Making Decisions about Parental Mental Health: An Exploratory Study of Community Mental Health Team Staff

Adult mental health problems can impact on parents, and research highlights that their children are at higher risk of developing mental health problems. In extreme cases, mental health problems are associated with a risk of fatal child abuse. Despite this, there are few studies exploring clinical decision-making by adult mental health professionals.

This study used qualitative methods to explore Community Mental Health Team (CMHT) workers’ experiences of decision-making in the interface between mental health and child welfare. Workers were interviewed about their experiences of clinical decision-making regarding child welfare. Interviews and accounts were analysed using Interpretative Phenomenological Analysis. Influences on decision-making were explored and triangulated with the accounts of Named Nurses for Child Protection.

The findings revealed that CMHT participants were aware of their responsibilities towards children, but a complex synthesis of factors impacted on their sense-making about risk and welfare. Three superordinate themes emerged: the tensions of working across systems; trying to balance the perceptions and feelings involved in sense-making; and the role that interpersonal dynamics play in the understanding and management of risk. This paper focuses in particular on perceptions and feelings. Copyright © 2011 John Wiley & Sons, Ltd.

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The Prevalence of Mental Health Problems

At any one time, approximately one in five adults of working age will suffer with a mental health problem, typically anxiety or depression. Estimates suggest that 30–50 per cent of

* Correspondence to: Dr Khadj Rouf, Consultant Clinical Psychologist, Oxfordshire and Buckinghamshire NHS Foundation Trust, Witney CMHT, Nuffield Health Centre, Welch Way, Witney OX28 6JX, UK. E-mail: Khadj.Rouf@obmh.nhs.uk

Khadj Rouf*  
Oxfordshire and Buckinghamshire NHS Foundation Trust, UK

Michael Larkin  
Department of Psychology, University of Birmingham, UK

Geoff Lowe  
Department of Psychology, University of Hull, UK

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‘One in five adults of working age will suffer with a mental health problem’
these adults are parents, meaning approximately two million children live with a parent with a mental health problem (Gould, 2006). One person in 250 will suffer from a psychotic illness (Department of Health, 1999). This is not to negatively stereotype all parents with mental health problems but,

‘… the presence of a mental illness in a parent can adversely affect the way in which that parent accomplishes the tasks and responsibilities of parenthood and, similarly, the stresses of parenthood can precipitate or exacerbate mental ill health.’ (Falkov and Lindsey, 2002, p. 8)

The Impact on Parenting

The parenting capacity of adults with mental health problems is on a continuum, ranging from unimpaired to severe. At one end of the continuum, many adults suffering mental health issues do parent well (Parrott et al., 2008). There is little evidence that people suffering from severe mental illness, such as schizophrenia, are more at risk than the general population of physically abusing their children (Oates, 1997). Further along the continuum, there may be unintended impacts on children. Cleaver et al. (2010) suggest negative parenting can include insensitivity to children’s needs, increased criticism of children and high levels of expressed anger; the impacts of these will differ depending on the child’s developmental stage. Research indicates that children of parents with mental health problems are themselves at higher risk (40–60%) of developing mental health problems (Beardslee et al., 1998). Weissman et al. (2006) followed up 151 children of depressed and non-psychiatrically ill parents and found that the risk for anxiety, depression and substance misuse was approximately three times higher in the children of depressed parents.

At the severe end of the continuum, mental illness is associated with compromised parenting capacity. The ‘toxic trio’ of parental substance abuse, mental ill health and domestic abuse increases risk to children (Brandon, 2009). Gibbons et al. (1995) found that mental illness was recorded for 13 per cent of child protection referrals to eight social service departments in England. Falkov (1996) reviewed 100 cases and found mental health problems were associated with a risk of fatal child abuse in a quarter of cases. Reder and Duncan (1999) highlighted that 43 per cent of their sample of parents in 49 ‘Part 8’ Reviews had mental health problems, whilst Brandon (2009) undertook a qualitative review of 47 serious case reviews and noted parental mental health problems in 55 per cent of cases.

These findings highlight the need for parental mental health to be considered across agencies (HM Government, 2010) and for
the Care Programme Approach documentation within mental health settings to be used to assess, record and action any concerns about children from adult clients (National Patient Safety Agency, 2009). The impact of psychiatric symptoms on parental capacity and the importance of addressing the needs of the whole family within Community Mental Health Teams (CMHTs) has been highlighted (Royal College of Psychiatrists, 2002). Clearly, sound professional decision-making needs to underpin comprehensive assessment and intervention.

**The Role of Professional Decision-making**

Decision-making has been defined as: ‘the act or process of choosing a preferred option or course of action from a set of alternatives. It precedes and underpins almost all deliberate or voluntary behaviour’ (Colman, 2006, p. 192).

In real life, people are systematically biased in their judgements and are influenced by emotion, framing and social factors. There is evidence that people rely on inductive processes (previous experience, intuition) when making decisions. Reliance on heuristic or mental shortcuts, typical of everyday decision-making (Kahneman et al., 1990) can have serious implications in child protection (Munro, 1999). Although professional training encourages rational and analytical decision-making based on evidence, this is not always utilised (Grimshaw et al., 2001).

Despite the potential impact of parental mental health upon children, there have been few studies exploring clinical decision-making by mental health professionals. The literature focuses mainly on fatal child abuse cases. Common issues identified include poor communication, ineffective assessment and decision-making, lack of inter-agency co-operation, poor recording and lack of information on genograms (Axford and Bullock, 2005; Falkov, 1996; Gabbott and Hill, 1994; Munro, 1996; Reder and Duncan, 1999; Reder et al., 1993; Sinclair and Bullock, 2002).

Munro’s (1999) content analysis of 45 British inquiry reports from 1973–94 explored common errors in individual decision-making by social workers. She found predictable errors in reasoning amongst workers, such as discounting evidence that contradicted the worker’s view of the family. She argued that there is an interaction between internal mechanisms of decision-making and external demands. People take mental shortcuts partly because of the constraints of memory and attention when faced with a high volume of information. She comments that ‘professionals with heavy caseloads and limited time can easily
feel overwhelmed by the range of potentially important details to consider when assessing a family (p. 754).

Personal experience with difficult decisions shows us that we are not logic machines; our decisions can often be based on feeling and emotion (Beach and Connolly, 2005). Mood can affect decision-making and positive emotion can lead to improved decision-making. This is pertinent as child protection work is stressful (Cousins, 2004; West, 1997), and there is some indication that practitioners’ feelings help to alert them to child protection concerns (Ling and Luker, 2000).

There are mixed findings in relation to decision-making in child welfare studies. Child protection work is often framed in terms of risks or losses. Kelly and Milner (1996) suggest that this leads workers to be more risk-seeking in their work. They conducted a documentary analysis of child protection inquiries and noted several themes concerning information-processing errors. Notably, they argued that when workers felt certain that the child may lose the mother–child relationship, they took more risks in order to preserve that bond. The authors noted how workers were often having to decide between two imperfect and uncertain options, which made decision-making complex and difficult.

However, there is also evidence that workers do show risk aversion under conditions of uncertainty. This has been illustrated in child protection work by the study conducted by Spratt (2000, 2001). This research looked at 200 consecutive referrals to family services in Northern Ireland. When referrals were initially triaged by senior social workers, 27 per cent were framed as needing a child protection investigation. After investigation, 70 per cent of these were reclassified as less serious. Spratt argues that workers were classifying any degree of risk as child protection within a context where errors in child protection were framed as morally reprehensible. The consequent caution led to a high number of false positives, but was a way of managing personal risk. In a further study, vignettes were created for the most ambiguous referrals. Whereas 30 had previously been classified as requiring ‘child protection’, in the new condition, only three per cent of these cases were given that label. Again, this demonstrated how the framing of information can shift risk perceptions.

McConnell et al. (2006) examined context contingent decision-making in child protection cases. They conducted 17 group interviews with a total of 155 child protection workers. Themes identified in decision-making where parents had a disability (sensory, learning or mental illness) were perceptions of neglect, parental compliance within the child protection process, the fear of public criticism (which often led to defensive practice) and pressure on resources. Staff often hoped to effect change, showing...
that feelings play a part in the decision-making process. They concluded that:

‘professional practices in action are rarely determined by individual workers...these practices are normally taken from the culture in which they are embedded and from where workers take their cues for action’ (p. 238).

These findings seem supportive of interactional models, which look at the interplay of factors across different layers of systems. It is important to understand the experiences of CMHT staff in making decisions about clients who are also parents of dependent children. It is striking that there are few studies exploring how clinicians experience decision-making in the ‘swampy lowland of practice’ (Darlington and Scott, 2002, p. 1). Exploring the clinician experience could facilitate insights into what enhances or interferes with decisions about parenting capacity. This, in turn, could improve training, assessment and service provision in the interests of safeguarding children and supporting vulnerable families. Hence, this study explored CMHT workers’ experiences of decisions in the interface between mental health and child welfare.

Methodology

The study used the qualitative method, Interpretative Phenomenological Analysis (IPA). IPA allows exploration phenomenon at an individual, psychological level (Smith and Osborn, 2003; Willig, 2001), and lends itself well to exploratory research. If the researcher has an ‘insider’s perspective’, this can enrich the findings. The researcher interprets the experience of participants and reflects on their own position, both personally and theoretically, thus acknowledging that no research is value neutral (Forshaw, 2007). The study focused on the following research questions:

1. How do clinicians make decisions about child welfare/protection in adult mental health cases?
2. What factors do they perceive as affecting their decision-making?

Ethical approval was granted by the local Research Ethics Committee. Consent from participants included permission to use anonymised quotes for publication. The study was undertaken as part of a professional qualification (top-up doctorate in clinical psychology), and sponsored by the local Mental Health Trust.

Participants were interviewed following a semi-structured format. They discussed experiences of making decisions in mental health cases where clients had children. Named Nurses for Child Protection were also asked to keep diaries about their decision-making; these were a record of observations, reflections,
dilemmas and decisions. All data were transcribed verbatim and systematically analysed using IPA (Smith and Osborn, 2003). This involved detailed reading and re-reading of material on a case-by-case basis; themes gradually emerged within interviews. Eventually, overarching themes across cases were identified. All data were subjected to reliability checks.

Profile of Participants

The researcher contacted 99 CMHT staff. Thirteen staff opted into the study, which was a lower than expected response rate. The mean time since qualification for participants was 15.6 years, ranging from six to 23 years. The sample consisted of three community psychiatric nurses (CPNs), three psychologists, three social workers and four psychiatrists. Five Named Nurses for Child Protection also participated. The Named Nurses have a role in training and advising staff, policy development, risk assessment, reviewing serious incidents and linking across agencies, including the Local Safeguarding Children’s Board. Their mean time since qualification as health visitors was 17.2 years (range 7–24 years). Their observations from diaries were used to triangulate the understanding of the interviews, examining whether these different sets of data had points where they intersected and diverged.

Results

The study explored clinicians’ experiences of decision-making about child welfare/protection. The analysis of data from the interviews and diaries yielded three superordinate themes, as can be seen in Figure 1. These superordinate themes comprise subordinate themes and subcategories which can be seen in Table 1. This paper focuses particularly on the third superordinate theme relating to the internal experience of decisions.

Figure 1. Superordinate themes involved in decision-making
Superordinate Theme: The Tensions of Working Across Systems

Unsurprisingly, systems impacted on decisions, and participants expressed tensions around their job role, differences in power, inter-agency tensions and pressure at work. This involved tensions around their role, finding it difficult to focus on children; an awareness of power and powerlessness; differing thresholds for intervention for children across agencies; and work stress.

Superordinate Theme: The Role that Relationships Play in Understanding and Managing Risk

The quality of working and therapeutic relationships featured strongly in decision-making. Participants valued trusting relationships. For instance, participants felt that collaborative relationships...
‘The better the inter-professional relationship, the easier it was to talk about worrying cases’

‘Some participants referred to decision-making as instinctive, which seemed to consist of personal experience and intuition’

‘Gut reactions’ arose in situations where participants had a ‘felt’ sense that something was wrong’

with clients mediated perceptions of risk. Good relationships between colleagues facilitated discussions about stressful cases. Team meetings could be supportive and reassuring, though this depended on team culture. Relationships with team colleagues were important and influenced participants’ risk perceptions, providing reassurance and a place to share ideas. The better the inter-professional relationship, the easier it was to talk about worrying cases.

Superordinate Theme: Trying to Balance the Perceptions and Feelings Involved in Sense-making

This theme captured the internal experience of decision-making. Participants were trying to balance formal knowledge and implicit knowledge based on personal experience. They talked about ‘weighing up’ information and synthesising this into some meaningful view. Decision-making in this area was stressful, uncertain and complex. ‘Gut feelings’ or intuition often alerted participants to something being wrong. They also talked about risk saturation and how this could potentially affect people within and across agencies.

Feelings Influencing Decision-making

‘Gut reactions’ arose in situations where participants had a ‘felt’ sense that something was wrong. A social worker talked about experiences of visiting families where superficially everything seemed fine, but there was a ‘sense’ that something was wrong. When asked to elaborate on this ‘gut feeling’, the participant said: ‘Uneases you – you know it makes you feel uneasy.’ (5) One psychologist commented on ‘gut feelings’ as follows: ‘I haven’t got any firm evidence. I just feel very uncomfortable about it. I’m just not entirely happy about – it’s got a bad feel to it’ (Psychologist 10). Another psychologist commented that:

‘So all the time making these judgments and it’s only now that I’m speak, speaking to you, I, I guess this is part of the intuition we’re talking about, we’re constantly making assessments and judgments about people.’ (Psychologist 11)

Some participants referred to decision-making as instinctive, which seemed to consist of personal experience and intuition. Another social worker commented that: ‘You have to use your intuition a bit and your experience a bit’ (Social Worker 1).

Some used these ‘gut reactions’ as valid information. A CPN said: ‘I know what my gut reactions are’ (CPN 8).

Another participant commented on how gut reactions were used as a steer for further action, whilst acknowledging the potential pitfalls of making automatic decisions: ‘And probably our instincts are right, that the children are fine [pause] but you know, but we are not asking the questions’ (Psychiatrist 7).
Another issue, linked to gut reactions, was participants’ use of personal experiences as a benchmark. One used personal parenting experience when assessing cases: ‘I suppose I come to it more as a mother, than as a clinician’ (Psychologist 10).

A CPN also used personal experience as a benchmark for judging how children were functioning: ‘when you’ve, when you’ve got your own children it interests you a lot more, because you do measure it on what you do’ (CPN 8).

These participants identified with the child, thinking about how their own children might feel in the same situation. For instance, a participant commented that:

‘I think about [pause] how I would feel for my child to be in that family, or, or I sort of, I might contrast erm, I hope to contrast – if you hear about things that sound, you know, really difficult, you think about how it is for your child and how it might be for that child in comparison.’ (Psychologist 10)

However, participants were also aware of the dangers of making direct comparisons based on subjective experience: ‘you’ve got to be careful not to measure it too much on your own stuff’ (CPN 8).

Some participants implied that their decision-making had become ingrained or well learned through experience. Once again, trying to articulate this decision-making process was difficult:

‘yes there are lots of things about the client. And you’re gonna ask me what they are and [laughs] they’re those things that are so sort of embedded in your subtle intuition as a clinician, it’s gonna really, it’s gonna make me struggle [sighs].’ (Psychologist 11)

It seems that ‘gut reactions’ are an important influence on decision-making and that these gut feelings are difficult to articulate. These feelings are implicit and consist of a ‘felt’ sense based upon personal and clinical experiences gained over time.

Risk Saturation
Participants mentioned how risk perception could impact on their feelings and decision-making. For instance, a psychiatrist talked about how serious incidents heightened perception of risk and anxiety around managing risk: ‘You just need something to go bad, to go badly wrong with a child and I’d bet you’d be over-reacting to everything’ (Psychiatrist 12).

Breaks from work were described as leading to a reduction in the ability to tolerate risk:

‘If there have been severe untoward incidents, it’s what’s happening in terms of your whole perception of risk management and support if you make a difficult decision. And I, I certainly find that after a holiday my ability to tolerate risk reduces.’ (Psychiatrist 12)
The quote suggests that working with risk is anxiety-provoking and potentially overwhelming. It may be that being exposed to a large amount of risk on a continuous basis can shift perceptions and feelings about managing risky situations. The participant reflected on how differing baselines of risk across agencies could link to differing responses to that risk: ‘so our perception of what’s risky is different to how a G.P. would assess just because we see so much of it’ (Psychiatrist 12).

The main issue that emerged here was the feeling that colleagues could potentially become desensitised to risk via a form of risk saturation:

‘if when you get burnt out there’s just so much risk around your thresholds – you know I think we do that, it happens with suicidality but it must happen in other assessments of risk – you’re seeing so much you know, unless you’ve actually thrown yourself under a bus, we’re not interested in the referral because you’re not really trying, you know.’ (Psychiatrist 12)

A psychologist noted that: ‘I feel they perhaps colleagues have got quite sort of thick skins or have learned to tolerate seeing things that are quite sort of uncomfortable’ (Psychologist 10).

Such a strategy may be a survival mechanism for working within a stressful environment, though this could impact negatively on decision-making about child welfare:

‘there isn’t a lot of capacity to start thinking about [pause] you know sometimes you just turn away from things that are too difficult or too complex [sighs] and think I’ve got enough to worry about…[.] And I hope that one doesn’t do that about child protection issues, but I suppose it’s a danger isn’t it?’ (Psychologist 10)

Weighing It All Up

Participants considered multiple factors when making decisions under conditions of uncertainty, and talked about trying to ‘weigh up’ information. They did not want to make snap decisions.

Uncertainty – ‘That’s Not Clear Cut’

Several participants talked about there being a ‘grey area’ where it was difficult to decide whether children were suffering because of parental mental health problems. This ‘grey area’ was where there is no clear evidence of abuse but there are concerns about children’s welfare. For instance, a participant commented that: ‘I mean sometimes because we discuss in our meetings erm other cases. And you know, I think ‘oh if it was me I’d have gone to social services’, but other people sort of
say, ‘oh no’ (CPN 4). This participant also felt that making decisions about risk could be difficult: ‘I mean sometimes it is quite clear that there’s a risk and then sometimes it’s a bit more vague’ (CPN 4).

Several participants talked about how difficult it was to judge whether there was a damaging experience occurring for the child. There was complexity or ambiguity associated with these decisions. Participants felt particularly concerned about the emotional impact upon children over time.

Some participants explained that trying to distinguish between normal and abnormal parental behaviour could be difficult. For instance, a social worker described how clients become pathologised once they come into contact with mental health services, recounting a case where a new mother had said: ‘I get so angry sometimes with the baby I just have these thoughts. I feel like throwing it against the wall.’ (Social Worker 3). The mother was feeling overwhelmed by parenting a new baby, and was distressed by her own feelings. The worker reflected upon how emotional honesty could then be labelled pathological, when actually it was the expression of relatively normal parental frustrations: ‘it’s a sort of difficult one because the more open people are and I think actually in a sense, it’s fairly normal for mothers to feel angry with their children at times’ (Social Worker 3).

Another participant commented on the dilemma of interpreting whether parental verbalisations of distress were merely the expression of feelings or implied threats to act: ‘How far do you go if someone says something risky?’ (Social Worker 1). This social worker also noted that: ‘the child protection team wouldn’t thank us if we reported everybody who had unacceptable thoughts.’

There were dilemmas about judging risk. One person commented: ‘you’re always in a, in an uncertain place’ (Psychologist 10).

Worry about Decisions

Many participants talked about their feelings about their decisions, and several issues are captured in this quote, including fear of poor assessment, destroying the relationship with the client and unwanted media attention:

‘you have this fear of upsetting the therapeutic relationship [pause]. You worry that you’re [pause] reacting too strongly to a situation. You are misjudging it. You know, you think you are seeing something that you are not. I suppose the other fear is that you’re missing something, and you’ll get blamed for it. That sort of thing…(...) I mean that is what you tend to read in the press, isn’t it? You see these cases where there is clear abuse going on and nothing seems to have been done.’ (Psychiatrist 7)
Another participant talked about the anxiety of decision-making in this area:

‘You know, you go home on a Friday with your fingers crossed, sometimes with people, and you think, ‘Oh god, I hope they’re alright. I hope I’ve made the right decision’, and I hope, you know, a lot of it is quite selfish, because I think I don’t want it to come back down on me. I’ve done everything I can with this person, and you know, they might go and harm themselves, but when there’s children involved [laugh]…it’s just so much more vulnerable because they are not making that choice to be there…’ (CPN 8)

In summary, decision-making around parental mental health and child protection was described as being complex and stressful. Some participants had worries and uncertainty about the outcome of cases. Some mentioned a fear of repercussions against them, either within the organisation or from media scrutiny. Clinicians appeared to be working in partial darkness, with uncertainty about the level of risk that parental mental health problems pose to child welfare. Unless there was clear evidence of abuse, workers struggled to be conclusive about risk, and worried about whether their interventions had been sufficient.

**Triangulation**

The accounts of Named Nurses enriched the data and highlighted some interesting similarities and differences between the two groups.

In terms of similarities, the themes which emerged from the interviews were echoed in the diaries. Systemic issues were very important in both groups. Liaison and the quality of relationships were an important part of the experience. There was supporting evidence that workers contacting the Named Nurses were finding the decision-making stressful, feeling uncertainty and concern. Some Named Nurses themselves echoed that decisions were stressful. Named Nurses noted that staff felt powerless in the face of systems. There were references to delays or failure to act by other professionals in the network.

There were also differences in the accounts of CMHT staff and Named Nurses. Firstly, interviews allowed more in-depth data to be gathered. Secondly, the Named Nurses were obviously giving advice which CMHT workers were not. Thirdly, the interviews looked at retrospective accounts, whilst the diaries focused on real-time decision-making. This real-time element allowed more insights into the sense-making process. There was evidence of questioning, actively identifying gaps in knowledge, considering hypotheses and making intervention plans. Interestingly, there was not an emphasis on intuition, perhaps because the Named Nurses were not having direct contact with clients. Some of the professionals approaching
the Named Nurses did mention ‘gut feelings’ alerting their concerns; in these cases, the Named Nurses helped staff think through the evidence explicitly. The Named Nurses’ accounts also confirmed the stressful impact of a high volume of cases.

Discussion

This study focused on experience of decisions about parenting in mental health. Participants demonstrated an awareness of professional responsibilities to children, but were unsure if it was their role to judge parenting capacity. Other factors impacted on their decisions, which reflected system pressures, the dynamics of relationships and attempts to weigh up all the information. There was evidence that participants used a combination of formal and intuitive knowledge in decision-making; feelings were implicated in all aspects of decision-making.

Systems Implications

The study highlighted that further training and support for CMHT staff is needed for them to be clearer about their professional roles in relation to children. As the worker is focused on the adult client, it may be easy to lose sight of children (Cousins, 2004), which can mean that child protection concerns may not be held in mind.

Organisations which have good safety records tend to recognise the human dimension in error, actively try to reduce this and are constantly aware of the possibility of error (Reason, 2000). Serious systemic mistakes occur because of multiple layers of error, which occur cumulatively. These arise because of unsafe individual acts or because latent conditions in the system allow errors. This seems to fit with inquiry findings which highlight errors in individual and systems decisions. It implies that taking a systems approach to understanding error is more fruitful than an individualistic model.

Systems improvements could include employing parental mental health workers to help clients with parenting issues. Early intervention could enhance parental engagement and reduce resistance to intervention (Stanley et al., 2003). Risk assessment documentation and practice could be more explicit and detailed regarding parents, in line with recent guidance (HM Government, 2010; National Patient Safety Agency, 2009).

Common thresholds are needed for referral regarding child protection, particularly for children who may be emotionally vulnerable because of parental mental distress (Kearney et al., 2003). Some of the comments in the current study mirror previous findings from other clinicians and service users about the difficulty of accessing services (Stanley et al., 2003);
integrated services and inter-agency training are key (Department of Health, 1995). The current study supports other findings that systemic changes in health and social care have widened gaps between services, leading to differences in risk assessment and poor communication (Barbour et al., 2002).

**Relationships with Team Colleagues**

In this study, team meetings were mentioned as an important place to discuss cases, to share responsibility and to seek reassurance. Some workers did not find team meetings supportive, so there is a need to address the culture of team decisions and build cohesion. However, teams can reach consensus too rapidly without detailed discussion (‘groupthink’). Steps to counteract this, could include clinicians taking on the role of dissenters to force the team to think widely about their cases (Kelly and Milner, 1996).

**Individual Decision-making**

Reviews of inquiries have repeatedly reported biases in human reasoning. It would be helpful to teach practitioners to reflect on information-processing biases and mental shortcuts (Munro, 1999). Similarly, it would be useful to encourage the use of interactional models to formulate cases (see Reder and Duncan, 1999, 2004). Interactional models take account of multiple influences upon family life, ranging from wider society to particular family scripts occurring over time. These models take account of cultural scripts, power and acknowledge the dynamic nature of risk. Such models help to develop a clearer understanding of risks to children in families where there are mental health problems. They can provide a way of synthesising complex information which contains different layers of meaning. It may also make the practitioner’s frame of reference more explicit and improve intervention across agencies.

**Reflections on Methodology**

The study was small and local, and so the findings must be seen within that context. The semi-structured interviews allowed the capture of rich experiences which would not have been possible by questionnaire. The diaries kept by the Named Nurses enriched the interpretation of the CMHT data, and allowed triangulation of the findings. However, the Named Nurses were not all experienced in mental health issues, and as specialist advisors, did little clinical work; their experiences are different to front-line clinicians.

Participants may have already been sensitive to the needs of children, so their experiences may not be typical of CMHT staff. Accounts may have been biased because of recalling information,
or giving socially desirable answers. The researcher is a local practitioner which may have made it harder for some people to be frank, perhaps fearing judgement (even though it was made it clear that this was not the case).

A key requirement for the IPA approach is for the researcher to declare and own their personal viewpoint (Stiles, 1999). The researcher approached the topic expecting participants to have low awareness about child welfare. However, participants were aware of responsibilities to children. It was unexpected and disappointing that inter-agency working seemed problematic, especially as this is a repeated theme from inquiries.

In terms of the personal standpoint, the study was approached with a particular set of work experiences and a personal history which inevitably impact on the interpretation of the data. As a clinician with a feminist perspective, the researcher identified issues of power within people’s accounts. The research was also conducted as part of a clinical doctorate, so pragmatism was required about how much was achievable within the deadlines.

**Conclusion**

The accounts of participants go some way to understanding the decision-making experience in the interface between adult mental health and child protection. The findings echo those of other studies of the tensions in inter-agency working (Kearney et al., 2003). However, this was a small-scale study and further research into the experiences of parents and children within the mental health system could inform service planning and delivery. This could build on findings of previous studies (Stanley et al., 2003), and help to tailor interventions which can develop resilience factors for families facing mental health problems (Parrott et al., 2008; Social Care Institute for Excellence, 2009).

This study highlights that professional decision-making is a very human affair. Integrated work practices, based on reflective thinking, sound knowledge and good relationships can foster a culture where human error is minimised.

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References


