

**PERSON-CENTRED & COLLABORATIVE
MENTAL HEALTH CARE
(Using the Tidal Model)**

TURNING THE TIDE HANDBOOK

(Inclusive of 2 DVDs)

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FOREWORD

The changes in mental health care provision in the UK over this last fifteen years are unprecedented. With the closure of the large psychiatric hospitals and the increased emphasis on community care for those people experiencing mental distress there have been both positive and negative consequences.



Alongside these changes we have witnessed the emergence of Evidence Based Practice; in some cases this has contributed to a de-emphasis on Values Based Practice resulting in low morale amongst staff who report feeling unable to spend time with service-users due to emphasis on targets and increased paperwork, and service-users often feeling devalued and not listened to.

The Inpatient Forum at the Centre of Excellence in Interdisciplinary Mental Health are pleased to have collaborated with the Birmingham and Solihull Mental Health NHS Trust through Bill Gordon on this project which they feel moves some way towards addressing these issues for both staff and service-users.

Phil Barker and Poppy Buchanan-Barker's Tidal Model has provided the context for the exploration of these possibilities. The Forum, a group of people who have direct knowledge of Inpatient Services from personal experience or through caring for people who have used the services, have adapted the Tidal Model and the paperwork which goes with it so that it has the potential to work effectively within a busy mental health system for both staff and service-users. The Forum have a wish to see this project impact the system in a useful way making the inpatient experience positive for service-users and rewarding for staff.

Acknowledgements

We would like to thank Phil Barker and Poppy Buchanan-Barker for all the work that has gone before and for their unerring contribution to mental health. All those who have contributed to the work book, Tracey Holley, Paul Roberts, Peter Grinnell, Lloyd Tatham, Adrian Fisher, Alex Davis, Joy Blackledge; to Bill Gordon who has continued to believe in the importance of assisting change through collaboration and most especially Joanne Barber for her timeless commitment to making the language useful and simple. A final special mention should be made to Dee Partridge and Pam Newby who filmed and edited the discussion and produced the DVDs. I hope that those who use this material find at least one small aspect of it that would be useful for them on their journey in the mental health services.

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INTRODUCTION

In a general hospital, good care for a patient involves seeing to physical needs, trying to alleviate discomfort and distress, doing tests, and administering treatments. The nurse does most of these things.

In a psychiatric hospital, the needs of the patient are somewhat different. The traditional role of care is commonly seen as one of observation, risk management, and drug dispensing. Where appropriate, physical needs are met.

In fact, good care for mental health patients involves much more than this. Although it can be seen as primarily the responsibility of the nurse, all staff must play their part within a multi-disciplinary context. This handbook is an attempt to explain the importance of this kind of care, and give some guidelines on how it can be delivered.

Terminology & basic approach

Historically doctors and general nurses have spoken in terms of having *patients*, social workers and counsellors in terms of having *clients*, mental health services in terms of having *service-users*, with service-users of mental health services calling themselves *survivors* of these services. In this manual, for the sake of clarity, we will refer not primarily to patients or clients but to 'the person' or to 'the person in care' and to service-users, depending on the context. Although the TM originally emerged out of the nursing profession, any mental health worker (psychiatrist, psychologist, occupational therapist, etc.) can use the basic theory and specific practice (with modifications) of the TM as these, under whatever name, inform or should inform all good person-centred collaborative care.

What is good care?

This handbook seeks to answer this question in simple down-to-earth terms. It will show how use of the TM underpins best practice in acute and other inpatient settings and how a genuinely collaborative and person-centred approach to care within mental health should be reflected in the clinical paper work that underpins the practice.

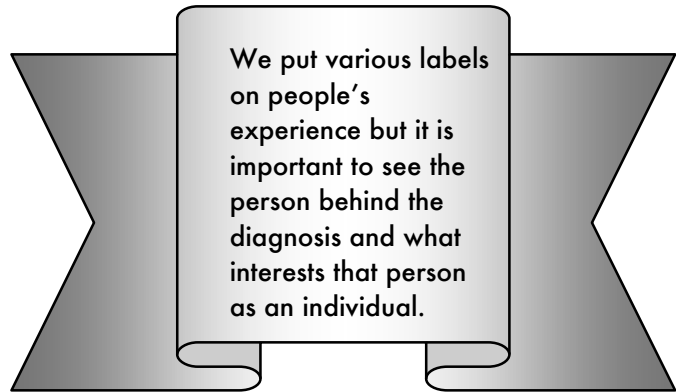
What are mental health problems?

It might be assumed, that all people who are in-patients on a psychiatric ward, have a "mental illness" and that their treatment depends on the type of illness they have. However, a definition of what constitutes a mental illness is almost impossible to achieve. We all have tendencies to certain moods, thoughts and patterns of behaviour; they are part of our individual personalities. Who is to say when these are considered abnormal?

Severe mental problems have been thought to be associated with a lack of insight. This means that the person does not accept that their strange thoughts or experiences do not reflect reality as perceived by others. However, even this is no longer thought to be a very useful guide.

In addition, many people who are being treated as in-patients on psychiatric wards within the UK are not “mentally ill”, by anyone’s definition. They may be socially disruptive, very unhappy, homeless and/ or suffer from drug or alcohol abuse.

Basically, people are admitted to a psychiatric hospital for more practical reasons. They may be unable to tolerate their level of mental distress, other people may be complaining about their behaviour, or they may be a danger to themselves or others. The question is, how does one decide how best to help so many disparate individuals caught up in personal crisis.



THE MEDICAL MODEL

What is it?

Doctors in all branches of medicine are ultimately responsible for making the decisions about the management of their patients. To do this, they make a diagnosis, according to the particular pattern of symptoms of each person. Often, and increasingly, results of physical and biochemical tests are taken into account. This diagnosis is worked out to correspond as accurately as possible to causes and/or available treatments, and enables the doctor to predict what is likely to help.

Ever since the 19th century, psychiatrists have similarly sought to categorise the people they are trying to help. For this, particular combinations of moods, behaviour and thought patterns are seen as important. This is a complicated and skilled process and has been a subject of many disagreements over the years.

However, in 1952, the diagnostic and statistical manual of mental disorders (DSM) was published in an attempt to aid and standardise diagnosis in psychiatry. This is based on the experiences of doctors and their patients over many years. It is still being constantly revised and updated.

The DSM is widely accepted to be a helpful way of classifying the type of mental health problems people may suffer from. It is used, often successfully, to point to specific treatment. It can help when assessing risk, need for admission and/or compulsory treatment. It is especially important for suggesting appropriate medication, which is often helpful, and can be crucial for recovery.

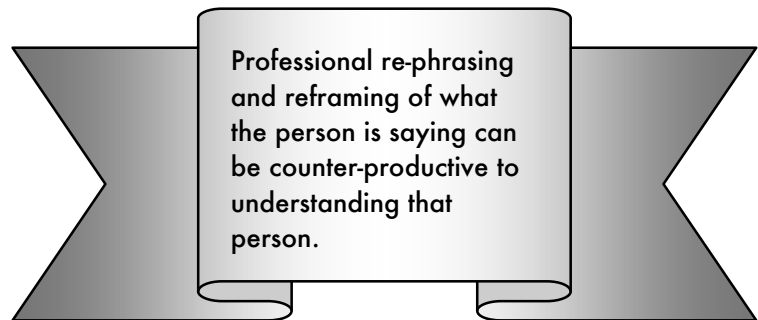
This “Medical model” implies that specific biological diseases of the brain cause mental health problems. However, many doctors now think that psychological and environmental difficulties may be at least as important. Some biological abnormalities may in fact be the result of these difficulties, rather than the cause

of the illness in the first place. Some people are doubtless more susceptible than others.

For every person described as “mentally ill”, there are probably many contributing factors, which the doctors must try to take into account when deciding about treatment. This does not alter the fact that, in practice, the DSM is a useful guide.

Why is the medical model insufficient on its own?

We know that the care in in-patient psychiatric services over the years has been sadly lacking because of the results of research and the number of service-users who have said so.¹ Recovered service-users are called “survivors”! We must accept that it is not always possible or helpful to classify people purely in terms of standard psychiatric categories. Many of these people would benefit from a more individual and personal approach.



There are good reasons for this.

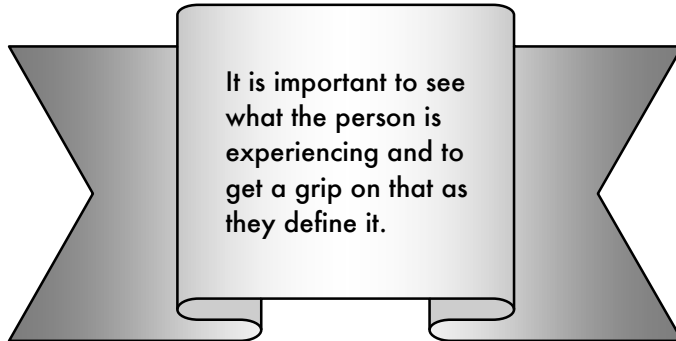
- ✓ There are no universally accepted physical or biochemical tests for functional psychiatric illness.
- ✓ There are often no specific known causes.
- ✓ Although drug treatment can often help, it is seldom completely effective.
- ✓ There are many variables adding to the biological one, which can complicate the issue still further.
- ✓ “Nervous breakdowns” are often triggered by situations people find themselves in.
- ✓ Recovery often includes thinking about relationships, occupation and/or spirituality.
- ✓ There is a huge variety of presentation, with no two persons being the same.

Since assessing anyone’s mental health problems depends almost totally on the person’s account of his/her experiences, this account is seen to be very important. The person’s experiences are unique to them, and known completely only by the person themselves. This makes making a diagnosis very difficult and more of an art than a strict science. We are all under the influence of such complex biological, psychological and environmental interactions, that we cannot hope to neatly classify everyone with a mental health problem.

¹ Campbell (1999), Hall B (1996)

What alternatives are there?

As early as 1952, Peplau wrote about her own philosophical approach to nursing.² (Interpersonal Relations in Nursing: A Conceptual Frame of Reference for Psychodynamic Nursing). This can readily be applied to the mental health field. She suggests,



If nursing is ever going to become the holistic, person-centred activity that it believes it is already, then it must reject the notion of packaging people and their care according to medical diagnostic criteria."

For Peplau, the focus of nursing is quite clear:

"We have no real interest in people's diseases or their health for that matter; nurses are interested in people's relationships with their illness or with their health."

This shifts the emphasis away from medical diagnosis towards interpersonal relationships as the context of recovery. No longer is the role of the nurse determined primarily by the medical model.

According to Peplau:

- ✓ caring practices should help people understand their difficulties and need for help, whether or not a clear medical diagnosis is involved;
- ✓ the person in care needs help to recognise and plan to use whatever medical services are available;
- ✓ the mental distress so often involved, must be used positively to motivate change.

Questions for reflection and group discussion

1. How do mental health problems differ fundamentally from a physical health problem such as diabetes or cancer?

² Paplau (1985/1988)

2. What are the strengths and limitations of the medical model when it is applied to mental health problems?
3. In the light of your personal experience why do people tend to get admitted to acute inpatient services? Discuss examples.
4. What, in your view, is the main purpose of inpatient psychiatric services?

THE TIDAL MODEL

What is the Tidal Model (TM)?

The TM emerged in the late 1990's from the work of Phil and Poppy Buchanan-Barker in Newcastle. They are now developing the model further, with colleagues in several countries.³ It is called the "*Tidal Model*" because it draws its core philosophical metaphor from chaos theory, such that the unpredictable - yet bounded - nature of human behaviour and experience is compared to the dynamic flow and power of water and the tides of the sea.⁴

The TM is an approach to the **discovery** of mental health; focuses on helping people **recover** their personal story, as a first step towards **reclaiming** control over their lives.

(Phil Barker 2008)

The TM is a philosophical approach to the art of helping people with mental health problems. It suggests that our mental wellbeing depends on our individual life experience, including our sense of self, perceptions, thoughts and actions. At the core of everyone is the unique story of the experience of living, and of life itself. An essential part of this story concerns our interactions with other people. Although we are all different, we are all human and depend on one another.

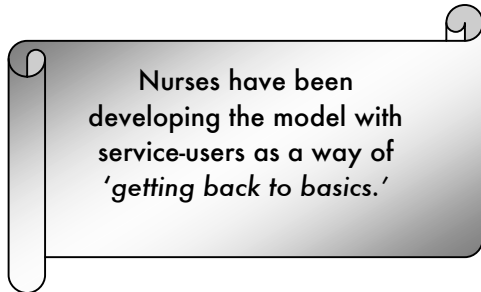
When someone has mental health problems, they often have extreme or upsetting life experiences, that are preventing them functioning in their current situation. Very often, there is a threat to self, the heart of our life experience. Very often the person becomes isolated even from friends and family. It is only by drawing close and listening to their "story" or the account they give of

³ Barker P (2001) (a), Barker & Barker (2005)

⁴ See Barker P (2000). *The Tidal Model: Theory and Practice* page 4

themselves and their experience that we can begin to understand, work out with them what might be done to help.

These things have implications for the sort of care such people really need.



- ✓ the person needs to be encouraged to tell and even write down his/her story, in their own words
- ✓ this story must be listened to and respected, and used to help do assessments and plan care and treatment
- ✓ staff should work collaboratively with the person in care as much as possible
- ✓ the importance of simple understanding, care and encouragement cannot be underestimated. Each interaction with another person can potentially help repair, or damage still further, the person's vulnerable sense of self

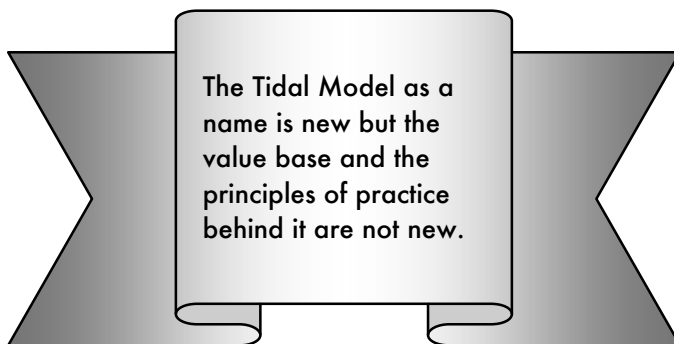
All this leads to the concept of building a therapeutic relationship. Applied to care-giving, it uses the nurse /patient relationship, described so long ago by Peplau. In the context of this relationship, people in care should have a chance to tell their story and have it listened to, understood and valued.

In addition, they receive the personal acceptance and nurturing which they may need to start moving towards recovery.

The *WHY* the *HOW* and the *WHAT*

The main reason for working with people in this kind of way is that good care involves considering *WHY* this person is experiencing this particular life difficulty *right now*, *HOW* the person sees their problem or situation, and *WHAT* they think is likely to work for them or be counter-productive for them under present circumstances.

The TM focuses on the different needs of each individual, while recognising the common humanity we all share. It focuses on people as individuals, rather than on their symptoms, or on statistical populations or diseases. It is a solution-focused rather than a problem-focused approach to care. It therefore contributes a different and complementary view of the person and the person's difficulties.



Nurses with service-users have been developing the model for about 10 years. Many have seen it as a way of going back to basics in their work. Research suggests that implementing the Model reduces the length of inpatient stays and makes re-admission less likely. It also seems to reduce the frequency of violent or abusive incidents that often take place on an in-patient ward.

At present, many users of the mental health services feel powerless and misunderstood. Often, mental health workers only manage observation, containment and paperwork, and morale is low. We need to 'turn the tide' into a more positive, healing direction of care. We believe, on the basis of good evidence, that the basic principles which inform the TM, if put consistently into practice, can do just that.⁵

Questions for reflection and group discussion

1. The TM aims to help people reclaim their life story, which has often been colonised by professional workers, and sometimes by family and friends. When a person is admitted to an inpatient service, staff necessarily take note of the doctor's and social worker's version of events and of what this person's problems are and why they are being admitted to hospital. But, unfortunately, the professional construction of 'the problem' is sometimes not balanced by the persons' own story and account of events, which can be simply dismissed as 'crazy'.

What problems, both short and long-term can arise when this happens? Why do people tend to get admitted to acute inpatient services? Discuss examples.

2. Some people think that the approach to mental health care suggested above is just 'common sense'. It is accepted good practice and what we should all be doing anyway. If this is so why do you think it is in fact so uncommon within many psychiatric inpatient services?

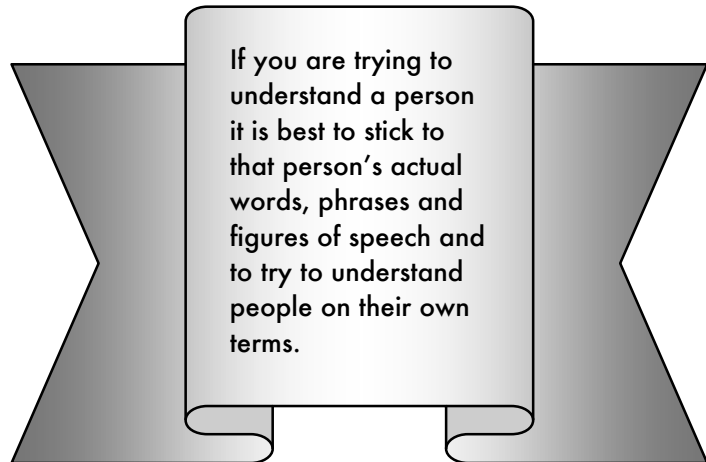
⁵ Barker (ed) (2003), Barker & Barker (2005)

METAPHORS

What are the TM metaphors?

A metaphor is a figure of speech in which a word or phrase is applied to something to which it is not (normally) literally applicable, and where one thing is seen as symbolic of something else. For example, our ordinary speech is full of metaphors such as *"I'm dead tired"* *"She's the apple of my eye"* *"He wore me down"*, *"I'm heartbroken"*, *"Strong as an ox"*.

The TM is so called because of the "tidal" metaphors on which it is based. It is worth describing these in some detail as they illustrate the practical application of the model. The issue is about the service-users account of their own situation and experience. This can be richly metaphorical in content. It may be initially difficult to understand and dismissed accordingly as 'nonsense' when it is not. The TM values the language people actually use to describe their experience of any mental disorder and distress.



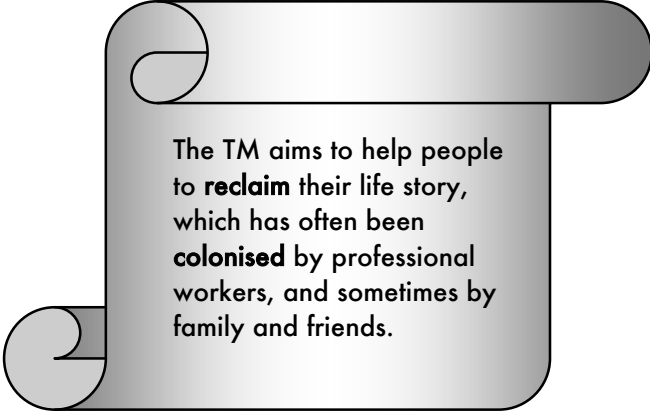
The major TM metaphor is taken from chaos theory where the unpredictable-yet bounded- nature of human behaviour and relationships is compared to the turbulent flow and power of WATER. There is also the idea of the sea in all its vastness and our relative vulnerability.

It is as if we are all small boats, or coracles, on a journey across the ocean of life. Each coracle is a different size and shape and has different strengths and weaknesses and is of a different age. In this way we are all vulnerable. Seawater is in constant flux, the tides ebb and flow continuously and there are powerful and unpredictable currents with waves crashing on the seashore. Nothing is ever still.

Depending on where we find ourselves in the ocean of life, we can succumb to different kinds of disasters such as rape, sexual or physical abuse, which are often experienced as a 'robbery of the self'. Such traumas would also include severe interpersonal difficulties, emotional or physical loss, depression or sustained periods of stress, acute or chronic alcohol/drug abuse, leading to an experience of complete breakdown or 'shipwreck'. We can be 'broken' and stranded on rocks.

We can collide with other coracles. We often do not even know what is just round the corner. Our coracles may get so damaged or be so poorly constructed in the

first place that we are in very real danger of sinking and drowning in the sea of life. We can lose our way, or become totally directionless and aimless on our journey.



The TM aims to help people to **reclaim** their life story, which has often been **colonised** by professional workers, and sometimes by family and friends.

A central task of TM collaborative care is to help people develop awareness of **how** their own experience of mental health or unwellness ebbs and flows; **how** distress comes and goes and - most importantly - **what** the person, or others, are doing right now to influence it in positive or negative ways. **How** does our action or inaction help or hinder the person's recover and ability to get on, positively with their life right now?

WHAT ARE THE IMPLICATIONS FOR HOW WE RELATE TO PEOPLE IN OUR CARE?

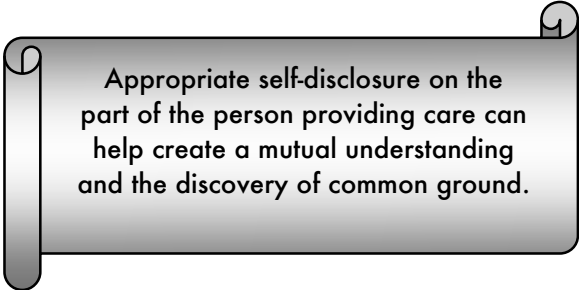
It really matters!

A serious mental health problem, unlike many physical ones, attacks our coracle of life, our deepest and innermost sense of self. This often leads to poor self-esteem, inner conflict, and even loss of personal identity. Such people, although they may not appear to be so on the surface, are actually very vulnerable. They are in a serious crisis, and their situation can be as important as how their coracle is damaged.

We, as helping professionals, have the power to contribute positively or negatively to this situation. We can provide a crucial lifeline simply by reaching out, caring, and holding hope for someone in crisis. Or we can alienate people by patronising them, saying negative things about them or disempowering them and ignoring their feelings just by the way we treat them even though we do so in an officially 'professional' manner.

Do not think you are immune

Each one of us is like a small craft on the ocean of life. We all have our different vulnerabilities, life journey and difficult times. But, basically, we are more the same, being human, than we are different.



Appropriate self-disclosure on the part of the person providing care can help create a mutual understanding and the discovery of common ground.

For the helping professional, the most crucial implication of this is to recognise one's own limitations and vulnerability. Remember it could be you! The person in

care needs respect and deserves to be treated as you would like to be treated yourself under similar circumstances.

Offer a life-line

"For me spirituality wasn't a factor in recovery from madness toward some form of sanity. Rather madness was essential in the recovery process from a spiritual crisis."

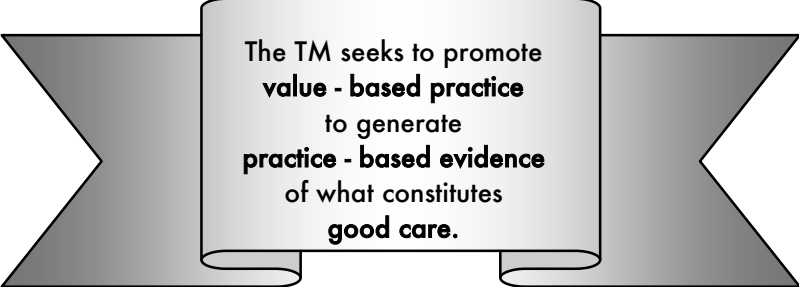
Platz 2003 as quoted by Phil Barker

If we go through a mental health crisis we may need a lifeboat, or at least a lifeline to hang on to. We may need someone to get close enough to us to offer this to us. If our coracle is damaged, leaking and no longer seaworthy, we may need to be taken to a safe haven where appropriate repairs can be made. We will need someone to support us during that process while we pick up the pieces of our lives. Depending on what has happened to us, we may need help over a short period, or perhaps for a much very long time.

Sometimes we might feel as if we are no longer moving forward in our life journey. We may have lost all hope. In the short term, we may need encouragement to hold onto some hope and somehow see the light at the end of the tunnel. In the longer term, *spiritual issues* become important for some people.⁶ These might give us meaning and purpose in life, helping us to keep going when things are tough, helping us to stay on course when we seem to have lost direction.

Be interested and curious. Who is this person?

If I am a service-user, what has happened to my coracle in the past has determined, at least to some extent, how things are for me now. My present situation, and the journey that led up to it, is unique to me, only I can and do experience it, and *I am the expert in it*. For every service-user looking for a pathway towards recovery, their own individual and complete story is the crucial tool. We all have our own 'personal toolkit' from previous life experiences. Present and past relationships, spiritual and cultural issues could be important, but are highly individual, and best worked on by discussion with the person in care.



The TM seeks to promote
value - based practice
to generate
practice - based evidence
of what constitutes
good care.

The TM is an approach that centres on people's lived experience and thus on the story of their lives.

The model is about people (not clients, or patients or service-users or psychiatric diagnoses) and it reflects the belief that at the core of us all is our personal life-

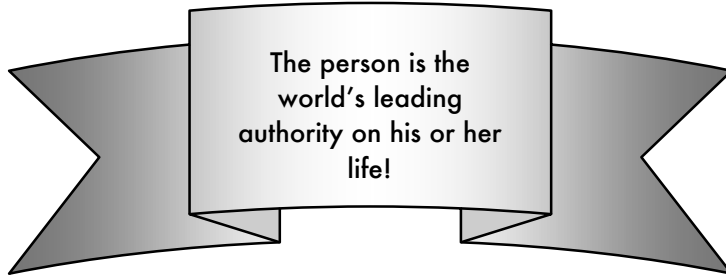
⁶ Cornah, D (2006)

story. We must, therefore, be genuinely interested in the person's story and version of events. Only then, will we begin to understand that person.

Service-user input: allow people to reclaim their life-story

In the end we can never totally understand someone else's individual life story. Only they know what it feels like. It is therefore important that service-users be involved in their own assessment and care plans and that *what* they say about

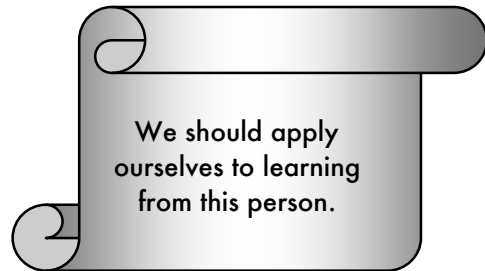
themselves and 'what works for them' in terms of improving their mental health be taken seriously.



Sometimes treatment can be prescribed without any meaningful discussion with the service-user in which the service-user's views, concerns

and wishes are not taken seriously into consideration. Some mental health professionals may think, 'we know better' about the user's story than the service-user does, and we may thus "colonise (or take over) the person's story" and re-write it from our own 'professional' perspective.

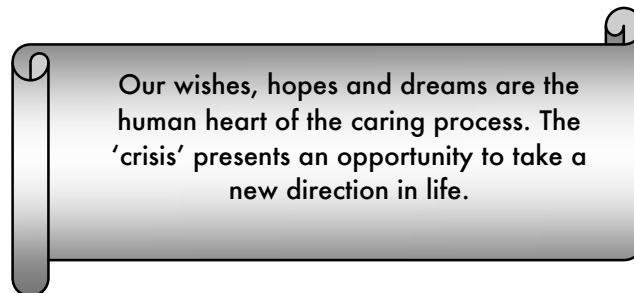
This professional re-construction and retelling of the person's life-story and its meaning can, on occasion, over-ride the person's own understanding so that their story is at first suppressed and ultimately silenced or eclipsed within the system. The person's own 'voice' just does not appear anywhere in the professional record or paperwork associated with professional assessments, diagnosis or treatment.



However only the person themselves is actually entitled or qualified to tell his or her story, and only they can say if a particular treatment is helping them or not. People need to reclaim their own story and such an act of reclamation can be the first step in the direction of genuine recovery and positive change. There are two distinct features of the TM.

Therapeutic relationships

It is seen that much of the help that any service-user in hospital crucially needs can be given simply by someone reaching out to them as one person to another. They need someone to get alongside, listen, encourage them in their distress, and help them find their own pathway to recovery.



Also there is the fact that the person and their situation will be in constant flux and each day will be different. This means the person's needs will always be changing, and their care should be changing, accordingly, to meet those changing needs.

Within the acute inpatient setting, the therapeutic relationship between staff and service-user attempts to meet these ever changing needs on a daily basis. It seeks to provide individualised care over a specific period of time, during which the changing needs of the service-user can be monitored, and their care plan modified accordingly.

Thus, although we all may assume that helping professionals will care about people and care for them if required, the TM gives special emphasis to the need for professional staff *to care with* the person in care, developing a constructive, collaborative conversation with them about their care. If no such meaningful conversation is forthcoming (for whatever reason) the care given can hardly be called therapeutic. This conversation will be in constant flux, as indeed we all are, on the ocean of life. The therapeutic relationship can act as the basis for this person-centred collaborative care in which the needs and views of the whole person are truly valued during their stay as an inpatient.

Questions for reflection and group discussion

1. Have you heard of the Tidal Model? What does the TM mean to you?
2. Where are you in your own life journey?
3. The meaning of life is essentially expressed through stories and by means of metaphors or figures of speech ('This is like that'.) Whilst avoiding professional 'jargon', write down a list of as many metaphors as you can which might be related to the experience of mental health breakdown and recovery. Discuss their significance for you.

4. Why is it important for service-users to be directly involved in the self-assessment of their own problems and needs and in the planning of their own care?
5. What tends to happen when there are disagreements within the multi-disciplinary team or between the doctor and the person in care, regarding his or her care and treatment?
6. How might these disagreements be best resolved? Give some examples from your own experience of both good and bad resolutions of such disagreement.

THE ROLE OF THE MENTAL HEALTH WORKER

How do we make 'therapeutic relationships'?

We have said that the concept of the therapeutic relationship is crucial to the delivery of truly collaborative care. Every person in care should have the opportunity of making such a relationship with a staff member. Very often, this will be a nurse, but it could be anyone in the multidisciplinary team.⁷ The relationship is based upon a commitment to listen to this person in care, to try and understand how he or she feels, and to learn the story of this person's life *as they tell it*, which has led up to this. At each point, the staff member will try to work out with this person how best their immediate needs can be met. The whole process of building such a relationship is highly skilled and can be very challenging. It can only be done sensitively and over a period of time. It is a creative process and different for each person in care.

Bridging

When people are admitted to psychiatric in-patient services, they often feel distressed, isolated and confused. Some feel very angry and suspicious especially if they have been admitted against their will on a section of the Mental Health Act. Mental pain is eased if people feel understood, listened to and reassured. Thus, the first task is to reach out towards the person in care with compassion and respect, thus creating a therapeutic (or healing) - "bridge over troubled water". This bridging is both creative and risky and is a two-way process.⁸

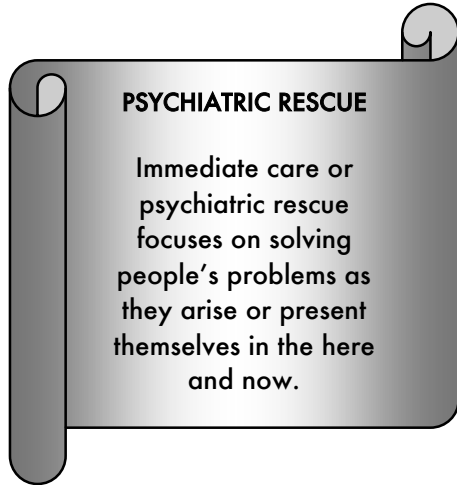
According to Barker and Barker (2005) "bridging" involves constructing a means of crossing some threatening water, so that we might reach something of

⁷ Barker and Barker (2005)

⁸ Barker and Barker (2005)

importance on the other side. In the context of mental health care, what we wish to 'cross' is the threatening waters of madness, and what we aim to 'reach' is the person in distress".

The bridging metaphor also acknowledges that the bridge may be made of almost any material, and might be made to last, or just a temporary structure. Like a bridge, everyone reaches out to others in their own distinctive way.



Knowing you/known me

Having made contact with the person, we can then offer the support, hope and encouragement they need to get through the initial period. Over time, we hope to turn this dependent type of relationship into one that is trusting and two-way, what Barker has called "*knowing you/known me*".

This is built on mutual respect and openness. We hear and record the person's whole story as that person sees it and tells it, in his or her own words. We then encourage each person in their day-to-day progress, and help him or

her see wisdom in their previous experiences that might apply to their present situation.

Skilled mental health care can help people refocus their lives, through various medical, practical, psychological or spiritual approaches or by just being a good listener and encourager. Above all the person in care needs to be re-empowered, rather than simply told 'what is wrong with them' or told what to do. In all of this, it must be remembered what care *means* in the context of mental health. Phil Barker challenges us with a stark choice:

"Shall we share in the distress of people in our care, acknowledging that these people are hurting like us, but either more so, or with a different voice? Or shall we distance ourselves from those whom we describe as one of the 57 varieties of mental illness, each of which is itself a mixture?"⁹

How does it work out in practice?

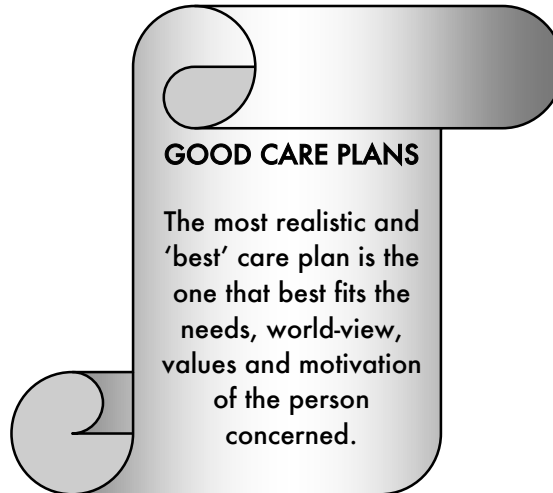
Making therapeutic relationships with people in care must be given priority. This is both a ward management issue and a clinical practice issue. Time must be given daily to each person in care. If it is *not given* (for whatever reason) the result is a toxic rather than a therapeutic ward environment. This time is the most precious thing any person in care can have. Staff must always be reliable and make every effort not to let the people in their care down pleading they are just too busy doing other things to talk to them.

Having reclaimed the story of their own breakdown and distress, the person in care can then begin to map out a new course of recovery for themselves – one small step at a time, and one day at a time, with the help of others.

⁹ Barker P (1999)

The TM assumes that the best that we as professional caregivers can do or offer is to be *genuine supporters of the person who suffers*. Our task is to provide, as best we can, the conditions under which people can find and access the resources (very broadly defined) they need to undertake a journey towards mental health and/or spiritual recovery, which is meaningful *to them*.

To ensure that this process is, in reality, underway, there are a variety of documentation forms associated with undertaking person-centred collaborative care. These are completed regularly, in the service-user own words. Discussion of the issues raised on the forms should help the service-users identify major problems, see who are the key people in their lives, and see what strengths and weaknesses they themselves bring to solving their current difficulties. Any progress from day to day, however small, must be recorded; what seems to help this person and what does not should also be noted.



The completed paperwork is used as evidence to show what changes are taking place over time in the opinion of the service-user, to bring the whole person and his or her need for care into view and by giving a down-to-earth focus on what may need to happen next in order to promote this person's recovery, to aid forward care planning with the person, and inform progress in recovery to the MDT. They thus form an integral part of the CPR (Care Programme Approach) and the ICR (Integrated Care Record).

It is essential, however, that the paperwork should not be a barrier to the formation of a therapeutic relationship. *Their purpose should be carefully explained in advance to service-users, and the documentation forms made freely available for them to look at.* Whilst documenting the person's story, summaries of the key points are preferable to whole paragraphs, leaving adequate time and space for free conversation.

The following is a summary of the sort of issues that need to be during the person's stay, and is the basis for the documentation. It concerns 3 distinct aspects of the person's thoughts and feelings at any particular time – the domains of self, world and others-, and the possibility of group care.

DOMAINS OF SELF, WORLD AND OTHER

The self

The self-domain is the subjective experience. This is the most immediate concern. It includes how people feel about themselves *right now*, their current level of distress and any associated risks. It identifies with them what needs to be done here and now to ease their distress and insecurity. In the longer term, discussions of spiritual issues can be helpful. People's view of what life means to them, can give renewed purpose and motivation for change.

The world

The world-domain is the story the person tells. It involves the whole story of what has happened to this particular person and how this situation has occurred, from *their* point of view. It can concern their relationships with family, or otherwise, employment or lack of it, accommodation issues, intolerable pressures, bizarre and confusing thoughts, bitter disappointments, present anger, with specific fears and hopes about the future. It also can include previous encounters with the mental health services, whether or not these have been helpful, and the whole issue of compulsory treatment if relevant.

The others

The others-domain is the person's support network. This primarily concerns people who are most important to this person, including family, friends, and helping professionals within the MDT. Often other people in the service can be a source of friendship and understanding. User groups can be helpful for social contact and discussing coping strategies. These resources are brought together to help construct practical recovery plans. Initially this means recovery from the immediate crisis, but as things improve, plans are made for support after leaving hospital. This is crucial because community based resources can hopefully be sufficient in the long term, for the person (now no longer a patient) discharged from the mental health services.

Group care

As recovery can be described as a journey it is important that people be able to share their discovery-journey with other travellers. Given the common experience of being human, group-based support within the acute inpatient setting has proved to be a key factor in assisting recovery. Within group-work people should be given an opportunity to:¹⁰

- ✓ share their experiences of difficulty, distress or disability
- ✓ obtain down-to-earth human support from their peers – people who are 'in the same boat'
- ✓ view their problems from a different perspective – through the experienced eyes and ears of the other group members

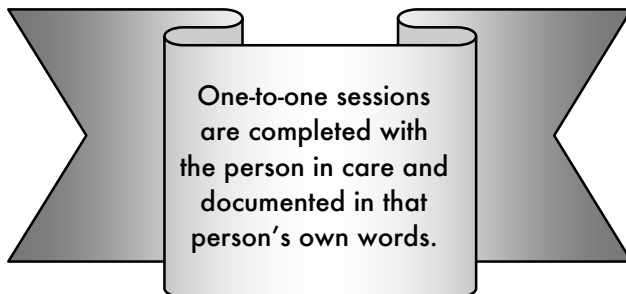
¹⁰ Barker and Barker (2005)

- ✓ enjoy the experience of being the helper, as opposed to being the 'one who is helped'
- ✓ explore different, potentially new, options for resolving problems of living, from the experiences of other people
- ✓ gain an opportunity to 'stand back' from problems, by discussing them in the abstract

DOCUMENTING COLLABORATIVE CARE PLANNING

Documenting people's self-assessments and contributions to care

There are 5 different pieces of paper work which, as part of the Integrated Care Record (ICR), should be *written in the service-users' own words* at different stages of the person's stay on the ward. Spending time with service-users to do this is essential and is not the same thing as seeking information or making a diagnosis, recording events, third person observations or clinical decisions'. It is about fostering the care relationship and negotiating a therapeutic alliance with service-users. The purpose of the service-user documentation is to help ensure that service-users' own stories and version of events is given respectful attention



by the care team and incorporated within the MDT care planning process.

The following forms seek to capture and document this person-centred, collaborative care, which values the service-users voice.

On Admission

PERSONAL SAFETY AND SECURITY PLAN (part of the Interim 72 hour in-patient care plan)

This should be part of any normal admission procedure. It is one aspect of the formal risk assessment process. It gives people the opportunity to contribute to this and to discuss with a member of staff what can be done to make them feel more safe and secure. It can help decide how to best manage times of great distress or feelings of being out of control. This plan can also be used at other times, as appropriate, for example, after an incident or restraint, or when the person seems particularly agitated or distressed, or when they are on continuous observation.

Within the first 1-3 weeks

HOLISTIC SELF-ASSESSMENT

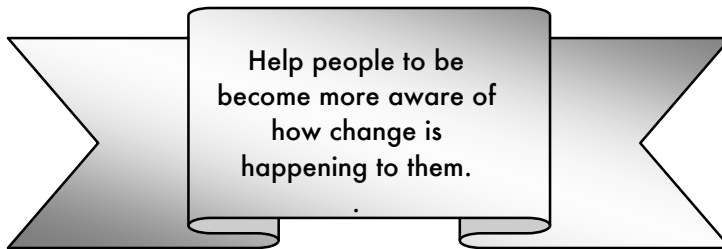
The timing of this should be delayed until engagement and a two-way conversation is possible. Perseverance and a tactful approach towards the service-user are essential. This assessment is vital, and must not be forgotten.

Once it has been done, it is not repeated. This assessment gives the person the chance to record their complete story in their own words, and have it listened to and valued and incorporated into the care plan.

Ongoing collaborative documentation

ONE-TO-ONE SESSIONS

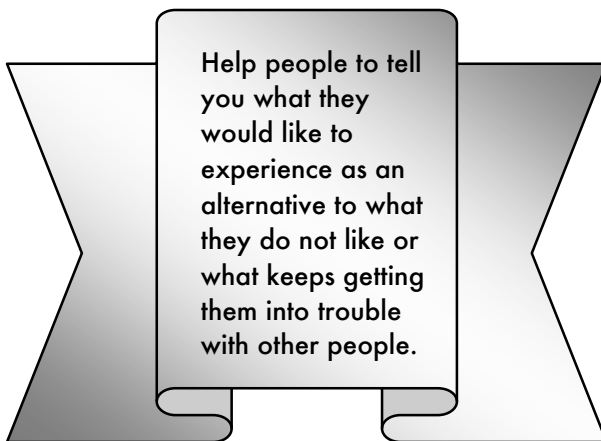
Service-user collaborative care planning should be undertaken once or twice per week for every person in care, or even more often if required. It is the service-



user's contribution to their ongoing care, and should be done collaboratively, in their own words. By meeting regularly with the person in care, we can be more aware of their needs and wishes, and help address

problems as they arise. Appropriate activities while on the ward can be set up. Input from an occupational therapist can be arranged if desired. Some people find benefit from various kinds of art therapy, including art, music, dance, or drama, if these are available. Short-term goals can be revised from day to day. Improvements, however small can provide a positive focus to discussions.

PRE MDT REVIEW



This should be done with all service-users within 24 hours of each multi-disciplinary meeting when their case will be discussed. It gives service-users a chance to discuss issues that they want to be raised at the ward round with their doctor and other members of the multi-disciplinary Team.

It is important that everyone knows the service-users' views of their own progress and treatment in the MDT. Other issues include

compulsory detention or treatment and the person's readiness to go on leave. Particularly important is the person's views about their medication, whether or not it is helpful, and whether the side effects are troublesome. Other types of support and help can be discussed. This helps everyone at the ward round to make suitable decisions as to what treatment is best for each individual person.

Prior to leave or discharge:

It is important to record and discuss service-users' worries about returning home. This can be a frightening prospect, especially if the person is going back to a difficult situation. Appropriate support and treatment at home can then be

worked out in collaboration with the service-user. This process helps service-users to look forward and make plans for the future.

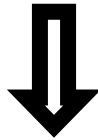
RETURN FROM LEAVE

This should be done collaboratively with each service-user upon return from overnight, weekend or longer period of leave. On returning, problems encountered while on leave can be used to plan further treatment and support, which might be needed in the longer term. Suitable coping strategies should be discussed and recorded. In this way, the service-user will find things easier when they are finally discharged.

SUMMARY OF COLLABORATIVE DOCUMENTATION

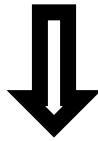
ON ADMISSION

PERSONAL SAFETY AND SECURITY PLAN
(part of the Interim 72 hour in-patient plan)

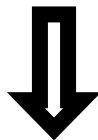


WITHIN THE FIRST 1- 3 WEEKS

HOLISTIC SELF-ASSESSMENT



ONGOING COLLABORATIVE DOCUMENTATION



(Once or twice a week or more often when required)

Can be inclusive of:

ONE -TO -ONE SESSIONS

PRE MDT REVIEWS

RETURN FROM LEAVE

PRE DISCHARGE REVIEW

PERSONAL SAFETY AND SECURITY PLAN ¹¹

To be completed with the service-user and written in the service-users own words

What can I do to help myself feel more safe and secure?

I feel angry and confused about being brought here. But I do not want to get into any trouble.

I will read over letters from my friends every day. Doing this bolsters my self-esteem.

I will make a note every day of the people who value me for who I am and what they say about me.

I will listen to music on my iPod and talk to people. This usually helps me deal with my voices.

What can others do to help me feel more safe and secure?

The staff will ask me how I am doing several times a day.

The staff will be happy to talk to me whenever I feel the need.

Someone will ask Dick to come and see me and bring Mo his dog. I like Mo - he is a great dog.

Interim (72 hour) in-patient care plan

Specimens of completed paperwork

Legal status	Observational level	Leave status

Admitting Worker	Name Signature Date
Service-user	Signature Date
Care Plan Review Date (must be within 72 hours)	Date

Original to be retained by patient/service-user. A copy to be filed in the ICR

¹¹ Barker P (2000). *The Tidal Model: Theory and Practice*. unpublished manual reproduced under licence agreement by the Birmingham and Solihull Mental Health NHS Trust & Barker and Buchanan-Barker (2005) *The Tidal Model: A guide for mental health professionals*, Brunner-Routledge, Hove and New York,

HOLISTIC SELF-ASSESSMENT ¹²

To be completed with the service-user and documented in the service-user's own words

NAME: <i>Claire Sweeney</i>	DATE: <i>10/9/08</i>
NAMED WORKER:	NHS No: <i>0000000</i>

REASON FOR ADMISSION

Trigger Questions:

Why have you come here? What is the problem? When did you first notice it? How do you feel about it? How has it changed over time?

I've been brought here under a section because I complained to the police about a doctor and I want to see him charged. Nobody believes me and they treat me like a crazy woman. Also I have skeletons of my dead baby in my head.

How has it affected your life? (How have you changed?)

At first, I felt wiped out, devastated. I felt cut off from everybody. Alone. I also felt possessed by demons.

Nothing much has changed over time. But because things should be better., it is actually worse. Things keep getting worse over time. That really scares me.

Relationship with family and friends?

This has caused friction between me and my man and my father. Nobody believed this has happened

This has also affected my son - who has been fostered out. He thinks I am a crazy woman and I think I've been a bad mum. Maybe if he'd had a better start, he'd have turned out differently

¹² Barker P (2000). *The Tidal Model: Theory and Practice*. unpublished manual reproduced under licence agreement by the Birmingham and Solihull Mental Health NHS Trust & Barker and Buchanan-Barker (2005) *The Tidal Model: A guide for mental health professionals*, Brunner-Routledge, Hove and New York

ONE-TO-ONE SESSION¹³

To be completed with the service-user and documented in the service-user's own words

NAME: <i>Claire Sweeney</i>	DATE <i>18/9/08</i>
NAMED WORKER: <i>Mary Brown</i>	NHS No <i>0000000</i>

General discussion/prompt questions: How are you today? What have you been doing? What is/was/might be different? What has been working for you and why? Any problems?

I feel worse now that I am here. I keep thinking how useless I am and that it's all my fault. I still feel all coiled up like a tight spring inside.

I have been keeping to myself and thinking a lot. I could socialise a bit more

I went for a walk today looking at birds and thinking about what it would be like to be a bird. I think this just kept my mind off how I was feeling inside. I did not feel all coiled up inside as much and was a bit more at ease. Paying attention to things outside myself seems to work for me. But I feel angry and frustrated that I cannot come and go as I like and have to be accompanied by a nurse if I do go for a walk.

Personal aim/goals	What do I plan to do? (ordinary, down-to-earth types of things)
<i>I will try to talk more to other patients. Engage with more activities on the ward.</i>	<i>I'll sit with others in the lounge and try reading or writing my diary. I will tell nurses if I need to talk. I will engage in more activities on the ward and try to focus attention on activities and events 'outside myself'</i>
Staff support: In what ways can we help?	Any other questions?
<i>Encourage me to engage more with others. Encourage me to focus on <u>doing</u> rather than <u>feeling</u>. At least one short one-to-one session daily. Ask me how I am getting on – several times a day.</i>	<i>I find talking this way difficult but understand the point of it. I'm so useless. I can't even write.</i>

¹³ Barker P (2000). *The Tidal Model: Theory and Practice*. unpublished manual reproduced under licence agreement by the Birmingham and Solihull Mental Health NHS Trust & Barker and Buchanan-Barker (2005) *The Tidal Model: A guide for mental health professionals*, Brunner-Routledge, Hove and New York

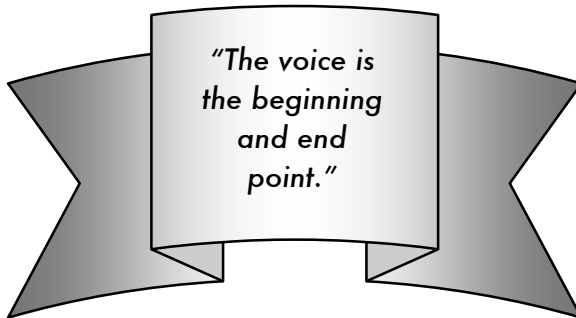
Information for service-users

The following information is routinely given to people admitted to the inpatient services to help them understand the whole assessment and care planning process.

- ✓ Your own story and version of events will be given full attention by the staff team.
- ✓ An initial assessment of your needs will be undertaken with you and written down in your own words.
- ✓ Care planning will be focused on your actual needs, wants and wishes and reviewed with you on a regular basis, written in your own words.
- ✓ You will be helped to discover what recovery and mental wellness might look like for you and to experience taking positive steps in the direction of your desired goals.

Possible problems

It can be very difficult or in some cases impossible to complete the assessment forms for a variety of reasons. A person in care, especially if being detained against their will in hospital, can be physically violent, may seek to abscond, and may initially refuse to engage with staff. Some, although not actually violent, can be verbally aggressive and uncooperative in answering questions.



These situations are common and understandable in people who are being compulsorily detained or treated against their will. Their admission can just fuel their anger, suspicion, and sense of injustice. From previous experience using the principles and practice of the TM, however, untoward or violent incidents are far less common when we persevere in trying to relate to difficult service-users and, through

perseverance and goodwill succeed in doing so.¹⁴

The sooner the person in care feels understood, the sooner he or she will calm down and become more trustful and co-operative. Of course, the necessary precautions have to be taken to make sure no one gets hurt before this happens. Other service-users cannot relate initially because they are so distressed, confused or preoccupied with their own thoughts and feelings. They may not be capable of giving coherent answers to questions at this stage. Some may be willing or even eager to talk but have such bizarre thoughts that their answers seem to us unintelligible. These ideas may be considered psychiatrically delusional. But it must be remembered that these ideas are real and very important to the person. It is helpful to accept their validity and imagine what it must feel like to hold those beliefs. These can then be better understood and discussed.

¹⁴ Gordon, W, Morton, T, & Brooks, G (2004)

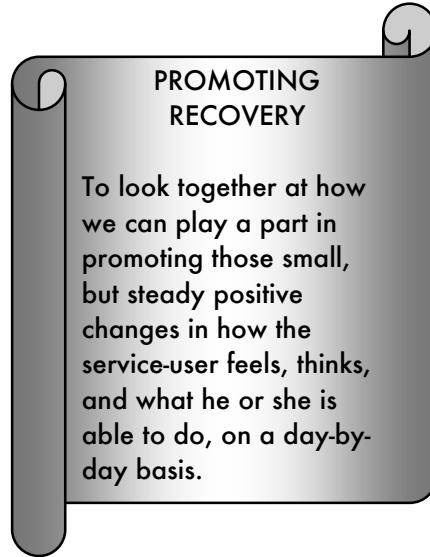
If working collaboratively with the person is not possible at first, we must return regularly, over a period of days or weeks, to see if engagement becomes possible. The commitment shown by the staff team will aid the start of a positive, therapeutic relationship between most if not all service-users and the nursing team. All difficulties must be discussed with the people in care if possible, and with colleagues. The documentation on some occasions can be left for the person to fill in alone if appropriate. If all else fails and no progress is made over a prolonged period, other sources of the relevant information are sought.

Questions for reflection and group discussion

1. If you were admitted to a psychiatric inpatient service, what would be your most urgent and greatest needs? What would your relatives want to know before they left you there?
2. How does the Tidal Model help us to meet these needs?
3. Consider the formation of a trusting relationship, completing the documentation, and your contribution to the MDT.
4. What is involved in the formation of a trusting therapeutic relationship with a service-user who has just been admitted to the ward (perhaps against their will), who is distressed, confused, angry, or frightened? Discuss.
5. What tends to happen if you do not engage positively with the people in your care?
6. In what way can the requirement to complete paperwork interfere with your developing therapeutic relationships?
7. Have you ever been in a situation where your job was seen to be essentially custodial, and where your role was confined to dispensing medication, containing people on the ward or escorting them off it? What are your views about that?
8. From your own experience, what needs to change in mental health care?
9. What, in your opinion, is good care?

WHAT IS REQUIRED OF US

Communication & interviewing skills



- ✓ ability to listen
- ✓ to give one's attention to the other in an accepting, interested and non-judgmental way
- ✓ ability to empathise
- ✓ to be able to get the feel of someone else's situation and what it feels like to be them. This requires imagination and compassion.
- ✓ to be able to relate to and foster trust with a variety of different people.
- ✓ to help people who are often confused and distressed to identify key issues and how

these might be resolved.

- ✓ to be good at encouraging and empowering others.
- ✓ to be able to communicate with the rest of the MDT and to act as the service-user's advocate if appropriate.

Good Judgement

- ✓ to be able to assess risk and when compulsory detention or treatment may be necessary
- ✓ to be able to judge the right time to discuss sensitive or difficult issues
- ✓ to be tactful and yet caring in approaching hostile, suspicious or embittered people
- ✓ to know when someone is likely to be able to do things for themselves and when they need more help
- ✓ to be able to gently challenge the "poor me" mentality, without making people feel blamed or patronised, and encourage the necessary efforts of will to find a more positive direction

Appropriate Knowledge

- ✓ to recognise symptoms of a person's mental health problem that would be likely to respond to particular medication or psychological remedies
- ✓ accurate knowledge about possible medication side effects or contraindications is also essential. This can then be discussed with the person in care and also with nursing colleagues, the doctor and the MDT.

Personal qualities

We need to be trustworthy, honest, and compassionate and show humility. We need to be strong enough to empathise with someone in distress without being

dragged down themselves. It is only then that we can relate successfully in a two-way relationship with the people in our care and work effectively with colleagues.

10 COMMITMENTS AND 20 COMPETENCIES ¹⁵

Collaborative and person-centred care is based on a number of core value assumptions, the **Ten Commitments**, concerning the nature of human experience and the nature of person-centred and collaborative ways of working with others. This way of working is reflected, clinically, through the practice of the **20 Clinical Competencies**.

THE TEN COMMITMENTS

The 10 Commitments are the final arbiter as to whether or not we are working within the philosophy of collaborative person-centred care within mental health.

The 10 commitments also distil the essence of the principles, philosophy and value base of the TM.

1. **Value the voice** - the person's story is the beginning and endpoint of the helping encounter. The story that unfolds includes not only the account of their distress, but also their hope for its ultimate resolution.
2. **Respect the language** - every person has a unique way of telling their own life story, representing to others what they know and how they feel about themselves and their situation. Their language – with its unusual grammar, personal metaphors and perspective – is the ideal medium for revealing the way ahead towards recovery.
3. **Develop genuine curiosity** - The person in care is telling, writing and in some ways 'editing' or seeking to re-write their own life story in the light of recent events which are causing them distress. But this does not mean their life is an open book. We need to show genuine respect and interest in the story that is being told to us, *even when it appears quite bizarre*, in order to better understand the storyteller.
4. **Become the apprentice** - the person is the world's expert on his or her own life story. We can learn a lot from this person and from his or her story, but only if we apply ourselves respectfully *to the*

¹⁵ Barker P (2000). *The Tidal Model: Theory and Practice*. unpublished manual reproduced under licence agreement by the Birmingham and Solihull Mental Health NHS Trust & Barker and Buchanan-Barker (2005) *The Tidal Model: A guide for mental health professionals*, Brunner-Routledge, Hove and New York

art of active listening to those who are in distress and in mental pain.

5. **Reveal personal wisdom** - People have a powerful store of wisdom – about themselves, the world and others – and this is articulated through the telling and writing of their own story.
6. **Know that change is constant** - We need to help people become more AWARE of how change is happening, and how they might use their knowledge to steer themselves out of danger and distress, into a course of relative safety and recovery.
7. **Use the available tool kit** - the person’s story contains numerous examples of what has worked for them in the past or what might work for them here and now to further their recovery.
8. **Craft the next step beyond** - We need to help the person construct an appreciation of what needs to happen or to be done next to promote their recovery. This is one of the functions of frequent collaborative planning.
9. **Give the gift of time** - There is nothing more valuable than the time staff and the people in care spend together. Quality time is the midwife of change.
10. **Be personally transparent** - The person in care and the helper should be a team working together. If a therapeutic alliance is to prosper, we all must learn to respect and trust one other and to be open, honest, and speak the truth as we see it within a safe, therapeutic environment of care.

20 CLINICAL COMPETENCES

COMPETENCY 1: The ability to respectfully and actively listen to other people’s stories and version of events, giving them your undivided attention.

COMPETENCY 2: The ability to help others write their own story in their own words and to see this as an essential part of the ongoing process of assessment and care.

COMPETENCY 3: The ability to help others express themselves always in their own language.

COMPETENCY 4: The ability to help others express their understanding of their experiences through the use of stories, anecdotes, or metaphors.

COMPETENCY 5: Showing genuine curiosity about people's stories by asking them for clarification of particular points, and by requesting further examples or details.

COMPETENCY 6: The ability to help others unfold their story at their own rate.

COMPETENCY 7: The ability to develop a practical nursing care plan, which expresses, wherever possible, the stated needs, wants or wishes of the person in care.

COMPETENCY 8: The ability to assist people to identify their specific problems of living, and what might be done to address or overcome these.

COMPETENCY 9: The ability to help others to identify and develop awareness of their own personal strengths and weaknesses.

COMPETENCY 10: The ability to help others develop a positive self-belief, thereby promoting their ability to take personal responsibility for their own choices and actions.

COMPETENCY 11: The ability to help people to be aware, at all times, of the purpose of all professional assessments and care.

COMPETENCY 12: To ensure that people are provided with (or have easy access to) their own copies of all assessment and care planning documentation.

COMPETENCY 13: The ability to help others become more aware of what works for or against them including any issues of potential risk to themselves or others.

COMPETENCY 14: The ability to help people identify who the key people are that can best help them with specific issues and to give them the kind of support they need.

COMPETENCY 15: The ability to help people identify what kind of change might be a 'step in the right direction' for them to take right now to promote their recovery and good relationships

COMPETENCY 16: The ability to help others to identify what further steps might need to be taken for them to improve their present situation and mental health.

COMPETENCY 17: Helping people to be aware that dedicated time is being given to them to address their specific needs.

COMPETENCY 18: Helping people recognise the value (and quality) of the time being given to their ongoing assessment and care by others.

COMPETENCY 19: Helping people to develop an increasing awareness of very small changes – in their thoughts, attitudes, feelings or behaviour.

COMPETENCY 20: Assisting others to develop an increasing awareness of how they, other people or events have influenced (or are continuing to influence) these changes.

HOW ARE WE OURSELVES SUPPORTED?

Any mental health worker involved in making relationships of this sort must have regular non-managerial supervision.¹⁶ Working as a nurse or other clinician directly responsible for the care of patients on busy acute in-patient wards is a stressful and emotionally draining job and such workers need regular support and encouragement to persevere with the tasks at hand in the right kind of spirit.

When problems do occur, we should know where to turn for discussion, ideas or advice. This is particularly important when we have intensive, prolonged contact with someone we find demanding, difficult, upsetting, frightening, or hard to relate to or empathise with. We may also need support in how best to communicate with other colleagues and with other members of the MDT.

Questions for reflection and group discussion

1. Think about the reasons why you came into the mental health caring profession. List what you feel are your own strengths and weaknesses as a person and as a professional caregiver.
2. What are your major personal support needs at work?
3. How can these best be met?
 - within and by the staff team
 - by your employer
 - through regular non-managerial supervision

¹⁶ Birmingham and Solihull Mental Health Trust policy for Clinical Supervision (2005)

CONCLUSION

The importance of standard medical or psychological approaches to mental health problems is not in doubt. The TM is a different, more individual, approach with an important contribution to make. It can readily be applied to the practice of mental health nursing.

Under this approach, we seek to form therapeutic relationships with the people in our care. This privileged role means that we probably know service-users' true experiences, needs and desires better than anyone else. We must make sure that each person's voice is heard, and be proactive in helping appropriate treatment, care and support to take place. Mutual cooperation in this between the different members of MDT is essential.

Our crucial professional relationship with service-users at the point of their greatest need and distress on a day-by-day basis is the foundation of all good mental health care, and may have more healing potential than any purely psychological therapy or chemical or psychological intervention.

Questions for reflection and group discussion

1. What difference might the TM make to the way you approach people in your care within an inpatient setting?
2. What difference might the TM make to what you do *in practice*?
3. What difference might the service-user notice?
4. How might working with the TM affect the nursing contribution to the MDT?
5. Discuss or think about this: What is Hall feeling concerned or worried about? Do you think his concerns are justified? If so, how can we address those concerns by the way in which we undertake mental health care within the acute residential services?
6. Discuss or think about the quotation from Hall, following:

A professional diagnosis, once made, argues Hall...¹

"...Separates the knower from the known, because it invites the health professional to focus on the diagnosis rather than the person with the diagnosis. By categorising aspects of the person (e.g. the mind, the emotions) as a disease the whole person can easily be viewed and then treated as a disease... people then lose control of their own destiny, since the most powerful judgements of them as people are controlled by experts in psychiatry.

THE TIDAL MODEL

1. Develops an understanding of the service-user's care needs through collaborative working.
2. Develops a therapeutic relationship with service-users through discrete methods of empowerment and solution-focused emphasis on recovery.
3. Key documentation is completed with the service-user and written in the service-user's own words.
4. Establishes 'care' as an educative element at the very heart of all interdisciplinary intervention

Phil Barker

CASE STUDIES

Take one or more examples of people you have known or helped within an inpatient setting and reflect or discuss in a group the following questions.

1. How did this person describe his or her problem and reason for admission?
2. How did this person's account of themselves and their situation differ from the account of others, especially that of the psychiatrist, social worker, or family?
3. Did you find it difficult relating to this person? If so, why?
4. What were their immediate needs requiring care and how did you try to make sure these needs were met?
5. Was it possible to establish a trusting relationship with this person? If so, how did you do it? If not, what were the difficulties?
6. How did this person's needs change over time?
7. What was your role concerning this person within the MDT?
8. Do you think that this person was given suitable care and treatment?
9. Could the application of the TM have improved the care and treatment this person received?
10. What inspires and challenges you most about the TM when applied to mental health care?

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