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ORIGINAL RESEARCH

Psychiatric nurses' attitudes towards children visiting their parents in psychiatric inpatient units

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Background. The provision of care for children of parents with a mental health problem is an area that is frequently neglected by health-care practitioners.

Objectives. The aim of the overall study was to explore psychiatric nurses' knowledge of, attitudes and practice towards the support needs of children whose parent has a mental health problem. This paper specifically addresses the views of psychiatric nurses towards children visiting their parent in a mental health inpatient facility.

Method. This study employed a self-completion survey design with a sample of 114 registered psychiatric nurses from one integrated mental health service in Ireland.

Results. The majority of participants were in favour of children visiting their parent when in hospital, but were of the view that the visiting areas should be away from the main ward location and designed to be child-friendly. Many expressed concerns about the standard of visiting facilities and worried about the potentially negative impact of a visit on the child's well-being. In relation to education on child-care issues, a significant majority of the participants reported not having received any education in the child-care issues identified and, as a likely consequence, rated their knowledge as insufficient.

Conclusions. This study highlights the need for further work in the areas of practitioner education, child-friendly visiting facilities, and the development of policy and practice guidelines around children whose parents experience a mental health problem.

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Key words: Attitudes, children, inpatient mental health facility, parents with mental health problems, visiting.

Introduction

Nurses working in adult mental health services are in an ideal position to engage with the children of people who use the services by virtue of the fact that they are the profession that most often visits service users in their own home and are the group that provides 24-hour care on inpatient units (Devlin & O'Brien, 1999; Korhonen *et al*. 2010). Indeed, mental health nursing has been cited as one of the few disciplines in the multidisciplinary team who may have knowledge of whether a service user has children (Meadus & Johnston, 2000; Riebschleger, 2004; Somers, 2007), yet little research exists on the nurse's role with these children (Korhonen *et al*. 2010). Specifically, no Irish research has been published on mental health nurses' practices or views on children visiting a parent while in hospital. Yet, research does suggest that children may feel reassured by a visit to their parent, particularly if they receive a welcoming approach from ward personnel (Scott *et al*. 2007) and if the visit is in the context of an organised intervention (Poehlmann *et al*. 2010). Previous research carried out with Irish psychiatrists working in adult mental health services found that although 97% of the sample was in favour of children visiting their parent, their views were influenced by concerns for the child's welfare, the parent's condition and the suitability of the inpatient facility for children visiting (O'Shea *et al*. 2004). This paper examines Irish psychiatric nurses' attitudes towards children visiting a parent in a mental health inpatient facility.

Background

The impact of parental mental ill health on children is well documented, with studies demonstrating how some children assume burdensome responsibilities inappropriate to their age and worry about developing the same mental health problem as their parent (Rutter, 1966; Meadus & Johnston, 2000; Handley *et al*. 2001; Mordoch & Hall, 2002; Riebschleger, 2004). Other studies highlight the impacts of parental illness

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on children's schooling and friendships, as well as the continuous frustration experienced by children due to lack of information or involvement (Garley *et al*. 1997; Meadus & Johnston, 2000; Mordoch & Hall, 2002; Scott *et al*. 2007). For children whose parent has been hospitalised, this may be experienced as a painful and emotional time, especially if it is a first separation (Rutter, 1966; Meadus & Johnston, 2000; Handley *et al*. 2001; Mordoch & Hall, 2002; Riebschleger, 2004).

The stigma and secrecy that surround mental health problems may make it difficult for the child to seek assistance (Riebschleger, 2004). In addition, parental fears of having their children removed from their care can promote silence and make help-seeking behaviour a challenge (Handley *et al*. 2001). Despite this, research suggests that children of parents with a mental health problem continue to be unsupported, ignored and left with many unanswered questions and concerns (Handley *et al*. 2001; Scott *et al*. 2007; Somers, 2007). In Aldridge's (2006) view, mental health practitioners are overly focused on the 'ill' parent or on child protection issues and, consequently, neglect the support and information needs of children. It is not surprising, therefore, that mental health practitioners have been accused of engaging in a 'culture of reluctance' when it comes to the needs of these children (Howard, 2000; Turner, 2009).

Indeed, the lack of assessment of parental status or discussion of service users' needs in relation to their children is an international phenomenon. Numerous studies have identified incidences of incomplete or non-documentation of the existence of children in the case files of their parents (Montoliu Tamarit & Yin Har Lau, 2002; Cowling *et al*. 2004; Riebschleger, 2004; O'Brien *et al*. 2011) leading researchers to describe them as 'invisible' (Somers, 2007) or 'hidden' (Fudge & Mason, 2004) children. Children have also reported that they find mental health professionals unfriendly towards them, not introducing themselves to children when visiting their parent or not asking them if they have any questions or concerns (Scott *et al*. 2007). A study conducted in Australia with a sample of nine staff working in an acute inpatient mental health facility reported that while in principle participants supported children visiting their parents, there were substantial difficulties and barriers to such visits (O'Brien *et al*. 2011). These included a lack of specific guidelines related to visits, an absence of resources, and deficits in practitioners' knowledge and skills in how to respond to children's information and support needs (O'Brien *et al*. 2011). Within Ireland, O'Shea *et al*.'s (2004) survey of 148 psychiatrists found that 90% of the respondents were of the view that inpatient facilities were not child-friendly, with only 11% reporting the availability of a dedicated visiting room for children. It would appear that indeed these children are often forgotten and mental health services have done little to prepare staff or the environment to make children feel welcome, safe and included in their parent's plan of care.

Methods

Aim and objectives

The aim of the overall study was to explore psychiatric nurses' knowledge of, attitudes and practice towards the support needs of children whose parent has a mental health problem. This article specifically addresses the views of psychiatric nurses towards children visiting their parent in a mental health inpatient facility.

Study design

This study employed a self-completion survey design with a sample of registered psychiatric nurses from one integrated mental health service in Ireland.

Survey design

In the absence of a pre-designed validated survey instrument, a self-reporting anonymous questionnaire was developed by the researchers informed by their clinical experience and a previous study by O'Shea *et al*. (2004) on psychiatrists' attitudes to children visiting parents hospitalised because of mental health problems. The questionnaire consisted of 44 questions divided into six sections: demographics, education and training, self-perception of knowledge, confidence in practice, clinical practices, and attitudes towards children visiting their parent. The questionnaire used a combination of closed, Likert scale and open-ended questions that allowed respondents to write-in additional comments. This article reports on 22 of the questions, including demographics and attitudes towards children visiting their parent; additional results in relation to knowledge, confidence and clinical practice are published in another article (Houlihan *et al*. 2013).

Validity

Content validity of the survey was determined using the content validity index with a panel of five experts in the field of mental health education, practice and management (Parahoo, 2006). Overall, the panel was very positive about the questionnaire and only minor changes were made following feedback. The questionnaire was then piloted (Burns & Grove, 2009) with a sample of 18 registered psychiatric nurses working outside of the main study site to test for face validity.

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Again, only minor changes were made to the wording and sequencing of the survey following the pilot.

Sampling

All 180 registered psychiatric nurses employed in the study site were eligible to participate in the research. Inclusion criteria were that the participant was a registered psychiatric nurse on the live register of An Bord Altranais (Irish Nursing Board), employed as a psychiatric nurse in the study site and willing to consent to take part. The sample was drawn using non-probability convenience sampling. The study was carried out in an urban mental health service that provided care to a population of over 154 000 people. The service included inpatient care facilities consisting of acute adult, acute elderly and acute adolescent care. Out-patient care consisted of day hospitals, day centres, psychotherapy services, substance misuse and community teams. Visiting facilities for children within the hospital consisted of a room located in another building away from the main ward areas. The room was multipurpose, as it functioned as a waiting room, meeting room and visiting room. The room was not designed with children in mind as it was furnished with a number of single chairs that surrounded the perimeter walls. Children's toys, children's books, electronic game stations and a television set were notably absent.

Data collection

Access to the study site was granted by the Director of Nursing of the service following ethical approval from the researchers' university. All 180 potential participants within the mental health service received a survey pack containing a survey, information leaflet and a pre-addressed stamped envelope. Potential participants were invited to read a participant information leaflet explicitly outlining the objectives of the study and which included specific information around consent, confidentiality and publication. Once satisfied with the conditions of the study, participants were then invited to complete the questionnaire and return it. A follow-up reminder was sent 3 weeks later to encourage those who had not returned the questionnaire to do so. Return of the questionnaire was taken as consent. In total, 114 surveys were returned, representing a 63% response rate.

Data analyses

Statistical analyses were conducted using SPSS 17.0. In terms of attitudes towards visiting, attitudes were assessed on 14 Likert scale questions. The questions asked about whether respondents felt children should visit their parents in inpatient units, how visits should be arranged, who should supervise visits and where visits should take place. Respondents were asked to rate their level of agreement or disagreement with statements on the scale of: strongly agree (1), agree (2), unsure (3), disagree (4) or strongly disagree (5) and the frequencies for each statement were calculated. For ease of interpretation, the strongly agree and agree response were grouped into one category titled 'agree' and the strongly disagree and disagree responses were group into a 'disagree' category. Respondents were also asked about their knowledge of nine child-friendly subjects, including the Children First Guidelines, the impact of a parental mental health problem on the child and how to work with children who have parents in an inpatient unit for a mental health problem. Respondents reported their level of knowledge on a five-point scale: excellent (1), good (2), sufficient (3), insufficient (4) and none (5). For ease of interpretation, those who reported excellent or good knowledge were amalgamated into one category, and those who reported insufficient or no knowledge were combined. As all figures were rounded to the nearest whole number, the percentages in the tables below total from 99% to 101%. Qualitative comments from section six of the survey were typed verbatim and analysed using content analysis (Burns & Grove, 2009). The comments were read for meaning, coded, compared and classified into categories according to their theoretical importance.

Ethical considerations

Ethical approval was granted by the Faculty of Health Sciences Ethics Committee at the university.

Results

Demographics

The sample was roughly 80% female and 20% male, with a wide spread of age ranges represented. Nearly half of the sample had a diploma or BSc qualification, with a further 10% having a post-graduate or MSc qualification. There was a wide spread around the number of years respondents had been qualified as a psychiatric nurse, with 45% having been qualified for more than 11 years. The majority of the sample was staff nurses (60%), with smaller proportions working as Clinical Nurse Managers, Community Mental Health Nurses and Clinical Nurse Specialists positions. No respondents were Advanced Nurse Practitioners. There were slightly more nurses working in hospital rather than community settings. The demographics of the sample are presented in Table 1.

Should children visit their parent in an inpatient psychiatric setting?

Nearly 60% ($n = 66$) of the sampled nurses agreed that children should visit their parent when they are an

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inpatient in a psychiatric setting, while 34% ($n = 38$) were unsure and 6% ($n = 7$) did not agree with children visiting their parent in an inpatient psychiatric setting.

Table 1. *Demographics of sample*

Variables	*n* (%)
Gender ($n = 114$)	
Female	90 (79)
Male	24 (21)
Age ($n = 114$)	
20–31	43 (38)
32–42	30 (26)
43–54	30 (26)
55–65	11 (10)
Highest qualification ($n = 113$)	
RPN or dual qualification	34 (30)
Diploma or BSc	54 (48)
Postgraduate diploma or MSc	22 (19)
Other	3 (3)
Years qualified ($n = 113$)	
<1 year	3 (3)
1–5 years	30 (26)
6–10 years	29 (26)
11–15 years	8 (7)
>16 years	43 (38)
Position ($n = 114$)	
Staff nurse	68 (60)
CNM I or CNM II	19 (17)
CMHN	18 (16)
CNS	9 (8)
Location ($n = 113$)	
Hospital	63 (56)
Community	47 (42)
Other	3 (3)

CNM, Clinical Nurse Managers; CMHN, Community

Where should children visit their parents?

The vast majority of participants disagreed with children visiting parents in the main ward area (80%, $n = 91$) or in the parent's bedroom (71%, $n = 80$). However, nearly three-quarters of the sample (73%, $n = 83$) were in favour of children visiting their parent in a location away from the ward. While over half of participants (55%, $n = 62$) were in favour of children having supervised access (accompanied by relative/guardian/practitioner) to the grounds of the hospital, a significant percentage were unsure (30%, $n = 33$) or disagreed (15%, $n = 17$); these results are shown in Table 2.

What should visiting facilities for children be like?

The vast majority of the participants agreed (95%, $n = 107$) that child visiting areas should be adjoining, but separate from, the main ward in home-like settings with facilities such as sofas, a self-contained toilet and baby changing areas. Furthermore, the majority (85%, $n = 96$) felt that children should have access to toys provided by the hospital in the visiting area. The full results are presented in Table 2.

Lending support to this, the participants' qualitative comments suggested that existing facilities were not optimal for children's visits and required improvement. They highlighted the need for 'a child-friendly visiting environment… attached to the ward with toys, TVs, sofas and books'. They felt this would create a comfortable environment that would ultimately improve the experience of the child visiting his/her parent.

What should be considered prior to children visiting their parents?

The vast majority of the sample (96%, $n = 110$) felt that the potential impact of a parent's mental health status

Table 2. *Statements on visiting areas*

Statements	Agree [*n* (%)]	Unsure [*n* (%)]	Disagree [*n* (%)]
Children should visit their parent in the main ward area, for example, the patient's sitting room ($n = 114$)	8 (7)	15 (13)	91 (80)
Children should visit their parent in their bedroom area on the acute ward ($n = 112$)	12 (11)	20 (18)	80 (71)
Children should visit their parent in a location away from the ward ($n = 114$)	83 (73)	18 (16)	13 (11)
Children should have supervised access to the grounds of the hospital ($n = 112$)	62 (55)	33 (30)	17 (15)
Child visit areas should be adjoining, but separate from, the main ward in homely settings with facilities such as sofas, self-contained toilet and baby changing areas ($n = 113$)	107 (95)	5 (4)	1 (1)
Children should have access to toys, provided by the hospital, in the visiting area ($n = 113$)	96 (85)	12 (11)	5 (4)

Mental Health Nurses; CNS, Clinical Nurse Specialists.

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Table 3. *Statements on what should be considered prior to children visiting their parents*

Statements	Agree [*n* (%)]	Unsure [*n* (%)]	Disagree [*n* (%)]
The impact that a parent's mental health status may have on the child's well-being should be considered prior to the child visiting their parent ($n = 114$)	110 (96)	3 (3)	1 (1)
Child visits should be discussed by the multidisciplinary team prior to the arrangement of a child visit to a psychiatric setting ($n = 114$)	108 (95)	5 (4)	1 (1)

Table 4. *Statements on arrangement of visits*

Statement	Agree [*n* (%)]	Unsure [*n* (%)]	Disagree [*n* (%)]
Children should have their visits to a psychiatric setting coordinated by a designated person ($n = 114$)	107 (94)	6 (5)	1 (1)
Children should be supervised during their visit to an inpatient unit by a relative or guardian ($n = 114$)	101 (89)	12 (11)	1 (1)
In the absence of a relative or guardian, children should be supervised during their visit to an inpatient unit by the patient's key nurse ($n = 113$)	84 (74)	22 (20)	7 (6)
In the absence of a relative or guardian, children should be supervised during their visit to an inpatient unit by an allocated social worker ($n = 113$)	67 (59)	30 (27)	16 (14)

on a child's well-being should be considered prior to a child visiting his/her parent and that the multidisciplinary team should discuss child visits prior to the arrangement of the visit to a psychiatric setting (95%, $n = 108$). These results are displayed in Table 3.

The qualitative comments also supported a shared concern for the safety and emotional welfare of the child while visiting. A number of participants commented on the need for discussion between the multidisciplinary team, the parent service user, and family including 'extended family member or guardian' prior to the child being offered a visit to see his/her parent. In addition, participants were of the view that the mental health status of the parent should be assessed and considered by the team prior to any visit.

How should child visits to inpatient psychiatric units be arranged?

More than 90% of the sample felt that children should have their visits to a psychiatric inpatient setting coordinated by a designated person. Nearly nine out of 10 participants (89%, $n = 101$) felt that children should be supervised during their visit by a relative or guardian. In the absence of a relative or guardian, many participants agreed (74%, $n = 84$) that the service user's key nurse should supervise the visit, with a much smaller number agreeing that the supervising person should be an allocated social worker (59%, $n = 67$). Considerable minorities of the sample were not sure or disagreed with the key nurse (26%, $n = 29$) or an allocated social worker (41%, $n = 46$) supervising the child's visit in the absence of a relative or guardian. These results are presented in Table 4.

Qualitative comments supported the need for children's visits to be supervised. While nurses did highly regard child safety and welfare, they were also concerned that the service user parents should not experience 'authoritarian attitudes' or 'over-surveillance' during visits. To minimise the possibility of families feeling over-supervised, some participants suggested the use of 'two way mirrors' within visiting areas, as they were of the view these would 'allow privacy, encourage bonding between child and adult and be less invasive'. In addition, many stressed the value of having the support of psychologists, childcare workers and mental health social workers for child visits.

Knowledge on child-friendly practice issues

In relation to education on child-care issues, a significant majority of the participants reported not having received any education in the nine child-care issues identified and, as a likely consequence, over 44%, the participants rated their knowledge in all the areas as none or insufficient. Specifically, over 70% of participants rated their knowledge as none or insufficient in talking to a child about a parental mental

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Table 5. *Self-rated knowledge on child-friendly practice issues*

Topic	Excellent/good knowledge [*n* (%)]	Sufficient knowledge [*n* (%)]	None/insufficient knowledge [*n* (%)]
The procedure for reporting child welfare concerns ($n = 112$)	28 (25)	35 (31)	49 (44)
The 'Children First' national guidelines ($n = 112$)	26 (23)	29 (26)	57 (51)
The impact of parental mental health problems on children ($n = 113$)	24 (21)	33 (29)	56 (50)
Supporting parents with mental health problems who have children ($n = 113$)	24 (21)	37 (33)	52 (46)
Services available to children experiencing psychological distress ($n = 113$)	22 (19)	21 (19)	70 (62)
Creating a child-friendly service ($n = 112$)	19 (17)	20 (18)	73 (65)
Support needs of children whose parent has a mental health problem ($n = 113$)	15 (13)	24 (21)	74 (66)
Talking to a child about a parent's mental health problem ($n = 111$)	10 (9)	23 (21)	78 (70)
Assessing the parent–child relationship ($n = 112$)	11 (10)	21 (19)	80 (71)

health problem and in assessing the parent–child relationship. See Table 5 for complete results.

In light of this self-reported lack of knowledge, it is not surprising that in many of the qualitative comments participants requested further education 'on all sections of the questionnaire', including 'age appropriate communication skills' and 'child appropriate terminology'. In addition, participants sought a greater level of guidance through the development of formal policies around visiting and their role in supporting children.

Discussion

Irish mental health policy, as outlined in the 'Vision for Change' (Department of Health and Children, 2006), directs mental health service providers to be mindful of the presence of children whose parent has a mental health problem and to adopt supportive and child-friendly approaches to service provision. However, the exact number of children within Ireland affected by parental mental health issues is unknown; although, studies elsewhere suggest that between 20% and 35% of service users are parents (Cowling, 1999; Australian Infant Child Adolescent and Family Mental Health Association, 2001; Maybery *et al*. 2009). The Health Research Board in Ireland does not collect statistics on the number of service users who have children nor was there evidence of systematic practices or policies regarding children within mental health services during the annual inspection by the Mental Health Commission (2007, 2008). In relation to visiting, findings of this study suggest that psychiatric nurses are positive towards children visiting parents during hospitalisation. However, 6% of the sample did not think children should visit and about one-third was unsure. These figures are slightly higher than the 3% of psychiatrists in Ireland who did not believe children should visit their parents (O'Shea *et al*. 2004). Two reasons may explain this. First, nurses may be more adamant that the current inpatient facilities for child visits are inadequate. Second, perhaps due to limited education and knowledge in child-friendly mental health practice, the nurses in this study may be more risk-averse or operate an over-protective practice towards the service user and child. Indeed, the self-reported lack of knowledge on child-friendly practices suggest that nurse education programmes are adult- as opposed to child focused and require urgent review to ensure they are in line with the current policy and ethos of providing child-friendly services.

Previous research suggests that if visits are organised appropriately with adequate support, children benefit from visiting parents who have been admitted to mental health services (Poehlmann *et al*. 2010). However, similar to other studies, while the participants in this study supported visiting, they expressed concerns about the standard of facilities and worried about the potentially negative impact of a visit on the child's well-being (O'Brien *et al*. 2011). To minimise the potentially negative impact, the vast majority were of the view that a parent's mental health status should be considered and discussed by the multidisciplinary team prior to a child visiting and that visits should be discussed with the parent service user and extended family, if appropriate. In view of the limited visiting facilities for children within the study site, it was not surprising that the vast majority of participants

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advocated for child-friendly visiting facilities. This reflects positively that nurses have an understanding that children are vulnerable to the impact of parental illness and are positively disposed to discussing the needs of the children with their multidisciplinary colleagues.

Opinions amongst the sample concerning the location considered most appropriate for visits were not unanimous. Though nurses were strongly against visits occurring in the main ward areas or in a patient's bedroom, many remained undecided, illuminated by the relatively high number of answers categorised as 'unsure'. This result is again potentially due to concerns for the safety and well-being of the children, as hospital wards can be a frightening place for children (O'Shea *et al*. 2004; Scott *et al*. 2007; O'Brien *et al*. 2011) and it is important that visits are well supported and made as positive of an experience as possible. Indeed, the notion of 'child-friendly' practices motivated many to write open responses on the need to improve visiting facilities and to enhance multidisciplinary engagement with and between the family, the ill parent and the child. The majority of nurses felt that child-friendly visiting areas should be provided but positioned away from ward areas. In addition, participants were sensitive to the needs of parents, wishing to ensure visits were positive for both the child and service user and were concerned to minimise any sense of surveillance or authoritarian attitudes from practitioners. The participants' concern with over-surveillance and authoritarian attitudes of staff is to be welcomed, given the documented fears of parents with mental health problems, especially mothers, around loss of custody (Diaz-Canjela & Johnson, 2004; Anderson *et al*. 2006; Montgomery *et al*. 2006; Begley *et al*. 2010). However, the mention of using 'two may mirrors' appears paradoxical, and may be interpreted as a covert way of increasing surveillance and a reinforcement of Foucault's 'panoptic' (Foucault, 1991). In addition, the use of such a surveillance strategy may heighten parents' lack of trust and fears when they become aware of its use.

The issue of who is responsible for children when they visit is an emerging theme within the nursing literature (Devlin & O'Brien, 1999; Scott *et al*. 2007; Korhonen *et al*. 2010). Many times visits are outside office hours and in the absence of a carer, guardian or other practitioner, the responsibility appears to be placed within nursing (O'Brien *et al*. 2011). In this study, more than 90% of the nurses felt that there should be a designated person who coordinates the visits for children and the majority felt that children should be supervised by a relative or guardian during their visit. While most nurses supported the service user's key nurse or a social worker supervising the visit in the absence of a relative or guardian, substantial minorities of the nurses were not sure or disagreed that a key nurse or social worker should supervise the visit. This aligns with themes raised in previous study by O'Shea *et al*. (2004) and O'Brien *et al*. (2011) where participants raised issues around whose responsibility it would be to supervise visiting children, as well as who might be suitable in helping a child understand his or her parent's illness. The psychiatrists in previous study by O'Shea *et al*. (2004) described concerns around who would 'prepare the child beforehand and discuss the visit with him/her subsequently', which in their view was 'an important preventative measure' (p. 47).

While this study provides some insights into a previously under-researched area and the findings are reflected in the context of published international literature, they must be considered in light of the following limitations. The study was conducted within one service with a small number of participants; consequently, the results are non-generalisable to all registered psychiatric nurses in Ireland. Second, participants self-selected to complete the survey so it is difficult to say how those nurses who did not choose to participate might have responded. Finally, although the survey instrument was reviewed by an expert panel, tested for validity and piloted, it requires further testing to ensure that any findings are statistically robust.

Even in light of these limitations, it is recommended that robust and standard practice guidelines for child visiting be developed by mental health services in Ireland. These guidelines must take into consideration and address the concerns raised by this study, as well as be in line with children's rights, best interests and national policy regarding their welfare. It is hoped that such guidelines would provide a consistent framework for all staff to operate in as regards children visiting their parent. In order to develop these guidelines, further research is required. First, the impact on a child's well-being of visiting a parent in a mental health ward must be further researched to assess how children feel about visiting their parents, what they view as positive and negative aspects of the visit and what support they would like. In addition, given the reported lack of knowledge among this cohort of staff, there is an urgent need for further education in this area. Modules for practitioners need to be developed and evaluated at undergraduate, postgraduate and in-service level.

Conclusion

Mental health problems do not impact solely on the individual with the mental health issue but affect the whole family, including the children. In Ireland, nurses' clinical responsibilities towards the protection

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of child welfare are implicit in constitutional law (Government of Ireland, 1937), statutory law (Government of Ireland, 1991, 2001) and health policy (Department of Health and Children, 2000; Department of Children and Youth Affairs, 2011). Irish health policy highlights the duty of care that health service personnel have towards all children and mandates clinicians to be vigilant to the needs and welfare of children (Government of Ireland, 1937, 1991, 2001). In addition, the protection of children is mandated by the *Children First Guidelines: National Guidelines for the Protection and Welfare of Children* (Government of Ireland, 1937). This study suggests that further work in the areas of practitioner education, child-friendly visiting facilities, and the development of policy and practice guidelines are urgently required if aspirations around family-focused care are to be realised within Irish mental health services. The inclusion of the needs of children is essential within all undergraduate, postgraduate and in-service education programmes for mental health practitioners. In addition, the Mental Health Commission needs to consider the inclusion of child-friendly visiting facilities and policies as one criterion within their quality reviews of inpatient services. Without a concerted effort on behalf of policy, practice and education, the needs of children whose parent is admitted to a mental health service may continue to be neglected.

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Conflicts of Interest

The authors report no conflicts of interest. There were no sources of support for this study.

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