

The 10 Tidal Commitments

Buchanan-Barker P and Barker P J (2007)

The Problem of Recovery

20th Century psychiatry focused mainly, although not exclusively, on the containment of mental *illness* - doing things *to* patients, or *for* them, to reduce disturbance, rather than working *with* people, to develop more personally meaningful ways of living. By the end of the 20th century the assumption that professionals could 'fix' mental illness, was waning and increasingly was overtaken by the view that people should participate in, if not actually lead, their own 'recovery' (Davidson and Strauss, 1992). The concept of 'recovery' has become a key aspect of mental health policy in many Western countries, especially where mental health legislation or policy is under review: e.g. New Zealand (Mental Health Commission NZ, 2001), England (Repper, 2000), Scotland (Scottish Executive, 2006) and Ireland (Mental Health Commission, 2006). Government-led reviews of mental health nursing in England (Department of Health, 2006) and Scotland (Scottish Executive, 2006) proposed that nurses should adopt a 'recovery focus', with its attendant 'values', as part of the modernisation of the discipline. However, the exact nature of these 'recovery values' seems unclear. O'Hagan (2004), in New Zealand, acknowledged that, as another "import from America", recovery tended to emphasise individual over social processes. Given that it had evolved from "psychiatric rehabilitation (American recovery) was perhaps driven more by professionals than by service users"(O'Hagan, 2004:1) and that "much of the American recovery literature accepted, at least implicitly, the biomedical model of

'mental illness' (and) did not necessarily reflect all the values of the user/survivor movement" (O'Hagan, 2004:2). O'Hagan's reservations about pasting a recovery philosophy over traditional 'mental illness' values is well stated. People may well be 'ill at ease' with themselves or others, or 'ill-fitted' for the challenges that life presents. However, many might reject the idea that they are 'mentally ill', in any traditional medical sense. This is neither a theoretical nor a semantic dispute. When people locate their problems within the world of their lived-experience, the metaphorical nature of their 'illness' can become clear, with implications for any 'recovery journey'..

The contemporary mental health recovery literature appears to differ little from the philosophical assumptions of *Alcoholics Anonymous (AA)* and *Narcotics Anonymous (NA)*, from over 60 years ago (Frank, 1996), which first promulgated ideas about empowerment, mutual support and self-help, common to today's mental health recovery literature. *AA* and *NA* recognised that, however useful professional help might be, recovery had to be pursued actively by the person.

Over the past twenty-five years recovery has been proposed as an alternative to mainstream ideas of psychiatric care, especially for people with so-called 'serious' and/or 'enduring' forms of mental illness (Chamberlin, 1978; Deegan, 1988; Anthony, 1993). At the same time, the passive 'patient' role has been transformed into the active 'user/consumer' of services (Barham and Hayward, 1991; Deegan, 1993), or what Manos called the 'prosumer' – someone directly influencing the help they required (Manos, 1993).

Many of the significant descriptions of recovery were developed by people who

had been (or still were) psychiatric 'patients' and who professed a more optimistic, empowering, approach to identifying the help people might need to deal with problems of human living.

Indeed, recovery appears to be based more on philosophical conviction than scientific evidence. Recovery proponents argued that people with serious mental illness *could* recover, and described some of the social and interpersonal processes, which appeared to aid or enable recovery (Fisher, 1999). These accounts, which emphasise *personal* experience, echo Samuel Smiles ideas about 'living by example' when he first coined the term 'self help' in the 19th century (Smiles, 1996). How such accounts fit with the objective, unworldly 'evidence' beloved by researchers, politicians and professionals, is not at all clear (Goode, 2000). However, mainstream services often assimilate alternative concepts, if only to become more 'consumer-friendly' (Barker and Buchanan-Barker, 2003). Where government departments espouse recovery, whilst promoting ideas of 'compulsory treatment', or 'compliance', conflicts are inevitable (McLean 2003; Neuberger, 2005). In part, this derives from the philosophical tension between the *person*-focus of recovery and the *patient* (or illness) focus of psychiatric medicine.

Sally Clay is a mental health advocate, and psychiatric survivor, with a 35-year long experience of psychiatric 'care and treatment', with no illusions about the ephemeral nature of concepts like 'recovery' or how they might be used to meet political agendas. Almost a decade ago she wrote:

"Recovery is the latest buzz word in the mental health field. For the last year or so, I have been labelled 'recovered from mental illness'" (Clay, 1999: 26).

When invited to discuss her 'recovery' with psychiatrists in New York State, she observed that the resulting discussions failed to address:

"the nature of mental illness itself. ...If we are recovered, what is it that we have recovered from? If we are well now and were sick before, what is it that we have recovered to? ...The psychiatrists in our dialogue become visibly uneasy when the subject arises, and they divert the discussion to less threatening lines of thought. 'Coping mechanisms' are just such a diversion, an attempt to regard the depth of madness as something that can be simply 'coped' with." (Clay, 1999:26-27)

The concept of recovery may well be so deeply personal that it defies definition. However, it has also become an important social construct, which potentially might mean different things to different people.

Clarifying the Value Base of Recovery

Any aspect of health or social care practice has a long developmental history and an even longer timeline of theoretical and philosophical influence. Today's popular 'evidence-based talking cure' – CBT – derives from the work of Beck (1952) and Ellis (1958), from fifty years ago, both of whom traced their philosophical influences back centuries. Notably, they devoted decades to describing and illustrating their discrete therapeutic processes, before beginning to study (research) their potential efficacy.

In this context the Tidal Model of Mental Health Recovery (Barker, 1998; Barker and Buchanan-Barker, 2005) is fairly young. Since its launch a decade ago it has generated almost 100 projects in the UK, Ireland, Canada, Japan, Australia and New Zealand, from outpatient addictions, through acute and forensic units, to the care of

older people with dementia (Buchanan-Barker, 2005). Beyond the mental health field, practitioners in palliative care are exploring the Tidal Model as an alternative philosophy for death and dying. Here we aim to clarify the distinguishing philosophical assumptions of Tidal theory (Brookes, 2006) by explicating the human values of the Tidal Model (the Ten Commitments) which provide a basis for auditing recovery-focused practice.

Although there are numerous models of 'recovery', Tidal was probably the first recovery model to be developed by nurses in practice, (Brookes, 2005) drawing drawn mainly upon nursing research (Barker et al, 1999; Barker and Buchanan-Barker, 2005; Vaughn et al, 1995;. Tidal was originally described as a philosophical approach to the development of *practice-based-evidence* in mental health care; inviting practitioners to ask: '*how do we tailor care to fit the specific needs of the person and the person's story and unique lived experience, so that the person might begin, or advance further on the voyage of recovery*'? (Barker, 2000). In that sense, it focuses on enabling ways of living a *constructive life*, albeit under difficult circumstances.

The person is the key driver within the recovery process, but the practitioner can help unlock the person's potential for recovery.

The Tidal recovery attitude is expressed through six key philosophical assumptions:

1. A belief in the *virtue of curiosity*: the person is the world authority on their life and its problems. By expressing genuine curiosity, the professional can learn something of the 'mystery' of the person's story.
2. Recognition of the *power of resourcefulness*. Rather than focusing on problems, deficits and weaknesses, Tidal seeks to reveal the many resources available to the person – both personal and interpersonal – that might help on the voyage of

recovery.

3. Respect for the *person's wishes*, rather than being paternalistic, and suggesting that we might 'know what is best' for the person.
4. Acceptance of the *paradox of crisis* as opportunity. Challenging events in our lives signal that something 'needs to be done'. This might become an opportunity for change in life direction.
5. Acknowledging that all goals must, obviously, *belong to the person*. These will represent the small steps on the road to recovery.
6. The virtue in *pursuing elegance*. Psychiatric care and treatment is often complex and bewildering. The simplest possible means should be sought, which might bring about the changes needed for the person to move forward.

Tidal developed from practice-based research conducted in the mid-1990s in England, Northern Ireland and the Republic of Ireland into what people *needed* nurses *for*, what people and their families *valued* in nursing, and what nurses *did* that appeared to make a difference (Barker *et al*,1999). Over the past decade other mental health professionals and consumers have helped further develop the model. Tidal is committed to compassionate caring and genuine 'nursing' – providing the conditions necessary for growth and development - but recognises that this is not restricted to the professional discipline of nursing (Barker and Buchanan-Barker, 2005). In particular, people with experience of psychiatric care, participated in the design, evaluation and development of the original Model and, over the past five years, other 'user/consumer-consultants', from different countries, have helped refine the philosophical basis of Tidal, by helping

clarify its value base.

The Ten Tidal Commitments and the 20 Tidal Competencies

The Tidal Model embraces specific assumptions about people, their experience of problems of human living and their capacity for change (Barker and Buchanan-Barker, 2005). From these assumptions we have developed a set of related values which provide practitioners with a philosophical focus for helping people make their own life changes, rather than trying to manage or control 'patient symptoms' (Barker and Buchanan-Barker, 2005). The Ten Commitments remind us that although rules come from the head, reflecting our masculine selves (*animus*), commitment comes from the feminine heart (*anima*). To help judge the extent to which practitioners, in any setting, employ the Ten Commitments in 2002 we were invited to develop the 20 Tidal Competencies, which have since been used to audit recovery practice in several projects, notably in England (Gordon et al, 2005) and Scotland (Lafferty and Davidson, 2006). Here, we present each Commitment accompanied by the respective Tidal Competencies.

Value the voice: the person's story represents the beginning and endpoint of the helping encounter, embracing not only an account of the person's distress, but also the hope for its resolution. The story is spoken by the voice of experience. We seek to encourage the true voice of the person – rather than enforce the voice of authority. Traditionally, the person's story is 'translated' into a third person, professional account, by different health or social care practitioners. This becomes not so much the person's story (my story) but the professional team's view of that story (history). Tidal seeks to help people develop their unique narrative accounts into a formalised version

of 'my story', through ensuring that , all assessments and records of care are written in the person's own 'voice'. If the person is unable, or unwilling, to write in their own hand, then the nurse acts as secretary, recording what has been agreed, conjointly, is important – writing this in the 'voice' of the person.

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.

Respect the language: people develop unique ways of expressing their life stories, representing to others that which only they can know. The language of the story – complete with its unusual grammar and personal metaphors – is the ideal medium for illuminating the way to recovery. We encourage people to speak their own words in their distinctive voice.

Stories written about patients by professionals are, traditionally, framed by the arcane, technical language of psychiatric medicine or psychology. Regrettably, many service users and consumers often come to describe themselves in the colonial language of the professionals who have diagnosed them (Buchanan-Barker and Barker, 2002). By valuing – and using - the person's natural language, the Tidal practitioner conveys the simplest, yet most powerful, respect for the person.

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*.

Develop genuine curiosity: the person is writing a life story but is in no sense an 'open book'. No one can know another person's experience. Consequently, professionals need to express genuine interest in the story so that they can better understand the storyteller and the story.

Often, professionals are only interested in 'what is wrong' with the person, or in pursuing particular lines of professional inquiry – for example, seeking 'signs and symptoms'. Genuine curiosity reflects an interest in the person and the person's unique experience, as opposed to merely classifying and categorising features, which might be common to many other 'patients'.

Competency 5: The practitioner shows interest in the person's story by *asking for clarification of particular points, and asking for further examples or details*.

Competency 6: The practitioner shows a willingness to help the person in *unfolding the story at the person's own rate*.

Become the apprentice: the person is the world expert on the life story. Professionals may learn something of the power of that story, but only if they apply themselves diligently and respectfully to the task by becoming apprentice-minded. We need to learn from the person, what needs to be done, rather than leading.

No one can ever know another person's experience. Professionals often talk 'as if' they might even know the person better than they know themselves. As Szasz noted: "How can you know more about a person after seeing him for a few hours, a few days or even a few months, than he knows about himself? He has known himself a lot longer! ...The idea that the person remains entirely in charge of himself is a fundamental premise" (Szasz, 2000).

Competency 7: The practitioner develops a care plan based, *wherever possible*, on the *expressed needs, wants or wishes of the person*.

Competency 8: The practitioner helps the person identify specific problems of living, and what might need to be done to address them.

5. **Use the available toolkit:** the story contains examples of 'what has worked' for the person in the past, or beliefs about 'what might work' for this person in the future. These represent the main tools that need to be used to unlock or build the story of recovery. The professional toolkit - commonly expressed through ideas such as 'evidence-based practice' - describes what has 'worked' for other people. Although potentially useful, this should only be used if the person's available toolkit is found wanting.

Competency 9: The practitioner helps the person develop awareness of what works for or against them, in relation to specific problems of living.

Competency 10: 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.

6. **Craft the step beyond:** the professional helper and the person work together to construct an appreciation of what needs to be done 'now'. Any 'first step' is a crucial step, revealing the power of change and potentially pointing towards the ultimate goal of recovery. Lao Tzu said that the journey of a thousand miles begins with a single step. We would go further: any journey begins in our *imagination*. It is important to imagine – or envision – moving forward. Crafting the step beyond reminds us of the importance of working with the person in the 'me now': addressing what needs to be done now, to help advance to the next step

Competency 11: 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 12: 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.

7. **Give the gift of time:** although time is largely illusory, nothing is more valuable. Time is the midwife of change. Often, professionals complain about not having enough time to work constructively with the person. Although they may not actually 'make' time, through creative attention to their work, professionals often find the time to do 'what needs to be done'. Here, it is the professional's relationship with the concept of time, which is at issue, rather than time itself (Jonsson, 2005).. Ultimately, any time spent in constructive interpersonal communion, is a gift – for both parties (Derrida ,1992).

Competency 13: The practitioner helps the person develop their awareness that

dedicated time is being given to addressing their specific needs.

Competency 14: The practitioner acknowledges the value of the time the person gives to the process of assessment and care delivery.

8. Reveal personal wisdom: Only the person can know him or her self. The person develops a powerful storehouse of wisdom through living the writing of the life story. Often, people cannot find the words to express fully the magnitude, complexity or ineffability of their experience, invoking powerful personal metaphors, to convey something of their experience (Barker, 2002). A key task for the professional is to help the person reveal and come to value that wisdom, so that it might be used to sustain the person throughout the voyage of recovery.

Competency 15: The practitioner helps the person identify and develop awareness of personal strengths and weaknesses.

Competency 16: The practitioner helps the person develop self-belief, therefore promoting their ability to help themselves.

9. Know that change is constant: change is inevitable for change is constant. This is the common story for all people. However, although change is inevitable, growth is optional. Decisions and choices have to be made if growth is to occur. The task of the professional helper is to develop awareness of how change is happening and to support the person in making decisions regarding the course of the recovery voyage. In particular, we help the person to steer out of danger and distress keeping on the course of reclamation and recovery.

Competency 17: The practitioner helps the person develop awareness of the

subtleties of changes – in thoughts, feelings or action.

Competency 18: The practitioner helps the person develop awareness of how they, others or events have influenced these changes.

10. **Be transparent:** if the person and the professional helper are to become a team then each must put down their 'weapons'. In the story-writing process the professional's pen can all too often become a weapon: writing a story that risks inhibiting, restricting and delimiting the person's life choices. Professionals are in a privileged position and should model confidence by being transparent at all times; helping the person understand exactly what is being done and why. By retaining the use of the person's own language, and by completing all assessments and care plan records together (in vivo), the collaborative nature of the professional-person relationship becomes even more transparent.

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.

Reclamation: In Our Own Voice

Many psychotherapeutic models develop a special language that is awkward to use and patronising to the uninitiated. In pursuit of the 10 Commitments, the Tidal Model eschews the use of jargon, valuing instead ordinary language, especially the

everyday vernacular of the person, family or friends.

Traditionally, psychiatry has devalued the person's voice, by promoting diagnostic jargon (Kirk and Kutchins, 1997). Given the power imbalance between professionals and their 'patients' many people end up describing their own experience in the technical language of psychiatry and psychology, as if their own story was inadequate (Furedi, 2003), suggesting that the psychiatric narrative has colonised all our lives (Barker, 2003). The Tidal Model asserts that 'lived experience' is understood best through use of natural language – using the metaphors and grammar that fits most easily with the way people talk naturally about their experiences. Consequently, Tidal focuses on helping people *reclaim* the story of their distress and, ultimately, their whole lives.

In human affairs, *reclamation* means the efforts necessary to *seek the return of one's property*. In the psychiatric context, reclamation means the return of one's personhood and its accompanying story. The Latin root (*reclamare*) means 'to cry out against'. Arguably, the emergence of the 'user/consumer' voice is one of the most powerful developments in mental health, worldwide, in the past 30 years. Such groups are reclaiming their story and personhood, through the act of 'speaking up' or 'speaking out', which is central to the act of reclamation within Tidal.

In Tidal terms reclamation refers to the pursuit of a productive use of something that was lost or considered worthless. Typically, land submerged by the sea, is reclaimed for use as part of the mainland. In the same sense, that part of the person's life, which was submerged – and invalidated – by the effects of mental distress, is reclaimed to become part of the whole person. Like land reclamation, the reclaimed

experience of mental distress is beyond value. Once brought (metaphorically) to the surface, it becomes (again) part of the person's *whole* lived experience.

The first Tidal step in facilitating reclamation, is to write all the main assessment 'stories' and subsequent descriptions of necessary care, in the person's own voice; rather than translate these into professional note-taking. This focus on 'my story' appeals to users and consumers, illustrating the practitioner's desire to work actively *with* the person; co-creating the story of the care. The psychiatric survivor and consumer advocate Sally Clay wrote:

"The Tidal Model makes authentic communication and the telling of our stories the whole focus of therapy. Thus the treatment of mental illness becomes a personal and human endeavour, in contrast to the impersonality and objectivity of treatment within the conventional mental health system. One feels that one is working with friends and colleagues rather than some kind of "higher-up" providers. One becomes connected with oneself and others rather than isolated in a dysfunctional world of one's own (Clay, 2005)".

Focusing on the Person

The person's story describes not only the circumstances that led to the person's need for help, but holds the promise of what needs to be done to begin the process of recovery. Although influenced by different schools of psychotherapy, Tidal emphasises ordinary conversation, which has a power that stands apart from that found in the therapeutic discourse (Zeldin, 2000) and the 'narrative' of everyday 'story-telling'

(Brunner, 1990). As Fisher noted, human beings are *homo narrans*: natural story-tellers, constantly updated by the process of telling stories (Fisher, 1987).

Commonly people with experience of Tidal say that “it doesn’t feel as if I am being treated; it just feels as if someone is listening to me” and want to tell a story about what it was like. A woman with a long history of psychiatric hospitalisation recognised how this ‘ordinary’ experience could become ‘extraordinary’:

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

To emphasise the centrality of practical action within Tidal, we borrowed the term – ‘doing what needs to be done’ – from the work of Shoma Morita, the Japanese psychiatrist who developed a form of ‘constructive living’ therapy, in the 1920s (Morita et al, 1998). Working within the ‘me-now’ of the story, the conjoint work of the professional and the person in care involves negotiating what needs to be done, which might begin to address or respond to a current problem of human living.

Problematising Tidal

Within a decade the Tidal Model has progressed from a local solution for mental health

nursing to an international model of mental health recovery, recognised and practised in several different countries. Those developing Tidal-focused services appear to derive something personally or professionally satisfying from the Tidal Model itself, many noting that its inherent values reminds them why they 'came into the field in the first place'. They often complain that they had no ambition to 'carry out observation protocols', 'implement control and restraint procedures', 'attend endless meetings' or 'shuffle paper'. Instead, they took up caring to help people address, manage or otherwise 'recover' from whatever problems have overtaken them in their lives. By embracing Tidal, they appear to be reclaiming their original caring vocation.

As Tidal practice has evolved over the past decade, we felt an increasing obligation to clarify its philosophical – or value - base. We have reflected greatly on what we value – as persons and professionals– and also have learned much, over several decades, about what other people value. In helping others introduce Tidal into their practice we have tried to clarify what the Tidal Model 'stands for' and how it might be pursued. In so doing we have favoured the kind of everyday language that characterises the model itself. No philosophical system will satisfy everyone, but the values embraced by the Ten Commitments appear to have a broad constituency, across nations, societies and cultures.

However, for some, "the only way to genuinely test .. whether (the Tidal model) ... makes a real difference" would be through "a carefully planned and fairly large-scale clinical trial" (Gamble and Wellman, 2002: 743). We are not averse to others undertaking such 'scientific' studies, but this is not one of our priorities. The major social movements, which have blossomed in our lifetime - feminism , black power and gay rights - did not reshape social attitudes and behaviour through the use of the

randomised control trial, or any other 'scientific' method. Instead, they employed the ancient philosophical method of rhetoric. The 'success' of recovery movements, like AA, and the continued rise of the user/consumer 'movement' worldwide is also based on rhetoric and organised social action, seeking to communicate the beliefs and values of the group.

Gordon et al (2005) argued that ample evidence existed for the impact of Tidal on practice. However, we would still urge caution. People often ask: 'does the Tidal model work?' We wonder what, exactly, they mean. All theories are merely 'suppositions or systems of ideas, explaining something' (OED). Models represent highly simplified descriptions of the 'thing' itself - in this case the process for enabling recovery. Therefore, we find it more appropriate to ask: '*in what way*, does the Tidal Model 'work' *for whom* and *to what particular purpose*? At least in human affairs, ultimately, no 'model' and its supporting 'theory' can be shown to 'work'. Only the individual practitioners and the organisational systems which support practice, might be viewed as 'working'. However, we need also to ask: 'working to what particular purpose'?

Here we have attempted to clarify the Tidal 'purpose', by reframing its original philosophical assumptions and describing how, through ongoing collegiate dialogue we developed the Ten Commitments, which attempt to clarify the Tidal values and, the 20 Tidal Competencies, which might contribute to the study of recovery practice. We recognise that Tidal – as a developing theory of the recovery process and model for its practice – distils many thousands of voices of people who helped us to develop the

model and who are the real 'guardians' of Tidal theory and practice. Many nurses take this guardianship role very seriously since it appears to extend their passion for reclaiming the practice of caring in its myriad forms. It seems appropriate to end with the voices and the values of Brookes, Murata and Tansey (2006):

"We valued the nurses' stories. Now we collect stories that tell of their successes and their frustrations practising Tidal...We continue to strive to transform nursing practice and contribute to person's journeys of recovery. There is ebb and flow in the process of implementing the model. Sometimes we faced setbacks, or at times we felt becalmed. There would also be times of success, great celebration and breakthroughs. We are sustained by our passion for excellence in psychiatric and mental health nursing and care – and by the stories (pp462-3).

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What are the 10 Tidal Commitments in the Tidal Model. 1. value the voice 2. respect the language 3. develop genuine curiosity 4. become an apprentice 5. use the available toolkit 6. craft the step beyond 7. give the gift of time 8. reveal personal wisdom 9. know that change is constant 10. be transparent. The Tidal Model uses the power of _ metaphor. Steps in the WRAP process. The Tidal Model is a recovery model for the promotion of mental health developed by Professor Phil Barker, Poppy Buchanan-Barker and their colleagues. The Tidal Model focuses on the continuous process of change inherent in all people. It seeks to reveal the meaning of people's experiences, emphasising the importance of their own voice and wisdom through the power of metaphor. It aims to empower people to lead their own recovery rather than being directed by professionals. The Tidal Model References The Ten Tidal Commitments 1 2 The Tidal Model of Mental Health Recovery and Reclamation Using the Tidal Model of Mental Health Recovery Nursing Theorists and their Work 3 4 6 5 7 8 10 9 Key Concepts Intro Developed by Phil Barker Developed by mental.Â The Ten Tidal Commitments. 1. 2. The Tidal Model of Mental Health Recovery and Reclamation. Using the Tidal Model of Mental Health Recovery. Nursing Theorists and their Work.