knows a lot about mental health problems - and what it is like to be treated as hopelessly and chronically 'mentally ill' For Sally, the experi-
ence was a human and spiritual problem. Her experience of breakdown—what she chose to call ‘madness’ - was all about being Sally Clay. The long and difficult process of recovery was about recovering what it meant to be human and to be Sally Clay.

Recalling her breakdown and recovery Sally wrote:

"Everywhere these days we see people living lives of quiet desperation. We who have experienced mental illness have all learned the same thing, whether our extreme mental states were inspiring or frightening. We know that we have reached the bare bones of spirit and of what it means to be human. Whatever our suffering, we know that we do not want to become automatons, or to wear the false facade that others adopt"

Sally also knew that madness frightens people—even when they refuse to admit that they are frightened.

"Whether we have had revelations or have hit rock bottom, most of us have also suffered from the ignorance of those who fear to look at what we have seen, who
always try to change the subject. Although we have been broken, we have tasted of the marrow of reality. There is something to be learned here about the mystery of living itself, something important both to those who have suffered and those who seek to help us. We must teach each other”.

The Key Tidal Question

The Tidal Model is focused on asking one important question:

• how can we help people address, deal with, overcome or come to terms with their problems of human living?

Whether we are professionals, friends, family members or someone who is in ‘the same boat’, the answer is the same.

1. First, we must let the person teach us about her or his experience.

2. Then, and only then, we can begin to explore—with the person—what might need to be done if the person is to address, resolve, fix or come to terms with this particular problem of human living.

Writing about the Tidal Model, Sally said:

“The Tidal Model makes authentic communication and the telling of our stories the whole focus of therapy. Thus, the treatment of mental illness be-
comes a personal and human endeavour. One feels that one is working with friends and colleagues, rather than some kind of ‘higher up’ providers”.

Complex Problems—and Simple Solutions

The problems of human living that bring people into mental health care are usually very serious and sometimes life threatening. We believe that these complex problems will need equally complex solutions. Usually, we also assume that such solutions can only be provided by highly expert, highly qualified, specialist helpers.

One of the paradoxes of human living, revealed in the Tidal Model, is that quite simple things can often have a powerful effect on complex problems!

However, this does not mean that helping offer such simple solutions is easy, or that anyone can do this. We still require people who are highly expert, and highly qualified. However, their qualifications need to be in human relationships. We need people who can use their skills as a human being to become an effective helper.

Learning from the Person

There are two key human skills needed to help another person. These are humility and patience.

We need to remind ourselves that we have no idea what it is like to be another person, and do not know what this other person is experiencing. For that reason we need to be ready to learn. We need to allow the person to teach us about their ex-
Like most people, we have never been to the moon. We have looked at it through a telescope and we can remember watching Neil Armstrong take his ‘first big step for Mankind’ on TV almost 40 years ago. However, knowing about things ‘from the outside’ is not the same as having insider knowledge. If we wanted to know what it was like to travel to and walk upon the moon we would need to ask an astronaut - someone who had gone far beyond the boundaries of our experience. Neil Armstrong and other astronauts could teach us a lot about ‘moon-walking’, and space travel, even if we had no intention of following in their footsteps.

This analogy holds true for the experience of the problems of living we call ‘mental illness’ or ‘mental health problems’. We can learn a lot about what it is like to be in the grip of various kinds of mental distress. Even if we think that we shall never follow the person into 'madness', there is much that we can learn about what appears to be an alien experience.

By learning something about such experiences, the people we are trying to help will become less like ‘aliens’. We may begin to understand them—and their problems of human living—better.

**Living with chaos—learning from experience**

We like to think that our lives follow some rules and stay within certain boundaries. However, the reality of our life is that it is not at all predictable, and often is quite chaotic. None of us know what is likely to happen next. We simply pretend or hope that
we do. The idea that life might have its own agenda is simply too frightening.

What does this have to do with mental health? It seems clear that we only find out exactly how people became ‘mentally ill’, what sense they made of it, and how they recovered, after the event. People look back on their experiences and from those reflections they learn something about what has happened, they learn from the reality of their experience. Reflection—thinking about our lives—is a wonderful tool. Reflection holds up a mirror to our experience.

In trying to help people, we need to be careful that we do not end up trying to control their experience of their problems. We need to allow people time to reflect, so that they can learn from their own experience. Hopefully, this will result in them becoming wiser about what has happened to them. When we ask people like Sally Clay what kind of a nurse was really helpful, the answer often is - ‘someone who didn’t try to control me completely...someone who let me own my experience’.

The Caring Lifesaver

People who are in mental distress need support. Ideally, they need someone who can meet their needs without entirely sacrificing themselves in the process. Lifesavers recognise that someone is drowning and execute swift and efficient rescue, without risking drowning themselves in the process. They 'get involved' with the person, and 'share the experience of drowning'. However, by keeping themselves in balance, they avoid 'going down' with the person they seek to rescue.

This is a useful analogy for all helpers. If we are to help the person avoid 'drowning in their distress', we must get involved; we must share something of their experience; we
must show them that we are not afraid to get 'into the swim' with them. However, we need to maintain our balance, or else we all risk 'going under'.

Learning how to get involved without risking our own emotional security doesn't come easily. It is not something that can be learned from books or videos. Certainly, it is not a lesson that can be learned from reading a short manual like this, or attending a two-day workshop. It has to be learned from practice. However, knowing how difficult it might be to acquire such a human skill, is the first step towards acquiring it. If we can do nothing else, we can remind you how difficult - and possible lengthy - the process of learning how to 'stay in balance', might be.

We all need to share our experiences, and learn from one another, whether we call this clinical supervision or 'just talking'. The important thing to remember is that we need to keep on learning from one another's experience.

The Tides of Change

Human experience has a fluid nature—constantly on the move, constantly shifting. "All is flow" as Epictetus said. Many models of human functioning deceive us into assuming that people are unchanging, like rocks. A better metaphor for the state of being human is water.

The Tidal Model uses water as the core metaphor for both the lived experience of the person who enters mental health care, and the care system that needs to mould itself around the person.

The water metaphor is appropriate for several reasons.
• The ebb and flow of our lives is reflected in the way we breathe in and out, like waves lapping at the shore
• All human life emerged from the ocean
• All of us emerged from the waters of our mother's wombs
• Water is used all over the world as a metaphor for cleansing of the spirit.
• Water evokes the concept of drowning, used frequently by people who feel overwhelmed by their experiences.
• The power of water is not easy to contain. We can scoop water from the sea, but we cannot scoop out a whole ocean
• The only way we can cope with the power of water, is to learn how to live with its forces - we learn how to swim in water, or we build boats that float on the waves. Ultimately - however - the power of water is unpredictable.

The Changing Face of Water

The Tidal Model begins from four simple, yet important starting points:

• The primary therapeutic focus in mental health care lies in the community. A person's natural life is an 'ocean of experience'. The psychiatric crisis is only one thing, among many, that might threaten to 'drown' them. Ultimately, the aim of mental health care is to return people to that 'ocean of experience', so that they might continue with their life voyage.

• Change is a constant, ongoing, process. However, although people are constantly changing, this may be beyond their awareness. One of the main aims of the approaches used within the Tidal Model, is to help people develop their awareness of the small changes that, ultimately, will have a big effect on their lives.

• Empowerment lies at the heart of the caring process. However, people
already have their own ‘power’. We need to help people ‘power-up’, so that they can use their own personal power to take greater charge of their lives, using this in constructive ways.

- The nurse and the person are united (albeit temporarily) like dancers in a dance. When an effective helping encounter takes place, how do we tell the dancer from the dance? This reminds us that genuine caring encounters involve ‘caring with’ the person, not just ‘caring about’ the person, or doing things that suggest we are ‘caring for’ them.

The Tidal Metaphor

The idea of the 'ocean of experience' reminds us that life is a developmental voyage that all people make as they travel through various stages in their lives. This is a voyage of exploration and discovery, where we find out things about ourselves and our life.

However the life voyage gives us not only the opportunity to discover things, but also carries many risks: metaphorical storms, as well as the risk of running aground, or of the ship sinking. The seaworthiness of the ship may be a good metaphor for the person’s health status or constitution. The extent to which we are able to journey across our ocean of experience is dependent on the physical body on which we roll out the story of our human lives.

However, when people experience a disruption of their sea-journey, they may - like Coleridge’s Ancient Mariner, be becalmed at sea. Depression often has just such a becalming effect. Or, they may be thrown violently on to the rocks. Psychosis often appears like the experience of shipwreck. Either way, a signal emerges that something special needs to be done and, if this is to be ultimately successful, needs to be followed up with a range of interventions - from simply
keeping the person afloat (community support) to deep sea-diving (exploring the 'submerged' causes of the crisis).

This is hardly a new perspective on the human condition. However, our discoveries of how people function, psychologically and socially, often gets in the way of our appreciation of what our lives mean - in human terms.

Dickens acknowledged the tidal nature of life and death, through his character - Mr Peggoty, who reminded us that the child 'flows' out of the waters of the mother's womb:

"People can't die along the coast, except when the tide's pretty nigh out. They can't be born, unless its pretty nigh in - not properly born, till flood. He's a going out with the tide."

A similar understanding is found in much eastern thought, where the breath -the life force or prana - heralds life with each inhalation, and death with each exhalation. People, are therefore, poised, constantly on the tidal cusps of life and death.

Most famously, however, Shakespeare summed up the fundamental assumptions of the Tidal Model in Julius Caesar:

"There is a tide in the affairs of men,
Which, taken at the flood, leads on to fortune;
Omitted, all the voyage of their life
Is bound in shallows and miseries.
On such a full sea are we now afloat,
And we must take the current when it serves,
Or lose our ventures."

"
Stop working so hard

The Tidal Model aims to provide person-centred care, or where appropriate family-centred care. This should recognise the person's fundamental need for security - both existential and physical; acknowledging the person's capacity to adapt to changing life circumstances; emphasising the person's existing resources, both personal and interpersonal. Tidal acknowledges that we should aspire to do as little as we need to do to help support the person. We need to make sure that we are helping and enabling, not interfering. We need to make sure that we are not ‘working too hard’ to change people.

Genuine ‘nursing’ occurs when the person begins to experience growth and development. Nursing originally meant to provide the person with nourishment. Nothing has changed across the centuries. Today, people in mental distress need the nourishment that nursing can offer. They need the human support that will help them to deal more effectively with the tidal forces that have rocked their lives. They need help to gain the confidence to get back in their boat and push off, from the shore, to begin again the journey on their ocean of experience.

When we have asked people to tell us about their experience of ‘good nursing’ it is exactly this kind of support that has been most highly prized—and remembered.
Tidal Values

The **Tidal Model** is based on 10 discrete values concerning human experience and helping relationships – the **Ten Commitments**. These commitments govern all aspects of the practice of the Tidal Model but especially when:

- Conducting the Holistic Assessment
- Conducting the One-to-one sessions
- Developing the Personal Security Plan
- Conducting group work.

We have developed 20 specific **Tidal Competencies** to help evaluate or audit the practice of the **Tidal Model**. These competencies are framed around the key principles within the **Ten Commitments**. Here, we describe briefly each of the **Ten Tidal Commitments** alongside the **20 Tidal Competencies**.

1. **Value the voice**: the person’s *story* of the experience of mental distress or related problems of living linked to mental distress is the beginning and endpoint of the whole helping encounter. The person’s story embraces not only the account of the person’s distress, but also the hope for its resolution.

   **Competency 1**: The practitioner demonstrates a capacity to *listen actively to the person’s story*.

   **Competency 2**: The practitioner shows commitment to helping the person *record her/his story in her/his own words* as an ongoing part of the process of care.

2. **Respect the language**: the person has developed a unique way of expressing the life story, and representing to others that which the person alone can know.
Competency 3: The practitioner helps the person express her/himself at all times in her/his own language.

Competency 4: The practitioner helps the person express her/his understanding of particular experiences through use of personal stories, anecdotes, similes or metaphors.

3. Become the apprentice: The person is the expert on their life story. The practitioner learns from the person about ‘what needs to be done’ or ‘what works’.

Competency 5: The practitioner develops a care plan based, wherever possible, on the expressed needs, wants or wishes of the person.

Competency 6: The practitioner helps the person identify specific problems of living, and what might need to be done to address them.

4. Use the available toolkit: The person’s story contains examples of ‘what has worked’ or ‘what might work’ for this person. These represent the main tools that need to be used to unlock or build the story of recovery.

Competency 7: The practitioner helps the person develop awareness of what works for or against them, in relation to specific problems of living.

Competency 8: The practitioner shows interest in identifying what the person thinks specific people can or might be able to do to help them further in dealing with specific problems of living.

5. Craft the step beyond: The helper and the person work together to construct an appreciation of what needs to be done ‘now’. The first step is revealing the power of change and pointing towards their ultimate goal.
Competency 9: The practitioner helps the person identify what kind of change would represent a step in the direction of resolving or moving away from a specific problem of living.

Competency 10: The practitioner helps the person identify what needs to happen in the immediate future, to help the person to begin to experience this ‘positive step’ in the direction of their desired goal.

6. Give the gift of time: the time the practitioner and the person spend together is the foundation stone of the process of change.

Competency 11: The practitioner helps the person develop their awareness that dedicated time is being given to addressing their specific needs.

Competency 12: The practitioner recognises the value of the time the person gives to the process of assessment and care delivery.

7. Develop genuine curiosity: the person is writing a life story but is no open book. Practitioners need to develop ways of expressing genuine interest in the story so that they can better understand the storyteller.

Competency 13: The practitioner shows interest in the person’s story by asking for clarification of particular points, and asking for further examples or details.

Competency 14: The practitioner shows a willingness to help the person in unfolding the story at the person’s own rate.

8. Know that change is constant: the key principle of the Tidal Model is that change is inevitable since change is constant. The task of the professional helper is to develop awareness of how that change is happening and how that knowledge might be used to steer the person out of danger and distress back on to the course of reclamation and re-
Competency 15: The practitioner helps the person develop awareness of the subtlest of changes – in thoughts, feelings or action.

Competency 16: The practitioner helps the person develop awareness of how they, others or events have influenced these changes.

9. Reveal personal wisdom: the person has developed a powerful storehouse of personal wisdom in the writing of the life story. One of the key tasks for the helper is to assist in revealing that wisdom.

Competency 17: The practitioner helps the person identify and develop awareness of personal strengths and weaknesses.

Competency 18: The practitioner helps the person develop self-belief, therefore promoting their ability to help themselves.

10. Be transparent: the relationship is based on mutual confidence.

Competency 19: The practitioner aims to ensure that the person is aware, at all times, of the purpose of all processes of care.

Competency 20: The practitioner ensures that the person is provided with copies of all assessment and care planning documents for their own reference.
Tidal Beliefs

The Tidal Model is based on four core assumptions about nursing practice.

1. *Mental health nursing is an interactive, developmental, human activity, more concerned with the future development of the person, than with the origins or causes of their present distress.*

   It is important to consider the possible influence of history (life events) and physical and social factors on the person’s present problems. However, the primary focus of nursing is on the person’s relationship with health and illness – not on illness itself. Nursing is focused on identifying what needs to be done to help the person overcome, or adapt to, the problems of living that may be diagnosed as one form of ‘mental illness’ or another.

2. *The experience of problems of human living is expressed by the person through some public display of distressing or disturbing behaviour, or through talking about ‘private events’ (thoughts, feelings beliefs etc) that are known only to the person concerned.*

   Although the person’s ‘distressing behaviour’ may be witnessed by others – e.g. family, friends and professional staff - the human experience of distress is always invisible. Nursing aims to help the person access and review such experiences, in an effort to re-author the person’s life, and to begin the healing of past and present distress, as part of the person’s human development.
3. The nurse and the person-in-care are engaged in a relationship based on mutual influence.

Nursing care is not a one-way process. Nursing involves caring with, rather than caring for, the person. The collaborative nature of the caring relationship can produce changes for the nurse, as well as the person-in-care.

4. What is commonly called ‘mental illness’ involves a wide variety of problems of human living. Nursing is focused on addressing these problems, within the person’s everyday world of experience.

Although nurses spend time with the person, reviewing and anticipating life events, the primary focus is on engaging with the real world of the person’s experience. Nursing is focused not on health or illness specifically, but on the person’s experience of and relationship to, health or illness.

The Tidal Metaphor

It is commonly assumed that people have ‘needs’ – to be loved, cared for, looked after, helped etc. These needs are not fixed, but fluid – constantly shifting. The Tidal Model employs the water metaphor to remind us that all human experience is constantly in flux, constantly shifting.

We believe that people live on a metaphorical ocean of experience. Everyday life appears to have boundaries and limits, but these are illusory: no more real than the concept of the horizon.

When we journey across the ocean the horizon moves with us, always remaining the
same distance away. The horizon metaphor suggests the limitless nature of personal experience – the illusory ‘boundaries of the self’.

The Tidal metaphor also suggests that the various journeys people make during their lives are like sea voyages. People often talk about their ‘personal development’ or the ‘stages’ or ‘phases’ they have passed through in their lives. These are similar to sailing from one port to another, from one continent to another. Whether great or small, our life voyages influence our development as persons. Travel broadens the mind, in the sense that life voyages change our experience of ourselves and of the world in which we live.

The metaphorical ocean of experience provides the setting for all our ‘life events’. People may experience trauma, which can appear ‘as if’ they have been ‘robbed’ of aspects of their personal identity, as if they had been boarded by pirates. The experiences of rape, physical and sexual abuse, torture and physical injury are the most common examples of such a ‘robbery of the self’.

People may experience other forms of trauma, from 'storms at sea' to 'running aground on the rocks'. Everyday traumas - such as relationship difficulties, loss, or sustained periods of stress - can result in a metaphorical 'emotional shipwreck'.

More Key Questions
The practice of the Tidal Model involves asking 4 questions;

1. **Why this - why now?** We need to consider, first of all, why the person is experiencing this particular life difficulty now? The focus of care is very much on what the person is experiencing now, and what needs to be done now to address, and hopefully resolve, this problem.

2. **What works?** We need also to ask 'what works' (or might work) for the person under the present circumstances? This represents the 'person-centred' focus of care. Rather than use standardised techniques or therapeutic approaches, which may have general value, we aim to identify either what has worked for the person in the past or, what might work for
this person in the immediate future - given their history, personality, and general life circumstances?

3. **What is the person's personal theory?** Finally, we need to consider how the person understands her or his problems. What 'sense' does the person 'make' of her or his problems. Rather than giving the person a professionalised explanation of her or his difficulties -in the form of some theory or a diagnosis- we try to understand how the person understands their experience. What is the person's 'personal theory'?

4. **How to limit restrictions?** We should aim also to use the least restrictive means of helping the person to address and resolve their difficulties. Although this is often taken as read, the Tidal Model tries to identify how little the nurse might do to help the person, and how much the person might do to help bring about meaningful change. Together, these might represent the least restrictive intervention.
The primary focus of nursing care is to identify what needs to be done now, to address the person's actual needs, difficulties or problems of living.

A secondary, but no less important aim of care is to identify what needs to be done now to reduce the likelihood that potential problems or difficulties, will develop in the future. In this sense, nursing care is both present and future directed.

The continuum of care ranges across a wide spectrum - from helping the person to resolve current, actual problems, through to helping the person develop a deeper understanding of how specific problems of living have developed, and how the person might begin to resolve them, or come to terms with them. This understanding might help the person deal more effectively with potential problems in the future.
The Need for Immediate Care

When people need help to deal with life problems, which have arisen suddenly, or have become increasingly challenging, they need immediate care to help find ways of addressing these problems. When people experience such ‘acute’ crises they are often admitted to hospital, or to some other supportive setting. The focus in such settings is to identify ‘what needs to be done’ to help people to return home, and to pick up their lives as best as they can. Immediate care, in general, focuses on addressing the person's problems in the short term.

However, such crises can also be addressed and resolved as part of 'community care' without requiring admission to a residential facility. Much community care involves anticipating, or trying to prevent or resolve such crises. Immediate care might be required, therefore, as a response to an initial mental health crisis, when someone enters the mental health system for the first time, or when a crisis occurs in the life of someone who already is a user of mental health services.

Immediate care is focused on trying to find practical solutions to the person's immediate problems, using the personal and interpersonal resources identified in the Holistic Assessment (See Page 67). This is augmented, where appropriate, by the development of the Personal Security Plan (See Page 60). This identifies what needs to happen to ensure the person’s physical and emotional security, and to offset any risk of harm from others.

The Need for Developmental Care

At the other end of the continuum, people may need to develop further their understanding of the nature and function of their problems: what are these problems and how do they affect them? Alternatively, they might need to develop their ability to deal with, or live with such problems. Here the person needs developmental care. People at this end of the continuum may be receiving follow-up care at home after a stay in hospital, or they may be receiving longer-term support, either at home or in residential care, as part of an
ongoing programme of rehabilitation. *Developmental care* focuses on more intensive and long-term support.

During *developmental care* emphasis is given to helping the person develop greater understanding of the nature and function of problems of living. This form of care may be part of a more intensive course of rehabilitation, or extensive recovery programme. Developmental care usually also involves a more sustained period of support, either by a dedicated individual or professional team, whether in a hospital, clinic or community setting.

**Transitional Care**

Where preparations are being made to admit a person to hospital or to discharge a person home, the person needs *transitional care*. This form of care is also required when someone is moving from one care setting to another, perhaps in another part of the service. An admission to hospital, or a transfer from one therapeutic team, or therapist, to another can often be traumatic. *Transitional care* aims to ensure that the person experiences the smoothest possible passage (or transition) from one setting to the other.

At the same time it is important to ensure that all necessary information about the nature of the care on offer and the kind of care expected, is passed from one care setting to another. An important nursing responsibility within transitional care is to ensure that appropriate liaison with colleagues takes place, and that the person is involved as much as possible, in making the arrangements for this transfer of care. The Figure on page 37 illustrates the common phases involved in moving through the *Tidal* care continuum.

On entering the service—whether a hospital setting, a clinic or the person’s own home — the initial focus is on ‘orientating the person to immediate care’: developing an understanding of the person’s immediate needs, and organising the team to begin to explore those needs, and provide general support.

This leads to more focused exploration of the person and her/his story, through the *Holistic Assessment* and (where appropriate) *Security Assessment*. The person’s problems of living
and/or need for support are explored further in dedicated one-to-one sessions and sessions focused on developing a ‘personal security plan’.

Alongside this individual work the person is introduced to three forms of group work, where the person will be able to access support from peers and provide support to others. The kind of care required is determined, largely, by where the person stands on the care continuum. When the person first enters the mental health service, they will be assessed for their immediate care needs. Immediate care is focused on offering the simplest possible form of intervention that might be necessary to ‘turn the person around’ and help the person return to the wider ‘ocean of experience’ of everyday life.

Immediate care is focused on identifying solutions to the person’s immediate problems, using the personal and interpersonal resources identified in the Holistic Assessment. This solution-focused, and short-term approach is supported - where appropriate - with the Personal Security Plan. This identifies what needs to happen to ensure the person’s physical and emotional security, and to offset any risk of harm coming to the person, or others.

Where the person requires developmental care, emphasis will be given to helping the person develop skills, or ways of dealing with life problems, in the medium to longer term. This help may come in the form of a rehabilitation programme, discrete counselling or psychotherapy. Developmental care may also involve the offer of a sustained period of support, either by an identified professional or team, or by a team working in concert with community based support groups.

Where the person needs transitional care effective and efficient team-working is vital. Although teamwork is central to all three levels of care, when the person is passing from one care setting to another, the need for liaison and communication between all parties, including the person and the family, is essential.
On the next page we provide an overview of the ‘voyage’ the person might take through any service—from entry to any one of a number of ‘exits’.
The Tidal Model

Enters service

Re-enters service

Developmental Care Plan

Transitional Care Plan

Orientation to Immediate Care

Holistic Assessment

Security Assessment

Group work 1/2/3

One-One Sessions

Personal Security Planning

Immediate Care Plan

Map of the Care Continuum
The Model of the Person

In the Tidal Model the person is represented by three personal domains: Self, World and Others. A domain is a sphere of control or influence: a place where the person experiences or acts out aspects of private or public life. More simply, a domain is a place where someone lives.

The domains are like the person’s home address. Their house or flat has several rooms, but the person is not to be found in each of these rooms all the time. Sometimes the person is in one room, and sometimes in another. The personal domains are similar. Sometimes the person is mainly spending time in the Self domain, and at other times is mainly spending time in the World or Others domains.

The Self Domain is the private place where the person lives. Here the person experiences thoughts, feelings, beliefs, values, ideas etc, which are known only to the person. In this private world the distress called ‘mental illness’ is first experienced. All people keep much of their private world secret, only revealing to others what they wish them to know. This is why people are often such a ‘mystery’ to us, even when they are close friends or relatives.
In the **Tidal Model** the **Self** domain becomes the focus of our attempts to help the person feel more ‘safe and secure’; where we try to help the person address and begin to deal with the private fears, anxieties and other threats to emotional stability, which are related to specific problems of living. The main focus is to develop a ‘bridging’ relationship (described on Page 43) and to help the person develop a meaningful **Personal Security Plan**. (see Page 60) This work becomes the basis of the development of the person’s ‘self-help’ programme, which will sustain the person on return to everyday life.

**The World Domain** is the place where the person shares some of the experiences from the **Self** domain, with other people, in the person’s social world. When people talk to others about their private thoughts, feelings, beliefs or other experiences known only to them, they go to the **World Domain**.

In the **Tidal Model** the **World Domain** becomes the focus of our efforts to *understand* the person and the person’s problems of living. This is done through use of the **Holistic Assessment** (described on Page 67). At the World Domain we also try to help the person to begin to identify and address specific problems of living, on an everyday basis. This is done through use of dedicated **One-to-One Sessions** (described on Page 83)

**The Others Domain** is the place where the person acts out everyday life with other people—family, friends, neighbours, work colleagues, professionals etc. Here the person engages in different interpersonal and social encounters, within which the person may be influenced by others, and may—in turn—influence others.

The organisation and delivery of professional care and other forms of support is located in the **Others Domain**. However, the key focus of the Tidal Model is on three dedicated forms of group work—Discovery, Information-Sharing and Solution-finding.
By participating in these groups, the person develops awareness of the value of social support, which (s)he can both receive from and give to others. This becomes the basis of the person’s appreciation of the value of mutual support, which can be accessed in everyday life.
The Benefits of Recording ‘in situ’.

All records of meetings, assessments or care plans developed with the person, are recorded ‘live’, in situ — in the place where the conversation, assessment etc took place.

NB: The person’s own words are always used to record the person’s contribution, and where the nurses are making plans, the person’s own words are also used as ‘direct quotes’. The person is always offered the pen at the outset, and invited to complete the record. (Where people are unable or unwilling to do this, the person can return the task to the nurse, with their dignity intact).

There are several benefits to the use of such live recording:

1. **Value**: By being directly involved in the process, the person feels valued. Active involvement in the process of recording shows respect for the person’s contribution.
2. **Joint Ownership**: By recording together the work that is being done by the person and the nurse, a sense of genuine collaboration develops. The work belongs to them both—equally.
3. **Accuracy**: By recording the outcome of the conversation live the chances of distorting, or reframing what has been said, is reduced. The actual record of the meeting or session is an accurate record, agreed by the parties involved.
4. **Person-centred focus**: By recording the person’s own words the nurse, or other professional, shows a commitment to working with the person, on developing meaningful, constructive attempts to address current problems of living.
5. **Economy**: By recording sessions live—in situ—the nurse will save time, which otherwise would have been spent in the office, trying to recall what exactly had been said.
The Self Domain

Developing Emotional security

In the Self Domain we help the person to experience the degree of emotional security necessary to feel able to confront and address the challenges presented by various problems of living.

We do this by developing a Bridging relationship, which aims to break down the sense of separation and foster a sense of human connectedness.

Then, we help the person to begin to develop a Personal Security Plan, which will identify what the person, and others, need to do to help the person feel more emotionally secure—and therefore, physically safe.

This will form the basis for the future development of the person's everyday notion of 'self care' or 'self help'.
Life and its many risks
Although it is dangerous to generalise, most people who need the support of mental health care experience what might be called a 'crisis of the self' – finding it difficult to live with themselves, or with other people – with the result that other people find it difficult to live with them.

People with any form of mental distress often experience a sense of 'threat'. This can range from experiences within the person (e.g. feelings of worthlessness or hopelessness, or hearing persecutory voices) to the effects of the world outside (stigma, persecution, discrimination or abuse).

The focus of our work within the Self Domain is to learn something of the threats to the person's emotional and physical security and to help the person to work out what needs to be done to minimise these threats.

Nursing has always included an appreciation of the need to ensure the physical safety of the person, with care plans focused on (for example) reducing the risk of falling, in frail people, or the risk of physical ill-health in those who appear unable, or unwilling, to cater for their physical needs.

Currently, much emphasis is given to people who may present a risk to themselves - through self-harm, suicide, self-neglect or harm to others. However, in our view, all these different problems have a common denominator—some mystery that lies deep within the Self Domain.
Bridging – building emotional security

From Relationships to Partnerships

Within less than a decade, the concept of ‘risk’ has become a central focus of mental health policy and practice. All services – whether in the public, private or voluntary sectors – are obliged to incorporate various forms of ‘risk assessment’ to identify people who may be at risk of harming themselves or others. The failure to assess for such risks would be viewed as negligence on the part of the organisation, and could result in severe financial penalties. Professionals who fail to assess for such risks, face equally severe professional sanctions.

Consequently, various processes of ‘risk assessment’ and ‘risk management’ are employed as a form of contemporary governance, in an effort to best meet the fiscal needs of the organisation and to safeguard the person in care.

The ‘nurse-patient relationship,’ first described over fifty years ago by Hildegard Peplau, is a major ‘given’ of nursing practice. However, simply spending time with the person is not enough. This dedicated time must embrace some activity, which nurtures communication about the person’s distress or difficulty, so that some further action might develop that will begin to address and resolve the person’s problems.

A major problem with recent developments in mental health care involves the careless borrowing of concepts (like partnership or consumer) from business and commerce; re-applying them, with little critical consideration, to quite different contexts. The ‘partnership’ between nurses (and other health and social care workers) and the people in their care could hardly be more different from the free-market of commerce.

This suggests the need to ‘unpack’ the language of care and, perhaps, to use more meaningful language.
Observation and risk

In many mental health settings, if a person is thought to pose a risk to themselves or others, some form of ‘observation’ is recommended. In many countries, these observations will be framed by some policy or protocol. However, at least to the layperson ‘observation’ must represent a curiously illogical response to a human crisis.

If we were on a ship and noticed that water was flooding the lower decks, no reasonable person would put this ‘flooding situation’ under observation. Instead, after ensuring that the flooding could not spread to other parts of the ship, (making the situation safe), an appropriately trained person would begin to explore the ship for a possible source of the problem.

We believe that this example provides a perfect analogy for the mental health care setting. If a person is deemed to be at risk then the general situation of the person needs to be ‘made safe’ – by providing social support and physical comfort. Then, an appropriately-trained person needs to begin to explore the possible sources of the ‘risk’.

- What is happening within the person’s internal world that might be generating displays of ‘risky’ behaviour?
- What needs to be done – by the person and specific members of the professional team – to reduce or resolve these problems or issues, and thus reduce the level of risk?

From Engagement to Bridging

In the early development of the Tidal Model attempts were made to represent, as precisely as possible, ‘what’ nurses did in the name of caring – especially for people at risk, who often retreat from human contact. We recognized that professionals needed to ‘reach out’ in some way, to make contact with the person. We called this process ‘engagement’.

Over the years, in workshops and ongoing discussion with colleagues in various Tidal Model projects, we grew dissatisfied with the concept of ‘engagement’.
The Tidal Model

- The concept of ‘engagement’ now features in many government’s policy documents and also in the professional literature. Often the meaning of the term used varies, with the result that the original concept has become blurred.
- Although ‘engagement’ can mean a ‘moral commitment’ – as in a ‘wedding engagement’, more commonly it implies ‘an encounter between hostile forces’, as found in a number of conflicts around the world.

We reviewed alternative names for the supportive human process we think is necessary to reach out to people in distress, in an effort to connect with them, meeting them – at the very least - halfway. Finally, we decided to re-name this process – bridging.

**Bridging – what you see is what you get!**

*Bridging* provides an apposite metaphor for the necessary work of supporting people in distress, who may also be ‘at risk’.

- People have built bridges since the dawn of humankind, across all societies and cultures. As a result, the ‘need to build bridges’ between alienated individuals, has become a popular English metaphor.
- ‘Bridging’ is the ‘thing’ that all bridges do, whether they are grand pieces of engineering or simpler structures. All bridges ‘do’ the same thing. The purpose of ‘bridging’ is to break down separation and to foster connectedness.
- ‘Bridging’ often involves a means of crossing threatening water, so that we might reach something of importance on the other side. With any bridge, there are always two sides and there is always a gap. Metaphorically, this represents the way people are separated by differences of understanding, power or status.
- The gap can be ‘bridged’ using any kind of material – from the rope bridge over a gorge in the Andes, to the steel and rivets of the Forth Rail Bridge. This reminds us that we can use any means at our disposal to ‘reach across’ the gap that appears to separate two people.
- The ‘bridge’ is not a judge – it connects everyone who expresses the desire to cross over, no matter who they are or where they have been.
‘Bridge’ traffic is not one-way, but allows those using it to move back and forwards if they wish.

When two people meet on a ‘bridge’, there is no fixed meeting place, in the same sense that the bridge is a ‘seamless’ connection between two opposites.

In snooker and billiards, the ‘bridge’ – which may be an actual device or simply the shape of the player’s free hand – provides the support necessary for playing a difficult shot. This offers a fine metaphor for the challenge nurses face in dealing with risk.

The Purpose of Bridging in Mental Health Care

In mental health care, we need to ‘cross’ the threatening waters of madness to ‘reach’ the person in distress. The bridging metaphor reminds us of the creativity and effort involved in building a bridge to connect with a person who may be alienated, isolated, threatened and fearful. This is not easy. It should be a highly valued professional responsibility, not a ‘routine chore’ left to support workers, students or security staff.

Building such bridges has inherent dangers. Bridge builders need to act skillfully and carefully, acknowledging all the risks that might be involved. They also need to ensure that the ‘basic building blocks’ are in place. In mental health care, these ‘building blocks’ are human processes. These metaphors remind us of the dangers of bureaucratic systems which risk dehumanizing both the person and those delivering ‘standardised’ processes of care.

Most significantly, ‘observation’ is a thing (noun), whereas ‘bridging’ is indicative, denoting the activity involved in caring. The team may have an ‘observation policy document’ that sits on the office desk, and which directs them regarding ‘what to do’ and ‘when’. ‘Bridging’ does not exist outside of the interpersonal relationship between the nurse and person in care. ‘Bridging’ can only develop as the two people begin to make contact. We can only know how bridging ‘works’ by examining the shared outcomes of ‘bridging’ as a human encounter. Like playing a musical instrument or riding a bicycle, we can only learn ‘bridging’ by doing it.
Bridging—Some Simple Examples

As Sally Clay noted in our introduction, people who are at ‘risk’ - of any kind—are experiencing some kind of threat to their emotional (or spiritual) equilibrium. They may be tormented by invisible demons, anguishing over some past misdeed (real or imaginary) or ‘angering’ over some slight or insult, however recent or ancient. In every case, the story of the hurt, bitterness or despair lies deep within the person, buried within the Self Domain.

Our task is to try to make contact with the person - to reach out to the person—letting them know that we are aware (as much as we can be) that they are hurting, angry or distressed. We hold out a metaphorical hand in the hope that the person will take it and we can then pull together, to begin to explore the problem, in an effort to find out what needs to be done.

It goes without saying, that there is no single way to do this. We have to use all our imagination, all our experience—as a human being, if not also as a professional—to create that connection; to build the bridge that will break down separation and foster a sense of connectedness.

The ‘High Risk’ Situation

Where the person is deemed to be at high risk of coming to harm, care is focused on ensuring that the person is provided with the highest level of support possible.

It would be inappropriate to try to define, exactly, how the team might ‘bridge’ with the person who is in such obvious distress, or under such a serious threat. Here we offer a simple overview of how the team might approach this critical task.

Let ‘human concern’ be our guide

- The nurse responsible for the person's care should make the person aware of the team's concern for her or his welfare.
• The nurse should discuss with the person how best to organise the person’s care in the short term (e.g. the next 24hrs)
• The nurse should then ask the person if they would like to ask any questions or comment on their situation.

N.B. In keeping with the principles of the Tidal Model, it should go without saying that this process will be collaborative. If the person appears to reject the need for this support the nurse should acknowledge this and note the person's views, as appropriate. An attempt should then be made to explain, perhaps with different examples, why the team is concerned for the person at this time.

I have been thinking about how things are going for you. A few things you have said make me feel that, perhaps, you are feeling a bit fragile. For the time being I would like to give you as much support as we can. I have suggested this to my colleagues. I think we need to help you through this difficult period. I’ll arrange for either myself or one of the other nurses to be with you most of the time, so that you can feel supported, and maybe get some help with things, when you need it. We could talk things through, or just help you get through the day. I’ll arrange to meet with you tomorrow around this time, so that we can discuss how you are feeling then—and to see what you think of the support we have offered. We can talk about what you think needs doing then. How do you feel about this?

The Significant Risk Situation

Where the person appears be at significant risk of coming to harm, care is focused on providing the person with regular support throughout the day and night. Again, it is important to convey the team's concern for the person’s welfare, and to explain, in simple ordinary language how the team hopes to support the person.

• The nurse should tell the person that the team has concerns for their welfare.
The person should be advised that a nurse will contact them regularly throughout the day, to ask how they are doing, and to find out if the person needs anything,

Wherever possible, the nurse will try to arrange to meet the person’s needs, either then or as soon as possible afterwards.

During the night, someone will check regularly to see to see that the person is comfortable, or to check if they need anything.

I think that you are doing well at the moment. But, maybe you still need a bit of support. Things have not been easy for you over the past few days. I’ll be checking in with you from time to time, just to ask how you are doing. I’ll also ask some of my colleagues to do the same. That way, we can find out if you need anything, need to talk about anything, or maybe arrange some activity. We are in your hands. Just let us know. However, if you need anything, at any time, just let me or any of my colleagues know. How do you feel about that?

The Low Risk situation

It is always dangerous to define any situation as 'low risk' since a crisis usually comes out of 'nowhere'. However, that said, where the person appears to be at low risk of coming to harm, the focus of the bridging relationship is on providing meaningful, but intermittent support throughout the day and night.

The person should be advised that the team still has some concerns for their welfare

The person should be advised that a nurse will make contact with the person at points during the day, to ask how they are doing, and to find out whether or not the person needs anything.

Finally, the person should be asked if they would like to make any comments or suggestions.
The ‘No Risk’ Situation

Where the person does not appear to be in any apparent risk care focuses on developing some of the more ‘active’ relationships.

- Organise more One-to-One Sessions, focused on addressing the specific problems that brought the person into care, or which stimulated a crisis. These sessions will focus on establishing what needs to be done to reduce or resolve the effects of the problems or crisis.

- Arrange a family meeting, (where appropriate) involving appropriate family members who are actively involved with the person. The participants should be decided by the person. The focus of this meeting should be to address what needs to be done (or to happen) to reduce or resolve the problem or crisis, and the part each person can play in achieving this.

- Encourage the person to join one of the group sessions. Here the person can begin to draw on support from peers, rather than from professional staff alone.

- The person should be advised of the various forms of support available, including details of the various options available in the form of individual, family and group support.

NB Where care is delivered within the community - either in the person’s home, as part of a partial hospitalisation or 'out-patient' programme - this level of support will be negotiated 'by arrangement'.
Being Human—Being Creative

It is all too easy to fall into the trap of ‘dispensing’ standardised care. This must be avoided at all costs.

When working with people who are in any way ‘at risk’, our efforts should be focused on valuing the person, respecting them as a person, and conveying our genuine concern for their welfare. (If any member of the team does not feel this concern, then the possibility of offering meaningful, effective, care is obviously impossible).

As Hilda Peplau observed over 50 years ago, the key ‘therapeutic tool’ that nurses use in their work, is nothing other than themselves. Nursing is, among other things:

“a maturing force and an educative instrument. By means of effective nursing, individuals and communities can be helped to use their capacities to bring about changes that influence living in desirable ways”.

To be able to help people influence their lives in desirable ways, nurses need to be flexible, pragmatic and — most of all — creative.

We cannot tell you how to be creative but, for the sake of the people that you work with, we hope that you will use all your human creativity, to help them learn from their experience, as you support them in making meaningful changes in their lives.
The purpose of the Monitoring Assessment is to help the person identify and examine the threats and other emotional insecurities that increase the risk of harm to self or others.

Exploring emotional threat

If the team have reason to believe that the person is in any way at risk, of harming themselves or others, then it will be necessary to explore the Self Domain—sensitively and collaboratively. The Monitoring Assessment (see appendix 3) is a vital part of this exploration, providing not only a means to build further ‘bridges’ with the person, but also to open the way for the development of the Personal Security Plan (see next section). (This Assessment has been the subject of much revision since it was first developed ten years ago).

The Monitoring Assessment has 3 objectives:

1. To help the person to begin to assess their own risk status. This helps further in the ‘powering up’ process.
2. To provide a simple measure of the perceived level of risk - from both the person and the nurse’s perspective
3. To identify what might help to reduce the level of risk.

The Monitoring Assessment should be completed by a nurse, or other team member, who has a responsibility for the overall care of the person.

The Monitoring Assessment should be conducted in private, is not necessarily time-consuming, and may take no more than a few minutes to complete.
Overview of the Assessment

The nurse begins by offering a general introduction to the assessment, and then opens with a general question about the person’s feelings.

I was hoping that we might talk a bit today about how you are feeling. I know that things have been a bit difficult for you over the past few days. I have brought along a format that I have found useful. We call it the ‘Monitoring Assessment’. I guess it tries to do what it says—monitor how you are feeling - so that we can work out what might need to be done, to help you. I’ve brought a copy for you. Is it OK to talk you through this?

Well, the first thing is to ask how you are feeling. I said that I thought things were a bit difficult for you. That’s just how I see things. How are you feeling?

After the person has talked, at least a little, about how they are feeling, or what is ‘happening’, the nurse encourages the person to make a note of these feelings (or thoughts etc) in their own words OR makes a note on behalf of the person.

Next, the nurse explores the possible impact—or effect—of those feelings (etc) on their everyday life, again inviting the person to make a note of the rating, that best represents how safe and secure the person feels.

Would you like to make a note of how you are feeling there—where it says “How I am feeling” So given that you feel (naming the feelings mentioned) how safe and secure do you feel today, in yourself? If I said, say, on a scale 0-10, where 0 meant you felt really vulnerable, not at all safe and secure, and 10 meant you felt as safe and secure as you could be, where would you say you are now?
Since the purpose of the assessment is to explore how the person might further develop a sense of personal security, the nurse then asks:

I see, you feel about 8 just now—that’s pretty vulnerable, yes? So tell me, what helps you feel more secure in yourself—even just a little more secure? What sorts of things do you do that helps you feel a bit more safe and secure? Maybe you could write these down with me, where it says “What helps me now?”

Next, the nurse encourages the person to judge the extent to which she feels at any risk to herself or others. What are the chances that you will harm yourself?

OK So what do you think are the chances that you will harm yourself? Use that same scale—0-10 (with 0 being 'no chance at all' and 10 being a 'very definite chance') how would you rate yourself right now?

If there is any chance of self harm the nurse asks the person to enter the rating in the box “What chance is there that I might come to harm?” Next, the nurse explores the person’s judgement of the usefulness of support.

Now here’s an important question... for me anyway. To what extent do you think I might be able to help you—to feel more secure in yourself, and therefore to feel safer? If you use the same scale, 0-10, what would you say? 10 would mean that you are really certain that you could be helped and 0 means there is ‘no chance’ that I might help you. What would you say?
If the person gives a high rating in answer to the question “Could I be helped to feel more secure?” (over 5) the nurse would explore the person’s reasons for believing this.

So you feel fairly positive about me being able to help you — 6, that’s seems pretty positive. Can I ask, why do you think I might be able to help you? What do you think I might be able to do that would be different?

The nurse follows this up by exploring the kind of support the person might get from other people, that might help develop a sense of emotional security.

Good. So you think that if I could do that (naming the activity) you would find that helpful. I see. And who else do you think might help you right now? And what kind of things might they do, that might help you?

The answers are then entered in the box “What else might be helpful?”

Before closing, the nurse asks how confident the person is that (s)he can keep her or himself 'safe' until they meet again (specifying when the next meeting will be). The same scale (0-10) is used, to indicate “not confident at all —0” and “very confident – 10”.

After the person has entered a rating for confidence the nurse then rates how confident (s)he feels about the person’s safety.

OK You have rated yourself 8. That means that you are pretty confident that you can keep yourself safe until we meet next. Now, if I was to ask myself to give a rating, I guess I might say that I am about 4 or 5. I guess I am not quite as confident as you. (Enters the rating in the box—”How confident are you?”) Maybe we could talk a bit about that. Why do you think you feel confident, but I am not quite as confident?
NB: Where the ratings offered by the person and the nurse differ, this should be discussed. The aim is not to reach a consensus, but to air, openly, the different reasons why the person takes this view and the nurse takes a differing view. Ultimately, the team will need to make a decision regarding how its members will care for the person, if only to safeguard itself from any possible accusation of negligence. However, by openly exploring the person’s view of the risk situation and, perhaps, contrasting this with the nurse’s perspective, an honest, open dialogue is beginning to take place. Hopefully, this will provide a springboard for more open and honest dialogue, leading to more meaningful, collaborative care. This is the beginning of ‘bridging’ (see page 45).

Timing
The Monitoring Assessment should be completed whenever the person appears to present a risk to self or others. The assessment usually serves as a preparation for developing the Personal Security Plan. (See next section) The Assessment can be used repeatedly, to help the team members, and the person, gain an appreciation of how the perceived risks are changing, however subtly, from day to day.

Distinctive Features
The key features of the Monitoring Assessment are:

- The person is involved actively in making judgements about the perceived level of risk
- The assessment focuses on exploring the person’s ‘private world’ and further enables the ‘bridging’ necessary for the development of a close, confiding relationship
- The person’s view of the risk situation is respected
- Open dialogue is encouraged—even where views might differ
- The record is completed in the person’s own words, wherever possible by the person him or herself.
The whole process demonstrates a commitment to collaboration.

The process of the assessment provides a springboard for the Personal Security Plan, and further steps in the direction of ‘self help’.

An illustration of a completed Monitoring Assessment is provided on the next page.
The Tidal Model

The Monitoring Assessment

- How I am feeling: Shaky. Head is rushing. Can't seem to think.
- How safe and secure do I feel? (0-10): 4
- What helps me just now?: Sleeping. Talking sometimes. A smoke.
- What chance is there that I might come to harm? (0-10): 6
- Could I be helped to feel more secure? (0-10): 7
- What else might be helpful?: Getting outside at night—see the stars. Talking to Jim (boyfriend).
- How confident am I? (Person) (0-10): 8
- How confident are you? (Staff) (0-10): 5
The Tidal Model

From Care to Self Help

The focus of all Tidal care within the Self Domain is to identify any serious risks that the person might pose to themselves or others, and to try to provide the conditions necessary for the person to feel (at least a little) more emotionally secure. All these efforts emphasise open, collaborative assessment, concluding with the development of open, collaborative plan of care and support—the Personal Security Plan.

Originally called the ‘Security Plan’, people in receipt of Tidal care suggested that we change the name to Personal Security Plan to signify that this belonged to them, not the staff team. The plan is, however, developed conjointly, by the person and one of the nursing team and has two aims:

1. To define what (exactly) the person might be able to do for themselves to reduce the likelihood of coming to further harm, or harming others, and how the person might feel more emotionally secure.

2. To identify what other people—team members, other people in care, friends etc—might do to enable this.
The Personal Security Plan is the bedrock of the person's contribution to their own care plan and represents a critical step from being ‘cared for’ to ‘self care’ or self help. The importance of the Personal Security Plan cannot be over-emphasised. If the person does not feel secure - emotionally as well as physically - then all other offers of help, however sophisticated and appropriate, may have little positive effect.

NB: Given the shifts that occur in the person's sense of emotional security - from day to day, if not from moment to moment - it is vital that the Personal Security Plan is updated regularly.

Where the person is identified as a 'high risk' the plan may need to be updated daily. Where the person has moved into Transitional Care, or where the level of risk is thought to be reduced, or low, the review of the Personal Security Plan may need to be less frequent.

Safety and Security

Traditionally, services have focused on making sure that people in care are kept safe. Usually this ranges from removing or monitoring access to parts of the environment that might, reasonably, be assumed to represent a risk, to removing access to objects, materials and other people that might prove harmful. Clearly, these 'common sense' precautions are a vital part of ensuring a person’s security.

However, windows, glass, knives etc do not represent the most serious threats to the person’s security. The real threats lie within the person’s Self Domain—in the form of thoughts, feelings, beliefs, memories etc - that might lead the person towards using the outside world to harm him or herself, or others. Consequently, the Personal Security
Plan focuses on what is happening 'within' the person’s Self Domain.

The aim is to identify how the person might be able to manage these thoughts and feelings and so feel more emotionally secure.

In developing the Personal Security Plan the nurse assumes that the person already possesses the personal resources necessary to manage the risk, but needs some help to clarify how they might do this on a daily basis. This assumption is another example of the ‘powering up’ approach of the Tidal Model—helping the person to use her or his own personal ‘power’ to positive, rather than negative effect.

The development of the Personal Security Plan involves asking the following three questions:

1. What has the person done in the past that appeared to reduce the risk of possible harm to self or others, and foster a sense of ‘emotional security’?
2. What is the person doing now to reduce or offset the risk of harm and feel more emotionally secure?
3. What help does the person receive from others that helps to reduce the risk of harm and foster emotional security?
4. How might the person use these personal 'resources' to develop their own Personal Security Plan?

Illustration

Nurse: So you feel that you might harm yourself again?

Person: I guess. It goes around in my head - the thoughts I mean - it goes round in my head most of the time. I just feel that its all so pointless. I'm going to do it again. I know I am.
Nurse: So how do you deal with that? How do you deal with those thoughts going round in your head?

(NB: The nurse does not ask if the person can deal with these thoughts, but assumes that the person already does.)

Person: Well, I'm not sure I do. I mean, I hadn't thought about it really. They seem to have a life of their own...the thoughts, I mean.

Nurse: Well, you must be doing something, something really powerful, because you haven't harmed yourself since you came to us.

Person: Yes, but that's because I'm here, isn't it?

Nurse: Well, maybe we should talk about that. You spend a lot of time on your own here, don't you?

Person: Yes. But what's that got to do with anything?

Nurse: Well, if you are on your own that 'we' aren't stopping you harming yourself, or doing anything else for that matter.

Person: Well....alright, I see what you mean.

Nurse: I'd like to talk with you about two things - two really important things. First of all, what can you do to help yourself with your present problems? I suspect that you are already doing something to deal with these thoughts about harming yourself? Maybe we should try to find out what that is. Secondly, I'd like to know what I, or anyone else, can do to help you to deal with these thoughts? How do you feel about talking about that?

Person: Well...OK.

Nurse: So tell me, what kind of things have you done in the past that you think has helped you to deal with thoughts about harming yourself?

Person: Well...I have sometimes talked about it to someone. That sometimes helps, well just for a short time. Not completely, you know, they still are there.

Nurse: OK. That's really interesting, so talking to someone can be helpful. Anyone in particular?

Person: Well, maybe Janine - my friend. She really understands me. We go back a long
Nurse: OK., so Janine can be helpful to talk to. Who else do you find it helpful to talk to?

The nurse encourages the person to make a note on her **Personal Security Plan** that ‘talking to Janine’ is one thing that she can do to help herself feel a little more secure, before exploring other possibilities.

Nurse: So what else have you done in the past that has been helpful in any way? (Notice that the nurse assumes that the person has done something. This kind of question encourages the person to explore personal resources that she may not be aware of.)

Person: Well it seems silly but sometimes I just tell the voices to ‘Fuck off!’

Nurse: (Laughing) And do they... fuck off I mean?

Person: Well for a little while maybe.

Nurse: Hmm, seems like that's a good one too, maybe you should make a note of that too.

Working together in this way, the nurse and the person build up an idea of the kind of practical things that the person can or might do to help feel more secure and what help the person might receive from others. This also includes some information about how these different things ‘work’ for the person—what they currently ‘do’ or ‘might do’ for her. This helps the person to build up some ‘personal wisdom’ about what works!

A completed example of a **Personal Security Plan** is shown over the page.
**Personal Security Plan**

**What can I do that might help me feel more safe and secure?**

- Talk to my friend Janine—I feel understood
- Read letters from my mother—I feel loved
- Make a note each day of the people who value me—I feel a bit better ‘bout myself
- Listen to music on my walkman—forget about things for a while

**What can other people do that might help me feel more safe and secure?**

- I’d like the nurses to ask how I’m doing—would show they were interested in me
- I’d like Max to bring his dog Toby to see me.—Toby makes me happy
- I’d like to talk to someone from the Hearing Voices group—maybe they could tell me how they manage their voices
The World Domain

Reclaiming the Story

In the World Domain we help the person to reclaim the story of breakdown and recovery.

We do this by asking—"who is this person" and "what are the person’s problems of living", which the person might need help in addressing.

We answer these questions, first of all by completing the Holistic Assessment. This begins the collaborative conversation that will run through the relationship, like a strong current—guiding the flow of all subsequent conversations.

This will lead us, naturally, to arrange dedicated One-to-One Sessions, where we shall explore with the person specific problems of living, in an attempt to develop a collaborative plan of caring support that will begin to address them.
The Tidal Model

The purpose of the Holistic Assessment is to develop a conversation, within which people can begin to tell the story of how they came to need help, and can begin to discuss how they might address their problems of living.

Telling the Story

When people have a ‘crisis’ or ‘breakdown’ or are diagnosed with some form of ‘mental illness’ they experience problems of human living that are, at least at first, entirely private. These experiences exist within the Self Domain – in the private world of personal experience. In time, the person may begin to express aspects of these problems in their everyday world, where they will become noticeable to other people: family, friends and eventually mental health professionals. However, it may take a long time for these ‘private’ problems to be made ‘public’.

Some people – such as those who ‘suddenly’ commit suicide – may never make their private problems public. As a result friends and family are often mystified.

When a person enters mental health care who they are and what has been happening in their life is largely unknown. The professional team may have some information, which identifies the person, but this will be largely superficial. More importantly, it will likely represent one person’s story or a previous team’s story about the person.

In developing Tidal care we aim to answer these questions:

.
The Tidal Model

- **Who** is this person;

- **What** has happened in their life to bring them into our care; and

- **How** can we help them to begin to deal with this situation?

In the **World Domain**, nurses aim to learn something of the person’s world of experience, so that they might understand better the problems of living experienced by the person. In the 'search for understanding' the nurse uses the **Holistic Assessment** to establish what aspect of the person's world of experience is important **now**, and how that experience has come to be so important for the person.

The **Holistic Assessment** (See appendix) involves an intimate, trusting conversation with the person that will form the basis for the therapeutic relationship necessary to meet the person's nursing needs.

**What are the aims of the Holistic Assessment?**

The **Holistic Assessment** is used to;

- Give the person the opportunity to **describe, discuss and examine** their experience of illness and health,

- Develop a **personal care plan** - focused on the person's unique needs, as the person perceives them.

- Develop a **collaborative** relationship between the nurse and the person in care, which emphasises ‘working together’ and ‘exploring’ the person's needs and problems.
· Develop an empowering relationship within which the nurse helps the person to make informed decisions and choices.
· Find out 'who' is the person.

What are the objectives of the Holistic Assessment?

The Holistic Assessment has four dimensions. It aims to establish:

· What are the person’s present ‘problems’ or ‘needs’?
· What is the scale of these problems/needs? How big are they?
· What aspects of the person's life might help to resolve such problems, or meet such needs?
· What needs to happen to bring about change?

People rarely talk naturally about different aspects of their problems. Usually, a problem of living - whatever it is called - is experienced 'whole' or complete. The Holistic Assessment tries to draw together - as far as is possible - the person's experience of different aspects of problems of living into something that approximates that 'complete experience'. The Holistic Assessment tries to produce a representation of the person's problems that seems real.

Traditional assessment is invariably written in professional language or terminology.

· The results of the Holistic Assessment are presented in the person's own
'voice', using the person's own natural language. By giving the person back their own voice, this will be received as an 'empowering gesture' - showing how much the person's own words are valued.

Traditional assessments are usually based on a highly professional relationship, where the nurse, or some other professional, is the 'expert'.

- The Holistic Assessment emphasises collaboration and dialogue, recognising that the person in care is the expert on these problems or needs.

**When should the Assessment be completed?**

The aim of the Holistic Assessment is to establish the person's perspective on their need for nursing. The Holistic Assessment may, therefore, be used in any setting - acute ward, community setting, day care etc.

- The Holistic Assessment should be completed as soon as possible after the person's entry into the service.
- Where the person is unable (for whatever reason) or unwilling to collaborate in the assessment, this should be deferred until later, and a provisional supportive care plan introduced, designed by the primary nurse or team.

**How should the assessment be undertaken?**

The assessment should be conducted in a setting where privacy and the minimum of disruption can be guaranteed.
The nurse should start by aiming to put the person at ease, before beginning the assessment process.

The person should be given a copy of the Assessment to refer to during the interview. This may be done prior to the session.

The nurse should explain the purpose of the assessment, referring to each page in turn.

The person should be invited to write their responses to each of the main questions, as the assessment progresses. (The nurse should offer the person the pen to write the responses). This will emphasise the empowering nature of the whole process.

If the person is unable (or unwilling) to complete the summary themselves, or would prefer not to, the nurse will complete the recording of the responses to the questions, on the person's behalf.

Before recording anything, the nurse should check with the person that (s)he has understood correctly what has been said. Such constant checking will develop further the collaborative nature of the assessment and will enhance the person's trust in the nurse.

**How should the Assessment be recorded?**

Traditionally, assessments are summarised and presented in the professional's voice: (e.g. "The patient *reported* that she had difficulty sleeping.... or "she *said* she felt tired.")
The Holistic Assessment is focused on the person's immediate understanding of their problems and needs. Consequently, the details of the assessment are presented in the person's voice. (See completed example in Appendix 4).

Who should complete the Assessment?

The Holistic Assessment should be completed by a member of the team, who is likely to have a major involvement in the care of the person. This may be the person's assigned primary nurse, case manager or keyworker, who will be responsible for the overall design, development and management of the care plan.

Should anyone else be involved in the Assessment?

The nurse will usually conduct the assessment with the person alone, ensuring privacy and confidentiality. In some cases the person may request the presence of a relative, friend or advocate, for moral support. Such requests should be honoured. In such instances, however, the friend or advocate will usually not contribute to the assessment process, but will merely help the person to make her or his own responses.

On some occasions it may be considered appropriate to conduct the assessment with the person along with a member of the family. Where such a conjoint assessment is conducted, the nurse should ensure that the assessment reflects the perceived problems, needs and wants of the person in care, as distinct from the needs and wishes of the family member.
How often should the assessment be repeated?

Traditionally, assessments are repeated at intervals to measure change or identify new problems. The Holistic Assessment is used, primarily, as a means of helping the person to tell her/his story. It is also used to introduce the person to the collaborative relationship with the nurse, and to collaborative care-planning.

The care plan, which will develop from the Holistic Assessment, will identify how the person and the team should respond to the identified problems of living. This care plan will embrace specific One-to-One sessions, which will provide an ongoing assessment of changes in the nature and function of specific problems of living. Consequently, repetition of the Holistic Assessment is unnecessary.

Completing the Holistic Assessment

Each page of the assessment should be completed along with the person (and any significant other). This will increase confidence in your ambition to work collaboratively with the person from the outset.

Introduction (p 1)

- On the first sheet of the Holistic Assessment (see Appendix 2) identify the person, and the nurse completing the assessment, along with the date and time of the assessment.
- Enter a brief summary of the circumstances, which brought the person into the service (ward, unit or community programme).
- Finally, make a note of the person's assigned primary nurse or keyworker.
Overview of Problem or Need (pages 2 and 3)

In beginning the formal part of the Holistic Assessment the nurse should try to establish the person's perception of what has brought them into hospital or care (etc) or, alternatively what they need or wish to talk about.

- Do not ask specifically about 'problems'. (Many people do not believe that they have any problems!). Instead, ask more open questions, which will allow the person to talk about what is important, in their own words.

Illustration

- "OK Bob, tell me then, what have you brought with you, that you want to talk about (or need to talk about)?"
- "So, what would you like to talk about? What's on your mind? Where shall we begin?"
- "What has brought you here (hospital, unit, programme etc)?"
- "Why do you think I have been asked to see you?"
- "What has been happening for you recently, that you would want to talk about (or need to talk about)?"

Problem Origins (How this began)

The focus of the assessment is on the person's experience now. However, people often expect, or want, to spend some time putting their present situation in context. For this reason it is important to begin at the beginning. Ask the person about the background to whatever it is that has brought the person to the service.
Illustration:

- When did you first *notice* (the problem or issue)?
- When did you first *become aware of* ?
- ...and this all started, *when*?
- ...tell me a bit about what was going on in your life when this all started.

Past Problem Function (How this affected me)

The next set of questions aim to explore the person’s direct experience of the problem of living: what effect did this have on their life? A useful way to introduce these questions is by summarising briefly the origins of the problem. This also shows the person that the nurse has been listening carefully to the unfolding story.

Illustration

- “...so (summarising the origins) how did that affect you at first?
- Tell me a bit more about how that affected you.
- ...so, what effect did that have on you and your life?

Past emotions (How I felt in the beginning)

The next set of questions examines the emotional impact of the problem *in the beginning*.

Illustration

- ...and how did you feel about that, at the time?
- ...and how did you feel about that, in the beginning?

Developmental history (How things have changed over time)

The nurse is developing a good idea of where the problem first emerged into the person’s
world of experience, how if affected the person and what feelings were associated (then) with the problem. Now the nurse tries to bring the situation up to date.

**Illustration**

- (Summarising briefly, the problem origins, effect and feelings) So, that was then. In what way have things changed for you now?
- ...in what way have things changed over time—between then and now?
- How would you describe things now? What is different now?

**Relationships** (The effect on my relationships)

Even highly personal problems are experienced interpersonally. Even if other people who share the person's world are unaware of the fine detail of the problem, they may well be affected by it, and indeed may contribute towards it. The nurse now explores briefly the effect of the problem on the person's relationships.

**Illustration**

...and how has all of that (the problem) affected your relationships with other people?

tell me a bit about how that has affected your relationships - with friends, family (work colleagues if appropriate) or just 'other people' in general?

so what do other people say about (the problem)?

**Current Emotions** (How do I feel now?)

The next stage of 'bringing the problem up to date’ involves exploring the current emotional context: how do you feel now? or how do you feel about all of that (the problem) now? Or what feelings do you have about (the problem) now, at this very moment?

**Holistic Content** (What do I think this means?)

Now that the nurse has a very good idea of what is the nature and function of
the problem, it is time to explore its meanings. The nurse might ask the person directly, what they think all of this means, or might choose to preface this question with a simple warning.

**Illustration**

*(Summarising briefly - “So you first became aware of this ....and at that time ....was happening in your life, and this affected you by ..........and you felt ................. Now, you think that it has affected your friends and family........and now you feel ....).*

“So, can I now ask you, what does all of this mean for you?”

**Illustration**

I'd like you to think about this next question. It's an important question. For I would like to know what you make of all this. You have told me your story of what has brought you here (or what has happened to you, what you think is wrong), and how you feel about things. So what does it all mean for you - on a personal level?

**Holistic Context** (What does this say about me as a person?)

Taking the exploration of meanings one stage further, the nurse invites the person to think about what 'all of this' might mean for them 'as a person'.

**Illustration**

...so what do you think that this says about you, as a person?

**Needs, wants and wishes** (What needs to happen now/what do I want or wish would happen?)
Having gained a detailed picture of the problem and its wider context, the nurse now moves on to consider what might need to be done, by way of a nursing response. The answer to the final two questions in this section will help the team decide what kind of intervention the person thinks might be appropriate.

Illustration

- ...and what would you hope would be done about all of that (summarising the problem)?
- ...and what would you want to happen now?
- If I was able to grant you one wish, in relation to what we have been talking about, what would you wish for?
- ...and what else might you wish for?

Expectations

Finally, in this section, the nurse tries to establish what the person’s expectations are of the nursing team. What do they expect that the nurse, or other members of the team, to do for them?

- this is the last question in this section, and it is also an important one. What do you expect me to do for you? What do you think that my colleagues might be able to do to help you?
In the next section, the nurse will try to evaluate the problem, using a simple rating format. Before moving on to this next stage, the nurse should again ask for permission to proceed.

- I'd like now to get an idea of how 'big' a problem all of this is for you.
- Is it OK if we carry on? (If the person says 'no', return to this at some later point)
- I want to ask you three questions. They are on the top of the page. They are very important questions. Indeed, all these questions are important. However, these three questions will help my colleagues and I get an idea of how distressing you find this problem. Also, it will tell us to what extent this problem upsets the living of your life. And finally, it will tell us how much control you think that you have over the problem - to what extent you can deal with it. How does that sound?

Before beginning the rating, the nurse needs to know if the problem should be evaluated 'as a whole' or are there different 'parts' to the problem.

- We can use this format to get an idea of how 'big' the problem is. Do you want to talk about the problem as a whole, or do you want to split it up into some of the bits that you have been talking about? We can either write down 'the whole thing' or we can break it up into different parts. What do you say?

The nurse should then evaluate each 'part' of the problem, or the 'whole problem' with the person.

- Using this rating scale here (See Appendix 3), where 1 means 'you are not at all distressed' and 10 means 'you couldn't imagine being any more distressed', where would you say you are right now? How much distress, between 1 and 10 is the problem giving you now?
- And, using the same scale, to what extent does (name problem) affect or disrupt the living of your life? 1 means it doesn't disrupt your life at all, and 10 means you...
couldn't imagine your live being any more disrupted.

- Finally, I would like to get an idea of the extent to which you think that you can exert some control over this (problem). 1 means that you feel that you can do nothing to influence, or control, the problem. 10 means that you have complete control over it. Where would you put yourself right now?

The ratings should be entered into the boxes for each aspect of the problem before proceeding to the final stages of the assessment. *Complete these ratings for each identified 'sub-problem'.*

**Personal Resources (Page 5)**

The nurse now opens the assessment out to consider some of the personal 'assets' or 'resources' of the person. Who are the people, things and beliefs that are important to the person, and that might play a part in the ultimate care plan.

**The people who are important**

- tell me a bit about the people who are important to you in your life.
- Who are they, and in what way are they important to you? (The names of each person should be entered in the box, alongside a brief note that explains *why* the person thinks they are important).

**The things that are important**

- Tell me about the things that are important to you. What 'things' would you miss if suddenly they weren't there any more.
  
  ...and why is this (naming the thing) important to you? The names of each thing - along with a brief description of its importance -should be entered in the box.
The ideas about life that are important

- What beliefs about life in general are important to you?
- People often have certain values, or rules, by which they live their life - a personal philosophy, perhaps. What are the values or rules for your life?

Again, these ideas, beliefs or values should be noted, along with an explanation of why they are important.

Resolution of the Problem Need (Page 6)

In the last stage of the assessment, the nurse asks the person what it would be like to have the problem resolved, or the need met. The answer will help to identify the final goal of any intervention, in the person’s own words.

How will I know that the problem has been solved, or the need met?

The nurse explores with the person the idea of what it will be like when their ‘problem’ is no longer a problem; or their ‘need’ has been met. If appropriate, the person is encouraged to ‘imagine’ what this would be like. In framing these questions it is important to assume that this will happen. Framing the question in this way will help the person to imagine a future without the problem.

- How will you know when this problem (naming it) is no longer giving you problems, or making your life difficult?
- What will life be like for you when this problem (naming it) is no longer a problem?
- If I could wave a magic wand and make your problem disappear - which of course I can’t - what is the first thing that you would notice that is different?
- When this (naming it) is no longer a problem, for you what will be different?
- What else will be different?
What needs to change for this to happen?

The final question invites the person to reflect on what might be necessary for this change to occur.

• What do you think needs to change for this to no longer be a problem for you?
• What can you do to help this to happen?
• What can anyone else do that might help this to happen?
• What do you think you will notice—in yourself, your life, or other people, that will tell you that things are changing?
• What do you think other people will notice that is different about you when this is no longer a problem for you?

Conclusion of the Assessment

At the end of the assessment the nurse should offer the person an opportunity to make any final comments, or to comment on the process of the assessment itself.

The nurse should then advise the person 'what happens next' and should thank the person for their help with the assessment.

• Well, now that we’ve finished I shall go and make a copy of this and bring it back to you, so that you can keep it. So that you will know exactly what we have been talking about here today. I shall put the original in your nursing notes, so that the rest of the team will know what we have been discussing here. They will find that very helpful.

• Before we go I would like to thank you for your help with this. I know that this kind of thing can be very difficult and sometimes we seem to be going over the same old ground. However, I have found this really helpful and I am sure my colleagues will too. So, thanks very much once again.
Reclaiming the Story

In completing the Holistic Assessment the person has begun to tell the story of what brought her/him into mental health care. More importantly, the person has begun to reclaim this personal story as the most meaningful account of what has happened to bring the person into mental health care. This act of reclamation is, in our view, the first step in recovery. Before the person can recover her or his life, (s)he must reclaim the story of that life, embedding that story within her or his experience as a person. Many stories will be written – by different members of the health and social care team – about the person, in the form of notes, records, letters, reports etc. However, the most vital story is always the person’s own story – “my story”! It is vital for it is the one story that is actually lived by the person. All the others are merely stories about the person, from the perspective of the onlooker.

This conversation about ‘my story’ is continued in dedicated One-to-One Sessions, where the person is encouraged to discuss further these problems of living, by talking about what is a problem, issue or difficulty today. The key focus of these One-to-One Sessions is to help the person become more aware of how change is a part of life; and how the problems (s)he experiences, change – even in a very small way – under certain conditions. The development of this awareness began in the Holistic Assessment when the nurse helped the person discuss what it would be like not to have the problem, and what might need to change, or to happen, to help bring that change about.

Powering-up the Person

In all care settings time should be dedicated to focussed One-to-One Sessions. Initially, this contact may be highly informal, as the nurse tries to gain the persons confidence, and begin to develop the collaborative relationship further. Gradually, the nurse will take this relationship on to a more focused basis, encouraging the person to explore how things
either are changing, what things would be like if the situation changed, or how things used to be in the past, when the person was free of this particular problem.

**Purpose**

The **One-to-One Session** should appear like an ‘ordinary conversation’. The **purpose** of the Session is to help the person become aware of:

- changes that are already going on within them,
- how they might help develop these changes,
- how the nursing team, or others might play a part in promoting **small, but steady changes** in how the person feels or thinks and in what the person is able to do, on a daily basis.

All this is part of the ‘powering up’ process, where the person is encouraged to find resources within her or himself, which can be used to address different problems of living.

**NB** Although people often 'wait' for change to come about, change is an ongoing process. Change is happening for you, even as you read these words. Change flows through the person almost invisibly, like water. The nurse aims to help the person begin to notice these small changes, which represent the tiny steps that are being taken on the long road to recovery. However, first of all the person must begin to imagine what that journey of recovery might be like. In that sense, the journey of a thousand miles truly begins in the imagination.
Illustration

In the One-to-One Session illustrated on the page 91, ‘Clare Sweeney’ is meeting with a nurse, ‘Mary Burns’. The session is focused on a conversation between Mary and Clare, in which the nurse tries to help Clare to notice small changes in her feelings and then to negotiate a practical ‘assignment’ that she can carry out by herself, which will use this ‘personal knowledge’. The aim of the session is to ‘power up’ Clare, helping her to become aware of what she can do for herself, and what untapped capacities she might possess. However, the nurse also discusses how she, and her colleagues, might support Clare to do something different, in dealing with this problem.

Given that this is a record of an aspect of the care given to Clare, details of the time and date are included and, wherever possible, both nurse and the person in care sign the record, to confirm that this is their joint work.

As with the Holistic Assessment, the nurse begins by outlining the purpose of the session, inviting Clare to write her responses, as the sessions proceeds. If she is unable or unwilling, the nurse will complete this on her behalf, but in her own words.

The One-to-One Session format on Page 91 includes two columns for recording. The left (shaded) column, is dedicated to recording the person’s responses and comments during the session. The right-hand column, is used to make notes that will inform the team about the Session and what the team members need to do to support the person.

NB: We have numbered the questions to draw attention to the order in which they flow. The record does not include this numbering.
1. Introducing the Session

Mary: Hi Clare, it’s nice to see you again. We had one of these sessions yesterday. Yes? I thought that went very well for the first time. I know it can all seem a bit strange. But, like I said yesterday, this is simply some time set aside for you to talk about whatever is important for you, right now. Hopefully, by talking, the two of us together, you will come up with some ideas about how you might deal with the kind of things that are bothering you. Are you ready to get started?

Clare: I guess so.

2. What’s the problem?

It is important to give the person a few minutes to talk about ‘the problem’ or issue or difficulty. The person needs that time to connect with the story.

However, it is important also to move the conversation on, fairly quickly, to talking about ‘what might need to be done’.

Mary: So, what have you brought with you that you want to talk about? What’s important for you today?

Clare: Well….I don’t know. It’s all so pointless. I just don’t think…..I mean, its….I am so hopeless. Its me. I know it’s me. I am the one that’s pointless. I am the useless one.

Mary: OK. Tell me a bit more about this feeling of ‘hopelessness’, ‘pointlessness’. What is that all about?

Clare: Oh, I have always felt that. Well, maybe not always, but for a long time. I’m useless. It’s me, I know it’s me.

Mary: You feel bad about yourself. Yes?

Clare: (Laughing and crying) You bet. Oh, I’m just so USELESS.
3. Imagining the Future (My aim)

Mary: OK. You feel really bad about yourself. I see. How would you like to feel about yourself? How would you want to be?

Clare: (After a long pause). Well, not like this. I don’t know. Not like this. I would like to feel better about myself….or better than this. I have never felt good about myself.

Mary: So, you would like to feel ‘better about yourself’ Yes?

Clare: Yes. Better.

Mary: Here (pointing to the form) it says, ‘my aim’. Would you like to write here that you ‘would like to feel better about yourself’?

Clare: I can’t be bothered. You do it if you like.

Mary: OK. (Writing) I’m writing here, as if you were writing it...I would like to feel better about myself.

Clare: OK. I suppose so...but it won’t do much good. I’m so useless. It's all my fault, anyway.

4. Noticing change (What have I noticed that is different?)

Clare was encouraged to recall a walk she took a few days earlier, with some other women and one of the staff, around the grounds. Mary encouraged Clare to make a note of this on the Session record.

Mary: So...tell me about the last time that you didn’t feel quite so bad about yourself, or maybe when you didn’t think about yourself, one way or another?

Clare: Oh, that’s difficult.

Clare recalled that the nurse was talking about the birds in the garden and she thought to herself “what would it be like to be a bird—to be free” Mary encouraged her to make a note of this on the record.
6. Using experience (What can I do with this?)

**Mary:** That’s really interesting. So it seems that when you are doing things like ‘going out walking’ and ‘thinking about what it’s like to be a bird’ *somehow* you become less aware of yourself, and how you *feel* about yourself. You seem to lose that self-consciousness that you talk a lot about. Have I heard you correctly? Is that right?

**Clare:** I suppose so. I must have stopped thinking about myself *cos* I was thinking about what it would be like to be that little bird. Yes.

**Mary:** So what could you do with that...with that knowledge you have about yourself?

Clare was to talk about what she might ‘do’ with her knowledge about herself. Eventually, she said, “I suppose I could do more things. I do spend a lot of time in my room, because I find doing things difficult—being with people”. Mary encouraged her to make a note of what she *could* do, and Clare wrote: “Sit about less. Do more stuff”

7. Doing what needs to be done (What will I do next?)

**Mary:** Let’s talk about how you are going to do that Clare—‘sit about less. Do more stuff’. What do you *need* to do next? What is the very first thing you need to do?

After a few minutes, Clare decided that what she really needed to do was to “try to work out some kind of plan for my day”, and Mary encouraged her to make a note of this on the record.

8. Taking help from others (How will the team help?)

**Mary:** OK. So you have some kind of a plan, about what you need to do next. How could I help you to follow through on that? Or how could other members of the team help you to follow through on this?

Clare decided that the nurses should just encourage her to do more things with other people, like going out for walks. She also thought that maybe she should spend more time doing things and less time sitting around talking and thinking about herself and her life. *Mary* made a note of this on the record.
9. General support (How will the team offer general support?)

Mary: So, the team will give you these ‘nudges’ if you like, to help keep you going. What else could we be doing—in general—to support you? What sorts of things would you find helpful?

Clare decided that all she really needed “right now” was to get “reminders” about sticking to what she had set for herself, and maybe the team members could ask how things were going, “two or three times a day”. Mary made a note of this for her colleagues.

10. The focus of the Session (What have we discussed?)

Mary: Well, we are starting to wrap things up now. Before we do that, what should I tell the rest of the team that we have been talking about here, today?

Clare thought about this for a few minutes and then said that “really this is all about how I have never liked myself all that much and I feel really negative towards myself.” Mary asked if it was OK to write this down on the record, and Clare agreed. She added, “tell them also that we have been talking about how I might deal with this better. What my options are right now”. Mary summarised this, using Clare’s own words, on the record.

11. Reflection (How did I find this session?)

Mary: Well Clare, before we wind up, tell me how you have found this session? I found this very interesting. How was it for you?

Clare said that she still found “talking about myself really difficult. That is nothing new”. She added, “but I think I see the point of it now. I am not sure I did the last time we talked”. Mary invited Clare to make her comments on the session and then asked if she would like to sign the sheet, to show that she approved of all that was written down.
Collaboration, care and communication

The One-to-One Session can be conducted in any setting—from a formal consulting room to under a tree in the garden. The setting is not as important as its purpose.

The purpose of the One-to-One Session is to:

- Provide the person with genuine care, by expressing sustained interest in the person as a person. This is achieved by focusing attention on what the person experiences, developing a conversation around this, all the time respecting the words, phrases and metaphors that the person uses to describe these experiences.
- Help the person to feel that the nurse is working with her or him—genuinely interested in developing this conversation in a genuine spirit of collaboration. This is achieved by the nurse repeatedly checking with the person that she has heard the person correctly, and also making sure that full agreement has been reached on what is being discussed.
- The key purpose of these Sessions is to communicate an understanding about ‘what needs to be done NOW!’ What does the person need to do—and what does the nurse, her colleagues, or perhaps someone else who is important to the person, need to do, to help support constructive change.
Name: Clare Sweeney  
Date: 22/06/2004
Nurse: Mary Burns  
Time: 3.15pm

3. My aim: To feel better about myself

4. What have I noticed that is different?
When I’m out walking.

5. What was I doing?
Looking at birds, wondering what it would be like to be a bird

6. What can I do with this?
Sit about less – do more stuff.

7. What will I do next?
Try to work out some kind of a plan for my day

8. How will the team help?
Encourage Clare to do things with other people
Encourage Clare to focus on ‘doing’ rather than ‘feeling’

9. How will the team offer general support?
Offer Clare ‘reminders’ about her plan for the day.
Ask Clare how she is getting on – 2 or 3 times a day

10. What have we discussed?
Clare has never liked herself all that much and feels really negative towards herself. We talked about how she can deal with this – what her options are just now.

11. How did I find this session?
This is really difficult but I see the point of it now.

Signed: Clare Sweeney  
Date: 22/June/03
Signed: M Burns  
Date: 22nd June 2003
In the Others Domain we help the person to develop awareness of the many aspects of her or his life that are not faulty, broken or otherwise ‘problematic’. These valuable assets, strengths and positive attributes, will play a vital part in the recovery.

Here the person will also develop awareness of different sources of support, which are to found in other people who are, for the time being, ‘in the same boat’ - other people in care.

The person will also develop awareness of how (s)he can provide support to others, thereby recognising her or his worth as a person.

These experiences of ‘self and others’ are nurtured through three different forms of group work—Discovery, Information-Sharing and Solutions.
Common Humanity

Every person’s specific problems of living are unique and particular to that person and their life circumstances. However, the problems of living, which bring people into mental health care, are surprisingly similar – with common denominators. People often believe that they are alone in their experience of distress or difficulty, but this is rarely the case. Given our common experience of ‘being human’ people can often find great support and consolation in the fact that their difficulties are shared by a wide range of other people, who are experiencing something very similar, within their lives.

Our problems of human living have much in common. Consequently, group work represents a vital part of the recovery process within the Tidal Model. Group work mirrors the experiences people have had, throughout their lives, in ‘learning to be human’.

As they grow up, people go to school, college and often university, to learn about different topics and subjects; learning to be a nurse, doctor or motor mechanic.

Q. Where do people learn to become a human being?

A. In early life, within their families, then with various groups of friends and colleagues, with whom they discuss their lives, and share different experiences

We grow into mature human beings by attending the various vital, but informal group sessions held at the ‘university of life’ - behind the bike sheds at school, down the pub with our mates,
by joining clubs, associations etc.

The Tidal Model reproduces this ‘university of life’ by holding different informal groups, where people can learn more about themselves – what they think, feel and believe – and can learn more about other people, with whom they share their world of experience.

In group situations people have an opportunity to:
- Share their experiences of difficulty or distress
- Gain support from other people who are ‘in the same boat’
- View their problems—and their lives—from a different perspective, through other people
- Experience being the ‘helper’ for a change—offering support to other people
- Explore new options for dealing with problems
- Learn from other’s experiences
- Take stock of their lives and their value as a person

The Three Tidal Groups
The Tidal Model uses three kinds of group work. These are summarised briefly below. These are unlikely to be the only form of group work that might be helpful for the person. Other recreational, developmental or therapeutic groups will be used at the discretion of the team, to meet the discrete needs of the person or family.

However, our experience with the Tidal Model over the past decade, suggests that the Tidal groups are powerful, not least because of their simplicity and ordinariness. The Tidal groups differ so much from the other ‘therapy’ groups that people often forget that this group is part of their recovery programme.

The Discovery Group
Originally called the Recovery Group this group was renamed by people at the Rangiaipa forensic service in New Zealand. They told us that they had discovered so much about themselves, other people in the unit and the staff, that they thought that
'Discovery' was a more appropriate name for the group.

The **Discovery Group** provides a setting within which people have an opportunity to talk about themselves and aspects of their life, with other people in care, and staff members, in a highly supportive atmosphere. Becoming a 'patient' in a mental health service can often be an alienating experience. Often people retreat from everyday social situations, withdrawing from the world and all social life has to offer. This can compound the person’s feelings of isolation and personal failure, affecting the person’s sense of self—especially their value as a person.

The **Discovery Group** aims to provide a setting within which people might experience a boost to their self-esteem. The **Discovery Group** provides an opportunity for members to develop their ability to share with others, on a simple yet hopefully rewarding basis, just through talking.

There are no set rules for the group but we have found the following format to be of immense value, confirmed by much of the ongoing research into the effects of Tidal, on people and services.

**The Facilitators**

Two nurses, or other staff members, act as facilitators. They will participate in the group, as appropriate, to help get the conversation ‘flowing’, but also to ‘model’ the value of ‘talking about oneself’. Often, in other ‘therapy’ groups, the facilitators ‘keep their distance’, maintaining a distinct ‘professional persona’. In the **Discovery Group** it is important that the people in the group get to know something about the staff members as persons. This helps them realise that we are not ‘patients’ and ‘staff’ but we are all people—with lives of our own, dreams and nightmares, ambitions and failures.

To begin, the facilitators introduce themselves and offer a simple rationale for the group, before leading off.
The Conversational Structure
The aim of the group is to develop a fairly light hearted conversation, which will also allow people an opportunity to reflect on themselves, their lives and what is important in life.

Although there is no single way to develop this conversation, for several years we have used the following format.

- A set of cards, each in a sealed envelope, is placed on a chair.
- ‘Volunteers’ are invited to come up and pick an envelope.
- The ‘volunteers’ are asked to hold on to their envelope, as the facilitators explains what is in the envelopes.
- Each envelope is numbered (e.g. 1-10).
- In each envelope is a card, with three questions.
- The person with envelope No 1 is invited to open the envelope, read the questions on the card and then choose one question, which the person would like to answer.
- The person is then encouraged to read out the question to the group before answering it.
- After the first person has spoken the facilitators open up the question to the rest of the group, inviting others to comment on what the first person has said, or to give their own answer to the question.
- It is important that the group facilitators also speak, perhaps asking one another what they would say in reply to this or that question.
- The group ends when all the envelopes have been opened and the questions cho-
Examples of Questions
We have developed hundreds of questions, grouped under theme headings, so that each card will have three questions, on a similar theme. The order of the questions usually progresses from fairly straightforward questions to more challenging or though-provoking ones.

Simple:
- What book or record would you wish to have with you on a desert island?
- Describe your favourite photograph
- What item would you save if your home went on fire?

More challenging:
- What would you like to achieve in the future?
- If you had three wishes, what would you wish for?
- Health, wealth or happiness. What is most important to you?

Light relief:
- What question would you like to ask the whole group?
- What question would you like to ask one person in the group?
- What question would you like to ask the group facilitators?

It is important that participants are helped to feel at ease since none of the questions have any 'right or wrong' answers. The group wants to hear what participants think and feel - no more and no less. However, many of the questions will raise important issues for people, and hopefully will gently encourage participants to recognise their strengths and the steps they have already taken in their recovery.

The Discovery Group may be led initially by members of the team, but in time members of the group may take turns at leading the session. In many Tidal projects, the people in care have played a big part in developing the format and structure of
the Group, generating questions, making alternative suggestions as to how the group should run. This sense of shared ownership—between people in care and the staff team—is central to the philosophy of the Tidal Model.

The Discovery Group is focused – as the name suggests – on helping people discover things about themselves and other people with whom they share their lives. This focus is constructive, hopeful, optimistic and hopefully, life-enhancing. Given this focus, it is inappropriate to discuss 'problems'. If any members raise problems within the group, and express a desire to discuss them, the facilitators should encourage the person to bring this to the Solutions Group or to raise this issue in a One-to-One Session.

Timing of the Discovery Group
Experience has taught us that a good time to hold the Discovery group, is late morning, just before lunch time. Many people find it difficult to 'get going' in the early morning. Holding the group around 11.00 am provides a useful 'booster' to the day, and often provides interesting things to continue talking about over lunch.

The Information-Sharing Group
Mental health care can often be a bewildering experience. The language of psychiatry, psychology and social work can present huge stumbling blocks to understanding, especially where jargon is used to redefine often simple, everyday concepts. As a result people in care (and often their families) need information about the services on offer, and other opportunities for support that might lie beyond the present care setting. Some of these 'information needs' will be met within the individual contact with team members. However, since a lot of the information people need is common to groups of people, there is a great value in coming together to discuss this.

Any number of topics could be discussed at an Information-Sharing Group. Here we have listed some of the more popular topics, addressed in different Tidal projects.
• **Medication** - its effects, side effects etc. Often this group is facilitated by the pharmacist, who is knowledgeable and is not involved directly with the people asking about medication.

• **Talking therapies** - what kind of psychotherapy or counselling is available? What does it involve? How useful is it? This might be led by a therapist or counsellor from the service.

• **Benefits** - how to apply and who qualifies? A representative from a benefits agency or an advocate is the most useful facilitator.

• **Community support** - what support will be available when the person leaves hospital? Who offers it and what does it involve? Representatives from ‘mutual support groups’ or the ‘Hearing Voices Network’, can offer useful advice.

• **Police and the law**—Representatives from the local police force or legal advocacy services, can help people discuss legal issues and how they might obtain support with these in the community.

**Organising the Group**

In most settings, arrangements will be made to find out what topics would interest the people in the service. A dedicated ‘white board’ might be used to invite people to nominate their particular interests. Alternatively, a piece of paper can be circulated, inviting people to register ideas for a group. Once the team has identified what is the most popular topic, a suitable group convener can be identified and the time and place of the session negotiated.

The contribution to the **Information-Sharing Groups** of user-advocates, or survivors with specialist knowledge, should be encouraged. Many user-advocates have developed valuable knowledge about services, or methods of dealing with various problems of living, as part of an everyday living lifestyle. The contribution of people with such experience cannot be underestimated. In many cases such individuals will be able to communicate with the person in care, in ways that professionals cannot.
Timing of the Information Sharing Group

Although such groups are often offered only occasionally - for example weekly - in settings like an acute ward, there may be great value in providing such groups on a daily basis, to provide stimulation and information. These groups work best in the evenings - when people feel more relaxed and are winding down for the day. This is often the best time, also, for people who are offering their help in running the group.

The Solutions Group

The Solutions Group involves helping people to learn more about themselves and their problems, and instilling hope in their recovery. Traditional 'group therapy' is often used to focus on how people have developed their present problems, and aims to unravel some of the complexity which surrounds the origins of their problem. The Solutions Group continues the emphasis of the One-to-One Sessions, where the person explores how change is happening already, as part of the person’s life.

The Solutions Group is highly practical and focuses on conversations about change, encouraging the person to find similarities and 'common ground' with other group members.

The Solutions Group should be led by nurses, who are also involved in working directly with the people, on an individual basis.

Organisation of the Group

Usually, participants are encouraged to attend the group by staff who are working with them on an individual basis. Often, the nurse will suggest that some issue or problem
might be usefully discussed at the **Solutions Group**. In this way, when the group meets, at least two or three people will already have given some thought to raising an issue or problem. Usually, the Group will comprise six to eight people, however only one or two of them might offer a subject for discussion.

**Structure of the Group**

Usually, only one facilitator will open the group, providing an introduction and a rationale for the group.

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Good afternoon everyone, my name is Brenda. I am going to run the group today. I see a few familiar faces—nice to have you back. For those of you who are new, I hope you will get something from this afternoon. My job here is really just to direct the flow of the conversation. I am not going to be taking any active part, other than just encouraging you to talk to one another. What we do here is, in a moment I shall ask someone to talk about some problem or difficulty that they are having just now, and I’ll ask the rest of you to talk with them about that. It is pretty straightforward. We have found that lots of people get a lot of support and encouragement from ‘just talking’ like this. I hope that happens today. Well, let’s get started. Who has brought something along that they feel OK about talking about?

**Powering up people**

People can feel very intimidated in a group, especially if they are the sole focus of attention. For this reason it is important to support the person, so that they feel that they are not put under too much pressure. In the **Solutions Group** we do this by making sure that the person is in the ‘driving seat’ at all times, steering their own course through the conversation.
It is important that the person feels ‘in control’ at all times. By ‘fielding’ questions, and giving the person the final choice, including to reject the questions, the person speaking feels emotionally secure.

As the person answers questions from other group members, the story of distress or difficulty begins to develop, naturally. (In our experience, this is very similar to the way people talk in ‘ordinary groups’ when someone has a problem or difficulty. By using this process, we are ‘normalising’ the group conversation).

**Seeking Permission**

After taking a few ‘rounds’ of question the facilitator asks the person if (s)he would be willing to hear what other people have to say about the problem or issue?

I think that people have a fairly good idea now of what you are talking about, Jack. How would you feel about hearing what others think about all of this? (If the person agrees) OK then. What do others think about the story Jack has been telling us? What do you want to say to him? Maybe some of you have had similar experiences, that you would want to tell him about? (If the person is not ready then more questions are invited).
Group Empathy and Sympathy

At this point, some members will ‘make suggestions’ - “If I were you I would….” and others will continue to ‘ask questions’. However, in our experience, at this point many participants ‘hear’ their own story being told by the speaker. The story ‘rings a bell’ for them, and some kind of empathy develops.

“Well, I know it isn’t exactly the same, but listening to you….just reminds me of what’s been happening with me lately. I just can’t sleep. Tried everything. Nothing makes any difference. A bit like you, really. Only different problem, if you see what I mean”.

The facilitator encourages the group members to make their comment, inviting the original speaker (Jack) to respond, if he wishes, perhaps by making a comment him/herself.

Through this highly-supportive process, the speaker often develops awareness that ‘his problem’ may be different from others, but has much the same kind of effect or impact on their lives. Frequently, the speaker also gains sympathy and encouragement from others, which, invariably, is valued more highly than it would be if it came from a professional therapist.

In preparing to conclude this discussion the facilitator asks one final, important question.

“OK Jack, before I thank you on behalf of the group, I have just one question that I want to ask you. You brought this story about (naming the problem or issue) to us 20 minutes ago. I am now wondering, after talking with us, tell us what’s different?

NB: The facilitator does not ask if anything is different. Instead, the person is invited to think about ‘difference’, based on the assumption that things cannot stay exactly the same.
The Beginning of a Solution?

In many respects the **Solutions Group** is badly named. The group does not actively seek a solution and rarely does any one person come up with a clear cut answer to the problems they have brought to the group. However, the person has taken some very important steps in discussing the problem with others, and in hearing how this relates to others’ world of experience. In that sense they may well have taken vital steps *towards* finding some kind of solution (however temporary) for the problem.

“Well Jack, on behalf of the group I would just like to thank you for speaking today. This is never easy. I am sure if I was sitting where you are, I would have found this very difficult indeed. You have told us about how you feel a little bit different, having listened to what others have said, and realised that you are not alone in this. That is good. So maybe you haven’t found an ‘answer’ to this, but maybe you have taken some really important steps towards finding your own answer—finding your own solution. We all wish you well with that.
Working with people with serious problems of human living is rarely easy. It requires the investment of considerable time and emotional commitment. In this manual we have offered the simplest of introductions to the practice of the **Tidal Model**. To translate this into a meaningful understanding of **Tidal's** potential to enable and facilitate recovery, you must engage with our ideas, rendering them meaningful within your own world of practice.

We have used repeatedly the term *care*: a simple word that still carries considerable power, which can be used to great effect, as an aid to recovery. If you have been as fortunate as us then your earliest memories will have been of being *cared for* as a child, within the family. As you have grown up you will have encountered many people who *cared about* you as a person, whether friend, lover, colleague or kin. The **Tidal Model** encompasses both these important forms of caring, adding its own strand—*caring with* people: working with them in such a way that they feel supported to do whatever they consider important. We believe that such ‘caring with’ is good for both parties involved in the caring relationship. At some point, we forget who is ‘doing’ the caring, and realise that we are *both* in a ‘caring relationship’.

We emphasise caring for another important reason. Many people today—including some nurses—appear embarrassed to talk about caring. Is it too old-fashioned or too ‘soft’? In our view, fashions are fickle—they come and they go. Caring can’t be part of any fashion, since it has been around since the dawn of humankind and is prized by people everywhere we go in the world. More importantly, we have witnessed some of the finest examples of ‘caring’ offered and enacted by some remarkably big, hearty men and women, who in other situations might easily appear forbidding and fearsome. So, perhaps now is the time to finally escape from the caring stereotypes, accepting that *caring is human*. This is one of the most valued human activities in any civilised society.

We wish you every success in helping people navigate their voyage of recovery.
We wish you every success in living a full and meaningful life.
We hope that the ideas in this manual help you to fulfil both these important human aims.

Yours in Friendship

Poppy and Phil
On the following pages we provide blank copies of some of the key templates from the Tidal Model and a guide to further reading.

1. The **Holistic Assessment**
2. The **One-to-One Session**
3. The **Monitoring Assessment**
4. The **Personal Security Plan**
5. A short **Reference list**
The Tidal Model

The Holistic Assessment
The Tidal Model

Name:

Assessing Nurse:

Date: Time:

Others present:

Summary:

Primary Nurse/Keyworker:

Signature: Date:

The Holistic Assessment

Complete assessment as soon as possible after entry to service.

1. Explain purpose of assessment

2. Encourage active participation

3. Record person’s name/assessing nurse/keyworker

4. Record date and time

5. Record names of others present – e.g. advocate, student, friend

6. Record brief summary of circumstances of entry to service

7. Inform person of Primary Nurse/Keyworker and record details

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How this all began:

How this affected me:

How I felt in the beginning:

How things have changed over time

How this affected my relationships:

The Holistic Assessment

Entry to the service: “What has brought you here... how have you come to be here, now?”

Problem origins: “...so, when did you first notice... or become aware of...?”

Past problem function: “...and how did that affect you in the beginning?”

Past emotions: “...and how did you feel about that at the time?”

Historical development: “...and in what way have things changed over time?”

Relationships: “...and how has that affected your relationships with people?”

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How do I feel now:

What do I think this means?:

What does all of this say about me as a person?:

What needs to happen now/what do I want or wish would happen next?:

What do I expect the nurse to do for me?:

The Holistic Assessment

Ask permission to continue

Current emotions: “...and how do you feel about that, now?”

Holistic content: “...and what does all of that mean for you?”

Holistic context: “...and what does that say about you as a person?”

Needs, wants, wishes: “...and what would you hope would be done about that?”

Expectations: “...and what do you think that we can do for you here, in this service?”

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- List person's main problems/needs
- Check wording with the person
- Enter rating for each problem/need or the 'whole thing'

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Evaluation of the problem or need

- To what extent does this distress you?
- To what extent does this interfere with your life?
- To what extent can you control it?

### Distress

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The Tidal Model

People who are important:

Things that are important:

Ideas or beliefs about life that are important:

The Holistic Assessment

Personal Resources

Ask person to describe personal or interpersonal assets or resources that might help in the resolution of the problem or need

Who... is important in your life – family, friends, groups, others? Why... are they important to you?

What things... are important in your life – e.g. money, home, possessions etc? Why... are they important to you?

What beliefs or values are important to you about life in general, faith, or personal philosophy? Why are these beliefs and values important to you?
The Tidal Model

How will I know that the problem has been resolved or the need has been met?

What needs to change for this to happen?

The Holistic Assessment

Resolution

Ask person to describe what it would be like to be without the problem, or to have the need met.

How... will you know when this problem has been resolved or this need has been met?

Give me an example of how things will be different.

What needs to change to allow this to happen?

How will this change show itself – in you, other people, or any other aspect of your everyday life?
The One-to-One Session
### Person

**What have I noticed that is different?**

**What was I doing?**

**What can I do with this?**

**What will I do next?**

**How did I find this session?**

### Team

**What have we discussed?**

**How will the team help?**

**How will the team offer general support?**
The Monitoring Assessment
The Tidal Model

The Monitoring Assessment

- How I am feeling
- How safe and secure do I feel? (0-10)
- What helps me just now?
- What chance is there that I might come to harm? (0-10)
- Could I be helped to feel more secure? (0-10)
- What might be helpful?
- How confident am I? (0-10)
- How confident are you?
The Personal Security Plan
Personal Security Plan

What can I do that might help me feel more safe and secure?

What can other people do that might help me feel more safe and secure?
Books and papers relevant to the Tidal Model

Books


Papers


Barker P and Buchanan-Barker P (2003) Beyond empowerment: revering the storyteller Mental Health Practice 7 (5) 18-20

Barker P and Buchanan-Barker P (2004) Bridging: Talking meaningfully about the care of people at risk Mental Health Practice 8 3 12-16
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Lafferty S and Davidson R (2006) Person-Centred Care in Practice: An account of the implementation of the Tidal Model in an adult acute admission ward in Glasgow. *Mental Health Today* (March) pp 31-34


For more information and contacts visit the Tidal Websites.

www. tidal-model.com www.tidal-model.co.uk

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