Why children affected by parental mental illness must be seen and heard
Introduction

In October 2018, we launched ‘Being Seen and Heard’ – Our Time’s campaign to give a voice to the 3.4 million children and young people who live with a parent with a mental illness. [1] These children are amongst the most vulnerable and neglected in the country.

Our Time, the only UK charity solely supporting children and young people whose parents have a mental illness, wants to secure recognition for this group within public policy and funding frameworks by 2021.

The stakes are high. Without help, 70% (3.1 million) of these children will go on to develop mental health problems themselves at huge expense to the public purse. [2] Early intervention is known to be the most cost-effective way to mitigate this. [3][4]

In this report, we present compelling evidence, including newly commissioned analysis from Ernst and Young (EY), to support our assertion that prioritising and investing in services for children of parents with mental illness (COPMI) makes both moral and financial sense.

Background

In 1999, at the ‘Keeping the Family in Mind,’ conference, children affected by parental mental illness, gave an impassioned plea to have their voices heard. Despite often being closest to their parent’s illness, they felt ignored. This was eloquently summed up by a conference participant: “The mental health services came in like the SAS to take our parent. No-one explained anything, no-one asked our advice or what we knew.”

Two decades on, little has changed. In the UK, children affected by parental mental illness have no specific recognition. The government keeps no statistics about their numbers, and provides no statutory provision. Support is entirely dependent on local funding. This is not the case in other countries. In Australia, they are known as COPMI (children of parents with mental illness), and as ‘young relatives’ in most Nordic countries.

The UK recognises the needs of young carers but not the specific challenges experienced by children whose parents have a mental illness. For all intents and purposes, this group remains hidden in plain sight and on a trajectory to becoming the patients of the future.
Sizing the problem

An estimated 3.4 million children and young people in the UK live with a parent with a mental illness. This is projected to rise to 4.5 million by 2021 (Ernst & Young). [1]

The Children’s Commissioner Vulnerability Report (2018) finds that in an average classroom, eight children (25%) will have a parent with mental health problems. [5]

The presence of mental illness in a parent negatively impacts all aspects of a child’s development: cognitive, language, educational, social, emotional and behavioural. [3][5][6]

Without intervention to support their development, 70% of these children risk developing at least one minor adjustment problem by adolescence. With two ill parents, there is a 30-50% chance of the child becoming seriously mentally ill. [2]

EY analysts predict that by 2021, this would amount to 3.1 million COPMI developing mental health problems themselves, at a huge human and economic cost.

If a quarter of these young people develop depression by 2021, EY projects a cost to government of £470 million. This is the tip of the iceberg — depression is just one of many ill-consequences likely to befall this group. Other potential long-term consequences include: disrupted education, restricted peer relationships (due to carer role), financial hardship, potential separation from parents, stigma, future physical and mental health problems, greater risk of suicide, unemployment, marital problems, crime and violence. [1][3][5][6][7]

The World Health Organization has identified children affected by parental mental illness as being at ‘high risk of experiencing family discord and psychiatric problems’. [7]

In July 2018, experts writing in BMJ Paediatric, reported that children whose parents suffer from depression are more likely to use health services including A&E. [8]

We know from research into adverse childhood experiences (ACEs), of which parental mental illness is one, that trauma and toxic stress affects the child’s developing brain architecture and functioning, because exposure to ongoing
stress puts the brain into flight/fight/freeze mode with reduced capacity for reasoning and impulse control.\[^{[3][6]}\]

Without intervention, the long-term prospects are bleak.

EY predicts that by 2021, the cost of doing nothing would amount to between £33 billion and £180 billion.\[^{[1]}\]

**The case for intervention**

Harm can be prevented or reduced through early interventions that build protective factors and resilience. International research identifies three protective factors that help:

- Knowing you are not alone
- Having a good explanation
- Having a trusted adult to talk to

Our Time’s interventions harness these protective factors and have been shown to increase understanding of mental illness, improve parent-child relationships, reduce feelings of fear, shame and isolation, and boost confidence.\[^{[3][4]}\]

If Our Time was able to address just 1% of the total child population expected to develop depression by 2021, this could potentially save the government £4.7 million (£23.5 million if Our Time helped 5% of that population). EY predicts similar savings for the prevention of other harms (for example, those associated with anti-social behaviour).\[^{[1]}\]

**Recommendations**

- Government to recognise and count the number of children of parents with mental illness (COPMI) and to include them in all policy around young people’s mental health and wellbeing
- Establish NICE guidelines and referral pathways for COPMI
- Make it mandatory for adult mental health professionals to collect data on COPMI
- Commission support services in every local authority in the UK to identify and support COPMI
• Make this issue a priority in the public health agenda and raise awareness to ensure parental mental illness is recognised as a serious risk to a person’s wellbeing and life chances

• Include COPMI in the ‘mental health in schools’ strategies and plans

• Share the Our Time model and Our Time resources widely, particularly among commissioners in social care and public health

• Invest in training professionals to provide early intervention services

Our Time’s Charter for Change (see appendix) shows the journey from where we are today to where we need to be. By implementing our recommendations, we are confident of positive change and envisage a better future for this vastly neglected group.

Conclusion

'Being Seen and Heard' is a rallying cry to policymakers at a national and local level; to mental, public and community health professionals, to commissioners, and educators to help us achieve recognition, awareness, support and investment for this long neglected group.

The cost to the individuals involved, to society at large, and the public purse is too high. Turning a blind eye is no longer an option.
### Our Time’s Charter for Change

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<tr>
<td>Adult mental health professionals or social workers rarely talk to children</td>
<td>Open discussion and public awareness of effects of parental mental illness on children, through legislation, policymakers and commissioners</td>
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<td>Referrals made to child protection and young carers services</td>
<td>Commitment in secondary care services to discuss the needs of the child</td>
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<td>Child has no understanding of how the illness works and how it affects the parent’s mind</td>
<td>Family understands the benefits of talking to the child about the mental illness</td>
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<td>Child left out of decisions about the parents and their care</td>
<td>Primary care assigns dedicated member to work with parent to understand and address the impact on the child</td>
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<td>Families highly suspicious of professional intervention so actively hide difficulties</td>
<td>Dedicated team with mental health services committed to a discussion with children and parents</td>
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<td>Children’s resilience negatively affected, child becomes less able to cope and is at risk of becoming mentally ill</td>
<td>Follow up discussion to help the child think about what is needed and to make the appropriate referral to support the child</td>
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<td>Schools not aware of the risk of parental mental illness on children’s wellbeing and educational attainment</td>
<td>Schools aware of the issue and trained to provide the right support</td>
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References

1. Ernst & Young, ‘Sizing the Problem – analysis by EY,’ commissioned by Our Time
5. Children’s Commissioner Vulnerability Report, 2018
6. Welsh Adverse Childhood Experiences (ACE) study, Public Health Wales, Centre for Public Health, Liverpool John Moores University, 2015

Additional references
