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Current Practices and Barriers of Family-focused Care of Patients with Severe Mental Illness and Their Children: A Survey Among Czech Psychologists and Psychiatrists

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Abstract

Background: Children of parents with mental illness are known to be at risk of developing mental illnesses due to hereditary and socio-economic factors. The family-focused practice in the treatment of adult patients with severe mental illness benefits patients and their children, and can help prevent mental health problems in children of parents with mental illness. Therefore, professionals caring for adult patients must contribute to the early identification of families at risk and initiate the necessary care.
Objective: This study aimed to determine the current practices of psychologists and psychiatrists in the Czech Republic—the extent to which they include parental issues and their patients' children in their treatment, how informed they are about the available support, their attitudes toward a family-focused practice, potential barriers to family-focused practice, and recommendations for improvements in care for children of parents with mental illness.
Methods: A structured online questionnaire completed by 193 professionals (51.8% psychiatrists, 48.2% psychologists) working with adults with severe mental illness in various healthcare settings.
Results: A large majority (95.9%) of respondents regularly asked about the parenting status of their patients and 75.1% had a positive attitude toward involving children more in treatment. Although most respondents were comfortable discussing parenting (91.2%), they only discussed parenting topics if the patients themselves brought them up. Minors were rarely invited to treatment (26.4%), usually on a one-off basis. Major barriers cited include a lack of set procedures for working with families, lack of coherence of services, lack of time, shortage of professionals to refer to, and perceived lack of training and experience.
Conclusion: Although most professionals know that their patients have children and believe that children of parents with mental illness are at risk of developing problems, they are hindered by a variety of organizational and systemic barriers in implementing the family-focused approach more frequently in practice. Subject to wider expert discourse, the findings may contribute to informed policy formulation.

Keywords: Children of parents with mental ilnness; mental health practitioners; parenting; child mental health prevention; family-focused practice; severe mental illness.

Introduction

Among patients being treated for severe mental illness (SMI), one-third are parents (1, 2). This is confirmed by data from the Czech Republic, where 35% of hospitalized patients of productive age were parents and 16% had a minor child at the time of hospitalization (3).

A parent's SMI affects the entire family, including children's physical and mental health. The negative effects that parent's SMI has on children are well-documented (4). Children of parents with mental illness (COPMI) are at increased risk of developing mental illness themselves due to hereditary factors, and this risk is further increased by stressful conditions such as financial strain, lower socio-economic status, symptoms of parental mental illness, more frequent hospitalizations of parents, additional 'adult' responsibilities for children, or stigmatization (5,6,7). The effects on children are summarized in a recent clinical review as the development of psychiatric issues, emotional difficulties, self-directed aggression, behavioral difficulties, cognitive dysfunctions, and problematic social outcomes (4). Family-focused practice (FFP) involves the patient's family in the

treatment process, aiming to support both the patient's recovery and the well-being of family members, especially children. Numerous studies show that FFP contributes to successful treatment, increases the family members' understanding of mental illness, facilitates communication among family members, and improves their attitude toward mental illness (8, 22, 23). Factors such as parenting style and family functioning mediate the negative impact on COPMI (4), and their accurate knowledge about parental mental illness serves as a buffer against potential risks and empowers them against misperceptions and self-blame (9, 10). Additionally, COPMI want to receive proper information about their parents' condition (5) and want to be seen as full-fledged members of the family, participate in the treatment, and deal with the illness together (9). Still, children's literacy about parental illness tends to be low, they have limited access to adequate, non-stigmatized information and they are unable to seek professional help themselves (11, 12).

Preventive family-focused intervention reduces the risk of mental illness in children (13, 14). Most studies on this topic come from Western countries, where more attention is paid to COPMI and intervention programs have begun to emerge (Australia, Norway, Denmark, The Netherlands, Portugal, USA, Canada). However, a recent study from India has also confirmed that psychoeducation and early involvement of the family in the patient's treatment were facilitating factors for seeking care, while barriers to help-seeking by mothers with SMI were the expected stigma, misinterpretation of information, and unavailability of healthcare providers (15).

The successful development and implementation of intervention programs requires the creation of specific, legislatively supported procedures leading to the systematic identification of at-risk groups, cooperation between care providers, availability of experts with the necessary professional competencies, and cultivation of the necessary motivation in professionals (16).

Current mental health practice still largely focuses only on the patient's treatment, with little consideration for the patient's home environment. For example, a European study found that only 2% of family members of patients with schizophrenia received some form of psychoeducation (17). In the UK, despite the mandatory requirement to ascertain parental status in patients, a quarter of mental health practitioners do not routinely ascertain whether their patients have children (18). Few countries have government policies setting mandatory requirements for identifying and supporting families with mental illness. Some of these nations include the UK, Sweden, Norway, Canada, Australia, and China (for more details see (19)). In the Czech Republic, current legislation does not mandate the identification of COPMI. Additionally, the Czech healthcare system operates with a division between adult and pediatric care, lacking a family-based general practitioner model that could address the needs of all family members comprehensively. Compared to countries such as the UK, Norway, or Australia, where policies explicitly mandate identification and support for COPMI, the Czech Republic lacks a systemic, policy-level framework. This absence of formal guidelines contributes to the invisibility of these children in routine mental health care. Furthermore, Czech mental health services are divided between the public and private sectors, often with limited communication or data-sharing between them. While the public sector provides care within state-funded facilities, private psychiatrists frequently operate independently. This fragmentation further complicates coordinated support for families and children. It seems that government policies are fundamental but not the only necessary condition to improve the care of COPMI. Zalewski et al. mention that in the case of treatment of adult patients with mental illness, there are no established standards of care and no guidelines to support the parenting role of patients or to identify and refer children to follow-up services (20).

A systematic literature review by Dolman et al. analyzed health professionals' attitudes toward mothers with SMI(21). The study extracted four main themes representing barriers to treatment: feelings of discomfort (anxiety and additional responsibility), stigma (difficulty viewing mothers with SMI as "good mothers"), need for education, and integration of services. Other papers focused on the most common barriers—the clinicians' theoretical orientation (therapeutical approach), the client–practitioner relationship, practitioner training, and competency, and the availability of mental health services for children and parents (20).

Mayberry and Reupert described the hierarchical barrier model which hinders the adult mental health workforce from becoming family-focused (22). According to them, there is "a large gulf between what psychiatric services could/should provide and what they do in practice" (22, s.784). Their suggested solutions are (1) organizational support at the baseline (2) workforce attitudes, skills, and knowledge, (3) client engagement, and (4) involvement of the patient's family, including children. A recent review from Gregg et al. states that perceptions of practitioners, their attitudes, perceived organizational support, and their skill and knowledge are more influential than service-based factors (such as work setting) (23).

From our previous research, we know that in the Czech Republic, there is a good level of awareness

regarding the parental status of hospitalized psychiatric patients, specifically, information on parenthood itself was available in 99.7% of cases in medical records (3).

However, to our knowledge, there is still no data in the Czech Republic on how and whether professionals work with the whole family system in practice, whether they inform children about the patient's illness, whether they include children in their care, and how they perceive the involvement of children in the treatment of adults with SMI. This study is the first to seek answers to these questions and examine the status of COPMI care in the Czech Republic. Finding answers to these questions can shed light on the experiences of practitioners and help create a foundation for supportive programs for COPMI in the Czech Republic. In doing so, the study also contributes to the groundwork needed for implementing family-focused practice in a way that reflects the local context. In addition, it can help create recommendations to improve the system of care for COPMI, stimulate additional research on this topic, and lead to comparison with foreign studies.

Therefore, we formulated the following research questions:

1) What are the current practices among Czech mental health professionals regarding the identification and involvement of minors in the treatment of patients with SMI?

2) What attitudes do Czech mental health professionals hold toward including children in the treatment of parents with SMI?

3) What barriers do Czech mental health professionals perceive when attempting to engage children in the treatment of their parents with SMI?

4) What recommendations do professionals suggest to improve the practice of identifying and supporting COPMI in the Czech context?

Method

A questionnaire survey was conducted online among psychiatrists and psychologists working in healthcare facilities throughout the Czech Republic. The questionnaire was completed anonymously via the Limesurvey platform. We defined SMI based on the ICD-10 diagnoses as reported in other studies (e.g., 7). Thus, in this study, SMI refers to schizophrenia disorder (F2), periodic depressive disorder (F33), and bipolar affective disorder (F31). Other diagnoses were excluded due to the study's focus on parents with SMI only.

Ethics

This study was conducted after obtaining approval from the ethics committees of Masaryk University (EKV-2021-108). The survey was anonymous, and respondents were informed about the study, privacy, and terms at the beginning of the survey. The respondents filled out the questionnaire after providing informed consent.

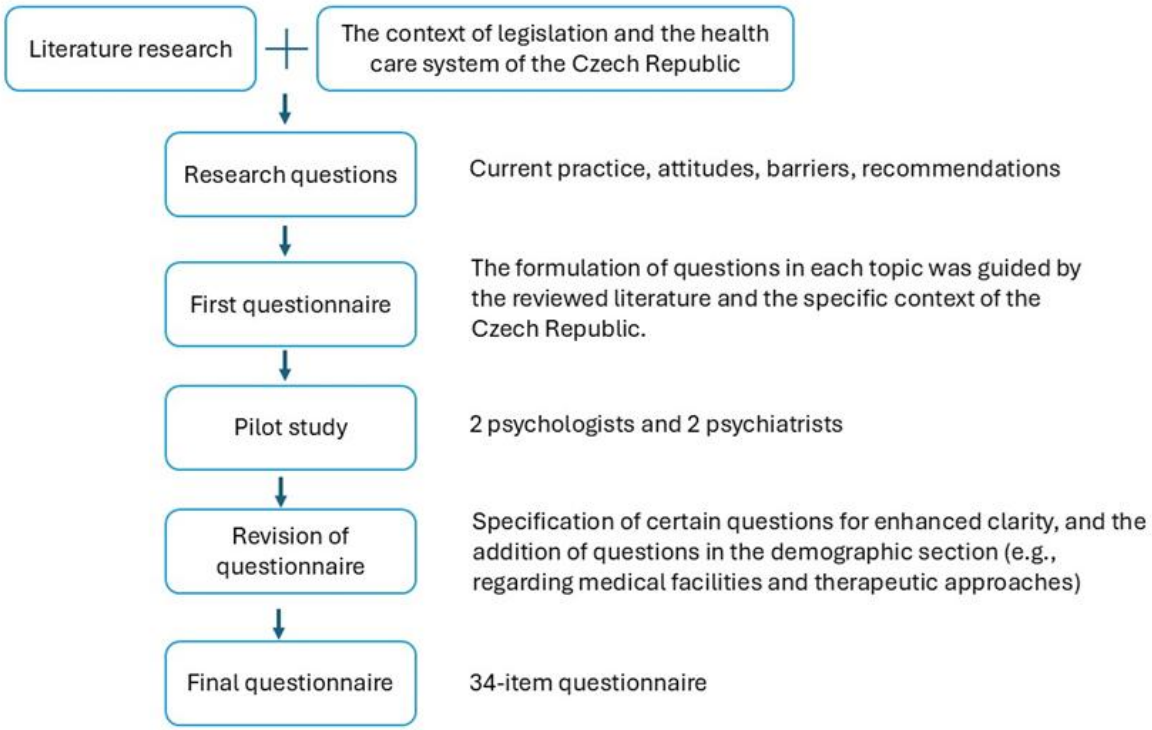

FIGURE 1: Process of development of the questionnaire.

Instrument Creation

We created a study questionnaire to capture the specific context of the Czech healthcare system. The development of the questionnaire followed a multi-step process (see Figure 1).

First, relevant literature was reviewed, including studies on family-focused practices and existing research on the attitudes and barriers experienced by mental health professionals working with adult patients (21–26). Inspiration was taken from the Family-Focused Mental Health Practice Questionnaire (27). We also considered the legal and institutional specifics of the Czech healthcare system, including the structure of training and specialization.

Second, we formulated an initial set of items covering five thematic areas: demographic and work characteristics, current practice, personal attitudes, perceived barriers (professional, systemic, and organizational), and recommendations for practice.

Third, the 31-item version of the questionnaire was reviewed by the research team and pilot-tested with four mental health professionals (two psychologists and two psychiatrists) from different clinical backgrounds.

Fourth, based on the pilot feedback, several items were revised for clarity and three new questions were added to the demographic section. This resulted in the final 34-item version of the questionnaire, which included both factual items (e.g., demographic and work-related characteristics) and multi-statement scales targeting attitudes, perceived barriers, and recommended practices.

Different types of response formats were used depending on the character of the information being collected. This choice was informed by existing literature and aimed at ensuring that both subjective attitudes and objective characteristics could be appropriately captured. A detailed description of the specific response formats is provided below. The number of questions associated with each thematic area is summarized in Table 1. However, only a subset of items relevant to the study aims is reported and analyzed in this paper.

Questionnaire Content

For the questionnaire topics, see Table 1.

Most questions in the demographic and work characteristics section used fixed-response formats such as multiple choice or categorical options. The current practice section included questions about frequency, and the answer options were: Always (in 75-100% of cases), Often (in 50-75% of cases), Sometimes (25-50%), Rarely (5-25%), and Never (0% of cases). One question was in the multiple choice format ("Which family member do you discuss your patient's illness with?"). The section of personal attitudes and perceived barriers contained 21 items with five-point Likert-type questions (1 – agree, 2 – rather agree, 3 – neither agree nor disagree, 4 – rather disagree, 5 – disagree). One question was in a yes-no format ("Would you like to see a change in the legislation framework according to the Norwegian model?") and one in multiple-choice format ("Why has the child not been invited to a joint meeting with you?"). The recommendation for practice section had five-point Likert-type questions and multiple-choice questions.

Data collection

Based on the National Register of Health Service Providers, we contacted via email all healthcare facilities that provide psychiatric or clinical psychological care to adult patients with mental disorders (this included representatives from large psychiatric hospitals as well as small outpatient clinics or individuals). A total of 1100 medical institutions and private practices were sent a request to participate in the study during February 2023. The follow-up set of requests to increase the respond rate was sent in the 1st week in April 2023, and the data collection ended on April 21, 2023.

Data analyses

Quantitative data were analyzed using SPSS 27 software with descriptive statistics.

We conducted exploratory factor analysis (EFA) to examine the underlying structure of the questionnaire and to assess whether the data supported the theoretically proposed thematic groupings. The initial item allocation was based on prior literature and conceptual considerations and was refined based on the EFA results.

Specifically, EFA was conducted on a subset of 21 items related to attitudes and perceived barriers in order to identify underlying dimensions within the data. Since no standardized instrument was available in the Czech context, EFA was selected as an appropriate method for uncovering latent constructs based on participants' responses. Prior to conducting EFA, the suitability of the data was assessed using the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy and Bartlett's test of sphericity. EFA was conducted using Principal Component Analysis (PCA) with Varimax rotation (Kaiser normalization). Six components with eigenvalues above 1.0 were extracted, and factor retention was guided by the scree plot and interpretability. However, the sixth component was weakly defined and lacked theoretical interpretability; thus, the final solution retained five components that were both statistically robust and conceptually meaningful. Factor loadings

TABLE 1. Questionnaire topics

Topic	Content	Item example	Number of questions
Demographic and work characteristics	Gender, age, profession, type of medical facility (in-patient, outpatient…), length of experience, psychotherapeutic education, parenthood	In what type of facility do you work with patients with SMI? Are you a parent?	10
Current practice	Routines of identification of parental status, frequency, and ways of instructing adult patients on how to educate children about SMI, involvement of family members in the treatment, professional awareness of available services, and materials.	In the following questions, think of your typical practice and select the most suitable option on the following scale: Always – 75 – 100 % of cases Often – 50 – 75 % of cases Sometimes – 25 – 50 % of cases Rarely – 5 – 25 % of cases Never – 0 % of cases - How often do you purposefully ask your clients with SMI if they have children?	11
Personal attitudes	Attitudes toward the involvement of minor children in treatment, discussing parenting in adult patient's treatment, the ability to practice a family-oriented approach, family-focused policy	What do you think of involving minor children in the treatment? (5-point Lickert scale agree/disagree) - It's helpful. - It's not appropriate for a child. - It's not appropriate for the patient. - It can prevent the development of problems in the child. - This increases the likelihood of improvement in the patient's condition.	3
Perceived professional, systemic and organizational barriers	Skills and knowledge, concerns about a therapeutic alliance, insecurity, reasons to not invite a child into parent´s treatment, systemic and organisational barriers	What are the barriers to involving minor children in your work with a client? (5-point Lickert scale agree/disagree) - I don't have enough experience to involve children. - I don't have the appropriate training to involve children. - If I involve a patient's child in my practice, I would be assuming too much responsibility, as it is beyond my role. - I feel uncertain about working with my patients' children. - Involving children is outside my area of expertise.	7
Recommendations for practice	Improvement recommendations for provision of support/professional support to COPMI	Select the level to which you agree with the following statements. (5-point Lickert scale agree/disagree) - The current system is adequate regarding care of psychiatric patient's children - I would welcome better support for children of parents with SMI	3

of ≥ .40 were considered significant, and items with high cross-loadings were reviewed for possible exclusion. The five retained components explained 63.0% of the total variance and reflected a coherent factor structure aligned with the underlying constructs of attitudes and perceived barriers related to discussing parenting in mental health care.

The components were labeled based on the thematic content of the highest-loading items, informed by both statistical outcomes and theoretical relevance. Two components captured attitudes and beliefs (Awareness of the negative impact of SMI on children and Workforce attitudes regarding involving children), while three reflected perceived barriers (Fear of losing rapport, Feeling incompetent to work with children, and Feeling confident in parenting topics). The use of Varimax rotation, which assumes orthogonal (i.e., uncorrelated) factors, was supported by both the statistical results and the theoretical distinctiveness of the identified dimensions.

Nonparametric tests, specifically the Mann-Whitney U tests, were used to detect differences in attitudes between respondents based on professional role and parental status, as the data were primarily ordinal (e.g., Likert-type scales) and did not meet the assumptions required for parametric tests (such as normal distribution). We approached the investigation of differences based on respondents' professional roles and parental status drawing on insights from previous international studies (e.g. 18, 22). Due to the limited sample size, however, we refrained from conducting more granular analyses, such as those segmented by therapeutic approach. Where no statistically significant difference was found, we chose not to include detailed statistical results in the text to maintain readability and focus on the main findings.

In the tables, means and standard deviations were reported to summarize the central tendency and variability of responses, which facilitated concise comparison across groups. In contrast, percentages for selected items were presented in the text to provide a more intuitive and accessible summary of key findings. While we acknowledged that Likert-type responses are ordinal, reporting means and SDs is a common practice in survey research and offers a compact way to convey group-level trends.

Participants

A total of 193 individuals responded and completed the questionnaire, of whom 51.8% were psychiatrists and 48.2% were psychologists. Most respondents were women (75.1%), and 77.2% were parents. The mean age of respondents was 47.5 years (SD = 11.4) and varied from 25 to 77 years. Detailed demographic information is seen in Table 2.

TABLE 2. Descriptive statistics of demographic variables (N = 193)

	N	(% of the sample)
Gender		
Female	145	(75.1)
Male	48	(24.9)
Profession		
Psychiatrist	100	(51.8)
Clinical psychologist	73	(37.8)
Psychologist in healthcare	20	(10.4)
Age category (years)		
<30	14	(7.3)
31-40	40	(20.7)
41-50	72	(37.3)
51-60	42	(21.8)
>60	25	(13.0)
Type of medical facility		
Inpatient psychiatry	49	(25.4)
Outpatient psychiatry	57	(29.5)
Outpatient Clinical Psychology	56	(29.0)
Private practice	18	(9.3)
Other (mental health centres, day-care centres, employed in several facilities)	13	(6.8)
Years of experience (years)		
0-5	15	(7.8)
5-10	27	(14.0)
10-20	47	(24.4)
20 and more	104	(53.9)
Psychotherapeutic training		
Yes	160	(82.9)
No	33	(17.1)
Parenthood		
Parent	149	(77.2)
Non parent	44	(22.8)

Results

The findings are presented in four thematic areas corresponding to the structure of the questionnaire: current practice, personal attitudes, perceived professional, systemic and organizational barriers, and recommendations for practice.

1. Current practice

This section presents findings on how professionals typically identify parental status, communicate with patients about their children, and involve family members in the treatment process. These areas were assessed through five questions, comprising a total of seven items used in the analysis.

Routines of identification parental status

The majority (95.9%) of respondents specifically asked ("always" or "often") most of their patients if they had children. More than half of the respondents (57.5%) stated that their patients have brought the

topic of parenting into treatment ("always" or "often"); by contrast, 12.4% of respondents reported that patients do not bring up the parenting topic ("rarely" or "never").
One third of respondents (36.3%) reported that they "always" or "often" informed their adult patients on how to talk with their children about their SMI, while another third (38.3%) did so only "sometimes".

Involvement of family members in treatment
The majority of respondents discussed the patient's illness with the patient's partner (71.5%), adult offspring (69.4%), and other relatives (parents, siblings) (66.3%). In addition, 15.0% of respondents discussed the parental illness with minor children. However, 16.1% of respondents did not include any other family members and worked solely with the patients.
A quarter of respondents (26.4%) had invited a minor child to a joint consultation at least once. However, this was mostly a one-time visit (74.5%). Regarding how often respondents offered joint meetings with children, 67.8% invited children rarely, 33.3% invited them sometimes, and one respondent always invited children.

2. Personal attitudes
The results of two subscales derived from the exploratory factor analysis (Awareness of the negative impact of SMI and Workforce attitude regarding involving children) and an additional question on policy improvement are presented here.
Awareness of the negative impact of SMI
When presented with the statement that SMI always negatively affects the child, 57,0% of respondents agreed and 22.8% marked the neutral option "neither agree nor disagree" (for mean agreement levels, see Table 3). Moreover, 87,0% of respondents considered COPMI at increased risk for developing psychological difficulties. There was no significant difference in awareness of the negative impact on the child between psychiatrists and psychologists and between parents and non-parents.

Workforce attitude regarding involving children in the parent's treatment
The subscale Workforce attitude regarding involving children consisted of 7 items, and descriptive statistics (means and SDs) are provided in Table 3. Respondents answered a question about their views on involving minor children in the treatment of an adult patient. Overall, 75.1% of respondents (agree or rather agree) considered children's involvement as helpful for both the child and the patient, 24.9% considered it inappropriate for the child, and 10.4% responded it could be detrimental to the patient. Additionally, 19.2% of respondents indicated that they did not consider children mature enough to be involved in adult treatment. No significant differences in attitudes were found between psychiatrists and psychologists, or between respondents who were parents and those who were not.

Policy improvement
More than half of the respondents (58.5%) answered 'yes' to the question of whether they would like to see a change in the legislation framework according to the Norwegian model, wherein clinicians have a legal duty to inform their patients' minor children about their parents' situation and to offer follow-up services (28).

3. Perceived professional, systemic and organizational barriers
3.1. Professionals' barriers to addressing parental issues and engaging minors in treatment
This subsection includes three subscales based on exploratory factor analysis (Feeling confident in parenting topics, Fear of losing rapport, and Feeling incompetent in working with children), as well as one additional item related to the reasons for not inviting children to a joint session.

TABLE 3. Attitude subscales (1 - agree to 5 - disagree)

	Mean	SD
Subscale *Awareness of the negative impact of SMI (Cronbach's alfa = 0.67)*		
Serious mental illness of a parent always has negative psychosocial effects on children	2.41	1.10
Minor children of parents with SMI are at increased risk of developing psychological or other difficulties	1.80	0.81
Subscale *Workforce attitude regarding involving children (Cronbach's alfa = 0.84)*		
It's helpful.	1.93	0.92
It's not appropriate for a child.	3.88	1.17
It's not appropriate for the patient.	3.80	1.02
It can prevent the development of problems in the child.	2.44	1.01
This increases the likelihood of improvement in the patient's condition.	2.33	0.88
Involving children could impair the patient's condition.	3.88	0.88
I don't work with my patients' children because they're not mature enough.	3.56	1.77

TABLE 4. Barriers subscales (1 - agree to 5 - disagree)

	Mean	SD
Subscale *Feeling confident (Cronbach's alfa = 0.75)*		
I can assess how my patients can provide day-to-day care for children.	2.16	0.86
I can counsel patients on how they can talk to their children about SMI.	1.83	0.84
I can discuss the topic of parenting with patients easily.	1.41	0.71
Subscale *Fear of losing rapport (Cronbach's alfa = 0.67)*		
I don't bring up parenting issues because it interferes with the therapeutic relationship.	4.39	0.78
Dealing with parental issues would place an additional and excessive burden on the patient.	4.09	0.87
There is not enough time for parenting issues in the session.	3.97	1.15
Involving children could impair the therapeutic rapport with the patient	3.72	1.03
Subscale *Feeling incompetent to work with children (Cronbach's alfa = 0.86)*		
I don't have enough experience to involve children.	2.58	1.37
I don't have the appropriate training to involve children.	3.10	1.33
If I involve a patient's child in my practice, I would be assuming too much responsibility, as it is beyond my role.	3.19	1.93
I feel uncertain about working with my patients' children.	3.32	1.27
Involving children is outside my area of expertise.	3.58	1.29

Feeling confident in parenting topics.

The Feeling confident subscale included three items and focused on professionals' perceived competence in addressing parenting issues (see Table 4 for the corresponding means and SDs). Here, 72.0% of respondents reported (agree or rather agree) that they were able to assess their patients' day-to-day parenting care. Confidence in counselling on how to communicate mental health issues with children was reported by 83.4% of respondents, and 91.2% were comfortable discussing parenting. In addition, 64.8% of respondents stated that they only addressed parenting issues if the patient brought it up.

No differences were found between psychiatrists and psychologists on this scale. Respondents who were parents felt significantly more confident in discussing parenting topics than non-parents ($U=2228$; $z=-3.23$; $p=0.001$).

Fear of losing rapport.

The subscale, Fear of losing rapport, consisted of four items (see Table 4) and focused mainly on the barriers to addressing parental issues when treating patients. Most respondents (75,6%) did not report (disagree or rather disagree) that raising parenting issues would interfere with the therapeutic relationship. A quarter (24.4%) stated (agree or rather agree) that dealing with parental issues would place an additional and excessive burden on the patient. Only 14.5% of respondents reported (agree or rather agree) that there was not sufficient time to deal with parenting issues in the session. Psychiatrists were significantly more likely ($U=5904$; $z=3.43$; $p<0.001$) to perceive a lack of time to deal with parenting issues than were psychologists. The involvement of children was perceived (agree or rather agree) by 14% of respondents as disrupting the therapeutic relationship with the patient. There was no significant difference between parents and non-parents in this scale.

Feeling incompetent to work with children.

This subscale had five items, and the overall tendencies are summarized by the means and SDs in Table 4. Respondents answered the question What barriers do you perceive in involving minor children in your work with patients?

Lack of experience was reported (agree or rather agree) by 49.2% of respondents and lack of training

TABLE 5. Why has the child not been invited to a joint meeting with you? (N=142; multiple choice)

	N	%
It is not my area of expertise.	51	35.9%
I had not thought of that.	41	28.9%
The parents disagreed with my suggestion to bring the child in for counselling.	27	19.0%
I am not trained/educated/competent to work with children.	26	18.3%
I do not consider it appropriate.	22	15.5%
I do not have the time capacity for this.	20	14.1%
Due to policies of the organization (workplace).	16	11.3%
I am referring the child to a child specialist.	10	7.0%
There was no reason/possibility/opportunity.	10	7.0%
The initiative should come from the patient.	9	6.3%
The child was too young/the offspring was an adult.	5	3.5%

by 36.8%. Involving children in treatment was perceived by 32% of respondents as too much responsibility beyond their competence and 30.6% (agree or rather agree) expressed uncertainty about working with children. Finally, 22.8% of respondents stated that involving children was outside their area of expertise.

Psychiatrists percieved themselves as significantly less competent to involve children than psychologists (U=3603; z=-2.70; p=0.007). Respondents who were parents perceived themselves as more competent to involve children than non-parents (U=2580; z=-2.14; p=0.032).

Barriers to clinicians inviting children to joint sessions.
Of all respondents, 73.6% (n=142) never invited a patient's minor child for consultation. We asked them about the reasons through multiple-choice question. Table 5 provides an overview of why respondents did not invite minors.

3.2. Organizational and systemic barriers

This subsection focuses on organizational and systemic obstacles to involving children in care. It includes Likert-scale responses regarding workplace-related barriers and professionals' views on broader shortcomings of the current system, as identified in a multiple-choice question.

Respondents answered the question "What barriers prevent you from involving children in treating your patients?" and selected options on a 5-point Likert scale. (see Table 6 for descriptive statistics).

According to 43% of the respondents (who agreed or rather agreed), the reimbursement of these services by health insurance companies is problematic, and 54.9% agreed (or rather agreed) with statement that they did not have enough time to involve children. Although the majority of respondents reported there was no problem with the physical space at their facility (only 30.6% of respondents cited lack of space as an issue), the bigger issue was the lack of appropriate procedures for working with families (58.5%).

Respondents were asked what they perceived as the shortcomings of the current system of care for minor children of their patients (multiple-choice question). Most respondents perceived a shortage of professionals in the Czech Republic (80% respondents), a lack of liaison between child and adult mental health care (72%), and no services available to refer COPMI (71%). The mental health care system is underfunded according to 59.6% of respondents, and almost half the respondents considered the lack of liaison between inpatient and outpatient services (45.1%) and between health and social services (44.6%) as barriers.

4. Recommendations for practice

This section summarizes how professionals assess the current system of care for COPMI, what interventions they consider helpful, and whether they would welcome support in addressing this topic in their practice. These aspects were assessed using three Likert-type items and one multiple-choice question.

The majority of respondents (82% who agreed or rather agreed) reported that the current system of care for COPMI is inadequate and 87% (agreed or rather agreed) would welcome increased support for their work in this area.

We also asked what interventions, according to the respondents, could improve the support for COPMI (multiple-choice question). The establishment of support groups and intervention programs in social services was suggested by 81.5%, and within the healthcare system by 78.3%. Three-quarters of respondents supported including the topic in professional education (75.1%), along with greater availability of educational materials for patients and their children (75.7%). More frequent involvement of children in clinical-psychological or psychiatric care was reported by 47.1% of respondents.

Finally, 72% of respondents (agree or rather agree) indicated that they would welcome better support for themselves—from organizations, education, or the system—when working with children or addressing parenthood-related topics.

Discussion

The presented study describes the current state of practice among Czech psychiatrists and psychologists regarding the involvement of minors in the care of adult patients with SMI. It was found that only a small number of the respondents work with the children of their patients, and although they are aware of the risks to the children of their patients and generally hold positive attitudes towards involving children in care, they are frequently hindered by a range of barriers.

TABLE 6. Organizational and systematic barriers in involving children (1 - agree to 5 - disagree)

	Mean	SD
Operational factors at my facility do not allow involving children in treatment.	3.22	1.46
Reimbursement of these services from insurance companies is problematic	2.89	1.48
Insufficient time for inviting children.	2.64	1.29
Insufficient physical space to work with the family.	3,49	1.39
Lack of appropriate programs and procedures for working with families.	2.62	1.37

Current practice in the identification and communication of parental issues

In this study, almost all respondents reported that they regularly asked whether their patients have children. These findings are consistent with the results of our previous study based on medical records related to the identification of parental status in patients with SMI (3). The results from the Czech Republic indicate relatively good practice in identifying minors (95.9% of professionals routinely inquire), which is notably more frequent than that reported in international studies. The results of parental status identification vary in the international literature, for example, in a UK audit of 100 adult mental health cases, 62 were asked if they had dependent children, whereas, in more recent research, three-quarters of professionals were routinely asked if the service user had children (29, 18). Similarly, a Norwegian study reported that 56% of health professionals did not identify patients' minor children, and a five-year follow-up study in the same clinic found that 28% of health professionals did not identify patients' minor children (30).

However, asking about parental status does not imply that patients are asked about their needs and specifics in practice. For example, among multidisciplinary adult mental health practitioners in the UK, less than half of the professionals routinely ask patients about the quality of their relationship with their children (39.6%) or whether their children have emotional or behavioral difficulties (29.5%) (18). In the current study, more than half the respondents said that the topic of parenting was raised by patients during sessions, while 12.4% said that patients did not discuss it with them. It would be interesting to explore in more detail the barriers that patients face when not discussing parenting with professionals. If parents themselves were able to explain their illness to their children, it would help prevent negative effects on children (45). However, patients usually do not have the same awareness of the negative impact of the illness on their children, may lack communication skills, fear that the information will jeopardize their relationship with their child or take away their ability to care for their child (31), and sometimes have mixed feelings about receiving support with parenting (32). Therefore, it is the professionals who must educate patients and children about the implications and raise the issue with patients. In this study, three-quarters of respondents had advised parents on how to communicate with their children, felt fairly confident (83.4%) in advising on how to talk to patients' children, and were comfortable (91.2%) in discussing parenting (parents were more confident than non-parents). Lack of time for parenting topics was reported by only 14.5% of respondents (psychiatrists more often than psychologists). They also do not think that the topic of parenting would disrupt the therapeutic alliance. We hypothesize that the greater certainty in parenting themes is related to the fact that professionals identify parenting conventionally, and perhaps see parenting topics as part of the patient's treatment, but usually only when the topic is raised by the patients themselves (65% discuss parenting after patients bring it up) – same as reported by other studies (33, 34, 35).

Attitudes and their discrepancy with current practice

The majority of respondents believed that COPMI are at increased risk of developing mental health problems and more than half believed that a parent's SMI will always negatively affect the child. Three-quarters of respondents believed that involving children in care can be helpful, in contrast to a quarter who considered it inappropriate. This puts our findings in line with other studies where professionals have had generally positive attitudes toward the involvement of children in the treatment of adult patients (35, 36).

However, positive attitudes toward involving children in treatment are at odds with current practices. In this study, although respondents felt fairly confident about working on parenting issues with patients themselves and felt there was sufficient time in sessions to do so, they felt less confident about working directly with children (only 48.2% felt confident) and only a quarter of respondents had ever invited a child into a session. Yet only 14% of respondents felt that the potential inclusion of a child would disrupt the therapeutic relationship with the patient. This discrepancy may be related to structural and personal barriers, such as limited training in child-focused methods, uncertainty about appropriate ways to involve children, or a lack of institutional emphasis on family-focused practice. This trend is also evident abroad: research in Finland found that although nurses regularly collected information about clients' children, most nurses did not regularly meet those children (37). In a Norwegian study, 5 out of 9 therapists from a psychiatric clinic invited the children, citing uncertainty, fear of increased workload, or more complex treatment as reasons for less involvement (38). In this study, the most common reasons for never having invited a child to a joint session were: outside area of expertise (35%), not thought of it (28.9%), patients do not want it (19%), lack of training (18.3%), and finding it inappropriate (15.5%). According to Haukø and Stamnes, it appears socially unacceptable for therapists treating adults to investigate children's circumstances during treatment, as adult psychiatric care is primarily focused on the individual patient's mental health (38).

However, supportive interventions for families are limited when children are removed from adult care (37). In addition, we know that children want to be included in the care themselves and want to be informed about their parent's treatment (39). Maybery and Reupert state that although professionals find the inclusion of children in care useful, these same professionals also assume limits in skill and knowledge (22). In this study, professionals perceived a lack of experience in working with children, a lack of appropriate procedures for working with families, a lack of time, inadequate financial compensation from health insurance companies, a lack of training, and taking on too much responsibility.

Barriers and experts' suggestions for improvement

Mayberry and Reupert, in their hierarchical model of barriers, rank organizational support, such as policies focused on family and child screening, assessment guidelines, and protocols, at the very base (22). More than half of the respondents in this study would welcome a change in legislation to allow greater involvement of children, which would set the foundation for systemic change in our country. Gregg et al. conclude that perceptions of practitioners, personal attitudes, perceived organizational support, and skill and knowledge are more influential than service-based factors (23). From the available data, we cannot draw conclusions about which barriers are more influential; what we ultimately find important anyway is the need to influence both personal (skill and knowledge, etc.) and organizational (policy settings, legislation, reimbursement from insurance companies) barriers at the same time, because in both cases professionals perceived a limitation to providing more care to COPMI.

Concerning experience in working with children, the training of psychiatrists and clinical psychologists in the Czech Republic is differentiated (child certification is a superstructure after clinical psychology and specialization in psychiatry), which results in a very demanding training and contributes to a shortage of professionals in this area. A shortage of professionals was perceived as a problem by 80% of respondents, and 71% recommended greater coherence between child-oriented and adult-oriented services. Similar systemic barriers have been described in other countries as well. For example, studies from Norway and Australia have reported that the lack of formal procedures, insufficient collaboration between adult and child services, and time constraints are common obstacles in addressing the needs of COPMI (22, 24). In the Czech Republic, the reported lack of referral options and perceived shortage of specialists may reflect the demanding qualification requirements for professionals working with children and families, which can limit workforce capacity. These international comparisons support the relevance of our findings and highlight areas where organizational improvements and resource allocation may be needed. In this context, the fact that only half of the respondents said they felt inadequately experienced to work with children still appears to be a fairly promising result. Psychiatrists and non-parents rated themselves as significantly less competent in involving children to patients' treatment compared to psychologists and parent respondents. Some studies confirm that professionals are not taught about family-focused themes in their curriculum (37, 40). In this study, three-quarters of professionals expressed a desire to see the topic included in professional training and would welcome endorsement for themselves. Previous research shows that family/child training has a positive impact on family-focused practice; professionals who have received family training are more likely to access parents' awareness of their children's well-being and more likely to gather information about patients' children (23). Although COPMI care is still at a nascent stage in our country, some programs are already available, such as Child Talks + (41) or the translated manuals by Solantaus (42, 43). A structured interview guide entitled "Let's talk about children" can help professionals with more precise and systematic identification of children's needs (44).

Limitations

Our study has certain limitations. First, relying on diagnostic criteria, such as those from the ICD-10, can be limiting, as there are alternative definitions of SMI that may consider factors beyond symptomatology, such as functional impairment or other criteria. In this study, we define SMI based on the ICD-10 diagnosis rather than functional criteria, as this diagnostic system is more commonly used in mental health settings in the Czech Republic. One limitation of the study is the inability to determine the exact percentage of respondents who consented to participate. This is due to the data collection method, which involved approaching both individuals and entire facilities, where the total number of individuals approached was beyond our control. Another study limitation was the use of exploratory factor analysis (EFA), which inherently involves a degree of subjectivity—particularly in decisions about the number of factors to retain, where the risk of under- or over-extraction cannot be entirely ruled out. Another of the constraints of this study was the relatively small sample size, which did not allow for more detailed statistical analyses (e.g., between different types of workplaces). As such, the findings should be interpreted as exploratory and indicative, rather than

broadly generalizable. Selection bias may have occured due to the self-selection of participants, as professionals with more positive attitudes toward working with families or a greater interest in the topic may have been more likely to participate. In addition, as with all self-report data, socially desirable responding cannot be ruled out, although the fully anonymous nature of the questionnaire may have helped reduce this risk. Despite efforts to reach professionals across various settings and roles, access to the survey may have varied. Individuals contacted directly might have had a higher motivation to respond than those invited through institutional channels. These factors could have contributed to an overrepresentation of more engaged professionals, which may further limit the generalizability of the findings.

The use of a non-standardized questionnaire may also be a limitation, but in our setting, there was no standardized instrument available to measure the attitudes of professionals. Therefore, the results cannot be quantitatively compared with other studies. One limitation of the present study is that it did not explore potential interconnections between the identified barriers. Future research could benefit from examining how these factors may influence each other.

Recommendations for future research and practice

This research provides the first step for follow-up studies focused on mapping the needs of families with a member with SMI in detail and from the perspectives of families themselves. Based on our findings, we offer suggestions that could help improve COPMI care. First, it is important to spread awareness among professionals not only about the risk factors for COPMI but also about the possibilities of support for the families. This could be done through a comprehensive publication or brochure providing an overview of available support options, not just educational materials for families, but also a summary of organizations providing intervention and support programs. It would be appropriate to encourage and increase awareness of existing intervention programs and develop comprehensive recommendations and working practices for professionals wishing to increase the involvement of their patients' children in their practice. A change in policy and the inclusion of the issue in the curriculum of professional training could be adopted as a long-term goal for the future.

Strenghts of the study

This study is the first to examine how mental health professionals working with adult patients with SMI in the Czech Republic address the topic of their patients' minor children. It provides novel insight into clinical practices, perceived barriers, and professional attitudes in a context that has previously received little empirical attention. The questionnaire was developed based on international research and tailored to the Czech healthcare system. It covered a broad range of areas including current practice, perceived barriers, and recommendations, and was pilot-tested with professionals from diverse clinical backgrounds. As such, the study offers a structured and contextually grounded contribution to the international body of research on COPMI-related care.

Clinical significance

The significance of the study lies in the fact that it brings attention to the personal, training-related, and systemic barriers faced by mental health professionals in providing care to COPMI. Given that this is the first study on COPMI care in the Czech Republic, it may provide valuable insight into the issue and make room for further follow-up studies. The results can complement international research on this topic and provide a general comparison between countries, which can be valuable for mutual enrichment. In addition, the study could help stimulate a discussion among professionals on this subject and broaden the perspective on the care of SMI patients and their children.

Conclusion

Although most respondents are aware that their patients have children and recognize the potential risks for offspring of parents with SMI, they are hindered by various organizational and systemic barriers that limit the more frequent implementation of a family-focused approach. The majority of experts consider the current system of care for COPMI inadequate. Over half of the respondents would welcome legislative changes, and most advocate for more intervention programs and accessible support not only for COPMI and their parents but also for professionals working in this area. It is not enough to rely on the goodwill and isolated efforts of individual professionals. Without systemic change and stronger emphasis on professional education and training, the needs of these vulnerable children and their families will remain unmet. The findings of the study can inform the design of targeted interventions. Future programs should address not only the needs of families, but also equip professionals with the tools and support necessary to implement family-focused care more effectively. Further qualitative research involving both professionals and families is needed to deepen understanding and guide the development of effective, responsive interventions.

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Conflicts of interest

The authors declare no conflicts of interest.

References

1. Benders-Hadi N, Barber M, Alexander MJ. Motherhood in women with serious mental illness. Psychiatr Q 2013;84(1):65–72. https://doi.org/10.1007/s11126-012-9227-1

2. Howe D, Batchelor S, Bochynska K. Prevalence of parents within an adult mental health service: Census results 2008-2011. Australas Psychiatry 2012;20(5):413–418. https://doi.org/10.1177/1039856212 459583

3. Havelková A, Havelka D, Bartošová KK. Prevalence of parenthood among hospitalized adult patients with severe mental illness: a quantitative data analysis. Frontiers in Psychiatry 2024;15:1-9. https://dx.doi.org/10.3389/fpsyt.2024.1386842

4. Argent, SE, Kalebic N, Rice F, Taylor P. Offspring outcomes when a parent experiences one or more major psychiatric disorder(s): A clinical review. Evidence-Based Mental Health 2020;23(3):113–121. https://doi.org/10.1136/ebmental-2019-3001234

5. Gladstone BM, Boydell KM, Seeman MV, Mckeever PD. Children's experiences of parental mental illness: a literature review. Early Interv Psychiatry 2011;5(4):271–289. https://doi.org/10.1111/j.1751-7893.2011.00287.

6. Pierce M, Hope HF, Kolade A, Gellatly J, Osam CS, Perchard R, Kosidou K, Dalman C, Morgan V, Di Prinzio P, Abel KM. Effects of parental mental illness on children's physical health: Systematic review and meta-analysis. Br J Psychiatry 2020;217(1):354–363. Cambridge University Press. https://doi.org/10.1192/bjp.2019.216

7. Rasic D, Hajek T, Alda M, Uher R. Risk of mental illness in offspring of parents with schizophrenia, bipolar disorder, and major depressive disorder: a meta-analysis of family high-risk studies. Schizophr Bull 2014;40(1):28–38. https://doi.org/10.1093/schbul/sbt114

8. Foster K, O'Brien L, Korhonen T. Developing resilient children and families when parents have mental illness: a family-focused approach. Int J Ment Health Nurs 2012;21(1):3–11. https://doi.org/10.1111/j.1447-0349.2011.00754.x

9. Grove C, Reupert A, Maybery D. Gaining knowledge about parental mental illness: how does it empower children? Child Fam Soc Work 2015;20(4):377–386. https://doi.org/10.1111/cfs.12086

10. Riebschleger J, Tableman B, Rudder D, Onaga E, Whalen P. Early outcomes of a pilot psychoeducation group intervention for children of a parent with a psychiatric illness. Psychiatr Rehabil J 2009;33(2):133–141. https://doi.org/10.2975/33.2.2009.133.141

11. Bilsborrow S, Lynsey S, Nikki, Tracey, Peter, Alan. What we want from mental health professionals: "telling it like it is." In Parental Psychiatric Disorder 2015 (pp. 16–19). Cambridge University Press. https://doi.org/10.1017/CBO9781107707559.003

12. Grove C, Riebschleger J, Bosch A, Cavanaugh D, van der Ende PC. Expert views of children's knowledge needs regarding parental mental illness. Child Youth Serv Rev 2017;79:249–255. https://doi.org/10.1016/j.childyouth.2017.06.026

13. Beardslee WR, Wright EJ, Gladstone TRG, Forbes P. Long-term effects from a randomized trial of two public health preventive interventions for parental depression. J Fam Psychol 2007;21(4):703–713. https://doi.org/10.1037/0893-3200.21.4.703

14. Siegenthaler, E, Munder, T, Egger, M. Effect of preventive interventions in mentally ill parents on the mental health of the offspring: Systematic review and meta-analysis. J Am Acad Child Adolesc Psychiatry 2012;51(1), 8-17.e8. https://doi.org/10.1016/j.jaac.2011.10.018

15. Banerjee D, Arasappa R, Chandra PS, Desai G. "Hear me out": Experiences of women with severe mental illness with their healthcare providers about motherhood. Asian J Soc Psychol 2021;55. https://doi.org/10.1016/j.ajp.2020.102505

16. Farářová A, Papežová H. Preventive interventions designed for families in which a parent suffers from a mental disorder. Ceskoslovenska Psychologie 2024;68(1):67–79. https://doi.org/10.51561/cspsych.68.1.67

17. Rummel-Kluge C, Pitschel-Walz G, Bäuml J, Kissling W. Psychoeducation in schizophrenia - Results of a survey of all psychiatric institutions in Germany, Austria, and Switzerland. Schizophr Bull 2006;32(4):765–775. https://doi.org/10.1093/schbul/sbl006

18. Dunn A, Startup H, Cartwright-Hatton S. Adult mental health service engagement with patients who are parents: Evidence from 15 English mental health trusts. Br J Clin Psychol 2022;61(2):335–348. https://doi.org/10.1111/bjc.12330

19. Yao H, Guan L, Zhang C, Pan Y, Han J, He R, Chang Z, Zhou T, Du C, Wu T, Sun J, Yuan Y, Maybery D, Ma H. Chinese mental health workers' family-focused practices: a cross-sectional survey. BMC Health Serv Res 2021;21(1). https://doi.org/10.1186/s12913-021-06572-4

20. Zalewski M, Goodman SH, Cole PM, McLaughlin KA. Clinical considerations when treating adults who are parents. Clin Psychol Sci. 2017;24(4): 370–388. Blackwell Publishing Inc. https://doi.org/10.1111/cpsp.12209

21. Dolman C, Jones I, Howard LM. Pre-conception to parenting: A systematic review and meta-synthesis of the qualitative literature on motherhood for women with severe mental illness. Arch Womens Ment Health 2013;16(3):173–196. https://doi.org/10.1007/s00737-013-0336-0

22. Maybery D, Reupert A. Parental mental illness: A review of barriers and issues for working with families and children. J Psychiatr Ment Health Nurs 2009;16(9):784–791. https://doi.org/10.1111/j.1365-2850.2009.01456.

23. Gregg L, Adderley H, Calam R, Wittkowski A. The implementation of family-focused practice in adult mental health services: a systematic review exploring the influence of practitioner and workplace factors. Int J Ment Health Nurs 2021;30(4):885–906. Blackwell Publishing. https://doi.org/10.1111/inm.12837

24. Lauritzen C, Reedtz C, Van Doesum K, Martinussen M. Factors that may facilitate or hinder a family-focus in the treatment of parents with a mental illness. J Child Fam Stud 2015;24(4):864–871. https://doi.org/10.1007/s10826-013-9895-y

25. Reupert A, Maybery D. Workforce capacity to respond to children whose parents have a mental illness. Aust N Z J Psychiatry 2006;40(8):657–664. https://doi.org/10.1080/j.1440-1614.2006.01865.x

26. Tchernegovski P, Reupert AE, Maybery DJ. How do Australian adult mental health clinicians manage the challenges of working with parental mental illness? A phenomenological study. Child Fam Soc Work. 2018;23(3):381–389. https://doi.org/10.1111/cfs.12426

27. Maybery D, Goodyear M, Reupert A. The family-focused mental health practice questionnaire. Arch Psychiatr Nurs 2012;26(2):135–144. https://doi.org/10.1016/j.apnu.2011.09.001

28. Norwegian Ministry of Health and Care Services. The Health Personnel Act. 2010. Https://lovdata.no/dokument/NL/lov/1999-07-02-64/KAPITTEL_2#%C2%A710a

29. Gatsou L, Yates S, Hussain S, Barrett M, Gangavati S, Ghafoor R. Parental mental illness: incidence, assessment and practice. Ment Health Pract 2016;19(5):25–27. https://doi.org/10.7748/mhp.19.5.25.s18

30. Reedtz C, Lauritzen C, Stover YV, Freili JL, Rognmo K. Identification of children of parents with mental illness: A necessity to provide relevant support. Front Psychiatry 2019;10(1). https://doi.org/10.3389/fpsyt.2018.00728

31. Reupert A, Cuff R, Maybery D. Helping children understand their parent's mental illness. Parental Psychiatric Disorder 2015:201–276. Cambridge University Press. https://doi.org/10.1017/CBO9781107707559.020

32. Hafting M, Gullbrå F, Anderssen N, Rørtveit G, Smith-Sivertsen T, Van Doesum K. Overcoming clinician and parent ambivalence: General practitioners' support of children of parents with physical or mental illness and/or substance abuse. Front Psychiatry 2019;10(1). https://doi.org/10.3389/fpsyt.2018.00724

33. Diaz-Caneja A, Johnson S. The views and experiences of severely mentally ill mothers. Soc Psychiatry Psychiatr Epidemiol 2004;39(6). https://doi.org/10.1007/s00127-004-0772-2

34. Tchernegovski P, Hine R, Reupert AE, & Maybery DJ. Adult mental health clinicians' perspectives of parents with a mental illness and their children: Single and dual focus approaches. BMC Health Services Research 2018;18(1). https://doi.org/10.1186/s12913-018-3428-8

35. Ward B, Reupert A, McCormick F, Waller S, & Kidd S. Family-focused practice within a recovery framework: practitioners' qualitative perspectives. BMC Health Services Research 2017;17(1);234. https://doi.org/10.1186/s12913-017-2146-y

36. Tchernegovski P, Reupert AE, & Maybery DJ. How do Australian adult mental health clinicians manage the challenges of working with parental mental illness? A phenomenological study. Child and Family Social Work, 2018;23(3);381–389. https://doi.org/10.1111/cfs.12426

37. Korhonen T, Pietilä AM, Vehviläinen-Julkunen K. Are the children of the clients' visible or invisible for nurses in adult psychiatry? - A questionnaire survey. Scand J Caring Sci 2010;24(1):65–74. https://doi.org/10.1111/j.1471-6712.2009.00686.

38. Haukø BH, Stamnes JH. To what extent do therapists in adult psychiatry involve the children of mentally ill patients? 2009. http://www.hint.no/hint/fagportal/bibliotek/hint_publikasjoner

39. Fudge E, Mason P. Consulting with young people about service guidelines relating to parental mental illness. AeJAMH 2004;3(2):50–58. https://doi.org/10.5172/jamh.3.2.50

40. Riebschleger J, Scheid J, Luz C, Mickus M, Liszewski C, Eaton M. How are the experiences and needs of families of individuals with mental illness reflected in medical education guidelines? Acad Psychiatry. 2008;32(2):119–126. https://doi.org/10.1176/appi.ap.32.2.119

41. E-clinic z.ú. 2024. ChildTalks+. Https://Childtalks.Cz/.

42. Solantaus T. Co trápí naše rodiče: příručka pro děti a mládež, jejichž maminka nebo tatínek mají problémy s duševním zdravím. Centrum pro rozvoj péče o duševní zdraví. 2009a.

43. Solantaus T. Jak pomohu svému dítěti? Příručka pro rodiče, kteří mají problémy s duševním zdravím. Centrum pro rozvoj péče o duševní zdraví. 2009b.

44. Solantaus T, Paavonen EJ, Toikka S, Punamäki RL. Preventive interventions in families with parental depression: children's psychosocial symptoms and prosocial behaviour. Eur Child Adolesc Psychiatry 2010;19(12):883–892. https://doi.org/10.1007/s00787-010-0135-3

45. Rapa E, Ilyas A, de Cassan S and Dalton LJ. Experiences of patients talking about mental illness with their children: a qualitative study. Front. Psychol. 2025; 15:1504130. doi: 10.3389/fpsyg.2024.1504130