Chapter

KidsTime Workshops: Strengthening Resilience of Children of Parents with a Mental Illness

Klaus Henner Spierling, Kirsty Tahta-Wraith, Helena Kulikowska and Dympna Cunnane

Abstract

This chapter will introduce children of parents with mental illness (COPMI) as a group and explain the impact and risk factors of parental mental illness on children. We will provide examples of approaches that can help children in this situation, using the KidsTime Workshop model as a case study. We will describe the approaches and methods of the KidsTime practice model and explain how a combination of family therapy and systemic therapy influences, together with drama, can create an effective multi-family therapy intervention. It will describe the impact of the KidsTime model, including testimonials from children and families, and highlight the evidence in support of preventative approaches, as well as the barriers to securing investment for these interventions. The chapter will conclude with recommendations for practice.

Keywords: parental mental illness, children, multi-family, systemic therapy, drama

1. Introduction

Children of parents with a mental illness face childhoods that can be full of challenging experiences, threatening their quality of life, development and long-term outcomes [1–4]. However, these children are not an officially recognised group in the UK, and data and statistics are not gathered about them. While UK policies recognise the needs of young carers, they do not address the specific challenges experienced by children whose parents have a mental illness. This is not the case in other countries; in Australia, these children are officially known as children of parents with mental illness (COPMI) and as "young relatives" in most Nordic countries. Children of parents with a mental illness remain a hidden group in the UK, and many are reluctant to identify as young carers due to the shame and stigma often associated with mental illness, making them vulnerable and at risk of neglect.

The UK Children's Commissioner Vulnerability Report (2018) found that in an average classroom, eight children have a parent with mental health problems—this is the equivalent to 25% of the UK school population [3]. In 2018, Our Time, a UK charity that advocates for and offers support to this group did an analysis of the existing data (supported by a team from Ernst and Young), which found that in

excess of 3.4 million children and young people in the UK are currently living with a parent with a mental illness [5]. Further evidence indicates that, without support, 70% of these children are likely to go on to develop mental health problems themselves. With two ill parents, there is a 30–50% chance of the child developing a *serious* mental illness later in life [6]. A WHO review stated: "Children with a parent who has a mental illness or substance use disorder are placed at high risk of experiencing family discord and psychiatric problems. The intergenerational transfer of mental disorder is the result of interactions between genetic, biological and social risk factors occurring as early as pregnancy and infancy" [7, 8].

In Germany, where Our Time's partners, the "KidsTime Netzwerk", use the KidsTime Workshop model to support children and families, research has identified 3.8 million children affected by parental mental illness [9].

1.1 Summary of key facts and statistics

- In excess of 3 million children in the UK live with a parent with a mental health issue.
- Average of 8 children in an average classroom will be in this situation.
- 20–25% of the school population.
- 70% likely to develop a mental health condition.
- Parental mental illness is one of the 10 adverse childhood experiences (ACEs), which has a lifetime impact on both physical and mental health.
- Parental mental illness (PMI) is a root cause of many other ACEs.
- WHO identifies PMI as one of the most important public health issues of our generation.
- Intervention late after the onset of an ACE is less likely to be effective. Rising thresholds for acute support are exacerbated by significant reductions in early intervention spending by local authorities.
- By focusing on clinically diagnosable mental illnesses, the children and adolescent service (CAMHS) interventions are too late to address ACEs.
- In 2018 the Children's Commissioner reported that despite the new provisions in law, 4 in 5 young carers were not identified.

Research into adverse childhood experiences, known as ACEs [10], identifies parental mental illness as one of the ten most powerful sources of toxic stress in young people. The presence of mental illness in a parent is known to negatively impact a child's cognitive and language development, educational achievement and social, emotional and behavioural development [2–4, 10]. It can lead to anxiety and guilt coming from a sense of personal responsibility. Where there is severe mental illness in a parent and no second parent who is well it can lead to neglect or abuse. These children are also at greater risk of bullying, a lower standard of living and financial hardship [2–5, 9].

Figures 1 and **2** show the lifetime impact of adverse childhood experiences affecting the mental and physical health of the individual as a result of toxic stress.

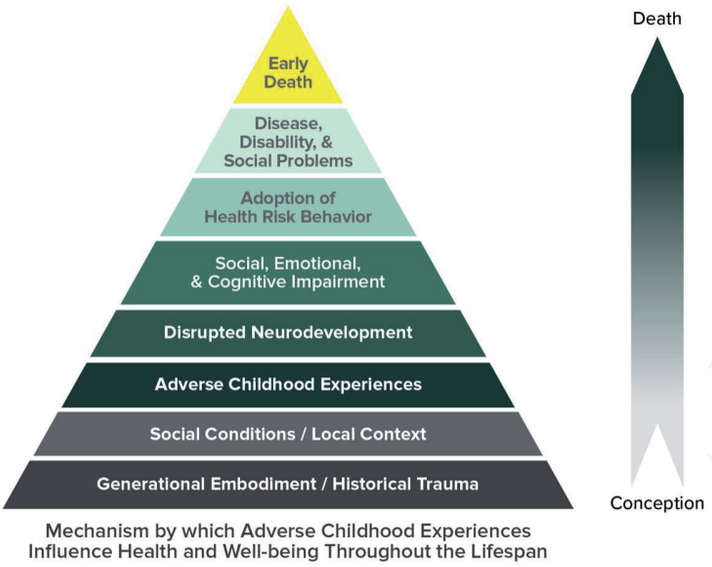

Figure 1.
The ACE pyramid (Centers for Disease Control and Prevention, cdc.gov).

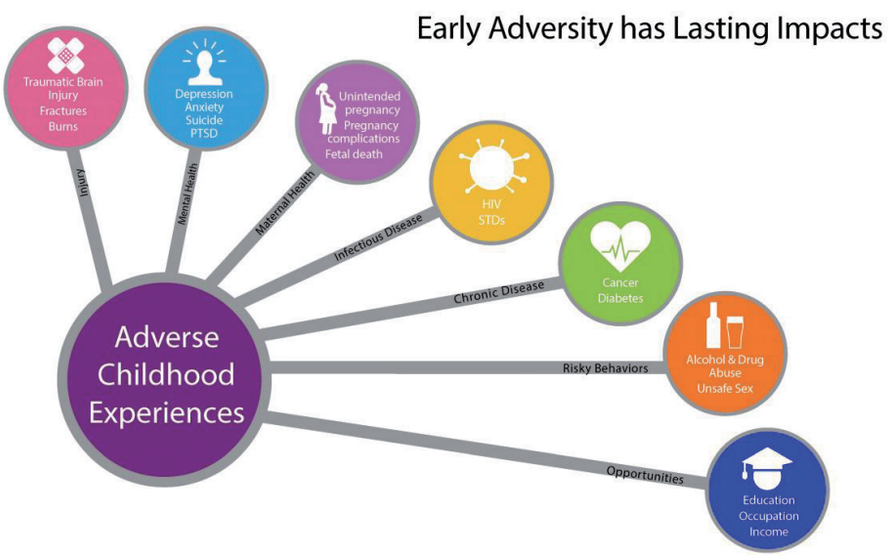

Figure 2.
Long-term effects of ACEs (Centers for Disease Control and Prevention, cdc.gov).

1.2 A hidden risk

The hidden status of these young people in the UK means that they have no statutory entitlement to specific support related to parental mental illness. Provision of formal, organised support or targeted intervention is therefore at the discretion of local funding bodies or entirely dependent on the voluntary sector. Any informal support is dependent on the awareness and understanding of professionals coming into contact with these children to identify and support their needs. However, this sometimes requires stepping outside of the remit of current practice and expertise, adding an additional "burden" to already high workloads. Additionally, many professionals report worrying about talking to children in this situation, as they are concerned about "*saying the wrong thing*" or "*making the situation worse*". Social service providers are dominated by risk concerns and are therefore reluctant to intervene in this area, which means that low intensity, early help is not commissioned. Despite these challenges, there are things that can be done to help children in this situation, enabling them to thrive, despite their

adversity. There is evidence to suggest that relatively simple and low-cost interventions can build protective factors and the resilience of children and young people affected by parental mental illness, reducing their risk of harm and of developing problems themselves in later life [2, 11].

This chapter will explain the impact of parental mental illness on children and the associated risk factors. We will provide examples of approaches proven to help children in this situation, using the KidsTime model as a case study. We will describe the approaches and methods of this practice model and explain how a combination of family therapy and systemic therapy approaches, together with drama, can create an effective multi-family therapy intervention. We will provide evidence of the impact of the KidsTime model and highlight some of the barriers to securing investment for preventative approaches. The chapter will conclude with recommendations for practice.

2. Parental mental illness (PMI) and its impact on children and young people

This section outlines some of the common difficulties experienced by children and young people who have a parent with a mental illness. These include but are not limited to:

2.1 Parental emotional availability and its impact on the child-parent relationship

Research, using case studies and personal testimonies, depict the kinds of difficulties experienced by children and young people growing up in a family where there is a parent with a mental illness. For example, it is common for children, particularly younger children, to report experiencing the same symptoms as their parents, i.e., symptoms caused by the parent's diagnosis, such as delusions [12]. explains this can be due to the parent's illness limiting their emotional availability to their child. Both symptoms of the illness and side-effects of the medication can result in emotional withdrawal from the child, which the child typically perceives as rejection. The child therefore intensifies his or her attempts to achieve closeness with the parent, which may cause the parent to withdraw further. Not only does this create a vicious cycle of interaction between the parent and the child, but these attempts can expose the child to further risk, such as the distress of being drawn into the parent's psychopathological symptoms that are not their own. This is particularly likely in the absence of a sufficient explanation of the parent's mental illness that could enable the child to differentiate between behaviours caused by the illness and those that are not [12, 13].

2.2 Burden of caring roles and responsibilities on young people

The experience of living with a parent who has a mental illness often means that the child or young person often adopts caring roles in their family, which are not age-appropriate. They may fill any gaps in their parent's role, which the parent is not consistently able to fill themselves due to their illness. This is the case both when the parent is markedly unwell and thus genuinely less able and also when the parent is able, but the child has become used to fulfilling this role or does so in anticipation of the parent's next period of illness. The young person may care for their parent and other family members practically, through assuming responsibility for structuring the daily life of the family, fulfilling siblings' needs or household tasks, but also emotionally, in that their mind is occupied by issues related to their parent's wellbeing [12, 13]. These children also

experience frequent role reversal, as they help their parent manage symptoms of their mental illness, such as emotional distress or behavioural difficulties. This often leads to *parentification* and loss of focus on the child's needs by both the affected parent and the child themselves [9, 14].

The long-term impact of such experiences can be that children in this situation gradually form a view of the adults around them as having limited capabilities and therefore do not trust or expect adults to meet their needs. The responsibilities they believe they must fulfil themselves are a large burden for a young person to carry. These young people will often experience feelings of guilt in taking over the parent's role and inadequacy, while trying, and inevitably failing, to navigate such unrealistic responsibilities. This can also negatively impact their own self-esteem and sense of self-efficacy, and they may start to question their capabilities in other spheres of their life, which also has an adverse effect on their wellbeing. This combination of taking responsibility for others and worrying that they are not up to it is often carried into later life and causes hidden stress and sometimes prevents them from fulfilling their full potential [14, 15].

2.3 Shame and stigma

Children of parents with a mental illness and their families suffer from the shame and stigma surrounding mental illness in multiple ways [9, 14, 16]. It hinders communication about mental illness and emotions more generally within the family. It also hinders communication and the development of supportive bonds outside of the family, i.e., with extended family, community and other social networks. This leads to feelings of isolation and withdrawal from social interaction [9, 14]. As a result, many children of parents with a mental illness feel very different to their peers:

> *"Well, all of last week I wasn't in (school), because I was ill. I think, sometimes, my friends might think that I've been avoiding them, or bullies might think they have affected me so much that I'm not coming to school anymore." (Young boy, KidsTime Workshop)*

> *"So, it's nice to finally meet people that know how it feels, especially, like in school, barely anybody would have the same situation, but when I come to KidsTime, there's all these people around me that have similar situations to my family and me." (Teenage girl, KidsTime Workshop)*

Such shame, stigma and isolation, combined with children's imagination, means many of these children live with damaging fears and/or misconceptions about mental illness. For example, they fear they will "catch" their parent's illness, that they are predetermined to developing it themselves, or that they caused the illness or its symptoms [15, 16]. The shame, stigma, fear and isolation further decrease the likelihood that they will ask for help, advice or information that would reassure them and enable them to make sense of their situation and develop strategies for coping with it.

3. Protective factors

The KidsTime model is built on three principles in its work with children and families affected by parental mental illness and will be described in more detail in the next section [2, 11].

1. Having a good explanation

2. Having a trusted adult to talk to

3. Knowing you are not alone

3.1 The importance of a good explanation

Many children affected by parental mental illness report receiving little or no information or explanation about their parent's illness. Even at the point of hospitalisation, only ~1 in 3 young people receive any information about their parent's situation [17]. Not having an explanation or not understanding what is happening can be an unsettling experience in itself. However, young people who have been given an explanation often identify this as a key factor in helping them to cope with their situation. Receiving an explanation about their parent's mental illness could make a significant difference in helping affected children to feel more in control of their situation. It could also mitigate the impact or even prevent the development of frightening misconceptions about mental illness and the confusion and self-blame many young people feel about the origins of the illness and its symptoms. This would enable children to differentiate between their parent's "ill" and "non-ill" behaviours and thus also decrease the likelihood of adopting any of these behaviours themselves [13]. Having a good explanation is one of three protective factors identified by international research as key in building resilience for children whose parent/s have a mental illness.

There is a lack of specialist support for children affected by parental mental illness in the UK. These children may cross paths with multiple services, such as health services, children's social care, schools or professionals directly involved in their parent's psychiatric or social care. However, these professionals do not have the awareness or understanding of the unique experiences of children living with, or caring for, a parent with mental health issues and also often lack confidence in speaking to children about mental illness. The negative impact of this is twofold: Firstly, it reinforces these young people's disillusionment with adults as protective or supportive figures. Secondly, these young carers remain under the radar and are therefore unlikely to receive a satisfactory explanation or helpful support. However, the potential harm and many of the risks associated with having a parent with a mental illness can be addressed by training adults to provide good, child-friendly explanations and appropriate support, which increase the protective factors and develop the child's resilience, examples of which will be given in the following sections.

4. Specialist intervention: the KidsTime Workshops

Adverse childhood experiences (ACE) have recently become the focus of research and public discourse. However, despite its official recognition as an ACE, parental mental illness has been somewhat overlooked in this debate, and there is no recognition or provision for children affected by parental mental illness in England.

Our Time is a UK charity that was set up to advocate on behalf of this group through raising awareness of the issue and developing specific support through the KidsTime Workshop approach, which has been adopted across the UK, Germany and Spain. These are multi-family support groups that combine systemic family therapy approaches, drama and play to provide families with the three protective factors outlined above. There are currently 12 KidsTime Workshops operational in England, supporting up to 250 children and their families.

5. The KidsTime model

KidsTime Workshops take place once a month, after school, for ~2.5 h, and are run by a multidisciplinary team of at least three members of staff. The model requires the following critical staff members:

- Clinical Lead, with a clinical background working in mental health services (often a psychiatrist or clinical psychologist or family therapist)
- Drama Lead, who has experience in creative and drama-led group work with children
- Logistical Lead/Coordinator, responsible for managing referrals, engaging and supporting families to attend the workshop and logistics (venue, equipment, transportation, etc.)

5.1 Workshop structure

5.1.1 Seminar (adults and children together)

The group begins with all staff and families, (typically 6–10 families per workshop), coming together for a playful activity, followed by a seminar-style session that explores a single topic related to (parental) mental illness. The Clinical Lead facilitates this session using informal discussion and playful activities. Importantly, the particular topic will have been identified by the families themselves as something they want to discuss, for example, what to do in a crisis.

The KidsTime Workshops have developed a model for explaining mental illness to children. Explanations are provided by the Clinical Lead, which is relevant to the seminar topic (i.e., not at every workshop). The Clinical Lead will employ visual aids and clear, simple and child-friendly language to describe how the brain works and how it can become "overloaded" as well as other aspects of mental illness (e.g., side-effects of medication) without being a diagnosis specific. An example of this can be seen in the videos, "*What does it mean to have a parent with a mental illness?*" and, for younger children, "*Making sense of mental illness*", available on the Our Time website: www.ourtime.org.uk.

5.1.2 Group work (adults and children separate)

After the seminar, the families separate into two groups, one for adults and the other for children, which run in parallel for 1 h. The children's group is facilitated by the Drama Lead. It starts with group games to help the children relax and focus, followed by drama work during which the young people create, rehearse, perform, and film a dramatic scene. The drama content will often be related to the seminar topic, but it is important that the children are free to set and interpret the topic themselves. The drama allows the children and young people to address issues of interest or concern without having to expose their own personal situation, giving them a voice and a way to explore different perspectives and reactions to difficult family issues.

The adult group consists of the parents or carers (sometimes guardians, grandparents or close relatives), with or without a mental illness, and explores their experiences of being a parent with a mental illness or supporting the family in which this is the issue, sometimes using the seminar topic as a starting point. The

discussion is facilitated by the Clinical Lead who ensures that the experiences and needs of the children are a central focus. The adult group provides an opportunity for parents to talk more openly about their own experience and the challenges of parenting with a mental illness in a non-judgemental environment and to receive support and encouragement from one another.

5.1.3 Community time and reflection (adults and children together)

The children, parents and staff reunite after their respective groups for 30–45 min. First, everyone takes a break and shares food together (traditionally pizza because the children like it and it is easy to prepare). Then, everyone watches the film of the young people's drama, which leads to a collective group discussion about what the drama communicates and what insights the children and young people have demonstrated in their dramatisation. The parents contribute to the discussion by sharing a summary of their group discussion and their own reflections from watching the drama.

While the KidsTime Workshop model draws on some therapeutic methods and techniques, KidsTime is not designed as a form of therapy, but it is therapeutic in its effects. The design aims to create a community where the families can safely share their experience and knowledge and are listened to and able to ask the questions they need to ask without fear of judgement or having solutions imposed on them. The aim is to provide information, support and some relief to the families through a social intervention, while children and their needs remain the focus. Cooklin et al. state that an explicitly therapeutic intervention directed at the children may lead to the child seriously misjudging their predicament and adding to the sense that they (the child) are the problem and encourage further mistrust in adults [16] because they are not taken seriously. Firstly, the offer of therapy to the child may be falsely perceived as confirmation that they, like their parents, are going to develop a mental illness. Secondly, as these children will often adopt responsibilities beyond their years, in nature and volume, there is a risk that the child or young person would conclude that they are somehow failing to solve the problem or feel dismissed and undermined, if treated as a passive recipient of therapy. Therefore, the approach of professionals should aspire to take the role of an understanding, friend/mentor or relative rather than the formal and inevitably hierarchical role in which a therapist may be perceived.

> *"KidsTime has helped myself and my son to learn about my mental health, together. There's a great understanding of how they can help us, how they can help myself, my child, and, also, it's a place that you are accepted to have mental health (problems) and it not be a stigma. For the first time you can openly talk about any of your issues and concerns." (Mother, KidsTime)*

> *"Because it's somewhere where you can go to be with somebody that you know understands how you feel, and they might have the same situation too, and they just cheer you up, so it's a great place to go. Sometimes your parents are on medication or there is something wrong, so this just is a place to come to to calm you down." (Young boy, KidsTime)*

6. Key approaches

This section outlines some of the key approaches employed by the KidsTime model to achieve the desired protective factors, particularly and uniquely, an age-appropriate explanation of mental illness, its treatments and impact.

6.1 Systemic influences

The model views and encourages families to appreciate the systemic contributors to experiences; that the experience of each individual in the family results from their relationships with other members of the family; and what their feelings and thoughts about these relationships are. Based on this, the individual forms their view of themselves and perceptions of others. Bringing the whole family together to think about their situation and find ways of managing their lives in the context of the illness is one of the innovative and most powerful aspects of the model.

The KidsTime model recognises and aims to counter the potentially damaging effect of parental mental illness on the quality of social interactions within the family and with the wider social environment and support networks (other families and services, etc.) including social care providers, teachers and even the school. It aims to do so through facilitating communication between family members, with the focus of helping them understand the role of each person and the impact of parental mental illness on them. The model aims to promote social ties and trust between family members, neighbours and the general social world within which the family is located.

In general, families develop different patterns of internal communication and sharing of experiences. In families affected by parental mental illness, there is often little or no communication about the mental illness, due to shame and stigma, and a lack of understanding about mental illness [15, 16]. KidsTime Workshops aim to combat this stigma and social withdrawal by encouraging families to speak more freely about mental illness and finding creative ways to make this easier. Adapted systemic therapy methods, such as sculpture work, are used to help families visualise relationships and patterns of communication; this facilitates mutual reflection and discussion in the group helping them to identify their current patterns and how to develop healthier ones [18].

> *"My daughter, she was very quiet. She would sit in her room all the time and now, because of KidsTime, we can have half an hour to 45 minutes family time, and ask, "How has your day been?" and we can get a nice polite answer (from her). If anything does affect her, she can open up and get it off her chest, and if we can help, we can help." (Father, KidsTime)*

While the effect of parental mental illness on the children is the overarching focus of the parent and children's groups within the KidsTime model, parents' reactions to the impact of their illness are also actively discussed and considered. This results in children communicating their experiences to, and receiving feedback from, their family and the wider group (and vice versa), leading to a multi-systemic perspective rather than one-direction linear communication. This also leads to group interactions in which everyone is considered on the same level and equally able to contribute to discussion, thereby recognising the young people's knowledge and experience and the roles they perform within family life.

Also consistent with systemic approaches, the KidsTime model puts special emphasis on recognising and promoting families' capabilities. Families are respected as autonomous, self-organising systems and capable experts in their own situation. Within this, particular efforts are made to appreciate the young people's knowledge and expertise in their parent's mental health. Indeed, young carers will often notice signs of crisis or decline in their parents far earlier than the parent themselves or professionals. However, for a number of reasons that can be very frustrating and damaging for the child, this expertise is often invalidated in their interactions with the adults around them. Children and young people express

frustration that they are often the closest observer of the parent and have responsibilities beyond their years and yet are not consulted, listened to, and frequently talked over by professionals. This combination of shouldering adult responsibility and being treated as a child who has no information or insight is particularly difficult and leads to mistrust and resignation on the child's behalf, adding to the notion that they are on their own with the problem and that adults cannot be relied upon, which leads to hyper-independence. The KidsTime model aims to be realistic about the different family situations and challenges and to support and empower affected young people within their roles to develop appropriate coping strategies that will help them to understand and manage their own situation rather than "fixing" the problem for them and importantly knowing what to do in a time of crisis and developing a network of people to whom they can turn to for help when they notice that their parent's mental health is deteriorating. This means that awareness raising and the education of professionals is a key factor in supporting these children and young people.

6.2 Multi-family work

Multi-family work is based on systemic approaches; it aims to combine the benefits of single-family therapy with group therapy while still encouraging the agency of all individuals participating.

The coming together of families in similar situations has multiple benefits, particularly when the shared experiences are as stigmatised and hidden as those related to parental mental illness. It enables affected families to discuss mental health issues without one child, parent or family feeling exposed, judged or different. It is also crucial that facilitators do not single anyone out. The KidsTime Workshop model encourages openness and reflection, and, through conversations about mental illness and common experiences, it reduces the often-associated stigma and shame-induced isolation. Unlike in the outside world, at KidsTime, the individuals and families are no longer the odd ones out:

> *"Since we've been coming here for a year and a half they (the children) get to see other children with parents with mental health (problems), and there's other families in same situation, so they don't feel so alone, because, I think, before, they thought our family was really strange. They've seen other people the same as us." (Mother, KidsTime)*

Multi-family work, in this context, is intended to enable solidarity and a sense of community between families, a sense that "we are all in this together". The individual family is viewed as part of the wider system of multiple families—a system that all families contribute to and benefit from. The families build a social network and mutually support each other. One of the most powerful ways in which this happens is the socialising and exchanging of experiences, ideas and advice facilitated by the multi-family model. In the KidsTime Workshop, families use each other as resources. Sharing in a multi-family group means they learn from each other's experiences and perspectives and are empowered to make changes themselves. In this sense, the multi-family model is intended to contribute towards helping families to help themselves; it allows individual parents and children to hear both positive and corrective responses from other adults and children, which may be both more acceptable and meaningful than comments from professionals [16, 18].

Actively involving families in discussion of similar problems in other families strengthens the self-esteem and agency of all involved. When experiencing difficulties, people tend to develop rigid and narrow ways of problem solving but are

still often able to offer useful ideas to others in similar situations. Drawing on the expertise and experiences of families in similar situations leads to families viewing themselves more positively, as more capable. This strengthens self-esteem and the family's sense of agency and for the adults, in particular, a sense of pride as capable parents. In turn, this may enable families to become more resourceful and creative in finding solutions for their own difficulties [18]. Thus, the group becomes more powerful than any single therapist.

6.3 Drama work

Methods of creative therapy and drama work are powerful tools in creating a playful attitude and a relaxed, light-hearted atmosphere. This facilitates young people to have fun and foster positive relationships with each other and their families. It is within this type of setting that the young people are able to relax and to engage with drama as a powerful, therapeutic tool in the ways outlined below. Children of parents with a mental illness are often highly anxious and stressed, and the drama and games, first and foremost, allow them to forget their worries and just have fun, to be a child and to be able to play like a child, free from the burden of looking out for their parents, because they are safe in the parent's group.

In the young people's group, playful exercises are combined with devising and acting out fictional scenes together. Designing the content of these dramas acts as a channel of free expression for fear, anger and anxiety or other difficult emotions that a young carer may struggle to access and express in daily life. The invention of fictional characters also means children can choose to play out different perspectives and new narratives—ideals of who they want to be. This encourages optimism and gives them a sense of control over their situation, thereby enhancing their self-esteem and trust in their ability to take action.

While the dramas do address parental mental illness, they often do so in an indirect or metaphorical way. They allow the children to differentiate from the illness, exploring it from a removed and outside perspective and not getting caught up in it. Indeed, the staff are careful not to lead the young people into sharing their specific experiences, as the drama work is intended to act as a helpful tool to enable young people to explore their experiences from a distance, to make up stories and create roles that focus on general aspects of mental illness and crisis.

The dramas tend to capture the everyday experiences of the children and, in a more or less explicit way, the impact of their parent's mental illness. The dramas are filmed and played back to parents and staff and therefore serve as an effective channel for young people to communicate their experiences and fears. Moreover, the themes and experiences depicted in the dramas are not owned by one person; they are devised, played out and therefore communicated, as a group; this feels safer and less threatening for the young people to express and for the adults to receive.

The dramas are also useful in communicating important messages and explanations of mental illness to young people. The KidsTime model emphasises that explanations should address and challenge presumptions and fears that young people have about mental illness, for example, that they might "catch the illness themselves", which the dramas frequently illustrate. In order to reduce rigid ideas and fears about mental illness in young people, the dramas should also present mental illness as a changeable process rather than as a fixed, constant entity. Including the subject of mental illness in dynamic dramas is particularly useful as it depicts mental illnesses through characters' experiences rather than through listing signs and symptoms of diagnostic criteria.

The drama work contributes to the aim of the workshops in creating a space where "kids can be kids". The drama is part of a predictable and secure structure

within which children do not take the lead, do not have to feel responsible and are thus able to relax and play in their more age-appropriate roles. In this way, the drama work enables the team to strike the important balance between the serious and the playful. The overall aim of the workshops is to provide a relaxed environment within which young people can explore and recognise their own roles, and the challenges within these, and have this validated by others while remaining optimistic and hopeful for the future. At KidsTime, young people are encouraged to recognise their successes and strengths despite their difficult situation and to have fun while doing so, which is enabled by creating an environment where they can engage in more age-appropriate roles and activities. The ability to play is a fundamental aspect of psychological health and creativity, and this is built into the method. It is noticeable that when children first come into the workshop, the ability to join in and play is very low but grows quite quickly once they feel safe.

> *"It's good, because we get to play games, and parents get to go upstairs, and we get to stay downstairs and have some fun."*
>
> *"KidsTime is a good place to go because you get to play games, run about, have fun and have pizza."*
>
> *"KidsTime is a wonderful place to go and you can express your feelings."*
> *(Testimonies from young children, KidsTime)*

6.3.1 KidsTime participant (aged 17)

> *"People think depression is when you feel low and want to kill yourself. But there is so much more to it than that. My mum has schizoaffective disorder. That means she gets schizophrenia symptoms, such as hallucinations, and mood disorder symptoms, including mania and depression. She mixes up reality with imagination. She takes antidepressants and sleeping pills but there is often no way of knowing what state she is going to be in.*
>
> *My dad found out about KidsTime when he was looking for ways to help me. I already knew about my mum's illness, but it was good to know that there are people who, like me, have to remind their parents to shower and eat.*
>
> *People say mental illness is invisible, but you can usually tell by the look on someone's face or the way they are not keeping up with personal hygiene that they are unwell. Being a carer for my mum is not a bad thing, but it is a responsibility. I know that sometimes she does not want to talk she just wants me to sit with her. The annoying thing is that because I have lived with my mum, I can usually tell when other people are down as well. You start to feel guilty if the people around you are not happy, which is illogical, but I cannot help it. That is one of the things we have talked about at KidsTime—the burden of having that insight. My school and college mates do not understand that, but with my friends from KidsTime we can just jump straight into a deep conversation, and that means a lot to me."*

7. Impact and evaluation of the KidsTime Workshops

To date, several evaluations of the KidsTime Workshops have been carried out, using a variety of methodologies, the findings of which are summarised in the

following paragraphs. As a general rule, individual feedback forms are completed by the adults and children after each workshop. A study of the German KidsTime Workshops found that [19]:

- 95% of families submitting evaluations stated they benefited from attending the workshops and wanted to continue attending.

- All family members stated they had learned something new about mental illness at the workshops and that the workshops helped them to talk about mental illness within and outside of their families.

- Watching and reflecting on the children's drama film, as well as the multi-family group format (particularly the feeling of solidarity among families) were viewed as helpful catalysts in enabling the open discussion of issues that may have been perceived as being too "shameful" to talk about outside of the group.

Similar themes were present in the children's feedback; however, the most important impact for children was the sense of freedom they experienced in being able to return some of the responsibility to adults they could trust and talk to and in connecting with adults in a more positive way, challenging their previous thoughts and feelings about adults and professionals coming into contact with them and their families. The feedback especially highlighted how children experienced KidsTime Workshops as a secure framework within which they could act more freely [19].

In England, an evaluation by the Anna Freud Centre for Children and Families found that the workshops increased understanding of mental illness, improved parent-child relationships, reduced feelings of fear, shame and isolation and boosted confidence in children and young people [2, 11]. Due to the nuances and the number of factors at play within the workshops, Our Time has found that case studies are a useful tool in understanding the impact of these interventions on children and families. An analysis of recent family case studies in England has identified the following key themes: Rise in confidence among children and young people, improved relationships within and outside of the family, making new friendships and increased knowledge and understanding of mental illness.

Findings from the different evaluations undertaken to date demonstrate that the strength of the workshops lies in their ability to facilitate communication and positive relationship building within and outside of the family, providing effective peer support for children and parents and, in tackling the shame, stigma and misconceptions surrounding mental illness, reducing feelings of fear and isolation and raising young people's confidence and self-esteem [2, 11, 19].

8. The case for investing in preventative approaches

A common barrier to setting up and maintaining a KidsTime Workshop is securing funding for a preventative model. The fundamental rationale for the workshops is to prevent young people from developing psychopathology themselves. However, funding for support for people who do not have a formal diagnosis is almost impossible to obtain within curative and risk-oriented medical systems, which are often the result of restrictive fiscal policies that will only allocate funding for critical interventions. However, what such policies and approaches fail to address is that, without appropriate universal, preventative support in place beneath thresholds for critical services, the demand for these services will continue to grow at an alarming rate, leading to significantly increased costs in the medium to long term.

In relation to children of parents with a mental illness, the stakes are high. An estimated 3.4 million children and young people in the UK live with a parent with a mental illness. 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 [6]. For example, if a quarter of these young people develop depression by 2021, the projected cost to the UK government could be up to £470 million [5]. 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 and crime and violence [2–5, 10]. Consequently, without intervention, the long-term prospects are bleak, and the cost of doing nothing could amount to £17 billion per year in the UK alone [20]. In comparison, the cost of preventative approaches is relatively small. To give an example, in England, it costs ~£2000 per family, per year, to take part in a monthly KidsTime Workshop, while an initial assessment by Child and Adolescent Mental Health Services costs £700 per child, prior to any intervention taking place.

While the case for prevention is clear, support for early intervention requires a culture shift across the health, social care and education system, which can only be achieved through policy change and the allocation of appropriate funds to facilitate this at a more local level. This will have to include training and awareness raising for professionals who deal with children in the course of their work, including adult mental health professionals. For this reason, organisations such as Our Time are campaigning for government to count the numbers of children affected by parental mental illness and to invest in prevention to help break the cycle of intergenerational mental illness.

9. Conclusion and recommendations for practice

This chapter has provided an overview of the workings and impact of multi-family approaches in supporting families affected by parental mental illness, using the KidsTime Workshops as a case study example. It has described the benefits of a more informal and non-therapeutic, multi-family intervention in helping children and families to understand and communicate about mental illness. As well as highlighting the potential risks associated with having a parent with a mental illness, it has demonstrated the power of receiving a clear explanation in helping children to understand and cope with their situation. Access to a supportive and non-judgmental environment where families can share experiences and talk to others in the same situation has been identified as a key protective factor for children and their parents, as illustrated in the feedback and testimonials from families listed in this article. Recommendations for professionals and practitioners working with children and young people affected by parental mental illness are to:

- Notice these children, and recognise the role they play in caring for their parents.
- Recognise and acknowledge that they are experts in their family situation, with often very advanced knowledge and insight into their parent's illness and/or behaviours.
- Provide children with clear explanations of their parent's illness and what is happening to the parent and for the reasons behind decisions (e.g., when a parent is hospitalised).

- Recognise that these children may fear or reject traditional interventions. Ask children what would help and listen to what they have to say, so that any support offered does not undermine or further isolate the child or young person.

Those interested in trialling multi-family interventions for children affected by parental mental illness should pay attention to the following principles:

- Create a relaxed, safe and supportive environment that is welcoming for parents and children.
- Avoid imposing traditional hierarchical structures, i.e., of professional and patient, and, instead, encourage staff to adopt the role of a friendly helper to facilitate trust and communication within and outside of the family.
- Provide clear age-appropriate explanations for mental illness.
- Use a range of creative methods, such as drama, to engage and make it a fun experience for children, to enable exploration of the subject from different perspectives and to encourage reflection.

Further information and guidance about the KidsTime model, including how to set up a KidsTime Workshop, is available on the Our Time website: www.ourtime.org.uk.

Author details

Klaus Henner Spierling[1*], Kirsty Tahta-Wraith[2], Helena Kulikowska[2] and Dympna Cunnane[2]

1 Agaplesion Diakonieklinikum, Rotenburg, Germany

2 Our Time, London, England

*Address all correspondence to: h.spierling@diako-online.de

References

[1] Wiegand-Grefe S, Jeske J, Bullinger M, Plass A, Petermann F. Lebensqualität von Kindern psychisch kranker Eltern. Zusammenhänge zwischen Merkmalen elterlicher Erkrankung und gesundheitsbezogener Lebensqualität der Kinder aus Elternsicht. Z f Psychiatrie, Psychologie und Psychotherapie. 2010;**58**(4):315-322

[2] Cooklin A. Promoting children's resilience to parental mental illness: Engaging the child's thinking. Advances in Psychiatric Treatment. May 2013;**19**(3):229-240

[3] Children's Commissioner Vulnerability Report. 2018

[4] Welsh Adverse Childhood Experiences (ACE) study. Public Health Wales. Centre for Public Health, Liverpool John Moores University; 2015

[5] Ernst and Young. Sizing the Problem—Analysis. Our Time

[6] Rubovits PC. Project CHILD: An intervention programme for psychotic mothers and their children. 1996

[7] Effective Interventions and Policy Options, WHO (2004). Parents with Mental Disorders and Mental Health Fact Sheet 2016. Available from: www.who.int/mediacentre/factsheets.f220/en/

[8] Hetherington R, Baistow K, Katz I, Trowell J. The Welfare of Children with mentally ill parents: Learning from Inter-country comparisons WHO paper. 2001

[9] Mattejat F, Remschmidt H. Kinder psychisch kranker Eltern. Deutsches Ärzteblatt. 2008;**105**(23):413-418

[10] Felitti Vincent J, Robert A, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The adverse childhood experiences (ACE) study. American Journal of Preventative Medicine. 1998;**14**(4):245-258

[11] Evaluation Report of KidsTime Workshops, Anna Freud Centre, (2010-2011). KidsTime Workshop Manual, & Wolpert. An exploration of the experience of attending the KidsTime programme for children with parents with enduring 7 mental health issues: Parents' and young people's views, Clinical Child Psychology and Psychiatry; 2014

[12] Wiegand-Grefe S, Cronemeyer B, Plass A, Schulte-Markwort M, Petermann F. Psychische Auffälligkeiten von Kindern psychisch kranker Eltern im Perspektivenvergleich. Kindheit und Entwicklung. 2013;**22**(1):31-40

[13] Cooklin A, Cunnane D. Learning from the kidstime model. Rotenburg: Conference bag-kipe; 2018

[14] Wagenblass U. Risiko-und Schutzfaktoren bei Kindern psychisch kranker Eltern. In: Vortrag im Rahmen der Fachtagung vom Runden Tisch in Braunschweig: Frühe Kindheit—Frühe Hilfen; 2009. Im Web: https://wwwvhs-braunschweigde/vhshdf/downloads/hdf-fachtagung/Prof-Dr-Wagenblass_15-05-09pdf [Zugriff: 4 November 2015]

[15] Wiegand-Grefe S, Halverscheid S, Plass A. Kinder und ihre psychisch kranken Eltern. Familienorientierte Prävention—Der CHIMPs-Beratungsansatz. Göttingen: Hogrefe; 2011

[16] Cooklin A, Bishop P, Francis D, Fagin L, Asen E. The Kidstime Workshops. A Multi-Family Intervention for the Effects of Parental Mental Illness. London: CMHS Publications; 2012

[17] Bohus M, Schehr K, Berger-Sallawitz F, Novelli-Fischer U, Stieglitz R, Berger M. Kinder psychisch kranker Eltern. Eine Untersuchung zum Problembewußtsein im klinischen Alltag. Psychiatrische Praxis. 1998;**25**:134-138

[18] Asen E, Scholz M. Praxis der Multifamilientherapie. Heidelberg: Carl-Auer; 2012

[19] Spierling KH. Kidstime workshops—ein Projekt mit Multifamilienarbeit für Familien mit psychisch erkrankten Elternteilen. Systeme. 2016;**30**(1):54-74

[20] The Cost of Late Intervention: Early Intervention Foundation Analysis. 2016